NHS
Stockport
NHS Foundation Trust

BOARD OF DIRECTORS

MEETING HELD IN PUBLIC

7 APRIL 2022

Making a difference every day.

NHS Stockport NHS Foundation Trust

Board of Directors Meeting
Thursday, 7 April 2022
Held at 9.30am at Pinewood House Education Centre

(This meeting is recorded on Webex)

AGENDA

Time			Enc	Presenting
0930	**1.**	Apologies for absence		
	2.	Declaration of Interests		**All**
0935	**3.**	Patient Experience Team – Presentation		**Patient Experience**
0950	**4.**	Minutes of Previous Meeting – held on 3 February 2022	✓	**L Sell**
	5.	Action Log	✓	**L Sell**
1000	**6.**	Chair's Report	✓	**L Sell**
1010	**7.**	Chief Executive's Report	✓	**K James**
	8.	**Performance**		
1020	8.1	Integrated Performance Report • Quality • Operational Performance • Workforce • Finance	✓	**K James / Executive Directors**
	9.	**Quality**		
1040	9.1	Learning from Deaths Report (Quarterly)	✓	**A Loughney**
1050	9.2	Safer Care Report (Quarterly)	✓	**N Firth**
	10.	**People**		
1100	10.1	Staff Survey Report	✓	**A Bromley**
1110	10.2	Freedom to Speak Up Report	✓	**C Parnell / P Elms**
1120	**COMFORT BREAK**			
	11.	**Strategy**		
1130	11.1	Equality, Diversity & Inclusion Strategy	✓	**A Bromley**
	12.	**Governance**		
1140	12.1	Board of Directors Standards of Business Conduct including: • Annual Fit & Proper Person • Declarations of Interests • Non-Executive Director Independence	✓	**R McCarthy**
1150	12.2	Annual Review of FT Code of Governance	✓	**R McCarthy**
1155	12.3	Appointment of Senior Independent Director	✓	**M Logan-Ward**
	13.	**Standing Committee Reports**		

1200	13.1	Board Committees – Key Issues & Assurance Reports: • Finance & Performance Committee • People Performance Committee • Quality Committee *(Including Maternity Services Report)* • Audit Committee	✓ *To follow*	**Committee Chairs**
1215	13.2	Board Committees Annual Review: Including Terms of Reference and Work Plans for approval	✓	**R McCarthy**
	14.	**Closing Matters**		
	14.1	Any Other Business		
	15.	**Date, Time & Venue of Next Meeting**		
	15.1	Wednesday, 1 June 2022, 9.30am, Pinewood House Education Centre		
	15.2	Resolution: *"To move the resolution that the representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to commercial interests, sensitivity and confidentiality of patients and staff, publicity of which would be premature and/or prejudicial to the public interest".*		
1220		**Close**		

STOCKPORT NHS FOUNDATION TRUST

Minutes of the meeting of the Board of Directors held in public on Thursday, 3 February 2022 9.30am in Lecture Theatres, Pinewood House, Stepping Hill Hospital

Present:

Prof T Warne	Chair
Mrs C Anderson	Non-Executive Director
Mrs C Barber-Brown	Non-Executive Director
Mr A Bell	Non-Executive Director
Ms A Bromley	Director of People & Organisational Development
Mrs N Firth	Chief Nurse
Mr J Graham	Director of Finance / Deputy Chief Executive
Mr D Hopewell	Non-Executive Director
Mrs K James OBE	Chief Executive
Dr M Logan-Ward	Non-Executive Director
Dr A Loughney	Medical Director
Mrs J McShane	Director of Operations
Mrs M Moore	Non-Executive Director
Ms J Newton	Associate Non-Executive Director *
Mr J O'Brien	Director of Strategy & Partnerships
Mrs C Parnell	Director of Communications & Corporate Affairs *
Dr L Sell	Non-Executive Director

** indicates a non-voting member*

In attendance:

Mrs S Curtis	Deputy Company Secretary
Mr P Featherstone	Director of Estates & Facilities
Mrs R McCarthy	Trust Secretary
Mr D Reason	Associate Director of Estates & Facilities

Observing:

Ms S Alting	Lead Governor
Dr L Wilson	ST4 Doctor / HEENW RCP Chief Registrar

01/22 Apologies for Absence

There were no apologies for absence.

The Chair welcomed Board members and observers to the meeting, and made specific reference to Ms S Alting, recently appointed Lead Governor, and Mr J O'Brien, Director of Strategy & Partnerships, who was attending his first Board meeting since his appointment as Director of Strategy & Partnerships.

02/22 Declaration of Interests

There were no declarations of interest.

03/22 Patient Story

The Chair reminded the Board that the purpose of patient story was to bring the patient's voice to the meeting, providing real and personal examples of relating to the Trust's quality and safety agendas.

The Chief Nurse introduced a patient story video, which detailed issues around the loss of patient property and subsequent improvements made to processes in this area.

The Chair welcomed the improvements made and thanked all colleagues involved.

The Board of Directors received and noted the patient story.

04/22 Minutes of the previous meeting

The minutes of the previous meeting of the Board of Directors held on 2 December 2021 were agreed as a true and accurate record of proceedings.

The Deputy Chair referred to minute 274/21, Draft Digital Strategy, and noted further detail regarding Artificial Intelligence (AI) had been requested within the strategy.

The Chief Executive confirmed the strategy included high-level detail regarding AI, noting action for the Director of Informatics to ensure further description/detail of how AI was currently utilised would be disseminated to Board members (ACTION).

05/22 Action Log

The action log was reviewed and annotated accordingly.

06/22 Chair's Report

The Chair presented a report reflecting on recent activities within the Trust and the wider health and care system.

He briefed the Board on the content of the report and noted that today was 'Time to Talk Day', which was an important national initiative focusing on mental health and wellbeing.

The Chair referred to the significant operational pressures and thanked Executive Team colleagues for their hard work and leadership during these difficult times.

The Board of Directors:

- Received and noted the report.

07/22 Chief Executive's Report

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

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

- NHS Operating Framework 2022/23
- Integrated Care Board Development
- CQC's Good rating for A&E
- Top marks for Urogynaecology Team

The Board of Directors formally thanked all colleagues and system partners for their contribution to the outcome of the CQC Inspection.

The Board of Directors:

- Received and noted the report.

08/22 Covid Briefing

The Chief Nurse briefed the Board on the latest Covid position in the hospital and the locality and highlighted the associated adverse impact on operational performance. She noted that nosocomial rates and Covid-related hospital admissions were now decreasing, with the highest positive Covid rates currently experienced amongst children and younger people.

The Board heard that the Trust had restricted visiting in line with Greater Manchester (GM), and that a unified approach with GM continued in this area.

In response to a comment from the Director of Finance about the difference in Covid guidance for healthcare settings and the rest of the public, the Chief Nurse noted that the guidance for healthcare settings had not changed, and there continued to be a requirement for social distancing and mask wearing.

The Board of Directors:

- Received and noted the verbal briefing.

09/22 Integrated Performance Report

The Chief Executive introduced the Integrated Performance Report (IPR), which included exception reports for areas of most significant note. She highlighted a national emphasis on recovery and noted ongoing work with GM partners to address the issue around green site access.

QUALITY

The Medical Director and Chief Nurse presented the quality section of the IPR and highlighted performance and mitigating actions around mortality metrics, sepsis recognition, falls and Clostridium Difficile.

The Chief Nurse noted that the Quality Committee had considered the quality metrics in detail and advised the Board of ongoing work with the IT department regarding the future presentation of the data.

OPERATIONAL

The Director of Operations presented the operational section of the IPR and highlighted the continued operational pressures and the consequent adverse impact of the Covid surge on the Emergency Department (ED) 4-hour target.

She noted the adverse impact of care home restrictions on the Trust's bed occupancy rates, and highlighted issues regarding staff sickness and availability, which were impacting the Trust's elective recovery. She commended the staff response during these challenging times to ensure patient safety.

The Director of Operations reported continued positive performance regarding ambulance turnover times and an improvement in 62-day cancer performance. She also welcomed the opportunities to access additional capacity for cancer and elective patients through the independent sector and advised that work continued with GM around long term recovery in this area.

The Chair noted that the decision to pause elective work had been taken collectively across the GM, and he also commended the ambulance turnaround times, which were a testament to the hard work of colleagues.

WORKFORCE

The Director of People & OD presented the workforce section of the IPR and highlighted performance and mitigating actions around sickness absence, appraisals, and agency costs.

In response to a question from a Non-Executive Director who queried how the Trust assessed the effectiveness of health and wellbeing initiatives, the Director of People & OD acknowledged that, although many initiatives were taking place, further work was required to measure their effectiveness. She advised that a recruitment process was underway for a Deputy Director of OD, and that this would be included within their portfolio.

The Chief Executive commented that the impact of the GM resilience hub had been evaluated, with positive feedback received, however agreed that further work was required internally to measure effectiveness and impact of schemes.

A Non-Executive Director acknowledged the upward trend in appraisals, particularly given the staffing challenges, and queried how the Trust measured the quality of appraisals. The Director of People & OD advised that a yearly audit on appraisals took place, which focused on the quality aspect of appraisals. She advised that the outcome of the audit was reported through the People Performance Committee and also informed the appraisal process. The Medical Director also advised that a quality impact assessment was undertaken for medical appraisals and briefed the Board on the process.

In response to a question from a Non-Executive Director about the use of temporary staff and processes in place to ensure quality of care was not compromised, the Chief Nurse briefed the Board on the robust processes implemented in this area, including the block booking of bank staff through NHS Professionals to support continuity. She also briefed the Board on the continued work around substantive recruitment to address workforce issues on a long term basis.

FINANCE

The Director of Finance presented the finance section of the IPR and advised that the Trust had achieved a break-even position at Month 9, after discounting £0.4m from the sale of assets, and was also forecasting to break even at year end.

The Director of Finance advised that the Trust had maintained a sufficient cash position and, while the capital expenditure was behind plan in month, the Trust continued to forecast the in-year delivery of the 'Plan B' capital plan.

The Director of Finance highlighted financial risks around the balancing of the financial position given the non-recurrent funding release, slippage on schemes due to staffing availability, recurrent Cost Improvement Programme (CIP) delivery and the emerging increased investment requirements for 2022/23.

In response to a question from a Non-Executive Director about future system funding arrangements, the Director of Finance advised that further clarity was awaited in this area and the Finance & Performance Committee and Board would be kept updated on developments.

The Board of Directors:

- Received and noted the Integrated Performance Report

10/22 Vaccination as a Condition of Deployment (VCOD) Update

The Director of People & OD presented a report updating the Board on the vaccination as a condition of deployment (VCOD) position. She advised that significant work had taken place across the Trust in response to the legislation requiring Covid-19 vaccination as a condition of deployment, which was due to come in from 1 April 2022,

however, as of 31 January 2022, the Secretary of State had announced that this was being reconsidered and the Trust had paused further individual discussions pending the parliamentary process.

The Director of People & OD briefed the Board on the work that continued to take place, including work with staff side colleagues.

The Medical Director and the Chair expressed their disappointment regarding the decision at such a late stage and the Chair thanked colleagues for all their hard work in this area.

The Board of Directors:

- Noted the report and the verbal update and agreed to be kept updated on progress.

11/22 Health and Wellbeing Pledge Update

The Director of People & OD presented an update report, following commitment by the Board of Directors in December 2021 to the Health and Wellbeing Pledge, which sought to shift focus from sickness absence to a person-centred approach to health and wellbeing. The Board heard that actions to support the pledge included the development of a wellbeing and attendance management policy framework that supported flexibility and considered a person centric approach.

The Director of People & OD highlighted collaborative work with Tameside and Glossop Integrated Care NHS Foundation Trust to share learning and peer support for the development of the delivery actions.

The Chief Executive highlighted the challenges in implementing a new and significantly different approach and the need to support teams in this area. The Director of People & OD supported these comments and the challenges in shift from a policy-centric approach.

The Chair commented that the Health and Wellbeing Pledge had originated in the North West and queried if there were any central resources or materials Trusts could use. The Director of People & OD advised that information was being shared between Greater Manchester (GM) HR Directors and would find continue to explore shared resources.

The Chief Nurse noted that the pledge aligned with the compassionate leadership approach and emphasised the importance of ensuring that staff side colleagues were fully aware of the Trust's plans around the revised approach to health and wellbeing.

A Non-Executive Director referred to people management and commented that it would be helpful to quantify how much time managers would require to implement the revised approach and establish if they had the necessary capacity to do so. The Director of People & OD acknowledged this comment, and referred to the Chief Nurse's earlier comment, expressing her view that the approach was largely a shift in 'how' people did things as opposed to the 'what' and noted that this would be part of the organisational development work to be taken forward. The Non-Executive Director commented that it would be beneficial to consider the areas that could be measured, potentially utilising of improvement methodology.

The Board of Directors:

- Received and noted the update report

The Director of Estates & Facilities and the Associate Director of Estates & Facilities joined the meeting

12/22 Green Plan

The Director of Estates & Facilities and the Associate Director of Estates & Facilities presented the Trust's Green Plan, which was a strategy for a sustainable future, setting out the Trust's aims and commitments to improve the environment for its communities and become a sustainable healthcare provider. The Board heard that the 2021/22 NHS Standard Contract required all trusts to have a Green Plan.

The Associate Director of Estates & Facilities delivered a supporting presentation, which included the following subject headings:

- Background
- Define Scope: Greenhouse Gases / Scope
- Calculate Emissions: Change 2013 – 2021
- Identify Roadmap: By Scope
- Governance
  - Establishment of a Green Plan Committee
  - Nominated Non-Executive and Executive Director leads
- What will the Green Plan deliver?

The Deputy Chair welcomed the Green Plan and referred to the overarching GM sustainability plan and queried how the Trust worked with One Stockport from a place-based context. The Director of Estates & Facilities noted that sustainability and move towards net zero was a key focus of the Stockport Strategic Estates group, noting partnership work in progress.

In response to a question from the Medical Director queried the associated cost benefits, the Associate Director of Estates & Facilities commented that while the Trust tracked its energy consumption, further work was required to comprehensively measure the associated cost benefits of the various elements of the Green Plan. The Director of Estates & Facilities noted that there was a significant opportunity around cost avoidance through energy activity. The Director of Finance acknowledged the clear cost avoidance benefits associated with the plan and noted that key metrics, including cost and benefits, would be identified as part of the process.

The Senior Independent Director highlighted the challenges around measuring the environmental impact on our population and their health, and that work was required to establish how this information could be captured. She noted that this would also drive stakeholder engagement.

In response to a suggestion from the Director of Communications & Corporate Affairs, the Associate Director of Estates & Facilities agreed to involve the Communications Team in socialising and engaging colleagues in the plan.

The Chief Executive welcomed the plan and the clear pathway it provided and highlighted the importance of colleague engagement in this area.

The Director of Strategy & Partnerships referred to the implementation of the plan and the need to integrate into service change, noting opportunity for environmental/sustainability impact within the business case template. The Director of Operations endorsed these comments, noting the importance of operational planning in this area.

The Chair welcomed the plan, noting that further work would be required to ensure the wider sustainability policies were also actioned going forward.

The Board of Directors:

- Received and noted the report
- Approved the Green Plan for submission to NHS England/Improvement

The Director of Estates & Facilities and the Associate Director of Estates & Facilities left the meeting

13/22 Board Assurance Framework 2021/22

The Chief Executive presented the Board Assurance Framework (BAF) 2021/22. She briefed the Board on the content of the report and noted that that all of the principal risks had been reviewed and confirmed by the relevant Board Committees, and the Committees had broadly acknowledged that actions had progressed to mitigate risks, albeit the operating environment remaining significantly challenging.

In response to a question from a Non-Executive Director about the anticipated dates for achieving the target scores, the Chief Executive noted that this was considered by the Risk Management Committee and agreed to include the target dates in future reports.

In response to a question from a Non-Executive Director about measuring the quality and effectiveness of the mitigation plans, the Chief Executive briefed the Board on how the Risk Management Committee reviewed the risks and associated mitigating plans and action taken if the target scores were not being achieved, acknowledging that further work was required to ensure this was appropriately evidence.

The Director of Finance and the Chair of the Audit Committee highlighted the role of the auditors in reviewing the BAF, which provided a further layer of assurance in this area.

The Chair commented that the BAF continued to be an iterative process, and should shape the agendas of the Board Committees, and welcomed the improvements made to the BAF.

The Board of Directors:

- Received and noted the report
- Confirmed the Board Assurance Framework 2021/22 as at January 2022

14/22 Board Committee Assurance

<u>People Performance Committee</u>

The Chair of People Performance Committee (Non-Executive Director) presented a key issues and assurance report from the People Performance Committee meeting held on 9 December 2021. She briefed the Board on the content of the report and highlighted the Committee's consideration of equality, diversity & inclusion; a statutory, mandatory and role specific training review; and the People Plan.

<u>Finance & Performance Committee</u>

The Chair of Finance & Performance Committee (Non-Executive Director) presented a key issues and assurance report from the Finance & Performance Committee meeting held on 16 December 2021. She briefed the Board on the content of the reports and highlighted discussions around a Cost Improvement Programme (CIP) workshop, approval of several business cases relating to equipment, the developing financial position, and operational performance and the importance of system work in this area.

A Non-Executive Director commented that in considering the business cases, the Committee had discussed risks around ageing estate and equipment and had requested for this issue to be further considered. The Chair of the Finance & Performance Committee paid tribute to the Finance Team, and the Director of Finance noted that it had been a joint effort with the Director of Operations, Medical Director and Chief Nurse who had led the work with divisions around the ageing equipment.

The Chief Executive highlighted the importance of having a five-year asset replacement strategy going forward and the Medical Director noted that the Digital Strategy included a tracking system which would help identify equipment that needed replacing.

Quality Committee

The Chair of Quality Committee (Non-Executive Director) presented a key issues and assurance report from the Quality Committee meeting held on 25 January 2022. She briefed the Board on the content of the report and highlighted the Committee's consideration of the following topics: 'Hello my name is' campaign; deteriorating patient group; insulin administration; ability to reduce paediatric ENT waiting list; notification of serious incidents; infection prevention and control; clinical audit; maternity improvement; results governance; and waiting list harms.

The Board of Directors:

- Received and noted the Committee Reports

15/22 Date, time and venue of next meeting

The next meeting of the Board of Directors held in public would be held on Thursday, 7 April 2022, commencing at 9.30am in the Lecture Theatres, Pinewood House.

16/22 Resolution

The Board resolved that:

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

Papers for Information

The Board received the following paper for information:

- Stockport Health & Well Being Board – Shadow Locality Board Report

Signed:_____Date:_____

BOARD OF DIRECTORS PUBLIC MEETING ACTION TRACKER

Meeting	Minute reference	Subject	Action	Bring Forward	RO
01/04/21	87/21	IPR - Quality	Mental Health Strategy for Stockport to be presented to the Board. **Update 7 Oct 2021** – It was noted that the Mental Health Strategy would not be ready for the November Board meeting, and Dr Loughney agreed to advise on timescales. **Update 2 Dec 2021** – To be presented to the Board meeting in April 2022. **Update 7 April 2022** – Discussion re Mental Health strategy/plan via Quality Committee. To be presented to Quality Committee, May 2022.	May 2022	A Loughney
07/10/21	232/21	Board Committee Assurance – Quality Committee	The Medical Director advised that a Research & Innovation Strategy was in the process of being prepared and would be presented to a future Board meeting. **Update 7 April 2021** – Development of Research Strategy in progress. To be presented June 2022.	July 2022	A Loughney
02/12/21	269/21	National Inpatient Survey Results 2020	The Chief Nurse agreed to invite representatives from the Patient Experience Team to present at a future Board meeting.	April 2022	N Firth
02/12/21	274/21	Draft Digital Strategy	A Non-Executive Director requested that digital skills/training be included in the Board development plan. **Update 3 Feb 2022** – Board Development Programme 2022/23 to be set by March 2022. **Update 7 April 2022** – Board Development Programme 2022/23 established. Digital included as topic for further	Closed	T Warne

Meeting	Minute reference	Subject	Action	Bring Forward	RO
			development.		
03/02/22	04/22	Minutes of Previous Meeting (Draft Digital Strategy)	The Deputy Chair noted that the Director of Informatics had been asked to include further detail about Artificial Intelligence (AI) in the Digital Strategy, which had not been included in the version circulated. The Chief Executive agreed to follow this up with the Director of Informatics to ensure that the AI detail was included in the final strategy. **Update for 7 April 2022** – Briefing note about AI circulated to Board members. Action complete.	Closed	K James / P Nuttall

On agenda
Not due
Overdue
Closed

Stockport NHS Foundation Trust

Meeting date	7th April 2022	x	Public		Confidential	Agenda item
Meeting	Board of Directors					
Title	Chair's Report					
Lead Director	Trust Chair		Author	Professor Tony Warne		

Recommendations made / Decisions requested

The Board of Director is asked to receive and note the content of the report.

This paper relates to the following Corporate Annual Objectives-

	1	Deliver safe accessible and personalised services for those we care for
	2	Support the health and wellbeing needs of our communities and staff
	3	Co-design and provide Integrated Service Models within our locality and across our acute providers
	4	Drive service improvement, through high quality research, innovation and transformation
	5	Develop a diverse, capable and motivated workforce to meet future service and user needs
	6	Utilise our resources in an efficient and effective manner
	7	Develop our Estate and IM&T infrastructure to meet service and user needs

The paper relates to the following CQC domains-

	Safe		Effective
	Caring		Responsive
x	Well-Led		Use of Resources

This paper is related to these BAF risks		**PR1.1**	There is a risk that the Trust delivers sub-optimal quality services and fails to meet regulatory standards
		PR1.2	There is a risk that the Trust fails to reduce harm against agreed baseline
		PR1.3	There is a risk that patient flow plans are not effective leading to decline in A&E performance
		PR1.4	There is a risk that inclusive restoration plans to address elective backlog are not delivered
		PR2.1	There is a risk that the Trust fails to support and engage its workforce

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

Where issues are addressed in the paper-

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

Executive Summary

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

1. PURPOSE OF THE REPORT

The purpose of this report is to advise the Board of Directors of the Chair's reflections on his recent activities. I apologise for not being at today's meeting. I'm on a long-postponed honeymoon, the arrangements for which were made a long time before I took up the role of Chair.

2. EXTERNAL PARTNERSHIPS

Since we last met as a Board in public, the world familiar to us has changed in an unbelievable and unprecedented way. As I write this report the invasion and war in Ukraine has been ongoing for over a month. Our Board, at its recent Board Development Day, acknowledged our solidarity with the people of Ukraine and all those impacted by this dreadful conflict. My understanding is that we have five Ukrainian colleagues working in our Trust, and no Russians. Individually, and I'm sure collectively, we keep all those caught up in this war in our thoughts and prayers.

Our Trust, along with our partners, Stockport Metropolitan Borough Council and Stockport Clinical Commissioning Group, have well-established, effective and collaborative ways of working to ensure that refugees and/or asylum seekers coming to the area have their health and social care needs appropriately met. I remain confident that should the need arise, we will continue to work together in meeting the needs of any Ukrainian displaced persons coming to Stockport.

I have continued to promote the work of our Trust with our partners in both health and social care. I participated in a national meeting facilitated by NHS Providers, at which, Amanda Pritchard, Chief Executive of the NHS England led a conversation around tackling racism in health care organisations, and the need to become anti-racist. It was a challenging conversation. I'm pleased to see on today's agenda, discussion of our own Equality, Diversity and Inclusion Strategy. It provides the Board with a clear way forward to further developing and improving our organisational approach to tackling racism as well as all forms of discrimination.

I attend the March Stockport Health and Wellbeing Board. It was an opportunity to acknowledge and say thank you to Andrea Green (Chair of Stockport CCG) Cath Munro (GP and Clinical Chair Stockport CCG) and Councillor Jude Wells (SMBC) for their contributions to the Board and to the developments of health and care services in Stockport. All three colleagues will be leaving their roles in the near future, and the March meeting was their last. On behalf of the Board, I would like to add our thanks for all they have done in ensuring we have a strong partnership in place, something upon which we can continue to build on and grow in the future.

One of the agenda items at the March meeting was a discussion on the emergent Stockport Mental Health and Wellbeing Strategy. Although as a Trust we do not

provide direct mental health care, we will continue ensure the mental health and wellbeing of our patients is promoted and protected as they use our wider services.

I attended two NHS England North West Regional, meetings. At the second meeting Sir David Sloman (Chief Operating Officer) spoke about the continuing need to protect our ambulance services and their ability to respond to the most serious Category 1 and 2 emergency 999 calls. Whilst the North West were, as a region, performing better than the rest of England, we are still not meeting the national targets for attendance times, and ambulance turnaround times. Continued and growing demands for emergency and urgent care coupled with rising numbers of patients medically fit, but not able to leave hospital because an appropriate place for on going care is not available, add to these difficulties. You will see for this months Integrated Performance Report, that despite extraordinary demands at our emergency department, over time, we are consistently having some of the best ambulance turnaround times in Greater Manchester.

I was able to spend a very informative and interesting afternoon with colleagues at Tameside & Glossop Integrated NHS Trust. I was able to meet with their Digital Health Team and also meet colleagues who had designed, built and were operating their digital patient information system. Both these were very powerful examples of how health care services can be transformed through the innovative use of new technology and in particular data analysis and management. These approaches are very much at the heart of our recently approved Digital Strategy.

I continue to actively use social media to promote and support the work of our Trust, and regularly feature my experiences as Chair of Stockport FT in my weekly blog. Last month I was able to participate in four Chair and NED webinars hosted by the Good Governance Institute – these looked at: Compassionate Leadership; Achieving Population Health; Patient Safety; and Clinical Presence/Clinical Voice.

I attended the *Stronger Things 2020* conference. Run by New Local, an independent thinktank and network with a mission to transform public services. It provides a home to over 70 councils, health care organisations and other independent community-based organisations with the aim of developing sustainable, inclusive and community powered public services. It was a very inspirational conference, and I have a great deal to share as we continue to develop our approach to locality placed based services, and engagement with our communities.

3. TRUST ACTIVITIES

I have continued to meet with our Council of Governors both formally and informally. The Council of Governors were able to conduct a great deal of business last month, including approving the areas of skills and experience we will be seeking in individuals as we appoint new NEDs in the forthcoming months. Council of

Governors colleagues participated in a lively engagement event that was part of our review of our research strategy. The strategy that will come to Board in due course.

Covid restrictions have continued to make it difficult to visit clinical areas as often as I would like. However, I was able to spend some time this month with colleagues working in the Stroke Services. We were able to have a wide-ranging discussion that looked at both the achievements and ambitions of the service as well as the wider vision for the Trust.

Since we last met, I have chaired three appointment panels for new Consultants. We have been able to appoint two new Gastroenterology Consultants, one Radiology Consultant and one Urology Consultant. Each of these panels attracted high calibre candidates, all of whom were active researchers and keen to work collaboratively with colleagues in strengthening services across the South East Sector.

4. STRENGTHENING BOARD OVERSIGHT

Our Board development journey continues. Last month we participated in two externally facilitated sessions. The first helped us explore our role as an anchor organisation in contributing to the wider Greater Manchester Integrated Care System, and in particular, how we might engage in place-based approaches to health and care services. There was a clear opportunity to build back fairer with SMBC colleagues and organisations and groups in the voluntary sector.

The second session was very much a direct part of our well led improvement journey. The focus was on exploring how we might best build into our everyday activities, kindness and civility as we continue to work towards developing an organisational culture that is characterised by compassion, trust and kindness.

Work has been completed on reviewing the terms of reference for each of the Board assurance committees, the outcomes of which will be noted at this Board meeting. The review also allowed me to pause and reflect on two other aspects of our well led improvement journey. It is almost a year since I joined our Trust. At that time, we did not have a Board Assurance Framework or an Integrated Performance Report that were fit for purpose. As you will see from the papers at today’s Board, we now have both, and both are now of a high standard in terms of providing Board oversight and assurance. So, I will end this report by saying a huge thank you to all my Board colleagues who have made this achievement possible in such a timely way.

5. RECOMMENDATIONS

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

Stockport NHS Foundation Trust

Meeting date	7 April 2022	x	Public		Confidential	Agenda item
Meeting	Board of Directors					
Title	Chief Executive's Report					
Lead Director	Chief Executive		Author	Director Communications & Corporate Affairs		

Recommendations made/ Decisions requested

The Board is asked to receive and note the content of the report.

This paper relates to the following Corporate Annual Objectives-

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

The paper relates to the following CQC domains-

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

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

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

Where issues are addressed in the paper-

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

Executive Summary

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

- ICB Chief Executive appointed
- Urgent and emergency care campus
- Stockport Improvement Board to stand down
- Maternity incentive scheme
- Top JAG rating
- Our commitment to no smoking
- Public Sector Catering Awards
- Army support
- 1000th robotic prostrate surgery
- National CNS Day
- Apprentice of the Year

1. PURPOSE OF THE REPORT

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

2. REGIONAL NEWS

2.1 ICB Chief Executive appointed

Mark Fisher CBE has been appointed as Chief Executive Designate of NHS Greater Manchester Integrated Care Board when it comes into being on 1 July 22.

He will take over from Sarah Price, who is currently Interim Chief Officer, and work alongside Sir Richard Leese, who was recently appointed as the Chair of the ICB.

Mark has held a number of director and chief executive level roles across the public sector, including the Department of Work and Pensions and the Cabinet Office. He will take up the new role in GM after service as director general and secretary to the Grenfell Tower inquiry.

The ICB will be responsible for implementing the overall NHS strategy in Greater Manchester (GM), fulfilling all the NHS statutory functions as set out in the 2021 Health and Care Bill including:

- setting strategy to achieve national priorities and GM priorities,
- allocation of NHS resources to support this strategy,
- overseeing the commissioning of primary and specialised care,
- ensuring the component programmes and organisations fulfil their collective and individual responsibilities for delivering their contribution to the GM aims as agreed in the planning process,
- assigning resources,
- securing assurance and ensuring - with our partners – that the right activities are focused on securing the best outcomes for our communities.

3. TRUST NEWS

3.1 Urgent and emergency care campus

Work on developing our new urgent and emergency care campus at Stepping Hill Hospital has taken a step forward as NHS England/NHS Improvement (NHSE/I) has confirmed we can now move on with the development of a full business case.

The confirmation was given at a recent meeting of NHSE/I's Joint Investment Sub-Committee, which reviewed the Trust's' outline business case for the scheme that is to receive £30.6m of national funding.

A huge amount of work has gone into developing the outline business and will continue with the creation of the full business case. Site preparation work for the campus is due to start in August 2022, with the development expected to be complete by March 2024.

3.2 Stockport Improvement Board to stand down

Following the Care Quality Commission's last full inspection of the Trust in early 2020, which resulted in a rating of "requires improvement", NHS England/NHS Improvement (NHSE/I) convened an improvement board.

The board is includes Trust executive directors as well as colleagues from commissioners, the local authority, ambulance and mental health services. Over the last two years they have worked together to address a range of issues highlighted by the inspection, and to monitor progress in delivering an improvement plan for health services in Stockport.

At the most recent meeting of Stockport Improvement Board NHSE/I agreed that so much improvement has been made by local partners that future meetings can been stood down. This is positive news for everyone in Stockport who has worked so hard over the last year to make so many positive changes to a wide range of services.

3.3 Maternity incentive scheme

NHS Resolution has confirmed that the Trust has complied with all ten safety actions for year three of the national maternity incentive scheme, which was set up to support delivery of safety maternity care.

This is a testament to the hard work of our maternity colleagues in ensuring they meet the national safety standards and provide the best possible care to local families.

3.4 Top JAG rating for

Our endoscopy decontamination team was recently given Green status - the top possible rating – in the national Joint Advisory Group on GI Endoscopy (JAG) decontamination audit.

The independent JAG auditor, who carried out the inspection, described our service as one of the best they had seen in the country and they commended all team members for their achievement.

Our hospital sterilisation and disinfection unit and endoscopy decontamination service are responsible for making sure all flexible endoscopes are high level disinfected and safe for patient use. They also provide all the flexible endoscopes required for the thousands of procedures which take place at the hospital each year.

3.5 Our commitment to No Smoking

We are clear about our commitment to being a smoke free hospital site and supporting both patients and staff to quit smoking to improve their health.

To mark No Smoking Day on 9 March our CURE team demonstrated that stopping smoking can also have huge financial benefits. The team calculated that since they were formed in September 2020 they have helped patients to save on average £1,560 each, adding up to almost £500,000.

The CURE team is part of a GM project providing comprehensive secondary care treatment for smokers admitted to hospital. The team is committed to ensuring that every smoker admitted to the hospital is offered specialist support to quit while they are in hospital, and to stay smoke free after discharge too.

3.6 Public Sector Catering Awards

Our exemplar catering team have been shortlisted in four separate categories of the Public Sector Catering Awards being presented today (7 April).

The awards, which will be presented in a ceremony in London, celebrate the best in public sector catering. Duncan O'Neil is up for the title of Catering Manager of the Year and Nick Roberts, head chef, has been shortlisted in the Hospital Catering category, while the whole team has been chosen for both the Hospital Catering and Team of the Year categories.

Last year the team was named as one of just 14 exemplar services nationally for demonstrating high standards of NHS catering, and since then they have been sharing their approach with other catering teams across the country.

3.7 Army support

We recently had the opportunity to thank soldiers from the Scots Guards for the support they provided to services across Stepping Hill Hospital over the winter months.

Army and Navy personal had been stationed in hospitals across GM since early January 2022, and 11 guardsmen have worked with us to provide valuable support with portering, transporting goods and equipment, and helping on ward.

During a fairly short space of time with us they became valued colleagues and a real part of the Stockport team and we hold a ceremony to publicly thank them for their efforts.

3.8 1000th robotic prostrate surgery

Our surgical team have celebrated a landmark as they performed their 1000th successful operation for prostate cancer patients using a hi-tech surgical robot.

The operation was carried out using the Da Vinci X fourth generation surgical robot, which can be used to treat prostate, bladder and kidney cancer patients. The dexterity of the robot means surgeons can operate with more precision, and with less trauma to the body than with normal surgery; reducing anaesthesia, blood loss, pain and discomfort.

As a result recovery times are swifter too. Prostate cancer patients can usually leave hospital within 24 hours, while bladder cancer patients can leave hospital an average of five days sooner than with previous surgery. The robot was first used in 2015, when at the time it was the first robot of its type in GM

3.9 National Cancer Clinical Nurse Specialist Day

Rebecca Costello, one of our clinical nurse specialists (CNS), featured in a specially created video to mark National Cancer CNS Day last month.

She is one of more than 20 CNS working at Stepping Hill Hospital and in community services to provide care, treatment and support for people with cancer. The national day was launched to encourage more nurses to consider a career in cancer care and in the video Rebecca talked about why she loves her role so much.

3.10 Apprentice of the Year

Jordan Booth, a trainee nursing associate (TNA) working on a gastroenterology ward at Stepping Hill Hospital, has been named as Apprentice of the Year by the University of Salford's School of Health and Society.

He began his two year placement as a TNA at the hospital in March 2021 and Jordan works alongside his nursing colleagues on the ward developing his skills and knowledge while helping the team provide care for patients with gastro conditions.

He was nominated by a number of colleagues who praised his hard work, positive attitude, and caring professionalism. They said Jordan's willingness to go above and beyond while supporting those working alongside him marked him out as a truly outstanding apprentice who is destined for an excellent career in nursing.

4. RECOMMENDATION

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

Stockport NHS Foundation Trust

Meeting date	7th April 2022	✓	Public		Confidential	Agenda item
Meeting	Board of Directors					
Title	Integrated Performance Report					
Lead Director	Chief Executive		Author	Head of Performance		

Recommendations made / Decisions requested

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

This paper relates to the following Corporate Annual Objectives-

X	1	Deliver safe accessible and personalised services for those we care for
	2	Support the health and wellbeing needs of our communities and staff
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The paper relates to the following CQC domains-

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

This paper is related to these BAF risks	X	**PR1.1**	There is a risk that the Trust delivers sub-optimal quality services and fails to meet regulatory standards
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	X	**PR3.1**	There is a risk that effective partnership and accountability arrangements are not in place at ICS and locality provider level
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Where issues are addressed in the paper-

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

Executive Summary

The Integrated Performance Report is presented to provide Board oversight of:

- Performance against the identified key metrics
- Issues that are affecting performance
- Actions described to mitigate and improve performance in the exception reports

Integrated Performance Report

NHS Stockport NHS Foundation Trust

Integrated Performance Report

Reporting Period February 2022

Quality | Operations | Workforce | Finance

Integrated Performance Report

NHS Stockport NHS Foundation Trust

Trust Highlight Report

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

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

It should be noted that despite the continuing pressures within urgent care, Stockport is top of the GM performance table for A&E type 1 attends.

Quality Highlights
Exception reports included this month relate to performance against **Sepsis, Mortality, Hospital Onset Covid, C.Difficile, Maternity Continuity of Carer and Written Complaints rate** metrics due to under-achievement in month.

Improvements to note relating to Quality include the Medication Incident rate, which has remained below the local benchmark now for three consecutive months, and the significant reduction in the Falls rate (Moderate Harm and above) in month.

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

-

Financial Highlights
The Trust has a break-even position at Month 11, after discounting the £0.4m from the sale of assets and consolidating the pharmacy shop into the group position. This remains in line with planning assumptions for month 11

The Trust is forecasting a break-even position for year end.

As described earlier there will be variances in categories within the overall plan, however it is only the bottom line that the Trust is being managed against.

The balancing of the financial position & CIP, including the additional £3.3m, has been achieved through non-recurrent funding release and slippage on schemes due to unavailability of staffing – including planned Winter schemes

The Divisions have achieved their allocated CIP to month 11 and are forecast to achieve for 21/22 but predominantly on a non-recurrent basis.

Winter costs incurred in month 11 include the costs of the additional nursing incentive payment which has had good take up and was extended. However, costs remain lower than the original plan.

Additional income has been received in month, but plans are in place to manage the year-end financial position across the Stockport system.

The Trust has maintained sufficient cash to operate during February.

Capital spend is £13.5m at the end of Month 11 which is £4.4m behind the profiled plan. The full plan for the year being worked to is £27m. The Trust continues to forecast that the Plan will be delivered in year.

Risks
There is a risk of additional funding being allocated to the Trust alongside slippage on revenue schemes, which could lead to an under-spend at year end. All options are being explored to ensure the best position for Stockport as a system.

The larger risk is the size of the CIP challenge and the emerging increased investment requirements for 2022/23, as highlighted in the update on 22/23 planning where the CIP requirement is 5%.

Depending on the agreement for the financial plan for 22/23, for example if the Trust were to report a deficit, then the cash-flow position will need to be agreed across GM. The majority of contract values and their associated cash have been agreed but the clarification is on system top up funding.

Integrated Performance Report

NHS Stockport NHS Foundation Trust

Summary Dashboard

Performance

Blue indicates that the measure has met the target.

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

Target assurance

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

Blue indicates that variation is consistently passing the target

Orange indicates that variation is consistently falling short of the target

Forecast position

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

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

Quality Metrics	Performance		Target assurance		Forecast
VTE Risk Assessment	Dec-21	98.3%	>= 95%		
Sepsis: Timely recognition	Feb-22	98.3%	>= 95%		
Sepsis: Antibiotic administration (12mth)	Feb-22	81.4%	>= 95%		
Medication Incidents: Rate	Feb-22	3.62	<= 4		
Mortality: HSMR	Nov-21	1.07	<= 1		
Mortality: SHMI	Aug-21	1.01	<= 1		
Never Event: Incidence	Feb-22	0	<= 0		
Serious Incidents: STEIS Reportable	Feb-22	3	<= 7		
Stroke: Overall SSNAP Level	Dec-21	A	>= C		
Hospital Onset Covid (HOC) Rate	Feb-22	41.4%	<= 30.38%		
C.Diff Infection Count	Jan-22	48	<= 33		
MRSA Infection Count	Jan-22	1	<= 0		
Falls: Rate of Moderate Harm and Above	Feb-22	0.06	<= 0.12		
Pressure Ulcers: Hospital, Category 2	Jan-22	75	<= 78		
Pressure Ulcers: Hospital, Category 3 and 4	Jan-22	8	<= 12		
Maternity: Continuity of Care, Booked	Feb-22	50%	>= 53.33%		
Maternity: Continuity of Care, Ethnic Minority	Feb-22	58.8%	>= 62.5%		
Maternity: Continuity of Care, Deprivation	Feb-22	63.6%	>= 62.5%		
Maternity: Continuity of Care, Receipt	Jan-22	3.6%	>= 51.67%		
Friends & Family Test: Response Rate	Jan-22	20.4%	>= 18.7%		
Friends & Family Test: Positive Responses	Jan-22	92.2%	>= 91.6%		
Written Complaints Rate	Feb-22	8.11	<= 5.2		
Complaints: Timely response	Feb-22	91.2%	>= 95%		

Operational Metrics	Latest Performance		Target	Forecast
A&E: 4hr Standard	Feb-22	64%	>= 95%	
A&E: 12hr Trolley Wait	Feb-22	9	<= 0	
Diagnostics: 6 Week Standard	Feb-22	25.2%	<= 1%	
Cancer: 62 Day Standard	Feb-22	70.8%	>= 85%	
Cancer: 104 Day Breaches	Jan-22	6	<= 0	
Referral to Treatment: Incomplete Pathways	Feb-22	52%	>= 92%	
Referral to Treatment: 52 Week Breaches	Feb-22	3707	<= 0	
No Criteria To Reside (NCTR)	Feb-22	117	>= 92%	
Outpatient DNA rate	Feb-22	7.5%	<= 5.5%	
Theatres: Capped Utilisation	Feb-22	65.9%	>= 90%	
Outpatient Clinic Utilisation	Feb-22	82.5%	>= 90%	
Total Elective Activity vs. Plan (IP & DC)	Feb-22	-13%	>= 0%	
Total Elective Activity Restoration (IP & DC)	Feb-22	76.7%	>= 95%	

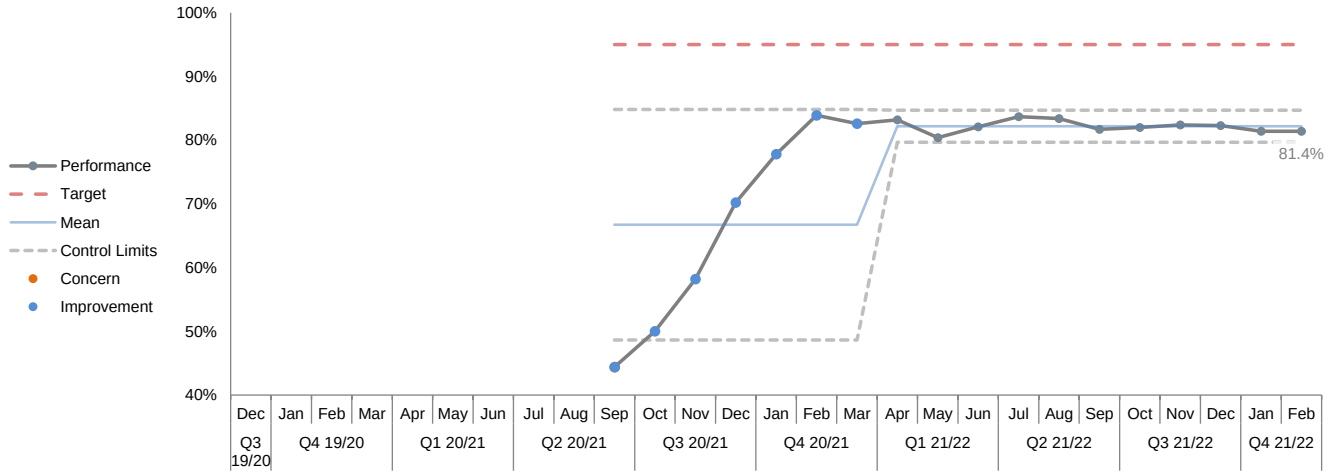
Workforce Metrics	Latest Performance		Target	Forecast
Substantive Staff-in-Post	Feb-22	93%	>= 90%	
Sickness Absence: Monthly Rate	Feb-22	5.8%	<= 4%	
Workforce Turnover	Feb-22	14.6%	<= 11%	
Appraisal Rate: Overall	Feb-22	92.3%	>= 95%	
Statutory & Mandatory Training	Feb-22	88.8%	>= 95%	
Bank & Agency Costs	Feb-22	16.2%	<= 5%	

Finance Metrics	Latest Performance		Target	Forecast
Financial Controls: I&E Position	Feb-22	0%	<= 0%	
Cash Balance	Feb-22	62.2		
CIP Cumulative Achievement	Feb-22	1.4%	>= 0%	
Capital Expenditure	Feb-22	43.7%	<= 10%	

Quality Operations Workforce Finance

Integrated Performance Report

NHS Stockport NHS Foundation Trust

Measure	**Sepsis: Antibiotic administration (12mth)** The number of patients who received IV antibiotics within agreed standards for sepsis patients, as a percentage of those eligible patients audited and found to have sepsis. Performance is based on a rolling 12-month. Data for the current month is based on part-validated data, and a fully validated position is updated one month in arrears.
Performance of this measure over time	
What the chart tells us	Since the recording of performance began in Sep20, there has been a steady improvement in performance. Apr21 sees performance stabilise, with a new average of 82%. There have been significant changes in performance since that time.
Narrative	**Issues:** The rolling 12 month average compliance with timely antibiotic administration is 81.4%. In month there were 2 eligible patients, both of which had treatment within the defined timescales. **Actions & Mitigations:** Sepsis performance is reviewed as part of the StARS accreditation and contributes to the overall outcome of the assessment.

Latest Performance	Next Month Forecast
	

Variance

Latest Month	Actual
Feb-22	81.4%

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

Assurance

Target

>= 95%

Performance consistently falls short of the target value

Quality | Operations | Workforce | Finance

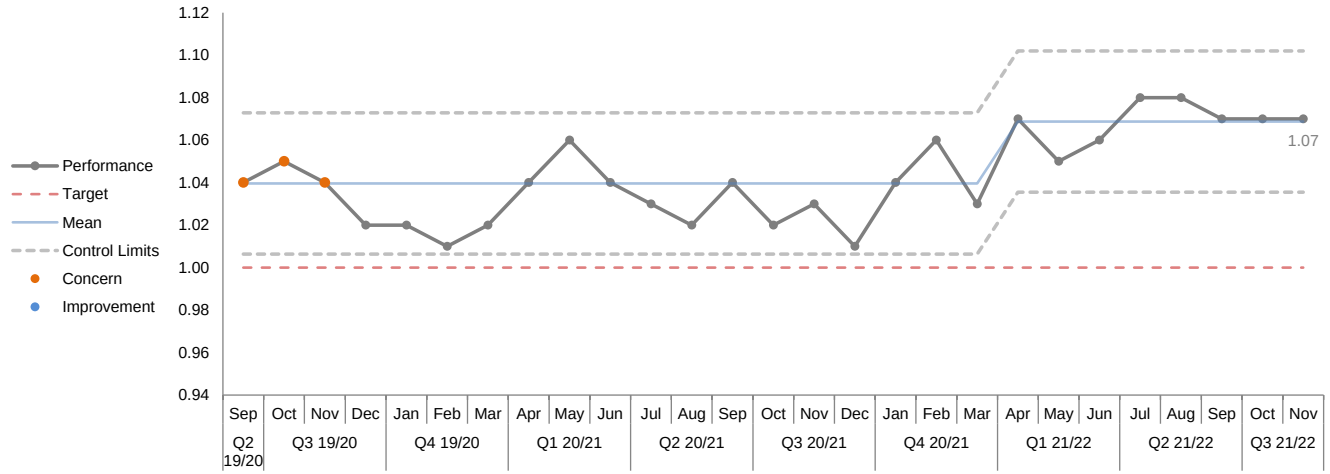
Integrated Performance Report

NHS Stockport NHS Foundation Trust

Measure	**Mortality: HSMR** This is the ratio between the actual number of patients who either die while in hospital compared to the number of patients that would be expected to die based on whether patients are receiving palliative care, and socio-economic deprivation.

Latest Performance | **Next Month Forecast**

Performance of this measure over time



Variance

Latest Month	Actual
Nov-21	1.07

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

Assurance

Target
<= 1

Performance is consistently achieving the target

What the chart tells us	Up until February 2021 there was variation in the mortality rate month to month, but there were no significant changes. This changes from March 2021, where we can see a consistent improvement in performance with a new average mortality rate below the expected level. Since March, there have been no further significant changes to mortality rates.

Narrative

Issues:	Actions & Mitigations:
We have recently changed our reporting tool from CHKS to HED and in taking this step, our calculated mortality ratios have risen to slightly over the expected values. The themes initially look similar to those previously noted such as urinary tract sepsis and cancer related deaths.	Themes to be reviewed in greater detail over the next month using the new analysis tools provided by HED.

Quality | Operations | Workforce | Finance

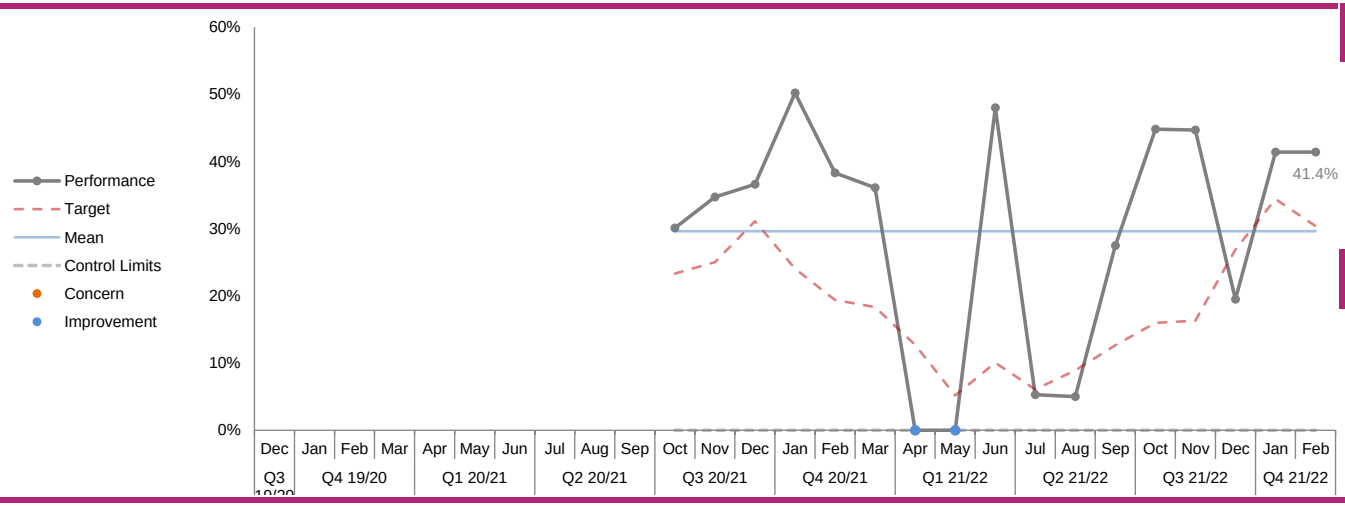
Integrated Performance Report

NHS Stockport NHS Foundation Trust

Measure	**Hospital Onset Covid (HOC) Rate** The number of patients diagnosed with probable and definite hospital onset covid-19, as a percentage of all patients diagnosed with covid-19. Patients diagnosed 8-14 days following admission are classed as probable HOC, and patients diagnosed 15+ days following admission are classed as definite HOC. The target for this indicator represents the regional average at the time of reporting.

Latest Performance	Next Month Forecast
	

Performance of this measure over time



Variance

Latest Month	Actual
Feb-22	41.4%

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

Assurance

	Target
	<= 30.38%

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

What the chart tells us

Although performance between Oct20 and Mar21 was consistently above the GM average, we saw an improvement in Apr21 and May21 with 0 hospital on-set Covid-19 infections. Performance spiked again in Jun21, but dropped back below the GM average for July and August. September shows an increase and a return to above the GM average, and other than a fall below the GM average in Dec21, performance has been above the GM average each month.

Narrative

Issues:	Actions & Mitigations:
The Trust has reported 99 COVID-19 positive cases in February with 41 of these being nosocomial which is a reduction on the previous month. The Trust currently has a rate of 41% against the North West rate of 30%. Stockport had very high rates Re CDT and we compare quite well in GM	Extra panel meetings have been undertaken to review cases. However due to the spreadability of Omicron it has been difficult to determine in a number of cases whether the organisation contributed to the development of Covid due to multiple factors. Working with the communications team to ensure messages of 'Living with Covid-19' within healthcare settings has not changed and for staff to remain vigilant.

Quality | Operations | Workforce | Finance

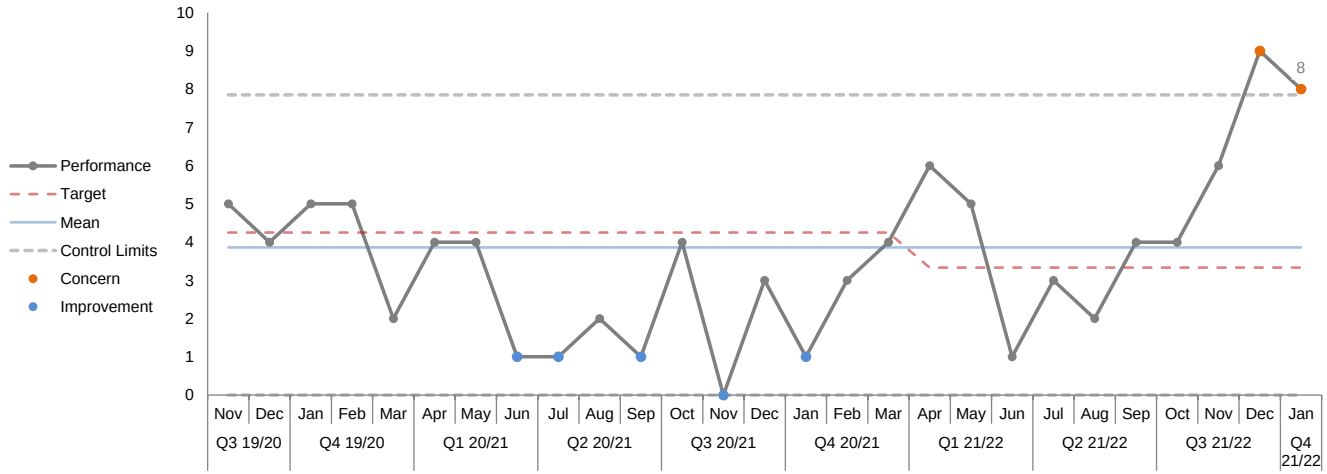
Integrated Performance Report

NHS Stockport NHS Foundation Trust

Measure	**C.Diff Infection Count** Total number of C.Diff infections.

Latest Performance | **Next Month Forecast**

Performance of this measure over time



Variance

Latest Month	Actual
Jan-22	48

The data shows special cause variation, indicated by values above the upper control limits.

Assurance

Target

<= 33

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

What the chart tells us

The control limits in the chart are very wide, suggesting that month to month the number of infections reported is quite inconsistent and variable. The chart shows that performance for 2020/21 was below target. Targets have been lowered from April 2021 onwards but April and May have seen higher than average number of infections reported. This has dropped for June July and August, but returned to above average level since that point. The latest data show that the cumulative total for the Trust is currently above expected levels.

Narrative

Issues:

Internal trajectory for 2021-22 is 40 cases with each Division having an apportioned share of those cases.

