SFT Public Board Meeting - June 2025

Thu 05 June 2025, 09:30 - 13:00

Pinewood House Education Centre

NHS Stockport NHS Foundation Trust

Agenda

09:30 - 09:30
0 min

1. Apologies for Absence

09:30 - 09:30
0 min

2. Declaration of Interests (Verbal)

09:30 - 09:35
5 min

3. Staff Story (Verbal)

Information *Amanda Bromley*

09:35 - 09:35
0 min

4. Minutes of Previous Meeting - held on 3 April 2025 (Paper)

Decision *David Wakefield*

04 - Public Board Minutes - 3 April 2025.pdf (10 pages)

09:35 - 09:40
5 min

5. Action Log (Paper)

Discussion *David Wakefield*

05 - Public Board Action Log - June 2025.pdf (2 pages)

09:40 - 09:50
10 min

6. Chair's Report (Paper)

Discussion *David Wakefield*

06 - Chairs Report - June 2025.pdf (4 pages)

09:50 - 10:00
10 min

7. Chief Executive's Report (Paper)

Discussion *John Graham*

07 - Chief Executive's Report - June 2025.pdf (5 pages)

PLANNING

10:00 - 10:10
10 min

8. Final Trust Operational & Financial Plan 2025/26 (Paper)

Discussion *Paul Buckley / John Graham*

08 - Final SFT Operational Plan 202526.pdf (4 pages)

10:10 - 10:30
20 min

9. Corporate Objectives

9.1. Corporate Objectives and Outcome Measures 2025/26 (Paper)

Decision *Paul Buckley*

09.1 - SFT Corporate Objectives 2024-25 End Year Report & 2025-26 Outcome Measures.pdf (15 pages)

9.2. Risk Appetite Review 2025/26 (Paper)

Decision *John Graham*

09.2 - Risk Appetite Review 2025-26.pdf (6 pages)

FINANCE & PERFORMANCE

10:30 - 10:35
5 min

10. Finance & Performance Committee Key Issues Report (Paper)

Discussion

10a - Finance & Performance Committee AAA Report - Front Sheet.pdf (2 pages)
10b - Finance & Performance Committee AAA Report - April & May 2025.pdf (3 pages)

10:35 - 10:55
20 min

11. Integrated Performance Report - Month 1 (Paper)

Discussion *Executive Directors*

11a - Integrated Performance Report - Front Sheet May 25.pdf (2 pages)
11b - Integrated Performance Report - May 25.pdf (22 pages)

10:55 - 11:05
10 min

12. Financial Position - Month 1 (Paper)

Discussion *John Graham*

12a - Financial Position Month 1 2025-26 - Front Sheet.pdf (3 pages)
12b - Financial Position 2025-26 M01.pdf (18 pages)

11:05 - 11:15
10 min

13. Opening Budgets 2025/26 (Paper)

Decision *John Graham*

13 - Opening Budget 2025-26.pdf (9 pages)

QUALITY

11:15 - 11:20
5 min

14. Quality Committee Key Issues Report (Paper)

Discussion *Louise Sell*

14a - Quality Committee AAA Report - Front Sheet.pdf (2 pages)
14b - Quality Committee AAA Report - April and May 2025.pdf (4 pages)

11:20 - 11:30

15. Transformation & Continuous Improvement Strategy Report (Paper)

10 min

Discussion *Hannah Silcock*

- 15a - Transformation & Continuous Improvement Strategy Report 2024-25 - Front Sheet.pdf (3 pages)
- 15b - Transformation & Continuous Improvement Strategy Report 2024-25.pdf (57 pages)

11:30 - 11:40 10 min

COMFORT BREAK

PEOPLE

11:40 - 11:45 5 min

16. People Performance Committee Key Issues Report (Paper)

Discussion *Beatrice Fraenkel*

- 16a - People Performance Committee AAA Report - Front Sheet.pdf (2 pages)
- 16b - People Performance Committee AAA Report - May 2025.pdf (2 pages)

11:45 - 11:55 10 min

17. Workforce Equality, Diversity & Inclusion Strategy Report (Including Statutory Reporting (Paper)

Discussion *Amanda Bromley*

- 17 - Workforce EDI Strategy Progress Report - June 2025.pdf (55 pages)

11:55 - 12:05 10 min

18. Safer Care (Staffing) Report (Paper)

Discussion *Nicola Firth / Andrew Loughney*

- 18a - Safer Care (Staffing) Report - Front Sheet.pdf (3 pages)
- 18b - Safer Care (Staffing) Report - June 2025.pdf (31 pages)

12:05 - 12:15 10 min

19. Freedom to Speak Up Report (Paper)

Discussion *Nadia Walsh*

- 19 - Freedom to Speak Up Report - June 2025.pdf (11 pages)

GOVERNANCE

12:15 - 12:20 5 min

20. Audit Committee Key Issues Report (Paper)

Discussion *David Hopewell*

- 20a - Audit Committee AAA Report - Front Sheet.pdf (2 pages)
- 20b - Audit Committee AAA Report - May 2025.pdf (3 pages)

12:20 - 12:30 10 min

21. Annual Review of Provider Trust Code of Governance (Paper)

Decision *Rebecca McCarthy*

- 21 - Annual Review of Provider Trust Code of Governance.pdf (27 pages)

12:30 - 12:40
10 min

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

Decision *John Graham*

22 - Annual Self-Certification CoS7 2024-25.pdf (6 pages)

12:40 - 12:50
10 min

23. Going Concern Declaration (Paper)

Decision *John Graham*

23 - Going Concern Assessment 2024-25.pdf (4 pages)

CLOSING MATTERS

12:50 - 12:50
0 min

24. Any Other Business

DATE, TIME & VENUE OF NEXT MEETING

12:50 - 12:50
0 min

25. Thursday 7 August 2025, 9.30am, Pinewood House Education Centre

12:50 - 12:50
0 min

26. Resolution:

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

NHS Stockport NHS Foundation Trust

STOCKPORT NHS FOUNDATION TRUST
Minutes of a meeting of the Board of Directors held in public
Held on Thursday 3 April 2025, at 9.30am in Pinewood House Education Centre, Stepping Hill Hospital

Members Present:

Mr David Wakefield	Joint Chair
Dr Samira Anane	Non-Executive Director
Mr Anthony Bell	Non-Executive Director
Mrs Amanda Bromley	Director of People & OD
Mr Paul Buckley	Director of Strategy & Partnerships*
Mrs Nicola Firth	Chief Nurse
Mrs Beatrice Fraenkel	Non-Executive Director
Mr John Graham	Chief Finance Officer / Deputy Chief Executive
Mr David Hopewell	Non-Executive Director
Mrs Karen James	Chief Executive
Dr Marisa Logan-Ward	Non-Executive Director / Deputy Chair
Dr Andrew Loughney	Medical Director
Mrs Jackie McShane	Director of Operations
Dr Louise Sell	Non-Executive Director

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

Quorate: Yes

In attendance:

Mrs Soile Curtis	Deputy Trust Secretary
Mrs Rebecca McCarthy	Trust Secretary

Apologies:
None

* *indicates a non-voting member*

REF No/Yr.	ITEM	ACTION OWNER
28/25	**Apologies for Absence** The Joint Chair welcomed everyone to the meeting. There were no apologies for absence.	
29/25	**Declarations of Interest** The Joint Chair declared that he was also Chair of University Hospitals of North Midlands NHS Trust.	
30/25	**Staff Story** The Board watched a video regarding the Healthcare Cadet Programme, noting that the number of cadets had significantly increased since inception of the programme, and the Trust had extended the partnership to include Manchester College, UCEN Manchester and Macclesfield College. In response to a query from the Joint Chair regarding alternative programmes, the Director of People & Organisational Development (OD) provided further clarity, noting that the cadet programme ran alongside the apprenticeship programme.	

	The Board of Directors received and noted the Staff Story.	
31/25	**Minutes of Previous Meeting** The minutes of the previous meeting held on 6 February 2025 were agreed as a true and accurate record.	
32/25	**Action Log** The action log was reviewed and annotated accordingly.	
33/25	**Chair's Report** The Joint Chair presented his first report to the Board since commencing in the role on 1 April 2025. The Board of Directors received an update on the following: - Changes to NHS England - Operational Planning 2025/26 **The Board of Directors received and noted the Chair's Report.**	
34/25	**Chief Executive's Report** The Chief Executive presented a report providing an update on local and national strategic and operational developments, including: - NHS Greater Manchester - Corporate Objectives & Outcome Measures 2025/26 - Operational Performance - Trust Values Launched - Acute Electronic Patient Record - Hospital Site & Estate - Key Successes and Celebrations In response to a question from Mrs Beatrice Fraenkel, Non-Executive Director, querying how the impact of the newly launched Trust values would be measured, the Director of People & OD advised that the Staff Survey results were a key source for measuring the impact of the Trust values, in addition to feedback sought via 'Big Conversations' and walkarounds. Mr Anthony Bell, Non-Executive Director, commented that the car parking programme had been discussed at the Finance & Performance Committee and he welcomed the wide-ranging engagement in this area. In response to a question from Mr Anthony Bell, Non-Executive Director, regarding the Electronic Patient Record (EPR) business case, the Chief Executive advised that the business case would be updated following completion of the procurement process, which was expected to run for 3 months. Mr Bell stressed the importance that the Board was provided sufficient time to review the business case and allow time for iteration if necessary. In response to a question from Dr Samira Anane, Non-Executive Director, querying compatibility between community EMIS and EPR systems, the Chief Executive confirmed that integrability was key in the development of the EPR, noting this was being highlighted to potential suppliers. **The Board of Directors received and noted the Chief Executive's Report.**	
35/25	**Finance & Performance Committee Alert, Assure & Advise (AAA) Report** The Chair of Finance & Performance Committee (Mr Anthony Bell, Non-	

	Executive Director) presented the AAA report from the Finance & Performance Committee meetings held on 20 February 2025 and 20 March 2025. He briefed the Board on the content of the report and detailed key financial and operational issues and associated key risks considered. Dr Louise Sell, Non-Executive Director, referred to the paediatric audiology matter, which had also been discussed at the Quality Committee through a patient safety lens. She queried mitigating actions in this area, acknowledging that this was a national issue that required external support to resolve. The Board heard that the Trust had stopped taking new referrals due to a national mandate and expressed collective concern regarding the adverse impact on children. There followed a comprehensive discussion, and in conclusion it was agreed that a deep dive would be presented to the Quality Committee regarding paediatric audiology, including timeline for compliance with national standards, risks to children whilst waiting and cost of a compliant service **(ACTION)** **The Board of Directors reviewed and confirmed the Finance & Performance Committee AAA Report, including actions taken.**	**Chief Nurse**
36/25	**Integrated Performance Report** The Chief Executive introduced the Integrated Performance Report (IPR), which included exception reports for areas of most significant note. **Quality** The Chief Nurse and Medical Director presented the quality section of the IPR and highlighted challenges and mitigating actions regarding sepsis, infection prevention & control (IPC), falls, pressure ulcers and maternity due to under-achievement in month. The Medical Director advised that the SHMI mortality rates continued to be low, with the Trust reported with the lowest rates across GM. The Board heard that timely administration of antibiotics within the necessary timescales continued to be challenging, albeit performance had improved in December 2024. It was noted that the Transformation Team were providing support to enable further service improvements around sepsis. The Chief Nurse reported a deteriorating position regarding falls and infection rates for Clostridium Difficile (CDiff) and MRSA. She provided an overview of improvements around pressure ulcers. In response to a question from the Joint Chair querying whether there was a connection between pressure ulcers and long waits in Emergency Department (ED), the Chief Nurse confirmed that harm reviews had not identified a link between pressure ulcers and long waits, noting that cases primarily related to medical devices which had been resolved following an improvement project. She confirmed that the Quality Committee received updates on any clinical harms. In response to a question from Dr Marisa Logan-Ward, Non-Executive Director, regarding issues around antibiotic administration, the Medical Director confirmed that to date, harm reviews had not identified any patient harm due to delayed antibiotic administration. He expressed confidence that	

	the ongoing improvement project led by the Transformation Team would support sustained improvement. The Joint Chair noted that GM was ranked 39th out of the 42 Integrated Care Boards (ICBs) in relation to CDiff. performance. There followed a discussion regarding potential causation and in conclusion, it was agreed that the Quality Committee would undertake a deep dive regarding the outcome of system / national research regarding prevalence of CDiff, recognising GM is an outlier in this area. Furthermore, it was suggested that the deep dive should include work from the GM Quality Committee. **(ACTION)**	**Chief Nurse**
	Operations The Director of Operations presented the operational performance section of the IPR and highlighted challenges and mitigating actions regarding Emergency Department (ED) performance, patient flow, diagnostics, cancer, Referral to Treatment (RTT), community, outpatient efficiency, outpatient procedures and theatre efficiency metrics due to under-achievement in month. The Board heard that performance against the ED trajectory had shown a further improvement but remained outside the target thresholds. It was noted that the key drivers related to increased demand and acuity, suboptimal bed occupancy, high levels of No Criteria to Reside (NCTR) and delayed discharges. The Director of Operations reported positive performance against most cancer metrics in month, with 62-day performance just below the trajectory. The Director of Operations advised that diagnostic performance remained challenging, with paediatric audiology a key risk to achieving the year-end target. The Board heard that improvements continued with the Trust's RTT position in 52 and 65 week waits. In response to a question from Mr Anthony Bell, Non-Executive Director, regarding theatre late starts, it was agreed that an update would be presented to the Finance & Performance Committee, including reasons / key themes for late starts, impact of nursing and clinical leadership in addressing the issue, and mitigating actions. **(ACTION)** In response to a question from Dr Samira Anane, Non-Executive Director, regarding digitisation of the pre-operative process, the Director of Operations stated that digitisation would enable a more efficient process and alleviate pressure on staff in this area. Mr David Hopewell, Non-Executive Director, referred to the new NHS priorities for 2025/26, and it was noted that the Trust's performance against the measures would be reported through the Finance & Performance Committee. In response to a question from the Joint Chair regarding the potential impact of the Emergency & Urgent Care Centre (EUCC) on ED 4-hour performance, the Director of Operations stated that system flow was key to enabling	**Director of Operations**

	sustained improvements. She noted that, while the EUCC was expected to improve ED 4-hour performance, risks remained regarding staffing the new facility. In response to a further question from the Joint Chair regarding benefits realisation of the EUCC business case, the Director of Operations confirmed that post-implementation realisation of business cases was included on the Finance & Performance Committee work plan and the EUCC review was due to be reported to the Committee in Q4 2025/26. Dr Louise Sell, Non-Executive Director, expressed her view that opportunities for improvement remained regarding flow in relation to pathways 2 and 3. The Director of Operations acknowledged the comment and highlighted the ongoing system challenge, stating that locality support was required to improve the effectiveness of the pathways. It was noted that the Finance & Performance Committee would continue to be updated on progress in this area. **People** The Director of People & Organisational Development (OD) presented the people section of the IPR and highlighted challenges and mitigating actions regarding sickness absence, appraisal rates and mandatory training due to under-achievement in month. She briefed the Board on mitigating actions regarding sickness absence, highlighting focused work with divisions, and advised that the Sickness Absence Policy was being reviewed to ensure greater grip and control in this area. **Finance** The Board received and noted the finance section of the IPR, noting that more detailed financial information was provided within the Finance Report. **The Board of Directors received and noted the Integrated Performance Report.**	
37/25	**Finance Report** The Chief Finance Officer presented a report providing an update on the financial performance for Month 11 2024/25. The Board heard that overall, the Trust position at Month 11 was a deficit of £1.9m, which was a positive variance of £0.2m to plan. It was noted that at this point the forecast for year-end was a deficit of £2.1m, which was favourable to plan by £0.4m as agreed with the GM Integrated Care System (ICS). However, a number of technical accounting adjustments were acknowledged, including an impairment of the EUCC and the transfer of The Meadows building and land. The Board heard that the variance to date related to Elective Recovery Fund (ERF) underperformance, pay award pressure and enhanced care, offset by additional activity related income and grip and control actions. In response to a question from the Joint Chair, the Chief Finance Officer provided further clarity on The Meadows transaction, including impact on Public Dividend Capital (PDC) and interest, would be reported through the Audit Committee.	

	The Chief Finance Officer advised that the Trust had delivered profiled savings of £19.4m at Month 11, which was £0.6m ahead of profiled plan. It was noted that whilst the Trust was forecasting delivery of the full plan, there was a shortfall on recurrent savings of circa £5m. The Chief Finance Officer advised that agency costs had continued below the 3.2% target at 2.7% in February 2025. It was noted that agency expenditure remained a key focus within the financial plan and performance was overseen by the operational Workforce Efficiency Group, particularly looking forward to 2025/26 when the targets would be further reduced. The Board heard that the Trust's cash balance at the end of February 2025 was £32.7m. The Chief Finance Officer advised that to date, the Trust had spent £30.9m against a Capital Plan of £35.4m, and highlighted expenditure relating to the Emergency & Urgent Care Campus, the MRI scheme and essential network cabinet refresh. It was noted that the current forecast had been revised to an underspend of £0.7m, which had been agreed as part of the GM capital control total. The Board heard that the Trust was forecasting to deliver the financial plan for 2024/25, subject to risks highlighted. In response to a comment from the Joint Chair, the Board of Directors recognised the significant work taking place to produce the year-end accounts and thanked all staff for their efforts in this area. Dr Louise Sell, Non-Executive Director, stressed the importance of not including reference to single patients in public facing Board reports. **The Board of Directors received and noted the Finance Report.**	
38/25	**Opening Budgets 2025/26 Update** The Chief Finance Officer presented an Opening Budgets 2025/26 Update Report. He advised that due to the delay in the approval of the final annual financial plan for 2025/26, the Board of Directors were not able to formally approve the opening budgets for the year prior to 1 April 2025. The Board of Directors were asked to confirm that directors had the approved authority to operate under the standing financial instructions and scheme of delegation. The Chief Finance Officer stated that the Opening Budgets would be presented to the Finance & Performance Committee and the Board of Directors once the final plan had been agreed. **The Board of Directors received and report and confirmed that directors have the approved authority to operate under the standing financial instructions and scheme of delegation.**	
39/25	**Overarching Review of Outpatients B Closure** The Director of Operations presented a report providing an overview of the key impact resulting from the closure of the Outpatients B (OPB) department in November 2023, drawing on quantitative and qualitative information captured at the time of the closure and retrospectively.	

	The Director of Operations advised that the situation had been managed as an internal critical incident with business continuity arrangements enacted. The Board recognised the significant adverse impact of the OPB closure on patients and staff, and the impact on the ability to provide suitable space for outpatients clinics to take place. The Board acknowledged and welcomed the business continuity arrangements and joint working of teams that had enabled the rehousing of services and reinstatement of capacity. The Director of Operations advised that the new outpatients facility was due to be operational in late summer / early autumn. In response to a question from Mrs Beatrice Fraenkel, Non-Executive Director, querying how learning had been taken from the OPB closure in order to plan for other areas of the Trust's estate, the Director of Operations stated that business continuity plans had been reviewed and/or developed for 23 buildings identified as the Trusts poorest condition estate, and mitigating action taken as appropriate. In response to a comment from Dr Louise Sell, Non-Executive Director, regarding potential patient harm because of the OPB closure, the Medical Director and Chief Nurse expressed view that it would be challenging to identify specific harm as a result of the closure. It was agreed that the Quality Committee would explore any potential patient harm as part of the Patient Safety Report. **(ACTION)** **The Board of Directors received and noted the Overarching Review of Outpatients B Closure Report.**	**Chief Nurse / Medical Director**
40/25	**Quality Committee Alert, Assure & Advise (AAA) Report** The Chair of Quality Committee (Dr Louise Sell, Non-Executive Director) presented the AAA report from the Quality Committee meetings held on 25 February 2025 and 25 March 2025. She briefed the Board on the content of the report and detailed key quality related issues considered. In response to a question from the Joint Chair regarding the outcome of the Get it Right First Time (GIRFT) review, the Medical Director and Chief Executive provided contextual information in this area. They highlighted a national shortage of care of the elderly consultants and that an alternative model needed to be explored as a consequence. **The Board of Directors reviewed and confirmed the Quality Committee AAA Report, including actions taken.**	
41/25	**Stockport Locality Update** The Director of Strategy & Partnerships presented a report providing an update on the collaborative working arrangements within Stockport that the Trust participates in, and other matters being taken forward within the borough in relation to health and care. The Board received an update on progress with aspects of the ONE Stockport Health and Care Plan, the GM community services review and the Provider Partnership. In response to a question from Mrs Beatrice Fraenkel, Non-Executive Director, querying the use of quantitative data to inform the commissioning of services within the Locality, the Chief Executive advised that the Trust was	

	working with the Local Authority, utilising data analytics, to ensure models of care can be developed to address the population needs. In response to a question from the Joint Chair regarding the Stockport Place forecast outturn overspend of £9.8m, the Chief Finance Officer confirmed that the projected adverse variance formed part of the overall GM 2024/25 financial position. **The Board of Directors received and noted the Stockport Locality Update Report.**	
42/25	**People Performance Committee Alert, Assure & Advise (AAA) Report** The Chair of People Performance Committee (Mrs Beatrice Fraenkel, Non-Executive Director) presented the AAA report from the People Performance Committee meeting held on 13 March 2025. She briefed the Board on the content of the report and detailed key people related issues and associated key risks considered. **The Board of Directors reviewed and confirmed the People Performance Committee AAA Report, including actions taken.**	
43/25	**Staff Survey** Director of People & OD presented the results of the 2024 National Staff Survey. She briefed the Board on the content of the report, noting an overall response rate of 45.3%. The Board noted positive scores regarding the Trust and managers being committed to supporting flexible working, health and wellbeing being a priority and managers valuing team members' work. The Board heard that the key area of focus for this year would include putting the learning from the Civility Saves Lives programme into practice, introducing the Sexual Safety Policy, guidance and training and further improving appraisal discussions. Mr Anthony Bell, Non-Executive Director, expressed concern regarding the levels of violence and aggression experienced by ethnic minority staff, noting that this issue had been raised at the Race Equality Staff Network, and queried what the Trust could do to further support those members staff. The Director of People & OD briefed the Board on support currently available to staff and suggested that this should be further explored at the Race Equality Staff Network to seek suggestions for support that would be valued by staff. She agreed to facilitate HR contact with the staff network. Dr Marisa Logan-Ward, Non-Executive Director, advised that following the publication of the staff survey results, Equality, Diversity & Inclusion (EDI) had been highlighted as a key focus for the region in planning priorities. The Board reaffirmed the importance of a Board-led approach in this area. Mrs Beatrice Fraenkel, Non-Executive Director, sought further understanding of the responses to questions concerning violence and bullying. She queried further information regarding colleagues involved and where in the Trust, to enable understanding of perpetrators and hot spots. The Director of People & OD confirmed the staff survey results were considered by each division providing further focus of identification of hotspots. She noted that the national system used by the Trust would have limitations regarding the	

	granularity of reporting that was possible. The Board heard that violence and aggression updates were reported through to People Performance Committee. In response to a question from Mrs Beatrice Fraenkel, Non-Executive Director, querying how the Trust took learning from staff raising concerns and whether improvements were being implemented as a consequence, the Director of People & OD advised that the effectiveness of the processes for staff to raise concerns was reported through to the People Performance Committee, Board of Directors and Audit Committee. She noted that Freedom to Speak Up was one of many routes available for staff to raise concerns. **The Board of Directors received and noted the 2024 National Staff Survey Results.**	
44/25	**Audit Committee Alert, Assure & Advise (AAA) Report** The Chair of Audit Committee (Mr David Hopewell, Non-Executive Director) presented the AAA report from the Audit Committee meeting held on 18 February 2025, detailing key issues considered. **The Board of Directors reviewed and confirmed the Audit Committee AAA Report, including actions taken.**	
45/25	**Board Assurance Framework 2024/25 – Quarter 4** The Chief Executive presented the Board Assurance Framework (BAF) 2024/25 as at the end of Quarter 4, noting that the majority of risks had been reviewed via the respective Board Committees. She briefed the Board on the report and the principal risks and associated mitigations. Furthermore, a gap analysis between current and target risk score was provided. The Chief Executive advised that following review and discussion at Board Committees, it was proposed to decrease risk scores for Principal Risks 2.1, 6.1 and 7.2. The Chief Executive advised that the Trust's significant risks from the corporate risk register were provided in the report to ensure alignment between operational and principal risks. The Joint Chair welcomed the BAF document, suggesting further direct mapping of the actions to the gaps in control. Mr Anthony Bell, Non-Executive Director, noted the need for the Board's risk appetite to reflect the uncertain operating environment. Mrs Beatrice Fraenkel, Non-Executive Director, commented that she would welcome further clarity regarding shared risk and where cross referencing of risk was relevant between Board Committees. **The Board of Directors reviewed and approved the Board Assurance Framework 2024/25 as at Quarter 4, including action proposed to mitigate risks.**	
46/25	**Board Committees Annual Review: Including Terms of Reference and Work Plans for Approval**	

	The Trust Secretary presented the outcome of the annual reviews of Board Committees (Finance & Performance Committee, People Performance Committee and Quality Committee) including confirmation of the effective operation of the Committees during the year, opportunities for improvement and review of the Terms of Reference and Work Plans, which were presented for approval. Regarding opportunities for improvement, the Board heard that a continued focus on reporting for the purpose of assurance at a strategic level was recognised, with reports to draw out key matters for attention or decision, rather than operational detail. Mr Anthony Bell, Non-Executive Director highlighted the importance of being able to flex Committee Work Plans during the year to enable Committees to address any matters arising through the GM system. The Joint Chair welcomed the introduction of the Alert, Assure and Advise Reports in Committee reporting, noting that the format enabled a clear focus on the key issues. **The Board of Directors reviewed and approved the outcome of the Board Committee Annual Reviews 2024/25 including approval of the Terms of Reference and Work Plans for the following:** - **Finance & Performance Committee** - **People Performance Committee** - **Quality Committee**	
47/25	**Annual Trust Seal Report** The Trust Secretary presented a report on the use of the Common Seal during 2024/25. **The Board of Directors received and noted the report and confirmed the use of the Common Seal during 2024/25.**	
48/25	**Any Other Business** There was no other business.	
49/25	**Board Work Plan & Attendance** The Board of Directors noted the Board Work Plan and Attendance.	
50/25	**Date and Time of Next Meeting** Thursday 5 June 2025, 9.30am, Pinewood House Education Centre.	
51/25	**Resolution** *"To move the resolution that the representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to commercial interests, sensitivity and confidentiality of patients and staff, publicity of which would be premature and/or prejudicial to the public interest".*	

McCarthy Rebecca 29/05/2025 17:56:54

Signed:_____Date:_____

BOARD OF DIRECTORS PUBLIC MEETING ACTION TRACKER

Action Log Ref No/Yr.	Meeting Date	Minute Ref	Item	Action	Responsible	Status
04/24	3 October 2024	113/24	Estates & Facilities Update	Overarching review of the impact of Outpatients B closure incorporating quality, operational performance, people and finance. **Update April 2025** – Report on agenda. Action closed.	Director of Operations	Closed
01/25	3 April 2025	32/25	Finance & Performance Committee AAA Report – Paediatric Audiology Issue	An update report would be presented to the Quality Committee regarding paediatric audiology. **Update June 2025** – Deep dive scheduled for the June Quality Committee meeting. It is proposed to close the action on the Board action log and transfer to Quality Committee.	Chief Nurse	Closed
02/25	3 April 2025	36/25	Integrated Performance Report – Quality	Quality Committee to undertake a deep dive regarding the outcome of system / national research regarding prevalence of CDiff, recognising GM is an outlier in this area (include work from GM Quality Committee. **Update June 2025** – Action transferred to the Quality Committee action log with a deep dive scheduled for the October Quality Committee meeting. It is proposed to close the action on the Board action log and transfer to Quality Committee.	Chief Nurse	Closed
03/25	3 April 2025	36/25	Integrated Performance Report – Operations	It was agreed that an update on theatre late starts would be presented to the Finance & Performance Committee, including reasons / key themes for late starts, impact of nursing and clinical leadership in addressing the issue, and mitigating actions. **Update June 2025** – Deep Dive scheduled for the	Director of Operations	Closed

Action Log Ref No/Yr.	Meeting Date	Minute Ref	Item	Action	Responsible	Status
				May Finance & Performance Committee meeting. It is proposed to close the action on the Board action log.		
04/25	3 April 2025	39/25	Outpatients B Closure Review	Quality Committee to explore any potential patient harm as part of Patient Safety Report. **Update June 2025** – Scheduled for the September Quality Committee meeting. It is proposed to close the action on the Board action log and transfer to Quality Committee.	Chief Nurse / Medical Director	Closed

On agenda
Not due
Overdue
Closed

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

Stockport NHS Foundation Trust

				Agenda No.	
Meeting date	5 June 2025	**Public**	X	**Confidential**	
Meeting	Board of Directors				
Report Title	Joint Chair's Report				
Director Lead	David Wakefield, Chair	**Author**	David Wakefield, Chair		

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

This paper relates to the following Annual Corporate Objectives

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

This paper relates to the following Board Assurance Framework risks

	PR1.1	There is a risk that the Trust does not deliver high quality care to service users
	PR1.2	There is a risk that patient flow across the locality is not effective
	PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan
	PR2.1	There is a risk that the Trust is unable to sufficiently engage and support our people's wellbeing
	PR2.2	There is a risk that the Trust does not actively participate in local collaborative programmes/neighbourhood working to improve primary and secondary health outcomes
	PR3.1	There is a risk that place-based partnership working does not effectively support delivery of Stockport ONE Health & Care (Locality) Board priorities and address health inequalities in Stockport
	PR3.2	There is a risk that partnership working in Greater Manchester do not effectively address unwarranted variation of services and improve health inequalities
	PR3.3	There is a risk that opportunities for collaboration between Stockport NHS Foundation Trust and Tameside & Glossop Integrated Care NHS Foundation Trust are not optimised
	PR4.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit and retain the optimal number of staff, with appropriate skills and values
	PR4.2	There is a risk that the Trust's workforce is not reflective of the communities served

	PR5.1	There is a risk that the Trust does not implement high quality service improvement programmes
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	PR6.1	There is a risk that the Trust does not deliver the annual financial plan
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	PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus

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 and Diversity impacts	
Financial impacts if agreed/ not agreed	
Regulatory and legal compliance	
Sustainability (including environmental impacts)	

Executive Summary

This highlights key matters for the attention of the Board from the Joint Chair covering national, regional and Trust issues.

1. Operating Environment 2025/26

At the end of 2024/25, plans to abolish NHS England (NHSE) and integrate its functions with the Department of Health & Social Care (DHSC) within two years were announced. This change aims to reduce duplication and bureaucracy, and save money, with the goal of returning resources to frontline services and delivery of better care. Specifically, the move is expected to lead to a reduction of around 50% in the combined size of NHSE and the DHSC.

In line with the above, in May 2025, we saw the first version of the Model Integrated Care Board (ICB) Blueprint. The blueprint sets out expectations for ICB's to deliver a 50% reduction in their running costs by the end of Q3 2025/26, whilst also setting out the refreshed role for ICBs as strategic commissioners. Meanwhile, Sir Jim Mackey, Chief Executive NHSE, has written to all NHS trusts requesting a reduction in corporate cost growth by 50% during Q3.

The NHS performance assessment framework for 2025/26 has been released, and all trusts and ICBs will be placed in segments ranging from 1 (high performing) to 4 (low performing) with an additional segment 5 to indicate the most intensive support requirement.

The Trust Board is very aware of the consequences of being placed in the worst tiers and we are ready to adapt to this evolving context to avoid this possibility.

2. Collaboration with Tameside & Glossop Integrated Care NHS Foundation Trust (T&G ICFT)

My role as Joint Chair, representing both Stockport NHS Foundation Trust and T&G ICFT, was a key next step in strengthening collaboration between the two organisations. During my first month in post, I lead board development sessions with both Trust Boards, considering our top challenges, followed by our current collaboration and partnerships, and what the future strategy for our Trusts could look like.

As referenced above, we are all aware of the financial and operational challenges facing the NHS and the broader economic context we are working in. Both Trusts have submitted challenging operational and financial plans for 2025/26. While the Trusts remain as separate organisations, with several shared leaders, we must maximise the potential for joint working for the benefit of the local populations, patients and staff.

We will seek to do this going forward by bringing both Trust Boards together for future development sessions. We will develop a clear vision on what will be achieved by working together through our joint organisational strategy. Concurrently, we must also consider collaborative/joint governance arrangements, that will allow us to maximise the benefits of closer working, whilst ensuring the statutory responsibilities of both Trusts are maintained. Many different collaborative/joint governance models have emerged up and down the country. Over the coming months we will begin to explore these different models, considering what arrangements would work best to deliver our joint ambitions. Engagement with our Council of Governors will also take place on these matters.

3. Trust Activities

Since joining the Trust, I have undertaken a range of other activities and visited many of our wards and departments including A, B & C Wards, our Emergency Department, Same Day Emergency Care, Acute Medical Unit (AMU) and Intensive Care (ICU), along with Audiology and several Outpatient Areas. I have found these visits really helpful, as I look to grow my understanding of the issues faced by staff and patients alike. The visits also help to put our operational performance into context, and they have given me an opportunity to hear the staff voice.

I have also attended several national meetings/conferences where we heard from the new NHS England CEO, Sir Jim Mackey, reiterating the parlous state of NHS finances and outlining the

requirement for every provider to break-even and to become financially sustainable. This message was repeated by a junior government minister at a Chairs meeting. The Trust has responded well to the challenges posed and we have developed plans to achieve break-even, but we recognise the many risks in delivering them.

I attended a Greater Manchester Providers Chairs meeting where we each shared the pressures and challenges faced. It became apparent that we are not alone in having to make difficult decisions on how we meet the targets and the requirement to collaborate was crystallised if efficiencies in clinical pathways and support services are to be realised.

NHS Stockport NHS Foundation Trust

				Agenda No.	7
Meeting date	5 June 2025	**Public**	X	**Confidential**	
Meeting	Board of Directors				
Report Title	Chief Executive Officer's Report				
Director Lead	Karen James, Chief Executive	**Author**	Rebecca McCarthy, Trust Secretary		

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

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

	Safe		Effective
	Caring		Responsive
X	Well-Led		Use of Resources

This paper relates to the following Board Assurance Framework risks

	PR1.1	There is a risk that the Trust does not deliver high quality care to service users
	PR1.2	There is a risk that patient flow across the locality is not effective
	PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan
	PR2.1	There is a risk that the Trust is unable to sufficiently engage and support our people's wellbeing
	PR2.2	There is a risk that the Trust does not actively participate in local collaborative programmes/neighbourhood working to improve primary and secondary health outcomes
	PR3.1	There is a risk that place-based partnership working does not effectively support delivery of Stockport ONE Health & Care (Locality) Board priorities and address health inequalities in Stockport

	PR3.2	There is a risk that partnership working in Greater Manchester do not effectively address unwarranted variation of services and improve health inequalities
	PR3.3	There is a risk that opportunities for collaboration between Stockport NHS Foundation Trust and Tameside & Glossop Integrated Care NHS Foundation Trust are not optimised
	PR4.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit and retain the optimal number of staff, with appropriate skills and values
	PR4.2	There is a risk that the Trust's workforce is not reflective of the communities served
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	PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus

Where issues are addressed in the paper

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

Executive Summary

This report provides an update on matters of interest, which have arisen since the last Board meeting including:

- NHS Performance Assessment Framework
- Model ICB Blueprint
- Supreme Court Ruling
- Potential Industrial Action
- Trust Operational Performance
- Emergency & Urgent Care Campus Opening
- Visit from Mayor of Greater Manchester
- Success & Celebrations

1. Purpose of the Report

The purpose of this report is to inform the Board of Directors of key strategic and operational developments, alongside recognition of key successes and celebrations.

2. NHS Performance Assessment Framework

NHS England (NHSE) are currently consulting on the updated NHS performance assessment framework for 2025/26. The intention is to publish the final framework at the end of Q1, with the first formal segmentation of all trusts and integrated care boards (ICBs) being undertaken and published in July.

The new framework seeks to enhance accountability and clarify the roles and responsibilities of NHSE, ICBs and providers:

- NHSE will focus on performance improvement and support for the three government shifts.
- The role of ICBs as strategic commissioners with responsibility to assess population need and arrange services to meet those needs.
- Providers remain responsible for the provision of high-quality services, with an expectation to comply with the NHS provider licence and contractual obligations.

NHSE's assessment of providers and ICBs will measure their delivery against an agreed set of metrics. The proposal is to use fewer metrics, focused on short-term priorities, to calculate a segment decision. The segments will range from 1 (high performing) to 4 (low performing). Organisations with the most intense support needs will enter the recovery support programme (RSP) and will be allocated a segment of 5.

As part of the assessment process, NHSE will also assess the leadership capability of providers and ICBs, based on qualitative information including reports from other regulators such as the Care Quality Commission (CQC). Insights gathered from these assessments will not influence the segmentation score but will be used alongside segmentation scores to direct performance improvement activities and support or intervention.

The draft framework states that providers will not have their scores adjusted to reflect wider system performance and any organisation reporting a financial deficit is limited to segment 3 (but may still be placed in segment 4 or 5).

NHSE state that the framework is intended to support providers and ICBs, see high performing systems across the country and embed earned autonomy and incentives. Whilst supporting poorly performing organisations, NHSE intend to work with high performing organisations to shape and drive national policy and to test new models of care.

3. Model ICB Blueprint

In May 2025, NHSE shared the first version of the Model ICB Blueprint. This sets out expectations for ICB's to deliver a 50% reduction in their running costs by the end of Q3 2025/26 and maintained on a recurrent basis into 2026/27. The blueprint makes clear that savings cannot be achieved by shifting costs to providers unless this results in a genuine net saving.

The blueprint also sets out the refreshed role for ICBs as strategic commissioners, and the system leadership role in improving population health, reducing inequalities, and ensuring access to high-quality care.

To support changes, the blueprint sets out which existing functions should be further developed to support a more focused role for ICBs, and which should be transferred to other parts of the system including providers.

4. Supreme Court Ruling

On 16 April 2025, the Supreme Court ruled that the legal definition of a woman within the Equality Act (2010) is based on biological sex. We are awaiting national guidance about what that will mean for our workforce and the services we provide and will provide further updates as we know more. Whilst we await further guidance, we have started reviewing implications in readiness.

We are fully committed to ensuring every patient receives quality care that meets their needs and upholds their privacy and dignity, that our staff are safe and comfortable at work.

5. Potential Industrial Action

In May 2025, the BMA (British Medical Association) announced they were balloting Resident Doctors on industrial action, related to the 2025/26 pay award. In addition, Unison is balloting their members to ascertain if they are prepared to take part in strike action. At this moment in time, the Trust is awaiting the outcome of both ballots which will become known early July.

6. Trust

6.1 Operational Performance

At the start of 2025/26, the Trust has continued to face operational challenges. Performance against both the Emergency Department 4-hour standard and 12-hour trolley waits were below the national access standard, albeit there has been improvement in the 4-hour standard with performance for April above the planned improvement trajectory.

Performance for elective care is also challenged, with the latest referral to treatment (RTT) performance below national access standards, notwithstanding significant improvements in reducing those patients with the longest waits. Diagnostic performance has seen a deterioration, with notable pressures in Audiology, as previously reported to the Board of Directors, and some clinic capacity now to be reinstated for Paediatric Audiology. The Trust is achieving cancer standards.

6.2 New Emergency Department Entrance Open

The first patients were accepted into the new improved Emergency Department entrance, as the major Emergency and Urgent Care Campus (EUCC) project came to completion in May 2025, following three years of work from our capital projects team and colleagues, together with contractors Tilbury Douglas.

6.3 Visit from Mayor of Greater Manchester

Our pathology lab had a successful visit from the Mayor of Greater Manchester, Andy Burnham, to witness the transformative impact of digital pathology on patient care and medical diagnostics. He met with Deputy Chief Executive, John Graham and pathology staff who demonstrated how digital pathology is revolutionising the field and enhancing patient care, modernising medical diagnostics and reducing turnaround times for patients waiting for test results.

7. Successes & Celebrations

7.1 International Midwife & Nurses Day

In May we celebrated both International Day of the Midwife (5 May) and International Nurses' Day (12 May). The two days offered a chance for us to reflect on and share our appreciation for all our

midwifes and nurses. I would like to express my thanks to our midwifes and nurses for their unwavering professionalism, hard work and compassion.

7.2 Veteran Aware Reaccreditation

The Trust has recently been reaccredited as a Veteran Aware Trust. In May, the Trust received confirmation from the Veterans Covenant Healthcare Alliance which recognised the significant work undertaken since the trust's initial accreditation awarded in 2019. The letter thanked all involved in demonstrating commitment to the Armed Forces Covenant and being an exemplar of the best standards of care for the Armed Forces community.

7.3 Bronze award from the North West Black Asian and Minority Ethnic Assembly

The Trust received a bronze award from the North West Black Asian and Minority Ethnic Assembly for the development of its anti-racist work. The award recognised the success of the trust's anti-racist initiatives, which were the result of partnership between its inclusion and colleague experience team, patient experience team, and its race equality staff network members, with support from the Trust's board of directors.

7.4 Public Sector Catering Awards

Congratulations to the Catering Team, who are finalists in the 'Hospital Catering Team of the Year' category at this year's Public Sector Catering Awards, which celebrate the highest standards in the industry. The team have triumphed at the Public Sector Catering Awards in previous years, as well as receiving other awards, including the title of 'exemplar site' from NHS England for other catering teams to follow.

NHS Stockport NHS Foundation Trust

				Agenda No.	8
Meeting date	5 June 2025	**Public**	**X**	**Confidential**	
Meeting	Board of Directors				
Report Title	Operational Plan 2025/26 – Final Submission				
Director Lead	Paul Buckley, Director of Strategy and Partnerships	**Author**	Andy Bailey, Deputy Director of Strategy & Partnerships Angela Dawber, Head of Strategy & Partnerships		

Paper For:	**Information**	X	**Assurance**		**Decision**	
Recommendation:	The Board are recommended to note the update on the final operational plan submission and the summary plan on a page.					

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

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

This paper relates to the following Board Assurance Framework risks

✓	PR1.1	There is a risk that the Trust does not deliver high quality care to service users
✓	PR1.2	There is a risk that patient flow across the locality is not effective
✓	PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan
✓	PR2.1	There is a risk that the Trust is unable to sufficiently engage and support our people's wellbeing
✓	PR2.2	There is a risk that the Trust does not actively participate in local collaborative programmes/neighbourhood working to improve primary and secondary health outcomes
✓	PR3.1	There is a risk that place-based partnership working does not effectively support delivery of Stockport ONE Health & Care (Locality) Board priorities and address health inequalities in

		Stockport
✓	PR3.2	There is a risk that partnership working in Greater Manchester do not effectively address unwarranted variation of services and improve health inequalities
✓	PR3.3	There is a risk that opportunities for collaboration between Stockport NHS Foundation Trust and Tameside & Glossop Integrated Care NHS Foundation Trust are not optimised
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✓	PR7.3	There is a risk that the Trust does not materially improve environmental sustainability
✓	PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus

Where issues are addressed in the paper

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

Executive Summary

The purpose of this report is to provide a summary of the material changes in our final operational plan submission. Tameside and Glossop Integrated Care NHS Foundation Trust plans are also included for information.

