Public Board meeting

Thu 01 February 2024, 09:30 - 12:30

Pinewood House Education Centre

NHS Stockport NHS Foundation Trust

Agenda

09:30 - 09:30
0 min

1. Apologies for absence

09:30 - 09:30
0 min

2. Declaration of Interests

09:30 - 09:35
5 min

3. Patient Story

09:35 - 09:35
0 min

4. Minutes of Previous Meeting held on 7 December 2023 (Paper)

Marisa Logan-Ward

- 04 - Public Board Minutes - 7 Dec 2023.pdf (14 pages)

09:35 - 09:40
5 min

5. Action Log (Paper)

Information *Marisa Logan-Ward*

- 05 - Public Board Action Log - February 2024.pdf (2 pages)

09:40 - 09:50
10 min

6. Annual CNST Board Declaration (Paper)

Decision *Nicola Firth*

- 06a - Board of Directors CNST YR 5 Submission.pdf (8 pages)
- 06b - Annexe A Compensatory Rest Evidence.pdf (4 pages)
- 06c - Annexe B CNST YR 5 Action Plan for Compensatory Rest Period.pdf (1 pages)
- 06d - Annexe C - Stockport Neonatal Workforce CNST Action Plan December 2023.pdf (4 pages)
- 06e - Annexe D - Action Plan - Safety Action 5 One to One Care in Labour.pdf (2 pages)
- 06f - Annexe E Copy of CNST Y5 Action Plan.pdf (2 pages)
- 06g - Annexe F Copy of MIS YR 5 Board Declaration.pdf (23 pages)

09:50 - 10:00
10 min

7. Chair's Report (Paper)

Discussion *Marisa Logan-Ward*

- 07 - Chairs Report - February 2024.pdf (4 pages)

10:00 - 10:10
10 min

8. Chief Executive's Report (Paper)

Discussion *Karen James*

08 - Chief Executive Report - February 2024.pdf (6 pages)

PERFORMANCE

10:10 - 10:30
20 min

9. Integrated Performance Report (Paper)

Discussion *Karen James / Executive Leads*

- Quality
- Operational Performance
- Workforce
- Finance

09a - Integrated Performance Report - Front Sheet - February 2024.pdf (2 pages)
09b - Integrated Performance Report (Dec 23 data) - Final.pdf (21 pages)

10:30 - 10:45
15 min

10. Finance Report - Financial Position Month 9 (Paper)

Discussion *John Graham*

10a - Financial Position Report Month 9 2023-24 - Front Sheet.pdf (3 pages)
10b - Financial Position 2023-24 M9.pdf (11 pages)

PEOPLE

10:45 - 10:55
10 min

11. Well Being Guardian Report (Verbal)

Discussion *Marisa Logan-Ward*

10:55 - 11:10
15 min

12. Integrated People & Organisational Development Plan Progress Report (Paper)

Discussion *Amanda Bromley*

12 - People & OD Plan Update - February 2024.pdf (7 pages)

11:10 - 11:20
10 min

13. Annual Nursing & Midwifery Establishment Review (Paper)

Discussion *Nicola Firth*

13 - Annual Nursing & Midwifery Establishment Review.pdf (9 pages)

11:20 - 11:30
10 min

14. Safer Staffing Report (Paper)

Discussion *Nicola Firth / Andrew Loughney*

14a - Safer Staffing Report.pdf (2 pages)
14b - Safer Staffing Report - January 2024.pdf (26 pages)

11:30 - 11:40
10 min

COMFORT BREAK

QUALITY

11:40 - 11:50
10 min

15. EPRR Update - NHS England Core Standards (Paper)

Discussion *John Graham*

- 15a - EPRR Update - NHS England Core Standards.pdf (4 pages)
- 15b - EPRR Core Standards Self Assessment Action Plan 2023 24.pdf (4 pages)

GOVERNANCE

11:50 - 12:00
10 min

16. Board Assurance Framework - Q3 2023/24 (Paper)

Decision *Karen James*

- 16a - Board Assurance Framework Q3 2023-24 - Front Sheet.pdf (5 pages)
- 16b - Appendix 1 - Board Assurance Framework Q3 2023-24.pdf (20 pages)
- 16c - Appendix 2 - Significant Risk Register (January 2024).pdf (2 pages)

12:00 - 12:10
10 min

17. Standards of Business Conduct:

Decision *Rebecca McCarthy*

17.1. Non-Executive Director Independence (Paper)

- 17.1 - Independence of Non-Executive Directors 2023-24.pdf (5 pages)

17.2. Board of Directors Declarations of Interest (Paper)

- 17.2 - Directors Register of Interests 2023-24.pdf (6 pages)

17.3. Annual Fit & Proper Person Review (Paper)

- 17.3a - Fit & Proper Persons Requirement 2023-24.pdf (5 pages)
- 17.3b - Appendix 1 - DRAFT Fit & Proper Persons Policy - January 2024.pdf (38 pages)
- 17.3c - Appendix 2 - Annual NHS Fit & Proper Person Test (FPPT) Submission Form.pdf (5 pages)

STANDING COMMITTEE REPORTS

12:10 - 12:30
20 min

18. Board Committees - Key Issues Reports:

Discussion

- 18a - Board Standing Committees Key Issues Reports - Front Sheet.pdf (2 pages)

18.1. People Performance Committee (Paper)

Beatrice Fraenkel

- 18b - People Performance Committee - Key Issues Report - January 2024.pdf (3 pages)

18.2. Finance & Performance Committee (Paper)

Anthony Bell

- 18c - Finance & Performance Committee - Key Issues Report - January 2024.pdf (4 pages)

18.3. Quality Committee (Paper)

Mary Moore

18d - Quality Committee - Key Issues Report - January 2024.pdf (3 pages)

CLOSING MATTERS

12:30 - 12:30
0 min

19. Any Other Business

DATE, TIME & VENUE OF NEXT MEETING

12:30 - 12:30
0 min

20. Thursday, 4 April 2024, 9.30am, Pinewood House Education Centre

12:30 - 12:30
0 min

21. Resolution:

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

NHS Stockport NHS Foundation Trust

STOCKPORT NHS FOUNDATION TRUST
Minutes of a meeting of the Board of Directors held in public
Held on Thursday 7 December 2023, at 9.30am in Pinewood House Education Centre, Stepping Hill Hospital

Members Present:

Prof Tony Warne	Chair
Mr Anthony Bell	Non-Executive Director
Mrs Amanda Bromley	Director of People & Organisational Development
Mrs Nicola Firth	Chief Nurse
Mrs Beatrice Fraenkel	Non-Executive Director
Mr John Graham	Chief Finance Officer / Deputy Chief Executive
Mr David Hopewell	Non-Executive Director
Mrs Karen James	Chief Executive
Dr Andrew Loughney	Medical Director
Mrs Mary Moore	Non-Executive Director
Dr Louise Sell	Non-Executive Director
Mr Meb Vadiya	Associate Non-Executive Director *

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

Quorate: Yes

In attendance:

Mrs Soile Curtis	Deputy Trust Secretary
Mrs Rebecca McCarthy	Trust Secretary
Ms Caroline Simpson	Chief Executive, Stockport MBC
Ms Angela Brierley	Director of Transformation
Ms Hannah Silcock	Head of Transformation
Mr Peter Nuttall	Director of Informatics
Mrs Helen O'Brien	Head of Communications
Mr Tom Finnigan	Guardian of Safe Working

Observing:

Mrs Sue Alting	Lead Governor
Mr Paul McCrory	Member of the public

Apologies:

Dr Samira Anane	Non-Executive Director
Dr Marisa Logan-Ward	Non-Executive Director / Deputy Chair
Mrs Jackie McShane	Director of Operations
Mrs Caroline Parnell	Director of Communications & Corporate Affairs*

** indicates a non-voting member*

REF No/Yr.	ITEM	ACTION OWNER
136/23	**Apologies for Absence** The Chair welcomed everyone to the meeting. Apologies for absence were noted as above.	

	The Chair advised that this would be the last Board meeting attended by Mr Meb Vadiya, Associate Non-Executive Director. The Board of Directors thanked Mr Vadia for his contribution to the Board of Directors and expressed their best wishes for the future.	
137/23	**Declarations of Interest** There were no declarations of interest.	
138/23	**Patient / Staff Story** The Board of Directors watched a video outlining support offered by the Trust's chaplaincy and spiritual care service to parents who had lost babies. The Board heard that the baby loss service facilitated by the chaplaincy also provided an opportunity for families to support each other. It was noted that monthly memorial services were held at the hospital chapel and streamed online, and an annual service was held at St George's Church in Stockport. **The Board of Directors received and noted the Patient Story and acknowledged the value of the baby loss service to the community.**	
139/23	**Minutes of Previous Meeting** The minutes of the previous meeting held on 5 October 2023 were agreed as a true and accurate record.	
140/23	**Action Log** The action log was reviewed and annotated accordingly.	
141/23	**Chair's Report** The Chair presented a report reflecting on recent activities within the Trust and the wider health and care system. The Board of Directors received an update on external partnerships, Trust activities and strengthening Board oversight. The Chair highlighted the sad passing of two great supporters of the Trust, John Pantall, Public Governor, and Imelda Mounfield, who with her husband had raised significant funds for the Trust Charity. The Board of Directors conveyed its condolences to both families. **The Board of Directors received and noted the Chair's Report.**	
142/23	**Chief Executive's Report** The Chief Executive presented a report providing an update on local and national strategic and operational developments, including: • Addressing financial challenges • New Secretary of State • Reinforced Aerated Autoclaved Concrete (RAAC) capital scheme • Outpatients B closure • New laboratory information system • Martha's Rule • Innovation bid • Cadets and student nurses • Menopause clinic	

	• Making a Difference Everyday (MADE) awards • LGBT Champion • Allied Health Professional of the Year • Unsung Hero **The Board of Directors received and noted the Chief Executive's Report.**	
143/23	**One Stockport: One Future** The Board of Directors welcomed Ms Caroline Simpson, Chief Executive of Stockport Metropolitan Borough Council (SMBC), to the meeting. The SMBC Chief Executive delivered a presentation, advising that the One Stockport Borough Plan had been launched in March 2021, following engagement with locality partners, including the Trust. The Board heard that the Borough Plan set out a collective future vision for Stockport, comprising shared ambitions of 'One Heart, One Home, and One Future'. The SMBC Chief Executive advised that the One Stockport: One Future Plan marked the next phase of the journey, focusing on the 'One Future' element of the plan over the next 15 years. The Board heard that the following '5 big things' had been identified with the aim to collaboratively transform Stockport to make it the best place to live: • Good jobs and homes • Best place to grow up • Best health and care • Thriving neighbourhoods • Clean, green transport. The SMBC Chief Executive invited Board members to provide feedback on the One Stockport: One Future plan, including delivery of the 5 big things, noting that the plan was due to be launched in March 2024, including deliverables and outcome measures to ensure the plan was delivering intended benefits. Board members welcomed the plan and the presentation. Mr Tony Bell, Non-Executive Director, noted the importance of ensuring that there were skilled people in Stockport to fill in the opportunities provided, including employment and housing. The Director of People & Organisational Development (OD) confirmed that the 'growing our own workforce' element was being considered by a joined group with One Stockport, forming an important part of the collaboration. Mrs Beatrice Fraenkel, Non-Executive Director, highlighted the importance of partnerships, including clarity required of each partners roles in delivering the plan, and supporting each other in the context of changing healthcare. The Medical Director stressed the importance of ensuring that physical and mental health were given equal footing in the plans. Dr Louise Sell, Non-Executive Director, queried if local faith and community groups had been engaged in the development of the plan. The SMBC Chief Executive highlighted engagement with other stakeholders that had taken place to date, including engagement with the voluntary, community and faith sector.	

	The Chief Nurse welcomed the partnership working and noted the importance of green spaces, particularly in the context of mental health, wellbeing of people and families, and reducing obesity. The Chief Finance Officer reflected on the return of investment and how this could be quantified from a wider economic perspective, with a focus on getting the best value of the Stockport pound. Mr David Hopewell, Non-Executive Director, queried any barriers to the plan delivery and what the unique selling point (USP) was for Stockport. With regard to the barriers and challenges, the SMBC Chief Executive highlighted the requirement for significant investment. She welcomed the positive collective vision between the Stockport partners and noted that Stockport's geographic location and growing business community was one of its USPs. The Chair thanked the SMBC Chief Executive for the presentation and affirmed the Board's commitment to working alongside the SMBC and system partners in taking the plan forward. **The Board of Directors received and noted the One Stockport: One Future presentation and affirmed its support to progressing the plans.** *The SMBC Chief Executive left the meeting*	
144/23	**Annual Emergency Preparedness, Resilience and Response (EPRR) Report – Core Standards and Statement of Compliance** The Chief Finance Officer presented the Annual EPRR Report, providing oversight of the improvements made in emergency preparedness and action required to ensure the Trust achieves full compliance with the core standards by April 2024. The Board of Directors acknowledged that the past couple of years had been particularly challenging with regard to resilience and business continuity. The Chief Finance Officer noted positive progress made with the recruitment of a substantive EPRR Manager, which would be a joint appointment with Tameside & Glossop Integrated Care NHS Foundation Trust. **The Board of Directors approved the Annual EPRR Report, including compliance position with the core standards.**	
145/23	**Ratification: Quarter 4 Revenue PDC Support Submission to NHS England** The Chief Finance Officer presented a Revenue Support Public Dividend Cash (PDC) Application Report. It was noted that to ensure the application for £16m PDC Revenue Support could be submitted by the 1 December 2023 deadline, following review and support by Finance & Performance Committee, the Board of Directors virtually approved the application. The Chief Finance Officer briefed the Board on the content of the report and highlighted the daily defensive cash measures taken by the Trust. Further to the Board Resolution approving the Revenue Support Application	

	process and in accordance with NHSE requirement for challenge to plans, the Board of Directors was asked to ratify the virtual approval of the application for £16m PDC revenue support in Q4 2023/24. **The Board of Directors received and noted the report and ratified the virtual approval of the application for £16m PDC revenue support in Q4 2023/24.**	
146/23	**Transformation:** • **Continuous Improvement Strategy** • **NHS Improving Patient Care Together (IMPACT) Assurance Report** The Board of Directors welcomed the Director of Transformation and Head of Transformation to the meeting. The Board received a report outlining a new draft joint Continuous Improvement Strategy for Stockport NHS Foundation Trust (SFT) and Tameside & Glossop Integrated Care NHS Foundation Trust (TGICFT), with an aim to supporting both organisations build an improvement culture of continuous improvement. The Director of Transformation and Head of Transformation briefed the Board on the content of the report, highlighting the shared ambitions over the next three years to embed a culture of continuous improvement and provide our workforce with the skills, knowledge and support required to continue to deliver cutting edge services. The Board received a further report regarding the NHS IMPACT Framework launched by NHSE in September 2023, describing how the Trust would meet the following five principles through the newly developed Continuous Improvement Strategy: - Building a shared purpose and vision - Investing in people and culture - Developing leadership behaviours - Building improvement capability and capacity - Embedding improvement into management systems and processes The Chair expressed view regarding terminology used within the report, commenting that the schemes referred to in the reports tended to relate to service improvements rather than transformation. He also highlighted the importance of ensuring the ambitions of the Continuous Improvement Strategy were interlinked with other Trust strategies, including the Organisational Development and Communications Strategies. Mr Tony Bell, Non-Executive Director, welcomed the engagement at the recent transformation event. He commented, however, that he did not feel the Continuous Improvement Strategy addressed the more significant transformational schemes required to safeguard the future sustainability of the organisation. The Director of Transformation highlighted the locality-wide programmes in place around the four key priorities: frailty, diabetes, cardiovascular and alcohol related harms. The Chief Executive acknowledged that the alignment with the developing GM-wide strategic schemes could be further articulated in the reports.	

	Mrs Beatrice Fraenkel, Non-Executive Director, highlighted the importance of strategic understanding and how that line of sight, including the understanding of risk, sits within our reporting. Dr Louise Sell, Non-Executive Director, commented on the importance of the system partnership work being resourced appropriately to enable delivery of the ambitions. The Director of Transformation highlighted some gaps in locality roles, albeit progress was being made with support being allocated to programmes. Furthermore, the need for transformative and creative thinking following the Outpatient B closure was highlighted. The Medical Director welcomed the Continuous Improvement Strategy, noting the need for alignment with the Clinical and Research & Development Strategies. Board members highlighted the importance of celebrating successes and measuring impact to build momentum and increase appetite for transformational work. The Chair summarised the discussion, noting the need for further alignment between the Continuous Improvement Strategy and other Trust strategies and GM-wide transformational schemes. **The Board of Directors received and noted the Transformation reports.** *The Director of Transformation and Head of Transformation left the meeting*	
147/23	**Digital Strategy Progress Report** The Board welcomed the Director of Informatics to the meeting. The Director of Informatics presented a report providing a 6-monthly update on the delivery of the Trust's Digital Strategy, which had been approved by the Board of Directors in December 2021. He briefed the Board on the content of the report and provided a detailed progress update against the seven 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 The Board heard that overall, the delivery of the Digital Strategy was progressing well, albeit slow progress was noted with regard to the Electronic Patient Record (EPR) programme. It was noted that further clarity was awaited regarding timelines, and that the EPR business case would go through the relevant governance process in due course. Mr Tony Bell, Non-Executive Director, advised that in reviewing the Digital Strategy Progress Report, the Finance & Performance Committee had requested further detail about outcome measures to be included in the next 6-monthly update report.	

	In response to a question from the Chair regarding clinical engagement, the Director of Informatics confirmed positive engagement with clinicians. The Chief Nurse and Medical Director endorsed the efforts made in this area, noting a consequent positive impact on patient care. With regard to the development of the patient portal, the Director of Informatics advised that TGICFT was a pilot site for the portal, and once the pilot had been successfully completed, the system would be rolled out across GM. In response to a question from Mrs Beatrice Fraenkel, Non-Executive Director, about the use of artificial intelligence (AI) in flagging up patient safety issues, the Director of Informatics noted that the Trust was participating in projects in this area, albeit was not leading in this field due to the specific expertise needed. In reference to AI, the Medical Director highlighted the need to ensure robust governance arrangements were in place ahead of introducing any new technology as diagnostic tools relating to decision making. In response to a question from Mrs Beatrice Fraenkel, Non-Executive Director, regarding progress around inter-connectivity of patient information across the whole system, the Chief Executive advised that the digital arm of Health Innovation Manchester considered digital issues across GM, including system integration. The Director of Informatics commented that the patient record portal would be an important development in this area, providing a concrete output of collaboration between providers and primary care. Dr Louise Sell, Non-Executive Director, queried if the Trust had structured guidance about the safety and effectiveness of different types of consultation, including face to face, video and telephone. The Director of Informatics noted that the Trust did not have a specific policy in this area. In response to a comment from Mrs Mary Moore, Non-Executive Director, about the need to consider accessibility issues for virtual consultations, including for those who are hard of hearing, it was noted that this would be reviewed as part of the IT strategy, on a specialty by specialty basis. Dr Louise Sell, Non-Executive Director, suggested that locality-wide consideration should also be given to having community hubs for people who did not have good internet connection at home. **The Board of Directors received and noted the Digital Strategy Progress Report.** *The Director of Informatics left the meeting*	
148/23	**Communications & Engagement Strategy Progress Report** The Board welcomed the Head of Communications to the meeting. The Head of Communications presented a report providing an update on the delivery of the Communications & Engagement Strategy 2023-2026. The Head of Communications briefed the Board on key achievements in delivering the 2023/24 objectives and noted operational pressures and demand for communications support that had adversely impacted on full plan delivery, thus some activities would now be taken forward to 2024/25. The Board heard that the Communications Team's focus for the remainder of the	

	year would be maintaining existing Trust communication channels and delivering the re-development of the Trust's website. The Chair suggested that consideration should be given to closer working of the Communications Team and Transformation Team to combine resources in an impactful way, and enable greater engagement with colleagues and communication of transformational developments. **The Board of Directors received and noted the Communications & Engagement Strategy Progress Report** *The Head of Communications left the meeting*	
149/23	**Integrated Performance Report** The Chief Executive introduced the Integrated Performance Report (IPR), which included exception reports for areas of most significant note. **Operational** The Chief Executive presented the operational performance section of the IPR and highlighted challenges and mitigating actions regarding Emergency Department (ED) performance, patient flow, diagnostics, cancer, Referral to Treatment (RTT), outpatient efficiency, and theatre efficiency metrics due to under-achievement in month. The Chief Executive reported that current performance against the ED 4-hour standard continued to benchmark well across Greater Manchester (GM), with Stockport ranking third for type-1 performance at 63.59% year to date. The Board noted, however, the impact of the significant numbers of ED attendances. The Board heard that 12-hour waits were reduced and robust processes for managing, reviewing, and providing assurance for assessment of harm relating to the delays were fully embedded within the service. The Chief Executive highlighted the challenges of accessing timely care home beds, which continued to severely impact the Trust's ability to discharge or transfer patients with no criteria to reside in a timely manner. The Chief Executive advised that diagnostic performance remained above target thresholds, and whilst capacity had been challenged by industrial action, endoscopy and imaging were showing much improved positions. The Board heard that ECG capacity remained an area of concern, although support from the Community Diagnostic Centre had greatly improved the current position. The Chief Executive reported that cancer performance remained extremely challenged due to the impact of industrial action and the sustained increase in demand. She advised that divisional teams had revised improvement trajectories across these standards assuming no further industrial action. It was noted that the current forecast indicated that the Trust would achieve both the 28-day standard and the 63+ backlog target by year-end, with 62-day performance increasing to 75%. In response to a question from Mr Meb Vadiya, Associate Non-Executive Director, querying if the operational challenges were likely to continue to next year, the Chief Executive commented that the only way to address the	

challenges was working more collaboratively, acknowledging that any resolutions would take time to embed, including addressing the no criteria to reside issue.

In response to a question from Mrs Beatrice Fraenkel, Non-Executive Director, about the impact of the national immigration policy, the Medical Director and Director of People & OD highlighted concerns in this area, noting potential adverse impact on healthcare support roles, social care and the wider care system. The Director of People & OD briefed the Board on mitigating actions in this area, including 'growing our own' workforce.

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

The Medical Director advised that the Trust was performing well against the timely recognition of sepsis metric, with performance being close to target levels. He noted, however, that antibiotic administration within the necessary timescales continued to be challenging, highlighting key themes in this area.

The Chief Nurse advised that infection rates for C.diff and E.coli continued to be significantly higher than associated thresholds. She noted that C.diff themes from the avoidable cases were linked with antibiotic appropriateness, course length, and course numbers which appeared to have increased following the Covid pandemic. The Board heard that the Trust had signed up to a national campaign regarding E.coli which was hoped to have a positive impact on the reduction in E.coli, locally and nationally. The Chief Nurse also highlighted the importance of hand hygiene, noting significant levels of norovirus in Stockport.

The Chief Nurse reported that maternity had seen a slight increase in the number of registrable stillbirths and neonatal deaths. She advised that the Maternity Unit had been placed on a temporary divert a total of ten times between July and October, but noted that the recent successful recruitment of midwives to address performance in this area.

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

The Director of People & OD reported that sickness absence was above target for October, noting that an increase had been expected due to seasonal variation. She briefed the Board on mitigating actions, including targeted support and promotion of health & wellbeing support.

The Director of People & OD advised that agency costs were lower than average for the fifth consecutive month, reporting 4.7% for October. She noted, however, that performance was still slightly above the NHSE target, and highlighted the grip and control measures in this area.

	The Board heard that whilst workforce turnover was still above the target, performance continued on an improved trajectory. It was noted that mandatory training compliance was also showing significant improvements. In response to questions from Mr David Hopewell, Non-Executive Director, and Mrs Beatrice Fraenkel, Non-Executive Director, about the cost of sickness absence, it was noted that the Finance & Performance Committee would consider this further at its January meeting. In response to a question from Dr Louise Sell, Non-Executive Director, querying what support was available to staff who were off sick, and perhaps on waiting lists for external support or treatment, the Director of People & OD noted that any issues would be addressed on an individual basis as part of sickness absence meetings. The Chief Executive highlighted ongoing work to understand the complex issues for long term sickness absences and address these accordingly. Mrs Beatrice Fraenkel, Non-Executive Director, reflected on the impact of violence and aggression to staff, and the need for greater understanding of the factors that might trigger aggression from patients and visitors to enable mitigations. It was noted that the People Performance Committee would explore this issue further. **Finance** The Chief Finance Officer presented the finance section of the IPR and advised that the Trust had submitted a plan with an expected deficit of £31.5m for the financial year 2023-24. He advised that the deficit assumed delivery of an efficiency target of £26.2m, of which £10.3m was recurrent. The Chief Finance Officer reported that at Month 7, the Trust position was a deficit of £20.7m, which was £2.0m adverse to plan. The Board heard that this was a deterioration of £0.2m in month, and that the adverse variance was driven by the impact of industrial action by junior doctors and consultants, undelivered efficiency savings, open escalation wards, enhanced staffing levels to support the high level of attendances in ED, the elective recovery fund estimated penalty from April to October, and the cost of the pay award for 2023/24 over and above expected funding. The Chief Finance Officer reported that the Trust's efficiency plan for 2023/24 was £26.2m (£10.3m recurrent) and at Month 7 the Trust was ahead of plan by £0.4m due to a one of non-recurrent benefit in month 6. The Board heard that the efficiency plan had predominantly been delivered non-recurrently, and the Chief Finance Officer highlighted ongoing work to identify additional recurrent schemes. The Chief Finance Officer confirmed that the Trust had maintained sufficient cash to operate in October 2023, but noted risks in this area. It was noted that the Capital plan for 2023/24 was £62.7m, but this was subject to final confirmation as the GM position remained oversubscribed. The Board heard that at month 7, expenditure was behind plan by £5.3m, however this would be re-profiled into future months. **The Board of Directors received and noted the Integrated Performance Report.**	

150/23	**Mid-Year Review: Corporate Objectives and Outcome Measures** The Chief Executive presented a report providing a high-level overview of progress made against the 2023/24 corporate objectives and key outcome measures during the first six months of the year. She briefed the Board on the content of the report, noting overall positive progress made towards the corporate objectives, with a number of actions completed ahead of schedule. She also highlighted areas where progress had been adversely impacted by industrial action and lack of mutual aid. The Chair commended the progress made, particularly in the context of significant operational challenges, and congratulated all staff involved for this achievement. **The Board of Directors received and noted the Mid-Year Review: Corporate Objectives and Outcome Measures**	
151/23	**Board Confirmation of Trust Response to NHS England operational guidance letter: Addressing the significant financial challenges created by industrial action** The Chief Executive advised that on 8 November 2023, Integrated Care Systems (ICSs) received operational guidance relating to the impact of industrial action on forecast delivery of 2023/24 plans. The Board hear that, as a consequence, a rapid two-week exercise had been initiated, requiring ICSs and Trust Boards to sign off and submit key finance, performance and capacity commitments to NHS England by 22 November 2023. The Chief Executive presented a report providing an update on the submission made to GM ICS and NHS England, recommitting the Trust to: • Deliver our financial plan for 2023/24 • Prioritise delivery of the 4hr A&E standard by March 2024 • Deliver planned reductions in the 62-day cancer backlog. The report also highlighted the following changes: • revised trajectory of 75.4% for the Faster Diagnosis Standard • reduction of 8 G&A beds due to the re-phasing of the EUCC build • revised forecast of 1,543 65-week waits by year-end • revised forecast of 351 78-week waits. Acknowledging the Trust response would not be reviewed by the Trust Board ahead of the 22 November 2023 submission deadline, the Chief Executive confirmed that the Board of Directors had virtually approved delegated authority for sign off by Chair and Chief Executive to ensure timely submission, with an acknowledgement that the response would be presented for ratification at the Board meeting in December. **The Board of Directors ratified the Trust response to the NHS England Operational Guidance Letter *'Immediate actions to address significant financial challenges",* following delegated approval to the Trust Chair and Chief Executive to sign off the response, thereby enabling submission to NHS England by the required deadline.**	

152/23	**Safer Care Report** The Chief Nurse and Medical Director presented a report providing assurances and risks associated with safe staffing, alongside actions to mitigate the risks to patient safety and quality, based on patients' needs, acuity, dependency and risks. The Board acknowledged the ongoing high levels of operational demand within the acute and community services, which was having an impact on patient and staff experience. It was noted that demands within the ED remained significant, impacted by large numbers of patients who no longer required a hospital bed, and that this demand was being operationally managed by senior teams and on-call colleagues with continual dynamic risk assessments conducted. The Board also acknowledged the impact and associated challenges of the industrial action. In response to a question from Dr Louise Sell, Non-Executive Director, the Medical Director briefed the Board on support available to clinicians, including SAS doctors, to progress in their role. The Chair welcomed the successful recruitment to nursing, midwifery and consultant positions and noted positive comments received from candidates about team working and support available in this Trust. **The Board of Directors received and noted the Safer Care Report.**	
153/23	**Guardian of Safe Working Annual Report** The Board of Directors welcomed the Guardian of Safe Working to the meeting. He presented a Guardian of Safe Working Annual Report and briefed the Board on its content. He confirmed that no immediate safety concerns had been identified during the reporting period. The Board of Directors acknowledged the decision taken by the Guardian of Safe Working to stand down from this role, and thanked Mr Tom Finnigan for all his work as the Guardian of Safe Working. In response to a question from Mrs Beatrice Fraenkel, Non-Executive Director, the Medical Director provided further clarity about the process for issuing fines, noting a scheme of delegation for the Guardian of Safe Working in this area. **The Board of Directors received and noted the Guardian of Safe Working Annual Report and recorded its appreciation to Mr Tom Finnigan for his work as the Guardian of Safe Working.** *The Guardian of Safe Working left the meeting*	
154/23	**Board Committees – Key Issues Reports** **Finance & Performance Committee** The Chair of Finance & Performance Committee (Mr Tony Bell, Non-Executive Director) presented the key issues reports from Finance & Performance Committee meetings held on 19 October 2023 and 16 November 2023. He briefed the Board on the content of the reports and detailed key financial and operational issues and associated key risks	

	considered. **The Board of Directors reviewed and confirmed the Finance & Performance Committee Key Issues Report, including actions taken.** **People Performance Committee** The Chair of People Performance Committee (Mrs Beatrice Fraenkel, Non-Executive Director) presented the key issues report from the People Performance Committee meeting held on 9 November 2023. She briefed the Board on the content of the report and detailed key people related issues considered. In response to a comment from the Chair about the need for each Board member to have a specific objective relating to equality, diversity & inclusion, the Director of People & OD confirmed that this would be progressed as part of the new appraisal framework. **The Board of Directors reviewed and confirmed the People Performance Committee Key Issues Report, including actions taken.** **Quality Committee** The Chair of Quality Committee (Mrs Mary Moore, Non-Executive Director) presented the key issues report from the Quality Committee meetings held on 24 October 2023 and 28 November 2023. She briefed the Board on the content of the report and detailed key quality related issues considered at the meeting. **The Board of Directors:** • **Reviewed and confirmed the Quality Committee Key Issues Report, including actions taken.** • **Reviewed and confirmed the Maternity Services Reports.** **Audit Committee** The Chair of Audit Committee (Mr David Hopewell, Non-Executive Director) presented the key issues report from the Audit Committee meeting held on 23 November 2023. He briefed the Board on the content of the report, and detailed key audit related issues considered at the meeting. In response to a question from Mrs Mary Moore, Non-Executive Director, about the stock management review which had received limited assurance, the Chair of Audit Committee confirmed that the associated recommendations and actions would be tracked through the follow up process. **The Board of Directors:** • **Reviewed and confirmed the Audit Committee Key Issues Report, including actions taken.**	
155/23	**Any Other Business** There was no other business.	
156/23	**Date and Time of Next Meeting** Thursday, 1 February 2024, 9.30am, Pinewood House Education Centre.	
157/23	**Resolution**	

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

Signed:_____Date:_____

BOARD OF DIRECTORS PUBLIC MEETING ACTION TRACKER

Action Log Ref No/Yr.	Meeting Date	Minute Ref	Item	Action	Responsible	Status
01/22	1 Dec 2022	199/22	Freedom to Speak Up Toolkit	The Board of Directors agreed that a workshop / group maybe established to further consider and progress the toolkit prior to bringing it back to the People Performance Committee and Board if required. **Update February 2023** – Date to be confirmed. **Update March 2023** – Freedom to Speak Up Report, including update regarding Action Plan to progress recommendations from toolkit to be presented at PPC in May 2023, and determine if requirement for further workshop. **Update June 2023** – Discussed via PPC and agreed to defer establishing a working group at this time. Further action to be determined as required. **Update October 2023** – Further review of toolkit and action plan agreed to be presented to PPC in March 2024 – Confirmed on PPC Work Plan. The Board agreed to keep the action open as the toolkit would require Board sign off once it had been through PPC.	Director of People & OD / Director of Communications & Corporate Affairs	April 2024
01/23	3 Aug 2023	94/23	Integrated Performance Report – Workforce	The Board requested quantitative information on the cost of sickness absence and bank and agency usage above target, and what the financial savings would be if the Trust was able to reduce to the target.	Chief Finance Officer	On Agenda

Action Log Ref No/Yr.	Meeting Date	Minute Ref	Item	Action	Responsible	Status
				Update December 2023: Discussed at Finance & performance Committee, November 2023. Work underway to review. Agreed to be presented to Finance & Performance in January, and onward to Board via Key Issues Report.		

On agenda
Not due
Overdue
Closed

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

NHS Stockport NHS Foundation Trust

Meeting date	1st February 2024	**Public**	X	**Agenda No.**	**6**
Meeting	Board of Directors				
Report Title	Clinical Negligence Scheme for Trusts (CNST) Year 5 Maternity Incentive Scheme – Board Declaration				
Director Lead	Nic Firth, Chief Nurse	**Author**	Divisional Director of Midwifery & Nursing / Deputy Head of Midwifery & Nursing		

Paper For:	**Information**		**Assurance**		**Decision**	X
Recommendation:	The Trust is required to submit our completed board declaration form for the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) by the 1st February 2024 at 12 noon to NHS Resolution (NHSR); compliance is demonstrated with ten out of ten safety actions. There are two safety actions that require action plans as part of the submission, which do not impact on achieving full compliance with the ten safety actions. **The Board of Directors is asked to review the Maternity Incentive Scheme Year 4 Report, and support the recommendation from Quality Committee, to approve submission of the Trust Board declaration form, to be signed by the Chief Executive.**					

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

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

This paper relates to the following Board Assurance Framework risks

X	PR1.1	There is a risk that the Trust does not deliver high quality care to service users
	PR1.2	There is a risk that patient flow across the locality is not effective
	PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan
	PR2.1	There is a risk that the Trust is unable to sufficiently engage and support our people's

		wellbeing
	PR2.2	There is a risk that the Trust's services do not fully support neighbourhood working
	PR3.1	There is a risk in implementing the new provider collaborative model to support delivery of Stockport ONE Health & Care (Locality) Board priorities
	PR3.2	There is a risk that the Trust does not deliver a joint clinical strategy with East Cheshire NHS Trust
	PR4.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit and retain the optimal number of staff, with appropriate skills and values
	PR4.2	There is a risk that the Trust's workforce is not reflective of the communities served
	PR5.1	There is a risk that the Trust does not implement high quality transformation programmes
	PR5.2	There is a risk that the Trust does not implement high quality research & development programmes
	PR6.1	There is a risk that the Trust does not deliver the annual financial plan
	PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial recovery plan
	PR7.1	There is a risk that the Trust does not implement the Digital Strategy to ensure a resilient and responsive digital infrastructure
	PR7.2	There is a risk that the estate is not fit for purpose and/or meets national standards
	PR7.3	There is a risk that the Trust does not materially improve environmental sustainability
	PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus

Where issues are addressed in the paper

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

Executive Summary

This report details the position of the Trust's maternity service in relation to the 10 Safety Actions we are required to meet as part of the CNST year 5 maternity incentive national scheme.

On review of the standards and in line with the submission requirements of the board assurance framework, the Trust will be compliant with ten out of ten safety actions.

This submission is subject to the approval of action plans in relation to safety actions 4 and 5 which are outlined as appendices within this report.

Evidence demonstrating the necessary sub requirements is collated within a locally shared drive and is overseen as a standing agenda item under 'CNST Year 5' via the divisional governance structure, Patient Safety Group, Quality Committee and Maternity & Perinatal Safety Champions Meeting – with membership including the Non-Executive Director Maternity Safety Champion.

The Chief Nurse and Medical Director have oversight of the collated evidence.

Sub sections of evidence supporting Safety Actions 1, 2, 3, 4, 5, 6, 7, 8, 9 and 10 have also been

submitted and discussed with the Local Maternity and Neonatal System and ICB at a joint assurance meeting. Evidence required by the LMNS and ICB has been uploaded and shared via the NHS futures platform.

Further to review at Quality Committee on 24th January 2024, the Board are asked to note the submission, including the action plans contained within the appendices which meets the national requirements and the overall action plan for Safety actions 1 – 10 with embedded evidence.

All the evidence for Safety actions 1 – 10 is listed in Annexe E against each action requirement. Evidence has been made available for the board of directors to review in preparation for the board declaration submission on the 1st February 2024.

Appendices

- Annexe A – Narrative and evidence demonstrating compliance with safety action 4 a – Obstetric and Medical workforce compensatory rest.
- Annexe B – Action plan Safety action 4 a – Obstetric and Medical Workforce compensatory rest
- Annexe C – Action plan safety action 4 c – Neonatal Medical Workforce
- Annexe D – Action plan safety action 5 - One to one care in labour
- Annexe E – CNST Year 5 Overall action plan and evidence
- Annexe F – CNST Year 5 Board declaration documentation

Following review of the CNST Year 5 Maternity Incentive Scheme submission and Board declaration form, alongside Quality Committee recommendation of approval, the Chief Executive has confirmed she is fully assured and in agreement with the compliance submission, and that her signature be applied to the Board declaration form. Furthermore, the Chief Executive has ensured that the Accountable Officer (AO) for the Integrated Care System (ICB) is apprised of the Maternity Incentive Scheme safety actions' evidence and Board declaration form requirements.

Subject to approval by the Board of Directors, the Trust Board declaration form of compliance for CNST will be submitted to NHS Resolution.

1. Purpose

1.1. The purpose of this report is to update the current position in relation to the Clinical Negligence Scheme for Trusts (CNST) 10 Safety Actions and to present an overview and action plans for Obstetric and medical workforce compensatory rest provisions, NNU medical and nursing workforce and providing one to one care in labour.

2. Background

Year five of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) to support the delivery of safer maternity care began on 26th May 2023. As in year four, the scheme incentivises 10 maternity safety actions. This year, the 10 actions are similar to previous years but with additional detail under each theme. The MIS applies to all acute trusts that deliver maternity services and are members of the CNST. In July 2023 there were two amendments made to Safety action three and Safety action nine. Following communication in July a further review of the standards was undertaken and in October 2023 amendments were made to safety actions one and eight this was in response to ongoing industrial action.

In summary annual CNST premium and incentives are detailed below:

Area	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
General	6,830,719	5,852,774	5,613,309	5,969,453	5,669,517	5,865,673	6,658,658
Maternity - standard	3,358,871	2,872,027	4,159,025	5,316,487	6,197,981	7,014,650	7,536,109
Maternity - incentive	335,887	287,203	415,903	531,649	619,798	701,465	753,611
	10,525,477	9,012,004	10,188,237	11,817,589	12,487,296	13,581,788	14,948,378
TOTAL CNST	**10,525,477**	**9,012,004**	**10,188,237**	**11,817,589**	**12,487,296**	**13,581,788**	**14,948,378**
LTPS	177,942	172,694	193,604	170,681	178,108	231,541	208,370
PES	36,847	19,620	26,231	33,775	29,990	33,082	39,279
GRAND TOTAL	**10,740,266**	**9,204,318**	**10,408,072**	**12,022,045**	**12,695,394**	**13,846,411**	**15,196,027**

Trusts that can demonstrate they have achieved all the 10 safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

Trusts that do not meet all 10 safety actions will not recover their contribution to the CNST maternity incentive fund but may be eligible for a small discretionary payment from the scheme to help them make progress against actions they have not achieved.

The financial and safety impact of not meeting CNST standards is significant. Obstetric incidents can be catastrophic and life-changing, with related claims representing the scheme's biggest area of spend. Provision for the maternity incentive scheme was built into the CNST maternity pricing for 2023/24.

Each of the 10 actions aims to improve safety in maternity and neonatal care by raising the standard of key themes which can affect outcomes in care, including clinical staffing, service user engagement/collaboration, training, incident reporting and investigation and Board level engagement with maternity services. Every standard is linked to delivering best practice and a high-quality healthcare experience for all women and babies.

The table below demonstrates the Trust's current RAG rated position against the 10 actions: -

Safety Action	Maternity Safety Action	Action Met? (Y/N/Partial)
1	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	Yes
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Yes
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?	Yes
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Yes
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes
6	Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?	Yes
7	Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?	Yes
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	Yes
9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	Yes
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme?	Yes

To demonstrate compliance with safety action 4 a, 4 b and safety action 5 the trust is required to have board approved action plans for elements within the actions. There is a total of three action plans for approval.

3. Matters under consideration.

The requirement under safety action 4 a) relates to the implementation of the RCOG guidance on compensatory rest.

- **Safety action 4:** Can you demonstrate an effective system of clinical workforce planning to the required standard?

a) Obstetric medical workforce
3) Trusts/organisations should implement RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day. Services should provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings.

The trust can demonstrate that compensatory rest is provided by the department of Obstetrics and Gynecology, which is evidenced in ANNEXE A. In response to the CNST Safety action 4 requirement an RCOG compensatory rest guideline will be developed (ANNEXE B).

The requirement under safety action 4 c) relates to Neonatal medical workforce.

c)Neonatal medical workforce
The neonatal unit meets the relevant British Association of Perinatal Medicine (BAPM) national standards of medical staffing. If the requirements have not been met in year 3 and or 4 or 5 of MIS, Trust Board should evidence progress against the action plan developed previously and include new relevant actions to address deficiencies. If the requirements had been met previously but are not met in year 5, Trust Board should develop an action plan in year 5 of MIS to address deficiencies. Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN).

The Trust remains partially compliant regarding the BAPM national standards for medical staff. The gap remains in the tier one rota, and 0.2 WTE consultant, a business case to support funding for 3 tier one trainees and 0.2 WTE consultants post has been agreed in principle by the Executive team but requires final approval and sign off from the Stockport Integrated Care partnership. There is a robust action plan in place. (ANNEXE C)

The requirement under safety action 5 refers to providing 100% one to one care in labour.

Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator status and the provision of one-to-one care in active labour. Must include plan for mitigation/escalation to cover any shortfalls.

One to one care in active labour is reported monthly on the RCOG Maternity dashboard. Evidence of compliance between May – December 2023 is demonstrated in ANNEXE D. The range of compliance is between 97% - 99.5%, themes identified are the number of babies born before arrival, fully dilated on admission and precipitate labour/staffing. The action plan in ANNEXE D addresses all three themes and will be monitored through the divisional risk and governance group and Maternity and perinatal safety champions.

4. Recommendations

Our current assessment is that the Trust will be fully compliant with ten out of the ten safety actions following approval of action plans in relation to safety action 4 and safety action 5 which are outlined as appendices within this report.

In order to be eligible for payment under the scheme, Trusts must submit their completed Board declaration form to NHS Resolution by 12 noon on 1 February 2024 and must comply with the following conditions:

- Trusts must achieve all ten maternity safety actions.

- The declaration form is submitted to Trust Board with an accompanying joint presentation detailing position and progress with maternity safety actions by the Director of Midwifery/Head of Midwifery and Clinical Director for Maternity Services

- The Trust Board declaration form must be signed and dated by the Trust's Chief Executive Officer (CEO) to confirm that:

    - The Trust Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required safety actions' sub-requirements as set out in the safety actions and technical guidance document included in this document.

    - There are no reports covering either year 2022/23 or 2023/24 that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration (e.g. Care Quality Commission (CQC) inspection report, Healthcare Safety Investigation Branch (HSIB) investigation

reports etc.). All such reports should be brought to the MIS team's attention before 1 February 2024.

- The Trust Board must give their permission to the CEO to sign the Board declaration form prior to submission to NHS Resolution. Trust Board declaration form must be signed by the Trust's CEO. If the form is signed by another Trust member this will not be considered.

- In addition, the CEO of the Trust will ensure that the Accountable Officer (AO) for their Integrated Care System (ICB) is apprised of the MIS safety actions' 5 evidence and declaration form. The CEO and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the compliance submission to NHS Resolution

Further to Quality Committee review, the Board of Directors is recommended to:

- Receive assurance that actions plans are in place against safety action 4 and 5
- Approve that the evidence provided meets the necessary sub requirements in order to be able to submit the Trust Board declaration.
- Approve for the Chief Executive to sign the Trust Board declaration on behalf of the Board of Directors.

Compensatory Rest – CNST Safety Action 4

Stockport NHS Foundation Trust

a) **Obstetric medical workforce**

3) Trusts/organisations should implement RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day. Services should provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings.

rcog-guidance-on-compensatory-rest.pdf

Update – currently there is no SOP in place. Activities the following day are cancelled where appropriate on direction from the Consultant. Some of the Obstetric Consultants have a non-working morning on the rota the following morning from being on call as demonstrated in the next 3 slides

An action plan is also in place to address the need to create a local SOP for Consultant rest in line with RCOG guidelines.

Compensatory Rest – CNST Safety Action 4

Stockport NHS Foundation Trust

Below are some examples of where activity has been cancelled due to being called in over night.

STEPPING HILL HOSPITAL - OBSTETRICS & GYNAECOLOGY ROTA

MONTH: WEEK: VERSION: 2

Day	MON	TUE	WED	THU	FRI	SAT	SUN
Date	23/10/2023	24/10/2023	25/10/2023	26/10/2023	27/10/2023	28/10/2023	29/10/2023
	WEEK 1						
LABOUR WARD CONSULTANT (08:30-17:00)							
	AHS	LMB	KPK	LMB	RO	KPK	KPK
	AHS	LMB	KPK	AHS	RO		
	SCC	LYT	KPK		RO		
OBSTETRICIAN	RO (on-call)		AHS (on-call)	MHP (on-call)			
ON-CALL CONSULTANT FOR OBSTETRICS & GYNAECOLOGY (17:00-08:30)							
	KPK	SCC	SHB	MK	HES	KPK	KPK
		NO CEPOD					
am		M2WR/ANC	A/L	A/L	A/L		
pm	SPA	PPCC	A/L	A/L	A/L		
20:30-08:30		D/S					
am	CEPOD/WR	D/S	CORBAR	D/S	POST		
pm	EPAU	D/S	SPA	PMB OPH	CALL		
twilight				D/S			
am	A/L	A/L	THEATRE	ADMIN	ELEC CS		
pm	A/L		SPA	VALIDATION	SPA		
twilight							
am	ADMIN		D/S	UROGYNAE	THEATRE	ON-CALL	ON-CALL
pm	GOPD	SPA (1-3pm)	D/S	EPAU/SPA	THEATRE		
twilight			D/S				
am	A/L			A/L	A/L		
pm	A/L	A/L	A/L	A/L			
twilight							
am	SCAN	COLP	M2WR/ANC	ADULT SAFEGUAR	SGA CLINIC		
pm	ADMIN	RAINBOW	MDT/SPA				
20:30-08:30				ON-CALL			
am	ADU		A/L		D/S		
pm	L OBS DUTIES	A/L	A/L		D/S		
twilight	ON-CALL				D/S		
am	MYOSURE	ADMIN	MYOSURE		THEATRE	GOPD	GOPD
pm	FPD DUTIES	COLP	MDT/SPA	FPD DUTIES	GOPD	GOPD	GOPD
twilight							
am	THEATRE		ADMIN	COLP	MDT/CD DUTIE		
pm	THEATRE		MDT/SPA	GOPD	CD DUTIES		
twilight	D/S						
am	ADMIN	THEATRE	CEPOD/WR	ADULT	UROGYNAE		
pm	COLP	COLP	MDT/SPA	SAFEGUARDING			
twilight							
am			PMB OPH	CEPOD/WR			
pm			SPA	FERTILITY	THEATRE		
twilight			ADMIN				
am		A/L	A/L	A/L	A/L		
pm		A/L	A/L	A/L	A/L		
twilight							
am	D/S	PMB OPH	SPA	ELEC CS	CEPOD/WR	GOPD	
pm	D/S	SPA	PMB OPH	D/S	PMB OPH	GOPD	
twilight			ON-CALL				

AHS was called in overnight on the 25/10/23.

On the 26/10/23 we had to cancel SHB training to cover the section list in the morning and MK to cover DS in the afternoon. You can see the changes to the rota

O & G Consultant Rota 2023

STEPPING HILL HOSPITAL - OBSTETRICS & GYNAECOLOGY ROTA

MONTH: WEEK: VERSION: 3

Day	MON	TUE	WED	THU	FRI	SAT	SUN
Date	23/10/2023	24/10/2023	25/10/2023	26/10/2023	27/10/2023	28/10/2023	29/10/2023
	WEEK 1						
LABOUR WARD CONSULTANT (08:30-17:00)							
	AHS	LMB	KPK	LMB	RO	KPK	KPK
	AHS	LMB	KPK	MK	RO		
	SCC	LYT	KPK	LMB	RO		
OBSTETRICIAN	RO (on-call)		AHS (on-call)	MHP (on-call)			
ON-CALL CONSULTANT FOR OBSTETRICS & GYNAECOLOGY (17:00-08:30)							
	KPK	SCC	SHB	MK	HES	KPK	KPK
		NO CEPOD					
am		M2WR/ANC	A/L	A/L	A/L		
pm	SPA	PPCC	A/L	A/L	A/L		
20:30-08:30		D/S					
am	CEPOD/WR	D/S	CORBAR	D/S	POST		
pm	EPAU	D/S	SPA	PMB OPH	CALL		
twilight							
am	A/L	A/L	THEATRE	ADMIN	ELEC CS		
pm	A/L		SPA	D/S	SPA		
twilight							
am	ADMIN		D/S	UROGYNAE	THEATRE	ON-CALL	ON-CALL
pm	GOPD	SPA (1-3pm)	D/S	EPAU/SPA	THEATRE		
twilight			D/S				
am	A/L			A/L	A/L		
pm	A/L	A/L	A/L	A/L			
twilight							
am	SCAN	COLP	M2WR/ANC	ADULT SAFEGUAR	SGA CLINIC		
pm	ADMIN	RAINBOW	MDT/SPA				
20:30-08:30				ON-CALL			
am	ADU		A/L		D/S		
pm	L OBS DUTIES	A/L	A/L		D/S		
twilight	ON-CALL				D/S		
am	MYOSURE	ADMIN	MYOSURE		THEATRE	GOPD	GOPD
pm	FPD DUTIES	COLP	MDT/SPA	FPD DUTIES	GOPD	GOPD	GOPD
twilight							
am	THEATRE		ADMIN	COLP	MDT/CD DUTIE		
pm	THEATRE		MDT/SPA	GOPD	CD DUTIES		
twilight	D/S						
am	ADMIN	THEATRE	CEPOD/WR	ELEC CS	UROGYNAE		
pm	COLP	COLP	MDT/SPA	SPA			
twilight							
am			PMB OPH	CEPOD/WR			
pm			SPA	FERTILITY	THEATRE		
twilight			ADMIN				
am		A/L	A/L	A/L	A/L		
pm		A/L	A/L	A/L	A/L		
twilight							
am	D/S	PMB OPH	SPA	POST	CEPOD/WR	GOPD	
pm	D/S	SPA	PMB OPH	CALL	PMB OPH	GOPD	
twilight			ON-CALL				

Compensatory Rest – CNST Safety Action 4

Stockport NHS Foundation Trust

O & G Consultant Rota 2023

		STEPPING HILL HOSPITAL - OBSTETRICS & GYNAECOLOGY ROTA						
		MONTH:	July 2023		WEEK:	1	VERSION:	4
Day		MON	TUE	WED	THU	FRI	SAT	SUN
Date		03/07/2023	04/07/2023	05/07/2023	06/07/2023	07/07/2023	08/07/2023	09/07/2023
		WEEK 1						
LABOUR WARD CONSULTANT (08:30-17:00)								
		AHS	LMB	HES	LYT	MUE	MK	MK
		AHS	LMB	HES	LYT	MK		
		SCC	OAS	MMS	LYT	HES		
OBSTETRICIAN			MUE (on-call)	AHS (on-call)	MHP (on-call)		LMB	LMB
ON-CALL CONSULTANT FOR OBSTETRICS & GYNAECOLOGY (17:00-08:30)								
		SHB	SCC	SHB	MK	OAS	MK	MK
	am	ADU	M2WR/ANC	SPA	D/S	M2WR/ANC	GOPD	
	pm	SPA	PPCC	CON MTG	D/S	ADU	GOPD	
	20:30-08:30				D/S			
	am	CEPOD/WR	D/S	CORBAR	DEBRIEF	CEPOD/WR	RESIDENT DAY	RESIDENT DAY
	pm	EPAU	D/S	CON MTG	PMB OPH	STOP		
	twilight							
	am	M2WR/ANC	PMB OPH	THEATRE	ADMIN	VALIDATION	ON-CALL	ON-CALL
	pm	GOPD		CON MTG	VALIDATION	D/S		
	twilight					SPA		
	am	A/L	A/L	A/L	A/L	A/L		
	pm	A/L	A/L	A/L	A/L	A/L		
	twilight							
	am	POST CALL			THEATRE	MDT/ADMIN		
	pm	COLP	GOPD	CON MTG	THEATRE (R)			
	twilight							

McCarthy Rebecca 30/01/2024 09:18:02

SMG was called in overnight on the 2/7/23 and we had to cancel his Colp clinic un the morning on the 3/7/23

Compensatory Rest – CNST Safety Action 4

NHS Stockport NHS Foundation Trust

O & G Consultant Rota 2023

STEPPING HILL HOSPITAL - OBSTETRICS & GYNAECOLOGY ROTA

MONTH: WEEK: VERSION: 5

Day		MON	TUE	WED	THU	FRI	SAT	SUN
Date		27/11/2023	28/11/2023	29/11/2023	30/11/2023	01/12/2023	02/12/2023	03/12/2023
		WEEK 2						
DELIVERY SUITE CONSULTANT								
	0830-1300	MUE	HES	MUE	MHP	EL-NEMR	HES	HES
	1300-1700	AHS	EL-NEMR	AHS	MHP	MK		
	1700-2030	MUE	EL-NEMR	MMG	MHP	HES		
OBSTETRICIAN		MUE (on-call)		LMB (on-call)	LYT (on-call)		LMB	LMB
ON-CALL CONSULTANT FOR OBSTETRICS & GYNAECOLOGY (17:00-08:30)		HES	MMG	SMG	KPK	SHB	HES	HES
	am	ADMIN/TRAININ	M2WR/ANC	LIEU	POST	OB HAEM(10-12)		
	pm		RAINBOW	LIEU	CALL	PMB OPH		
	20:30-08:30				ON-CALL			
	am	CEPOD/WR	SPA	CORBAR		ELEC CS	RESIDENT DAY	RESIDENT DAY
	pm	EPAU		SPA		EPAU		
	twilight	ADMIN		ON-CALL				
	am	M2WR/ANC	PMB OPH	THEATRE	ADMIN	VALIDATION		
	pm	GOPD		SPA	PMB OPH	D/S		
	twilight							
	am	ADMIN	UROGYNAE	ADMIN/SPA	UROGYNAE	CEPOD/WR		
	pm	GOPD	PMB OPH	SPA	EPAU/SPA	THEATRE		
	twilight							
	am	THEATRE	ONCOL		THEATRE (R)	MDT/ADMIN		
	pm	COLP	GOPD	MDT/SPA	THEATRE (R)			
	twilight							
	am	SCAN	COLP	M2WR/ANC	D/S	SGA CLINIC		
	pm	SPA	SCANNING	MDT/SPA	D/S	COLP		
	20:30-08:30				D/S	SPA		
	am		ADU	ANC (PMH)	ADMIN	M2WR/ANC		
	pm		SPA	SPA		CT DUTIES		
	twilight							
	am		SBL & FETAL	COLP	M2WR/ANC	THEATRE		GOPD
	pm	FPD DUTIES	MONITORING	MDT/MTG	FPD DUTIES	GOPD	GOPD	GOPD
	twilight			D/S				
	am	MYOSURE	SBL & FETAL	ADMIN	COLP	MDT/CD DUTIE		
	pm	ONC	MONITORING	MDT/SPA	GOPD			
	twilight							
	am	ADMIN	CEPOD/WR	UROGYNAE	COLP	UROGYNAE		
	pm		PERINEAL	MDT/SPA	GOPD	THEATRE		
	twilight							
	am		D/S	PMB OPH	BUXTON		ON-CALL	ON-CALL
	pm			SPA	GOPD	THEATRE		
	twilight					D/S		
	am	D/S	ELEC CS	D/S	CEPOD/WR	POST		
	pm	THEATRE		SPA		CALL		
	twilight	DS/ON-CALL						
	am		SPA	CEPOD/WR	ADMIN	THEATRE		
	pm	D/S	GOPD	D/S				
	twilight							

LYT was called in overnight on the 30/11/23.
AHS covered PMB clinic on the 1/12/23 in the afternoon and Ob Haem clinic was cancelled.