There were eight cases in January; six cases have been presented at the HCAI panel of which 5 were deemed unavoidable and 1 case was avoidable.

The Trust is over the proposed internal trajectory for the end of January with a total of 48 cases. YTD 31 cases have been classed as unavoidable, 2 cases avoidable and 15 cases remain outstanding.

The increase in Clostridium Difficile across the Trust is a major concern. Current cases in February that have not been officially signed off yet show this continued trend.

Other Trusts across Greater Manchester also appear to be seeing an increase, however as the official figures are produced quarterly this information will not be available until the end of March.

Actions & Mitigations:

Microbiologists are working with ICU staff on a trial to review a marker prior to prescribing antibiotics to ensure appropriateness of antibiotic usage. The aim, following a successful trial, would be to implement across other areas of the trust.

Review of the process for Clostridium Difficile investigations in regards to roles and responsibilities.

Discussions are taking place with the Health Protection Team to review the prescribing of antibiotics during the pandemic.

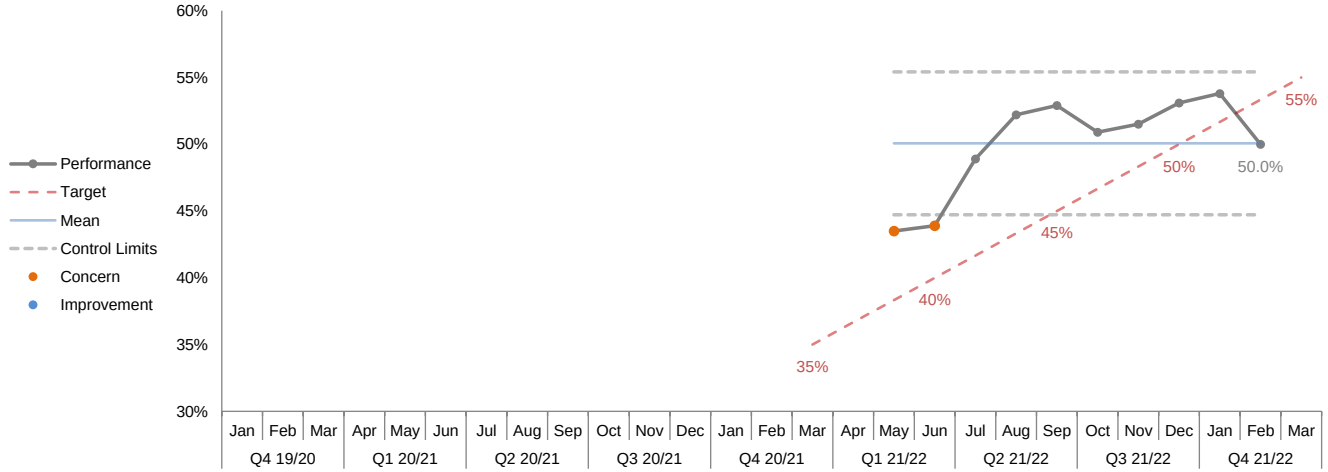
Quality | Operations | Workforce | Finance

Integrated Performance Report

NHS Stockport NHS Foundation Trust

Measure	Maternity: Continuity of Care, Booked Total number of women at 29 weeks gestation booked onto a Continuity of Care (COC) pathway, as a percentage of all women at 29 weeks during the month.	Latest Performance	Next Month Forecast
			

Performance of this measure over time



Variance

Latest Month	Actual
Feb-22	50%

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

Assurance

Target
>= 53.33%

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

What the chart tells us

Since Jul21, performance has been consistently between 49% and 54% with no significant changes. Performance is being measured against an improvement trajectory, to attain 55% by end of March 2022.

Narrative

Issues:	Actions & Mitigations:
The decline in the outcomes for providing intrapartum care is reflective of the community team members being asked to support clinically in the inpatient area's to support staffing deficits therefore, resulting in less flexibility and availability within the teams.	A deep dive is under way into the number of women that were eligible for CoC that did not receive it from December to date, to identify any additional barriers. We aim to keep the focus on providing intrapartum care where possible and address any barriers identified. The publication of 'Delivering Midwifery Continuity of Carer at full scale' in October 2021 has changed the direction of the continuity agenda and now refers to putting in 'building blocks' for sustainable models of MCoC with a focus on the most vulnerable women and those from Black, Asian, minority ethnic backgrounds. Deputy Head of Midwifery and Nursing to support Community Matron to produce a local plan to present to board, prior to wider distribution to the LMS.

Quality | Operations | Workforce | Finance

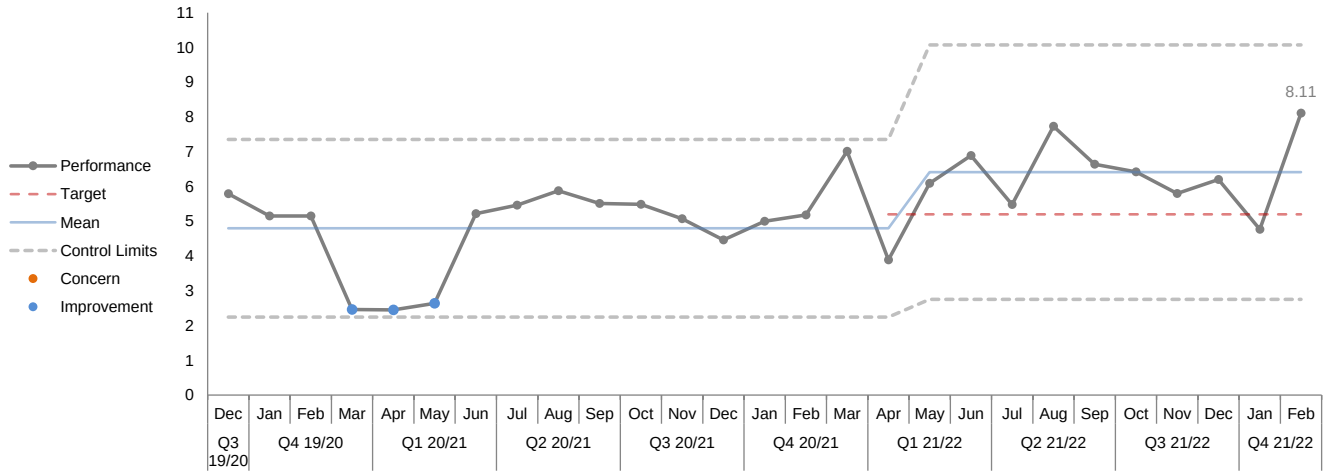
Integrated Performance Report

NHS Stockport NHS Foundation Trust

Measure	Written Complaints Rate The total number of formal written complaints received, divided by the whole time equivalent staff per 1000. Calculation of this metric was modified for May 2021 in line with the Model Hospital definition.

Latest Performance	Next Month Forecast

Performance of this measure over time



Variance

Latest Month	Actual
Feb-22	8.11

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

Assurance

Target
<= 5.2

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

What the chart tells us

From May21 onwards, a new higher level of complaints rate can be seen increasing from 4.8 to 6.2 for every 1000 WTE of staff. Performance has been variable since that point, but there have been no significant changes.

Narrative

Issues:

There has been a notable increase in the complaints rate in February.
The top five themes for formal complaints in February 2022 was as follows:
1. Communication
2. Clinical treatment
3. Patient care
4. Staff values & behaviours
5. Property (specially loss of patient property)

The top five themes for informal concerns in February 2022 was as follows:
1. Appointments
2. Communication
3. Waiting time
4. Admissions and discharges
5. Patient care

There continues to be a small number of cases where demand on our staff and services, as well as staff absence, is having an impact on our ability to provide complainants with a response to their concerns within timescales.

Actions & Mitigations:

The PALS & Complaints team continue to focus on resolving concerns informally where appropriate with the hope to reduce the number of formal complaints being received which continues to be high.

When we are unable to provide complainants with a response within the timescale, the complainant will be contacted and kept informed. Where necessary, new timescales will be agreed with the complainant.

PALS & complaints team continue to liaise with the divisions and external organisations with the aim of maintaining the Trust complaints response rate above 95%.

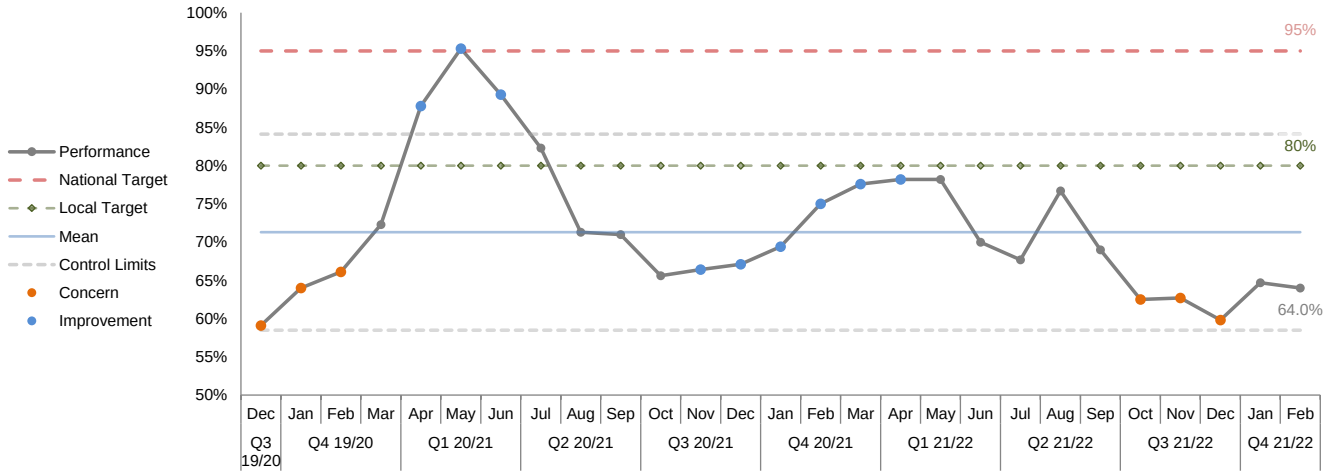
Quality | Operations | Workforce | Finance

Integrated Performance Report

NHS Stockport NHS Foundation Trust

Measure	A&E: 4hr Standard The percentage of patients who were admitted, discharged, or leave A&E within 4 hours of their arrival.	Latest Performance	Next Month Forecast
			

Performance of this measure over time



Variance

Latest Month	Actual
Feb-22	64%

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

Assurance

Target >= 95%

Performance consistently falls short of the target value

What the chart tells us

The chart shows that performance is significantly improved between Apr20 and Jun20, but returns to normal performance levels around the average from Aug20 onwards. Performance between Oct20 and May21 did show an improving trend to a high of 78% in April and May. Performance deteriorates through to Dec21 and appears to be stabilising around 60-65%.

Narrative

Issues:

Performance in February was 64%, Stockport is top of the GM performance table for 4hr Type 1
Drivers affecting performance in month were:

- Continued high levels of demand, 302 on average per day.
- Pressures within hospital with high levels of bed occupancy leading to more patients clerked in ED and increased length of stay
- ED congested due to lack of discharges
- Ambulance handover times dipped due to lack of capacity in department
- Nursing workforce challenges

Nine patients waiting in excess of 12 hours were reported in January due no bed capacity. All reportable 12 hour trolley waits were awaiting a medical bed. No Mental Health breaches reported in month.

Actions & Mitigations:

Estates work to reinstate the CDU facility is yet to be completed and is awaiting final sign-off prior to full implementation.

Locality working to mitigate the NcTR position remains challenging.

Transformational work continues on initial assessment, navigation and triage to improve processes and performance against the 15 minute standard.

Quality | **Operations** | Workforce | Finance

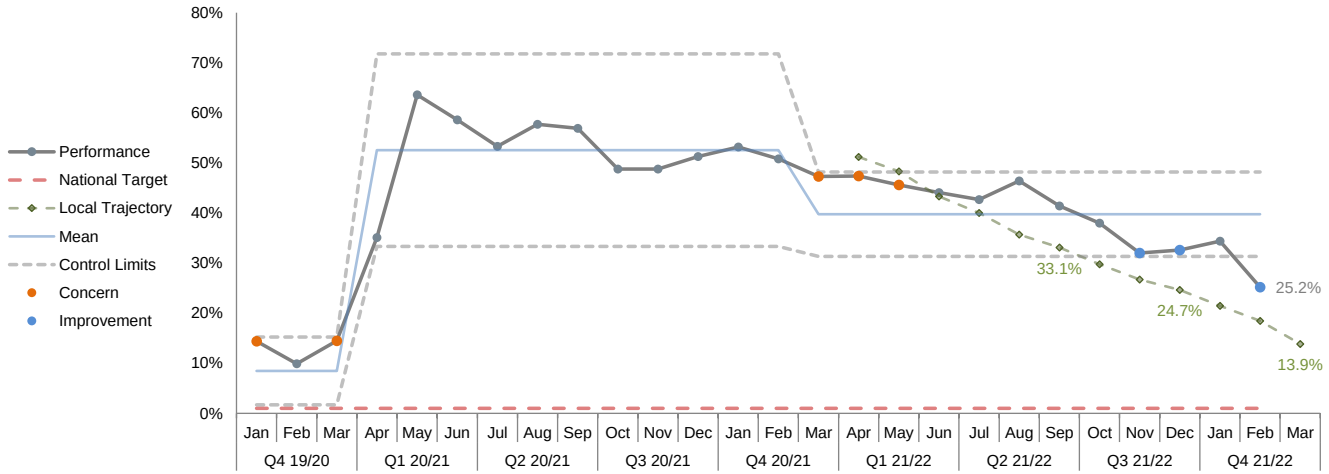
Integrated Performance Report

NHS Stockport NHS Foundation Trust

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

Latest Performance	Next Month Forecast
	

Performance of this measure over time



Variance

Latest Month	Actual
Feb-22	25.2%

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

Assurance

Target

<= 1%

Performance consistently exceeds the target value

What the chart tells us

Performance in May20 was at its lowest, with 63.6% of diagnostics breaching the 6 week target. Performance has been improving steadily since that point, with a significant improvement seen from Mar21 onwards. Performance has continued to improve, with Feb22 showing the lowest level of breaches since the pandemic began.

Narrative

Issues:	Actions & Mitigations:
Good progress in reducing diagnostic waiting times continues, with the percentage of patients waiting 6+ weeks decreasing to 25% at the end of February. Whilst Endoscopy continues to be the key driver of the overall adverse position, pressures remain within Echocardiography, and more recently staffing constraints have affected the MR waiting time. CT, Ultrasound, Dexa and Audiology all remain compliant with the 6 week diagnostic standard.	The Endoscopy department have continue to work with Endocare during Q4, which is significantly reducing the number of patients waiting for their investigation. Estates work in ECG has recently been completed which will increase ECG capacity and facilitate a reduction in waiting times moving forward. Additional MR capacity at UHSM has been secured along with a static scanner on-site for 5 weeks from the beginning of April.

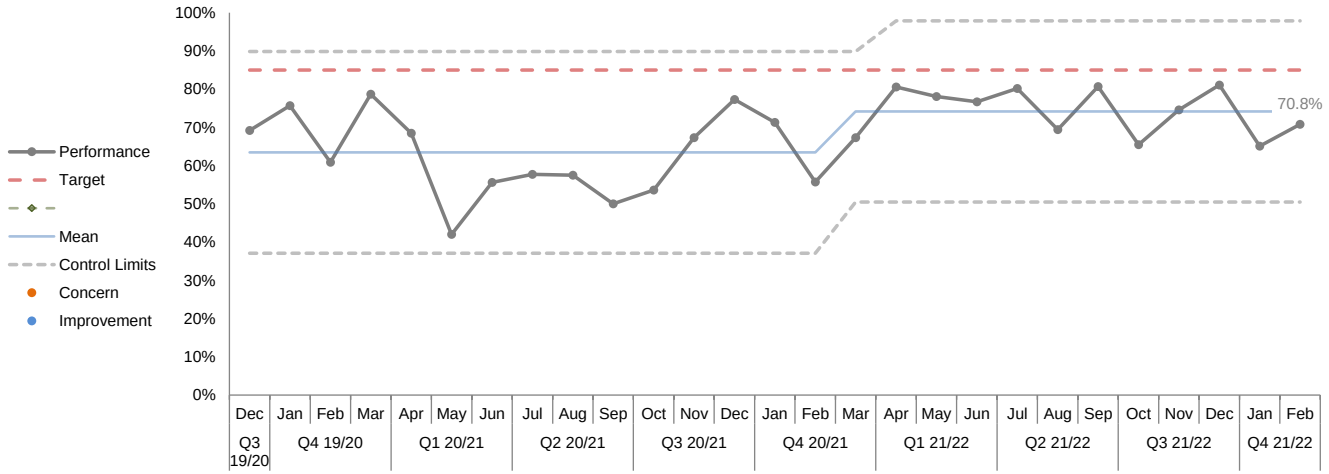
Integrated Performance Report

NHS Stockport NHS Foundation Trust

Measure	**Cancer: 62 Day Standard** The percentage of patients on a cancer two-week-wait pathway that have received their first treatment within 62 days of GP referral. Screening referrals are not reported as not statistically viable due to low number received

Latest Performance	Next Month Forecast
	

Performance of this measure over time



Variance

Latest Month	Actual
Feb-22	70.8%

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

Assurance

Target

>= 85%

Performance consistently falls short of the target value

What the chart tells us	For much of the reporting period, performance has been variable between 40% and 80% with an average of 63.5%. From Mar21 onwards there is a marked improvement in performance and a new average of 74.8% is being achieved. Performance had been above this average for a period, but the latest data shows a fall in performance levels.

Narrative	Issues:	Actions & Mitigations:
	The latest performance for the 62 day standard in February is 70.8%. The increase in non-elective pressures during December and January have resulted in extended waits for some surgical diagnostic procedures and treatments.	Much improved performance against the 28 day Faster Diagnosis Standard in February, supporting earlier diagnosis and treatment planning for patients. Radiology continue to improve on time from referral to scan and reporting. The cancer transformation programme continues which includes improvement plans across Radiology and the Clinical Divisions.

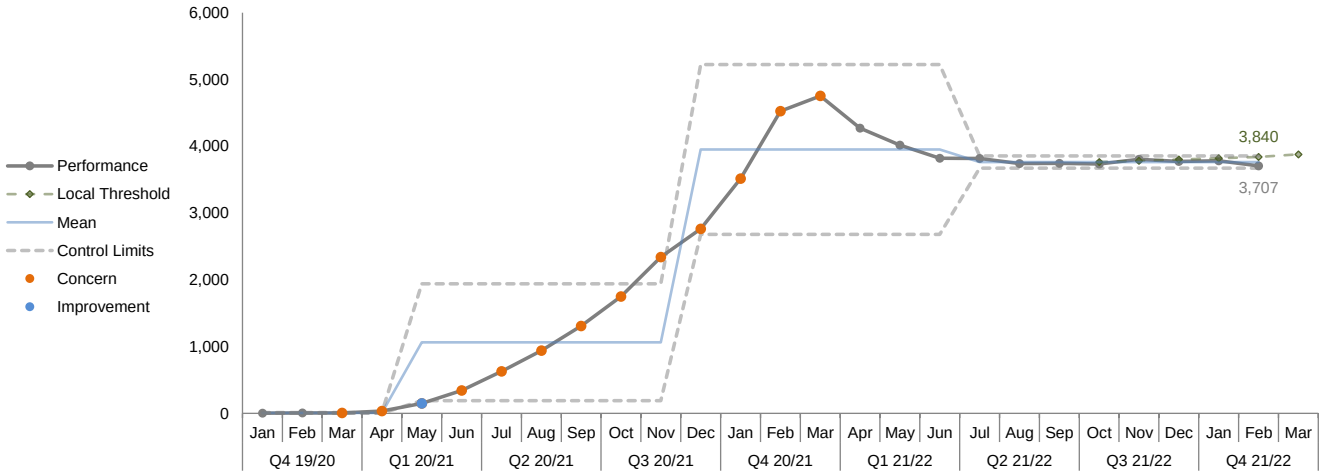
Quality | Operations | Workforce | Finance

Integrated Performance Report

NHS Stockport NHS Foundation Trust

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

Performance of this measure over time



Variance

Latest Month	Actual
Feb-22	3707

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

Assurance

Target

<= 0

Performance consistently exceeds the target value

What the chart tells us

From Mar20 a trend of worsening performance can be seen, which continues through to Mar21. Performance then appears to improve between Apr21 and Jul21. From Aug21 performance is much more consistent and stable, with the waiting list size being maintained between 3800 and 3700 for the last several months.

Narrative

Issues:	Actions & Mitigations:
The number of patients waiting over 52 weeks for treatment to commence reduced slightly in February. Elective capacity issues continue to be impacted by the urgent care demand and workforce sickness across the Divisions leading to longer waits for non-urgent patients. The ENT service in particular has significant capacity pressures.	A step change in elective operating capacity is planned from May, following the opening of ward M6. This will facilitate the re-opening of the day-case unit and enable much higher throughput of routine elective cases. Endoscopy continue to work with Endo-care and are significantly reducing the waiting times for endoscopic procedures. Capacity for ENT has recently been secured with Beacon Medical Services and Manchester Surgical Services. Transfer of patients is planned to commence in April. Efficiency work across Outpatient clinics will also result in increased activity levels.

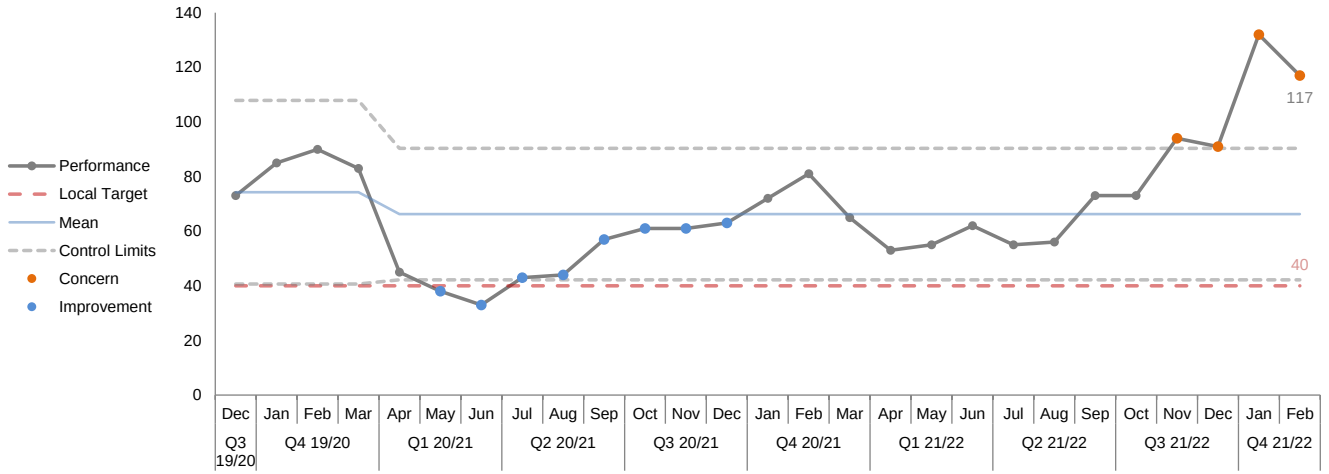
Integrated Performance Report

NHS Stockport NHS Foundation Trust

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

Latest Performance	Next Month Forecast

Performance of this measure over time



Variance

Latest Month	Actual
Feb-22	117

The data shows special cause variation, indicated by performance outside the upper control limits.

Assurance

Target

<= 40

Performance consistently exceeds the target value

What the chart tells us

The charts shows that from April 2020 there was a significant change, with a new lower average number of patients with No Criteria to Reside. May and Jun20 show a significantly lower number of patients, but between Jul20 and Oct21 there are no significant changes in performance. The latest four months have seen a significantly higher number of patients reported each month.

Narrative

Issues:

The number of patients with no criteria to reside in month remains high and was significantly impacted by the reduced community capacity with many care homes being closed as a result of IPC issues and staff shortages. Many homes are now opening however staffing restrictions are still impacting on the utilisation of beds and homes are determining the number of patients they will take daily which impacts on the number of patients the trust are able to discharge daily.
Care in the community is also a challenge as again access to capacity is challenging.

The challenges re community capacity is having a significant impact on the Trusts ability to discharge into the community under the discharge to assess model.

The number of Out of Area patients has also maintained its high numbers with other localities struggling to access community capacity. Social Care capacity for patients requiring pathway 1 discharge support continues to be a theme, with workforce shortages the key constraint.

Actions & Mitigations:

Working alongside system partners is supporting the discharge of patients on pathways 1 & 2, and tactical meetings remain in place to support mitigation of any blockages or barriers.

Discussions with partners continue regarding capacity , particularly around winter resilience and additional spot purchase beds is in place.

Work with partners to access OOA placements continues and meetings take place daily with North Derbyshire and East Cheshire colleagues to support mitigating actions which prevent flow.

The model and plan for discharge to asses capacity longer terms is taking place with specific modelling looking at capacity required, particularly on a seasonal basis. This work will inform the future provision however procurement of community capacity and the aligned staffing models to support delivery of care to commissioned beds is a potential risk going forward if beds are spread across a number of sites.

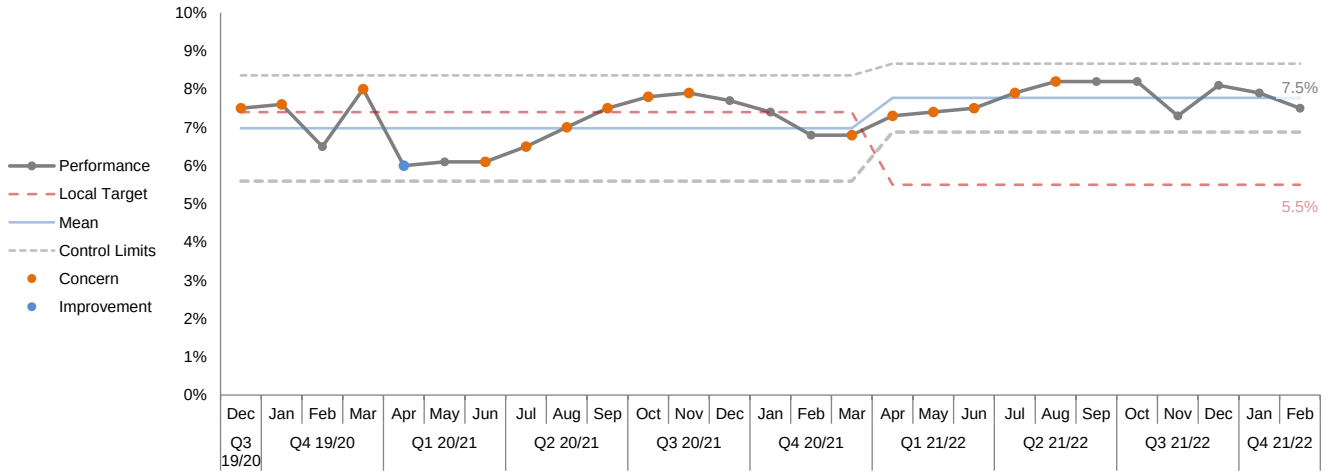
Integrated Performance Report

NHS Stockport NHS Foundation Trust

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

Latest Performance	Next Month Forecast
	

Performance of this measure over time



Variance

Latest Month	Actual
Feb-22	7.5%

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

Assurance

Target: <= 5.5%

Performance consistently exceeds the target value

What the chart tells us	Between Jun20 and Nov20 a trend of increasing DNA rates is seen. This drops back to just below average for Feb and Mar21. Apr21 shows the start of a significant change, and average DNA rates increase from 7.0% to 7.7%. Since Aug21, there have been no significant changes in DNA rates.

Narrative

Issues:	Actions & Mitigations:
The DNA rate fell back to 7.5% in February, from 8.1% in December and 7.9% in January. Ongoing consideration that there is a correlation between high community COVID19 infection rates and high DNA's rates has been identified, especially in paediatrics. It should be noted that the Trust currently benchmarks very well compared to its Greater Manchester peers. Outpatient clinic utilisation is below expected levels. Areas of concerns on a month by month basis are escalated to teams.	Where appropriate, services continue to encourage the use of Patient Initiated Follow-up within certain clinics and locations. An Outpatient data analysis piece of work has identified areas for improvement in clinic utilisation, and will be monitored as part of the Outpatient Improvement Programme. As part of the 2022/23 planning process, efficiency gains by reducing DNA rates and improving clinic utilisation have been applied from month 4.

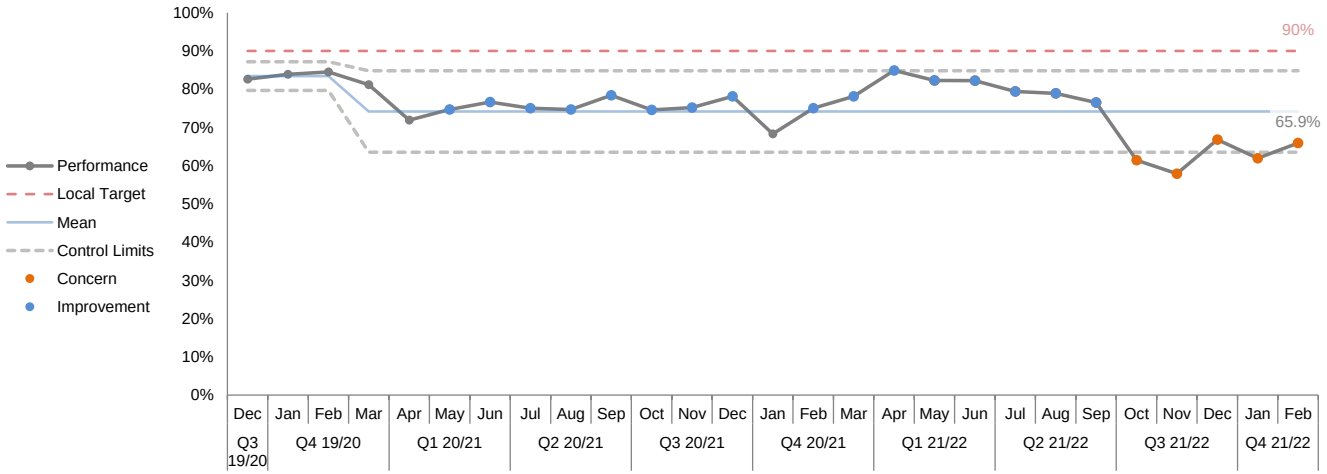
Integrated Performance Report

NHS Stockport NHS Foundation Trust

Measure	Theatres: Capped Utilisation The actual session times as a percentage of the planned session time. Based on the time from the start of the session to the end of the session unless it lasts longer than the planned session minutes in which case it is capped at 100%. Downtime between operations in a session is included in these utilised minutes. Excludes emergency/trauma sessions, obstetric and endoscopy activity. Planned session time based on delivered sessions only.

Latest Performance	Next Month Forecast
	

Performance of this measure over time



Variance

Latest Month		Actual
Feb-22		65.9%

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

Assurance

Target

>= 90%

Performance consistently falls short of the target value

What the chart tells us

The chart shows that prior to Mar20 we maintained an average utilisation of 83%, but in Apr20 there is a significant drop 74.6%. on average. Performance has been consistent since that time, with periods of above-average performance seen between Feb21 and Sep21. Oct21 sees a significant drop in performance, which has continued to be significantly lower than average for the last 5 months.

Narrative

Issues:	Actions & Mitigations:
Theatre productivity has been adversely affected by the loss of elective beds to support urgent care flow.	The Trust will re-focus on theatre productivity during Q1 of 2022/23, as the elective bed base increases, facilitating a higher level of operating and efficiency to resume.

Quality | Operations | Workforce | Finance

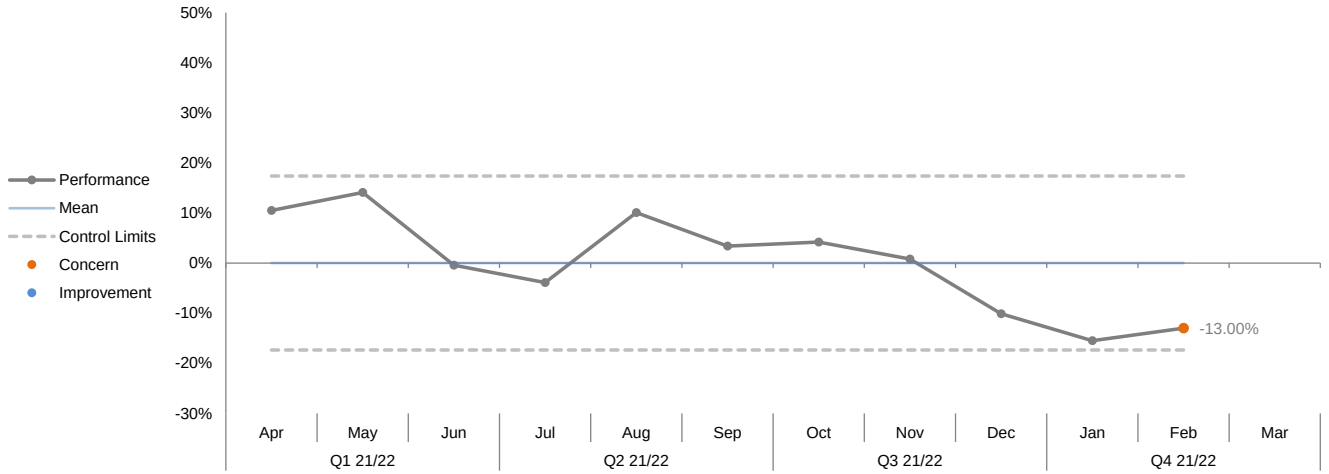
Integrated Performance Report

NHS Stockport NHS Foundation Trust

Measure	**Total Elective Activity vs. Plan (IP & DC)** The percentage variance between the total elective activity (Elective-Inpatient and Daycase) and the total planned elective activity submitted for 2021/22. Excludes Breast Surgery and Swanbourne House activity. Based on the flex/freeze position, not the SUS position. A value above 0% indicates that activity is above planned levels.

Latest Performance	Next Month Forecast
	

Performance of this measure over time



Variance

Latest Month		Actual
Feb-22		-13%

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

Assurance

Target

>= 0%

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

What the chart tells us

The chart shows that performance against the activity plan has been variable across the year, but largely above plan between April and November. Since December we have been below plan, with the latest figures for February showing a significant drop.

Narrative

Issues:

The elective plan was 13% adverse in February and the Elective (IP/DC) activity was76.7% restored compared to 2019/20 levels.

The ability to restore as effectively in over the last three months has been impacted by the acute increase in COVID pressures and winter pressures, affecting elective service delivery.

Actions & Mitigations:

The Trust will continue to utilise mutual aid for cancer/P2 elective procedures in both the Independent sector and at the Christie.

A step change in elective operating capacity is planned throughout quarter 1, with the relocation of day-case work toward D5 and the, ward M6 May.

The Trust-wide focus on non-elective patient flow and levels of NcTR continues. This is the key enabler to enable a return to the required elective bed base.

Recovery is also reliant upon no further surge in COVID demand.

Quality | Operations | Workforce | Finance

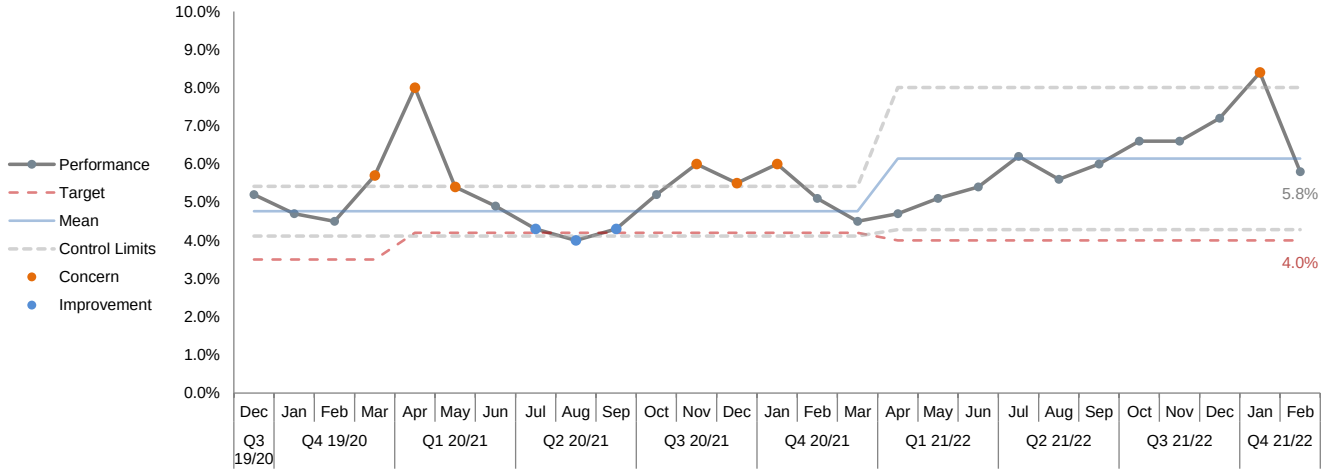
Integrated Performance Report

NHS Stockport NHS Foundation Trust

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

Latest Performance	Next Month Forecast
	

Performance of this measure over time



Variance

Latest Month	Actual
Feb-22	5.8%

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

Assurance

Target

<= 4%

Performance consistently exceeds the target value

What the chart tells us	During the period Mar20-May20 we saw an unusually high spike in sickness absence levels, but this returns to normal levels the following month, dropping to a new low of 4% by Aug20. A significant increase in sickness rates can be seen from Apr21 onwards as the average sickness rates increase from 4.7% to 6.2%. Another significant increase can be seen in Jan22 with a rate of 8.4% - the highest across the whole reporting period. However, February sickness levels do seem to have dropped back to expected levels.

Narrative

Issues:	Actions & Mitigations:
The cost of sickness absence in Feb 22 is £747K; an increase of approximately £467K from the previous month. COVID-related sickness has decreased from 3.08% in Jan 22 to 1.27% in Feb 22; however it is anticipated that in line with increasing infection that this will increase in March.	Managing Covid absence and self isolation continued despite significant drop in related absence. Wellbeing initiatives continued to be promoted in January and February. Staff Psychological & Wellbeing Support (SPAWs) service launched in February, with a positive uptake via self referrals. Regular management of staff in accordance with our Supporting Attendance policy and support provided by occupational health. The pause of VCOD implementation impacted on some staff absences.

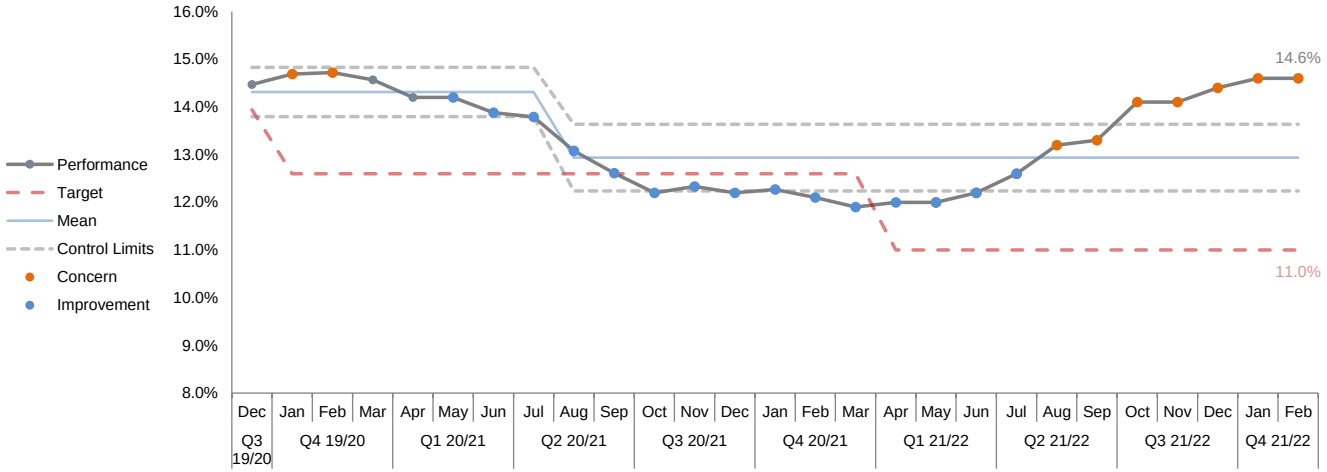
Integrated Performance Report

NHS Stockport NHS Foundation Trust

Measure	**Workforce Turnover** The percentage of employees leaving the Trust and being replaced by new employees.

Latest Performance	Next Month Forecast
	

Performance of this measure over time



Variance

Latest Month		Actual
Feb-22		14.6%

The data shows special cause variation, indicated the latest value being above the upper control limits.

Assurance

Target
<= 11%

Performance consistently exceeds the target value

What the chart tells us

An improving trend in turnover can be seen over a 14-month period between May20 and and Jul21.
From Apr21 a new turnover target was introduced, but since then turnover has continued to increase month-on-month. The last 5 months turnover is flagged in the chart as a significant concern with values consistently higher that the expected range.

Narrative

Issues:

The top known leaving reason is Voluntary Resignation:
– Work Life Balance (16.47%)
– Relocation (13.80%)
– Retirement Age (11.55%).

Actions & Mitigations:

A retention 'watch list' has been compiled to understand the drivers of high turnover and provide focussed support.

A revised approach to exit interviews has been agreed and launched.

Retention performance has been a focus of our monthly Performance Review meetings and will be included going forward.

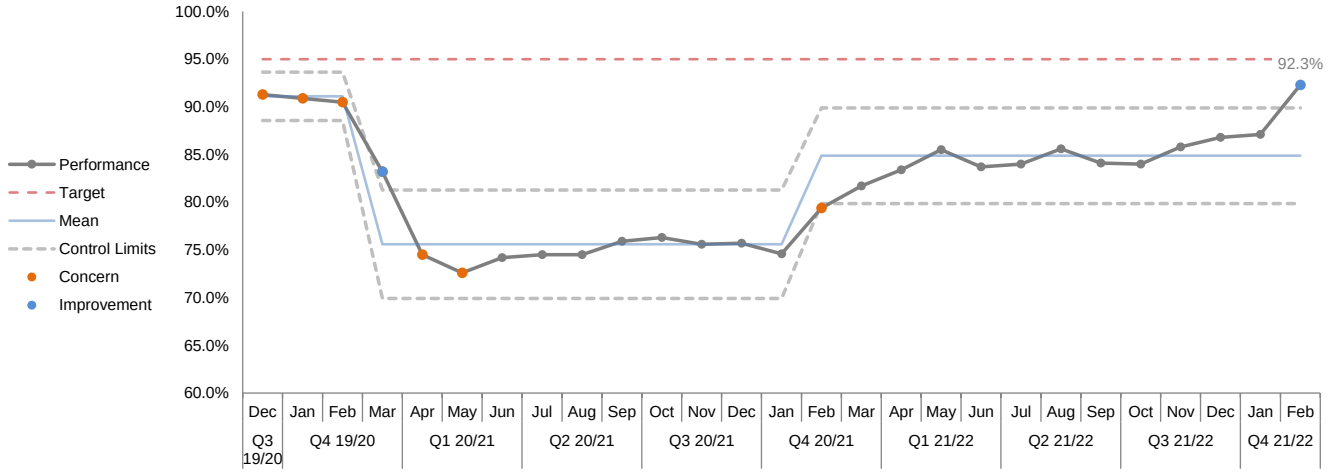
Flexible working initiatives continue to be promoted and managers supported to consider requests and staff in achieving an improved work-life balance.

Integrated Performance Report

NHS Stockport NHS Foundation Trust

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

Performance of this measure over time



Variance

Latest Month	Actual
Feb-22	92.3%

The data shows special cause variation, indicated by a value outside the upper control limits.

Assurance

Target

>= 95%

Performance consistently exceeds the target value

What the chart tells us

The chart shows that from Feb21 onwards, there is a improvement in performance with a new average of 84.9%. There have been no significant changes changes in performance since then, until the latest month, with February showing a significant improvement to 92.3%.

Narrative

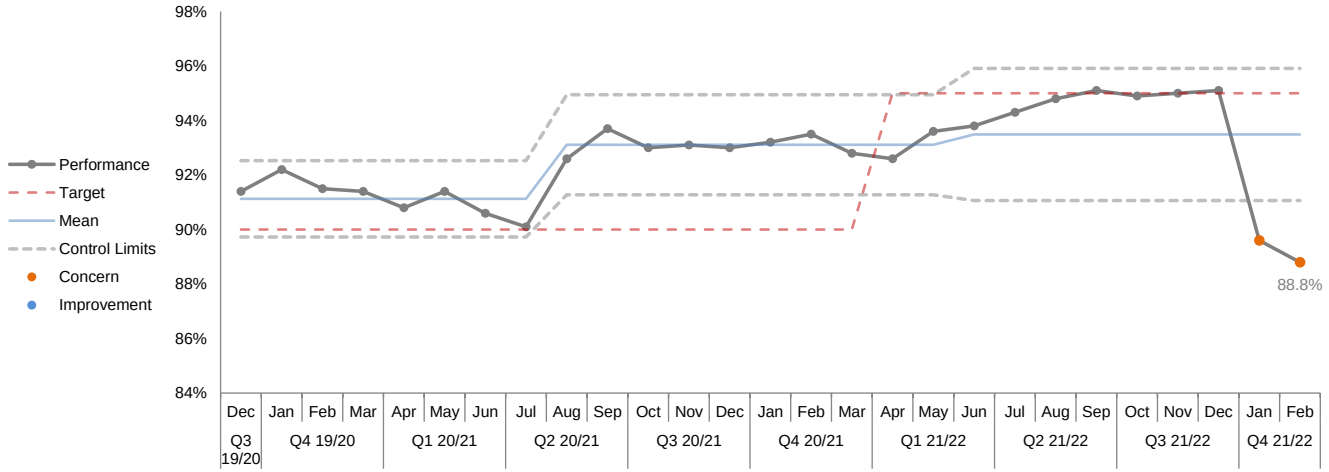
Issues:	Actions & Mitigations:
Compliance is currently at 92.3% ,which is a large improvement from previous months and a testament to the hard work of all involved. All Divisions have seen improvements, with Estates & Facilities and Womens', Children, & Diagnostics reporting a compliance rate of 93.7% and 93.46% respectively.	The OD and HR Teams continue to offer support in the form of trajectory and tailored reports to each division. Appraisal training is offered as part of the Leadership Programme on a monthly basis for both appraisees and appraisers.

Integrated Performance Report

NHS Stockport NHS Foundation Trust

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

Performance of this measure over time



Variance

Latest Month		Actual
Feb-22		88.8%

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

Assurance

Target >= 95%

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

What the chart tells us

A new higher average level of performance is then seen from Aug20 onwards, varying between 92 and 95%. A new target was introduced in April 2021, and performance continues to improve through to Dec21. Latest performance figures for Feb22 show a significant drop in performance to 88.8%, the lowest performance across the whole reporting period.

Narrative

Issues:	Actions & Mitigations:
As of January 2022, additional levels of Mandatory Training have been included in the overall performance target. As anticipated and reported previous this has had a negative impact on compliance, which has been reduced to 88.8%.	Detailed staff training compliance information is circulated on a monthly basis, and line managers can see live training compliance via manager self service in ESR. Capacity for Resus training is exceeding the required number of spaces to reach the target, and where staff do not attend - this is recorded and distributed to divisional triumvirates on a weekly basis for monitoring and action. A train the trainer model for resus is being explored to enable a more flexible offer. Information Governance is an additional area of focus, as this is an annual requirement for all staff. The IG team provide many options, support and direct action to teams where required to improve compliance

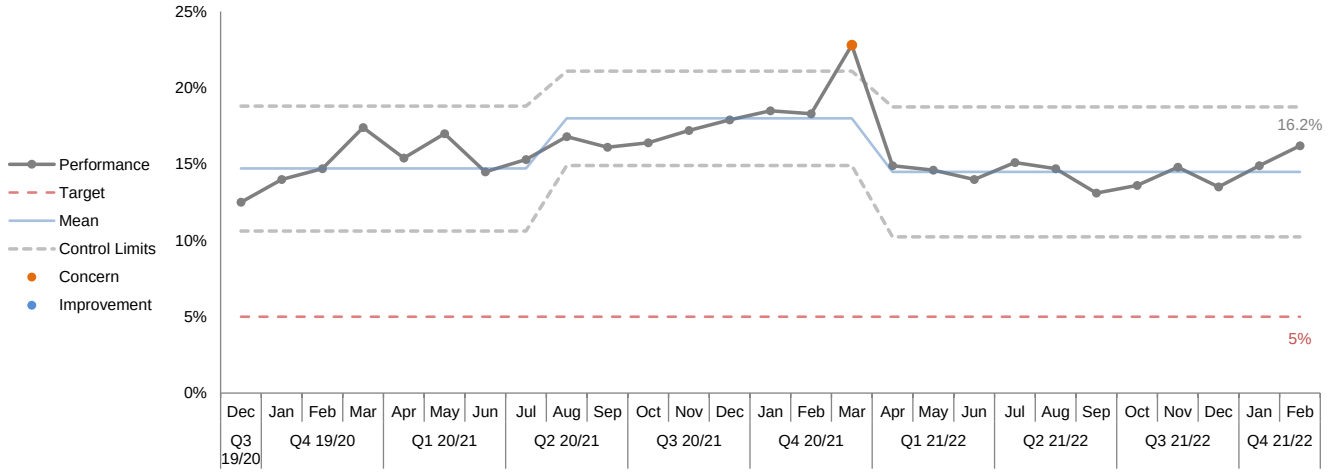
Integrated Performance Report

NHS Stockport NHS Foundation Trust

Measure	**Bank & Agency Costs** The total bank & agency cost as percentage of the total pay costs

Latest Performance	Next Month Forecast
	

Performance of this measure over time



Variance

Latest Month	Actual
Feb-22	16.2%

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

Assurance

Target

<= 5%

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

What the chart tells us

From Aug20, there is a step increase in bank & agency costs Mar21, with the March position being significantly higher than that. From Apr21 the average bank & agency costs drop to 14.5%, which is lower than pre-pandemic levels. Since then bank & agency costs have been variable, but there have been no significant changes.

Narrative

Issues:	Actions & Mitigations:
The total bank and agency spend in Feb 22 was £4.11M, which represents 16.18% of the total pay bill within the month and is £339K higher than in Jan 22. The Division with the highest bank & agency spend in Feb 22 was M&UC (£1.38M), Followed by Surgery with £980K.	Substantive recruitment initiatives continue, supported by international recruitment programme and representation at regional recruitment drives. The continuation of the bank winter incentive n place to avoid use of the more premium agencies. Weekly executive scrutiny, challenge and approval of bank and agency requests.

Stockport NHS Foundation Trust

Meeting date	2 December 2021	x	Public		Confidential	Agenda item
Meeting	Board of Directors					
Title	Learning from Deaths Quarterly Report: Q3					
Lead Director	Andrew D. Loughney Medical Director		Author	Suzy Collins Learning from Deaths Lead		

Recommendations made/ Decisions requested

The Board of Directors is asked to:

- Note the processes that the Trust has in place that allow it to learn from deaths
- Consider and confirm whether the actions arising from that process have been appropriate and thereby to take assurance

This paper relates to the following Corporate Annual Objectives

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

The paper relates to the following CQC domains

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

This paper is related to these BAF risks	X	**PR1.1**	There is a risk that the Trust delivers sub-optimal quality services and fails to meet regulatory standards
	X	**PR1.2**	There is a risk that the Trust fails to reduce harm against agreed baseline
		PR1.3	There is a risk that patient flow plans are not effective leading to decline in A&E performance
		PR1.4	There is a risk that inclusive restoration plans to address elective backlog are not delivered
		PR2.1	There is a risk that the Trust fails to support and engage its workforce
		PR2.2	There is a risk that the Trust's services do not reliably support neighbourhood population health and future care needs
		PR3.1	There is a risk that effective partnership & accountability arrangements are not in place at ICS and locality provider level
		PR4.1	There is a risk that there is insufficient capacity and capability to deliver Trust, locality and system wide transformation
		PR5.1	There is a risk that robust plans to recruit, train and retain the right staff to meet service needs are not implemented
		PR5.2	There is a risk that the Trust does not deliver the Equality, Diversity & Inclusion Strategy
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		PR6.2	There is a risk that the Trust fails to develop a multi-year financial recovery plan to secure financial sustainability
		PR7.1	There is a risk that the estate is not fit for purpose and does not meet national standards

		PR7.2	There is a risk that the Trust does not materially improve environmental sustainability
		PR7.3	There is a risk that there is no identified funding mechanism or insufficient funding to support strategic regeneration of the hospital campus
		PR7.4	There is a risk that the Trust fails to develop and implement a responsive and resilient Digital Strategy

	Section of paper where covered
Equality, diversity and inclusion impacts	none
Financial impacts if agreed/ not agreed	none
Regulatory and legal compliance	none
Sustainability (including environmental impacts)	none

The purpose of the report is to provide the Board with information about the Learning from Deaths process in the Trust, to summarise the learning that has been gained in the last quarter and to provide high level information about the actions that have been taken in response.

With respect to process:

- The team of Medical Examiners has now been expanded in advance of the rollout of the function to cover community deaths. Four of the team are General Practitioners.
- Some vacancies have arisen in the trust's LFD team of reviewers and these are now being recruited to.
- A template letter is now in use, informing relatives/carers, when a Learning from Deaths review has been conducted and learning has been derived.
- The first of the Trust's LFD workshops was held in December 2021 and further workshops are being scheduled for 2022.

With respect to clinical practice the following themes have been identified:

- Although the standard of clinical documentation is generally good, some of the clerking and note-taking during ward rounds could be improved. Professional and/or clinically accurate language should be adhered to.
- Patients with complex medical needs should not be cared for on non-medical wards if this can be avoided. Ideally, such patients should be admitted onto medical wards and allocated to the correct specialist service at the earliest opportunity post-take.
- Although NEWS scoring is a good tool for the identification of a deteriorating patient, escalation to the Registrar on call should also be considered for patients who are deteriorating but who have not yet triggered an alert.
- Learning disability patients should have full documentation of their degree of learning disability and capacity.

The Trust's updated Learning from Deaths Policy has been ratified.

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1 Purpose

1.1 The purpose of this quarterly report is to provide assurance to the Board of Directors around the Learning from Deaths function of the Trust

1.2 The report therefore outlines the Trust's Learning from Deaths process, presents the high level themes identified during the last quarter and describes the Trust's response to those findings.

2. Background and Links to Previous Papers

2.1 The Trust's Learning from Deaths policy is based on the recommendations of the National Quality Board (2017). The purpose of the process is to ensure that opportunities are taken to learn from the care received by patients dying in the Trust so that actions can be taken to improve the quality and safety of patient care.

2.2 The Trust uses a data collection form based on the Structured Judgement Review (SJR) methodology, which is published in conjunction with the National Mortality Case Record Review programme.

2.3 Cases are selected from a number of sources including all: deaths where families, staff or the Medical Examiners have raised concerns, maternal deaths, surgical deaths, paediatric and neonatal deaths, stillbirths, deaths from the LEDER programme, deaths in critical care, theatres or recovery, deaths in the Emergency Department, cardiac arrest deaths and deaths due to epilepsy, asthma or diabetic ketoacidosis.