These matters have previously been considered by respective Board of Directors through the extraordinary meetings held in April to consider the requirements to submit a complaint plan(s) covering operational performance, finance and workforce.

For Stockport

- **ED 4hr performance** – delivery against 78% target in March 2026 only (no further change to trajectory)
- **Diagnostics DM01** – delivery of a compliant plan by year end, on the basis that the ICB supports a solution resulting in mutual aid for the paediatric audiology patients on the Stockport waiting list. Plan assumes a resolution is in effect from 2nd half of the year

- **Workforce** - adjusted to include additional Bank and Agency target reductions (-76.33 WTE) and a 50% reduction in corporate growth compared with 2018/19 (-4.74 WTE)
- **Financial plan** - commitment to deliver revenue control total of £43.2m, subject to GM assurances regarding additional income and Future Funding Flows.
- **Capital plan** - no changes, compliant plan as per previous board agreement.

For Tameside

- **ED 4hr performance** – delivery against 78% target in March 2026 only (no further change to trajectory)
- **RTT time to first appointment** – amended trajectory in line with national target set for the trust
- **Workforce** - adjusted to include reduction in WTEs to incorporate CIP/TEP resulting in a net reduction from 2024/25 of 77WTE (last submission was 0 reduction)
- **Financial plan** - commitment to deliver revenue control total of £31.8m, subject to GM assurances regarding additional income and Future Funding Flows.
- **Capital plan** - no changes, compliant plan as per previous board agreement

Both final submissions are reliant upon the support outlined from the ICB to achieve the revenue financial control totals.

A summary plan on a page has been devised to reflect the submission made (**Appendix 1**). Additional detail to support the summary plan on a page has been developed that reflect the wider plans for 2025/26 that will be shared across the Trust

Appendix 1 – Summary Plan on a Page

C Compassion | A Accountability | R Respect | E Excellence

NHS Stockport NHS Foundation Trust

Reducing Waiting Times

- Reduce the waiting list by **6,657**
- Nobody waiting over 52 weeks
- **65%** seen within 18 weeks
- **67%** for first appointment
- **85%** day case rate
- **85%** theatre utilisation
- **<5%** diagnostics over 6 weeks

Improving Emergency Care

- **78%** seen in ED within 4 hrs by Mar 2026
- Reduce 12 hour waits to **10.5%**
- Average ambulance handover 27 mins – none over 45 minutes
- Over **70%** urgent community responses within 2 hours

Improving Quality

- Surpass national cancer standards
  - **80%** diagnosed in 28 days
  - **75%** seen in 62 days
  - **91%** treated in 31 days
- Reduce length of stay
- **£35.4m** Capital Programme

Improving Productivity

- Balanced financial position
- Deliver **£29.2m** Trust Efficiency Programme
- Cap agency spend at **£6.3m**
- Cap bank spend at **£30.9m**
- DNA rate target of less **6.3%**
- Increase PIFU rates to **5%**

Supporting our Workforce

- Improve staff retention to **11.5%**
- Reduce sickness rates to **5.5%**
- **1%** reduction in WTEs via Trust Efficiency Programme
- **11%** reduction in bank staff
- **31%** reduction in agency staff

Reducing Inequality

- **80%** virtual ward occupancy
- No community waits over 52 weeks

Stockport NHS Foundation Trust
Operational Plan 2025/26

NHS Stockport NHS Foundation Trust

				Agenda No.	9.1
Meeting date	5 June 2025	**Public**	X	**Confidential**	
Meeting	Board of Directors				
Report Title	Corporate Objectives and Key Outcome Measures End Year Outcome 2024/25 and Outcome Measures 2025/26				
Director Lead	Paul Buckley, Director of Strategy and Partnerships	**Author**	Matthew Edwards, Strategy and Partnerships Manager		

Paper For:	**Information**		**Assurance**		**Decision**	X
Recommendation:	The Board are asked to: a) Note the end-of-year progress against the key outcome measures for 2024/25. b) Approve the key outcome measures for 2025/26.					

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

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

This paper relates to the following Board Assurance Framework risks

✓	PR1.1	There is a risk that the Trust does not deliver high quality care to service users
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Where issues are addressed in the paper

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

Executive Summary

This paper reports on end-year progress against the Trust objectives key outcome measures for 2024/25. It also includes the key outcome measures for 2025/26.

Corporate Objectives and Key Outcome Measures
End Year Outcome 2024/25 and Outcome Measures 2025/26

1. Purpose

1.1 The purpose of this report is to present an end-year progress report against the Trust's corporate objectives key outcome measures for 2024/25.

1.2 The report also includes the key outcome measures for 2025/26.

2. Background

2.1 Following approval by the Trust Board to maintain the same overarching Corporate Objectives for 2024-25, a set of key outcome measures were developed. These allow the Executive Team and Board to monitor key programmes of work, enabling the Trust to meet its statutory obligations and deliver its strategic plans.

3. Progress Update

3.1 The report indicates progress using a Red, Amber and Green (RAG) rating system. Red indicates this has not been delivered in year as planned, amber has progressed but not achieved as planned and green has been achieved.

3.2 Out of the 50 objectives, there were 7 recorded as red, 12 recorded as Amber, 31 recorded as green (**Appendix 1**).

3.3 There are some acronyms used in the report, which are highlighted below:

ACP- Advanced Clinical Practitioners
CNST- Clinical Negligence Scheme for Trusts
CSL- Civility Saves Lives
EIA- Environmental Impact Assessment
EUCC- Emergency and Urgent Care Campus
FBC- Full Business Case
FTSU- Freedom to Speak Up
ITT- Invitation to Tender
LMNS- Local Maternity and Neonatal System
NEETS- Not in Employment, Education or Training
OBC- Outline Business Case
PIFU- Patient Initiated Follow Up
PSIRF- Patient Safety Incident Response Framework
StARS- Stockport Accreditation and Recognition Scheme
UTC- Urgent Treatment Centre
WEG- Workforce Efficiency Group
YTD- Year to Date

4. Key Outcome Measures for 2025/26

4.1 The Trust's corporate objectives flow from national guidance, regional and locality plans, which and are reflected in the Executive Directors objectives set each year. For

2025/26 the remain the same and are a joint set with Tameside and Glossop Integrated Care NHS Foundation Trust (T&G).

4.2 The key outcome measures are included in **Appendix 2**. Again, these are a joint set with T&G.

5. Recommendation

5.1 The Board are asked to;

a) Note the end-of-year progress against the key outcome measures for 2024/25.
b) Approve the key outcome measures for 2025/26.

Appendix 1 - Key Outcome Measures 2024/25

1 - Deliver personalised, safe and caring services		
Key Outcome Measures *How will we know we will have achieved our objectives?*	**RAG Rating**	**End of Year Progress**
Deliver national waiting time / performance requirements, including: • 78% seen within 4hrs in ED by March 25	R	The Trust put forward a trajectory of 65.0% for the end of March 2025, which was over-achieved with a performance of 69.0%. This includes both T1 and T3 activity, T3 includes SHH and Community UTC
• 92% bed occupancy for G&A, Paeds and Adult Critical Care across 2024/25	G	Average bed occupancy for the total G&A bed base YTD stands at 93.1% which is in line with trajectory. However, broken down by area sees a higher occupancy across the adult bed base of 93.5%, and lower occupancy in paediatric and critical care areas (Paediatric G&A 60.3%, Adult Critical Care 67.7%)
• Maintain zero waits of over 65 weeks for elective care by Sep 24	G	The position at the end of March-25 was 34 patients waiting over 65 weeks. Many of these remaining patients were due to patient choice or complexity factors. This represents a 94.9% reduction over the past year.
• Reduce waits of over 52 weeks for elective care by end of Mar 25	G	The position at the end of March-25 was 1644 patients waiting over 52 weeks. This represents a 45.4% reduction over the past year.
• 77% performance against cancer faster diagnosis standard by Mar 25	G	The Trust delivered and remained ahead of its improvement trajectory throughout the year, exceeding the 77% national target for 8 out of 12 months. Forecast end of March-25 position is 82.2%
• 70% performance against cancer 62 day waits standard by Mar 25	G	The Trust delivered and remained ahead of its improvement trajectory throughout the year, exceeding the 70% national target for 8 out of 12 months. Forecast end of March-25 position is 73.2%.
• 95% performance diagnostic tests in under 6 weeks by Mar 25	A	The position at the end of March-25 was 76.7%. A pause in the paediatric audiology service has been the primary driver for this deteriorated position. Challenges are also being experienced in MR scanning, Endoscopy and Echocardiography. Recovery plans are in place for those areas and the Trust continues to increase activity internally and through the Community Diagnostic Centre
• Improve access to virtual wards by ensuring utilisation is consistently above 80%, with a focus on frailty, acute respiratory infection, heart failure and CYP.	R	The position at the end of March-25 was 56.45% utilisation of the 50 available Virtual Ward beds: a deterioration from December position. (73.48% of the beds utilised were attributed to admission avoidance and 26.52% step down.) Deep Dive is being undertaken to understand the reasons for the drop in referrals.
• 85% Theatre Utilisation	A	Stockport CTTU is 80.1% which is above the national average. Specialty level analysis is being undertaken with trajectories and action plans in place. Booked utilisation increased to 107%. Hospital on the day cancellations reduced by 30%. Average late starts time decreased to 35 minutes, (below national average). A review of procedure times and coding is being undertaken.
• Proportion of all outpatient attendances that are for first appointments or follow-up appointments attracting a procedure tariff to 46% across 2024/25	R	Stockport rate is 43.3% for 24/25, lower than the national requirement and slightly lower than the 44% submitted operational plan. Stockport is in the second quartile and benchmarks against a national rate of 44.7% and GM Peers 43.3%. An electronic

1 - Deliver personalised, safe and caring services		
Key Outcome Measures *How will we know we will have achieved our objectives?*	**RAG Rating**	**End of Year Progress**
		clinic outcome system (CLIO) has been developed and implemented alongside a review of coding of procedures being undertaken in outpatient clinics.
To ensure the new Patient Safety Incident Response Framework (PSIRF) is embedded across the organisation.	G	PSIRF related processes were trialled and tested in 2023/24 with a formal launch and full transition completed on 1st April 2024. Throughout 2024/25 the way in which the Trust responds to patient safety incidents has been in line with the new national requirements and work to embed the changes across all areas of the Trust has been ongoing. Trust has developed a Patient Safety Incident Response Plan. The Trust is currently reviewing the ongoing training requirements for the organisation relating to PSIRF and related learning responses including patient safety incident investigations (PSII), After action review (AAR), multi-disciplinary team responses (MDT), SWARM huddles etc. This will be a key priority for 2025/26 for the organisation to ensure that skills are embedded across the organisation.
To improve the quality and safety of our services through delivery of the Quality and Safety Strategy Objectives for 2024/25.	G	Progress towards objectives is regularly communicated to Quality Committee, which includes. • Being on Track with progress against implementation of Saving Babies Lives Care Bundle Implementation Plan v3 as detailed in CNST - Year 6 successfully achieved • Smoking At Time of Delivery National Target 4.0%- At end of March 2025, the Trust is on an upward trajectory, currently 7.14%. There is an action plan place • Transition for young people to adult services continues to be a priority. NHS E has extended funding for a further year to ensure the TYA project for Diabetes can continue this vital work for the transition of young people into adult services. • Target of 5% Reduction in overall number of falls per 1000 bed days (BD) = Ratio 2.68 per 1000 BD. Current 598 = 2.64 per 1000 BD. • 90% target for Timely recognition of Sepsis. Currently at 96% (rolling 12 month performance).
Continue to implement the three-year delivery plan for maternity and neonatal services, including making progress towards the national safety ambition. McCarthy Rebecca 29/05/2025 17:56:54	G	Quarterly submissions provided to LMNS shows progress being on track for full implementation of all 4 themes of the plan. Trust is fully compliant with all ten safety actions for CNST year 6. CNST year 7 launched on 2 April 2025. Joint LMNS and Regional team visit on 15th October 2024 to review Maternity & Neonatal collaborative working, final report received December 2024 with recommendations for areas to be focused on, action plan in place to be monitored through divisional & regional governance processes. Next annual visit is November 2025. Neonatal - Fi Care re- accreditation completed in November 2024, have sustained Green. Neonatal team remain compliant with all but one BAPM standard, which relates to tier 1 medical cover, business case is with the Specialist Commissioner for review and decision.

1 - Deliver personalised, safe and caring services		
Key Outcome Measures *How will we know we will have achieved our objectives?*	**RAG Rating**	**End of Year Progress**
To continue the roll out of the StARS Accreditation Programme, improving the number of areas achieving 'green' and 'blue' status.	G	As of March 2025, 17 areas attained Blue StARS status, increase of 7 from previous year. 6 areas successfully retained their Blue StARS status, with 1 area pending panel attendance. This reflects established quality, and safety practices and demonstrates full team engagement with the StARS accreditation programme. All targets set for 2024/2025 were exceeded. With more areas now achieving green and blue status, frequency of assessments has been reduced, allowing for potential expansion of the program. Collaboration ongoing with colleagues from Clinical Scientific Services to develop StARS standards for outpatient areas.

2 - Support the health and wellbeing needs of our community and colleagues		
Key Outcome Measures *How will we know we will have achieved our objectives?*	**RAG Rating**	**End of Year Progress**
To support the Health & Wellbeing of our colleagues through a range of Health & Wellbeing initiatives, reducing sickness and absence levels.	A	Our March 2025 end of year rolling sickness level was 5.83% against a target of 5.5%. This is split by 1.87% short term and 3.96% long term absence. In March 2024 our overall sickness rate was at 4.92% this sickness rate increased to 6.28% in July 2024 and to 6.42% in December 2024 and has been reduced to 5.51%. This is slightly higher than the previous year which has seen a higher level of Noro virus. Long term sickness levels have returned to their lowest levels in 12 month (3.38% from a height of 4.32% in July 2024). We continue to deliver a range of health and wellbeing initiatives, to support staff to remain in work, reduce absence length and return to work as soon as possible, with reasonable adjustments in place.
To take an active role in the delivery of Locality Provider Collaborative programmes to improve primary/secondary health and wellbeing outcomes through evidence-based interventions.	G	Trust is fully engaged in a range of collaborative programmes of work across the locality. Trust has progressed the planned review of the current priorities and also the role of the provider partnership group, which is due to complete in Q1 2025.
The Trust Strategy is refreshed during Q4 following the appointment of a new chair	R	Initial engagement has taken place with the Board and a revised strategic framework supported. Timeline and process are due to be considered by the Board in Q1 2025 that will see a new joint organisational strategy being developed with Tameside & Glossop ICFT a planned timescale for completion is the end of Q1 2026/27.
The Trust Planning round is undertaken and completed in Q3-Q4 2024/25.	G	A joint Planning Executive oversight group is now in place as is a planning team to oversee the planning round both externally and internally. The Trust is engaged with the GM planning hub and the locality to ensure plans are robust and aligned. A summary operational plan is being developed.

3 -Develop effective partnerships to address health and wellbeing inequalities.		
Key Outcome Measures *How will we know we will have achieved our objectives?*	**RAG Rating**	**End of Year Progress**
To progress further integration of corporate functions across Tameside and Stockport which includes HR, BI, IT, Strategy and Estates.	G	Each Director has identified areas that have been the subject to Executive Team review and update to the Board that demonstrate what has been and what will be done in support of corporate/non-clinical integration.
To develop joint working opportunities for collaboration between Tameside & Glossop and Stockport within the priority clinical services identified; Gastroenterology & Radiology.	G	The joint Clinical Service Partnerships Group continues to oversee this work and has seen progress within Radiology, Gastroenterology and more recently Pharmacy services. All Divisional Strategies have been completed and the final work to draw the outputs of this into a new joint Clinical Strategy with Tameside & Glossop ICFT is in progress and due to complete at the end of Q1 2025/26.
To monitor the benefits of collaboration between Tameside & Glossop and Stockport	G	Process is in place to identify and monitor the anticipated benefits associated with the collaborative work between both Trusts. This will be brought to the Executive Team for review and reported to the Board thereafter in the next scheduled update in October 2025.
To increase participation and awareness of the wider partnership agenda across locality and GM collaborative programmes e.g. GM Sustainability Plan	G	Reports covering pertinent matters from within the locality was presented to the Board in October and April. Relevant matters within GM have been covered with various reports to the Board. A new GM update is to be provided in October 2025. The Trust was engaged in the development of the locality sustainability plan.
Continue to address health inequalities and deliver on the Core20PLUS5 approach, for adults and children and young people	G	The Trust has completed a self-assessment, held a Board Development Session and established an internal multidisciplinary Health Inequalities Group. A Health Inequalities workplan is in place
Support the locality vision for development of an intermediate care facility ensuring it supports the needs of the Trust and Community Patient Population.	A	Trust continues to work with the local authority on the St Thomas' development in order to resolve to the queries following a review by the Board of the Outline Business Case. Continued discussions taking place to determine the final operational arrangements, which will determine the Trust's role in the provision of services

4 - Develop a diverse, talented and motivated workforce to meet future service and user needs		
Key Outcome Measures *How will we know we will have achieved our objectives?*	**RAG Rating**	**End of Year Progress**
To continue with the OD, Talent and Leadership Plan, strengthening leadership and management approaches, fostering and improving working relationships within teams and across the organisation.	G	Continue to strengthen our approach to developing positive working relationships across the Trust, evidenced in our 2024 staff survey scores – moving from a score of 6.71 in 2022 to 6.90 in 2024. Key achievements include: • Enhanced our leadership & management development offer through introduction of coaching skills training course, 1-day introduction to compassionate & inclusive leadership course, appraisals with impact training, inclusive recruitment training etc. • Designed and launched new multi-disciplinary 'Leading with Impact'

4 - Develop a diverse, talented and motivated workforce to meet future service and user needs		
Key Outcome Measures *How will we know we will have achieved our objectives?*	**RAG Rating**	**End of Year Progress**
		Development Programme. To date 30 individuals on band 8A and above, including Medical Consultants and Clinical Directors have started the programme. • Provided OD consultancy support to help improve working relationships. • Designed and launched the new C.A.R.E. values & behaviours and introduced the new Let's Talk Conversation Toolkit to help improve appraisal and 121 discussions. • Delivered phase 1 of the Trust's Civility Saves Lives Programme – 48% of the workforce attended the CSL awareness session. This is now being followed by phase 2 of the programme. • Delivered a sexual safety pilot training programme between October and December 2024. Pilot has been evaluated and informed a roll-out plan starting in Q1 2025-26.
To develop workforce plans that builds on the future workforce requirements, new roles, apprenticeships and is in line with the NHS Long Term Workforce Plan.	G	Workforce approach has been to develop plans to fill our vacancies, reducing reliance on temporary staffing. Maximising our grow our own priorities creating internal career pathways with 58 ACPs with a further 9 in September. We have supported development of nursing and AHP colleagues through apprenticeships; we increased the number of live apprentices to 196 across 36 distinct apprenticeship programmes aiding workforce development.
Continue implementation of the Equality, Diversity & Inclusion Strategy focussing on progression/talent management and improving colleague experience.	A	The Trust continues to implement the EDI Strategy 2022-25. In the last 12 months, we have had a specific focus on the following areas to help accelerate the progress of our EDI journey: • Inclusive recruitment: The target was to reduce the score to under 1.5, however a score of 1.61 shows a worsening position. • Becoming an anti-racist organisation: We have been accredited as Bronze by the NW BAME Assembly, Anti-Racism Framework. 2 other Trusts within Greater Manchester are bronze award holders. • Bullying and harassment: BAME staff reporting bullying is 15.32%. This is above target but an improvement in the previous 12 months. Disability/long-term health condition was 16.81%, a worsening position on the previous 12 months. (Target=<10%; currently 16.81%)
Continue to build the Place-Based collaborative working partnership with the Local Authorities within Tameside & Stockport, working with colleges in both localities to co-create and deliver employment opportunities for our residents of Stockport and Tameside.	G	Strengthened collaboration with partners inc: Stockport MBC, Department for Work and Pensions, Trafford and Stockport College Group, Manchester College, UCEN Manchester college and the King's Trust. Offering opportunities for work experience and pre-employment programmes for Young Care Leavers, long term unemployed, and young people not in employment, education or training (NEET). Increased the number of T levels by 80% from 100 and led the way in GM to expand placement opportunities to include areas such as maternity. 24 Pre-Employment Placements have taken place (inc NEETS & Young Care Leavers)

4 - Develop a diverse, talented and motivated workforce to meet future service and user needs		
Key Outcome Measures *How will we know we will have achieved our objectives?*	**RAG Rating**	**End of Year Progress**
		with 14 individuals gaining employment post programme. We have facilitated 184 Work Experience placements.
To reduce bank and agency usage, particularly premium expenditure in line with NHSE targets.	A	The Trust Workforce Efficiency Group (WEG) continues to focus on temporary staffing expenditure. In March 2025, 1.93% of total pay bill related to agency usage, below the 2024/25 target of 3.2%, Agency price cap compliance increased to 63% in March 2025 which is above NW NHSE target of 60%. Revised medical bank rates, agreed across GM, to be implemented from May 2025.
Increase staff retention and attendance through implementation of all elements of the People Promise retention interventions	G	Turnover rate in March 2025 was 10.84% - below our target of 12.5%, and a decrease of 0.07% compared to Feb 2025. In April 2024 this was 11.4%. Turnover saw a notable decrease between October 2024 and January 2025. A career progression task group has been established for delivering specific EDI actions. Our grow our own initiatives have supported Health Care Support Workers to progress onto funded Student Nursing Associate and Degree Nurse Apprenticeships – 6 qualified in July 2024 with a further 20 on programme due to qualify in 2025.
To respond proactively to staff survey feedback to demonstrate improvements.	G	The overall response rate was 45.3% which was 1.8% higher than the previous year (43.5%). Improved scores for 1 of the 9 People Promise elements/themes (not statistically a significant change): We work flexibly. Showed a decreased score for 8 of the 9 People Promise elements/themes (though not statistically a significant change). 2 (2%) questions showed a significant improvement. 10 (9%) showed a significant decline. 95 (895) of the questions showed no significant movement. Stockport's results were the second highest in GM amongst peer provider organisations. Utilising the 2024 staff survey results to target particular interventions such as reasonable adjustment training, big conversation sessions, and promoting phase two of the CSL Programme which are 'Having the Conversation' sessions.

5 - Drive service improvement through high quality research, innovation and transformation.		
Key Outcome Measures *How will we know we will have achieved our objectives?*	**RAG Rating**	**End of Year Progress**
Develop locality-wide research programmes through facilitation of system wide trials.	A	For 2024/25: 29 new studies opened at Stockport across 14 specialities, compared to 39 new studies across 17 specialities in 2023/24. This decrease if predominantly due to studies coming into the portfolio with increased complexity compared to the previous year as well as more limited staffing in the RD&I office to support the project management around an increased volume of new study set-

5 - Drive service improvement through high quality research, innovation and transformation.		
Key Outcome Measures *How will we know we will have achieved our objectives?*	**RAG Rating**	**End of Year Progress**
		up opportunities.
To implement the Trust Research and Development Strategy objectives for 2024/25.	A	Strategic delivery of the 5-year RD&I strategy is coming to its mid-point at the end of 2024/25 with ~70-75% on target: Key areas to work on continue to be: Improving the research infrastructure and development of a full quality management system across the 2 sites to provide consistency and efficiency in research delivery, as well as focussing on increasing our commercial portfolios for income generation to sustain our current and future research delivery workforce. .
To implement the Trust Transformation & Service Improvement strategy objectives for 2024/25.	G	SFT Transformation Team have supported with 21 different improvement schemes throughout the year. We developed a joint Continuous Improvement Strategy, aligned to the NHS IMPACT Framework. Completed year one of our implementation plan, with plans commencing for year 2.
To deliver, in partnership, the Community Diagnostic Centre, to the agreed specification by Q3 2024/25.	G	CDC opened on 1st August 2024. Provision of MR/CT/Dexa scanning & ECHO with over 10,000 patients seen in the first six months. Full IT integration work progressing. Addition of Ultrasound completed in March 2025.
To complete an update of the Trust's website.	R	Work has continued but a revised completion date is now October 2025.

6 - Use our resources efficiently and effectively.		
Key Outcome Measures *How will we know we will have achieved our objectives?*	**RAG Rating**	**End of Year Progress**
To deliver the Trust's Financial, Revenue and Capital Plan.	G	The Trust ended the financial year 2024/25 £16.9m adverse to plan. This is £0.4m favourable to plan for GM ICB system reporting purposes, which is the agreed out-turn position.
To deliver the Trust's financial efficiency programme (STEP/CIP).	G	The Trust delivered the full £24.6m savings target in 2024/25. Recurrently £7.1m was delivered, which is a £5.2m shortfall for 2025/26.
To complete the final accounts for the year end which receive a compliant audit report.	G	Final accounts completed and external audit review underway. On track to deliver as planned.
To improve operational and clinical productivity, making full use of the opportunities highlighted through GIRFT, The Model Health System and other benchmarking and best practice guidance.	G	Trust performance report encompasses the following metrics (Theatre Productivity/ utilisation, Patient per list, Outpatient utilisation, Remote attendances, DNA rates, PIFU rates, Utilisation of A&G and LOS – Elective & non-elective) to help improve operational and clinical productivity. The Trusts internal GIRFT 'Further Faster' programme is well embedded and has supported improved performance against several metrics through identifying areas of opportunity and best practice, benchmarking using model health system data, and shared learning. Trust is in the top quartile nationally for PIFU and A&G and has made gradual improvement on theatre utilisation and DNA rates

7 - Develop our Estate and Digital infrastructure to meet service and user needs.		
Key Outcome Measures *How will we know we will have achieved our objectives?*	**RAG Rating**	**End of Year Progress**
To complete the Emergency Department (ED) expansion scheme.	A	The ED expansion scheme is now due to be completed in May 2025 following delays within the programme.
To complete the Meadows PFI hand back process.	G	The Meadows PFI hand back process has completed in September 2024. A further piece of work has been taken forward on the facility being transferred to Pennine Care NHS FT which is planned to complete in May 25.
To complete the EPR Business Case and recruitment process across both Tameside and Stockport	A	The OBC was passed by national EPRIB (EPR Investment Board) on December 11th, 2024. The Trust published ITT (Invitation to Tender) on the 3rd of April 2025. Contract Award Decision expected August 2025.
The rollout of the new digital Laboratory Information System is completed.	A	Cellular pathology & Microbiology due to go live in June 2025. Biochemistry, Haematology & Blood Transfusion implementation due September 2025, following analyser replacement programme completion
To agree a plan for the replacement or refurbishment of the Beech House datacentre to mitigate significant issues with cooling equipment.	R	Feasibility study completed and initial options generated, which are being reviewed to ensure any solution is both affordable and delivered in a shorter timeframe. Updated business case will be produced with a view that an approved scheme will be taken forward in 2026/27. Mitigations in place are reflected in updated business continuity plan.
To develop and implement a Way Finding Strategy.	R	There has been a series of workshops held with multiple stakeholders to look at the development of a way finding strategy which commenced in April 2025.
To deliver the Trust's Green Plan objectives for 2024/25	G	Joint Green Plan in development to be presented to board in summer of 2025. Over the past 12 months, Trust has made positive progress to promote Net Zero Clinical Transformation. Other key projects delivered this year include: • 8 large trees planted on site to improve nature and greenspace • Staff travel survey completed • Improved waste segregation • Your Medicine Matters encouraging patients to bring their own medicine into hospital • 10% social value included in tenders to understand suppliers commitment to net zero • Continued to review the restaurant and patient menu and introduced lower carbon dishes
To continue to engage key stakeholders in the development of the new hospital OBC and to complete a transition plan for the hospital site to address the poor capital stock.	A	Strategic Outline Business Case for new hospital has been completed. Existing property stock within the Trust is being managed within current constraints. Priorities will be reevaluated and further updates provided after commencement of new Executive Director of Estates and Facilities across both trusts in June 25.
To develop a business continuity plan for Pathology services to address the fragility of the estate.	G	Outline scheme has been developed with estates for the minimum requirement for an on-site Pathology service that supports acute services. Capital funding not

7 - Develop our Estate and Digital infrastructure to meet service and user needs.		
Key Outcome Measures *How will we know we will have achieved our objectives?*	**RAG Rating**	**End of Year Progress**
		available at present to support further progression. Work ongoing to identify alternative options in the event of building failure.
To progress the revised TIF scheme to build a new Outpatient facility subject to NHSE approval.	G	Business case approved. Building is being progressed at pace following the completion of the re-design. Building is scheduled to be completed at the end of August so will be operational in September 2025.

Appendix 2 - Key Outcome Measures 2025/26

	Key Outcome Measures *How will we know we will have achieved our objectives?*	Executive Director Lead(s)
1 - Deliver personalised, safe and caring services		
	Deliver national waiting time / performance requirements, including:	
	• Improve the percentage of patients waiting no longer than 18 weeks for treatment to 65% nationally by March 2026	JMcS/JOB
	• Improve the percentage of patients waiting no longer than 18 weeks for a first appointment to 72% nationally by March 2026	JMcS/JOB
	• Reduce the proportion of people waiting over 52 weeks for treatment to less than 1% of the total waiting list by March 2026	JMcS/JOB
	• Improve performance against the headline 62-day cancer standard to 75% by March 2026	JMcS/JOB
	• Improve performance against the 28-day cancer Faster Diagnosis Standard to 80% by March 2026	JMcS/JOB
.	• Improve A&E waiting times, with a minimum of 78% of patients admitted, discharged and transferred from ED within 4 hours in March 2026 and a higher proportion of patients admitted, discharged and transferred from ED within 12 hours across 2025/26 compared to 2024/25	JMcS/JOB
	To improve the quality and safety of our services through delivery of the Quality and Safety Strategy Objectives for 2025/26.	NF/JB
	Develop a joint quality strategy in Q3 2025/26.	PB
	Continue to implement the three-year delivery plan for maternity and neonatal services, including making progress towards the national safety ambition.	NF/JB
	To continue the roll out of the StARS Accreditation Programme, improving the number of areas achieving 'green' and 'blue' status.	NF/JB
2 - Support the health and wellbeing needs of our community and colleagues		
	To support the Health & Wellbeing of our colleagues through a range of Health & Wellbeing initiatives, reducing sickness and absence levels.	AB
	Develop a new joint operational planning process and complete in Q4 2025/26.	PB
	Develop a new joint organisational strategy by the end of Q1 2026/27.	PB
3 -Develop effective partnerships to address health and wellbeing inequalities.		
	To progress further integration of corporate functions across Tameside and Stockport which includes HR, BI, IT, Strategy and Estates.	All
	Develop a new joint clinical strategy by Q2 2025/26.	PB
	To develop joint working opportunities for collaboration between Tameside & Glossop and Stockport within the priority clinical services identified; Gastroenterology, Radiology, Pathology and Pharmacy.	PB
	Implement the health inequalities action plan and progress each of the underpinning actions within each of the five priorities.	DS/AL
	Support the locality vision for development of an intermediate care facility in Stockport ensuring it supports the needs of the Trust and Community Patient Population.	JMcS/PB
4 - Develop a diverse, talented and motivated workforce to meet future service and user needs		
	To continue with the OD, Talent and Leadership Plan, strengthening leadership and management approaches, fostering and improving working relationships within teams and across the organisation.	AB
	To develop workforce plans that builds on the future workforce requirements, new roles, apprenticeships and is in line with the NHS Long Term Workforce Plan.	AB
	Continue implementation of the Equality, Diversity & Inclusion Strategy focussing on progression/talent management and improving colleague experience.	AB
	Continue to build the Place-Based collaborative working partnership with the Local Authorities within Tameside & Stockport, working with colleges in both localities to co-create and deliver employment opportunities for our residents of Stockport and Tameside.	AB

	Key Outcome Measures *How will we know we will have achieved our objectives?*	Executive Director Lead(s)
	To reduce bank and agency usage, particularly premium expenditure in line with NHSE targets.	All
	Increase staff retention and attendance through implementation of all elements of the People Promise retention interventions.	AB
	To respond proactively to staff survey feedback to demonstrate improvements.	All
5 - Drive service improvement through high quality research, innovation and transformation.		
	To implement the Trust Research and Development Strategy objectives for 2025/26.	DS/AL
	To implement the Trust Transformation & Service Improvement strategy objectives for 2025/26.	KJ
	To complete an update of the Trust's website.	PN
6 - Use our resources efficiently and effectively.		
	To deliver the Trust's Financial, Revenue and Capital Plans.	All
	To deliver the Trust's financial efficiency programmes.	All
	To complete the final accounts for the year end which receive a compliant audit report.	JG
	To improve operational and clinical productivity, making full use of the opportunities highlighted through GIRFT, The Model Health System and other benchmarking and best practice guidance.	DS/AL
7 - Develop our Estate and Digital infrastructure to meet service and user needs.		
	To complete the EPR Business Case by January 2026 and recruitment process across both Tameside and Stockport by March 2026.	PN
	The rollout of the new digital Laboratory Information System is completed. T&G - October 2025 – Blood Transfusion; February 2026 - Microbiology SFT - June / July – Microbiology and Cellular Pathology; September / October – Biochemistry, Haematology and Blood Transfusion.	 JOB JMcS
	To develop and implement a Way Finding Strategy.	GH
	To deliver the Trust's Green Plan objectives for 2025/26	GH
	To continue to engage key stakeholders in the development of the new hospital OBC for Stockport and to complete a transition plan for the hospital site to address the poor capital stock.	GH
	To develop a business continuity plan for Pathology services to address the fragility of the estate.	JMcS/JOB
	To develop a car parking strategy for Stockport and implement year one of the agreed changes.	GH
	To develop a site rationalisation plan for Stockport by March 2026.	GH

NHS Stockport NHS Foundation Trust

Meeting date	5 June 2025	**Public**	X	**Agenda No.**	9.2
Meeting	Board of Directors				
Report Title	Risk Appetite Review 2025/26				
Director Lead	Karen James, Chief Executive	**Author**	Rebecca McCarthy, Trust Secretary		

Paper For:	**Information**		**Assurance**		**Decision**	X
Recommendation:	**The Board of Directors is asked to:** - **Review and approve the Trust's risk appetite to support development of the Board Assurance Framework 2025/26.**					

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

	Safe		Effective
	Caring		Responsive
X	Well-Led		Use of Resources

This paper relates to the following Board Assurance Framework risks

All

Where issues are addressed in the paper

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

Executive Summary

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

Following approval of the Corporate Objectives and Outcomes Measures 2025/26 by the Trust Board, the BAF 2025/26 will be developed. Recognising that risk appetite changes over time as the environment and operating conditions change, it is beneficial for the Trust Board to regularly review its risk appetite, particularly ahead of developing the BAF.

Since the Trust Board last considered its risk appetite in 2024/25, the operating environment remains one of notable financial and operational challenge. At the onset of 2025/26, longer-term NHS reform was announced in response to these challenges.

In this context, the Trust will be required to adopt an 'open' risk approach to finance, exploring all potential delivery options and transformational changes to deliver its control total and move to a position of greater financial sustainability. This approach has previously been supported by the Trust Board. Balancing this is a 'cautious' approach to risk relating to quality, specifically with regards to patient safety, and any new initiatives or procedures that could potentially increase the likelihood of harm to patients.

The Trust Board is asked to consider if any changes are required to the below risk appetite for 2025/26:

Risk Element	Risk Appetite
Finance / Value for Money	Risk Level: Open Risk Appetite: High
Compliance / Regulation	Risk Level: Cautious Risk Appetite: Moderate
Quality & Outcomes	Risk Level: Cautious Risk Appetite: Moderate
Reputation	Risk Level: Open Risk Appetite: High
People	Risk Level: Open Risk Appetite: High
Innovation	Risk Level: Seek Risk Appetite: Significant

1. Introduction

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

1.2 The Corporate Objectives and Outcomes Measures 2025/26 will be presented to the Trust Board for approval at its meeting in May 2025, enabling development of the BAF 2025/26.

2. Current Risk Appetite (2024/25)

2.1 The risk appetite considered and agreed by the Trust Board in June 2024, was as follows:

Risk Element	2024/25	Statement
Finance / Value for Money	Risk Level: Open Risk Appetite: High	We are prepared to accept some financial risk as long as appropriate controls are in place. We have a holistic understanding of VFM with price not the overriding factor.
Compliance / Regulation	Risk Level: Cautious Risk Appetite: Moderate	We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision.
Quality & Outcomes	Risk Level: Cautious Risk Appetite: Moderate	Our preference is for risk avoidance. However, if necessary, we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place.
Reputation	Risk Level: Open Risk Appetite: High	We are prepared to accept the possibility of some reputational risk as long as there is the potential for improved outcomes for our stakeholders.
People	Risk Level: Open Risk Appetite: High	We are prepared to accept the possibility of some workforce risk, as a direct result from innovation as long as there is the potential for improved recruitment and retention, and developmental opportunities for staff.
Innovation	Risk Level: Seek Risk Appetite: Significant	We will pursue innovation – desire to 'break the mould' and challenge current working practices. New systems / technologies viewed as a key enabler of operational delivery.

2.4 The basis of the above was:

- Risk Element: Finance – Board members discussed the adoption of a cautious versus open approach to finance risk, considering the significant financial scrutiny facing the Trust and GM ICS. Recognising the Trust's financial deficit and necessity to explore all potential delivery options to move to a position of greater financial sustainability, the Board agreed an 'open'

approach would be appropriate at this time. It was recognised that adoption of an 'open' approach would be balanced by a cautious risk appetite for Quality & Outcomes risks.

- Risk Element: Compliance/Regulation – Board members acknowledged the range of regulatory bodies, with potential for risk appetite to differ based on specific regulator, with a cautious approach adopted in the main.

- Risk Element: Reputation – Board members agreed that, in exploring all potential delivery options, it would be necessary to manage the challenges and risks that come with transformational change, therefore aligning with an 'open' risk appetite.

- Risk Element: People – Board members agreed to the continuation of an 'open' risk appetite, acknowledging the pilot of digital technologies within the People Directorate, which may be considered disruptive.

- More generally, Board members recognised the Risk Appetite Framework provided a framework to guide both optimal and tolerable positions in relation to risk in pursuit of strategic objectives. It was also acknowledged that decisions about specific investments, projects, and strategic initiatives would have interdependencies and considerations across the various elements of risk within the framework.

3. Risk Appetite Review 2025/26

3.1 Current Environment & Operating Conditions:

- Following election in 2024, the Government has set out its intention to reform the NHS. The NHS 10 Year Health Plan will be published in the Spring, focusing on 3 big shifts: from hospital to community, from analogue to digital, and from sickness to prevention, in turn helping to cut waiting times, tackle health inequalities and make the NHS sustainable.

- The Government has made clear that the NHS must live within its means, with focus on improving efficiency and productivity. In line with this, plans have been announced to abolish NHS England (NHSE) and integrate its functions with the Department of Health & Social Care (DHSC) over a two-year period. Integrated Care Boards (ICBs) have been requested to reduce costs by 50% and provider Trusts required to reduce corporate cost growth by 50% in 2025/26.

- As part of the 2025/26 operational planning, the Trust was required to reconsider initial financial plan submissions. The final financial plan for 2025/26, agreed as part of the Greater GM ICS, is a plan compliant with the control total (breakeven position). The plan is based on several assumptions relating to additional income, and achievement of a challenging Cost Improvement Programme (CIP).

- Activity plans for 2025/26 recognise achievement is contingent on the assumption of no further increases in demand, albeit this is unlikely to materialise.

- Workforce plans for 2025/26 are contingent on realisation of sickness absence improvement plans and continuation of improvement in recruitment and retention rates. However, there is potential for further industrial action during the year.

- Further collaboration and transformation with T&G ICFT, and across GM and Locality, is recognised as necessary to improve access for patients, achieve clinical standards, alongside improving operational performance, productivity and financial efficiency.

3.2 In April 2025, the Trust Board requested Quality Committee oversee the quality and safety impact of high-risk schemes to achieve the control total. In the first phase of its considerations, Quality Committee also considered if any change should be made to the risk appetite for ‘Quality/Outcomes’ and ‘Compliance/Regulation’ (Current Risk Level: Cautious, Risk Appetite: Moderate).

The outcome of the Quality Committee review was that there should be no change to risk appetite for these risk elements. However, acknowledging ‘quality of care’ refers to care that is safe, effective, and provides a positive patient experience, it was acknowledged that minimising risks and avoiding harm to patients would remain a priority, however a more tolerant approach may be needed when considering risks that impact patient experience. The Quality Committee agreed that the BAF 2025/26 would therefore include a principal risk in relation to each element of ‘quality of care’.

3.3 Further to the above, the Trust Board is invited to consider if any changes are required to the current risk appetite (as set out at 2.1).

Risk Appetite Framework

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

NHS Stockport NHS Foundation Trust

				Agenda No.	
Meeting date	5 June 2025	**Public**	X	**Confidential**	
Meeting	Board of Directors				
Report Title	Finance & Performance Committee – Alert, Advise & Assure Report				
Director Lead	Anthony Bell, Chair of Finance & Performance Committee	**Author**	Anthony Bell, Chair of Finance & Performance Committee Soile Curtis, Deputy Company Secretary		

Paper For:	**Information**		**Assurance**	X	**Decision**	
Recommendation:	The Board of Directors is asked to note the report from the Finance & Performance Committee including matters for escalation to the Board of Directors.					

This paper relates to the following Annual Corporate Objectives

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

This paper relates to the following CQC domains

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

This paper relates to the following Board Assurance Framework risks

	PR1.1	There is a risk that the Trust does not deliver high quality care to service users
X	PR1.2	There is a risk that patient flow across the locality is not effective
X	PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan
	PR2.1	There is a risk that the Trust is unable to sufficiently engage and support our people's wellbeing
X	PR2.2	There is a risk that the Trust does not actively participate in local collaborative programmes/neighbourhood working to improve primary and secondary health outcomes
X	PR3.1	There is a risk that place-based partnership working does not effectively support delivery of Stockport ONE Health & Care (Locality) Board priorities and address health inequalities in

		Stockport
X	PR3.2	There is a risk that partnership working in Greater Manchester do not effectively address unwarranted variation of services and improve health inequalities
X	PR3.3	There is a risk that opportunities for collaboration between Stockport NHS Foundation Trust and Tameside & Glossop Integrated Care NHS Foundation Trust are not optimised
	PR4.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit and retain the optimal number of staff, with appropriate skills and values
	PR4.2	There is a risk that the Trust's workforce is not reflective of the communities served
X	PR5.1	There is a risk that the Trust does not implement high quality service improvement programmes
	PR5.2	There is a risk that the Trust does not implement high quality research & development programmes
X	PR6.1	There is a risk that the Trust does not deliver the annual financial plan
X	PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial sustainability plan
X	PR7.1	There is a risk that the Trust does not implement the Digital Strategy to ensure a resilient and responsive digital infrastructure
X	PR7.2	There is a risk that the estate is not fit for purpose and/or meets national standards
X	PR7.3	There is a risk that the Trust does not materially improve environmental sustainability
X	PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus

Where issues are addressed in the paper

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

Executive Summary

The Board of Directors has established the following Committees:

- People Performance
- Finance & Performance
- Quality
- Audit Committee

The Committees have no executive powers, other than those specifically delegated within their Terms of Reference, but they can make recommendations to the Board of Directors for approval. The Committees are to report to the Board of Directors by means of a Key Issues Report summarising business conducted by the Committee together with key actions and/or risks.