O & G Consultant Rota 2023

STEPPING HILL HOSPITAL - OBSTETRICS & GYNAECOLOGY ROTA

MONTH: WEEK: VERSION: 6

Day		MON	TUE	WED	THU	FRI	SAT	SUN
Date		27/11/2023	28/11/2023	29/11/2023	30/11/2023	01/12/2023	02/12/2023	03/12/2023
		WEEK 2						
DELIVERY SUITE CONSULTANT								
	0830-1300	MUE	HES	MUE	MHP	EL-NEMR	HES	HES
	1300-1700	AHS	EL-NEMR	AHS	MHP	MK		
	1700-2030	MUE	EL-NEMR	MMG	MHP	HES		
OBSTETRICIAN		MUE (on-call)		LMB (on-call)	LYT (on-call)		LMB	LMB
ON-CALL CONSULTANT FOR OBSTETRICS & GYNAECOLOGY (17:00-08:30)		HES	MMG	SMG	KPK	SHB	HES	HES
	am	ADMIN/TRAININ	M2WR/ANC	LIEU	POST	POST		
	pm		RAINBOW	LIEU	CALL	CALL		
	20:30-08:30				ON-CALL			
	am	CEPOD/WR	SPA	CORBAR		ELEC CS	RESIDENT DAY	RESIDENT DAY
	pm	EPAU		SPA		EPAU		
	twilight	ADMIN		ON-CALL				
	am	M2WR/ANC	PMB OPH	THEATRE	ADMIN	VALIDATION		
	pm	GOPD		SPA	PMB OPH	D/S		
	twilight							
	am	ADMIN	UROGYNAE	ADMIN/SPA	UROGYNAE	CEPOD/WR		
	pm	GOPD	PMB OPH	SPA	EPAU/SPA	THEATRE		
	twilight							
	am	THEATRE	ONCOL		THEATRE (R)	MDT/ADMIN		
	pm	COLP	GOPD	MDT/SPA	THEATRE (R)			
	twilight							
	am	SCAN	COLP	M2WR/ANC	D/S	SGA CLINIC		
	pm	SPA	SCANNING	MDT/SPA	D/S	COLP		
	20:30-08:30				D/S	SPA		
	am		ADU	ANC (PMH)	ADMIN	M2WR/ANC		
	pm		SPA	SPA		CT DUTIES		
	twilight							
	am		SBL & FETAL	COLP	M2WR/ANC	THEATRE		GOPD
	pm	FPD DUTIES	MONITORING	MDT/MTG	FPD DUTIES	GOPD	GOPD	GOPD
	twilight			D/S				
	am	MYOSURE	SBL & FETAL	ADMIN	COLP	MDT/CD DUTIE		
	pm	ONC	MONITORING	MDT/SPA	GOPD			
	twilight							
	am	ADMIN	CEPOD/WR	UROGYNAE	COLP	UROGYNAE		
	pm		PERINEAL	MDT/SPA	GOPD	THEATRE		
	twilight							
	am		D/S	PMB OPH	BUXTON		ON-CALL	ON-CALL
	pm			SPA	GOPD	THEATRE		
	twilight					D/S		
	am	D/S	ELEC CS	D/S	CEPOD/WR	POST		
	pm	THEATRE		SPA		CALL		
	twilight	DS/ON-CALL						
	am		SPA	CEPOD/WR	ADMIN	THEATRE		
	pm	D/S	GOPD	D/S		PMB OPH		
	twilight							

CNST Safety Action 4 – Compensatory Rest

Stockport NHS Foundation Trust

Organisation:	Stockport NHS Foundation Trust
Lead Officer:	Dr Sonia Chachan
Position:	Clinical Director
Tel:	0161 419 5542
Email:	Sonia.chachan@stockport.nhs.uk
Address:	Stockport NHS Foundation Trust

Version	Date
1	08/12/23

Status Key	
1	Not complete / no progress reported/ timescales not met by more than 6 months/ no evidence provided
2	Actions partly or mostly achieved / timescales not met by 3- 6 months / some evidence outstanding
3	All actions complete but awaiting evidence / timescales within 3 months
4	All actions completed and good supporting evidence provided

Ref	Area of Focus	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (document or hyperlink)	Current Status 1 2 3 4
1.	There is no SOP in place with regards to compensatory rest where Consultants and Senior Specialty and Specialist doctors are working as non resident on call out of hours and do not have sufficient rest to undertake their normal working duties the following day.	SOP to be developed in line with RCOG guidance	Dr Sonia Chachan / Dr Rachel Owen	March 2024		

Neonatal CNST Workforce Action Plan

Version	Date
6	October 22
7	March 23
8	September 23
9	December 23

Organisation:	Stockport NHS Foundation Trust
Lead Officer:	Dr Carrie Heal/Rachael Whittington
Position:	Clinical lead DND
Tel:	(0161) 419 5520
Email:	Rachael.whittington@stockport.nhs.uk
Address:	Neonatal Unit, Stockport NHS Foundation Trust

Status Key	
1	Not complete / no progress reported/ timescales not met by more than 6 months/ no evidence provided
2	Actions partly or mostly achieved / timescales not met by 3- 6 months / some evidence outstanding
3	All actions complete but awaiting evidence / timescales within 3 months
4	All actions completed and good supporting evidence provided

Ref	Area of Focus	Key Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (document or hyperlink)	Current Status 1 2 3 4
1.	Medical Workforce standards not met as per British Association of Perinatal Medicine (BAPM) recommendation - Tier 1 (SHO) level rota.	Review of current service provision (dedicated tier 1 doctor 9am-7pm Mon-Fri*)* Tier 1 rota to be supported by NLS *trained* midwifery staff and the Neonatal nursing team. Tier 1 induction includes NLS training. Tier 1 trainees accompanied to deliveries until assessed as competent. Increased Consultant support with resident consultant twilight cover. Additional Tier 2 cover 9-5pm at the weekends for 52 weeks/year.	Dr C Heal Lead Clinician NNU Dr Elizabeth Newby – Clinical Director.	Review every 3 months. Business case September 2023	**October 2022** 2 WTE Medical Support Workers employed until March 2023 and 2 Advanced Clinical Practitioners (ACPs) qualified September 2022 - supporting Tier 1 rota on twilight, late evenings, and weekend cover. 2 further ACPs in training Plan to consider business case to increase Tier 1 numbers while ACPs in training. **September 2023** • Actions completed but remain non-compliant to BAPM standards as no dedicated Tier 1 doctor for NNU 24/7. • Standards reviewed as part of CNST year 5 maternity incentive scheme. • Risk assessment reviewed and updated. • New action to produce full business case with options appraisal to fulfil rota requirements.	

		September 2023 Business Case to be produced to address shortfalls in medical workforce based upon options appraisal and workforce models. Revisit job planning and rota options. Ongoing work with ODN to support specialist training and Advanced Clinical Practitioners that are NW regional wide. Role of the ACP and Medical Support Workers supporting tier 1 rota currently Further development of ACP roles within Division to have 6 WTE.			• Risk assessment completed – mitigation around support from Middle Grade and Consultant rota cover expansion as interim measure. **December 2023** A BAPM Compliance Business Case has been submitted and agreed in principle by the Trust Executive Team for 3.0 WTE Tier 1 Trainees. This would provide cover for 19:00 - 09:00 on weekdays and 48-hour cover at the weekend. This request for additional funding has now been submitted to Stockport Integrated Care Partnership for review and approval.	
2.	Medical Workforce standards not met as per British Association of Perinatal Medicine (BAPM) recommendation - Tier 2 (Registrar) level rota.	Extra trust middle grade doctor on the Tier 2 rota since 2020 – gives extended hours all year round with dedicated NNU cover Monday to Friday 09.00 – 21.00 and 09.00 – 17.00 at weekends. All Tier 2 Doctors assessed individually and supported appropriately during their post. Extended winter cover gives additional support from Consultant tier. ACPs in training will support rota from 2023. Options appraisal (as above) to consider recruiting to ANP substantive posts and further training posts.	Dr C Heal Lead Clinician NNU Dr Elizabeth Newby – Clinical Director.	Review every 3 months. Interim options appraisal August 2021 Business case September 2021	**October 2022** 2 Middle Grades until 9pm Monday - Friday and until 5pm at weekends. Resident Consultant in place until 12 midnight October- December supporting Middle Grade rota at busiest time of year. Plan to increase Middle Grade cover in **March 23** New rotation in place rota so that two Middle Grades 9am-9pm 7 days/week.	

		July 21 Options appraisal to consider Staff Grade options to support out of hours and weekend cover. **October 2022** Following review full compliance for tier 2 rota March 2023				
3.	Consultant paediatrician workforce standards for Local Neonatal Units not met.	Review of consultant cover for NNU and Job plans. All paediatricians are expected to show evidence of ongoing training including NLS at appraisal. The Unit is supported by the Network with immediate advice available from our link tertiary unit transport team. Review of all rotas to ensure safe cover within the NNU. Options appraisal followed by Business Case to be produced to address shortfalls in medical workforce including Consultant cover.	Dr C Heal Lead Clinician NNU Dr Alison Jobling Associate Medical Director Dr Elizabeth Newby – Clinical Director	Annual review	**October 2022** Neonatal Hot Week system in place providing dedicated NNU cover Monday - Friday. Dedicated Consultant Ward Round 3 months of year (October – December) with plan to increase in January 2024 to 6 months a year (October – March). Outside of these times weekend cover by Consultant covering NNU and Paediatric Ward Planned review of investment required to support 7 days per week 365 days per year. **September 2023** New action to produce full business case with options appraisal to fulfil rota requirements. **December 2023** Funding has been received via the NWNODN for additional Consultant time (0.6 WTE) from October 2023. A further 0.2 WTE has been identified internally from within the Directorate. A BAPM Compliance Business Case has been submitted and agreed in principle by the Trust Executive Team for 0.2 WTE Consultant, to allow for the recruitment of a 10PA Consultant position.	

					This request for additional funding has now been submitted to Stockport Integrated Care Partnership for review and approval. Once this Consultant has been appointed, we will then be BAPM compliant from a Consultant perspective.	
4.	Nursing Standards not met as per Service specification and BAPM standards. All nursing tool calculators look at workforce requirements needed to meet activity demands.	Review of Nurse Staffing establishment and skill mix. Reconfigure nursing establishment. 6 Monthly completion of NWNODN workforce tool kit. Workforce review completed identifying BAPM gaps. Subsequent funding revised from Neonatal network to achieve standard. from Neonatal Network Twice Daily staffing reviews against activity by senior Nurses. With circulated sit rep to senior management team. Use of adapted Shelford safe staffing tool in place Robust escalation process in place	Pamela Hardy	Annual review against BAPM standards	**February 2022** • Funding from Neonatal network of £207,418 to achieve BBAPM compliance and supernumerary shift lead based on activity. • Recruitment commenced. • Recruitment into registered posts completed. • Recruitment to band 4 posts ongoing • Budgeted work force meets BAPM staffing requirements based on Q1 activity. • Realignment of budget completed to reflect QIS posts required. **September 2023** • Daily staffing reviews embedded in practice. • Sit rep sent to both maternity and paediatrics. • Robust escalation process in place if units BAPM needs exceeds staffing numbers.	

Action Plan - CNST YR 5 – Safety action 5 1:1 care in labour

NHS Stockport NHS Foundation Trust

Organisation:	Stockport NHS Foundation Trust
Lead Officer:	Sarah McManus/Jane Ingleby
Position:	Inpatient Maternity Matron + Interim Community Matron
Tel:	
Email:	Sarah.mcmanus@stockport.nhs.uk Jane.ingleby@Stockport.nhs.uk
Address:	SHH

Version	Date
1	*04/01/2024*

Status Key	
1	Not complete / no progress reported/ timescales not met by more than 6 months/ no evidence provided
2	Actions partly or mostly achieved / timescales not met by 3- 6 months / some evidence outstanding
3	All actions complete but awaiting evidence / timescales within 3 months
4	All actions completed and good supporting evidence provided

Ref	Standard	Key Themes + Actions	Lead Officer	Deadline for action	Progress Update Please provide supporting evidence (document or hyperlink)	Current Status 1 2 3 4
1	**Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?** d) All women in active labour receive one-to-one midwifery care. Target 100% **Achieved** May – 99.1% June – 98.9% July – 97.4% August – 99.5% September – 97.8%	**Born Before Arrival** • Midwives to discuss signs of labour and ensure all contact numbers are made available. • Increase awareness of signs of labour at antenatal education session • Raise awareness of BBA's to midwifery team to ensure risk assessment completed on first contact.	Inpatient and Community midwifery matron	**29/2/2024**	Requests made to add to all safety huddles and discussed at daily community hand overs. Information to be shared with all the staff regarding 1:1 care in labour and themes with a specific focus on BBA's	

	October – 98.9% November – 99.5% December 98.5% An action plan detailing how the maternity service intends to achieve 100% compliance with 1:1 care in active labour	• Dedicated midwife for telephone triage	Deputy HOM/Triage Manager	**29/2/2024**	Appointed to 16 hour telephone triage midwife post start date TBC Non – clinical midwife undertaking role currently. Staffing budget review planned to make provisions for 7 day PW established post	
		Fully Dilated on admission • Same as above	Inpatient and Community midwifery matron	**29/2/2024**	Requests made to add to all safety huddles and discussed at daily community hand overs. Information to be shared with all the staff regarding 1:1 care in labour and themes with a specific focus on BBA's	
		Precipitate labour/staffing • Ongoing recruitment for B5/B6 midwives	All managers/ recruitment and retention midwife	**ongoing**	Rolling band 5/6 advert on TRAC Plan to recruit newly qualified midwives from April 2024	
		• Review IOL pathway on delivery suite	Intrapartum Manager/Inpatient matron/	**31/03/24**	Review location of IOL's on delivery suite and IOL care pathway	

McCarthy,Rebecca 30/01/2024 09:18:02

Action Plan Sign Off

Name: … …… **Date**: ……

Action ID	Specific action to be implemented	Action Owner	Target date	RAG	Comments	Evidence
Deadline for reported to NHS Resolution by 1st February 2024						
Safety Action 1 Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?						
SA1 a	All eligible perinatal deaths from should be notified to MBRRACE-UK within seven working days. For deaths from 30 May 2023, MBRRACE-UK surveillance information should be completed within one calendar month of the death.	Amanda Killen/Rachel Owen	30/05/2023 - 07/12/2023		Notifications must be made, and surveillance forms completed using the MBRRACE-UK reporting website (see note below about the introduction of the NHS single notification portal). The PMRT must be used to review the care and reports should be generated via the PMRT. A report has been received by the Trust Executive Board each quarter from 30 May 2023 that includes details of the deaths reviewed. Any themes identified and the consequent action plans. The report should evidence that the PMRT has been used to review eligible perinatal deaths and that the required standards a), b) and c) have been met. For standard b) for any parents who have not been informed about the review taking place, reasons for this should be documented within the PMRT review.	**Evidence to support SA1 a,b,c + d - All required evidence submitted within the qualifying time period** - PMRT quarterly report for reporting period April to June 2023 - PMRT quarterly report for reporting period July to September 2023 - PMRT quarterly report for reporting period October - December 2023 - Maternity highlight report September/November 2023 - Maternity highlight report December 2023
SA1 b	For 95% of all the deaths of babies in your Trust eligible for PMRT review, parents should have their perspectives of care and any questions they have sought from 30 May 2023 onwards.	Amanda Killen/Rachel Owen/Jaine Jennings	30/05/2023 - 07/12/2023			As above
SA1 c	For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 30 May 2023. 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed to the draft report stage within four months of the death and published within six months.	Amanda Killen/Rachel Owen/Jaine Jennings	30/05/2023 - 07/12/2023			As above
SA1 d	Quarterly reports should be submitted to the Trust Executive Board from 30 May 2023.	Amanda Killen/Rachel Owen/Jaine	30/05/2023 - 07/12/2023			**Evidence to support SA1 d** - Quality Committee work plan to demonstrate Bi Monthly reporting to board - Quality Cimmittee agenda including Maternity presentations for
Safety Action 2 Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?						
SA2_A	Trust Boards to assure themselves that at least 10 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023. Final data for July 2023 will be published during October 2023.	Steph Bray/James Whalley/Marie Dooley	30/05/2023 - 07/12/2023		The "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series can be used to evidence meeting all criteria.	**Evidence to support SA2 a, b, c, d + e.** **All required evidence submitted within the qualifying time period** - Email containing evidence of a pass for the CNST score card for July reporting period – PASS - Evidence also available at Microsoft Power BI
SA2_B	July 2023 data contained valid ethnic category (Mother) for at least 90% of women booked in the month. Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)	Steph Bray/James Whalley/Marie Dooley	30/05/2023 - 07/12/2023			Same as above
SA2_C	Trust Boards to confirm to NHS Resolution that they have passed the associated data quality criteria in the " Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023 for the following metrics:	Steph Bray/James Whalley/Marie Dooley	30/05/2023 - 07/12/2023			Same as above
SA2_C1	MCoC - Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks and also have the CoC pathway indicator completed.	Steph Bray/James Whalley/Marie Dooley	30/05/2023 - 07/12/2023			Same as above
SA2_C2	Over 5% of women recorded as being placed on a CoC pathway where both Care Professional ID and Team ID have also been provided.	Steph Bray/James Whalley/Marie Dooley	30/05/2023 - 07/12/2023			Same as above
SA2_D	Trusts to make an MSDS submission before the Provisional Processing Deadline for July 2023 data by the end of August 2023.	Steph Bray/James Whalley/Marie Dooley	30/05/2023 - 07/12/2023			Same as above
SA2_E	Trusts to have at least two people registered to submit MSDS data to SDCS Cloud who must still be working in the Trust.	Steph Bray/James Whalley/Marie Dooley	30/05/2023 - 07/12/2023			Same as above
Safety Action 3 Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?						
SA3 a	Pathways of care into transitional care (TC) have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care.	Helen Large/Sarah McManus/Emma Griffin/Stacey Longworth/ Rachel Owen/Carrie Heal	30/05/2023 - 07/12/2023		Evidence for standard a) to include: Local policy/pathway available which is based on principles of British Association of Perinatal Medicine (BAPM) transitional care where: □ There is evidence of neonatal involvement in care planning □ Admission criteria meets a minimum of at least one element of HRG XA04 □ There is an explicit staffing model □ The policy is signed by maternity/neonatal clinical leads and should have auditable standards. □ The policy has been fully implemented and quarterly audits of compliance with the policy are conducted.	**Evidence to support SA 3 a,c - All required evidence submitted within the qualifying time period** - Transitional care guideline – Author Carrie Heal (Neonatal Consultant) - Labour ward forum agenda and minutes - Transitional Care audit for Q1 and Q2
SA3 b	A robust process is in place which demonstrates a joint maternity and neonatal approach to auditing all admissions to the NNU of babies equal to or greater than 37 weeks. The focus of the review is to identify whether separation could have been avoided. An action plan to address findings is shared with the quadrumvirate (clinical directors for neonatology and obstetrics, Director or Head of Midwifery (DoM/HoM) and operational lead) as well as the Trust Board, LMNS and ICB.	Helen Large/Sarah McManus/Emma Griffin/Stacey Longworth/ Rachel Owen/Carrie Heal	30/05/2023 - 07/12/2023		Evidence for standard b) to include: □ Evidence of joint maternity and neonatal reviews of all admissions to the NNU of babies equal to or greater than 37 weeks. □ Evidence of an action plan agreed by both maternity and neonatal leads which addresses the findings of the reviews to minimise separation of mothers and babies born equal to or greater than 37 weeks. Evidence that the action plan has been signed off by the DoM/HoM, Clinical Directors for both obstetrics and neonatology and the operational lead and involving oversight of progress with the action plan. □ Evidence that the action plan has been signed off by the Trust Board.	**Evidence to support SA3 b, c. All required evidence submitted within the qualifying time period** - ATAIN audit for Q1 and Q2 - Labour ward forum agenda and minutes
SA3 c	Drawing on the insights from the data recording undertaken in the Year 4 scheme, which included babies between 34+0 and 36+6, Trusts should have or be working towards implementing a transitional care pathway in alignment with the BAPM Transitional Care Framework for Practice for both late preterm and term babies. There should be a clear, agreed timescale for implementing this pathway.	Helen Large/Sarah McManus/Emma Griffin/Stacey Longworth/ Rachel Owen/Carrie Heal	30/05/2023 - 07/12/2023		Guideline for admission to TC to include babies 34+0 and above and data to evidence this is occurring OR An action plan signed off by the Trust Board for a move towards a transitional care pathway for babies from 34+0 with clear time scales for full implementation. Validation process Self-certification by the Trust	**Evidence to support SA3 a, c. All required evidence submitted within the qualifying time period** -Transitional care guideline – Author Carrie Heal (Neonatal Consultant) - Labour ward forum agenda and minutes - Transitional Care audit for Q1 and Q2
Safety Action 4 Can you demonstrate an effective system of clinical workforce planning to the required standard?						
SA4 a 1) a,b,c	**Obstetric medical workforce** NHS Trusts/organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas: a. currently work in their unit on the tier 2 or 3 rota or b. have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP) or c. hold an Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums.	Kelly Curtis/Sonia Chachan	30/05/2023 - 07/12/2023		Trusts/organisations should audit their compliance via Medical Human Resources and if there are occasions where these standards have not been met, report to Trust Board Trust Board level safety champions and LMNS meetings that they have put in place processes and actions to address any deviation. Compliance is demonstrated by completion of the audit and action plan to address any lapses.	**SA4 a 1) a,b,c All required evidence submitted within the qualifying time period** - Audit O&G Locums 01/02/23-01/08/23 – criteria met action plan not required.
SA4 a2	**Obstetric medical workforce** Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings.	Kelly Curtis/Sonia Chachan	30/05/2023 - 07/12/2023		Trusts/organisations should use the monitoring/effectiveness tool contained within the guidance (p8) to audit their compliance and have a plan to address any shortfalls in compliance. Their action plan to address any shortfalls should be signed off by the Trust Board, Trust Board level safety champions and LMNS.	Same as above
SA4 a3	**Obstetric medical workforce** Trusts/organisations should implement RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day. Services should provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings.	Kelly Curtis/Sonia Chachan	30/05/2023 - 07/12/2023		Trusts/organisations should provide evidence of standard operating procedures and their implementation to assure Boards that consultants/senior SAS doctors working as non-resident on-call out of hours are not undertaking clinical duties following busy night on-calls disrupting sleep, without adequate rest. This is to ensure patient safety as fatigue and tiredness following a busy night on-call can affect performance and decision-making. Evidence of compliance could also be demonstrated by obtaining feedback from consultants and SAS doctors about their ability to take appropriate compensatory rest in such situations.	**SA 4 a) Point 3** - Working Time Regulations Policy (Trust wide policy) - Compensatory rest evidence and action plan - BMA compensatory rest guidance - Evidence of compensatory rest allocation
SA4 a4	**Obstetric medical workforce** Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/ when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance.	Kelly Curtis/Sonia Chachan	30/05/2023 - 07/12/2023			**SA 4 a) Point 4** - Labour Ward consultant duties and responsibilities policy - Consultant presence audit May 2023 – December 2023
SA4 b	**Anaesthetic medical workforce** A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard	charlotte Ash	30/05/2023 - 07/12/2023		The rota should be used to evidence compliance with ACSA standard 1.7.2.1.	**SA4 b)** - Narrative to support Anaesthetic workforce - Anaesthetic rota submitted as evidence.
SA4 c	**Neonatal medical workforce** The neonatal unit meets the relevant British Association of Perinatal Medicine (BAPM) national standards of medical staffing. If the requirements have not been met in year 3 and or 4 or 5 of MIS, Trust Board should evidence progress against the action plan developed previously and include new relevant actions to address deficiencies. If the requirements had been met previously but are not met in year 5, Trust Board should develop an action plan in year 5 of MIS to address deficiencies. Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN).	Rachael Whittington	30/05/2023 - 7/12/2023		The Trust is required to formally record in Trust Board minutes whether it meets the relevant BAPM recommendations of the neonatal medical workforce. If the requirements are not met, Trust Board should agree an action plan and evidence progress against any action plan developed previously to address deficiencies. A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal Operational Delivery Network (ODN).	**SA 4 c)** - NWNODN Workforce action plan - BAPM Business case presented at Executive Team 31/10/2023
SA4 d	**Neonatal nursing workforce** The neonatal unit meets the BAPM neonatal nursing standards. If the requirements have not been met in year 3 and or year 4 and 5 of MIS, Trust Board should evidence progress against the action plan previously developed and include new relevant actions to address deficiencies. If the requirements had been met previously without the need of developing an action plan to address deficiencies, however they are not met in year 5 Trust Board should develop an action plan in year 5 of MIS to address deficiencies. Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN).	Rachael Whittington	30/05/2023 - 7/12/2023		The Trust is required to formally record to the Trust Board minutes compliance to BAPM Nurse staffing standards annually using the Neonatal Nursing Workforce Calculator (2020). For units that do not meet the standard, the Trust Board should agree an action plan and evidence progress against any action plan previously developed to address deficiencies. A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal Operational Delivery Network (ODN).	**SA4 d)** Compliance met year 4
Safety Action 5 Can you demonstrate an effective system of midwifery workforce planning to the required standard?						

SA5 a	A systematic, evidence-based process to calculate midwifery staffing establishment is completed.	S Hyde	30/05/2023 - 07/12/2023		The report submitted will comprise evidence to support a, b and c progress or achievement. It should include: A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated. In line with midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. Where Trusts are not compliant with a funded establishment based on BirthRate+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls. The plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified must be shared with the local commissioners. Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staffing. o The midwife to birth ratio o The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives. Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward co-ordinator status and the provision of one-to-one care in active labour. Must include plan for mitigation/escalation to cover any shortfalls.	**SA5 a)** - Birth Rate + final report received March 2023
SA5 b	Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above.	S Hyde	30/05/2023 - 07/12/2023			**SA5 b)** - Slide presented at quality committee demonstrating Midwifery staffing as part of the Maternity highlight report September, November (2023) + January (2024)
SA5 c	The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service.	R Alexander-Patton	30/05/2023 - 07/12/2023			**SA5 c)** - Slide presented at quality committee demonstrating Midwifery staffing. - Quality Committee agenda
SA5 d	All women in active labour receive one-to-one midwifery care	R Alexander-Patton	30/05/2023 - 07/12/2023			**SA5 d)** - Slide presented at quality committee demonstrating Midwifery staffing.
SA5 e	Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year five reporting period.	S Hyde	30/05/2023 - 07/12/2023			**SA5 e)** - Biannual staffing paper presented to board November 2023 and November 2023 Quality committee agenda.
Safety Action 6 Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version three?						
SA6 1	Provide assurance to the Trust Board and ICB that you are on track to fully implement all 6 elements of SBLv3 by March 2024.	S Hyde/ R Alexander-Patton	01/02/2024			**SA6 1)** - All evidence to support safety action 6 submitted to the LMNS and ICB. Compliance for CNST across all 6 elements of SBLv3 for CNST met. - All evidence submitted demonstrates that the Stockport Maternity services are on
SA6 2	Hold quarterly quality improvement discussions with the ICB, using the new national implementation tool once available	S Hyde/ R Alexander-Patton	01/02/2024			**SA6 2)** Quarterly meeting held October 2023 amd January 2024 with the LMNS and ICB.
Safety Action 7 Listen to women, parents and families using maternity and neonatal services and coproduce services with users						
SA7 1	Ensure a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) is in place which is in line with the Delivery Plan and MNVP Guidance (due for publication in 2023).Parents with neonatal experience may give feedback via the MNVP and Parent Advisory Group.	S Hyde/ R Alexander-Patton	07/12/2023		Minutes of meetings demonstrating how feedback is obtained and evidence of service developments resulting from coproduction between service users and staff. Evidence that MNVPs have the infrastructure they need to be successful. Workplans are funded. MNVP leads, formerly MVP chairs, are appropriately employed or remunerated and receive appropriate training, administrative and IT support. The MNVP's work plan. Evidence that it is fully funded, minutes of the meetings which developed it and minutes of the LMNS Board that ratified it. Evidence that service users receive out of pocket expenses, including childcare costs and receive timely payment for these expenses.	**SA7 1)** - Screenshot of contract with details of funded hours - Draft Copy of GMEC LMNS Service specification - Evidence of engagement with the Neonatal Parent Engagement Lead - Minutes and Agenda's Maternity and Perinatal Safety Champions - Agenda MNVP engagement event
SA7 2	Ensuring an action plan is coproduced with the MNVP following annual CQC Maternity Survey data publication (due each January), including analysis of free text data, and progress monitored regularly by safety champions and LMNS Board.	S Hyde/ R Alexander-Patton	07/12/2023		Evidence that the MNVP is prioritising hearing the voices of neonatal and bereaved families as well as women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation, given the findings in the MBRRACE-UK reports about maternal death and morbidity and perinatal mortality.	**SA7 2)** - CQC survey and combined action plan in place and due to be discussed at October 2023 Maternity and Perinatal safety champions meeting.
SA7 3	Ensuring neonatal and maternity service user feedback is collated and acted upon within the neonatal and maternity service, with evidence of reviews of themes and subsequent actions monitored by local safety champions.	S Hyde/ R Alexander-Patton	07/12/2023			**SA7 3)** - The MVP undertook the 15 steps walk round and an action plan was produced in collaboration with the midwifery team and the MVP group.
Safety Action 8 Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?						
SA8 1	A local training plan is in place for implementation of Version 2 of the Core Competency Framework.	S Whitehead/RAP/Kelly Curtis	12 consecutive months from the end date used to calculate percentage compliance to meet Safety Action 8 in the Year 4 scheme		A training plan should be in place to cover all six core modules of the Core Competency Framework over a 3-year period, starting from MIS year 4 in August 2021 and up to July 2024. Trusts should update their existing training plans in alignment with Version 2 of the Core Competency Framework.	**SA8 1)** - Copy of GMEC core competancy Framework v2 with embedded training plans submitted and approved
SA8 2	The plan has been agreed with the quadrumvirate before sign-off by the Trust Board and the LMNS/ICB.	S Whitehead/RAP/Kelly Curtis	12 consecutive months from the end date used to calculate percentage compliance to meet Safety Action 8 in the Year 4 scheme			Same as above
SA8 3	The plan is developed based on the "How to" Guide developed by NHS England.	S Whitehead/RAP/Kelly Curtis	12 Econsecutive months from the end date used to calculate percentage compliance to meet Safety Action 8 in the Year 4 scheme			Same as above
Safety Action 9 Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?						
SA9 a	All six requirements of Principle 1 of the Perinatal Quality Surveillance Model must be fully embedded.	S Hyde/ R Alexander-Patton	01/08/2023		Evidence for point a) is as per the six requirements set out in the Perinatal Quality Surveillance Model and specifically: Evidence that a non-executive director (NED) has been appointed and is working with the Board safety champion to address quality issues. Evidence that a non-executive director (NED) has been appointed and is working with the Board safety champion to address quality issues. Evidence that a monthly review of maternity and neonatal quality is undertaken by the Trust Board, using a minimum data set to include a review of thematic learning of all maternity Serious Incidents (SIs). To review the perinatal clinical quality surveillance model in full and in collaboration with the local maternity and neonatal system (LMNS) lead and regional chief midwife, provide evidence to show how Trust-level intelligence is being shared to ensure early action and support for areas of concern or need.	**SA9 a)** - Maternity Highlight report front cover sheet June/September/November 2023 and January 2024 - Maternity Highlight report June/September/November 2023 and January 2024 - Emails from Mary Moore (NED) and Andrew Loughney (ED) - Quality Committee workplan 23/24
SA9 b	Evidence that discussions regarding safety intelligence; concerns raised by staff and service users; progress and actions relating to a local improvement plan utilising the Patient Safety Incident Response Framework are reflected in the minutes of Board, LMNS/ICS/ Local & Regional Learning System meetings.	S Hyde/ R Alexander-Patton	01/08/2023		Evidence that in addition to the monthly Board review of maternity and neonatal quality as described above, the Trust's claims scorecard is reviewed alongside incident and complaint data. Scorecard data is used to agree targeted interventions aimed at improving patient safety and reflected in the Trusts Patient Safety Incident Response Plan. These discussions must be held at least twice in the MIS reporting period at a Trust level quality meeting. This can be a Board or directorate level meeting.	**SA9 b)** - Quality committee minutes – PSIRF discussed with themes and trends - Patient Safety Incidents reported to Quality Committee Q1, Q2 and Q3
SA9 c	Evidence that the Maternity and Neonatal Board Safety Champions (BSC) are supporting the perinatal quadrumvirate in their work to better understand and craft local cultures.	S Hyde/ R Alexander-Patton	01/08/2023		Evidence that the Board Safety Champions have been involved in the NHS England Perinatal Culture and Leadership Programme. This will include: Evidence that both the non-executive and executive maternity and neonatal Board safety champion have registered to the dedicated FutureNHS workspace to access the resources available. Evidence in the Board minutes that the work undertaken to better understand the culture within their maternity and neonatal services has been received and and that any support required of the Board has been identified and is being implemented.	**SA9 c)** - Maternity and Perinatal Safety Champions Meeting minutes •May 2023 •July 2023 •August 2023 •November2023 - Email confirmation of engagement with Perinatal culture leadership programme
Safety Action 10 Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB/CQC/MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 30 May 2023 to 7 December 2023?						
SA10 a	Reporting of all qualifying cases to HSIB/CQC//MNSI from 30 May 2023 to 7 December 2023.	Marie Dooley	30/05/2023 - 07/12/2023		Trust Board sight of Trust legal services and maternity clinical governance records of qualifying HSIB/CQC/MNSI/EN incidents and numbers reported to HSIB/CQC/MNSI and NHS Resolution. Trust Board sight of evidence that the families have received information on the role of HSIB/CQC/MNSI and EN scheme. Trust Board sight of evidence of compliance with the statutory duty of candour.	**SA10 a, b + c** All qualifying HSIB/MNSI and EN are reported and shared through the serious incident review group and through the divisional governance reporting structure. The reports and outcomes are shared through quality committee.
SA10 b	Reporting of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 30 May 2023 until 7 December 2023.	Marie Dooley	30/05/2023 - 07/12/2023			Same as above
SA10 c	For all qualifying cases which have occurred during the period 30 May 2023 to 7 December 2023, the Trust Board are assured that: i. the family have received information on the role of HSIB/CQC/MNSI and NHS Resolution's EN scheme; and ii. there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.	Marie Dooley	30/05/2023 - 07/12/2023			Same as above

Maternity incentive scheme - Guidance

Trust Name	**Stockport NHS Foundation Trust**
Trust Code	**T572**

This document must be used to complete your trust self-certification for the maternity incentive scheme safety actions and a completed action plan must be submitted for actions which have not been met. Please select your trust name from the drop down menu above. **Your trust name will populate each tab. If the trust name box is coloured pink please update it.**

Guidance Tab - This has useful information to support you to complete the maternity incentive scheme safety actions excel spreadsheet. **Please read the guidance carefully.**

The Board declaration form must not include any narrative, commentary, or supporting documents. Evidence should be provided to the Trust Board only, and will not be reviewed by NHS Resolution, unless requested.

There are multiple additional tabs within this document:

Tab A - safety actions entry sheets (1 to 10) - Please select 'Yes', 'No' or 'N/A' to demonstrate compliance as detailed within each condition of the scheme with each maternity incentive scheme safety action. Note, 'N/A' (not applicable) is available only for set questions. The information which has been populated in this tab, will automatically populate onto tab D which is the board declaration form.

Tab B - **safety action summary sheet** - This will provide you information on your Trust's progress in completing the board declaration form and will outline on how many Yes/No/N/A and unfilled assessments you have. This will feed into the board declaration sheet - tab D.

Tab C - action plan entry sheet - This sheet will enable your Trust to insert action plan details for any safety actions not achieved.

Tab D - Board declaration form - This is where you can track your overall progress against compliance with the maternity incentive scheme safety actions. This sheet will be protected and fields cannot be altered manually. If there are anomalies with the data entered, then comments will appear in the validations column (column I) this will support you in checking and verifying data before it is discussed with the trust board, commissioners and before submission to NHS Resolution.

Upon completion of the following processes please add an electronic signature into the allocated spaces within this document. Two electronic signatures of the Trust's CEO and AO of the ICS will be required in Tab D as outlined in order to declare compliance stated in the board declaration form with the safety actions and their sub-requirements, one signature to confirm that the declaration form has been submitted to Trust Board with an accompanying joint presentation detailing position and progress with maternity safety actions by the Director of Midwifery/Head of Midwifery and Clinical Director for Maternity Services and two signatures to declare that there are no external or internal reports covering either 2022/23 financial year or 2023/24 that relate to the provision of maternity services that may subsequently provide conflicting information to your Trust's declaration. Any such reports should be brought to the MIS team's attention before 1 February 2024.

If you are unable to add an electronic signature, the board declaration form can be printed, signed then scanned to be included within the submission.

Any queries regarding the maternity incentive scheme and or action plans should be directed to **nhsr.mis@nhs.net**
Technical guidance and frequently asked questions can be accessed here:
https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/maternity-incentive-scheme/

Submissions for the maternity incentive scheme must be received no later than 12 noon on 1 **February 2024** to nhsr.mis@nhs.net
You are required to submit this document signed and dated. Please do not send evidence to NHS Resolution.

Version Name: MIS_SafetyAction_2024

Safety action No. 1

Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?

From 30 May 2023 until 7 December 2023

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have all eligible perinatal deaths from 30 May 2023 onwards been notified to MBRRACE-UK within seven working days?	Yes
2	For deaths from 30 May 2023, was MBRRACE-UK surveillance information completed within one calendar month of the death?	Yes
3	For at least 95% of all deaths of babies who died in your Trust from 30 May 2023, were parents' perspectives of care sought and were they given the opportunity to raise questions?	Yes
4	Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 30 May 2023 been started within two months of each death? This includes deaths after home births where care was provided by your Trust.	Yes
5	Were 60% of these reviews completed to the point that at least a PMRT draft report has been generated by the tool within four months of each death?	Yes
6	Were 60% of the reports published within 6 months of death?	Yes
7	Were PMRT review panel meetings (as detailed in standard C) rescheduled due to the direct impact of industrial action, and did this have an impact on the MIS reporting compliance time scales?	N/A
8	Is there an action plan approved by Trust Boards to reschedule these meetings to take place within a maximum 12-week period from the end of the MIS compliance period.	N/A
9	If PMRT review panel meetings (as detailed in standard C) have needed to be rescheduled due to the direct impact of industrial action, and this has an impact on the MIS reporting compliance time scales, how many meetings in total were impacted?	N/A
10	PMRT review panel meetings (as detailed in standard C) have needed to be rescheduled due to the direct impact of industrial action, and this has an impact on the MIS reporting compliance time scales, how many cases in total were impacted?	N/A
11	Have you submitted quarterly reports to the Trust Executive Board from 30 May 2023 onwards? This must include details of all deaths reviewed and consequent action plans.	Yes
12	Were quarterly reports discussed with the Trust maternity safety and Board level safety champions?	Yes

Safety action No. 2

Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

From 30 May 2023 until 7 December 2023

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Was your Trust compliant with at least 10 out of 11 Clinical Quality Improvement Metrics (CQIMs) by passing the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023? Final data for July 2023 will be published during October 2023.	Yes
2	Did July's 2023 data contain a valid ethnic category (Mother) for at least 90% of women booked in the month? Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)	Yes
Has the Trust Board confirmed to NHS Resolution that they have passed the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023 for the following metrics:		
3	i. Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks also have the Continuity of Carer (CoC) pathway indicator completed.	Yes
	If maternity services have suspended all Continuity of Carer (CoC) pathways, criteria ii is not applicable:	
4	ii. Over 5% of women recorded as being placed on a Continuity of Carer (CoC) pathway where both Care Professional ID and Team ID have also been provided.	Yes
5	Did the Trust make an MSDS submission before the Provisional Processing Deadline for July 2023 data by the end of August 2023?	Yes
6	Has the Trust at least two people registered to submit MSDS data to SDCS Cloud who must still be working in the Trust?	Yes

Safety action No. 3
Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?

From 30 May 2023 until 7 December 2023

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
a) Pathways of care into transitional care have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care.		
1	Was the pathway(s) of care into transitional care jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies? Evidence should include: ● Neonatal involvement in care planning ● Admission criteria meets a minimum of at least one element of HRG XA04 ● There is an explicit staffing model ● The policy is signed by maternity/neonatal clinical leads and should have auditable standards. ● The policy has been fully implemented and quarterly audits of compliance with the policy are conducted.	Yes
2	Are neonatal teams involved in decision making and planning care for all babies in transitional care?	Yes
b) A robust process is in place which demonstrates a joint maternity and neonatal approach to auditing all admissions to the NNU of babies equal to or greater than 37 weeks. The focus of the review is to identify whether separation could have been avoided. An action plan to address findings is shared with the quadrumvirate (clinical directors for neonatology and obstetrics, Director or Head of Midwifery (DoM/HoM) and operational lead) as well as the Trust Board, LMNS and ICB.		
3	Is there evidence of joint maternity and neonatal reviews of all admissions to the NNU of babies equal to or greater than 37 weeks?	Yes
4	Is there an action plan agreed by both maternity and neonatal leads which addresses the findings of the reviews to minimise separation of mothers and babies born equal to or greater than 37 weeks?	Yes
5	Is there evidence that the action plan has been signed off by the DoM/HoM, Clinical Directors for both obstetrics and neonatology and the operational lead and involving oversight of progress with the action plan?	Yes
6	Is there evidence that the action plan has been signed off by the Trust Board, LMNS and ICB with oversight of progress with the plan?	Yes
c) Drawing on the insights from the data recording undertaken in the Year 4 scheme, which included babies between 34+0 and 36+6, Trusts should have or be working towards implementing a transitional care pathway in alignment with the BAPM Transitional Care Framework for Practice for both late preterm and term babies. There should be a clear, agreed timescale for implementing this pathway.		
7	Is there a guideline for admission to TC that include babies 34+0 and above and data to evidence this occuring?	Yes
8	OR An action plan signed off by the Trust Board for a move towards a transitional care pathway for babies from 34+0 with clear time scales for full implementation?	N/A

Safety action No. 4

Can you demonstrate an effective system of clinical workforce planning to the required standard?

From 30 May 2023 until 7 December 2023

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
a) Obstetric medical workforce		
Has the Trust ensured that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas after February 2023 following an audit of 6 months activity :		
1	a. Locum currently works in their unit on the tier 2 or 3 rota?	Yes
2	**OR** b. they have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progression (ARCP)?	N/A
3	**OR** c. they hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums?	N/A
4	Has the Trust implemented the RCOG guidance on engagement of long-term locums and provided assurance that they have evidence of compliance?	Yes
5	**OR** Was an action plan presented to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and Local Maternity and Neonatal System (LMNS) meetings? https://rcog.org.uk/media/uuzcbzg2/rcog-guidance-on-the-engagement-of-long-term-locums-in-mate.pdf	N/A
6	Has the Trust implemented RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day, and can the service provide assurance that they have evidence of compliance?	No
7	**OR** Has an action plan presented to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings? https://www.rcog.org.uk/media/c2jkpjam/rcog-guidance-on-compensatory-rest.pdf	Yes
8	Has the Trust monitored their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/ when a consultant is required to attend in person?	Yes
9	Were the episodes when attendance has not been possible reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance?	N/A
Do you have evidence that the Trust position with the above has been shared:		
10	At Trust Board?	Yes
11	With Board level safety champions?	Yes
12	At LMNS meetings?	Yes
b) Anaesthetic medical workforce		
13	Is there evidence that the duty anaesthetist is immediately available for the obstetric unit 24 hours a day and they have clear lines of communication to the supervising anaesthetic consultant at all times? In order to declare compliance, where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1)	Yes
	The rota should be used to evidence compliance with ACSA standard 1.7.2.1 (A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients)	
c) Neonatal medical workforce		
14	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of medical staffing and is this formally recorded in Trust Board minutes?	No
15	If the requirement above has not been met in previous years of MIS, Trust Board should evidence progress against the previously agreed action plan and also include new relevant actions to address deficiencies. If the requirements had been met previously but they are not met in year 5, Trust Board should develop and agree an action plan in year 5 of MIS to address deficiencies. Does the Trust have evidence of this?	Yes
Was the agreed action plan shared with:		
16	LMNS?	Yes
17	ODN?	Yes
d) Neonatal nursing workforce		
18	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of nursing staffing? And is this formally recorded in Trust Board minutes?	Yes
19	If the requirement above has not been met in previous years of MIS, Trust Board should evidence progress against the previously agreed action plan and also include new relevant actions to address deficiencies. If the requirements had been met previously but they are not met in year 5, Trust Board should develop and agree an action plan in year 5 of MIS to address deficiencies. Does the Trust have evidence of this?	N/A
Was the agreed action plan shared with:		
20	LMNS?	N/A
21	ODN?	N/A

Safety action No. 5

Can you demonstrate an effective system of midwifery workforce planning to the required standard?

From 30 May 2023 until 7 December 2023

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	a) Has a systematic, evidence-based process to calculate midwifery staffing establishment been completed? Evidence should include: A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated	Yes
2	b) Can the Trust Board evidence midwifery staffing budget reflects establishment as calculated in a) above? Evidence should include: ● Midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. ● Where Trusts are not compliant with a funded establishment based on BirthRate+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls. ● The plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified must be shared with the local commissioners. ● Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staffing. ● The midwife to birth ratio ● The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives.	Yes
3	c) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service. Can you provide evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating **100% compliance** with supernumerary labour ward co-ordinator status? The Trust can report compliance with this standard if failure to maintain supernumerary status is a one off event, however **the Trust cannot report compliance with this standard if the coordinator is required to provide any 1:1 care for a woman and/or care in established labour during this time.** If the failure to maintain supernumerary status is a recurrent event (i.e. occurs on a regular basis and more than once a week), the Trust should declare non-compliance with the standard and include actions to address this specific requirement going forward in an action plan. This plan must include mitigation/escalation to cover any shortfalls. Please note - Completion of an action plan will not enable the Trust to declare compliance with this standard.	Yes
4	d) Have all women in active labour received one-to-one midwifery care?	No
5	If you have answered **no** to standard d, have you submitted an action plan detailing how the maternity service intends to achieve 100% compliance with 1:1 care in active labour?	Yes
6	Does the action plan include a timeline for when this will be achieved and has this been signed off by Trust Board?	Yes
7	e) Have you submitted a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year five reporting period?	Yes

Safety action No. 6

Can you demonstrate that you are on track to fully implement all elements of the Saving Babies' Lives Care Bundle Version Three?

From 30 May 2023 until 7 December 2023

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Have you provided assurance to the Trust Board and ICB that you are on track to fully implement all 6 elements of SBLv3 by March 2024?	Yes
2	Do you hold quarterly quality improvement discussions with the ICB, using the new national implementation tool? Confirmation is required from the ICB with dates, that two quarterly quality improvement discussions have been held between the ICB (as commissioner) and the Trust using the implementation tool that included the following: ● Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element. ● Progress against locally agreed improvement aims. ● Evidence of sustained improvement where high levels of reliability have already been achieved. ● Regular review of local themes and trends with regard to potential harms in each of the six elements. ● Sharing of examples and evidence of continuous learning by individual Trusts with their local ICB and neighbouring Trusts.	Yes
3	Using the new national implementation tool, can the Trust demonstrate implementation of 70% of interventions across **all** 6 elements overall?	Yes
4	Using the new national implementation tool, can the Trust demonstrate implementation of at least 50% of interventions within **each** of the 6 individual elements?	Yes

Safety action No. 7

Listen to women, parents and families using maternity and neonatal services and coproduce services with users

From 30 May 2023 until 7 December 2023

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Is a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) in place which is in line with the Delivery Plan?	Yes
2	Has an action plan been co-produced with the MNVP following annual CQC Maternity Survey data publication (January 2023), including analysis of free text data, and progress monitored regularly by safety champions and LMNS Board?	Yes
3	Is neonatal and maternity service user feedback collated and acted upon within the neonatal and maternity service, with evidence of reviews of themes and subsequent actions monitored by local safety champions?	Yes
4	Can you provide minutes of meetings demonstrating how feedback is obtained and evidence of service developments resulting from co-production between service users and staff?	Yes
5	Do you have evidence that MNVPs have the infrastructure they need to be successful such as receiving appropriate training, administrative and IT support?	Yes
6	Can you provide the local MNVP's work plan and evidence that it is funded?	Yes
7	Do you have evidence that the MNVP leads (formerly MVP chairs) are appropriately employed or remunerated (including out of pocket expenses such as childcare) and receive this in a timely way?	Yes
8	Can you provide evidence that the MNVP is prioritising hearing the voices of families receiving neonatal care and bereaved families, as well as women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation?	Yes

Safety action No. 8

Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

From 1 December 2022 to 1st December 2023

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	A local training plan is in place for implementation of Version 2 of the Core Competency Framework	Yes
Can you evidence that the plan has been agreed with:		
2	Quadrumvirate?	Yes
3	Trust Board?	Yes
4	LMNS/ICB?	Yes
5	Has the plan been developed based on the four key principles as detailed in the "How to" Guide for the second version of the core competency framework developed by NHS England?	Yes
6	Can you evidence service user involvement in developing training?	Yes
7	Can you evidence that training is based on learning from local findings from incidents, audit, service user feedback, and investigation reports?	Yes
8	Can you evidence that you promote learning as a multidisciplinary team?	Yes
9	Can you evidence that you promote shared learning across a Local Maternity and Neonatal System?	Yes
Can you demonstrate the following at the end of 12 consecutive months ending December 2023? 80% compliance at the end of the previously specified 12-month MIS reporting period (December 2022 to December 2023) will be accepted, provided there is an action plan approved by Trust Boards to recover this position to 90% within a maximum 12-week period from the end of the MIS compliance period. In addition, evidence from rotating obstetric trainees having completed their training in another maternity unit during the reporting period (i.e. within a 12 month period) will be accepted. If this is the case, please select 'Yes'		
Fetal monitoring and surveillance (in the antenatal and intrapartum period)		
10	90% of obstetric consultants?	Yes
11	90% of all other obstetric doctors contributing to the obstetric rota (without the continuous presence of an additional resident tier obstetric doctor)?	Yes
12	90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives) and maternity theatre midwives who also work outside of theatres?	Yes
Maternity emergencies and multiprofessional training		
13	90% of Obstetric consultants?	Yes
14	90% of all other obstetric doctors including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota?	Yes
15	90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres) and bank/agency midwives?	Yes
16	90% of maternity support workers and health care assistants attend the maternity emergency scenarios training?	Yes
17	90% of obstetric anaesthetic consultants?	Yes
18	90% of all other obstetric anaesthetic doctors (staff grades and anaesthetic trainees) who contribute to the obstetric rota?	Yes
19	Can you demonstrate that **at least one** emergency scenario is conducted in a clinical area or at point of care?	Yes
20	Can you demonstrate that 90% of all team members have attended an emergency scenario in a clinical area **or** does the local training plan (Q1) include a plan to implement attendance at emergency scenarios in a clinical area for 90% of all team members?	Yes
Neonatal basic life support		
21	90% of neonatal Consultants or Paediatric consultants covering neonatal units?	Yes
22	90% of neonatal junior doctors (who attend any births)?	Yes
23	90% of neonatal nurses (Band 5 and above who attend any births)?	Yes
24	90% of advanced Neonatal Nurse Practitioner (ANNP)?	Yes
25	90% of midwives (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives)?	Yes
26	All trusts must have an agreed plan in place, including timescales, for registered RC-trained instructors to deliver the in-house basic neonatal life support annual updates and their local NLS courses by 31st March 2024.	Yes
27	Have you declared compliance for any of Q10-Q25 above with 80-90%?	No
28	If you are declaring compliance for any of Q10-Q25 above with 80-90%, can you confirm that an action plan has been approved by your Trust Board to recover this position to 90% within a maximum 12-week period from the end of the MIS compliance period?	N/A

Safety action No. 9

Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	**Required Standard A.** **Evidence that all six requirements of Principle 1 of the Perinatal Quality Surveillance Model have been fully embedded and specifically the following:-**	Yes
2	Does your Trust have evidence that a non-executive director (NED) has been appointed and is working with the Board safety champion to address quality issues?	Yes
3	Does your Trust have evidence that a review of maternity and neonatal quality is undertaken by the Trust Board at every Trust Board meeting, using a minimum data set to include a review of the thematic learning of all maternity Serious Incidents (SIs)? It must include: • number of incidents reported as serious harm • themes identified and action being taken to address any issues • Service user voice feedback • Staff feedback from frontline champions' engagement sessions • Minimum staffing in maternity services and training compliance	Yes
4	Do you have evidence that the perinatal clinical quality surveillance model has been reviewed in full in collaboration with the local maternity and neonatal system (LMNS) lead and regional chief midwife? And does this evidence show how Trust-level intelligence is being shared to ensure early action and support for areas of concern or need.	Yes
Required standard B. **Have you submitted evidence that discussions regarding safety intelligence; concerns raised by staff and service users; progress and actions relating to a local improvement plan utilising the Patient Safety Incident Response Framework are reflected in the minutes of:**		
5	The Trust Board?	Yes
6	LMNS/ICS/Local & Regional Learning System meetings?	Yes
7	Do you have evidence that the progress with actioning named concerns from staff feedback sessions is visible to staff?	Yes
8	Do you have evidence that Trust's claims scorecard is reviewed alongside incident and complaint data? Scorecard data is used to agree targeted interventions aimed at improving patient safety and reflected in the Trust's Patient Safety Incident Response Plan. These quarterly discussions must be held at least twice in the MIS reporting period at a Trust level quality meeting. This can be a Board or directorate level meeting.	Yes
9	**Required standard C.** **Have you submitted evidence that the Maternity and Neonatal Board Safety Champions are supporting the perinatal quadrumvirate in their work to better understand and craft local cultures?**	Yes
10	Have you submitted the evidence that both the non-executive and executive maternity and neonatal Board safety champion have registered to the dedicated FutureNHS workspace with confirmation of specific resources accessed and how this has been of benefit?	Yes
11	Have there been a minimum of two quarterly meetings between board safety champions and quadrumvirate members between 30 May 2023 and 1 February 2024?	Yes
12	Have you submitted evidence that the meetings between the board safety champions and quad members have identified any support required of the Board and evidence that this is being implemented?	Yes

Safety action No. 10

Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB/MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 to 7 December 2023?

Requirements number	Safety action requirements	Requirement met? (Yes/ No /Not applicable)
1	Complete the field on the Claims Reporting Wizard (CMS), whether families have been informed of NHS Resolution's involvement, completion of this will also be monitored, and externally validated.	Yes
2	Have you reported all qualifying cases to HSIB/CQC/MNSI from 6 December 2022 to 7 December 2023?	Yes
3	Have you reported all qualifying EN cases to NHS Resolution's EN Scheme from 6 December 2023 until 7 December 2023?	Yes
	For all qualifying cases which have occurred during the period 6 December 2022 to 7 December 2023, the Trust Board are assured that:	
4	The family have received information on the role of HSIB/MNSI and NHS Resolution's EN scheme	Yes
5	There has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour	Yes
	Can you confirm that the Trust Board has:	
6	Sight of Trust legal services and maternity clinical governance records of qualifying HSIB/MNSI/EN incidents and numbers reported to HSIB/MNSI and NHS Resolution?	Yes
7	Sight of evidence that the families have received information on the role of HSIB/MNSI and the EN scheme?	Yes
8	Sight of evidence of compliance with the statutory duty of candour?	Yes

NHS Resolution

Section A : Maternity safety actions - Stockport NHS Foundation Trust

Action No.	Maternity safety action	Action met? (Y/N)
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Yes
3	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?	Yes
4	Can you demonstrate an effective system of clinical workforce planning to the required standard?	Yes
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes
6	Can you demonstrate that you are on track to fully implement all elements of the Saving Babies' Lives Care Bundle Version Three?	Yes
7	Listen to women, parents and families using maternity and neonatal services and coproduce services with users	Yes
8	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?	Yes
9	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	Yes
10	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB/MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 to 7 December 2023?	Yes

NHS Resolution

Section B : Action plan details for Stockport NHS Foundation Trust

An action plan should be completed for each safety action that has not been met

Action plan 1

Safety action		**To be met by**	
Work to meet action			
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner			
Lead executive director			
Amount requested from the incentive fund, if required			
Reason for not meeting action			
Rationale			
Benefits			
Risk assessment			

	How?	Who?	When?
Monitoring			

Action plan 2

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 3

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 4

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 5

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 6

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 7

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 8

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 9

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 10

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Maternity Incentive Scheme - Board declaration form

Trust name	**Stockport NHS Foundation Trust**
Trust code	**T572**

All electronic signatures must also be uploaded. Documents which have not been signed will not be accepted.