2.4 These account for around 10% of hospital deaths. Additional cases are added if capacity allows and/or following an extraordinary event – such as our recent Covid deaths.

2.5 All Learning from Deaths reviewers are clinicians (mostly Consultants) and each Division is represented. There is also a Learning from Deaths Trust Lead.

2.6 Each quarterly report is considered by the Trust's Mortality Review Group. Where potential changes in practice are thought to be worth considering, the relevant bodies are informed via the Patent Safety Group (see below), for example, advice may be given to the Transformation Team or the originating Division.

2.7 The Mortality Review Group also provides data and leads discussion at the Deteriorating Patient Group meeting monthly and provides the Patent Safety Group with a quarterly report for consideration.

2.8 A Learning from Deaths Newsletter is produced and circulated widely across the Trust to promote learning and findings are also considered and disseminated at divisional level. The last newsletter was published in December 2021 and the next is imminent.

3. Matters under consideration

3.1 Regarding Trust processes:

3.1.1 Medical Examiners are now embedded in the Trust and the team has now been expanded in advance of the roll out of the service to cover community deaths.

3.1.2 The Trust's Learning from Deaths Policy has been updated and ratified.

3.1.3 A template letter is now in use to inform relatives/carers, when a Learning from Deaths review has been conducted that has derived significant learning.

3.1.4 The Learning from Deaths microsite is up and running and an expanded number of useful documents is being made available on the site.

3.1.5 The first of the Trust's LFD workshops was held in December 2021 and further workshops are being scheduled for 2022.

3.2 Regarding clinical practice:

3.2.1 Although the standard of clinical documentation is generally good, some of the clerking and note-taking during ward rounds could be improved. Professional and/or clinically accurate language should be adhered to. This request has been disseminated through the LFD newsletter and documentation audits are also being conducted and reported through the Clinical Effectiveness Group.

- Patients with complex medical needs should not be cared for on non-medical wards if this can be avoided. Ideally, such patients should be admitted onto medical wards and allocated to the correct specialist service at the earliest opportunity post-take. These instructions have been disseminated to trainees and consultants in the medical specialties by the AMD for Medicine.

- Although NEWS scoring is a good tool for the identification of a deteriorating patient, escalation to the Registrar on call should also be considered for patients who are deteriorating but who have not yet triggered an alert. The utility of NEWS is already considered by the Deteriorating Patient Group and is subject to a CQUIN audit for the subset of patients requiring Critical Care admission. The broader issue of escalation for non-triggering patients with clinical evidence of deterioration will now be considered by the Deteriorating Patent Group.

- Learning disability patients should have full documentation of their degree of learning disability and capacity. This has been highlighted through the LFD newsletter but will also be the subject of focus on an upcoming Grand Round to ensure broader reflection and discussion.

4. Areas of Risk

4.1 The number of reviewers in the Medical and Surgical Divisions is below an optimal level. An active recruitment effort is underway, potentially including non-medical personnel with appropriate clinical experience.

4.2 The Trust appreciates that as we take on the recovery of our services post pandemic, an element of fatigue will be evident amongst clinical staff. The LFD process is, however, vital for the safe functioning of our services so staff will be supported as individually necessary to deal with the workload, for example, by ensuring that job plan content matches the time LFD requirement.

5. Recommendations

5.1 The Board is invited to note the content of this report and to take assurance.

Meeting date	7 April 2022	x	Public		Confidential	Agenda item
Meeting	Board of Directors					
Title	Safer Care Report – April 2022					
Lead Director	Chief Nurse		Author	Deputy Chief Nurse		

Recommendations made / Decisions requested

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

This paper relates to the following Corporate Annual Objectives-

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

The paper relates to the following CQC domains-

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

This paper is related to these BAF risks	x	**PR1.1**	There is a risk that the Trust delivers sub-optimal quality services and fails to meet regulatory standards
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			provider level
		PR4.1	There is a risk that there is insufficient capacity and capability to deliver Trust, locality and system wide transformation programmes
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Where issues are addressed in the paper-

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

Executive Summary

This report provides the Board of Directors with the latest position in relation to key care staffing assurances. Current challenges regarding maintaining safe staffing levels are highlighted, alongside the actions being taken to mitigate risks identified. Safely staffing our clinical areas remains the prime focus of all operational discussions in relation to the care we can safely deliver for our patients, with a continued focus on scrutiny of all types of incidents, complaints and patient feedback to triangulate & provide support where needed.

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Nursing & Midwifery Staffing Update Report Board of Directors

Presenter: Nicola Firth, Chief Nurse

Your Health. Our Priority.

Purpose of report

- To inform the Trust Board of the latest position in relation to key care staffing assurances
- To advise Trust Board of current challenges regarding maintaining safe staffing levels, and of the actions being taken to mitigate risks identified.
- To inform Trust Board of measures being taken to enable employees to safely remain in work by supporting their health and wellbeing.

Executive Summary

Stockport NHS Foundation Trust

- Maintaining safe staffing levels to meet the current demands of services remains a challenge
- Significant recruitment of registered nursing staff and health care assistants, including international nurses.
- There is a continued focus on scrutiny of all types of incidents, complaints and patient feedback to triangulate & provide support where needed.

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Nursing & Midwifery Staffing

Nursing & Midwifery Staffing

NHS Stockport NHS Foundation Trust

Current situation and challenges:

- Maintaining safe staffing levels to meet current demands across the organisation continues to be a challenge, a position which reflects both the regional and national picture, with non-established areas being opened in response, and an increase in acuity.

- Ensuring a leadership focus on safe staffing throughout these sustained and significant operational pressures is a significant necessity. This is being constantly and consistently managed and demonstrated by senior nursing and midwifery leaders, who continually have oversight, insight and foresight to confirm that the risk is being controlled and mitigated to ensure that this does not impact on the care, quality and safety of the patients within the organisation.

- The Trust are also actively engaged in a national Health Care Support Worker Recruitment and Retention Campaign with all vacancies recruited to (prior to the new establishments).

- Safecare Lead commenced post in December & new Workforce Matron commenced January 2022.

- Nursing, midwifery and AHP recruitment campaigns in progress with the reestablishment of recruitment fairs, universities and colleges.

- A 12 month contract has been approved with the social media company Just-R. Over the next 12 months they will focus on raising the profile of the Trust via social media platforms, promote & publicise all events for registered and non-registered staff.

Safe Care

NHS Stockport NHS Foundation Trust

- Safecare lead commenced role in December 2021. Working closely with the Healthroster Team & Workforce Matron.

- Safecare lead working hours include Saturday & Sunday ensuring safe staffing over the weekend.

- Census data collected 3 times a day & monitored closed by Safecare Lead.

Nursing and Midwifery Staffing

Stockport NHS Foundation Trust

Specific actions to mitigate risk and to ensure oversight, Insight and foresight

- Implementation of Safecare live giving oversight for all areas of acuity and safe staffing levels
- There is ongoing work, in partnership with NHS Professionals, to oversee temporary staffing pay rates, develop initiatives to increase fill rates and review processes to cascade unfilled shifts to agencies with a significant reduction in agency staff.
- Significant reduction in the use of off-frame work agency staff with none being utilised during this reporting period.
- Continuous oversight of our position is appraised in collaboration with regional colleagues and National Directors of Nursing regarding skill mix, ratio and guidance. The GM Chief Nurses group review this for consistency.

Safe Care Indicators

NHS Stockport NHS Foundation Trust

- Quality metrics and areas of harm are triangulated with incidents, complaints, patient experience feedback, acuity and dependency, capacity and staffing levels. These are discussed at department level safety huddles, directorate and business group governance meetings, through the integrated performance review, and the board assurance committees.

- Falls prevention work continues, with incidents being robustly investigated, themes identified, a revision of the falls policy, a review of the enhanced care policy. Significant improvement in falls with harm during the latter part of the quarter.

- Tissue Viability improvement work is a key priority with all incidents undergoing a robust review, and Trust wide themes being discussed and learning shared. Improvements are noted during the latter quarter of the year.

Nursing and Midwifery Staffing

NHS Stockport NHS Foundation Trust

- The Stockport Accreditation & Recognition System (StARS) designed to measure the quality of care provided by individuals and teams throughout the Trust has been rolled out and is on track to achieve the trajectory.

- Community and paediatric areas have now been assessed.

- There has been a full programme of events for ‘Marvellous March’ supported by all of the divisions.

Patient and Family Experience

NHS Stockport NHS Foundation Trust

- Visiting restrictions have been reviewed and visitors are welcome across all areas.
- Gathering patient and family feedback is extremely important. All services are resumed for the data collection.
- The key themes from complaints remains communication. A communication sheet has been developed and is being launched across all areas.

Nursing Vacancies & Turnover

Stockport NHS Foundation Trust

- 124 registered nursing staff vacancies at band 5 and above
- However:
  - 23 registered Nurse Associates (and 20 in training)
  - 124 registered nursing staff recruited with an offer of employment
  - 54 nurses awaiting their PIN working at band 4
  - Monthly groups of international nurses starting at Trust.

N&M

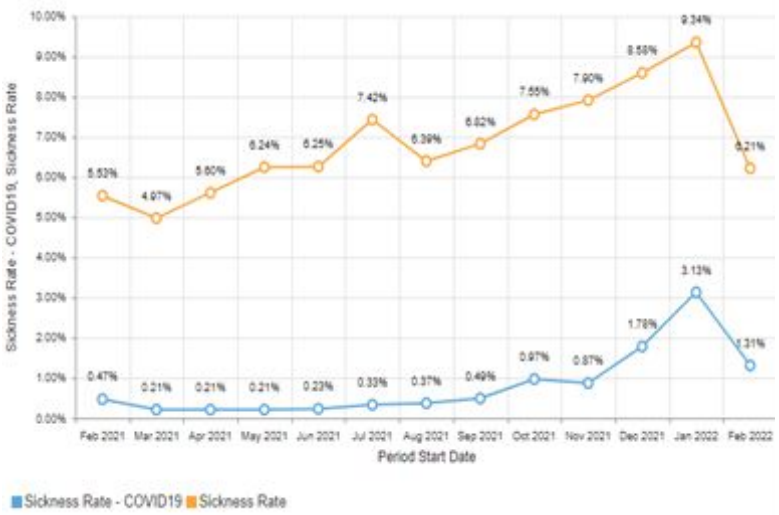
AHP's

Staff sickness/absence

Stockport NHS Foundation Trust

- In month sickness for both staff groups has seen an upward trend during the 12 months up to January 2022, however in February 2022 N&M reduced to % and AHP reduced to 3.13% (Rolling 12 month sickness rates also show upward trend)
- Covid-related sickness decreased for both staff groups in February
- N&M in-month sickness in February 2022 is 0.70% higher than February 2021
- AHP in-month sickness in February 2022 is 0.31% higher than February 2021
- Surgery is the only division to reduce sickness absence rates from March 2021 to February 2022

N&M



AHP's

Health Rostering – period 28th March – 24th April

NHS Stockport NHS Foundation Trust

Improving position every month with increasing number of 'blue sky' rosters

BG	Annual Leave %	Roster Approval (Full) Lead Time Days	Total Unavailability %	% Changed Since Approval	Total Hours balance
ED	7	83	14	21	34
IC	12.3	32.8	21.5	32.9	119.88
Medicine	13.8	31.11	24.8	40.6	199.69
S,GI&CC	13.1	32.84	26.2	32.3	264.82
W, C & D	13.9	33.25	30.5	18.2	39.55

Metric	Description	Target - Green	Amber	Red
Annual Leave %	The calculation is the sum of annual leave hours divided by the sum of contracted hours for all people on the roster divided by 100.	11% - 17%	9% - 10.9% & 17.1% - 18.9%	8.9% or below & 19% +
Roster approval (full) lead time days	The number of days the roster is approved prior to the roster commencing.	42+	30-41	0-29
Total Unavailability %	This includes, Annual Leave, Other Leave, Parenting, Sickness, Study Leave, Unknown and Working Day.	0-21%	22-34.9%	35%+
Changes Since Approval	Number of changes that have taken place on the roster since the roster was approved.	0-24.9%	25-49.9%	50% +
Unused Hours per 4 week roster	This shows the total figure for the unit over the 4 week roster period.	n/a	n/a	n/a

International Nurse Recruitment Campaign

NHS Stockport NHS Foundation Trust

- Since November 2021 116 international nurses have passed their OSCEs, received their NMC PIN and working as registered Band 5s.

- The Trust's campaign for 2022 has begun with our first group of 8 new arrivals starting at the Trust this week. A further 110 nurses will have started by the end of 2022.

- The Trust continues to be an employer of choice for international nurses. Many choose to join the Trust on the recommendation of a friend or family member already working here; contributing to a stronger workforce, ensuring retention & a supportive community.

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Recruitment Initiatives

NHS Stockport NHS Foundation Trust

- Attending university careers fairs to engage with students & promote the Trust as employer of choice
- Attending school & further educational institutes to talk about nursing as a career
- Facilitating Trust bespoke recruitment events for registered nursing staff & students. To ensure maximum promotion engaging with social media company Just-R
- Co-ordination of HCA recruitment event in central Stockport. Prime location for local people visiting shopping centre
- Engaging with NHSE/I regarding recruiting HCAs

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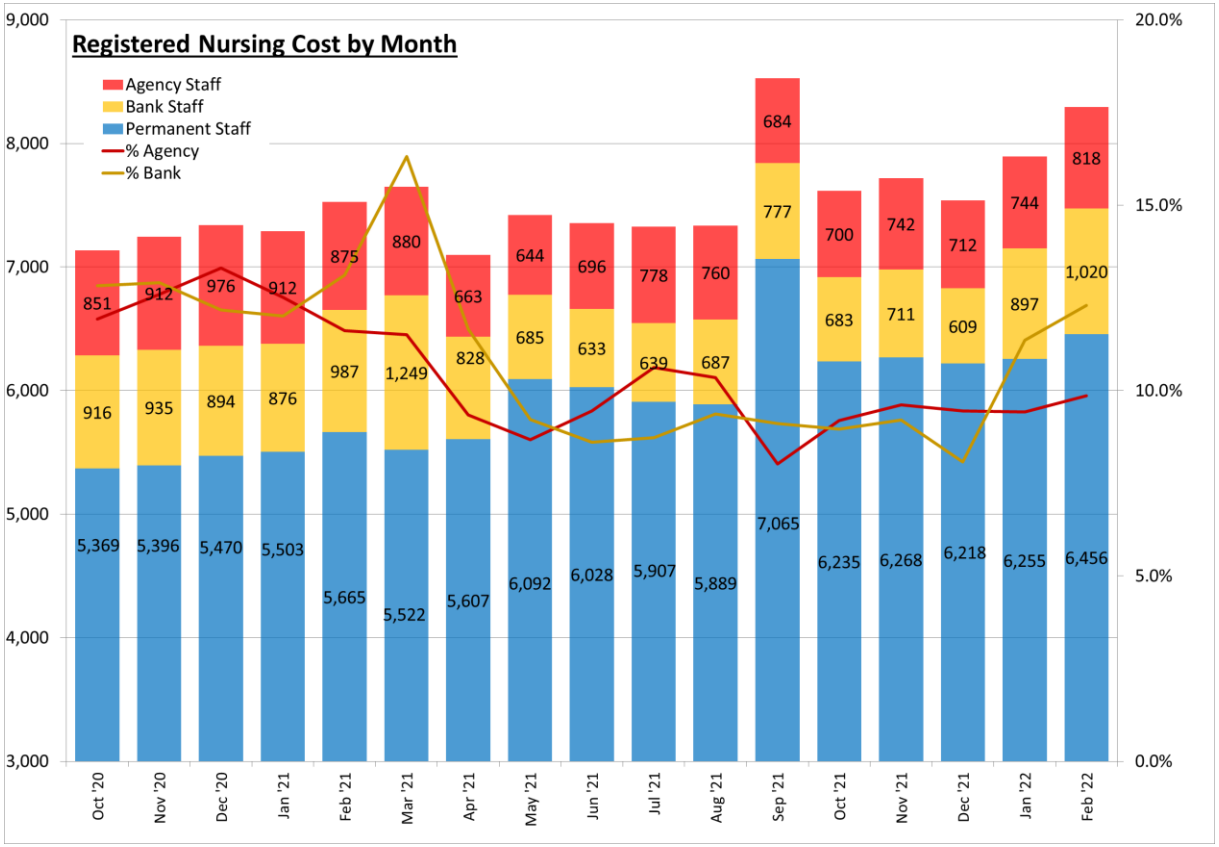
Finance

Registered Nurse staffing costs

Stockport NHS Foundation Trust

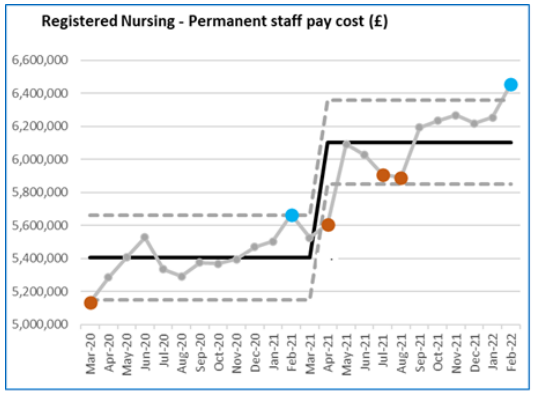
The chart below shows the registered nursing costs for the past 17 months split by permanent staff, bank and agency

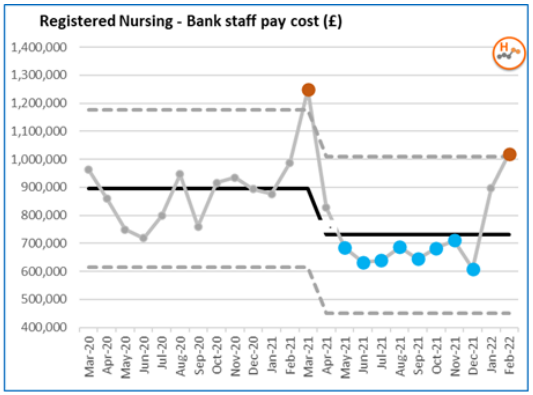


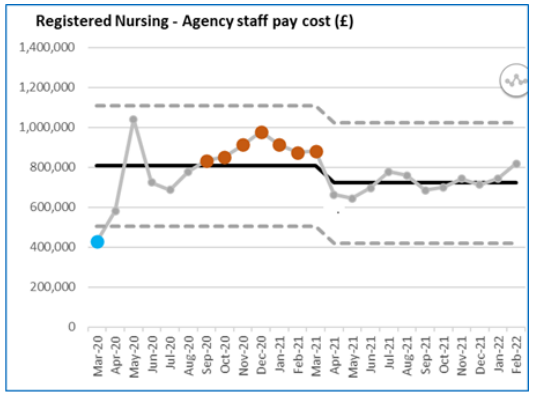
The increase in bank and agency use, has a direct correlation to the Covid-19 pandemic during the months of January and February 2022

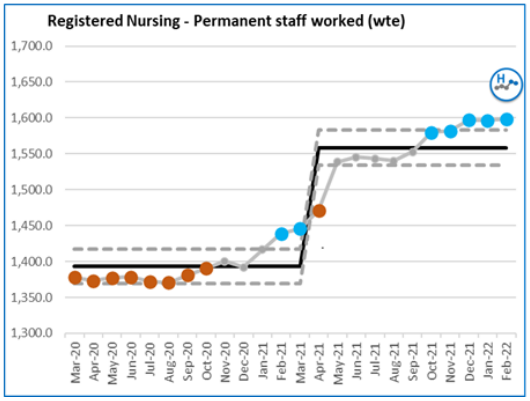
Understanding the drivers of the financial position – registered nursing cost and WTE trends

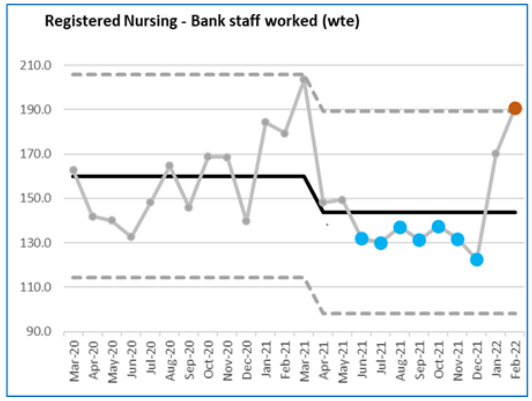
Stockport NHS Foundation Trust

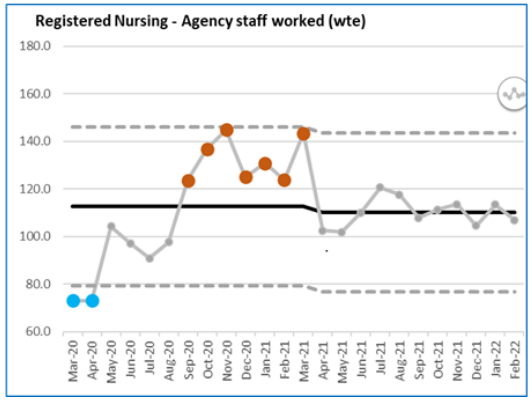












This shows an improving sustained trend, in the numbers of permanent WTE over the past 5 months

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Health & Well Being

Staff Health & Wellbeing

Stockport NHS Foundation Trust

- There is a continued awareness of the immense pressure staff are under currently and how their usual support mechanisms may be impacted upon their health and wellbeing remains a priority
- The Trust has supported the clinical psychology teams to provide support to teams
- Senior Nurse walk around continues to have a focus on staff wellbeing
- Executive walkabout Wednesday has been introduced with a focus on staff wellbeing
- The Trust are working with colleagues from the mental health Trust to promote support for all staff.

Stockport NHS Foundation Trust

Meeting date	7 April 2022	X	Public		Confidential	Agenda item
Meeting	Board of Directors					
Title	2021 NHS Staff Survey Results					
Lead Director	Director of People & OD	Author	Head of Learning & OD			

Recommendations made/ Decisions requested

The Board of Directors are requested to asked to receive the 2021 NHS Staff Survey results for Stockport NHS Foundation Trust, and note that the results have been considered by the People Performance Committee in March 2022 and will be distributed to Divisional Leadership teams for consideration and action.

This paper relates to the following Corporate Annual Objectives -

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

The paper relates to the following CQC domains -

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

This paper is related to these BAF risks		**PR1.1**	There is a risk that the Trust delivers sub-optimal quality services and fails to meet regulatory standards
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		PR7.4	There is a risk that the Trust fails to develop and implement a responsive and resilient Digital Strategy

Where issues are addressed in the paper-

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

Executive Summary

The 2021 NHS Staff Survey Results have been presented in alignment with the NHS People Plan & People Promise. In 2021 the Trust undertook a full census survey, via a mixed mode of questionnaires (paper & email). There were 2392 responses received, which is 43% of eligible staff and falls below the national average of 46.4%.

Our results are benchmarked against 126 Acute and Acute and Community providers.

Highlights

- Q21b My organisation acts on concerns raised by patients/service users up from 68.5% to 69.5%
- Q16b In the last 12 months have you personally experienced discrimination at work from manager/team leader/colleague? Decreased from 8% to 6.9%
- I would feel secure raising concerns about unsafe clinical practice increased from 71.4% to 74.9% and above the average for all other organisations in our peer group
- I have adequate materials, supplies and equipment to do my work increased to 49.5% form 47.1%
- Team working scores increased and above the average (7a, 7b,7c 7d,7e)
- Line management scores also increased and above the average.
- EDI scores positive.

Lowlights

- Recommendation as a place to work whilst remained unchanged our score falls below the average (55.5% compared with the average of 58.4%)
- If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation reports a slight decline, falling below the average (59.8% compared with 66.9%)

- Scores around feeling recognised and rewarded are slightly below the average.
- My organisation is committed to helping me balance my work and home life is below the average; however, we do score favourably in relation staff feeling able to approach their immediate line manager and talk openly about flexible working
- Staff engagement scores, motivation & advocacy decreased on previous year.
- Staff intention to leave is marginally higher than 2021 (32.7% up from 31%) and this score is higher than the average (31.3%).

- However, comparing Stockport FT's results with those across England, Stockport was in the category of the most improved five hospitals in England.

Next Steps

- Following the removal of the embargo on 30th March 2022 our results will be widely shared with Divisional Leadership Teams, and colleagues to share the findings and to shape the actions / required responses.

National NHS Staff Survey 2021

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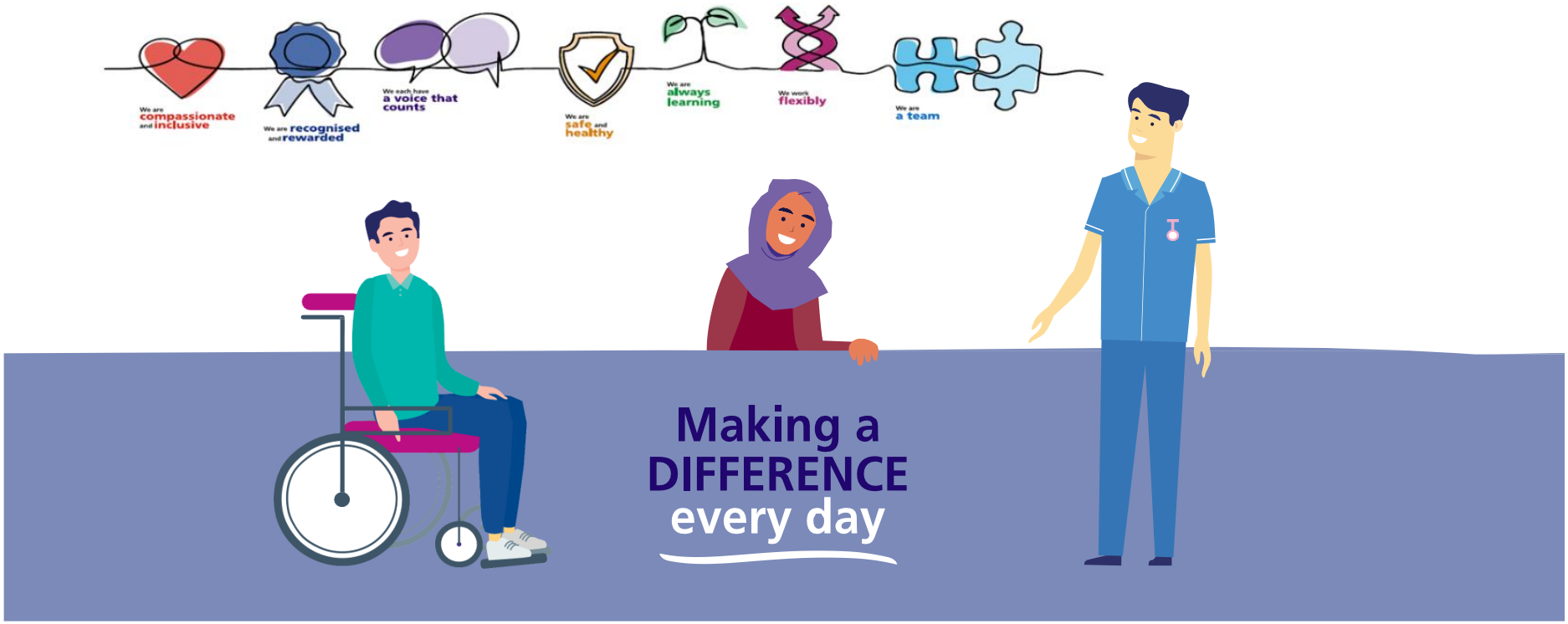


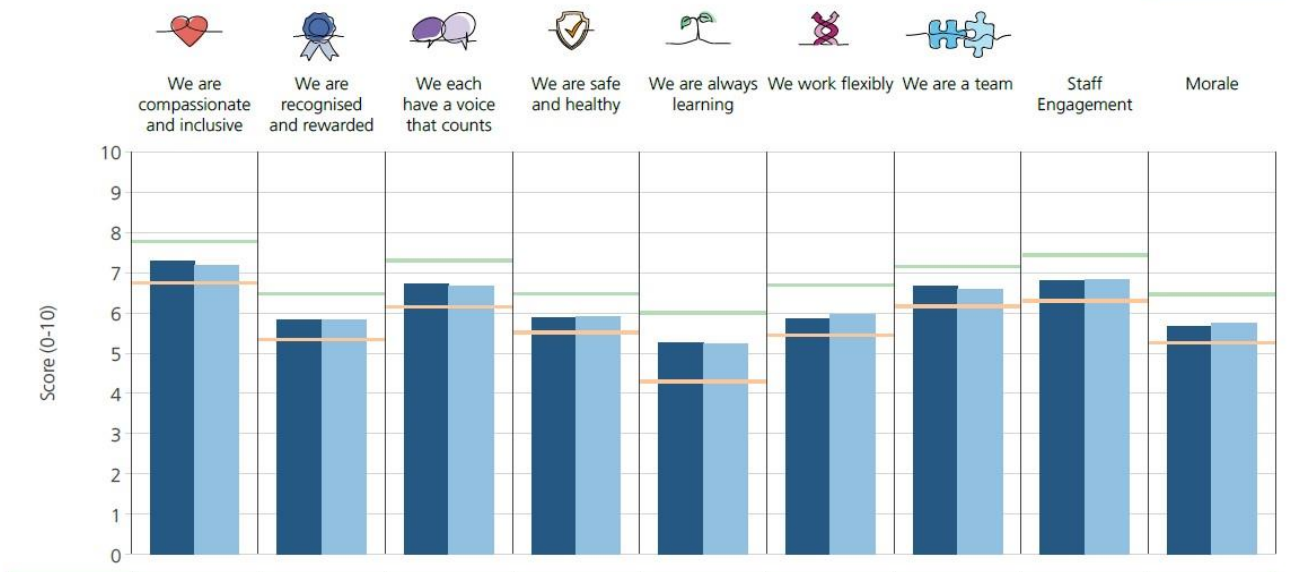
Overview

Survey Coordination Centre

2021 NHS Staff Survey Results > People Promise and theme results > **Overview**

NHS

NHS Stockport NHS Foundation Trust



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Best	7.8	6.5	7.3	6.5	6.0	6.7	7.1	7.4	6.5
Your org	7.3	5.8	6.7	5.9	5.3	5.9	6.7	6.8	5.7
Average	7.2	5.8	6.7	5.9	5.2	5.9	6.6	6.8	5.7
Worst	6.7	5.3	6.1	5.5	4.3	5.4	6.2	6.3	5.3
Responses	2,256	2,304	2,226	2,248	2,159	2,289	2,271	2,309	2,303

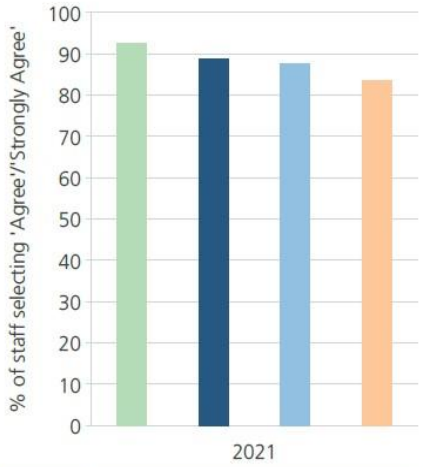
9

We are in line with the benchmark (our peer organisations) average or above, against all areas.

We are compassionate and inclusive

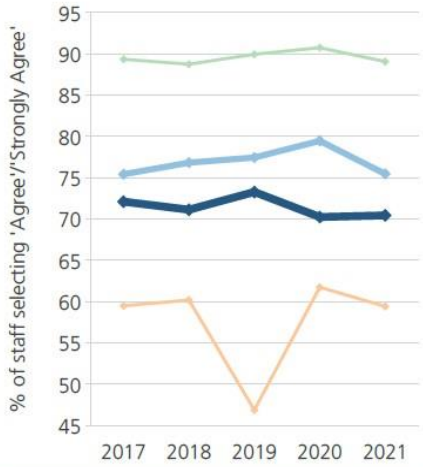
Q6a
I feel that my role makes a difference to patients / service users

Due to changes in this year's survey it is not possible to display trend data for this question



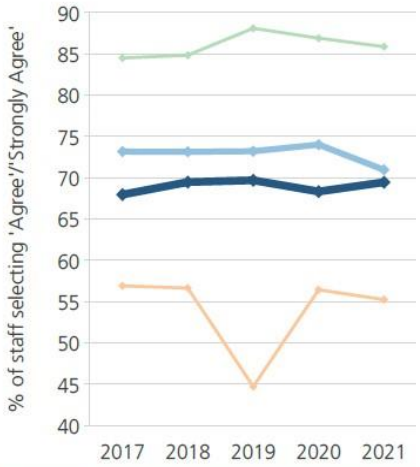
Best	92.6%
Your org	88.8%
Average	87.7%
Worst	83.5%
Responses	2,224

Q21a
Care of patients / service users is my organisation's top priority



Best	89.3%	88.7%	90.0%	90.7%	89.1%
Your org	72.1%	71.1%	73.3%	70.2%	70.4%
Average	75.4%	76.8%	77.4%	79.5%	75.5%
Worst	59.5%	60.2%	46.9%	61.7%	59.4%
Responses	2,033	596	2,675	2,663	2,234

Q21b
My organisation acts on concerns raised by patients / service users



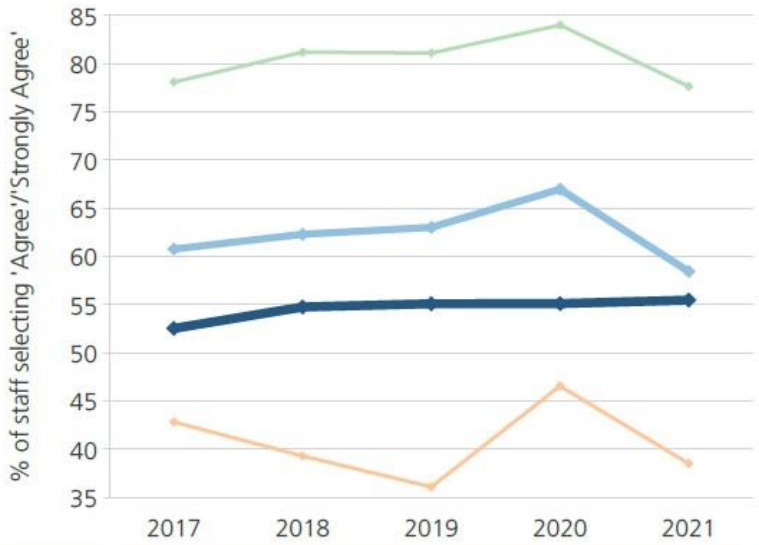
Best	84.5%	84.8%	88.1%	86.9%	85.9%
Your org	68.0%	69.5%	69.7%	68.3%	69.5%
Average	73.2%	73.1%	73.2%	74.0%	71.0%
Worst	56.9%	56.6%	44.7%	56.4%	55.2%
Responses	2,031	593	2,668	2,660	2,231

NHS Stockport NHS Foundation Trust

- ✓ Our response for 2021 has improved.
- ✓ Q21a of care of patients being our priority – improved slightly.
- ✓ Q21b in relation to raising concerns – improved..

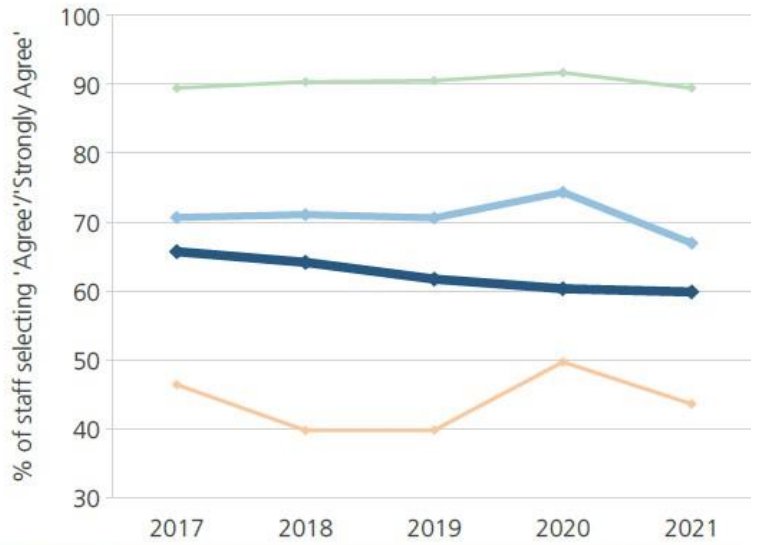
We are compassionate and inclusive

Q21c
I would recommend my organisation as a place to work



	2017	2018	2019	2020	2021
Best	78.1%	81.2%	81.1%	84.0%	77.6%
Your org	52.5%	54.8%	55.1%	55.1%	55.5%
Average	60.8%	62.3%	63.0%	67.0%	58.4%
Worst	42.8%	39.3%	36.1%	46.5%	38.5%
Responses	2,033	595	2,661	2,670	2,235

Q21d
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation

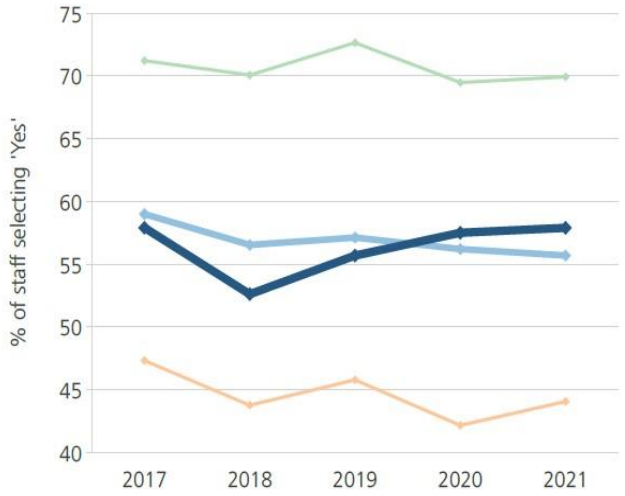


	2017	2018	2019	2020	2021
Best	89.5%	90.4%	90.5%	91.7%	89.5%
Your org	65.7%	64.1%	61.7%	60.3%	59.8%
Average	70.7%	71.1%	70.6%	74.3%	66.9%
Worst	46.4%	39.7%	39.8%	49.7%	43.6%
Responses	2,025	598	2,670	2,665	2,235

We are compassionate and inclusive

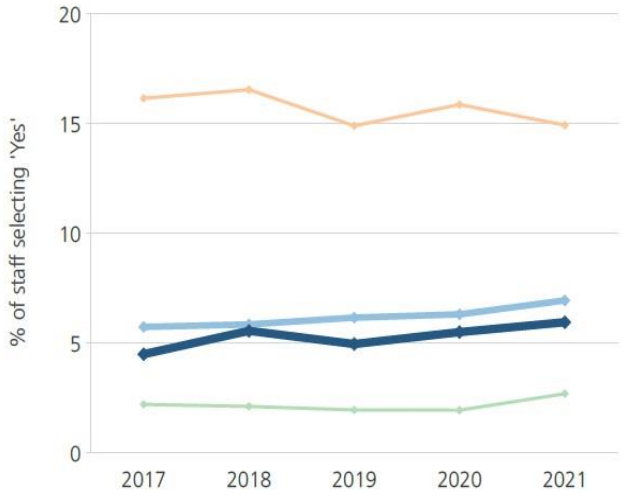
Diversity & Equality and Inclusion

Q15
Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?



	2017	2018	2019	2020	2021
Best	71.2%	70.1%	72.6%	69.5%	69.9%
Your org	57.9%	52.6%	55.7%	57.5%	57.9%
Average	59.0%	56.5%	57.1%	56.2%	55.7%
Worst	47.3%	43.8%	45.8%	42.2%	44.1%
Responses	2,022	602	2,699	2,680	2,243

Q16a
In the last 12 months have you personally experienced discrimination at work from patients / service users, their relatives or other members of the public?



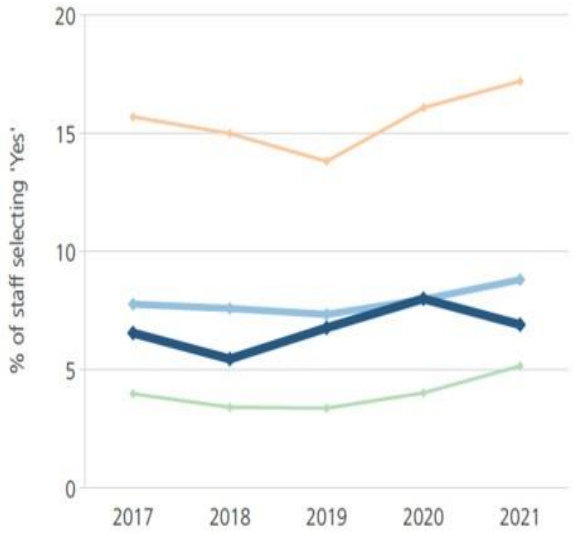
	2017	2018	2019	2020	2021
Worst	16.1%	16.5%	14.9%	15.8%	14.9%
Your org	4.5%	5.5%	4.9%	5.5%	5.9%
Average	5.7%	5.8%	6.1%	6.3%	6.9%
Best	2.2%	2.1%	1.9%	1.9%	2.7%
Responses	2,037	601	2,705	2,680	2,259

NHS Stockport NHS Foundation Trust

We are compassionate and inclusive

Diversity & Equality and Inclusion

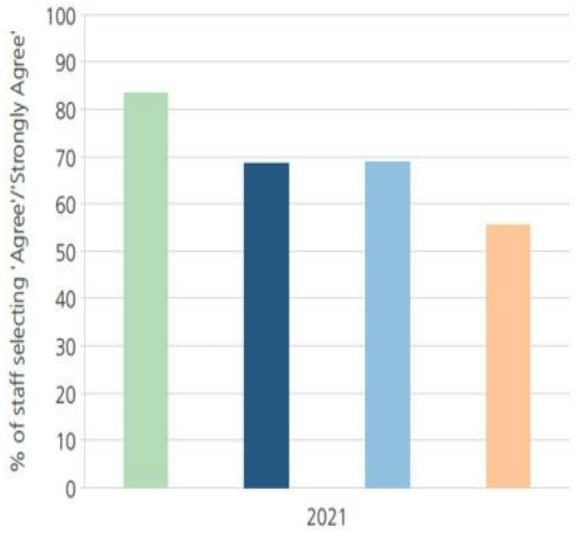
Q16b
In the last 12 months have you personally experienced discrimination at work from manager / team leader or other colleagues?



	2017	2018	2019	2020	2021
Worst	15.7%	15.0%	13.8%	16.1%	17.2%
Your org	6.5%	5.4%	6.8%	8.0%	6.9%
Average	7.8%	7.6%	7.3%	8.0%	8.8%
Best	4.0%	3.4%	3.4%	4.0%	5.1%
Responses	2,047	590	2,702	2,679	2,257

Q18
I think that my organisation respects individual differences (e.g. cultures, working styles, backgrounds, ideas, etc).

No trend data are shown as this is a new question



	2021
Best	83.4%
Your org	68.7%
Average	68.8%
Worst	55.5%
Responses	2,253

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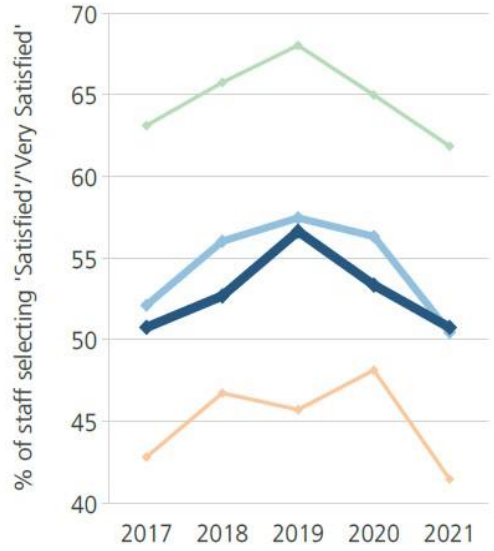
We are recognised and rewarded

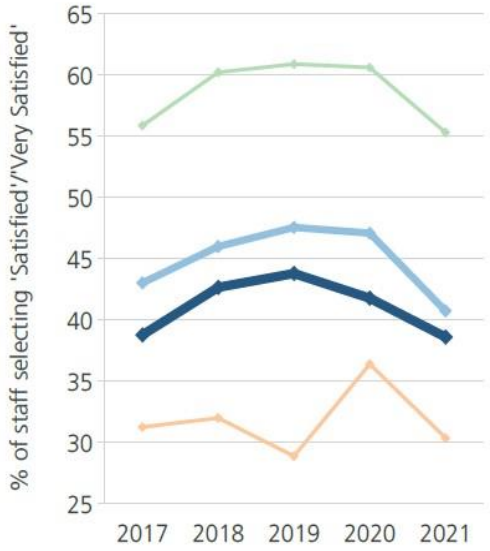
We are recognised and rewarded

Q4a
The recognition I get for good work



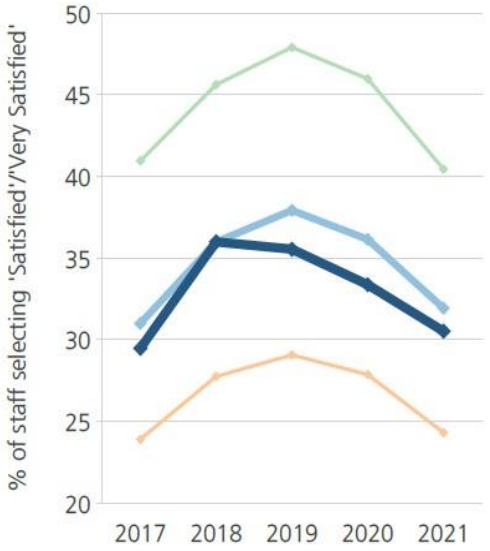
	2017	2018	2019	2020	2021
Best	63.1%	65.8%	68.0%	65.0%	61.9%
Your org	50.8%	52.7%	56.6%	53.3%	50.7%
Average	52.1%	56.0%	57.5%	56.3%	50.5%
Worst	42.8%	46.7%	45.7%	48.1%	41.5%
Responses	2,121	607	2,741	2,717	2,306

Q4b
The extent to which my organisation values my work



	2017	2018	2019	2020	2021
Best	55.8%	60.2%	60.8%	60.6%	55.2%
Your org	38.7%	42.6%	43.7%	41.7%	38.5%
Average	43.0%	45.9%	47.5%	47.0%	40.7%
Worst	31.2%	31.9%	28.8%	36.3%	30.3%
Responses	2,111	607	2,738	2,706	2,303

Q4c
My level of pay



	2017	2018	2019	2020	2021
Best	40.9%	45.6%	47.9%	46.0%	40.4%
Your org	29.5%	36.0%	35.5%	33.4%	30.5%
Average	31.0%	36.0%	37.9%	36.1%	31.9%
Worst	23.9%	27.8%	29.1%	27.9%	24.3%
Responses	2,120	608	2,731	2,710	2,298

We each have a voice that counts

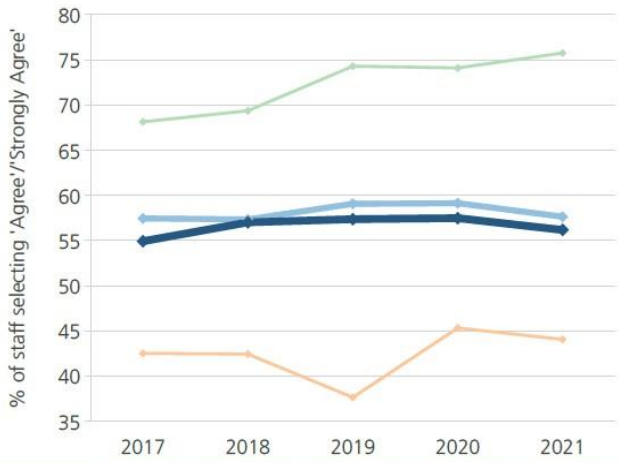
Raising Concerns

NHS Stockport NHS Foundation Trust

Q17a
I would feel secure raising concerns about unsafe clinical practice

	2017	2018	2019	2020	2021
Best	76.4%	76.9%	79.7%	77.7%	82.9%
Your org	71.5%	70.8%	69.6%	71.3%	74.9%
Average	69.4%	69.8%	70.8%	71.8%	73.9%
Worst	58.9%	60.8%	58.7%	62.7%	66.2%
Responses	2,052	596	2,689	2,667	2,260

Q17b
I am confident that my organisation would address my concern



	2017	2018	2019	2020	2021
Best	68.1%	69.4%	74.3%	74.1%	75.7%
Your org	54.9%	57.0%	57.4%	57.5%	56.2%
Average	57.4%	57.3%	59.1%	59.1%	57.6%
Worst	42.5%	42.4%	37.6%	45.3%	44.1%
Responses	2,051	596	2,689	2,672	2,258

We are safe and healthy

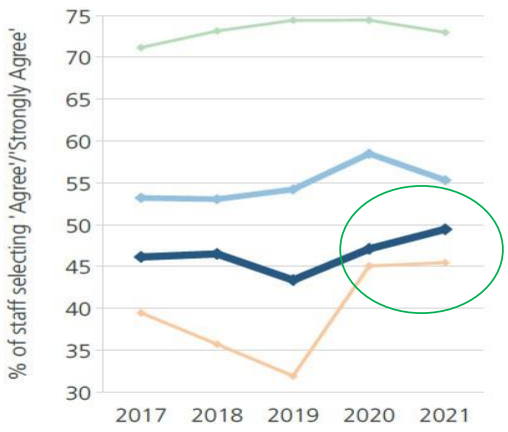
Health and Safety Climate

NHS Stockport NHS Foundation Trust

Q3g
I am able to meet all the conflicting demands on my time at work

	2017	2018	2019	2020	2021
Best	61.8%	59.4%	59.2%	62.1%	54.7%
Your org	39.7%	42.3%	42.7%	43.8%	42.4%
Average	44.8%	45.1%	46.7%	47.6%	43.3%
Worst	36.6%	36.1%	36.2%	38.4%	34.6%
Responses	2,112	610	2,741	2,706	2,302

Q3h
I have adequate materials, supplies and equipment to do my work



	2017	2018	2019	2020	2021
Best	71.2%	73.2%	74.4%	74.4%	73.0%
Your org	46.1%	46.5%	43.4%	47.1%	49.5%
Average	53.2%	53.0%	54.2%	58.5%	55.3%
Worst	39.5%	35.7%	31.9%	45.1%	45.5%
Responses	2,116	607	2,749	2,714	2,308

Q3i
There are enough staff at this organisation for me to do my job properly

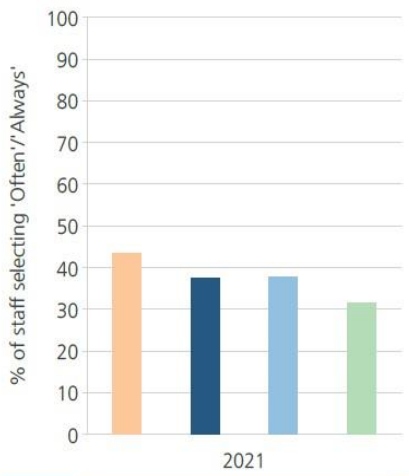
	2017	2018	2019	2020	2021
Best	44.4%	44.5%	48.1%	52.4%	37.8%
Your org	26.4%	24.5%	23.1%	27.8%	22.9%
Average	30.2%	30.6%	30.9%	36.9%	26.0%
Worst	20.3%	19.3%	20.9%	26.1%	18.2%
Responses	2,121	606	2,748	2,709	2,308

We are safe and healthy

Burnout

Q12a
How often, if at all, do you find your work emotionally exhausting?

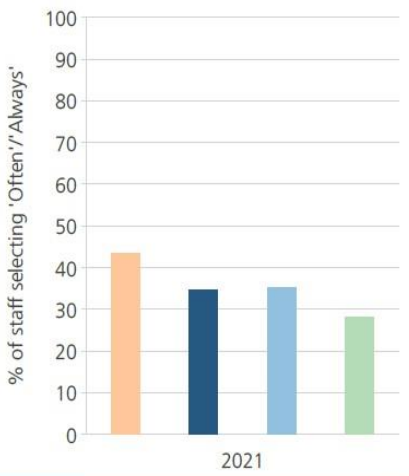
No trend data are shown as this is a new question



Worst	43.4%
Your org	37.5%
Average	37.7%
Best	31.4%
Responses	2,261

Q12b
How often, if at all, do you feel burnt out because of your work?

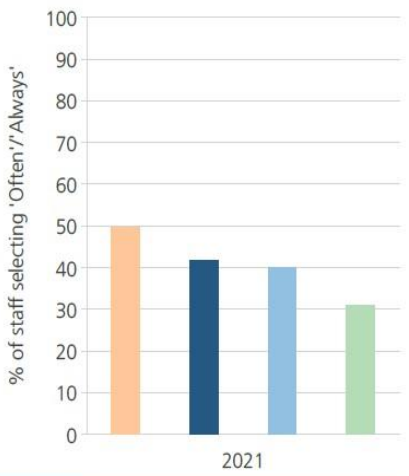
No trend data are shown as this is a new question



Worst	43.3%
Your org	34.7%
Average	35.2%
Best	28.1%
Responses	2,259

Q12c
How often, if at all, does your work frustrate you?

No trend data are shown as this is a new question



Worst	49.7%
Your org	41.6%
Average	39.9%
Best	30.8%
Responses	2,261

NHS Stockport NHS Foundation Trust

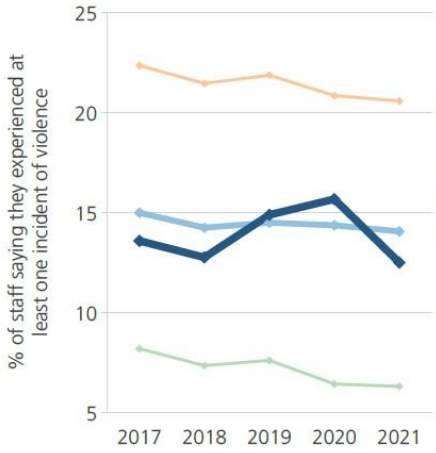
This is a new group of questions for 2021 and therefore there are no comparators for previous years.

We are safe and healthy

Negative Experiences

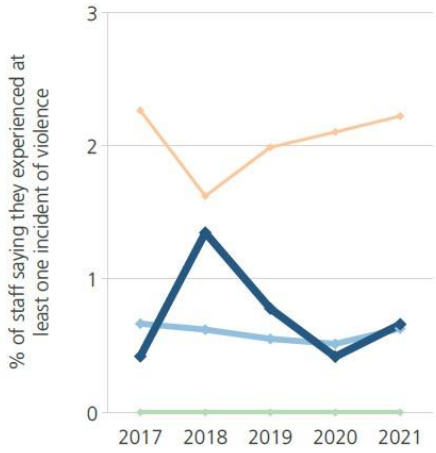
NHS Stockport IS Foundation Trust

Q13a
In the last 12 months how many times have you personally experienced physical violence at work from patients / service users, their relatives or other members of the public?