A summary is provided for the Board of Directors of the key matters and decisions from the meetings of the Finance & Performance Committee held during April and May 2025, noting areas of alert, advice and assurance.

NHS Stockport NHS Foundation Trust

ALERT, ADVISE & ASSURE (AAA) REPORT	
Name of Committee/Group	Finance & Performance Committee
Chair of Committee/Group	Tony Bell, Non-Executive Director
Date of Meeting	17 April 2025 and 15 May 2025
Quorate	Yes

The Finance & Performance Committee draw the following key issues and matters to the Board of Directors' attention:

1.	**Agenda**	In April, the Committee considered an agenda which included the following: • Operational Performance Report • Finance Report – Month 12 • Operational Plan • Financial Plan (Revenue and Capital) • Mid-Year Implementation Appraisal of TIF Outpatients Business Case • Standing Committees: - Capital Programme Management Group: Key Issues Report and Terms of Reference and Work Plan 2025/26 (Approved) - Digital & Informatics Group: Terms of Reference and Work Plan 2025/26 (Approved) In May, the Committee considered an agenda which included the following: • Operational Plan • Opening Budgets • Finance Report – Month 1 • Productivity and Stockport Trust Efficiency Programme (CIP / STEP) • Annual Costing Submission • Annual Procurement Programme and Progress Report • Pharmacy Shop Opening Budgets • Operational Performance Report • Performance Framework • Theatre Late Start Deep Dive • Post Implementation Appraisal of Community Diagnostic Centre Business Case • Green Plan Progress Report • Key issues Reports: - Capital Programme Management Group - Digital & Informatics Group
2.	**Alert**	Concerns regarding Stockport Trust Efficiency Programme (STEP) / Cost Improvement Plan (CIP) being £0.7m behind plan at month 1, with Committee noting consequent lack of assurance regarding year-end delivery. It was noted that the Trust was expected to identify the unidentified STEP gap by the end of June 2025. Concerns regarding paediatric audiology and the consequent adverse impact on the diagnostic target and future sustainability of the service. It was noted that the Quality Committee would undertake a deep dive on the issue at its June meeting.

3.	**Advise**	The Committee received the Finance Report for Month 1 and noted: • The Trust had delivered its Financial Plan 2024/25. • Overall, the Trust position at month 1 was a deficit of £1.2m which was line with the Financial Plan, and at this point the forecast for year-end was also in line with plan. • The STEP plan for 2025/26 was £29.2m (£20.5m recurrent). The Committee heard that STEP of £10.1m (35%) had been actioned against the in-year target, and year to date STEP was £0.7m behind the efficiency plan. • The Trust has maintained sufficient cash to operate during April. • The Capital forecast for 2025/26 was £35.4m, in line with plan. The Committee received a report detailing a mid-year implementation appraisal of the TIF Outpatients Business Case. It was noted that the new outpatient facility was on track to be handed over to the Trust at the end of August 2025 within the capital envelope, providing a full restoration of all specialities. The Committee received a report providing a high level summary of the material changes in the Trust's final Operational Plan submissions. It was noted that a plan on a page summary of the final Operational Plan would be presented to the June Board meeting. The Committee received a report outlining the proposed budgets for 2025/26 and the budget setting approach. The Committee recommended the Opening Budgets 2025/26 to the Board of Directors for approval. The Committee received an Annual Procurement Programme and Progress Report and sought further clarity on a number of areas, including potential savings at GM level. The Committee received a report detailing the proposed Pharmacy Shop opening budgets for 2025/26 and the next steps in the budget setting process. The Committee heard that collaboration opportunities were being explored with Tameside & Glossop Integrated Care NHS Foundation Trust. The Committee received a report providing an update on the Trust's Performance Review Framework for 2025/26. The Committee queried if quarterly Performance Review meetings were regular enough and suggested exploring the merit of having external input to the challenge process to provide more rigour. The Committee received the Operational Performance Report for Month 1, acknowledging the continued operational pressures and action being taken to improve performance. The Committee heard that the Trust continued to perform below the national target against some of the core operating standards, whilst improvement was being sustained particularly around elective and cancer care. Performance against the ED 4-hour standard has remained consistent and whilst below the national standard, performance was above the April trajectory. The Committee received a report detailing the recent trends in the number of late starts seen in Theatres, focusing on the period September 2024 to March 2025. The Committee noted actions taken to mitigate late starts and maintain the improved position.

		The Committee received a report detailing the post implementation review for the Community Diagnostic Centre (CDC). The Committee noted the planned versus actual delivery of associated targets and expressed concern regarding the lack of benefits realised. The Committee requested that a further update on mitigating actions be provided to the Committee. The Committee received a report providing an update on progress made against the delivery of the Trust Green Plan in 2024/25.
4.	**Assure**	The Committee acknowledged positive assurance regarding cancer performance, noting that all cancer standards have achieved the target and benchmark well nationally. The Committee received a Costing Submission 2024/25 – Pre-Submission Planning Report and confirmed the systems and processes in place as sufficient to provide assurance on the plan to complete the mandated costing submissions for 2024/25.
5.	**Referral of Matters/Action to Board/Committee**	The Committee recommended the Opening Budgets 2025/26 to the Board of Directors for approval.
6.	**Report compiled by:**	**Anthony Bell, Non-Executive Director**
7.	**Minutes available from:**	**Soile Curtis, Deputy Company Secretary**

NHS Stockport NHS Foundation Trust

				Agenda No.	11
Meeting date	5th June 2025	**Public**	x	**Confidential**	
Meeting	Board of Directors				
Report Title	Integrated Performance Report				
Director Lead	Chief Executive	**Author**	Peter Nuttall, Director of Informatics		

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

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

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

This paper relates to the following Board Assurance Framework risks

x	PR1.1	There is a risk that the Trust does not deliver high quality care to service users
x	PR1.2	There is a risk that patient flow across the locality is not effective
x	PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan
x	PR2.1	There is a risk that the Trust is unable to sufficiently engage and support our people's wellbeing
	PR2.2	There is a risk that the Trust does not actively participate in local collaborative programmes/neighbourhood working to improve primary and secondary health outcomes
x	PR3.1	There is a risk that place-based partnership working does not effectively support delivery of Stockport ONE Health & Care (Locality) Board priorities and address health inequalities in Stockport

x	PR3.2	There is a risk that partnership working in Greater Manchester do not effectively address unwarranted variation of services and improve health inequalities
x	PR3.3	There is a risk that opportunities for collaboration between Stockport NHS Foundation Trust and Tameside & Glossop Integrated Care NHS Foundation Trust are not optimised
x	PR4.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit and retain the optimal number of staff, with appropriate skills and values
	PR4.2	There is a risk that the Trust's workforce is not reflective of the communities served
	PR5.1	There is a risk that the Trust does not implement high quality service improvement programmes
	PR5.2	There is a risk that the Trust does not implement high quality research & development programmes
x	PR6.1	There is a risk that the Trust does not deliver the annual financial plan
x	PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial sustainability plan
	PR7.1	There is a risk that the Trust does not implement the Digital Strategy to ensure a resilient and responsive digital infrastructure
	PR7.2	There is a risk that the estate is not fit for purpose and/or meets national standards
	PR7.3	There is a risk that the Trust does not materially improve environmental sustainability
	PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus

Where issues are addressed in the paper

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

Executive Summary

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

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

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

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

BUSINESS INTELLIGENCE

NHS Stockport NHS Foundation Trust

Integrated Performance Report

Reporting period

April 2025

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

Quality Highlight

Exception reports included this month relate to performance against Sepsis, Infection Prevention Control, Pressure Ulcers, Complaints, and Maternity.

- Sepsis timely recognition continues to perform well against the target, despite seeing a drop in performance since December 2024. Antibiotic administration performance shows no significant changes or improvements and remains below target.
- Reported infection rates for C. diff show strong deterioration in performance for April, with an additional 7 C. diff cases reported. Following case reviews, antibiotic guidelines have been updated.
- The number of hospital-acquired pressure ulcers show sign of improvement across all categories. Community-acquired pressures ulcers do show an increase in numbers. Although very few are due to lapses in care.
- The Trust written complaints rate has not seen any significant changes since January 2024. Timely response to complaints has improved in the latest month and is back to 100% for April 2025.
- Smoking during pregnancy performance has not changed significantly, although latest performance is reported below the improvement trajectory required to achieve the 4% target by the end of 2028.

McCarthy, Rebecca
29/05/2025 17:56:54

Operations Highlight

Exception reports included this month relate to performance against Emergency Department, Patient Flow, Diagnostics, Cancer, RTT, Community, Outpatient Efficiencies, Theatres, and Outpatient Procedures.

- Performance against the ED 4-hour standard shows strong improvement between February and April 2025. The department saw an increase in the number of 12-hour waits.
- The number of patients with “No criteria to reside” increased in April to 72, equating to 12.2% of adult occupied beds. This remains above the planned level of 61.
- Diagnostic performance remains challenging, with actions identified to support improvement across Audiology, Echo, MR, and Endoscopy.
- Most reported cancer standards continue to perform well, with the latest 62-day performance just below the trajectory. Final validated performance is expected to achieve.
- RTT patients over 52-weeks are below trajectory, with slight increases to patients over 65-weeks. Capacity in ENT and T&O Knees have been a concern.
- Virtual ward utilisation continues to show deterioration in performance. Series of actions underway aimed at improving communication and knowledge of the service.
- Outpatient efficiencies in PIFU and Clinic Utilisation continue to perform well with both achieving their targets in April 2025. DNA rates remain above the target threshold but does show signs of improvement.
- There have been no significant changes to performance in theatre capped touch time utilisation. Improvement trajectory and action plans have been developed, with regular performance meetings to monitor and drive improvements.

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

Workforce Highlight

Exception reports included this month relate to performance against Sickness Absence, Appraisal rates, and Mandatory training.

- Monthly sickness absence rates remain above the target threshold. Sickness oversight reviews continue for each division, with a focus on options for interventions and actions to support reductions in short term absence episodes.
- Agency costs continue to show an improving position with decreasing trends since October 2024.
- Workforce turnover has shown improvement month to month since September 2024 and shows strong improvement from January 2025 onwards.
- Appraisal rates show strong deterioration from January 2025 onwards. Decreased performance was anticipated due to appraisal activity being aligned to the new appraisal window process.
- Mandatory training rates are showing a strong deterioration in performance, with a below average trend seen since September 2024. Additional mandatory training days are planned, which are intended to compliment the existing offer and increase access to training sessions.

McCarthy Rebecca 29/05/2025 17:56:54

Finance Highlight

The annual plan for 2025-26 is to deliver a balance plan. At month 1 both in year and year to date, the Trust has a £1.2m deficit, which is in line with the Trust's financial plan

- The forecast at month 1 is that the Trust will achieve the annual plan.
- The Trust STEP target for 2025-26 is £29.2m, of which £20.5m (70%) is recurrent and £8.6m (30%) is non-recurrent. In year £10.1m (35%) of the full year CIP target has been delivered, and £7.6m (37%) of the recurrent target.
- The status of the Trust CIP delivery is being monitored on a weekly basis by NHSE. By the end of June 2025 there is a requirement for:
  - 75% of schemes to have been fully scoped, including PID approval
  - Zero unidentified balance
- The Trust has maintained sufficient cash to operate during April. Cash is expected to decrease by £31.6m by the end of the financial year which is line with the Trusts annual plan.
- The Trust has submitted a capital plan of £35.4m including £1.9m for IFRS16.

	Reporting Period	Target 24/25	Actual YTD	6-mth Trend	Actual Month	Current Period	1-mth Forecast
Quality Scorecard							
Mortality: SHMI	Feb-24 to Jan-25	≤ 100		→	93	●	●
Sepsis: Antibiotic administration	May-24 to Apr-25	≥ 90%		→	75.8%	▲	▲
Sepsis: Timely recognition	May-24 to Apr-25	≥ 90%		↓	95.4%	●	●
C.diff infection rate	May-24 to Apr-25	≤ 32.75		↓	42.28	▲	▲
Covid-19 infection rate	May-24 to Apr-25			↑	1.14		
E. coli infection rate	May-24 to Apr-25	≤ 31.41		→	33.55	▲	▲
MRSA infection rate	May-24 to Apr-25	≤ 0		↓	0.92	▲	▲
Stroke: Overall SSNAP Level	Sep-24	≥ C		→	A	●	●
Falls causing moderate+ harm	Apr-25	≤ 22	1	→	1	●	●
Falls due to lapses in care	Apr-25	≤ 425	10	→	10	●	●
Falls rate	Apr-25	≤ 3.51	3.14	→	3.14	●	●
Pressure Ulcers: Community, Cat 2	Apr-25	≤ 114	16	↘	16	▲	▲
Pressure Ulcers: Community, Cat 3&4	Apr-25	≤ 38	4	→	4	▲	▲
Pressure Ulcers: Hospital, Cat 2	Apr-25	≤ 79	0	↗	0	●	●
Pressure Ulcers: Hospital, Cat 3&4	Apr-25	≤ 8	0	↗	0	●	●
Complaints: Timely response	Apr-25	≥ 95%	100%	↗	100%	●	●
Complaints: Written Complaints Rate	Apr-25	≤ 7.9	10.12	→	10.12	▲	
Never Event Incidence	Apr-25	≤ 0	0	→	0	●	●
Patient Safety Alerts	Apr-25	≤ 0	0	→	0	●	●
Patient Safety Incident Investigatio..	Apr-25		4	→	4		
Patient Safety Incident Rate	Nov-24 to Apr-25			→	94.2		
Early Neonatal Deaths	Apr-25	≤ 0	0	→	0	●	●
Maternity Diverts	Apr-25	≤ 0	0	→	0	●	●
Registrable Stillbirth Rate	Apr-25	≤ 0	4.52	→	4.52	▲	▲
Registrable Stillbirths	Apr-25	≤ 0	1	→	1	▲	▲
Smoking at Pregnancy	Apr-25	≤ 5.3%	1.5%	→	1.5%	●	●

Legend

1-month Forecast

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

Current Period

- ● target achieved
- ▲ target not achieved

6-month Trend

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

	Reporting Period	Target 24/25	Actual YTD	6-mth Trend	Actual Month	Current Period	1-mth Forecast
Operational Scorecard							
4hr Standard	Apr-25	≥ 66.1%	68.3%	↑	68.3%	●	▲
Patients in department over 12hrs	Apr-25	≤ 11%	12.1%	↗	12.1%	▲	▲
Ambulance handover time	Apr-25	≤ 19.04		↗	27.43	▲	▲
No criteria to reside (NCTR)	Apr-25	≤ 45	72	→	72	▲	▲
Adult G&A Bed Occupancy	Apr-25	≤ 92.3%	96.3%	↘	96.3%	▲	▲
Timely discharge	Apr-25	≥ 85%	80.4%	↓	80.4%	▲	▲
Average discharge delay	Apr-25	≤ 6.2		↘	5.5	●	●
Diagnostics: 6-week Standard	Apr-25	≤ 25.5%	27.4%	↘	27.4%	▲	▲
62-day standard	Apr-25	≥ 70%	69.2%	→	69.2%	▲	▲
31-day standard	Apr-25	≥ 92.6%	91.5%	→	91.5%	▲	▲
28-day standard (FDS)	Apr-25	≥ 77%	80.9%	↗	80.9%	●	●
14-day standard (2WW)	Apr-25	≥ 93%	95.6%	↘	95.6%	●	●
Incomplete pathways 18-week %	Apr-25	≥ 54.2%		↑	55.2%	●	▲
52-week breaches	Apr-25	≤ 1654		→	1460	●	▲
65-week breaches	Apr-25	≤ 0		↑	39	▲	▲
52-week breach %	Apr-25	≤ 4.6%		↑	4.1%	●	●
Wait for first attendance 18-week %	Apr-25	≥ 62.5%	63.9%	↑	63.9%	●	▲
Virtual Ward Utilisation	Apr-25	≥ 80%	48.9%	↓	48.9%	▲	▲
Urgent Community Response	Mar-25	≥ 70%		→	97%	●	●
Outpatient DNA rate	Apr-25	≤ 6.3%	6.8%	↑	6.8%	▲	▲
Outpatient clinic utilisation	Apr-25	≥ 90%	95.7%	↗	95.7%	●	●
Patient initiated follow up (PIFU)	Apr-25	≥ 5%	5.3%	↘	5.3%	●	●
Capped Touch Time Utilisation	Apr-25	≥ 80%	78.3%	↗	78.3%	▲	▲
Length of stay: Elective	Feb-25	≤ 2.9		→	2.2	●	●
Length of stay: Non-elective	Feb-25	≤ 10.3		↑	10.2	●	●
OP First Attend and Procedure	Apr-25	≥ 42.8%	42%	↘	42%	▲	▲
Workforce Scorecard							
Substantive Staff-in-Post	Apr-25	≥ 90%	95.1%	↑	95.1%	●	●
Sickness Absence: Monthly Rate	Apr-25	≤ 5.5%	5.8%	→	5.8%	▲	▲
Workforce Turnover	Apr-25	≤ 12.7%	11.7%	↑	11.7%	●	●
Staff Retention Rate	Apr-25		99.3%	↑	99.3%		
Appraisal Rate: Overall	Apr-25	≥ 95%	85%	↓	85%	▲	▲
Mandatory Training	Apr-25	≥ 95%	93.7%	↓	93.7%	▲	▲
Agency Costs %	Apr-25	≤ 3.2%	1.9%	↑	1.9%	●	●
Finance Scorecard							
Capital Expenditure	Apr-25	≤ 10%		↓	456.2%	▲	▲
Cash Balance	Apr-25			↑	35.6		
CIP Cumulative Achievement	Apr-25	≥ 0%		↓	-32.9%	▲	▲
Financial Controls: I&E Position	Apr-25	≤ 0%		→	-0%	●	●

Quality **Sepsis**

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
Sepsis: Timely recognition	The number of patients who are screened for sepsis, as a percentage of those eligible patients audited.	>= 90%	95.4%	↓	● ● ● ● ●	●
Sepsis: Antibiotic administration	The number of patients who received IV antibiotics within agreed timescales for sepsis patients, as a percentage of eligible patients audited and found to have sepsis.	>= 90%	75.8%	→	▲ ▲ ▲ ▲ ▲	▲

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

Timely recognition

- 94% timely recognition in April
- 12 month rolling figure 95%, ahead of trust target.
- 61/65 sepsis triggers were reviewed on time
- 4 audit fails for TR: ward B2, A1,D8 (x2)
- Delays:
  A1 – 21mins (OOH) 2222 not utilised
  B2 – 36mins (OOH) 2222 utilised
  D8 – 6mins
  D8 – 8mins (OOH) 2222 utilised
- All fails were Red Flag Sepsis, where 3 happened out of hours and 2222 was not utilised on one occasion

Antibiotic administration

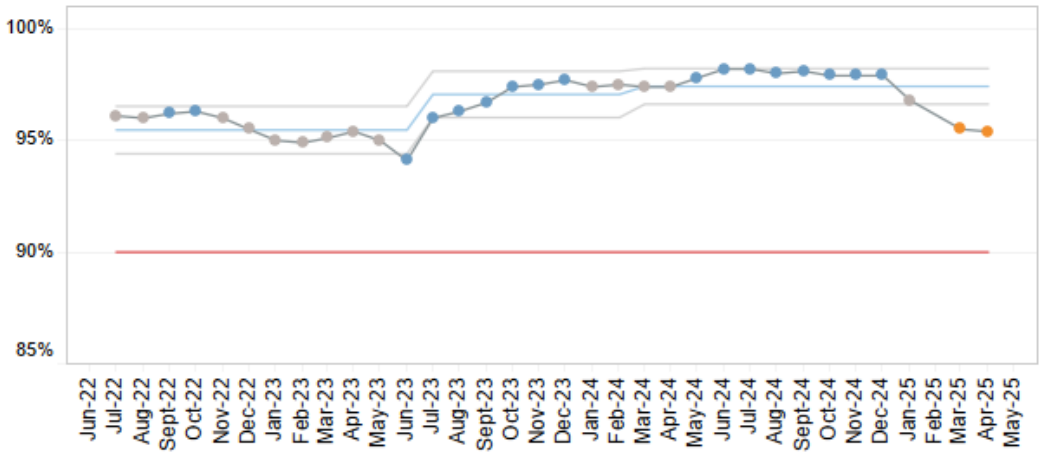
- April compliance is 69%.
- 12 months rolling figure now 76% below trust target.
- 11/16 patients screened for sepsis received antibiotics in accordance with trust guidelines.
- Red flag sepsis: 5/9 were compliant
- Amber flag sepsis: 6/7 were compliant
- 2 audit fails for antibiotic administration: ward A1 and AMU
- Ward A1:
  Red Flag Sepsis trigger, happened out of hours, 2222 not utilised,
  Delay time: 111 mins – Prescribed at 00:25, administered at 00:30
- AMU
  Red Flag Sepsis trigger, Not OOH, Delay time: 136 mins – Prescribed at 15:42, administered at 17:43

Key Events/ Ongoing Issues

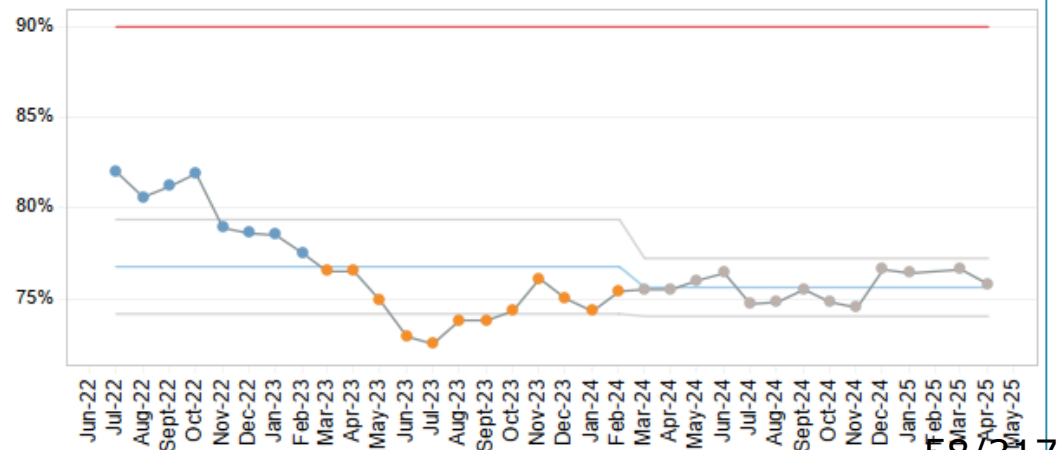
- 2222 continues to be underutilised during out of hours for red flag sepsis
- Ongoing Sepsis education with clinical induction
- Sepsis practitioner band 5 role secondment job out and interview for the post are scheduled on 9 May 2025
- Ongoing planning for Sepsis road show for world Sepsis Day in September
- Sepsis toolbox session to commence May
- Sepsis quarterly newsletter out this May

Update provided by	Christe Bolanio
Executive Lead	Andrew Loughney

Performance for Sepsis: Timely recognition



Performance for Sepsis: Antibiotic administration



Quality **Infection Prevention & Control**

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
C.diff infection rate	The number of hospital-onset Clostridioides Difficile (C. diff) infections per 100,000 bed days for patients aged 2 years and older.	<= 32.75	42.28	↓	▲ ▲ ▲ ▲ ▲ ▲	▲
MRSA infection rate	The number of hospital-onset Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia infections per 100,000 bed days.	<= 0	0.92	↓	▲ ▲ ▲ ▲ ▲ ▲	▲
E. coli infection rate	The number of Escherichia Coli (E. coli) bacteraemia infections per 100,000 bed days.	<= 31.41	33.55	→	▲ ▲ ▲ ▲ ▲ ▲	▲

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

C.diff infection rate

- There were 9 HOHA and 3 COHA cases in April, totalling 12 cases YTD. The Trust is over the projected threshold of 6.7 for the end of April.
- 7 cases have been presented to the HCAI Panel, with a further 5 currently outstanding. The most common themes for learning are complex/high risk patients, antibiotic usage and maintaining IPC standard practices across the Trust.
- The latest National figures (February 2025) rates show Stockport is ranked third out of the seven GM Trusts which is the same as last month (1st is best). Out of the 42 ICB's across the UK, GM is ranked 38th which is the same as the previous month. (42 being the worst)
- The National team continue to monitor closely Stockport's increase month on month and actions we are taking.
- Following the review of cases last month with a potential link of using co-amoxiclav in treatment of sepsis of unknown origin, the antibiotic guidelines have changed effective from the 1 May 2025.

MRSA infection rate

- The Trust had 0 cases of MRSA Bacteraemia in April. The Trust has had no cases in 2025-26 against a zero-tolerance threshold.
- The latest National figures (February 2025) rates show Stockport is ranked first out of the seven GM Trusts, which is the same as the previous month, the best within GM. We await the National updated figures to determine whether Stockport continues to be ranked 1st.

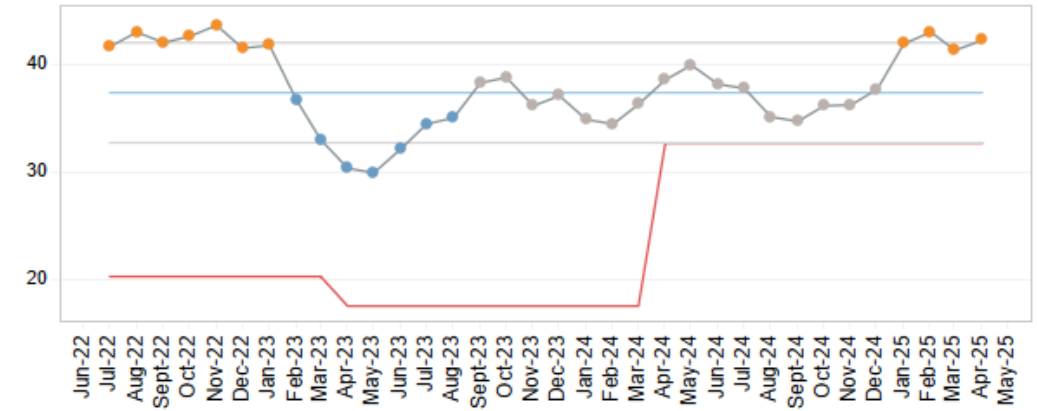
E. coli infection rate

- There were 6 HOHA and 1 COHA case in April totalling 7 YTD. The Trust is over the projected threshold of 5.7 for the end of April.
- The latest National figures (February 2025) rank Stockport fourth out of the seven GM Trusts which is the same as the previous month.
- The urinary catheterisation policy has been ratified and awaiting the policy approval panel for uploading to the microsite. Urology have been asked to ensure all working documents are available on their microsite prior to the approval and uploading of the policy.

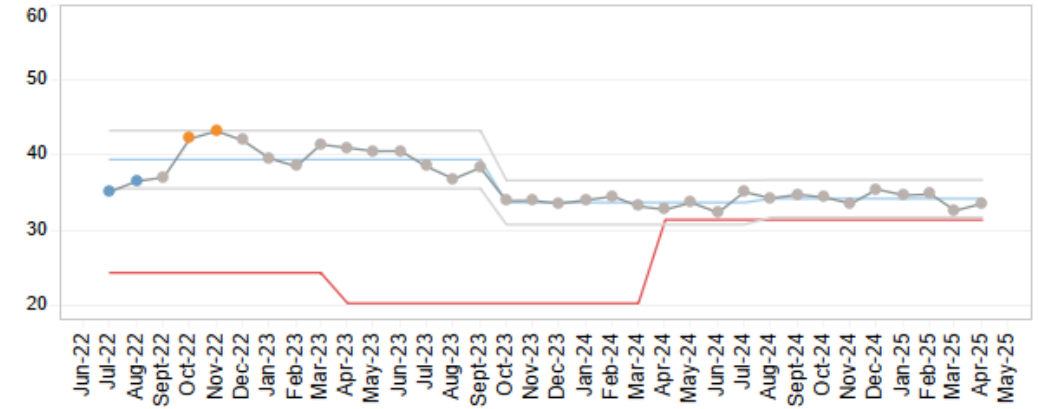
COVID-19

- The Trust had 10 new COVID-19 positive cases in April of which 4 were nosocomial.
- The Trust currently has a Hospital Onset Covid (HOC) rate of 40% which is an increase of 2% from last month.
- We are unable to determine how we compare with other Trusts across GM, locally we are working closely with ED & acute physicians to ensure the National guidance for swabbing is followed.

Performance for C.diff infection rate



Performance for E. coli infection rate



Update provided by	Nesta Featherstone
Executive Lead	Nic Firth

Quality & Safety report
Exception

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Quality Pressure Ulcers

		Target	Actual	6-month trend	Previous Performance							1-month Forecast
Hospital, Category 2	Total number of category 2 pressure ulcers in a hospital setting - includes device-related pressure ulcers.	<= 6	0	↗	▲	●	●	●	●	●	●	●
Hospital, Category 3&4	Total number of category 3 and category 4 pressure ulcers in a hospital setting - includes device-related pressure ulcers.	<= 0	0	↗	●	▲	▲	▲	●	▲	●	●
Community, Cat 2	Total number of category 2 pressure ulcers in a community setting.	<= 9	16	↘	●	▲	●	▲	▲	▲	▲	▲
Community, Category 3&4	Total number of category 3 and category 4 pressure ulcers in a community setting - includes device-related pressure ulcers.	<= 3	4	→	▲	▲	●	●	▲	▲	▲	▲

Hospital Acquired

The Trust has set a target to reduce the number of hospital-acquired pressure ulcers caused by lapses in care. Additionally, targets have been established for the timely investigation of pressure ulcer incidents, focusing on learning from these incidents according to the PSIR framework.

- Current Data: This month (April), there have been no category 2 pressure ulcers reported
- Strategies: Achieving a pressure ulcer free month is a great start to the year and on track to meet our targets.

The Trust aims to achieve zero hospital-acquired category 3 or 4 pressure ulcers due to lapses in care.

- Current Data: This month (April), there have been no category 3 or 4 pressure ulcers reported

Community Acquired

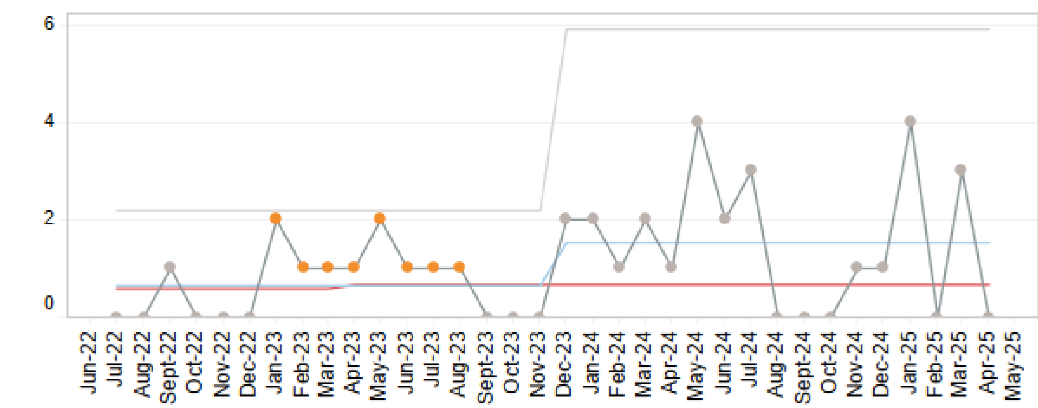
The Trust has set a target to reduce the number of community-acquired pressure ulcers due to lapses in care. Targets have also been set for the timely investigation of pressure ulcer incidents, focusing on learning from these incidents according to the PSIR framework.

- Current Data: This month (April), 16 category 2 pressure ulcers were reported.
- Trends: The number of pressure ulcers in the community continues to be high but with very few reported with lapses in care. The ongoing work-streams in community are aiming at working closely with patients and carers to enhance pressure ulcer prevention

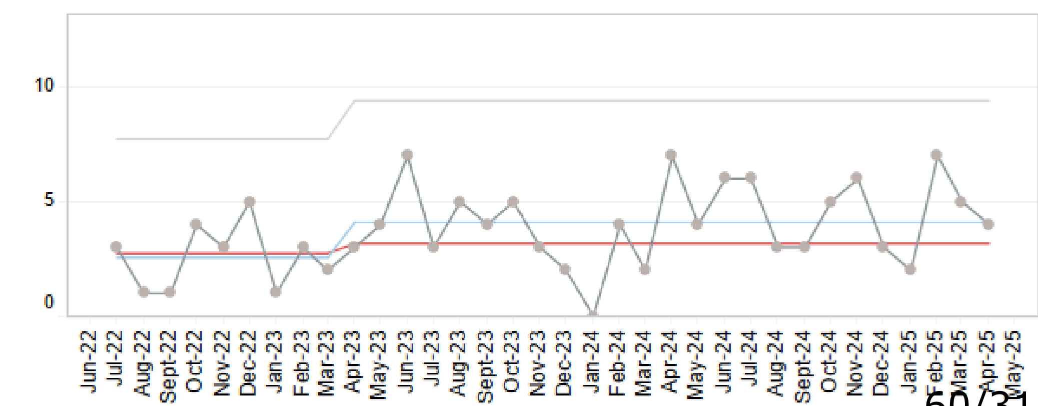
The Trust aims to achieve zero category 3 or 4 pressure ulcers in the community due to lapses in care.

- Current Data: This month (April), 4 category 3 or 4 pressure ulcers were reported in the community
- Investigations: Each incident is investigated and reviewed to identify any learning or lapses in care. Unfortunately, there continues to be delays with the investigations to be presented at PSIRG for review and no outcomes of these incidents are as yet available.

Performance for Pressure Ulcers: Hospital, Cat 3&4



Performance for Pressure Ulcers: Community, Cat 3&4



Update provided by	Lisa Gough
Executive Lead	Nic Firth

Quality **Complaints**

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
Written Complaints Rate	Number of formal written complaints received, calculated as an incidence rate for every 1000 whole time equivalent staff in post.	<= 7.9	10.16	→	▲ ▲ ▲ ● ▲ ▲	□
Timely response	The total number of formal complaints responded to within agreed timescales, as a percentage of all formal complaints responded to.	>= 95%	100%	↗	▲ ▲ ● ● ▲ ●	●

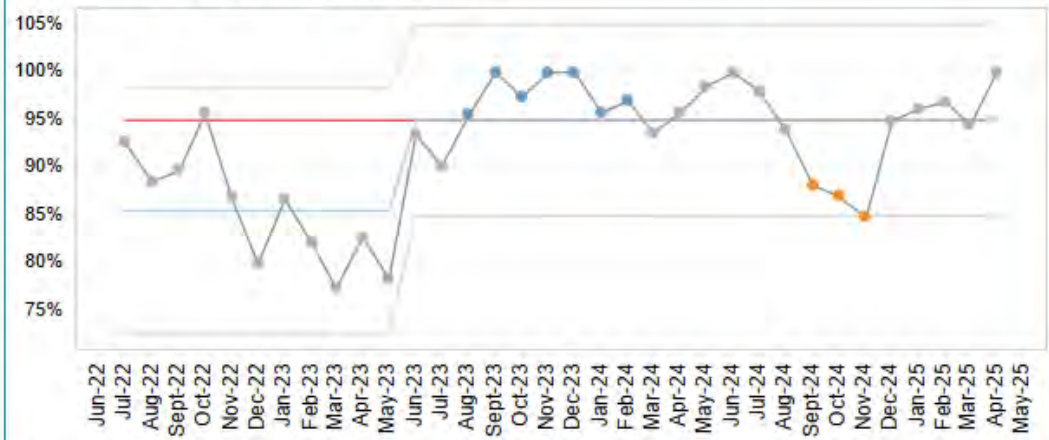
Timely response

- 50 responses were sent out in April 2025 all of which were sent within the agreed timeframe, resulting in a 100% response rate.
- The PALS team continue to receive a significant number of contacts and they are striving to ensure early resolution of concerns. However, the organisation continues to see a high number of complaints being received.
- The team continues to work with the clinical divisions to improve the quality and timeliness of responses received, which requires continuous monitoring and challenge to ensure responses are as robust and timely as possible. The team continue to work under significant pressure to maintain a high response rate.

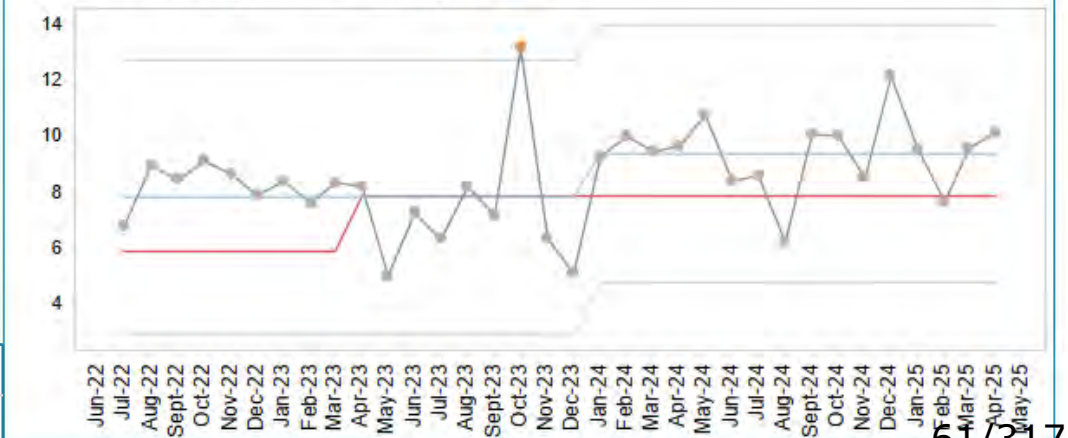
Written Complaints Rate

- 57 formal complaints were received in April 2025 - Clinical Support Services = 0, Integrated Care =3, Medicine & UC = 23, Surgery = 20, Women & Children = 8, Corporate = 2, Estates & Facilities = 1
- The PALS & Complaints team continue to focus on resolving concerns via early resolution where appropriate with the hope to reduce the number of formal complaints. It is noted that there has been an increase in paediatric audiology enquiries due to the pause in the service.
- Top five themes for formal complaints in April 2025 was as follows:
    1. Clinical treatment
    2. Communication
    3. Admin procedures and record management
    4. Admission and discharges
    5. Appointments
- Top five themes for informal concerns in April 2025 was as follows:
    1. Appointments
    2. Communication
    3. Access to treatment or drugs
    4. Waiting times
    5. Staff values and behaviours

Performance for Complaints: Timely response



Performance for Complaints: Written Complaints Rate



Signed off by	Natalie Davies
Executive Lead	Nic Firth

Quality **Maternity**

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
Early Neonatal Deaths	The number of babies born with signs of life, that have died with within the first 7 completed days of life.	<= 0	0	→	● ● ● ● ● ●	●
Registrable Stillbirths	The number of babies born without signs of life due to stillbirth or termination of pregnancy that occurs after a gestation of 24 weeks (168 days) or more.	<= 0	1	→	▲ ● ● ▲ ● ▲	▲
Registrable Stillbirth Rate	Calculated as a rate per 1000 registrable births.	<= 0	4.52	→	▲ ● ● ▲ ● ▲	▲
Smoking In Pregnancy	The number of women known to be smokers at the time of delivery, as a percentage of all deliveries in the month.	<= 5.3%	1.5%	→	● ▲ ● ▲ ▲ ●	●
Maternity Diverts	The total number of occasions the maternity unit has been unable to admit women during the reporting period.	<= 0	0	→	● ▲ ● ● ● ●	●

Smoking in Pregnancy: This metric excludes women whose smoking status was not known at the time of delivery, and only includes women initially booked with us who then delivered with us. Women known to be smokers at the time of delivery are defined as pregnant women who self-reported that they were smokers. This includes any cigarettes or tobacco at all, but excludes non-combustible nicotine products, such as e-cigarettes or other nicotine containing products. If a woman intends to give up smoking after the delivery, but was a smoker up until the delivery date they are included in this count.

Smoking in pregnancy

The percentage of women (who had initially booked and progressed to deliver with our service) who were smoking at time of delivery in April 2025 was 1.5%, our second-best rate to date and well below target. Further details of SATOD rates will be explained in a separate slide for PSG and Quality Committee.

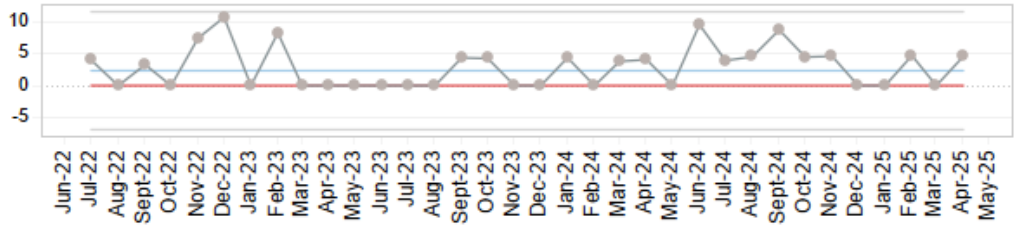
Registerable stillbirths

There was 1 Registerable Stillbirth in April 2025 at a gestation of 40+1. The mother attended Maternity Triage querying labour and FDIU was identified. The stillbirth was documented as timing unknown whilst under review; due to uterine activity it was reported to MNSI as possible Intrapartum Stillbirth. Parents have declined MNSI process. Discussed at PSIRG 09/05/2025, no omissions in care found, confirmed to continue with PMRT process.

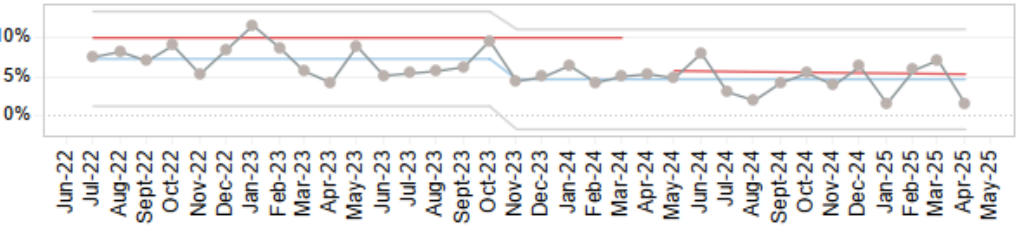
Registerable stillbirth rate

The registerable stillbirth rate for April 2025 is 4.52 per 1000.