	Safety actions	Action plan	Funds requested	Validations
Q1 NPMRT	Yes		-	
Q2 MSDS	Yes		-	
Q3 Transitional care	Yes		-	
Q4 Clinical workforce planning	Yes		-	
Q5 Midwifery workforce planning	Yes		-	
Q6 SBL care bundle	Yes		-	
Q7 Patient feedback	Yes		-	
Q8 In-house training	Yes		-	
Q9 Safety Champions	Yes		-	
Q10 EN scheme	Yes		-	
Total safety actions	**10**	**-**		
Total sum requested			**-**	

Sign-off process confrming that:

* The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets standards as set out in the safety actions and technical guidance document and that the self-certification is accurate.

* The content of this form has been discussed with the commissioner(s) of the trust's maternity services
* There are no reports covering either **this year (2023/24) or the previous financial year (2022/23)** that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration. Any such reports should be brought to the MIS team's attention.
* If applicable, the Board agrees that any reimbursement of maternity incentive scheme funds will be used to deliver the action(s) referred to in Section B (Action plan entry sheet)
* We expect trust Boards to self-certify the trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of board governance which the Steering group will escalate to the appropriate arm's length body/NHS System leader.

Electronic signature of Trust Chief Executive Officer (CEO):	
For and on behalf of the Board of	Stockport NHS Foundation Trust
Name:	
Position:	
Date:	

Electronic signature of Integrated Care Board Accountable Officer:	
For and on behalf of the board of	Stockport NHS Foundation Trust
Name:	
Position:	
Date:	

McCarthy Rebecca 30/01/2024 09:28:02

NHS
Stockport
NHS Foundation Trust

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

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

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

	Safe		Effective
	Caring		Responsive
X	Well-Led		Use of Resources

This paper relates to the following Board Assurance Framework risks

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

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

Where issues are addressed in the paper

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

Executive Summary

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

1. Introduction

This is my first report to the Board since I commenced in the role of Interim Chair of Stockport NHS Foundation Trust on 1st January 2024. Having been a Non-Executive Director since 2019, this is an exciting opportunity. It is a privilege to serve the Trust as Interim Chair.

On behalf of the Board of Directors I would like to express thanks and appreciation to Professor Tony Warne who left the organisation at the end of December to take up his new role as Chair of Greater Manchester Mental Health NHS Foundation Trust. Tony joined Stockport NHS FT in 2020 at what was such an important time to take up such a critical role. I want to reflect on and acknowledge Tony's contribution the Trust's achievements over the last three years. He was a consistent and positive influence and created important connections with colleagues across all settings and services. I'm sure you will join me in wishing Tony all the best in his new role.

2. External Partnerships

I attended the Stockport Health and Wellbeing Board where the latest draft of the One Stockport Plan was presented, and Stockport Council's new Director of Public Health presented the latest figures on Healthy Life Expectancy (HLE) a key outcome measure in assessing the extent to which health is improving and disparities are narrowing.

I met with the Chairs from Sector 3, Mastercall, Viaduct, Pennine Care, and HealthWatch. These are bi-monthly meetings and an opportunity to share issues and challenges faced by these Stockport focused organisations. At this meeting we explored a number of interrelated issues including workforce pressures, flow and discharges, Child and Young People's Mental Health.

I am due to attend the Greater Manchester Trust Chairs meeting on in February and have separately met with Evelyn Asante-Mensah (Pennine Care), Aislynn O'Dwyer (East Cheshire) and Jane McCall (Tameside & Glossop).

As a Non-Executive Director on the Health Service Safety Investigation (HSSIB) I continue to gain important insight into healthcare safety investigations from a national perspective. This month the HSSIB board meeting was held at the Air Accident Investigation Branch (AAIB) in Farnborough where senior leadership teams discussed how Safety Management Systems (SMS) are used in safety-critical industries and how the principles of an SMS could contribute to more effective safety management in healthcare.

3. Trust Activities

I am delighted to be part of the Trust's reverse mentoring scheme and have been paired with one of our colleagues from the Transformation Team. In the scheme, board members and senior managers are mentored by a junior colleague from a black and ethnic minority background or with a disability. The aim is to increase our understanding of the barriers facing colleagues with a different background.

As part of the financial turnaround programme of NHS Greater Manchester ICB, supported by PwC, I have attended two Stockport's Finance and Recovery Meetings. Whilst these meetings are formal and provide challenge, I found them to be supportive and action orientated towards improvement.

This month's informal Non-Executive/Governor meeting (bi-monthly) was very well attended. Governors shared topics that had been raised by members, including communication, outpatient appointments and discharges. These are important sessions that keep non-execs and governors connected and further strengthen triangulation.

I was delighted to hear that Mary Moore, our Chair of Quality Committee has been appointed as Non-Executive Director on the board of Wigan, Wrightington and Leigh NHSFT. Another important connection within the Greater Manchester system. I'm sure the Board will want to join me in congratulating Mary on her new role.

4. Strengthening Board Oversight

The next event is scheduled for 7th March. I am currently engaging with Executive and Non-Executive Directors to review the Board Development Programme for 2024/25. The Walkabout Wednesday programme continues.

5. Other activities:

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

- Regular discussions with Non-Executive Directors, Executive Directors, Chief Executive and the Deputy Chief Executive
- Meeting with the Lead Governor
- Meeting with Stockport Council Cabinet Member for Health & Social Care

NHS
Stockport
NHS Foundation Trust

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

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

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

	Safe		Effective
	Caring		Responsive
X	Well-Led		Use of Resources

This paper relates to the following Board Assurance Framework risks

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

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

Where issues are addressed in the paper

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

Executive Summary

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

- Industrial Action
- NHS GM Integrated Care - Finance Update
- NHS GM Integrated Care – 2024/25 Planning Update
- Operational Pressures
- Outpatients B Update
- Handover of Rapid Assessment Unit
- Visit from Leader of Liberal Democrats
- Awards

1. Purpose

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

2. Industrial Action

At the end of December and start of January, our junior doctors took part in the British Medical Association's (BMA) latest rounds of industrial action, Wednesday 20th December – Saturday 23rd December, and Wednesday 3rd January to Tuesday 9th January. The January strike was the longest period of industrial action since strikes began.

As with previous industrial action, actions and plans were put in place to ensure staffing levels were safe, and minimise risk during the strike, which included the cancellation of some elective procedures. No further strike action has been announced for junior doctors at this time.

In late November it was announced that the government and unions had reached an agreement to put an offer to union members for consultants, with a similar announcement made in December for SAS doctors. These pay offers will be subject to votes in January 2024 to see if they are accepted by members; in the meantime, no future action will be announced for consultants and SAS doctors until the outcome of these votes.

3. GM Integrated Care

NHS GM Integrated Care - Finance Update

The GM ICB is reporting a year-to-date deficit of £187m against a plan of £15m deficit; a significant variance of £172m, and at Month 8, is reporting a forecast breakeven position against plan. In relation to the variance, £62.7m related to NHS provider positions and £109.5m related to NHS GM. The NHS GM position has improved in Month 8 due to a range of mitigations as part of the turnaround programme and the increased slippage on particular GM programmes.

Pressures continue to remain relating to mental health, out of area placements, prescribing and continuing healthcare. Additionally, a £84m variance is included in the NHS GM position relating to the system wide efficiency target hosted by NHS GM.

NHS GM Planning 2024/25

The first of three planned sessions to engage with GM system leaders in terms of the approach to, and requirements of the planning round for 24/25 took place on 12th December 2023, the next is planned for 29th January 2024, and aims to enable a strategic and integrated approach to the planning round, as well as an opportunity for challenge, confirming collective priorities and ensuring alignment of draft and final plans. In addition to this, the forum is also a critical space for the system leadership community to build relationships and consider how the system work together to realise the ambitions and deliver collective, co-produced plans in the context of the GM operating model and five-year strategy. The sessions are attended by Place Leads, Trust CEOs, Primary Care and VCSE leads. The final session will be in March 2024.

Following the first session, NHS GM has set out a proposed approach that builds on the discussions of the session and responds to the request from localities for clarity about their role in planning for 2024/25, which involves collectively (GM and localities) agreeing the areas of priority focus as part of the 2024/25 GM System Delivery Plan and updated GM Joint Forward Plan.

4. Operational Pressures

The months of December and January are traditionally the most pressured for NHS services, including urgent and emergency care services. Trusts across Greater Manchester have been providing services under considerable pressure, with challenges around waiting times and bed capacity to accommodate patients requiring acute care.

Our Trust has been no different in this respect with considerable pressure experienced throughout our emergency care pathway. In the first week of January, we saw 2,131 patients in our Emergency Department, 93 more than the previous week, and we did escalate our pressures to OPEL4 level at times. Our team worked tirelessly to cope with the increased demand, working closely with partners to help discharge patients from hospital who were medically fit to go home. We also worked closely with communications partners in the region to share messages about our pressures, to ensure patients continue to choose the right services for them.

Coupled with industrial action, and the closure of Outpatients B during this period, the operational pressures have had an impact on our elective recovery position, and our efforts to meet the end of year national target. The Trust has continued to prioritise urgent and cancer elective patients for treatment. We have also continued to prioritise long waiting routine patients.

The remainder of Quarter 4 is expected to be particularly challenging as we work to maintain our emergency care pathways and achieve the requirements for our longest waiting elective patients.

5. Closure of Outpatients B

Our Outpatient B department closed its doors on 23rd November 2023. The building is currently being emptied of all equipment in preparation for demolition.

Over 50% of our outpatient activity is now temporarily located across the hospital site. We are currently working closely with our Ophthalmology and orthodontist teams for a medium term solution to house these services and their specialist equipment.

6. Handover of our Rapid Assessment Unit

We have celebrated a construction milestone to enhance emergency and urgent care for patients at Stepping Hill Hospital, with a light switch on of the Trust signage.

The event marks the completion of the new Rapid Assessment Unit in the Emergency and Urgent Care Campus. In attendance to mark this milestone, I was joined by representatives from the Trust Governors, Board members and emergency service leads, and firms Tilbury Douglas, Rider Hunt and Hive.

The scheme comprises a full-scale remodelling of the existing Emergency Department at the Hospital with approximately 2,600sqm of internal refurbishment, along with a remodelling of the existing ambulance drop-off. There will be new assessment, treatment and consultation areas for several key emergency and urgent care services including the children's emergency department, mental health, and medical same day emergency care.

Once completed, the campus will help to enhance emergency and urgent care for the local population of Stockport, as well as residents in High Peak and Cheshire East, where patients, their

families and carers will receive high quality care. The campus will be opening for patients during the new year.

7. Ed Davey, Leader of Liberal Democrats visits Stepping Hill Hospital

We were visited by Ed Davey, Leader of the Liberal Democrats on his recent visit to Stockport. During his visit, he toured our site to look at our ageing estate, along with Councillor Mark Hunter, Leader of Stockport Council and Councillor Tom Morrison, Liberal Democrat Parliamentary Candidate for Cheadle.

Following the visit, Lisa Smart, Liberal Democrat Parliamentary Candidate for Hazel Grove, has launched a petition for a new hospital in Stockport.

8. Awards

Trust receives top rating for patient care

Our outpatient oncology chemotherapy services have received the top rating for patient care following an independent inspection.

The hospital's Laurel Suite received the Quality Mark from The Christie, which is an international leader in cancer care.

In the first inspection since the COVID-19 lockdown, The Christie inspection team observed and reviewed services, including asking patients and staff their opinions both as a questionnaire and face-to-face.

Standards under review included clinical safety, good communication with patients, friendliness and openness of staff, high standards of documentation, and overall quality of care. All were found to be of high quality with the inspection team highlighting that *'patient feedback was truly outstanding, as was the staff survey feedback'.*

The Laurel Suite team provides chemotherapy and supportive drug treatments for cancer patients and sees around 6,500 appointments a year.

SAS doctor colleague of the year

A Stepping Hill Hospital orthopaedic doctor has been named as a colleague of the year in regional awards for trauma and orthopaedic doctors.

Antonio Frasquet was named as 'SAS (specialist, associate specialist and specialty doctors) Colleague of the Year' by the North West Orthopaedic Trainees Association (NWOTA), which represents all the Trauma and Orthopaedic trainees in the NW (Eastern) Deanery.
This was the first award of its kind from the NWOTA.

Stockport Parenting Team first in country to receive new Invest In Play support award

The specialist Parenting Team in Stockport have become the first in the country to receive accreditation in a new parenting programme Invest in Play.

The team have been awarded as the first UK Invest in Play (iiP) Level 4 Facilitators following an independent assessment from organisers of the new programme.

The invest in play (iiP) parent programme is a 12 session course for parents of children age 2-12 years. It has been developed by an international not-for-profit organisation with a mission to support children and their caregivers around the world. The course has been shown to build children's social skills, self-confidence and help them to regulate their emotions, helping parents with compassionate and practical strategies to support their children. It helps many children including those struggling with low self-esteem, behavioural difficulties, ADHD and Autism.

Feedback from parents and carers supported by the team has been overwhelmingly positive. One user has written 'this course has changed my life and my family's life too: and I know it will change many others'.

The specialist Stockport Parenting team is part of the Stockport Family Children's Services, an integrated partnership of health, early years, family help, social care and education services, provided between Stockport NHS Foundation Trust, Stockport Metropolitan Borough Council. They support parents and carers to understand the emotional and behavioural difficulties their child may be experiencing in order to improve parent-child relationships and family harmony.

NHS Stockport NHS Foundation Trust

Meeting date	1st February 2024	**Public**	x	**Agenda No.**	9
Meeting	Board of Directors				
Report Title	Integrated Performance Report				
Director Lead	Chief Executive	**Author**	Peter Nuttall, Director of Informatics		

Paper For:	**Information**		**Assurance**	x	**Decision**	
Recommendation:	The Board of Directors is asked to note and discuss performance against the reported metrics. This includes the described issues that are affecting performance and any mitigating actions to improve performance that are described in the exception reports.					

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

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

This paper relates to the following Board Assurance Framework risks

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

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

Where issues are addressed in the paper

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

Executive Summary

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

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

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

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

BUSINESS INTELLIGENCE

NHS Stockport NHS Foundation Trust

Integrated Performance Report

Reporting period

December 2023

Introduction

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

Quality Highlights

Exception reports included this month relate to performance against Sepsis, Infection Prevention and Control, Incidents and Pressure Ulcers due to under-achievement in month.

- The Trust is performing well against the Timely Recognition of Sepsis metric and achieving well above target levels. Antibiotic administration within timescales continues to be challenging. Key themes include fails occurring out of hours (7 out of 8), delayed prescribing being a factor in all incidents and failure by clinician to complete Sepsis6 in a timely manner.
- Reported infection rates for C.diff and E.coli continue to be significantly higher than the thresholds set by the UKHSA. C.diff themes from the avoidable cases are linked with antibiotic appropriateness, course length, and course numbers which appear to have increased following the COVID pandemic.
- Numbers of hospital-acquired category-2 pressure ulcers are still within target threshold; however, December was the highest month YTD for category-2 pressure ulcers (8). There has been an increased focus on training and engagement with AHPs and we are developing the digital pressure ulcer risk assessment tool. Community-acquired pressure ulcers continue to be a challenge, as reported previously, patient decision-making is a primary theme. We are continuing to develop work streams to support community nurses in their communication with patients. One of the category-3 community acquired pressure ulcers showed some areas in which we can learn, and these have been shared with the team.

Operations Highlights

Exception reports included this month relate to performance against ED, Patient Flow, Diagnostics, Cancer, RTT, Outpatient Efficiency, and Theatres due to under-achievement in month.

- Current performance against the 4-hour standard continues to benchmark well across Greater Manchester, with Stockport ranking 2nd for type-1 performance at 63.21% year-to-date. 12-hour waits have drastically increased and robust processes for managing, reviewing, and providing assurance for assessment of harm in respect of the delays, are fully embedded within the service.
- The challenges of accessing timely care home beds continue to impair the Trust's ability to discharge or transfer patients with 'no criteria to reside' in a timely manner; however, NCtR patients have decreased this month.
- Diagnostic performance has been challenged by industrial action and long-term sickness amongst other things. Endoscopy has also suffered due to repeat/return procedures and now has a waiting list of 66 patients waiting over 6 weeks. Imaging has suffered over the festive period due to annual leave as well as the above.
- Cancer performance has continued to improve. 62-day performance for November was up 6.2% vs October and 28-day performance for December was up 3.9% vs November. Support from the national team and Cancer Alliance has supported this improvement.

Workforce Highlights

Exception reports included this month relate to Sickness Absence, Turnover, Mandatory Training, and Appraisals due to under-performance in month.

- Sickness Absence is above target for December and has increased from November (+0.62%); however, it is much improved from December 2022 (-1.18%). Rolling 12-month absence is also ahead of target. Mental health is one of the main contributors to staff not being in work but has showed improvement. Seasonal illness has increased month on month and is now the 2nd highest reason for absence. Preventative measures are in place including flu vaccinations being offered and there has been an appointment of a staff MSK physio.

- Although still above the target, workforce turnover is showing a steady decline and heading towards the target of 12.5%. It is also a much improved position vs December 2022 (-0.67%). Voluntary resignation and work-life balance are the top-two reasons for leaving for 2023.

- Mandatory training is showing significant improvements but has dipped slightly below target at 94.98%. This is due to industrial action and is expected to be remedied via additional sessions in January.

Finance Highlights

- The Trust has submitted a plan with an expected deficit of £31.5m for the financial year 2023-24. The deficit assumes delivery of an efficiency target of £26.2m of which £10.3m is recurrent.

- At month 9, the Trust position is £1.0m adverse to plan – a deficit of £24.8m. This is an improvement of £0.3m in month.

- The drivers of the movement from plan are the impact of industrial action by junior doctors and consultants, the ERF estimated penalty from April to December, risks around contract income and the cost of the pay award for 2023-24 over and above expected funding.

- The Trust continues to operate with additional capacity open in escalation beds and enhanced staffing levels to support the high level of attendances in the emergency department.

- The CIP plan for 2023-24 is £26.2m (£10.3m recurrent). The CIP plan for month 9 is £19.3m; and at this point the delivery against the target is break-even. The majority of the CIP delivered is non-recurrent. Further work continues to take place to identify additional recurrent schemes.

- The Trust has maintained sufficient cash to operate during December.

- The Capital plan for 2023-24 is £62.7m, the latest expenditure forecast is £46.1m. At month 9, expenditure is behind plan by £6.4m; however, this spend will be reprofiled into future months.

Integrated Performance Report
Scorecard

BUSINESS INTELLIGENCE

NHS Stockport NHS Foundation Trust

	Reporting Period	Target 23/24	Actual YTD	6-mth Trend	Actual Month	Current Period	1-mth Forecast
Quality Scorecard							
Mortality: SHMI	Sep-22 to Aug-23	≤ 100		↑	93	●	●
Sepsis: Timely recognition	Jan-23 to Dec-23	≥ 90%		↑	97.7%	●	●
Sepsis: Antibiotic administration	Jan-23 to Dec-23	≥ 90%		→	75%	▲	▲
C.diff infection rate	Jan-23 to Dec-23	≤ 17.63		→	61.74	▲	▲
Covid-19 infection rate	Jan-23 to Dec-23	≤ 4.27		↑	1.59	●	●
MRSA infection rate	Jan-23 to Dec-23	≤ 0		→	2.7	▲	▲
E. coli infection rate	Jan-23 to Dec-23	≤ 20.27		→	116.27	▲	▲
Medication incident rate	Jul-23 to Dec-23	≤ 4.64		↓	5.99	▲	▲
Patient safety incident rate	Jul-23 to Dec-23	≤ 69.24		↓	85.01	▲	▲
STEIS reportable incidents	Dec-23	≤ 4	39	↗	2	●	●
Stroke: Overall SSNAP Level	Sep-23	≥ C		→	A	●	●
Falls rate	Dec-23	≤ 3.51	2.98	→	3.06	●	●
Falls due to lapses in care	Dec-23	≤ 425	205	↗	15	●	●
Falls causing moderate+ harm	Dec-23	≤ 22	5	→	1	●	●
Pressure Ulcers: Hospital, Cat 2	Dec-23	≤ 79	47	→	8	▲	●
Pressure Ulcers: Hospital, Cat 3&4	Dec-23	≤ 8	8	↘	2	▲	▲
Pressure Ulcers: Community, Cat 2	Dec-23	≤ 114	104	→	14	▲	▲
Pressure Ulcers: Community, Cat 3&4	Dec-23	≤ 38	36	→	2	●	▲
Complaints: Written Complaints Rate	Dec-23	≤ 7.9	7.47	→	5.13	●	●
Complaints: Timely response	Dec-23	≥ 95%	93.9%	↗	100%	●	●
Early Neonatal Deaths	Dec-23	≤ 0	2	→	0	●	●
Registrable Stillbirths	Dec-23	≤ 0	2	→	0	●	●
Registrable Stillbirth Rate	Dec-23	≤ 0	0.93	→	0	●	●
Smoking In Pregnancy	Dec-23	≤ 10%	6%	→	5%	●	●
Maternity Diverts	Dec-23	≤ 0	10	↗	0	●	●

	Reporting Period	Target 23/24	Actual YTD	6-mth Trend	Actual Month	Current Period	1-mth Forecast
Operational Scorecard							
Ambulance handover delays	Mar-23	≤ 5%	23%	→	22.6%	▲	▲
4hr Standard	Dec-23	≥ 76%	63.4%	↘	56.6%	▲	▲
Patients in department over 12 hrs	Dec-23	≤ 2%	8.6%	↓	14.7%	▲	▲
No criteria to reside (NCTR)	Dec-23	≤ 73	807	↗	72	●	●
Discharge ready	Dec-23		80.6%	→	79.8%	○	□
Delayed discharges	Dec-23		4%	→	3.9%	○	□
Diagnostics: 6 Week Standard	Dec-23	≤ 5%	13.1%	↘	15.4%	▲	▲
62-day standard	Dec-23	≥ 85%	52.9%	↗	67.4%	▲	▲
28-day standard (FDS)	Dec-23	≥ 75%	64.5%	→	69.1%	▲	▲
14-day standard (2WW)	Dec-23	≥ 93%	97%	→	98.3%	●	●
Incomplete pathways 18-week %	Dec-23	≥ 92%		→	48.8%	▲	▲
52-week breaches	Dec-23	≤ 3803		↑	3611	●	●
65-week breaches	Dec-23	≤ 0		→	1192	▲	▲
Activity vs. Plan: Elective	Dec-23	≥ 100%	101.9%	→	102.1%	●	●
Activity vs. Plan: Outpatient	Dec-23	≥ 100%	99.7%	↘	90.7%	▲	▲
Activity vs. Plan: ED Attendances	Dec-23	≤ 100%	100.9%	↘	104.2%	▲	▲
Outpatient DNA rate	Dec-23	≤ 6.3%	7.8%	↘	8.2%	▲	▲
Outpatient clinic utilisation	Dec-23	≥ 90%	89.6%	→	89.8%	▲	▲
Patient initiated follow up (PIFU)	Dec-23	≥ 4.61%	3.6%	→	3.7%	▲	▲
Capped Touch Time Utilisation	Dec-23	≥ 85%	68.7%	→	67%	▲	▲
Average cases per 4-hour session	Dec-23	≥ 2.8	2.76	→	2.71	▲	▲
Workforce Scorecard							
Substantive Staff-in-Post	Dec-23	≥ 90%	91.8%	↑	93.5%	●	●
Sickness Absence: Monthly Rate	Dec-23	≤ 6%	5.9%	↘	6.3%	▲	▲
Workforce Turnover	Dec-23	≤ 12.5%	14.4%	↗	13.5%	▲	▲
Staff Retention Rate	Dec-23		98.9%	→	99%	○	◎
Appraisal Rate: Overall	Dec-23	≥ 95%	89.8%	→	89.4%	▲	▲
Mandatory Training	Dec-23	≥ 95%	94.2%	↗	95%	●	●
Agency Costs %	Dec-23	≤ 3.7%	5.2%	↗	3.6%	●	●
Finance Scorecard							
Capital Expenditure	Dec-23	≤ 10%		→	-38.2%	●	●
Cash Balance	Dec-23			↘	18.5	○	○
CIP Cumulative Achievement	Dec-23	≥ 0%		↗	0.1%	●	●
Financial Controls: I&E Position	Dec-23	≤ 0%		↗	4.3%	▲	▲

Legend

1-month Forecast

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

Current Period

- ● target achieved
- ▲ target not achieved

6-month Trend

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

Quality: Sepsis

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
Sepsis: Timely recognition	The number of patients who are screened for sepsis, as a percentage of those eligible patients audited.	>= 90%	97.7%	↑	● ● ● ● ● ●	●
Sepsis: Antibiotic administration	The number of patients who received IV antibiotics within agreed timescales for sepsis patients, as a percentage of eligible patients audited and found to have sepsis.	>= 90%	75%	→	▲ ▲ ▲ ▲ ▲ ▲	▲

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

Antibiotic Administration

- December compliance 68%.
- 12- month rolling figure now 75%, below trust target of 95%
- 17/25 patients screened for sepsis received antibiotics in accordance with trust guidelines.
- 8 fails - 7 occurred out of hours.
- 3 fails within Medicine, 1 fail in Integrated Care, and 4 within Surgery.
- Delays: 40 min, 3hour 6min, 22 min, 14 min, 26min, 50 min, 6hours 13min, 4hour 41 min.
- Themes: delayed prescribing also factor in all incidents. Prescribing as scheduled dose in 3 incidents added to delay.
- Sepsis6 completed late by clinician in 4 incidents and only 1 completed in a timely manner.

Timely Recognition

- 99% timely recognition in December.
- 12- month rolling figure 97.7% ahead of trust target of 95%.
- 105 records included in audit.
- Fail occurred in Medicine, out of hours, 2222 not utilised.

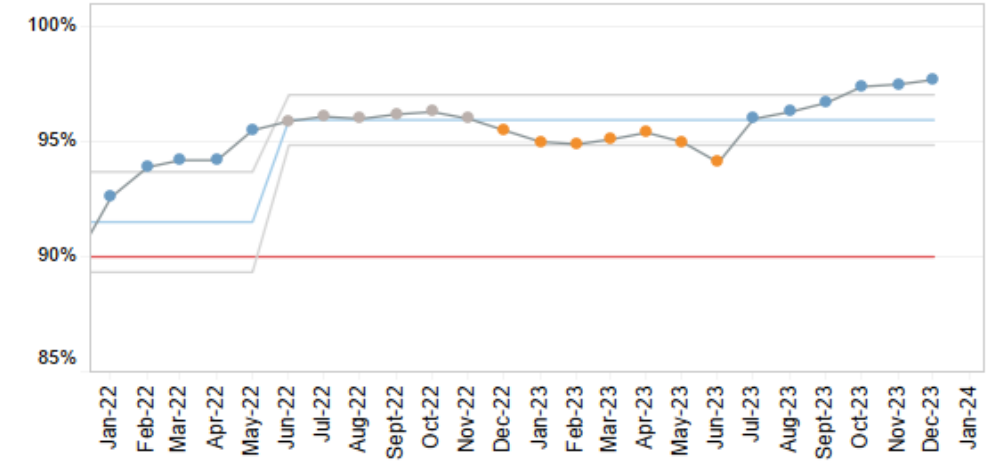
Key Actions January

- Continue trial AQ audit.
- Revisit senior nurse toolbox rollout to Surgery Division.
- 23 staff attended toolbox sessions December.
- Await amber/ red flag workflow changes.
- Raise inappropriate prescribing as scheduled dose- to- treat sepsis via Risky Business.

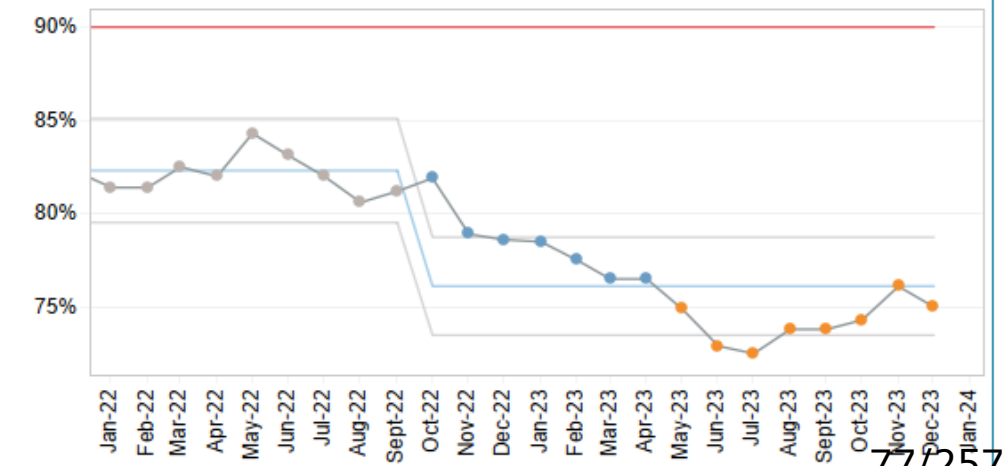
McCarthy,Rebecca 30/01/2024 09:18:02

Signed off by	Emily Abdy
Executive Lead	Nicola Firth

Performance for Sepsis: Timely recognition



Performance for Sepsis: Antibiotic administration



Quality: Infection Rates

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
C.diff infection rate	The number of hospital-onset Clostridioides Difficile (C. diff) infections per 100,000 bed days for patients aged 2 years and older.	<= 17.63	61.74	→	▲ ▲ ▲ ▲ ▲ ▲	▲
Covid-19 infection rate	The number of Covid-19 infections per 1,000 bed days.	<= 4.27	1.59	↑	● ● ● ● ● ●	●

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

C.Difficile Infection Rate
There were 5 HOHA (hospital- onset) and 2 COHA (community- onset) cases in December, totalling 64 YTD. The Trust is over the projected threshold of 30 for the end of December and over the 2023-24 threshold of 40 cases for the year.

60 cases have been presented to the HCAI Panel. 9 cases have been deemed Avoidable and 51 cases deemed Unavoidable. 4 cases await panel review in January.

The latest national figures (October 2023) rate Stockport fifth out of the seven GM Trusts.

UKHSA are investigating a newly- evolving ribotype (955) which has emerged in the last 2 years. The new variant has caused 2 large hospital outbreaks in England. The IPC team is monitoring this development closely.

COVID-19 Infection Rate
The Trust had 18 new COVID-19 positive cases in December, of which 2 were nosocomial. This is a decrease of 4 positive cases and a decrease of 4 HOC case numbers on the previous month.

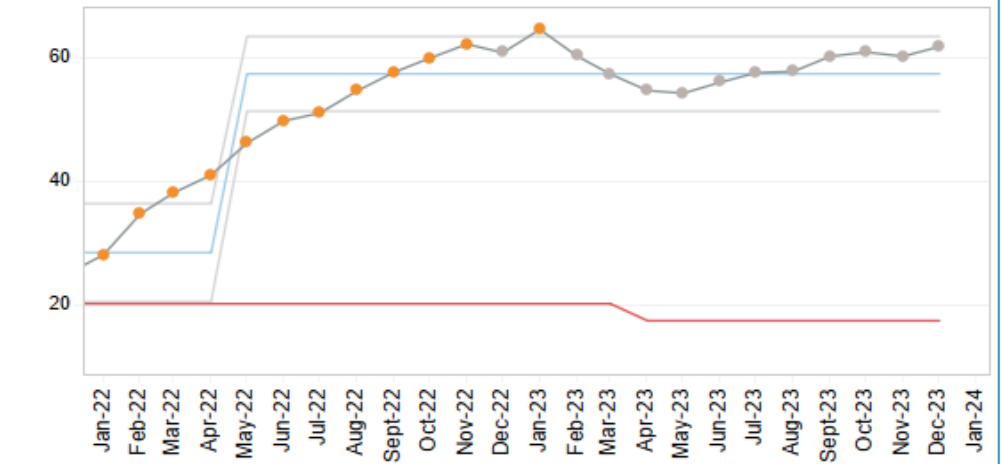
The Trust currently has a HOC rate of 11% which is a decrease of 16% from last month.

Winter escalation plan has now been agreed and is in place.

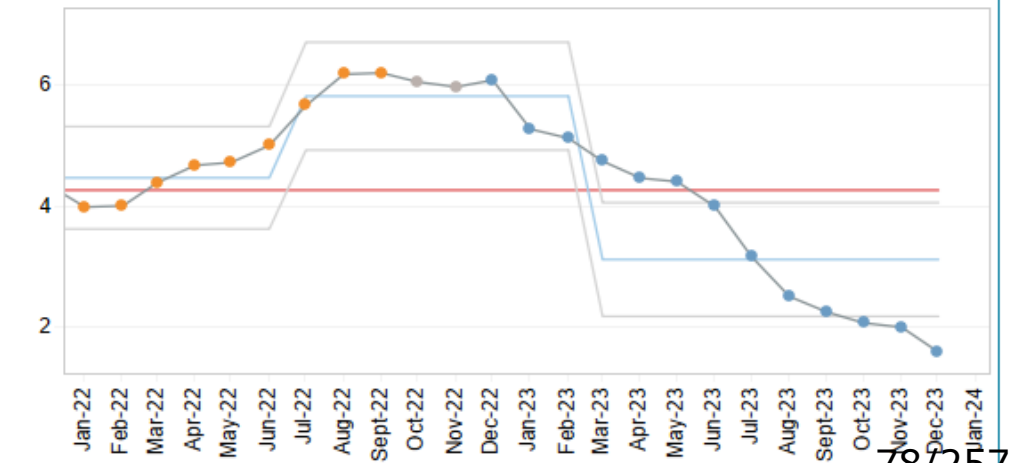
Both nationally and across GM numbers of respiratory viruses are starting to increase.

McCarthy,Rebecca
30/01/2024 09:18:02

Performance for C.diff infection rate



Performance for Covid-19 infection rate



Signed off by	Nesta Featherstone
Executive Lead	Nicola Firth

Quality: Infection Rates (continued)

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
E. coli infection rate	The number of Escherichia Coli (E. coli) bacteraemia infections per 100,000 bed days.	<= 20.27	116.27	→	▲ ▲ ▲ ▲ ▲ ▲	▲
MRSA infection rate	The number of hospital-onset Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia infections per 100,000 bed days.	<= 0	2.7	→	▲ ▲ ▲ ▲ ▲ ▲	▲

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

E.Coli Infection Rate
There were 2 HOHA and 1 COHA in December, totalling 52 cases YTD. The Trust is over the projected threshold of 35 for the end of December and over the 2023-24 threshold of 46 cases for the year.

The latest national figures (October 2023) rate Stockport fourth out of the seven GM Trusts.

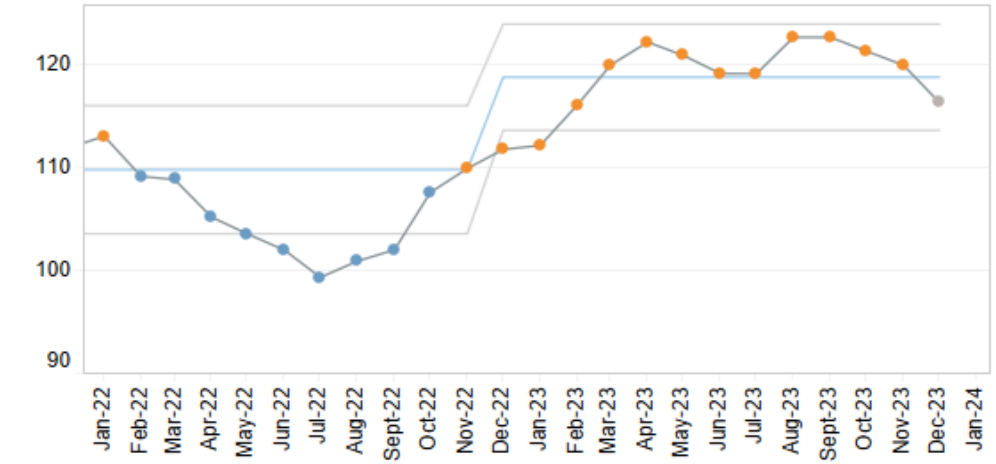
The trust is supporting the national UTI campaign to raise awareness.
A full review of urinary catheter care and management across the Trust is currently underway to standardise practice.

MRSA Infection Rate
The Trust has had 0 cases of MRSA in December against a zero-tolerance threshold set by the UKHSA.

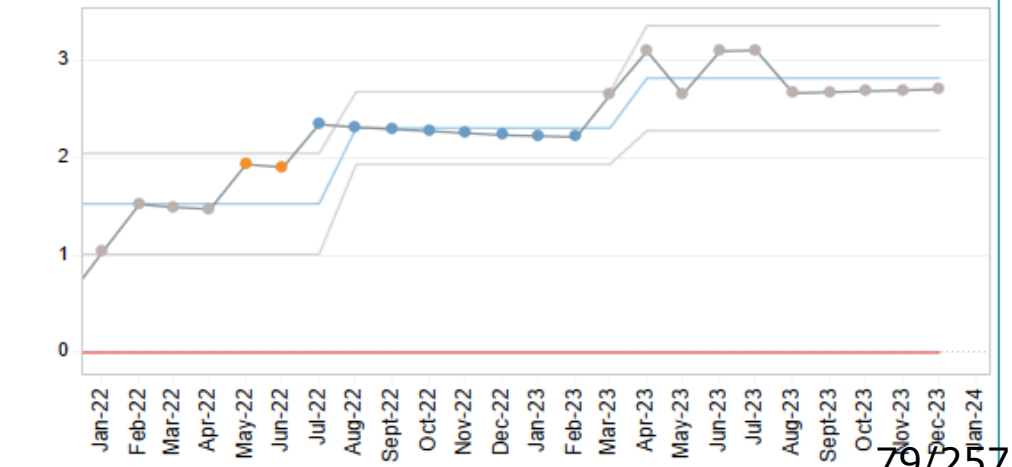
The latest national figures (October 2023) rate Stockport third out of the seven GM Trusts.

McCarthy,Rebecca
30/01/2024 09:18:02

Performance for E. coli infection rate



Performance for MRSA infection rate



Signed off by	Nesta Featherstone
Executive Lead	Nicola Firth

Quality: Incidents

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
Medication incident rate	The number of medication incidents, calculated as an incidence rate for every 1000 bed days. This average is calculated using a rolling 6 months of data.	<= 4.64	5.99	↓	▲ ▲ ▲ ▲ ▲ ▲	▲
Patient safety incident rate	The number of patient safety incidents, calculated as an incidence rate for every 1000 bed days. This average is calculated using a rolling 6 months of data.	<= 69.24	85.01	↓	▲ ▲ ▲ ▲ ▲ ▲	▲
STEIS reportable incidents	The total number of STEIS reportable incidents. Target/benchmark based on the median performance for 2021/22 financial year.	<= 4	2	→	▲ ● ▲ ▲ ● ●	●

Medication Incident Rate
There are no issues related to medication incidents to report.

Medication incidents are reviewed at Incident Review Group on a weekly basis..

Patient Safety Incident Rate
There are no issues related to patient incidents to report.

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

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

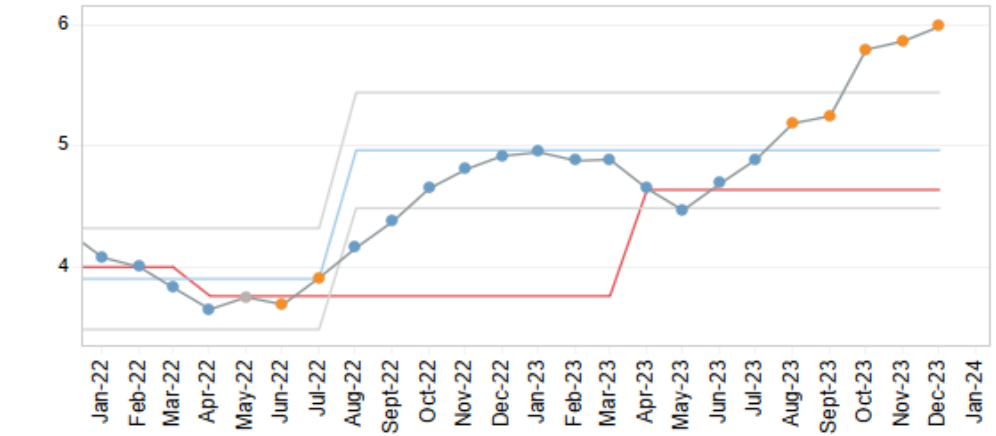
STEIS Reportable Incidents
There were 2 serious incidents declared and submitted to StEIS in December 2023:

- Patient lost to follow- up;
- Delayed escalation.

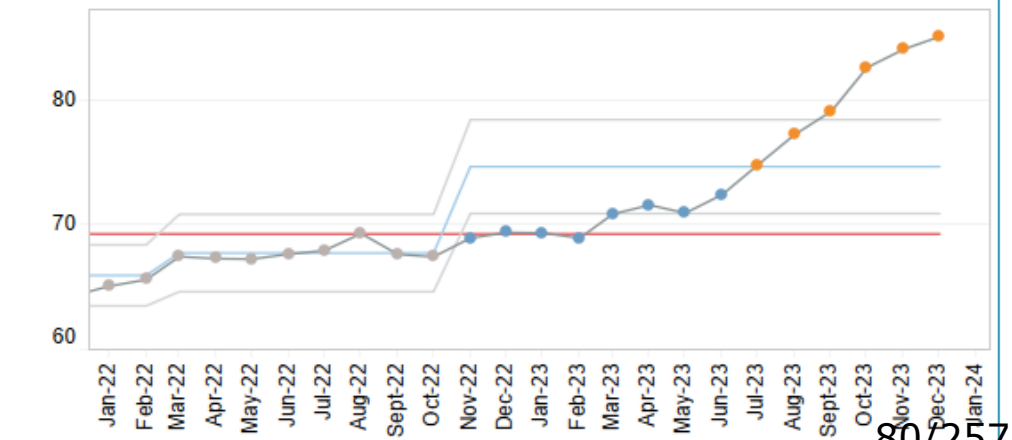
Investigations have commenced to identify root causes for each incident and to ensure appropriate actions to reduce future risk of reoccurrence are identified.

McCarthy,Rebecca
30/01/2024 09:18:02

Performance for Medication incident rate



Performance for Patient safety incident rate



Signed off by	Natalie Davies
Executive Lead	Nicola Firth

Quality: Pressure Ulcers

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
Hospital, Category 2	Total number of category 2 pressure ulcers in a hospital setting - includes device-related pressure ulcers.	<= 6	8	→	▲ ● ● ● ▲ ▲	●
Hospital, Category 3&4	Total number of category 3 and category 4 pressure ulcers in a hospital setting - includes device-related pressure ulcers.	<= 0	2	↘	▲ ▲ ● ● ● ▲	▲
Community, Cat 2	Total number of category 2 pressure ulcers in a community setting.	<= 9	14	→	▲ ▲ ▲ ▲ ▲ ▲	▲
Community, Category 3&4	Total number of category 3 and category 4 pressure ulcers in a community setting - includes device-related pressure ulcers.	<= 3	2	→	● ▲ ▲ ▲ ● ●	▲

Hospital

This month (October data) we have had 6 category 2 pressure ulcers reported- 2 of which were as a result of a medical device. This is a slight increase from previous months; however, the Trust remains on trajectory to meet the reduction target.

The main work streams in progress now are developing the 'purpose t' pressure ulcer risk assessment tool into digital version (using Patientrack) and reviewing the training provision and role-specific requirements.

Increased engagement and training has taken place with allied health professionals (physios, OT, social workers, and discharge co-coordinators) with further sessions planned Additional toolbox training sessions are being developed with the CPF teams across all divisions to promote pressure- ulcer- prevention awareness.

The annual pressure relieving mattress audit is taking place this month.

This month (October data) there has been 0 Category 3 or 4 pressure ulcers.

Community

This month (October data) we have had 11 category 2 pressure ulcers reported. The community is currently over trajectory to meet the reduction target.

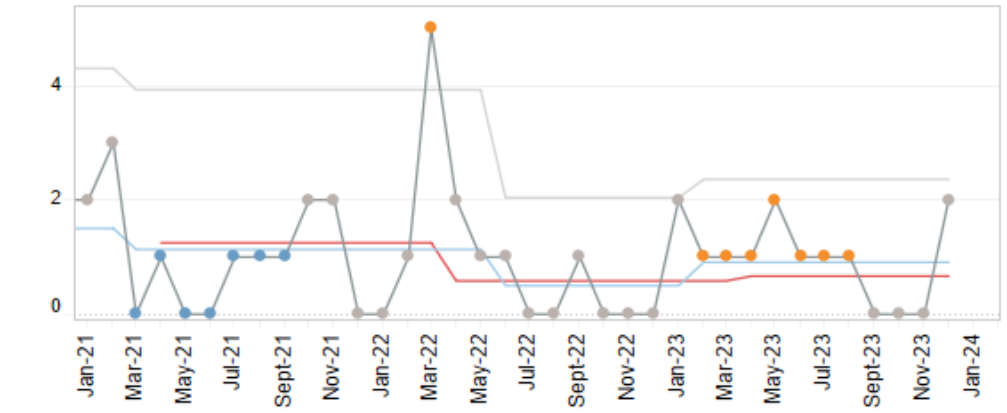
Trend analysis is ongoing in the community and there are minimal incidents that identify missed opportunities or lapses in care.

The Trust is aiming to achieve no Category 3 or 4 pressure ulcers as a result of a lapse in care.

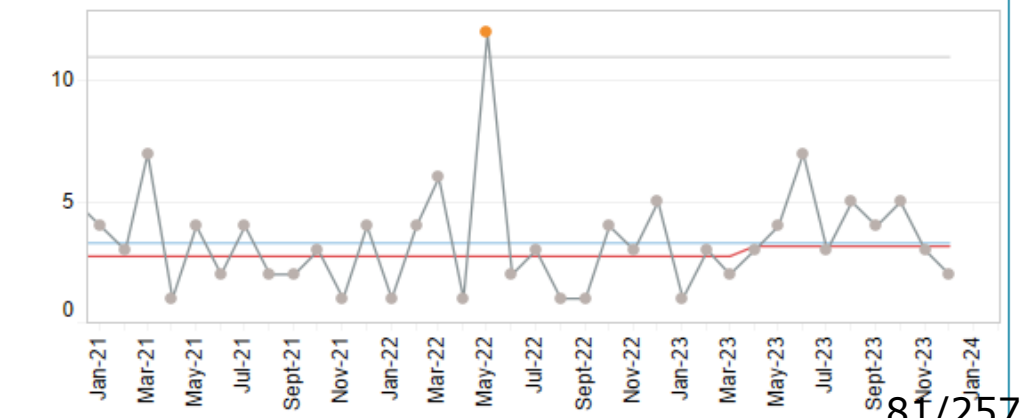
This month (October data) there has been 5 Category 3 or 4 pressure ulcers in the community. There continues to be high numbers of patients developing category 3 or 4 pressure ulcers in the community, each individual investigation has shown no lapses in care provided.

A thematic review of all category 3 or 4 pressure ulcers occurring in community patients over the last 6 months has been undertaken, the primary theme has shown decision making by the patient as the main factor. Work streams are in development to help our community nurses in their communication with patients and providing information to patients to help them make informed decisions.

Performance for Pressure Ulcers: Hospital, Cat 3&4



Performance for Pressure Ulcers: Community, Cat 3&4



Signed off by	Lisa Gough
Executive Lead	Nicola Firth

Operations: ED

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
4hr Standard	The number of patients who were admitted, discharged, or leave A&E within 4 hours of their arrival, as a percentage of all patients attending A&E.	>= 76%	56.6%	↘	▲ ▲ ▲ ▲ ▲ ▲	▲
Patients in department over 12 hrs	The number of patients spending 12 hours or more in department, as a percentage of all patients attending the emergency department.	<= 2%	14.7%	↓	▲ ▲ ▲ ▲ ▲ ▲	▲

December 2023 performance against the UEC 4hr standard saw a decrease to 56.6% compared to 62.7% in November 2023. Overall performance benchmarks well across GM. Stockport's ED YTD performance is currently 63.21%, ranking 2nd in GM for type 1 4hr performance (excluding RMCH).

Performance has been impacted adversely by patient flow linked to an increase in bed occupancy, patient acuity, and reduction in the discharge profile. December saw a large increase in 12- hour waits totalling 505 patients, compared to 224 in November. Robust processes for managing, reviewing and providing assurance for assessment of harm in respect to 12hr breaches are fully embedded within the service. No harm has been identified.

Key Actions - ED

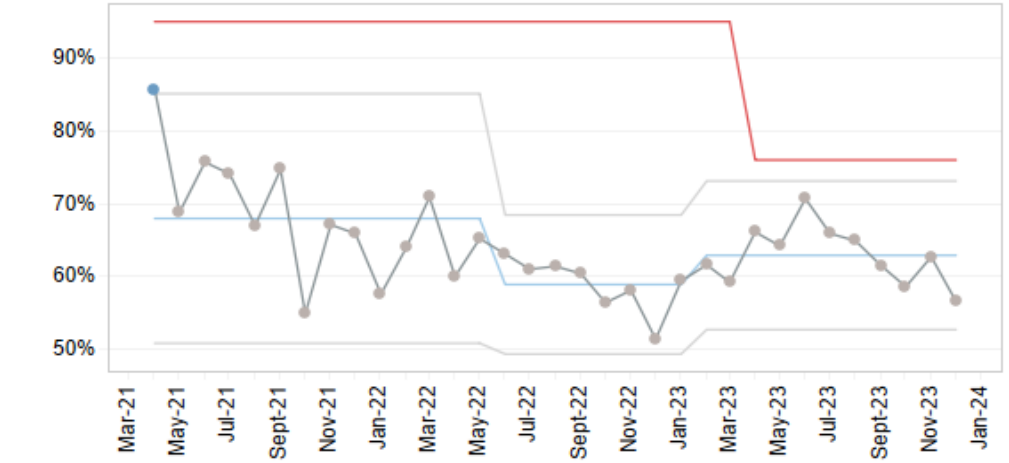
- ED/Trust recovery action plan developed with clear objectives to achieve 76% in by March 2024.
- Review of the ED workforce model considered by Executive Team. Further work required.
- Partnership collaboration continues with Pennine Care, with weekly and monthly meetings ongoing to discuss and resolve service challenges.
- Soft launch of E-triage commenced in December 2023; to be evaluated in Q4.
- Engagement with primary care to bolster attendance and admission avoidance, use of the virtual ward & Age UK.

Key Actions – Programme of Flow

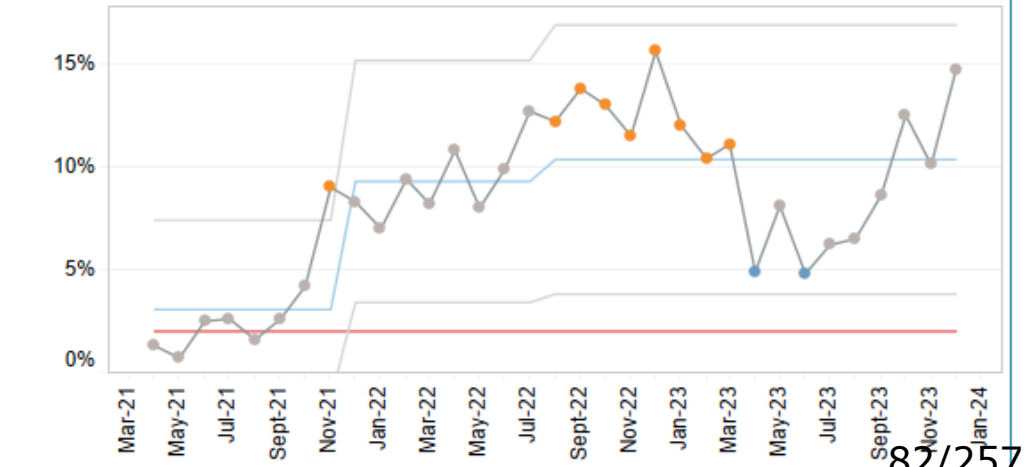
- MDT provision increased to support demand during 'winter pressures'.
- Digitalisation – To progress the embedding of technology to support efficient and effective patient safety and flow, with a particular focus on wards and Patient Flow team.
- Discharge Policy – to share the discharge policy with all teams to support improved patient experience, reduce LOS, and ensure our teams have the tools to support safe and effective discharge.

McCarthy,Rebecca
30/01/2024 09:18:02

Performance for 4hr Standard



Performance for Patients in department over 12 hrs



Signed off by	Beverley Burnett
Executive Lead	Jackie McShane

Operations: Patient Flow

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
No criteria to reside (NCTR)	Number of patients with "No Criteria to Reside". This metric is a mean average per day for each month.	<= 73	72			
Discharge ready	The number of patients discharged from hospital on the same day as their discharge ready date, as a percentage of all patients patient discharges.		79.8%			
Delayed discharges	The number of patients discharged from hospital 7 days or more after their discharge ready date, as a percentage of all patients patient discharges.		3.9%			

The number of patients with no criteria to reside (NCtR) in month is showing a reduction. Work continues to embed and improve operational system and processes across the wards and within the Discharge to Assess services especially across Pathway 1 and 2.

Challenges to achieving the NCtR Target

Accessing timely care home beds and community packages of home care and reablement is adversely impacting on patient flow through the hospital, community D2A beds, and the community D2A Hub. Access to a D2A bed is further challenged as private providers are selective regards to the patient cohort they will accept.

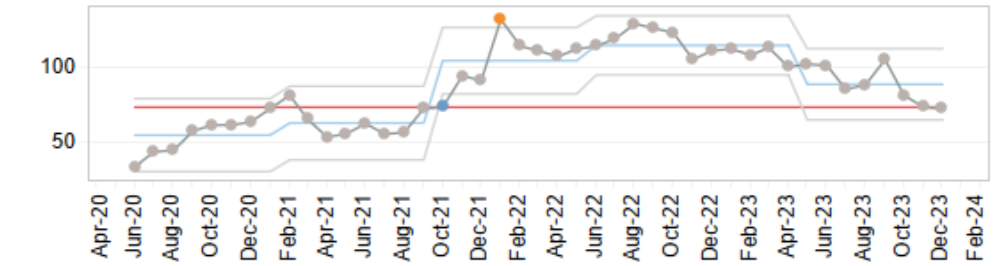
Decommissioning of community D2A beds at Bramhall Manor Care Home from 35 to 25 will take place from 31.12.23. It is proposed that spot purchasing of beds will support Pathway 2 flow. Decommissioning of care packages (Pathway 1) from a private provider will also be implemented. The impact of the new model regards Pathway 2 and Pathway 1 flow will be monitored closely.

The number of NCtR out-of-area patients remains high with other localities struggling to access community capacity within their areas which is impacting on the ability to discharge / transfer patients to their local area. North Derbyshire and East Cheshire continue to have the highest number of out-of-area NCtR patients and a longer length of stay from being identified as NCtR. Meetings are taking place weekly with out-of-area partners to support improved flow out of the acute and escalation processes are in place.

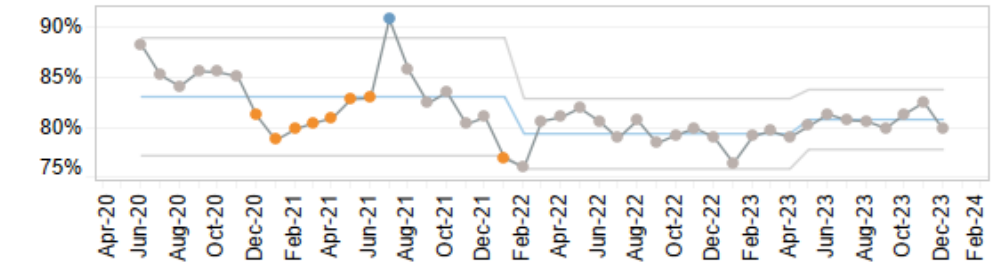
Key Actions

- The Programme of Flow is reviewing all LLOS patients and increased number of MDTs are taking place throughout the week within Acute and Community bed bases.
- Escalation of Derbyshire delays to GM SCC due to lack of engagement.
- Locality led safe and timely discharge work is progressing along with support from ECIST to commence in January-24.
- Impact of spot purchase provision to be evaluated in January-24.

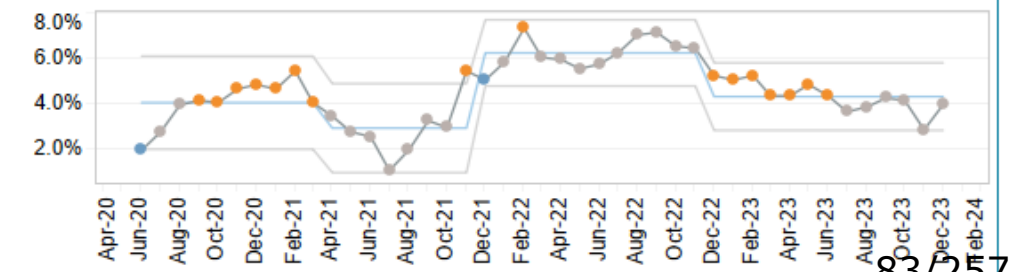
Performance for No criteria to reside (NCTR)



Performance for Discharge ready



Performance for Delayed discharges



Signed off by	Margaret Malkin
Executive Lead	Jackie McShane

Operations: Diagnostics

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
Diagnostics: 6 Week Standard	The percentage of patients referred for diagnostic tests who have been waiting for more than 6 weeks.	<= 5%	8.7%	→	▲ ▲ ▲ ▲ ▲	▲

ECG
Performance has improved month on month for ECHO over the past months; however, sickness in the team has impacted on further improvements in the month of November and December and will continue into January 2024. Low rate of WLI uptake for December and the added impact of 2 x bank holidays were also significant. Consultant annual leave has also impacted on STRESS ECHO lists.