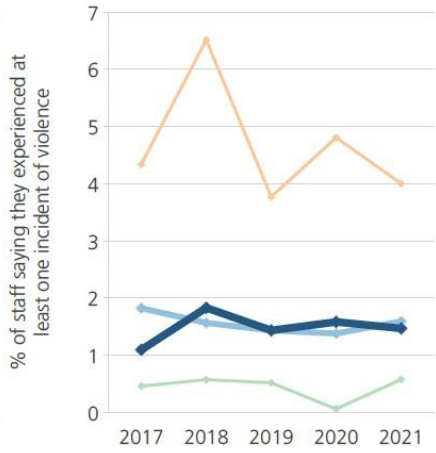
	2017	2018	2019	2020	2021
Worst	22.3%	21.4%	21.8%	20.8%	20.6%
Your org	13.6%	12.7%	14.9%	15.7%	12.5%
Average	15.0%	14.2%	14.5%	14.3%	14.0%
Best	8.2%	7.3%	7.6%	6.4%	6.3%
Responses	2,051	602	2,713	2,693	2,258

Q13b
In the last 12 months how many times have you personally experienced physical violence at work from managers?



	2017	2018	2019	2020	2021
Worst	2.3%	1.6%	2.0%	2.1%	2.2%
Your org	0.4%	1.3%	0.8%	0.4%	0.7%
Average	0.7%	0.6%	0.6%	0.5%	0.6%
Best	0.0%	0.0%	0.0%	0.0%	0.0%
Responses	2,021	598	2,692	2,677	2,245

Q13c
In the last 12 months how many times have you personally experienced physical violence at work from other colleagues?



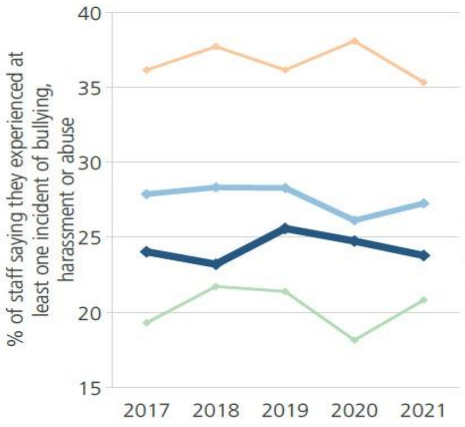
	2017	2018	2019	2020	2021
Worst	4.3%	6.5%	3.8%	4.8%	4.0%
Your org	1.1%	1.8%	1.4%	1.6%	1.5%
Average	1.8%	1.6%	1.4%	1.4%	1.6%
Best	0.5%	0.6%	0.5%	0.1%	0.6%
Responses	2,017	595	2,691	2,681	2,241

We are safe and healthy

Negative Experiences

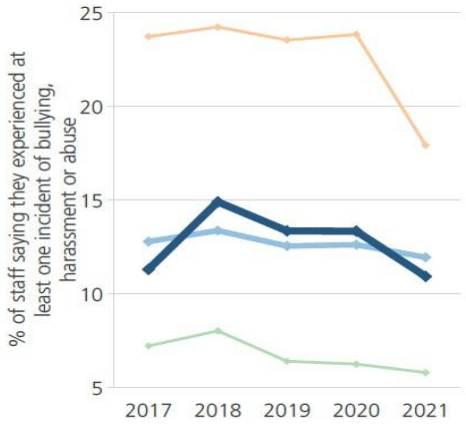
NHS Stockport NHS Foundation Trust

Q14a
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from patients / service users, their relatives or other members of the public?



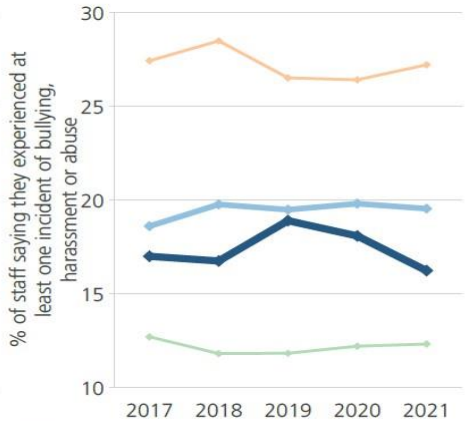
	2017	2018	2019	2020	2021
Worst	36.1%	37.7%	36.1%	38.1%	35.3%
Your org	24.0%	23.2%	25.6%	24.7%	23.8%
Average	27.9%	28.3%	28.3%	26.1%	27.3%
Best	19.3%	21.7%	21.4%	18.1%	20.8%
Responses	2,045	600	2,695	2,577	2,169

Q14b
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from managers?



	2017	2018	2019	2020	2021
Worst	23.7%	24.2%	23.5%	23.8%	17.9%
Your org	11.3%	14.9%	13.3%	13.3%	10.9%
Average	12.8%	13.3%	12.5%	12.6%	11.9%
Best	7.2%	8.0%	6.4%	6.2%	5.8%
Responses	2,009	595	2,677	2,564	2,159

Q14c
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from other colleagues?



	2017	2018	2019	2020	2021
Worst	27.4%	28.5%	26.5%	26.4%	27.2%
Your org	17.0%	16.7%	18.9%	18.1%	16.2%
Average	18.6%	19.7%	19.5%	19.8%	19.5%
Best	12.7%	11.8%	11.8%	12.2%	12.3%
Responses	2,014	588	2,678	2,570	2,156

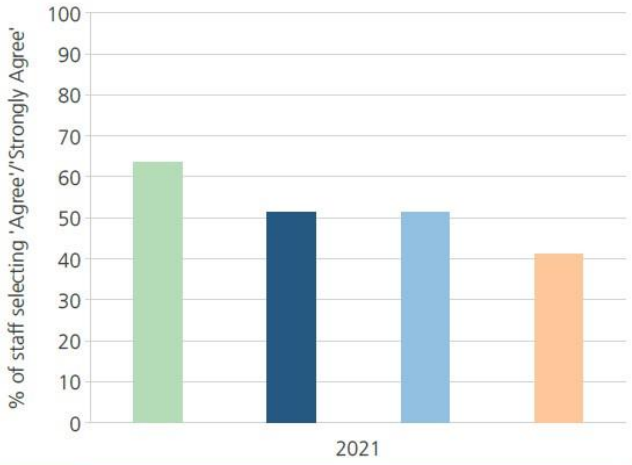
We are always learning

Development & Appraisals

NHS Stockport NHS Foundation Trust

Q20d
I feel supported to develop my potential

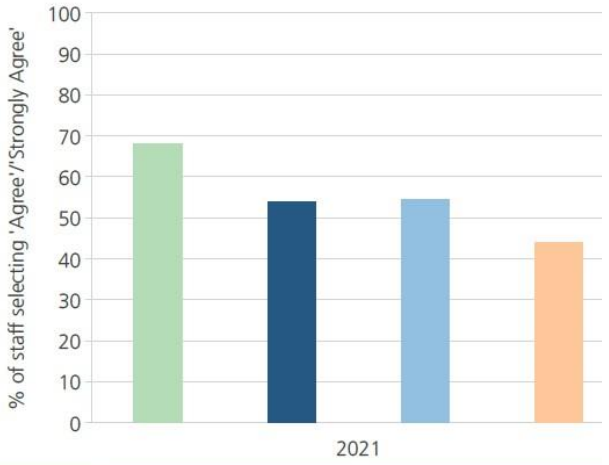
No trend data are shown as this is a new question



Best	63.5%
Your org	51.3%
Average	51.3%
Worst	41.0%
Responses	2,250

Q20e
I am able to access the right learning and development opportunities when I need to

No trend data are shown as this is a new question



Best	68.0%
Your org	53.8%
Average	54.4%
Worst	44.1%
Responses	2,249

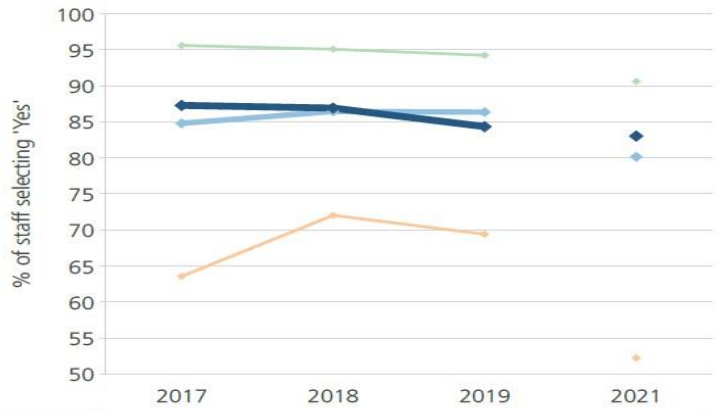
We are always learning

Development & Appraisals

NHS Stockport NHS Foundation Trust

Q19a
In the last 12 months, have you had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review?

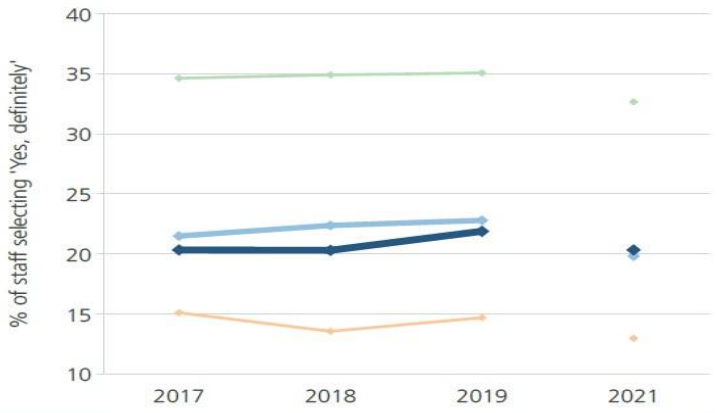
Note that Q19a-d were not asked in 2020. In interpreting these results, consideration should be given to the gap in the data series and evidence of changes to the response profiles over time.



	2017	2018	2019	2021
Highest	95.6%	95.1%	94.2%	90.6%
Your org	87.3%	86.9%	84.3%	83.0%
Average	84.8%	86.4%	86.3%	80.1%
Lowest	63.5%	72.0%	69.4%	52.2%
Responses	2,037	597	2,687	2,258

Q19b
It helped me to improve how I do my job

Note that Q19a-d were not asked in 2020. In interpreting these results, consideration should be given to the gap in the data series and evidence of changes to the response profiles over time.



	2017	2018	2019	2021
Best	34.6%	34.9%	35.1%	32.7%
Your org	20.3%	20.3%	21.9%	20.3%
Average	21.5%	22.4%	22.8%	19.8%
Worst	15.1%	13.6%	14.7%	13.0%
Responses	1,749	517	2,245	1,860

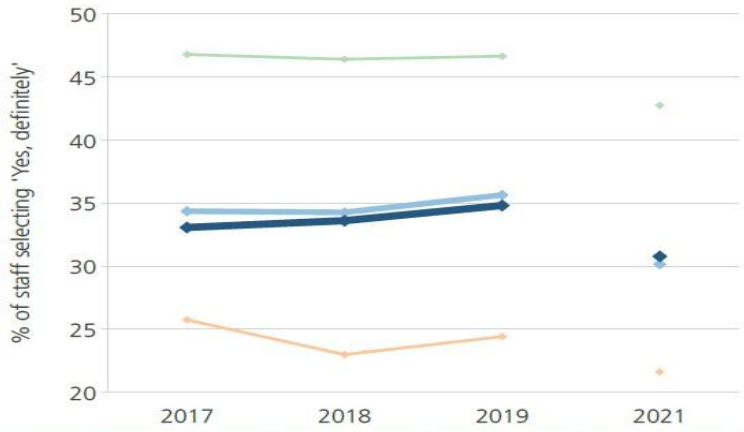
We are always learning

Development & Appraisals

NHS Stockport NHS Foundation Trust

Q19c
It helped me agree clear objectives for my work

Note that Q19a-d were not asked in 2020. In interpreting these results, consideration should be given to the gap in the data series and evidence of changes to the response profiles over time.



	2017	2018	2019	2021
Best	46.8%	46.4%	46.7%	42.8%
Your org	33.1%	33.6%	34.8%	30.8%
Average	34.4%	34.3%	35.6%	30.2%
Worst	25.7%	23.0%	24.4%	21.6%
Responses	1,751	516	2,247	1,859

Q19d
It left me feeling that my work is valued by my organisation

Note that Q19a-d were not asked in 2020. In interpreting these results, consideration should be given to the gap in the data series and evidence of changes to the response profiles over time.

	2017	2018	2019	2021
Best	42.1%	42.4%	43.4%	38.9%
Your org	26.1%	28.0%	30.3%	29.2%
Average	29.8%	31.7%	33.2%	29.3%
Worst	21.8%	20.8%	18.9%	21.6%
Responses	1,747	513	2,246	1,857

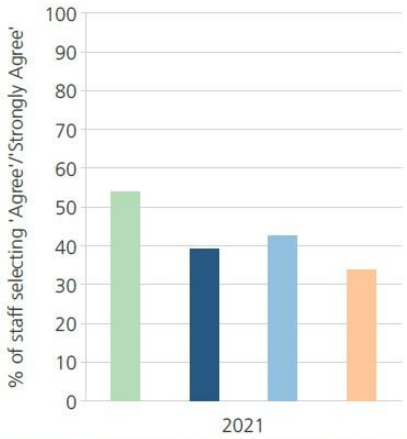
We work flexibly

Support for work -life balance & working flexibly

NHS Stockport NHS Foundation Trust

Q6b
My organisation is committed to helping me balance my work and home life

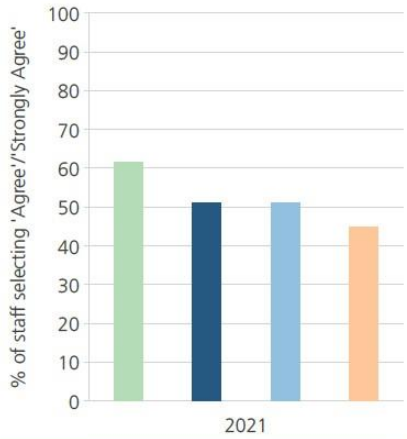
No trend data are shown as this is a new question



Best	53.8%
Your org	39.2%
Average	42.6%
Worst	33.8%
Responses	2,296

Q6c
I achieve a good balance between my work life and my home life

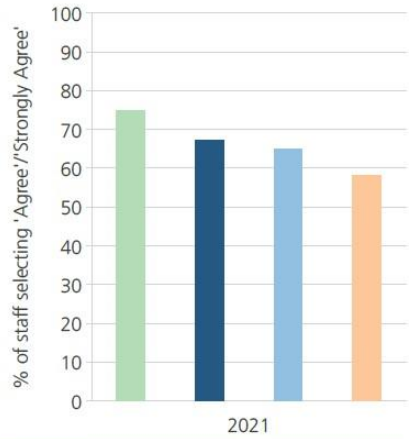
No trend data are shown as this is a new question



Best	61.6%
Your org	51.1%
Average	51.1%
Worst	44.7%
Responses	2,300

Q6d
I can approach my immediate manager to talk openly about flexible working

No trend data are shown as this is a new question



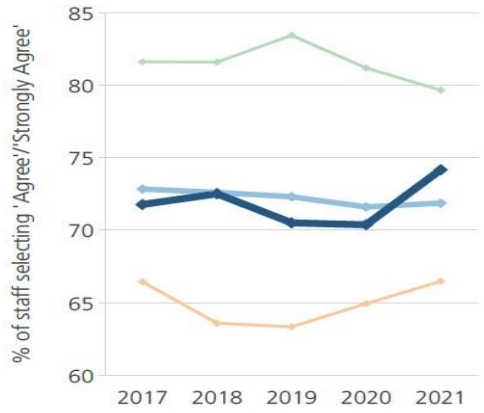
Best	74.8%
Your org	67.2%
Average	65.0%
Worst	58.2%
Responses	2,299

We are a team

Team working

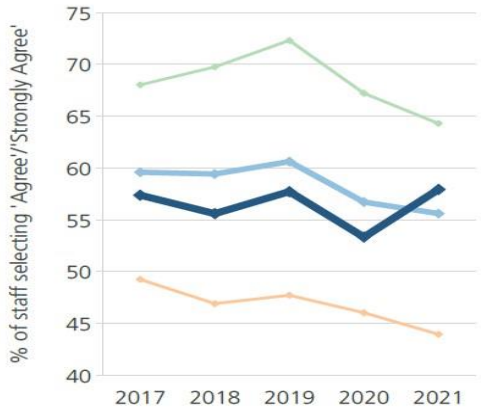
NHS Stockport NHS Foundation Trust

Q7a
The team I work in has a set of shared objectives



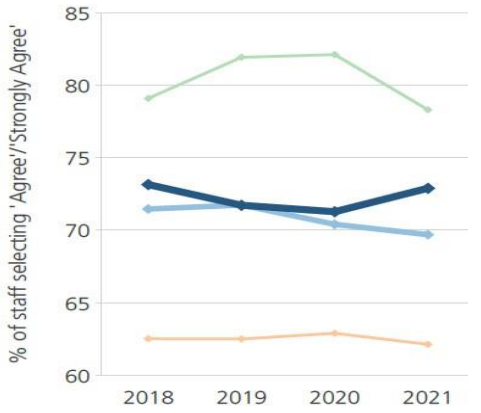
	2017	2018	2019	2020	2021
Best	81.6%	81.6%	83.4%	81.2%	79.6%
Your org	71.8%	72.5%	70.5%	70.4%	74.2%
Average	72.8%	72.6%	72.3%	71.6%	71.9%
Worst	66.4%	63.6%	63.3%	64.9%	66.5%
Responses	2,120	607	2,723	2,678	2,289

Q7b
The team I work in often meets to discuss the team's effectiveness



	2017	2018	2019	2020	2021
Best	68.0%	69.8%	72.3%	67.2%	64.3%
Your org	57.4%	55.6%	57.7%	53.3%	57.9%
Average	59.6%	59.4%	60.6%	56.7%	55.6%
Worst	49.2%	46.9%	47.7%	46.0%	43.9%
Responses	2,124	608	2,748	2,708	2,293

Q7c
I receive the respect I deserve from my colleagues at work



	2018	2019	2020	2021
Best	79.1%	81.9%	82.1%	78.3%
Your org	73.1%	71.7%	71.3%	72.9%
Average	71.5%	71.7%	70.4%	69.7%
Worst	62.5%	62.5%	62.9%	62.1%
Responses	607	2,760	2,716	2,296

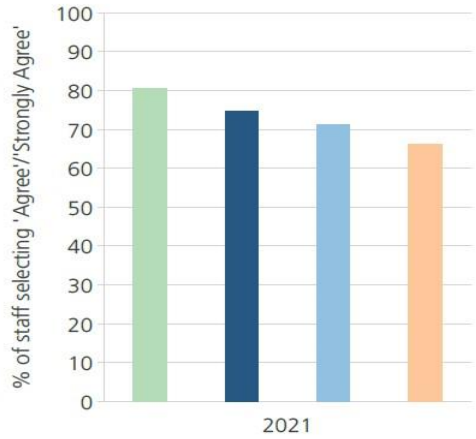
We are a team

Team working

NHS Stockport NHS Foundation Trust

Q7d
Team members understand each other's roles

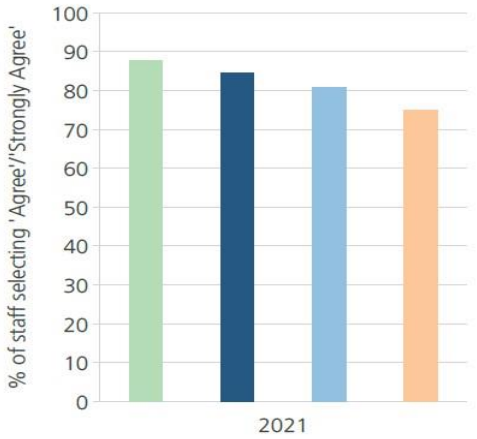
No trend data are shown as this is a new question



Best	80.6%
Your org	74.6%
Average	71.3%
Worst	66.1%
Responses	2,290

Q7e
I enjoy working with the colleagues in my team

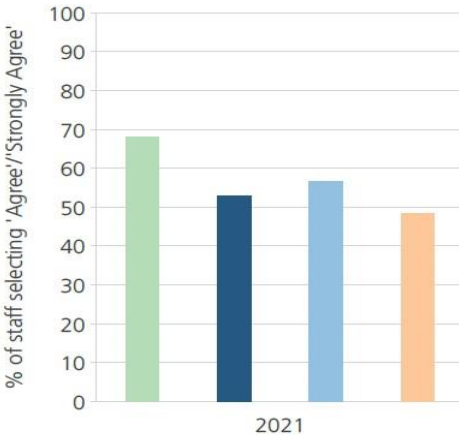
No trend data are shown as this is a new question



Best	87.6%
Your org	84.6%
Average	80.7%
Worst	74.9%
Responses	2,292

Q7f
My team has enough freedom in how to do its work

No trend data are shown as this is a new questio



Best	68.0%
Your org	52.8%
Average	56.6%
Worst	48.2%
Responses	2,291

We are a team

Line Management

NHS Stockport NHS Foundation Trust

My immediate manager encourages me at work

	2018	2019	2020	2021
Best	76.9%	79.3%	77.3%	77.8%
Your org	64.1%	69.6%	69.4%	71.0%
Average	68.5%	70.2%	69.2%	69.0%
Worst	60.0%	56.8%	60.5%	61.6%
Responses	606	2,726	2,699	2,269

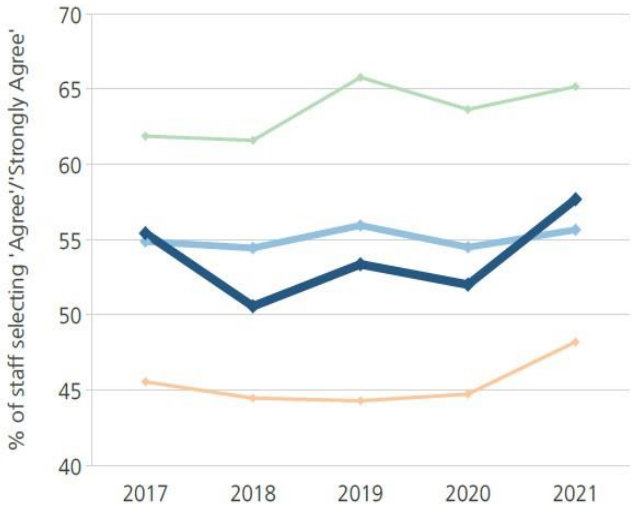
My immediate manager gives me clear feedback on my work

	2017	2018	2019	2020	2021
Best	69.1%	69.3%	71.7%	70.3%	70.6%
Your org	64.1%	56.8%	61.4%	60.7%	63.3%
Average	61.2%	60.5%	61.9%	60.6%	60.7%
Worst	52.3%	50.7%	48.0%	51.3%	53.0%
Responses	2,061	603	2,727	2,699	2,270

We are a team

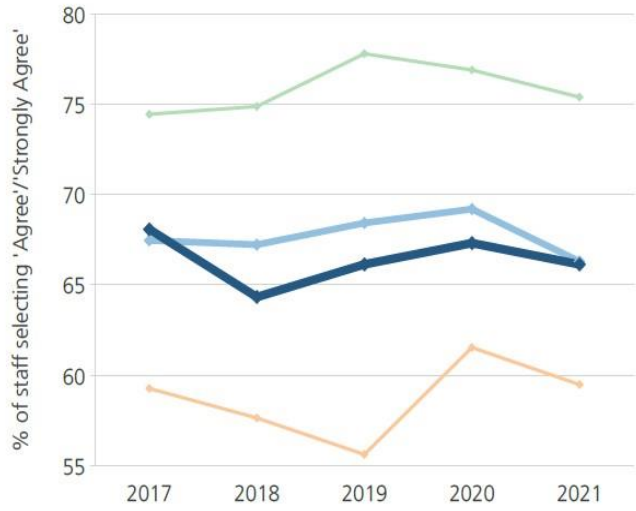
Line Management

Q9c
My immediate manager asks for my opinion before making decisions that affect my work



	2017	2018	2019	2020	2021
Best	61.9%	61.6%	65.8%	63.6%	65.2%
Your org	55.4%	50.6%	53.4%	52.0%	57.7%
Average	54.9%	54.4%	55.9%	54.5%	55.7%
Worst	45.6%	44.5%	44.3%	44.7%	48.2%
Responses	2,060	603	2,726	2,694	2,270

Q9d
My immediate manager takes a positive interest in my health and well-being



	2017	2018	2019	2020	2021
Best	74.4%	74.9%	77.8%	76.9%	75.4%
Your org	68.1%	64.3%	66.1%	67.3%	66.1%
Average	67.5%	67.2%	68.4%	69.2%	66.3%
Worst	59.3%	57.6%	55.6%	61.5%	59.5%
Responses	2,060	601	2,726	2,697	2,267

NHS Stockport NHS Foundation Trust

NHS
Stockport
NHS Foundation Trust

Themes –
Staff Engagement and Morale
WRES & WDES

Making a DIFFERENCE every day

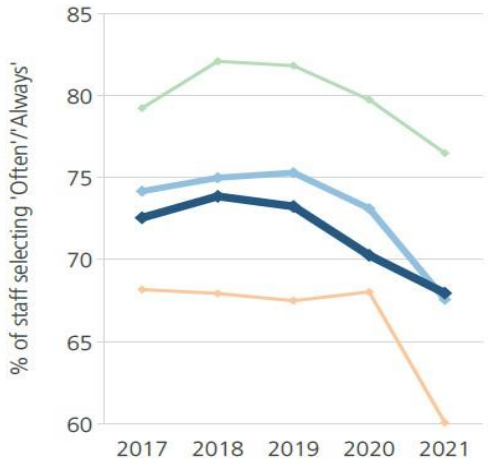
Staff Engagement – Motivation, Involvement and Advocacy

NHS Stockport NHS Foundation Trust

Q2a
I look forward to going to work

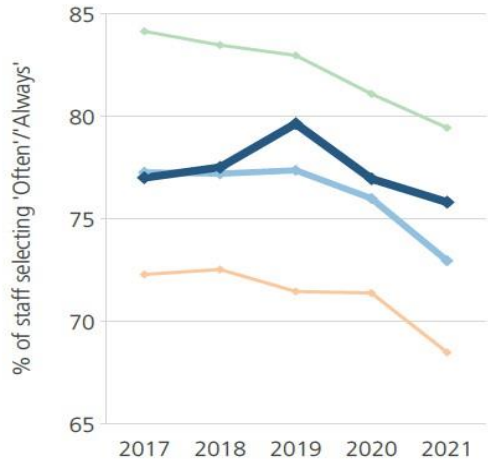
	2017	2018	2019	2020	2021
Best	66.7%	67.6%	68.8%	67.8%	60.8%
Your org	53.3%	59.6%	56.7%	54.0%	51.3%
Average	58.6%	59.5%	59.4%	58.6%	52.0%
Worst	50.2%	50.7%	47.2%	51.9%	42.7%
Responses	2,134	607	2,747	2,742	2,330

Q2b
I am enthusiastic about my job



	2017	2018	2019	2020	2021
Best	79.2%	82.1%	81.8%	79.7%	76.5%
Your org	72.5%	73.8%	73.2%	70.3%	67.9%
Average	74.2%	75.0%	75.3%	73.1%	67.6%
Worst	68.2%	67.9%	67.5%	68.0%	60.1%
Responses	2,093	601	2,737	2,728	2,324

Q2c
Time passes quickly when I am working

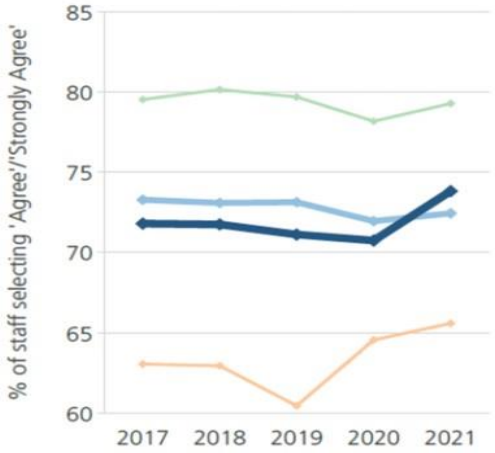


	2017	2018	2019	2020	2021
Best	84.1%	83.4%	82.9%	81.1%	79.4%
Your org	77.0%	77.5%	79.6%	76.9%	75.8%
Average	77.2%	77.2%	77.3%	76.0%	72.9%
Worst	72.3%	72.5%	71.4%	71.4%	68.5%
Responses	2,090	602	2,742	2,726	2,320

Staff Engagement – Motivation, Involvement and Advocacy

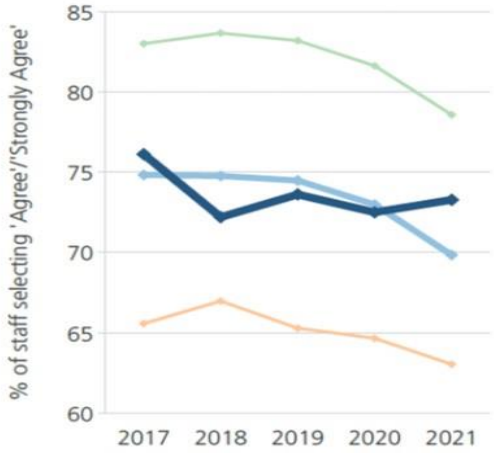
NHS Stockport NHS Foundation Trust

Q3c
There are frequent opportunities for me to show initiative in my role



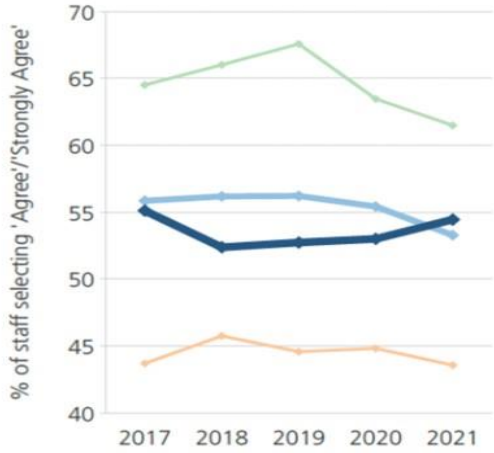
	2017	2018	2019	2020	2021
Best	79.5%	80.1%	79.7%	78.2%	79.3%
Your org	71.8%	71.7%	71.1%	70.7%	73.8%
Average	73.3%	73.1%	73.1%	71.9%	72.4%
Worst	63.0%	62.9%	60.4%	64.5%	65.6%
Responses	2,137	611	2,762	2,722	2,310

Q3d
I am able to make suggestions to improve the work of my team / department



	2017	2018	2019	2020	2021
Best	83.0%	83.7%	83.2%	81.6%	78.6%
Your org	76.1%	72.2%	73.6%	72.5%	73.3%
Average	74.8%	74.8%	74.5%	73.0%	69.8%
Worst	65.6%	67.0%	65.3%	64.7%	63.0%
Responses	2,128	606	2,758	2,722	2,310

Q3f
I am able to make improvements happen in my area of work

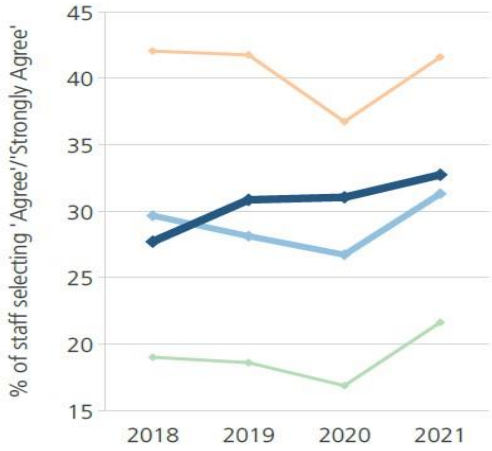


	2017	2018	2019	2020	2021
Best	64.5%	66.0%	67.6%	63.5%	61.5%
Your org	55.1%	52.4%	52.7%	53.0%	54.5%
Average	55.9%	56.2%	56.2%	55.4%	53.3%
Worst	43.7%	45.8%	44.6%	44.8%	43.6%
Responses	2,125	608	2,750	2,711	2,307

Morale – Thinking About Leaving and Work pressure

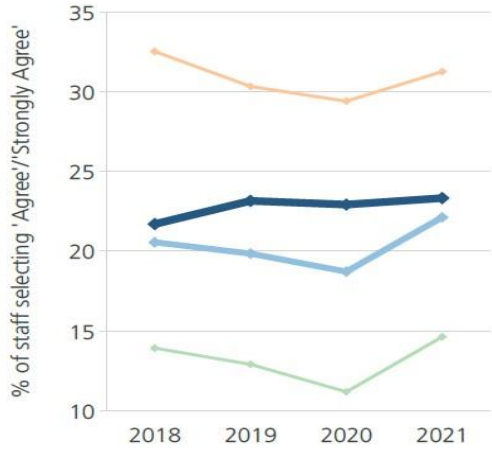
NHS Stockport NHS Foundation Trust

Q22a
I often think about leaving this organisation



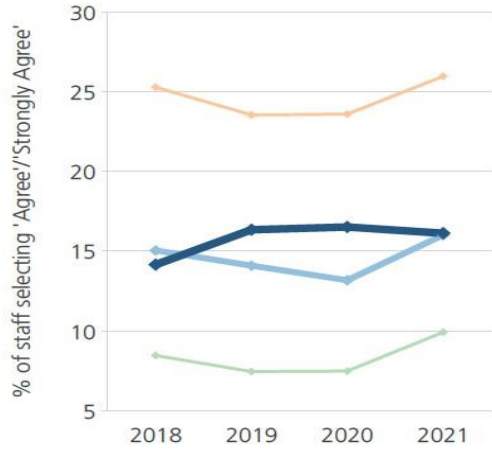
	2018	2019	2020	2021
Worst	42.0%	41.8%	36.7%	41.6%
Your org	27.7%	30.9%	31.0%	32.7%
Average	29.7%	28.1%	26.7%	31.3%
Best	19.0%	18.6%	16.9%	21.6%
Responses	602	2,676	2,671	2,231

Q22b
I will probably look for a job at a new organisation in the next 12 months



	2018	2019	2020	2021
Worst	32.5%	30.3%	29.4%	31.2%
Your org	21.7%	23.1%	22.9%	23.3%
Average	20.6%	19.8%	18.7%	22.1%
Best	13.9%	12.9%	11.2%	14.6%
Responses	600	2,668	2,667	2,228

Q22c
As soon as I can find another job, I will leave this organisation

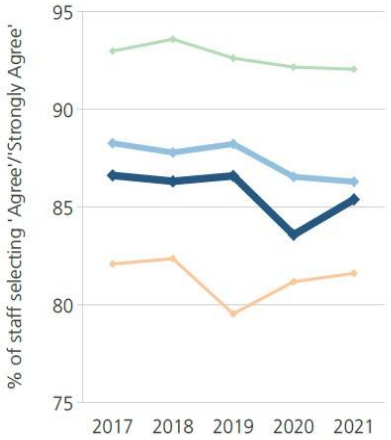


	2018	2019	2020	2021
Worst	25.3%	23.5%	23.6%	26.0%
Your org	14.1%	16.3%	16.5%	16.1%
Average	15.0%	14.1%	13.2%	16.0%
Best	8.5%	7.4%	7.5%	9.9%
Responses	599	2,662	2,668	2,229

Morale – Stressors

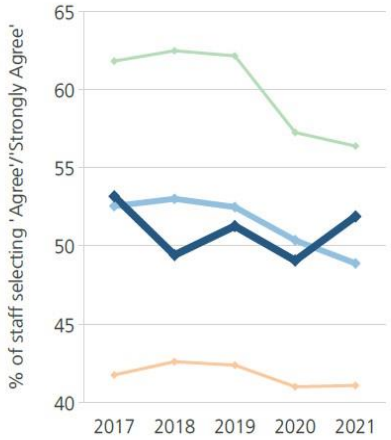
NHS Stockport NHS Foundation Trust

Q3a
I always know what my work responsibilities are



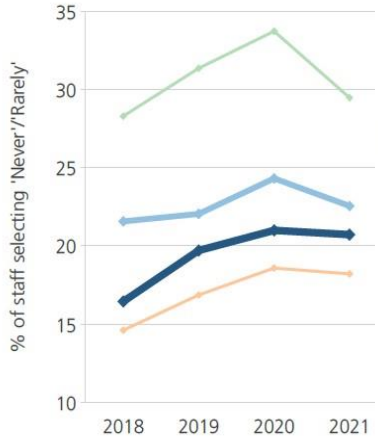
	2017	2018	2019	2020	2021
Best	93.0%	93.6%	92.6%	92.1%	92.0%
Your org	86.6%	86.3%	86.6%	83.6%	85.4%
Average	88.2%	87.8%	88.2%	86.5%	86.3%
Worst	82.1%	82.3%	79.5%	81.2%	81.6%
Responses	2,140	605	2,760	2,741	2,307

Q3e
I am involved in deciding on changes introduced that affect my work area / team / department



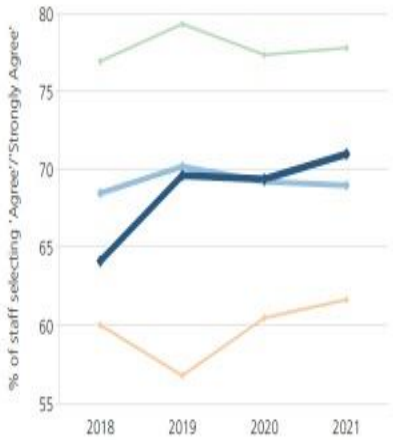
	2017	2018	2019	2020	2021
Best	61.8%	62.5%	62.1%	57.2%	56.4%
Your org	53.2%	49.4%	51.3%	49.1%	51.9%
Average	52.5%	53.0%	52.5%	50.4%	48.9%
Worst	41.7%	42.6%	42.4%	41.0%	41.1%
Responses	2,128	608	2,757	2,719	2,310

Q5a
I have unrealistic time pressures



	2018	2019	2020	2021
Best	28.3%	31.3%	33.7%	29.5%
Your org	16.4%	19.7%	21.0%	20.7%
Average	21.6%	22.0%	24.3%	22.5%
Worst	14.6%	16.9%	18.6%	18.2%
Responses	612	2,728	2,715	2,292

Q9a
My immediate manager encourages me at work



	2018	2019	2020	2021
Best	76.9%	79.3%	77.3%	77.8%
Your org	64.1%	69.6%	69.4%	71.0%
Average	68.5%	70.2%	69.2%	69.0%
Worst	60.0%	56.8%	60.5%	61.6%
Responses	606	2,726	2,699	2,269

WRES

% of staff experiencing bullying or abuse from patients, service users

	2017	2018	2019	2020	2021
White: Your org	23.6%	21.4%	25.1%	24.0%	23.3%
BME: Your org	23.4%	21.4%	28.2%	25.8%	23.6%
White: Average	27.1%	27.1%	27.7%	25.4%	26.5%
BME: Average	27.5%	28.8%	29.5%	28.0%	28.8%
White: Responses	1,820	514	2,315	2,176	1,831
BME: Responses	171	70	291	299	288

% of staff experiencing bullying or abuse from staff

	2017	2018	2019	2020	2021
White: Your org	21.6%	22.7%	25.0%	23.7%	21.2%
BME: Your org	27.2%	25.7%	29.1%	27.6%	22.5%
White: Average	23.9%	25.0%	24.4%	24.4%	23.6%
BME: Average	27.6%	28.7%	28.4%	29.1%	28.5%
White: Responses	1,802	512	2,317	2,176	1,833
BME: Responses	169	70	289	297	285

WRES

% of staff believing that the organisation provides equal opportunities for career progression

	2017	2018	2019	2020	2021
White: Your org	58.5%	55.1%	58.3%	59.1%	59.5%
BME: Your org	48.8%	38.9%	40.0%	47.6%	50.2%
White: Average	61.0%	59.0%	60.0%	59.4%	58.6%
BME: Average	48.8%	46.4%	46.6%	45.2%	44.6%
White: Responses	1,803	514	2,319	2,259	1,888
BME: Responses	168	72	290	315	303

% of staff experiencing discrimination at work from manager/team leader/colleagues

	2017	2018	2019	2020	2021
White: Your org	5.6%	4.3%	5.3%	6.4%	5.4%
BME: Your org	15.5%	8.7%	14.3%	18.1%	15.4%
White: Average	6.6%	6.3%	5.9%	6.1%	6.7%
BME: Average	14.9%	14.6%	14.1%	16.8%	17.3%
White: Responses	1,828	508	2,326	2,264	1,899
BME: Responses	168	69	287	309	305

WDES

% of staff experiencing bullying or abuse from patients, service users

	2018	2019	2020	2021
Staff with a LTC or illness: Your org	26.5%	30.9%	28.5%	28.7%
Staff without a LTC or illness: Your org	20.3%	24.6%	23.2%	21.9%
Staff with a LTC or illness: Average	33.6%	33.2%	30.9%	32.4%
Staff without a LTC or illness: Average	26.6%	26.5%	24.5%	25.2%
Staff with a LTC or illness: Responses	102	453	445	464
Staff without a LTC or illness: Responses	483	2,196	2,061	1,672

% of staff experiencing bullying or abuse from staff

	2018	2019	2020	2021
Staff with a LTC or illness: Your org	22.8%	21.0%	24.0%	16.6%
Staff without a LTC or illness: Your org	13.2%	11.9%	11.2%	9.1%
Staff with a LTC or illness: Average	19.6%	18.4%	19.3%	18.0%
Staff without a LTC or illness: Average	11.7%	10.8%	10.8%	9.8%
Staff with a LTC or illness: Responses	101	453	442	465
Staff without a LTC or illness: Responses	479	2,178	2,051	1,661

Average calculated as the median for the benchmark group

WDES

% of staff believing that the organisation provides equal opportunities for career progression

	2018	2019	2020	2021
Staff with a LTC or illness: Your org	47.1%	48.3%	51.7%	55.4%
Staff without a LTC or illness: Your org	54.2%	57.6%	58.4%	58.8%
Staff with a LTC or illness: Average	51.3%	51.9%	51.6%	51.4%
Staff without a LTC or illness: Average	57.4%	58.4%	57.4%	56.8%
Staff with a LTC or illness: Responses	102	458	458	480
Staff without a LTC or illness: Responses	485	2,193	2,149	1,729

% of staff experiencing discrimination at work from manager/team leader/colleagues

	2018	2019	2020	2021
Staff with a LTC or illness: Your org	22.8%	21.0%	24.0%	16.6%
Staff without a LTC or illness: Your org	13.2%	11.9%	11.2%	9.1%
Staff with a LTC or illness: Average	19.6%	18.4%	19.3%	18.0%
Staff without a LTC or illness: Average	11.7%	10.8%	10.8%	9.8%
Staff with a LTC or illness: Responses	101	453	442	465
Staff without a LTC or illness: Responses	479	2,178	2,051	1,661

Next Steps…

NHS Stockport NHS Foundation Trust

- Full report will be published – 30th March 2022 (under embargo until then)
- Report shared with Divisions, Teams and Colleagues
- Divisions will be supported by People and OD to develop their action plans
- Staff Survey results to be built into the Divisional Performance Reviews to enable progress on action plans to be shared

Making a DIFFERENCE every day

Stockport NHS Foundation Trust

Meeting date	7th April 2022	x	Public		Confidential	Agenda item
Meeting	Board of Directors					
Title	Freedom to Speak Up Report					
Lead Director	Caroline Parnell, Director of Communications and Corporate Affairs		Author	Paul Elms, Freedom to Speak up Guardian		

Recommendations made / Decisions requested

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

This paper relates to the following Corporate Annual Objectives-

	1	Deliver safe accessible and personalised services for those we care for
	2	Support the health and wellbeing needs of our communities and staff
	3	Co-design and provide Integrated Service Models within our locality and across our acute providers
	4	Drive service improvement, through high quality research, innovation and transformation
X	5	Develop a diverse, capable and motivated workforce to meet future service and user needs
	6	Utilise our resources in an efficient and effective manner
	7	Develop our Estate and IM&T infrastructure 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 is related to these BAF risks		**PR1.1**	There is a risk that the Trust delivers sub-optimal quality services and fails to meet regulatory standards
		PR1.2	There is a risk that the Trust fails to reduce harm against agreed baseline
		PR1.3	There is a risk that patient flow plans are not effective leading to decline in A&E performance
		PR1.4	There is a risk that inclusive restoration plans to address elective backlog are not delivered
	X	**PR2.1**	There is a risk that the Trust fails to support and engage its workforce
		PR2.2	There is a risk that the Trust's services do not reliably support neighbourhood population health and future care needs
		PR3.1	There is a risk that effective partnership and accountability arrangements are not in place at ICS and locality provider level

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

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	All
Sustainability (including environmental impacts)	N/A

Executive Summary

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

The Committee is asked to note the content of the report.

1. INTRODUCTION

1.`1 In line with national guidance the Trust has appointed a Freedom to Speak Up (FTSU) Guardian, who reports regularly on their activities to the People and Performance Committee and the Board of Directors.

2. ACTIONS UNDERTAKEN

2.1 Since last reporting to the Board the FTSU Guardian has continued to focus on awareness raising of their role and the importance of speaking up. This has included:

- Putting in place each aspect of the agreed Communications Plan
- Planning for and delivering a successful month of activity as part of National Freedom to Speak Up Month (detailed below)
- Undertaking regular site walk rounds to heighten awareness of the FTSU role and agenda, and to meet colleagues
- Met with the Non-Executive Lead on two occasions, and with the Chief Executive, on three occasions.
- Presented on all induction events.

2.2 He has also reviewed the FTSU activity of the Trust against the findings of a case review study in Blackpool and against the findings of an NHS England desktop review, to identify gaps and areas of weakness.

2.3 These gaps will be addressed following a 'workshop' to be held with Human Resource colleagues and will feature in a proposed Board Development session.

2.4 The Trust 'Raising Concerns' Policy has been reviewed and refreshed and is currently going through the accreditation process.

2.5 To mark six months in role the FTSU Guardian has reported to the Chief Executive, to his line manager and non-executive director lead, highlighting his initial thoughts in role, and suggesting where improvements can be made.

3. NATIONAL FREEDOM TO SPEAK UP MONTH (October 2021)

3.1 The FTSU Guardian would like to thank the members of the Board and senior leaders who supplied a photographed pledge, demonstrating their commitment and support to the agenda. This was a valuable way of publicising the importance of FTSU and helping to kick start the campaign.

3.2 These photographs were part of the FTSU Guardians social media campaign, which over the month resulted in over 40 tweets and Facebook posts with a reach of over 1000 likes, shares, and comments. Four of the FTSU Guardians tweets were re-tweeted by the National Guardian's office.

3.3 With the assistance of colleagues, an animated film was created, featuring a cartoon version of the FTSU Guardian to explain the role in a light-hearted way. It is available at - https://youtu.be/Dyy_Zdj-XQA

3.4 The Communications Team ensured that FTSU was featured in routine Trust communications, again utilising the Board pledge photographs.

3.4 Freedom to Speak Up pens were also designed, purchased, and distributed across the Trust to heighten awareness.

4. CASE WORK

4.1 The FTSU Guardian has been approached concerning 18 specific situations across the Trust since their last report.

4.2 A number of these contacts were signposted elsewhere or were situations dealt with by offering advice. Nine became formal referrals and four of those have been resolved.

5. THEMES AND TRENDS

5.1 The FTSU Guardian has identified the following emerging themes:

- Fear of detriment
- Investigation process
- Burn out
- The fear of detriment appears to be a deterrent to some staff members speaking up, and those that do so are in the main very keen that their identities are not shared.

5.2 A fear of detriment may demonstrate a view that colleagues will in some way suffer detriment by speaking up, and the desire for some people to want to remain anonymous may hinder proper investigation and examination of the facts; neither benefiting the complainant or the Trust. The FTSU Guardian has discussed this with the Chief Executive who supported further communications messages around this issue.

5.2 There is an emerging theme related to the process of dealing with serious complaints. These concerns include a lack of a consistent approach to keeping the FTSU Guardian and the complainant updated as to the progress of a case, and how some complainants are treated when they have raised concerns.

5.3 Communication by investigating officers should be improved as in some instances complainants feel unsupported or are unaware of next steps in the process. In a small number of cases complainants have had no contact after they have raised their concerns until it has been prompted by the Guardian.

5.4 A general and obvious theme of many of the FTSU Guardians conversations with colleagues concerns the ‘burn out’ reported by many staff as the pandemic continues, and a relief that it ‘appears’ to be coming to an end.

5.5 A small number of colleagues have made positive comments concerning the gift vouchers they received from the Trust.

6. ACCESSING THE FTSU SERVICE

6.1 A strong reoccurring message from the National Guardia's Office and in many of FTSU reviews that take place, is that all cohorts of staff should have routes to direct their concerns and to speak up, that they are comfortable with.

6.2 Although there is no evidence that any colleague in the Trust has had any issue approaching the FTSU Guardian, he is keen that potential alternatives are in place.

6.3 To this end, and in line with many other Trusts, the Guardian is exploring options for the development of a network of FTSU champions, ideally drawn from a wide range of backgrounds

7. THE REGIONAL / NATIONAL PICTURE

7.1 A new National Guardian was appointed in December. Dr Jayne Chidgey-Clark has more than 30 years' experience in the NHS, higher education, voluntary and private sectors. Her most recent roles include as non-executive director at NHS Somerset Clinical Commissioning Group (CCG) where she was a Freedom to Speak Up Guardian.

7.2 In March the National Guardians office circulated a new 'set of 12 principals' for the management of FTSU cases. The Trust's FTSU Guardian is very supportive of the principals, and they have been incorporated into the Speaking Up policy currently going through the internal approval process. It is hoped they will help to standardise the way in which we all handle cases and support complainants:

1. *There will be clear and accessible information on how to speak up.*
2. *Speaking up processes will be designed so that all workers can speak up easily.*
3. *Everyone who speaks up will be thanked.*
4. *Where appropriate, workers will be encouraged and supported to speak up locally.*
5. *If another organisation (e.g. another national body) better addresses a matter, workers will be supported to speak up to that organisation.*
6. *Workers will be offered information on other sources of advice and support.*
7. *Workers speaking up will be provided with a response in a timeframe that is made clear to them.*
8. *Responses to speaking up will include details setting out how the information provided was used for learning and improvement.*
9. *The confidentiality of those who speak up will be respected, subject to the need to ensure safeguarding requirements are met.*
10. *Where matters are raised anonymously, they will be responded to in accordance with these principles to the extent possible.*
11. *Workers will be given the opportunity to feedback on their experience of speaking up.*
12. *The speaking up arrangements' effectiveness will be monitored, and opportunities to improve taken.*

8. RECOMENDATIONS

8.1 The Board is recommended to:

Note the content of the report and the positive assurance on the implementation, approach, and activities of the FTSU agenda and the Guardian role.

Stockport NHS Foundation Trust

Meeting date	7th April 2022	X	Public		Confidential	Agenda item
Meeting	Board of Directors					
Title	Equality Diversity & Inclusion Strategy 2022-2025					
Lead Director	Director of People & OD	Author	EDI Manager			

Recommendations made/ Decisions requested

The Board of Directors is asked to review and approve the Equality Diversity & Inclusion Strategy 2022-2025, having been endorsed and recommended by the People Performance Committee in March 2022.

This paper relates to the following Corporate Annual Objectives-

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

The paper relates to the following CQC domains-

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

This paper is related to these BAF risks		**PR1.1**	There is a risk that the Trust delivers sub-optimal quality services and fails to meet regulatory standards
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		PR4.1	There is a risk that there is insufficient capacity and capability to deliver Trust, locality and system wide transformation programmes

		PR5.1	There is a risk that robust plans to recruit, train and retain the right staff to meet service needs are not implemented
	X	**PR5.2**	There is a risk that the Trust does not deliver the Equality, Diversity & Inclusion Strategy
		PR6.1	There is a risk that the Trust fails to deliver its agreed 2021/22 financial position
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		PR7.3	There is a risk that there is no identified funding mechanism or insufficient funding to support strategic regeneration of the hospital campus
		PR7.4	There is a risk that the Trust fails to develop and implement a responsive and resilient Digital Strategy

Where issues are addressed in the paper-

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

Executive Summary

The Equality Diversity and Inclusion (EDI) Strategy 2022-25 has been developed following the evidence deriving from our Workforce Race Equality Standard, Workforce Disability Equality Standard, Gender Pay Gap and results from the NHS Staff Survey 2020.

These metrics show that inequalities exist our staff with protected characteristics, reporting higher levels of poorer experience including harassment, bullying or abuse at work; greater inequalities in access to employment, development, and progression; lack of equitable representation across entry, middle and senior level roles and lack of diversity in leadership positions.

The focus for 2022-25 will be on the delivery of four key aims:

1. Current employees and future talent with protected characteristics are offered equality of opportunity and fair access to jobs, development and career progression
2. Employees with protected characteristics are enable to work free from discrimination, and bullying and harassment, in an inclusive work environment that embraces diversity
3. Current employees and future talent with protected characteristics are enabled into leadership positions to drive lived experience into the heart of decision-making and to ensure services are designed, developed and delivered with inclusivity
4. We are compliant with our responsibilities under the relevant legislation and our data and resulting reports are consistent and accessible, as are the calculation and data analysis methodologies

Our plans are ambitious; we will achieve our aims through the development of four organisational priorities:

- Workforce
- Culture
- Compliance
- Health inequalities

Health inequalities will be progressed in partnership with the Patient and Service Engagement team and key partners and across Commissioning areas and the Greater Manchester Inequalities programmes.

Equality, Diversity & Inclusion Strategy 2022-2025

1. Executive Summary

Our Equality Diversity and Inclusion (EDI) Strategy has been developed following the evidence deriving from our Workforce Race Equality Standard, Workforce Disability Equality Standard, Gender Pay Gap, and results from the NHS Staff Survey 2020. These collective metrics show that inequalities exist for our staff with protected characteristics[1], reporting higher levels of poorer experience, including harassment, bullying or abuse at work; greater inequalities in access to employment, development, and progression; lack of equitable representation across entry, middle and senior level roles and lack of diversity in leadership positions.