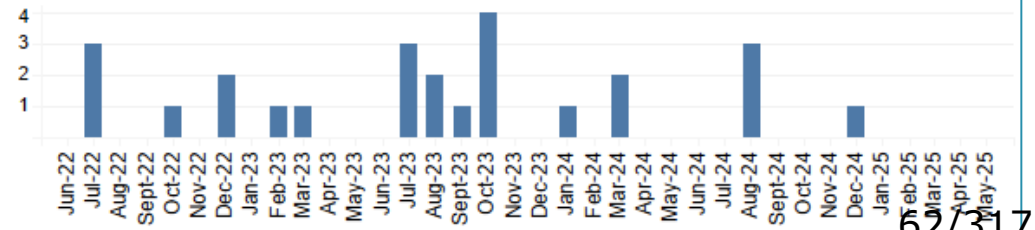
Performance for Registrable Stillbirth Rate



Performance for Smoking In Pregnancy



Performance for Maternity Diverts



Signed off by	Sharon Hyde
Executive Lead	Nic Firth

Operational Performance report
Exception

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Operations **Emergency Department**

	Target	Actual	6-month trend	Previous Performance	1-month Forecast
Patients in department over 12 hours — The number of type-1 patients spending 12 hours or more in department, as a percentage of all type-1 patients attending the emergency department.	<= 11%	12.1%			

Performance Summary

- April saw an increase in patients waiting more than12 hours in ED at 951.
- The number of patients waiting over 12 hours from the decision to admit to admission was 364 in April.
- April 2025 performance against the UEC 4hr standard was 68.3%. 8927 patients were seen in the hospital and a further 1209 patients were seen at the community UTC. The breakdown of performance was 64% on the hospital site, and 68.3% including the community UTC activity.
- Admissions to hospital from ED reduced in month at 85 per day, a 27.8% conversion rate, this does include admissions to the SDEC pathways. Excluding SDEC admissions, the conversion rate was 22.8%.

Risks and Issues

- Closed wards due to infection
- EUCC estate nearing completion, remaining work to finalise the new SDEC
- Nurse staffing challenges
- New GM medical bank rates
- Mental health model in the new unit

Actions and Mitigations

- Opening of new SDEC and changes to the inpatient bed base
- Weekly Trust 4hr clinical standards performance group is in place with full specialty representation with actions to improve position
- New programme of transformation work across UEC
- Plans to implement new acuity tool to replace MTS triage model
- EUCC nurse staffing approved
- Review of escalation areas
- Long waiting patient escalation procedure

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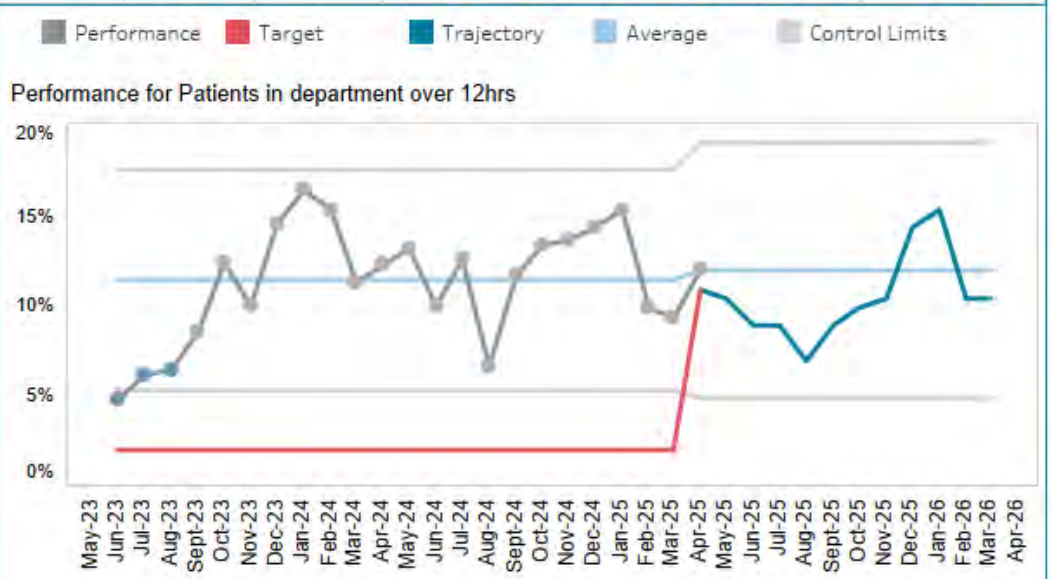

Signed off by	Ruth McNulty
Executive Lead	Jackie McShane

Operational Performance report
Exception

BUSINESS INTELLIGENCE

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Operations **Patient Flow**

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
No criteria to reside (NCTR)	Number of patients with "No Criteria to Reside". This metric is a mean average per day for each month.	<= 45	72	→	▲ ▲ ▲ ▲ ▲ ▲	▲
Adult G&A Bed Occupancy	The total number of occupied adult general & acute bed days, as a percentage of all available adult general & acute beds.	<= 92.3%	96.3%	↘	● ● ● ● ▲ ▲	▲

Performance Summary

- The average number of patients with a No Criteria to Reside increased slightly in April to 72 , which equates to 12.2% of adult occupied beds, this remains above the planned level of 61.
- Adult G&A bed occupancy in April was 96.3%, which is above the 92% NHSE target.
- Medical bed occupancy remains high, April was 98.4%.
- The average number of patients with a length of stay of 21+ days decreased slightly to 123 in April or 20.7% of occupied adult G&A beds. The national ambition is to get to 12%.

Risks and Issues

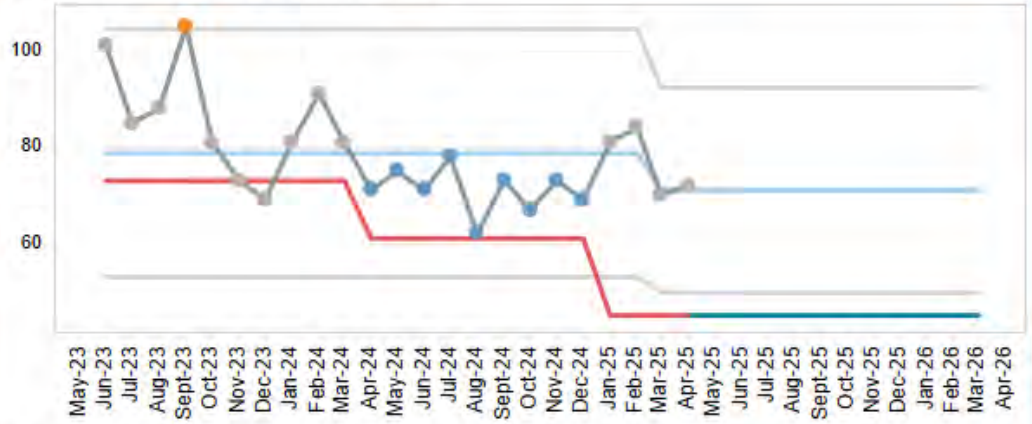
- Community capacity in Pathways 2 - 3, for Stockport. (Bramhall Manor reduced D2A bed capacity from 25 beds to 15 at the beginning of April.)
- Reduced Pathway 1 weekend discharge capacity as Stockport Adult Social Care (ASC) Reablement (REaCH) team only providing a 5 day offer for accepting referrals (no weekend offer).
- Community capacity in Pathways 1 - 3, for Derbyshire, East Cheshire and other areas.
- Ambulance availability for patients who cannot return to the community any other way.
- HCRs completed too late in the patient's stay, which then impacts on medication availability.

Actions and Mitigations

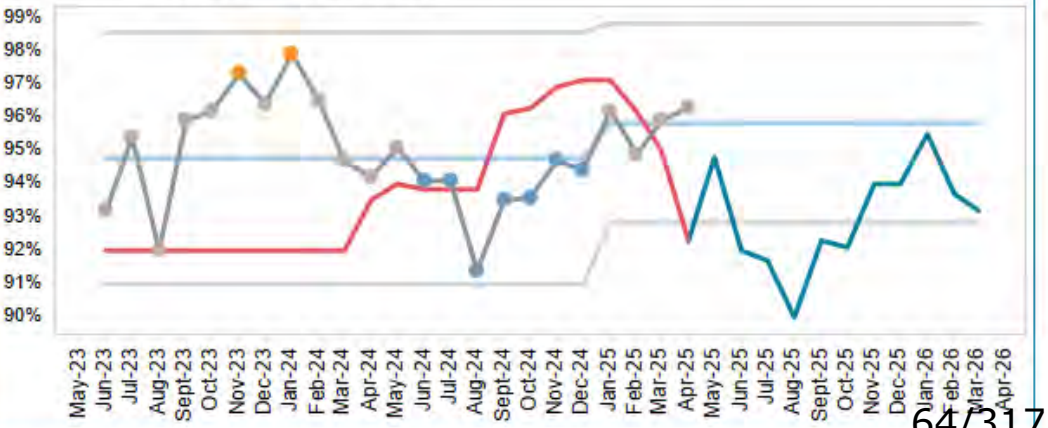
- Joint work with Acute Therapy team and Bed Base D2A Leads to review and challenge Pathway 2 referrals where alternative 'Home First' consideration needs experience in complex planning. This will support MDT conversations with patient and families.
- Working with Stockport ASC Reablement team reviewing processes to enable REaCH to operate over 7 days, accepting patients at a weekend and directly on discharge from hospital. This will release the D2A team to accept other patients and increase the overall capacity for Pathway 1 discharges.
- Continue to operate the Transfer of Care Hub (ToCH) 08:00 - 20:00 (Mon – Fri) to enable later triaging and discharge planning for patients with complex discharges.
- Working with all wards to set up Teams Chat with Transfer of Care Team / ToCH to improve communication, increasing flow and reduce the reliance and delays associated with telephone calls.

Performance | Target | Trajectory | Average | Control Limits

Performance for No criteria to reside (NCTR)



Performance for Adult G&A Bed Occupancy



Signed off by	Jane Ankrett
Executive Lead	Jackie McShane

Operational Performance report
Exception

BUSINESS INTELLIGENCE

NHS Stockport NHS Foundation Trust

Operations **Diagnostics**

	Target	Actual	6-month trend	Previous Performance	1-month Forecast
Diagnostics: 6-week Standard — The percentage of patients referred for diagnostic tests who have been waiting for more than 6 weeks.	<= 25.5%	27.4%			

Audiology

Risks and Issues

- Limited capacity to see paediatric patients as staffing go through required additional competency sign-off
- Workforce sickness levels remain high

Key Actions

- Reinstate additional clinics to see patients 5yrs+ as now have 1x Audiologist competency sign-off. Additional staff competency sign-off planned to allow for increased capacity for paediatric patients.
- A service development proposal has been submitted in relation to workforce and Estate

Echo

Risks and Issues

- DNA rates high with Stress echo
- Reduced appetite for WLI's from substantive staff
- 1x Physiologist on long term sickness meaning reduced clinic capacity for valve and echo slots
- Short term sickness within the team has led to 80 slots being lost in April for Echo

Key Actions

- Locum consultant providing additional Stress Echo capacity to cover consultant annual leave/COW weeks
- WLI's have been approved to provide additional capacity in May 2025
- Volunteer in place now supporting with call reminders which should support reduction in DNA rates

MR

Risks and Issues

- Ongoing high levels of cancer and inpatient demand for MR imaging
- Relocation of Canon scanner requiring downtime and loss of capacity

Key Actions

- CDC 6-week dedicated use for Stockport to increase activity and improve backlog
- Additional MR mobile provision onsite to improve position funded by 65ww slippage
- Improvement for CDC patient booking and utilisation with 7-day pre appointment phone ca

Endoscopy

Risks and Issues

- Significant increase in demand over Q3 and 4 24/25 has led to an increase in the waiting list size and longer waiting times for routine patients

Key Actions

- Additional lists over and above plan are being delivered to respond to the increase in demand and bring down the waiting list
- Focus on booking utilisation, cancellations and DNAs
- Recruitment to nurse endoscopist vacancy

Signed off by	Karen Hatchell / Ruth Sefton / Mike Allison
Executive Lead	Jackie McShane

Operational Performance report
Exception

BUSINESS INTELLIGENCE

NHS Stockport NHS Foundation Trust

Operations **Cancer**

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
62-day standard	The percentage of patients on any type of cancer pathway that have received their first treatment within 62 days of upgrade or GP referral. Includes two-we..	>= 70%	69.2%			
Patients waiting 63 days and over	The number of patients on a cancer pathway waiting 63 days and over, split by Two Week Wait, Screening, and Upgrade.	<= 45	58			

Performance Summary

- The final 62-day performance for March is 74.2 % which was above the year end trajectory target of 70.2%. The latest performance for April is 69.2 %.
- The Trust continues to achieve the 28-day FDS target with a strong performance of 82.1% in March.
- The 31-day performance is currently below the National standard of 96%.

Risks and Issues

- Oncology capacity deficit leading to extended appointment waits and impacting on 62-day performance.
- Robotic theatre capacity insufficient for demand. This is the key driver of the adverse 31-day position.
- Delays for patients requiring external diagnostic tests such as PET and CPEX .
- Risks remain around sustained delivery of performance once temporary funding of key posts supported by GM Alliance come to an end.

Actions and Mitigations

- Additional Oncology clinics continue to be secured for future months. The Christie are interviewing for an additional Urology Oncologist in May which will provide a substantive increase in capacity.
- A service development plan is in train to propose an alternative treatment for prostate cancer , negating robot requirement and supporting increasing throughput.
- The risk stratification surgical booking process for high-risk bladder cancer patients has been partially implemented which will support earlier treatment of muscle invasive cancers.
- Service Development Plans have been developed to support the substantive funding for some of the GM Alliance funded posts.

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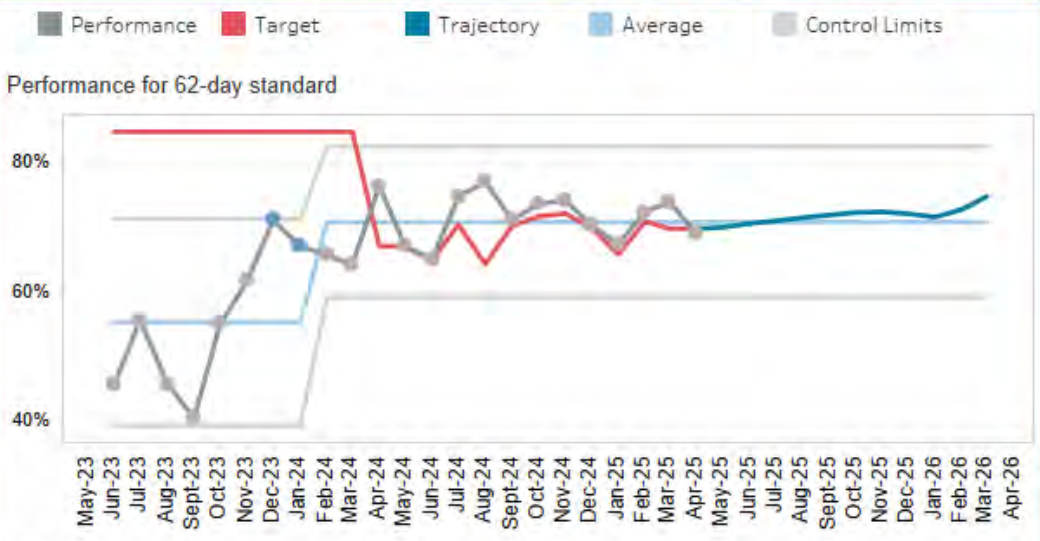

Signed off by	Andrew Tunnicliffe
Executive Lead	Jackie McShane

Operational Performance report
Exception

BUSINESS INTELLIGENCE

NHS Stockport NHS Foundation Trust

Operations **Referral to Treatment (RTT)**

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
Incomplete pathways 18-week %	Referral to treatment, the number of patients on an open pathway, whose clock period is less than 18 weeks, as a percentage of all patients on an open pathway.	>= 54.2%	55.2%			
65-week breaches	Referral to treatment, the total number of patients whose pathway is still open and their clock period is greater than 65 weeks at month end.	<= 0	39			

Performance Summary

- 65ww performance - Increased slightly to 39 breaches (35 March-25). Some are driven by patient choice and pathway complexity. There are a small number of breaches due to capacity constraints, particularly in ENT and T&O knees.
- 18-week performance – April final position was 55.2% which is in line with the improvement trajectory.

Risks and Issues

- Pause on paediatric audiology activity impacting on ENT 65ww breaches. Limited mutual aid support from MFT for these patients. Tests for Paediatrics patients over 4 years old can now be performed internally.
- Pathway delays due to complex diagnostics referred externally (Cardiology, Gastroenterology, & Surgery)
- Increase in Orthopaedic knee waits due to consultant vacancy & sickness
- Long wait times for 1st appointment remains a challenge across several specialties with significant impact in Cardiology, Chemical Pathology, Diabetes, Gastroenterology, Gynaecology, Haematology, Respiratory & Rheumatology

Actions & Mitigations

- Services are progressing multiple recruitments and additional capacity plans following approval of IPT elective business case.
- 3x weekly RTT performance PTLs remain in place to maintain rigor & drive performance.
- Participation in nationally "RTT Validation Sprint" from April to June aimed at increasing RTT clock stops above baseline to support waiting list reduction.
- Additional patient text validation of inpatient and day case waiting lists and the overdue follow-up waiting list.
- Internal and external escalation processes for diagnostic long wait delays remain in place.
- Continue to drive productivity and efficiency opportunities in elective pathways through the GIRFT Further Faster programme.

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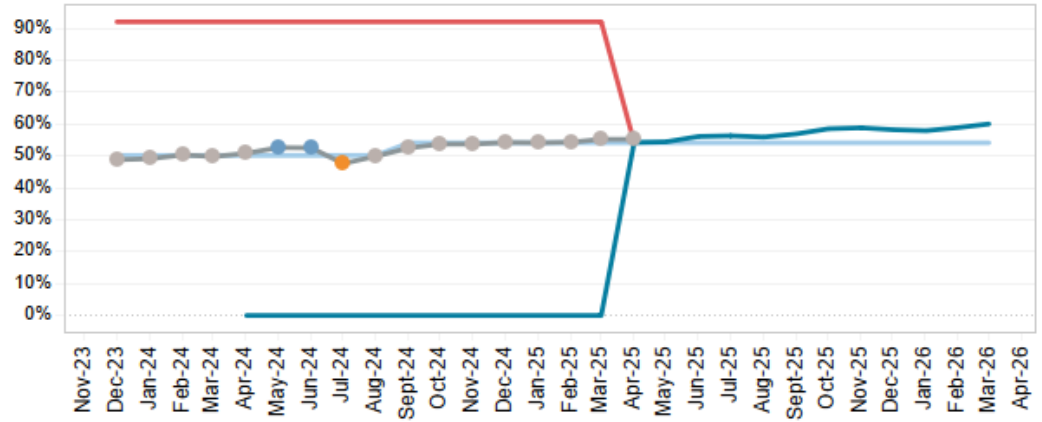
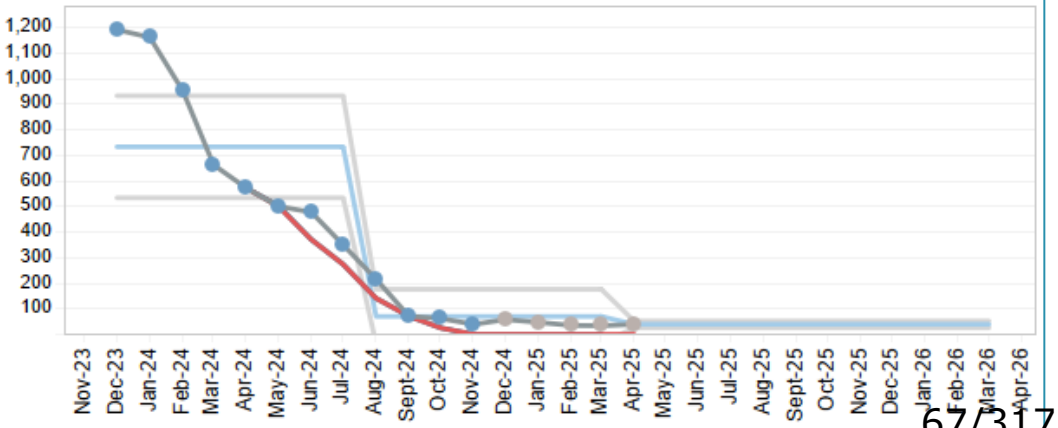
Performance for Incomplete pathways 18-week %



Performance for 65-week breaches



Signed off by	Andrew Tunnicliffe
Executive Lead	Jackie McShane

Operational Performance report
Exception

BUSINESS INTELLIGENCE

NHS Stockport NHS Foundation Trust

Operations **Community**

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
Virtual Ward Utilisation	The number of occupied bed days in the virtual ward service, as a percentage of the available bed days in the virtual ward service.	>= 80%	48.9%			

Virtual Ward

Performance Summary

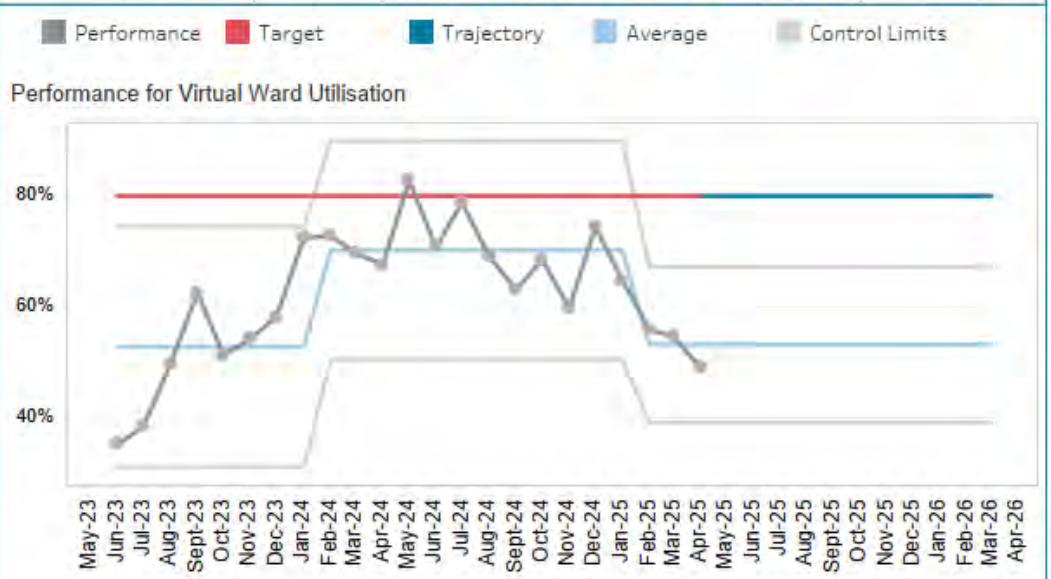
- The number of admissions to the virtual ward reduced slightly in April to 164 (March was 179), and the proportion of patients admitted on a step-down pathway has reduced to 19% (March was 29%).

Risks and Issues

- Currently not consistently meeting the 80% trajectory and a deteriorating position
- Pilot of the Stockport Integrated Care Co-ordination service is in its early stages of implementation and potentially leading to some inefficiencies which are being addressed.

Actions and Mitigations

- 'Comms' recovery plan underway. Radical review of all Comms to Primary & Acute Care
- Meeting with Medical Director early June to discuss KPIs for promotion of Early Supported Discharge via VW
- Pilot in Victoria Primary Care Network to commence on 19 May, which will enable direct referral of patients to reduce hospital attendance
- Pilot to commence direct referral from TECH company; Carecall to referral clients direct for assessment
- Direct bookable appointments via Adastra to be implemented.



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Signed off by	Jane Ankrett
Executive Lead	Jackie McShane

Operational Performance report
Exception

BUSINESS INTELLIGENCE

NHS Stockport NHS Foundation Trust

Operations **Outpatient Efficiencies**

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
Outpatient DNA rate	The number of appointments where the patient did not attend, as a percentage of all booked appointments.	<= 6.3%	6.8%			

Performance Summary

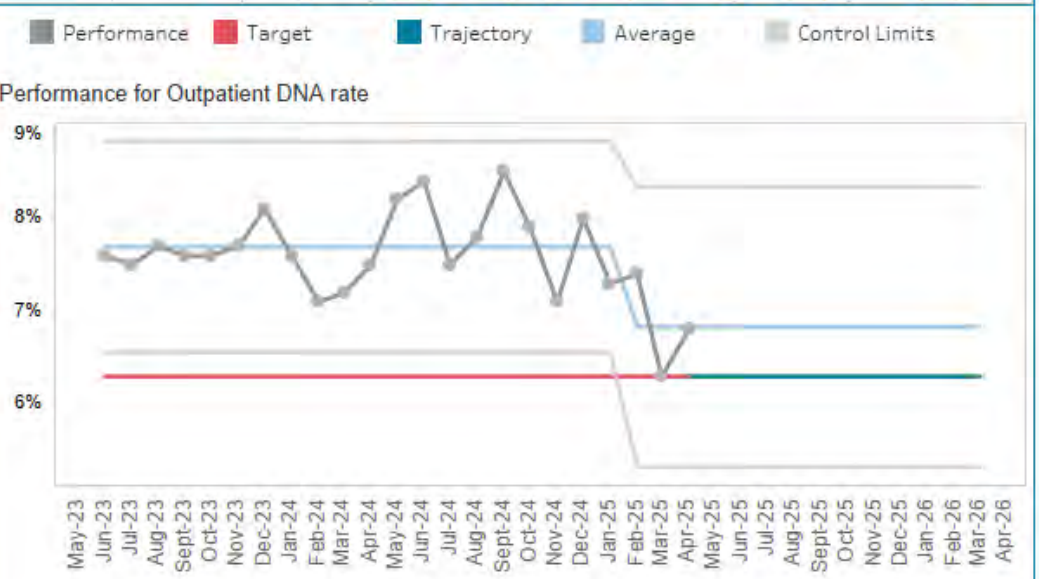
- The DNA rate for April was 6.8%, maintaining the improved trajectory over the last 6 months.
- As of 21st May performance for month to date was 6.3%.

Risks and Issues

- Fluctuation in outpatient booking centre capacity can impact on DNA rates. Recruitment to turnover and increased WTE from IPT funding in progress.
- Ongoing relocation of outpatient services following OPD B closure has an inherent increased risk of DNA
- Processes relating to non-face to face clinics

Actions and Mitigations

- T&F group work with Medicine & Paediatrics remains in place
- Ongoing review with HCC of the text reminder reporting system
- Actions taken through the GIRFT Further Faster initiative
- Ophthalmology Transformation Project focussing on DNA rate for this speciality



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Signed off by	Mike Allison
Executive Lead	Jackie McShane

Operational Performance report
Exception

BUSINESS INTELLIGENCE

NHS Stockport NHS Foundation Trust

Operations **Theatres**

	Target	Actual	6-month trend	Previous Performance	1-month Forecast
Capped Touch Time Utilisation — The overall time spent operating, calculated as a percentage of the overall planned session time. Session overrun time is excluded.	>= 80%	78.3%			

Performance Summary

- 78.1% capped utilisation in April 2025 which was a deterioration from March 2025 which was 80.3%
- Booked utilisation increased slightly at 109% in April for the Trust. This is an improvement of 2% compared to March 2025
- Improved average late starts in April (33 mins) compared to March 25 (35mins) but still an area for further improvement.
- Increase in on the day cancellation in April 2025 compared to March 2025. This was driven by an increase in trauma and emergency patients in April.

Key Risks/Issues

- Theatre nursing/staff rate changes continues to impact.
- Sub-optimal late starts and early finishes performance
- Pre-Op vacancies/sickness and capacity to supply slots
- Estates - broken lifts and issues with temperature controls

Actions and Mitigations

- Theatres Improvement programme (This has 3 streams: a) on the day cancellation; b)late starts and; c)flow from recovery area to ward
- Ophthalmology Improvement programme
- Theatre Performance Meetings, 3 x weekly to continue to support analysis, peer challenge and drive improvements
- Specialty update and challenge from the division to ensure that actions being undertaken to deliver against performance trajectory.
- Pre-Op transformation project commenced
- Agency staff being deployed to mitigate nurse staffing gaps.

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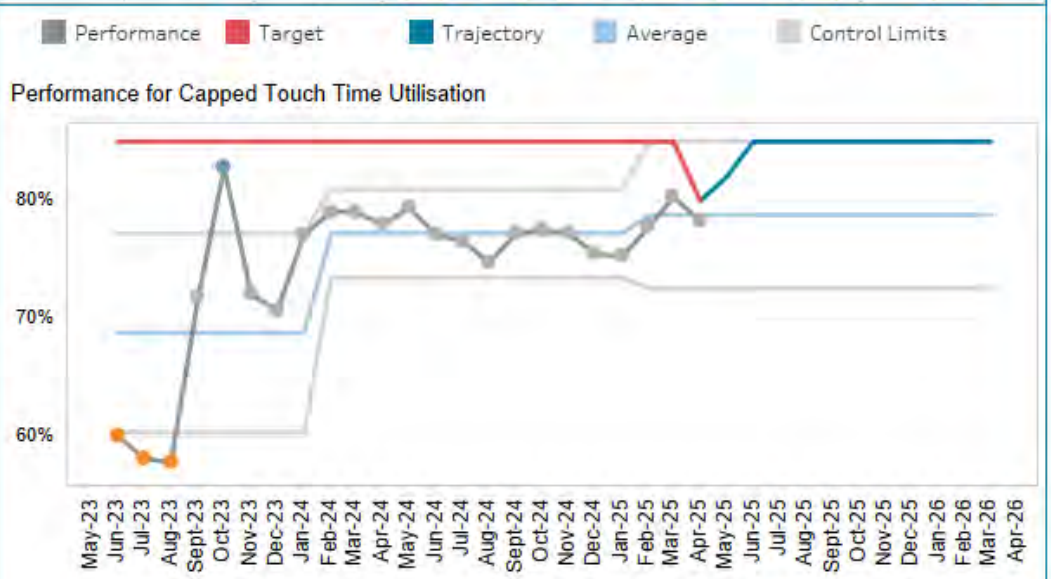

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Executive Lead	Jackie McShane

Operations **Outpatient First and Procedures**

	Target	Actual	6-month trend	Previous Performance	1-month Forecast
OP First Attend and Procedure	>= 42.8%	42%			

The total number of outpatient attendances that are a first-attendance, or are an outpatient procedure, as a percentage of all outpatient attendances.

Performance Summary

- Steady improvement has been seen during the year, primarily driven through validation work, although the last few months are seeing a small decline
- April performance is in line with the trajectory at 42%, this will likely increase once all outstanding appointments for the month are outcomed and coded on PAS.

Risks and Issues

- Poor engagement by clinicians recording the procedures being undertaken in outpatient clinics. (either via paper RTT forms or within the new digital electronic outcome form (CLIO).
- Transcription errors by administrative staff who transcribe the data into Patient Centre.
- Missing procedure codes on the electronic outcome form.

Actions and Mitigations

- On-going validations and engagement with administrative staff about correct recording processes on PAS.
- Benchmarking procedure coding by speciality to identify areas of opportunity.
- On-going work with divisions to highlight procedures being undertaken in clinics which are not captured on CLIO.
- Development to CLIO to add the additional procedures so they can be captured.
- Data quality reports highlighting mismatches in procedure transcribing onto PAS developed and share with teams.

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Updated provided by	Debbie Hope
Executive Lead	Jackie McShane

Workforce **Sickness Absence**

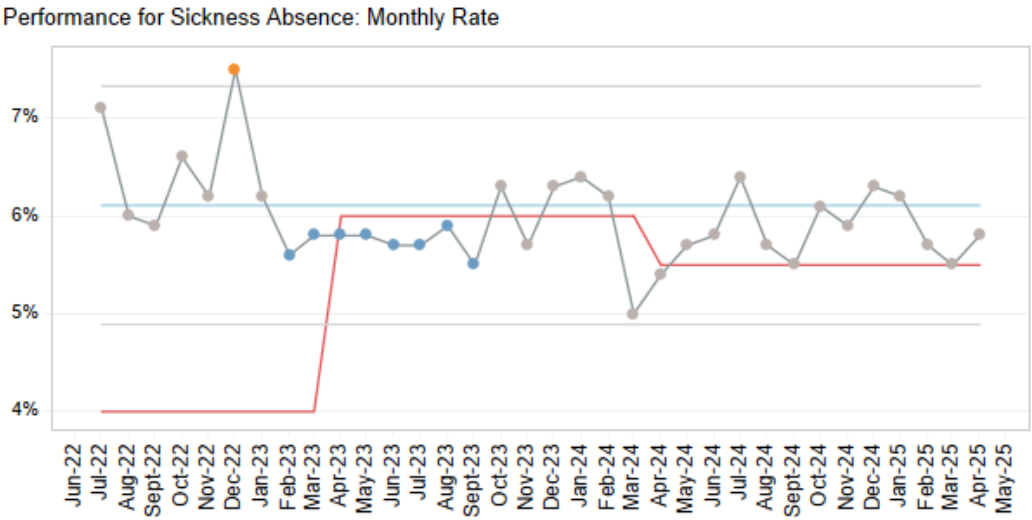
	Target	Actual	6-month trend	Previous Performance	1-month Forecast
Sickness Absence: Monthly Rate — The total number of staff on sickness absence, calculated as a percentage of all staff-in-post whole time equivalent.	<= 5.5%	5.8%			

The sickness rate for April is 5.81% this is a marginal increase of 0.3%. There has been an increase in long term sickness this month and more recently it has been observed within Estates & Facilities Division. The team have an aging profile, and the absences are associated with that profile. The Director of People & OD attended the E&F sickness absence meeting and received assurance that processes and plan are in place to resolve this.

Monthly Divisional Sickness oversight reviews, conducted by the Head of HR or the Deputy Director of People & OD, continue with each Division to address complex cases and prioritise a person-centred approach. The focus is to effectively manage staff with persistent or long-term absences. These reviews focus on supporting employees in their return from absence or appropriately escalate cases where there is no foreseeable return to work and agreeing a plan to exit the member of staff from the Trust.

Going forward the reviews will focus more on options for interventions and actions to support reductions in short term absence episodes, as the data shows that this is increasing.

In addition, we have undertaken a review of staff absence of 6 months or longer, with a focus on ensuring appropriate and timely management and escalating cases as appropriate as evidence shows that the timing of interventions is essential for a successful and earlier return to work, including phased return programmes together with appropriate reasonable adjustment to the role.



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Executive Lead	Amanda Bromley

Workforce **Appraisal Rate**

	Target	Actual	6-month trend	Previous Performance	1-month Forecast
Appraisal Rate: Overall — The percentage of overall staff that have been appraised within the last 15 months. Includes both medical staff and non-medical staff.	>= 95%	85%	↓	▲ ▲ ▲ ▲ ▲ ▲	▲

The Trust's overall appraisal compliance for April 2025 was 85% against the target of 95%. This is a 3% decline compared to the position in February 2025. The decreased performance was anticipated due to appraisal activity being aligned to the new appraisal window process.

As highlighted in previous reports, to help strengthen our performance management approach and enhance the quality of appraisals, an appraisal cascade approach has been implemented. Appraisal discussions are to take place during the 'appraisal window' which commenced on 1st April and will run until 30th September. There are set timescales within that period for appraisals to be completed for each tier of the structure, taking a top-down approach. This reinforces the Trust's corporate objectives and priorities at every level of the organisation.

To support the successful implementation of this new approach:

- Divisional Planning: HR colleagues have worked closely with Divisions to support them with appraisal plans that align with the new cascade structure. People and OD representatives have attended leadership meetings to reinforce the importance of tiered objective-setting that links directly to corporate priorities.
- Training and Development: A new training package for appraisers was launched, focusing on SMART objective-setting aligned with corporate and divisional goals. The training also includes guidance on delivering performance feedback with compassion and accountability. This training has now been fully rolled out and has also been embedded into the business-as-usual appraisal training programme moving forward.
- Updated Appraisal Materials: The "Let's Talk Appraisal" documentation has been revised to include the new C.A.R.E values and behaviours and place greater emphasis on setting objectives that align with the Trust's strategic aims.

Progress on compliance at each stage is in place to ensure delivery of the compliance target.

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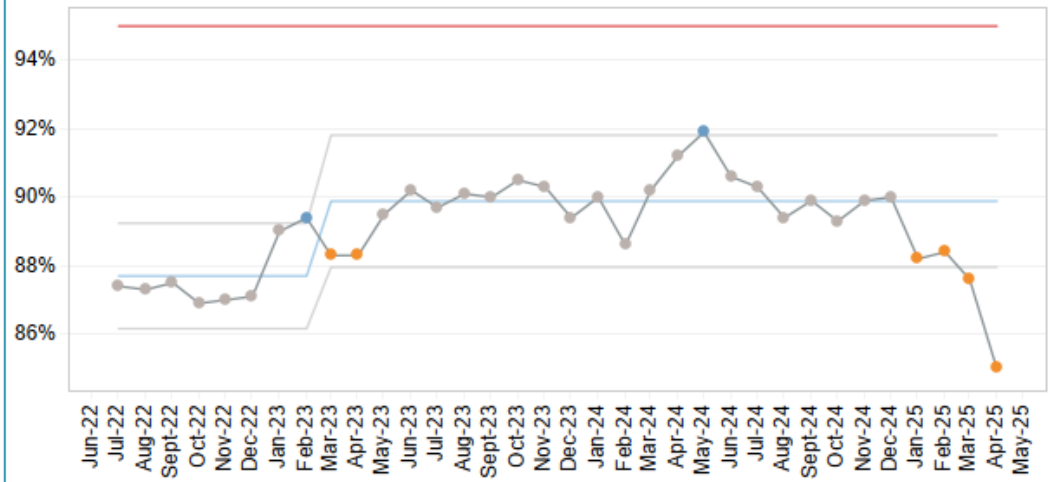
Performance for Appraisal Rate: Overall



Signed off by	Emma Cain
Executive Lead	Amanda Bromley

Workforce **Mandatory Training**

	Target	Actual	6-month trend	Previous Performance	1-month Forecast
Mandatory Training — The percentage of statutory & mandatory training modules showing as compliant.	>= 95%	93.7%	↓	▲ ▲ ▲ ▲ ▲ ▲	▲

Mandatory training currently stands at 93.7% for the month of April. Mandatory training days have been planned throughout the year with the first taking place on the 27th May. These days are intended to complement the current offer and increase access to training sessions.

Educators in each division are working with the Learning and Education Team to improve compliance in underperforming divisions.

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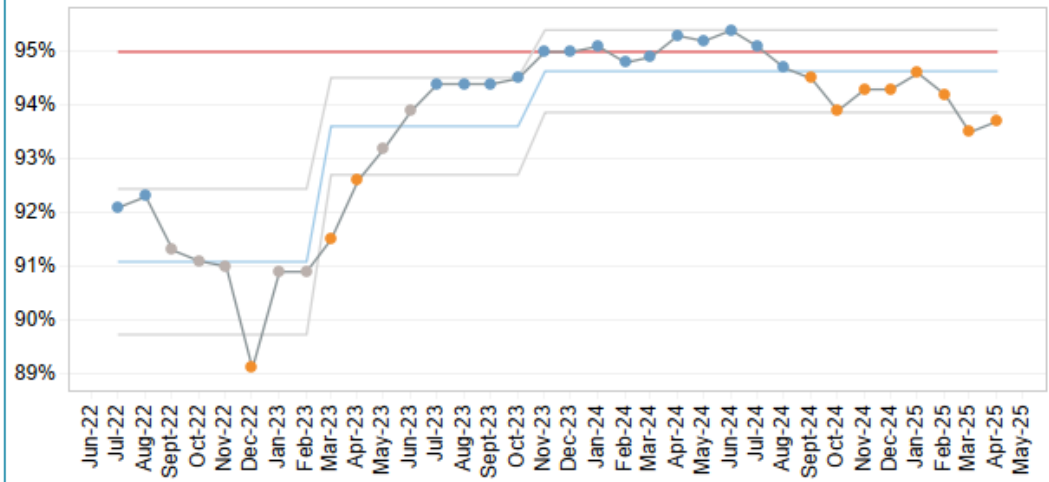
Performance for Mandatory Training



Signed off by	Emma Cain
Executive Lead	Amanda Bromley

Integrated Performance Report
Exception

BUSINESS INTELLIGENCE

NHS Stockport NHS Foundation Trust

Finance **Risks**

		Target	Actual	6-month trend	Previous Performance	1-month Forecast
Financial Controls: I&E Position	The actual financial position, displayed as a percentage variance from the planned financial position.	<= 0%	-0%	→	▲ ▲ ▲ ● ▲ ●	●
Cash Balance	The amount of cash balance in Trust accounts. Figures displayed are millions per month.		35.6	↑		
CIP Cumulative Achievement	The value of the actual CIP achievement, displayed as a percentage variance from the planned CIP achievement.	>= 0%	-32.9%	↓	● ● ● ● ● ▲	▲
Capital Expenditure	The actual capital expenditure, as a percentage of the planned capital expenditure. Performance is displayed as a percentage variance from the planned amount.	<= 10%	456.2%	↓	● ● ● ● ● ▲	▲

Risks

There are some key risks in the plan, which will be monitored throughout the year:

- Payments for variable activity within ICB contracts
- Achievement of the Trusts £29.2m Cost Improvement Plan (CIP)
- Inflationary pressures over and above those included in planning assumptions
- Potential industrial action related to the national pay award
- The impact of any unfunded pay award
- The requirement for enhanced care

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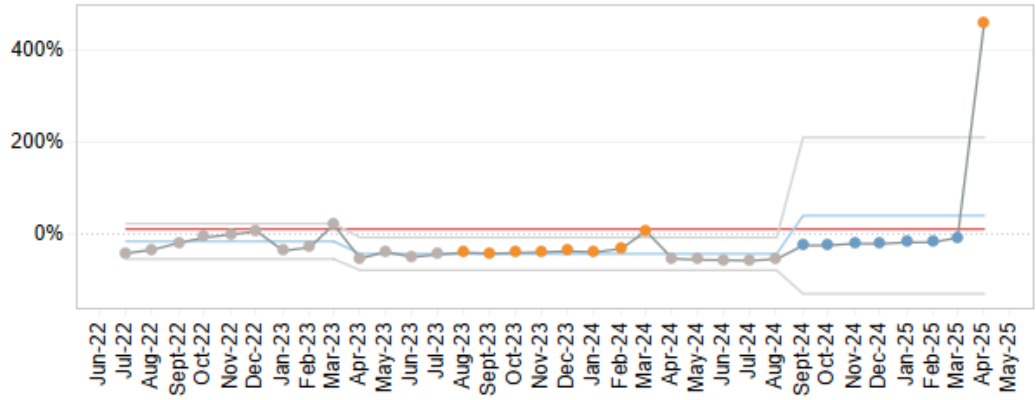
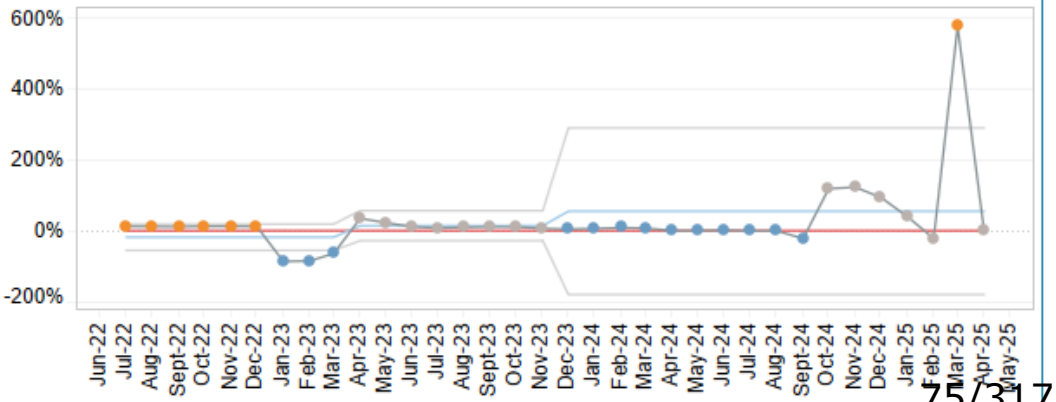
Performance for Capital Expenditure



Performance for Financial Controls: I&E Position



Signed off by	Kay Wiss
Executive Lead	John Graham

NHS Stockport NHS Foundation Trust

				Agenda No.	
Meeting date	**5th June 2025**	**Public**	**X**	**Confidential**	
Meeting	Board of Directors				
Report Title	Financial Position Month 1 2025/26				
Director Lead	John Graham Chief Finance Officer	**Author**	Kay Wiss Director of Finance		

Paper For:	**Information**		**Assurance**	**X**	**Decision**	
Recommendation:	The Board of Directors is asked to receive the Financial Position Report for Month 1 2025/26, to update on the current financial position in support of the Integrated Performance Report.					