Endoscopy
The Endoscopy backlog has decreased to 66 patients waiting over 6 weeks, maintaining the downward trajectory; 59 patients have dates, and the remaining 7 patients are awaiting a date. Pressure on Endoscopy remains as a result of the ongoing industrial action and return/repeat second procedures. The combined impact has meant that the trajectory for achievement of the 95% standard has been pushed out to March 24.

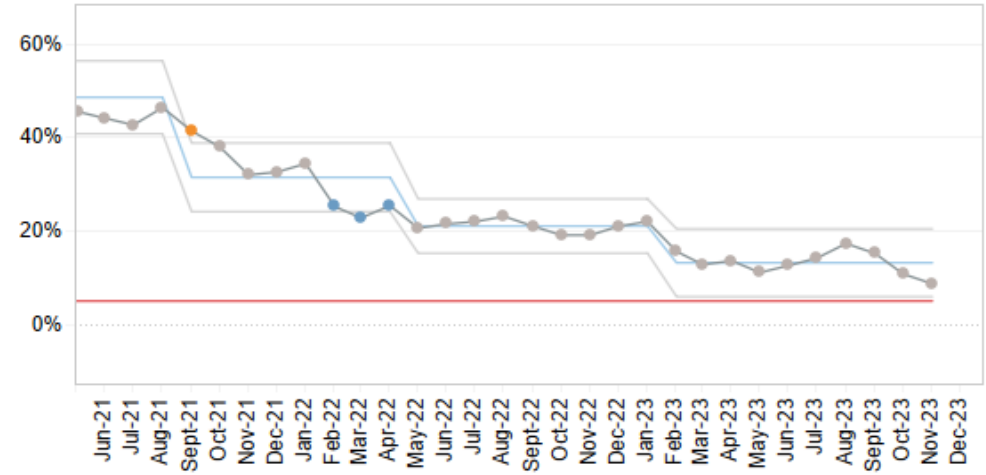
Imaging
Imaging backlog has increased to 289 patients waiting over 6 weeks, this is mainly from CT and Non-Obstetric Ultrasound (NOUS). There has been a significant increase in CT planned work which has impacted these figures with 50% more referrals for each of the last two months. This is combined with booking team challenges. NOUS has also seen an increase in patients over 6 weeks, due to a number of factors including lost lists for industrial action, bank holidays, and high clinician annual leave over the festive period. We are confident that the overall DM01 position for imaging can be recovered to the 95% standard by end of January 2024.

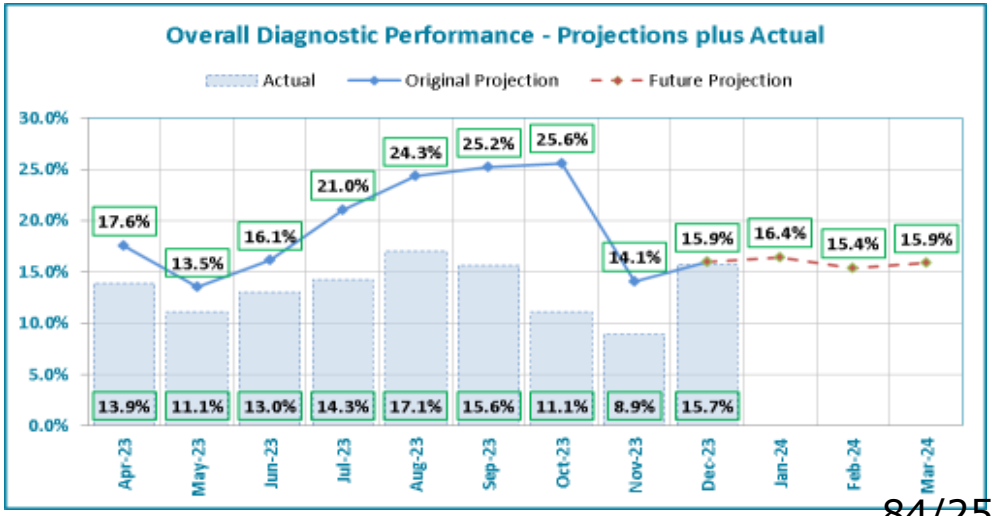
Key Actions

- CDC to support ECG capacity form January-24.
- Recovery plan for CT and NOUS in place and planned to recover by end of January 2023.

McCarthy,Rebecca
30/01/2024 09:18:02

Performance for Diagnostics: 6 Week Standard





Signed off by	Angela Barrett, Glenn Ellis, Stuart Cooper
Executive Lead	Jackie McShane

Operations: Cancer

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
62-day standard	The percentage of patients on any type of cancer pathway that have received their first treatment within 62 days of upgrade or GP referral. Includes two-we..	>= 85%	67.4%	↗	▲ ▲ ▲ ▲ ▲ ▲	▲
28-day standard (FDS)	The percentage of patients that are notified whether or not they have cancer within 28 days from the date of referral.	>= 75%	69.1%	→	▲ ▲ ▲ ▲ ▲ ▲	▲
14-day standard (2WW)	The percentage of patients on a cancer pathway that have attended their first outpatient appointment within 14 days of their GP referral.	>= 93%	98.3%	→	● ● ● ● ● ●	●

Cancer performance continues to show steady improvement across all standards. It is acknowledged, however, that continued industrial action may impact on progress.

The final 62- day performance for November is 60.5% , up from 54.3% in October.

28- day FDS performance is 65.2% for November with the latest position for December at 69.1%.

The 63+ backlog has remained at the reduced rate, achieving planned trajectory levels in December.

Challenges remain in terms of referral demand and the impact across clinical support services such as Radiology and Histopathology.

The organisation continues to be supported by both the national team and the regional Cancer Alliance in terms of identifying mutual aid and referral optimisation.

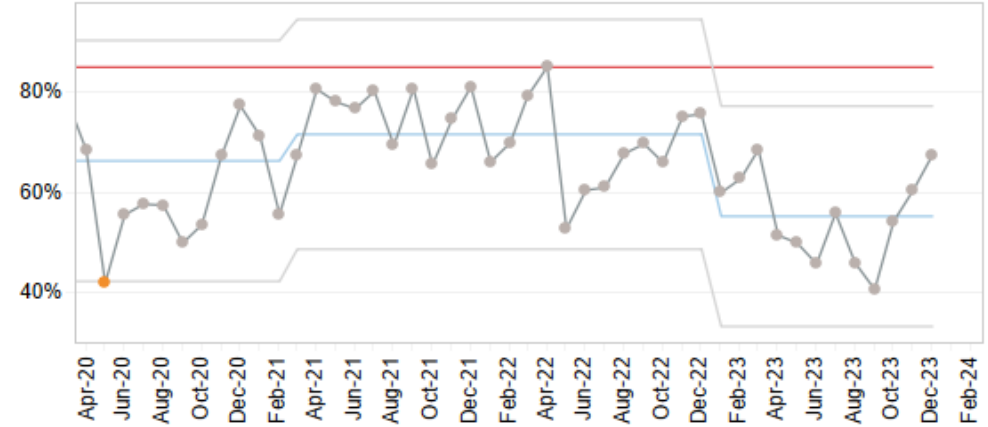
Key Actions

- Cancer Transformation manager to commence in post to support Urology.
- Implement further histology outsourcing in Q4, funded by the GM Cancer Alliance.
- Recruit to Urology consultant post in Q4, funded by the GM Cancer Alliance.

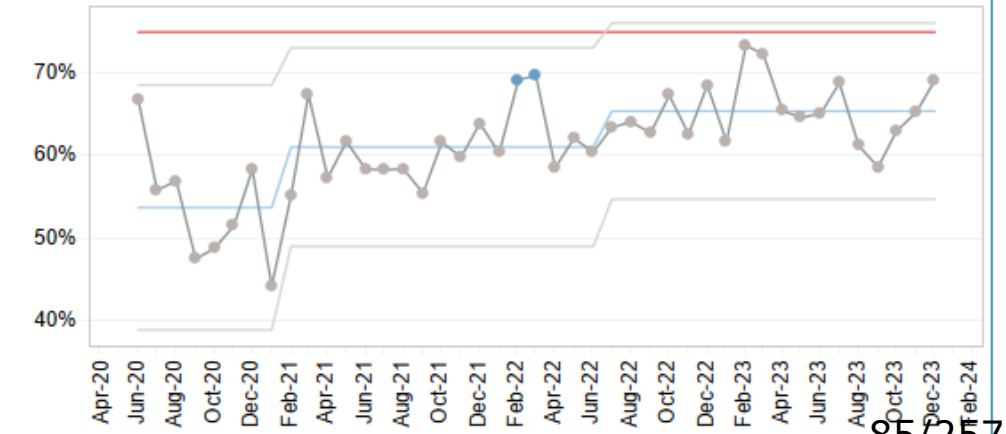
McCarthy,Rebecca
30/01/2024 09:18:02

Signed off by	Jo Pemrick
Executive Lead	Jackie McShane

Performance for 62-day standard



Performance for 28-day standard (FDS)



Operations: Referral to Treatment (RTT)

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
Incomplete pathways 18-week %	Referral to treatment, the number of patients on an open pathway, whose clock period is less than 18 weeks, as a percentage of all patients on an open pathway.	>= 92%	48.1%	→	▲ ▲ ▲ ▲ ▲ ▲	▲
52-week breaches	Referral to treatment, the total number of patients whose pathway is still open and their clock period is greater than 52 weeks at month end.	<= 3803	3652	↑	▲ ▲ ▲ ▲ ● ●	●
65-week breaches	Referral to treatment, the total number of patients whose pathway is still open and their clock period is greater than 65 weeks at month end.	<= 0	1200	→	▲ ▲ ▲ ▲ ▲ ▲	▲

December was a challenging month, with the number of patients waiting 65+ weeks to commence treatment increasing in month due to a combination of BMA industrial action, the closure of Outpatients B, and extreme bed pressures; however, the Trust has seen a reduction in 52+ week waiters and overall waiting list size due to the utilisation of the independent sector & waiting list validation text messages.

The Trust still has a very small number of patients waiting 104 + weeks. There were 2 patients waiting 104 + weeks at the end of December 2023. Of the 2 patients, 1 is clinically complex and the other patient has been transferred in from another provider.

The sudden closure of Outpatients B has had a significant impact on the specialties that have been unable to find alternative clinic areas, with Ophthalmology only able to deliver 26% of the outpatient activity that was planned for December, and Orthodontics unable to deliver any outpatient activity at all since the closure at the end of November.

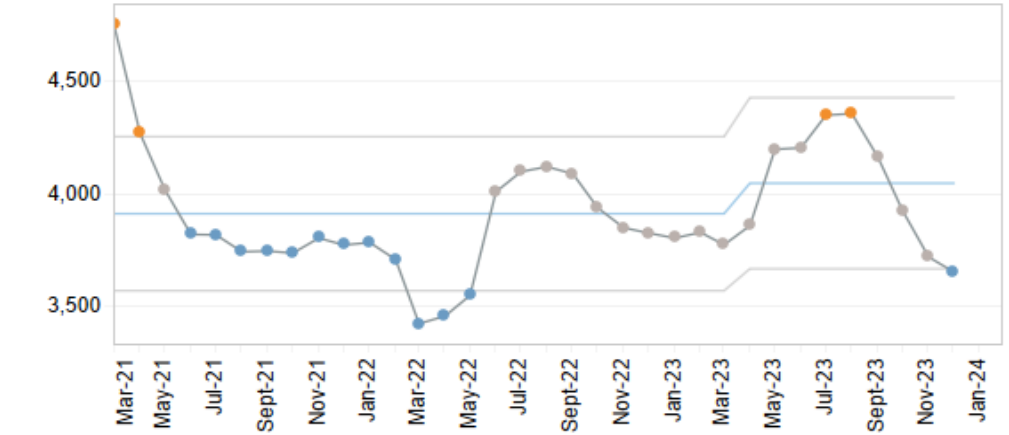
Teams have worked hard to provide additional capacity, prioritise long waiters and validate the waiting lists against the Access Policy. Work continues to try and meet the challenge of reducing to zero patients waiting over 78 & 65 weeks by the end of March 2024. The Trust is working collaboratively with other Greater Manchester Trusts to facilitate mutual aid opportunities to improve the position. In addition to this, the Trust has extended the use of waiting list validation text messages to include patients that are overdue for a follow-up appointment. Prior to December 2023, only patients awaiting a first outpatient appointment had been included in the waiting list text validation. The Trust contacted 34,650 patients in December, with 5.8% of the patients contacted confirming that they no longer need their appointment.

We continue to transfer/treat patients under the GM independent sector contract, taking up increased capacity for Gynaecology, ENT, Urology, Oral Surgery, Gastroenterology, and General Surgery. This will continue under the current GM contractual arrangements for the rest of 2023/24. There is still uncertainty around the independent sector contracting arrangements for 2024/25, and there is a risk that the capacity offer from independent sector providers will reduce.

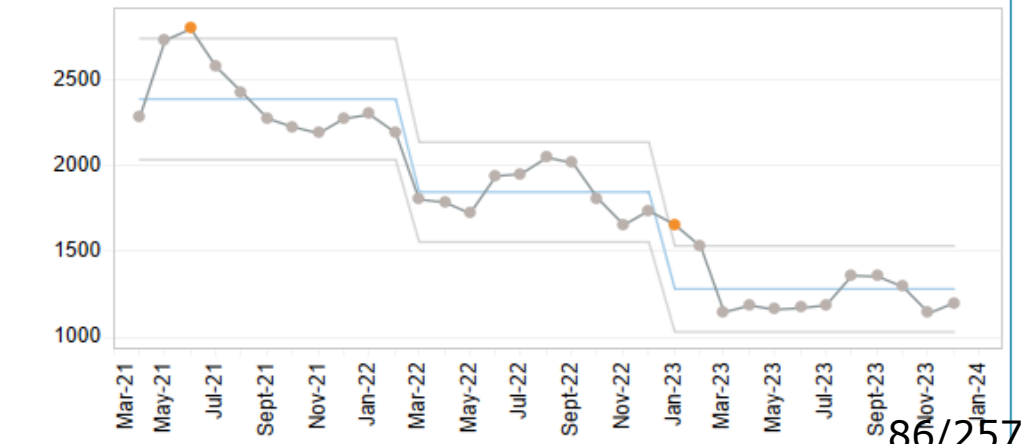
The Trust complied with the national directive for the Patient Initiated Digital Mutual Aid System (PIDMAS). We communicated with all patients within cohort 1, which included patients that had been waiting 40 weeks or more for treatment, to invite them to register their interest in moving to an alternative provider for treatment; however, patient uptake has been extremely low, and PIDMAS has made no impact on our elective recovery.

Signed off by	Dan Riley
Executive Lead	Jackie McShane

Performance for 52-week breaches



Performance for 65-week breaches



Operations: Outpatient Efficiencies

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
Outpatient DNA rate	The number of appointments where the patient did not attend, as a percentage of all booked appointments.	<= 6.3%	8.2%	↘	▲ ▲ ● ▲ ● ▲	▲
Outpatient clinic utilisation	The number of outpatient appointment slots booked, as a percentage of all outpatient appointment slots planned. Excludes cancelled clinic templates.	>= 90%	89.8%	→	▲ ▲ ▲ ▲ ▲ ▲	▲
Patient initiated follow up (PIFU)	The number of patients moved to a PIFU pathway as a result of an outpatient attendance, as a percentage of all outpatient attendances.	>= 4.61%	3.7%	→	▲ ▲ ▲ ▲ ▲ ▲	▲

DNA

A review of the nudge texts, number sent against the number of non-responders, has been carried out in November. A discrepancy was identified, and HCC have reviewed this and found some specialties where this request had not been applied; this has since been rectified. A review of the impact of this and costs will be undertaken by the OP Operational Group.

The letter portal notification wording has been reviewed.

Follow- up waiting list validation was also completed in December, removing 2017(5.6%) of patients. New patient text validation continues.

Clinic Utilisation

Overall utilisation is at 90% (when excluded clinics removed). Integrated Care, Women& Children, Medicine, and CCS meet the 90% target overall. The Booking Team performance was maintained at 94% overall but the services not managed centrally fell to 86% in December . The main areas affecting this position are Anti- Coagulation, Haematology, Neurophysiology, Pre-Op, & Anaesthetics.

Detailed information of utilisation continues to be shared with the Divisions, CDs, and DMs. This has also been discussed at the Trust Performance and Elective Care forums.

PIFU

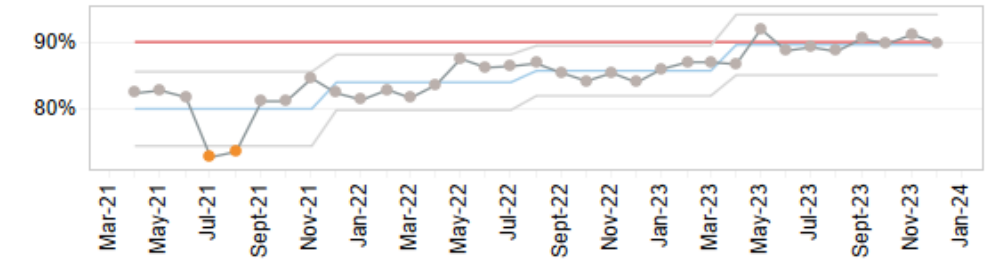
Performance has fallen to 3.7%, against a trajectory of 4.6% for December to meet the 5% target.

Speciality- based benchmarking data has been shared to look at further opportunities to improve use of this as a FU option.

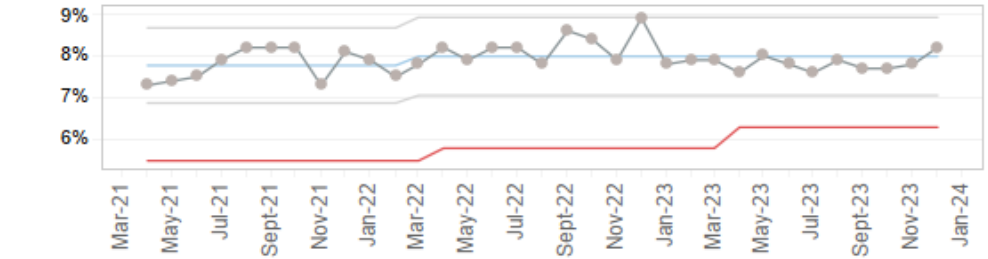
Specialities continue to engage with GIRFT Further Faster work with one of the initiative to assist teams looking at their use of and opportunities for PIFU.

Signed off by	Toni Coyle
Executive Lead	Jackie McShane

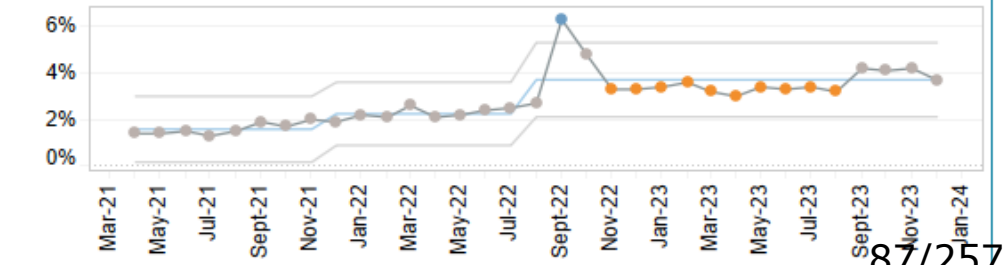
Performance for Outpatient clinic utilisation



Performance for Outpatient DNA rate



Performance for Patient initiated follow up (PIFU)



Operations: Theatre Utilisation

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
Capped Touch Time Utilisation	The overall time spent operating, calculated as a percentage of the overall planned session time. Session overrun time is excluded from the calculation of this measur..	>= 85%	67%	→	▲ ▲ ▲ ▲ ▲ ▲	▲
Average cases per 4-hour session	The total number of completed cases, calculated as a rate per 4-hour session equivalent. Excludes emergency and trauma sessions, and includes activity from ..	>= 2.8	2.71	→	● ▲ ▲ ● ▲ ▲	▲

Capped Touch-Time Utilisation

The Touch-Time Capped Utilisation performance for theatres has been erratic throughout 2023, with more pronounced deterioration at certain points (see bars on graph) at times of surges in non- elective medical bed demand. The best performing peer score is 84.8% - the Trust continues to perform lower compared to peers.

Average cases per 4-hour session

This metric has been impacted by converting IP to day- case lists - occasionally necessitated when the elective orthopaedic ward (B3) and day surgery ward (D6) has been unavailable due to NEL medical bed pressures. Further analysis of local and model health data is being overseen by the Theatre Performance Oversight Group, with the expectation that there will be greater standardisation of the booking process controls applicable to all operators.

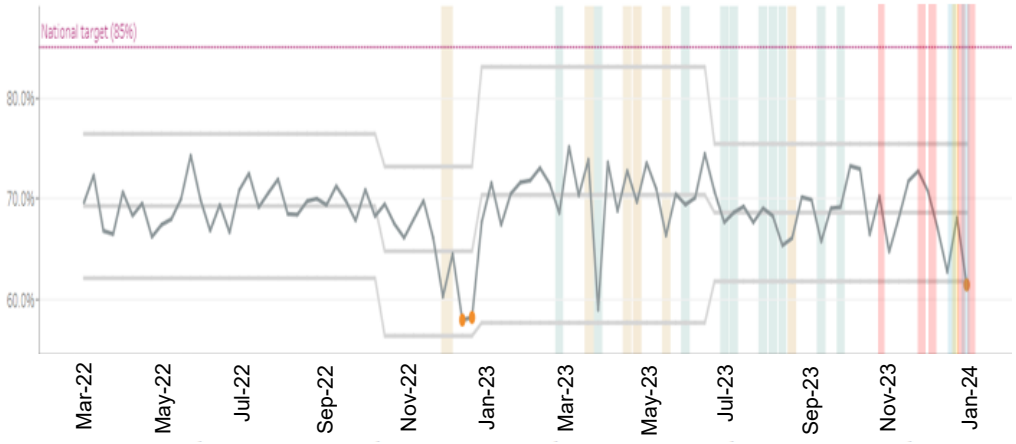
Key Actions

- Daily performance flash report implemented I January 24 and review meeting in place chaired by Director of Operations. Will continue until performance is sustained.
- Divisional weekly performance oversight group to analyse trends and initiated task & finish groups which is already making a difference; for example, process/controls and refresher training in Theatreman data entry.
- Engagement session with surgeons, anaesthetists, and theatre teams completed in December-23 and will continue in January-24 to drive knowledge and impact positively on performance.
- Improvement trajectory set as follows: Dec23 target of 71.7%, Jan24 target of 75.6%, Feb24 target of 81.0%, Mar24 target of 85.8%.

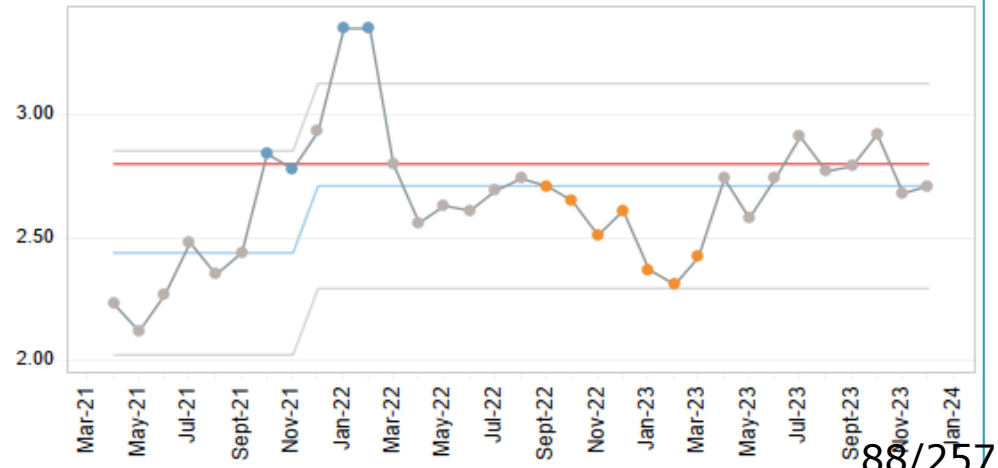
McCarthy,Rebecca
30/01/2024 09:18:02

Performance for Capped Touch Time Utilisation

Key to Columns in Graphs: Bank holidays, Industrial action, NEL medical bed pressures



Performance for Average cases per 4-hour session



Signed off by	Karen Hatchell
Executive Lead	Jackie McShane

Workforce: Sickness Absence

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
Sickness Absence: Monthly Rate	The total number of staff on sickness absence, calculated as a percentage of all staff-in-post whole time equivalent.	<= 6%	6.3%	↘	● ● ● ▲ ● ▲	▲

The in-month sickness rate in December 2023 has increased to 6.32%, up by 0.62% from November. Comparatively to December 2022 , the rate has decreased significantly from 7.50%. Our rolling 12- month absence figure is 5.9%, below our 6% target.

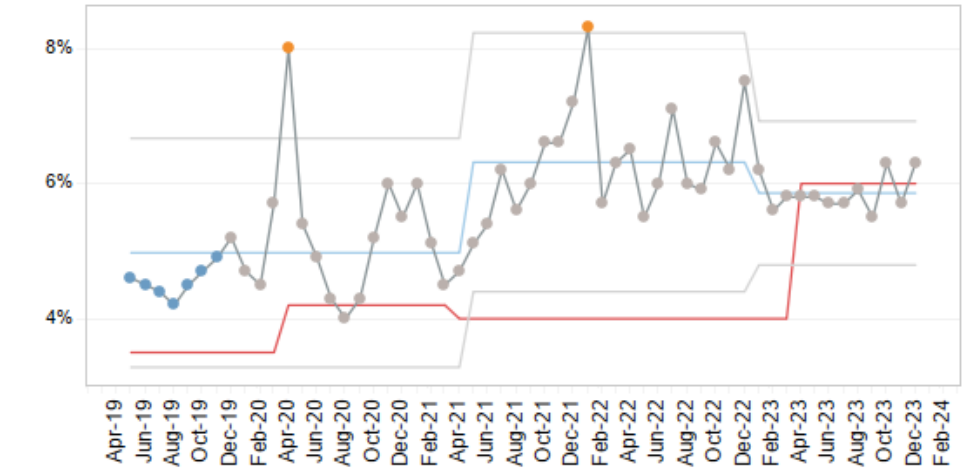
Our highest reason for absence remain mental health & anxiety, although there has been an in-month reduction. As expected, seasonal illness has increased in month and is now the second highest reason for absence, with MSK as the 3rd highest reason.

We continue to actively promote all health and well- being support mechanisms and are working with departmental managers focusing on preventive measures such as team risk stress assessments. We continue to offer and promote Flu Vaccination and have successfully appointed to a Staff MSK Physio who is expected to join the Wellbeing & Occupational Heath Team from February.

The Deputy Director of People & OD continues to have an oversight of attendance, meeting monthly with divisions to address complex cases, ensuring staff are receiving appropriate support and all cases are being managed effectively.

McCarthy,Rebecca
30/01/2024 09:18:02

Performance for Sickness Absence: Monthly Rate



Signed off by	Ian Henry
Executive Lead	Amanda Bromley

Workforce: Turnover

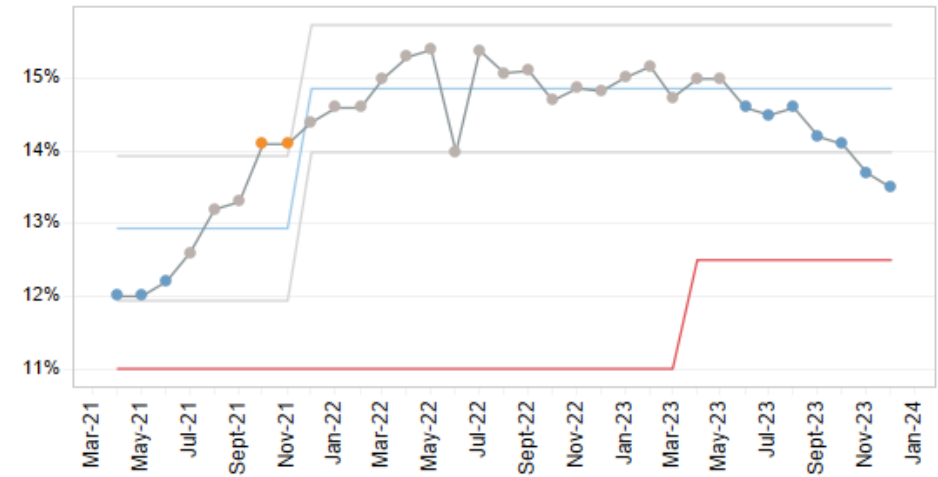
		Target	Actual	6-month trend	Previous Performance	1-month Forecast
Workforce Turnover	The percentage of employees leaving the Trust and being replaced by new employees.	<= 12.5%	13.5%			

The annualised turnover rate to December 23 was 13.47%, a reduction from November figure from 13.2%. Comparatively to December 2022, this is an improved position of 0.67% (Dec 22 14.14%)

Integrated Care has the highest turnover rate of 16.7%, followed by Women's & Children's (16.5%). Corporate Services has the lowest turnover rate (9.2%).

The top known leaving reasons for the 12 months to December was Voluntary Resignation:
– Work Life Balance - 12.61%;
– Relocation - 11.63%;
– Promotion - 9.75%.

Performance for Workforce Turnover



McCarthy,Rebecca
30/01/2024 09:18:02

Signed off by	Ian Henry
Executive Lead	Amanda Bromley

Workforce: Appraisals

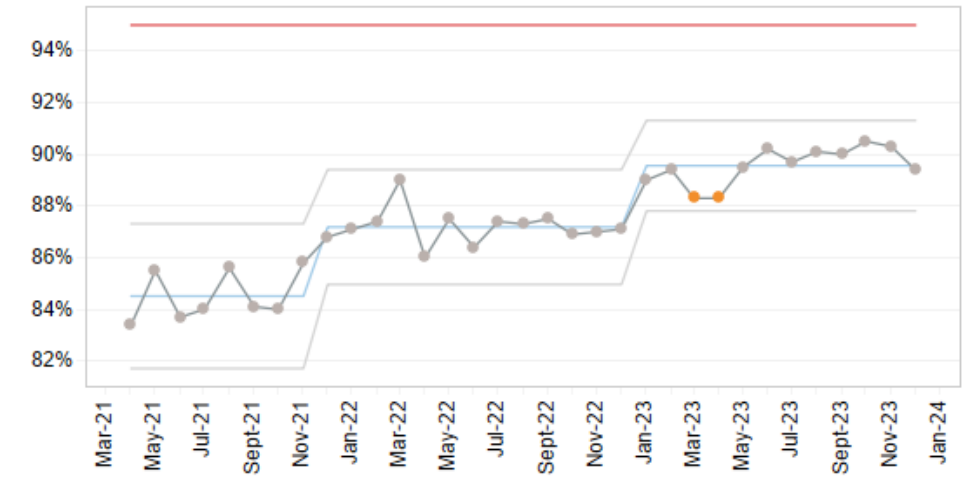
		Target	Actual	6-month trend	Previous Performance	1-month Forecast
Appraisal Rate: Overall	The percentage of overall staff that have been appraised within the last 15 months. Includes both medical staff and non-medical staff.	>= 95%	89.4%	→	▲ ▲ ▲ ▲ ▲ ▲	▲

Overall performance for appraisal compliance has seen a rise to 89.93%. This is an increase from 89.74% in December (November data). Non-medical appraisal rate is 89.74%, and the medical appraisal rate is 92.46%

The Education, OD, and HR Teams continue to support divisions in improving compliance across the Trust with regularly scheduled training sessions; comprehensive reports and trajectories available.

McCarthy,Rebecca
30/01/2024 09:18:02

Performance for Appraisal Rate: Overall



Signed off by	Joanne Martin
Executive Lead	Amanda Bromley

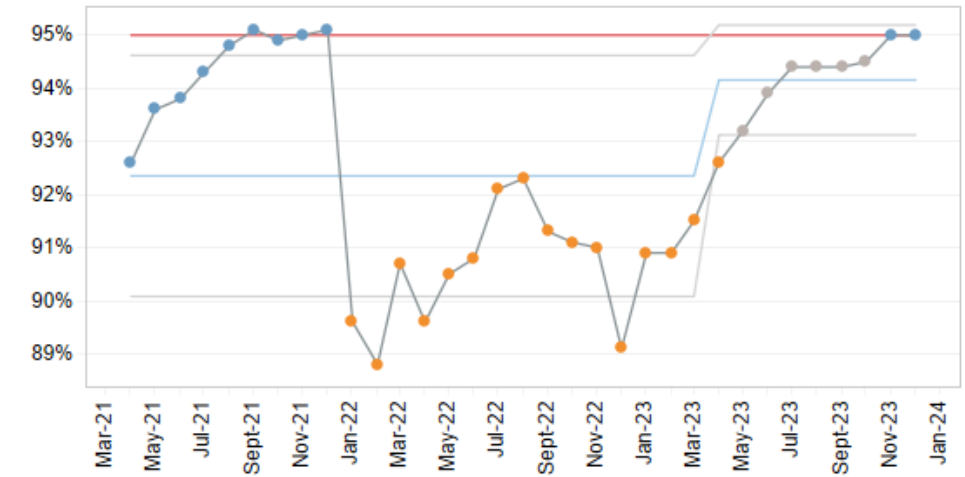
Workforce: Mandatory Training

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
Mandatory Training	The percentage of statutory & mandatory training modules showing as compliant.	>= 95%	95%			

Mandatory training has seen a slight decrease from 95.05% to 94.98% and is now just below target. This is owing to poor attendance at mandatory sessions during junior doctors' industrial action. In order to remedy this, the Education Team has provided additional sessions in January. There has also been a focus on completion of mandatory eLearning packages to improve compliance.

McCarthy,Rebecca
30/01/2024 09:18:02

Performance for Mandatory Training



Signed off by	Joanne Martin
Executive Lead	Amanda Bromley

Integrated Performance Report
Exception

BUSINESS INTELLIGENCE

NHS Stockport NHS Foundation Trust

Finance

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
Capital Expenditure	The actual capital expenditure, as a percentage of the planned capital expenditure. Performance is displayed as a percentage variance from the planned amount.	<= 10%	-38.2%	→	● ● ● ● ● ●	●
Cash Balance	The amount of cash balance in Trust accounts. Figures displayed are millions per month.		18.5	↘	□ □ □ □ □ □	□
CIP Cumulative Achievement	The value of the actual CIP achievement, displayed as a percentage variance from the planned CIP achievement.	>= 0%	0.1%	↗	▲ ▲ ● ● ● ●	●
Financial Controls: I&E Position	The actual financial position, displayed as a percentage variance from the planned financial position.	<= 0%	4.3%	↗	▲ ▲ ▲ ▲ ▲ ▲	▲

Risks

There is a forecast £1.1m-£1.4m pressure from pay award 2023-24 costs for both the Agenda for Change staff and the medical staff above national funding allocations.

The cost of industrial action was not included in the planning process. The gross cost of the industrial action to date is £2.3m; the pressure to month 8 of £2.1m has been covered by a share of the GM allocation. This does not include the cost of providing additional capacity to replace lost activity. Further industrial action has taken place in December 2023 and January 2024 – no funding has currently been identified for the impact of these actions.

The ERF position remains uncertain, but we are assuming an adverse impact to date and the rest of the financial year. The impact at month 9 is £0.9m with a forecast penalty of circa £1.3m in the year end forecast.

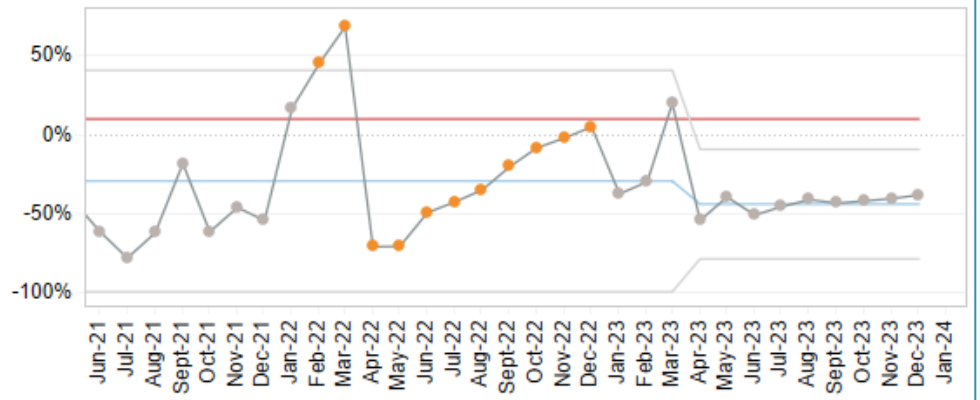
Income Assumptions – there is a risk that some of the income that has been included in the planning assumptions, which has not yet been confirmed in the GM contract, may not be received.

Escalation Capacity - alongside planned escalation capacity, additional beds over and above this level are open increasing the financial pressure.

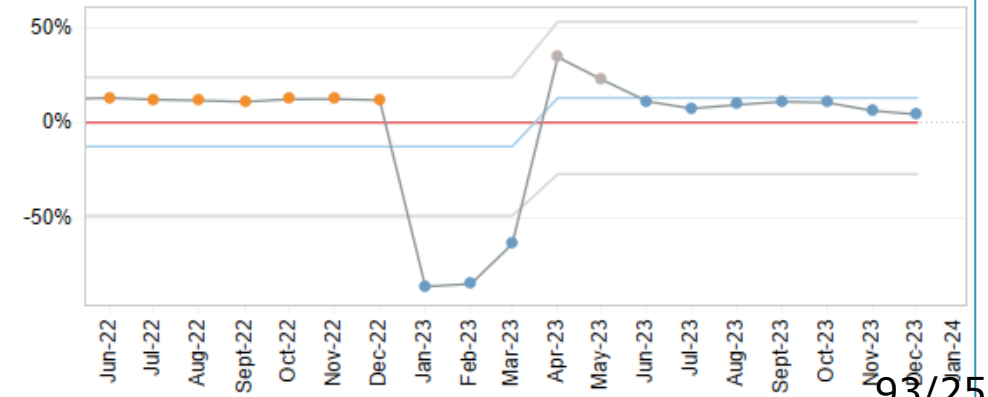
Cash flow – Based on the planned deficit of £31.5m, the Trust will require revenue support in 2023-24. A request was made to NHSE for revenue support in quarter 4.

There is an increasing cost of acuity in the Trust for enhanced care for patients. This also particularly links to the number of no criteria to reside patients who have complex needs and for whom CHC external placements cannot be found.

Performance for Capital Expenditure



Performance for Financial Controls: I&E Position



Signed off by	Tracy Coburn
Executive Lead	John Graham

NHS
Stockport
NHS Foundation Trust

Meeting date	1st February 2024	**Public**	**X**	**Agenda No.**	10
Meeting	Board of Directors				
Report Title	Financial Position Month 9 2023/24				
Director Lead	John Graham Chief Finance Officer	**Author**	Kay Wiss Director of Finance		

Paper For:	**Information**		**Assurance**	**X**	**Decision**	
Recommendation:	The Board of Directors is asked to receive the Financial Position Report for Month 9 2023/24, to update on the current financial position in support of the Integrated Performance Report and give assurance on the delivery of the financial plan for 2023/24.					

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

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

This paper relates to the following Board Assurance Framework risks

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

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

Where issues are addressed in the paper

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

Executive Summary

The Trust has a deficit of £24.6m at Month 9 (December) 2023-24, which is an adverse variance of £1m to plan. A detailed finance paper was presented to the Finance & Performance Committee on the 18th January 2024 and this paper is the summarised key extracts from that paper.

The paper seeks to give assurance that, subject to known risks as agreed within the GM ICB, that the Trust will:

- deliver its financial plan for 2023/24
- deliver its capital plan for 2023/24
- deliver its savings plan for 2023/24 with a requirement for increased recurrent delivery
- require cash borrowing in March 2024 which is subject to national approval

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

NHS
Stockport
NHS Foundation Trust

Board of Directors

1st February 2024

Financial Performance Month 9

John Graham
Chief Finance Officer

Contents

Stockport NHS Foundation Trust

1. Overall Financial Position M09 2023-24

Stockport NHS Foundation Trust

Income & expenditure Position	In-Month			Year to date			Forecast		
	Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m
Total Income	**36.6**	**35.6**	**(1.0)**	**315.3**	**315.8**	**0.4**	**419.9**	**420.5**	**0.5**
Substantive Staff	(22.6)	(22.4)	0.2	(206.4)	(205.0)	1.4	(274.7)	(272.3)	2.4
Bank Staff	(4.1)	(2.9)	1.2	(21.7)	(26.5)	(4.7)	(28.7)	(34.8)	(6.1)
Agency Staff	(1.7)	(1.0)	0.7	(15.4)	(12.6)	2.8	(20.4)	(16.7)	3.7
Pay Costs	(28.4)	(26.2)	2.2	(243.5)	(244.0)	(0.5)	(323.8)	(323.8)	0.0
Drugs	(2.0)	(1.9)	0.0	(17.5)	(17.7)	(0.2)	(23.3)	(23.6)	(0.3)
Clinical Supplies & Services	(2.2)	(2.4)	(0.3)	(18.9)	(21.1)	(2.2)	(25.2)	(28.1)	(2.9)
Other Non Pay Costs	(4.4)	(5.0)	(0.6)	(40.3)	(39.2)	1.1	(53.5)	(51.3)	2.3
Below the Line	(2.1)	(2.1)	0.0	(19.0)	(18.6)	0.3	(25.9)	(25.3)	0.6
Total Expenditure	**(39.1)**	**(37.8)**	**1.3**	**(339.1)**	**(340.6)**	**(1.5)**	**(451.7)**	**(451.9)**	**(0.2)**
TRUST SURPLUS / (DEFICIT)	**(2.5)**	**(2.2)**	**0.3**	**(23.8)**	**(24.8)**	**(1.0)**	**(31.8)**	**(31.4)**	**0.3**
Pharmacy Shop	-	-	-	-	-	-	-	-	-
Remove capital donations/grants/peppercorn lease I&E impact	0.0	0.0	(0.0)	0.2	0.2	0.0	0.3	0.3	0.0
Adjusted financial performance surplus/(deficit) for the purposes of system achievement	**(2.5)**	**(2.2)**	**0.3**	**(23.6)**	**(24.6)**	**(1.0)**	**(31.5)**	**(31.1)**	**0.3**

1. Overall Financial Position

NHS Stockport NHS Foundation Trust

The December 2023 (M09) financial position is a deficit of £24.8m which is £1.0m adverse to plan to date. This is an improvement of £0.3m in month which relates to inclusion of the Derby ICB contract income previously removed as a risk, but this benefit is partially offset by industrial action costs and the on-going depreciation income risk.

The key reasons for the variance to plan year to date are:

- £2.4m share of GM's national funding allocation
- (£2.3m) gross costs of covering the junior doctors' and consultant industrial action to date
- (£0.8m) pay award 2023-24 costs not fully funded
- (£0.9m) elective recovery fund (ERF) estimated penalty to M08 (GM calculation)
- (£0.8m) shortfall in GM funding allocation for depreciation to date
- £1.4m offset by other budget underspends and non-contract income above plan

The Trust continues to operate with additional capacity open in escalation beds and enhanced staffing levels to support the high level of attendances in the emergency department as well as patients with dementia and other continuing healthcare needs.

Following the review of the year end forecast as part of the GM wide PWC Financial Performance and Recovery work the forecast has been improved and is now expected to deliver a surplus against the plan of £0.3m

2. Divisional Financial Position

NHS Stockport NHS Foundation Trust

Division	In-Month			Year to date			Forecast		
	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Actual	Variance
Medicine	(5.7)	(6.0)	(0.2)	(51.9)	(54.2)	(2.3)	(68.8)	(72.1)	(3.2)
Emergency Department	(1.6)	(1.7)	(0.1)	(15.1)	(15.9)	(0.8)	(19.8)	(21.0)	(1.1)
Surgery	(6.6)	(7.1)	(0.4)	(60.2)	(62.3)	(2.2)	(80.1)	(83.2)	(3.1)
Women & Children	(3.6)	(3.5)	0.1	(33.6)	(31.5)	2.1	(44.3)	(42.4)	1.9
Integrated Care	(4.8)	(4.7)	0.1	(43.8)	(44.4)	(0.6)	(58.0)	(59.5)	(1.4)
Clinical Support Services	(3.5)	(3.6)	(0.1)	(30.8)	(31.8)	(1.0)	(41.1)	(42.7)	(1.7)
Estates & Facilities	(2.4)	(2.4)	(0.1)	(20.5)	(20.2)	0.3	(27.4)	(27.5)	(0.2)
Corporate	(2.9)	(2.7)	0.2	(25.0)	(23.5)	1.5	(32.9)	(31.6)	1.3
Pharmacy Trading Units	0.0	(0.0)	(0.1)	0.3	(0.1)	(0.4)	0.4	(0.1)	(0.6)
Divisional Total	**(31.1)**	**(31.7)**	**(0.6)**	**(280.5)**	**(283.7)**	**(3.3)**	**(372.0)**	**(380.1)**	**(8.1)**
Clinical income	33.8	32.6	(1.2)	289.6	287.8	(1.7)	385.5	383.4	(2.1)
General Trust	(5.2)	(3.1)	2.1	(32.8)	(28.9)	4.0	(45.2)	(34.7)	10.5
Total	**(2.5)**	**(2.2)**	**0.3**	**(23.8)**	**(24.8)**	**(1.0)**	**(31.8)**	**(31.4)**	**0.3**

The combined divisional position is £3.3m adverse year to date.

Top 5 variances within the divisions following the agreed non-recurrent monthly budget allocation are:

- Escalation capacity above funded levels £1.5m
- Other ward pressures covering sickness, vacancies and supernumerary staff £1.9m
- Waiting list initiatives (WLIs) to deliver activity £1.4m across all specialities (partially linked to 65 week wait funding received)
- Medical staffing costs (excluding escalation) £1.0m
- Energy & Utility Costs £0.3m

2. Divisional Financial Position

NHS Stockport NHS Foundation Trust

STAFF AND WTE RECONCILIATION

Staff Group	Employment Type	ACTUAL WTE M11 22/23	ACTUAL WTE M12 22/23	ACTUAL WTE M01 23/24	ACTUAL WTE M02 23/24	ACTUAL WTE M03 23/24	ACTUAL WTE M04 23/24	ACTUAL WTE M05 23/24	ACTUAL WTE M06 23/24	ACTUAL WTE M07 23/24	ACTUAL WTE M08 23/24	ACTUAL WTE M09 23/24
Registered nursing, midwifery and health visiting staff	Substantive	1,603.8	1,615.9	1,617.4	1,625.8	1,634.5	1,624.4	1,615.1	1,610.8	1,678.2	1,691.5	1,689.5
Healthcare scientists and scientific, therapeutic and technical staff	Substantive	642.7	649.5	653.4	646.1	642.7	641.8	638.3	647.3	657.5	659.7	660.8
Support to clinical staff	Substantive	1,152.3	1,144.6	1,143.3	1,104.2	1,097.9	1,098.7	1,078.5	1,083.9	1,097.9	1,091.7	1,100.4
Medical & dental	Substantive	570.7	580.6	566.8	570.9	588.2	572.7	569.2	588.9	596.3	586.2	605.0
Other	Substantive	1,355.2	1,365.2	1,358.6	1,356.1	1,369.8	1,365.4	1,379.0	1,388.2	1,388.8	1,389.4	1,393.8
Substantive		**5,324.7**	**5,355.7**	**5,339.4**	**5,303.1**	**5,333.1**	**5,302.9**	**5,280.1**	**5,319.0**	**5,418.7**	**5,418.6**	**5,449.6**
Registered nursing, midwifery and health visiting staff	Bank	172.5	196.5	159.2	165.3	155.4	169.0	174.4	175.8	188.3	189.8	163.4
Healthcare scientists and scientific, therapeutic and technical staff	Bank	0.1	0.1	0.1	0.1	0.1	0.1	0.1	-	0.1	0.1	0.1
Support to clinical staff	Bank	209.3	245.0	228.7	244.3	224.0	235.6	254.7	245.1	251.7	252.1	236.2
Medical & dental	Bank	33.3	50.0	52.5	38.7	49.7	48.5	50.8	43.2	50.9	45.8	43.0
Other	Bank	83.8	87.1	74.1	69.9	66.3	69.9	72.3	69.2	50.6	62.6	58.2
Bank		**498.9**	**578.7**	**514.5**	**518.2**	**495.4**	**523.1**	**552.3**	**533.3**	**541.5**	**550.4**	**500.9**
Registered nursing, midwifery and health visiting staff	Agency	119.1	145.8	123.0	112.9	101.0	81.4	77.4	71.7	75.5	59.7	54.7
Healthcare scientists and scientific, therapeutic and technical staff	Agency	46.0	52.8	43.9	51.3	48.1	30.0	36.8	22.8	23.3	20.1	20.3
Support to clinical staff	Agency	2.3	2.8	3.1	0.2	0.4	0.0	-	-	-	-	-
Medical & dental	Agency	48.7	60.8	47.5	52.4	49.7	46.0	46.0	39.8	42.4	44.5	31.0
Other	Agency	2.7	3.1	0.6	1.5	3.2	3.8	4.3	4.2	4.2	3.3	3.8
Agency		**218.8**	**265.3**	**218.1**	**218.3**	**202.4**	**161.3**	**164.4**	**138.5**	**145.4**	**127.5**	**109.7**
TOTAL		**6,042.4**	**6,199.6**	**6,072.0**	**6,039.5**	**6,030.9**	**5,987.2**	**5,996.8**	**5,990.8**	**6,105.6**	**6,096.5**	**6,060.1**

Substantive staffing has increased from month 8 mainly across medical and dental. In line with the nursing recruitment in September and October there has been a reduction in bank staff.

The reduction to 5 days for the agency cascade continues to have a positive impact on the use of agency staffing, and there has been a reduced take up of medical staffing shifts over the Christmas period.

3. STEP (Stockport Trust Efficiency Programme)

NHS Stockport NHS Foundation Trust

FULL YEAR 2023/24 STEP by Division £000s	Annual Target	Recurrent	Non-Recurrent	Total Delivered & Idntified in	Gap in Year	% Identified
Medicine	2,414	290	1,394	1,701	(713)	70%
Surgery	1,926	254	1,509	1,809	(117)	94%
Women & Childrens	1,192	38	1,304	1,351	159	113%
Integrated Care	1,935	470	1,263	1,764	(171)	91%
Clinical Support Services	1,318	87	420	771	(547)	58%
Estates & Facilities	627	96	687	829	202	132%
Corporate	888	212	847	1,059	171	119%
Sub-total for Divisions	*10,300*	*1,447*	*7,423*	*9,284*	*(1,016)*	*90%*
Technical	15,900	7,529	8,372	16,917	1,017	106%
TOTAL	**26,200**	**8,976**	**15,795**	**26,200**	**0**	**100%**

YEAR TO DATE (M9) 2023/24 STEP by Division £000s	Year to Date Target	Recurrent	Non-Recurrent	Total Delivered Year to Date	Gap Year to Date	% Identified
Medicine	1,811	217	940	1,157	(654)	64%
Surgery	1,445	128	1,223	1,350	(94)	93%
Women & Childrens	894	28	1,284	1,312	418	147%
Integrated Care	1,451	351	1,101	1,451	(0)	100%
Clinical Support Services	989	65	420	485	(503)	49%
Estates & Facilities	470	72	685	757	286	161%
Corporate	666	159	835	994	328	149%
Sub-total for Divisions	*7,725*	*1,020*	*6,486*	*7,506*	*(219)*	*97%*
Technical	11,575	5,572	6,239	11,811	236	102%
TOTAL	**19,300**	**6,592**	**12,725**	**19,317**	**17**	**100%**

IN MONTH (M9) 2023/24 STEP by Division £000s	In Month Target	Recurrent	Non-Recurrent	Total Delivered in Month	Gap in Month	% Identified
Medicine	201	24	94	118	(83)	59%
Surgery	161	22	125	147	(13)	92%
Women & Childrens	99	3	7	10	(89)	10%
Integrated Care	161	40	121	161	(0)	100%
Clinical Support Services	110	7	-	7	(103)	7%
Estates & Facilities	52	8	1	9	(44)	16%
Corporate	74	18	79	97	23	131%
Sub-total for Divisions	*859*	*122*	*427*	*549*	*(310)*	*64%*
Technical	1,452	653	1,058	1,711	259	118%
TOTAL	**2,311**	**775**	**1,485**	**2,260**	**(51)**	**98%**

The Trust STEP target for 2023-24 is £26.2m. This is split £10.3m recurrently allocated to Divisions, and £15.9m non-recurrent.

The top table shows the divisional progress on identification of schemes towards the target; the target of £26.2m has been identified of which £9.0m is recurrent.

The middle table shows the total delivered to date of £19.3m against the target of £19.3m resulting in a break-even performance at month 9.

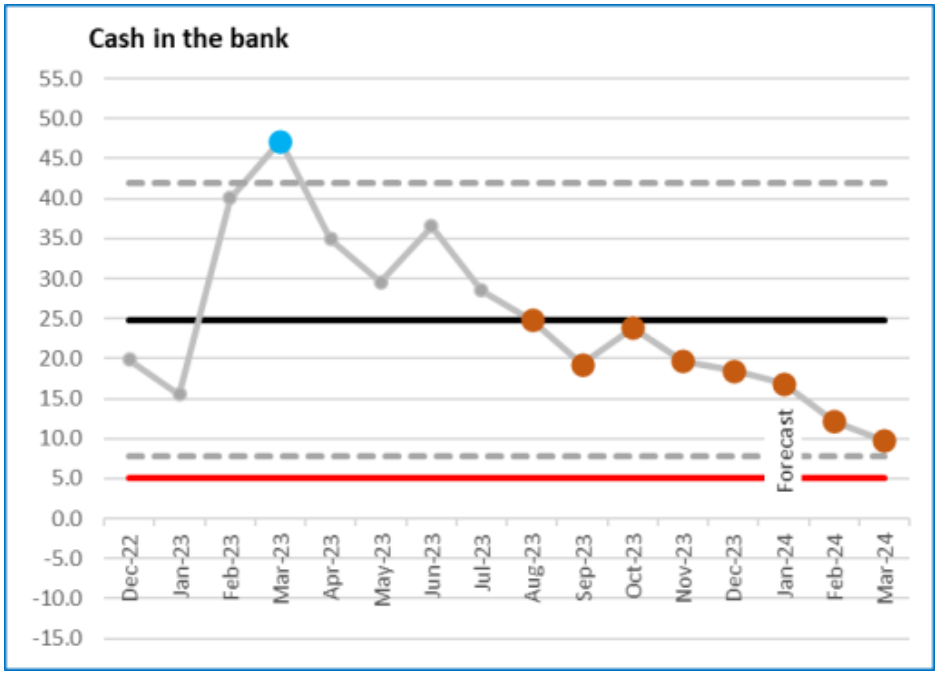
Non-recurrent vacancy factor continues to be transacted to gain consistency with other GM Trusts as part of the turnaround work. Some areas of the Trust have declared a vacancy factor as recurrent in previous years, as there is certainty of turnover. The recurrent nature of this will be considered as part of planning for 2024/25.

The Trust has fully identified savings for 23/24 and has identified non recurrent schemes to close the shortfall on the recurrent schemes of £1.0m.