To this end, our focus for 2022/25 will be on the delivery of four key aims:

1. Current employees and future talent with protected characteristics are offered equality of opportunity and fair access to jobs, development and career progression

2. Employees with protected characteristics are enabled to work free from discrimination, and bullying and harassment, in an inclusive work environment that embraces diversity

3. Current employees and future talent with protected characteristics are enabled into leadership positions, to drive lived experience into the heart of decision-making and to ensure services are designed, developed and delivered with inclusivity

4. We are compliant with our responsibilities under the relevant legislation and our data and resulting reports are consistent and accessible, as are the calculation and data analysis methodologies

Our plans are ambitious; we will achieve our aims through the development of four organisational priorities:

Priority 1 Workforce

Increased **BAME** diversity in:

Non-clinical:
- Bands 1-4 current 10.5%, target 12.5%
- Bands 5-7 current 6.9%, target 8%
- Bands 8A+ current 3%, target 8%

Clinical (non-medical and dental):
- Bands 1-4 current 18.4 %, target 20.4%
- Bands 5-7 current 17.7%, target 19.7%
- Bands 8A and above current 5.1%, target 8%

Increased **Disability** diversity by:
- Average across Trust: Current 3.2%, min target 8.2%

Non-clinical:
- Bands 1-4 current 4.4%, target 8.8%
- Bands 5-7 current 3.7%, target 7.4%
- Bands 8A+ current 2.6%, target 5.2%

Clinical (non-medical and dental):
- Bands 1-4 current 3.4%, target 6.8%
- Bands 5-7 current 2.9%, target 5.8%
- Bands 8A+ current 2.0%, target 4.0%

Increased Disability/LTC Representation on the Board by 6% (1 Person)

[1] Protected Characteristics include race, sex, disability, age, sexual orientation, gender reassignment, marriage and civil partnership, pregnancy and maternity, religion, and belief

Reduction in **Gender** Pay Gaps:

- Reduction in mean gender pay gap in line with latest available Public Sector Economy mean pay gap in 2026, or current figure of 15.5%, whichever is the smaller
- Female / Male parity in % application to Clinical Excellence Awards (CEA) -when process has recommenced
- Reduction in mean bonus gender pay gap current 51.4% to target <10%

Priority 2 Culture

Improve the experience of all staff with protected characteristics so that by April 2025, we have:

- Reduced disparity regarding entry into disciplinary processes to achieve parity for BAME staff: current (2021)1.14, target 1 (2025)
- Reduced disparity regarding entry into capability processes to achieve parity for disabled / LTC staff: current (2021) 1.22, target 1 (2025)

- Reduced disparity regarding shortlisting and being appointed from shortlisting
    - BAME: current relative likelihood 2.43 to target <1.5 relative likelihood

- Reduced disparity regarding bullying and harassment from managers / team leaders in the staff survey for BAME staff: current 18.1% to target <12%
- Reduced disparity regarding discrimination from managers / team leaders in the staff survey for disability / LTC staff: current 24% to target <10%

- 50% reduction in the career progression ratios across all bands for BAME staff
    - Lower to middle 2.1 (Bands1-4 moving up to Bands 5-7)
    - Middle to upper 2.0 (Bands 5-7 moving up to Bands 8A and above)
    - Lower to upper 4.3 (Bands 1-4 moving up to Bands 8A and above)

Priority 3 Assurance and Compliance

- Continued compliance with WRES / WDES data submissions
- Assurance methodology for WRES / WDES data submissions
- Implementation and development of Accessible Information Standard (AIS) and Equality Delivery System (EDS) and compliance with a minimum of ‘Achieving’
- Continued compliance with the Equality Act 2010

These outcomes will be overseen by the EDI Steering Group assured through to the Performance People Committee (PPC) and reported at People Engagement and Leadership Group (PELG).

Contents

1. Foreword by Karen James, Chief Executive, Stockport NHS Foundation Trust

I am thrilled to be introducing our new Equality, Diversity, and Inclusion (EDI) Strategy 2022-25. which has been developed to support our ambitions to become an employer of choice in a forever changing and competing environment. We want to attract, develop and retain the best, diverse talent and offer an inclusive, vibrant place of work all of which are essential ingredients for driving and delivering improved patient experience and outcomes.

As Chief Executive my personal ambition is for our staff to work together to deliver outstanding care. We can only achieve this if we actively create a culture which continually challenges us as individuals, and as an organisation we remain true, to our core values of We Care about our people, support them, and deliver on our promises. We Listen, act and learn from what we hear, We Respect, we are kind and helpful and expect the same in return.

I am proud to be leading an organisation where our staff actively uphold our values and behaviours. Like all NHS organisations however, we are on a continual improvement journey, at the heart of which, is the fundamental drive to deliver fair and inclusive services for all. This EDI strategy is an enabler of our efforts to raise the bar for staff and for our journey for our patient experience.

Karen Kames
Chief Executive

2. Introduction

This strategy sets out our high-level approach to delivering Equality, Diversity and Inclusion (EDI), for the benefit of our local health economy and the people we work with in line with our obligations, aims and objectives of the Equality Act 2010 and the Public Sector Equality Duty 2011.

We recognise that EDI is a central feature of delivering compassionate care and maintaining a quality driven highly-skilled workforce. Achieving diversity within our workforce and embedding inclusivity is a core requirement for all NHS health and care providers. The quality of patient experience cannot be separated from the quality of staff experience. Inequalities in workforce diversity cannot be divorced from inequalities of health outcomes, there maintains an interdependency and correlation.

We have an aspiration to ensure EDI is at the heart of everything we do. We believe that the EDI agenda is critical to building a sustainable workforce that is truly reflective of the diverse communities we serve. We also believe that in building a diverse workforce, we will increase the talent pool from which we recruit and build services that are responsive to the needs of the local community.

Our EDI Strategy has been developed in response to the findings of our Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) and in conjunction with results from our NHS Staff Survey 2020. These collective metrics show that inequalities exist for our staff with protected characteristics, reporting higher levels of poorer staff experience and inequitable diversity within leadership and across elements of the workforce.

We are ambitious providers of emergency and secondary care services for people of all ages. We provide extensive community services, integrated health and social care, early intervention, and prevention programmes, as well as highly specialised therapies and treatments. Our care focuses on enabling people to live well with their conditions and to work towards recovery.

3. Our EDI Legislative Context

Our strategy has been designed to enable our organisation to develop a place of work that is diverse and inclusive, where all current and future staff with protected characteristics are treated with fairness and equity, free from discrimination, bullying and harassment. The strategy is a direct response to our commitment to the delivery of our Public Sector Equality Duty (Equality Act 2010), to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not

4. How our EDI Strategy was developed

This EDI Strategy has been primarily developed in response to our NHS Staff Survey Results, the evidence contained within our Workforce Race Equality Standards and Workforce Disability Standards. Insights from the latest available data from these sources is utilised to develop the focus areas for the strategy and subsequent operating and action plans.

Additional consultation with key stakeholders was considered, including:

- Our senior leaders
- Our people working for the Trust
- Engagement with Unions
- Partners across the wider health and care system
- The Voluntary and Community Sector

Further, through a variety of conversations and using different evidence sources we asked people to contribute their views as to what an EDI Strategy should consider, respond to and priorities over the next four years. These conversations are informed through the various intersectional meetings across wide ranging audiences and our staff networks for our BAME colleagues, who currently make up 17.5% of our workforce and our disabled staff and staff with long term conditions, who currently make up 3.2% of our workforce.

This strategy takes account of local population demographics to ensure that our people targets are consistent with the population we serve, and performance is relevant and achievable, rather than using national benchmarks, which may be higher or lower than those within our region. However, recognition is given to some limitations in these datasets, such as the latest published date for census data.

Key themes have emerged, shaping the direction of our EDI Strategy and our future focus upon supporting the delivery of *'a great place to work'* with the ambitions contained within the Trust Strategy 2020-2025, 'Making a difference every day' which is to improve health outcomes for our local populations and wider health economy. Our EDI Strategy has been designed to facilitate the delivery of inclusive care with fair access to our services.

Finally, this strategy aligns where possible and practical to be consistent with the approach adopted by Tameside and Glossop ICFT and East Cheshire NHS Trust in support of shared learning and benchmarking across our Partnership arrangement, whilst still ensuring the strategy is tailored to the needs of our people and the population we serve.

5. NHS Staff Survey Results 2020 and other Key metrics

Whilst the 2020 National Staff Survey results have highlighted some improvements there are still significant areas of improvement required:

- Percentage of BAME staff experiencing harassment, bullying or abuse from patients, relatives of members of the public had fallen by 2.4% from 2019 to 2020 but remains 1.8 % **higher** at 25.8% in comparison to white staff at 24%.

- Disabled staff experiencing harassment, bullying or abuse from patients, relatives of members of the public is **higher** at 28.5% in comparison to 23.2% for non-disabled staff

- Percentage of BAME staff experiencing harassment, bullying or abuse from other staff or colleagues has **reduced** by 1.5% from 2019 to 2020 but remains 3.9% **higher** at 27.6% in comparison to white staff at 23.7%.

- Disabled staff experiencing harassment, bullying or abuse from staff or other colleagues is **higher** by 8.9% reported at 25.4% in comparison to 16.5% for non-disabled staff

- Percentage of BAME staff experiencing discrimination at work from a manager / team leader or other colleague has **risen** by 3.8% from 2019 to 2020 and is 11.7% higher at 18.1% in comparison to white staff, at 6.4%

- Percentage of disabled staff personally experiencing discrimination at work from a manager / team leader has **risen** by 3% in 2019 to 2020 and at 24% is 12.8% higher than for non-disabled staff, at 11.2%

- With regards to the staff survey results relating to the organisation acting fairly regarding career progression/ promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age, the table below highlights that SNHS Trust is performing above the national average and has improved on the 2019 result by 1%

Key finding 2020	2019 score	2020 score	National average score	Best performing score 2020	Worst performing score 2020
Q14 Does your organisation act fairly with regard to career progression/ promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age?	**85.4%**	**86.4%**	**84.9%**	**94.3%**	**66.5%**

However, the WDES reported that disabled staff felt **6.2% less** likely to have access to equal opportunities for career progression and promotion in comparison to non-disabled colleagues. The WRES reported that BAME staff felt **15.3% less** likely to have access to equal opportunities for career progression and promotion in comparison to white colleagues.

The evidence for inequity and inequality identified between staff with protected characteristics and staff overall in accessing jobs, developing to progress and being promoted lays a firm foundation for the work streams within this Strategy.

Additional to the staff survey, there are number of key insights from the WRES, WDES and GPG reporting metrics that inform and shape our EDI strategic response, as below:

WRES:

- The organisation is broadly exceeding the local population representation figures for BAME, but there is under-representation of BAME staff at higher bands across both clinical and non-clinical roles
- Within medical roles, BAME staff are significantly over-represented against the local population
- BAME staff feel less fairly treated with regards progression and this is borne out by the progression ratio data
- BAME persons are over 2 times less likely to be appointed to a role following shortlisting
- BAME staff report experiencing abuse, bullying or harassment by managers, team leaders, or other colleagues at over nearly three times the rate of their white counterparts

WDES

- The organisation is significantly under-represented against the local population in regards disability / Long Term Conditions (LTC) at all grades: more so at higher bands and in clinical roles
- There is minimal disabled / LTC representation in medical roles
- There is no disabled / LTC representation at board level
- Significant improvements have been made with regards the appointment of disabled LTC persons being appointed following shortlisting and in the likelihood of members of disabled staff entering the capability procedure
- Disabled staff reported experiencing abuse, bullying or harassment by managers, team leaders, or other colleagues at over double the rate of their non-disabled counterparts

Gender:

- The distribution of female staff across quartiles is such that the mean gender pay gap is significant, whereas the median gender pay gap, still exists, but is less significant

- There is under-representation of female staff within the highest percentile and a significant male skewing within this area
- A significant difference exists in the bonus gender pay gap, where there are large disparities both in terms of % awards made and the value of those awards.

6. The Scope of our EDI Strategy

We are keen to progress an intersectional approach to Equality, Diversity & Inclusion by addressing the inequalities and disparities faced by all groups with protected characteristics, whilst responding to national and regional race (WRES) and disability (WDES) agendas and this is reflected in the five aims of the Strategy.

This EDI strategy is ambitious and dedicated to improving the experiences of our people with protected characteristics. Our EDI Strategy is an enabler to elements of our People Plan Pillars:

- Strategic Workforce Development, Planning & Performance: We will support decision making through improved EDI data
- Culture, Engagement and Retention: We commit to 'secure inclusion for everyone'
- Resourcing: We will utilise EDI data to support 'targeted and streamlined recruitment'
- Training, Education & Practice Development: We will further develop the apprenticeship schemes and links to work placements, particularly for disabled candidates
- Leadership Development: We will support under-represented groups to progress to 'make staff voice even stronger in our leadership and governance'

This EDI Strategy has been designed to support the above objectives from an equality perspective as each have direct impact on our people with protected characteristics. EDI actions will feature in the overarching work programme of our People Plan. This way the EDI strategy should be seen as the foundation that runs through all actions and is central to everything we do.

Wider EDI workstreams including work on the Accessible Information Standard (AIS), 'All Equals Charter' and improving patient experience, will sit outside the scope of this strategy. However, they remain an interconnected driver for our patient experience programmes. The EDI Lead and Patient Experience Lead will work collaboratively to support both workstreams and further to ensure that the inequalities and barriers faced by staff are addressed to improve patient quality, patient safety, patient outcomes and reduce health inequalities and access to care.

To this end, four specific EDI priorities have been developed to progress the EDI agenda. Priorities 1 - 3 detailed below are in scope for this Strategy; Priority 4 will be progressed in partnership with the Patient and Service Engagement team and key partners and across Commissioning areas and the Greater Manchester Inequalities programmes.

PRIORITY 1 WORKFORCE

This priority workstream will seek to ensure we take positive action to close the inequality gaps faced by our existing and future staff with protected characteristics in response to the findings of the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) and Gender Pay Gap (GPG) reporting outcomes.

PRIORITY 2 CULTURE

This priority workstream will seek to ensure we cultivate a culture of equality, diversity, and inclusion, eradicating all experiences of discrimination based on race, sex, disability, age, sexual orientation, gender reassignment, marriage and civil partnership, pregnancy and maternity, religion and belief experienced by staff.

PRIORITY 3 COMPLIANCE

This priority workstream will seek to ensure continues compliance with the regulatory and statutory, processes and policies that protect the rights and interests of all staff and patients with protected characteristics in accordance with the Equality Act 2010. This workstream will ensure compliance with Gender Pay Gap, WRES and WDES reporting and EDS3 assessments.

PRIORITY 4 HEALTH INEQUALITIES

This priority workstream will seek to ensure we take positive action to close the inequality gaps faced by patients with protected characteristics and patients facing mental health, social isolation, or social deprivation.

To deliver on these priorities, Section 8 describes our objectives with a high-level action plan against each. Section 9 contains the overall targets that we aim to achieve by enacting the action plan. These shall be the performance metrics reported annually throughout the strategy implementation period.

7. EDI Objectives

Priority 1 Workforce

Objective 1: Recruitment

Ensure that we fulfil our Public Sector Equality Duty in response to the Equality Act 2010 to 'Advance equality of opportunity between people who share a protected characteristic and those who do not.'

We will ensure current employees and future talent with protected characteristics are offered equality of opportunity and fair access to.

	What we will do:	How we will know we have had impact:	Timescales - to be achieved by:	Targets
1.	We will build relationships with local organisations supporting people with protected characteristics into employment to ensure our vacancies reach a diverse audience, with a particular focus on disability/Long Term Condition (LTC)	We will see an increase in the number of people shortlisted/appointed from people with protected characteristics and individuals with disabilities /LTC	Y1 Establish recruitment networks and processes Y2-3 Maintain and progress to Y2/3 target	2021 baseline – 134 interviewed disabilities Y1 – 10% increase on baseline (147) Y2 – 20% increase on baseline (161) Y3 – 30% increase on baseline (174) 2021 baseline – 26 offers disability Y1 – 10% increase on baseline (29) Y2 – 25% increase on baseline (33) Y3 – 35% increase on baseline (35) Data source: applications and appointments for disability
2.	We will routinely share our vacancies to ensure our advertising efforts for new vacancies reach people with protected characteristics such as Job Plus, GM EDI Network, RNIB, Black History Recruitment, Pink News and Voice	We will see an increase in the number of people shortlisted / appointed from people with protected characteristics	Y1 Establish directory Y2-3 Maintain and track success	Disability as above 2021 baseline – 575 interviewed BAME Y1 – 10% increase on baseline (633) Y2 – 25% increase on baseline (719) Y3 – 55% increase on baseline (891) 2021 baseline – 85 offers BAME Y1 – 10% increase on baseline (94) Y2 – 25% increase on baseline (106) Y3 – 35% increase on baseline (132)

3.	We will undertake mandatory implicit and association bias awareness training as part of the recruitment training for all mangers with responsibility for current and future recruitment and selection This will form part of our adoption of the CURE model linking with the anti-racism framework. CURE Model • Cultural competency - ensuring we are able to understand, communicate and consider the needs of people from all diverse communities. • Unconscious bias - ensuring we have approaches or take actions that tackle bias, removing the ability for it to impact or minimising in decision making. • Representation - seeking to improve and increase representation from those within underserved communities within selection processes. • Empowerment - ensuring applicants from underserved communities are encouraged and supported to apply for roles and promotions.	We will see an increase in job offers made to people with protected characteristics from shortlisting and a reduction in the shortlisting to success relative likelihood ratio for BAME and disabled / LTC, tracked within WRES / WDES	Y1 Implement awareness training package Y2 Track impact Y3 Continue tracking impact and review	Disability and BAME increases as per 1 and 2
4.	We will work with managers to reduce barriers into employment by reviewing and drawing up role descriptions which are more accessible and user friendly and therefore targeted to a wider audience. To facilitate applications from our local population/community We will work with 'Pure Innovations', those on apprenticeships and Guaranteed Interview schemes to ensure people with protected characteristics can transition to employment following initial work experience and training programmes.	We will see an increase in job applications from people with protected characteristics	Y1 Pilot an area? Y2 -Y3 Implement random quality assurance	Disability and BAME increases as per 1 and 2

5.	We will work closely with our leadership teams to reinforce flexible working opportunities to remove barriers of access to employment for people with protected characteristics	We will see an increase in flexible working across our workforce	Y2 Track impact via WDES, GPG and flexible working data Y3 Continue tracking impact and review	2021 baseline – 1.15% of workforce in flexible working pattern (69). Y2 – 50% increase on baseline (104) Y3 – 100% increase on baseline (138)
6.	We will continue to work closely with our recruiting managers across Divisions to build competency in the Two Tick employment practice (Disability Confident Employer Accreditation Scheme) to remove barriers to employment for Disabled people. Working towards becoming a Level 3 Accreditation: Disability Confident Leader	We will see an increase in employment of disabled staff in our organisation, tracked within WDES	Y2 Gap analysis of progress to date against standard and create action plan Y3 implement action plan	Disability increases as per 1
7.	We will work with our recruiting managers to identify existing talent and proactively develop staff for internal promotion and progression opportunities for with protected characteristics when appropriate new vacancies arise towards equality of opportunity and support development and succession planning	We will see a reduction in the BAME progression disparity ratio	Y1 Create BAME talent pool Y2 Actively promote to recruitment managers to ensure they approach suitable candidates proactively Y3 Review and continue	BAME increases as per 2
8.	We will develop staff conducting interviews and selection for all Band 7 and above vacancies by providing appropriate toolkits for recruiting managers. E.g., offering maternity / paternity and returner's scheme support packages; more flexible work patterns: part-time; job share or compressed hours.	We will see an increase in the success rates of people with protected characteristics in the recruitment process at senior grade levels and a rebalance of gender within quartiles 3 and 4, with associated reduction in mean and median gender pay gaps, tracked within WDES and GPG reports	Y1 Review employment packages, identify improvements and create recruiting manager tool kits Y2 Educate interviewing staff with new employment packages	Disability and BAME increases as per 1 and 2 GPG baselines - Mean GPG 23%, Median GPG 4% Y1 – Mean GPG 22%, Median 3.5% Y2 – Mean GPG 19%, Median 2% Y3 – Mean GPG 15.5% Median <1% Quartile baselines -

			Y3 Track implementation and success	Quartile 3: 86% female Quartile 4: 71% female Y1 - Quartile 3 85% female Quartile 4 72% female Y2 - Quartile 3 83% female Quartile 4 74% female Y3 - Quartile 3 80% female Quartile 4 78% female
9.	We aspire to introduce diverse interview panels for selection processes for all Bands 8A and above. To manage the potential for any unconscious bias in recruitment processes. This may include people on the interview panel from below Band 8A and discharged using the pool EDI Champions network across the Trust.	We will see an increase in the success rates of people with protected characteristics applying for jobs successfully at senior levels and a rebalance of gender within quartiles 3 and 4, with associated reduction in mean and median gender pay gaps	Y1 Create pool of EDI Champions and promote to recruiters Y2-3 Track impact and use of resource	Disability and BAME increases as per 1 and 2 GPG impacts as per 9 Board of Directors diversity demographics increase by end of Y3.

Objective 2: Retention
Ensure that we fulfil our Public Sector Equality Duty in response to the Equality Act 2010 to 'Advance equality of opportunity between people who share a protected characteristic and those who do not.' We will ensure current employees and future talent with protected characteristics are treated with equability and stay with the organisation as 'a great place to work', as per the 2022-2025 Trust Strategy.

	What we will do:	How we will know we have had impact:	Timescales - to be achieved by:	Targets
10.	We will work in partnership with our medical leaders to offer coaching to female consultants to improve rates of successful female applications for the Clinical Excellence Awards (CEAs)	We will see an increase in the number of female applicants securing a Clinical Excellence Award and a reduction in the mean and median bonus pay gap	Y1 Establish senior clinical coaching support for CEA	Baseline – 29% female; 42% male receiving bonus Y1 – 32% female Y2 – 37% female Y3 - 42% female
11.	We will ensure reasonable adjustments are in place, insofar as operational requirements allow for staff with disabilities / LTC to maximise the time they are available to perform, without feeling pressured to attend work if unwell. Where operational requirements mean staff must attend site, all reasonable	We will see a reduction in lost working hours from staff with disabilities / LTC and a further reduction in these staff being taken	Y1 Brief managers on reasonable adjustment guidance Y2 Track impact via	Baseline capability disparity ratio 1.22 Y1 – 1.15 Y2 - 1.07

	adjustments shall be made to assist our staff in performing their duties. Training and support to line managers on these adjustments to be provided, with a particular focus on clinical environments	through the capability process	WDES and flexible working data Y3 Continue tracking impact and review	Y3 – 1.0
12.	We will re-establish the Reciprocal Mentoring Scheme for BAME and Disabled Staff to support making applications for leadership roles	We will see an increase in internal successful applications for senior roles	Y1 Establish senior mentor network for BAME talent Pool and disabled / LTC staff Y2 Track impact via WDES BAME progression ratios Y3 Continue tracking impact and review	Baseline BAME middle to upper progression disparity ratio – 2.03 Y1 – 1.9 Y2 – 1.7 Y3 – 1.5

Objective 3: Progression

Ensure that we fulfil our Public Sector Equality Duty in response to the Equality Act 2010 to 'Advance equality of opportunity between people who share a protected characteristic and those who do not.'

We will ensure current employees and future talent with protected characteristics are enabled into senior leadership positions to drive lived experience into the heart of decision-making to ensure services are designed, developed, and delivered with inclusivity

	What we will do:	**How we will know we have had impact:**	**Timescales - to be achieved by:**	**Targets**
13.	Through our approach to Talent Management and our people plan, we will target female, BAME and disabled staff on development programmes and support managers with succession strategies to enable diversity and inclusion	We will see more staff with protected characteristics progressing and being promoted internally. Increased equality of progression on staff survey score and the progression ratio metric	Y1 Create a protected characteristic talent pool Y2 HR succession planning aligned to predictable churn/staff exit and talent pool skills match Y3 Management support to fulfil targeted roles	BAME progression disparity ratios between band clusters as per 13. Lower to upper progression disparity ratio baseline 4.3 Y1 – 3.5 Y2 – 2.9 Y3 – 2.1

14.	We will actively create and promote developmental opportunities including access to leadership courses, secondments, shadowing, work experience and mentoring to BAME and disabled / LTC staff operating to optimise readiness for senior leadership roles. We will ensure that the mentorship programme is reciprocal such that senior leaders can appreciate the specific issues encountered by staff with protected characteristics	We will see more staff with protected characteristics progressing and being promoted. Increased equality of progression on staff survey score and the progression ratio metric	Y1-2 Establish mentoring programmes for people with protected characteristics Y2 Establish training requirements for leadership courses Y3 Implement	As per 14

Priority 2 Culture

Objective 1: Staff Experience

Ensure that we fulfil our Public Sector Equality Duty in response to the Equality Act 2010 to 'foster good relations between people who share a protected characteristic and those who do not'. We will ensure employees with protected characteristics are able to work, free from discrimination, bullying and harassment in an inclusive work culture that embraces diversity.

To address the disparity evident in the poorer experience of staff with protected characteristics as evidenced above, there needs to be a renewed leadership focus to ensure all managers and team leaders are trained and aware of their responsibilities to create the necessary conditions for a more diverse and inclusive place of work for all staff with protected characteristics:

	What we will do:	**How we will know we have had impact:**	**Timescale- to be achieved by:**	**Targets**
15.	We will relaunch the Staff Networks, Equality Champions and Allies network. The Board Members shall be nominated as Sponsors and one member aligned to each group.	We will see an increase in staff joining staff networks. Clear leader ownership to empower the network with network members having direct access to Sponsors providing a platform for peer-to-peer confidence. Improvement in National Staff Survey (NSS) reporting.	Y1-2 Review staff networks identify improvements, refresh process, brief managers and relaunch Y2-3 Track implementation and effectiveness	Membership growth Y1 5 new members per group Y2 7 new members Y3 10 new members
16.	We will embed EDI capability and competence for inclusive leadership and management practice into all	Improved staff experience of management reported in the NSS, WRES and WDES	Y2 Review leadership programmes and identify	Y2 determine baseline for amount

	current and future leadership and management development programmes for all managerial staff and team leaders		how to integrate Y3 Implement	of programmes and identify how to integrate Y3 Implement and measure how many staff receive training
17.	Using the Anti Racism Framework (ARF), we will incorporate the 'Hate Crime and Respect' campaign that is currently focussed on reducing abuse towards staff from patients and visitors, to extend this internally to drive a zero-tolerance culture. This shall be included in staff / team briefings and other literature available to all staff and linked to FTSU processes.	Greater incident reporting and an overall reduction in staff reporting Bullying Harassment and Abuse in the NSS over the three-year period.	Y1-2 Review existing programmes and incorporate ARF. Develop process and implement Y3 Implement and track impact	Y1 determine baseline of reported incidents Y2/3 Increased staff reporting
18.	Using the Cure Model as our platform we will build into our existing leadership programme (clinical and non-clinical) equality Masterclasses to develop staff competence around EDI and Protected Characteristics	We will see improvements in staff experience evidenced in the NSS	Y1 Create leadership training package Y2 Implement and track impact Y3 Continue tracking impact and review	Increases as per 19.
19.	We will develop a rolling events calendar to align with national and local campaigns/events such as PRIDE, Black History Month, Disability Awareness Week which will raise awareness of the discrimination faced by people with protected characteristics and to foster good relations between protected and non-protected characteristics	Shouldn't the impact be about seeing an improvement in staff experience, by raising the awareness	Y1 Roll out calendar of events and programme schedules Y2 review and continue	Y2 Develop events calendar and promote. Establish baseline of attendance Y3 establish % increase in attendance

Priority 3 Assurance and Compliance

Objective 1: Data Assurance, Conformity and Continuity

Ensure that SNHSFT fulfils the Public Sector Equality Duty in response to the Equality Act 2010 to Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act. We will ensure all data sources and calculation methodologies shall be logged, stored and consistently applied across all compliance areas to ensure that we are providing information that is compliant with the full requirements of the Act and is free from duplication, error, and is replicable year-on-year.

	What we will do:	**How we will know we have had impact:**	**Timescale- to be achieved by:**	**Targets**
20.	We will produce complete the annual WRES, WDES, Gender Pay Gap and Equality Annual Reporting reports, highlighting the results through the governance framework and building in action plans into the EDI programme.	Data submissions completed in line with reporting requirements.	Y 1 -Y3	Y1-Y3 Complete all reports and submissions in a planned and timely way. .
21.	We will ensure all EDI grievances and or concerns raised are reported appropriately either informally or formally e.g., equality champion network are logged; for the purposes of identifying trends throughout the organisation. Review on a minimum of a basis and to capture other metrics which are not currently reported under WRES / WDES e.g., abuse / harassment based upon religion, LBGT	Increased reporting volumes initially, with a subsequent reduction in staff grievances through application of learning from reviews	Y1 Define system and process Y2 Launch and implement reviews. Outcomes incorporated into action plans Y3 Reassess effectiveness	Y2 Obtain a baseline of incoming grievances outside of those formally reported and recorded (Trend analysis) Y3 Assess effectiveness

Objective 2: EDS2 Framework Adoption

Ensure that SNHSFT fulfils the Public Sector Equality Duty in response to the Equality Act 2010 to Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.

Using EDS self-assessment framework, we will reassess the organisation using the EDS2 Framework to help our organisation, in discussion with local partners including local populations, review and improve our performance for people with characteristics protected by the Equality Act and align outcomes with our requirements for the CQC.

	What we will do:	**How we will know we have had impact:**	**Timescale- to be achieved by:**	**Target**
22.	Complete the Equality Delivery System (EDS) process including stakeholder consultation as defined within the standard	We will demonstrate 'Achieving' status or above	Y1 Establish position on maturity matrix Y2 Gap analysis and plan to reach achieving status in all domains Y2-3 Implement plan	Y1 To complete process

8. 2022/25 Destination

The journey ahead is no doubt complex. For decades, research has shown that staff from Black, Asian and Minority Ethnic (BAME) backgrounds, disabled staff and staff with protected characteristics experience discrimination, harassment, and exclusion in the workplace and in in the NHS. This discrimination is not only harmful to employees but also potentially to our population as 94% of our workforce are also local residents.

Evidence has also shown time and time again that having a more representative workforce and diversity at senior leadership levels results in better outcomes for the public and creates a more inclusive, engaged and efficient workforce. It is to this end that SNHSFT will increase the focus on equality, diversity and inclusion agenda aiming to deliver the following outcomes over the next three years,

Priority 1 Workforce

Increased BAME diversity in:

- Non-clinical: Bands 1-4 current 10.5%, target 12.5%
- Non-clinical: Bands 5-7 current 6.9%, target 8%
- Non-clinical: Bands 8A and above current 3%, target 8%
- Clinical (non-medical and dental): Bands 1-4 current 18.4 %, target 20.4%
- Clinical (non-medical and dental): Bands 5-7 current 17.7%, target 19.7%
- Clinical (non-medical and dental): Bands 8A and above current 5.1%, target 8%

Increased Disability diversity by:

- Average across trust: current 3.2%, min target 8.2%
- Non-clinical: Bands 1-4 current 4.4%, target 8.8%
- Non-clinical: Bands 5-7 current 3.7%, target 7.4%
- Non-clinical: Bands 8A and above current 2.6%, target 5.2%
- Clinical (non-medical and dental): Bands 1-4 3.4%, target 6.8%
- Clinical (non-medical and dental): Bands 5-7 2.9%, target 5.8%
- Clinical (non-medical and dental): Bands 8A and above current 2.0%, target 4.0%
- Increased Disability / LTC diversity on our Board by 6% (1 person)

Reduction in Gender Pay Gaps:

- Reduction in mean gender pay gap in line with latest available Public Sector Economy mean pay gap in 2026, or current figure of 15.5%, whichever is the smaller
- Female / Male parity in % application to Clinical Excellence Awards (CEA)
- Reduction in mean bonus gender pay gap current 51.4% to target <10%

Priority 2 Culture

Improved the experience of all staff with protected characteristics so that by 2026, we have:

- Reduced disparity regarding entry into disciplinary processes to achieve parity for BAME staff: current 1.14, target 1
- Reduced disparity regarding entry into capability processes to achieve parity for disabled / LTC staff: current 1.22, target 1

- Reduced disparity regarding shortlisting and being appointed from shortlisting
    - BAME: current relative likelihood 2.43 to target <1.5 relative likelihood

- Reduced disparity regarding bullying and harassment from managers / team leaders in the staff survey for BAME staff: current 18.1% to target <12%
- Reduced disparity regarding discrimination from managers / team leaders in the staff survey for disability / LTC staff: current 24% to target <10%

- 50% reduction in the career progression ratios across all bands for BAME staff
    - Lower to middle 2.1 (Bands1-4 moving up to Bands 5-7)
    - Middle to upper 2.0 (Bands 5-7 moving up to Bands 8A and above)
    - Lower to upper 4.3 (Bands 1-4 moving up to Bands 8A and above)

Priority 3 Assurance and Compliance

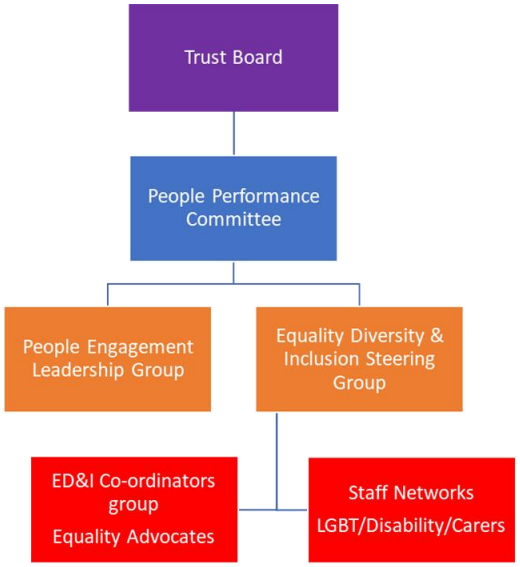
- Continued compliance with WRES / WDES data submissions
- Assurance methodology for WRES / WDES data submissions
- Implementation and development of Accessible Information Standard (AIS) and EDS
- Continued zero enforcement actions / prosecutions under the Equality Act 2010

These outcomes will be overseen by the EDI Steering Group and reported through to the People in Performance Committee (PPC) and People Engagement Leadership Group (PELG)

The objectives relating to compliance will be overseen by the EDI Steering Group.
The Patient Engagement and Service User group will oversee Priority 4, Health Inequalities, representatives from the EDI group will attend the Patient Engagement and Service User Group and the Head of Patient Engagement will attend the EDI Steering Group.

9. Governance Arrangements

The work of the EDI Strategy will be governed in line with the current arrangements for workforce performance monitoring, assurance and accountability:



Group	Function	Meets	Accountable officer
People Performance Committee	Performance scrutiny/ assurance	Bimonthly	Chair of PPC Committee
EDI Steering Group (Membership TBA)	Operational oversight	Bimonthly	Director of People & OD
PELG	Decision	Monthly	Deputy Director of People & OD
Subgroups	Delivery	Monthly	EDI Workforce Associate Director of Workforce Delivery
			EDI Culture Head of Learning and Development
			EDI Compliance & Assurance EDI Manager
			EDI Health Inequalities Matron for Patient Experience











References

Fair Experience For All Project SEARCH	NHS England & NHS Improvement, 2019 DFN Project SEARCH
Diversity and Inclusion are not optional extras if the NHS wishes to improve	Rodger Kline, 2018
Stockport JNSA	Stockport Local Authority
NHS Staff Survey Results	SNHSFT 2020
Equality Act 2010	
Human Right Act 1998	
Health and Social Care Act, 2012	
Equality Diversity System (EDS) 2014	
Gender Pay Gap Information 2020 - 2021	SNHSFT
WRES, 2020 - 2021	SNHSFT
WDES, 2021	SNHSFT
Interim People Plan 2019 Anti- racism Framework CURE Inclusive Recruitment Approach and Toolkit	NHSI North West BAME Academy North West BAME Academy

Stockport NHS Foundation Trust

Meeting date	7 April 2022	x	Public		Confidential	Agenda item
Meeting	Board of Directors					
Title	Standards of Business Conduct					
Lead Director	Caroline Parnell, Director of Communications & Corporate Affairs		Author	Soile Curtis, Deputy Company Secretary		

Recommendations made / Decisions requested

The Board of Directors is asked to:

- Review and confirm the interests declared by the Board of Directors;
- Review and confirm that it considers the Chair and Non-Executive Directors to be independent; and
- Endorse the Chair's annual assessment of the Fit and Proper Person requirements for the Board of Directors, subject to any further action to be taken with respect to annual update/DBS checks.

This paper relates to the following Corporate Annual Objectives-

	1	Deliver safe accessible and personalised services for those we care for
	2	Support the health and wellbeing needs of our communities and staff
	3	Co-design and provide Integrated Service Models within our locality and across our acute providers
	4	Drive service improvement, through high quality research, innovation and transformation
	5	Develop a diverse, capable and motivated workforce to meet future service and user needs
	6	Utilise our resources in an efficient and effective manner
	7	Develop our Estate and IM&T infrastructure to meet service and user needs

The paper relates to the following CQC domains-

	Safe		Effective
	Caring		Responsive
x	Well-Led		Use of Resources

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

BAF risks		**PR1.4**	There is a risk that inclusive restoration plans to address elective backlog are not delivered
		PR2.1	There is a risk that the Trust fails to support and engage its workforce
		PR2.2	There is a risk that the Trust's services do not reliably support neighbourhood population health and future care needs
		PR3.1	There is a risk that effective partnership and accountability arrangements are not in place at ICS and locality provider level
		PR4.1	There is a risk that there is insufficient capacity and capability to deliver Trust, locality and system wide transformation programmes
		PR5.1	There is a risk that robust plans to recruit, train and retain the right staff to meet service needs are not implemented
		PR5.2	There is a risk that the Trust does not deliver the Equality, Diversity & Inclusion Strategy
		PR6.1	There is a risk that the Trust fails to deliver its agreed 2021/22 financial position
		PR6.2	There is a risk that the Trust fails to develop a multi-year financial recovery plan to secure financial sustainability
		PR7.1	There is a risk that the estate is not fit for purpose and does not meet national standards
		PR7.2	There is a risk that the Trust does not materially improve environmental sustainability
		PR7.3	There is a risk that there is no identified funding mechanism or insufficient funding to support strategic regeneration of the hospital campus
		PR7.4	There is a risk that the Trust fails to develop and implement a responsive and resilient Digital Strategy

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 sections
Sustainability (including environmental impacts)	N/A

Executive Summary

This report provides information about:

- The declared interests of all Board members;
- The independence of Non-Executive Directors in line with the NHS FT Code of Governance (Provision B.1.2).
- The Board's compliance with the Fit and Proper Person Requirements (FPPR).

1. Purpose

1.1 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,
- The independence of Non-Executive Directors, and
- Executive and Non-Executive Directors' compliance with the Fit and Proper Person Requirements.

2. Register of Interests

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. In addition, the FT 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.

2.2 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.

2.3 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.

2.4 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. 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.

2.5 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.

3. Independence of Non-Executive Directors

3.1 Provision B.1.2 of the NHS Foundation Trust Code of Governance 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.

3.2 Provision B.1.1 of the NHS Foundation Trust Code of Governance requires the Board of Directors to identify in the Annual Report each Non-Executive Director that it considers to be independent. The provision states that:

"The Board should determine whether the director is independent in character and judgement and whether there are relationships or circumstances which are likely to affect, or could appear to affect, the director's judgement".

3.3 The Board of Directors should state its reasons if it determines that a director is independent despite the existence of relationships or circumstances which may appear relevant to its determination. The Code of Governance sets out relevant criteria as follows:

- Whether the individual had been an employee of the Trust within the last five years,
- Whether the individual has, or has had within the last three 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,
- Whether the individual has received, or receives, remuneration from the Trust in addition to a director's fee, participates in a performance-related pay scheme or is a member of the Trust's pension scheme,
- Whether the individual has close family ties with any of the Trust's advisers, directors of senior employees,
- Whether the individual holds cross-directorships or has significant links with other directors through involvement in other companies or bodies,
- Whether the individual has served on the Board of the Trust for more than six years from the date of their first appointment,
- Whether the individual is an appointed representative of the Trust's university, medical or dental school.

3.4 Declarations of independence, based on the criteria detailed, have been completed by the Chair and each Non-Executive Director. **Appendix 2** provides information to enable the Board of Directors to determine the independence of individual Non-Executive Directors.

3.5 All Non-Executive Directors have declared that they do not meet the criteria and therefore would consider themselves to be independent, with the exception of one Non-Executive Director who declared that they have served on the Board for more than six years from the date of first appointment.

3.6 Mrs Catherine Anderson has served two three-year terms and was re-appointed by the Council of Governors for further one-year term, from 1 January 2022 to 31 December 2022 (in accordance with guidelines set out in the FT Code of Governance). The reappointment was subject to robust review, noting that Mrs Anderson continued to effectively challenge and make a positive contribution to the Board of Directors, as evidenced via most recent appraisal.

3.7 In reaching a conclusion on Non-Executive Director independence, the Board should consider the outcomes of the declaration process together with the content of the Register of Interests and observations on the independent nature of colleagues' performance. In acknowledgement of the above, 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 2021/22.

4. Fit and Proper Person Requirement (FPPR) for Directors

4.1 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.

4.2 The Trust's Fit and Proper Persons Policy, developed in line with the regulations, requires every Executive and Non-Executive Director to make an annual Fit and Proper Persons declaration.

4.3 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 fitness test and do not meet any of the 'unfit' criteria.

4.4 An annual assessment, with respect to compliance with FPPR, has been completed during March 2022. This included review of the following for each individual Board member:

- Director's FPPR Self-Declaration **(Appendix 3)**
- Review against core public information sources
- Professional registration check (applicable to Chief Nurse and Medical Director)
- Undischarged bankrupt or sequestration check
- Disqualified director check

4.5 Comprehensive evidence of all the above is held securely, in individual personal files, by the Trust Secretary and the outcome of the assessment has been considered and reviewed by the Chair.

4.6 Board members have been assessed as compliant with the Fit & Proper Person requirements in accordance with Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. However, eleven Board members did not confirm sign up to the online DBS system as part of the self-declaration. Evidence of a completed DBS check was confirmed for all individuals, alongside 'confirmed' status to all other statements in the self-declaration. Furthermore, it is noted that three Directors, holding a contract of employment with Tameside & Glossop Integrated Care NHS FT (T&G) are not required to sign up to the online DBS system as part their employment contract arrangements.

4.7 A review of the Fit and Proper Persons policy arrangements is to be undertaken by the Director of People & Organisational Development, as part of the planned standardisation of policies by May 2022. Subject to outcome of the review, individual Board members will be made aware of further action to be taken with respect to annual update/DBS checks

5. Recommendations

5.1 The Board of Directors is asked to:

- Review and confirm the interests declared by the Board of Directors;
- Review and determine the independence of each Non-Executive Director; and
- Endorse the Chair's annual assessment of the Fit and Proper Person requirements for the Board of Directors, subject to any further action to be taken with respect to annual update/DBS checks.

Appendix 1 – Board of Directors Register of Interests

Stockport NHS Foundation Trust Board of Directors
Register of Interests
March 2022

Name and Position	Declared Interests
Professor Tony Warne Chairman	• Nil
Dr Marisa Logan-Ward Non-Executive Director Deputy Chair	• Kingsbridge Health Ltd - Management Consultancy to public and private enterprises in relation to pathology and scientific services. Includes a consultancy contract providing the role of Chief Scientific Advisor to Acacium Group - provider of healthcare solutions including staffing
Mrs Catherine Anderson Non-Executive Director Senior Independent Director	• Partner and Director, Anderson Power Consulting • Partner and Director, Birchenough Construction • Director and Hon Secretary, Lake District Boat Club • Foundation Director and Chair, Emmaus Catholic Academy Trust • Director and Chair South Liverpool Education Trust
Mrs Catherine Barber-Brown Non-Executive Director	• Director and Joint Founder, Barber-Brown Strategic Consulting Ltd • Associate, Well North Enterprises CIC • Associate, Prospect Business Consulting • Peer Associate, Local Government Association • Associate, Campbell Tickell • Mentor, Praetura Ventures
Mr Tony Bell Non-Executive Director	• Non-Executive Director, Inclusion Housing CIC • Non-Executive Director, Wythenshawe Community Housing Group • Non-Executive Director, Lumen Housing • Vice-Chair – Cariocca Enterprises • Chair of Advisory Group – The Training Brokers
Mr David Hopewell Non-Executive Director	• Nil
Mrs Mary Moore Non-Executive Director	• Shareholder, Scenario Health
Dr Louise Sell Non-Executive Director	• 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 • RO Appraiser, NHSE/I
Ms Joanne Newton Associate Non-Executive Director	• Lay member, Heywood, Middleton & Rochdale CCG • Niece is a physiotherapist with the MSK team, Stockport NHS Foundation Trust
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 Director of Finance / Deputy Chief Executive	• Chair of the Multi School Academy Trust – Schools in Liverpool, Lydiate Learning Trust • Chair, CIMA's NW Area • Member of CIMA's Council • Member of Management Committee of Las Calas, Lanzarote, Resort Solutions Limited
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
Mrs Nicola Firth Chief Nurse	• Nil
Dr Andrew Loughney Medical Director	• Nil
Mrs Jackie McShane Director of Operations	• Nil
Mr Jonathan O'Brien Director of Strategy & Partnerships	• Executive Director of Strategy & Planning – Joint appointment held between Stockport NHS Foundation Trust and Tameside & Glossop Integrated Care NHS Foundation Trust
Mrs Caroline Parnell Director of Communications & Corporate Affairs	• Founding Partner of Sentry PR, Communications Consultancy • Associate Consultant, Dearden HR and Kingsgate

Appendix 2: Independence of Non-Executive Directors

Relationships or circumstances which may be relevant to the Board's determination of the independence of Non-Executive Directors *(The NHS FT Code of Governance, Monitor, July 2014)*	**TW**	**CA**	**CBB**	**DH**	**JN**	**LS**	**MLW**	**MM**	**TB**
Has been an employee of the Trust within the last five years	N	N	N	N	N	N	N	N	N
Has, or has had within the last three 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	N	N
Has received, or receives, remuneration from the Trust in addition to a director's fee, participates in a performance-related pay scheme or is a member of the Trust's pension scheme	N	N	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	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	N	N
Has served on the Board of the Trust for more than six years from the date of their first appointment	N	Y	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	N	N

Appendix 3 – FPPR Self Declaration

Fit and Proper Person Self Declaration

In line with the requirement for Directors of an NHS Trust to be a fit and proper person, I hereby declare that:-

Declaration	**Confirmed / Not Confirmed**
I am of good character by virtue of the following:-	
• I have not 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.	
• I have not been erased, removed or struck-off a register of professionals maintained by a regulator of health or social care.	
• I have not been sentenced to imprisonment for three months or more within the last five years.	
• I am not an undischarged bankrupt.	
• I am not the subject of a bankruptcy order or an interim bankruptcy order.	
• I do not have an undischarged arrangement with creditors.	
• I am not included on any barring list preventing me from working with children or vulnerable adults.	
• I confirm that I have signed up to the online DBS system and annual checks, as agreed by the Board and that I have made my line manager aware of any changes in line with Trust policies.	
I have the qualifications, skills and experience necessary for the position I hold on the Board.	
I am capable of undertaking the relevant position, after any reasonable adjustments under the Equality Act 2010.	
I have not been responsible for any misconduct or mismanagement in the course of any employment with a CQC registered provider.	
I am not prohibited from holding the relevant position under any other law e.g. under the Companies Act or the Charities Act.	

Signed:	
Name:	
Position:	
Date:	

Stockport NHS Foundation Trust

Meeting date	7 April 2022	x	Public		Confidential	Agenda item
Meeting	Board of Directors					
Title	Foundation Trust Code of Governance Annual Review 2021/22					
Lead Director	Caroline Parnell, Director of Communications & Corporate Affairs		Author	Rebecca McCarthy, Trust Secretary		

Recommendations made / Decisions requested

The Board of Directors is asked to review and confirm the outcome of the annual review of compliance with the FT Code of Governance.

This paper relates to the following Corporate Annual Objectives

x	1	Deliver safe accessible and personalised services for those we care for
	2	Support the health and wellbeing needs of our communities and staff
	3	Co-design and provide Integrated Service Models within our locality and across our acute providers
	4	Drive service improvement, through high quality research, innovation and transformation
	5	Develop a diverse, capable and motivated workforce to meet future service and user needs
	6	Utilise our resources in an efficient and effective manner
	7	Develop our Estate and IM&T 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

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

An annual review of Stockport NHS Foundation Trust's (SFT) compliance with the NHS FT Code of Governance has been undertaken. SFT complies with the Code's provisions, except for:

- Provision B.6.2

Evaluation of FT boards should be externally facilitated at least every three years.

SFT's Annual Report 2021/22 will confirm compliance with the provisions of *the Code* and an explanation of the reasons for departure from B.6.2 on the basis that:

An externally facilitated Board evaluation was completed by Deloitte LLP during 2014/15. In November 2017, a Well Led Review self-assessment was undertaken in anticipation of an externally facilitated evaluation during 2018/19. This was subsequently superseded by a CQC Well-Led Inspection in October 2018. In addition, an NHS England/Improvement Governance Review was undertaken in November 2019, with a further CQC Well-Led Inspection in February 2020. In light of the above, alongside avoidance of additional operational pressures during the pandemic, a full externally facilitated evaluation was not determined an effective use of resources during 2021/22. The Board supported an independently facilitated Well Led Mapping Review, conducted by AQuA (Advanced Quality Alliance). The review provided an independent overview of the Trust's evidence against the eight Key Lines of Enquiry (KLOEs) within the Well Led framework, and further developmental actions for the purpose of continuous improvement

The Board will note that there are a number of areas where compliance is achieved through the inclusion of relevant statements in the Annual Report. These are currently referenced as compliant by means of the 2020/21 Annual Report and the Board can be assured that all entries will be considered during preparation of the 2021/22 Annual Report.

1. Introduction and Context

1.1. The NHS Foundation Trust Code of Governance (the Code) was first published in 2006, revised in 2010 and, following significant regulatory change as a result of the 2012 Act, was updated in January and July 2014.

1.2. The provisions of the Code, as best practice advice, do not represent mandatory guidance however, statutory requirements are highlighted within the Code, disclosure requirements are imposed and FTs are strongly encouraged to take full account of the provisions.

1.3. Compliance against the Code is to be published within the Annual Report in line with the NHS Foundation Trust Annual Reporting Manual.

2. Code of Governance Review 2021/22

2.1 A compliance checklist has been prepared and is included for reference at Annex A. The checklist summarises the principles and supporting principles of the Code and provides a high-level assessment of compliance against all provisions, including reference to evidence for relevant Code provisions.

2.2 The checklist confirms that SFT complies with the Code's provisions - with a number of developmental actions identified to further support compliance - with the exception of:
Provision B.6.2:
Evaluation of FT boards should be externally facilitated at least every three years.

2.3 SFT's Annual Report 2021/22 will confirm compliance with the provisions of *the Code* and an explanation of the reasons for departure from B.6.2 on the basis that:

An externally facilitated Board evaluation was completed by Deloitte LLP during 2014/15. In November 2017, a Well Led Review self-assessment was undertaken in anticipation of an externally facilitated evaluation during 2018/19. This was subsequently superseded by a CQC Well-Led Inspection in October 2018. In addition, an NHS England/Improvement Governance Review was undertaken in November 2019, with a further CQC Well-Led Inspection in February 2020. In light of the above, alongside avoidance of additional operational pressures during the pandemic, a full externally facilitated evaluation was not determined an effective use of resources during 2021/22. The Board supported an independently facilitated Well Led Mapping Review, conducted by AQuA (Advanced Quality Alliance). The review provided an independent overview of the Trust's evidence against the eight Key Lines of Enquiry (KLOEs) within the Well Led framework, and further developmental actions for the purpose of continuous improvement.

A Board development session is scheduled for July 2022 to consider progress against the developmental actions and the Trust's approach for 2022/23.

2.4 The Board will note that there are a number of areas where compliance is achieved through the inclusion of relevant statements in the Annual Report. These are currently referenced as compliant by means of the 2020/21 Annual Report and the Board can be assured that all entries will be taken into account during preparation of the 2021/22 Annual Report.

Annex A – Compliance Checklist FT Code of Governance - 2021/22

A. Leadership

A.1 The role of the board of directors

Main Principle
Every NHS foundation trust should be headed by an effective board of directors. The board is collectively responsible for the performance of the NHS foundation trust.

The general duty of the board of directors, and of each director individually, is to act with a view to promoting the success of the organisation so as to maximise the benefits for the members of the trust as a whole and for the public

Section	Code Provision	2021/22 Position	Developmental Action	Comply or Explain
A.1.1	▪ Sufficiently regular meetings of the Board ▪ Formal schedule of matters reserved for decision by the Board ▪ Clear statement detailing role and responsibilities of Council of Governors (CoG) ▪ Statement explaining how disagreements between the CoG and Board will be resolved ▪ Annual Report to describe how Board and CoG operate	▪ Board met sufficiently regularly during 2021/22 to fulfil their responsibilities. Attendance register held by Company Secretary. ▪ Approved Constitution and Standing Orders (SO)s in place setting out: – Decisions reserved for the Council of Governors (CoG) includes role and responsibilities of CoG – Decisions reserved for the Board of Directors includes role and responsibilities of Board ▪ Mechanism in place to resolve disagreements between the Board and CoG as stated within Constitution. ▪ Senior Independent Director (SID) supports CoG and Board relationships as required. Annual Report describes how Board and CoG operate.		Comply
A.1.2	▪ Annual Report: ○ Identify Chairman, Deputy Chairman, CEO and SID ○ Chair and members of Audit and Remuneration Committees ○ Number of meetings of Board, Audit, Remuneration Committee and individual attendance of members.	▪ Annual Report 2020/21 identifies key members of the Board, Audit and Nominations Committees. Annual Report 2021/22 to include this information. ▪ Number of meetings and attendance reported within Annual Reports (as above).		Comply
A.1.3	▪ Board to issue objectives of Trust highlighting balance of interests of patients, community and other	▪ Trust annual plan is developed in line with national planning requirements within year, including the principal objectives and outcome measures that		Comply

Annex A – Compliance Checklist FT Code of Governance - 2021/22

Section	Code Provision	2021/22 Position	Developmental Action	Comply or Explain
	stakeholders – as basis for decision making/forward planning	balance interests of patients and local community and key stakeholders.		
A.1.4	▪ Adequate systems in place to measure and monitor effectiveness, efficiency, economy and quality. ▪ Board to regularly review against regulatory requirements and approved plans	▪ Board committee structure (assurance framework) in place to oversee delivery of annual plan and regulatory requirements – Committee Effectiveness Internal Audit – Substantial Assurance. ▪ Regular review by Board and Board Assurance Committees of: Integrated Performance Report, Finance Report including progress against Cost Improvement Programme, People Performance and Quality & Safety Dashboards. ▪ Quarterly Cost Improvement Programme Report & Medium/Long Term Financial Strategy Report via Finance & Performance Committee scheduled 2022/23 ▪ Established business case review process, including post business case benefits realisation review. ▪ Established Audit Committee, including review of Internal Audit and External Audit plans.		Comply
A.1.5	▪ Relevant metrics, measures, milestones and accountabilities to be in place to assess delivery of performance ▪ Where appropriate, independent advice should be commissioned by the Board (in high risk/complex areas) to provide adequate and reliable level of assurance	▪ Integrated Performance Report sets out performance against relevant internal and external standards/metrics. ▪ Divisional Performance Review process established. Key themes and issues reported to Finance & Performance Committee. ▪ Independent advice commissioned by Board, as appropriate.		Comply
A.1.6	▪ Board to report on its approach to clinical governance and its plans to improve clinical quality ▪ Board to record where, within the structure of the organisation, consideration of clinical governance occurs	▪ Board approved Quality Strategy in place. ▪ Oversight of clinical governance and quality established within approved Board governance arrangements – Reporting via Quality Committee, and onward to Board as required. ▪ Quality Accounts produced annually.		Comply
A.1.7	▪ CEO to follow procedure set by Monitor for advising Board and CoG and recording and submitting objections to decisions of Board in	▪ CEO fully aware of responsibilities within Accounting Officer Memorandum – Statement within Annual Report 2020/21. To be included in Annual Report 2021/22 ▪ Scheme of Reservation & Delegation, approved via		Comply

Annex A – Compliance Checklist FT Code of Governance - 2021/22

Section	Code Provision	2021/22 Position	Developmental Action	Comply or Explain
	matters of regularity and wider responsibilities of the Accounting Officer procedure.	Audit Committee & Board, sets out Delegations derived from Accounting Officer Memorandum ▪ Responsibilities set out in Standing Orders for Board and CoG.		
A.1.8	▪ Board to establish constitution and standards of conduct for the Trust and its staff in accordance with The Nolan Principles	▪ SFT Constitution in place. ▪ SFT values established. ▪ Conflicts of Interest Policy established for all staff setting out standards of business conduct. ▪ Annual Standards of Business Conduct Review for all Board Directors		Comply
A.1.9	▪ Board to operate a code of conduct that builds on values and reflects high standards of probity and responsibility ▪ Board should follow policy of openness and transparency and make clear how potential conflicts of interest are dealt with.	▪ Adopted Code of Conduct. ▪ Standards of Business Conduct review for Board conducted annually. ▪ Board meetings held in public. Proceedings and decision making that conflict with the need to protect the interest of the public or commercial matters managed in private session and agenda published.		Comply
A.1.10	▪ Appropriate insurance cover to cover the risk of legal action against directors	▪ Directors currently covered by NHSLA/Constitution provisions		Comply

Annex A – Compliance Checklist FT Code of Governance - 2021/22

A.2 Division of responsibilities

Main Principle
There should be a clear division of responsibilities at the head of the NHS foundation trust between the chairing of the boards of directors and the council of governors, and the executive responsibility for the running of the NHS foundation trust's affairs. No one individual should have unfettered powers of decision.