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

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

This paper relates to the following Board Assurance Framework risks

	PR1.1	There is a risk that the Trust does not deliver high quality care to service users
	PR1.2	There is a risk that patient flow across the locality is not effective
	PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan
	PR2.1	There is a risk that the Trust is unable to sufficiently engage and support our people's wellbeing
	PR2.2	There is a risk that the Trust does not actively participate in local collaborative programmes/neighbourhood working to improve primary and secondary health outcomes

	PR3.1	There is a risk that place-based partnership working does not effectively support delivery of Stockport ONE Health & Care (Locality) Board priorities and address health inequalities in Stockport
	PR3.2	There is a risk that partnership working in Greater Manchester do not effectively address unwarranted variation of services and improve health inequalities
	PR3.3	There is a risk that opportunities for collaboration between Stockport NHS Foundation Trust and Tameside & Glossop Integrated Care NHS Foundation Trust are not optimised
	PR4.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit and retain the optimal number of staff, with appropriate skills and values
	PR4.2	There is a risk that the Trust's workforce is not reflective of the communities served
	PR5.1	There is a risk that the Trust does not implement high quality service improvement programmes
	PR5.2	There is a risk that the Trust does not implement high quality research & development programmes
X	PR6.1	There is a risk that the Trust does not deliver the annual financial plan
X	PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial sustainability plan
	PR7.1	There is a risk that the Trust does not implement the Digital Strategy to ensure a resilient and responsive digital infrastructure
	PR7.2	There is a risk that the estate is not fit for purpose and/or meets national standards
	PR7.3	There is a risk that the Trust does not materially improve environmental sustainability
	PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus

Where issues are addressed in the paper

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

Executive Summary

The Trust has agreed a balanced financial plan for 2025/2026 with a CIP(STEP) programme of £29.2m.

The Trust plan was for a deficit of £1.2m at Month1 and the Trust was in line with this plan. A detailed finance paper was presented to the Finance & Performance Committee on the 15th May 2025 and this paper is the summarised key extracts from that paper.

From an overall plan perspective at this early stage in the financial year the Trust is forecasting a balanced year-end position.
The Trust has delivered savings of £10.1m of at Month 1 which is 35% of the full year target of £29.2m. However in month the target was to deliver £2.0m and only £1.3m was transacted. This continues to be a

key area of focus for the Trust and plans to deliver the full target for the year are being accelerated as 75% need to be fully developed and documentation approved by the end of June 2025, in accordance with NHSE NW requirements.

Temporary staffing costs are £2.9m on month and further guidance will be issued from NHSE in May 2025 as how the required reductions will be tracked. However reducing temporary spend remains one of the key focus areas within the financial plan and is overseen by the Workforce Efficiency Group.

The Trust's cash balance at the end of April 2025 was £35.9m.

The Trust has spent £2.9m on capital costs in Month 1 against a plan of £2.8m. The Trust's annual submitted capital plan is £35.4m.

Stockport Foundation Trust

Finance Report Month 1
2025/26

John Graham - Chief Finance Officer

Contents

Overall Financial Position

Income & expenditure Position	April 2025 (M01) Budget £m	April 2025 (M01) Actual £m	April 2025 (M01) Variance £m	Year to Date Budget £m	Year to Date Actual £m	Year to Date Variance £m	Forecast Budget £m	Forecast Actual £m	Forecast Variance £m
Total Income	**41.6**	**41.3**	**(0.2)**	**41.6**	**41.3**	**(0.2)**	**504.6**	**504.6**	**-**
Substantive Staff	(27.3)	(27.6)	(0.3)	(27.3)	(27.6)	(0.3)	(327.2)	(327.2)	-
Bank Staff	(2.6)	(2.3)	0.3	(2.6)	(2.3)	0.3	(30.8)	(30.8)	-
Agency Staff	(0.5)	(0.6)	(0.1)	(0.5)	(0.6)	(0.1)	(6.3)	(6.3)	-
Pay Costs	(30.4)	(30.5)	(0.1)	(30.4)	(30.5)	(0.1)	(364.4)	(364.4)	-
Drugs	(2.1)	(1.9)	0.2	(2.1)	(1.9)	0.2	(25.7)	(25.7)	-
Clinical Supplies & Services	(2.5)	(2.6)	(0.0)	(2.5)	(2.6)	(0.0)	(28.6)	(28.6)	-
Other Non Pay Costs	(5.5)	(5.5)	0.0	(5.5)	(5.5)	0.0	(55.9)	(55.9)	-
Below the Line	(2.2)	(2.2)	0.1	(2.2)	(2.2)	0.1	(30.3)	(30.3)	-
Total Expenditure	**(42.8)**	**(42.6)**	**0.2**	**(42.8)**	**(42.6)**	**0.2**	**(504.9)**	**(504.9)**	**-**
TRUST SURPLUS / (DEFICIT)	**(1.2)**	**(1.2)**	**0.0**	**(1.2)**	**(1.2)**	**0.0**	**(0.3)**	**(0.3)**	**-**
System reporting adjustments	0.0	0.0	(0.0)	0.0	0.0	(0.0)	0.3	0.3	-
Adjusted financial performance surplus/(deficit) for the purposes of system achievement	**(1.2)**	**(1.2)**	**(0.0)**	**(1.2)**	**(1.2)**	**(0.0)**	**0.0**	**0.0**	**-**
Stockport Trust Efficiency Programme (STEP)	2.0	1.3	(0.7)	2.0	1.3	(0.7)	29.2	29.2	-
Efficiencies as % of expenditure	*4.7%*	*3.1%*		*4.7%*	*3.1%*		*5.8%*	*5.8%*	
Capital expenditure	(2.8)	(2.9)	(0.1)	(2.8)	(2.9)	(0.1)	(35.4)	(35.4)	-

Summary of Financial Performance

Stockport NHS Foundation Trust

At this point in the year there are few variances to report on.

- **In month and Year to date:** The Trust has a £1.2m deficit, which is in line with the Trust's financial plan.

- **Forecast:** The Trust anticipates meeting its financial plan in full. There are some key risks in the plan, which will be monitored throughout the year:
  - Payments for variable activity within ICB contracts
  - Achievement of the Trusts £29.2m Cost Improvement Plan (CIP)
  - Inflationary pressures over and above those included in planning assumptions
  - Potential industrial action related to the national pay award
  - The impact of any unfunded pay award
  - The requirement for enhanced care

- **Cost Improvement Programme (CIP):** The Trust has delivered £10.1m (35%) of the full year CIP target, and £7.6m (37%) of the recurrent target. The status of the Trust CIP delivery is being monitored on a weekly basis by NHSE. By the end of June 2025 there is a requirement for:
  - 75% of schemes to have been fully scoped, including PID approval
  - Zero unidentified balance

- **Cash:** The Trust has maintained sufficient cash to operate during the month and is forecasting sufficient through to year-end.

- **Capital:** The Capital forecast for 2025-26 is £35.4m, in line with plan.

Run Rate Analysis

Stockport NHS Foundation Trust

Run Rate Trends - Rolling 15 months - £

Month	Income	Non-Pay	Pay	Total
Feb-24	35,163	(10,847)	(27,596)	(3,280)
Mar-24	52,343	(15,273)	(39,442)	(2,372)
Apr-24	35,614	(12,688)	(27,949)	(5,023)
May-24	35,934	(11,177)	(28,174)	(3,416)
Jun-24	36,485	(12,846)	(28,663)	(5,024)
Jul-24	36,405	(12,224)	(28,578)	(4,396)
Aug-24	36,727	(13,039)	(28,179)	(4,492)
Sep-24	62,593	(12,508)	(28,303)	21,783
Oct-24	47,219	(14,230)	(34,307)	(1,318)
Nov-24	39,094	(10,436)	(29,541)	(883)
Dec-24	40,629	(12,165)	(28,841)	(377)
Jan-25	39,868	(10,340)	(29,189)	339
Feb-25	40,154	(10,387)	(28,820)	947
Mar-25	64,303	(29,909)	(51,217)	(16,823)
Apr-25	41,342	(12,124)	(30,458)	(1,241)

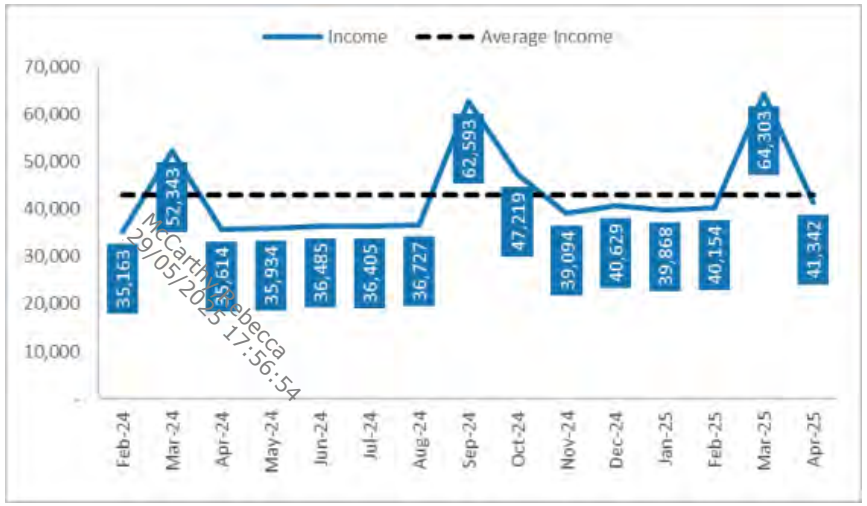
Key Movements

The graphs and tables in this slide give a rolling 15-month view of income, pay and non-pay expenditure trends.

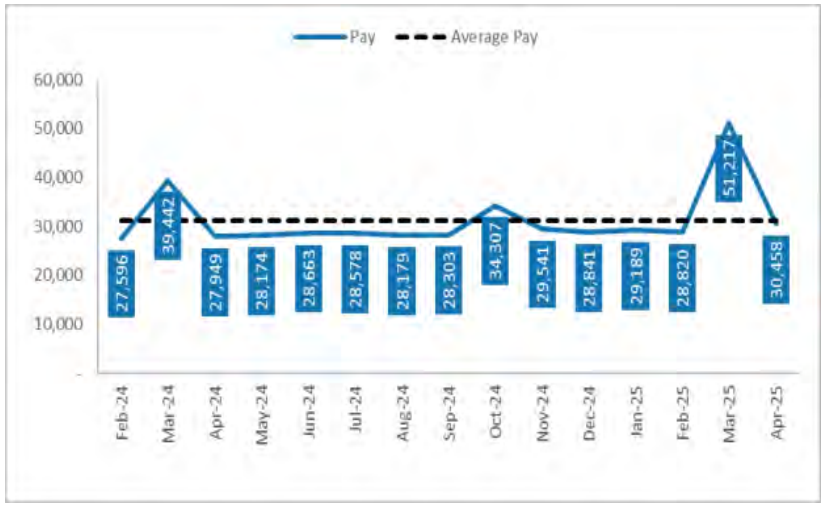
At the end of 2024-25 there was an increase in all areas, due to impairments and losses, all of which were anticipated and agreed with GMICS.

Month 1 of 2025-26 has seen income, pay and non-pay return to previous trend levels, after accounting for inflationary impacts. Pay inflation has been included at 4.72%.

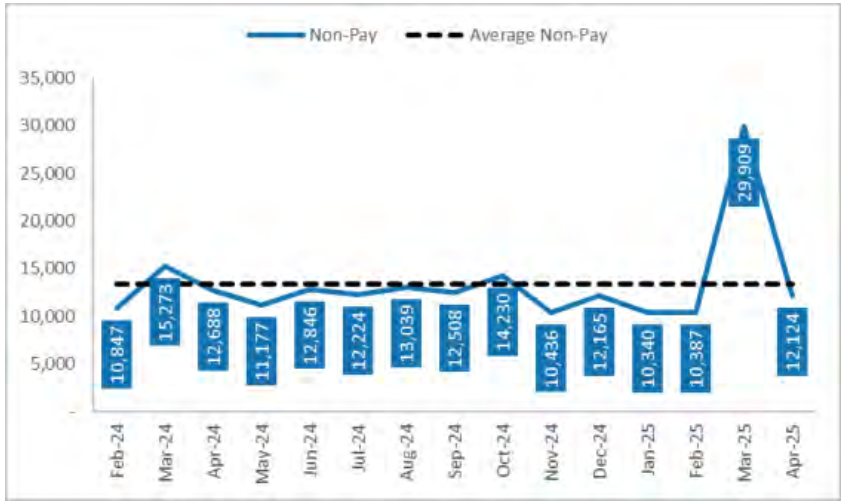
Income



Pay



Non-Pay



Stockport
NHS Foundation Trust

Income & Variable Activity Payments

Income Position

Stockport NHS Foundation Trust

Income & expenditure Position	April 2025 (M01) Budget £m	April 2025 (M01) Actual £m	April 2025 (M01) Variance £m	Year to Date Budget £m	Year to Date Actual £m	Year to Date Variance £m	Forecast Budget £m	Forecast Actual £m	Forecast Variance £m
Greater Manchester ICB (Core and delegated)	32.4	32.3	(0.1)	32.4	32.3	(0.1)	388.7	388.7	-
Derby and Derbyshire ICB (Core and delegated)	3.2	3.2	0.0	3.2	3.2	0.0	38.1	38.1	-
Cheshire and Merseyside ICB (Core and delegated)	1.8	1.8	0.0	1.8	1.8	0.0	22.1	22.1	-
Specialised Commissioning	0.3	0.3	0.0	0.3	0.3	0.0	3.8	3.8	-
Low value activity	0.1	0.2	0.0	0.1	0.2	0.0	1.7	1.7	-
Local Authority	0.5	0.5	0.0	0.5	0.5	0.0	6.1	6.1	-
Injury cost recovery scheme	0.1	0.0	(0.0)	0.1	0.0	(0.0)	0.7	0.7	-
Other income from patient care	0.0	0.0	(0.0)	0.0	0.0	(0.0)	8.8	8.8	-
Clinical Income from Patient Care Activities	**38.5**	**38.4**	**(0.1)**	**38.5**	**38.4**	**(0.1)**	**470.0**	**470.0**	**-**
Research & Development	0.1	0.1	(0.0)	0.1	0.1	(0.0)	1.1	1.1	-
Education & Training	0.9	1.0	0.1	0.9	1.0	0.1	9.9	9.9	-
Pharmacy Trading Units Income	0.5	0.3	(0.2)	0.5	0.3	(0.2)	7.2	7.2	-
Other Income	1.6	1.6	(0.0)	1.6	1.6	(0.0)	16.5	16.5	-
Donations of cash for charitable assets	-	-	-	-	-	-	-	-	-
Other Income	**3.1**	**2.9**	**(0.1)**	**3.1**	**2.9**	**(0.1)**	**34.7**	**34.7**	**-**
Total Income	**41.6**	**41.3**	**(0.2)**	**41.6**	**41.3**	**(0.2)**	**504.6**	**504.6**	**-**

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The clinical income year to date position is £0.1m adverse to plan. However, the Trust is forecast to be in line with plan by year end.

Conversations are currently taking place with commissioners around final contract offers for 2025-26. The values in the table opposite represent the latest confirmed values.

Activity and corresponding financial targets are currently being loaded into the Trusts Service Line Activity Monitoring (SLAM) system, aligned to the Annual Plan. This will support the reporting of the elements of clinical income that are paid on an activity basis from month 2 onwards.

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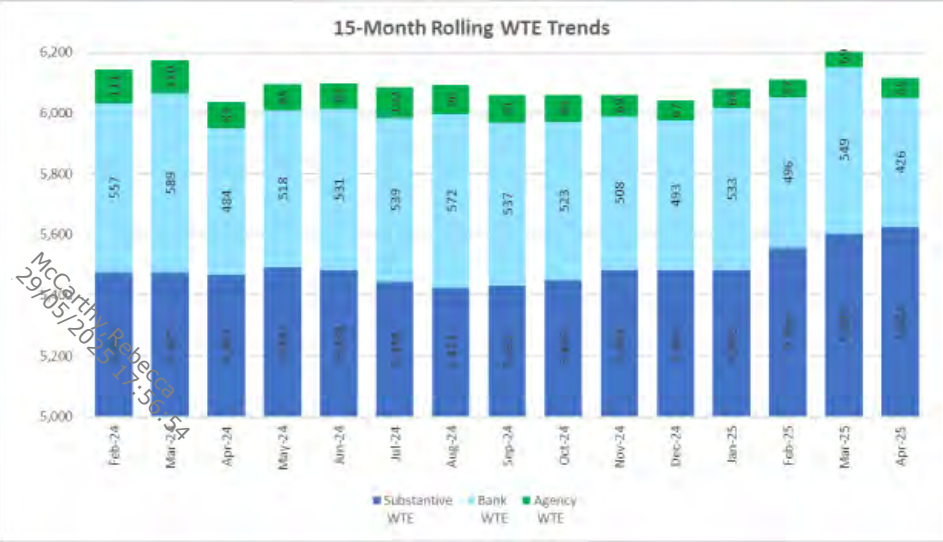
Workforce & Temporary Staffing

Staff and WTE reconciliation - WTE

Month	Substantive WTE	Bank WTE	Agency WTE	Total WTE	Bank % of WTE	Agency % of WTE
Feb-24	5,476	557	111	6,143	9.1%	1.8%
Mar-24	5,475	589	110	6,173	9.5%	1.8%
Apr-24	5,467	484	85	6,036	8.0%	1.4%
May-24	5,491	518	85	6,095	8.5%	1.4%
Jun-24	5,484	531	83	6,097	8.7%	1.4%
Jul-24	5,444	539	102	6,085	8.9%	1.7%
Aug-24	5,424	572	96	6,092	9.4%	1.6%
Sep-24	5,432	537	91	6,060	8.9%	1.5%
Oct-24	5,449	523	89	6,060	8.6%	1.5%
Nov-24	5,481	508	69	6,058	8.4%	1.1%
Dec-24	5,482	493	67	6,042	8.2%	1.1%
Jan-25	5,483	533	64	6,080	8.8%	1.1%
Feb-25	5,556	496	57	6,109	8.1%	0.9%
Mar-25	5,603	549	69	6,221	8.8%	1.1%
Apr-25	5,624	426	65	6,115	7.0%	1.1%
Movement	21	(124)	(4)	(106)		



WTE Summary

Total WTE has decreased by 106 in the first month of 2025/26 compared to March 2025, a decrease of 124 bank WTE, a decrease of 4 agency, offset by an increase of 21 WTE substantive staff.

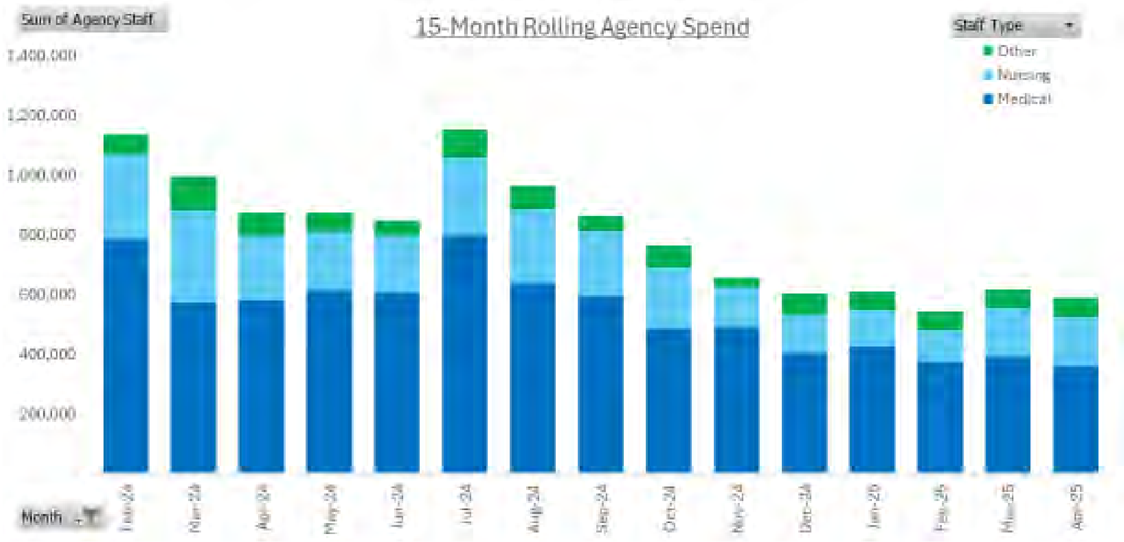
This was following an increase in March temporary staffing, required to cover shifts in Surgery, Medicine and Facilities due to higher sickness rates and additional annual leave cover as previously noted.

A further factor in the in-month decrease in bank WTE are the reduced NHSP rates implemented across the Trust in March. This has led to a decreased uptake of bank shifts, particularly in the Surgery Division. This is posing a risk of agency being used as an alternative to cover shifts.

For 2025/26, the Trust has submitted a compliant annual plan, which includes a reduction in bank WTE of 56.7 and a reduction in agency WTE of 19.6. Staff in post numbers for WTE are below the agreed plan in Month 1 by 142.90.

Staff and WTE reconciliation - £

Stockport
NHS Foundation Trust



As detailed in the previous slide, for 2025/26, the Trust has submitted a compliant annual plan, which includes a phased reduction in bank WTE of 56.7 and a phased reduction in agency WTE of 19.6. This means that the Trust's annual expenditure limits are £30.9m for bank and £6.3m for agency. Further detail of comparisons to plan and phasing will be reported from Month 2 which will align with the GM ICB and NHSE reporting requirements which have yet to be received.

April agency costs are £0.6m and bank costs are £2.3m. If this level of expenditure continues agency spend will be £0.7m adverse to plan and bank spend would be £3.3m favourable to plan. This doesn't account for any seasonal trend or pay uplift agreements above the 4.72% included in plans.

Positively, both bank and agency spend has decreased in month and temporary staff usage is a key focus of the Trusts Workforce Efficiency Group (WEG).

NHS
Stockport
NHS Foundation Trust

Trust Efficiency Programme

STEP (Stockport Trust Efficiency Programme)

Stockport NHS Foundation Trust

The Trust STEP target for 2025-26 is £29.2m, of which £20.5m (70%) is recurrent and £8.6m (30%) is non-recurrent.

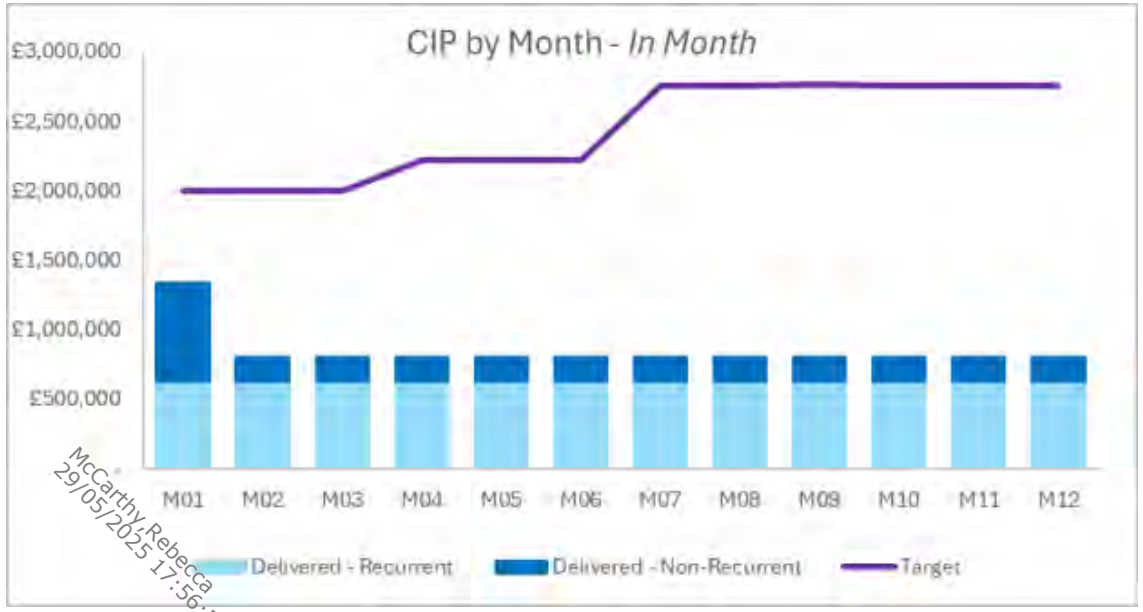
In year £10.1m (35%) of the full year CIP target has been delivered, and £7.6m (37%) of the recurrent target.

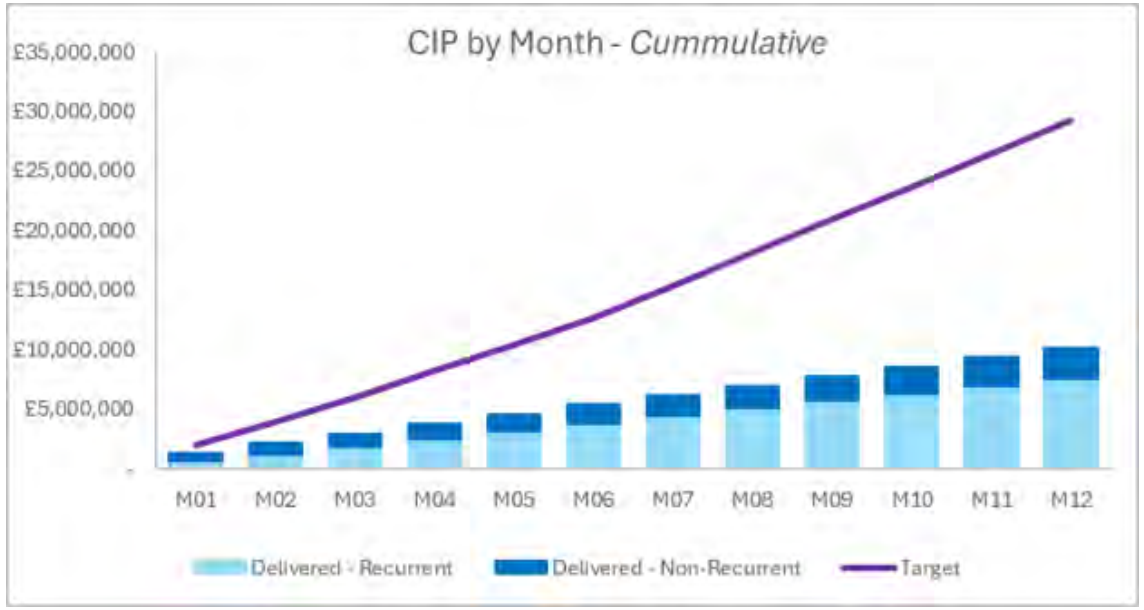
Schemes have been identified in year for 85% of the total target, leaving an unidentified gap of £4.3m. Externally the Trust is reporting forecast delivery of 100% of the in-year target, anticipating that the current unidentified gap will be identified by the end of June 2025.

			2025/26 In Year £'000							2025/26 Recurrent £'000						
Division	Target YTD	Delivered YTD	Target - FYE	Delivered	Green	Amber	Red	Gap	% Identified	Target Recurrent	Delivered	Green	Amber	Red	GAP	% Identified
Medicine and Urgent Care	411	60	4,933	717	-	324	1,300	2,592	47%	3,476	47	-	503	1,570	1,356	61%
Surgery	324	329	3,889	1,000	279	21	331	2,257	42%	2,740	291	315	24	435	1,674	39%
Women & Children	161	51	2,228	614	-	1,207	356	51	98%	1,570	15	-	13	362	1,180	25%
Integrated Care	154	4	1,854	49	326	1,011	42	426	77%	1,307	18	326	1	32	930	29%
Clinical Support Services	159	141	2,305	392	397	751	1,523	(757)	133%	1,624	244	484	377	1,718	(1,199)	174%
Estates & Facilities	122	10	1,470	117	-	81	132	1,140	22%	1,036	12	-	58	257	709	32%
Corporate	136	17	1,627	200	90	-	-	1,337	18%	1,146	29	145	-	-	972	15%
Sub-total Divisions	**1,467**	**611**	**18,306**	**3,090**	**1,093**	**3,395**	**3,683**	**7,046**	**62%**	**12,899**	**655**	**1,271**	**976**	**4,374**	**5,623**	**56%**
General Trust	530	729	10,894	7,065	-	6,000	600	(2,771)	125%	7,676	6,911	-	-	-	765	90%
TOTAL	**1,997**	**1,340**	**29,200**	**10,154**	**1,093**	**9,395**	**4,283**	**4,275**		**20,575**	**7,567**	**1,271**	**976**	**4,374**	**6,388**	
TOTAL IDENTIFIED		**1,340**		**TOTAL IDENTIFIED**				**24,925**			**TOTAL IDENTIFIED**					**14,187**
	YTD gap	*657*				*In Year gap*		*4,275*					*Recurrent gap*			*6,388*
	%Identified	**67%**				***%Identified***		**85%**					***%Identified***			**69%**

STEP (Stockport Trust Efficiency Programme)

The profile of savings required across the year is shown in the purple lines on the below charts, highlighting an increased requirement in the second half of 2025-26.

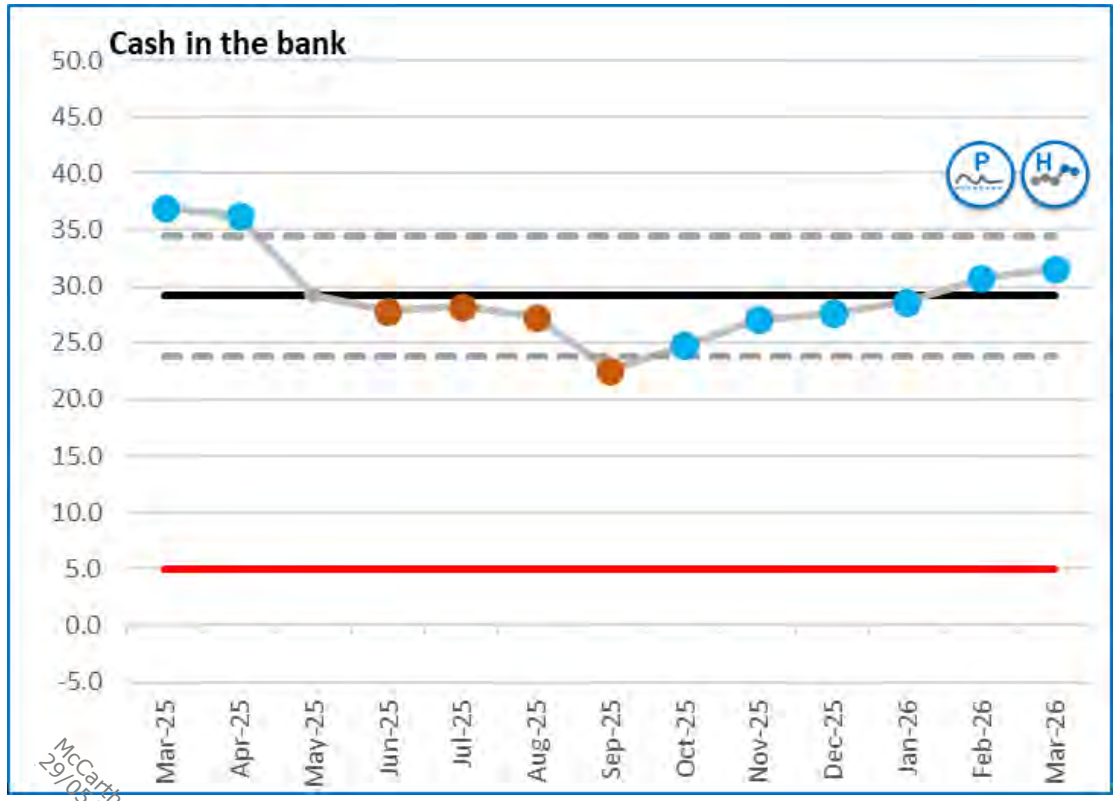




Stockport
NHS Foundation Trust

Cash, Capital & PFI

Cash



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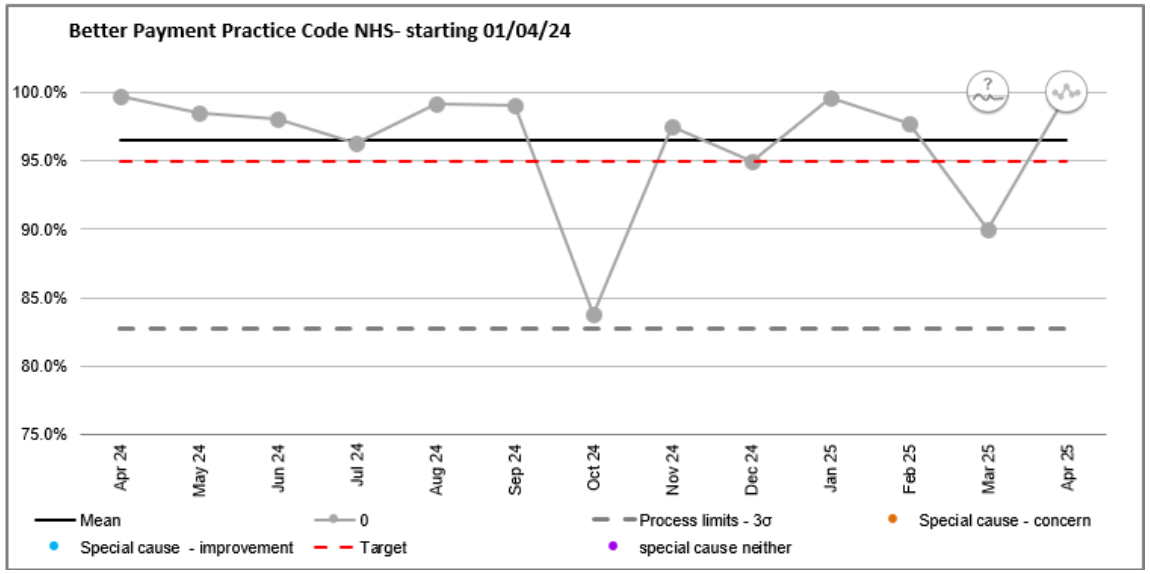
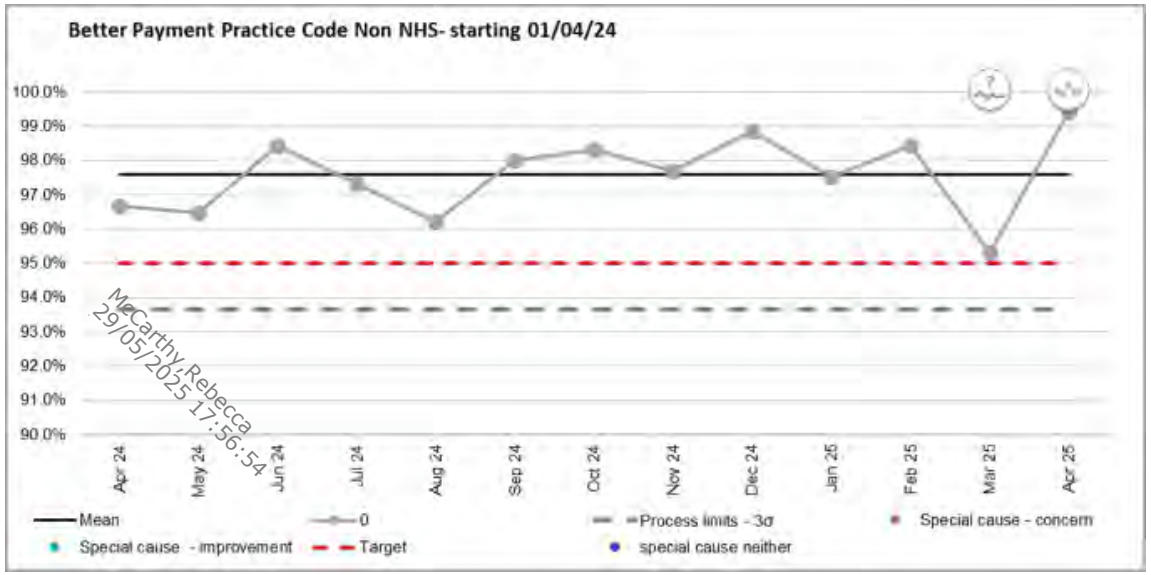
- Cash balances at the end of April were £35.9m for the Trust and £0.2m for the Pharmacy Shop subsidiary, a decrease from £36.97m at year-end.
- Cash balances are expected to decrease to approximately £31.6m by the end of the financial year (March 2026), in line with the Trusts annual plan.
- Built into the forecast is an anticipated repayment of Capital PDC received in prior years, due to be paid back in March 2026.
- The cashflow monitoring group continue to monitor cash balances on a regular basis, highlighting areas of concern and risk and investigating variances to forecasted cashflows.

Better Payments Practice Code





- The Better Payment Practice Codes (BPPC) sets the target for 95% of all valid invoices to be paid within the agreed timeframe.
- Performance against the standard is reported for both NHS and non-NHS invoices, as shown as a trend in the charts opposite and summary in the table below.
- The NHS BPPC performance has returned to normal levels since the reduction in March, which was due to settlement of several invoices following a review of purchase and sales ledger balances across GM Trusts, as previously reported.

	BPPC 24/25 Final		BPPC M01	
Better payment practice code	Number	Value £000's	Number	Value £000's
Non NHS				
Total Bills paid in the year	55,410	229,437	5,079	24,496
Total bills paid within target	53,999	220,511	5,003	24,325
Percentage of bills paid within target	97%	96%	99%	99%
NHS				
Total Bills paid in the year	6,104	14,882	855	999
Total bills paid within target	5,915	12,167	850	997
Percentage of bills paid within target	97%	82%	99%	99%
Total				
Total Bills paid in the year	61,514	244,319	5,934	25,495
Total bills paid within target	59,914	232,679	5,853	25,322
Percentage of bills paid within target	97%	95%	99%	99%

Capital

Division £m	March 2025 (M12) Budget £m	Actual £m	Variance £m	Year to Date Budget £m	Actual £m	Variance £m	Forecast Budget £m	Actual £m	Variance £m
Estates	(2.8)	(2.8)	(0.1)	(2.8)	(2.8)	(0.1)	(11.8)	(11.8)	-
Equipment	-	-	-	-	-	-	(0.7)	(0.7)	-
Digital	-	-	-	-	-	-	(21.0)	(21.0)	-
Sub-total	**(2.8)**	**(2.9)**	**(0.1)**	**(2.8)**	**(2.9)**	**(0.1)**	**(33.5)**	**(33.5)**	**-**
IFRS16	-	-	-	-	-	-	(1.9)	(1.9)	-
Total Capital	**(2.8)**	**(2.9)**	**(0.1)**	**(2.8)**	**(2.9)**	**(0.1)**	**(35.4)**	**(35.4)**	**-**

Key Points

- The Trust has submitted a capital plan of £35.4m including £1.9m for IFRS16.

- PDC Allocations for the year total £19.8m, made up of;
  - £15.0m for EPR
  - £2.5m for Estates Safety
  - £1.8m for UEC
  - £0.3m for Elective Recovery
  - £0.2m for Diagnostics

- Capital spend in April 2025 relates to the two schemes carried forward from 2024/25;
  - Emergency Care Campus
  - Outpatients Modular Building

Statement of Financial Position

	As at 28/02/2025 £000's	As at 31/03/2025 £000's
Total Non-Current assets	**265,031**	**243,325**
Current Assets and (Liabilities)		
Inventories	1,287	1,139
Trade Recievables and accrued income	18,872	20,915
Assets held for sale	6,050	7,050
Cash and cash equivalents	33,584	36,968
Current Liabilities	(71,772)	(74,959)
Provisions	(508)	(1,442)
Net Current Assets/Liabilities	**(12,487)**	**(10,329)**
Total Assets Less Current Liabilities	**252,544**	**232,996**
Non-Current (Liabilties)		
Borrowings: leases	(9,475)	(8,040)
Borrowings: DHSC capital loans	(13,775)	(12,223)
Provisions	(2,874)	(2,789)
Total Non-Current Liabilities	**(26,124)**	**(23,052)**
Total Assets Employed	**226,421**	**209,944**
Financed By Taxpayers Equity		
Public dividend capital	253,902	262,692
Revaluation reserve	68,266	59,614
Income & Expenditure Reserve	(95,747)	(112,362)
Total Taxpayers Equity	**226,421**	**209,944**

- The table opposite is an updated closing Statement of Financial Position for 2024/25. The Month 1 data is not currently available.
- The major change to the balance sheet reflects the impairment charge following the valuation exercise completed at year-end.

Meeting date	5 June 2025	**Public**	**X**	**Agenda No.**	13
Meeting	Board of Directors				
Report Title	Opening Budgets 2025/26				
Director Lead	John Graham, CFO/Deputy CEO	**Author**	Kay Wiss, Director of Finance		

Paper For:	**Information**		**Assurance**		**Decision**	X
Recommendation:	The Board of Directors are asked to approve the opening budgets for 2025/2026					

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

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

This paper relates to the following Board Assurance Framework risks

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

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

Where issues are addressed in the paper

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

Executive Summary

The Finance & Performance Committee considered the opening budget for 2025/26 at their meeting on the 15th May 2025 and are recommending the paper for approval by the Board of Directors.