4. Cash

a. Cash Position

Stockport NHS Foundation Trust



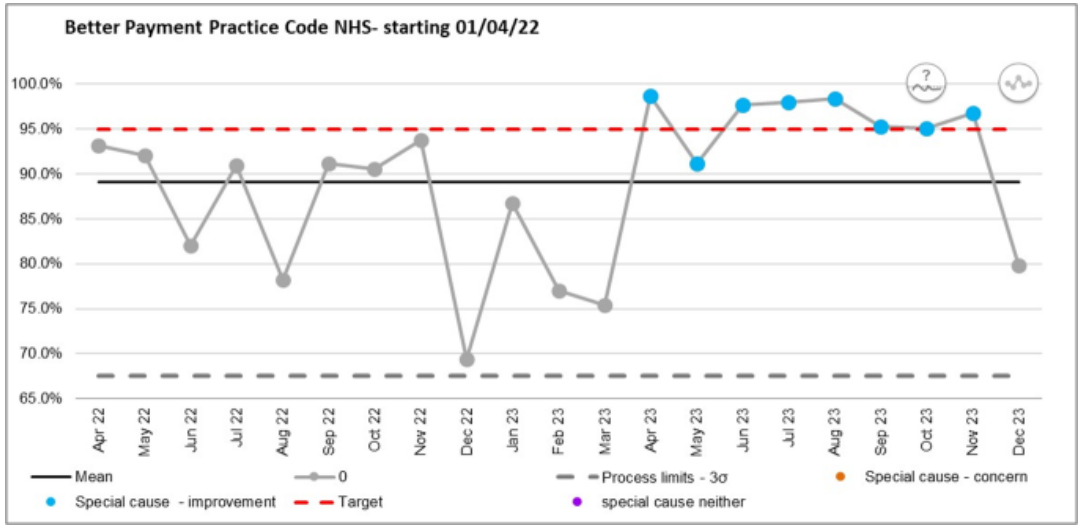
- Cash as the end of December was £18.5m, a reduction of £1.2m from November.
- The decrease is linked the planned deficit.
- The Cashflow Monitoring group will continue to closely monitor the cash position.

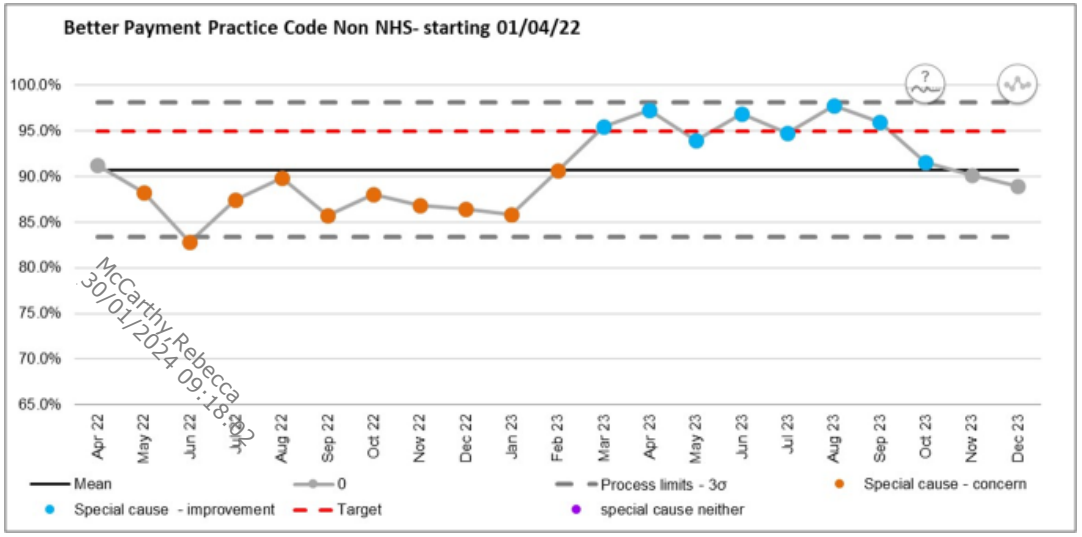
A request was made to NHSE on 1st December 2023 for Revenue Support PDC in Quarter 4 of £16m, with an updated forecast schedule to be submitted in January 2024.

The cash risk remains at a score of 15 and on the significant risk register pending the application for revenue support.

4. Cash

b. Better Payment Practice Code





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

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

Performance against the standard has improved in 2023-24 from 2022-23 levels for both NHS and non-NHS invoices, however recent reductions in performance are being reviewed further.

5. Capital

NHS Stockport NHS Foundation Trust

Description	Month 09 Budget	Month 09 Actual	Month 09 Variance	Year To Date M09 Budget	Year To Date M09 Actual	Year To Date M09 Variance	Forecast Budget	Forecast Actual	Forecast Variance
Estates	3.9	2.3	(1.6)	22.3	15.9	(6.4)	39.0	32.8	(6.2)
Equipment	0.2	0.1	(0.1)	0.9	0.6	(0.3)	1.8	2.0	0.2
IFRS16	-	1.4	1.4	2.1	1.4	(0.7)	12.4	5.6	(6.8)
IT	0.2	0.2	0.0	1.0	2.0	1.0	9.5	5.7	(3.8)
Total	**4.3**	**4.1**	**(0.2)**	**26.3**	**19.9**	**(6.4)**	**62.7**	**46.1**	**(16.6)**

The £46.1m forecast shown is as per the latest NHSE return including £32.1m PDC.

- Emergency & Urgent Care Campus (EUC) - £16.5m
- Electronic Patient Record (EPR) - £3.6m
- Targeted Investment Fund (TIF) - £5.2m
- Aseptics - £5.0m
- RAAC - £1.3m
- LIMS - £0.5m

- The internal programme has been reduced by £7.2m following discussions with GM, with the capital plan still under review as it remains over committed. CPMG are actively monitoring the forecast spend in respect of any changes to the capital allocations
- Most of the capital spend to M9 relates to the Emergency Campus Development.
- Internally funded Estates schemes are progressing with contractors now on site and should see spend coming back in line with the plan.
- The IT variance is in relation to the Network Cab Scheme approved beyond the original plan.
- IFRS16 variances relate to changes made in the latest NHSE return, including removal of Cherry Tree lease, blood science contract and updating of 23/24 property rentals
- The Year-to-Date variance relating to IFRS16 is due to final confirmation of 23/24 rent figures.

6. Risks to Delivery of Plan

NHS Stockport NHS Foundation Trust

The Trust can give a high level of assurance that the financial plan for 2023/24 will be delivered as per the forecast agreed within the GM ICS for Month 9. A series of risks to the financial position have been shared as part of the improvement work in the GM ICS and there is agreement on how these should be treated.

The Finance & Performance Committee have been briefed on the full range of risks on the 18th January 2024 and have discussed the actions in place.

Other internal risk to highlight are:

- There is an increasing cost of acuity in the Trust for enhanced care for patients. This also particularly links to the number of no criteria to reside patients who have complex needs and for whom CHC external placements cannot be found.

- The Trust has already seen higher OPEL scores and emergency demand increasing over December and January and there is likelihood that this will result in additional cost of staffing cover as ward capacity is flexed.

- It is also clear that there is no further release of funding to support increased pressures over the winter period and costs need to be carefully managed within the plan.

- Cash remains a key risk and an application for funding was submitted to NHSE on the 1st December 2023. However this was delayed due the receipt of the additional £2.4m national funding but given the risks above cash continues to be carefully managed.

NHS Stockport NHS Foundation Trust

Meeting date	1st February 2024	**Public**	✓	**Agenda No.**	12
Meeting	Board of Directors				
Report Title	People & OD Plan Update				
Director Lead	Amanda Bromley, Director of People & OD	**Author**	Emma Cain – Deputy Director of People & OD Lisa Gammack – Deputy Director of OD		

Paper For:	**Information**		**Assurance**	X	**Decision**	
Recommendation:	The Board of Directors are asked to receive progress against delivery of the Trust's People and Organisational Development Plans.					

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

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

This paper relates to the following Board Assurance Framework risks

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

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

Where issues are addressed in the paper

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

Executive Summary

The purpose of this report is to provide the Board of Directors with an update and oversight of the progress of delivery against priorities as detailed in the People & OD plan. An update was previously reported to Board August 2023. Against a backdrop of industrial action, increasing operational demands on services, and emerging priorities, the majority of the actions that were planned to be delivered within Q3 have been completed or are on track to be completed in Q4.

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

Our priority areas will continue to be our focus, looking to deliver an improved retention position, reducing turnover and supporting a 'grow our own' approach to our career progression and talent management. Working to continue our improvement journey in respect of our agency spend is a high priority and linked into our recruitment plans. We will continue to look for opportunities for collaboration, focussing on a joint approach to delivering our people priorities in line with the NHS Long Term Workforce Plan. We will continue to deliver the People & OD Plan alongside the EDI Strategy 2022-25 and Health and Wellbeing Plan. We are committed to having a relentless focus on progressing our improvement journey to creating a more compassionate and inclusive culture.

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

1. Introduction

1.1 The purpose of this report is to provide the Board of Directors with an update and oversight of the progress of delivery against priorities as detailed in the People & OD Plan. An update was previously reported to Board August 2023.

2. Priorities

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

2.2 Against a backdrop of industrial action, increasing operational demands on services, and emerging priorities, the majority of the actions that were planned to be delivered within Q3 have been completed or are on track to be completed in Q4.

3. Impact

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

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

People Key Performance Indicators:

- ✓ Annualised (adjusted) Turnover rate has continued to reduce from 14.48% (April 23) to 13.03% (Dec 23)
- ✓ Reduction in agency spend as a % of pay to 3.5% in December 2023, against a target of 3.7%. We continue to achieve our no 'off framework' spend.
- ✓ Sickness Absence Rate remains challenging, achieving above our target of 6% in December 2023, at 6.31%. Our year-to-date position is 5.9% against our 6% target. We have been on an upward trajectory for our rolling 12-month attendance, from our lowest point of 93.45% in December 2022 to 94.1% in December 2023.
- ✓ We achieved our mandatory training compliance of 95% in December 2023

3.3 We are also seeing positive movement within our EDI statistics:

- ✓ The number of colleagues in the organisation who are BAME has increased from 23% (November 22) to 25% (November 23).
- ✓ More of our staff are declaring a disability, increasing from 4% (November 22) to 5% (November 23).
- ✓ WRES findings published from the 1 April 2022 and 31 March 2023 reporting period demonstrated that the relative likelihood of staff from ethnic minority groups entering a formal disciplinary process compared to white staff was 1.14. This figure was 0.77 in 2022.

4. Progress Update

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

Priority	Key Area of Focus	Current Status
Organisational Development	Board & Executive Team Development	On track
	Trust-Wide Leadership & Management Development Offer	Behind plan (and on track to completion)

	Civility Saves Lives Programme	Behind plan (and on track to completion)
	Onboarding	Behind plan (and on track to completion)
	Coaching & Mentoring	On track
	Talent Management & Succession Planning	Behind plan (more work required to get on track)
	Career Progression	Behind plan (more work required to get on track)
Equality, Diversity & Inclusion	Career Progression opportunities for BME staff	Behind plan (and on track to completion)
	Review of recruitment process to reduce/remove barriers.	Behind plan (and on track to completion)
	Review of disciplinary progress to reduce likelihood of BME staff entering formal process.	On track
	Improving the way in which Staff Networks work.	On track
	Disability – improvement of metrics & handling of reasonable adjustments.	On track
	Improved programme of widening participation.	On track
Place Based Programmes	Attracting the local population, partnership working as part of the One Stockport Programme.	On track
Collaboration	Continue to look at opportunities to collaborate e.g. Knowledge & Library Services (KLS), Resus Faculty, etc.	On track
	Commence work with Payroll.	On track
	Continue with Occupational Health collaboration programme of work.	On track
Medical Staffing/ Agency Expenditure	Review opportunities for increased grip/control to reduce expenditure.	On track
Sickness Absence	Development and implementation of person-centred absence management and wellbeing policy & approach. Reduce sickness absence.	On track

4.1 Organisational Development Plan

The OD Service is a collaborative function, led by the Deputy Director of OD that supports both Stockport FT and Tameside and Glossop ICFT. Both Trusts have ambitious OD Plans and so we actively explore opportunities where we can do things once (where appropriate) and share learning for the benefit of both organisations.

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

- **Leadership and Management Development** – We successfully designed and launched the first element of the refreshed offer of the 1-day 'Introduction to Compassionate & Inclusive Leadership' course which runs monthly. To date 123 managers/supervisors/team leaders have attended and a further 91 individuals are due to attend during Q4 2023-24. The course continues to evaluate positively, and attendees have been actively encouraging colleagues to attend.

  Professor Michael West and Henry Fraser (mouth artist & motivational speaker) delivered inspirational talks at the Nursing Senior Leadership Conference in November 2023.

  We have designed a 'Managers Welcome Session' which all line managers (regardless of grade) that join the Trust will be invited to attend from April 2024, complementing the 'Trust Welcome Session' that all employees attend. A 'Brilliant Basics Programme' for line managers is in development which will be delivered by internal specialists and external training providers and work has started on designing Multi-Disciplinary Leadership Development Programmes aimed at different leaders within the organisation. The timing of the programmes will be dependent on

securing the required funding to commission external training providers to deliver some elements of the programmes. At this stage we are working towards the first programme for individuals on band 7/8A and above launching around June 2024.

- **Improved Working Relationships** – Our Civility Saves Lives Programme, delivered by an external company called Rambutan, launched in November 2023 with the first series of sessions for consultants and managers (band 7 & above) running until January 2024. Sessions for the wider workforce will be delivered from February to December 2024.

  Several divisional/departmental leadership development sessions have been designed and facilitated which has been positively received. Evaluation of team effectiveness interventions has so far solely centred on participants' initial reaction to the intervention and whether the learning objectives were met. Feedback from all the interventions was very positive. A more in-depth evaluation approach is in development that will measure to what extent participants' behaviour has changed and team objectives have been met due to the intervention.

- **Onboarding** – A proposal to refresh the content and format of the fortnightly 'Trust Welcome' sessions has been developed and following stakeholder engagement will be in place from April 2024, aligning with the work that is commencing on reviewing the Trust's values and behaviours and the launch of the 'Managers Welcome' sessions.

- **Coaching and Mentoring** – Individuals, on an ad-hoc basis, continue to be supported to access free coaching via the NW Leadership Academy's Coaching Hub. We are also better utilising the executive coaching offer for our Executive Directors. We currently have a small internal pool of qualified coaches within the Trust that is providing support to individuals. Arrangements are in place to enable two employees (starting in late January 2024) to complete the Level 5 Coaching Professional Qualification funded by the Trust's apprenticeship levy. We are establishing a coaching network to support our internal coaches (qualified and trainee) with their ongoing development and supervision.

- **Talent Management & Succession Planning** - Disappointingly we have not been able to progress the key actions relating to talent management, succession planning and career progression that are outlined in the OD plan. This has been due to competing demands, emerging priorities and limited staffing resource. We have carried out research work into different talent management models and succession planning tools and a paper outlining a proposed approach is in development and will outline a revised timeline for this area of work. We aim to take the paper to the relevant decision-making group by the end of February 2024

4.2 **Equality Diversity & Inclusion**

- In response to the findings of our WRES report and staff survey, to reduce the likelihood of BAME staff entering a formal process, we have introduced a conduct review panel, attended by executive directors, which reviews all cases prior to the commencement of any formal investigation, with a focus on ensuring equity and consistency of application and the consideration of alternative approaches. We have completed a review and lessons learned from our employment tribunal, embedding this approach into our business-as-usual practices.
- Career progression opportunities for BAME staff - There has been an extremely low take up of the Trust's new Reverse Mentoring Scheme from BAME and disabled staff despite ongoing promotion. To date, 2 x NEDs and 1 x Director have been matched with an employee and have started their mentoring relationship. The OD Service will continue to promote the benefits and encourage employees to take part.
- Review of recruitment process to reduce/remove barriers - A first application and support clinic were set up and all applicants from the quarterly recruitment event were invited. Unfortunately, despite candidates booking a slot we had zero attendees. We plan to repeat a further clinic session in Q4 2023/24 to assess appetite for this support and then evaluate whether this is something which we will continue with during 2024/25. We have held a collaborative inclusive recruitment workshop which was attended by both Stockport's and Tameside's Recruitment Teams. The two teams explored the social model of disability and developed an Inclusive Recruitment Action Plan which will be shared with the EDI Steering Group in February 2024.

During Q4 we will be exploring the development of a Recruitment / EDI dashboard on People Analytics to enable quarterly review of all data & evaluation of impact/outcomes.

- Improving the way in which Staff Networks work – We have completed a review of the staff networks and relaunched them with an assigned Board Sponsor and dedicated time for the network chairs to carry out their important roles. Work is underway to help increase participation in the networks and a new Neurodiversity Staff Network has been launched.
- Disability: improvement of metrics & handling of reasonable adjustments – We have completed an awareness campaign, promoting the use of the disability passport. Reviewed our approach to ensure a person-centred approach and that all adjustments are documented and undertaken quarterly case reviews to share learning. During Q4 an audit to confirm the usage of the Disability Passport and propose improvements will be undertaken, supported by the continuation of our lessons learned approach and engagement with the DAWN Staff Network, monitoring impact through WDES.

4.3 Place Based Programmes

In support of attracting the local population, partnership working and engagement in the One Stockport Programme we have:

- Developed and implemented several career pathways, which are included in the recruitment of these roles, for example pharmacy, nursing, allied health professionals. Our career development pathways are underpinned by apprenticeships, for example TNA / RDNA / AHPA / Assistant Therapist Apprenticeships.
- We have successfully supported a 'Care Leavers' into work programme, with our first candidates now secured in employment.
- We have commenced our cadet programme and are working to expand the placement areas and pathways across SMBC and the wider locality.
- We have continued to build on our successful widening participation programme, as reported to People Performance Committee in May 2023, increasing our numbers of work experience participant and placements.

4.4 Collaboration

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

- Established a joint KLS (Library) Service and Strategy across both organisations.
- Established the Resus Faculty across Stockport and Tameside. Our clinical skills teams, resus teams and AIM faculties are working collaboratively to support each site for the provision of training.
- Collaboration arrangements are in place for our Wellbeing & Occupational Health Service across both organisations.
- We have completed the necessary approvals for a change in payroll provider and are working through the transition arrangements, our payroll services will be provided by Tameside from April 2024.
- We have continued to engage with East Cheshire on the Clinical Strategy work, participating in the support of the development of the clinical pathways and establishing a joint recruitment protocol. However, in line with the pause on this activity, going forward our focus on collaboration activity will primarily be with Tameside.

4.5 Agency Expenditure

We have continued to work to review opportunities to reduce our agency expenditure and to look to increase grip/control, as appropriate. There has been a review of our weekly Staffing Approval Group (SAG) widening attendance. We have also introduced an enhanced grip and control approach to

recruitment, with all band 7 and below being approved via SAG and any other roles are considered by the Executive Team. We continue to look to support the reduction of agency spend by converting agency workers to bank, supporting recruitment campaigns. The ability to reduce our temporary staffing expenditure has been significantly impacted by industrial action and the continuing need for escalation areas.

4.6 **Sickness Absence**

In line with the NW Wellbeing Charter, we have been engaging with the development of person-centred absence management and wellbeing policy & approach. Our policy has been developed and is working through our internal processes for approval, alongside this we have been working with Tameside colleagues, who are an early adopter site, to look at the approach for implementation. It is anticipated that the person-centred wellbeing policy will be launched from April 2024, in advance of this the HR team are already using this ethos in support of staff who have been absent from work.

In support of reducing our sickness absence levels the Deputy Director of People & OD has been attending monthly meetings with each of the Divisions, with a focus on the most complex and longest absence cases. We have launched our Staff Menopause Service, which has been well received and is providing support to staff affected by the menopause and managers/leaders in understanding what support is available for them and their staff. In response to the increase, we have had in absence related to musculoskeletal we ran our back care campaign to raise awareness and have successfully recruited to a MSK Physiotherapist who will join our Wellbeing & Occupational Health Service in Q4.

5. Next Steps

5.1 Our priority areas will continue to be our focus, looking to deliver an improved retention position, reducing turnover and supporting a ‘grow our own’ approach to our career progression and talent management.

5.2 Working to continue our improvement journey in respect of our agency spend is a high priority and linked into our recruitment plans.

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

5.4 We will continue to deliver the People & OD Plan alongside the EDI Strategy 2022-25 and our Health & Wellbeing Plan. We are committed to having a relentless focus on progressing our improvement journey to creating a more compassionate and inclusive culture and are looking forward to sharing the latest staff survey results with Board in March.

6. Recommendations

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

NHS Stockport NHS Foundation Trust

Meeting date	1st February 2024	**Public**	X	**Agenda No.**	13
Meeting	Board of Directors				
Report Title	Annual Nursing & Midwifery Establishment Review				
Director Lead	Nic Firth, Chief Nurse	**Author**	Helen Howard, Deputy Chief Nurse		

Paper For:	**Information**		**Assurance**	X	**Decision**	
Recommendation:	The Board of Directors are asked to receive the report, including assurance that the investment in nursing and midwifery staffing has provided the organisation with safe staffing establishments. There a small number of identified areas requiring a further review and these will be completed within the divisions and in consideration with the Deputy Chief Nurse and Chief Nurse.					

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

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

This paper relates to the following Board Assurance Framework risks

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

	PR3.2	There is a risk that the Trust does not deliver a joint clinical strategy with East Cheshire NHS Trust
X	PR4.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit and retain the optimal number of staff, with appropriate skills and values
X	PR4.2	There is a risk that the Trust's workforce is not reflective of the communities served
	PR5.1	There is a risk that the Trust does not implement high quality transformation programmes
	PR5.2	There is a risk that the Trust does not implement high quality research & development programmes
X	PR6.1	There is a risk that the Trust does not deliver the annual financial plan
	PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial recovery plan
	PR7.1	There is a risk that the Trust does not implement the Digital Strategy to ensure a resilient and responsive digital infrastructure
	PR7.2	There is a risk that the estate is not fit for purpose and/or meets national standards
	PR7.3	There is a risk that the Trust does not materially improve environmental sustainability
	PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus

Where issues are addressed in the paper

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

Executive Summary

This paper provides the assurances and risks associated with 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 assistant 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 4 tools are used to determine safe nurse staffing levels; The Safer Nursing Care Tool (SNCT), Community Safer Nursing Care Tool (CSNCT) Emergency Department Safer Nursing Care Tool (EDSNCT), are used in conjunction with Professional Judgement (PJ) to triangulate the patient needs to determine safe staffing levels. These tools were introduced within a stringent quality control framework to ensure a robust approach was maintained for data collection and consistency.

There are staffing meetings twice daily to discuss safer nurse and midwifery staffing, with positive divisional representation. Staffing in extremis business continuity plans are initiated where staffing levels fall below the expected ratios. The senior nursing and midwifery leadership teams consider the risks utilising the above tools to make an informed decision based on the need of the service and the level of risk. A weekly staffing meeting chaired by the Deputy Chief Nurse and attended by the Healthroster team, NHS Professionals and HR colleagues. Additionally, there is a monthly staffing meeting that provides the assurance to the People and Performance Committee, and further to the Board of Directors.

2.1 Nursing and Midwifery Vacancy Data by Division

The Trust has agreed to recruit to turnover for registered staff to ensure clinical areas continue to be safely staffed.

Registered Nurses & Midwives	FTE Actual	Variance FTE	Post Recruited to in TRAC FTE & awaiting start dates
Clinical Support Services	59.24	-9.05	7
Emergency Department	114.03	-9.42	6
Integrated Care	347.43	-51.69	28
Medicine & Urgent Care	352.46	-38.94	11
Surgery & GI	432.39	-49.51	21
Women, Children & Diagnostics	401.81	-33.31	20
Grand Total	**1825.03**	**-172.20**	**132**

** Information provided by Workforce – October 2023 data (most up-to-date data)*

2.2 StARS Accreditation

Stockport Accreditation & Recognition System (StARS) was introduced in April 2021 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.

As a result of an unscheduled ward visit the Quality and senior leadership teams review the ward's clinical and non-clinical processes and procedures. The information provided and evidence observed is collated and the Quality and senior leadership teams will conduct a thorough assessment following the Trust's 14 standards and provide a final report. The outcome of the assessment dictate the rating and establish if the ward requires support in preparation for a second review or continue until they are next reviewed. (See Appendix 1 for ward/unit StARS results from April 2021 – September 2023).

Clinical Support Services (CSS) are not currently undergoing the StARS accreditation process as the current standards are not suitable for the services. This is currently under review.

3. DIVISIONAL REVIEWS

3.1 Medicine & Emergency Department

The Division of Medicine and the Emergency Department have funded establishments that have been assessed and confirmed as correct; with the exception of 4 areas requiring an increased focus. These areas are Hyper Acute Stroke Unit Laurel suite, Pacing Suite and Ward E3. The division are currently reviewing these areas and in discussion with the Chief Nurse.

The emergency department establishments currently meet RCN national guidance although the staffing model is currently being reviewed in line with the demand growth.

Recruitment for registered staff is on-going with planned recruitment events scheduled. Turnover has increased slightly.

3.2 Surgery, Critical Care and Theatres

The Division of Surgery, Critical Care and Theatres have funded establishments that have been assessed and confirmed as correct; with the exception of 1 area requiring an increased focus. Ward D1 requires a staffing establishment review with consideration of the acuity and ratio calculation.

3.3 Integrated Care & District Nursing

The Division of Integrated Care has identified there has been an increased number of patients transferred to all wards and who are assessed as requiring enhanced supervision. In particular Bluebell, 25 beds, where all patients are accommodated in single bedrooms, and therefore there are challenges for bay nursing to be established. There are high levels of enhanced care usage required due to the complex nature of patient's needs. The division have submitted a staffing proposal for AMU, Bluebell, AFU and MSDEC to the Executive Team for consideration.

Medical SDEC

There have been recent changes in staffing model due to the move from SDEC footprint to AMU. An establishment review will be required with a view to the completion of the UECC.

District Nursing

Total number of district nurses 189.6 WTE. Broadly establishments are correct although a rapid team has been piloted to support unplanned community work and alleviate the pressures incurred when receiving urgent calls. The outcome of the pilot will inform further service development.

3.4 Women & Children's and Maternity

Midwifery establishments using the birth rate plus tool, 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 is in line with RCN guidance.

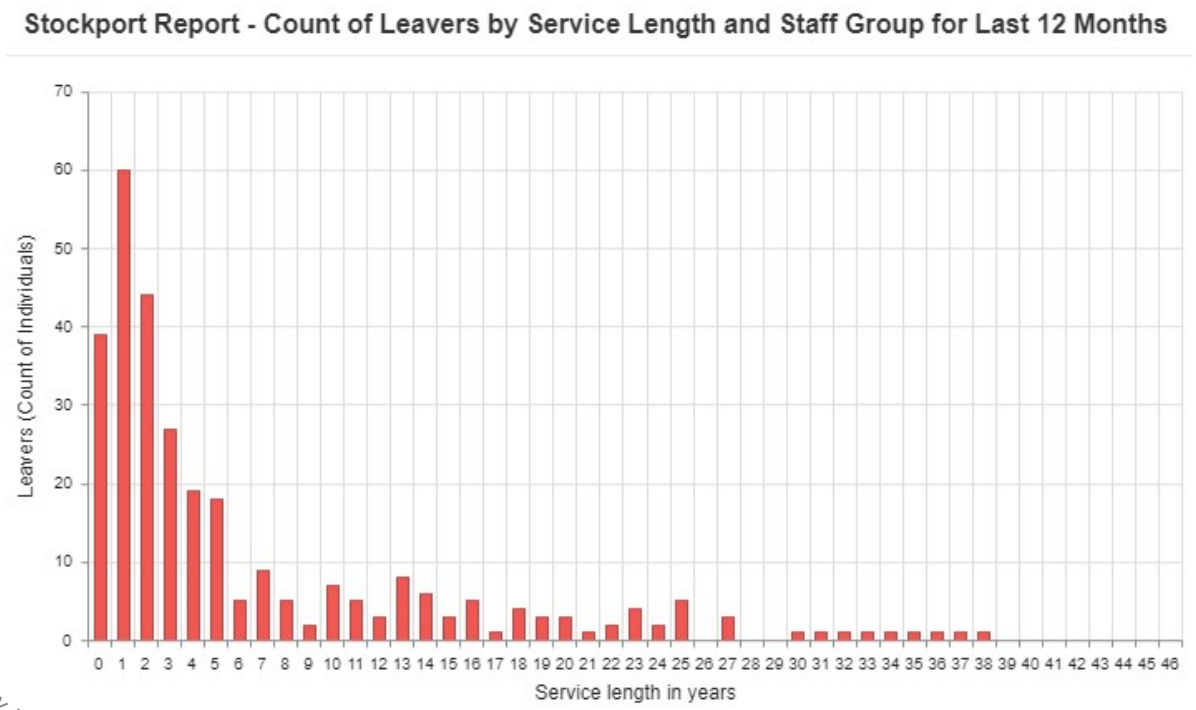
The Neonatal unit meets the BAPM standards.

3.5 Clinical Support Services

Clinical Support Services is a relatively new division and therefore the first occasion it has been included in the strategic staffing review. The division covers Outpatients A, B and C, Bobby Moore Unit, Chest clinic, Dental clinics and Endoscopy. The staffing establishments for Endoscopy and outpatient areas have been deemed to be funded and suitable for the current provision of services.

4. Retention

The Trust's priority is to improve retention, focusing on the staff within the first 2 years of employment at the Trust, and in providing staff with excellent career development opportunities and to ensure their well-being and a healthy work/life balance.



*Data from People Analytics

The Grow and Support Our Workforce (GROW) pathway has been introduced which provides Band 5 RNs with the opportunity to transfer to an alternative clinical area and experience working in a different environment and with a new team.

One of the themes of the NHS People Promise is “We are a team” with a focus on a new starter’s recruitment experience, from the interview, through the employment process, their induction to the Trust and working environment, and providing support as they progress from learner to active practitioner. The Trust has created the new role of a Pastoral Care Lead who will undertake these responsibilities. The Pastoral Care Lead will work closely with the new starter’s manager and link in with the Practice Education Facilitators (PEFs) during the Preceptorship Programme. The role is funded for 18 months as a secondment, career development opportunity for an established member of staff, or fixed term contract.

5 Summary

Enhanced Supervision has been highlighted throughout all the strategic staffing reviews and will remain part of the divisional performance reviews. The improved processes for authorisation and monitoring of enhanced supervision resulted in a reduction in the use and costs of security and are recognised as an appropriate way of supporting patients. Bank costs have, as an expected consequence, seen an increase.

The strategic staffing review can effectively support that the nursing and midwifery establishments are correct and those areas that have been identified as requiring a review, will be reviewed by the divisions with oversight of the Deputy Chief Nurse and approval by the Chief nurse.

6 Recommendations

The Board of Directors are asked to note and accept the contents of this report and receive assurance that the investment in nursing and midwifery staffing has provided the organisation with safe staffing establishments. There a small number of identified areas requiring a further review and these will be completed within the divisions and in consideration with the Deputy Chief Nurse and Chief Nurse.

APPENDIX 1

The Safer Nursing Care Tool data in support of the nursing establishment review 2023/24

Unit	0	Level 1a	Level 1b	Level 2	Level 3
Acute Frailty unit D4	0.00%	0.00%	98.36%	1.64%	0.00%
Acute Medical Unit (AMU)	0.00%	1.54%	85.04%	13.28%	0.14%
Devonshire Centre	0.00%	0.51%	95.63%	3.86%	0.00%
Ward Bluebell Meadows	0.00%	1.77%	75.35%	22.88%	0.00%
Ward A11 Heart Care Unit	27.73%	19.24%	30.43%	22.60%	0.00%
Ward A3 Respiratory	0.18%	5.55%	90.53%	3.73%	0.00%
Ward B2	7.48%	42.72%	49.80%	0.00%	0.00%
Ward B4 Winter Escalation	0.00%	0.00%	100.00%	0.00%	0.00%
Ward B5 Escalation Ward	2.40%	44.91%	50.70%	2.00%	0.00%
Ward B6 Escalation	6.72%	6.93%	84.18%	1.96%	0.21%
Ward C3	0.00%	48.52%	51.48%	0.00%	0.00%
Ward C4 General Med	0.00%	17.79%	82.21%	0.00%	0.00%
Ward C6 General Medicine	4.35%	38.46%	57.19%	0.00%	0.00%
Ward E1	2.78%	1.27%	92.70%	3.24%	0.00%
Ward E2	8.40%	28.44%	61.91%	0.83%	0.42%
Ward E3 Respiratory	2.23%	41.38%	51.09%	5.30%	0.00%
Ward Hyper Acute Stroke Unit	4.36%	27.27%	51.06%	16.81%	0.50%
Ward A1 Escalation 33A20	0.05%	7.85%	87.76%	4.33%	0.00%
Ward B3 New	0.00%	0.00%	100.00%	0.00%	0.00%
Ward D1 38A22	4.02%	37.04%	48.61%	10.33%	0.00%
Ward D2	0.16%	3.07%	96.55%	0.22%	0.00%
Ward D5 General Surgery	22.27%	40.43%	35.35%	1.95%	0.00%
Ward D6 Day Case	85.95%	14.05%	0.00%	0.00%	0.00%
Ward D7 Urology & ENT	35.09%	19.01%	45.50%	0.40%	0.00%
Ward D8/SAU 32G10	12.15%	34.15%	53.70%	0.00%	0.00%
Ward M4 36B23	0.00%	1.82%	96.36%	1.82%	0.00%
Ward M6 36B26	8.60%	29.59%	61.80%	0.00%	0.00%
Jasmine Ward 27F14	98.87%	0.56%	0.28%	0.28%	0.00%
Neonatal Ward 22D16	0.00%	0.00%	0.00%	0.00%	100.00%
Tree House 21D12	77.29%	4.15%	17.91%	0.66%	0.00%

**Data provided by Healthroster – November 2023*

Appendix 2

Number and colour ratings of StARS accreditations between Quarter 1 & 2 2023/24

MEDICINE								
A3/HACA	1	2	3	4	5	6 (May 2023)		
Ward A10	1	2	3	4	5	6		
Ward A11	1	2	3	4	5	6	7	
Ward B2	1	2	3 (March 2023)	4 (Sept 2023)				
Ward B4	1	2	3	4		5	6 (Oct 2023)	
Ward B5	1	2	3	4 (Jan 2023)				
Ward B6	1	2	3	4		5 (March 2023)		
Ward C3	1	2	3	4		5		
Ward C4	1	2	3	4 (April 2023)				
Ward C6	1 (Dec 2021)	2 (Sept 2022)	3 (April 2023)					
Ward E1	1	2	3	4		5 (August 2023)		
Ward E2	1	2	3	4		5	6	
Ward E3	1	2	3	4		5	6	7 (July 2023)
ED	1	2	3	4	5			
SURGERY								
Ward A11	1 (Feb 2022)	2 (April 2022)	3 (July 2022)	4 (April 2023)				
Ward B3	1	2	3	4		5	6	7 (April 2023)
Ward D1	1	2	3	4		5	6	7 (July 2023)
Ward D2	1	2	3 (April 2023)					
Ward D5	1	2	3	4	5	6	7	8
Ward D6	1	2	3	4		5 (August 2023)		
Ward D7	1	2	3	4		5		6 (July 2023)
Ward 8/SAU	1	2	3	4	5	6	7 (June 2023)	
Ward M4	1	2	3	4	5	6	7	8 (Aug 2023)
Ward M6	1	2	3	4	5	6 (August 2023)		
ICU	1	2	3	4 (March 2023)				
Theatres	1	2	3					
IC								
AFU	1	2	3	4	5	6 (June 2023)		
AMU	1	2	3	4	5	6	7 (May 2023)	
Devonshire	1	2	3	4	5	6 (August 2023)		
Bluebell	1	2	3	4	5 (Sept 2023)			
DISRICT NURSING								
Bramhall/Cheadle	1 (Aug 2022)	2 (April 2023)						
Cheadle/Gatley	1 (Jan 2022)	2 (Nov 2022)	3 (Oct 2023)					
Marple	1 (June 2022)	2 (Nov 2022)	3 (Nov2023)					
Tame Valley	1 (Oct 2022)	2 (Oct 2023)						
Werneth	1 (Feb 2023)							
Heatons	1 (May 2023)							
Victoria	1 (Aug 2023)							
W&C's								
Treehouse	1	2	3 (Feb 2023)					
Jasmine	1	2	3	4	5	6 (June 2023)		
Mat 1	1	2	3					
Mat 2	1	2	3	4				
Mat 3	1	2						

Data provided by the Quality Team – November 2023

NHS Stockport NHS Foundation Trust

Meeting date	1st February 2024	**Public**	X	**Agenda No.**	14
Meeting	Board of Directors				
Report Title	Safer Staffing Report				
Director Lead	Nic Firth, Chief Nurse	**Author**	Helen Howard, Deputy Chief Nurse		

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

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

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

This paper relates to the following Board Assurance Framework risks

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

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

Where issues are addressed in the paper

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

Executive Summary

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

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

We continue to experience high levels of operational demand within the acute and community services which we are aware is having an impact on patient experience and staff experience. The demands within the Emergency Department remain significant, impacted on by large numbers of patients who do not require a hospital bed any longer. This demand is operationally managed by our senior teams and on call colleagues with a continual dynamic risk assessments being carried out.

NHS
Stockport
NHS Foundation Trust

Safe Staffing Report – January 2024

Report of: Helen Howard
Deputy Chief Nurse

Contents

Stockport NHS Foundation Trust

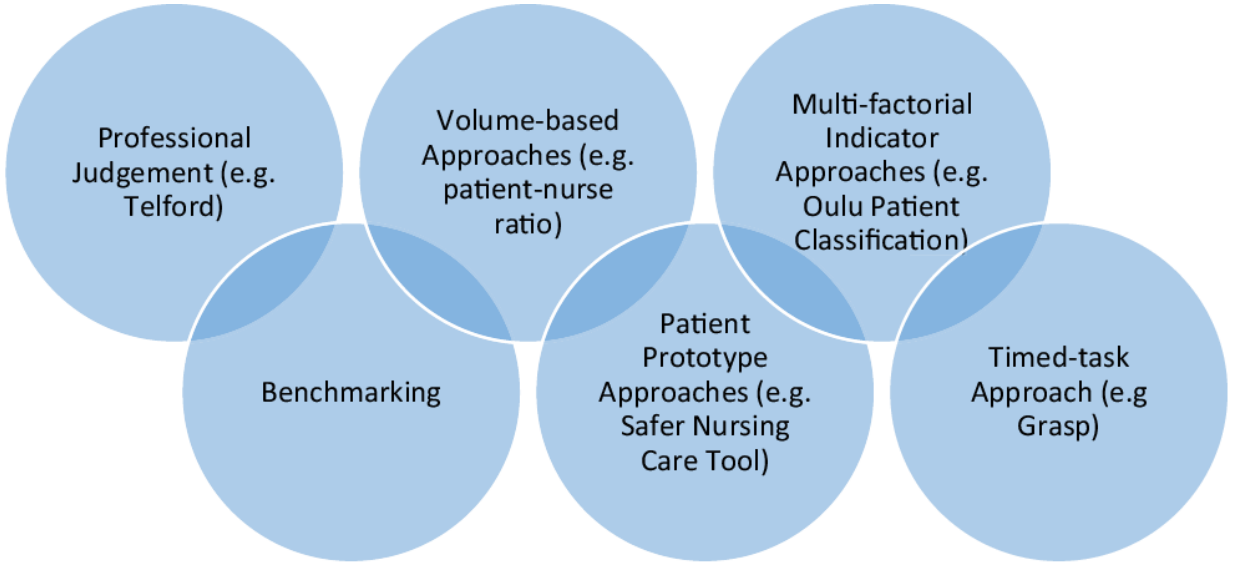
1. Introduction

NHS Stockport NHS Foundation Trust

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

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

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



1. Introduction

Stockport NHS Foundation Trust

Safe staffing is a fundamental part of getting care and support right for individuals. Across the organisation it is essential that there is the right quantity of skilled staff to meet the needs of the service. Evidence based decision making on safe and effective staffing is a requirement for all NHS organisations. We continue to focus on patient safety and patient experience, in relation to safer staffing utilising a triangulated approach.

Safer Nursing Care Tool

The Safer Nursing Care Tool (SNCT) is a NICE endorsed evidence based tool currently used in the NHS and includes tools for the following settings:

- adult inpatient wards in acute hospitals (updated 2023)
- adult acute assessment units (updated 2023)
- children and young people's inpatient wards in acute hospitals
- mental health inpatient wards
- emergency departments

Primarily used by the nursing workforce, the development of these tools has been led by a core group of experienced professional leaders and leading academics.

These tools support chief nurses to determine optimal nurse staffing levels helping NHS hospital staff measure patient acuity and/or dependency to inform evidence based decision making on staffing and workforce. The tools can also support organisations to deliver evidence based workforce plans to support existing services or to develop new services.

2. Healthroster

NHS Stockport NHS Foundation Trust

The Trust uses SCNT at the daily staffing meetings to review staffing levels in conjunction with acuity levels of patients. The census is completed 3 times per day.

Processes for improving the Key Performance Indicator (KPI) :

- A roster dashboard is currently in development & will be piloted in the new year, which will cover all rostered areas and be able to be presented as a continuum as requested.
- Additional duties have reduced by 1818.71
- Safecare completion rates have increased by 14.93%
- Annual Leave is on target for the month of December 2023
- Roster approval times have improved by 35 days across the Trust

Roster period : 4 December – 31 December 2023								Roster period : 6 November – 3 December 2023	
Business Division	Annual Leave %	Roster Approval (Full) Lead Time Days	Total Unavailability %	% Changed Since Approval	Unused hours (4 week period)	Over contracted hours (4 week period)	Total Hours balance	Additional Duties in hours (Total Hours)	Safecare % compliance across 3 Census periods (average)
ED	14%	63.5	19.4%	17.5%	499.5	274.8	224.8	171.83	n/a
IC	12.3%	61.6	19%	32.8%	1,313.3	461.4	851.9	3,825.12	54.76%
Medicine	14.1%	54	23.7%	33%	1,472.5	1,080.6	392	5,273.98	59.71%
S&CC	11.4%	51.66	23.8%	28.8%	1,575.8	863.9	711.3	3,295.79	57.74%
W&C	15.1%	60.76	33.7%	29.1%	1,011.4	462.3	549.1	618	70.83%
CSS	15.5%	12.66	18%	12%	191	21.33	212.33	627.75	n/a
Total					6,064	3,164	2,941	13,812.47	60.76%

Data provided by the Rostering Team

3. Vacancies

Stockport NHS Foundation Trust

Registered Nurses & Midwives	FTE Actual	Variance FTE	Post Recruited to in TRAC FTE & awaiting start dates
Clinical Support Services	55.88	-13.46	2
Emergency Department	118.19	-5.26	31
Integrated Care	359.28	-34.03	4
Medicine & Urgent Care	352.47	-38.93	20
Surgery & GI	441.65	-40.24	10
Women, Children & Diagnostics	404.32	-30.80	16
Grand Total	1827.03	-167.07	28

The data above covers the positions of registered nurses (RNs) and registered midwives (RMs), nursing associates (NAs) and staff awaiting PINS in November 2023

The Trust encourages Student Nurses to use the Trust QR code to register their interest. Apply for a job on Trac and will be interviewed if they are successful at the shortlist stage. Moving forward if the applicant is successful at interview the "Corporate Services" will stay in contact with the applicant.

Obtaining accurate information on the number of vacancies within the Trust has proved difficult, and this is an ongoing issue, as data is provided from a number of sources such as Finance and Workforce (from Trac and ESR) and the figures do not correlate. A piece of work is currently being undertaken to ensure that this issue does not continue.

4. NHS Professionals

NHS Stockport NHS Foundation Trust

The table below illustrates the % of shifts picked up by staff in October and November compared to the demand that was sent out.

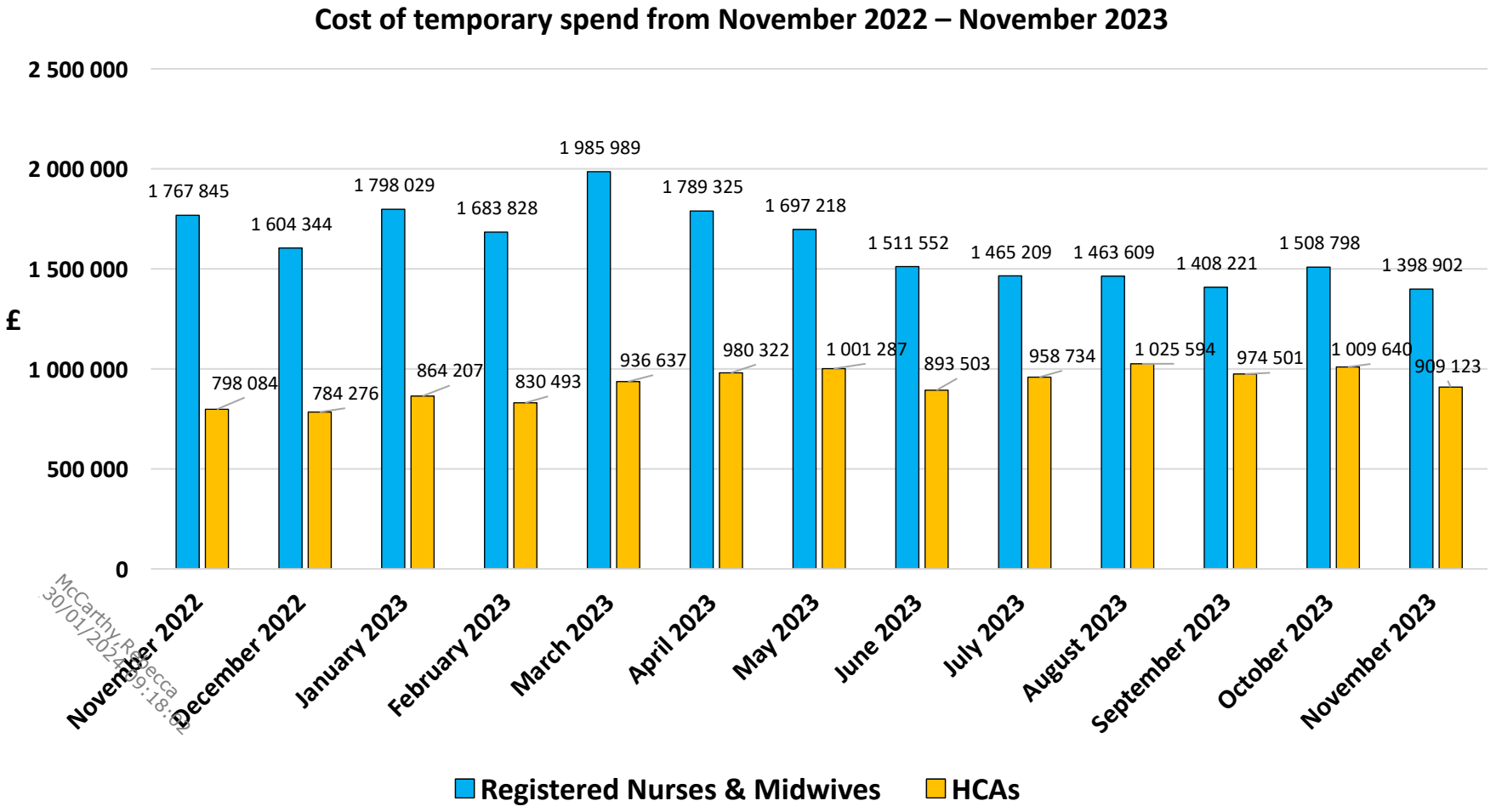
	October 2023			November 2023		
Nursing	**Day**	**Night & Saturday**	**Sunday & BH**	**Day**	**Night & Saturday**	**Sunday & BH**
Band 2	69.70%	98%	98.30%	78.40%	97.50%	98.30%
Band 3	68.10%	95%	100%	68.70%	94.60%	97.60%
Band 4 & 5	69.30%	93.50%	92.50%	78.20%	93.30%	96.80%
Band 6 & 7	52.20%	45.40%	72.80%	87.20%	96.90%	98.60%

	October 2023			November 2023		
Maternity Triage Maternity 2 Maternity 3 Jasmine Delivery Suite	**Day**	**Night & Saturday**	**Sunday & BH**	**Day**	**Night & Saturday**	**Sunday & BH**
Band 2	57.30%	98.20%	93.90%	80%	94.70%	100%
Band 3	0	0	0	0	0	0
Band 4 & 5	0	0	0	100%	100%	100%
Band 6 & 7	20.80%	35.40%	63.40%	38%	27.30%	55%

5. Nursing & Midwifery Temporary Staffing

NHS Stockport NHS Foundation Trust

The table below illustrates the 'month on month' cost to the Trust of temporary staffing for RNs, RMs and Health Care Assistants (HCAs).



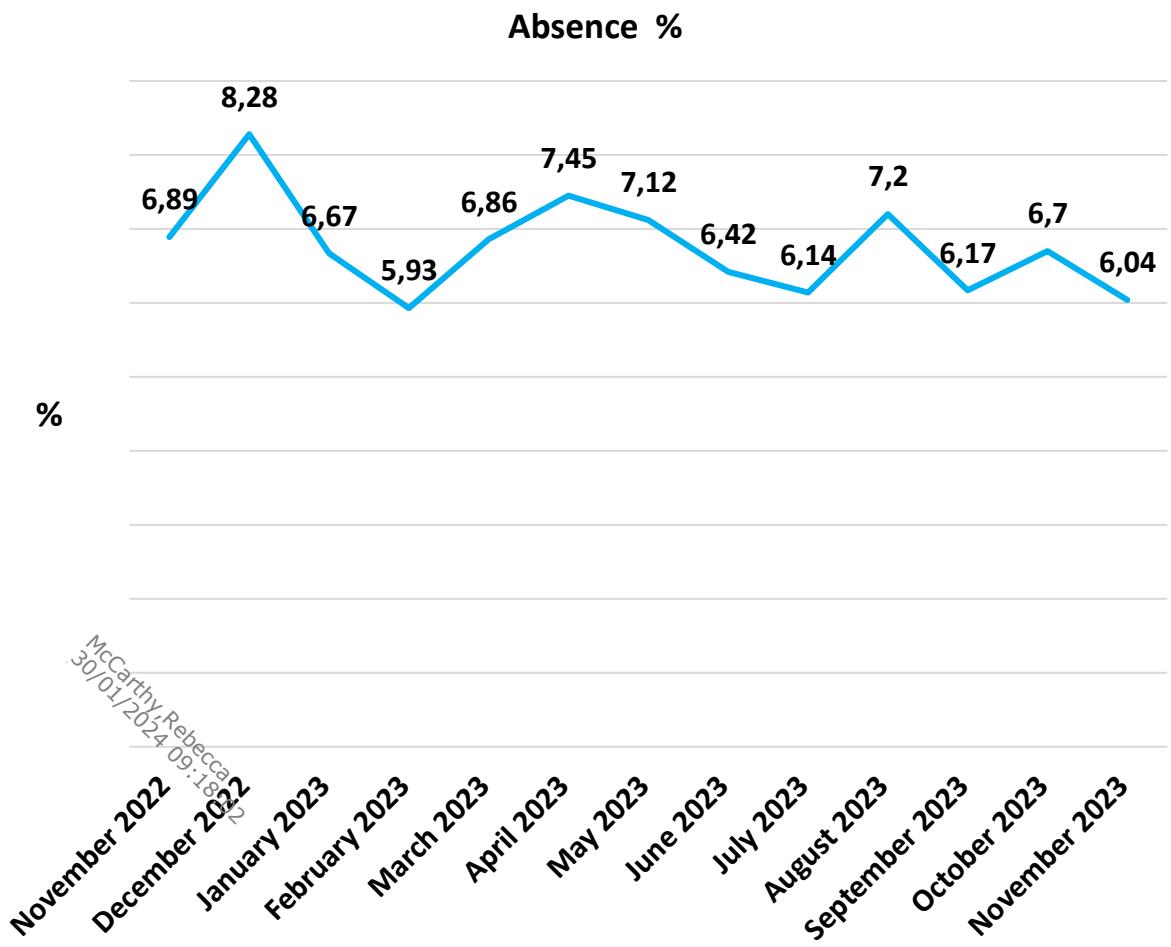
Data provided by People Analytics

6. Nursing & Midwifery Absences

Stockport NHS Foundation Trust

Figures reported in November illustrate a decrease in the number of absences for RNs and RMs. We see our highest absence rates during school holidays. 'Looking after our people' **NHS People Plan**.

Role	Sickness %
AHPs	4.40%
RNs & RMs	6.72%
Students	0.22%



- The main reason for reported absence is Anxiety, Stress and Depression
- Managers work closely with Occupational Health in exploring alternative working patterns to ensure staff have a healthy work/life balance
- Support provided by the Trust's confidential Staff Psychology and Wellbeing Service (SPAWS)
- PNAs on hand to provide coaching and career advice

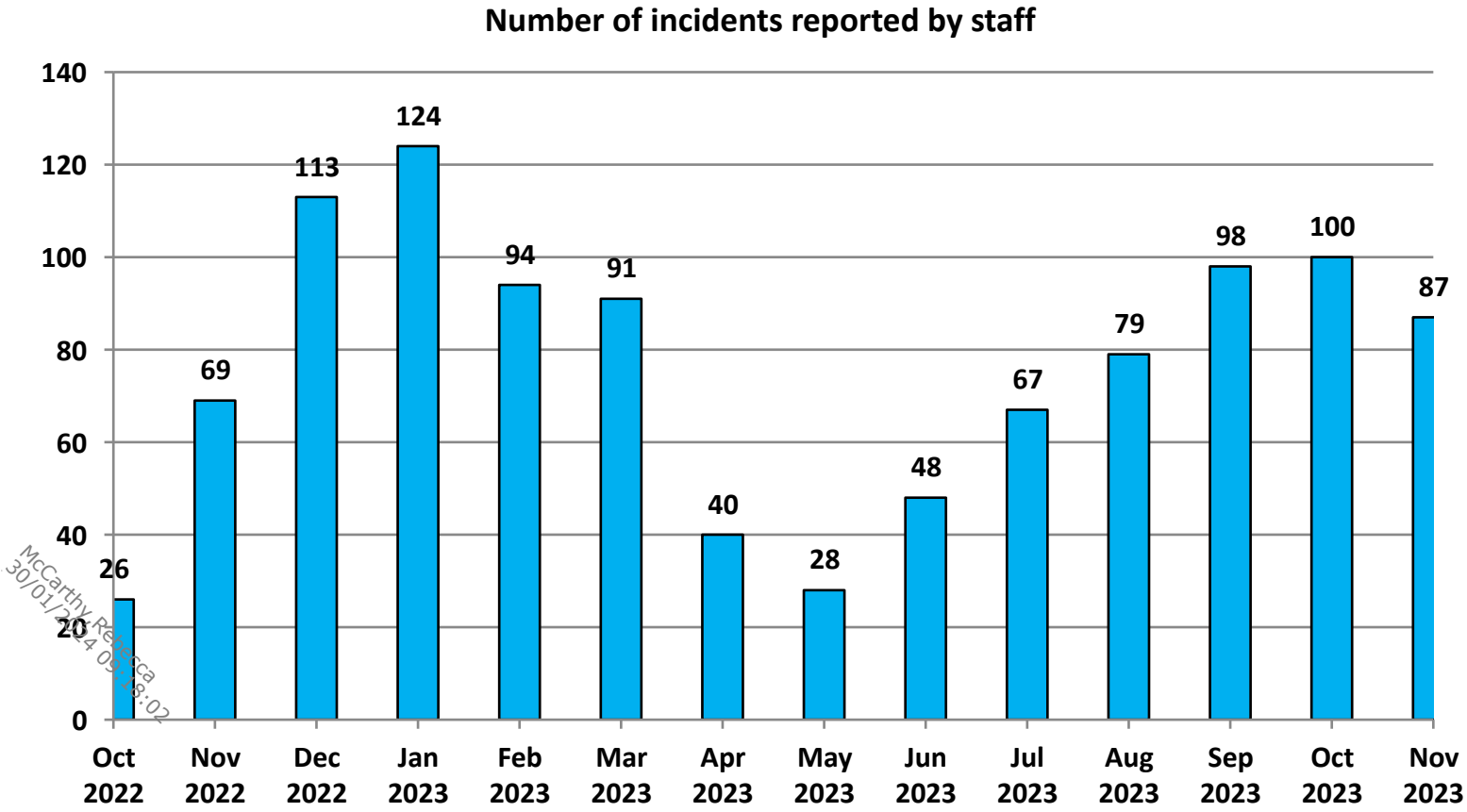
Data provided by People Analytics & Workforce

7. Nursing & Midwifery Risk Highlights

NHS Stockport NHS Foundation Trust

The Trust actively encourages staff to report incidents caused by staffing shortfalls via Datix.