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
A.2.1	▪ Division of responsibilities between the chairperson and chief executive should be clearly established, set out in writing by the Board.	▪ Division of responsibility between Chair and CEO set out in writing in Scheme of Reservations and Delegation.		Comply
A.2.2	**Statutory Requirement:** ▪ Role of Chair and CEO must not be undertaken by same individual	▪ Position of Chair and CEO held by different individuals. Confirmed within Annual Report.		Comply

Annex A – Compliance Checklist FT Code of Governance - 2021/22

A.3 The chairperson

Main Principle
The chairperson is responsible for leadership of the board of directors and the council of governors, ensuring their effectiveness on all aspects of their role and leading on setting the agenda for meetings.

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
A.3.1	▪ Chair should, on appointment, meet the independence criteria set out in B.1.1 ▪ CEO should not go on to be chairperson of the same NHS foundation trust	▪ Chair's job description and person specification details the requirement for the Chair to meet current independence criteria. Confirmed on appointment. ▪ Annual review takes place of the independence of all Non-Executive Directors (NEDs), including Chairman.		Comply

Annex A – Compliance Checklist FT Code of Governance - 2021/22

A.4 Non-executive Directors

Main Principle
As part of their role as members of a unitary board, non-executive directors should constructively challenge and help develop proposals on strategy. Non-executive directors should also promote the functioning of a board as a unitary board.

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
A.4.1	▪ Board to appoint Senior Independent Director (SID), in consultation with the CoG	▪ Current SID - Mrs Catherine Anderson. CoG consulted on proposed appointment of Dr Louise Sell in February 2022. Appointment to be confirmed by Board in April 2022.		Comply
A.4.2	▪ Chairperson to hold meetings with the NEDs without the executives present ▪ Led by SID, non-executive directors should meet without the chairperson, at least annually, to appraise chairpersons performance and if deemed appropriate.	▪ Chair meets with NEDs without executives present on a weekly basis. ▪ CoG approved process for Chair's appraisal confirms SID to meet with NEDs without chairperson present.		Comply
A.4.3	▪ Where directors have concerns, which cannot be resolved, they are recorded in the board minutes ▪ On resignation, director to provide written statement if have any concerns	▪ Board minutes fully record all matters raised, discussions, concerns, and agreements. Board meeting minutes are reviewed at the subsequent Board meeting to ensure they provide a true account of the proceedings. ▪ Resignation of director not occurred in year.		Comply

Annex A – Compliance Checklist FT Code of Governance - 2021/22

A.5 Governors

Main Principle

The council of governors has a statutory duty to hold the non-executive directors individually and collectively to account for the performance of the board of directors. This includes ensuring the board of director's acts so that the foundation trust does not breach the conditions of its license. It remains the responsibility of the board of directors to design and then implement agreed priorities, objectives and the overall strategy of the NHS foundation trust.

The council of governors is responsible for representing the interests of NHS foundation trust members and the public and staff in the governance of the NHS foundation trust. Governors must act in the best interests of the NHS foundation trust and should adhere to its values and code of conduct.

Governors are responsible for regularly feeding back information about the trust, its vision and performance to members and the public, and the stakeholder organisations that either elected them or appointed them. The trust should ensure governors have appropriate support to help them discharge this duty.

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
A.5.1	▪ CoG to meet sufficiently regularly – at least four times a year ▪ Governors should make every effort to attend CoG. Trust should facilitate attendance	▪ CoG meetings take place regularly, five times a year, held virtually during 2020/21. Annual calendar of meeting produced and disseminated at the beginning of the year to facilitate attendance. ▪ Attendance monitored and action taken when necessary.		Comply
A.5.2	▪ CoG not too large to be unwieldy. ▪ CoG should be of sufficient size for requirements of duties ▪ Role, structure, composition and procedures of the CoG to be reviewed regularly (see B.6.5)	▪ Composition of the CoG reviewed and approved by CoG in July 2019. Composition of CoG to be reviewed in September 2020, to be effective from the date of the transaction. ▪ SFT CoG comprises of 29 governors. ▪ Training and development plan in place to support governors in conducting roles and duties. ▪ Standing Orders of the CoG in place.	Review of required changes to the composition of the Council of Governors to be conducted in line with changes to Health & Social Care Act – Jul 2022 Collective CoG performance evaluation mechanism to be developed – Jan 2023	Comply

Annex A – Compliance Checklist FT Code of Governance - 2021/22

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
A.5.3	▪ Annual Report - to identify governors and constituency, whether elected or appointed and term of office - identifies nominated Lead Gov. ▪ Record of meetings and attendance at CoG to be kept and made available to members on request	▪ Annual Report 2020/21 identifies governors, constituencies, class and term of office. To be included in Annual Report 2021/22. ▪ Record of governor attendance at CoG maintained and available on request		Comply
A.5.4	▪ Roles and responsibilities of CoG set out in written document – with explanation of responsibilities of CoG towards members and other stakeholders, and how governors will seek views and inform them.	▪ Roles & responsibilities of the CoG are set out in the Constitution, Standing Orders and Scheme of Reservations & Delegation and 'Roles & Responsibilities' document shared with governors as part of induction. ▪ Communications & Corporate Governance team support governors to inform and seek views of members.	Membership strategy refresh – May 2022	Comply
A.5.5	▪ Governors have a responsibility to make CoG arrangements work and should take the lead in inviting the CEO, Execs and NEDs to meetings ▪ Any Governors may raise questions about the affairs of the NHS foundation trust	▪ Chair and Lead Governor engage in CoG agenda setting process ▪ Chief Executive, Executive Directors and NEDs routinely attend CoG meetings ▪ All Governors proactively invited to raise questions on any issue ▪ Chair and NEDs meet with governors informally during the year to discuss issues and answers any queries.		Comply
A.5.6	▪ CoG to establish policy for engagement with Board – for concerns regarding performance of Board, compliance with new provider licence or other matters ▪ CoG to input into board's appointment of a SID (See A.4.1)	▪ Process in place to resolve disagreements between the Board and CoG as stated within Constitution. ▪ SID appointed by Board in collaboration with the CoG. Governors aware of role of SID.	Strengthen compliance via distinct Policy for Raising Serious Concerns – Jul 2022	Comply
A.5.7	▪ CoG to ensure its interaction and relationship with the Board is appropriate and effective. Timely communication of relevant information and unambiguous language.	▪ Chief Executive, Executive Directors and NEDs routinely attend CoG meetings ▪ NEDs provide regular summary report to CoG regarding matters considered via Board Committees.		Comply

Annex A – Compliance Checklist FT Code of Governance - 2021/22

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
A.5.8	▪ CoG should only use power to remove chair or NED after exhausting all other means of engagement with Board ▪ CoG should raise any issue with Chairman with the SID in first instance.	▪ This provision covered within Constitution. Not applicable during 2021/22.		Comply
A.5.9	▪ CoG to receive and consider other appropriate information to discharge its duties, including clinical and operational data	▪ Relevant information made available to CoG regarding quality, operational performance, people performance and quality of care, alongside key strategic developments.		Comply
A.5.10	**Statutory Requirement:** ▪ CoG to hold NEDs individually and collectively to account for the performance of the Board	▪ Governor observation of Board meetings. ▪ NED attendance and interaction at CoG meetings. ▪ Regular Chair & NED briefing sessions ▪ CoG approved Chair & NED appraisal process ▪ CoG established Nominations Committee for detailed review of Chair and NED appraisal, with final CoG review and approval ▪ CoG appoint all NEDs (& Chair) and ensures this responsibility is highlighted during selection and appointment process.		Comply
A.5.11	**Statutory Requirement:** ▪ CoG to receive the annual accounts; any report of the auditor on them; and the annual report.	▪ Received annually at CoG. Last received in November 2021.		Comply
A.5.12	**Statutory Requirement:** ▪ Governors provided with agenda prior to any meeting of the board, and a copy of approved minutes as soon as practicable afterwards	▪ Agenda and minutes published on the Trust website prior to any meeting of the Board. There is no legal basis on which the minutes of private sessions of board meetings should be exempted from being shared with the governors, however for data protection or commercial reasons, governors should respect the confidentiality of these documents.		Comply
A.5.13	**Statutory Requirement:** ▪ CoG may require one or more directors to attend a meeting to obtain information about trust performance or directors performance of duties to help CoG decide on proposing a vote on trust or directors performance	▪ SFT Constitution sets out that the CoG has this ability ▪ Directors regularly attend CoG meetings.		Comply

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Section	Code Provision	Current Position	Developmental Action	Comply or Explain
A.5.14	**Statutory Requirement:** ▪ Governors can refer question to independent panel for advising governors. ▪ More than 50% of governors must approve this referral ▪ CoG should have dialogue with Board before considering a referral.	▪ *Independent Panel for Advising Governors disbanded in 2017 – Provision no longer applicable.*		
A.5.15	**Statutory Requirement:** ▪ Governors to use their rights and voting powers to represent interests of members/public on major decisions taken by Board: - More than half Board and CoG to approve a change to constitution of the NHS foundation Trust - More than half Board and CoG to approve significant transaction - More than half Board and CoG to approve merger, acquisition, separation or dissolution - More than half Board and CoG to approve increase to non-NHS income ≥ 5% a year Governors to determine whether non-NHS work will significantly interfere with trust's principal purpose.	▪ Provision set out in SFT's Constitution and Standing Orders of the CoG.		Comply

Annex A – Compliance Checklist FT Code of Governance - 2021/22

B. Effectiveness

B.1 The composition of the board

Main Principle
The board of directors and its committees should have the appropriate balance of skills, experience, independence, and knowledge of the NHS foundation trust to enable them to discharge their respective duties and responsibilities effectively.

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
B.1.1	▪ Board to identify in annual report each NED it considers to be independent ▪ Board should determine whether NEDs are independent in character, judgement and whether there circumstances or relationships could exist that affect such independence ▪ Board to state its reasons if it determines that a director is independent despite relevant circumstance/criteria	▪ Annual Report identifies each NED considered by the Board to be independent. ▪ Board states its reasons if it determines that a director is independent despite relevant circumstance/criteria		Comply
B.1.2	▪ At least half the Board, excluding chairperson, should comprise independent NEDs	▪ There are currently 14 voting members of the Board, excluding the chairperson, this includes six Executive Directors and six NEDs. ▪ All current NEDs considered to be independent ▪ Annual review of NED independence (April each year)		Comply
B.1.3	▪ No individual should hold at the same time position of director and governors of any NHS foundation trust	▪ Trust Constitution prevents an individual holding office as both director and governor at the same time ▪ Provisions included in eligibility for directors and governors		Comply
B.1.4	▪ Annual Report to detail each director's area of expertise and clear statement about Board's balance, completeness and appropriateness to the FT ▪ Both statements to be available on FT's internet site	▪ Annual Report 2020/21 detail's each director's area of expertise and statement about Board balance, completeness, and appropriateness to the Trust. To be included in Annual Report 2021/22. ▪ Annual Reports available on SFT website.		Comply

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B.2 Appointments to the board

Main Principle
There should be a formal, rigorous and transparent procedure for the appointment of new directors to the board. Directors of NHS foundation trusts must be "fit and proper" to meet the requirements of the general conditions of the provider licence.

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
B.2.1	▪ Nominations committee(s) to be responsible for the identification and nomination of executive and non-executive directors ▪ Nominations committee(s) should give full consideration to succession planning taking into account future challenges, risks and opportunities facing the FT and skills and expertise required within the Board to meet them.	▪ Board established Remuneration and Appointments Committee for Executive Directors: ○ reviews the structure, size and composition of the Board and, where appropriate, make recommendation/s to the Board for change ○ determines succession plans for the CEO and other Executive Directors and assist in determining the responsibilities of and procedures for appointment of Executive Directors, including the CEO ▪ Review of Board composition, including Executive Director succession planning and NEDs skills audit conducted in 2020/21 determined forthcoming non-executive directors with expertise in people/organisational development and place-based care systems to be appointed. Recommendation supported by CoG Nominations Committee. ▪ CoG established Nominations Committee for NEDs		Comply
B.2.2	▪ Directors and governors to meet "fit and proper" persons test described in provider licence i.e. without recent criminal conviction or director disqualification and not bankrupt. ▪ Trusts to abide by CQC guidance regarding appointments to senior positions	▪ Compliance regime in place for Fit and Proper Persons requirement – reviewed annually by Board (April) ▪ Directors sign Annual Fit and Proper Person Requirement Self-Assessment. ▪ Trust Management of Employment Checks Policy in place and covers all Director level appointments. ▪ At election, governors self-declare eligibility in line with fit and proper person requirements for governors. ▪ Governors complete annual declaration of interests and self-assessment of compliance with fit and proper person for governor.	Council of Governors – Review of Register of Interests & Fit & Proper Person compliance – Jul 2022	Comply

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Section	Code Provision	Current Position	Developmental Action	Comply or Explain
B.2.3	▪ There may be one or two nominations committees, if two one for Exec Directors and one for Non-Exec Directors ▪ Nominations committee(s) should evaluate, at least annually, the balance of skills/experience on the board and prepare a description of the role and capabilities for a particular appointment, including Chair	▪ Nominations Committee in place for NED appointments ▪ Remuneration Committee in place for Executive Director appointments ▪ See B.2.1. Job Description & Person Specification prepared including specific expertise, background, skills and qualities (as agreed) for each vacancy.		Comply
B.2.4	▪ Chairman or an independent NED to chair the nominations committees ▪ A Governor can chair the committee for the appointment of NEDs or Chairman.	▪ Trust Chair identified as chair for both Committees. ▪ When the Chair's nomination is being considered the Deputy Chair or relevant identified member chairs the committee.		Comply
B.2.5	▪ Governors should agree with the nominations committee a clear process for the nomination of a new chair and NEDs ▪ Nominations committee should make recommendations to the CoG	▪ Nominations Committee agreed process for recruitment of Non-Executive Directors, including final recommendation to the CoG. ▪ In 2021/22 CoG supported the recommendation from Nominations Committee with respect to the reappointment of one NED, for a further term of one year; and confirmed recruitment and selection process for two new NEDs.		Comply
B.2.6	▪ Nominations committee responsible for appointment of NEDs, and any interview panel, should consist of a majority of governors	▪ Nominations Committee and Selection Panels consist of majority of governors.		Comply
B.2.7	▪ CoG to take into account the views of the board of directors on the qualifications, skills and experience required for each non-executive director position	▪ Nominations Committee received recommendation from Remuneration & Appointments Committee (proposals approved by Board) regarding future NED appointments. Specifications presented to the CoG prior to each recruitment process.		Comply
B.2.8	▪ Annual report should describe the appointment process followed by CoG for NEDs and Chair	▪ Process described in Annual Report 2020/21. To be included in Annual Report 2021/22 as required.		Comply
B.2.9	▪ An independent external adviser should not be a member or have a vote on nominations committee(s)	▪ Independent external advisers do not have vote on nominations committees.		Comply

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Section	Code Provision	Current Position	Developmental Action	Comply or Explain
B.2.10	▪ Separate section of the annual report should describe work of nominations committee, including board appointments process	▪ Annual Report 2020/21 includes section about the Remuneration & Appointments Committee / Nominations Committee and details of any Executive Director / NED appointment processes. To be included in Annual Report 2021/22.		Comply
B.2.11	**Statutory Requirement:** ▪ Chairperson, NED's and, except in case of appointment of CEO, the CEO appoint executive directors	▪ Chairperson, NEDs and CEO approval of all Executive Director appointments (CEO does not approve a CEO appointment)		Comply
B.2.12	**Statutory Requirement:** ▪ CoG to approve CEO appointment following appointment by committee of chair and NEDs	▪ Constitution requires CEO appointment to be CoG approved. ▪ CoG approved substantive appointment of CEO, made by Chair and NEDs in October 2021.		Comply
B.2.13	**Statutory Requirement:** ▪ CoG responsible for appointment, reappointment and removal of chairperson and other NED's	▪ CoG's Nominations Committee oversees the processes leading to CoG fulfilling its responsibility to appoint, reappoint or remove chairperson and other Non-Executive Directors.		Comply

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B.3 Commitment

Main Principle
All directors should be able to allocate sufficient time to the NHS foundation trust to discharge their responsibilities effectively

Section	Code Provision	Current Position	Action Required	Comply or Explain
B.3.1	▪ Chair's appointment: nominations committee should prepare JD, including time commitment and availability in times of emergency ▪ Chair's significant commitments to be disclosed to the CoG before appointment and disclosed in annual report ▪ Changes in commitments to be reported to CoG as they arise and disclosed in next annual report ▪ Chair of FT cannot, at the same time, be the substantive chair of another FT	▪ Chair's job description covers time commitment and availability in times of emergency ▪ Commitments reviewed by Nominations Committee during appointment process to ensure no significant commitments that would interfere with the demands of the role. ▪ Changes in commitments would be reported to CoG if they arised.		Comply
B.3.2	▪ NED terms and conditions should be made available to the CoG ▪ Letter of appointment should set out expected time commitment ▪ NEDs to undertake to have sufficient time to fulfil role ▪ NED significant commitments should be disclosed to CoG before appointment and as changes arise	▪ NED terms and conditions outlined in application pack and role description, available online during appointment process and via Trust Secretary's office at other times ▪ Letter to NED on appointment – confirms expected time commitment ▪ NEDs undertake to have sufficient time to fulfil role ▪ Significant commitments disclosed to CoG prior to appointment and reappointment.		Comply
B.3.3	▪ Board should not agree to full-time exec taking on more than one non-exec directorship of an FT or other organisation of comparable size/complexity, nor chairmanship	▪ This provision would be reviewed if the circumstance arose.		Comply

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B.4 Development

Main Principle
All directors and governors should receive appropriate induction on joining the board of directors or the council of governors and should regularly update and refresh their skills and knowledge. Both directors and governors should make every effort to participate in training that is offered.

Section	Code Provision	Current Position	Action Required	Comply or Explain
B.4.1	▪ Chair should ensure new directors and governors receive full, formal and appropriate induction ▪ Directors should seek to engage with key stakeholders (patients, clinicians, staff) ▪ Directors to have access to training courses	▪ Induction programmes in place for directors and governors ▪ Number of stakeholder engagement processes and practices in place that involve patients, public and staff engagement. ▪ Directors have access to individual and collective training/development as necessary or as requested.	Commence Non-Executive Director Site Visits Programme – Q1 2022/23	Comply
B.4.2	▪ Chair to regularly review and agree with each director training and development needs	▪ Development needs for all Directors are agreed via Chairman (for NEDs) and CEO (for Directors) and are reviewed annually. Chair aware of all development needs for individual Directors via Remuneration & Appointments Committee.		Comply
B. 4.3	**Statutory Requirement:** ▪ Board to ensure CoG have skills and knowledge to discharge duties appropriately	▪ Training and development programme established for governors, including both internal external opportunities. Information included in Annual Report.		Comply

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B.5 Information and Support

Main Principle
The board of directors and the council of governors should be supplied in a timely manner with relevant information in a form and of a quality appropriate to enable them to discharge their respective duties. Statutory requirements on the provision of information from the board of directors to the council of governors are provided in 'Your Statutory Duties: A reference guide for NHS foundation trust governors'.

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
B.5.1	▪ Board and CoG should be provided with high quality, appropriate information. ▪ Board and CoG should agree their information needs with EDs through the Chair ▪ Information for boards should be concise, objective, accurate and timely, accompanied by clear explanations of complex issues ▪ Board should have complete access to any information necessary, including access to senior managers and other employees	▪ Suite of reports, including background information provided to Board and CoG. ▪ Standardised front sheet for Board and CoG papers to ensure clarity and appropriate review of paper. ▪ Board has full access to all sources of information as requested.		Comply
B.5.2	▪ In challenging assurances received from Executive, Board need not seek to appoint an adviser for every issue but should ensure sufficient information and understanding to make informed decision. ▪ When complex or high risk issues arise, first course of action should be to encourage deeper analysis in timely manner within the FT. On occasion, NEDs may reasonably decide that external assurance is appropriate.	▪ Effective challenge and request for further information and analysis demonstrated at Board and Audit Committee – evidenced within relevant minutes, action sheet and follow-up actions.		Comply
B.5.3	▪ Board to ensure NEDs have access to independent professional advice and training courses/material where judged necessary ▪ Decisions to appoint an external adviser should be collective decision of the majority of NEDs ▪ Availability of independent external sources of advice should be made clear at appointment	▪ Independent advice, information and training made available as necessary/requested		Comply

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Section	Code Provision	Current Position	Developmental Action	Comply or Explain
B.5.4	▪ Committees and CoG to have sufficient resources to undertake duties	▪ Committees and CoG provided with sufficient resources, supported by Corporate Governance team.		Comply
B.5.5	▪ NED's should consider whether they are receiving necessary information in a timely manner and feel able to raise appropriate challenge of recommendations of the Board	▪ Standardised front sheet for Board papers to ensure clarity and appropriate review of paper. ▪ Board has full access to all sources of information as requested. ▪ NED able to raise any concerns about the information they receive and their ability to raise appropriate challenge via either Chair or relevant Executive Lead. ▪ Non-Executive Director challenge is routinely recorded in minutes of Board / Committee meetings. ▪ Committee Effectiveness Internal Audit – Substantial Assurance.		Comply
B.5.6	▪ Governors should canvass the opinion of their members, and for appointed governors the bodies they represent, on the FTs forward plans ▪ Annual Report to state how this requirement has been undertaken	▪ Governors aware of responsibility to canvass opinion of members/bodies they represent. ▪ Views of Council of Governors sought in development of the Trust's Strategy 2020-2025. ▪ Albeit the pandemic impacted opportunity for governors to undertake a broad range of engagement, governors shared feedback received from members/bodies at CoG meetings and informal meetings with Chair & NEDs on key strategic developments and plans. ▪ Member's newsletter highlights key developments for the Trust giving information on how members can contact their governor representatives.	Membership strategy refresh – May 2022	Comply
B.5.7	▪ Board should take account of the views of the CoG on the forward plans and communicate where views have been incorporated, and if not, reasons for this.	▪ See B.5.6 ▪ Views of Council of Governors sought in development of the Trust's Strategy 2020-2025. ▪ Governors remained appraised of key strategic developments in relation to the	Trust Planning Discussion – CoG February 2023	Comply

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Section	Code Provision	Current Position	Developmental Action	Comply or Explain
		forward plans of the Trust via the Chair's Report, Chief Executive's Report and identified topic presentations, including GM & locality plans, at each meeting of the CoG and were able to provide view.		
B.5.8	**Statutory Requirement:** ▪ Board must have regard for the views of the CoG on the trusts forward plan	▪ As described at B.5.6 and B.5.7 above.		Comply

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B.6 Evaluation

Main Principle
The board of directors should undertake a formal and rigorous annual evaluation of its own performance and that of its committees and individual directors.

The outcomes of the evaluation of the executive directors should be reported to the board of directors. The chair should take the lead on the evaluation of the executive directors.

The council of governors, which is responsible for the appointment and re-appointment of non-executive directors, should take the lead on agreeing a process for the evaluation of the chairman and the non-executives, with the chairman and the non-executives. The outcomes of the evaluation of the chairman should be agreed by him/her with the SID. The outcomes of the evaluation of the non-executive directors and the chairman should be reported to the governors. The governors should bear in mind that it may be desirable to use the senior independent director to lead the evaluation of the chairman.

The council of governors should assess its own collective performance and its impact in the NHS foundation trust.

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
B.6.1	▪ Board should state in the annual report how evaluation of board, committees and directors has been undertaken, bearing in mind the desirability for independent assessment, and the reason why the trust adopted a particular method of performance evaluation	▪ Statement included in Annual Report 2020/21. To be included in Annual Report 2021/22 including outcome of annual review of Board Committees and Committee Effectiveness internal audit. ▪ Remuneration & Appointments Committee reviews performance evaluation of each Executive Director. ▪ Nominations Committee reviews performance evaluation of each NED and Chair.		Comply
B.6.2	▪ Evaluation of FT boards should be externally facilitated at least every three years. ▪ Monitor's board leadership and governance framework to be used as basis for this evaluation ▪ External facilitator to be identified in annual report and statement made to any connection to Trust	▪ Independent Board Governance Review completed by Deloitte LLP during 2014/15. ▪ Well Led Review self-assessment undertaken in November 2017 in anticipation of an externally facilitated evaluation in 2018/19. This was superseded by a CQC Well-Led Review in October 2018, NHS England/Improvement Governance Review in (November 2019) and CQC Well-Led Review in February 2020. ▪ In light of the above, alongside avoidance of additional operational pressures during the pandemic, a full externally facilitated evaluation was not determined an effective use of resources	Board Development Session - Well Led Framework for Governance Approach 2022/23, including consideration of externally facilitated review – Jul 2022	Explain

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Section	Code Provision	Current Position	Developmental Action	Comply or Explain
		during 2021/22. The Board supported an independently facilitated Well Led Mapping Review, conducted by AQuA, providing an overview of the Trust's evidence against the 8 Key Lines of Enquiry (KLOEs) within the Well Led framework, and further developmental actions for the purpose of continuous improvement.		
B.6.3	▪ SID to lead performance evaluation of Chairperson, within framework agreed by CoG	▪ Appraisal process for Chairman, led by SID, within framework agreed by CoG		Comply
B.6.4	▪ Chairperson, with assistance from Trust Secretary, should use performance evaluations to determine individual and collective professional development programme for NED's	▪ Personal and professional objectives for NEDs agreed via Chair as part of appraisal process.		Comply
B.6.5	▪ CoG should periodically assess its collective performance and communicate to members how they have discharged duties	▪ Collective performance evaluation of Council of Governors presented in December 2018. Further periodic evaluation paused during pandemic. ▪ Presentation to AMM about CoG performance including how they have performed statutory duties and responsibilities. ▪ Regular communications to members via Members Newsletter.	Collective CoG performance evaluation mechanism to be developed – Jan 2023	Comply
B.6.6	▪ Clear policy and a fair process for the removal of any governor that consistently and unjustifiably fails to attend CoG meetings, has a conflict of interest, or fails to discharge their responsibilities ▪ Removal may be appropriate where behaviours or actions by a governor or group of governors is incompatible with values/behaviours of Trust ▪ Independent assessor can be used	▪ Approved Code of Conduct for Governors in place that details of values and the requirement of adherence and outlines circumstances that would result in removal of governor - agreed and signed by all governors. ▪ Consideration of independent assessor would be made if situation arose.		Comply

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B.7 Re-appointment of directors and re-election of governors

Main Principle
All non-executive directors and elected governors should be submitted for re-appointment or re-election at regular intervals. The performance of executive directors of the board should be subject to regular appraisal and review. The council of governors should ensure planned and progressive refreshing of the non-executive directors.

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
B.7.1	▪ Chair to confirm to governors that performance of NED proposed for re-appointment continues to be effective ▪ Any term beyond six years (two three year terms) for NED – rigorous review and take account of the need for progressive refreshing of the Board ▪ In exceptional circumstances, NEDs may serve longer than six years (two three-year terms following authorisation of the FT) but subject to annual reappointment. May affect independence.	▪ Chair confirms to governors, via Nominations Committee, that performance of any NED proposed for re-appointment continues to be effective or otherwise. ▪ Term of office for NEDs and Chair considered and agreed by Nominations Committee, in full consideration of NHS England/Improvement (previously Monitor's) guidance of terms of no more than three years and any term beyond six years requiring rigorous review. ▪ One Non-Executive Director (Mrs Catherine Anderson) has served longer than 6 years. Mrs Catherine Anderson re-appointment was subject to review by the Nominations Committee and CoG approved the recommendation for reappointment in October 2021 for a further term of office of one year, from 1st January 2022 to 31st December 2022.		Comply
B.7.2	▪ Elected governors must be re-elected at regular intervals – no more than three years ▪ Biography details, and any other relevant information, to be made available at election ▪ Prior performance information, such as attendance records to also be made available at election	▪ Elected governors' term of office set at no more than three years ▪ Biography details and past attendance published during election.		Comply
B.7.3	**Statutory Requirement:** ▪ CoG to approve CEO appointment at first general meeting following appointment by committee of chair and NEDs ▪ Appointment of all other execs by	▪ Constitution requires CEO appointment to be CoG approved. CoG approved appointment of CEO by Chairman and NEDs – October 2021. ▪ Executive Director appointments to-date approved by CEO, Chair and all other NEDs.		Comply

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Section	Code Provision	Current Position	Developmental Action	Comply or Explain
	committee of CEO, Chair and NEDs			
B.7.4	**Statutory Requirement:** ▪ NED's, including chairperson, appointed by CoG for specified terms subject to re-appointment thereafter at intervals of no more than three years	▪ Term of office for NEDs and Chair considered and agreed by Nominations Committee, in full consideration of NHSI's (previously Monitors) guidance of terms of no more than three years.		Comply
B.7.5	**Statutory Requirement:** ▪ Elected governors subject to re-election by members at regular intervals not exceeding three years	▪ Elected governors' term of office set at no more than three years.		Comply

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B.8 Resignation of directors

Main Principle
The board of directors is responsible for ensuring on going compliance by the NHS foundation trust with its licence, its constitution, mandatory guidance issued by Monitor, relevant statutory requirements and contractual obligations. In so doing, it should ensure it retains the necessary skills within its board and directors and works with the council of governors to ensure there is appropriate succession planning.

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
B.8.1	▪ The Board of Directors should not agree to an executive member of the Board leaving the employment of an NHS foundation trust, except in accordance with the terms of their contract, including but not limited to service of their full notice period and/or material reductions in their time commitment to their role, without the Board first having completed and approved a full risk assessment.	▪ Remuneration & Appointments Committee provide full consideration to such matters as they arise.		Comply

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C. Accountability

C.1 Financial, quality and operational reporting

Main Principle
The board of directors should present a fair, balanced and understandable assessment of the NHS foundation trust's position and prospects

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
C.1.1	▪ Directors should explain responsibility for preparing annual report and accounts in the annual report ▪ Directors should state that the report and accounts are fair, balanced and understandable, and provide information necessary for patients, regulators and other stakeholders to assess the trusts performance, business model and strategy ▪ Should be a statement by auditors about their reporting responsibilities ▪ Directors should also explain approach to quality governance.	▪ Directors Statements, Auditors Statements and Annual Governance Statement included in Annual Report 2020/21 incorporating all required statements. To be included in Annual Report 2021/22.		Comply
C.1.2	▪ Directors should report that the FT is a going concern	▪ Review of Going Concern at Audit Committee and relevant inclusion within Annual Report.		Comply
C.1.3	▪ At least annually, Board should set out financial, quality and operating objectives and sufficient information to allow members/governors to evaluate FT's performance	▪ Annual Plan including objectives and key performance indicators/measures. Integrated Performance Report reviewed via Public Board and Non-Executive Director's Report to CoG providing high level overview of delivery against key performance metrics throughout the year. ▪ Annual Report and Accounts provides annual overview of performance, available on SFT website and presented to CoG annually.		Comply
C.1.4	▪ Board must notify Monitor, CoG and the public if appropriate, about any major new developments which may lead to a substantial financial, performance or reputation change	▪ Effective and regular engagement with the NHS Engagement/Improvement. ▪ Board continually considers public communication.		Comply

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Section	Code Provision	Current Position	Developmental Action	Comply or Explain
	▪ Board must notify Monitor and CoG and consider whether to bring to public attention all information concerning a financial or performance change which would have a significant impact on the FT if made public	▪ Chair and NEDs provides regular report to CoG members about key matters discussed and decisions made at Board. ▪ Board meetings held in public and papers published on the Trust website, alongside meeting recording.		

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C.2 Risk management and internal control

Main Principle
The board of directors is responsible for determining the nature and extent of the significant risks it is willing to take in achieving its strategic objectives. The board should maintain sound risk management systems.

The board of directors should maintain a sound system of internal control to safeguard patient safety, public and private investment, the NHS foundation trust's assets, and service quality. The board should report on internal control through the Annual Governance Statement (formerly the Statement on Internal Control) in the annual report.

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
C.2.1	▪ Directors to maintain oversight of risk management and internal control and report to members and governors in the annual report ▪ Review should cover financial, clinical, operational controls, compliance controls and risk management systems	▪ Board Assurance Framework established and reviewed via Internal Audit as compliance with NHS requirements. ▪ Approved Risk Management Strategy. Chief Executive chairs Risk Management Committee reporting to Audit Committee. ▪ Annual Internal Audit Plan is risk based and constructed in full collaboration with Audit Committee to ensure that there is an effective internal audit function established by management that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee and Board. ▪ Annual Governance Statements compiled by the CEO, reviewed by Auditors, Audit Committee and approved/signed by CEO ▪ Annual Report (including AGS) presented to Governors and Members at CoG and AMM respectively		Comply
C.2.2	▪ Disclose in Annual Report if trust has internal audit function, structure and role it performs. If it does not have an internal audit function, processes it employs for evaluating and continually improving internal control processes	▪ Confirmation and relevant information included in Annual Report 2020/21. To be included in Annual Report 2021/22.		Comply

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C.3 Audit committee and auditors

Main Principle
The board of directors should establish formal and transparent arrangements for considering how it should apply the corporate reporting and risk management and internal control principles and for maintaining an appropriate relationship with the NHS foundation trust's auditors.

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
C.3.1	▪ Board must establish an audit committee composed of at least three independent NEDs ▪ Board should satisfy itself that at least one member of audit committee has recent/relevant financial experience ▪ Chairman of the trust should not chair or be a member of the audit committee, he can attend by invitation as appropriate.	▪ Audit Committee established by Board. Membership includes at least 4 independent NEDs ▪ Board has appointed Chair of Audit Committee with relevant financial experience. ▪ Trust Chair attends Audit Committee by invitation only.	.	Comply
C.3.2	▪ Main roles and responsibilities of audit committee should be set out in publicly available ToR	▪ Appropriate terms of reference established for Audit Committee. Reviewed by Audit Committee in April 2021, and subsequently reported to the CoG via Key Issues & Assurance Report. ToR to be presented to Board for approval as part of annual committee review in June 2022, and will be publicly available via Trust Secretary. ▪ Chair of Audit Committee provides regular update about matters reviewed at Audit Committee to the Group CoG.		Comply
C.3.3	▪ CoG should take lead in agreeing with audit committee the criteria for appointing, reappointing and removing auditors	▪ In October 2019 CoG awarded external audit contract to Mazars LLP for three years to cover financial years 2019/20, 2020/21 and 2021/22. Further to report and recommendation from Audit Committee, in February 2022, CoG approved extension of the External Audit Contract with Mazars LLP for a further term of two years to the 31st March 2024.		Comply
C.3.4	▪ Audit Committee should make a report to CoG about the performance of the external auditor to enable the CoG to consider re-appointment.	▪ See C.3.3		Comply

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Section	Code Provision	Current Position	Developmental Action	Comply or Explain
	▪ Audit Committee should make recommendations about appointment, re-appointment and removal of external auditor, and approve remuneration and terms of engagement of the external auditor			
C.3.5	▪ If the CoG does not accept the audit committee's recommendation, the Board should include explanatory statement in annual report – setting out reasons why CoG has taken different position.	▪ Information to be included in Annual Report if situation arose.		Comply
C.3.6	▪ FT should appoint external auditor for a period of three to five years.	▪ Comprehensive market-testing and procurement exercise undertaken in 2019 to select External Auditor. CoG appointed Mazars as External Auditor in October 2019 for a period of three years with an option for this to be extended by a further 2 year subject to mutual agreement.		Comply
C.3.7	▪ When CoG ends an auditor's appointment in disputed circumstances, chair should inform Monitor of reasons behind decision	▪ An issue of this nature has not arisen to date. Chair to inform NHEI if situation arose.		Comply
C.3.8	▪ Audit committee should review arrangements by which staff can raise issues in confidence about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. ▪ Audit committee should ensure proportionate and independent investigation and follow-up action	▪ Periodic report included in Audit Committee work plan to review systems in place to ensure staff can raise issues in confidence about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters ▪ Regular counter-fraud update reports received by Audit Committee		Comply
C.3.9	▪ Annual Report should describe how Audit Committee has discharged its responsibilities, including: - Significant issues in relation to financial statements, operations and compliance and how addressed;	▪ Section within the Annual Report 2020/21 that comprehensively reports on how Audit Committee has discharged its responsibilities. To be included in Annual Report 2021/22.		Comply

Annex A – Compliance Checklist FT Code of Governance - 2021/22

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
	- How it assessed effectiveness of external audit process and approach to appointment of external auditor, value of service, length of tender and when tender last conducted - If auditor provided non-audit services, value of non-audit services provided and how auditor objectivity and independence is safeguarded			

Annex A – Compliance Checklist FT Code of Governance - 2021/22

D. Remuneration

D.1 The level and components of remuneration

Main Principle
Levels of remuneration should be sufficient to attract, retain and motivate directors of quality, and with the skills and experience required to lead the NHS foundation trust successfully, but an NHS foundation trust should avoid paying more than is necessary for this purpose and should consider all relevant and current directions relating to contractual benefits such as pay and redundancy entitlements

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
D.1.1	In designing schemes of performance-related remuneration of executive directors, the remuneration committee should: ▪ Consider whether directors should be eligible for annual bonuses. If so, conditions should be relevant, stretching and designed to match long term interests of public. ▪ Payouts should be subject to challenging performance criteria reflecting FT objectives ▪ Performance criteria and any upper limits for annual bonuses and incentive schemes should be set and disclosed ▪ Remunerations Committee to consider pension consequences and associated costs of basic salary increases, especially directors close to retirement - only basic pay should be pensionable	▪ The terms of reference for the Remuneration & Appointments Committee cover the requirements of this provision ▪ Not currently applicable.		Comply
D.1.2	▪ Levels of remuneration for chair and other NEDs should reflect time commitment and responsibilities	▪ Level of remuneration for Chair and NEDs reviewed by CoG Nominations Committee in February 2022, in line with NHSE/I remuneration structure for NHS provider chairs and non-executive directors. Reported to and approved by CoG – time commitment and responsibilities taken into account.		Comply

Annex A – Compliance Checklist FT Code of Governance - 2021/22

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
D.1.3	▪ When Executive Director is released to work as non-executive elsewhere, the remuneration disclosure of the annual report should include whether or not director will retain such earnings	▪ Remuneration disclosure of Annual Report will include information if required. ▪ Not applicable at present.		Comply
D.1.4	▪ Remuneration committee should carefully consider compensation commitments of directors' in the event of early termination – the aim to avoid rewarding poor performance	▪ Provision covered within terms of reference Remuneration & Appointments Committee		Comply

Annex A – Compliance Checklist FT Code of Governance - 2021/22

D.2 Procedure

Main Principle
There should be a formal and transparent procedure for developing policy on executive remuneration and for fixing the remuneration packages of individual directors. No director should be involved in deciding his or her own remuneration

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
D.2.1	▪ Board must establish remuneration committee of NEDs, including at least 3 independent NEDs ▪ Remuneration Committee terms of reference to be made available ▪ Where remuneration consultants are appointed, statement made available about whether connection with FT	▪ Remuneration & Appointments Committee established including all NEDs. Annual review of NED independence confirmed. ▪ Remuneration & Appointments Committee terms of reference available for review via Trust Secretary ▪ Statement re remuneration consultants would be included in relevant Annual Report – not currently applicable.		Comply
D.2.2	▪ Remuneration committee to have responsibility for setting remuneration for all exec directors, including pension rights and any compensation payments ▪ Remuneration committee should recommend and monitor the level and structure of remuneration for senior management	▪ Remuneration & Appointments Committee terms of reference set out all aspects of this provision.		Comply
D.2.3	▪ CoG should consult with external professional advisers to market-test remuneration levels of the chair and other non-execs at least once every three years	▪ Level of remuneration for Chair and NEDs reviewed by CoG Nominations Committee in February 2022, in line with NHSE/I remuneration structure for NHS provider chairs and non-executive directors.		Comply
D.2.4	**Statutory Requirement:** ▪ The council of governors is responsible for setting remuneration of NED's and Chairperson	▪ See D.1.2 and D.2.3		Comply

Annex A – Compliance Checklist FT Code of Governance - 2021/22

E. Relations with stakeholders

E.1 Dialogue with members, patients and the local community

Main Principle
The board of directors should appropriately consult and involve members, patients and the local community.

The council of governors should represent the interests of trust members and the public.

Notwithstanding the complementary role of the governors in this consultation, the board of directors as a whole has responsibility for ensuring that regular and open dialogue with its stakeholders takes place.

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
E.1.1	▪ Board should make available a public document setting out its 'involvement' policy	▪ Membership strategy approved by CoG in March 18. Refresh paused due to pandemic. ▪ Patient Experience Strategy in place setting out involvement of patients, service users, family, and carers. ▪ Board approved Quality Strategy.	Membership strategy refresh – May 2022 Patient Experience strategy refresh – May 2022	Comply
E.1.2	▪ Board should clarify in writing how public interests will be represented ▪ Approach to addressing overlap and interface between governors and local consultative forums in place to be included.	▪ Included in Annual Report 2020/21. To be included in Annual Report 2021/22. ▪ Membership strategy describes approach between governors and local community forums. ▪ Composition of CoG includes HealthWatch and Community/Voluntary Sector Appointed Governors to address overlap.	Membership strategy refresh – May 2022	Comply
E.1.3	▪ The Chairman should ensure the views of governors and members are communicated to the Board ▪ The Chair should discuss the affairs of the FT with governors ▪ NEDs to attend governor meetings ▪ SID should attend sufficient meetings of governors to listen to views and develop understanding	▪ Chairman's Report at CoG & Board meetings. ▪ Minutes record the attendance of NEDs (including SID) at CoG meetings. ▪ NED (including SID) participation in joint informal NED/Governor sessions. ▪ Chairman ensures appropriate discussion of the Trust's affairs with governors		Comply

Annex A – Compliance Checklist FT Code of Governance - 2021/22

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
E.1.4	▪ Board should ensure effective mechanisms for communication between governors and members from its constituencies ▪ Contact procedures for members that wish to communicate with governors and/or directors should be made clearly available to members on the FTs website and in the annual report	▪ Whilst the pandemic has impacted governors' opportunities to engage directly with members and the public, mechanisms have included: Trust Newsletter (3 x year) including update on governors and how to contact governors. ▪ Contact procedures publicly available via website and Annual Report.	Membership strategy refresh – May 2022	Comply
E.1.5	▪ Board should state in annual report how members of the Board, in particular NEDs, develop an understanding of the views of governors and members	▪ Information included in Annual Report. See E.1.3.		Comply
E.1.6	▪ Board should monitor how representative its membership is, and the level and effectiveness of engagement and include in Annual Report ▪ This should be used to review the Membership Strategy, taking into account emerging best practice	▪ Annual Report 2020/21 includes membership section as required. To be included in Annual Report 2021/22 – Including membership demographic analysis.	Membership demographic analysis to inform Membership strategy refresh – May 2022.	Comply
E.1.7	**Statutory Requirement:** ▪ Board must make board meetings and annual meeting open to public	▪ Board meetings open to public via virtual attendance throughout 2021/22 ▪ Annual Members Meeting held virtually in 2021		Comply
E.1.8	**Statutory Requirement:** ▪ Trust must hold annual members meetings, director to present annual report and accounts and any report of the auditor on the accounts	▪ Annual Members Meeting held virtually in November 2021. Agenda and meeting recording available on website.		Comply

Annex A – Compliance Checklist FT Code of Governance - 2021/22

E.2 Co-operation with third parties with roles in relation to NHS foundation trusts

Main Principle
The board of directors is responsible for ensuring that the NHS foundation trust co-operates with other NHS Boardies, local authorities and other relevant organisations with an interest in the local health economy.

Section	Code Provision	Current Position	Developmental Action	Comply or Explain
E.2.1	▪ Board should maintain a schedule of the third party bodies to which the FT has a duty to co-operate ▪ Directors should be clear of the form and scope of the co-operation	▪ Trust clear through development of Trust Strategy and annual operational plan key stakeholders and third-party bodies which it has a duty to cooperate. ▪ Directors aware of duty to cooperate and scope of cooperation with third party bodies.		Comply
E.2.2	▪ Board should ensure mechanisms are in place to co-operate with relevant third party bodies and that relationships are maintained ▪ Annually the Board should review effectiveness and relationships and take steps to improve them	▪ Trust Strategy and annual plan includes relevant objectives geared to ensuring the Trust is actively pursuing appropriate and effective relationships with third parties. ▪ Trust fully engaged in GM ICS and Locality developments/arrangements.		Comply

Stockport NHS Foundation Trust

Meeting date	7th April 2022	x	Public		Confidential	Agenda item
Meeting	Board of Directors					
Title	Appointment of Senior Independent Director					
Lead Director	Chair, Professor Tony Warne		Author	Rebecca McCarthy, Trust Secretary		

Recommendations made / Decisions requested

The Board of Directors is asked to approve the appointment of Dr Louise Sell as Senior Independent Director.

This paper relates to the following Corporate Annual Objectives-

	1	Deliver safe accessible and personalised services for those we care for
	2	Support the health and wellbeing needs of our communities and staff
	3	Co-design and provide Integrated Service Models within our locality and across our acute providers
	4	Drive service improvement, through high quality research, innovation and transformation
	5	Develop a diverse, capable and motivated workforce to meet future service and user needs
	6	Utilise our resources in an efficient and effective manner
	7	Develop our Estate and IM&T infrastructure to meet service and user needs

The paper relates to the following CQC domains-

	Safe		Effective
	Caring		Responsive
X	Well-Led		Use of Resources

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

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

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 (July 2014) states that, in consultation with the council of governors, the board should appoint one of the independent non-executive directors to be the senior independent director.

The Chair has recently reviewed the allocation of lead roles and committee membership for all Non-Executive Directors, specifically within the context of their term of office. As the current senior independent director, Mrs Catherine Anderson, will stand down as a Non-Executive Director in December 2022, it is proposed that another Non-Executive Director fulfils this role to provide continuity beyond the end of the calendar year.

In broad terms, the role of the senior independent director is to provide a sounding board for the chairperson, serve as an intermediary for other directors, when necessary, be available to governors regarding significant concerns and lead the performance evaluation of the chairperson.

In recognition of the range of skills and qualities and capacity to undertake the role, the Chair has approached Dr Louise Sell regarding this position. Dr Sell has confirmed her commitment to be appointed as senior independent director.

The above proposal for appointment was presented and supported by the Council of Governors at its meeting on 23rd February 2022.

1. Introduction

1.1 NHS Improvement (formally Monitor's) Code of Governance (July 2014) states that:

"A.4.1 In consultation with the council of governors, the board should appoint one of the independent non-executive directors to be the senior independent director to provide a sounding board for the chairperson and to serve as an intermediary for the other directors when necessary. The senior independent director should be available to governors if they have concerns that contact through the normal channels of chairperson, chief executive, finance director or trust secretary has failed to resolve, or for which such contact is inappropriate. The senior independent director could be the deputy chairperson."

1.2 The core elements of the senior independent director role are informed by the Code of Governance (Appendix 1). In broad terms the role of the senior independent director is to provide a sounding board for the chairperson, serve as an intermediary for other directors when necessary, be available to governors regarding significant concerns and leading the performance evaluation of the chairperson.

2. Process

2.1 The Chair has recently reviewed the allocation of lead roles and committee membership for all Non-Executive Directors, specifically within the context of their term of office.

2.2 As the current senior independent director, Mrs Catherine Anderson, will stand down in December 2022, it is proposed that another Non-Executive Director fulfils this role to provide continuity beyond the end of the calendar year.

2.3 In recognition of the range of skills, qualities and capacity to undertake the role, the Chair approached Dr Louise Sell regarding this position. The Chair specifically noted that Louise has extensive experience as an Executive Medical Director of an NHS Foundation Trust, and Responsible Officer, therefore accustomed to conducting robust appraisal processes with both clinical and non-clinical colleagues. Louise is comfortable contributing to a wide agenda and has significant experience of partnership working.

2.4 Dr Sell has confirmed her commitment to be appointed as senior independent director, with continued support to the Council of Governors via regular attendance at both Council of Governors meetings and informal meetings of Governors and the Chair & Non-Executive Directors.

2.5 The Council of Governors unanimously supported the proposal for the appointment of Dr Louise Sell as senior independent director at its meeting on 23rd February 2022.

ROLE DESCRIPTION

Role Title: **Senior Independent Director**

Responsible to: **Chairman**

Key Relationships: **Board of Directors**
Council of Directors

Appointment
The Board of Directors will appoint a Senior Independent Director from among the Non-Executive Directors. The appointment will be made in consultation with the Council of Governors.

Terms of Office
The Senior Independent Director will be appointed for a period not exceeding his / her current term as a Non-Executive Director. The appointment will be reviewed on an annual basis.

It is expected that this role will require additional time and commitment above that for other non-executive duties which could equate to a further one day per month. In recognition of this work an additional allowance of £1,000 will be made annually to the Senior Independent Director (subject to approval by the Council of Governors). Satisfactory performance in this role will be reviewed annually with the Chair.

Principle Duties

1. Provide a sounding board for the Chair.
2. Serve as an intermediary for other directors when necessary.
3. Be available to governors and members if they have concerns about the performance of the Board of Directors, compliance with the Provider Licence or welfare of the Trust which contact through the normal channels of Chairman, Chief Executive or Director of Finance has failed to resolve or for which such contact is inappropriate
4. To maintain sufficient contact with the Council of Governors, to form a clear and balanced understanding of their issues and concerns.
5. To take action as is necessary to bring any matters raised governors and members to resolution where they are raised specifically for the Senior Independent Director.
6. To lead the appraisal of the chairman having agreed the process for evaluation with the Council of Governors.
7. To meet with the Non-Executive Directors in the absence of the Chairman to evaluate his/her performance and include any points as part of a formal appraisal process.
8. To undertake a formal appraisal of the Chairman and provide a summary evaluation for consideration by the Council of Governors.
9. Such other functions as are compatible with this role and are agreed between the Director and the Chairman from time to time.

Stockport NHS Foundation Trust

Meeting date	7 April 2022	x	Public		Confidential	Agenda item
Meeting	Board of Directors					
Title	Finance & Performance Committee Key Issue & Assurance Report					
Lead Director	John Graham, Director of Finance Jackie McShane, Director of Operations		Author	Soile Curtis, Deputy Company Secretary		

Recommendations made / Decisions requested

The Board of Directors is asked to review and confirm the Finance & Performance Committee Key Issues & Assurance Report from the meetings held on 17th February 2022 and 17th March 2022.

This paper relates to the following Corporate Annual Objectives-

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

The paper relates to the following CQC domains-

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

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

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

Where issues are addressed in the paper-

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

Executive Summary

A Key Issues & Assurance Report summarising business conducted by the Finance & Performance Committee, together with key actions and/or risks, is presented to the Board for review. The reports relate to meetings held on 17th February 2022 and 17th March 2022.

KEY ISSUES AND ASSURANCE REPORT *Finance & Performance Committee* *17th February 2022*				
The Finance & Performance Committee draws the following matters to the Board of Director's attention-				
Issue	**Committee Update**	**Assurance received**	**Action**	**Timescale**
Finance Report	The Committee received the Finance report for Month 10 of 21/22.	The Committee noted the finance report for month 10 and had assurance on the forecasted delivery of a balanced financial plan. Noted additional income received in month, and plans are in place to manage the year-end financial position, along with challenge associated with recurrent CIP.		
Planning for 22-23	The Committee received an update on the 22/23 Trust planning submission.	The Committee noted risk associated with the assumptions for activity planning (no Covid), uncertainty with respect to income and ongoing discussion regarding allocations and risk with respect to required efficiency target. Also noted was the risk around workforce in particular the assumptions for sickness levels and turnover. Assurance received with respect to planning process and triangulation of planning.	Committee to have a separate session on CIP plans.	March 2022
Operational Performance Report	The Committee received the performance report for Month 10.	The Committee noted the operational performance measures below plan. It was noted that these reflected pressures resulting from the impact of the last covid wave, including the impact on staffing and community beds. The Committee noted the Outpatient Transformation work and success with PIFU, however further understanding of the links to inequalities required.	PIFU Deep Dive	June 2022

Future MR Provision	The Committee received a verbal update on the current MR service provision.	The Committee noted the current progress regarding the future MR service provision and were assured that there was no risk to patient access whilst the process of procurement was ongoing.	Report to be provided in line with procurement process	April 2022
Pacing Suite Business Case	The Committee received an update on the Pacing Suite Business Case.	The Committee noted the need to relocate the Pacing Suite to a suitable alternative location to ensure the Emergency & Urgency Care Campus footprint was able to be developed. The Committee supported the business case however noting that would have been valuable to consider as part of the original case for the Emergency & Urgency Care Campus.		
M6 Business Case (Option 3 Proposal)	The Committee received a verbal update on the M6 Business Case.	The Committee noted the progress on the development of Ward M6 and the delay in handover due to raw material issues. It was noted that the development of this ward formed part of the 22/23 plans and once planning was complete a paper would be presented to the Committee.		April/May 2022
Digital Funding Bids Follow Up Report	The Committee received Digital Funding Bids Follow Up Report.	The Committee noted the report and were assured that the capital investment would be made by the end of March 2022 and that there were sufficient resources in the team to be able to deliver the projects in 22/23.		
Equipment Replacement – Revised Process Update	The Committee received a verbal update on Equipment Replacement and the revised process.	The Committee noted the progress regarding equipment replacement that has been ongoing, and the links with the EBME Team in identifying additional requirement.		

Capital Planning for 2022/23	The Committee received Capital Planning for 2022/23 report.	The Committee noted the report and the plans for capital investment over the next 3 years. Detail regarding equipment priority list to be shared with the Committee.		