The Trust has set an income and expenditure financial plan with a deficit of £0.3m for 2025/26 aligned with the activity and workforce plans. For GM system reporting purposes this is a breakeven plan.

In accordance with the Standing Financial Instructions the Committee are asked to recommend that the Board of Directors approve the opening budgets for 2025/26 and this paper will set out:

- The assumptions made in the plan
- The key areas for investment to deliver the plan
- Risks to delivery of the plan

The Trust has a draft capital plan of £35.387m for 2025/26.

The paper recognises the submission made by the Trust on the 30th April 2025. This accepts the control total and the Trust will therefore receive £43.2m of system support funding which matches the control total.

The paper also recognises the current known risks to delivery.

1. Purpose

1.1 The Trust has been working on its financial plan in accordance with national guidance and as part of the Greater Manchester Integrated Care System.

1.2 The final financial template submission was submitted on the 30th April 2025; however there needs to be a sign off process for opening base budgets for 2025/26 so that financial governance in accordance with the Standing Financial Instructions (SFIs) section 3.1 is maintained. The Board of Directors previously noted the position from the 3rd April 2025 so that there would be an interim position until final plans were agreed. This paper confirms the final plan for 2025/26.

1.3 This paper will set out the proposed budgets for 2025/26 and the budget setting approach.

2. Background

2.1 The Board of Directors has previously considered operational planning papers for 2025/26 including the implications of agreeing to the control total in accordance with the GMU ICS plan.

3. Budget plan for 2025/26

3.1 The current financial plan has been submitted with a breakeven position for system reporting purposes. There is an adjustment of £0.3m relating to donated assets which means that underlying plan reconciles to £0.3m deficit and this can be summarised in Table 1 below and the full Income and Expenditure table is shown in Appendix 1.

Table 1

Income & Expenditure position Plan 2025/26	£m
Total Income	503.6
Substantive	(325.4)
Bank	(30.9)
Agency	(6.2)
Pay Costs	(362.5)
Drugs	(25.6)
Clinical supplies & services	(28.6)
Other non-pay	(56.7)
Below the line	(30.5)
Total Expenditure	(503.9)
GRAND TOTAL	(0.3)

3.2 The plan has been aligned to the activity and workforce plan and a summary of the key assumptions within the plan are covered in the following points:

3.3 Income – The Aligned Payment and Incentive (API) continues for contract income in 2025/26 this comprises fixed and variable elements. Almost all elective activity is included in the variable element and should be paid for using 100% of NHSPS unit prices. The Trust has set income budgets in line with the GM contract offer for both fixed and variable elements.

3.4 An exercise continues under the heading Future Funding Flows across the GM system to review the system funding and elements of the contract allocations that have taken place during the Covid years. This work continues but at the start of 2025/26 no decision has been taken to reallocate funds across GM trusts.

3.5 A proposal is currently being worked up for Derby and Derbyshire ICB reviewing their activity and contract value in line with the Future Funding Flows principles. New pathology prices have already been shared with Derby and Derbyshire ICB due to the significant activity increases and changing complexity of pathology delivery.

3.6 The Elective Recovery Fund variable payment scheme mechanism is no longer in place for 2025/26, however a similar mechanism will be used so that the Trust is paid variable income linked to activity for inpatient elective, day

case, out-patient procedures, out-patient first attends, unbundled radiology, drugs and devices. It should be noted that individual Trusts cannot deliver additional activity and assume payment, as target and performance thresholds are linked at GM level and all national funding has now been allocated to ICBs. Discussions are ongoing within GM as to how this will be dealt with across the ICB and how the risk will be managed, in term of both under and over performance. There is a financial risk in the plan if the Trust delivers activity at a different level than is included in the current contract offer.

3.7 **CQUIN –** The mandatory CQUIN scheme remains paused for 2025/26. Funding associated with CQUIN is within national tariff and within the opening baseline contract value.

3.8 **Bank & Agency –** The Trust continues to use bank and agency staffing to provide a safe level of cover. Nationally there is a requirement to reduce agency and bank expenditure as far as possible, as part of optimising cost and productivity. As a minimum all systems are expected to deliver a 30% reduction in agency costs and a 10% reduction in bank costs, based on 2024/25 forecast out-turn at M08.

3.9 In order to plan for this level of costs an adjustment has been made to the financial position at Trust level to recognise that there will be bank and agency costs at this ceiling level; without amending the structure of the Divisional budgets. This will assist with monitoring the plan at GM and NHSE level.

3.10 **Pay award –** The change to national insurance rates and national minimum living wage from 1st April 2025 have been reflected in divisional budgets. Contingency of £9.5m has been made for a pay award in accordance with planning principles for 2025/26, though actual costs could be in excess of this. Any further increases in pay award above the prescribed in planning guidance should be subject to additional funding from NHSE.

3.11 **Industrial action** – There were costs and impacts in activity from industrial action in 2024/25; these are not planned for in 2025/26.

3.12 **Drugs –** The Trust set the income budgets in line with 2024/25 forecast outturn. Under national payment rules these are chargeable on an actuals basis, however during 2024/25 GM managed risk regarding variable drugs and devices charges at an ICS level. Agreement is still to be reached with GM on how this will be treated in 2025/26. Specialist commissioners will continue to pay this on a variable basis.

3.13 **Clinical Supplies and Services –** An assessment of the clinical cost of delivering elective activity has been made and set within budgets.

3.14 **Other non-pay** – This includes the increasing costs of inflation for energy, supplies and external contracts. This also covers increased maintenance costs for the capital purchases made in previous financial years according to the warranty schedules. Inflation funding will be a key area of focus and will only be released into divisional budgets once actual costs are known and price increases from suppliers have been appropriately challenged. Approval for budget release is via the Financial Improvement Group (FIG) which meets monthly.

3.15 **Below the line** – Technical changes have been made in accordance with the changes for IFRS16 and for increased depreciation associated with the capital programme in 2024/25.

3.16 The **CIP plan** of £29.2m is 5.6%, £20.6m (70%) recurrent and £8.6m (30%) non-recurrent, has been agreed and for the purposes of the plan submission the breakdown according to the areas where the savings are planned to be released are in Table 3 below.

Table 3

£m	Recurrent	Non-Recurrent	TOTAL
Pay	15.2	5.3	**20.5**
Non-Pay	5.2	2.9	**8.1**
Income	0.2	0.4	**0.6**
TOTAL	20.6	8.6	**29.2**

3.17 At this stage the divisional budgets are being finalised and a full update will be given to the board in June.

3.18 **Capital plan** – the capital plan has currently been set for £35.387m, including:

- £15m Electronic Patient Record
- £4m Outpatients
- £2.5m Critical Infrastructure Estates Safety Schemes
- £1.8m Urgent Treatment Centre remodelling
- £1.4m Emergency and Urgent Care Campus
- £2.8m IFRS16 impact of leased assets

4 Areas of Risk

4.1 The position across the GM remains of concern as the system plans submitted by GM ICS in order to achieve the control totals contain a high degree of risk and the Board has articulated the risks in achieving its own control total through the submission of the annual plan which includes support from GM ICB in order to agree positive income outcomes.

4.2 Cash presents one of the greatest risks in the plan for 2025/26 and is reliant on delivering cash releasing savings of £29.2m. The Trust drew down revenue support in 2024/25 of £15.6m. The Trust has submitted a breakeven plan that does not require revenue support in 2025/26 but this relies on the Trust delivering its efficiency target of £29.2m with cash releasing impact. The current submission of the plan for capital is compliant with internal programme met by internal depreciation funding and includes PDC funding of £19.8m.

4.3 Inflation and the cost of living crisis is an on-going risk for all Trusts. System inflation funding was limited to 2.15% (4.15% inflation less 2.0% assumed efficiency), but the Trust's expected impact is in excess of this. Further cost increases, both direct to the Trust and those passed on through our supply chains, are a risk to the Trust financial position.

4.4 The effect of inflation and hardship on staff may also present a further risk to staffing and associated costs. Whilst industrial action was seen from junior medical staff in 2024/25 creating financial pressure in paying increased premium rates to Trust staff working additional hours to allow their colleagues to strike; there remains the risk of further action in 2025/26 depending on national pay award decisions.

4.5 As there is limited capital available to the Trust and the age and condition of the site is poor that there is a transferred increase in costs of revenue, either from additional failure of equipment or loss of productivity.

4.6 The activity pressures to deliver national priorities and success measures will be challenging for the Trust, particularly:

- 78% of emergency department (ED) patients seen within 4 hours – currently below 70% at March 2025
- Improve 18 week wait for first appointment to 72% by March 2026 – 54% at March 2025
- Reduce the proportion of people waiting over 52 weeks for treatment to less than 1% of the total waiting list by March 2026 – currently 1,727 at March 2025
- Reduction of agency spend by 30% to £6.3m, from £9.4m in 2024/25

Together with additional ED staffing to support growth in attendances, reliance on premium rate staffing to support on-going escalation beds and lack of community capacity, this presents a significant risk to the cost base of the organisation.

4.7 The financial reporting regime including access to revenue support is still being finalised and therefore this may present further risks. The Finance & Performance Committee and the Board of Directors will continue to be updated on this developing agenda.

5 Recommendations

5.1 The Board of Directors are asked to approve opening budgets for 2025/26

Appendix 1

Category £000s	**Annual Budget**
Block Contract / System Envelope	463,165
Other Non NHS Clinical Income	6,755
Clinical Income from Patient Care Activities	**469,920**
Research & Development	1,068
Education & Training	9,860
Pharmacy Trading Units Income	7,283
Other Income	15,449
Other Income	**33,662**
TOTAL INCOME	**503,582**
Pay Costs	(362,505)
Substantive Staff	*(325,392)*
Bank Staff	*(30,862)*
Agency Staff	*(6,252)*
Drugs	(25,582)
Clinical Supplies & Services	(28,622)
Other Non Pay Costs	(56,693)
TOTAL COSTS	**(473,402)**
EBITDA	**30,180**
Depreciation	(23,099)
Interest Receivable	577
Interest Payable	(772)
Unwinding of Discount	(30)
PDC Dividend	(7,150)
Total Below the Line	**(30,474)**
TRUST SURPLUS / (DEFICIT)	**(294)**

NHS Stockport NHS Foundation Trust

				Agenda No.	
Meeting date	5 June 2025	**Public**	X	**Confidential**	
Meeting	Board of Directors				
Report Title	Quality Committee – Alert, Advise & Assure Report				
Director Lead	Louise Sell, Chair of Quality Committee	**Author**	Louise Sell, Chair of Quality Committee		

Paper For:	**Information**		**Assurance**	X	**Decision**	
Recommendation:	The Board of Directors is asked to note the report from the Quality Committee including matters for escalation to the Board of Directors.					

This paper relates to the following Annual Corporate Objectives

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

This paper relates to the following CQC domains

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

This paper relates to the following Board Assurance Framework risks

X	PR1.1	There is a risk that the Trust does not deliver high quality care to service users
	PR1.2	There is a risk that patient flow across the locality is not effective
	PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan
	PR2.1	There is a risk that the Trust is unable to sufficiently engage and support our people's wellbeing
X	PR2.2	There is a risk that the Trust does not actively participate in local collaborative programmes/neighbourhood working to improve primary and secondary health outcomes
X	PR3.1	There is a risk that place-based partnership working does not effectively support delivery of Stockport ONE Health & Care (Locality) Board priorities and address health inequalities in Stockport

X	PR3.2	There is a risk that partnership working in Greater Manchester do not effectively address unwarranted variation of services and improve health inequalities
X	PR3.3	There is a risk that opportunities for collaboration between Stockport NHS Foundation Trust and Tameside & Glossop Integrated Care NHS Foundation Trust are not optimised
	PR4.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit and retain the optimal number of staff, with appropriate skills and values
	PR4.2	There is a risk that the Trust's workforce is not reflective of the communities served
X	PR5.1	There is a risk that the Trust does not implement high quality service improvement programmes
X	PR5.2	There is a risk that the Trust does not implement high quality research & development programmes
	PR6.1	There is a risk that the Trust does not deliver the annual financial plan
	PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial sustainability plan
	PR7.1	There is a risk that the Trust does not implement the Digital Strategy to ensure a resilient and responsive digital infrastructure
	PR7.2	There is a risk that the estate is not fit for purpose and/or meets national standards
	PR7.3	There is a risk that the Trust does not materially improve environmental sustainability
	PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus

Where issues are addressed in the paper

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

Executive Summary

The Board of Directors has established the following Committees:

- People Performance
- Finance & Performance
- Quality
- Audit Committee

The Committees have no executive powers, other than those specifically delegated within their Terms of Reference, but they can make recommendations to the Board of Directors for approval. The Committees are to report to the Board of Directors by means of a Key Issues Report summarising business conducted by the Committee together with key actions and/or risks.

A summary is provided for the Board of Directors of the key matters and decisions from the meetings of the Quality Committee held during April and May 2025, noting areas of alert, advice and assurance.

NHS Stockport NHS Foundation Trust

ALERT, ADVISE & ASSURE (AAA) REPORT	
Name of Committee/Group	Quality Committee
Chair of Committee/Group	Louise Sell, Non-Executive Director
Date of Meeting	22 April 2025 and 27 May 2025
Quorate	Yes
The Quality Committee draw the following key issues and matters to the Board of Directors' attention:	

1.	**Agenda**	In April, the Committee considered an agenda which included the following: • Learning from Deaths – Q3 2024/25 • Quality & Safety Integrated Performance Report • Standing Subgroup Reports: - Patient Experience Group Key Issues Report - Patient Safety Group Key Issues Report • Quality Committee Subgroups – Review and approval of Terms of Reference and Work Plans for Subgroups: - Patient Experience Group - Health & Safety Joint Consultative Group - Clinical Effectiveness Group - Patient Safety Group • Deep Dive: Risk Mitigation in the Operational Plan - Quality Impact Assessments for Cost Improvement Plans and high risk decisions - Review of quality and safety risk appetite • Quality Committee Work Plan & Attendance 2025/26 In May, the Committee considered an agenda which included the following: • Quality Impact Assessment Deep Dive • Annual Quality Account • Patient Safety Quarterly Report • Maternity Services - Maternity Perinatal Quality Report - Ockenden / Kirkup Return - Presentation in response to the action in relation to smoking in pregnancy - Quarterly Perinatal Mortality Review Tool Report • StARS Quarterly Report • Complaints Policy (For Approval) • Quality & Safety Integrated Performance Report • Standing Subgroup Alert, Advise & Assure (AAA) Reports: - Patient Safety Group AAA Report - Health & Safety Joint Consultative Group AAA Report - Trust Integrated Safeguarding Group Key Issues Report - Patient Experience Group AAA Report • Quality Committee Subgroups – Review and approval of Terms of Reference and Work Plans for Subgroups: - Trust Integrated Safeguarding Group • Quality Committee Work Plan & Attendance 2025/26

2.	**Alert**	<u>Patient Safety Group Key Issues Report – April and May</u> The issues regarding paediatric audiology have been previously reported to the Board. The committee heard in April that out of area referrals by GPs were now being rejected, reflecting the lack of mutual aid. In May the position remained unresolved with plans for an interim provider awaiting national sign-off and funding uncertain.
3.	**Advise**	<u>Quality & Safety Integrated Performance Report – April and May</u> • Performance in relation to pressure ulcers continues to be variable. The committee heard that we have a focus on improvement in the community and in undertaking harm free care reviews which enable us to understand where pressure ulcers are related to sub-optimal care and supports improvement activity. • The committee heard that waiting list validation continues and will develop further with the incentivised revalidation scheme. The committee sought assurance that this process will not further disadvantage already disadvantaged groups. Work is ongoing to segment wating list data, and this will be reported through the Health Inequalities group. • The committee noted the risk of harm experienced in pressurised urgent and emergency care services (see below). The committee noted that current confidence in the measures to mitigate our no criteria to reside position is low. Work continues to address this at a system level. • Cancer targets were met in March with a drop off in 62 day performance in April. <u>Patient Safety Quarterly Report - May</u> The committee received an initial report which aimed to triangulate ED pressures with incidents and complaints. Themes in complaints about waiting times, crowding and staff attitude are identified. Three safety incidents were identified. No direct causation of long waiting was identified in the learning from these incidents. Monitoring will continue. <u>Learning from Deaths – Q3 2024/25 – April</u> (and May action tracker) The committee heard that the Trust continues to review a significant proportion of deaths – 27% in this report against a national expectation of at least 10%. The report identified a shortfall in reviews undertaken in the surgical division and the Medical Director reported in May that this had been rectified. There were no outcome 1 review outcomes this quarter. The committee recognised the 9 reviews in which the review outcome was exemplary in addition to the 16 in which there was suboptimal care which was judged unlikely to have affected the outcome. The group has been asked to focus on learning from positive as well as negative reviews. Actions arising in the quarter are as follows;

		• A bid has gone to the digital prioritisation scheme to develop electronic referrals for SALT services • Learning in relation to VTE care is highlighted in the relevant newsletter • The Patient Safety Group will receive a report into a review of progress since the previous deep dive into end of life provision, noting that this is a recurring theme. <u>StARS Quarterly Report</u> The committee noted the ongoing embedding of good standards across in-patient and community services. The standards remain appropriate for the ED and CDU and work is ongoing to build on recent improvements in standards. <u>Patient Experience Group Key Issues Report</u> The committee noted work ongoing to ensure our response to complaints has service and clinical ownership and remains compassionate.
4.	**Assure**	<u>Deep Dive: Risk Mitigation in the Operational Plan - Quality Impact Assessments for Cost Improvement Plans and high risk decisions</u> This was initially discussed in April's meeting and the committee requested a further paper in order to seek assurance about the assessment of impact of quality, safety and experience. In May the committee reviewed the high-level plans for CIPs and other balancing actions which had been identified to achieve a 3% CIP, a 5% CIP and to control the remaining control total gap. The committee; • Noted a number of schemes which had been rejected or discontinued because they presented an unacceptable risk to quality and safety • Noted that where a scheme does not yet have adequate mitigation it is not yet progressing. • Noted that NICE guidelines are not to the forefront in decision making but that compliance with NICE guidance is reviewed in a regular 3 yearly cycle. • Noted that a number of schemes were in effect a decision not to invest in planned improvements. These schemes are not predicted to result in a decline in quality and safety but to postpone planned improvements to quality, safety and patient experience. • Noted that a number of schemes carry risk as a result of impacting on our ability to manage flow through the in-patient services of the Trust. • Noted that the mitigation for a number schemes requires a strong focus on vacancy management, bank and agency authorisation and monitoring of safe staffing. This approach while carrying some risk also carries the opportunity to improve quality safety and experience for patients and staff through an increased proportion of services being provided by substantive staff. The committee was assured about the implementation of the process to date. The committee discussed the ongoing surveillance of the approved schemes and the process of review of new schemes and schemes which are currently awaiting a final decision to progress. The committee will receive quarterly reports triangulating enacted schemes with reporting including incidents, complaints and

		operational performance. On a monthly basis the high level plans for new schemes or newly progressing schemes will be reviewed in order to support Board decision making. <u>Review of quality and safety risk appetite - April</u> The committee received a paper which outlined the rationale behind our risk level and appetite, and confirmed that for Quality and Outcomes our risk level remains cautious and our risk appetite moderate. <u>Quality & Safety Integrated Performance Report</u> • Mortality benchmarking within GM remains positive • Falls reduction improvement remains embedded <u>Maternity Perinatal Quality Report, Ockenden and Kirkup return and Quarterly Perinatal Mortality review Tool report - May</u> The committee received these papers which provide assurance of our compliance with national and LNMS reporting.
5.	**Referral of Matters/Action to Board/Committee**	<u>Patient Experience Group Terms of Reference and Workplan</u> The committee noted that patient involvement in the group membership is limited to Healthwatch. Whilst Healthwatch provide a valuable to the work of the group including signposting to other relevant organisations, the committee reflected that there is no supporting organisational Patient Engagement Strategy and that this should be reviewed in the Board strategic development.
6.	**Report compiled by:**	Dr Louise Sell (Chair of Quality Committee / Non-Executive Director)
7.	**Minutes available from:**	Mrs Soile Curtis (Deputy Company Secretary)

NHS Stockport NHS Foundation Trust

				Agenda No.	15
Meeting date	05 June 2025	**Public**	X	**Confidential**	
Meeting	Board of Directors				
Report Title	Transformation Team Annual Report and Strategy Update				
Director Lead	Angela Brierley, Director of Transformation	**Author**	Hannah Silcock, Assistant Director of Transformation		

Paper For:	**Information**	**X**	**Assurance**		**Decision**		
Recommendation:	The Board of Directors are asked to review and confirm the Transformation Team Annual Report 2024-25 and their update on progress for year 1 of the Trust's Continuous Improvement Strategy.						

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

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

This paper relates to the following Board Assurance Framework risks

	PR1.1	There is a risk that the Trust does not deliver high quality care to service users
	PR1.2	There is a risk that patient flow across the locality is not effective
	PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan
	PR2.1	There is a risk that the Trust is unable to sufficiently engage and support our people's wellbeing
	PR2.2	There is a risk that the Trust does not actively participate in local collaborative programmes/neighbourhood working to improve primary and secondary health outcomes

	PR3.1	There is a risk that place-based partnership working does not effectively support delivery of Stockport ONE Health & Care (Locality) Board priorities and address health inequalities in Stockport
	PR3.2	There is a risk that partnership working in Greater Manchester do not effectively address unwarranted variation of services and improve health inequalities
	PR3.3	There is a risk that opportunities for collaboration between Stockport NHS Foundation Trust and Tameside & Glossop Integrated Care NHS Foundation Trust are not optimised
	PR4.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit and retain the optimal number of staff, with appropriate skills and values
	PR4.2	There is a risk that the Trust's workforce is not reflective of the communities served
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	PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus

Where issues are addressed in the paper

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

Executive Summary

This report provides the Board with an overview of progress made in the first year of the Trust's Continuous Improvement Strategy, alongside the 2024–25 Annual Report from the Transformation Team. It highlights key achievements and outcomes across both Tameside and Glossop Integrated Care NHS Foundation Trust (ICFT) and Stockport NHS Foundation Trust (FT), showcasing a shared commitment to delivering high-quality, safe, and sustainable services for patients and communities.

A significant milestone in this first year has been the successful development and launch of the Trust's in-house Quality Improvement Training Programme, designed to build internal capability and embed continuous improvement practices across both organisations.

At Stockport NHS FT, 21 programmes of work supported by the Transformation Team have driven improvements both within the organisation and the wider locality. Notable highlights include:

- **Emergency Department (ED) Improvement Project:** Against the national ambition to ensure 78% of patients are admitted, transferred or discharged from ED within 4 hours, Stockport FT set an internal trajectory target of achieving 65% by March 2025, in recognition of ongoing challenges including the new Emergency and Urgent Care Campus build and estate; community provision; and flow across the organisation. Through the internal improvement work, we were pleased to exceed this plan and achieve 69.5% in February 2025. This also led to us being recognised as one of the most improved Trusts in the country against our 4 hour target, increasing by 9% in the 12 month period.

- **Theatres Transformation:** Key outcomes of this programme of work include reducing our inter-case touch-time from 24minutes to 12 minutes; realisation of opportunities for outpatient procedures; an 18% reduction in on the day cancellations; an increase of cases per list to 2.75 compared to a national median of 2.3; and an increase in the Trust capped touch-time utilisation increasing from 75.4% in June 2024 to 81.8% in March 2025, with a specific increase in Maple Suite from 54.2% to 76.9%.

- **Histopathology Improvement Project:** The Histopathology service supports our services in providing timely diagnosis, this project was introduced due to a large backlog within the service. Through the project the backlog was reduced by 70% and urgent cases being reported within 10 days increased from 39% to 71%. Furthermore, the project realised a saving of £131,000 through a reduction of outsourcing costs, and a saving of £26,000 on the waiting list iniative additional sessions, compared to the 12 months prior.

Across both organisations, the Transformation Team continues to work in partnership with operational and clinical colleagues, aligning transformation resources to support service excellence and foster a culture of continuous improvement.

The Board has received previous updates on transformation progress through the monthly Service Improvement Group, chaired by the Deputy Chief Executive.

The Board is asked to note the progress made to date and the impact delivered through the Continuous Improvement Strategy in its first year.

NHS
Tameside and Glossop
Integrated Care
NHS Foundation Trust

NHS
Stockport
NHS Foundation Trust

TRANSFORMATION TEAM
ANNUAL REPORT
2024-25

Prepared by :
Hannah Silcock
Assistant Director of Transformation

CONTENTS PAGE

MESSAGE FROM THE LEADERSHIP TEAM

Angela Brierley
Director of Transformation

Hannah Silcock
Assistant Director of Transformation

This Annual Report highlights the improvement work and the impact and breadth of the Transformation Team over the past 12 months.

The year has continued to be a challenging one for the NHS generally and for both Stockport NHS Foundation Trust and Tameside and Glossop Integrated Care NHS Foundation Trust, in particular, as demand for our services continues to grow and we maintain a focus on recovering full capacity. Our journey of improvement continues as we try to execute as much as possible, as rapidly as possible.

It has been a busy and productive year, covering a number of improvement schemes, plus the development of our Continuous Improvement Strategy, which aims to improve capacity and capability and grow our internal network of improvement leaders across both organisations.

We are immensely proud to be able to support our clinical and operational colleagues to deliver sustainable improvements across both organisations.

Finally, I would like to thank all the team and those involved in our programmes for their fantastic efforts in delivering improvements for patients and staff.

TRANSFORMATION TEAM

Across the NHS, we face a dynamic and evolving healthcare landscape, where operational challenges are increasingly complex. Meeting the growing demand for services, coupled with the ever-increasing pressure on resources, requires continued focus on improving both the quality and efficiency of care we deliver. This year, our Trusts have remained committed to addressing these challenges head-on, ensuring that we not only meet the immediate demands of our patients but also position ourselves for long-term sustainability and excellence to meet the needs of our local population.

This year, we have made significant strides in overcoming the pressures facing our service delivery. In line with the NHS IMPACT Framework, we are driving improvement across all levels of the organisation, striving to embed innovation and best practices that enhance care delivery, improve patient outcomes, and optimise operational efficiency. Through these improvements, we are dedicated to creating a future-focused, patient-centred approach to healthcare that is responsive, adaptable, and resilient.

Central to this progress has been a strong focus on building capability for improvement across our staff, supported by our ADOPT Continuous Improvement Strategy for the Trust.

TRANSFORMATION TEAM

ADOPT CONTINUOUS IMPROVEMENT

STOCKPORT FT TRANSFORMATION TEAM

TAMESIDE & GLOSSOP ICFT TRANSFORMATION TEAM

COMMUNICATIONS & PROMOTIONS

Stockport FT & Tameside & Glossop ICFT

OUR YEAR IN NUMBERS 2024-25

41 Award submissions

2 Health Service Journal Award Winners

1 Non-clinical team of the year MADE Award Shortlist

76 Posters

34 Training sessions delivered

9 Award shortlists

6 Campaigns

15 Completed programmes

26 Active programmes

2 Leaflets

3 Webinars delivered

37 Storyboards

5 Learn & Shares facilitated

5 Scopes completed with teams

45 Workshops

9 Newsletters

8 Podcasts

2 Transformation Events

3 Leaflets

57 Process Mapping sessions

13 Screensavers

5 External presentations

4 Infographics

17 Time & Motion studies

27 Adverts

33 Videos

11 Away Days supported

24 Surveys

10 Leadership QI project events

ADOPT CONTINUOUS IMPROVEMENT STRATEGY

This year has seen the commencement of the Trusts ADOPT Continuous Improvement Strategy. The strategy is a 3 year plan for the Trust focusing on our improvement journey.The following has been achieved within the 1st year of the strategy:

ALIGN to our strategic intentions

In the first year, significant progress was made in aligning with our strategic intentions. Baseline data for both Trusts was established, allowing for effective monitoring against NHS Impact. A comprehensive review of all programmes was conducted, with a focus on assessing financial, safety, and quality aspects of all Transformation schemes. Efforts to align materials with the new Trust Values began, emphasising excellence across the board. Additionally, engagement in national forums, including the Director of Improvement and Deputy Director of Improvement forums, ensured alignment with national standards. Collaborative meetings with multiple Trusts were held to support the development of team reviews, practices, and training packages.

DEVELOP a continuous improvement culture

To support the Trusts, a new continuous improvement methodology was designed, to meet the needs and assist the flexibility required to support the varying needs of the organisation. To wrap around this methodology, and focusing on improving our continuous improvement culture, a suite of training has been planned, with the fundamentals course now successfully launched across both Trusts. To wrap around this, and to support people running their own improvement initiatives, a weekly drop-in hub has commenced for people to be able to access Transformation Team support to assist them with their own improvement initiatives. Transformation events are held at each Trust to celebrate successes of improvement work that is happening, and the Transformation Team support the Health Service Journal (HSJ) application process and presentation process, which led to a HSJ award being won at both Trusts in 2024-25. Self serve guides are also in development to support people in their learning and improvement journeys.

ADOPT CONTINUOUS IMPROVEMENT STRATEGY

ORGANISATIONAL PARTNERSHIPS to deliver sustainable change

Throughout the year, we facilitated valuable Learn and Share sessions both between Tameside & Glossop ICFT and Stockport FT, as well as with external organisations, to improve our learning and broaden our ideas for improvement. We have introduced enhanced stakeholder checklists, to ensure all relevant parties are included in our Transformation programmes, with an attendance matrix introduced. Additionally, we have collaborated with the Public Health Consultant at Stockport to review health inequalities within our programmes of work and ensure an inequalities lens to our work moving forward, supporting this agenda for both organisations. Finally, we have supported system-wide initiatives, including Cancer, Frailty, and Urgent Emergency Care, to ensure sustainability of our work, including focus on prevention and early identification.

PEOPLE placed at the heart of our plans and engagements

In the first year, we piloted opportunities for staff to suggest improvements, including a new inbox system, and a Dragon's Den panel. Additionally, the team have developed a co-production training package, and have run an Evidence-Based Co-Design (EBCD) project at Stockport FT, which included attending specific training packages and disseminating the learning. This model is under review for future opportunities. Additionally, supporting the Trust agenda, the team have focused on developing our Equality Impact Assessment, and have worked with wider stakeholders to improve the robustness of this tool, leading to more meaningful impact for the people accessing our services.

TRAIN our people to deliver improvement

A big focus of our strategy over the fist year has been centered on building our training plan, to ensure we meet the needs of our organisations. We are pleased to report that we are now live with the first in our series of training sessions, our ADOPT Continuous Improvement Fundamentals course. To support this we have also launched a weekly drop-in hub, to support people running their own improvement projects. We have surveyed our staff to understand what bitesize sessions they would like to receive training on through our upcoming lunch and learns. As we move into our 2nd year, we are now building additional packages aimed at Senior Leaders and Senior Responsible Officers, alongside the second in the series of courses for our workforce.

ALIGN...

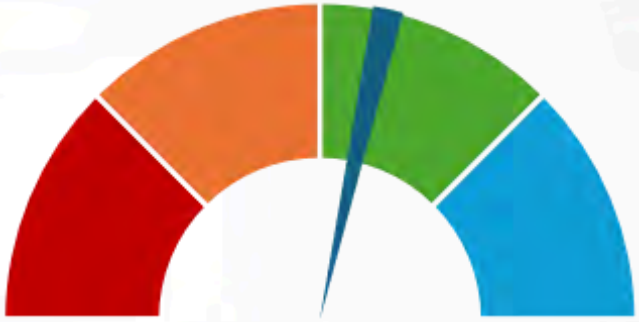
to our strategic intentions

In September 2023, NHS IMPACT (Improving Patient Care Together) was released. NHS IMPACT is a national improvement programme aimed at enhancing healthcare quality, efficiency, and patient outcomes across the NHS. It supports NHS leaders and staff in implementing evidence-based improvements through collaboration and shared best practices.

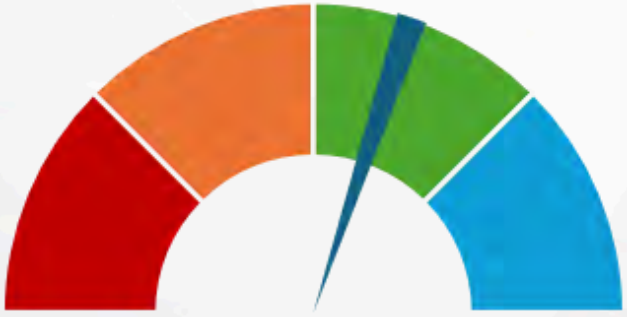
Utilising the 2023 NHS Staff Survey, a baseline for both positions was established against the 5 domains. The following pages show how the 2 Trusts are positioned when benchmarked nationally.

Stockport Foundation Trust NHS IMPACT Baseline (2023-24)

Shared Purpose and Vision
63.85%

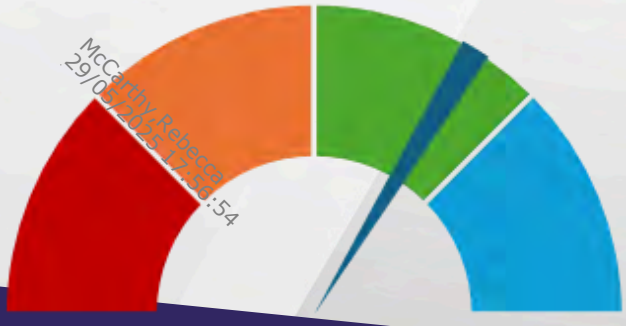


Investing in People & Culture
62.45%

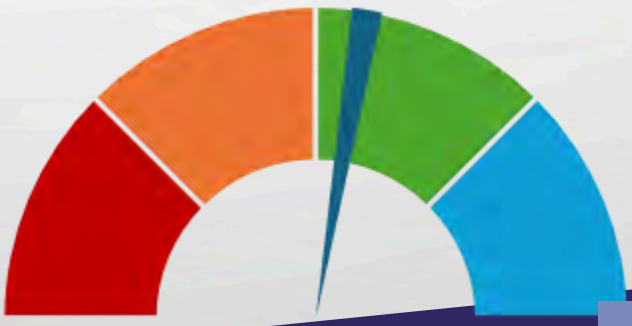


Developing Leadership Behaviours
71.97%

Building Improvement Capability & Capacity - 63.07%



Using Quality Management Systems
68.53%

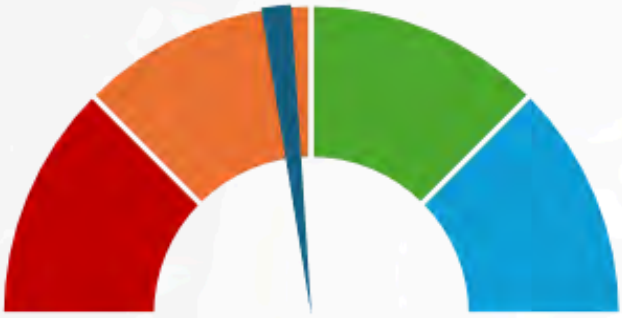


ALIGN...

to our strategic intentions

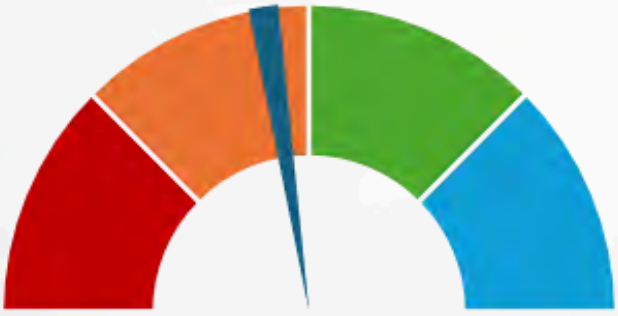
Tameside & Glossop Integrated Care NHS Foundation Trust
NHS IMPACT Baseline
(2023-24)

Shared Purpose and Vision
61.6%

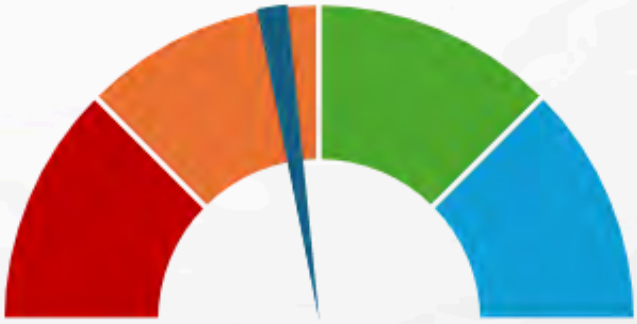


Investing in People & Culture
58.73%

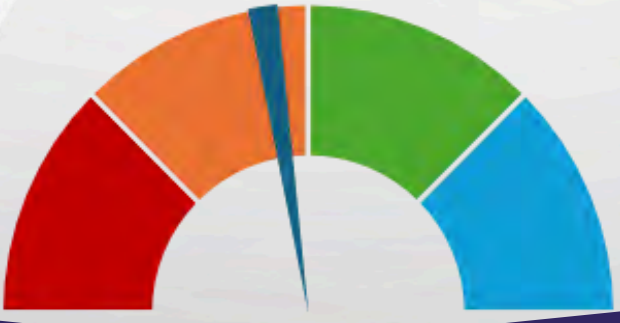
Developing Leadership Behaviours
67.94%



Building Improvement Capability & Capacity - 59.31%



Using Quality Management Systems
64.62%



DEVELOP
a continuous improvement culture

Tameside & Glossop ICFT Transformation Schemes 2024-25

Children's, Young People & Families Improvement Programme Phase 3				Dragon Medical One Implementation Programme
Radiology Improvement Project	Inpatient Flow & Discharge Processes Improvement Programme	Diabetes Service Improvement Project	Consultant to Consultant Referrals Improvement Project	Hot Gall Bladder Pathway Improvement Project Scope
Hospital Front Door Improvement Programme	Improving Cancer Outcomes Programme	Ageing Well Improvement Programme Scope	Cardiology Improvement Project	Theatres Improvement Programme
Pharmacy Robot Implementation Project	Sepsis Pathway Improvement programme	Patient Track Implementation Project	Maternity Improvement Project Phase 2	Heart Failure at Home Improvement project

This year has seen some significant progress in improvement work taking place across the Trust. Alongside improvement initiatives led at department level, the Transformation Team have been involved in 17 different schemes. Their involvement has ranged from supporting full programmes to conducting scoping exercises, aimed at assisting the Trust and locality in identifying and planning for the next steps in their development. These efforts reflect the Trust's commitment to continuous improvement and the enhancement of services across the board.

DEVELOP
a continuous improvement culture

Active Transformation Schemes - Tameside

Urgent Emergency Care Delivery Board 2024-2027

In response to the growing demand for urgent and emergency care services, our Trust, alongside local partners, has come together to launch a comprehensive, collaborative programme aimed at transforming how urgent and emergency care is delivered across the system. The Urgent and Emergency Care Delivery Board represents a unified effort to ensure that patients receive the right care, at the right time, in the right place, by the right team.

This programme is underpinned by a clear, three-year plan, focused on four key workstreams: Urgent Care at Home; Hospital Front Door; Inpatient Flow and Discharge Processes. Together, these workstreams form the foundation of our collective ambition to improve patient outcomes, reduce pressures on urgent and emergency care services, and ensure that patients move seamlessly through the system with timely access to appropriate care.

Hospital Front Door

Over the past 12 months, our Urgent Care department has undergone significant transformation, including the completion of a new capital build. This development has provided us with the ideal opportunity to maximise the use of our space and implement improved patient pathways. Given the national and local targets governing Urgent Care, a comprehensive programme of work was launched to address several key priorities, including:

- Streamlining and standardising pathways and processes to enhance patient experience.
- Eliminating 12-hour trolley waits, with an initial target of reducing them by 50% compared to last year.
- Achieving 78% 4-hour performance in the Emergency Department (ED).
- Improving our time-to-treatment indicators.
- Reducing the number of patients in ED for over 12 hours and decreasing total length of stay in the department.
- Improving ambulance turnaround times, with a clear trajectory for compliance.

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We are pleased to report significant progress in these areas. Notably, the relocation of our Urgent Treatment Centre (UTC) and Children & Young People's Emergency Department to the front door has allowed for smoother patient flow and a more streamlined service. Our efforts to enhance staff training, particularly within our nurse triage team, has resulted in the proportion of triages completed within 15 minutes of arrival increasing from 31.5% in January 2024 to 61.4% in January 2025.

In an effort to ensure patients are seen in the most appropriate setting, we have made improvements to our Medical, Surgical, and Frailty Same Day Emergency Care (SDEC) pathways. Collaboration with North West Ambulance Service now enables direct referrals to our Medical SDEC, which has contributed to a rise in the number of patients seen in SDEC from 1,551 in March 2024 to 1,988 in January 2025, easing pressure on our Emergency Department (ED). Additionally, a targeted improvement cycle introduced in January 2025 has reduced the time patients spend in the ED prior to being transferred to SDEC by 45 minutes.

Improvements have also been made in ambulance handovers, alongside clearer communication efforts to help patients understand alternative care options outside of the ED.

Our efforts in achieving the 4-hour target has seen Tameside Emergency Department improving by 8.2% from March 2024 - March 2025. This puts Tameside in the top 10 most improved nationally for March 2025.

Looking ahead, work is already underway to sustain and further build upon these achievements as we enter phase 2 of our 3-year plan, ensuring continued improvement in patient flow and the overall delivery of care.