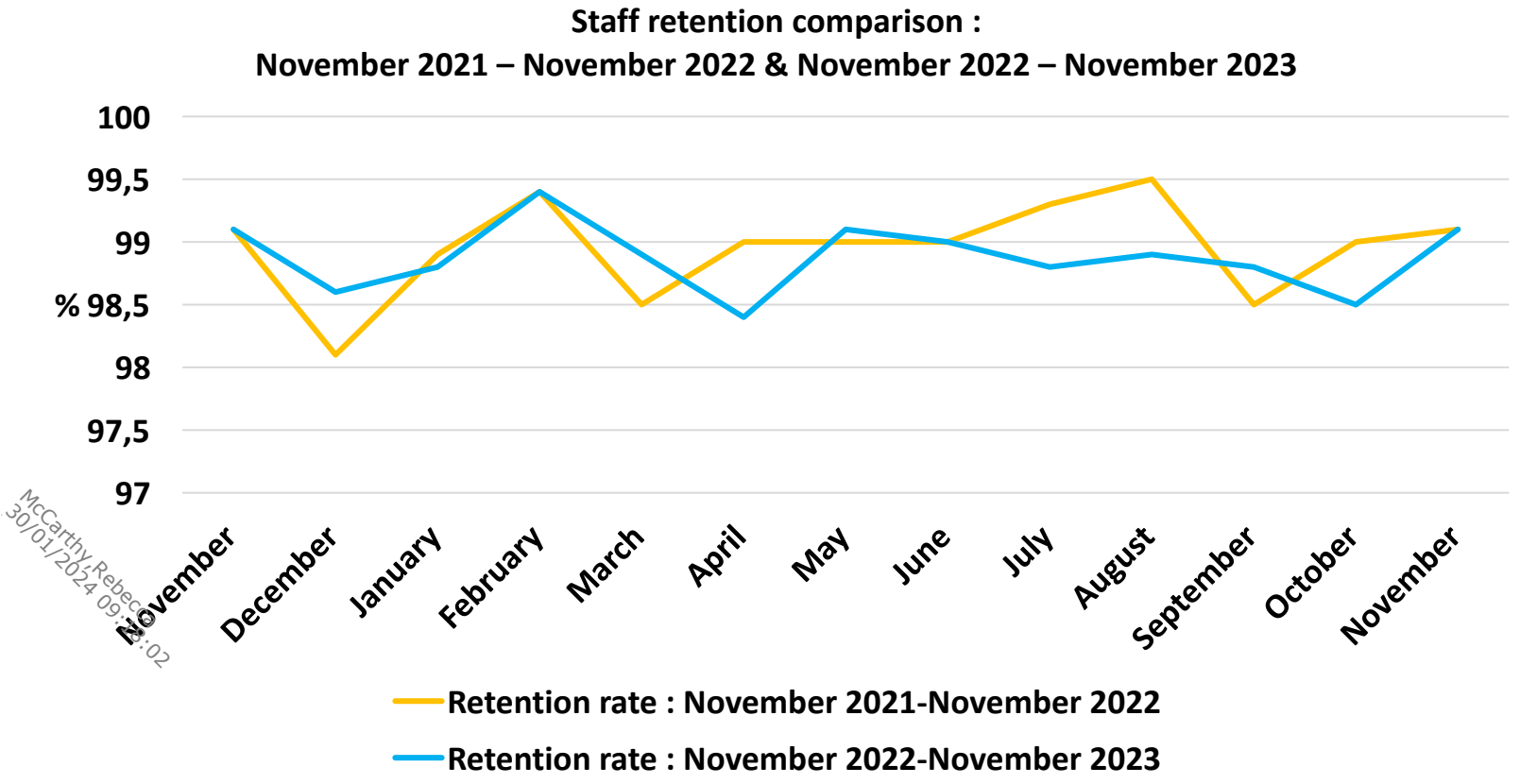
The graph illustrates the number of 'month on month' incidents. The increase in reporting staffing shortfalls is a positive indicator of staff feeling confident to escalate their concerns appropriately.



Data provided by Datix

8. Nursing & Midwifery Retention

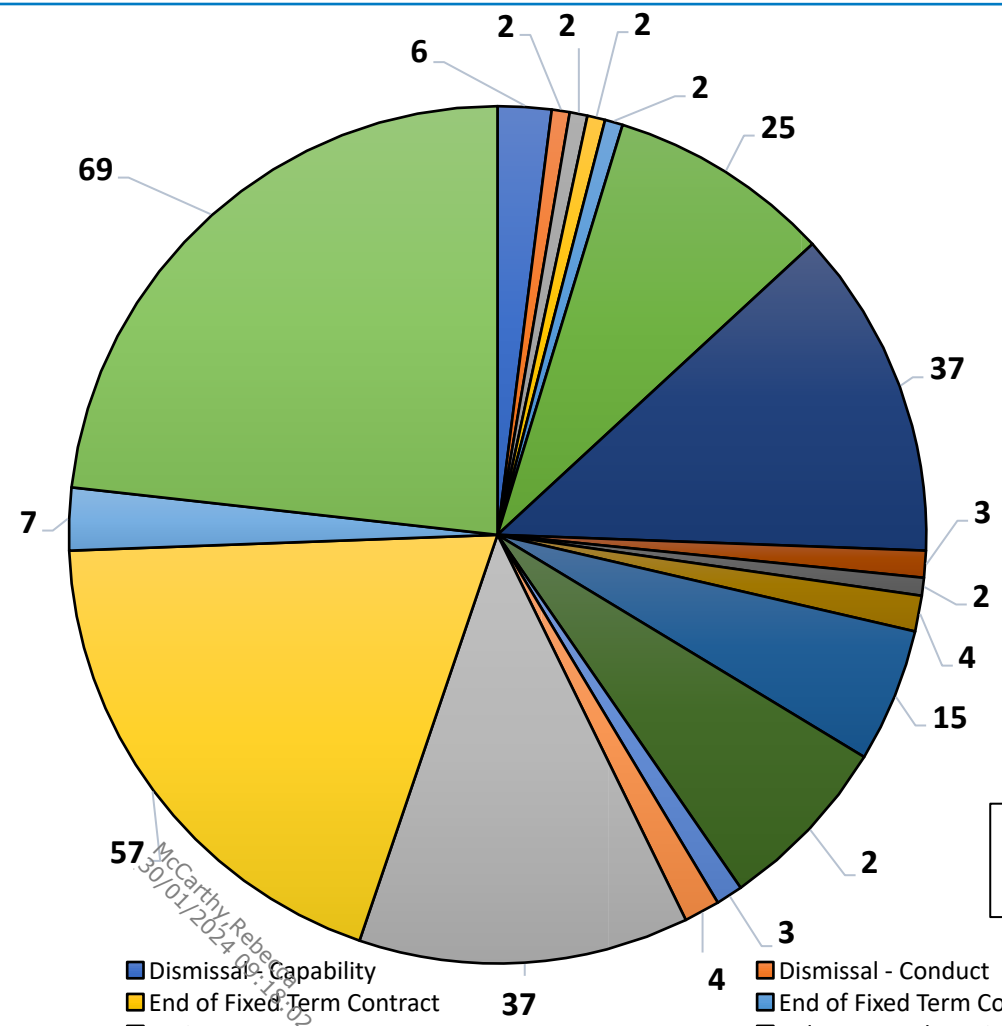
The chart below illustrates with the blue line that there has been an increase in staff retention. To enhance this funding has been approved for the role of Band 6 Pastoral Care Nurse (18 month fixed term contract). This role will involve supporting new starters from their interview, throughout the recruitment process and their initiation on the wards, support international HCAs throughout their OSCE process and represent the Trust at recruitment events. The role will also include managing the Grow & Retain our Workforce (GROW) pathway which enables RNs to internally transfer.



Data provided by People Analytics

9. Nursing & Midwifery – Reasons for Leaving

NHS Stockport NHS Foundation Trust



Number of leavers by reason November 2022 - November 2023

- The number of staff applying for the Professional Nurse Advocate (PNA) programme has increased, this investment will have a positive impact on supporting staff and increase in retention. unfortunately, funding has now ceased.
- To improve retention the role of a Pastoral Care Lead has been created to provide emotional and practical support for new starters, internationally educated nurses and HCAs. This is a Band 6 fixed term contract for 18 months

Data provided by People Analytics

10. Nursing & Midwifery Recruitment

NHS Stockport NHS Foundation Trust

- Theatres are holding an Open Day and recruitment event on the 6th January 2024
- Midwifery held a successful event recruiting 5.4 WTE midwives and are planning more events
- The Internationally Educated Nurses (IENs) recruitment programme has now finished. The focus is now on the IENs who are currently employed as HCAs in the Trust and to support them through the Objective Structured Clinical Examination (OSCE) process. Monies has been allocated to fund 10 HCAs through the OSCE with training provided by the OSCE Team, Pinewood House.
- Midwifery now have 3 Internationally Educated Midwives (IEMs) working at the Trust, 2 more will be joining within the next few months.
- As a result of successful recruitment events throughout 2023, 65 new nursing staff joined the Trust, a high percentage of who are newly qualified

10. Nursing & Midwifery Student Engagement

Stockport NHS Foundation Trust

At the request of the Senior Lecturer from the University of Salford the Workforce Matron & Matron for Medicine presented a "Meet the Matrons" talk to the nursing students. Two hundred nursing students attended the session, the session was very well received with excellent feedback from the learners. In April 2024 the Matrons have been invited to speak to 3rd year nursing students.

A selection of comments received from the students :

"I enjoyed the session. Very positive individuals, having them ask us questions too - was good. They were encouraging, it was good to have the opportunity to ask questions & raise a few concerns."

McCarthy,Rebecca 30/01/2024 09:18:02

"Good session, valid and great to get the discussions going. Thought provoking. Good to hear so many students had got job offers – positive."

"I really enjoyed the session. As a student given the opportunity of asking questions from matrons and getting some answers was helpful and inspiring too. Thank you to the team who delivered the message."

11. Recruitment and Training Pathways

NHS Stockport NHS Foundation Trust

To make the role of nursing more accessible the Trust has looked at alternative, more affordable and with more flexibility and different pathways for staff to qualify as a registered nurse or senior healthcare practitioner, instead of the traditional route via university. These opportunities re-enforce the Trust's policy on supporting staff development.

Nursing Cadet Scheme

The Trust is working in collaboration with Trafford College to support learners on a healthcare programme who are aged 16 and up. The Cadets are on placement at the Trust on Thursdays and Fridays (term time only) and rotate placement areas every 12 weeks. We currently have 25 cadets.

We have now developed relationships with Manchester College and have 45 T Level students commencing on placement in January. We will also be facilitating placements for students attending UCEN (University Centre of Manchester) who are studying at Level 4,5 and 6.

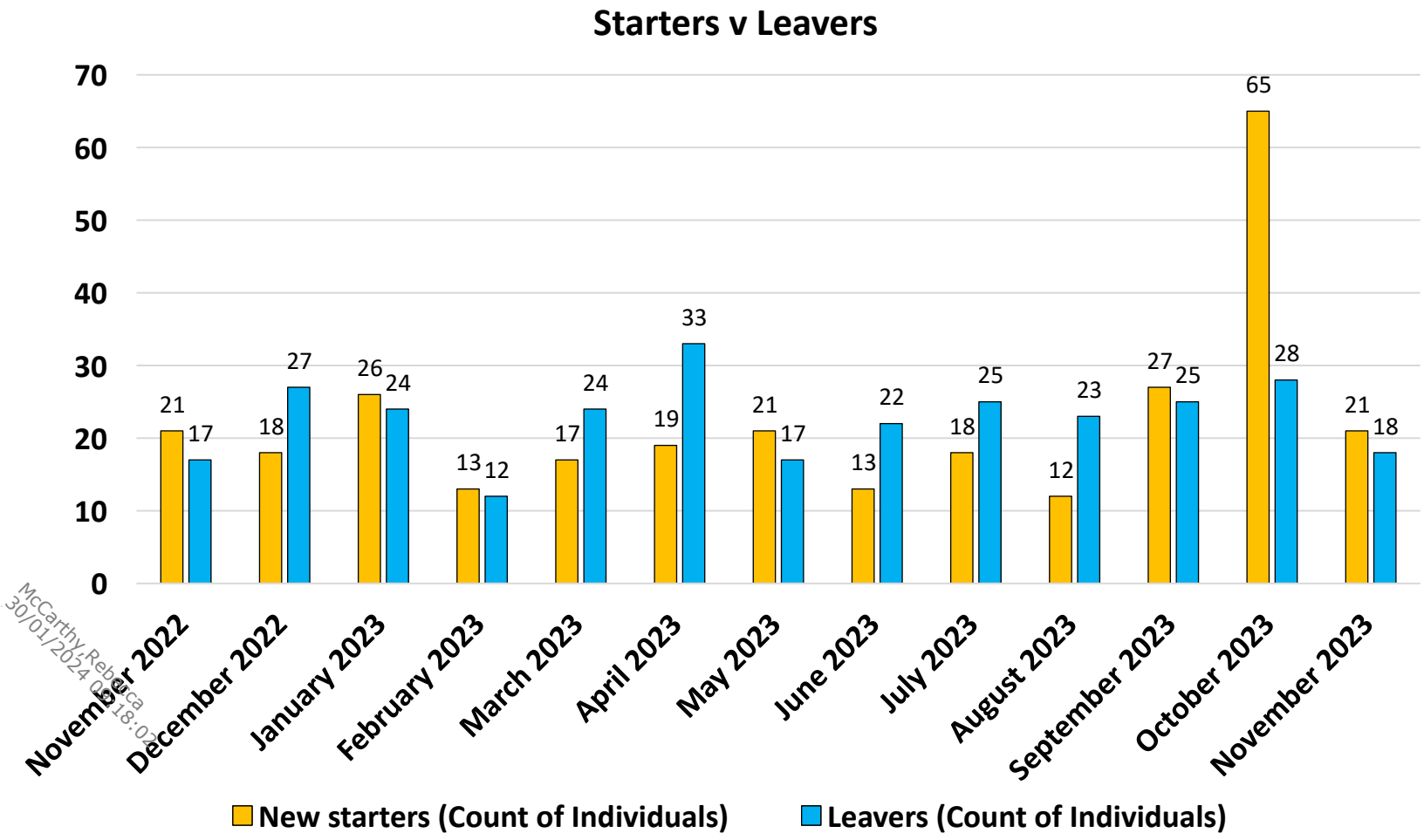
These learners will be actively seeking employment with the Trust (12 students).

In September 2024 we will be facilitating T Level placements for students at Macclesfield College. We anticipate the number of learners will increase from September 2024

12. Nursing & Midwifery Starters & Leavers

NHS Stockport NHS Foundation Trust

The success of recent recruitment events has resulted in the employment of a high number of nursing students who qualified in September. This is reflected in the high number of new nursing staff starting at the Trust in October.



Data provided by People Analytics

13. Allied Health Professionals – Radiology

Stockport NHS Foundation Trust

Further continuation of the recruitment strategy has seen further vacant posts filled. In relation to allotted establishment this equates to full establishment in the Band 6 cohort.

The Band 5 cohort was briefly over established, only dipping below establishment upon the appointment of several internal promotions. Of note, our plan to fortify the Nuclear Medicine staffing to mitigate the staffing risk ahead of the current team reaching retirement age is going particularly well.

Trainees

The two trainee appointments are undertaking the relevant qualification and should be up and running within 12 months. Both candidates bring other useful skills to the role and will be pivotal in the introduction of a Radiographer led Ultrasound guided cannulation service that will be accessible to all Radiology specialities, not just Nuclear Medicine.

International Recruits

Our new international recruits have been a great success, and all have been signed off with the exception of a late arrival in CT. All are making really good progress and have integrated well into the team. We have also recruited a number of newly qualified Radiographers, the last joining in September. Following their induction all will be working in the numbers by January 2024.

Locums Support

The use of locums has been reduced and continues to be reviewed regularly. And only used during cores hours to reduce the spend from enhancements. The exception is CT, but this is due to an unforeseen terminal illness presenting within the team suddenly.

Data provided by CSS

13. Allied Health Professionals – Radiology

NHS Stockport NHS Foundation Trust

A long overdue review of our allotted establishment has revealed a shortfall in staffing. The cause is multi-faceted and includes an increase in assets minus the staffing associated with the running of them, and a general increase in activity since the inception of the original establishment calculation.

Some specialities have seen an upwards of 150% increases since the last review in 2012. Work has been done with the help of Finance and the new calculation sees us missing roughly 6.5 WTEs at Band 6 level. Long term this will threaten further retraction of locum support given our priority of maintaining our services and offering responsive throughputs.

Overall staffing levels in Radiology are the best they have been for over a decade, although there is a clear requirement for an increase to our establishment if our reliance on agency is to be resolved.

- Full establishment Band 5
- Full establishment Band 6
- Nuclear Medicine future workforce planning going well
- Ongoing work in terms of building the case for increased establishments to match 150% increase in activity
- Plan to eradicate agency secondary to establishment review
- Staffing at most optimal level for a decade however continued focus necessary

Data provided by CSS

14. Allied Health Professionals

NHS Stockport NHS Foundation Trust

2023 saw a significant improvement in WTE vacancy rate, with efforts across the board to source, secure and retain high quality staff. Further efforts to target and refine the recruitment strategy through 2024 will see the Directorate focussing on key areas:

Capacity and Demand Analysis

- Operational Pathway Leads are currently undergoing an introduction to the process for capacity & demand reviews across our inpatient, outpatient and community services. In conjunction with job planning, this will give us an accurate and real time overview for our workforce deployment and any areas of particular concern. The Leads have embraced this project and are eager to get the formal process underway.

Agency Trajectory

- We have reduced our usage of agency staff across therapies, working with NHSP to start building a bank of suitable AHPs and enable a new approach for temporary staff across therapies. Recruitment to substantive posts for 2 of the 3 historic escalation wards is proceeding, which will deliver a further reduction in agency spend in early 2024.

Job planning

- AHP job plans are long overdue, and work has commenced to map our AHP workforce DCC and SPA hours to prepare for the introduction of robust capacity and demand analysis cycles.
- Effective job planning will provide a more structured framework that not only benefits our staff by addressing their professional needs and wellbeing but will also contribute to the overall effectiveness and efficiency of healthcare delivery across our MDT.
- Job satisfaction is pivotal to our recruitment & workforce strategy, & we recognise that when AHP staff have clearly defined roles, opportunities for growth, and a supportive work environment, job satisfaction tends to increase.

Data provided by Integrated Therapies & Boroughwide Services

14. Allied Health Professionals

NHS Stockport NHS Foundation Trust

Working with HEIs

- We are working with the University of Salford to support their 'Into Employment' final year module, focusing on preparing students more thoroughly for their transition into employment and setting out some clear expectations from employers to help them manage their beliefs and outlooks, and succeed in their early careers. It is also an opportunity to promote Stockport as an employer and as a place to work, working towards securing it as a first choice for AHPs across a competitive GM landscape moving forwards.

Apprenticeships

- It is widely recognised that the 'grow your own' approach is valuable to attract, train and recruit people local to the respective organisation and to improve the diversity of those trained. Integrated Therapies currently have a total of 9 apprentices on programme, across Physio, OT, Podiatry and Dietetics.
- We have successfully bid for HEE monies towards 5 support worker apprenticeships at Level 3 and Level 5, working to the guidance within the 'AHP Support Worker Competency, Education and Career Development Framework' and enabling the progression of our therapy assistants and assistant practitioners.
- Ways to pipeline further apprenticeships within a financially sustainable model are underway, focussing on the 'at risk' AHP groups to futureproof our invaluable multi-disciplinary workforce.

15. Midwifery Update

NHS Stockport NHS Foundation Trust

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

Obstetrics cover

- 24/7 Consultant obstetric cover on Delivery Suite
- 2/day 7 day/week Consultant ward rounds in place

Challenges

- Current registered vacancy inclusive of Inpatient & Outpatient area's 3.62 WTE, in addition to this there is currently a gap of 10.0 WTE on Maternity leave (due back April–June 2024). This equates to a total deficit of 13.62 WTE

Current Maternity position

WTE Actual	Number of WTE Vacancies	Post WTE Recruited to TRAC
160.48 (including Band 8 & above)	3.62 And 10 on Maternity Leave	5.4 accepted & awaiting start dates

Actions

- Weekly planned roster scrutiny meetings/E-Roster training sessions - continue
- Rolling advert for Band 5/6 midwives
- Recruitment day held & successfully recruited to 5.4 WTE midwives

Assurance

- All shift co-ordinators have supernumerary status.
- October 2023 showed we achieved 98.9% one to one care in labour (2 BBA's)
- Maternity Red Flags monitored & reported through division
- Fully engaged with Maternity support workers framework working group – agreed uplift for Band 2 to Band 3 Maternity Assistants (August 2023)
- Recurrent funding confirmed for Recruitment and Retention Midwife, Band 6 Preceptor Midwife and Band 3 Maternity Support Worker retention post
- Engaged with the International Educated Midwifery (IEM) recruitment programme & 3 commenced in post, awaiting arrival dates of an additional 2 IEMs
- Recruited to 2 Housekeepers & 4 MA roles. Ward Clerk recruitment ongoing

Data provided by the Division of Women & Children's

15. Midwifery Update

NHS Stockport NHS Foundation Trust

Maternity Red Flags

Maternity red flag events are events that are immediate signs that something may require action to stop the situation getting worse. Action includes escalation to the senior midwife in charge of the service, and the response may include allocating additional staff to the ward or unit.

Maternity red flags are monitored by the Maternity Manager of the day and the shift co-ordinators out of hours. Red flags are triggered by insufficient staffing levels resulting in the following:

- Delayed or cancelled time-critical activity
- Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing).
- Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication)
- Delay of more than 30 minutes in providing pain relief
- Delay of 30 minutes or more between presentation and triage
- Full clinical examination not carried out when presenting in labour
- Delay of 2 hours or more between admission for induction and beginning of process.
- Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output).
- Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour.

16. Medical Staffing

Stockport NHS Foundation Trust

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

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

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

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

Medical Staff	FTE Budgeted	FTE Actual	Variance FTE
Tier 3	253.18	227.22	-25.96
Tier 2	79.64	73.7	-5.94
Tier 1	114.619	150.4	35.78
Total	**447.44**	**451.62**	**4.18**

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

16. Medical Staffing

NHS Stockport NHS Foundation Trust

Consultant Recruitment

Medical Staffing continue to work with divisions to target recruitment campaigns in advance of when Doctors in training are set to become eligible to work as Consultants. This has seen recent success in November with the appointment of Consultants in Gastro, Paediatrics and Pathology.

We are currently actively working with divisions regarding recruiting Consultants in Medicine, Radiology, Microbiology, Anaesthetics and Critical Care.

International Medical Recruitment

In November Dr Shashidhara visited Dubai and India as part of the Trust's recruitment campaign for international Doctors to join the Trust as Tier 1 and Tier 2 levels. He linked in with specialities with regards to establishing what their needs are with the aim of appointing to all posts. The trip was successful and will help secure the required Doctors at Tier 1 and 2 level for the Trust.

SafeCare

A phased role out commenced in December 2022, and this will 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. The next phase is rolling this out to both Juniors and Consultants in the Women & Children's Division.

17. Good news

NHS Stockport NHS Foundation Trust

- As a result of a year of successful recruitment events there are no Band 5 RN vacancies in the Surgical division
- The Workforce Matron and Medicine Matron are asked to cover a full day of lectures at Salford university quarterly
- In the winter of 2022 AMU had 16 Band 5 RN vacancies, they now have no vacancies and have recently recruited 6 newly qualified nurses
- Creation of GROW microsite providing information about the internal transfer pathway for nursing staff
- The Trust's NHS Professionals Team have won a prize for the hospital with the best bank fill of registered nursing staff and midwives over Christmas in Greater Manchester

18. Going forward

Stockport NHS Foundation Trust

- Recruitment of a Pastoral Care Lead Band 6 18 month fixed term contract to support new starters joining the Trust, international nurses and HCAs
- Liaising with the ward managers to co-ordinate a corporate welcome to nursing staff joining the Trust
- Identification of a role with the skillset to promote recruitment campaigns and the Trust as an employer of choice
- Introduction and promotion of retention initiative the GROW pathway
- Ward allocation for nursing students qualifying in January-April 2024
- Formalise the pathway for international nurses working as HCAs to qualify as Band 5 registered nurses
- Taking photographs for recruitment campaigns
- Interviewing and filming staff – provided films
- Promoting events on social media platforms
- Contacting individuals who had registered an interest in attending the events
- Manage #supportteamstockport Facebook page & @stockportnursing twitter account

NHS Stockport NHS Foundation Trust

Meeting date	1st February 2024	**Public**	X	**Agenda No.**	15
Meeting	Board of Directors				
Report Title	EPRR Update – NHS England Core Standards				
Director Lead	John Graham Accountable Emergency Officer	**Author**	Ava da Costa Maia Interim Head of EPRR		

Paper For:	**Information**		**Assurance**	X	**Decision**	
Recommendation:	The Board of Directors is requested to receive the contents of this paper, including thew outcome of the Trust EPRR Self-Assessment and the assessment of the Regional Team, and confirm the improvement plans in place.					

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

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

This paper relates to the following Board Assurance Framework risks

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

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

Where issues are addressed in the paper

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

Executive Summary

This paper describes the NHS England (NHSE) Core Standards Assessment process and our findings following our self-assessment. It also highlights the regional position regarding NHSE Core Standards, and our plan to ensure that we continue to improve with regard to our emergency preparedness.

NHSE Core Standards have been set out to provide a framework of plans, procedures, policies and arrangements to ensure that NHS Providers are as resilient as possible. This is a useful process and helps us to inform ourselves about gaps in our EPRR arrangements, as well as enabling us to assure ourselves of our ability to respond to major and critical incidents.

We completed the Core Standards Self-Assessment and submitted this as required. As reported to the Board of Directors at its meeting on 7th December 2023, our findings indicated that we should declare partial compliance, and we developed an improvement plan that would deliver full compliance by March 2024.

This assessment was not accepted by our regional colleagues, with request for both assessments to be presented to the Board of Directors (Appendix 1). The Trust response does not reconcile with the Regional Team assessment and the Trust remains committed to implementing key actions plan to achieve full compliance by March 2024.

1. INTRODUCTION

This report summarises the NHSE Core Standards Self Assessment process, which provides a framework for our resilience arrangements, and helps us to understand whether our preparedness is robust or needs improvement. We assessed our arrangements and found that there were a number of areas in which we needed to improve, but that overall, we were partially compliant. This was reported to the Board of Directors at its meeting on 7th December 2023. We developed a plan to achieve full compliance by March 2024.

2. BACKGROUND

Every year, NHSE manages a programme of EPRR self-assessment in which a questionnaire is completed by providers and returned, and this helps NHSE to develop a sense of the resilience of NHS services across the UK. We participate in this, as it helps us to assure ourselves of our own resilience, and because we are aware of our responsibilities under the Civil Contingencies Act to have robust plans in place, and to collaborate with other agencies who respond in emergency situations.

This process has been part of an engagement and improvement process up until this year, in which a new approach to Core Standards was implemented by NHSE. The process was changed to one of inspection and compliance and was more onerous. A central repository of evidence was created into which we submitted our evidence of compliance. This evidence was then checked by regional colleagues, who did not agree with our self assessment. Engagement with other NHS providers has revealed that this was a picture reflected across other Trusts in the region.

3. CURRENT SITUATION

On receipt of feedback from regional colleagues, we underwent a sense check to verify our position regarding our compliance, and, in the same way that other Trusts have done, we assured ourselves that our initial findings were, in the main, correct. There were two small points of accuracy in the regional challenge, and these have been addressed, namely that the job descriptions of the AEO and the EPRR lead were not included in the evidence.

We therefore maintain our standing that we are partially compliant and due to comply fully with our Core Standards by the end of March 2024.

PRIORITIES GOING FORWARD

- **Mass Fatalities and Countermeasures**
  We will plan to follow the command and control arrangements in place regionally in an incident requiring mass fatalities response or countermeasures, so that we participate in the local health response rather than acting alone. Our plan will reflect this. We will need to procure gas tight body bags, which is currently being addressed.

- **Training and exercising**
  Our training department has been working on developing a way for us to develop, deliver, record and monitor specialist training as part of our central personal development management function. This is now in place, and we are in a position to retrospectively record the EPRR training that has taken place over the past year and develop an annual plan to ensure that the training we need takes place throughout the year. This system will also capture the ED decontamination training that takes place regularly for our ED staff.

We need to exercise communications cascade every 6 months, and this must therefore be commenced as a priority.

- **Lockdown**
  Lockdown on a site like Stepping Hill Hospital is always a little challenging because of the large footprint of the Trust buildings. A draft plan has been developed and is currently out for consultation.

- **Business Continuity Plans**
  The Business Continuity Plans that are currently in place are suitable from a compliance point of view but they are difficult to complete and unwieldy to use. A simpler version has been approved as part of the reviewed Business Continuity Plan for the Trust and this new version must be rolled out to all teams.

4. IMPROVEMENT PLAN

The action plan to attain full compliance with NHSE Core Standards is attached. If we focus on the remaining areas of weakness, we will be fully compliant by the end of March 2024, as planned.

5. CONCLUSION

It is requested that the contents of this paper are noted, and the improvement plans are supported.

Appendix 1 – Initial self-assessment review and supplementary evidence requests

CS	Domain	Standard	Detail of standard	Self-assessment rating	Check & Challenge rating	Action required	Comments or Recommendations - our current RAG
1	Governance	Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	G	A	Completed	
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	G	A	Completed	
3	Governance	EPRR board reports	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	G	A	16.01.2024 Annual report taken to Board 7 December 2023 27.11.20223 Last year's annual report remains current and in place. The next annual report is on track to be accepted by the Board in December 23.	
4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	G	A	27.11.2023 The 23/24 workplan has been submitted.	
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.	G	A	27.11.2023 Quarterly reports and monthly progress reports as well as the 2021 resource paper submitted, all of which show the EPRR resource currently in place.	
6	Governance	Continuous improvement	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	G	A	23.11.2023 The policy, regular reports and major incident plan all demonstrate clearly idenfitied processes for capturing learning, and show how the EPRR group tracks that learning and improvement.	
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	G	A	27.11.2023 Risks are reported in the quarterly report, and managed through the Trust's formal risk management processes. The major incident plan describes the basis for our resilience risk management as being the GM CRR which references the NRR.	
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	G	A	27.11.2023 Regular reports cite the risk management process, EPRR group agenda shows this is a standing item, minutes from Risk management committee show evidence of resilience risk discussion (although these were not submitted at the time as not yet available, the process was cited.)	
9	Duty to maintain plans	Collaborative planning	Plans and arrangements have been developed in collaboration with relevant stakeholders stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.	G	A	27.11.2023 GMAG minutes submitted	
10	Duty to maintain plans	Incident Response	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	G	A	27.11.2023 Described in major incident plan	
11	Duty to maintain plans	Adverse Weather	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	G	A	27.11.2023 We have opted to have a heat wave plan and an adverse weather plan. Arrangements are described within major incident plan which is our overall response plan, although we have specific contingency plans for heat wave and winter. Heat wave plan has since been ratified.	
12	Duty to maintain plans	Infectious disease	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	R	R	16.01.2024 Draft submitted to EPRR group in January 2024 27.11.2023 To start ratification process November 2023	
13	Duty to maintain plans	New and emerging pandemics	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	R	R	16.01.2024 Draft submitted to EPRR group in January 2024 27.11.2023 To start ratification process November 2023	
14	Duty to maintain plans	Countermeasures	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	R	R	16.01.2024 Draft submitted to EPRR group in January 2024 27.11.2023 To start ratification process November 2023	
15	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	G	A	27.11.2023 Completed	
16	Duty to maintain plans	Evacuation and shelter	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	G	A	27.11.2023 Completed	
17	Duty to maintain plans	Lockdown	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	A	A	To start ratification process November 2023	
18	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.	A	A	16.01.2024 Draft submitted to EPRR group in January 2024 27.11.2023 To start ratification process November 2023	
19	Duty to maintain plans	Excess fatalities	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	R	R	16.01.2024 Draft submitted to EPRR group in January 2024 27.11.2023 To start ratification process November 2023	
20	Command and control	On-call mechanism	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	A	A	27.11.2023 On call pack completed . Need to audit availability of resources 24/7.	
21	Command and control	Trained on-call staff	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	A	A	27.11.2023 Principles of Health Command training completed for Strategic and Tactical.	
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.	R	R	27.11.2023 TNA Completed, training plan for the year approved	
23	Training and exercising	EPRR exercising and testing programme	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	A	A	27.11.2023 Important to note that responding to Covid, IA and heat wave all fulfil this requirement. Exercising is not appropriate when operational pressures are at an elevated level.	
24	Training and exercising	Responder training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	R	R	27.11.2023 Training team now engaged to deliver the administration of EPRR training through ESR. Training team engaged with EPRR group and will present quarterly.	
25	Training and exercising	Staff Awareness & Training	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	G	A	27.11.2023 Major incident plan	
26	Response	Incident Co- ordination Centre (ICC)	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	A	A	27.11.2023 Need to establish checklist system - documentation is available in hard copy and online.	
27	Response	Access to planning arrangements	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	A	A	27.11.2023 Need to establish checklist system - documentation is available in hard copy and online.	
28	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	G	A	27.11.2023 Completed	
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	G	A	27.11.2023 The role and how to support loggists is in the major incident plan. It is clear in the major incident plan that loggists can be contacted via switchboard	
30	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	G	A	27.11.2023 This is described in the major incident plan. I do not know of any requirement to have a separate process to explain sign off when a report is completed on a set template. I would expect any person who has the responsibility as identified under the TMA and the Skills for Justice Minimal Occupational Standards to manage to sign off a sitrep without having to follow a separate process.	
31	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	27.11.2023 Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	G	A	27.11.2023 The document was submitted as evidence.	

32	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)	G	A	27.11.2023 The cited document was submitted. The standard requires that staff have access to the document but does not state that clarification is required to show how staff are able to access the microsite, which is a fundamental function of all staff groups working in the hospital.	
33	Warning and informing	Warning and informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	G	A	27.11.2023 Roles are clearly defined both in the Communication in a Crisis Plan, and in the Major Incident Plan, in narrative and in action cards. It is not unclear how the plan clearly indicates how communications fits into the wider response as it is described in both plans in narrative and action cards. The standard does not state that standardised communication messages should be available, or submitted. The TNA was submitted separately, and is in line with the MOS. The Communication in a Crisis Plan states that messages are drafted, developed and disseminated in line with the GM Communications Cell within the LHRP as standard. A separate process is not required. The standard did not state that evidence of 24/7 availability should be submitted although we can do this if required.	
34	Warning and informing	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.	G	A	Roles are clearly defined both in the Communication in a Crisis Plan, and in the Major Incident Plan, in narrative and in action cards. It is not unclear how the plan clearly indicates how communications fits into the wider response as it is described in both plans in narrative and action cards. The standard does not state that standardised communication messages should be available, or submitted. The TNA was submitted separately, and is in line with the MOS. The Communication in a Crisis Plan states that messages are drafted, developed and disseminated in line with the GM Communications Cell within the LHRP as standard. A separate process is not required. The standard did not state that evidence of 24/7 availability should be submitted although we can do this if required.	
35	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	G	A	27.11.2023 Roles are clearly defined both in the Communication in a Crisis Plan, and in the Major Incident Plan, in narrative and in action cards. It is not unclear how the plan clearly indicates how communications fits into the wider response as it is described in both plans in narrative and action cards. The standard does not state that standardised communication messages should be available, or submitted. The TNA was submitted separately, and is in line with the MOS. The Communication in a Crisis Plan states that messages are drafted, developed and disseminated in line with the GM Communications Cell within the LHRP as standard. A separate process is not required. The standard did not state that evidence of 24/7 availability should be submitted although we can do this if required.	
36	Warning and informing	Media strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	G	G	27.11.2023 Communication in a Crisis plan	
37	Cooperation	LHRP Engagement	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	G	A	27.11.2023 AEO has always been happy to attend LHRP meetings to which he has received invitations.	
38	Cooperation	LRF / BRF Engagement	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	G	A	27.11.2023 AEO has always been happy to attend LHRP meetings to which he has received invitations.	
39	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	G	A	27.11.2023 It is inappropriate for any Trust to act independently of the regional partnerships in terms of EPRR mutual aid requests. It is not necessary to have a separate process for MACA as this would be requested, surely, on a regional basis.	
43	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	A	A	Need to complete this as a region	
44	Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	G	A	27.11.2023 Business Continuity Plan. EPRR Policy	
45	Business Continuity	Business Continuity Management Systems (BCMS) scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	G	A	27.11.2023 BCP	
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).	G	A	27.11.2023 Included in BCP and policy	
47	Business Continuity	Business Continuity Plans (BCP)	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	G	A	27.11.2023 Included in BCP and policy	
48	Business Continuity	Testing and Exercising	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	G	A	27.11.2023 Evidence supplied included two post ex reports, learning following IA and exercises, EPRR group reports which include action plans. The standard did not request attendance lists.	
49	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	G	A	27.11.2023 Completed	

50	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	G	A	07.12.2023 Board report taken to Trust Board	
51	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	G	A	27.11.2023 Results of audit and action plan reported to the Board in December 2022	
52	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	G	A	27.11.2023 The EPRR policy, BCP and Major Incident Plan are all cear about the process for capturing learning and improvements. The EPRR TOR also provide detail on this.	
53	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	G	A	27.11.2023 The procurement team BCP was attached and details how the process is to be used. EPRR policy encompasses BCP. The Trust uses the Standard NHS Contract which has resilience built in to the contract requirements. There was no request for evidence of the training of those seeking assurance although this can be supplied. However, this is not required by this standard.	
54	Business Continuity	Computer Aided Dispatch	Manual distribution processes for Emergency Operations Centre / Computer Aided Dispatch systems are in place and have been fully tested annually, with learning identified, recorded and acted upon				
55	Hazmat/CBRN	Governance	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented	G	A	27.11.2023 CBRN SOP submitted. This details the planning, training and equipment required. Equipment checks and maintenance are completed 6 weekly. Training remains a gap, however this is captured in the deep dive assessment.	
56	Hazmat/CBRN	Hazmat/CBRN risk assessments	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	A	A		
57	Hazmat/CBRN	Specialist advice for Hazmat/CBRN exposure	Organisations have signposted key clinical staff on how to access appropriate and timely specialist advice for managing patients involved in Hazmat/CBRN incidents	G	A	27.11.2023 Major incident plan was submitted. The decision making process is as outlined in the Major Incident Plan. It is important that all incident responses are in line with the Major Incident Plan, with important specific contingencies, but not substantially different irrespective of the nature of the incident.	
58	Hazmat/CBRN	Hazmat/CBRN planning arrangements	The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangements, and which are supported by a programme of regular training and exercising within the organisation and in conjunction with external stakeholders	G	A	27.11.2023 CBRN SOP submitted. This details the planning, training and equipment required. Equipment checks and maintenance are completed 6 weekly. Training remains a gap, however this is captured in the deep dive assessment.	
59	Hazmat/CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate wet decontamination capability that can be rapidly deployed to manage self presenting patients, 24 hours a day, 7 days a week (for a minimum of four patients per hour) - this includes availability of staff to establish the decontamination facilities There are sufficient trained staff on shift to allow for the continuation of decontamination until support and/or mutual aid can be provided - according to the organisation's risk assessment and plan(s) The organisations also has plans, training and resources in place to enable the commencement of interim dry/wet, and improvised decontamination where necessary.	G	A	27.11.2023 CBRN SOP submitted. This details the planning, training and equipment required. Equipment checks and maintenance are completed 6 weekly. Training remains a gap, however this is captured in the deep dive assessment.	
60	Hazmat/CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed patients • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp- content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf	G	A	27.11.2023 Contained within CBRN SOP	
61	Hazmat/CBRN	Equipment - Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident, where applicable. Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations The PPM should include: - PRPS Suits - Decontamination structures - Disrobe and rerobe structures - Water outlets - Shower tray pump	G	A	Need to attach evidence from ED	
62	Hazmat/CBRN	Waste disposal arrangements	The organisation has clearly defined waste management processes within their Hazmat/CBRN plans	G	A	27.11.2023 Contained within CBRN SOP	
63	Hazmat/CBRN	Hazmat/CBRN training resource	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments	G	A	To obtain evidence from ED	
64	Hazmat/CBRN	Staff training - recognition and decontamination	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented	G	A	To obtain evidence from ED	
65	Hazmat/CBRN	PPE Access	Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS available for immediate deployment to safely undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7	G	A	27.11.2023 The standard does not require training records or equipment checks to be attached. CBRN SOP provides the required details.	

66	Hazmat/CBRN	Exercising	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	A	A	Check wih training team	

Partially compliant	Not compliant
15	1
24.6%	1.6%

61

Compliant
45
73.77%

NHS Stockport NHS Foundation Trust

Meeting date	1st February 2024	**Public**	X	**Agenda No.**	16
Meeting	Board of Directors				
Report Title	Board Assurance Framework 2023/24 – Quarter 3				
Director Lead	Karen James, Chief Executive	**Author**	Rebecca McCarthy, Trust Secretary		

Paper For:	**Information**		**Assurance**		**Decision**	X
Recommendation:	The Board of Directors is asked to review and approve the Board Assurance Framework 2023/24 as at Q3, including action proposed to mitigate risks.					

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

	Safe		Effective
	Caring		Responsive
X	Well-Led		Use of Resources

This paper relates to the following Board Assurance Framework risks

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

X	PR3.2	There is a risk that the Trust does not deliver a joint clinical strategy with East Cheshire NHS Trust
X	PR4.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit and retain the optimal number of staff, with appropriate skills and values
X	PR4.2	There is a risk that the Trust's workforce is not reflective of the communities served
X	PR5.1	There is a risk that the Trust does not implement high quality transformation programmes
X	PR5.2	There is a risk that the Trust does not implement high quality research & development programmes
X	PR6.1	There is a risk that the Trust does not deliver the annual financial plan
X	PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial recovery plan
X	PR7.1	There is a risk that the Trust does not implement the Digital Strategy to ensure a resilient and responsive digital infrastructure
X	PR7.2	There is a risk that the estate is not fit for purpose and/or meets national standards
X	PR7.3	There is a risk that the Trust does not materially improve environmental sustainability
X	PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus

Where issues are addressed in the paper

	Section of paper where covered
Equality, diversity and inclusion impacts	PR 4.2
Financial impacts if agreed/not agreed	PR 6.1 & 6.2
Regulatory and legal compliance	All
Sustainability (including environmental impacts)	PR 7.3

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 within the Board Assurance Framework 2023/24 have been assigned to a relevant Board Committee for oversight, with review of risks taking place during January 2024. In reviewing the principal risks and determining risk score, consideration was given to the key controls and assurances, any gaps and required actions.

At the end of Q3 2023/24, the most significant risks relate to delivery of the annual financial position, alongside future financial sustainability; delivery of operational access standards and the restoration of services; workforce challenges; and an ageing estate, with funding options for future estates developments not yet identified.

Risk to delivery of the Trust's annual financial position, and future financial sustainability, as part of Greater Manchester Integrated Care System (GM ICS), is subject to significant external scrutiny. Key gaps in control include the cumulative impact of industrial action, unrecognised growth in activity, and additional

staffing required to support increased demand, alongside ongoing temporary staffing costs to cover vacancies and sickness above the Trust target level. These key gaps in control are also reflected in the operational performance and workforce risks.

Review of Principal Risk 1.1, relating to quality of care, received scrutiny at Quality Committee in the context of these significant financial, operational and workforce related risks. Specifically, this included consideration of whether the risk score should increase. Following review of the established systems and processes to monitor quality of care and confirmation that there was not a deteriorating trend in quality metrics/measures, Quality Committee concluded that the controls, assurances, and mitigating actions supported the risk score remaining at 12 (4C x 3L). Notwithstanding this, Principal Risk 1.1 acknowledges a gap in assurance relating to evidence of harms due to the cumulative impact of industrial action and operational pressures, that may be indirect or subtle, and therefore difficult to identify. An action is in place to explore if additional surveillance for harm would be effective, alongside work with GM Clinical Effectiveness Group to determine whether GM wide surveillance for harm should be instituted.

The risk profile has remained stubborn since the start of the year. Several key gaps in control are out with the Trust's scope of control, and actions required to mitigate are both complex and require partner/system working. Notwithstanding this, Finance & Performance Committee highlighted the importance of setting realistic implementation dates for action, and delivery of actions within agreed timeframes.

The risks are prioritised as set out in table below and presented in full in the Board Assurance Framework 2023/24 (Appendix 1) as at the end of Q3.

No.	Principal Risk	C	L	Q1	Q2	Q3	Target Score
PR1.2	There is a risk that patient flow across the locality is not effective	4	4	16	16	16	8
PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan	4	4	12	16	16	8
PR4.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit and retain the optimal number of staff, with appropriate skills and values	4	4	16	16	16	8
PR6.1	There is a risk that the Trust does not deliver the annual financial plan	4	4	16	16	16	8
PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial recovery plan	4	4	16	16	16	6
PR7.2	There is a risk that the estate is not fit for purpose and does not meet national standards	4	4	16	16	16	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	4	4	16	16	16	8
PR1.1	There is a risk that the Trust does not deliver high quality care to service users	4	3	12	12	12	8
PR3.2	There is a risk that the Trust does not deliver a joint clinical strategy with East Cheshire NHS Trust	4	3	12	12	12	8
PR2.1	There is a risk that the Trust is unable to sufficiently engage and support our people's wellbeing	4	4	16	12	12	8
PR7.3	There is a risk that the Trust does not materially improve environmental sustainability	3	4	12	12	12	8
PR2.2	There is a risk that the Trust's services do not fully	3	3	9	9	9	6

	support neighbourhood working						
PR3.1	There is a risk in implementing the new provider collaborative model to support delivery of Stockport ONE Health & Care (Locality) Board priorities	3	3	9	9	9	6
PR4.2	There is a risk that the Trust's workforce is not reflective of the communities served	3	3	9	9	9	6
PR5.1	There is a risk that the Trust does not implement high quality transformation programmes	3	2	6	6	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	9	6
PR5.2	There is a risk that the Trust does not implement high quality research & development programmes	3	2	6	6	6	6

In addition, the Trust's significant risks from the corporate risk register (as presented to Risk Management Committee in January 2024), are provided at Appendix 2 to ensure there is alignment between operational and principal risks. The significant risks relate to the following areas:

Risk Subtype	No of Risks	Risks Identified
Capacity and demand of services	1	- 4 hr ED access target (16)
Environment	3	- Pathology estate not fit for purpose (15) - Electrical capacity (15) - Cooling in Beech House Data Centre (16)
Compliance	1	- Breach of Regulatory Reform (Fire Safety) Order 2005 (16)
Quality	2	- Harm to paediatric audiology patients (16) - There is a risk that the failure to achieve turnaround time targets for histopathology will impact on care for cancer patients (16)
Workforce	2	- Employee Relations & Industrial Action (16) - Staff shortage – Loss of DC cardioversion service and reduction in pacing procedures (16)
Financial	2	- Risk of insufficient cash reserves (15) - Financial risk of providing care and support to vulnerable asylum-seeking families (15)
Infection Prevention & Control	1	- Provision of robust service for VAD insertion (15)

Following review at Finance & Performance Committee, the risk relating to insufficient cash reserves will be reviewed in month, in light of the confirmed national mechanism for accessing cash. There remains a lack of clarity for accessing cash support within GM.

In addition, via the divisional governance process, risks relating to the closure of Outpatients B (OPD B) have been developed. There are currently two risks, with a residual risk score of 16, that will be presented to Risk Management Committee, as part of the Significant Risk Register, in February 2024 (subject to no reduction in score). A summary of the risks and key mitigations is as follows:

Risk relating to the loss of ophthalmology services due to the closure of OPD B

- All eye casualty and post-op patients are being seen through the Eye Centre. Pending CQC

confirmation, Mastercall is due to come online shortly, to provide additional capacity.

- A process for clinical review of longest waiting patients is in place to determine urgency. This process will continue until the position is stabilised and is monitored weekly.

Risk relating to the loss of the orthodontic service due to the closure of OPD B

- The process of mobilising Union Street Dental Clinic is underway, supporting utilisation of 2 rooms, Monday-Friday. The leasing arrangements are in place and work is taking place to address any area of staff concern, kit mobilisation etc. Patients are being assessed via telephone consultations.

The divisional & clinical governance processes in place ensure continued review of incidents and harms. It is anticipated the risk score will reduce when mitigations currently in train come online.

Stockport NHS Foundation Trust

Board Assurance Framework

2023/2024

Corporate Objectives 2023/24

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

1. Key to Board Assurance Framework

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

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

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

2. Risk Appetite Framework

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

3. Heat Map & Gap Analysis

Risk Matrix					
Impact	**Likelihood**				
	1 - Rare	2 - Unlikely	3 - Possible	4 - Likely	5 - Certain
1 - Negligible					
2 - Minor					
3 - Moderate		**5.2**	**2.2, 3.1, 4.2, 5.1, 7.1**		
4 - Major			**1.1, 3.2, 7.3**	**1.2, 1.3, 2.1, 4.1, 6.1, 6.2, 7.2, 7.4**	
5 - Catastrophic					

Gap Score Matrix (Difference between Target Score and Current Score)		
Gap score ≤0	Risk target achieved	**5.2**
Gap score 1 - 5	Tolerable	**1.1, 1.3, 2.1, 2.2, 3.1, 3.2, 4.2, 5.1, 7.1, 7.3**
Gap score 6 - 9	Close monitoring	**1.2, 4.1, 6.1, 6.2, 7.2, 7.4**
Gap score 10	Concern	
Gap score > 10	Serious	

4. Board Assurance Framework 2023/24

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 22/23	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 1 - Deliver personalised, safe and caring services																		
Principal Risk Number: PR1.1				**Risk Appetite: Moderate**														
There is a risk that the Trust 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	Quality Committee Subgroups established to direct policies and procedures relating to: Patient Safety, Clinical Effectiveness, Patient Experience, Health & Safety, Integrated Safeguarding Divisional Quality Boards established. SFT Quality Strategy 2021-2024 - Established subgroup of Patient Safety Group - Quality Safety & Improvement Group SFT Patient, Carer, Family & Friends Experience Strategy 2022-2025 SFT Mental Health Plan 2022-2025 CQC Action Plans in place (2022) Board approved Patient Safety Incident Response Plan, Aug 2023 Established process for managing and learning from: - Incidents including Serious Incidents and patient flow associated harms. - Duty of Candour - Complaints - Legal Claims Mechanisms in place to gather patient experience: - Family & Friends - Carers Opinion - Patient Stories - Walkabout Wednesday - Senior Nurse Walkarounds - Feedback Friday Clinical Audit & NICE Guidelines - Established clinical audit programme including national and locally prioritised audit based on risk assessment. - Compliance Review Process – All NICE documents relevant to SFT portfolio - Established process for review of NICE Guidelines Learning from Deaths - Mortality Review Policy - Learning from Deaths Review process - Medical Examiner Team - Freedom to Speak Up process established. New governance system for end of life care established, including internal group reporting to Stockport End of Life Care forum.	Impact of employee relations & industrial action issues Impact of continuing operational pressures Ineffective system for control of clinic outcome i.e., patient discharge v's clinical follow up required.	**Level 1 - Management:** Divisional Quality Boards (Monthly) – Quality & Safety Integrated Performance Report Divisional Clinical Audit Meeting (Quarterly) **Level 2 – Corporate** Quality Committee: - Quality IPR - Key Issues & 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) - CQC Inspection – Maternity Services – High Level Feedback (Awaiting Report) - StARS Position Statement & Key Themes (Quarterly) - Patient Safety Report (Quarterly) (Incidents, PALS/Complaints, Inquests, Claims) - Quality Strategy Progress Report (Biannually) - Maternity Services Report - Incorporates all improvement/action plans including: CNST, Saving Babies Lives, Continuity of Carer, Ockenden Report, Maternity Safety Support Programme (MSSP) - LMNS Insight Report NHSE/I NW - Learning from Deaths Reports / Mortality Reviews (Quarterly) Board of Directors: - IPR - Safe Care Report including nurse establishments/E-roster (Quarterly) and Annual Nursing Establishments Review - Guardian of Safe Working / Freedom to Speak Up Report to Board (Bi-annually) - Quality Strategy (Annual) Annual Quality Accounts **Level 3 - Independent** Friends & Family Test National Patient Experience Surveys: - Adult Inpatient Survey - National Cancer Survey - Emergency Department Survey MIAA Internal Audits 2022-23: • Risk Management (Substantial) • Clinical Audit (Substantial) • StARS (Substantial) • Quality Spot Checks (Substantial)	Robust evidence of harms relating to industrial action and operational pressures, acknowledging indirect or subtle harm may be difficult to identify. Unknown harm from clinical follow up.	Full implementation of Patient Safety Incident Response Framework & Plan Explore further surveillance for harm - Governance & Clinical Leads to confirm is additional surveillance for harm, related to industrial action and operational pressures, would be effective, to be reported to Patient Safety Group. Work with GM Clinical Effectiveness Group to determine whether GM wide surveillance for harm should be instituted. Patient Follow Up - Task and Finish Group to reconcile patient list and determine further action	March 2024 March 2024 April 2024 June 2024	4	3	12	12	12	12	12		4	2	8

4. Board Assurance Framework 2023/24

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 22/23	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 1 - Deliver personalised, safe and caring services																		
		Learning from Industrial Action Reviews established. StARS - Ward assurance & accreditation process established. Also established for: Paediatrics, Maternity, Theatres, Community. Safe Staffing - Defined Nurse Establishments - Defined Medical Establishments - Medical Job Planning process in place - Medical Appraisal & Revalidation process in place including quality assessment Maternity Improvement/Sustainability Plan in place and Maternity Strategy. Executive & Non-Executive Maternity Safety Champions in place, visits & meetings schedule. Trust & GM Command & Control Process established - Before, During and After Strike Action. Established Quality Impact Assessment in place for CIP/Business Case –Sign off by Medical Director, Chief Nurse and Director of People & OD		GMC Medical Trainees Survey													
Principal Risk Number: PR1.2								**Risk Appetite: Moderate**										
There is a risk that patient flow across the locality is not effective which may lead to patient harm, suboptimal user experience, and inability to achieve national access standards for urgent care and elective care	Finance & Performance Committee	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 and informed by Working Intelligently Group Reporting via Service Improvement Group Virtual Ward Weekly Trust Performance Meeting and weekly locality tactical meeting to seek support to mitigate risk – Attended by Divisional Director. Weekly – Locality Patient Flow meeting established. 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.	Capacity constraints in domiciliary & bed-based care impacting on levels of patients with no criteria to reside (NCTR). High levels of delayed discharges for out of borough patients. Lack of response from Derbyshire ICB. Significant increase in unfunded non-elective demand due to levels of patients with NCTR. Lack of standardised 7-day services across medical & surgical specialties to support discharge of non-elective patients. Locality Plan for Q4 2023/24 not agreed with Trust – Reduction in capacity for Pathway 1 and Pathway 2.	**Level 1 – Management** Divisional Operations Boards (Monthly) – Performance Management Report - ED Attendance - Overall bed occupancy rate - Patients No Criteria to Reside - ED 4 Hour Target Performance - Ambulance Handover times - ED 12 hour waits - Time to triage Daily Bed meetings (x 4) System dashboard of acute, intermediate and domiciliary care capacity **Level 2 – Corporate** Divisional Performance Review (Monthly) including targeted 'Deep Dives' Finance & Performance Committee - Operational Performance Report (Monthly) - Themes from Performance Review Working Intelligently Programme - Elective Length of Stay Integrated Performance Report – Board (Bimonthly)		Finalise recurrent Medical Staffing model	Q4 2023/24	4	4	16	16	16	16	16		4	2	8

4. Board Assurance Framework 2023/24

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 22/23	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 1 - Deliver personalised, safe and caring services																		
		Trust and system escalation process in place, aligned to a single OPEL system – Including divert of resource from elective activity to support flow. Bed Modelling – 18 Month Plan Workforce models in place – Reflect demand and flexible to adapt to surges. Learning from Deaths process includes: - Delayed admission - Delayed discharge Patient Flow Associated Harms – Review via Quality Committee. Robust phasing programme for building works as part of EUCC to ensure no loss of capacity.	Impact to be monitored.	**Level 3 – Independent** Urgent & Emergency Care Delivery Board NHSE – Activity Returns GM ICS reporting aligned to Tier 1 – Urgent Care		Escalation of Derbyshire delayed to discharge to GM SCC (Strategic Control Centre). Agreement for ECIST to (Emergency Care Intensive Support Team) support urgent care flow	Q4 2023/24 Q4 2023/24										
Principal Risk Number: PR1.3								**Risk Appetite: Moderate**										
There is a risk that the Trust does not have capacity to deliver elective, diagnostic and cancer care, including the clearance of surgical backlog caused by the Covid-19 pandemic, which may lead to suboptimal patient safety, outcomes and experience and inability to achieve national access standards	Finance & Performance Committee	Biweekly Trust Performance Meeting. Escalation process in place with Performance Team – 65+ week wait patients and any P2/cancer patients that are not dated. Clinical Prioritisation Group established & 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 Expansion of Endoscopy Authorisation (through Exec Management Team) to expand elective capacity through insourcing. Roll out of GIRFT Further Faster Recommendations by Specialty	Workforce – Sickness Absence & Recruitment Impact of urgent care pressures on elective capacity Delivery of national access standards predicated on availability of GM mutual aid – Insufficient. Current independent sector providers unwilling to takeover care for long waiting patients. Change to commission of independent sector for 2024/25, however reduces capacity for 2023/24. Significant increase in referrals for elective care, including from out of area. Cumulative impact of industrial action (Consultants & Juniors) having significant adverse impact on unbooked and cancelled appointments.	**Level 1 – Management** Divisional Operations Boards (Monthly) Trust Performance Meeting: - Elective demand - Activity v Plan (Waits) - % Patients on PIFU - Levels Advice & Guidance - Theatre Utilisation - Outpatient Utilisation - Endoscopy Utilisation Activity Management Group – Data review of elective activity				4	4	16	12	12	16	16		4	2	8
				Level 2 – Corporate Divisional Performance Review (Monthly) including targeted 'Deep Dives' Finance & Performance Committee Operational Performance Report (Monthly) - 52+ week waits - 65+ week waits - Overall RTT waiting list size - Cancer 2ww - Cancer 62 day - Diagnostic waits Quality Committee - Waiting List Harms Review (3 x year) Integrated Performance Report (Operational Performance) – Board (Bimonthly)													
				Level 3 – Independent SFT Tier 1 Elective Restoration Monitoring NHSE – Activity Returns		In Tier 1 for Elective Care – Regional monitoring & support to be determined.	Q4 2023/24											