KEY ISSUES AND ASSURANCE REPORT *Finance & Performance Committee* *17th March 2022*				
The Finance & Performance Committee draws the following matters to the Board of Director's attention-				
Issue	**Committee Update**	**Assurance received**	**Action**	**Timescale**
Finance & Performance Committee Annual Review 2021/22	The Committee considered the Finance & Performance (F&P) Committee Annual Report and suggested some amendments to the Committee work plan. It was noted that the consideration of the Committee's terms of reference had been deferred while further discussions continued around Committee membership.	The Committee agreed to review the updated terms of reference virtually prior to presentation to the April Board meeting for approval. The Committee reviewed and confirmed the F&P Committee Annual Report 2021/22 to be presented to the Board of Directors for approval, subject to the above caveats.	The Committee Annual Report, including Terms of Reference and Work Plan, would be presented to the Board for approval	April 2022
Capital Programmes Management Group – Terms of Reference and Annual Work Plan	The Committee reviewed the Capital Programmes Management Group (CPMG) terms of reference and annual work plan. The Committee agreed that reference to the Green Plan should be added to s4.4 of the terms of reference to ensure it was considered as part of each business case development.	Subject to the amendment to the terms of reference relating to the Green Plan, the Committee approved the CPMG terms of reference and work plan.		
Finance Report	The Committee considered the Finance report for Month 11 of 2021/22.	The Committee noted the Finance Report for month 11 and received assurance on the delivery of the financial plan, subject to the risks discussed. While the Trust was forecasting to deliver the capital plan by year-end, the Committee acknowledged challenges in this area. The Committee welcomed the positive position approaching year end, after a significantly challenging year. The Committee thanked the finance and operations teams for all their work in this area.	The Committee agreed to receive a report on the robustness of the temporary staffing forecast at the June meeting	June 2022

Planning for 2022/23	The Committee received a planning update presentation for 2022/23 and heard about the next steps ahead of the final submission to Greater Manchester on 15 April 2022.	The Committee endorsed the proposed approach that the Trust's planning submission should be realistic and supported the position regarding 3% CIP target to support patient safety and quality. It was noted that the Board of Directors would sign off the final planning submission.	The Board would receive a planning update at the April Board meeting The Committee agreed to receive an update on the longer term plan for community beds at the June meeting	April 2022 June 2022
Operational Performance Report	The Committee considered the operational performance report for Month 11.	The Committee noted that the performance was below plan; however, it was noted that this was in line with the pressures in the system seen in the rest of GM and nationally. The Director of Operations highlighted the continued non-elective pressures and no criteria to reside as significant areas of concern. The Committee heard about mitigating actions around resus and safeguarding training compliance.	The Committee agreed that an in depth analysis of the factors affecting A&E performance would be included in the May Operational Performance Report	May 2022
Board Assurance Framework (BAF)	The Committee received a report on the eight principal risks within the BAF assigned to the Committee.	The Committee approved the current position of the principal risks assigned to the Finance & Performance Committee, subject to review of risk score for Risk 1.4 (Elective Recovery). Committee noted Trust Secretary/Deputy Director of Finance/Director of Operations would continue to review risk descriptors/controls/assurance and the gaps in assurance to ensure these are narrated appropriately reflected on the BAF. The Committee members commended the improvements made to the BAF and thanked the Trust Secretary and the team for their work in this area.		
Capital Programme Management Group	The Committee received a key issues report from CPMG.	The Committee noted the key issues and assurance report from the CPMG meeting held on 15 February		

(CPMG)		2022.		
Policies for approval	The Committee received policies for approval	The Committee approved the following policies: • IT Acceptable Use Policy • Mobile Devices and Removable Media Security Policy		
NHS Property Services Outstanding Debt	The Deputy Director of Finance briefed the Committee regarding a long standing issue with NHS Property Services payments. Further update to be provided to F&P Committee, and Board, as required.			

Stockport NHS Foundation Trust

Meeting date	7 April 2022	x	Public		Confidential	Agenda item
Meeting	Board of Directors					
Title	People Performance Committee Key Issue & Assurance Report					
Lead Director	Amanda Bromley, Director of People & OD		Author	Soile Curtis, Deputy Company Secretary		

Recommendations made / Decisions requested

The Board of Directors is asked to review and confirm the People Performance Committee Key Issues & Assurance Report from the meetings held on 10th February 2022 and 10th March 2022.

This paper relates to the following Corporate Annual Objectives-

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

The paper relates to the following CQC domains-

	Safe		Effective
	Caring		Responsive
x	Well-Led		Use of Resources

This paper is related to these BAF risks		**PR1.1**	There is a risk that the Trust delivers sub-optimal quality services and fails to meet regulatory standards
		PR1.2	There is a risk that the Trust fails to reduce harm against agreed baseline
		PR1.3	There is a risk that patient flow plans are not effective leading to decline in A&E performance
		PR1.4	There is a risk that inclusive restoration plans to address elective backlog are not delivered
	X	**PR2.1**	There is a risk that the Trust fails to support and engage its workforce

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

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 sections
Sustainability (including environmental impacts)	N/A

Executive Summary

A Key Issues & Assurance Report summarising business conducted by the People Performance Committee, together with key actions and/or risks, is presented to the Board for review. The reports relate to meetings held on 10th February 2022 and 10th March 2022.

KEY ISSUES AND ASSURANCE REPORT *People Performance Committee* *10th February 2022*				
The People Performance Committee draws the following matters to the Board of Director's attention-				
Issue	**Committee Update**	**Assurance received**	**Action**	**Timescale**
Temperature Check	The Director of People & OD highlighted the continued significant operational pressures in the Trust and the consequent adverse impact on staff health and wellbeing. The Committee thanked all staff for their continued hard work during this difficult time.	The Committee received information regarding the health and wellbeing initiatives put in place and noted that the food related rewards had been particularly well received.	Ongoing monitoring	
Workforce Performance Report	The Committee considered the Workforce Performance Report and received an update on the following areas: sickness absence, training, appraisal, retention and vacancies, pay expenditure, divisional profiles, recruitment pipeline and vaccination update. Turnover was highlighted as an area of concern and the Committee heard of mitigating actions. The Committee also discussed bank and agency expenditure and noted actions to reduce on temporary staff.	The Committee received positive assurance about robust processes in place around the use of off framework agencies.	Ongoing monitoring	
People Plan Integrated Delivery Report	The Committee considered a report detailing progress made with the delivery of the Workforce & OD Integrated Plan up to the end of Q3. The Committee noted the next steps, which included closing all completed actions and developing plans for 2022/23.	The Committee noted significant progress made in this area.	Ongoing monitoring	

Freedom to Speak Up Report	The Committee received and noted the quarterly Freedom to Speak Up (FTSU) Report. The FTSU Guardian highlighted the National FTSU Month held in October 2021, and thanked Board colleagues for their support during that week. The FTSU Guardian highlighted themes including staff being fatigued as a consequence of the pandemic and continued operational pressures. He highlighted a fear of detriment being a deterrent to some staff members around speaking up and noted ongoing work to address this.	Positive assurance was gained on the work of the FTSUG and their profile within the Trust. Further work to increase the confidence of staff using the service.	Ongoing monitoring	
Guardian of Safe Working Report	The Committee received and noted the quarterly Guardian of Safe Working Report. The Guardian of Safe Working highlighted actions in place to address the concern raised by a small number of junior doctors to cover shifts as short notice, as previously reported to the Committee. It was noted that the major out of hours project would help improve the position further. The Committee heard that Dr Leigh Wilson had been appointed as Chief Registrar, and that the role was very much welcomed by the Guardian of Safe Working as an accessible point of contact for junior doctors. The Committee heard that work was ongoing to review the numbers of Chief Registrars going forward.	Positive assurance was received that junior doctors were aware of these safe working reporting processes and were using them.	Ongoing monitoring	

Vaccination as a Condition of Deployment Update	The Committee heard that significant work had taken place across the Trust in response to the legislation requiring Covid-19 vaccination as a condition of deployment, which was due to come in from 1 April 2022. As of 31 January 2022, the Secretary of State announced that this was being reconsidered and the Trust has paused further individual discussions. The Committee recognised the huge amount of work that had taken place by HR colleagues in this area and recorded its appreciation to all involved.	The Committee received positive assurance of actions taken in response to the change, including health and wellbeing support offered to staff adversely affected by the impact of the position.	The Committee would be kept updated once further guidance was received.	March 2022
Safe Staffing Report	The Committee considered a report providing assurances and risks associated with safe nurse and midwifery staffing and the actions to mitigate the risks to patient safety and quality. The Committee heard that the report was based on December's data, and that some of the metrics, including sickness absence, had improved in February 2022. The Committee noted turnover as an area of concern, and that this was also an issue regionally and nationally.	The Committee noted that a number of 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. A range of metrics relevant to aspects of patient safety, clinical effectiveness and patient experience are in place to determine safe staffing levels. Investment for the Trust's workforce has evidently supported the improvement in the ability to provide the assurance of a safely staffed hospital Trust which in turn results in Quality outcomes for patients and their families.	Ongoing monitoring	
E-rostering for Medical and Dental Staff	The Medical Director delivered a presentation on e-rostering for medical and dental staff. The Committee heard that Healthroster was currently used by all divisions for the recording of all unavailability and absences for medical and dental staff. The Committee acknowledged the significant amount of work that had gone	The Committee received positive assurance about e-rostering for medical and dental staff		

	into the project and thanked all involved for the achievement.			
Board Assurance Framework (BAF) 2021/22	The Committee reviewed the principal risks on the BAF.	The Committee approved the current position of the principal risks assigned to the People Performance Committee.		
JCNC Key Issues and Assurance Report	The Committee received and noted the JCNC key issues and assurance report.			
People Plan update	Following the publication of “the future of NHS human resources and organisational development”, which further develops the NHS People Plan a review of the current workplan will take place to ensure it is still fit for purpose.	Positive assurance was received on progress to date and the Committee acknowledged the hard work and the quantity of activity that had taken place by the team to meet current Plan requirements.	Ongoing monitoring	

KEY ISSUES AND ASSURANCE REPORT *People Performance Committee* *10th March 2022*				
The People Performance Committee draws the following matters to the Board of Director's attention-				
Issue	**Committee Update**	**Assurance received**	**Action**	**Timescale**
The committee received a "temperature check" from the Director of Workforce and OD.	It had been a very busy time, but absences were settling a little, especially those associated with covid. Turnover was a key issue and focus for the Trust, with detailed discussion planned on the agenda. Coming out of the recent wave of Covid, it was now possible to focus more on more proactive pieces of work. Attendees reflected that much had been learned over the last 2 years, including regarding medical education online and it was important to keep the positive changes	These issues were discussed and noted.	Ongoing monitoring	
The Committee received the draft Committee Annual Report incl ToR and Work Plan	The Committee Annual Report was agreed, and members noted the success of the many deep-dive sessions in helping the Committee to understand the key issues in more detail. The workplan and purpose of the Committee were agreed. It was agreed that EDI and Health and Wellbeing would be included in templates for each Committee report to include these topics as a "golden thread" throughout discussions as well as through the specific reports included in the workplan. It was agreed that the Wellbeing Guardian should be added to the membership of the committee and further discussion regarding membership. Clarity was requested on the level of delegation to the	Positive assurance	Finalisation of committee membership and clarification of wording reflecting the delegated authorities	April 2022

	Committee and associated wording in the ToR			
The Committee received the Terms of Reference of Subgroups for Approval	The Terms of Reference were approved	Positive assurance		
The Committee received the Workforce Performance Report	The report covered performance data for January, which was at the peak of the recent covid wave. It was noted that sickness absence levels had peaked in January and were now improving and the statutory and mandatory training levels had dipped as expected due to the new requirements discussed in previous meetings. Turnover levels were increasing and higher than target. Medical appraisal levels were going well but general appraisal levels had been constrained by levels of activity and sickness in January. The Committee discussed the possible drivers for increased sickness levels compared to the previous year. It was noted that recruitment time to process successful applications has decreased during the time the committee has been monitoring it	Positive assurance was provided some aspects of performance, however negative assurance was provided on sickness absence, turnover. Negative assurance on general appraisal and some aspects of statutory and mandatory training, in line with expectations.		
The Committee received a briefing on embargoed National Staff Survey results	The Committee discussed the results of the survey available to date, aspirations for the culture that the committee would like to see reflected in results, and next steps to support teams in planning and tracking actions once the embargo is lifted. The survey was undertaken in Sept-Nov 2021, during the height of covid, and is reported against the themes of the NHS People Promise	N/A – results under embargo		
The Committee	The PSED report presents information	Negative assurance was received on multiple	Recommend to Board	April 2022

received the Equality Duty Assurance Report PSED Standard and draft EDI Strategy	required to demonstrate compliance with our requirements under the general equality duty (equality information). This is to publish information to demonstrate compliance with the general equality duty and as such, the following information is provided in the report: • Staff in Post by relevant protected characteristic • Recruitment data by relevant protected characteristic • Leavers and staff turnover by relevant protected characteristic The Annual Report findings show that inequalities exist for our staff with protected characteristics, reporting higher levels of a poorer experience including harassment, bullying or abuse at work; greater inequalities in access to employment, development, and progression; lack of equitable representation across entry, middle and senior level roles and lack of diversity in leadership positions. The Committee agreed to recommend the EDI Strategy to the Board for approval, noting that the plans are ambitious. The recommended focus for 2022-25 will be on the delivery of four key aims: 1. Current employees and future talent with protected characteristics are offered equality of opportunity and fair access to jobs, development and career progression 2. Employees with protected characteristics are enabled to work free from discrimination, and bullying and harassment, in an inclusive work environment that embraces diversity 3.	aspects of ED&I, as noted. The Committee recommends the EDI Strategy to the Board to address these inequalities.	approval of EDI Strategy	

	Current employees and future talent with protected characteristics are enabled into leadership positions to drive lived experience into the heart of decision-making and to ensure services are designed, developed and delivered with inclusivity 4. We are compliant with our responsibilities under the relevant legislation and our data and resulting reports are consistent and accessible, as are the calculation and data analysis methodologies			

Stockport NHS Foundation Trust

Meeting date	7 April 2022	x	Public		Confidential	Agenda item
Meeting	Board of Directors					
Title	Quality Committee Key Issue & Assurance Report					
Lead Director	Nic Firth, Chief Nurse Dr Andrew Loughney, Medical Director		Author	Soile Curtis, Deputy Company Secretary		

Recommendations made / Decisions requested

The Board of Directors is asked to:

- Review and confirm the Quality Committee Key Issues & Assurance Report from the meetings held on 22nd February 2022 and 22nd March 2022.
- Receive and approve the Maternity Services Report (including Ockenden Progress Report and Maternity Services Sustainability Plan) following review and recommendation by Quality Committee

This paper relates to the following Corporate Annual Objectives-

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

The paper relates to the following CQC domains-

	Safe		Effective
	Caring		Responsive
x	Well-Led		Use of Resources

This paper is related to	**X**	**PR1.1**	There is a risk that the Trust delivers sub-optimal quality services and fails to meet regulatory standards
	X	**PR1.2**	There is a risk that the Trust fails to reduce harm against agreed baseline

these BAF risks		**PR1.3**	There is a risk that patient flow plans are not effective leading to decline in A&E performance
		PR1.4	There is a risk that inclusive restoration plans to address elective backlog are not delivered
		PR2.1	There is a risk that the Trust fails to support and engage its workforce
		PR2.2	There is a risk that the Trust's services do not reliably support neighbourhood population health and future care needs
		PR3.1	There is a risk that effective partnership and accountability arrangements are not in place at ICS and locality provider level
		PR4.1	There is a risk that there is insufficient capacity and capability to deliver Trust, locality and system wide transformation programmes
		PR5.1	There is a risk that robust plans to recruit, train and retain the right staff to meet service needs are not implemented
		PR5.2	There is a risk that the Trust does not deliver the Equality, Diversity & Inclusion Strategy
		PR6.1	There is a risk that the Trust fails to deliver its agreed 2021/22 financial position
		PR6.2	There is a risk that the Trust fails to develop a multi-year financial recovery plan to secure financial sustainability
		PR7.1	There is a risk that the estate is not fit for purpose and does not meet national standards
		PR7.2	There is a risk that the Trust does not materially improve environmental sustainability
		PR7.3	There is a risk that there is no identified funding mechanism or insufficient funding to support strategic regeneration of the hospital campus
		PR7.4	There is a risk that the Trust fails to develop and implement a responsive and resilient Digital Strategy

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 sections
Sustainability (including environmental impacts)	N/A

Executive Summary

A Key Issues & Assurance Report summarising business conducted by the Quality Committee, together with key actions and/or risks, is presented to the Board for review. The reports relate to meetings held on 22nd February 2022 and 22nd March 2022.

The Maternity Services Report, including Ockenden Progress and maternity Sustainability Plan (Appendix 1) as reviewed by Quality Committee is included for presentation to the Board.

KEY ISSUES AND ASSURANCE REPORT ***Quality Committee*** ***22nd February 2022***				
The Quality Committee draws the following matters to the Board of Director's attention-				
Issue	**Committee Update**	**Assurance received**	**Action**	**Timescale**
Patient Story	The Committee heard a patient story, the objective of which was to remind us why we are here and the values we have.	Positive assurance from patient story. A reminder that the principles of 'Hello my name is' contribute greatly to the patient experience at a time when they feel most vulnerable. All to promote we live our Trust and professional values		
Action Log	All outstanding actions for February 2022 were reviewed, with updates on progress or completion or on the agenda.	Not applicable.	Confirmation of date for Mental Health Strategy to be presented to Quality Committee.	April 2022
Quarterly CQC Update	The Deputy Director of Quality Governance presented the quarterly CQC Update providing an update on the following:	Positive (external) assurance from the CQC report on urgent and emergency care. CQC Insights Report reviewed, noting certain data was 2/3 years old. Indicators showed negative assurance in relation to hip fractures; a review of the suite of indicators would be undertaken, including any previous considerations by Clinical Effectiveness Group (CEG). Further assurance was sought regarding Children and Young Peoples (CYP) indicators. Deputy Director of Quality Governance confirmed that discussion took place within the divisional governance committees and would seek further detail regarding the specific indicators and action taken	Hip Fracture suite of indicators to be developed and reviewed CEG Further detail regarding the specific indicators and action taken	Q3 2022 Q3 2022
Nutrition & Hydration Deep	The Quality Matron and Nutrition Specialist Nurse presented a Nutrition &	Nutrition and hydration. Positive assurance from detailed presentation which made clear the	MUST assessment performance to SPC	Continue reporting

Dive	hydration deep dive including detail of the Monthly Steering Group chaired by the Deputy Chief Nurse and Consultant Gastroenterologist,	committed multidisciplinary nature of the team, reflected in active online presence. Positive contribution of the link nurse role. Good use of data through the interactive dashboard. Negative assurance about the rate of improvement of hydration and fluid balance metrics over the past six months. This and MUST, should remain an area of focus.	charts, to be considered via the Nutrition & Hydration Steering Group and subsequently to Patient Safety Group, reporting to the Quality Committee.	within cycles of business.
Patient Safety Group Key Issues & Assurance Report	The Medical Director presented the Patient Safety Group Key Issues & Assurance Report, which included update regarding a lengthy list of matters that can be reviewed in the minuets. Key metrics can be reviewed in the Integrated Performance Report	The following of note: - Divisional Deep Dive – Positive assurance - Mortality Review Group – Quarterly Report – Further work to support timeliness of LFD reviews, limited assurance. - Medical Examiners Update (Quarterly). Positive assurance - Learning from Deaths Reports including Divisional M&Ms. Positive assurance across divisions. - Maternity Improvement Plan Further assurance required with respect to maternity Continuity of Care – negative assurance about ability to achieve this throughout pregnancy and delivery at present but steady progress being made with booking metrics. - Report of Infection Prevention & Control Group Limited assurance C-diff and nosocomial Covid. - Notification of Serious Incidents including PFD - Litigation Report (later in this report) - Cancer Quality & Service Improvement Group Positive assurance, with consideration to assurance on Harm Reviews - Pressure Ulcers Improving assurance towards back on track - Use of Chemical Sedation – Audit (Bi-Annual)	Definition of Chemical Sedation to be reviewed	On-going On-going December 2021

		- Nutrition and Hydration Steering Group Quarterly Update. Positive assurance as in 'deep dive' - Resuscitation Group Key Issues and Assurance Report - Divisional Key Issues and Assurance Reports - IPR – Safety and Experience - Maximum Blood Order Schedule for approval	to reflect Trust Values	April 2022
Notification of Serious incidents	The Deputy Director of Quality Governance presented a report on data relating to serious incidents and a quarter report on Patient Safety Learning. The Committee received the comprehensive reports detailing number of incidents reported by type, themes and level of harm and a review of Serious Incidents.	The Committee received positive assurance on the process for reporting, investigating incidents, compliance with Duty of Candour and other reporting timeframes. Evidence of learning, e.g. grand rounds. 3 serious incidents were declared to the CCG via StEIS • Compliance with Duty of Candour by letter, within 10 days, was 89% • There were no overdue reports to the CCG. However, there was 1 outstanding Maternity investigation being conducted externally by the Healthcare Safety Investigation Branch (HSIB) that had exceeded the 60-day timeline • 3 investigations were completed and signed off through the Serious • Incident Review Group. Actions identified to reduce the likelihood of the same incident happening again are in the process of being implemented • No de-escalations were requested form the CCG • There was 1 outstanding serious incident action plan • The Trust received no new PFD notices from the Coroner in January 2022	Update to next Quality and performance Committee as per work plan. Check re RCA refresh training and peer to peer learning with Tameside.	Feb 2022 June 2022
Infection Prevention and Control Monthly Summary	A comprehensive report updated the committee on a wide range of IPC metrics and IPC BAF.	The Committee was reassured regarding daily focus on swabbing data and recent improvement. The Committee received negative assurance in achieving	Trust to track position and performance to be presented to Patient	March 20221

Report		compliance rates on day 3 & 6 in specific areas. Noted Clostridium difficile is increasing above its trajectory. Negative assurance on equipment audits	Safety Group in March 2022 and onward to the Committee.	
Quarterly Patient Safety Learning Report	The Deputy Director of Quality Governance presented the quarterly Patient Safety Learning Report	Limited assurance received with respect to falls, albeit robust discussion regarding the much-focused activity to reduce falls that remained ongoing. A deep dive into this complex area to be explored and reporting of rates rather than numbers for falls and pressure ulcers ongoing.	Deep dive to explore key contributing factors of falls prevention and the effectiveness of action/intervention taken Review of metric from numbers to rates.	
Clinical Effectiveness Group Key Issues and Assurance Report	Medical Director presented this report acknowledging its effectiveness has not yet achieved full maturity.	NICE – Positive assurance regarding process, and progress made regarding gradual clearing of backlog with only one division with significant proportion outstanding. Positive assurance about findings from review of compliance and action taken to close gaps where partially compliant. Positive assurance on progress towards CQUIN premium and plans to determine reporting and assurance.	Progress CQUIN planning and achievement	Q1,2 & 3, 2022/23
Stockport Accreditation & Recognition System (StARS) Progress Report	The Chief Nurse presented the StARS Progress Report providing the Committee with an update.	Positive assurance received: Accreditation assessments since the implementation of the scheme. Progress against agreed trajectories. Key issues and themes identified. In addition, areas of good practice and areas for improvement were highlighted, alongside actions being taken to drive improvement. Positive assurance that process well embedded and on track despite pause during omicron wave. Positive	Continue as planned. Description of wards to be included to give context.	Q1 2022/23

		early results from inclusion of integrated care division in the programme. Positive description of shared learning arising from the process.		
Quality & Safety Integrated Performance Report (IPR)	The IPR Report was presented, reviewed, and noted. Assurance was reviewed and agreed, and further actions and focus agreed. Many of the metrics and assurances in the IPR have been addressed in previous papers on this agenda and not repeated here.	Continued positive assurance that SHMI and HSMR both below expected range. Sepsis – positive assurance about recognition and discussion about presenting data on administration differently given small numbers Mixed assurance on medication incidents with inconsistent performance with no harm. VTE – good assurance that positive position is sustained and work is on-going to achieve continuous improvement. Positive assurance re Hospital onset Covid 5/15 presented to HCAI panel and deemed unavoidable. Continued variation in Sepsis: antibiotic administration, small numbers. Positive and negative assurance as described in previous agenda items.	Re Procurement of data provider for SHMI and HSMR. Consider how best to present sepsis data given small numbers skew percentage figures..	*)*

KEY ISSUES AND ASSURANCE REPORT *Quality Committee* *22nd March 2022*				
The Quality Committee draws the following matters to the Board of Director's attention-				
Issue	**Committee Update**	**Assurance received**	**Action**	**Timescale**
Patient Story	The Committee heard a patient story, the objective of which was to remind us why we are here and the values we have.	Positive assurance from the patient story, that Safeguarding team were able to support a patient with a learning disability to access an Outpatient appointment from arrival through to the appointment and beyond.	To always be responsive and make adjustments to be inclusive to all our patients who may have difficulties accessing our services	
Action Tracker	All outstanding actions for February 2022 were reviewed, with updates on progress or completion or on the agenda with the exception of the Mental Health Strategy.	Mental health strategy to be considered as a Stockport wide strategy in line with the 'One Stockport' approach. Further discussion required regarding review by the Committee.	Confirmation of future of Mental Health Strategy	April 2022
Matters arising CQC Update	The Deputy Director of Quality Governance provided verbal update	CQC Insights Report: Positive assurance and confirmation of action taken following presentation of the report at a previous Quality committee		
Patient Safety Group Key Issues & Assurance Report	The Medical Director presented the Patient Safety Group Key Issues & Assurance Report, which included update regarding a lengthy list of matters that can be reviewed in the minuets. Key metrics can be reviewed in the Integrated Performance Report	Positive assurance re. level of engagement divisions in the agenda Positive Assurance on End of Life - strategy and self-assessment against national criteria Significant Assurance on the Maternity Improvement Plan - and support of Sustainability Plan and Ockenden position VTE - positive assurance initial screening but negative assurance re assessment and prescription thrombosis prophylaxis - triangulation with recent incident noted	Update monthly following PSG	April 2022

		Blood transfusion - negative assurance re division engagement, Quality Committee deep dive noted. Limited assurance re prescribing of oxygen. No harm identified but need to change entrenched culture to reinforce it should be prescribed as would a medicine		
Notification of Serious incidents	The Deputy Director of Quality Governance presented a report on data relating to serious incidents and a quarter reports on Patient Safety Learning. The Committee received the comprehensive reports detailing number of incidents reported by type, themes and level of harm and a review of Serious Incidents.	Positive improvement in compliance Duty Of Candour Reported incident deteriorating and demise of patient in context of LD limited assurance, investigation awaited and link back to deteriorating patient group. Negative assurance re. fall incident – Falls deep dive planned and noted Verbal assurance re plan for RCA Training Negative assurance re. Cat 4 pressure ulcer which triangulated with a ward that also had negative StARS performance. Assurance of appropriate action being taken and positive assurance for overall achievement of Trust quality strategy objective to reduce stage 3 and 4 PU noted. Positive assurance no overdue incident action plans	Update to next Quality Committee as per work plan. Check re RCA refresh training and peer to peer learning with Tameside.	April 2022 June 2022
Infection Prevention and Control Monthly Summary Report	A comprehensive report updated the committee on a wide range of IPC metrics and IPC BAF.	IPC – Continued negative assurance Covid nosocomial, swabbing compliance and Cdiff.	Trust to track position and performance to be presented to Patient Safety Group in March 2022 and onward to the Committee.	April 2022
Clinical Effectiveness Group Key Issues and Assurance Report	Medical Director presented this report acknowledging its effectiveness has not yet achieved full maturity.	Positive assurance re engagement Divisions and subgroups - Further work to develop level of narrative and assurance for this group in line with PSG	Progress CQUIN planning and achievement	Q1,2 & 3, 2022/23

Maternity Services Report:	The Deputy Head of Midwifery presented the report including: Improvement Plan - Ockenden Progress - Maternity Sustainability Plan	Continued positive assurance on progress against the Sustainability Plan which has been signed off by the national team. Review of Ockenden Progress Report – One Year on. No areas of non-compliance. Assurance that there is a focus and grip. Still awaiting 'Ockenden 2'. Reviewed and confirmed position to be reported to Board. See attached report.	Continue with Maternity Champions meeting inclusive of a NED Champion	Bimonthly
Waiting List Harms		Waiting list harms - Positive assurance of process and action taken to prioritise children, albeit concern regarding impact of child development whilst waiting. Limited assurance regarding effectiveness of waiting well project – further information required and to be addressed in future report. Limited assurance of impact on other services/departments whilst waiting		April 2022
Quality & Safety Integrated Performance Report (IPR)	The IPR Report was presented, reviewed, and noted. Assurance was reviewed and agreed, and further actions and focus agreed. Many of the metrics and assurances in the IPR have been addressed in previous papers on this agenda and not repeated here.	Continued positive assurance that SHMI and HSMR both below expected range Sepsis – Positive assurance and refreshed metric. Positive assurance re hospital onset Covid 5/15 presented to HCAI panel and deemed unavoidable	Re Procurement of data provider for SHMI and HSMR. Consider how best to present sepsis data.	
Quality Committee Annual Review including - Terms of Reference - Work Plan 2022/23		Annual Review - Limited position regarding Patient Experience group noted and amendment made to Patient Experience Group Terms of Reference & Work Plan – Inclusion of mental health. Work Plan reviewed and approved subject to some amendments. Reviewed and approved subgroup ToR and Work Plans, subject to above.		

NHS
Stockport
NHS Foundation Trust

Maternity Improvement Plan

Quality Committee March 2022

Making a difference every day

Maternity Improvement Plan

NHS Stockport NHS Foundation Trust

The Aim: The Maternity Improvement plan incorporates all improvement/action plans the service is currently working towards. These plans are:

- CQC standards
- CNST Year 4
- Saving Babies Lives (SBL)
- Continuity of Carer pathway (COC)
- Maternity Safety Support Programme (MSSP)
- Ockenden Report

The Improvement plans are monitored and progressed through the Divisional Governance Structure, through to the Trust Patient Safety Group, then Quality Committee and Board of Directors as appropriate and in line with the workplan

Maternity Safety Support Programme (MSSP)

NHS Stockport NHS Foundation Trust

- **Recommendation following the previous visit from the MSSP Support team is for the maternity unit to formally be exited from the programme, following development of a sustainability plan to be signed off through local, regional and national boards.**

- Sustainability plan in full attached as appendix. This has been approved by the MSSP Improvement Adviser, Divisional Governance Meetings, Patient Safety Group, and is now presented to the Quality Committee for final ratification.

Ockenden Report

NHS Stockport NHS Foundation Trust

The Trust is required to submit a return for “Ockenden – 1 year on”

Workforce planning:
The Trust has fully engaged with national standards and recommendations and can confirm:

- Ensured compliance with “Birthrate plus” standards
- Submit Continuity of Carer compliance returns as requested by NHSE/I North West
- Engage with the universities regarding the progression of maternity students
- Are working with local and regional; colleagues regarding international recruitment of midwives

The full response is attached and has been through the Divisional Governance Structure, Patient Safety Group, with regional NHSE/I and is now presented to the Quality Committee for final view, and oversight before final presentation to the Board of Directors through the QC highlights report in April 2022.

7 Ockenden IEAs Update: One Year on	Compliant	Partially Compliant	Non-Compliant
1) Enhanced Safety			
A plan to implement the Perinatal Clinical Quality Surveillance Model	**Compliant** • A plan is in place with the LMS to implement the Perinatal Clinical Quality Surveillance Model.		
All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB	**Compliant** • Maternity Serious Incidents are presented at the Serious incident review group within 72 hours of being reported. All maternity serious incidents are discussed at the Local Maternity Systems (Greater Manchester and East Cheshire) safety Serious incident group. All incidents which meet HSIB's criteria are reported to HSIB and also investigated within the Trust.		
2) Listening to Women and their Families			
Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services	**Compliant** • All areas of maternity service included in Friends and Family feedback and display "You said – we did" boards. Bi- Monthly meetings with MVP take place. A work plan has been developed annually to address any midwifery issues which will inform any improvements to the service. Service users involved in the review of our Induction of Labour pathways and will be members of a disability discrimination audit team reviewing service improvement. • A good example of coproduction at SFT: As part of the induction of labour pathway the MVP are developing an induction of labour passport for women to improve the overall experience. The MVP have also recently completed an induction of labour survey from which we are awaiting feedback.		
Identification of an Executive Director with specific responsibility for maternity services and confirmation of a named non-executive director who will support the Board maternity safety champion	**Compliant** • Process and meetings in place for working collaboratively with the Maternity Safety Champions including bi-monthly meetings with compliance monitored via CNST. Membership is fully compliant with HOM, CD for O&G, Consultant Paediatrician, Exec Director (Medical Director) and Non-Exec director		
3) Staff Training and working together			
Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week		**Fully compliant - Monday to Friday** **Partially Compliant** - Saturday and Sunday until the new consultants starts April 2022, when we will be fully compliant 7 days a week.	
Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year.		**Compliant** • Multi disciplinary team training is undertaken on a monthly basis via PROMPT. The sessions are delivered by Consultant Obstetricians, PROMPT trained Midwives and Anaesthetists. Sessions are attended by Obstetricians, Anaesthetists, midwives and theatre team staff. Training compliances monitored and discussed at monthly Quality Board. **Partially Compliant** • Report to LMS 3 times per year – Submission document in draft with LMS awaiting final ratification due in May 22	

Confirmation that funding allocated for maternity staff training is ring fenced	**Compliant** • Funding has been ring fenced into the maternity budgets for training and this has been reinforced by the introduction of a PEF team which has increased capacity for leadership and training.		
4) Managing complex pregnancy			
All women with complex pregnancy must have a named consultant lead and mechanisms to regularly audit compliance must be in place	**Compliant** • All women are risk assessed at booking and any woman not suitable for midwifery led care are allocated a named consultant. An annual spot check audit is undertaken.		
Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres	**Compliant** • There is a referral process in place for women requiring maternal medicine input. The Trust works jointly across GMEC and has access to tertiary level care if indicated according to pathways and guidelines. Maternal medicine consultant is involved in regional maternal medicine network.		
5) Risk Assessment throughout pregnancy			
A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance	**Compliant** • All women are risk assessed at the antenatal booking and this is recorded on the maternity electronic patient records Euroking. The Trust has introduced a risk assessment which is attached to the antenatal hand held records. This risk assessment is completed at every contact and includes an ongoing review. Training re PCPs and informed consent is due to commence for all Midwives and Obstetricians on a mandatory basis April 2022 to support this.		
6) Monitoring Fetal Wellbeing			
Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines.	**Compliant** • The Trust has two Consultant Obstetrician leads for fetal physiology and a band 7 midwife who has a dedicated 2 days a week. There are monthly fetal monitoring teaching sessions in addition to monthly review of CTG cases.		
7) Informed Consent			
Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website.	**Compliant** • Pathways of care are clearly described on the Stepping Hill maternity service website and place of birth is described. Documents are available in different languages and there is a signpost to information of interpreters services if required.		

Maternity Sustainability Plan

Sustainability Action Plan	Specific actions to be implemented to ensure ongoing sustainability	Progress	Measurement	Outcomes	RAG Rating	SRO	Action Owner	Target Date/ Timeline
Sustained assurance surrounding safe staffing, appropriate skill mix & delivery suite coordinator supernumerary status - this oversight will be split to ensure clear delineation of Direct Clinical Care staffing /DS coordinator supernumerary status & all non-clinical roles	Ongoing midwifery staffing paper to Executive Team and Trust Board as per NICE Consider the Development of an on call senior leadership rota to ensure daily senior manager oversight Develop a duty manager/bleep holder position/rota to maintain and feed into the daily sitrep. GMEC joint recruitment of student midwives (ongoing)	Continue with daily sitreps Daily staffing is submitted of safe care live	Regular evidence of midwifery staffing to ET/Board as per NICE safer staffing. Input into Safe Care Life Monthly Dashboard Red Flag Incident Reporting Evidence of opt in midwives taking posts on qualification	Reduced divert/closures Robust oversight of staffing Safe service provision	Develop an on call senior leadership rota to ensure daily senior manager oversight Develop a duty manager/bleep holder position/rota to maintain and feed into the daily sitrep. GMEC joint recruitment of student midwives (ongoing)	Chief Nurse	Divisional Triumvirate	01/08/2022
Sustain leadership roles in line with the Royal College of Midwives Manifesto & the national self assessment tool for what good looks like within Obs/Gynae & Maternity - ensuring the maintenance of clinical and non clinical roles	Deputy Post approved Consider an increase to Clinical Directors PAs to a minimum of 3 PA's Triumvirate Coaching	Deputy HoM starts on 7th March 22 Head of Midwifery role reviewed and after discussion with North west Regional midwife and Chief nurse job title amended in line with other Directors of nursing within the organisation Explore with wider GMEC & University re the role of a consultant midwife for the trust (consider shared provision with the university)	Leadership as per national recommendations (Self Assessment Tool & RCM manifesto)	Improved governance surrounding womens health and maternity Improved experience for both staff & service users	Triumvirate Coaching to be arranged Consider expansion of CD PA's as part of 2022 job planning	Chief Nurse	Divisional Triumvirate	01/09/2022
Enhance Medical workforce	Additional MDT twice daily ward rounds including weekend and prespective cover	Recruited to one of the two 10 PA posts On going recruitment to second post	Ward rounds are in place but only every other weekend currently	Staff recruitment & retention Safe staffing levels Safer care	Start Date confirmed as 6th June 2022 Second consultant post out to advert with a provisional interview date held in June	Medical Director	Divisional Triumvirate	01/10/2022
Develop an enhanced Professional Midwifery Advocate model widening the support for all midwives	Service reconfiguration re: team model	Engaged with the Birmingham Model - model to be explored and query to link with GMEC colleagues to explore provision	KPI framework to monitor & evaluate the model to be developed. Matrix can be benchmarked on Birmingham's model	improved work morale improved sickness & retention safe care	Recruitment and retention midwife post out to advert 4 x PEF team 9 PMA in post to work along side R&R midwife	Chief Nurse	Divisional Triumvirate	01.09.2022

March 2022

Maternity Sustainability Plan

Action ID Sustainability Action Plan	Sustainability Action Plan	Specific actions to be implemented to ensure ongoing sustainability	Progress	Measurement	Outcomes	RAG Rating	SRO	Action Owner	Target Date/ Timeline
S05	Continue with the Quality Improvement work streams surrounding care provision with & without East Cheshire - focus on workforce sustainability in line with Continuity Commence MDT collaborative response to the rise in Induction of labour Ensure that QI methodology & tools are as part of business as usual & delivering in line with the maternity	A maternity strategy & vision to be presented at quality board Induction of labour task and finish groups facilitated by GMEC Sustainability paper in development with and without East Cheshire Capital investment in to the redesign of Maternity services in Stockport Continued representation on Matneo service improvement programme	Maternity Strategy Complete and awaiting ratification Task and Finish groups established for induction of labour Capital investment approved for design phase of refurbishment in Feb 2022 Maternity Sustainability paper in progress	Maternity Dashboard Paper to Operational Management Group Capital Investment Group	Safer & responsive care provision	Ongoing strategy work with SHH and EC	Chief Nurse/Medical Director/ Exec Director of Operations	Divisional Triumvirate	March 2023 Capital Investment plan over 3 years
S06	Ensure out of area women receive routine care in geographical area (regardless of place of birth choice) - therefore ensuring continuity & fluidity surrounding care is upheld	To collaborate with neighbouring Trusts	QI Working Group developed November 2021 to address OOA women opting for Stockport as a place of birth receives routine care with the named midwife from that specific geographical area.	CoC KPI Undertake a 6 monthly audit and feedback to Maternity G&R	Improved women experience COC upheld Safer care (particularly safeguarding)	Benchmarking against other trusts currently being undertaken	Chief Nurse	Divisional Triumvirate	01.09.22
S07	Maintain safety for mothers and babies, inclusive of the World Health Organisations five steps to safer surgery are carried out regularly to adhere to national recommendations and will be part of the ongoing annual forward audit plan.	NatSSIPs and LocSSIPs audit (ongoing) & forward annual audit plan	LocSSIPs audits routinely undertaken and recorded on AMAT.	Audits monitored monthly at Directorate meeting and Quality Board. Governance oversight at newly developed directorate governance and risk meetings.	Safe service provision Reduction in clinical incidents & never events	Business as usual	Chief Nurse	Divisional Triumvirate	Quarterly review at Maternity Governance

March 2022

Maternity Sustainability Plan

Action ID Sustainability Action Plan	Sustainability Action Plan	Specific actions to be implemented to ensure ongoing sustainability	Progress	Measurement	Outcomes	RAG Rating	SRO	Action Owner	Target Date/ Timeline
S08	Maintain assurance surrounding clear robust monitoring systems to improve quality and safety of women and babies using the service via the Maternity Risk Strategy & aligned with the Board Assurance Framework	Reconfiguration of divisional governance team (ongoing) Continue to triangulate themes from governance /service user voice & any compliments/concerns raised Maternity Risk Strategy	Dashboard metrics to be regularly reviewed via Directorate governance meetings & Labour ward forums - targeted work dependent on red flag areas / incident themes, escalation to Executive team meeting /Board where required Recently reconfigured & relaunch of governance WH meetings	Monthly Dashboard presented at Divisional Patient satiety and quality board MVP feedback Friends & Family Survey / Inpatient survey Staff Survey Compliments & Concerns Incident Reporting HSIB/SI's & Maternity Risk Strategy (annual	Safe service provision Responsive Improved women's experience	Continue to triangulate themes from governance /service user voice & any compliments/concerns raised. Maternity Risk Strategy complete	Chief Nurse	Divisional Triumvirate	Complete
S09	Maintain robust oversight of maternity divers and unit closures, ensuring diverts are kept to a minimum and limiting the impact on women using the service. Enhancing patient experience and providing assurance that patient safety is central to decision making	Twice daily staffing sitreps All Diverts are presented to the trust wide Serious Incident review Group which is held 3 times per week Follow GM Divert Policy	Local twice daily sitreps in place LMS daily sitreps - recoded via tableau for regional oversight/Collaborative working.	Safe care live / health roster Evidence of midwifery staffing to Executive Team / Board	Improved service user experience Improved staff experience Safer staffing principles upheld	Complete Business as usual	Chief Nurse	Divisional Triumvirate	Complete
S10	Sustain appropriate monitoring of any staff being moved from community or birth centres or from one clinical area to another.	Develop a monitoring system for when community staff are move from one clinical area to another -	included in the daily sitrep - ongoing monitoring	This can be audited via sitreps Board staffing papers	Improved staff & women experience, ensures triangulation of safer staffing and maintaining options for birth	Complete Business as usual	Chief Nurse	Head of Midwifery /Deputy Head of Midwifery	Complete
S11	Sustain appropriate monitoring when staff have been redeployed from planned mandatory study days to work in the clinical area - this will be captured via the annual TNA	Develop a monitoring system for when staff have redeployed from planned mandatory study days to work in a clinical area	Continue with daily SITREP & dependent on red flags - board paper/escalation	Evidence of monitoring system DD/ HOM approval needs to be sought before cancelling mandatory training Board staffing papers Stat Man monthly trajectory TNA to be revisited annually & inclusive of monthly trajectory vs staffing (maintain built in	Staff recruitment & retention Safe staffing levels Safer care	Complete Business as usual	Director of Workforce & OD	Head of Midwifery /Deputy Head of Midwifery	Complete

March 2022

Maternity Sustainability Plan

Action ID Sustainability Action Plan	Sustainability Action Plan	Specific actions to be implemented to ensure ongoing sustainability	Progress	Measurement	Outcomes	RAG Rating	SRO	Action Owner	Target Date/ Timeline
S12	Ensure maternity strategy & vision is revisited annually & aligns with the direction of travel/evolving national picture	Periodic review of the strategy - Annually	26/02/21 - all strategy sessions have now taken place. Drafts have been sent out and the strategy will go through the following forums in March/April 21. Labour ward forum, obs and Gynae directorate meeting, WCD quality board and safety champions. Meeting also being set up with chief nurse and medical director 30/03/21 - strategy draft completed and going through approval route 15/06/2021 - Strategy is completed	Strategy uploaded onto trust intranet and internet.	Strategy available to all Trust staff and members of the general public, outlining the maternity service vision for the next 3 years. The strategy will be updated in line with National Guidance.	Complete	Director of Strategy, Partnerships & Transformation	Divisional Triumvirate	Annual review

March 2022

Stockport NHS Foundation Trust

Meeting date	7 April 2022	x	Public		Confidential	Agenda item
Meeting	Board of Directors					
Title	Audit Committee Key Issue & Assurance Report					
Lead Director	John Graham, Director of Finance		Author	Lisa Byers, Assistant Director of Finance		

Recommendations made / Decisions requested

The Board of Directors is asked to review and confirm the Audit Committee Key Issues & Assurance Report from the meeting held on 24th March 2022.

This paper relates to the following Corporate Annual Objectives-

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

The paper relates to the following CQC domains-

	Safe		Effective
	Caring		Responsive
x	Well-Led		Use of Resources

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

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

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 sections
Sustainability (including environmental impacts)	N/A

Executive Summary

A Key Issues & Assurance Report summarising business conducted by the Audit Committee, together with key actions and/or risks, is presented to the Board for review. The reports relate to the meeting held on 24th March 2022.

NHS Stockport NHS Foundation Trust

KEY ISSUES AND ASSURANCE REPORT Audit Committee 24th March 2022
The Audit Committee draws the following matters to the Board of Director's attention -

Issue	Committee Update	Assurance received	Action	Timescale
Approval of Audit Committee Terms of Reference and Work Plan for inclusion in the Audit Committee's Annual Report 2021/22	The Committee received an update to the Audit Committee Terms of Reference and proposed Work plan for 2021/22.	Feedback was received and noted from Mazars on specific responsibilities and wording within the Terms of Reference. The timing of Committees for review of Key Issues and approval of the Annual Accounts and Annual Report was discussed.	Dates of Committee on the work plan to be looked at to bring timing of Committees back in line with dates pre-pandemic. A revised Terms of Reference and Work Plan to be submitted to the next Audit Committee.	May 2022
Internal Audit Progress Report	The Committee received a report of: • Progress against Plan • Follow up Tracker • Draft Internal Audit Plan 2022/23 • Draft Internal Audit Charter	The Committee received assurance that reviews are progressing well and on schedule to finalise in time of the 2021/22 Internal Audit Opinion. There were no significant issues to report on outstanding follow up actions. The Internal Audit progress against plan report was discussed and noted. The Committee received assurance that there was sufficient staffing resource to deliver the draft Audit Plan to the phases as timetabled. Recent delays were a consequence of Covid and sickness absences. In response to a question on working offsite assurance was received that the same standards and breadth of review was still undertaken compared to an onsite audit.	Recommendations are on track to be completed. One 'follow up' action is being reviewed by the new Director of Transformation.	April/May 2022 Q1 2022/23 January 2022

		The Committee received substantial assurance on the Business Case process Audit. MIAA stated that there was a standardised process, good reporting and effective monitoring in place. The Committee received substantial assurance from the Committee Effectiveness Audit that there is a good system of internal control and that controls are applied consistently. The review concluded that the three Trust Board committees; the Finance and Performance, the Quality Committee and the People Performance Committee, have established processes in place which enabled them to deliver their duties as delegated to them. MIAA were asked if there were other departments, other than Estates included in the review, where there was a lack of clarity on reporting through Committees. MIAA gave assurance that a full review of the Standing Financial Instructions has been undertaken in detail to address this. The Committee received confirmation that the Assurance Framework review found it met all three objectives: on structure - to meet NHS requirements, on engagement - that it is visibly used by the Board and on Quality - that it reflected risks as discussed by the Board. The Committee reviewed the Draft Internal Audit Plan and Internal Audit Charter.	The Committee requested that a Medical Staffing audit is added to the 3 Year Strategic Plan. The Committee approved the Draft Internal Audit	Q1 2022/23

			Plan 22/23 and noted the Draft Internal Audit Charter.	
Internal Audit Progress Report (continued)	The Committee received a report of: • Anti-Fraud Progress Report • Draft Anti-Fraud Plan 22/23	The MIAA counter fraud report was received and progress against work plan noted and approved. MIAA reported that the NHS Counter Fraud Authority National Exercise on Fraud Prevention Notices was completed to the 24th December 2021. The Committee received assurance that the Trust had not fallen victim to any of the recent fraud incidents as circulated in the past financial year. The Committee received an update on the draft Anti-Fraud Plan for 2022/23 and it was noted that a specific suggestion for a review of pre-employment checks was included.	The Committee approved the Draft Anti-Fraud Plan for 2022/23.	
External Audit Progress Report.	The Committee received: • External Audit Strategy Memorandum for 2021/22	The Committee received the Audit Strategy memorandum on planning for the 2021/2022 external audit. The strategy is consistent in scope with significant risks continued as in recent years. Additional focus will be placed on the adoption of IFRS 16 and the disclosure note and accounting for capital expenditure. Mazars gave assurance that interim audit work in January/February had progressed well.	The Committee approved the Audit Strategy Memorandum for 2021/22.	
Accounting Polices 2021/2022	The Committee received a report from the Director of Finance on the draft accounting policy note to be included in the financial statements for 2021/22.	The Committee received assurance that the draft accounting policy note was prepared in accordance with relevant International Financial Reporting Standards and latest NHSEI, DHSC and HM Treasury guidance. The Committee was updated on key	The Committee approved the draft accounting policy note for 2021/22. The draft accounting policies note will be reviewed for regular	April/May 2022

		accounting policy issues and judgements include the valuation of Land and Property and IFRS 16 disclosures on leases.	updates by NHSEI prior to the submission of the draft financial statements on the 26th April 2022 and any material changes presented to the May 2022 A Key Accounting Issues paper will be presented to the May 2022 Audit Committee.	
Risk Management Committee Summary Report	The Committee received: • a report on the work of the Risk Committee • a list of significant risks at the 1st March 2022 • Draft Terms of Reference and Work Plan for 2022/23	The Committee noted the report of the work of the Risk Committee and received assurance that the reporting of risk had developed. There was a significant improvement in the understanding of risk, detail and analysis and more assurance on what the key risks to the organisation are and how to record them. A question was asked what the tracked challenges and actions were to increase or decrease a risk score. A question was asked on non-executive director attendance at the Risk Committee.	The Director of Finance will follow up on the actions preceding a change to risk scores and how these are recorded. The Terms of Reference will be reviewed for non-executive attendance.	Q1 2022/23
Trust Committee updates	The Committee received verbal reports from the Chairs of key Board Committees.	The Committee noted the key risks identified in other Board Committees from the Chairs of the Finance and Performance, People Performance and Quality Committees.		

Stockport NHS Foundation Trust

Meeting date	7 April 2022	x	Public		Confidential	Agenda item
Meeting	Board of Directors					
Title	Board Committees Annual Review 2021/22					
Lead Director	Caroline Parnell, Director of Communications & Corporate Affairs		Author	Soile Curtis, Deputy Company Secretary		

Recommendations made / Decisions requested

The Board of Directors is asked to review and approve the Committee Annual Reviews 2021/22, including approval of Terms of Reference and Work Plans for the following:

- Finance & Performance Committee
- People Performance Committee
- Quality Committee

This paper relates to the following Corporate Annual Objectives-

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

The paper relates to the following CQC domains-

	Safe		Effective
	Caring		Responsive
x	Well-Led		Use of Resources

This paper is related to these BAF risks	All BAF risks

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 sections
Sustainability (including environmental impacts)	N/A

Executive Summary

The Terms of Reference of the Board Committees includes a requirement for an annual review of committee effectiveness, including compliance with the Terms of Reference, by the Board of Directors. Furthermore, the Committees are to review the Terms of Reference on an annual basis.

Board members should note that the annual reviews of the Terms of Reference and Committee effectiveness were deferred due to the Covid pandemic and while the outcome of the MIAA Committee Effectiveness Review was awaited.

The Finance & Performance Committee, People Performance Committee and Quality Committee considered their Committee Annual Review, including draft Terms of Reference and Work Plans, during March 2022. Following review, the documents are recommended to the Board for approval.

The Annual Review of the Audit Committee and the Remuneration Committee will be presented to the Board in June 2022 for approval, following year-end meetings of the Committees. The Charitable Funds Committee Annual Review will be presented to the next meeting of the Corporate Trustees in June 2022.

1. Introduction

1.1 The purpose of the report is to present the Committee Annual Reports, including Terms of Reference and Work Plans, for the Finance & Performance Committee, People Performance Committee and Quality Committee for approval.

2. Background

2.1 The Terms of Reference of the Board Committees includes a requirement for an annual review of the Terms of Reference by the Board of Directors.

2.2 The Terms of Reference also state that the Committees will evaluate their own membership and review the effectiveness and performance of the Committees on an annual basis.

2.3 Board members should note that the annual reviews of the Terms of Reference and Committee effectiveness were deferred due to the Covid pandemic and while the outcome of the MIAA Committee Effectiveness Review was awaited.

2.4 The Finance & Performance Committee, People Performance Committee and Quality Committee considered their Committee Annual Reports, including draft Terms of Reference and Work Plans throughout March. Following review and update, the documents are recommended to the Board for approval (included as **Appendix 1-3**).

2.5 The Annual Reports of the Audit Committee and the Remuneration Committee will be presented to the Board in June 2022 for approval, following year-end meetings of the Committees. The Charitable Funds Committee Annual Review will be presented to the next meeting of the Corporate Trustees in June 2022.

3. Outcome of Internal Audit Review on Committee Effectiveness

3.1 As part of the Trust's internal audit plan, a Committee Effectiveness internal audit was conducted in November/December 2021. The overall objective of the review was to provide an overview of the effectiveness of the design and operation of the Trust Board Committees, focusing on good practice for Committees and delivery of duties and compliance with Terms of Reference. The review also sought assurance that the statutory and regulatory duties of the Board were adequately represented in the governance structure and Committees on which the Board relies.

3.2 The outcome of the audit was 'Substantial Assurance', concluding that overall, the three Trust Board Assurance Committees have established processes in place which enabled them to deliver their duties as delegated to them by or aligned to the Scheme of Delegation and minimize the risk of blind spotted issues coming before the Board.

3.3 The review noted that the operations of the Committees were confirmed to be effective with good practice noted such as structured processes for formulating agendas from work plans and having detailed records of discussions and decisions maintained.

3.4 The review identified where the Trust can strengthen their governance processes, namely ensuring Terms of Reference and annual work plans were in place and fully aligned to the Scheme of Reservation and Delegation of Powers and timely / consistent dissemination of meeting papers. This report to the Board supports required actions to address recommendations from the Committee Effectiveness internal audit.

4. Recommendations

4.1 The Board of Directors is asked to:

- Review and approve the Committee Annual Reviews 2021/22, including Terms of Reference and Work Plans, of the Finance & Performance Committee, People Performance Committee and Quality Committee (included as **Appendix 1-3** respectively).

- Note the outcome of the Internal Audit Review on Committee Effectiveness.

NHS Stockport NHS Foundation Trust

Finance & Performance Committee Annual Review 2021/22

1. INTRODUCTION

1.1 The Finance & Performance Committee is asked to consider and confirm the Committee Annual Review, including the revised Terms of Reference and Work Plan, and recommend them to the Board of Directors for approval.

2. BACKGROUND

2.1 Section 7.1 of the current Terms of Reference requires that the Terms of Reference of the Finance & Performance Committee shall be reviewed by the Board of Directors annually. The Terms of Reference were last reviewed and approved by the Board of Directors on 29 November 2018 and are therefore now due for review.

2.2 Section 7.1 of the Terms of Reference also states that *"The Committee will evaluate its own membership and review the effectiveness and performance of the Committee on an annual basis".*

3. COMPLIANCE WITH TERMS OF REFERENCE

3.1 The Finance & Performance Committee has an annual work plan, which sets out the matters to be considered by the Committee to fulfil responsibilities set out in the terms of reference.

Appendix 1 details key matters/standard reports considered at the Finance & Performance Committee during 2021/22.