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Inpatient Flow and Discharge Processes Improvement Programme

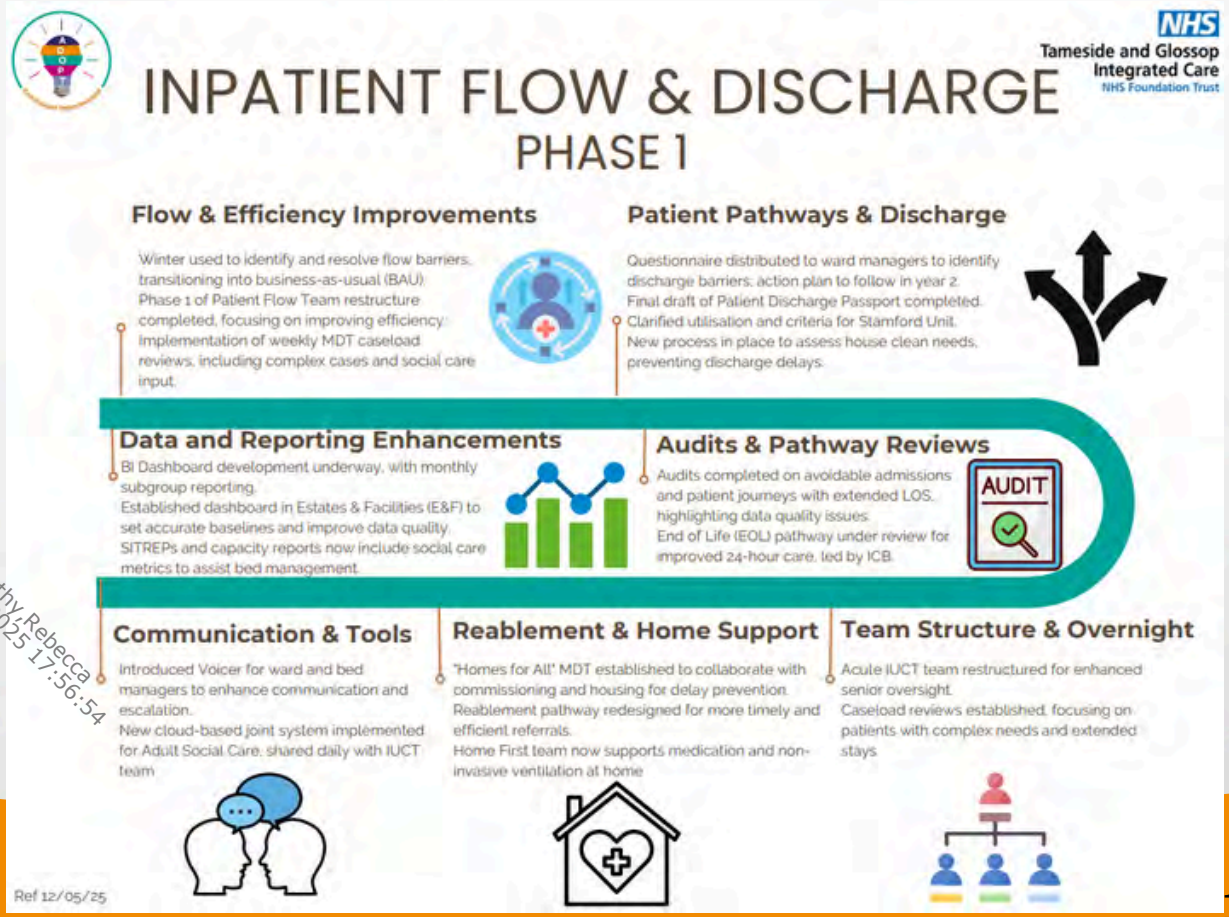
The aim of this programme is to support the work of Urgent Emergency Care Delivery Board to ensure we have effective flow through the hospital, which in turn supports our urgent and emergency care teams and processes.

Due to the size of this programme of work, and the number of teams involved, year 1 has been a year of significant scoping work to understand our areas for improvement, and prioritising this. The priorities of this scheme include:

- Ward Standards - In year 1 this will be covered by 2 workstreams: Expected Discharge Dates, Red & Green Days.
- Capacity and Flow - In year 1 this will be covered by 5 workstreams: Logistics support & escalation; Bed Management & Night Nurse Practitioner Team Structure; AM vs PM Discharges; Bed Availability & Professional Standards; and Avoidable admissions.
- Discharge - In year 1 this will cover 7 workstreams: No Criteria to Reside: Effective use of the Stamford Unit; Utilisation of Virtual Ward (specifically in a step-down approach); Pharmacy support to facilitate discharge; Improving the frailty offer; Social care improvement; and medical management for timely reviews to support discharge planning.

Through this work, the programme aims to:

- Reduce length of stay across general and acute inpatient areas by 2% by May 2027.
- Reduce the number of patients with a length of stay more than 21 days by 20 patients by May 2027.
- Reduce our no-criteria to reside patients by 10% by May 2025.
- Reduce the number of inpatient falls in all inpatient areas by May 2025.



DEVELOP
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Diagnostics Improvement Programme

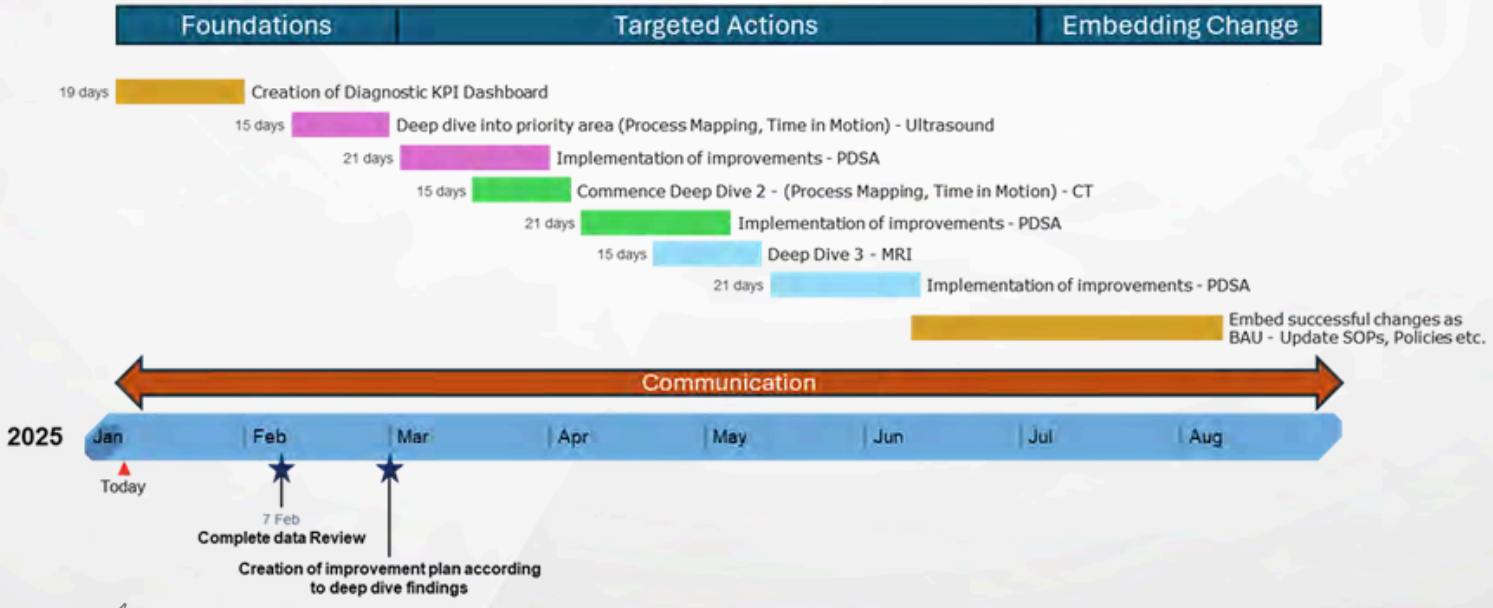
The Diagnostic Improvement Programme has been introduced to support the Urgent, Emergency Care Delivery work, acknowledging the strong interdependence timely diagnostics has on both our ED performance, and the flow through our hospital. The initial scope of the project is to focus on Radiology, with Pathology due to commence in year 2/3.

The Radiology Project aims to improve efficiencies and streamline pathways. To support this, a new data dashboard has been built by our colleagues in Corporate Information to aid deep dives and areas of focus in key modalities, including CT, Ultrasound and MRI. This has been supported by observational studies and time-in-motion studies to understand current issues and bottlenecks. Improvement plans have been co-created, working with Radiology staff and teams across the organisation.

Current work within this initiative includes:

- Review of portering working pattern.
- Open communications between consultants and radiologists.
- Education on scanning referral criteria.
- Manager of the day for Radiology.
- Recruitment and retention 2 year plan.

The below plan shows how the team aims to work through key modalities to implement sustainable change at pace.



The Urgent Emergency Care Delivery has set about an ambitious 3 year plan, to deliver sustainable outcomes. The progress of this will continue to be reported through to completion.

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Active Transformation Schemes - Tameside

Heart Failure at Home Project

Heart failure affects approximately 920,000 people in the UK, and this number is expected to rise significantly due to an ageing population and improved survival rates following acute cardiac events. To address this growing challenge, the Trust received funding from NHS England to pilot the Managing Heart Failure @Home Programme. This pilot project aims to empower patients to manage their heart failure safely at home through the use of digital tools and remote monitoring, ultimately enhancing care, reducing hospital admissions, and improving outcomes.

Launched in February 2024, the pathway has already begun onboarding patients. We are closely monitoring the programme's progress through Plan-Do-Study-Act (PDSA) cycles, ensuring continuous refinement and development to meet the evolving needs of both patients and services.

Through the pathway, patients are introduced to the MyGM Care application, where they submit key health metrics. These metrics are reviewed remotely by our Digital Health team, enabling early identification of any concerning trends. If necessary, this data triggers an escalation for a face-to-face review, facilitating timely intervention. The pathway has been co-designed with input from our Virtual Ward and IV Diuretics teams, ensuring that patients who require more intensive monitoring or treatment are swiftly referred, preventing unnecessary hospital admissions.

The programme is expected to deliver significant benefits for both patients and the Trust. By enabling earlier interventions, we anticipate improvements in patient experience, with better symptom control and quality of life. Additionally, the programme aims to reduce unplanned hospital admissions and emergency visits, easing pressure on acute services. An ongoing evaluation will assess the impact of the programme, using feedback from both staff and patients to continuously refine and improve the pathways, ensuring that we deliver the best possible care for those living with heart failure.

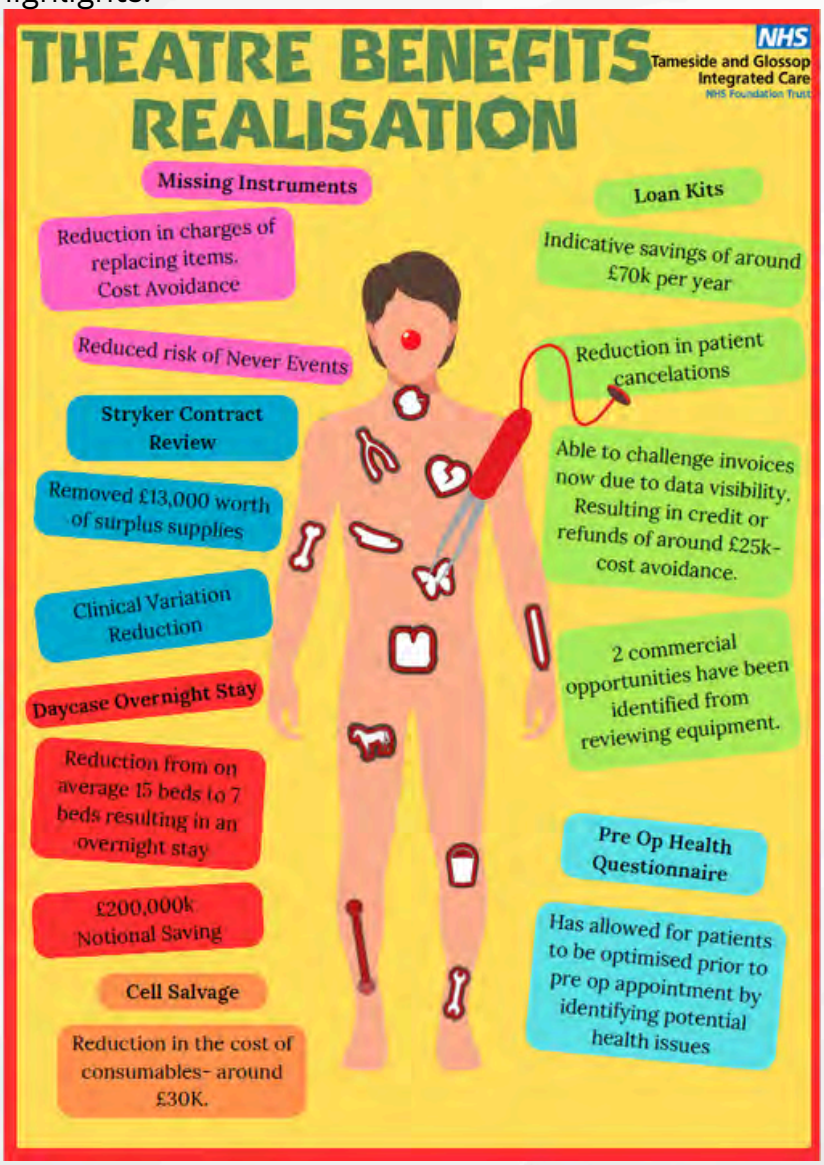
DEVELOP
a continuous improvement culture

Active Transformation Schemes - Tameside

Theatres Improvement Programme

While previous theatre programmes had achieved success, this phase was streamlined to focus on five critical areas, employing a Multi-Disciplinary Team (MDT) approach to ensure a broader range of teams were involved in the improvement process. The five key focus areas were: Inventory management; Pre-Op & Optimisation; 6/4/2 Model; Theatre Leadership; Day case

Due to the vast scope of the work, not all key achievements can be listed, but here are some of the highlights:



· Implemented a new inventory stock management system in theatres.
· Reviewed the loan kit process to enhance its relevance and effectiveness.
· Trialled the process of Lean Theatres and have begun spreading process to all corridors.
· Conducted a staffing review that resulted in a substantive second nurse on night shifts in day surgery, improving discharge support and reducing reliance on bank staff.
· Worked with physiotherapists and day surgery teams to ensure timely physiotherapy reviews, preventing unnecessary overnight stays.
· Co-located the pre-op team, enhancing teamwork and collaboration.
· Reviewed the patient health questionnaire to support virtual appointments and allow early optimisation (e.g., flagging hypertension to contact GPs before the scheduled pre-op appointment).
· Introduced all-day trauma lists four months ahead of schedule.

Through this work, improvements have been seen in many metrics. For instance, when comparing January 2025 data to January 2024 we have seen over a 50% reduction in on the day cancellations. Furthermore, since the introduction of all day lists, we have increased our trauma capped utilisation from 74% to consistently over 85%, meeting our target. Furthermore, following the introduction of all day lists, we have noted a significant reduction in theatre lists overrunning. Finally, there has been an over 50% reduction in planned day cases being converted to inpatients between August 2023 and September 2024 seen.

DEVELOP
a continuous improvement culture

Improving Theatres Productivity Programme - Benefits Realisation

Workstream Area	Financial Impact	Non-financial impact
Inventory - Loan kits	Indicative savings around (£70k per year) 2 commercial opportunities have become apparent from reviewing equipment. Will not benefit until 25/26. Challenging invoice as we now have visibility of what has been used vs not. Resulting in credit or refunds of around £25k (so far) cost avoidance	Cost avoidance from less kits being ordered Operational benefits and clinical benefits from less variation Reduction in sterilisation Reduced cancelations for patients
Inventory - Stryker Contract Review	Removed £13000 worth of surplus with Styker to give us credit – cost avoidance	Clinical variation reduction
Inventory - Cell Salvage	Reduction in the cost of consumables of approximately £30k	
Day Case - Length of Stay		Average 15 beds reduction to 7 bed average £200,000k (notional saving)

DEVELOP
a continuous improvement culture

Active Transformation Schemes - Tameside

Improving Cancer Outcomes Programme

Tameside services have made significant progress in the last year improving patient pathways, enhancing safety, and ensuring compliance with guidelines regionally and nationally.

Key achievements include the implementation of a FIT test tracking process to expedite colorectal cancer triage, the full rollout of the Hepato-Pancreato-Biliary (HPB) Best Timed Pathway, and a revised radiology pathway to manage demand. We have also introduced a referral assessment service to prevent delays and developed best-time pathways for urology, gynaecology, head & neck, and lung cancers, supporting the 28-day diagnostic target. Through this concerted effort, we have managed to consistently achieve the 77% Faster Diagnosis Standard since August 2024.

To enhance efficiency, we streamlined internal cancer referrals and introduced a radiology diagnostic request policy, ensuring appropriate priority coding better enabling patients to be placed on the best pathway to meet their needs.

Patient Stratified Follow-Up (PSFU) is a tailored approach to post-treatment care. It aims to improve patient experience and quality of life by implementing persoanlised follow-up pathways based on individuals needs. We have now established our Breast & Gynaecology pathways, and are developing our colorectal and urology pathways. Since launching, 400 patients are now on PSFU, with an anticipated 1200 patients expected to be on the pathway once the next 2 pathways are live.

Additionally, to further support our improvement journey, we have secured GMCA funding for colorectal cancer services to support a data migration and clinical validation project, ensuring a seamless transition to the new care model. These initiatives collectively enhance efficiency, patient experience, and clinical outcomes.

Children, Young People and Families Programme - Phase 3

We have been on a continued improvement journey with our Children, Young People and Families agenda. Consequently, following Phase 1 and Phase 2 or the programmes, we have provided support in scoping the art of the possible with the next phase of their journey, which will be led by the teams moving forward, taking the learning from earlier phases.

A capacity and demand review has occurred to ensure services are equitable, effective, and aligned with needs of families across the area. Current practices have also been reviewed, ensuring staff skills and resources are matched to demand, whilst also building stronger community pathways for families. This work seeks to address unwarranted variations in school nursing and explore ways to better support young parents in partnership with the Family Nurse Partnership Team.

This project aims to ensure Health Visiting and School Nursing services are better equipped to provide timely, comprehensive support to children and families across Tameside.

Reviewing the duty model, there will be a saving of 20 days/ 150 hours of clinical care and 75 hours of Healthcare Assistant time per week. This equates to £195,438 per annum. Additionally, review of EMIS templates has released approximately 200hours of Band 6 time per month.

DEVELOP
a continuous improvement culture

Recently Commenced Schemes - Tameside

Maternity Improvement Programme

In the first phase the Maternity Improvement Programme seeks to deliver improvements focused on antenatal care, responding to rising demand and system inefficiencies.

Core areas of review include ultrasound capacity, with analysis of demand, staffing levels, and opportunities to increase provision, such as training midwife sonographers. The programme will also look to review Maternity Unit Practitioner and consultant job plans, with a particular focus on diabetic patient pathways and reducing unnecessary follow-up appointments.

Alongside pathway mapping and data analysis, the team will review data quality issues including inappropriate referrals and duplicate bookings. Additionally, root cause analysis work will take place on the number of DNA's for antenatal appointments.

KPI's will measure success through increased scan capacity, reduced wait times, fewer DNAs and duplicate bookings. This work is closely aligned with future estate changes and wider plans to strengthen community maternity services.

Diabetes Improvement Project

This project has been developed to ensure our Diabetes service is in line with Department of Health & Social Care and NHS England Guidance. This includes:

- Increasing outpatient efficiency from 85% to 90%.
- Ensuring 0 patients are waiting more than 45 weeks for their first appointment.
- Delivering a 5% reduction in DNA rate.
- Implementing and achieving the national 5% target for Patient Initiated Follow Up

Through this, the project aims to maximise efficiency and reduce waiting times for patients under the care of the Community Diabetes Outpatient Service, aligning to financial, performance and delivery standards and ensuring patients receive their care in the right place.

Proposed benefits include:

- Reduced risk of avoidable patient harm from overdue follow up appointments
- Increase flexibility of how patients interact with the service
- Potential reduction of clinical and admin time wasted due to patients who DNA appointments (average tariff £150.76 per missed outpatient appointment, YTD DNA rate 21%)
- Potential income from missing clinic outcomes (average tariff £64.78 x 2,500 attendances, indicative increase in community income = £162,000.00 per year)
- Potential recharge of consumables for diabetic pumps to GP's as per guidance from neighbouring Trusts. Potential saving of £180,000.00 per year.

There is a 2 stage phased approach to the improvement project. Phase 1 focuses on aligning finance, performance oversight and delivery standards by process mapping patient flow, scheduling clinical validation and understanding the current position. Phase 2 focuses on delivering care in the right place by piloting PIFU pathways and exploring collective care approaches such as one stop clinics.

DEVELOP
a continuous improvement culture

Recently Commenced Schemes - Tameside

Consultant to Consultant referrals Project

Currently, the Trust does not have a standardised digital process for new patient referrals to outpatient booking teams from departments such as our Emergency Department (ED), Same Day Emergency Care (SDEC), and inpatient wards. Most internal referrals are completed using paper forms, which must then be scanned and emailed to the appropriate booking or specialty team. Additionally, internal triage processes are often heavily paper-based, requiring multiple manual steps, leading to inefficiencies and potential risks to patient safety. Whilst ensuring we do not operate outside of our contract arrangements, for referrals that do need to occur internally, this process will lead to benefits including a more lean process, improving efficiencies within our administration teams, alongside improved oversight of delays in our systems through timestamping at each stage of referral and triage, ensuring transparency, efficiency, and accountability; and finally improved sustainability and reduction in paper wastage at the Trust.

Pharmacy Robot Implementation Project

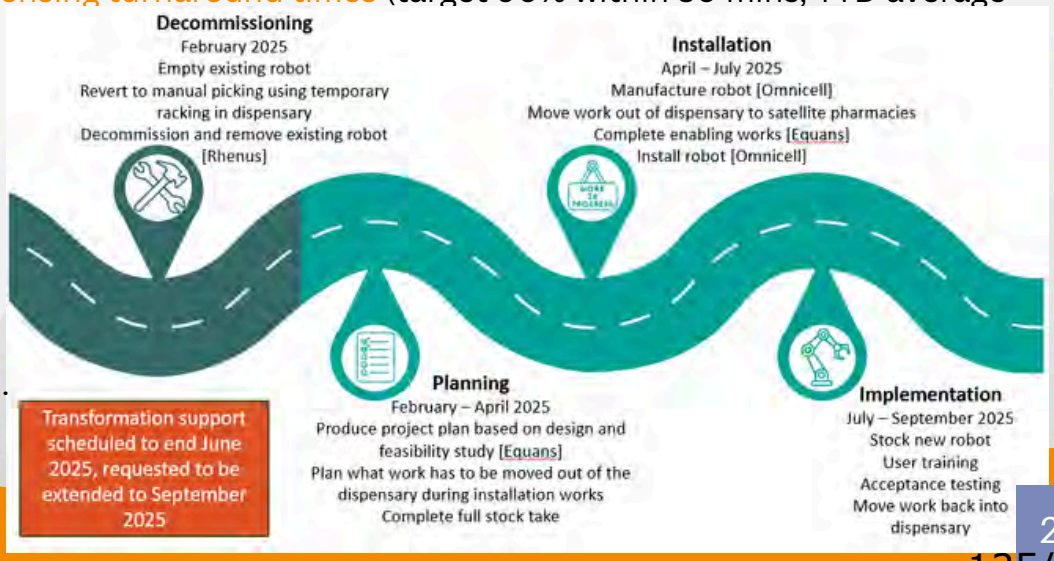
This project aims to maximise efficiency and improve accuracy of dispensing medications by replacing the current pharmacy robot with a new and more technologically advanced robot. The legacy robot was decommissioned in February 2025 with the new robot being installed in September 2025.

The project is structured in three parallel workstreams:

- Pharmacy Operational Workstream – to plan services to ensure the supply of medicines to patients is maintained throughout the decommissioning/installation works.
- Estates Workstream – to plan decommissioning/installation works and manage 3rd party contractors.
- Digital Workstream – to ensure compatibility of hardware, software and interfaces between the robot and Trust's IT systems.

Anticipated benefits include:

- Reduced picking errors.
- Improved discharge dispensing turnaround times (target 85% within 2 hours, YTD average 72%).
- Improved outpatient dispensing turnaround times (target 90% within 30 mins, YTD average 65%).
- Reduce expired stock in dispensary (target < 0.4%, YTD average 0.74%).
- Reduce wrong levels of stock in dispensary.
- Reduce late finishes for staff.
- Improve staff satisfaction.



DEVELOP
a continuous improvement culture

Scoped Improvement Projects - Tameside

Patientrack Implementation Project

The Transformation Team were requested to support the implementation and rollout of the Patientrack clinical observations software. Patientrack enhances nursing care by enabling bedside observations, reducing manual errors such as incorrect NEWS2 scores and misplaced documentation. The system displays electronic observations on a dashboard, alerts outstanding clinical duties, and triggers automatic escalation for deteriorating patients, facilitating early intervention.

Following the initial scope of the scheme, it became clear that initial investment is required for the hardware to support the full implementation of the software.

Dragon Medical Implementation Project

The Trusts Digital Dictation solution, Winscribe, was discontinued in June 2024. Consequently, a new solution was implemented, Dragon Medical Workflow Manager, whilst the project aimed to understand the benefits of a more advanced Dragon Medical system, Dragon Medical One.

Through this project, support was provided to IT and the Elective Access Team to identify areas of improvement, including quality issues with letters, system issues and training needs for both clinical and non-clinical staff.

A pilot study was conducted of Dragon Medical One in the High-risk Foot Team. However, to enable a further roll out and benefits realisation, more investment is required. In the meantime, the Trust will continue with Dragon Medical Workflow Manager.

Ageing Well Programme

To support a locality priority, as identified through the Tameside Provider Partnership, a scoping exercise was complete to review and refresh priorities for the programme.

Following discussion with key stakeholders, 5 key workstreams were identified. These are: Frailty; Falls; Community Deteriorating Patients; Care Homes; and Palliative and End of Life Care. Key objectives and KPI's were developed for each of the workstreams to enable measurement of improvement going forward.

Revalidation Process Review

The Trust manages annual appraisals for approximately 385 staff, requiring at least 65 appraisers to ensure balance, though current disparities in workload, lack of designated appraisers in some specialties, and system inconsistencies pose challenges. A phased improvement approach has been proposed—realigning roles under the Medical Director, improving processes through benchmarking and automation, and better integrating appraisals with job planning, recruitment, and retention. Emphasis is placed on supporting bank staff, enhancing cultural perceptions of appraisals, and strengthening leadership through medical development and clearer communication. The goal is a fair, consistent, and development-focused appraisal system that supports both regulatory compliance and staff wellbeing.

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Closed Transformation Schemes - Tameside

Hot Gallbladder Pathway Project

Hot Gallbladder refers to a medical condition involving acute inflammation of the gallbladder requiring prompt treatment. his project was initiated to scope a Hot Gallbladder Pathway to address urgent needs in managing symptomatic gallstone disease, aligning with NICE guidelines and GIRFT, which recommend cholecystectomy within 7 days for acute cholecystitis patients.

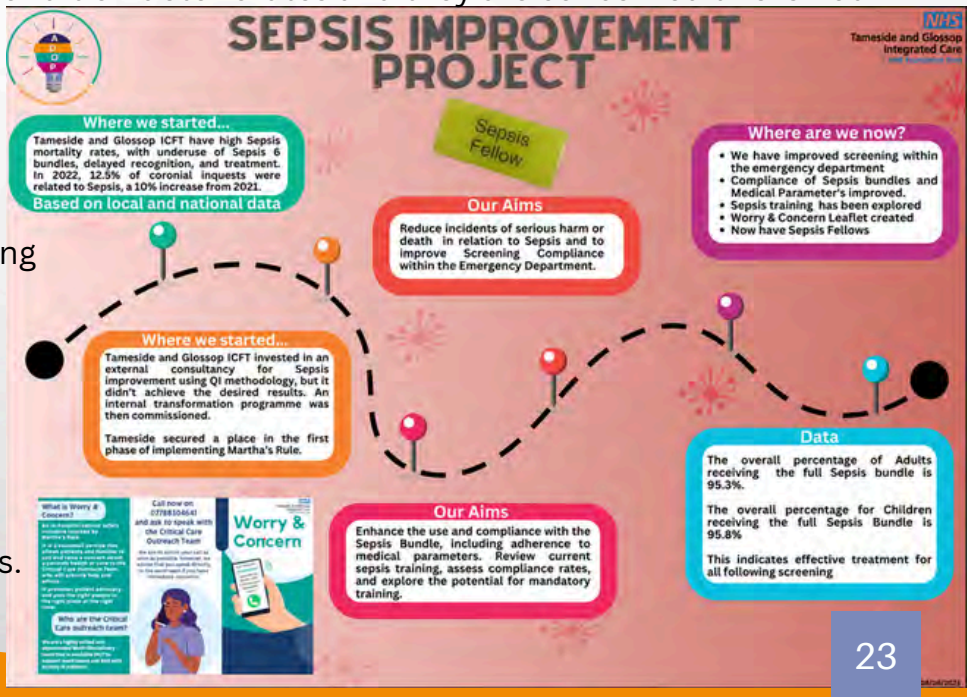
To develop the pathway, clinical processes were reviewed and mapped for patients in the ED and Integrated Surgical Gynae Unit, supported by an observational study of the patient journey. Additionally, clearly defined criteria were established to differentiate between "what's hot and what's not," allowing for streamlined patient entry into the pathway. This pathway will improve the efficiency of our service to meet local and national benchmarks, and yield several benefits, including reduced waiting times for cholecystectomy, fewer non-elective cholecystitis admissions, decreased urgent care visits for cholecystitis, and increased capacity on the emergency surgery list. The operational teams are now working on making the pathway live, with implementation planned for May 2025. This will be followed up in our Service Improvement Group in 6 months to monitor progress.

Sepsis Pathway Improvement Programme

Tameside & Glossop ICFT were recognised as a national outlier for Sepsis mortality rates, and we had an under-utilisation of the Sepsis 6 Bundles. To support our improvement journey in this area, a Trust-wide transformation scheme was established with the aim to reduce incidents of serious harm or death in relation to sepsis; improve screening compliance within the emergency department; improve use of, and compliance with the Sepsis Bundle including medical parameters; and understand current training in relation to Sepsis and review opportunities to improve this.

Some of the key achievements realised through this programme include:

- The introduction of Martha's Rule - providing patients and families with a way to seek an urgent review if they, or their loved one's condition deteriorates and they are concerned this is not being responded to.
- Significant reduction in incidents of serious harm or death in relation to Sepsis.
- Improved compliance rate for screening in ED, with us now achieving over 85% on a monthly basis.
- Our Sepsis Bundle compliance has increased from 40% to 80%.
- The Trust now has Sepsis Champions who are ensuring continued improvements are being made and early recognition of Sepsis.



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Stockport FT Transformation Schemes 2024-25

This year has seen a continued effort from Stockport FT in their improvement journey, with a significant amount of improvement work taking place across the Trust, whilst also working collaboratively as a wider system to achieve some of our ambitions. Alongside improvement initiatives led at department level, the Transformation Team have been involved in 21 different schemes. This has ranged from supporting full programmes to conducting scoping exercises, aimed at assisting the Trust and locality in identifying and planning for the next steps in their development. These efforts reflect the Trust's commitment to continuous improvement and the enhancement of services.

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Active Transformation Schemes - Stockport

Improving Cancer Outcomes Programme

In 2024/25 we have undertaken continual improvement work on a large number of initiatives including the 28-Day Faster Diagnosis Standard (FDS), 62-Day Decision to Treatment Standard, Cancer Upgrade Internal Referral Process , Cancer MDT Reform, Rapid Diagnostic Centre and Personalised Care.

In the past year the Trust has consistently met the 28- and 62-Day Standards of 77% and 70% respectively, with 82.1% and 74.2% being achieved respectively in March 2025. This is thanks to continual improvement cycles and transformation changes made across many different tumour groups/services. In turn, this provides a better patient experience, through faster communication of diagnosis, or ruling out of cancer.

Intensive work has taken place to improve the quality of suspected cancer referrals coming from internal Stockport FT services (e.g. ED, Outpatients, etc) with a new cancer upgrade proforma, tailored to individual service/tumour group needs. This has supported an improved waiting time for patients, through better quality referrals. We are also continuing with the embedding of the Greater Manchester Cancer Alliance cancer MDT standards for a true reform which maintains the foundations of communication, standardisation and accountability of all parts of this process.

We have introduced a robust system for internal referrers to refer directly to the Trust Rapid Diagnostic Service and improve on the current Stockport/Tameside cross-cutting approach to the care model.

Finally, the current achievements with the implementation of Personalised Care will continue, further to maintaining an effective and consistent Patient Stratified Follow-Up (PSFU) mechanism, along with the improvements to service Holistic Needs Assessments including the provision of Health and Wellbeing Support and, End of Treatment Summaries to fully support patients in their follow-up journeys.

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Improving Cancer Outcomes Programme - Benefits Realisation

Workstream Area	Financial Impact	Non-financial impact
Cancer Services: 28-Day Faster Diagnosis Standard (FDS) Performance Improvement	Upper GI: Replacement of 10 consultant triage slots p/w (£220 per slot) with 8 Advanced Clinical Practitioner triage slots p/w (£190 per slot) since Sep 2024.	Trust consistently meeting the NHS England Cancer 28-Day Standard (77%) by March 2025. Improved patient experience through faster communication of diagnosis or non-cancer to patients.
Cancer Services: 62-Day Referral to Treatment Performance Improvement		Trust consistently meeting the NHS England Cancer 62-Day Standard (70%) by March 2025. Improved Patient experience.
Cancer Services: Upgrade Process Improvement		Significant improvement in referral quality to internal SFT tumour group services due to opportunities to capture internal service information.
Cancer Services: Non-Specific Symptoms (Rapid Diagnostic Centre) Internal Referrals Process Implementation	Finance Benefits: Saving additional 1.0 WTE CNS through cross-cover provision.	
Cancer Services: Personalised Care Implementation, incorporating: 1. Patient Stratified Follow-Up 2. End of Treatment Summaries 3. Holistic Needs Assessments and Health & Wellbeing	Anticipated reduction in outpatient appointments due to support offered at end of pathway once fully operational (indicative example: Gynaecology Endometrial Follow-Up cohort comprised an estimated 128 follow-up OPAs from Jan – Dec 2024, across an estimated 74 patients) – introduction of PSFU would mean OPAs not required as replaced with annual follow-up letter).	With the full introduction of HNA, the Trust will have a reduction in admissions as needs are considered and acted upon at an early stage in the pathway.

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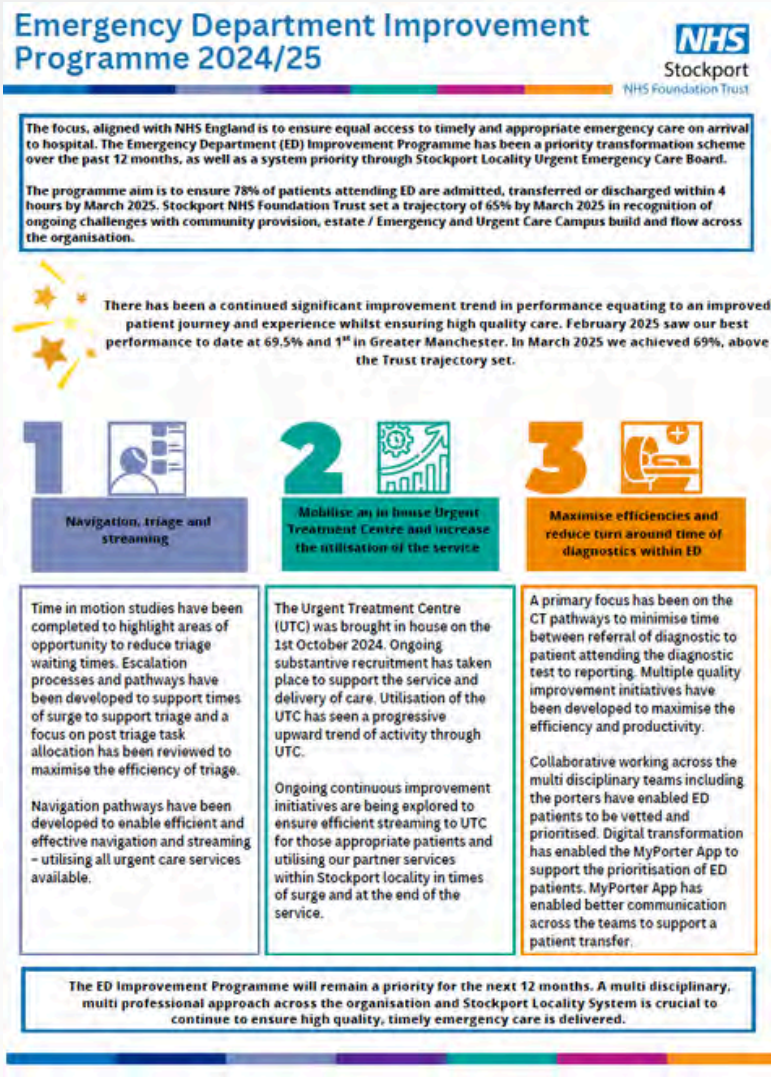
Active Transformation Schemes - Stockport

Emergency Department (ED) Improvement Programme

In response to the growing demand for urgent and emergency care services, our Trust ED Improvement Programme focus, aligned with NHS England, is to ensure equal access to timely and appropriate emergency care on arrival to hospital. The programme's aim was to ensure 78% of patients attending ED are admitted, transferred or discharged within 4 hours by March 2025 and focused on doing so through 3 areas: Navigation, triage and streaming; mobilising an in-house Urgent Treatment Centre (UTC) and increasing the utilisation of the service; maximising efficiencies and reducing turnaround times for diagnostics.



Through navigation, triage and streaming, time and motion studies have been completed to highlight areas of opportunity to support the reduction in triage waiting times. Escalation processes and pathways have been developed to support times of surge and post triage task allocation has been reviewed to maximise the efficiency of triage. This has led to a 10% increase of patients triaged within 15mins of arrival. Navigation pathways have been developed to enable efficient and effective navigation and streaming – utilising all urgent care services available.

Stockport NHS FT took over the management of the Urgent Treatment Centre on the 1st October 2024. The service was brought in-house as part of the efficiency programme and has delivered recurrent cost savings. As the model matures, we expect that daily streaming volumes will progress to circa 60 per day.

Finally, review of our CT pathways to minimise time between referral to diagnostic test and diagnostic test to report has been completed, supporting improved efficiency and productivity through improved vetting and prioritisation processes. Digital transformation has enabled the MyPorter App to support the prioritisation of ED patients with our portering colleagues through improved communication, consequently supporting more timely patient transfer.

Through our efforts, we have been acknowledge by NHS England as one of the most improved Trusts in the country against our 4 hour target, increasing by 9% between March 2024 and March 2025 - consequently being awarded £1million.

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Emergency Department (ED) Improvement Programme - benefits realisation

Financial Impact	Non-financial impact
• UTC: Mastercall contract to in house posts savings. Cost TBC. • Increase streaming to UTC/ increased activity within UTC = a reduction in treatment costs compared to if the patient was streamed to majors (reduction in diagnostics / cheaper workforce model) • Increased recruitment to substantive posts = Reduction in medical and nursing agency fees.	• UTC: Contract savings has allowed the operational model to be reviewed to pilot extended hours until midnight and review the opportunity to trial an additional clinician to support UTC demand. • Increased streaming efficiencies = increased flow through ED = more decongested ED department = has reduced the time the escalation areas are open = reduction in escalation workforce shifts required. • Increase in an HCA to support with post triage tasks will have a positive impact on time to be seen / assessment = less time spent in ED = reduces risk of deconditioning = reduces LOS • Improved streaming pathways ensures the right patient is in the right place at the right time being assessed by the team = better patient experience = reduced number of complaints / litigation costs.

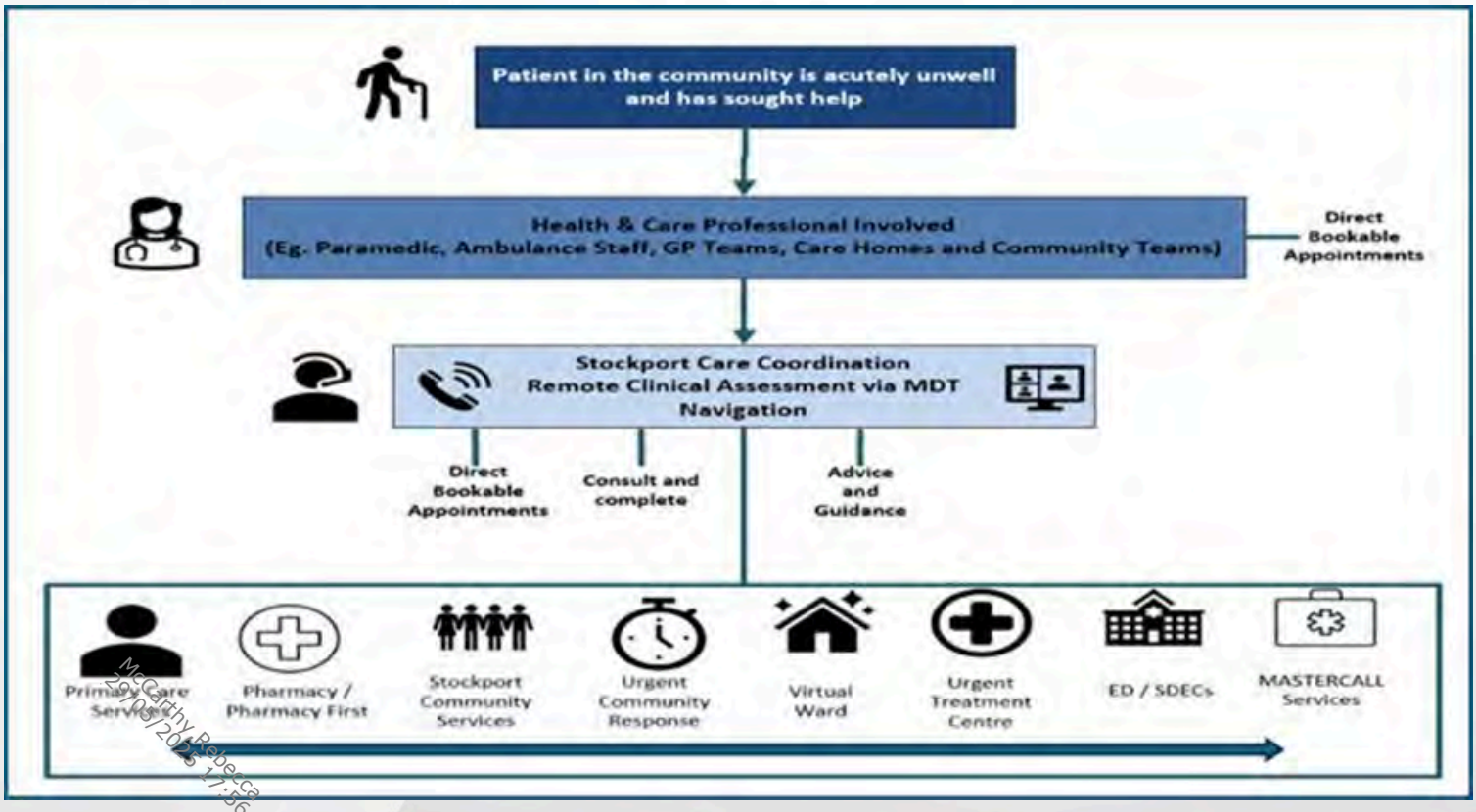
Active Transformation Schemes - Stockport

Stockport Care Co-ordination Implementation Project

The Stockport Care Coordination Centre is a single point of access service that has been developed in partnership with Tameside & Glossop ICFT's Digital Health Service and was launched in January 2025. The aim of the service is to provide a central point of contact for healthcare professionals to contact for a remote clinical assessment by a multidisciplinary team, and provide access to urgent care alternatives to ED.

Key outcomes include improved navigation to services such as the Urgent Community Response Team, Virtual Ward, UTC, and Same Day Emergency Care Units. Increased referrals from Healthcare professionals reflect strong uptake and positive impact. Central oversight of service capacity helps manage demand fluctuations, and integrated working has strengthened partnerships and built resilience across Stockport services.