4. Board Assurance Framework 2023/24

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 22/23	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 1 - Deliver personalised, safe and caring services																		
				GM productivity ranking – Benchmarked 4th in GM based on comparison to national peers.		ECIST – Support for Urgent Care pressures. Diagnostic to be completed.	Q4 2023/24											

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 22/23	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 2 - Support the health and wellbeing needs of our communities and colleagues																		
Principal Risk Number: PR2.1				**Risk Appetite: High**														
There is a risk that the Trust is unable to sufficiently engage and support our people's wellbeing, leading to low morale, higher turnover & sickness absence and gaps in the workforce that may impact on delivery of high quality care.	People Performance Committee	Approved People Plan in line with national People Strategy objectives – Including enabling approaches to Workforce Transformation (Planning); Leadership Development; Health & Wellbeing; Coaching; Resourcing; Organisational Development; Equality, Diversity & Inclusion, Talent Management & Succession Planning Approved Organisational Development Plan 2023-2025 Approved Health and Wellbeing Plan 2024. Approved People policies, procedures, guidelines and/or action cards in place (including. staff development; appraisal process; sickness and relationships at work policy) Vaccination programmes for both Influenza and Covid. Comprehensive staff wellbeing programme established including staff psychology and wellbeing service and staff menopause service. Collaborative Occupational Health Service with T&G – including Staff Counselling Service & Physio Fast Track Service Dying to Work Charter Big Conversation programme established. Process to improve response rate of 'reason for leaving' in place. Award & Recognition including Staff Awards (Oct 2022), MADE Awards, Long Service Awards Wellbeing Guardian supported by Schwartz Rounds Freedom to Speak Up Guardian / Guardian of Safe Working Divisional Staff Survey Action Plans 2022 in place. Confirmed approach to flexible working Industrial Action Planning Group in place Regular deep dive review of temporary staffing and sickness absence led by Director of People & OD established.	Embedded approach to Wellbeing Conversations Impact of employee relations & industrial action issues on morale and wellbeing Impact of continuing operational & external/internal financial pressures	**Level 1 - Management:** People, Engagement & Leadership Group - People Plan – Workstream Reports - Health & Wellbeing Plan 2024 – Workstream Reports Equality Diversity & Inclusion Steering Group - EDI Strategy Industrial Action Planning Group **Level 2 – Corporate** Performance Reviews – Workforce Metrics NHS People Plan Self-Assessment People Performance Committee - People Plan Update (bimonthly) - Workforce KPIs (bimonthly) - Freedom to Speak-up Report (Quarterly) - Freedom to Speak-up Guardian (Bi-annually) Integrated Performance Report (Workforce) - Board (Bimonthly) **Level 3 - Independent** CQC Well-led Mapping Report – Recognition of Staff Health & Wellbeing offer NHS National Staff Survey		Delivery Plan, including timescales and outcomes to support pledge for 'the wellbeing of our NHS people' to be developed in line with policies and guidance from the regional working group. Implementation of G2 eOPAS IT system for integrated OH service with T&G.	Mar 2024 (Awaiting regional guidance) Mar 2024	4	3	12	16	16	12	12		4	2	8
Principal Risk Number: PR2.2				**Risk Appetite: Moderate**														

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 22/23	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 2 - Support the health and wellbeing needs of our communities and colleagues																		
There is a risk that the Trust's services do not fully support neighbourhood working leading to suboptimal improvement in population health	Finance & Performance Committee	Operational & Winter Planning processes established with system arrangements. Capacity & demand modelling for community services Established joint community Health & Well Being programmes e.g. Waiting Well, Active Hospitals, Stop Smoking CURE project. Integrated service models established including: Adults: District Nursing Teams – Work across 7 PCNs with GPs, Social Care, VCSE Children's: Stockport Family – Health, Social Care & Education Adult's: Neighbourhood Leadership Group established with multi partner representation. Children's: Joint oversight groups established with multi partner representation (SEND, Public Health, Safeguarding, Mental Health) Trust represented on the One Stockport Health & Care Board (Locality Board) for Stockport via the CEO and Director of Strategy & Partnerships. Locality Provider Partnership (led by SFT) operational with defined workstreams and focus on population health. ONE Stockport Health and Care Plan & Delivery Plan/Outcomes developed with focus on reducing inequalities and improving population health outcomes. ICS employed Locality Deputy Place Lead in post.	Unfunded growth in demand for community services Capacity & demand modelling for community services to support appropriate deployment of resources. Alignment of Community Services to PCNs – Potential change to PCN geographical footprints	**Level 1 – Management** Divisional Quality & Operations Boards (Monthly) Performance Management Report - Integrated Care Division - Women, Children & Diagnostics Adult's: Neighbourhood Leadership Group (Monthly) Children's: - Joint Public Health Oversight Group - SEND Joint Commissioning Group - CYP mental health & Well-being Partnership Board - Joint Safeguarding Board **Level 2 – Corporate** Divisional Performance Review (Monthly) including targeted 'Deep Dives' Locality Provider Partnership (Monthly) Locality Board (Monthly) **Level 3 – Independent** Children's – SEND Inspection Ofsted Report – 'Good' SALT – External multiagency review – Pathways & capacity and demand	Community Services Dashboard ICS Acute Flow Dashboard	Align Trust community services & workforce to PCNs Integration of Community Services Dashboard to IPR Locality Neighbourhood Working Programme	Ongoing Q4 2023/24 Q4 2023/24	3	3	9	9	9	9	9		3	2	6

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 22/23	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 3 - Develop effective partnerships to address health and wellbeing inequalities																		
Principal Risk Number: PR3.1						**Risk Appetite: Significant**												
There is a risk in implementing the 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 ICS arrangements developed and approved by partners. CEO and Chair members of Stockport Health & Wellbeing Board ONE Stockport Health and Care Board (Locality Board) operational. Membership includes CEO, Director of Strategy & Partnerships & Chief Finance Officer ONE Stockport Plan and ONE Stockport Health and Care Plan. Stockport Provider Partnership operational, chaired by SFT CEO Provider Partnership identified key workstreams based on population health metrics. Recovery Objectives published in Planning Guidance 2023/34 in Trust Plan 2023/24	Controls not yet designed for the management of the One Stockport Health & Care Plan	**Level 1 – Management** **Level 2 – Corporate** Executive Team / Finance & Performance Committee oversight of key strategic matters Trust Board Reports (6 monthly) and as required and CEO Report including key strategic developments - ICS - Stockport One Health & Care Plan Joint system meetings on ONE Stockport plan Locality Provider Partnership (Monthly) Locality Board (Monthly) ICS Executive Meeting (Monthly) **Level 3 – Independent** Health & Wellbeing Board	Robust neighbourhood data to enable Provider Partnership to measure improvement in population health outcomes	Neighbourhood profiles to be produced by Local Authority BI Development of One Stockport: One Future (next stage of borough plan) and refreshed One Stockport Health & Care Plan	Q4 2023/24 March 2024	3	3	9	9	9	9	9		3	2	6
Principal Risk Number: PR3.2						**Risk Appetite: Significant**												
There is a risk that the Trust does not deliver on the ambitions of the 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. Case for Change presented to NHSE and ICB. Work programme in progress for 2023/24 including development of transformation workstreams and services to be considered as part of the OBC. Case for change in General Surgical and T&O pathways documented including high level costs. Stakeholder engagement plan in place including ICBs, LA, Healthwatch, DPHs, VCSE and NHSE regulators. NHSE Regulators and ICB Commissioners engaged in plans.	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 and no funding identified for 2024/25 financial year No current capital or recurrent funding identified from commissioners to support proposed service change in 2023/24	**Level 1 – Management** Joint Programme Board and Clinical Advisory Groups Programme Governance Meeting **Level 2 – Corporate** Executive Team oversight of key strategic matters. Trust Board & ECT/SFT Board to Board Reports **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		Identify funding for General Surgical & T&O pathways. Confirm stakeholder engagement requirements for change in General Surgical & T&O Pathways and conduct engagement. Determine if wider Pre-Consultation Business Case is required. Paper detailing requirements to be presented to Cheshire & Merseyside ICB	Q1 2024/25 Q4 2024/24 Q2 2024/25 Q4 2023/24	4	3	12	12	12	12	12		4	2	8

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 22/23	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 4 - Develop a diverse, capable and motivated workforce to meet future service and user needs																		
Principal Risk Number: 4.1				**Risk Appetite: High**														
There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit & retain the optimal number of staff, with appropriate skills and values, which may lead to suboptimal staff and patient experience.	People Performance Committee	Approved People Plan in line with national People Strategy objectives – Including enabling approaches to Workforce Transformation (Planning); Leadership Development; Health & Wellbeing; Coaching; Resourcing; Organisational Development; Equality, Diversity & Inclusion, Talent Management & Succession planning E-rostering and Job Planning in place to support staff deployment. E-Rostering Workforce Group established. Recruitment & Retention Implementation Plan in place, supported by Attract, Develop & Retain Group. Medical Workforce Group established. Defined safe medical and nurse staffing levels for all wards and departments. Safe Staffing Standard Operating Procedure deployed. Temporary staffing and approval processes with defined authorisation levels Bank & Agency Usage Deep Dive Undertaken. Mandatory Training Requirements set. Realignment of Role Essential Training Requirements Range of leadership and management development training sessions available with enhancements of leadership and development offer continuing as identified within OD Plan. Local/ Regional/National Education partnerships Alternative development pipelines in place – Degree Apprenticeships, Medical Support Workers, Cadet Programme commenced. Workforce Strategy & Divisional Workforce Plans Phase One – Talent Management & Succession planning - Executive Team succession plan complete.	Embedded system for identifying and managing talent not yet available Restrictions on staff capacity to attend and participate in mandatory/statutory training. Bank and agency staff costs above target. Escalation areas remaining open – staffing additional areas required.	**Level 1 - Management** People, Engagement & Leadership Group - People Plan – Workstream Reports Educational Governance Group - Exception reports for Mandatory & Role Essential Training, Attendance Equality, Diversity & Inclusion Steering Group - Staff Networks				4	4	16	16	16	16	16		4	2	8
				Level 2 – Corporate People Performance Committee – - Workforce Integrated Performance Report (Sickness Absence / Substantive Staff /Recruitment Pipeline / Appraisal, Turnover, Flexible Working Requests, Bank & Agency) - Safe Staffing Report (Quarterly) - Annual Nurse Establishments - Annual Medical Job Planning) - Annual Medical Revalidation Report Bank & Agency Usage – Review via Exec Team (Monthly)		Develop and implement phase two – talent management approach for the wider senior leadership team and managers	Q1 2024/25									
				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		Introduce a refreshed 121/Appraisal process	Q1 2024/25 (To align with the timing of the refresh of the Trust's Values & Behaviours)									
Principal Risk Number: 4.2				**Risk Appetite: High**														
There is a risk that the Trust's workforce is not reflective of the communities served and staff with a	People Performance Committee	Approved People Plan in line with national People Strategy objectives – Including Equality, Diversity & Inclusion, Talent Management & Succession planning	Career Development Programmes for staff with protected characteristics	**Level 1 - Management** WRES / WDES Steering Group - Oversight of WRES / WDES Annual Report and Action Plan		Establish Staff Neurodiversity Group – Executive Sponsor Confirmed	Q4 2023/24	3	3	9	9	9	9	9		3	2	6

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 22/23	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 4 - Develop a diverse, capable and motivated workforce to meet future service and user needs																		
protected characteristic having a suboptimal staff experience (career progression, turnover) which may lead to a poorer patient experience.		Equality, Diversity & Inclusion Strategy & Implementation Plan Staff Networks (BAME / Disability / Carer/ LGBTQ+) Completed review of staff networks and relaunched under agreed improvement arrangements. Senior medical leadership roles – Interview panel includes representation from staff with protected characteristics Hate Crime Reduction Policy in place (Red/Yellow card) Dying to Work Charter Accessible Scheme Civility Saves Lives Programme - Phase 1 Launched.	Development of Staff Network Chairs and the Staff Networks	Equality, Diversity & Inclusion Steering Group - Oversight of the EDI Action Plan		Hold staff listening sessions to understand the barriers to career progression.	Q4 2023/24											
				Level 2 – Corporate Performance Review (Monthly) including targeted 'Deep Dives' People Performance Committee - EDI Report (Biannually) - WRES and WDES Report - Gender Pay Gap report to Board - Annual EDI Report	EDI metrics to be built into People Analytics Dashboard.													
				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	Q4 22/23	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 5 – Drive service improvement through high quality research, innovation and transformation																		
Principal Risk Number: 5.1					**Risk Appetite: Significant**													
There is a risk that the Trust does not implement high quality transformation (service improvement) programmes, as identified through Trust and locality prioritisation, 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 Trust transformation programmes - Service Improvement Group (SIG) chaired by the Chief Executive. External resource in place to support Trust identified improvement programmes. Senior Responsible Officer, Clinical & Operational Lead in place for each Trust transformation programme Transformation Team supporting Stockport Provider Partnership (SPP). SPP identified key priority workstreams (Diabetes, Frailty, Cardiovascular & Alcohol Related Harm) for pathway redesign.	Capacity of operational teams to implement change due to operational pressures.	**Level 1 – Management** Transformation - Programme Boards Provider Partnership Key Priority Areas – Programme Boards				3	3	6	6	6	6	9		3	2	6
				Level 2 – Corporate Service Improvement Group – Monthly Transformation Programme Report & Quarterly Deep Dive: Review KPIs/Milestones Stockport Provider Partnership (Monthly) - Priority Workstreams Review Board Report: Transformation Programme (Biannually)	Stockport Provider Partnership priority workstreams at various stages of implementation.													
				Level 3 - Independent														
Principal Risk Number: 5.2					**Risk Appetite: Significant**													
There is a risk that the Trust does not implement high quality research & development programmes which may lead to suboptimal service improvements.	Quality Committee	SFT Research Team established. Joint Clinical Research, Development & Innovation Strategy 2022-2027 (SFT & T&G) & governance meetings in place to review work programme (as derived from strategy) Annual research programme in place.	Alignment of RD&I to clinical strategies, particularly cancer.	**Level 1 – Management** Clinical Effectiveness Group - Research & Innovation Progress Report - Annual Research & Innovation Report		Review of the RD&I governance team structures across SFT & T&G and implement revision to support improved workforce resilience. Review RD&I financial provision, ensuring financial assurance reporting is standardised across Trusts	2023/24 Q4 2023/24	3	2	6	6	6	6	6		3	2	6
				Level 2 – Corporate Quality Committee: - Clinical Effectiveness Group Key Issues & Assurance Report - Annual Research & Innovation Report 2022-23	Link between SFT & T&G governance to be defined	Cancer Strategy development to include Research, Development & Innovation element.	March 24											
				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	Q4 22/23	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 6 – Use our resources efficiently and effectively																		
Principal Risk Number: 6.1				**Risk Appetite: Moderate**														
There is a risk that the Trust does not deliver the 2023/24 financial plan leading to increased regulatory intervention	Finance & Performance Committee	Annual financial plan 2023/24 approved – Confirmed deficit as part of GM control total Indicative SFT Capital Plan 2023/24 set. Annual cash plan 2023/24 in place – Cash support if required from GM Approved Opening Budgets 2023/24 including requirement for recurrent and non-recurrent CIP Established STEP Programme (CIP) and oversight of delivery. Working Intelligently Group established – Data Analysis & Benchmarking – Workplan in place, informing STEP Programme. GM Productivity/Benchmarking data to support monitoring of service delivery, productivity & efficiency Divisional Performance Review process - including financial escalation actions based on control totals for divisions. SFT Finance Improvement Group established, chaired by Chief Executive Delivery of budget holder training and enhancements to financial reporting SFI's & Scheme of Delegation in place including authorisation limits – Revised & Board approved – December 2022 GM Financial Recovery Committee established – Chief Finance Officer member as Chair of GM DoFs GM Mandated Support & Turnaround Director appointed. GM PMO – Established to oversee implementation of PWC Diagnostic Review – Delivery of System Savings Executive Driver Group (Finance & Performance Recovery Exec Group) – Including GM Finance representatives, and Chairs of professional Director Groups (Nursing, Medical Operations), GM PMO and PWC Stockport System Finance Recovery Group established (Monthly)	Implementation of recurrent CIP Plan Financial impact of further industrial action post November 2023 Lack of clarity on mechanism for accessing cash support within GM Lack of clarity on Elective Recovery Fund (ERF) – Trust not currently at activity levels compared to 2019/20. Derbyshire ICB planning expectation on savings, resulting in reduction in income. GM ICS – Change in planning assumptions relating to depreciation, resulting in reduction in income. Finance workforce capacity to support regulatory submissions.	**Level 1 – Management** Division Operation Board - Finance Metrics Divisional CIP Meetings Finance Training Group – Training Materials Cash Action Group (Monthly) - Cash flow monitoring Financial Position Review Group (Monthly) **Level 2 – Corporate** CIP Oversight Group - Monthly chaired by Director of Operations. Division level reporting for all schemes and tracking of savings Financial Improvement Group (Monthly) Activity Management Group (Monthly) Finance & Performance Committee Finance Report (Monthly) CPMG – Capital Position Divisional Performance Review (Monthly) including Financial Position/CIP Integrated Performance Report (Finance) - Board (Bimonthly) Stockport System Financial Recovery Group (Monthly) **Level 3 - Independent** **External** Internal Audit Reports - Key Financial Systems (Substantial) 2021/22 - HFMA Financial Sustainability Review - Confirmation of Self-Assessment. - Provenance of Data (High) **GM ICS** Monthly Provider Finance Return including detailed commentary on financial position and reconciliation of workforce, productivity/finance and performance data. GM PMO – Reporting on workstreams identified in PWC Diagnostic Review – Delivery of System Savings **NHSE**	Visibility of performance against income block and non-block.	Ongoing actions from each GM Finance Recovery Meeting	Timelines for each action determined at each meeting	4	4	16	12	16	16	16		4	2	8

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 22/23	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 6 – Use our resources efficiently and effectively																		
				NHSE - North West Region oversight and triangulation of finance, activity and workforce data. Monthly Finance Return – Detailed commentary on financial position and Oversight of GM ICS based on the GM NHS SOF Rating 3													
Principal Risk Number: 6.2								**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. Board review of high-level actions required in order to avoid submitting a deficit plan (June 2023) GM Financial Recovery Committee established - Chief Finance Officer member as Chair of GM DoFs. GM Mandated Support & Turnaround Director appointed. Locality financial planning/position processes in place including monthly meeting Local Authority Treasurer & Trust CFO. Stockport System Financial Recovery Group established – Chief Finance Officer, Director of Finance & Director of Operations. Prioritisation of investments linked to planning priorities. Drivers of financial deficit review including benchmarking data and levels of efficiency & two-year financial forward view – Deficit & Opportunities to address – Review via Finance & Performance Committee (Jan 23) Established Trust planning processes - Triangulates activity, workforce and cost. GM Productivity/Benchmarking data to support monitoring of service delivery, productivity & efficiency	Underlying financial deficit Lack of certainty regarding system funding beyond 2023/24 including reductions due to convergence factor. Requirement for increased % CIP (recurrent/non-recurrent) GM Financial Risk Framework to be agreed. Elective Recovery Fund (ERF) remains unclear) – Trust not at activity levels compared to 2019/20. Growth in demand not recognised. Detailed planning guidance 2024/25 not yet released.	**Level 1 - Management** **Level 2 – Corporate** CIP Oversight Group - Monthly chaired by Director of Operations. Division level reporting for all schemes and tracking of savings Finance & Performance Committee - Finance Report (Monthly) Financial Improvement Group (Monthly) Stockport System Financial Recovery Group (Monthly) **Level 3 - Independent** Provider Director of Finance GM Meeting **GM ICS** Monthly Provider Finance Return including detailed commentary on financial position and reconciliation of workforce, productivity/finance and performance data. GM PMO – Reporting on workstreams identified in PWC Diagnostic Review – Delivery of System Savings **NHSE** NHSE - North West Region oversight and triangulation of finance, activity and workforce data. Monthly Finance Return – Detailed commentary on financial position and Oversight of GM ICS based on the GM NHS SOF Rating 3		Ongoing actions from each GM Finance Recovery Meeting	Timelines for each action determined at each meeting	4	4	16	16	16	16	16		4	2	8

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 22/23	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: Significant**														
There is a risk that the Trust does not implement the Digital Strategy designed to ensure a resilient and responsive digital infrastructure which may lead to inability to support improvements in quality of care and compromise of data/information.	Finance & Performance Committee	Digital Strategy 2021-2026 Capital plan in place for funding of Digital Strategy and receipt of capital funding for core elements of the Digital Strategy 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.		**Level 1 – Management** Digital & Informatics Group Digital Risk Register – Quarterly review via Risk Management Committee				3	3	9	9	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		Actions from MIAA audit relating to legacy systems and asset control.	Q4 2023/24											
				Level 3 - Independent Business Continuity Confirm and Challenge NHSE ISO 27001 Information Security Management Certification – Achieved November 2022 DCB 1596 Secure Email Standard Accreditation – Achieved February 2023. Internal Audit Report: Data Security and Protection (DSP) Toolkit – Moderate Assurance, MIAA, June 2023. Data Security and Protection Toolkit self-assessment submission June 2023 – Standards Met.		Development of action plan for Data Protection & Security Toolkit (DSPT) Assessment 2023	Q3 2023/24											
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 due to increasing maintenance requirements, 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 in place. Premises Assurance Model (PAM) Action Plan in place Estates & Facilities Performance Dashboard (Compliance & Performance Metrics) Site Development Strategy in place. Joint working arrangements with SMBC established to develop potentially community based solutions to support short to medium term development strategy.	Insufficient financial resources to enable optimum levels of estates maintenance investment Inability to deliver required upgrades due to access limitations related to clinical activity pressures Delivery/Transition plan to address highest risk capital stock and decompression of site. New 6 facet update survey currently being commissioned in accordance with planned activity.	**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				4	4	16	12	16	16	16		4	2	8
				Level 2 – Corporate Quality Committee - Health & Safety Group Key Issues Report Finance & Performance Committee - Capital Programme Management Group Key Issues Report	Additional structural surveys have also been commissioned for all Category D assets (to be undertaken by Marston and Grundy Structural Engineers).	Develop site development strategy delivery plan to reduce maintenance costs aligned to Project Hazel Review outcome of additional structural surveys of Category D buildings.	February 2024 (Progress Report) February 2024											

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 22/23	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 7 - Develop our estate & digital infrastructure to meet service and user needs																		
		Project Board and Senior Responsible Officer identified for major capital developments																
				Level 3 - Independent Estates Return Information Collection (ERIC) Model Hospital Data Set Estates & Facilities Compliance Review (MIAA 2020/21) – Substantial Assurance														
Principal Risk Number: 7.3				**Risk Appetite: Moderate**														
There is a risk that the Trust does not materially improve environmental sustainability which may lead to suboptimal support to locality ambitions and the NHS commitment to carbon reduction.	Finance & Performance Committee	Approved Green Plan in place. Green Plan Committee established and Green Plan Work Plan in place monitored by the committee. Approved Capital Programme 2022/23 Robust identification and stratification of sustainability-related risks. 6-facet survey completion and review of information Mechanisms in place to explore and develop sustainability approach across Stockport locality. Joint appointment of Sustainability Manager between Stockport and Tameside (To commence January 2024)	Insufficient financial resources to enable optimum levels of investment to deliver sustainability improvements. Decarbonisation Plan	**Level 1 – Management** Capital Programme Management Group - Compliance with agreed delivery programme - Confirmation of spend against approved budget Green Plan Committee - Monitoring of Green Plan delivery - Development of sustainability opportunities				3	4	12	8	12	12	12		4	2	8
				Level 2 – Corporate Annual Sustainability Report Finance & Performance Committee Estates Progress Report including Sustainability (Biannually)		Decarbonisation Plan	Q4 2023/24											
				Level 3 - Independent Estates Return Information Collection (ERIC)														
Principal Risk Number: 7.4				**Risk Appetite: Moderate**														
There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus which may lead to an adverse long-term impact on the Trust's capability to deliver modern and effective care.	Finance & Performance Committee	Strategic Regeneration Framework Prospectus completed. New Hospital Building Programme Expression of Interest submitted – Project Hazel Established governance structure to develop Outline Business Case Project Hazel Business Case ~~in~~ produced and approved by Board of Directors. Site Development Strategy to support and inform immediate site development and maintenance aspirations New Hospital Project Board established, chaired by SFT Chief Executive. including representation from key external partners. Estates Strategy Steering Group (ESSG) established, reporting to Finance & Performance Committee.	Insufficient financial resources to enable optimum levels of investment to deliver regeneration ambitions including Project Hazel. DHSC has confirmed that the Trust has been unsuccessful in securing necessary support from the New Hospital Building Programme. New Hospital Building Outline Business Case	**Level 1 - Management**				4	4	16	12	16	16	16		4	2	8
				Level 2 – Corporate Strategic Regeneration Framework Prospectus and Expression of Interest – Reviewed by Board		Review of funding approach with partners	Q4 2023/24											
				Level 3 - Independent														

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 22/23	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 7 - Develop our estate & digital infrastructure to meet service and user needs																		
		Joint working arrangements with SMBC established to explore strategic regeneration of the hospital campus.																

Appendix 2 – Stockport NHS Foundation Trust Significant Risk Register (as at January 2024)

Risk ID	Business Group	Risk Title	Consequence	Likelihood	Rating	Target Rating	Change since last report
130	Emergency Department and Clinical Decision Unit	There is a risk 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	↔
1004	Corporate – Estates and Facilities	There is a risk that the Trust is in breach of the Regulatory Reform (Fire Safety) Order 2005.	4	4	16	4	↔
1711	Corporate – Workforce	There is a risk of deterioration in employee relations and industrial action.	4	4	16	4	↔
2452	Clinical Support Services	There is a risk of the pathology estate not being fit for purpose or safe.	3	5	15	3	↔
101	Corporate - Finance	There is a risk that the Trust has insufficient cash reserves to operate.	5	3	15	5	↔
2609	Women and Children	There is a financial risk to the Division of providing required care and support to vulnerable asylum seeking families	3	5	15	2	↔
2247	Estates and Facilities	There is a risk that electrical capacity could prevent future electrical schemes and electrical purchases	3	5	15	3	↔
2650	Surgery	There is a risk of harm to paediatric patients if the audiology service does not comply with best practice recommendations	4	4	16	4	NEW
2647	Medicine	There is a risk of loss of DC cardioversion service & reduction in pacing procedure affecting patient care due to staff shortage	4	4	16	4	NEW
2596	Corporate – IT	There is a risk of total failure of the cooling in the Beech House Data Centre	4	4	16	8	NEW
2883	Corporate – Nursing	There is a risk of there being an inability to provide a robust service for the insertion of VADs	3	5	15	6	NEW
1288	Clinical Support Services	There is a risk that the failure to achieve turnaround time targets for histopathology will impact on care for cancer patients	4	4	16	8	NEW

NHS Stockport NHS Foundation Trust

Meeting date	1st February 2024	**Public**	X	**Agenda No.**	
Meeting	Board of Directors				
Report Title	Independence of Non-Executive Directors				
Director Lead	Dr Marisa Logan-Ward, Interim Chair	**Author**	Rebecca McCarthy, Trust Secretary		

Paper For:	**Information**		**Assurance**		**Decision**	X
Recommendation:	The Board of Directors is asked to review the declarations and confirm that it considers the Interim Chair and Non-Executive Directors to be independent, with an appropriate statement to be included in the Trust's Annual Report 2023/24.					

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

	Safe		Effective
	Caring		Responsive
X	Well-Led		Use of Resources

This paper relates to the following Board Assurance Framework risks

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

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

Where issues are addressed in the paper

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

Executive Summary

The Code of Governance for NHS Provider Trusts (October 2022) requires that at least half of the Board of Directors, excluding the Chair, should comprise Non-Executive Directors determined by the Board to be independent, and that a statement regarding this is made within the Trust's Annual Report.

Circumstances that are likely to impair, or could appear to impair, a non-executive director's independence include, but are not limited to, whether a director:

- has been an employee of the trust within the last two years
- has, or has had within the last two years, a material business relationship with the trust either directly or as a partner, shareholder, director or senior employee of a body that has such a relationship with the trust
- has received or receives remuneration from the trust apart from a director's fee, participates in the trust's performance-related pay scheme or is a member of the trust's pension scheme
- has close family ties with any of the trust's advisers, directors or senior employees
- holds cross-directorships or has significant links with other directors through involvement with other companies or bodies
- has served on the trust board for more than six years from the date of their first appointment
- is an appointed representative of the trust's university medical or dental school.

As at 1 February 2024, all Non-Executive Directors have declared that they do not meet any of the criteria

likely to impair, or could appear to impair their independence.

1. Purpose

The purpose of this report is to facilitate a decision by the Board of Directors relating to the independence of Non-Executive Directors.

2. Background & Context

2.1 Section B 2.7 of the Code of Governance for NHS Provider Trusts (the Code) (October 2022) requires that at least half of the Board of Directors, excluding the Chair, should comprise Non-Executive Directors determined by the Board to be independent.

2.2 Section B 2.6 of the Code requires the Board of Directors to identify in the Annual Report each Non-Executive Director that it considers to be independent.

2.3 Circumstances that are likely to impair, or could appear to impair, a non-executive director's independence include, but are not limited to, whether a director:

- has been an employee of the trust within the last two years
- has, or has had within the last two years, a material business relationship with the trust either directly or as a partner, shareholder, director or senior employee of a body that has such a relationship with the trust
- has received or receives remuneration from the trust apart from a director's fee, participates in the trust's performance-related pay scheme or is a member of the trust's pension scheme
- has close family ties with any of the trust's advisers, directors or senior employees
- holds cross-directorships or has significant links with other directors through involvement with other companies or bodies
- has served on the trust board for more than six years from the date of their first appointment
- is an appointed representative of the trust's university medical or dental school.

2.4 Where any of these or other relevant circumstances apply, and the Board of Directors nonetheless considers that the non-executive director is independent, this must be clearly explained why within the Annual Report.

3. Independence of Non-Executive Directors

3.1 Declarations of independence, based on the criteria detailed, have been completed by the Interim Chair and each Non-Executive Director. **Appendix 1** provides information to enable the Board of Directors to determine the independence of individual Non-Executive Directors.

3.2 All Non-Executive Directors have declared that they do not meet the criteria and therefore would consider themselves to be independent.

3.3 It is recommended that the Board of Directors determine that all Non-Executive Directors are independent and support an appropriate statement in the Annual Report 2023/24.

NHS Stockport NHS Foundation Trust

Appendix 1: Declarations of Non-Executive Director Independence

Relationships or circumstances which may be relevant to the Board's determination of the independence of Non-Executive Directors *(Code of Governance for NHS Provider Trusts, October 2022)*	**SA**	**TB**	**BF**	**DH**	**MLW**	**MM**	**LS**
Has been an employee of the Trust within the last two years	N	N	N	N	N	N	N
Has, or has had within the last two years, a material business relationship with the trust either directly or as a partner, shareholder, director or senior employee of a body that has such a relationship with the trust	N	N	N	N	N	N	N
Has received or receives remuneration from the trust apart from a director's fee, participates in the trust's performance-related pay scheme or is a member of the trust's pension scheme	N	N	N	N	N	N	N
Has close family ties with any of the Trust's advisers, directors of senior employees	N	N	N	N	N	N	N
Holds cross-directorships or has significant links with other directors through involvement in other companies or bodies	N	N	N	N	N	N	N
Has served on the Board of the Trust for more than six years from the date of their first appointment	N	N	N	N	N	N	N
Is an appointed representative of the Trust's university, medical or dental school	N	N	N	N	N	N	N

NHS Stockport NHS Foundation Trust

Meeting date	1st February 2024	**Public**	X	**Agenda No.**	
Meeting	Board of Directors				
Report Title	Register of Directors' Interests				
Director Lead	Dr Marisa Logan-Ward, Interim Chair	**Author**	Rebecca McCarthy, Trust Secretary		

Paper For:	**Information**		**Assurance**		**Decision**	X
Recommendation:	The Board of Directors is asked to review and confirm the interests declared by the Board of Directors.					

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

	Safe		Effective
	Caring		Responsive
X	Well-Led		Use of Resources

This paper relates to the following Board Assurance Framework risks

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

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

Where issues are addressed in the paper

	Section of paper where covered
Equality, diversity and inclusion impacts	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 is legally required to maintain a Register of Directors' Interests which should be available to the public. Interests to be declared include those relating to a) financial interests, b) non-financial professional interests, c) non-financial personal interests, d) indirect interests and e) organisational (loyalty) interests.

The Trust uses an online portal to record, and make publicly available, details of any actual or potential conflicts of interest, alongside gifts, hospitality, and sponsorship, for all staff, including the Board of Directors, throughout the year. The Register of Directors' Interests, as current, is provided at **Appendix 1**.

The Trust adopts a commonsense approach to the management of interests as outlined in the Conflicts of Interest Policy. Should action be warranted to mitigate potential or actual conflicts of interest, this would be proportionate and seek to preserve the spirit of collective decision-making wherever possible.

1. Purpose

The purpose of this report is to facilitate a decision by the Board of Directors relating to confirmation of the interests declared by the Board of Directors.

2. Background & Context

2.1 There is a legal requirement for the Trust to maintain a Register of Directors' Interests which should be available to the public. This requirement is incorporated in the Trust's Constitution.

2.2 In addition, the Foundation Trust Annual Reporting Manual requires that the Annual Report should disclose details of company directorships or other material interests in companies held by directors, where those companies or related parties are likely to do business with the NHS Foundation Trust. An alternative disclosure is to state how members of the public can gain access to the Register of Directors' Interests rather than listing all interests in the Annual Report. The Trust has adopted this latter form of disclosure.

2.3 Furthermore, the NHS Standard Contract General Conditions: GC27 Conflicts of Interest and Transparency on Gifts and Hospitality requires Trusts to maintain and publish on its website an up-to-date register containing details of all gifts, hospitality, and actual or potential conflicts of interest.

2.4 The Trust uses an online portal to record and publish details of any actual or potential conflicts of interest, alongside gifts, hospitality, and sponsorship, for all staff, including the Board of Directors, on a continual basis.

2.5 Interests are to be declared if they are material and relevant to the business of the Board relating to:

- *Financial interests* – Where an individual may get direct financial benefit from the consequences of a decision they are involved in making.
- *Non-financial professional interests* Where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making.
- *Non-financial personal interests* - Where an individual may benefit personally in ways that are not directly linked to their professional career and do not give rise to a direct financial benefit, because of the decisions they are involved in decision making.
- *Indirect interests* - Where an individual has a close association with another individual who has a financial interest.
- *Organisational (Loyalty) interests* - Where an individual's role in another organisation could result in actual or perceived conflicts of interest.

2.6 The Trust adopts a commonsense approach to the management of interests as outlined in the Conflicts of Interest Policy. Should action be warranted to mitigate potential or actual conflicts of interest, this would be proportionate and seek to preserve the spirit of collective decision-making wherever possible.

3. Register of Interests 2023/24

3.1 Members of the Board of Directors are required to make an annual entry via the online portal, even if it is to confirm no change to previous declarations or confirm a nil declaration.

3.2 Any changes throughout the year should be declared by the Board member at the earliest convenience, thereby a contemporary Board-level Register of Interests is maintained.

3.3 The current Register of Directors' Interests is included for reference in **Appendix 1**. Board members are requested to review and confirm that the current content is accurate and up to date.

NHS
Stockport
NHS Foundation Trust

Appendix 1: Stockport NHS Foundation Trust - Register of Director's Interests

Name and Position	Declared Interests
Dr Marisa Logan-Ward Interim Chair	• Kingsbridge Health Ltd – Management Consultancy to NHS and independent organisations in relation to Pathology and scientific services. • Non-Executive Director for Health Services Safety Investigations Body (HSSIB).
Dr Samira Anane Non-Executive Director	• Company Secretary – Orthpro • Regional BMA Committee Representative: Stockport, Manchester, Salford, Trafford • Deputy Chair – BMA England GP Committee • Trustee – Clare Wand Fund • Vice Chair – Manchester LMC • Board Member – Our People Trust • General Practitioner – GP City Health Centre (GTD Healthcare) • PCN Clinical Director (Manchester City Centre and Ancoats)
Mr Anthony (Tony) Bell Non-Executive Director	• Non-Executive Director, Inclusion Homes • Non-Executive Director, Wythenshawe Community Housing Group • Non-Executive Director, Lumen Housing *(to 30/11/23)* • Vice-Chair – Cariocca Enterprises • Chair of Advisory Group – The Training Brokers
Mrs Beatrice Fraenkel Non-Executive Director	• Trustee – Design in Mental Health • Trustee – Design Council • Remcol Ltd • Normal Properties Ltd • Sandown Property Holdings Ltd • Sandown Property Co. Liverpool Ltd • Member of the High Street Task Force • Design Code Pathfinders Programme Expert Panel Member • Panel Member for NW RIBA Design Review Panel 'Places Matter' • Board Director on the Board of Safehinge Primera
Mr David Hopewell Non-Executive Director	• Non-Executive Audit Committee member, Greater Manchester Integrated Care System
Mrs Mary Moore Non-Executive Director	• Shareholder, Scenario Health • Non-Executive Director NHS Wrightington Wigan and Leigh
Dr Louise Sell Non-Executive Director McCarthy, Rebecca 30/01/2024 09:18:02	• GMC Adviser – Health Examination and Supervision • Consultant Psychiatrist, Pennine Care NHS FT • Treasurer Addiction Faculty, Royal College Psychiatrists • Charitable Trustee, Early Break • Chair, Alcohol Clinical Guidelines Group, Public Health England • Responsible Officer Appraiser, NHS England
Mrs Karen James OBE Chief Executive	• Chief Executive, Tameside & Glossop Integrated Care Organisation – joint post with Stockport NHS Foundation Trust

Name and Position	Declared Interests
	• Sixth Form Governor – Tameside College • Member of Tameside TRENT School Academy
Mr John Graham Chief Finance Officer / Deputy Chief Executive	• Chair of the Multi School Academy Trust – Schools in Liverpool, Lydiate Learning Trust • Member, CIMA's NW Area • Member of CIMA's Council • Member of Management Committee of Las Calas, Lanzarote, Resort Solutions Limited • Chief Finance Officer – Joint appointment held between Stockport NHS Foundation Trust and Tameside & Glossop Integrated Care NHS Foundation Trust • Non-Executive Director – New Directions Sefton
Ms Amanda Bromley Director of People & OD	• Director of People & OD – Joint appointment held between Stockport NHS Foundation Trust and Tameside & Glossop Integrated Care NHS Foundation Trust • Employee Representative on Pension Board NHSBSA
Mrs Nicola Firth Chief Nurse	• Chief Nurse – Joint appointment held between Stockport NHS Foundation Trust and Tameside & Glossop Integrated Care NHS Foundation Trust
Dr Andrew Loughney Medical Director	• Nil
Mrs Jackie McShane Director of Operations	• Moorfield Community School Governor
Mrs Caroline Parnell Director of Communications & Corporate Affairs	• Founding Partner of Sentry PR, Communications Consultancy • Associate Consultant, Dearden HR and Kingsgate • Trustee, The Derwent Initiative

NHS Stockport NHS Foundation Trust

Meeting date	1st February 2024	**Public**	X	**Agenda No.**	
Meeting	Board of Directors				
Report Title	Fit & Proper Persons Test – Annual Assessment 2023/24				
Director Lead	Dr Marisa Logan-Ward, Interim Chair	**Author**	Rebecca McCarthy, Trust Secretary		

Paper For:	**Information**		**Assurance**		**Decision**	X
Recommendation:	The Board of Directors is asked to: • Review and approve the Fit & Proper Persons Policy • Endorse the Interim Chair's annual assessment of the Fit and Proper Person requirements for the Board of Directors.					

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

	Safe		Effective
	Caring		Responsive
X	Well-Led		Use of Resources

This paper relates to the following Board Assurance Framework risks

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

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

Where issues are addressed in the paper

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

Executive Summary

Since November 2014, Trusts have been required to ensure all director level appointments meet the Fit and Proper Persons Requirement, as set out under Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In August 2023, NHS England issued a Fit & Proper Person Test (FPPT) Framework, to support compliance with the regulatory requirements, introducing new checks and balances. NHS England have requested organisations adopt the FPPT Framework by 31st March 2024.

In summary, Trusts must not appoint a person to an executive or non-executive director level post unless they meet the below criteria, and must have in place systems to ensure on-going review of compliance:

- Are of good character
- Have the necessary qualifications, competence, skills and experience
- Are able to perform the work they are employed for after reasonable adjustments
- Have not been responsible for, privy to, contributed to or facilitated any serious misconduct or mismanagement when providing a service.

The Stockport NHS Foundation Trust Fit & Proper Person Policy has been updated to reflect the requirements of the new NHS England FPPT Framework. An annual assessment of compliance with the fit & proper person requirement has been undertaken in line with the draft Policy, and the outcome reviewed by the Interim Chair.

Following review, the Chair has concluded all directors continue to be ‘fit and proper persons’ in accordance with Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. As is required by the FPPT Framework, this will be confirmed in the NHS England Annual Review 2023/24 submission.

The FPPT Framework asks organisations to incorporate the Leadership Competency Framework (LCF) into annual appraisals of all directors; the LCF has not yet been published. Appraisals for directors will be undertaken during Q1 2024/25, following which the Interim Chair will inform the Board of Directors should any information come to light that changes the outcome of the annual assessment as presented.

1. Purpose

1.1 The purpose of this report is to:

- Confirm the systems and processes in place to ensure compliance with the Fit & Proper Persons Requirement for Directors, as set out under Regulation 5 of the Health and Social Care Act 2008, and the recently introduced NHS England Fit & Proper Person Test Framework
- Review and approve the Stockport NHS foundation Trust Fit & Proper Persons Policy
- Inform the Board of Directors of the outcome of the Interim Chair's annual review of compliance with the Fit and Proper Persons Test and seek endorsement of the outcome.

2. Background & Context

2.1 Since November 2014, Trusts have been required to ensure all director level appointments meet the Fit and Proper Persons Requirement, as set out under Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which were integrated into the Care Quality Commission's registration, monitoring and inspection requirements.

2.2 In summary, Trusts must not appoint a person to an executive or non-executive director level post unless they meet the following criteria:

- Are of good character
- Have the necessary qualifications, competence, skills and experience
- Are able to perform the work they are employed for after reasonable adjustments
- Have not been responsible for, privy to, contributed to or facilitated any serious misconduct or mismanagement when providing a service.

In addition, Trusts must have processes in place to ensure the on-going fitness of executive and non-executive directors.

2.3 In August 2023, NHS England issued a Fit & Proper Person Test (FPPT) Framework, developed in response to the recommendations made by Tom Kark KC in his 2019 Review of the FPPT. Legislation has not changed; the new framework supports compliance and includes additions to the checks and balances to ensure directors satisfy regulatory requirements.

NHS England have requested organisations adopt the FPPT Framework by 31st March 2024.

2.4 New requirements introduced via the FPPT Framework are summarised as:

- Additional checks of web-based registers to be completed on appointment for directors, with on-going annual review;
- A means of retaining information relating to testing the requirements of the FPPT using relevant fields added to the Electronic Staff Record (ESR);
- A set of standard competencies for all directors through a new appraisal proforma *(not yet published)*;
- A new way of completing board member references

2.5 In September 2023, a 'Stockport NHS Foundation Trust Fit & Proper Persons Test Privacy Notice' was issued to directors, including details of information to be collected and

processed in relation to the FPPT Framework, alongside details of the Trusts Senior Information Risk Owner (SIRO) and the Data Protection Officer.

2.7 It remains the responsibility of the Chair of the Trust to discharge the requirement placed on the Trust to ensure that all directors meet the fitness test and do not meet any of the 'unfit' criteria.

3. Fit & Proper Person Policy

3.1 The Stockport NHS Foundation Trust Fit & Proper Person Policy (Appendix 1) has been updated to reflect the requirements of the new NHS England FPPT Framework. The Policy details the processes in place to ensure compliance with both the Regulations and the FPPT Framework, and a process to deal with any concerns in this regard.

3.2 The Board of Directors is asked to review and approve the Policy, noting that the annual assessment for 2023/24 had been undertaken in line with the draft Policy.

4. Outcome of annual Fit & Proper Person Assessment

4.1 An annual assessment of compliance with the fit & proper person requirement was completed during December 2023 - January 2024. This included completion of all annual checks/reviews set out in the Board Fit & Proper Persons Checklist (Appendix 4 of the Policy).

4.2 Evidence of the above is held securely in individual electronic fit and proper persons files by the Trust Secretary.

4.3 Where Stockport NHS Foundation Trust is not the employing organisation for a director, a letter of confirmation has been received for each director from the Chair of Tameside & Glossop NHS Integrated Care NHS Foundation Trust (the employing organisation), confirming outcome of the annual assessment for each Director.

4.4 The Board Fit & Proper Person Checklists and Letters of Confirmation were reviewed by the Interim Chair, alongside individual's Fit & Proper Person Self-Attestation.

4.5 Following review, the Chair has concluded all directors continue to be 'fit and proper persons' in accordance with Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. As is required by the FPPT Framework, this will be confirmed in the NHS England Annual Review 2023/24 (Appendix 2) submission.

4.6 The FPPT Framework asks organisations to incorporate the Leadership Competency Framework (LCF) into annual appraisals of all directors; the LCF has not yet been published. Appraisals for directors will be undertaken during Q1 2024/25, following which the Board Fit & Proper Person Checklist will be updated. The Interim Chair will inform the Board of Directors should any information come to light that changes the outcome of the annual assessment as presented. In future years, the appraisal/LCF and FPPT annual assessment should all align.

NHS
Stockport
NHS Foundation Trust

FIT AND PROPER PERSON POLICY

CONTENTS

1. EXECUTIVE SUMMARY

1.1 From 27th November 2014, the Trust has been required to ensure that director level appointments meet the 'fit and proper persons test' set out in Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and which was integrated into Care Quality Commission's (CQC) registration, monitoring and inspection requirements.

1.2 In August 2023, NHS England issued the Fit and Proper Persons Test (FPPT) Framework, developed in response to the recommendations made by Tom Kark KC in his 2019 Review of the FPPT. The Framework introduced a means of retaining information relating to testing the requirements of the FPPT for individual directors, a set of standard competencies for all board directors, a new way of completing references with additional content whenever a director leaves an NHS board, and extension of the applicability to some other organisations, including NHS England and the CQC.

1.3 In summary, according to the above, Trusts must not appoint a person to an Executive or Non-Executive Director level post unless they meet the following criteria:

- Are of good character
- Have the necessary qualifications, competence, skills and experience
- Are able to perform the work they are employed for after reasonable adjustments
- Have not been responsible for, privy to, contributed to or facilitated any serious misconduct or mismanagement when providing a service.

2. PURPOSE AND SCOPE

2.1 The purpose of this Policy is to set out the requirements of Regulation 5 of the 2014 Regulations and describe how the Trust will comply with these, including implementation of the NHS England FPPT Framework (August 2023).

2.2 This Policy applies to all directors, defined as Executive and Non-Executive Directors, including permanent, interim (beyond 6 weeks) and associate positions, irrespective of their voting rights, who are members of the Board. This includes those directors who were already in post when the 2014 Regulations came into force.

3. ROLES AND RESPONSIBILITIES

3.1 Chair of the Trust

It is the responsibility of the Chair of the Trust to discharge the requirement placed on the Trust to ensure that all directors meet the FPPT and do not meet any of the 'unfit' criteria. This includes implementation of systems to ensure only those fit for the role of director are appointed; regularly reviewing the fitness of directors and having arrangements in place to respond to concerns about a director's fitness arising after the appointment.

3.2 Senior Independent Director

It is the responsibility of the Senior Independent Director to oversee the application of the FPPT for the Chair, as part of the annual appraisal process. In addition, the Senior Independent Director will oversee arrangements for investigation or determining interim arrangements during any period of investigation, suspension or restriction of duties, as a result of concerns raised about the Chair, including where the Chair has notified the Senior Independent Director they may no longer comply with the fit and proper persons requirements.

3.3 Trust Secretary

It is the responsibility of the Trust Secretary to support the Chair in ensuring compliance with the FPPT and this Policy. This will include informing the Chair of any concerns arising from completion of checks at appointment, and as part of the assessment of ongoing compliance with the FPPT. It is the responsibility of the Trust Secretary to ensure that evidence of compliance is maintained in individual fit and proper person files (local electronic file) and ensure the Board of Directors are informed of the outcome of the annual assessment.

3.4 Human Resources Department

It is the responsibility of the Workforce Team to ensure that pre-employment checks, and specified checks for on-going assessment, are carried out for directors, as set out in the Policy, and the corresponding Recruitment & Selection Policy. Working with the Trust Secretary, the Workforce Team will ensure all relevant information is held, as required, in individual fit and proper person files and updated in the electronic staff record (ESR) for directors.

3.5 Directors within scope of the Fit & Proper Person Policy

All directors within scope of the Policy (See Section 2.2) are responsible for ensuring they comply with the requirement of the FPPT and this Policy. This will include making self-declarations in a form prescribed by the Chair and providing any additional information required to demonstrate compliance with Regulation 5.

3.6 CQC

The CQC's role is to ensure NHS organisations have robust processes in place to discharge its responsibility under Regulation 5 and will consider this as part of Well Led reviews. This may involve checking fit and proper persons and/or personnel files.

Where the CQC receives information from a third party regarding an alleged lack of fitness of a director, the CQC will pass on all information of concern to the Trust. It will be for the Trust to consider whether the director in question remains or is a fit and proper person under the regulations and to provide the CQC with a comprehensive response on this matter.

The role of the CQC in determining whether information is satisfactory, is to form a view on the quality of the evidence and whether it has been taken into account.

Where the CQC finds that the organisation's processes are not robust, or an unreasonable decision has been made following concerns raised about an alleged lack of fitness of a director, the CQC will decide whether to take regulatory action, and what action to take on a case by case basis.

3.7 Council of Governors

It is the responsibility of the Council of Governors to receive information regarding the satisfactory completion of the FPPT assessment for new Chair and Non-Executive Director appointments. The Council of Governors, through the Chair, will wish to satisfy themselves that robust processes are in place to support both initial and ongoing review a person's fitness for appointment, including processes to respond to concerns.

4. REGULATION

4.1 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 5: Fit and Proper Persons: Directors:

A Trust must not appoint a person to a director level post unless:

- they are of good character;
- they have the necessary qualifications, competence, skills and experience;
- they are able by reason of their health, after reasonable adjustments are made, properly to perform their work;
- they have not been responsible for, been aware of, contributed to or facilitated any serious misconduct or mismanagement in the course of carrying on a regulated activity;

and

- none of the grounds of unfitness specified in Part 1 of Schedule 4 of the 2014 Regulations apply to them.

In assessing good character, consideration must be given to:

- Whether the person has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence, and
- Whether the person has been erased, removed or struck off a register of professionals maintained by a regulator of health care or social work professionals.

The grounds of unfitness specified in Part 1 of Schedule 4 of the 2014 Regulations are:

- The person is an undischarged bankrupt or a person whose estate has had a sequestration awarded in respect of it and who has not been discharged;
- The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland;
- The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986;
- The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it;
- The person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland;
- The person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.

4.2 Related Principles

4.2.1 Code of Conduct

All holders of public office are expected to work to the highest personal and professional standards. In support of this, Board members should abide by the 7 Principles of Public Life (Nolan Principles), as stated within the Directors Code of Conduct. These are:

Selflessness

Holders of public office should act solely in terms of the public interest.

Integrity
Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships.

Objectivity
Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.

Accountability
Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.

Openness
Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.

Honesty
Holders of public office should be truthful.

Leadership
Holders of public office should exhibit these principles in their own behaviour and treat others with respect. They should actively promote and robustly support the principles and challenge poor behaviour wherever it occurs.

4.2.3 Directors must familiarise themselves and act in accordance with the Conflicts of Interests Policy

4.2.2 **Serious Misconduct**
Serious misconduct or mismanagement means behaviour that would constitute a breach of any legislation/enactment CQC deems relevant to meeting these regulations or their component parts, behaviour which suppresses the ability of people to speak up about serious issues in the health service, whether by allowing bullying or victimisation of those who 'speak up' or blow the whistle, or by any form of harassment of individuals. Any deliberate suppression or falsification of records or relevant information should be regarded seriously. Further, serious misconduct should include reckless mismanagement which endangers patients; These are only examples and are not intended to be an exclusive list.

5 FIT AND PROPER PERSONS TEST PROCESS

5.1 New Appointments

5.1.1 Where specific qualifications are deemed necessary for a role, the Trust will make this clear in the person specification and will only employ those individuals that hold the required qualifications.

5.1.2 Where specific skills and experience are required, these will also be detailed in the person specification and the selection process will include qualitative assessment and values-based questions. Interview notes will be retained as evidence of compliance on the individual's fit and proper person file.

5.1.3 The Trust may consider that an individual can be appointed to a role based on their qualifications, skills and experience with the expectation that they will develop specific competence to undertake the role within a specified timeframe. Where this is the case, discussion and recommendations will be recorded and followed up as part of on-going review and appraisal.

5.2 Pre-Employment Checks

5.2.1 The Trust will make pre-employment checks in accordance with the Regulations and NHS Employment Check Standards issued by NHS Employers.

This will include:

- full employment history with documented explanation of any gaps
- obtaining at least one reference (see Section 6 - Board Member References)
- qualification and professional registration checks
- right to work checks
- proof of identity checks (including photograph)
- occupational health clearance
- appropriate DBS check

In addition, the following will be undertaken:

- search of insolvency and bankruptcy register
- search of disqualified directors register
- search of Charity Commission register of removed trustees
- web core public information search of the individual (See Appendix 1)
- employment tribunal judgement check
- social media check

Prior to commencement in role the director will be required to complete and sign:

- Social media declaration (See Appendix 2)
- Fit & Proper Person Self-Attestation Form (Appendix 3)
- Directors Code of Conduct

5.2.2 Evidence of the above will be documented on the individuals fit and proper persons file and relevant information recorded on the Electronic Staff Record (ESR).

5.2.3 A Board Fit & Proper Person Checklist (Appendix 4) will be completed and will be reviewed by the Chair to confirm that appropriate checks have been undertaken and to reach a judgement that the individual meets the fitness test before employment or engagement is confirmed.

5.2.4 Where information comes to light that a candidate does/may not comply with the regulations, the process for dealing with concerns will be followed (See Section 7).

5.2.5 The Chair reserves the right to use discretion to appoint a director in instances where all required information is not available and due consideration has been given to risk of employment.

5.2.6 On commencing in role, the director will be required to complete:

- An electronic declaration of interest submission, using the Trust declaration management system, details being advised at time of appointment.

5.3 On-going Review of Existing Directors

5.3.1 On-going review will take place to ensure that directors remain fit for their role. An assessment of continued fitness will be undertaken annually, which will include:

- completion of an annual Fit and Proper Person Self Attestation
- appraisal, including confirmation of completion of required training & development and demonstration of Trust values
- confirmation of any disciplinary/grievance/whistleblowing matter, relevant to Fit & Proper Persons, including confirmation of any upheld, ongoing or discontinued investigation
- professional registration checks (where relevant)
- check of DBS status (DBS to be undertaken at least every three years)
- search of insolvency and bankruptcy register
- search of disqualified Directors register
- search of Charity Commissions register of removed trustees

- web core public information search of the individual
- employment tribunal judgement check
- social media check
- maintenance of declared interests

5.3.2 Evidence of the above will be recorded on the individuals fit and proper person file and the individual's Board Fit & Proper Person Checklist updated.

5.3.3 The Chair (for Chief Executive and Non-Executive Directors), Senior Independent Director (for Chair) and Chief Executive (for Executive Directors) will review the individual's Board Fit & Proper Person Checklist and, as part of the appraisal process, conclude for each board member whether they are a fit and proper person in line with the regulations.

5.3.4 Following appraisal, the individual's Board Fit & Proper Person Checklist will be updated and reviewed by the Chair. Once the Chair is satisfied that the testing for all board members is complete, all FPPT sections of ESR will be updated.

5.3.5 An Annual NHS FPPT Submission Form (Appendix 5) will be presented to the Board of Directors by the Chair and subsequently submitted to the Regional Director, NHS England.