The Committee also requested the following deep dives / presentations, which were considered during 2021/22:

- PWC Outputs
- Cost Improvement Programme
- Medium Term Financial Strategy Development
- Transformation Project on Early Discharges
- Digital Strategy
- Digital Funding Bids Follow Up Report

In addition, the Committee has maintained comprehensive oversight of the financial planning requirements and regime throughout the year, recognising the complexity and challenges presented. Fully aligned to this, was comprehensive oversight of the development and delivery of the Trust's financial plan for both H1 and H2 2021/22 and the developing 2022/23 financial plan.

3.2 <u>Attendance</u>

Attendance at 2021/22 Finance & Performance Committee meetings is provided in Appendix 2. The Committee has met on ten occasions in 2021/22, and all meetings were quorate.

3.3 Terms of Reference

A review of the Committee Terms of Reference has been conducted. The revised Terms of Reference are included at Appendix 3 of the report for review prior to presentation to the Board of Directors for approval. Key changes include:

- Alignment with the Scheme of Reservation & Delegation for the Committee to receive, review and recommend to the Board of Directors as appropriate:
  - business cases with an investment value in excess of £50,000 (capital and/or revenue)
  - revenue expenditure (excluding consultancy services, capital and removal expenses) over £750,000
  - orders for schemes within the capital programme over £500,000
- Inclusion of subgroup - Digital & Informatics Group
- Inclusion of oversight of the development and delivery of the estates strategy
- Inclusion of oversight of sustainability plans.

3.4 Committee Work Plan 2022/23

The work plan for 2022/23 has been reviewed by the Committee Chair, Director of Finance, Director of Operations and the Company Secretary and is included at Appendix 4 for review prior to presentation to the Board of Directors for approval.

3.5 Outcome of Internal Audit Review on Committee Effectiveness

3.5.1 As part of the Trust's internal audit plan, a Committee Effectiveness internal audit was conducted in November/December 2021. The overall objective of the review was to provide an overview of the effectiveness of the design and operation of the Trust Board committees, focusing on good practice for committees and delivery of duties and compliance with Terms of Reference. The review also sought assurance that the statutory and regulatory duties of the Board were adequately represented in the governance structure and committees on which the Board relies.

3.5.2 The outcome of the audit was 'Substantial Assurance' concluding that overall, the three Trust Board assurance committees have established processes in place which enabled them to deliver their duties as delegated to them by or aligned to the Scheme of Delegation an minimise the risk of blind spotted issues coming before the Board.

3.5.3 The review noted that the operations of the committees were confirmed to be effective with good practice noted such as structured processes for formulating agendas from work plans and having detailed records of discussions and decisions maintained.

3.5.4 The review identified areas where the Trust can strengthen their governance processes namely ensuring terms of reference and annual work plans were in place and fully aligned to the Scheme of Reservation & Delegation of Powers and timely/consistent dissemination of meeting papers. Recommendation pertinent to the Finance & Performance Committee is reflected in the appended Terms of Reference and Work Plan included within this annual report.

Furthermore, actions are in place to address all recommendations from the Committee Effectiveness internal audit and follow up report will be considered via Audit Committee.

Appendix 1: Key Matters considered by Finance & Performance Committee 2021/22

FINANCE & PERFORMANCE COMMITTEE 2021/22

Topic	15 Apr 2021	20 May 2021	15 Jul 2021	19 Aug 2021	16 Sep 2021	21 Oct 2021	18 Nov 2021	16 Dec 2021	17 Feb 2022
Review of Committee Work Plan			✓						
Finance Report, inc. Agency Utilisation	✓	✓	✓	✓	✓	✓	✓	✓	✓
Financial Improvement Plan			✓						
Service Line Reporting	✓								
Model Hospital Opportunities			✓						
Pharmacy Shop – Financial Position						✓			
Post-implementation Appraisal of Projects			✓						
Capital Planning				✓	✓	✓			✓
Business cases:									
• **Digital & Informatics Funding Opportunities**						✓			
• **Defibrillator Replacement Business Case**						✓			
• **M6 Business Case**						✓			
• **Integrated Laparoscopic Theatre Business Case**								✓	
• **Theatre Equipment Business Case**								✓	
• **HSDU Equipment Business Case**								✓	
• **Ophthalmology Equipment Business Case**								✓	
• **Proposal on the use of Endocare for Endoscopy**								✓	
• **OBC for Wireless Business Case**								✓	
• **International Nurse Recruitment**								✓	
• **Pacing Suite Business Case**									✓
Contracts Report					✓				
New Hospital Programme			✓						
Treasury Management		✓							

Topic	15 Apr 2021	20 May 2021	15 Jul 2021	19 Aug 2021	16 Sep 2021	21 Oct 2021	18 Nov 2021	16 Dec 2021	17 Feb 2022
Operational Performance Report	✓	✓	✓	✓	✓	✓	✓	✓	✓
Operational and Financial Planning	✓	✓				✓	✓	✓	✓
Winter Planning				✓					
Urgent Treatment Centre GP Contract					✓				
One Stockport Health & Care Plan					✓				
MR Service Provision				✓					✓
IM&T Infrastructure		✓							
Unified Communications Project Update		✓							
Finance & Performance Related Risks	✓	✓	✓	✓					
Board Assurance Framework		✓			✓			✓	
Key Issues Reports:									
• **Capital Programme Management Group**		✓	✓	✓	✓	✓	✓	✓	✓
Procurement Strategy		✓							
Procurement Plan and Progress Report							✓		
Draft Digital Strategy							✓		
Policies for Approval			✓					✓	✓
Annual Review of Skills Development for Finance Staff						✓			

Appendix 2: Finance & Performance Committee 2021/22 Attendance Register

Member	Name	Apr 21	May 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Feb 22	Mar 22
Core Members											
Chair of F&P, Non-Executive Director	Catherine Anderson	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Non-Executive Director	David Hopewell	Y	Y	Y	Y	Y	Y	Y	A	Y	Y
Non-Executive Director	Louise Sell	Y	Y	Y	Y	A	Y	Y	Y	Y	Y
Non-Executive Director	Tony Bell		Y	Y	Y	Y	Y	Y	Y	Y	Y
Associate Non-Executive Director	Joanne Newton		Y				Y	Y	Y	A	Y
Director of Finance	John Graham	Y	Y	Y	A	Y	Y	Y	Y	Y	A
Director of Operations	Jackie McShane	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Director of Strategy & Partnerships	Jonathan O'Brien									Y	Y
Chief Nurse	Nic Firth	A	A	A	Y	Y	Y	A	A	Y	Y
Medical Director	Andrew Loughney	Y	A	Y	A	Y	Y	Y	Y	Y	Y
Deputy Director of Strategy & Partnerships	Andy Bailey	A	Y	Y	Y	Y	A	A	A		
Deputy Director of Finance	Kay Wiss	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Associate Director of Finance	Andy Large	Y	Y								
Associate Director of Finance: Financial Management	Jennifer Swinhoe			Y	Y	A	Y				
Company Secretary	Rebecca McCarthy					Y	Y	Y	Y	Y	Y
Director of Comms & Corporate Affairs	Caroline Parnell	Y	Y	Y	Y	A	Y	A	Y	Y	Y
Deputy Chief Nurse	Helen Howard	A (D)									
Non-Executive Director	Mary Moore					A (D)					
Was Meeting Quorate (Y/N)		**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**
Key											
Y	= Present										
A	= Apologies										
A (D)	= Attended as Deputy										

NHS Stockport NHS Foundation Trust

FINANCE & PERFORMANCE COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

1.1. The Board of Directors (the Board) hereby resolves to appoint a Committee, to be known as the Finance & Performance Committee.

1.2 The Finance & Performance Committee shall have terms of reference and powers delegated by the Board and is subject to such conditions, such as reporting to the Board, in accordance with any legislation, regulation or direction issued by the Trust.

1.3 Save where otherwise provided in these Terms of Reference, the Standing Orders of the Board apply to the proceedings of this Committee.

1.4 The Finance & Performance Committee's activities will support the development and delivery of the Trust's Strategy and Annual Plan.

2. PURPOSE OF THE COMMITTEE

The overarching purpose of Finance & Performance Committee is to:

2.1 Provide oversight and assurance on all aspects of the Trust's financial and operational performance against the agreed annual plan.

2.2 Support the Board in the development of future business plans.

2.3 Provide oversight and ensure appropriate governance mechanisms are in place to assure delivery of the Trust's digital, estates and sustainability related strategies and plans.

2.4 Ensure any associated risks, identified in relation to the above, are managed in accordance with the Trust's assurance framework and risk management arrangements.

2.5 To have oversight into the Trust's finance and performance related work with locality and system partners.

3. COMPOSITION & CONDUCT OF THE COMMITTEE

3.1 Membership

3.1.1 Committee membership will comprise:

- At least three Non-Executive Directors, one of whom shall be the Chair
- Director of Finance

- Director of Operations
- Director of Strategy & Partnerships

3.1.2 All statutory Directors are authorised to attend and speak at meetings of the Committee, when they judge appropriate.

3.1.3 There is an expectation that members will attend all meetings during the financial year. Individual attendance levels will be monitored by the Chair of the Committee who will take appropriate measures should attendance be less than 75%.

3.1.4 Nominated deputies may attend in the absence of any member; however, this shall be in an advisory capacity only and attendance of a deputy shall not count towards the attendance level set out in 3.1.2.

3.1.5 The following shall also attend Committee meetings:
- Deputy Director of Finance
- Assistant Director of Finance (Financial Services)
- Company Secretary

3.1.6 The Committee will invite other senior leaders to support specific matters as required.

3.2. Chair

3.2.1 The Chair of the Committee will be a Non-Executive Director.

3.2.2 Another Non-Executive Director will deputise as the Chair of the Committee in the Chair's absence.

3.3 Quorum

3.3.1 A quorum will consist of three members, provided that at least half of the attendees are Non-Executive Directors. Deputies in attendance do not count towards the quorum.

3.3.2 Members withdrawing from the meeting owing to a conflict of interest shall no longer count towards a quorum.

3.3.3 However, at the discretion of the Chair, matters and decisions deemed urgent may proceed within the absence of a quorum with any actions from that meeting being confirmed at the next full meeting.

3.4 Notice of meeting

3.4.1 Before each meeting, a notice of the meeting specifying the business proposed to be transacted and supporting papers for the business expected shall be sent by electronic mail to the usual place of business of each member, to be available at least five clear days before the meeting.

3.4.2 The Chair of the Committee may, at their discretion, allow additional agenda items and papers to be circulated after the notice of the meeting.

3.5 Frequency of meetings

3.5.1 The Committee shall meet at least 10 times per year.

3.5.2 The Chair may at times convene additional meetings of the Committee and/or request business that requires urgent attention is considered via email, for majority decision making. All decisions made via email will be confirmed at the next full meeting.

3.6. Administration

3.6.1 The Company Secretary will ensure appropriate administrative arrangements are in place and that minutes are recorded, confirmed and appropriately archived from each meeting.

4. DELEGATED AUTHORITY

The Finance & Performance Committee is authorised by the Board to:

4.1 Investigate any matter within these terms of reference.

4.2 Seek information from any Director, officer, or employee; and all Directors, officers and employees are directed to extend the fullest co-operation to the Committee in the discharge of its functions.

4.3 Within the procedures approved by the Board, obtain independent legal or other professional advice where required, including the attendance of independent advisers at meetings of the Committee.

5. RESPONSIBILITIES

The responsibilities of the Committee are to:

5.1 Finance

5.1.1 Seek assurance on the effectiveness of systems and processes that exist in relation to the development and delivery of the Trust's annual financial plan.

5.1.2 Review and recommend to the Board the annual financial plan / budget, including activity and workforce, and the associated financial budget.

5.1.3 Consider the levels of assurance provided from key financial metrics and monitor action/s to address any adverse trends against the agreed financial plan.

5.1.4 Oversee the development of the Trust's medium/long term financial strategy, ensuring annual financial plans are consistent with this, and recommend to the Board.

5.1.5 Seek assurance on:
- the planning of cost improvement programmes and delivery of in-year programmes
- the planning and delivery of the capital programme
- the effectiveness of Trust's procurement arrangements and delivery of the Trust's procurement programme to ensure compliance with regulations and maximise value for money

5.1.6 To keep under review issues such as cost transformation (reference costs) and to benchmark activity and performance and to act on any learning or remedial action required.

5.1.7 Receive, review and recommend to the Board as appropriate:
- business cases with an investment value in excess of £50,000 (capital and/or revenue)
- revenue expenditure (excluding consultancy services, capital and removal expenses) over £750,000
- orders for schemes within the capital programme over £500,000

5.1.8 Receive and review post implementation reviews of business cases in line with the above to ensure benefits realisation.

5.1.9 To approve the Trust's business case process and associated investment, appraisal, methodology.

5.1.10 Obtain assurance on the effectiveness and sustainability of the Trust's commercial activities.

5.2 Operational Performance

5.2.1 Seek assurance on the effectiveness of systems and processes that exist in relation to the development and delivery of the Trust's annual operational performance standards.

5.2.2 Review the levels of assurance provided from key operational performance metrics and monitor action/s to address adverse trends against the agreed operational plan.

5.2.3 Receive and review key themes, issues, and risks from the Trust's performance review process.

5.3 Digital & Informatics

5.3.1 Oversee the development and delivery of the Trust's digital strategy.

5.3.2 Seek assurance on the effectiveness of the Trust's information governance arrangements.

5.4 Estates

5.4.1 Oversee the development of the Trust's estates strategy and recommend to the Board.

5.4.2 Keep under review the financial and operational delivery of the Trust's estates strategy.

5.5 Sustainability

5.5.1 Have oversight of the development and delivery of sustainability requirements in line with national NHS guidance.

5.6 Other

5.6.1 Oversee the development and delivery of a strategic framework to ensure alignment / coordination of Trust-level strategic developments/strategies.

5.6.2 Oversee the development of relevant Trust-level strategies and plans and recommend to the Board.

5.6.3 Review the findings or major investigations or reviews (internal of external to the Trust) as delegated by the Board or on the Committees initiatives and consider management's response.

5.6.4 Review assigned risks from the Board Assurance Framework and associated significant risks from the Corporate Risk Register and ensure that mitigations are appropriately actioned.

5.6.5 Review and approve the Annual Report, Work Plans and Terms of Reference of any group/committee that reports directly to the Committee.

5.6.6 Undertake or consider on behalf of the Chairman or the Board such other related tasks or topics as

the Chairman or the Board may from to time entrust to the Committee. The Committee will work in partnership with other Committees of the Board to address matters that impact on the responsibilities of several Committees.

6. RELATIONSHIP WITH THE BOARD OF DIRECTORS

6.1 The Committee will report to the Board by means of a Key Issues Report summarising business conducted by the Committee together with key actions and/or risks.

6.2 The Key Issues Report will be forwarded to the Board following each Committee meeting.

6.3 Minutes of all Committee meetings will be available to all members of the Board on request.

7. RELATIONSHIP WITH OTHER GROUPS

7.1 The Committee shall have the power to establish sub-committees for the purpose of addressing specific tasks or areas of responsibility. In accordance with the Trust's Standing Orders, the Committee may not delegate powers to a sub-committee unless expressly authorised by the Board.

7.2 The Committee will receive reports, in the form of Key Issues Reports, from the following:
- Capital Programme Management Group
- Digital & Informatics Group

7.3 For the purpose of providing assurance regarding the controls in place for the management and mitigation of risks recorded on the Board Assurance Framework, the Committee (through its Chair) reports regularly to the Audit Committee.

8. REVIEW

8.1 The Committee will review its terms of reference and membership annually and recommend any changes to the Board for approval.

8.2 The Committee will review the effectiveness and performance of the Committee on an annual basis and report the outcome to the Board.

Appendix 4: Finance & Performance Committee: Work Plan 2022/23

			2022									2023		
	Items		**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
		Lead	**Q1**			**Q2**			**Q3**			**Q4**		
Finance														
1.	**Finance Report**	Director of Finance	●	●	●	●		●	●	●		●	●	●
2.														
3.	**Costing Transformation Programme (Reference Costs)**	Deputy Director of Finance						●						
4.	**Medium/Long Term Financial Strategy**	Director of Finance				●			●			●		
5.	**Cost Improvement Programme Progress Report** Including Data Sources	Director of Finance / Director of Operations	●			●			●			●		
6.	**Annual Review of Treasury Management Procedures**	Deputy Director of Finance						●						
7.	**Annual Procurement Programme & Progress Report**	Head of Procurement		●						●				
8.	**Business Cases / Contracts for recommendation to Board:** - business cases with an investment value in excess of £50,000 (capital and/or revenue) - revenue expenditure (excluding consultancy services, capital and removal expenses) over £750,000 - orders for schemes within the capital programme over £500,000		●	●	●	●		●	●	●		●	●	●
9.	**Post-implementation appraisal of Business Cases** (approved in line with the above)	Director of Strategy & Partnerships		●						●				
10.	**Business Case Template Review**	Director of Strategy & Partnerships			●									
Commercial Activity														
11.	**Pharmacy Shop Board**	Assistant Director of Finance	●					●						
Operational Performance														
12.	**Operational Performance Report** including - High Level Outcome of Performance Reviews	Director of Operations	●	●	●	●		●	●	●		●	●	●
13.	**Performance Framework**	Director of Operations		●										

Appendix 4: Finance & Performance Committee: Work Plan 2022/23

Planning														
14.	**Trust Planning**	Director of Strategy & Partnerships	●	●								●	●	●
15.	**Capital Programme**	Director of Finance	●											●
16.	**Winter Planning**	Director of Operations				●			●	●				
17.	**Strategic Framework**	Director of Strategy & Partnerships				●								
Estates & Sustainability														
18.	**Estates Strategy & Progress Report**	Director of Estates & Facilities				●						●		
19.	**Green Plan Progress Report**	Director of Estates & Facilities				●						●		
Risks														
20.	**BAF & Aligned Significant Risks**	Company Secretary		●		●			●			●		
Subgroups														
21.	**Capital Programmes Management Group Key Issues Report including** - Capital Programme Progress Report	Director of Finance	●	●	●	●		●	●	●		●	●	●
22.	**Digital & Informatics Group Key Issues Report including** - Information Governance - Digital Strategy Detailed Progress Report (September & March)	Director of Digital		●		●		●		●		●		●
Committee Business														
23.	Review and approve of **Terms of Reference**	Chair												●
24.	Review and approve of **Annual Work Plan**	Chair												●
25.	Review and approve **Finance & Performance Committee Subgroup Terms of Reference & Annual Work Plan**	Chair												●
26.	Informal Review of Committee Effectiveness	Led by Chair	●	●	●	●		●	●	●		●	●	●

Appendix 4: Finance & Performance Committee: Work Plan 2022/23

27.	Formal Committee Evaluation	Chair												•

Schedule as required: Major investigations or reviews (internal of external to the Trust) relevant to Finance & Performance Committee.

NB. Digital & Informatics Group Terms of Reference & Work Plan to be presented in April 2022. System/Locality Finance Report – Reporting schedule to be determined in line with Locality Plans.

NHS Stockport NHS Foundation Trust

People Performance Committee Annual Review 2021/22

1. INTRODUCTION

1.1 The People Performance Committee is asked to consider and confirm the Committee Annual Review, including the revised Terms of Reference and Work Plan 2022/23, and recommend them to the Board of Directors for approval.

2. BACKGROUND

2.1 Section 7.1 of the current Terms of Reference requires that the Terms of Reference of the People Performance Committee shall be reviewed by the Board of Directors annually. The Terms of Reference were last reviewed and approved by the Board of Directors on 1 November 2019 and are therefore now due for review.

2.2 Section 7.1 of the Terms of Reference also states that *"The Committee will evaluate its own membership and review the effectiveness and performance of the Committee on an annual basis".* This was last completed in April 2021, covering the year 2020/21.

The current review relates to effectiveness of the Committee during 2021/22, recognising informal discussion took place in October 2022 regarding the committee frequency and work plan.

3. COMPLIANCE WITH TERMS OF REFERENCE

3.1 The People Performance Committee has an annual work plan, which sets out the matters to be considered by the Committee to fulfil responsibilities set out in the terms of reference.

Appendix 1 details key matters and standard reports considered at the People Performance Committee during 2021/22. In addition, the Committee also requested the following deep dives / presentations, which have been considered:

- Spotlight on: Resus Training / International Nursing / Equality, Diversity & Inclusion / SAS and Locally Employed Doctors / Community Workforce
- Approach to Workforce Transformation
- Approach to Coaching
- Multi Professional Leadership Training
- Statutory, Mandatory & Role Specific Training Review
- E-Rostering

3.2 <u>Attendance</u>

Attendance at 2021/22 People Performance Committee meetings is provided in Appendix 2. The Committee has met on ten occasions in 2021/22, and all meetings were quorate.

3.3 <u>Terms of Reference</u>

A review of the Committee Terms of Reference has been conducted. The revised Terms of Reference are included at Appendix 3 of the report for review prior to presentation to the

Board of Directors for approval. There are no changes to the key function/responsibilities of the Committee; the format of the Terms of Reference has been updated to ensure standardisation.

3.4 Committee Work Plan 2022/23

The work plan for 2022/23 has been reviewed by the Committee Chair, Director of People & OD, Deputy Director of People & OD and the Company Secretary and is included at Appendix 4 for review prior to presentation to the Board of Directors for approval.

3.5 Outcome of Internal Audit Review on Committee Effectiveness

3.5.1 As part of the Trust's internal audit plan, a Committee Effectiveness internal audit was conducted in November/December 2021. The overall objective of the review was to provide an overview of the effectiveness of the design and operation of the Trust Board committees, focusing on good practice for committees and delivery of duties and compliance with Terms of Reference. The review also sought assurance that the statutory and regulatory duties of the Board were adequately represented in the governance structure and committees on which the Board relies.

3.5.2 The outcome of the audit was 'Substantial Assurance' concluding that overall, the three Trust Board assurance committees have established processes in place which enabled them to deliver their duties as delegated to them by or aligned to the Scheme of Delegation an minimise the risk of blind spotted issues coming before the Board.

3.5.3 The review noted that the operations of the committees were confirmed to be effective with good practice noted such as structured processes for formulating agendas from work plans and having detailed records of discussions and decisions maintained.

3.5.4 The review identified areas where the Trust can strengthen their governance processes namely ensuring terms of reference and annual work plans were in place, and fully aligned to the Scheme of Reservation & Delegation of Powers, and timely/consistent dissemination of meeting papers. Actions are in place to address all recommendations from the Committee Effectiveness internal audit and follow up report will be considered via Audit Committee.

Appendix 1: Key Matters considered by People Performance Committee 2021/22

PEOPLE PEFORMANCE COMMITTEE 2021/22

Topic	8 Apr 2021	13 May 2021	10 Jun 2021	8 Jul 2021	12 Aug 2021	9 Sep 2021	14 Oct 2021	9 Dec 2021	10 Feb 2022
Committee Chair's Annual Report to Trust Board	✓								
Director of Workforce & OD Briefing		✓	✓	✓	✓	✓			
Temperature Check							✓	✓	✓
Workforce Risk Register	✓	✓	✓	✓	✓				
Workforce KPI Report	✓		✓						
Workforce Performance Report		✓		✓	✓	✓	✓	✓	✓
Job Planning Report				✓			✓		
Facility Time Report				✓					
Our People Plan		✓						✓	
Workforce Plan		✓					✓		
People Plan Integrated Delivery Report	✓	✓	✓	✓	✓	✓	✓		✓
BAF 2021/22 – Principal Risk Review						✓		✓	✓
Employee Relations Report	✓								
Freedom to Speak Up Report	✓			✓			✓		✓
Guardian of Safe Working Report				✓		✓			✓
Vaccination as a Condition of Deployment Update									✓
HEENW / GMC Annual Reports						✓			
Medical Appraisal and GMC Revalidation Annual Report						✓			
EDI Reports						✓	✓		
Performance Appraisal Annual Report				✓					
Staff Friends and Family Survey				✓					

Topic	8 Apr 2021	13 May 2021	10 Jun 2021	8 Jul 2021	12 Aug 2021	9 Sep 2021	14 Oct 2021	9 Dec 2021	10 Feb 2022
National Staff Opinion Survey					✓				
Culture and Engagement Report	✓								
Agency Expenditure & Resourcing Report	✓								
Job Planning Report	✓								
Health & Wellbeing Updates	✓	✓	✓				✓		
Violence Prevention & Reduction Standard							✓		
Safe Staffing Report		✓	✓	✓		✓		✓	✓
Policies for approval		✓		✓	✓			✓	
Key Issues Reports:									
• **Workforce Improvement & Governance Group**	✓								
• **Joint Consultative & Negotiating Committee**	✓		✓		✓		✓	✓	✓
• **Joint Local Negotiating Committee**	✓		✓		✓		✓	✓	
• **Health & Wellbeing Steering Group**	✓	✓							
• **Educational Governance Group**	✓	✓			✓			✓	
• **People, Engagement & Leadership Group**		✓	✓	✓	✓	✓	✓	✓	
• **Equality, Diversity & Inclusion Group**		✓							

Appendix 2: People Performance Committee 2021/22 Attendance Register

Member	Name	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Dec 21	Feb 22	Mar 22
Core Members											
Chair of PPC, Non-Executive Director	Catherine Barber-Brown	Y	Y	Y	Y	Y	Y	Y	Y	A*	Y
Non-Executive Director	Catherine Anderson	Y	Y	A	Y	Y	Y	Y	Y	A	Y
Non-Executive Director	Mary Moore	Y	Y	Y	Y	A	Y	Y	Y	A	Y
Director of People & OD	Amanda Bromley				Y	Y	Y	Y	Y	Y	Y
Director of Finance	John Graham	A	Y	Y	Y	A	Y	Y	A	Y	Y
Chief Nurse	Nic Firth	Y	Y	Y	Y	Y	Y	Y	Y	Y	A
Medical Director	Andrew Loughney	Y	A	Y	Y	A	Y	Y	Y	Y	Y
Director of Operations	Jackie McShane	Y	A	Y	A	A	A	A	A	Y	Y
Regular Attendees											
Deputy Director of People & OD	Emma Cain	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Head of Learning & OD	Joanne Martin	Y	Y	Y	A	Y	Y	Y	A	Y	Y
Freedom to Speak Up Guardian	Paul Elms				Y			Y		Y	Y
Guardian of Safe Working	Thomas Finnigan				Y		Y			Y	
Director of Communications & Corporate Affairs	Caroline Parnell	Y	Y		A	Y	Y	Y		A	Y
Company Secretary	Rebecca McCarthy					Y	Y	Y	Y	Y	A
Head of Strategic Workforce Planning	Caroline Durdle		Y	Y	Y	Y	Y	Y	Y	Y	Y
Director of Medical Education	David Baxter		A	Y	A	Y	Y	A	A	Y	Y
EDI Manager	Nadia Baynham			Y		Y	Y	Y	Y	A	Y
Associate Director of Workforce Delivery	Suzanne Woolridge	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Head of HR	Tracey Etchells	Y	Y	Y	Y	Y	Y	Y	Y	A	Y
Deputy Director of Finance	Kay Wiss	A(D)				A(D)			A(D)		
Deputy Chief Nurse	Helen Howard		A(D)								
Deputy Chief Operating Officer	Claire Woodford						A(D)				
Was Meeting Quorate (Y/N)		**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**
Key											
Y	= Present										
A	= Apologies										
A (D)	= Attended as Deputy										

** The Trust Chair and Dr Marisa Logan-Ward, Non-Executive Director attended the meeting.*

Appendix 3: People Performance Committee Terms of Reference

PEOPLE PERFORMANCE COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

1.1. The Board of Directors (the Board) hereby resolves to appoint a Committee, to be known as the People Performance Committee.

1.2 The People Performance Committee shall have terms of reference and powers delegated by the Board and is subject to such conditions, such as reporting to the Board, in accordance with any legislation, regulation or direction issued by the Trust.

1.3 Save where otherwise provided in these Terms of Reference, the Standing Orders of the Board apply to the proceedings of this Committee.

1.4 The People Performance Committee's activities will support the development and delivery of the Trust's Strategy and Annual Plan.

2. PURPOSE OF THE COMMITTEE

The overarching purpose of People Performance Committee is to:

2.1 Provide oversight and assurance on matters relating to delivery of the Trust's people related strategies and plans.

2.2 Support the Board in the development of people related strategies and plans.

2.3 Ensure any associated risks, identified in relation to the above, are managed in accordance with the Trust's assurance framework and risk management arrangements.

2.2 To have oversight into the Trust's people related work with locality and system partners.

3. COMPOSITION & CONDUCT OF THE COMMITTEE

3.1 Membership

3.1.1 Membership will comprise:

- Three Non-Executive Directors, one of whom shall be the Chair
- Director of People & Organisational Development
- Chief Nurse
- Medical Director

3.1.2 All statutory Directors are authorised to attend and speak at meetings of the Committee, when they judge appropriate.

3.13 There is an expectation that members will attend all Committee meetings during the financial year. Individual attendance levels will be monitored by the Chair of the Committee who will take

appropriate measures should attendance be less than 75%.

3.1.4 Nominated deputies shall attend in the absence of any member; however, this shall be in an advisory capacity only and attendance of a deputy shall not count towards the attendance level set out in 3.1.3.

3.1.5. The following shall also attend Committee meetings:
- Deputy Director of People & Organisational Development
- Deputy Director of Organisational Development
- Associate Director of Workforce Delivery
- Well-Being Guardian
- Company Secretary

3.1.6 The Committee will invite other senior leaders to support specific matters as required including:
- Head of Strategic Workforce Planning
- Head of HR
- Head of Learning & OD
- Director of Medical Education
- Guardian of Safe Working
- Freedom to Speak Up Guardian
- Equality, Diversity, and Inclusion Manager

3.2. Chair

3.2.1 The Chair of the Committee will be a Non-Executive Director.

3.2.2 Another Non-Executive Director will deputise as the Chair of the Committee in the Chair's absence.

3.3 Quorum

3.3.1 A quorum will consist of three members, provided that at least half of the attendees are Non-Executive Directors. Deputies in attendance do not count towards the quorum.

3.3.2 Members withdrawing from the meeting owing to a conflict of interest shall no longer count towards a quorum.

3.3.3 However, at the discretion of the Chair, matters and decisions deemed urgent may proceed within the absence of a quorum with any actions from that meeting being confirmed at the next full meeting.

3.4 Notice of meeting

3.4.1 Before each meeting, a notice of the meeting specifying the business proposed to be transacted and supporting papers for the business expected shall be sent by electronic mail to the usual place of business of each member, to be available at least five clear days before the meeting.

3.4.2 The Chair of the Committee may, at their discretion, allow additional agenda items and papers to be circulated after the notice of the meeting.

3.5 Frequency of meetings

3.5.1 The Committee shall meet at least 6 times per year.

3.5.2 The Chair may at times convene additional meetings of the Committee and/or request business that requires urgent attention is considered via email, for majority decision making by members. All decisions made via email will be confirmed at the next full meeting.

3.6. Administration

3.6.1 The Company Secretary will ensure appropriate administrative arrangements are in place and that minutes are recorded, confirmed and appropriately archived from each meeting.

4. DELEGATED AUTHORITY

4.1 The People Performance Committee is authorised by the Board to investigate any matter within these terms of reference.

4.2 Seek information from any Director, officer, or employee; and all Directors, officers and employees are directed to extend the fullest co-operation to the Committee in the discharge of its functions.

4.3 Within the procedures approved by the Board, obtain independent legal or other professional advice where required, including the attendance of independent advisers at meetings of the Committee.

5. RESPONSIBILITIES

The responsibilities of the Committee are to:

5.1 Seek assurance on the effectiveness of systems and processes that exist in relation to delivery of the Trust's people related strategies and plans including:

- strategic workforce development
- culture
- engagement and retention
- resourcing; training, education and practice development
- leadership development

5.2 Review the levels of assurance provided from key people performance related metrics and monitor action/s to address any adverse trends against the agreed plans.

5.3 Receive and review the outcomes of staff surveys, including the annual NHS staff survey and surveys of staff undertaken by professional registration bodies, and associated action/s.

5.4 Review the effectiveness of arrangements in place relating to equality, diversity and inclusion in the Trust's workforce, including oversight of statutory reporting requirements and make recommendation to the Board.

5.5 Review compliance with statutory registration requirements for members of staff and make recommendation to the Board.

5.6 Review current cases of exclusion of staff from working at the Trust.

5.7 Oversee the development of people related strategies and plans and recommend to the Board.

5.8 Review and approve Trust level people related policy documents, as delegated by the Board.

5.9 Review the findings of major investigations or reviews (internal or external to the Trust) relevant to people, as delegated by the Board, or on the Committees initiatives and consider management's

response.

5.10 Review people related risks from the Board Assurance Framework and associated significant risks from the Corporate Risk Register and ensure that mitigations are appropriately actioned.

5.11 Review and approve the Annual Report, Work Plans and Terms of Reference of any group/committee that reports directly to the Committee.

5.12 Undertake or consider on behalf of the Chairman or the Board such other related tasks or topics as the Chairman or the Board may from to time entrust to the Committee.

The Committee will work in partnership with other Committees of the Board to address matters that impact on the responsibilities of several Committees.

6. RELATIONSHIP WITH THE BOARD OF DIRECTORS

6.1 The Committee will report to the Board by means of a Key Issues Report summarising business conducted by the Committee together with key actions and/or risks.

6.2 The Key Issues Report will be forwarded to the Board following each Committee meeting.

6.3 Minutes of all Committee meetings will be available to all members of the Board on request.

7. RELATIONSHIP WITH OTHER GROUPS

7.1 The Committee shall have the power to establish sub-committees for the purpose of addressing specific tasks or areas of responsibility. In accordance with the Trust's Standing Orders, the Committee may not delegate powers to a sub-committee unless expressly authorised by the Trust Board.

7.2 The Committee will receive reports, in the form of Key Issues Reports, from the following:

- Equality, Diversity & Inclusion Group
- People, Engagement & Leadership Group
- Joint Consultative & Negotiating Committee
- Joint Local Negotiating Committee
- Educational Governance Group

7.3 For the purpose of providing assurance regarding the controls in place for the management and mitigation of risks recorded on the Board Assurance Framework, the Committee (through its Chair) reports regularly to the Audit Committee.

8. REVIEW

8.1 The Committee will review its terms of reference and membership annually and recommend any changes to the Board for approval.

8.2 The Committee will review the effectiveness and performance of the Committee on an annual basis and report the outcome to the Board.

Appendix 4: People Performance Committee Work Plan 2022/23

			2022									2023		
	Items		**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
		Lead	**Q1**			**Q2**			**Q3**			**Q4**		
Assurance Reports														
1.	**E-Rostering**	Associate Director of Workforce Delivery										●		
2.	**Workforce Modelling & Planning**	Associate Director of Workforce Delivery		●						●				
3.	**Equality, Diversity & Inclusion Strategy**	Deputy Director of OD				●								●
4.	**WRES & WDES Report**	Deputy Director of OD				●								
5.	**Gender Pay Gap Report**	Deputy Director of OD				●								
6.	**Equality Duty Assurance Report PSED Standard**	Deputy Director of OD												●
7.	**Retention Programme**	Deputy Director of OD		●										
8.	**Health & Wellbeing**	Deputy Director of People & OD		●						●				
9.	**Flexible Working Programme**	Deputy Director of People & OD						●						
10.	**Staff Survey**	Deputy Director of OD		●				●						●
11.	**Resourcing Programme**	Associate Director of Workforce Delivery				●								
12.	**Annual Nursing & Midwifery Establishments**	Chief Nurse		●										
13.	**Safe Staffing Report**	Deputy Chief Nurse		●		●				●		●		
14.	**Training, Education & Clinical Development**	Head of Learning & OD								●				
15.	**HENW/GMC Annual Reports:** - **GMC Patient Survey Response Report** - **HENW Local Education Provider (LEP) Report** - **HENW Monitoring Visit (Annual Assessment Visit)** - **GMC National Trainee Survey**	Medical Director / Director of Medical Education						●						
16.	**Medical Appraisal & GMC Revalidation Annual Report**	Medical Director						●						
17.	**Consultant Job Planning Annual Report**	Medical Director				●								
18.	**Civility, Collective & Compassionate Leadership**	Deputy Director of OD										●		

19.	**Freedom to Speak Up Report**	Freedom to Speak Up Guardian				●						●		
20.	**Guardian of Safe Working Report**	Guardian of Safe Working				●						●		
21.	**Employer Relations & Exclusion Activity**	Deputy Director of People & OD		●						●				
22.	**People Integrated Performance Report**	All		●		●		●		●		●		●
Policies														
23.	**Policy Report for Ratification**	Deputy Director of People & OD		●		●		●		●		●		●
Risks														
24.	**BAF & Aligned Significant Risks**	Company Secretary		●		●				●		●		
Subgroups														
25.	**People, Engagement & Leadership Group**	Deputy Director of People & OD		●		●		●		●		●		●
26.	**Equality, Diversity & Inclusion Group**	Deputy Director of OD		●		●		●		●		●		●
27.	**Educational Governance Group**	Deputy Director of People & OD		●		●		●		●		●		●
28.	**Joint Consultative & Negotiating Committee**	Deputy Director of People & OD		●		●		●		●		●		●
29.	**Joint Local Negotiating Committee**	Deputy Director of People & OD		●		●		●		●		●		●
Committee Business														
30.	Review and approve of **Terms of Reference**	Chair												●
31.	Review and approve of **Annual Work Plan**	Chair												●
32.	Review and approve **People Performance Committee Subgroup Terms of Reference & Annual Work Plan**	Chair												●
33.	Informal Review of Committee Effectiveness	Led by Chair		●		●		●		●		●		●
34.	Formal Committee Evaluation	Chair												●

NHS Stockport NHS Foundation Trust

Quality Committee Annual Review 2021/22

1. INTRODUCTION

1.1 The Quality Committee is asked to consider and confirm the Committee Annual Review, including the revised Terms of Reference and Work Plan 2022/23, and recommend them to the Board of Directors for approval.

2. COMPLIANCE WITH TERMS OF REFERENCE

2.1 The Quality Committee has an annual work plan, which sets out the matters to be considered by the Committee to fulfil responsibilities set out in the terms of reference.

Appendix 1 details key matters and standard reports considered at the Quality Committee during 2021/22. In addition, the Committee also considered the following annual reports, strategies, and deep dive presentations:

- Annual Reports: Infection Prevention Control Report / Research / Patient Experience / Safeguarding
- Quality Accounts 2020/21
- Quality Strategy
- Safeguarding Strategy & Plan on a Page
- Mental Health Strategy (March 2022)
- Annual Medical Appraisal & Revalidation Report
- National Inpatient Survey Results & Actions
- Urgent Care & Emergency Services CQC Inspection Outcome
- Health & Safety Executive Inspection Outcome
- Antimicrobial Stewardship Review
- Tissue Viability Review
- Drug Fridges Review
- Results Governance Deep Dive
- Emergency Department Deep Dive
- Nutrition & Hydration Deep Dive

The Committee noted the Patient Experience Group, where review of the Safeguarding Group Report took place, had not reported during Q4 (Patient Experience Group to take place on 17th March and to be reported to Quality Committee – April 2022), and emphasised the importance of reporting from this group in line with the Work Plan 2022/23.

3.2 Attendance

Attendance at 2021/22 Quality Committee meetings is provided in Appendix 2. The Committee has met on ten occasions in 2021/22 to date, and all meetings were quorate. The attendance for the March meeting will be updated before the Committee Annual Review is presented to the Board of Directors.

3.3 Terms of Reference

A review of the Committee Terms of Reference has been conducted. The revised Terms of Reference are included at Appendix 3 of the report for review prior to presentation to the

Board of Directors for approval. Key changes include clarity regarding responsibility for the review of compliance with statutory and regulatory requirements for maternity services and environmental regulations/health and safety, with confirmation/recommendation to the Board as appropriate.

3.4 Committee Work Plan 2022/23

The work plan for 2022/23 has been reviewed by the Committee Chair, Chief Nurse, Medical Director, Deputy Director of Quality Governance & Company Secretary and is included at Appendix 4 for review prior to presentation to the Board of Directors for approval.

3.5 Outcome of Internal Audit Review on Committee Effectiveness

3.5.1 As part of the Trust's internal audit plan, a Committee Effectiveness internal audit was conducted in November/December 2021. The overall objective of the review was to provide an overview of the effectiveness of the design and operation of the Trust Board committees, focusing on good practice for committees and delivery of duties and compliance with Terms of Reference. The review also sought assurance that the statutory and regulatory duties of the Board were adequately represented in the governance structure and committees on which the Board relies.

3.5.2 The outcome of the audit was 'Substantial Assurance' concluding that overall, the three Trust Board assurance committees have established processes in place which enabled them to deliver their duties as delegated to them by or aligned to the Scheme of Delegation an minimise the risk of blind spotted issues coming before the Board.

3.5.3 The review noted that the operations of the committees were confirmed to be effective with good practice noted such as structured processes for formulating agendas from work plans and having detailed records of discussions and decisions maintained.

3.5.4 The review identified areas where the Trust can strengthen their governance processes namely ensuring terms of reference and annual work plans were in place, and fully aligned to the Scheme of Reservation & Delegation of Powers, and timely/consistent dissemination of meeting papers. Recommendation pertinent to the Quality Committee is reflected in the revised Terms of Reference, namely clarity regarding responsibility to review compliance with environmental/health and safety regulatory standards.

Actions are in place to address all recommendations from the Committee Effectiveness internal audit and follow up report will be considered via Audit Committee.

Appendix 1: Key matters considered by Quality Committee 2021/22

QUALITY COMMITTEE 2021/22

Topic	Apr 2021	May 2021	Jun 2021*	Jul 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Jan 2022	Feb 2022	Mar 2022
Divisional Report	✓	✓	✓								
Patient Safety Subgroup Key Issues Report *(Patient & Quality Subgroup until May 2021)*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Notification of Serious Incidents Report		✓	✓		✓	✓	✓	✓	✓	✓	✓
Infection Prevention Control (IPC) Report - Including IPC BAF		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicines Optimisation Group Report			✓								✓
Quarterly Patient Safety Report		✓			✓			✓		✓	
Clinical Effectiveness Group Key Issues Report			✓	✓	✓	✓	✓	✓	✓	✓	✓
Clinical Audit Report					✓			✓			
StARS Progress Report					✓			✓		✓	
Maternity Improvement Plan			✓				✓		✓		✓
Patient Experience Group Key Issues Report			✓		✓		✓				
Quarterly Safeguarding Report			✓		✓		✓				
Health & Safety Joint Consultative Group Key Issues Report		✓	✓	✓	✓	✓	✓	✓	✓		✓
CQC Update Report	✓	✓			✓			✓		✓	
Waiting List Harms Report	✓	✓	✓		✓				✓		✓
Quality & Safety Integrated Performance Report	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
BAF Principal Risks Review – Assigned to Quality Committee		✓			✓				✓		✓
Significant Risk Register Review (From Aug 21 – Significant Risks aligned to above BAF Principal Risks)		✓	✓	✓	✓				✓		✓

**Revised subgroup structure implemented.*

Appendix 2: Quality Committee Attendance Register 2021/22

Member	Name	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Jan 22	Feb 22	Mar 22
	Core Members											
Chair of Quality Committee, Non-Executive Director*	Dr Marisa Logan-Ward	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Non-Executive Director	Mary Moore	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Non-Executive Director	Dr Louise Sell	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Chief Nurse	Nic Firth	Y	Y	Y	A	Y	Y	Y	A	Y	Y	Y
Medical Director	Dr Andrew Loughney	A	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Director of Operations	Jackie McShane	Y	Y	A	Y	Y	Y	Y	Y	A	Y	A
	Regular Attendees											
Deputy Director of Quality Governance	Helen Kershaw / Natalie Davies	Y	Y	Y	Y	A	Y	Y	Y	Y	Y	Y
Deputy Chief Nurse	Helen Howard	Y	Y	Y	Y	Y	Y	Y	Y	Y	A	A
Deputy Medical Director	Dilraj Sandher	Y	Y	Y	A	Y	A	A	Y	A	A	A
Director of Communications & Corporate Affairs	Caroline Parnell	Y	Y	Y	Y	Y	A	A	A	Y	Y	Y
Trust Secretary	Rebecca McCarthy					Y	Y	Y	Y	Y	Y	Y
Was Meeting Quorate (Y/N)		**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	
Key												
Y	= Present											
A	= Apologies											
A (D)	= Attended as Deputy											

The attendance for the March meeting will be updated before the Committee Annual Report is presented to the Board of Directors.
Additionally, the Chief Executive attended 5 meetings during 2021/22.
*** Mrs Mary Moore commenced as Chair of Quality Committee from November 2021. Dr Marisa Logan-Ward continued as a member of Quality Committee.*

NHS Stockport NHS Foundation Trust

QUALITY COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

1.1. The Board of Directors (the Board) hereby resolves to appoint a Committee, to be known as the Quality Committee.

1.2 The Quality Committee shall have terms of reference and powers delegated by the Board and is subject to such conditions, such as reporting to the Board, in accordance with any legislation, regulation or direction issued by the Trust.

1.3 Save where otherwise provided in these Terms of Reference, the Standing Orders of the Board apply to the proceedings of this Committee.

1.4 The Quality Committee's activities will support the development and delivery of the Trust's Strategy and Annual Plan.

2. PURPOSE OF THE COMMITTEE

The overarching purpose of Quality Committee is to:

2.1 Provide oversight and assurance regarding the operation of systems and processes to ensure the quality of care, encompassing patient safety, clinical effectiveness, and experience, provided to users of the Trust's services.

2.2 Support the Board in the development of strategy related to quality of care.

2.3 Ensure any associated risks, identified in relation to the above, are managed in accordance with the Trust's assurance framework and risk management arrangements.

2.4 To have oversight into the Trust's quality-related work with locality and system partners.

3. COMPOSITION & CONDUCT OF THE COMMITTEE

3.1 Membership

3.1.1 Membership will comprise:

- Three Non-Executive Directors, one of whom shall be the Chair
- Chief Nurse
- Medical Director

3.1.2 All statutory Directors are authorised to attend and speak at meetings of the Committee, when they judge appropriate.

3.1.3 There is an expectation that members will attend all meetings during the financial year. Individual attendance levels will be monitored by the Chair of the Committee who will take appropriate measures should attendance be less than 75%.

3.1.4 Nominated deputies may attend in the absence of any member; however, this shall be in an advisory capacity only and attendance of a deputy shall not count towards the attendance level set out in 3.1.3.

3.1.5 The following shall also attend Committee meetings:

- Deputy Director of Quality Governance
- Deputy Chief Nurse
- Deputy Medical Director
- Divisional Director of Midwifery
- Maternity Safety Champion
- Head of Safeguarding
- Company Secretary

3.1.6 The Committee will invite other senior leaders to support specific matters, as required.

3.2. Chair

3.2.1 The Chair of the Committee will be a Non-Executive Director.

3.2.2 Another Non-Executive Director will deputise as the Chair of the Committee in the Chair's absence.

3.3 Quorum

3.3.1 A quorum will consist of three core committee members, provided that at least half of the attendees are Non-Executive Directors. Deputies in attendance do not count towards the quorum.

3.3.2 Members withdrawing from the meeting owing to a conflict of interest shall no longer count towards a quorum.

3.3.3 However, at the discretion of the Chair, matters and decisions deemed urgent may proceed within the absence of a quorum with any actions from that meeting being confirmed at the next full meeting.

3.4 Notice of meeting

3.4.1 Before each meeting, a notice of the meeting specifying the business proposed to be transacted and supporting papers for the business expected shall be sent by electronic mail to the usual place of business of each member, so as to be available at least five clear days before the meeting.

3.4.2 The Chair of the Committee may, at their discretion, allow additional agenda items and papers to be circulated after the notice of the meeting.

3.5 Frequency of meetings

3.5.1 The Committee shall meet at least 10 times per year.

3.5.2 The Chair may at times convene additional meetings of the Committee and/or request business that requires urgent attention is considered via email, for majority decision making. All decisions made via email will be confirmed at the next full meeting.

3.6. Administration

3.6.1 The Company Secretary will ensure appropriate administrative arrangements are in place and that minutes are recorded, confirmed, and appropriately archived from each meeting.

4. DELEGATED AUTHORITY

The Quality Committee is authorised by the Board to:

4.1 Investigate any matter within these terms of reference.

4.2 Seek information from any Director, officer, or employee; and all Directors, officers and employees are directed to extend the fullest co-operation to the Committee in the discharge of its functions.

4.3 Within the procedures approved by the Board, obtain independent legal or other professional advice where required, including the attendance of independent advisers at meetings of the Committee.

5. RESPONSIBILITIES

The responsibilities of the Committee are to:

5.1 Seek assurance on the effectiveness of systems and processes that exist to ensure quality of care, including patient safety, clinical effectiveness and patient & service user experience.

5.2 Review the levels of assurance provided from key performance indicators in relation to quality of care and monitor action/s to address any adverse trends.

5.3 Have oversight of compliance with the Care Quality Commission registration requirements and identify any risks that may prevent this and ensure mitigations are in place and delivered.

5.4 Review compliance with statutory and regulatory requirements and make recommendation / confirmation to Board as appropriate with respect to:

- infection prevention and control
- safeguarding
- maternity services
- health and safety

5.5 Review patient safety investigation findings, including root cause and agreed actions, to seek assurance regarding the governance of the process and appropriateness of actions and improvement identified.

5.6 Review the delivery of clinical audit programmes and the implementation of learning resulting from such programmes.

5.7 Review the delivery of activities in place to actively seek feedback from people using services and ensure feedback supports service improvement.

5.6 Receive and review the outcomes of national patient surveys and associated actions.

5.7 Ensure effective systems for learning are in place to drive change and support improvement in quality of care.

5.8 Oversee the development of quality related strategies and recommend to the Board.

5.9 Oversee preparation of the statutory Quality Accounts and any associated matters as required by the regulator (in association with Audit Committee).

5.10 Review the findings of major investigations or reviews (internal of external to the Trust) relevant to quality of care, as delegated by the Board or on the Committees initiative and consider management's response.

5.11 Review quality related risks from the Board Assurance Framework and associated significant risks from the Significant Risk Register and ensure that mitigations are appropriately actioned.

5.12 Review and approve the Annual Report, Work Plans and Terms of Reference of any group/committee that reports directly to the Committee.

5.13 Undertake or consider on behalf of the Chairman or the Board such other related tasks or topics as the Chairman or the Board may from to time entrust to the Committee.

The Committee will work in partnership with other Committees of the Board to address matters that impact on the responsibilities of several Committees.

6. RELATIONSHIP WITH THE BOARD OF DIRECTORS

6.1 The Committee will report to the Board by means of a Key Issues Report summarising business conducted by the Committee together with key actions and/or risks.

6.2 The Key Issues Report will be forwarded to the Board of Directors following each Committee meeting.

6.3 Minutes of all Committee meetings will be available to all members of the Board on request.

7. RELATIONSHIP WITH OTHER GROUPS

7.1 The Committee shall have the power to establish sub-committees for the purpose of addressing specific tasks or areas of responsibility. In accordance with the Trust's Standing Orders, the Committee may not delegate powers to a sub-committee unless expressly authorised by the Trust Board.

7.2 The Committee will receive reports, in the form of Key Issues Reports, from the following:

- Patient Safety Group
- Clinical Effectiveness Group
- Patient Experience Group
- Health & Safety Joint Consultative Group
- Safeguarding Group

7.3 For the purpose of providing assurance regarding the controls in place for the management and mitigation of risks recorded on the Board Assurance Framework, the Committee (through its Chair) reports regularly to the Audit Committee.

8. REVIEW

8.1 The Committee will review its terms of reference and membership annually and recommend any changes to the Board for approval.

8.2 The Committee will review the effectiveness and performance of the Committee on an annual basis and report the outcome to the Board.

Appendix 4: Quality Committee Work Plan 2022/23

			2022									2023		
	Items		**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
		Lead	**Q1**			**Q2**			**Q3**			**Q4**		
1.	**Patient Story**	Deputy Chief Nurse	●	●	●	●		●	●	●		●	●	●
2.	**Quality Deep Dives** *(To be scheduled as required)*													
	Transfusion Deep Dive	Medical Director	●											
	Falls Deep Dive	Chief Nurse		●										
3.	**Quality & Safety Integrated Performance Report**	Medical Director / Chief Nurse	●	●	●	●		●	●	●		●	●	●
Regulatory Compliance														
4.	**CQC Update**	Chief Nurse / Deputy Director Quality Governance	●			●			●			●		
5.	**Divisional Governance Project Implementation**	Deputy Director Quality Governance		●										
Assurance and Oversight Requirements														
6.	**Patient Safety Group Key Issues & Assurance Report**	Medical Director	●	●	●	●		●	●	●		●	●	●
6.1	**Notification of Serious Incidents**	Deputy Director Quality Governance	●	●	●	●		●	●	●		●	●	●
6.2	**Patient Safety Report** (Quarterly)	Deputy Director Quality Governance	.	.●				●		●			●	
6.3	**Infection Prevention and Control Summary Report** (Including IPC Board Assurance Framework) (Quarterly)	Chief Nurse	●			●			●			●		
6.4	**Annual Infection Control Report**	Chief Nurse		●										
7.	**Clinical Effectiveness Group Key Issues & Assurance Report including:** Quarterly Clinical Audit Programme Update Quarterly NICE Guidance Update	Medical Director	●	●	●	●		●	●	●		●	●	●
7.1	**Quality Strategy Progress Report**	Deputy Chief Nurse / Deputy Medical Director	●						●					
7.2	**StARS Progress Report**	Deputy Chief Nurse	.●	.		●			●			●		

7.3	**Annual Research Report**	Medical Director		●										
8.	**Patient Experience Group Key Issues & Assurance Report**	Chief Nurse	●	●	●	●		●	●	●		●	●	●
8.1	**Annual In-Patient Survey Report and Action Plan**	Deputy Chief Nurse				●			●					
9.	**Health and Safety JCG Key Issues & Assurance Report**	Deputy Director Quality Governance	●	●	●	●		●	●	●		●	●	●
9.1	**Annual Health & Safety Report**	Deputy Director Quality Governance		●										
10.	**Safeguarding Group Key Issues & Assurance Report**	Chief Nurse	●			●			●			●		
10.1	**Annual Safeguarding Report**	Deputy Chief Nurse			●									
11.	**Waiting List Harms Report**	Deputy Medical Director			●				●				●	
12.	**Maternity Services Report**	Divisional Director of Midwifery / Chief Nurse	●	●	●	●		●	●	●		●	●	●
13.	**External Visits & Inspections Register Report**	Deputy Director Quality Governance						●						●
14.	**Annual Quality Account**			● (Draft)	● (Final)									
Strategy														
15.	**Research Strategy**	Medical Director			●									
16.	**Mental Health Plan**	Medical Director / Deputy Chief Nurse	●											
17.	**Patient Experience Strategy**	Deputy Chief Nurse	●											
18.	**Patient Safety Strategy *(Date TBC)***	Deputy Director Quality Governance												
Risks														
19.	**BAF & Aligned Significant Risks**	Company Secretary	●			●			●			●		
Committee Business														
20.	Review and approve of **Terms of Reference**	Chair												●
21.	Review and approve of **Annual Work Plan**	Chair												●

22.	Review and approve **Quality Committee Subgroup Terms of Reference & Annual Work Plan**	Chair												●
23.	Informal Review of Committee Effectiveness	Led by Chair	●	●	●	●		●	●	●		●	●	●
24.	Formal Committee Evaluation	Chair												●

Schedule as required: Major investigations or reviews (internal of external to the Trust) relevant to quality of care.

NB. Safeguarding Group Terms of Reference and Work Plan to be presented – April 2022.