6. Board Member References

6.1 Appointment of a Director

6.1.1 The Board Member Reference (Appendix 6) template will be applied for all director appointments.

6.1.2 A minimum of two board member references will be obtained where the individual is from outside the NHS, or from within the NHS but moving into the board role for the first time. References should come from different employers and validate a period of six consecutive years of continuous employment (or explanation of any gaps) or training immediately prior to the application being made, where possible.

6.1.3 For an individual who moves from one NHS board role to another NHS board role, across NHS organisations, one reference from a separate organisation will be requested, where possible, in addition to the board member reference for the current board role.

6.1.4 It is acknowledged that where a previous employer is not an NHS organisation, or the individual is not a current board member at another NHS organisation, there may be greater difficulty in obtaining all information within the template. Nonetheless, every

practical effort to obtain such a reference which fulfils the board member reference requirements will be made.

6.2 Departure of a Director

6.2.1 The Trust will complete and maintain a Board Member Reference at the point where a director departs the organisation, irrespective of the reason for departing and whether there has been a request from another NHS employer.

6.2.2 The reference will be retained on the individuals fit and proper person file in line with the NHS England FPPT Framework.

7. Dealing With Concerns

7.1 If the organisation is made aware of, at any point, information that suggests an individual director does not meet the FPPT (e.g., through pre-employment checks, on-going review or through information provided to, or discovered by, the Trust), the matter shall be referred immediately to the Chair, (or the Senior Independent Director, if the concern relates to the Chair).

7.2 The Chair (or the Senior Independent Director), taking expert advice as necessary, will lead on addressing the concern/s on a case by case basis and will consider whether an investigation is necessary or appropriate given the allegation.

7.3 Where it is necessary to investigate or take action, the Trust's current people related policies and processes will apply. Immediate action will be taken to protect people receiving services from risk or potential risk.

7.4 The Chair (or Senior Independent Director) will put in place interim arrangements, if required, during any period of investigation, suspension or restriction from duties.

7.5 Where a director is deemed not to be a fit and proper person then action, as is proportionate, up to and including the termination of their engagement with immediate effect will be considered. Where an individual who is registered with a professional regulator (General Medical Council (GMC), Nursing & Midwifery Council (NMC) etc.) no longer meets the fit and proper person's requirement the Trust will also inform the regulator and take action to ensure the position is held by a person meeting the requirements.

7.6 Where concerns are substantiated but an individual is appointed or retained as a director, the rational for this will be recorded and retained in the individual's fit and proper person's file and made available to those that need to be aware of this.

7.7 Where an investigation is on-going at the time of annual assessment, confirmation of the investigation outcome will be provided to the Chair (or Senior Independent Director) at the conclusion of the investigation. The individual's Board Fit & Proper Person Checklist will be updated accordingly to reflect the outcome of the investigation and will be retained on the individual's fit and proper persons file.

7.8 The appointment or removal of any Non-Executive Director (including the Chair) will be in accordance with the Constitution, with final decision for appointment or removal resting with the Council of Governors.

10. Joint Appointments

10.1 In the case of any joint appointments between Stockport NHS Foundation Trust and another NHS organisation, the FPPT will be completed by the employing organisation.

10.2 Where Stockport NHS Foundation Trust is the employing organisation, a 'letter of confirmation' (Appendix 7) will be provided to the other contracting organisation, confirming outcome of the initial FPPT assessment and annual assessment.

10.3 Where Stockport NHS Foundation Trust is not the employing organisation, a 'letter of confirmation' will be requested from the employing organisation to confirm that the director has met the requirements of the initial FPPT assessment on appointment and on an annual basis.

10.4 In the case of joint appointments, the Chair will ensure appropriate channels of communication are in place with the other contracting organisation, to ensure each organisation can be kept abreast of any changes and any matters that may impact the FPPT assessment of a joint director on an ongoing basis.

11. IMPLEMENTATION

11.1

New Appointment

Workforce Team requests and/or completes:

- confirmation of full employment history with documented explanation of any gaps
- at least one reference (see Section: Board Member References)
- qualification and professional registration checks
- right to work checks

- proof of identity checks (including photograph)
- search of insolvency and bankruptcy register (Individual Insolvency Register (IIR) - Home (bis.gov.uk)
- search of disqualified Director's register (Search for disqualified company directors - GOV.UK (www.gov.uk)
- occupational health clearance
- appropriate DBS check
- Fit & Proper Person Self-Attestation Form
- Directors Code of Conduct
- Social Media Declaration

Trust Secretary requests and/or completes:

- search of Charity Commissions register of removed trustees (Search the Register of Removed Trustees (charitycommission.gov.uk)
- web / core public information search of the individual
- employment tribunal judgement check (Employment tribunal decisions - GOV.UK (www.gov.uk)
- social media check (basic web search of publicly available activity on social media accounts)

Evidence of all the above retained on FPP file by Trust Secretary.

Trust Secretary completes Board Fit & Proper Person Checklist for Chair review.

Trust Secretary informs HR of the outcome of the Chair's review and ESR Sign Off completed by Workforce Team. Formal employment contract issued by Workforce Team.

Annual Review

Trust Secretary requests and/or completes:

- search of insolvency and bankruptcy register
- search of disqualified Directors register
- search of Charity Commissions register of removed trustees
- web / core public information search of the individual
- employment tribunal judgement check
- social media check
- annual Fit and Proper Person Self Attestation
- annual declaration of interests

Workforce Team provides confirmation to the Trust Secretary:

- of any disciplinary/grievance/whistleblowing matter, relevant to Fit & Proper Persons, including confirmation of upheld, ongoing or discontinued investigation, recorded on the Trusts internal systems

- check of DBS status (DBS will be undertaken on at least a three year cycle)
- professional registration check (where relevant)

Evidence of the above retained on local FPP file by Trust Secretary and Board Fit & Proper Person Checklist updated accordingly.

The Chair (for Chief Executive and Non-Executive Directors), Senior Independent Director (for Chair) and Chief Executive (for Executive Directors) will review the Board Fit & Proper Person Checklist as part of the appraisal process.

Appraisal undertaken by Chief Executive, Chair or Senior Independent Director, including conclusion for each individual board member whether they are a fit and proper person in line with the regulations.

Trust Secretary updates Board Fit & Proper Person Checklists following appraisal for Chair review.

Trust Secretary informs Workforce Team of the outcome of the Chair's review and ESR Sign Off completed by HR.

Trust Secretary completes report for Board, including NHS England Annual Submission Form, confirming outcome of FPPT annual assessment.

Trust Secretary submits Annual Submission Form to Regional Director NHS England.

Departure of Director

Trust Secretary, requests information from Workforce Team as required, and completes Board Member Reference for retention on local FPP file.

12. MONITORING COMPLIANCE

12.1 The Trust is committed to ensuring compliance with documents and will actively monitor the effectiveness of such documents. Process for monitoring compliance with this policy:

CQC Regulated Activities	Process for monitoring e.g. audit	Responsible individual/ group/ committee	Frequency of monitoring	Responsible individual/group/ committee for review of results	Responsible individual/group/ committee for development of action plan	Responsible individual/group/ committee for monitoring action plan and implementation
CQC Inspection: Well Led	Internal Audit will be undertaken at least once every three	Chair	Annual	People Performance Committee	People Performance Committee	Trust Secretary

CQC Regulated Activities	Process for monitoring e.g. audit	Responsible individual/ group/ committee	Frequency of monitoring	Responsible individual/group/ committee for review of results	Responsible individual/group/ committee for development of action plan	Responsible individual/group/ committee for monitoring action plan and implementation
	years.					

13. REFERENCES AND ASSOCIATED DOCUMENTATION

13.1 This document should be read in conjunction with:

- Recruitment & Selection Policy
- Disciplinary Policy
- Conflicts of Interests Policy
- Social Media Guidelines

14. EQUALITY IMPACT ASSESSMENT

Office Use Only

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

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

1	**Name of the Policy/SOP/Service**	Fit & Proper Person Policy	
2	**Department/Division**	HR/Corporate	
3	**Details of the Person responsible for the EIA**	**Name:**	Chris Duffy
		Job Title:	Recruitment Manager
		Contact Details:	christopher.duffy@stockport.nhs.uk
4	**What are the main aims and objectives of the Policy/SOP/Service?**	Ensure that director level appointments meet the 'fit and proper persons test' set out in Regulation 5 of the 2014 Regulations (Regulation 5) and which was integrated into Care Quality Commission's registration, monitoring and inspection requirements.	

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

5	A) IMPACT **Is the policy/SOP/Service likely to have a <u>differential</u> impact on any of the protected characteristics below? Please state whether it is positive or negative. What data do you have to evidence this?** **Consider:** • What does existing evidence show? E.g. consultations, demographic data, questionnaires, equality monitoring data, analysis of complaints. • Are all people from the protected characteristics equally accessing the service?	B) MITIGATION **Can any potential negative impact be justified? If not, how will you mitigate any negative impacts?** ✓ Think about reasonable adjustment and/or positive action ✓ Consider how you would measure and monitor the impact going forward e.g. equality monitoring data, analysis of complaints. ✓ Assign a responsible lead. ✓ Produce action plan if further data/evidence needed ✓ Re-visit after the designated time period to check for improvement.	**Lead**
Age	No impact		
Carers	No impact		
Disability	No impact		
Race / Ethnicity	No impact		
Gender	No impact		
Gender Reassignment	Negative impact – Producing ID for pre-employment check and/or DBS may mean that a candidate has to disclose their gender history unwillingly.	All offer letters sent, advise applicants how to book a confidential document appointment and/or run a DBS check using the confidential checking process.	
Marriage & Civil Partnership	No impact		
Pregnancy & Maternity	No impact		
Religion & Belief	No impact		
Sexual Orientation	No impact		
General Comments across all equality strands	Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 sets out the criteria a director or equivalent must meet and mandates that all directors satisfy these criteria. The criteria are applied consistently		

	regardless of protected characteristics and consequently have a neutral impact.		

Action Plan

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

Action	Lead	Timescales	Review & Comments

EIA Sign-Off	**Your completed EIA should be sent to Equality, Diversity & Inclusion Manager for approval:** equality@stockport.nhs.uk **0161 419 4784**

15. Quality Impact Assessment

15.1 No Impact.

16. Data Protection Impact Assessment (DPIA)

Organisations must 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 on why it is not an issue*
A)	Will the process described involve the collection of new information about individuals?	X			NHS England Fit & Proper Person Test Framework for Board members issued in August 2023. In line with the framework, new data will be held about individuals in ESR and in local file. The processing of the data is necessary on the lawful basis set out in Article 6(1)(e) UK GDPR as the foundation for the database. This is because it relates to the processing of personal data which is necessary for the performance of the fit and proper person test which is carried out in the public interest and/or in the exercise of official authority vested in the controller. For CQC registered providers, ensuring directors are fit and proper is a legal requirement for the purposes of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and organisations are required to make information available connected with compliance to the CQC.
B)	Does the information you are intending to process identify individuals (e.g., demographic information such as name, address, DOB, telephone, NHS number)?	X			See Section 7 for all information recorded. Much of the personal information recorded is already collected and processed for other purposes than the FPPT, i.e., recruitment.
C)	Does the information you are intending toprocess involve sensitive information e.g.,health records, criminal records or other information people would consider particularly private or raise privacy concerns?	X			See Section 7.
D)	Are you using information about individuals for a purpose it is not currentlyused for, or in a way it is not currently used?		X		
E)	Will the initiative require you to contact individuals in ways which they may find intrusive[1]?		X		
F)	Will the information about individuals be disclosed to organisations or people who have not previously had routine access to the information?	X			Information is now required to be recorded on ESR, this will be undertaken by HR. Therefore, HR will have access to the outcome of the specific checks undertaken by the Trust Secretary.
G)	Does the initiative involve you using new technology which might be perceived asbeing intrusive? e.g., biometrics or facial recognition		X		
H)	Will the initiative result in you making decisions or acting against individuals in ways which can have a significant impact on them?	X			Where a person is deemed not to be a 'fit and proper person' following assessment, proportionate action, up to termination of engagement/employment, may be taken. This does not represent change since Version 2 of the Policy.
I)	Will the initiative compel individuals to provide information about themselves?	X			As detailed in Section 7 – Annual Self-Attestation required.

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.

17. DOCUMENT INFORMATION

Type of Document	Policy
Title	Fit and Proper Person Policy
Version Number	3
Consultation	
Recommended by	
Approved by	
Approval Date	
Next Review Date	
Document Author	Chris Duffy, Recruitment Manager Rebecca McCarthy, Trust Secretary
Document Director	Chair
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
2	December 2019	December 2019	Chris Duffy, Recruitment Manager	Policy review required
3	January 2024		Rebecca McCarthy, Trust Secretary	Issue of NHS England Fit & Proper Person Framework for Board Members, August 2023

18. APPENDICES

Appendix 1 – Core Public Information Sources

Core public information sources that CQC believe are relevant for Trusts to use as part of their Fit and Proper Persons Test due diligence (this list is not exhaustive):

- Any provider whose registration had been suspended or cancelled due to failings in care in the last five years or longer if the information is available because of previous registration with CQC predecessor bodies.
- Public inquiry reports about the provider.
- Information where we are notified about any relevant individuals who have been disqualified from a professional regulatory body. This information would be shared with the individual and the provider in accordance with the Data Protection Act.
- Serious case reviews relevant to the provider.
- Homicide investigations for mental health trusts.
- Criminal prosecutions against providers.
- Ombudsmen reports relating to providers

Appendix 2 - Social Media Declaration & Check

1. Do you have a Facebook account? Yes No

If yes, please provide your name as displayed on your profile:
.....

2. Do you have a X/Twitter account? Yes No

If yes, please provide your name as displayed on your profile:
……..

3. Do you have an Instagram account? Yes No

If yes, please provide your name as displayed on your profile:
……..

4. Do you have a TikTok account? Yes No

If yes, please provide your name as displayed on your profile:
……..

5. Do you have any other social media accounts? Yes No

If yes, please provide details of the social media accounts and the name displayed on your profile below:

Social Media Platform	Display Name

I confirm I have read the Trust's social media guidelines (Appendix 1):

Name:	
Job Title:	
Signature:	
Date:	
To be completed by Trust Secretary	
Date social media check undertaken:	
Concerns Identified:	Yes / No

SOCIAL MEDIA GUIDANCE FOR STAFF

1: Introduction

We use various social media, including Twitter, Facebook and Instagram, to keep people informed and updated about our latest news and events.

Our corporate social media accounts are managed by the communications team.

These brief guidelines are for staff using personal social media accounts and also for teams who want to set up Trust social media accounts for their service areas.

2: Personal social media accounts

- If staff using social media choose to show that they are linked with our Trust - i.e.: put in their description that they are a nurse here - they must never give personal details about patients, other staff or any other confidential information.

- They should adhere to the following policies:

    - IT Acceptable Use policy, which has a section about social media: here

    - The relevant professional code of conduct:
      https://www.nmc.or.uk/standards/guidance/social-media-guidance
      https://www.bma.org.uk/advice/employment /ethics/ethics-a-to z
      https://www.hcpc-uk.org/assets/documents /10005190Guidanceonsocialmedia-draftforconsultation
      https://www.pharmacyregulation.org/sites/default/files/demonstarting professionalism online.pdf

- They should adhere to section 6.2.6 (number 27) on the disciplinary policy which states that any act within or outside of the workplace which brings the reputation of the Trust, a profession, colleagues, or patients/service users into disrepute could constitute gross misconduct. This includes the following conduct online on social networking sites:

    - Sharing confidential information
    - Post inappropriate comments/pictures
    - Using social media sites to bully or intimidate colleague
    - Use of social networking sites in a way that is unlawful

- As a rule you should never give medical advice via social media. Where possible you should redirect someone to an NHS information page you feel would be helpful, or where they could find some relevant advice.

When using twitter as a professional be sure to:

- Have a simple twitter handle without abbreviations in and to have a profile picture of yourself
- Do not tweet political or critical messages

- Keep messages interesting, chatty, informal, topical – not boring, tweets with images/very short video clips are always more engaging that plain text
- Start following key individuals and organisations (professional and personal interest) – search for them and similar ones will then come up
- Don't post too often (eg: 10+ times a day), but not too little (eg: only once a week)
- Retweet and like other peoples content. Also reply and respond to people to create more engagement
- Use hashtags to help searches, link in with trending topics, or to make a point
- Mention others, putting twitter handles within the tweet
- Post web links, which can be shortened using http://tinyurl.com/

3: Service department social media accounts

Twitter accounts should not be named after particular departments but should be kept as personal accounts under an individual's name.

This is because large numbers of department accounts will confuse the public about what accounts to follow to keep up with Trust news, and risk repeating and diluting the official messages from our organisation.

There is also a reputational risk if they do not regularly post items (ie: look out of date) and/or respond to comments, messages, issues or complaints in an appropriate manner.

Staff can jointly promote the work of their department through their personal social media accounts, without any of these risk factors.

Major news can be sent to us so we can either tweet or retweet from our main @StockportNHS account (and any other appropriate social media accounts that we run), which will receive a much larger audience.

4: Social media account for very specific service areas or groups

Some service areas are able to set up a social media account for very targeted groups. Please speak to the communications team in advance of setting up anything via 0161 419 4451.

The following actions must be taken beforehand.

A: Named lead person identified to manage the Facebook account from the work place.
This person will need to ensure they have time to run and update the account (approx. an hour per day).

They must also have a deputy for when they are not at work (eg: on annual leave).

They will need:

- A good level of skill and understanding in using social media and its impact within the public. This includes skill in using 'plain English' and understanding how to professionally handle difficult interactions or complaints. It is also essential they fully understand the information governance issues around social media (eg: patient consent, how to handle confidential information).
- Extensive knowledge in their service area, so they can give correct advice where necessary and ensure regular updates about relevant upcoming events, awareness days etc.
- They must not use their privilege of being able to access social media from the work place to use their personal accounts.

B: Style and corporate image

STYLE: All social media accounts must fit with the theme and style of Stockport NHS Foundation Trust's existing social media accounts. This means you should follow the corporate image guidelines and;

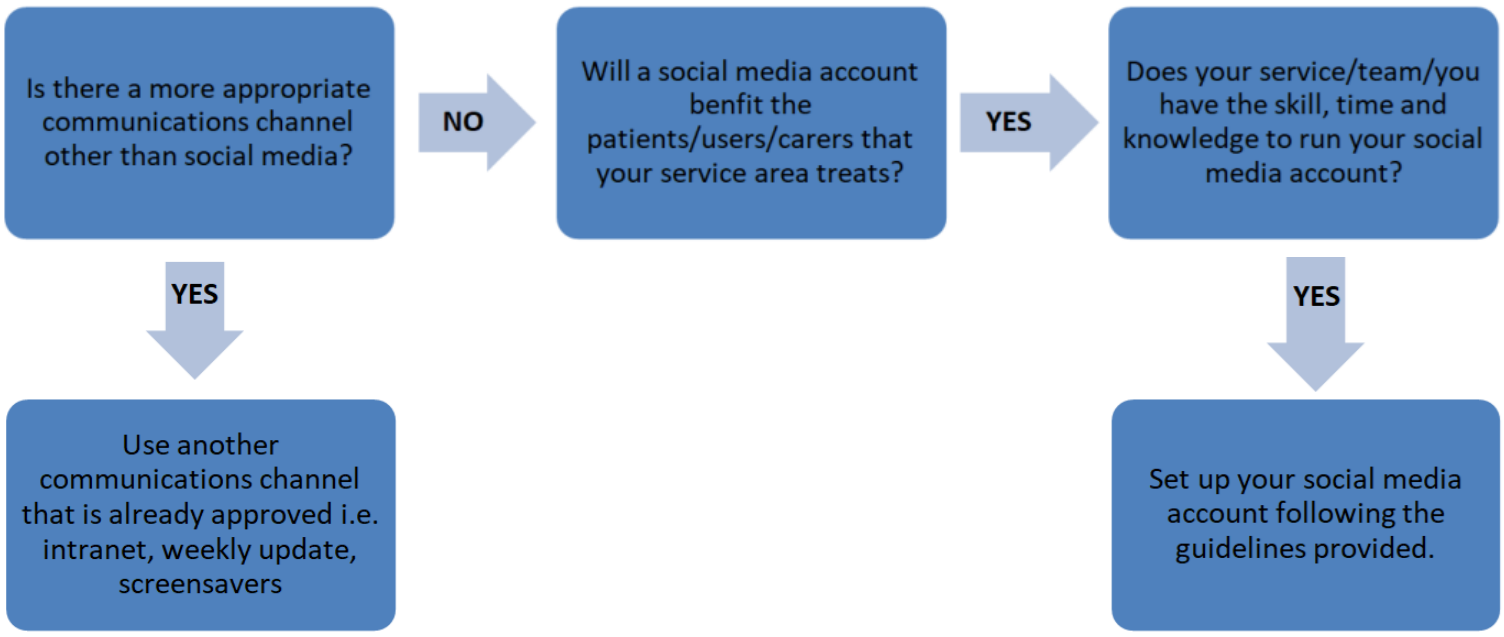
- Always use the official logo and name of the Trust,
- Make sure you show a very clear link to your own page and the relevant Stockport NHS Foundation Trust account
- Use clear appropriate images relevant to your service area. If you are using and image of a patient make sure you have a signed consent form that they are happy for you to use it.

DEALING WITH INAPPROPRAITE COMMENTS AND/OR COMPLAINTS:

- On your page you should always give people freedom of speech and opinion. Though we let people speak freely you should never tolerate a user who is posting offensive material on your page, using bad language, posting inappropriate content or being discriminative. You may remove their comments and block the user when you feel it is needed. The communications team can also advise.

- When dealing with complaints you should apologise if you see fit and then provide them with the telephone number and email details for our patient and customer service team so that the issue can be taken immediately off-line (0161 419 5678 / PCS@stockport.nhs.uk).

5. Process for teams who want to set up a social media account for very specific service areas or groups



Appendix 3 - New Starter & Annual Fit and Proper Person Self Attestation

Every board member is required to complete the self-attestation on appointment and annually. The completed attestation should be submitted to the Trust Secretary, on behalf of the Chair.

Fit and Proper Person Test new starter & annual self-attestation
Stockport NHS Foundation Trust

I declare that I am a fit and proper person to carry out my role. I:

- am of good character
- have the qualifications, competence, skills and experience which are necessary for me to carry out my duties
- where applicable, have not been erased, removed or struck-off a register of professionals maintained by a regulator of healthcare or social work professionals
- am capable by reason of health of properly performing tasks which are intrinsic to the position
- am not prohibited from holding office (e.g., directors disqualification order)
- within the last five years:
  - I have not been convicted of a criminal offence and sentenced to imprisonment of three months or more
  - been un-discharged bankrupt nor have been subject to bankruptcy restrictions, or have made arrangement/compositions with creditors and has not discharged
  - nor is on any 'barred' list.
- have not been responsible for, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity.

The legislation states: if you are required to hold a registration with a relevant professional body to carry out your role, you must hold such registration and must have the entitlement to use any professional titles associated with this registration. Where you no longer meet the requirement to hold the registration, and if you are a healthcare professional, social worker or other professional registered with a healthcare or social care regulator, you must inform the regulator in question.

Should my circumstances change, and I can no longer comply with the Fit and Proper Person Test (as described above), I acknowledge that it is my duty to inform the Chair.

Name	
Job Title	
Signature	
Date of Signature	
For Trust Secretary to complete	
Professional Registration (Ref No) (If applicable)	
Date of most recent DBS check	
Date of most recent appraisal	

For Chair to complete	
Signature of Chair to:	
Date:	

Appendix 4

Board Fit & Proper Person Checklist
Year:

The Board Fit & Proper Person Checklist will be completed on appointment and updated annually as part of the annual review of compliance (and as required). Where any issue arises from the checklist completion, the process for dealing with concerns will be followed.

Stockport NHS Foundation Trust		
First Name & Surname		
Job Title		
Date of Birth		
Start Date		
Job Description & Person Specification		
CV / Application Form		
Interview Details		
Contract		
	Complete No Concern / Concern	Date Completed
References x 2		
ID Checks		
Right to Work Check		
Qualifications / Professional Registration Check		
Occupational Health Clearance		
DBS (Type & Certificate Number)		
Signed Code of Conduct		

Below to be completed at appointment and annually		
	Complete No Concern / Concern	Date Completed
FPPR Self-Attestation		
Review against Web/Core Public Information Sources		
Professional Registration Check (if applicable)		

Undischarged Bankrupt or Sequestration Check		
Disqualified Director Check		
Charity Commissions Register of Removed Trustees Check		
Employment Tribunal Judgement Check		
Social Media Declaration & Check		
Declarations of Interest		
Review of below to be completed at appointment (via Board Member Reference) and annually		
	Complete No Concern / Concern	Date Completed
Disciplinary Findings		
Grievance		
Whistleblowing		
Disciplinary/grievance/whistleblowing findings upheld, ongoing or discontinued investigations.		
Appraisal Information		
	Complete No Concern / Concern	Date Completed
Satisfactory appraisal includes completion of Training & Development (Mandatory / Specific) demonstration of Trust values		
Appraiser (Name, Job Title)		

To be completed when Board Member leaves Trust		
	Confirmed No Concern / Concern	Date Completed
Board Member Reference		

For Chair to complete (or Senior Independent Director for the Chair)	
Signature of Chair / Senior Independent Director to confirm review:	
Date:	

Appendix 5 - Annual NHS Fit & Proper Person Test (FPPT) Submission Form

NAME OF ORGANISATION	NAME OF CHAIR	FIT AND PROPER PERSON TEST PERIOD / DATE OF CHAIR FINAL REVIEW:

Part 1: FPPT outcome for Board members including starters and leavers in period

Name	Date of appointment	Position	Confirmed as fit and proper?		Leavers only	
			Yes/No	Add 'Yes' only if issues have been identified and an action plan and timescale to complete it has been agreed	Date of leaving and reason	Board member reference completed and retained? Yes/No

Part 2: FPPT Reviews / Inspections

Reviewer / Inspector	Date	Outcome	Outline of key actions required	Date actions completed
CQC				
Other, e.g., internal audit, review board, etc.				

Part 3: Declarations

Declaration for Stockport NHS Foundation Trust [year]				
For the Senior Independent Director to complete:				
FPPT for the Chair	Completed by (role)	Name	Date	Fit and proper? Yes/No

For the Chair to complete:		
Have all board members been tested and concluded as being fit and proper?	Yes/No	If 'no', provide detail:
Are any issues arising from the FPPT being managed for any board member who is considered fit and proper?	Yes/No	If 'yes', provide detail:
As Chair of Stockport NHS Foundation Trust, I declare that the FPPT submission is complete, and the conclusion drawn is based on testing as detailed in the FPPT framework.		
Chair signature:		
Date signed:		
For the Regional Director to complete:		
Name:		
Signature:		
Date:		

Appendix 6 - Board Member Reference Form

Board Member Reference request: To be used only AFTER a conditional offer of appointment has been made. Information provided in this reference reflects the most up to date information available at the time the request was fulfilled.	
1. Name of the applicant	
2. National Insurance Number or Date of Birth	
3. Please confirm employment start and termination dates in Trust role each previous role *A: (If you are completing this reference for pre-employment request for someone currently employed outside the NHS, you may not have this information, please state if this is the case and provide relevant dates of all roles within your organisation)* *B: (As part of exit reference and all relevant information held in ESR under Employment History to be entered)*	
Job Title: From: To: Job Title From: To: Job Title: From: To: Job Title: From: To: Job Title: From: To:	
4. Please confirm the applicant's current/most recent job title and essential job functions (if possible, please attach the Job Description or Person Specification as Appendix A): *(This is for Executive Director board positions only, for a Non-Executive Director, please just confirm current job title)*	

5. Please confirm applicant remuneration in current role *(This question only applies to Executive Director board positions applied for)*	Starting:	Current:

6. Please confirm all Learning and Development undertaken during employment: *(This question only applies to Executive Director board positions applied for)*		
7. How many days absence (other than annual leave) has the applicant had over the last two years of their employment, and in how many episodes?	Days Absent:	Absence Episodes:
8. Confirmation of reason for leaving:		
9. Please provide details of when you last completed a check with the Disclosure and Barring Service (DBS) *(This question is for Executive Director appointments and Non-Executive Director appointments where they are already a current member of an NHS Board)*		
Date DBS check was last completed.	Date	
Please indicate the level of DBS check undertaken (basic/standard/enhanced without barred list/or enhanced with barred list)	Level	
If an enhanced with barred list check was undertaken, please indicate which barred list this applies to	Adults ☐ Children ☐ Both ☐	

10. Did the check return any information that required further investigation?	Yes □	No □
If yes, please provide a summary of any follow up actions that need to/are still being actioned:		
11. Please confirm if all annual appraisals have been undertaken and completed. *(This question is for Executive Director appointments and Non-Executive Director appointments where they are already a current member of an NHS Board)*	Yes □	No □
Please provide a summary of the outcome and actions to be undertaken for the last 3 appraisals:		
12. Is there any relevant information regarding any outstanding, upheld or discontinued complaint(s) or other matters tantamount to gross misconduct or serious misconduct or mismanagement including grievances or complaint(s) under any of the Trust's policies and procedures (for example under the Trust's Equal Opportunities Policy)? *(For applicants from outside the NHS please complete as far as possible considering the arrangements and policy within the applicant's current organisation and position)*	Yes □	No □
If yes, please provide a summary of the position and **(where relevant)** any findings and any remedial actions and resolution of those actions:		

13. Is there any outstanding, upheld or discontinued disciplinary action under the Trust's Disciplinary Procedures including the issue of a formal written warning, disciplinary suspension, or dismissal tantamount to gross or serious misconduct that can include but not be limited to: • **Criminal convictions for offences leading to a sentence of imprisonment or incompatible with service in the NHS** • **Dishonesty** • **Bullying** • **Discrimination, harassment, or victimisation** • **Sexual harassment** • **Suppression of speaking up** • **Accumulative misconduct** *(For applicants from outside the NHS please complete as far as possible considering the arrangements and policy within the applicant's current organisation and position)*	Yes □	No □
If yes, please provide a summary of the position and **(where relevant)** any findings and any remedial actions and resolution of those actions:		
14. Please provide any further information and concerns about the applicant's fitness and propriety, not previously covered, relevant to the Fit and Proper Person Test to fulfil the role as a director, be it executive or non-executive. Alternatively, state not applicable. *(Please visit links below for the CQC definition of good characteristics as a reference point) (7)(12)* **Regulation 5: Fit and proper persons: directors - Care Quality Commission (cqc.org.uk)** **The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (legislation.gov.uk)**		

15. The facts and dates referred to in the answers above have been provided in good faith and are correct and true to the best of our knowledge and belief.

Referee name (please print): …….. Signature: ……

Referee Position Held:

Email address: Telephone number:

Date:

Data Protection:

This form contains personal data as defined by the Data Protection Act 2018 and UK implementation of the General Data Protection Regulation. This data has been requested by the Human Resources/ Workforce Department for the purpose of recruitment and compliance with the Fit and Proper Person requirements applicable to healthcare bodies. It must not be used for any incompatible purposes. The Human Resources/Workforce Department must protect any information disclosed within this form and ensure that it is not passed to anyone who is not authorised to have this information.

Appendix 7 – Letter of Confirmation

[DATE]

The following wording will be updated as is applicable to the case and may consequently need addition or amendment. A confirmation at the time of initial appointment will be different to the annual core testing.

Dear [CHAIR NAME],

Fit and Proper Person Test

This confirmation letter is provided in connection with [name of board member, job title of board member, organisations that the joint board member post covers] for [year of test, e.g. 2023/24] as at [date of conclusion of annual FPPT for the individual] for the purpose of the Fit and Proper Person Test.

As Chair of [lead employer], I confirm that I have carried out the Fit and Proper Person Test for [name of board member].

The process and the evidence used by me in carrying out the Fit and Proper Person Test and in being able to reach a conclusion as to whether [name of board member] is fit and proper, is appropriate to reach that conclusion in the context of the Fit and Proper Person Framework. In accordance with the Fit and Proper Person Test Framework requirements and in reaching my conclusion that [name of board member] is fit and proper as at [date of conclusion of test], I have assumed that you know no reason that this is not an appropriate conclusion to reach.

Please would you sign and return this letter as confirmation of receipt and that there are no further matters which should be taken into consideration.

Yours sincerely,

…….. (signature)

…….. (chair of lead employer organisation)

Date……..

I confirm that I have received the outcome for the FPPT for [name of board member] and that I have provided any necessary information for you to reach this conclusion.

…….. (signature)

…….. (chair of lead employer organisation)

Date……..

Annual NHS Fit & Proper Person Test (FPPT) Submission Form

NAME OF ORGANISATION	NAME OF CHAIR	FIT AND PROPER PERSON TEST PERIOD / DATE OF CHAIR FINAL REVIEW:
Stockport NHS Foundation Trust	Dr Marisa Logan-Ward, Interim Chair	2023/24 / 23rd January 2024

Part 1: FPPT outcome for Board members including starters and leavers in period

Name	Date of appointment	Position	Confirmed as fit and proper?		Leavers only	
			Yes/No	Add 'Yes' only if issues have been identified and an action plan and timescale to complete it has been agreed	Date of leaving and reason	Board member reference completed and retained? Yes/No
Karen James	1 November 2021	Chief Executive	Yes			
Prof. Tony Warne	1 May 2021	Chair			31st December 2023. New position: Chair, Greater Manchester Mental Health NHS Foundation Trust	Yes
Dr Marisa Logan-Ward	1 August 2019	Interim Chair (Non-Executive Director / Deputy Chair)	Yes			

Amanda Bromley	1 November 2021	Director of People & Organisational Development	Yes			
Nic Firth	1 November 2020	Chief Nurse	Yes			
John Graham	20 May 2019	Chief Finance Officer / Deputy Chief Executive	Yes			
Dr Andrew Loughney	1 January 2021	Medical Director	Yes			
Jackie McShane	16 May 2021	Director of Operations	Yes			
Jonathan O'Brien	4 January 2022	Director of Strategy & Partnerships			30th September 2023. New position: Chief Operating Officer, Tameside & Glossop NHS Integrated Care NHS Foundation Trust	Yes
Caroline Parnell	1 November 2019	Director of Communications & Corporate Affairs	Yes			
Dr Samira Anane	1 September 2022	Non-Executive Director	Yes			
Anthony Bell	1 May 2021	Non-Executive Director	Yes			
Beatrice Fraenkel	4 January 2023	Non-Executive Director	Yes			
David Hopewell	1 July 2018	Non-Executive Director	Yes			
Mary Moore	1 October 2020	Non-Executive Director	Yes			
Dr Louise Sell	1 October 2020	Non-Executive Director / Senior Independent Director	Yes			
Mehboob Vadiya	6 February	Associate Non-Executive	Yes		31st December 2023.	Yes

	2022	Director			New full time position.	

Part 2: FPPT Reviews / Inspections

Reviewer / Inspector	Date	Outcome	Outline of key actions required	Date actions completed
Internal Audit: Well Led Position (Including Fit & Proper Persons)	Commenced January 2024	Awaiting Outcome		

NHS Stockport NHS Foundation Trust

Part 3: Declarations

Declaration for Stockport NHS Foundation Trust 2023/24				
For the Senior Independent Director to complete:				
FPPT for the Chair	Completed by (role)	Name	Date	Fit and proper? Yes/No
	Senior Independent Director	Dr Louise Sell		Yes

For the Chair to complete:		
Have all board members been tested and concluded as being fit and proper?	Yes/No	If 'no', provide detail:
	Yes	
Are any issues arising from the FPPT being managed for any board member who is considered fit and proper?	Yes/No	If 'yes', provide detail:
	N/A	
As Chair of Stockport NHS Foundation Trust, I declare that the FPPT submission is complete, and the conclusion drawn is based on testing as detailed in the FPPT framework.		
Chair signature:		
Date signed:		
For the Regional Director to complete:		
Name:		
Signature:		
Date:		

McCarthy Rebecca 30/01/2024 09:18:02

NHS Stockport NHS Foundation Trust

Meeting date	1st February 2024	**Public**	X	**Agenda No.**	18
Meeting	Board of Directors				
Report Title	Board Committee Assurance – Key Issues Reports				
Director Lead	Committee Chairs	**Author**	Soile Curtis, Deputy Company Secretary Rebecca McCarthy, Trust Secretary		

Paper For:	**Information**		**Assurance**	X	**Decision**	
Recommendation:	The Board of Directors is asked to: – Review the key issues and matters for escalation provided via the Board Committees					

This paper relates to the following Annual Corporate Objectives

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

This paper relates to the following CQC domains

	Safe		Effective
	Caring		Responsive
X	Well-Led		Use of Resources

This paper relates to the following Board Assurance Framework risks

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

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

Where issues are addressed in the paper

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

Executive Summary

The Board of Directors has established the following Committees:

- People Performance
- Finance & Performance
- Quality
- Audit Committee

The Committees have no executive powers, other than those specifically delegated within their Terms of Reference, but they can make recommendations to the Board of Directors for approval. The Committees are to report to the Board of Directors by means of a Key Issues Report summarising business conducted by the Committee together with key actions and/or risks.

A summary is provided for the Board of Directors of the key matters and decisions from the meetings of the Finance & Performance Committee, People Performance Committee, Quality Committee held during January 2024.

There has been no Audit Committee meeting since the last Board of Directors meeting.

NHS Stockport NHS Foundation Trust

KEY ISSUES REPORT	
Name of Committee/Group	People Performance Committee
Chair of Committee/Group	Mrs Beatrice Fraenkel, Noon-Executive Director
Date of Meeting	11 January 2024
Quorate	Yes

The People Performance Committee draws the following key issues and matters to the Board of Directors' attention:

Item	Key issues and matters to be escalated
Matters Arising	The Committee acknowledged the sad passing of Ms Caroline Durdle, Head of Strategic Workforce Development, noting that this was a huge loss to the HR team and the Trust. The Committee wished to convey its condolences to Caroline's family and the Director of People & OD advised that a memorial service would be held at the Trust on 31 January 2024.
People Integrated Performance Report	The Committee received the People Integrated Performance report, which provided an update on appraisals, time to hire, turnover, agency expenditure and attendance. The Committee confirmed performance in relation to attendance and mandatory training was within target, with all other metrics below target. It was noted, however, that performance had improved from last month for turnover and agency spend as a percentage of the total pay bill. The Committee acknowledged the adverse impact of the operational pressures and industrial action on the metrics.
Organisational Development Plan	The Committee received a report providing a 6-monthly progress update against the Organisational Development (OD) Plan 2023-25, against the following four priority areas aimed at improving organisational culture and performance: • Leadership and working relationships • Talent management • Innovation • OD Consultancy The Committee heard that Equality, Diversity & Inclusion (EDI) remained a golden thread throughout the OD work programme and a number of actions with in the plan were helping the Trust to achieve the ambitions set out in the EDI Strategy. The Committee noted good progress with the delivery of the action plan, but acknowledged the adverse impact of ongoing industrial action, increased operational demands and emerging priorities, which had delayed some planned events and activities and actions relating to talent management, succession planning and career progression. The Committee heard that a more robust evaluation approach was currently in development, which would measure the impact of OD intervention on participants' behaviour and achievement of team objectives.

Item	Key issues and matters to be escalated
Resourcing & Retention Programme	The Committee received a report providing an update on progress made with the Resourcing & Retention Programme in 2023/24, and the current programmes of work supporting the resourcing agenda aligned to Our People Plan with the aim of recruiting and retaining people and ensuring a sufficient workforce. The Committee confirmed that substantive staffing figures reported in November 2023 were in line with the Trust's operational planning assumptions for Month 8. Despite a challenging year, the Committee acknowledged good progress made against the action plan and noted that the objectives for 2024/25 would be further refined and updated following the completion of the operational planning round for 2024/25. The Committee reaffirmed the importance of patient safety, and the need to deliver safe services in the context of increased demand.
Wellbeing Guardian Report	The Committee received a verbal update from the Wellbeing Guardian (Non-Executive Director/Interim Chair). She highlighted the continued focus on health and wellbeing across the organisation and noted in particular the importance of the SPAWS service in supporting staff in this area. The Committee heard that further opportunities for health and wellbeing partnership working would be explored.
Freedom to Speak Up Report	The Committee received a Freedom to Speak Up Report providing an overview of the Freedom to Speak Up activities. The Committee noted the successful awareness campaign held during the Freedom to Speak Up Month, which had resulted in increased reporting and awareness, and the implementation of the Freedom to Speak Up Champions Programme. The Committee heard that there had been a significant rise in concerns raised during the reporting period, which was likely to be a consequence of the awareness campaign. The Freedom to Speak Up Guardian briefed the Committee on themes and trends observed, noting concerns around communication within the Community Services and the behaviour of some managers which was negatively impacting on staff's willingness to report issues. The Committee acknowledged the importance of psychological safety to help foster a safe speaking out culture.
Safe Care (Staffing) Report	The Committee received a report providing assurances and risks associated with safe staffing, alongside actions to mitigate the risks to patient safety and quality, based on patients' needs, acuity, dependency and risks. The Committee acknowledged the ongoing high levels of operational demand within the acute and community services, which was having an impact on patient and staff experience. It was noted that demands within the Emergency Department remained significant, impacted by large numbers of patients who no longer require a hospital bed, and that this demand and consequent adverse impact on patient flow was being operationally managed by senior teams and on-call colleagues with continual dynamic risk assessments conducted. The Committee also acknowledged the impact and associated challenges of the industrial action. The Committee agreed to increase the frequency of reporting of the Safe Care (Staffing) Report to the Committee from quarterly to bi-monthly, given the significant staffing challenges.

Item	Key issues and matters to be escalated
Annual Nursing & Midwifery Establishments	The Committee received the Annual Strategic Staffing Report which provided 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 Committee acknowledged that the underlying nurse staffing position had remained consistent with a reduction in nursing and midwifery vacancies and a levelling out in turnover. The Committee heard that systems were in progress to provide assurance that safer nursing and midwifery staffing across the organisation was a priority to maintain patient quality and safety, and that the Safer Nurse Care Tool (SNCT) enabled triangulation between patient acuity, the number of patients and the nursing staffing levels.
Board Assurance Framework and Aligned Significant Risks	The Committee received a report detailing the current position of the three principal risks assigned to the People Performance Committee. The Committee heard that a management review of the risks had taken place, and subsequently the consequence and likelihood had been scored, with current and target risk scores identified. In response to a question from the PPC Chair about how external financial pressures were articulated in the Board Assurance Framework, the Trust Secretary noted that currently the gaps in control included the impact of operational pressures, but agreed that this could be updated to read 'impact of external operational and financial pressures'. The Committee reviewed and approved the people related principal risks to be presented as part of the Board Assurance Framework 2023/24 to Board of Directors in February 2024.
Standing Committees	The Committee received and noted the following key issues reports: • Equality, Diversity & Inclusion Group • Educational Governance Group

NHS Stockport NHS Foundation Trust

KEY ISSUES REPORT	
Name of Committee/Group	Finance & Performance Committee
Chair of Committee/Group	Mr Anthony Bell, Non-Executive Director
Date of Meeting	18 January 2024
Quorate	Yes

The Finance & Performance Committee draws the following key issues and matters to the Board's attention:

Item	Key issues and matters to be escalated
Finance Report – Month 9 Position	The Committee heard that overall, the Trust position at Month 9 was adverse to plan by £1.0m, with a forecast year-end deficit of £31.1m, which was a favourable movement to the annual plan for 2023/24. The Committee noted an improvement of £0.3m in month, relating to inclusion of the Derby Integrated Care Board (ICB) contract income previously removed as a risk. It was noted that the key reasons for the variance to plan in month related to industrial action, pay award, open escalation wards, elective recovery fund (ERF) estimated penalty to Month 8 as calculated by GM, depreciation income risk, enhanced staffing levels to support the high level of ED attendances, and enhanced care for patients with dementia and other continuing healthcare needs. The Director of Finance advised that following the review of the year-end forecast as part of the GM wide PWC Financial Performance & Recovery work, the forecast had been improved and was now expected to deliver a surplus against the plan of £0.3m. It was noted that the Stockport Trust Efficiency Programme (STEP) plan for 2023/24 was £26.2m (£10.3m recurrent) and that the plan for Month 9 had been delivered (non-recurrently) and was in line with plan in month. The Committee noted a continued focus on recurrent delivery. The Director of Finance advised that ERF had been reported at Month 9 in line with national guidance, with an estimated under-performance of £0.9m. The Chief Finance Officer noted that the Trust had requested clarity around ERF, and that this would be considered in further detail at the next Finance & Performance Recovery Meeting. The Committee heard that the Trust had maintained sufficient cash to operate during December, but noted risks in this area and the assumption that the Trust would require revenue support in Quarter 4 2023/24. The Committee heard that the Capital Plan for 2023/24 was £62.7m, and that the internal programme had been reduced following discussions with GM and remained under review. It was noted that at Month 9 expenditure was behind plan by £6.4m. The Committee acknowledged the following key risks to delivery of the financial plan: • Derbyshire ICB contract issues • Industrial action • ERF • Capital • Depreciation funding

	• Outpatients B closure The Committee reaffirmed that quality and safety was paramount in the context of the GM turnaround work. The Committee concluded that it did not yet have full assurance regarding the financial outturn, given the associated risks and uncertainties in this area. The Committee had good assurance that the CIP target for 2023/24 would be achieved.
Cost of Sickness	The Committee received a presentation providing data from internal and external sources, including benchmarking to provide an indication of the cost of sickness, the unproductive salary costs and the cost of covering sickness. From a bank and agency perspective, the Director of Finance was pleased to report that the Trust had eliminated the use of off-framework agencies. The Committee welcomed the detailed breakdown of the cost of sickness, which would provide an opportunity for further focused work in divisions.
Elective Recovery Plan – National Tiering Status Q4 2023/24	The Committee received a report providing an update on the Trust's tiering status as part of the national elective recovery programme. The Committee heard that with effect from 17 January 2024, the Trust would be moving from Tier 2 to Tier 1, the highest level of support possible, in recognition of the residual number of 65 week waits without a plan by March 2024. The Director of Operations confirmed that this was reflective of the Trust's operational planning from the start of 2023/24, with the position exacerbated due to the lack of GM mutual aid. It was noted that the Trust would be receiving additional oversight from NHS England to support elective recovery and cancer programmes, and actions from the process would form part of future updates to the Finance & Performance Committee.
Operational Performance Report	The Committee received the Operational Performance Report, including performance against the strategic core operating standards, performance against the four key standards (A&E 4-hour standard, Cancer 62-day standard, 18-week Referral to Treatment (RTT) standard, and Diagnostic 6-week wait standard), and key Productivity, Efficiency & Transformation programmes. The Committee acknowledged the continued operational pressures and the action being taken to improve performance. The Committee heard that the Trust continued to perform below the national target against all of the core operating standards, however it was acknowledged that the Trust's performance compared favourably against GM peers for Emergency Department (ED) and Diagnostics performance. It was noted that the metrics had been adversely impacted by the BMA industrial action, resulting in significant elective cancellations. With regard to Urgent & Emergency Care, the Committee noted challenges in this area due to continued high attendance levels, higher acuity of patients and challenges to flow, and issues around no criteria to reside (NCTR), particularly for out of area patients. The Committee acknowledged the adverse impact of the reduced community bed base on patient flow and that it was unlikely that the Trust would achieve the ED performance trajectory by year-end. It was noted that recording of NCTR had improved following focused work by the Business Intelligence Team.

	The Committee requested further detail about theatre utilisation in next month's Operational Performance Report, including the outcome of a theatre utilisation deep dive and GM benchmarking information. The Committee reviewed and noted the Operational Performance Report and, as the December figures had not been finalised, it did not have full assurance about the delivery of the year-end targets.
GM Finance & Performance Recovery	It was noted that a written report would be presented to the February Committee meeting. The Committee received a brief verbal update on the contracting process, including a GM-wide exercise being undertaken about future funding flows.
GM Productivity Overview	The Committee received a report including a productivity pack that had been developed at GM Integrated Care Board (ICB) level to support performance and financial turnaround, providing a summary of key metrics and enabling a North West (NW) comparison for improvement purposes. It was noted that the productivity pack would be used to inform the Trust's CIP opportunities. The Committee heard that the Trust was performing favourably against its peers in a number of areas, including finance, but noted workforce issues as an area of concern. The Committee agreed to receive GM Productivity Overview updates on a quarterly basis, with the Committee Work Plan to be updated accordingly. The Board is asked to note that the Finance & Performance Committee has shared the productivity pack with the Chair of People Performance Committee for consideration, given the challenges around workforce and the Trust's ranking in this area. The Committee noted the contents of the report and the Trust's ranking against GM and NW peers. Whilst acknowledging potential volatility in month by month comparison, the Committee welcomed the opportunity provided to share better practice across the region and inform the Trust's CIP opportunities.
Costing Submission 2022/23	The Committee received a report providing an overview of the patient care costing submission to NHS England (NHSE), detailing the validation process undertaken and confirming compliance with costing standards. It was noted that the 2022/23 submission, which had been reviewed by the Chief Finance Officer and Director of Finance prior to submission, had been made on 15 December 2023 as per the national deadline. The Finance & Performance Committee approved the Costing Submission 2022/23 submitted to NHSE on 15 December 2023, as delegated by the Board of Directors, and confirmed it has been prepared and submitted in line with Approved Costing Guidance and NHSE submission and sign-off processes.
Treasury Management Policy McCarthy Rebecca 30/01/2024 09:18:02	The Committee reviewed the updated Treasury Management Policy to reflect the current financial regime in 2023/24 and current arrangements in place to manage the cash position. It was noted that the updated policy incorporated changes made to sections 3.6 and 3.32, as suggested by the Committee at its meeting in November 2023. The Committee approved the updated Treasury Management Policy.

Annual Procurement Programme and Progress Report	The Committee received and noted the Annual Procurement Programme and Progress Report. The Committee heard that overall, the Procurement team had managed to effectively conduct day to day procurement activities, including providing Materials Management services, undertaking tendering activity, monitoring supplier performance and leading on and supporting various GM procurement projects. Furthermore, the team was supporting the Trust to deliver the procurement projects on the 2023/24 capital programme.
Procurement Contracts for Approval	The Committee received a report detailing procurement processes in progress over £750K and recommended the award of the Clinical Waste tender to the Board of Directors for approval. The Committee also noted the status of the Trust's electricity contract, which was due to expire on 31 March 2024. The Committee noted potential inflationary risks in this area, and affirmed that further clarity was required about the use of frameworks.
Stepping Hill Site Development Delivery Plan – Progress Report	The Committee received a presentation outlining progress being made with development of the next phases of the Strategic Site Development Plan and the joint work with Stockport Metropolitan Borough Council (SMBC) in achieving a range of common objectives. The Committee received and noted the Stepping Hill Site Development Delivery Plan Progress Report.
Estates & Facilities Assurance Report	The Committee received and noted the Estates & Facilities Assurance Report. It was agreed that future iterations of the report should include a whole scope of estates & facilities compliance, including the areas the Trust was externally assessed against.
Board Assurance Framework (BAF) and Aligned Significant Risks	The Committee reviewed a report detailing the current position of the 11 principal risks assigned to the Finance & Performance Committee. It was noted that a management review of the risks had taken place, and subsequently the consequence and likelihood had been scored, with current and target risk scores identified. It was agreed that the likelihood score relating to the cash risk required further review from a wider system perspective. The Committee reviewed and approved the finance and performance related principal risks to be presented as part of the Board Assurance Framework 2023/24 to Board of Directors in February 2024.
Standing Committees	The Committee received and noted the following key issues reports: • Capital Programmes Management Group • Digital & Informatics Group • Estates Strategy Steering Group (including approval of Work Plan 2023/24)

NHS
Stockport
NHS Foundation Trust

KEY ISSUES REPORT	
Name of Committee/Group	Quality Committee
Chair of Committee/Group	Louise Sell, Non-Executive Director / Senior Independent Director
Date of Meeting	23rd January 2024
Quorate	Yes
The Quality Committee draws the following key issues and matters to the Board's attention:	

Item	Key issues and matters to be escalated
CQC Update	The Deputy Director of Quality Governance presented the report on CQC preparation and inspection to the end of December 2023. The Committee received positive assurance on the satisfactory resolution of enquiries received and an update on the work to progress the Emergency Department inspection action plan. The committee noted with concern that the outcome of the inspection of maternity services is still awaited.
Learning from Deaths Report (Oct 2023)	The Medical Director presented the Learning from Deaths Quarterly Report Q2 2023/24. The committee received positive assurance that the process undertaken and number of deaths reviewed are in line with the policy. The report detailed the numbers of patients receiving each of the 4 possible outcomes and the routes for the findings to inform existing operational, patient safety or clinical effectiveness groups. The themes identified this quarter centred around opportunities to improve care at the end of life and to avoid over-investigation. In addition, the impact of reduced flow through the hospital in being able to admit patients to speciality specific wards was noted, albeit with no harm identified.
StARS Progress Report – Q3 2023/24	The Deputy Chief Nurse presented the StARS quarterly report including confirmation of assessments completed and current assessment ratings at the end of Q3 2023-24 by division and area. The delivery of the accreditation programme continues to be impacted by the doctor's industrial action and sickness within the Quality Team. A plan is in place to achieve the trajectory by March 2024. The process continues to role out to Maternity, Theatres and Community services. The accumulation of green and blue ratings continues and overall the programme has achieved the targets set for 2023/24. Maternity now have no red ratings from the latest inspections. The committee received assurance that the rigour of inspections is tending to increase. Areas requiring most focus for improvement remain medicines management and infection control. Triangulation with a focus on care of the dying is noted with the inclusion of the Community Teams.
Quality & Safety Integrated	**Quality & Safety Integrated Performance Report (IPR)** Quality Committee reviewed the Integrated Performance Report, which included specific update on quality and safety metrics that were not achieving target,

Performance Report	alongside areas of sustained improvement and that were not covered elsewhere on the agendas. The continued attention to HSMR in addition to SHMI was noted, with improving positions. The Medical Director confirmed that the improvement work is underway with AQUA with initial data gathering in train in relation to sepsis, antibiotic administration. Cdiff and E coli continue to be above threshold, with the Trust part of a GM ICS collaborative to improve shared learning and ensure a joined-up system approach, particularly around antibiotics and community prescribing. The committee were assured that we continue to report incidents with a low proportion of incidents resulting in harm.
Maternity Services Report	Update received on key maternity improvement work streams including: Maternity Services • CNST Year 5 • Saving Babies Lives Care Bundle V3 • Midwifery Continuity of Carer pathway (MCOC) • Ockenden Reports (2020/2022) • East Kent Report (2022) • Three year delivery plan for maternity and neonatal services (2023) • Pregnancy Loss review (July 2023) • Perinatal quality surveillance dashboard highlight reports The focus of discussion was our CNST declaration of compliance. The required data has been submitted to the LMNS and the ICB, with no issues reported. The Quality Committee received assurance that we are compliant, either through having achieved each standard or by having a credible action plan to achieve it in line with the reporting guidance. The Quality Committee is therefore in a position to recommend that a Trust Board declaration is submitted before 12 noon on 1st February 2024. In addition, compliance or being on track for compliance with the mandated time-line assured was noted with all the work streams and all Maternity Services Reports were reviewed and are recommended to the Board of Directors in line with reporting requirements.
Board Assurance framework – Q3 2023/24 Review of principle Risks Assigned to Quality Committee	The Quality Committee discussed this paper at the beginning of the meeting and returned to it once all matters on the agenda had been considered in order to confirm position. Matters considered and the decision arrived at are set out in the accompanying Board paper on this matter.
Key Issues Reports	Regular key issues reports received, reviewed and confirmed/noted. Many of the exceptions from the subcommittees are explored in detail during the main agenda of the Quality Committee. **Clinical Effectiveness Group Key Issues Report**

	The Quality Committee received a report from the CEG from a suite of 3 meetings held in Q3, covering clinical audit activity, NICE compliance and general clinical effectiveness items. - GIRFT - Clinical Benchmarking - CQUIN - CAS - NatSSIPS - Maternity Dashboard - StARS - Corporate Quality Team - Divisional Updates - Record keeping - Policy on policies - Public Health - 7 day services - RD&I quality statement The committee noted the continued good progress in reviewing NICE guidance, noting the NICE policy, and commended the Clinical Audit Strategy. **Patient Safety Group Key Issues Report** - Serious Incident Related to Patient Safety - Annual Organ Donation Report - Maternity Services Report including CNST submission report - Deteriorating Patient Group Report - Safety and Improvement Strategy Group - Falls Report - IPR - Divisional Reports The Quality Committee received an update on the work to address and mitigate a backlog in Pathology. The committee enquired about the status of previous work on results governance and heard that this is now embedded in business as usual. The Committee noted the linkage between the Deteriorating Patient Group Agenda and the Learning from Deaths Agenda. The Committee received an update on early steps to pilot and introduce Martha's Rule. **Patient Experience Group Key Issues Report** - Patient Story - Walkabout Wednesday - Women and Children's - Community Divisional Update Consideration was given to standing this meeting down in response to operational pressures, resulting in the smaller number of reports considered. Work in ongoing to develop a new approach to reporting against the patient, family and carer experience strategy.