The initiative has been delivered at pace within existing resources, with staff development and process efficiencies embedded through regular SPRINT sessions involving all partners. Patients benefit from timely, appropriate care in community settings, improving experience and safety. Strong collaboration and a shared vision have underpinned successful implementation since January 2025.



Active Transformation Schemes - Stockport

Adult Community Services Single Point of Access Implementation Project

The Single Point of Access (SPoA) for Adult Community Services was created to be a central hub for receiving referrals, booking and managing appointments and responding to telephone enquiries from patients, families and healthcare professionals. The current service provides support for half of the Adult Community Services and receives positive feedback from patients and users. However, the long term ambition had always been to include all adult community services.

The Transformation Team have worked with the division to develop and assess a range of options for integrating the remaining services. The team engaged with stakeholders across the division to review the form, function and performance of the current SPoA and review the administrative roles, responsibilities and requirements for the teams which are not currently included.

The future model is now agreed and in phase 2, all remaining services will be integrated into the SPoA service. Anticipated benefits include, improved patient experience, streamlined access for service users, improved responsiveness and increased service resilience and business continuity.

Acknowledging the interdependencies and close working relationships between the adult community services SPoA and the Stockport Care Co-ordination Centre, these projects have now been brought together to ensure alignment.

Sepsis Improvement Programme

The Sepsis Improvement Programme focuses on meeting the latest NICE guidelines and improving sepsis recognition, diagnosis and early management across Stockport FT. This is a wide-ranging pan-organisational programme which has initially focused on completing a gap analyses in relation to national guidance versus current practice across six workstreams: Adult ED; Adult In-Patients; Paediatrics; Obstetrics; Neutropenia; and Out of Hours. Underpinning this programme will be IT updates to our systems, to ensure our sepsis early warning tools are NICE compliant.

The gap analysis has identified the following areas for improvement:

- Medical SDEC streaming for neutropenic patients
- NEWS2 policy update in conjunction with the out of hours team
- Utilisation of sepsis stickers to identify patients
- An acute oncology outpatients/ Laurel Suite admission pathway to be developed
- Improved communications to staff and patients regarding sepsis
- An out of hours escalation pathway and bleep utilisation development process

Model Hospital data indicates sub-optimal patient sepsis care costs secondary care £7,518 per patient versus optimal patient care costs of £2,318. If 25% of Stockport sepsis patients received optimal care with full benefits realisation, the annual saving would be £1,248,000, based on:

- 62% saving on in-patient secondary care costs
- 64% reduction in number of bed days (11 days to 4 days)
- 80% reduction in number of bed days in ICU (5 to 1)
- 15% reduction in mortality

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Active Transformation Schemes - Stockport

Histopathology Improvement Project

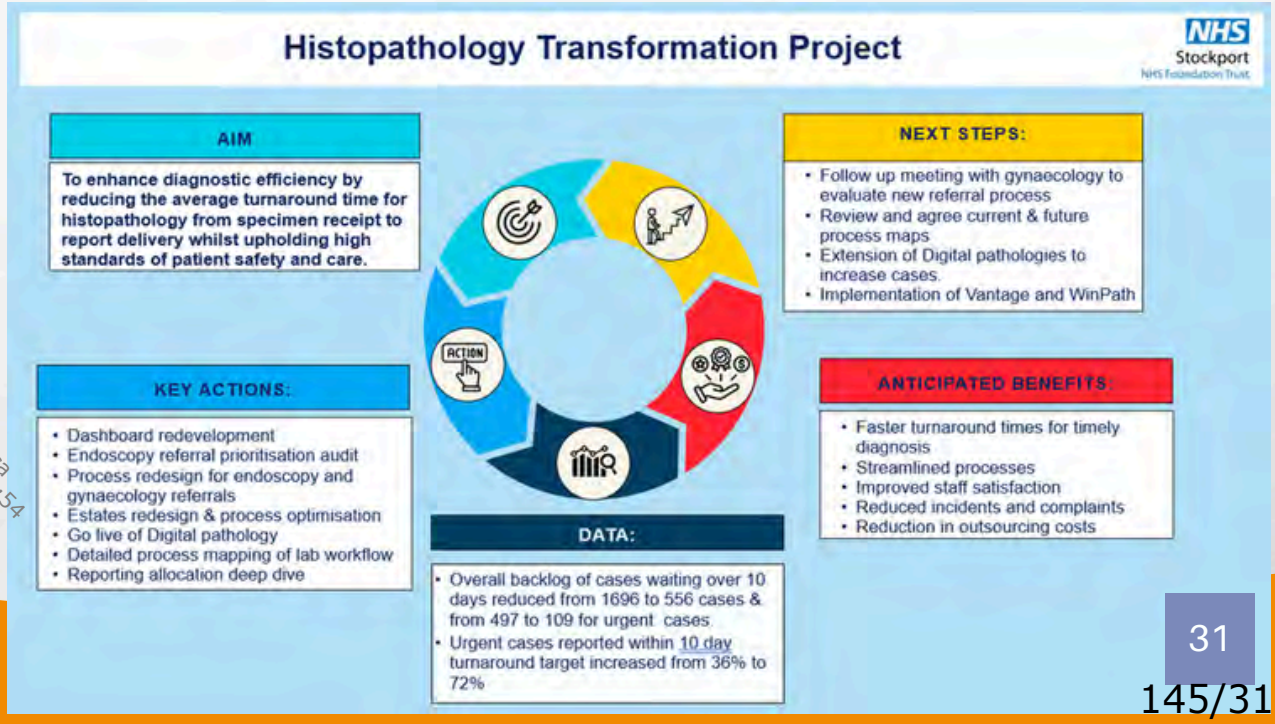
The Histopathology Improvement Project aimed to enhance diagnostic efficiency and patient experience, by reducing the average turnaround times across the histopathology diagnostic pathway, from specimen receipt to reporting. The project was structured around 3 key workstreams:

- Pre-referral - Exploring opportunities to improve the prioritisation of requests from specialities and reduce the number of requesting errors.
- Specimen Processing - Detailed process mapping of the laboratory processing pathway and the implementation of Digital Pathology for prostate and Urgent GI reporting.
- Diagnostic Reporting - Improving reporting workflows, the process of allocation and introducing a new KPI dashboard.

Through this project we have realised the following:

- The backlog of cases has reduced by 70%.
- Our urgent/two week wait cases being reported within 10 days has increased from 39% to 71%
- Reporting for all cases has more than doubled in performance.
- Outsourcing costs have been reduced from £272,600 in 2023/24 to £141,600 in 2024/25, leading to a saving of £131,000.
- The waiting list initiative additional sessions reduced from £73,300 in 2023/24 to £47,000 in 2024/25, leading to a cost saving of £26,000.

This year, the department has received substantial investment to support the reconfiguration of estates, the introduction of digital pathology, and the implementation of a new upgraded Laboratory Information Management System which will go live in summer 2025. The work undertaken within this project will help to maximise the potential of these new opportunities, reduce inefficiencies across the specimen processing and reporting pathways and reduce sample turnaround time.



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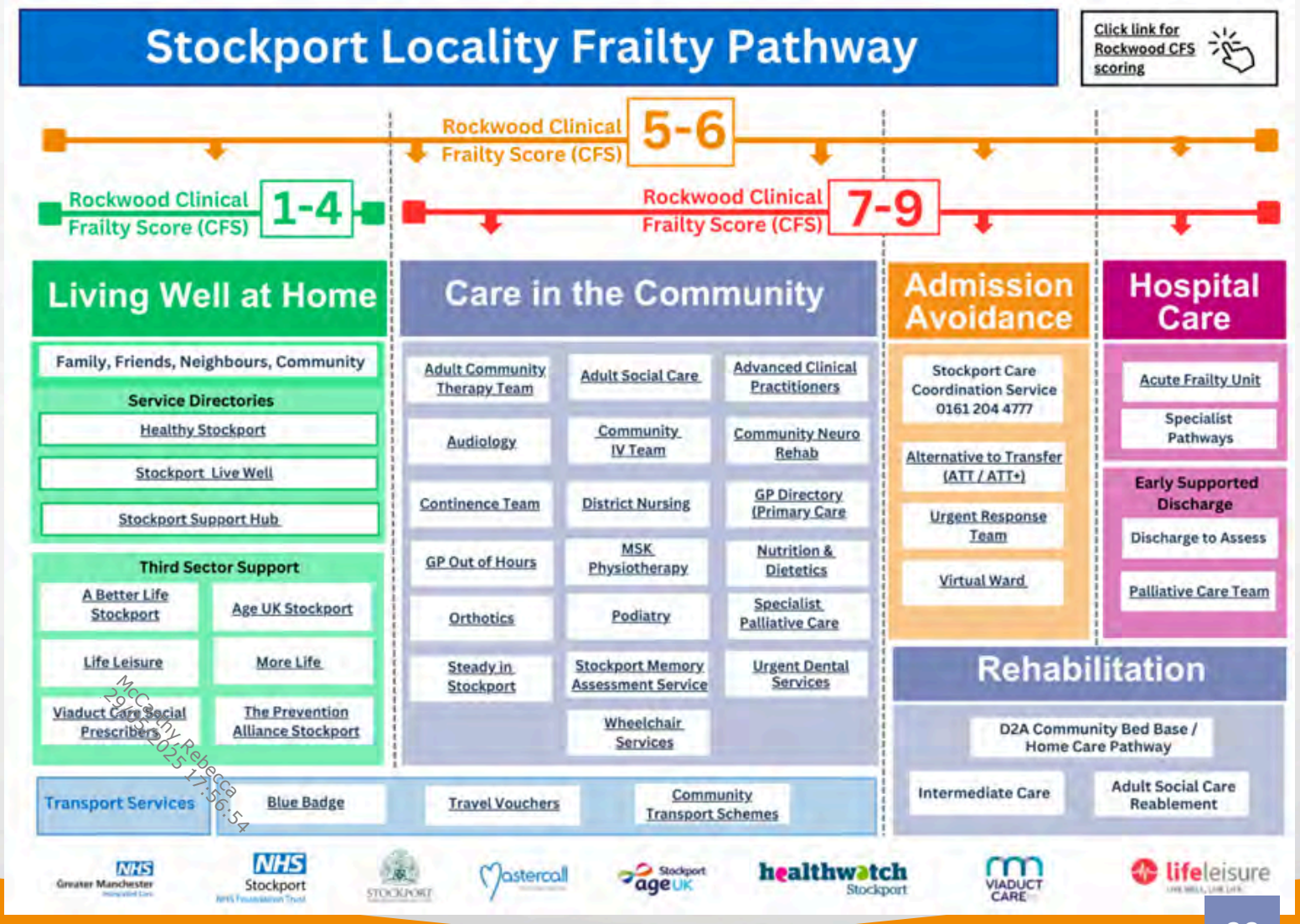
Active Transformation Schemes - Stockport

Frailty Improvement Programme

Preventing frailty and improving outcomes for people living with frailty in Stockport, remains a priority across the locality, being one of the 5 improvement programmes supported through Stockport's Provider Partnership. System partners have developed a collaborative programme – a blueprint dedicated to improving services and outcomes for people living with frailty and their families and carers. Four workstreams have been developed creating an end-to-end pathway focus. These workstreams include: independence and proactive approaches; acute care; long term care at home; and last 12 months of life.

This year has seen initiatives launched, such as the Keep On Keep Up (KOKU) Application; a digital hub to support people with digital technology; and confidence walks across the community to support falls prevention efforts. A research assistant has also been recruited in partnership with the University of Salford to review the benefits of strength based exercise. These initiatives support people living within our locality to prevent or live well with frailty. A Stockport locality frailty pathway directory has been produced to support the signposting of patients to the most appropriate services:



Active Transformation Schemes - Stockport

Frailty Improvement Programme continued

A Clinical Frailty Score (CFS) education workshop was hosted to increase awareness and recording of the CFS across the hospital and community services. Our Frailty Intervention Team processes and pathways have been reviewed to support timely identification of frail patients in the Emergency Department and ensure a holistic assessment and management plan on the Acute Frailty Unit. The development of the Acute Delirium Pathway has also been an exciting step forward to support our frail patients diagnosed with delirium.

Collaborative working across the Primary Care Networks (PCN's) and multidisciplinary teams has been key to the success of supporting patients in their own home environment. Frailty Coaches have been working with Advanced Care Practitioners (ACP's), focusing on patients who have had a recent fall to minimise the risk of falling again and/or preventing further deterioration.

A successful pilot was completed with ACP's attending the Palliative Care multi-disciplinary team meetings. This increased the number of patients highlighted to benefit from an advanced care plan in their last year of life. A Palliative Care Service Lead has also been successfully recruited.

System data has been a priority for this programme over the last year. NHS England facilitated a workshop in Stockport to review the SAMIT 75+ data for our locality. This has enabled clear key lines of enquiries to be identified, and the framing of our programme for the next 12 months.

Continence Improvement Project

The Continence Improvement Project has focused on the quality, productivity and financial efficiency of our Continence Service, with particular focus on our current ways of working, focusing on reducing referral to treatment times and waiting lists; reducing our overspend; reducing the complaints received.

This project has identified high-cost residential homes, for targeted cost reviews; implemented a new digital referral form to standardise our processes; collaborated with HealthWatch, to develop a patient information pack for new referrals; explored a pilot for transitioning users from disposable to reusable products; and assessed administrative integration with the Stockport Single Point of Access to streamline operations.

Through this work, benefits are still being realised, but include:

- Reduced delivery costs by half through increasing product delivery units to specific residential homes, reducing costs by £12.50 per delivery.
- Reduction in spend through a conversion to re-usable products, leading to an average cost saving of £63.30 per patient, per year.
- Improved patient experience following improved communications regarding their referral and waiting times.
- Increased clinical capacity through process efficiencies and reduced waiting lists.
- Anticipated opportunity to centralise the administrative roles to maximis team efficiencies and create a more resilient workforce model.

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Active Transformation Schemes - Stockport

Theatres Improvement Project - Phase 2

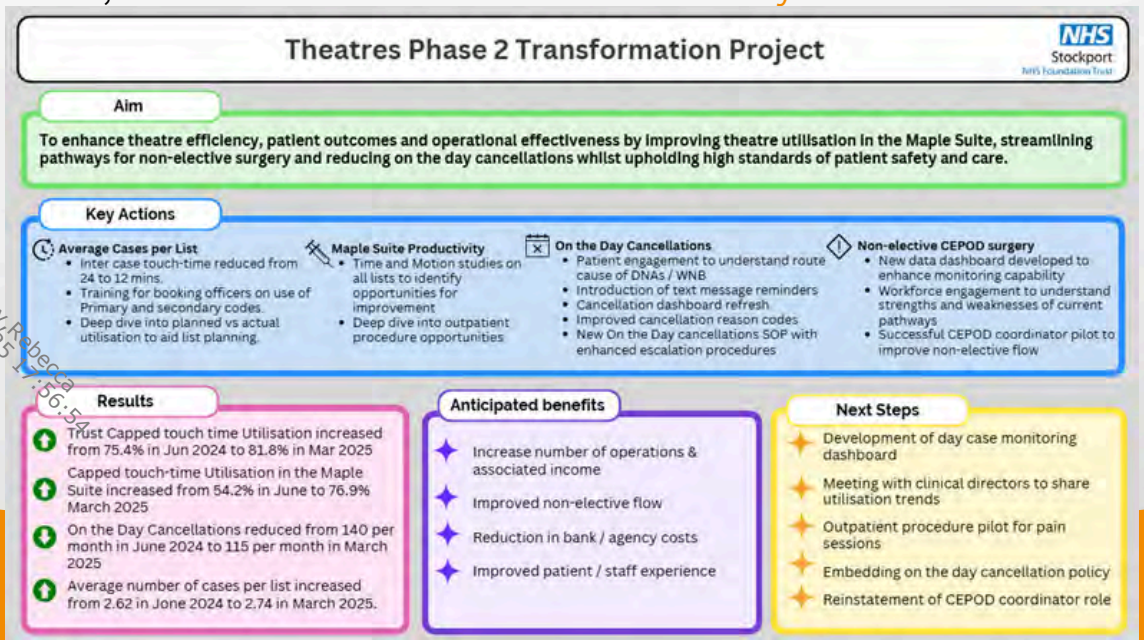
Building on the achievements made in their 2023-24 Health Service Journal award winning Theatre Improvement Programme, the aim of phase 2 of the project was to further enhance theatre efficiency, patient outcomes and operational effectiveness by increasing day case rates, improving theatre utilisation, streamlining pathways for non-elective surgery and reducing on the day cancellations.

Some of the key activities in the project include:

- Day Case Surgery: Deep dive into Day Case Surgery Performance data. Establishment of a new monthly listing outcome error report to improve the coding of intended management.
- Procedure times: Reduction of inter-case touch time to the new average to improve the planning of Theatre lists.
- Maple Suite Utilisation: Time and Motion exercises of all lists. Potential opportunities identified to develop an outpatient procedure model within some specialities.
- Deep dive into On the Day cancellation data. Update of the cancellation codes and SOP, development of a new text message reminder service for elective procedures.
- Non elective Surgery: Deep dive into the management of non-elective surgery. Implementation of a new pilot project to improve the flow of the non-elective gynaecology, urology and general surgery list by introducing the role of CEPOD coordinator.
- From the 1st April, we will be able to accurately monitor avoidable vs. unavoidable cancellations for the first time, to support improvement moving forward.

Achievements include:

- Trust Capped touch-time utilisation increased from 75.4% in June 2024 to 81.8% in March 2025
- Capped touch-time utilisation in the Maple Suite has improved from 54.2% to 76.9%
- Benchmarking our capped touch-time utilisation, we have improved from mid-quartile 2 in June 2024 to mid-quartile 3 in March 2025 (quartile 4 being the highest).
- In March 2025 we had increased our cases per list, now completing 2.75 compared to a peer and national median of 2.3.
- Since June 2024, we have had an 18% reduction in on the day cancellations.



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Active Transformation Schemes - Stockport

Pain Experience-Based Co-Design (EBCD) Project

Following funding received from the Health Foundation, this project aimed to co-design with patients and carers a safe, effective and streamlined Stockport Pain Management pathway, to improve patient experience and timely access to pain management services.

This project seeks to utilise an EBCD methodology to transform the patients pain management journey offering up to date, cost effective, patient centred care.

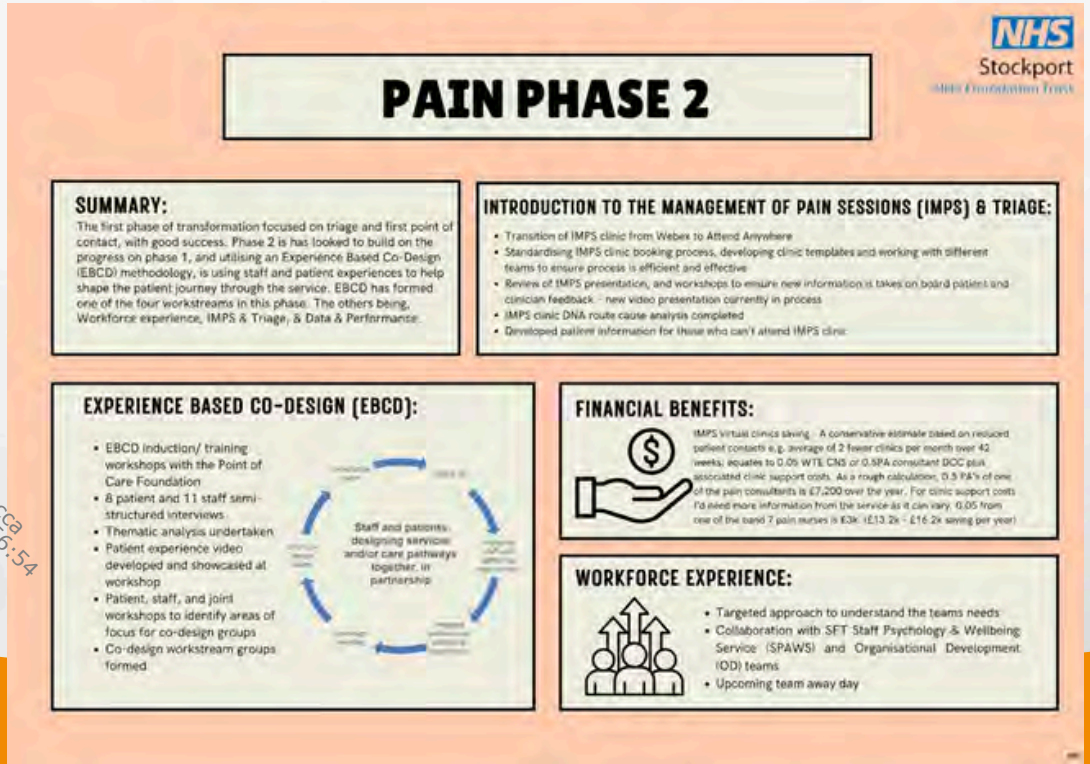
To date, in line with the Point of Care Foundation, Stockport FT have worked with an EBCD coordinator, specifically employed through the funding for this project. The methodology has seen:

- 8 patient and 10 staff semi-structured interviews conducted.
- Thematic interview analysis completed.
- Production of a patient experience video.
- Findings showcase events & workshops with patients and staff.
- A joint workshop held to decide on key themes for the co-design stage.
- Co-designed workstreams.

We are currently in an exciting stage, where the initial co-design groups have come together, and patients and staff collaboration has begun to find opportunities to take the pain management service forward.

This project represents Stockport FT's desire to explore new methods of innovation and has demonstrated how patient and staff priorities align when improvement is the overall goal.

The benefits of this project also extend to financial benefits. A conservative estimate based on reduced patient contacts required through our service will lead to between £13,200 and £16,200 per year, in line with 2024-25 pay rates through reduced patient contacts.



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Active Transformation Schemes - Stockport

Cardiology Improvement Project

This improvement project aims to enable Cardiology services to meet increased demand by delivering efficiency and productivity benefits through the following 4 workstreams:

- Referrals and triage - support utilisation of the electronic referral system (ERS) for triage
- Outpatient booking - improve pre-appointment pathways, clinic utilisation, and explore hybrid appointment models
- Diagnostics - explore ERS diagnostic integration solutions; implement paperless appointment booking for ECG's; and improve diagnostic turnaround targets
- Cardiac CT - explore bringing Cardiac CT scanning in-house

Reviewing our baseline position, it was noted that Cardiology has one of the highest rates of duplicate appointments in the Trust, with the majority originating from Primary Care. A cleanse is currently being completed and a thematic review being conducted to enable a focus on prevention and targeted primary care education.

The Cardiology diagnostic team noted a large proportion of their referrals from the stroke team, with a referral to test time of ~20 weeks. By exploring opportunities to increase collaboration with the Stroke team and undertake fitting of monitoring equipment before discharge, referrals could begin 72-hour ambulatory diagnostic monitoring on the same day of referral improving patient experience and clinical outcomes.

Furthermore, efficiencies have been noted through our booking processes and use of the EVOLVE system; and within the clinic templates. A clinic template review has meant that the Cardiology Clinic utilisation has now moved above 93% for the first time since May 2024. Volunteers have commenced a trial of call reminders for stress echo tests which have a historically high DNA rate of ~20%.

The Cardiology team are exploring opportunities to bring Cardiac CT scanning in house at Stockport FT which could generate more than £300,000 of additional income each year in addition to potential financial benefits listed below.

Improvements	Cost per Unit	Financial Benefit
2% reduction in DNA rate (50 people)	£120	£6,360
23.6% increase in Clinic Utilisation (224 appointments)	£165	£36,960

Scoped Transformation Schemes - Stockport

Attention Deficit Hyperactivity Disorder (ADHD) Pathway Review

The aim of the ADHD Pathway Project was to improve patient access to ADHD services by developing a single service to improve patient experience, quality and efficiencies across the pathway. The collaborative review with GM ICB and Stockport Locality leads aimed to minimise the risk of referrals being delayed, and/or missed between two separate services and organisations. Parent and child questionnaires were completed and feedback was analysed to support the development of the new pathway and model. Streamlining the pathway had anticipated benefits in reducing waiting times for assessment and treatment and a reduction in the duplication of resources and assessments, which in turn would lead to a financial saving.

The newly designed model was presented as part of a wider GM ICB Community Services review and further evaluation is ongoing.

Diabetes Hybrid Closed Loop Insulin Pump Scoping

The Stockport Diabetes Service is facing increasing patient demand which has already exceeded current capacity. An increasing population, as well as increasing prevalence of Type 1 Diabetes (T1D), combined with new NICE guidelines widening patient eligibility criteria for hybrid closed loop pumps means the service will need to significantly adapt to reduce current wailing lists for HCL pumps and meet a fourfold increase in demand within the next four years.

The Transformation Team undertook a 3 month scoping of existing T1D services across Stockport FT to identify opportunities for standardisation and collaboration, and to highlight areas for efficiency improvement. The current service spans our multidisciplinary teams across 3 of the Trusts divisions: Women's and Children; Integrated Care; and Medicine and Urgent Care.

The pathway mapping workshop identified over thirty opportunities for existing service improvement to explore. The focus going forward will be exploration of potential efficiencies generated from increased diabetes service integration and collaboration across Stockport FT.

Following the scoping exercise, a further 6 months of transformation resource has been granted to capitalise on the engagement and momentum between the services to realise the improvements. If effective, an annual saving of £365,054 could be noted from the project from the following areas:

- Annual Non-elective Bed Day Reduction of 504
- Annual Non-elective Admissions Reduction of 181
- Annual Non-elective Length of Stay (days) Reduction of 0.9
- Annual A&E attendances Reduction of 229

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Recently Commenced Schemes - Tameside

Ophthalmology Improvement Project

The Division of Surgery recently commenced a Transformation programme to review the Ophthalmology Service before its move into the new outpatients building. The project will review existing ways of working, benchmark the service against current guidance, and identify opportunities for improvement to optimise efficiencies and performance. Some of the main areas of focus will be, reviewing the services digital resources, pathway flow, and staffing skill mix.

Through this work, we aim to:
- Achieve 95% clinic utilisation target by August 2025.
- Achieve 85% theatre utilisation target by August 2025.
- Reduce DNA rates to 6% by August 2025.
- Increased PIFU within sub-specialities to 5% by August 2025.
- Review service against current guidance (e.g. GIRFT) ensuring closest adherence to by August 2025.

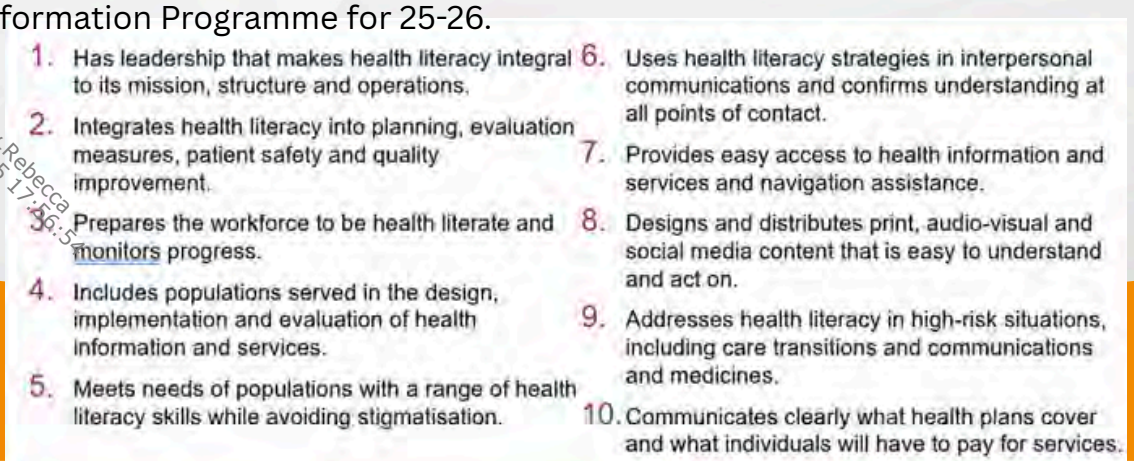
Anticipated benefits of this project are:
- Optimised outpatient & Theatre utilisation - this will have both quality benefits for our patients, and financial benefits for the organisation.
- Improved skill mix - this will enable improved staff experience, improved retention, increased optimisation, and reduce spend on bank staffing.
- Improved data recording practice - this will ensure Stockport FT is receiving correct payment for all ongoing service activity.

Health Literacy Improvement Project

6 in 10 adults in Stockport have low health literacy, with an estimated prevalence of low health literacy increasing over the next few decades. People with low health literacy are more likely to experience illness earlier in life, lower age mortality, struggle to self manage their health and experience difficulties in accessing appointments and care.

At Stockport NHS Foundation Trust we have began to review ways to become a health literate organisation. In March, the Transformation Team facilitated and lead on the first Trust's Health Literacy workshop, with representation from across all Divisions, services which span acute and community alongside our partners from Health Watch and the Stockport Council.

The workshop allowed opportunity for discussion on what we do well now and where are areas of opportunities are to achieve the 10 attributes of Health Literate Organisation. It will remain a priority Transformation Programme for 25-26.


1. Has leadership that makes health literacy integral to its mission, structure and operations.
2. Integrates health literacy into planning, evaluation measures, patient safety and quality improvement.
3. Prepares the workforce to be health literate and monitors progress.
4. Includes populations served in the design, implementation and evaluation of health information and services.
5. Meets needs of populations with a range of health literacy skills while avoiding stigmatisation.
6. Uses health literacy strategies in interpersonal communications and confirms understanding at all points of contact.
7. Provides easy access to health information and services and navigation assistance.
8. Designs and distributes print, audio-visual and social media content that is easy to understand and act on.
9. Addresses health literacy in high-risk situations, including care transitions and communications and medicines.
10. Communicates clearly what health plans cover and what individuals will have to pay for services.

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Closed Transformation Schemes - Stockport

Haematology Improvement Project

The Haematology Improvement Project aimed to enhance efficiency, productivity, and patient safety across the Haematology service in response to increasing demand. A collaborative, multi-professional approach enabled a full review of the patient journey and service structure.

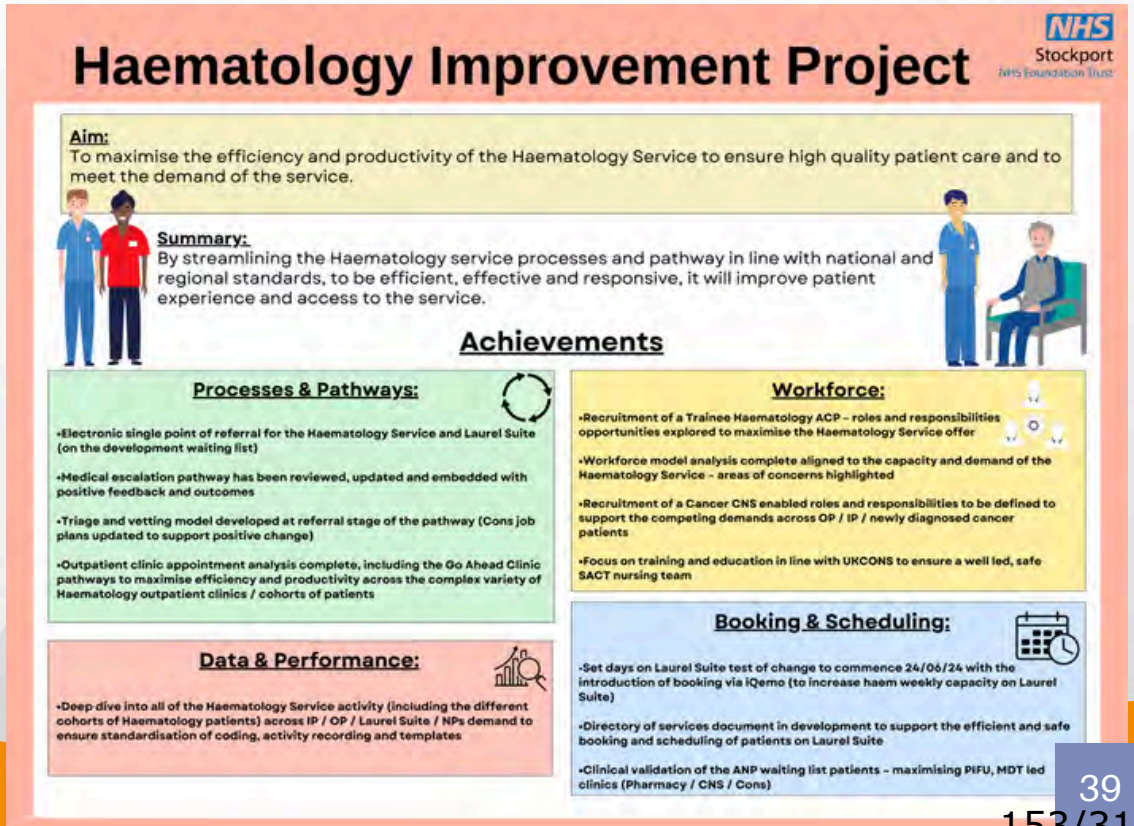
Key changes included revised job plans to support triage and Advice & Guidance (A&G), ensuring appropriate clinic allocation through robust vetting and clinical validation. Outpatient clinic templates were updated to better utilise MDT skill mix, and “Go Ahead” clinics were aligned with treatment timelines. A single-point referral process was introduced to streamline access.

Patient safety was strengthened through an updated escalation process for unwell patients on Laurel Suite, supported by a centralised booking and scheduling system via Outlook to improve timely assessments.

A comprehensive workforce gap analysis defined MDT roles and informed future planning. A full-team workshop improved cross-role understanding and highlighted service pressures.
Key outcomes and benefits:

- 91% of nurses completed the full UKONS course (target: 80%)
- A&G usage reached 100% for urgent and routine referrals, significantly exceeding the 16% national guidance
- New patients waiting over 10 weeks reduced from over 600 to 400 by January 2025
- Improved clinic utilisation and streamlined referral pathways
- Standardised coding and data recording through collaboration with Business Intelligence, coding, and health records teams

These improvements have led to measurable gains in workforce capability, patient flow, safety, and data quality across the Haematology service.



DEVELOP
a continuous improvement culture

Closed Transformation Schemes - Stockport

Children and Young People Improvement Programme Phase 2

The main focus of this programme has been to pilot a new Walk in Walk Out model for paediatric day case surgery. The new model prevents children who are assessed as low complexity from being admitted into a day case bed and instead discharged directly from second recovery in Theatre. The model has demonstrated many benefits including improved waiting times, reduced length of stay and improved patient and carer satisfaction. A new bespoke Walk in Walk out recovery area has been built in our Stockport FT Paediatric Theatre. Following completion of the initial build, and design of the new model of care, the first pilot took place on 10th December 2024. Initial feedback from staff and patients has been very positive and the foundations are in place for this model to be fully embedded.

Some feedback on the initial pilot includes:
Staff: "It all went really well and the feedback was very positive. I want to make a special mention to all the theatre staff who were marvellous and so supportive. Without them today would have been a disaster."
Patient/carer: "We had a fantastic experience here today. First trial of a WiWo list - amazing team here on the ward and amazing communication all round! friendly, helpful, all questions were answered and the emotional support was there. Thank you to the NHS and all that made her up."

Closed Transformation Schemes - Stockport

Gynaecology Same Day Emergency Care (SDEC) Implementation Review

The aim of this project was to review opportunities to transition the current Stockport Gynaecology (Gynae) emergency service towards a true SDEC model, allowing specialists to rapidly assess, diagnose and treat patients on the same day of arrival who would otherwise have been admitted to hospital.

The benefits of such a service would be:

- Increased senior clinician oversight
- Standardised triage model
- Management of high call volumes
- Accurate capture of service activity & consistent recording of re-admissions & follow up appointments
- Improved staff and patient feedback

Process mapping workshops allowed us to develop an “ideal” service model and a gap analysis was done to identify areas for change. We benchmarked our service against other Trusts Gynae SDEC services, and against our Medical SDEC service. Benchmarking highlighted how beneficial an SDEC model would be to Stockport FT. Therefore, we introduced a test of change which increased SHO oversight for the Gynae emergency area. This pilot further supported the evidence base gathered throughout the project, an options review is now underway by the service.

Diabetes Antenatal Care Improvement Review

As part of our ongoing commitment to delivering high-quality, patient-centred care, the Transformation team completed a focused review, aimed at enhancing the Diabetes Antenatal Service. Originally part of a broader diabetes pathway review, this evolved into a standalone piece of work to ensure the antenatal element was as efficient, effective, and patient-friendly as possible.

The transformation process began with a comprehensive service assessment, designed to understand the current landscape and identify areas for potential improvement. Through collaboration with key stakeholders across the service, key workflows and bottlenecks were identified, challenges reviewed and ideas for change co-produced.

The project team conducted a detailed time and motion study, providing further evidence of inefficiencies and highlighting opportunities for streamlining. Finally, a patient survey was conducted with the feedback offering a valuable baseline to help shape the direction of planned improvements.

Utilising these insights, the project team developed a set of clear, actionable steps. These included a review of clinic templates to improve appointment scheduling and capacity planning, as well as collaboration with the Facilities team to pilot enhancements to the outpatient clinic environment.

This focused review has laid the foundation for a more responsive and efficient Diabetes Antenatal service—enhancing productivity for staff and delivering a more positive experience for patients.

Closed Transformation Schemes - Stockport

Opioid Stewardship Improvement Project

In support of the national agenda for safer medicines use, this project was initiated to promote best practice in opioid prescribing and medicines management—particularly at the point of discharge. The aim was to reduce the risk associated with opioid use across the Trust, with a targeted focus on peri-operative prescribing.

The project had three core objectives:

- Optimise the pilot Peri-operative Pain Clinic
- Deliver targeted education on opioid stewardship to spread awareness
- Establish a system for tracking compliance with opioid safety standards

Working closely with the Business Intelligence (BI) team, we developed bespoke dashboards to understand and monitor opioid prescribing practices, particularly within the surgical division and take proactive steps to improve prescribing behaviours.

New prescribing templates have been introduced to ensure all opioid prescriptions included a defined duration and end date. This is an important step towards reducing unnecessary or prolonged opioid use. Educational outreach, both within and beyond the organisation, helped spread awareness of best practice across the locality. This was met with excellent feedback from staff and stakeholders.

A significant achievement of the project was the enhanced utilisation of the Peri-operative Pain Clinic. Referral rates for appropriate patients rose from below 20% to 69%, enabling more patients to receive specialist pain support pre- and post-operatively. In response to this increased demand, clinic capacity was expanded accordingly.

The project has delivered both quality and financial benefits, including:

- A change in pharmacy labelling practices for oral morphine, generating savings of £288.15 during this project.
- Promotion of safer prescribing practices by replacing co-codamol with morphine and paracetamol separately, in line with national guidance—offering an efficiency saving of £0.25 per prescription.
- This work has laid strong foundations for safer, more accountable opioid prescribing at Stockport FT and demonstrates the power of targeted, collaborative quality improvement initiatives in driving lasting change.

DEVELOP
a continuous improvement culture

Transformation Events

Both organisations held successful Transformation Events in 2024, celebrating the progress and achievements in improvement across the Trusts. Attendance at these events has grown each year, with over 200 people having been in attendance at each event this year, reflecting the increasing enthusiasm and pride our staff feel in the ongoing improvement efforts. This growing participation also highlights their strong desire to contribute to and shape the transformation journey.

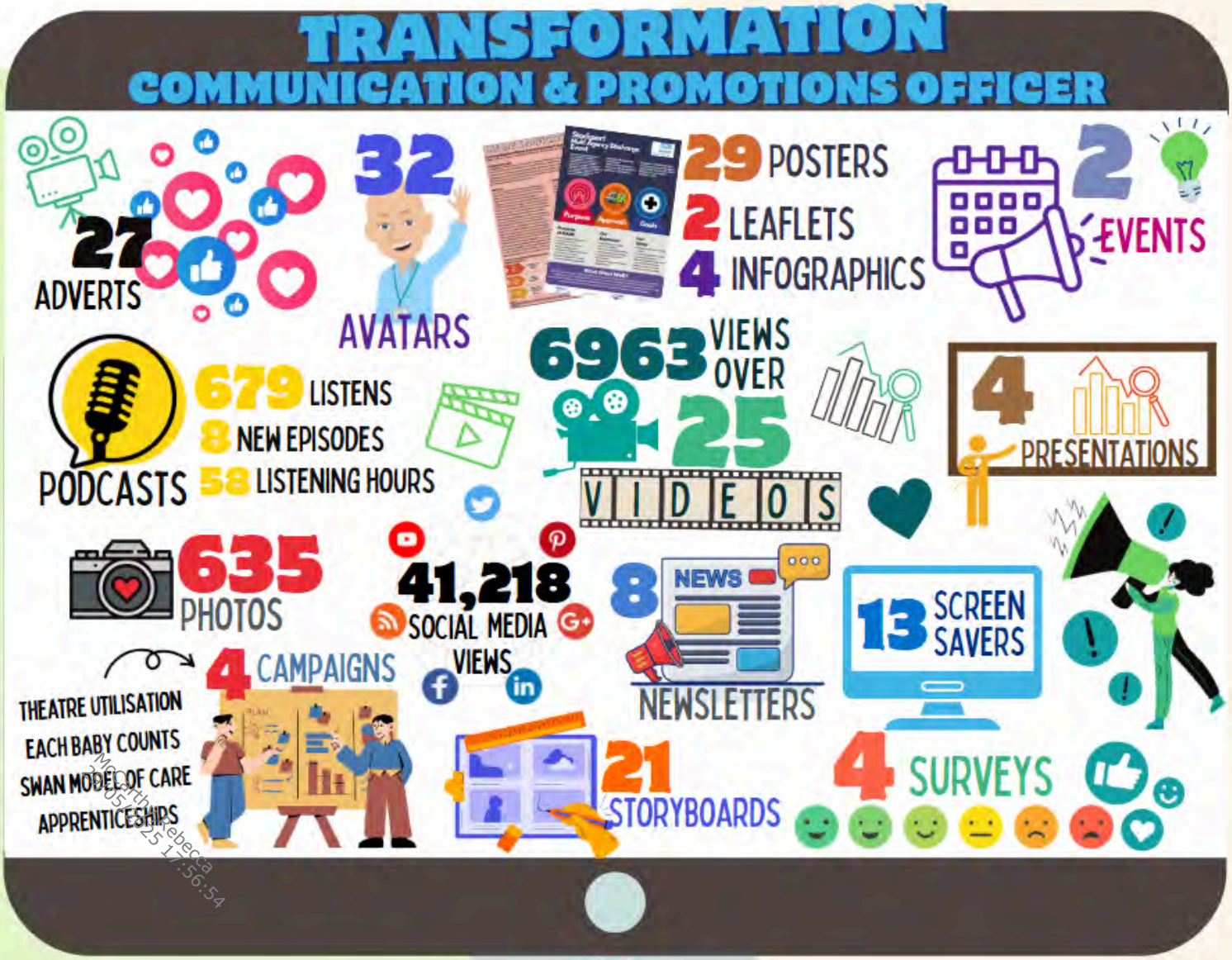
DEVELOP
a continuous improvement culture

Transformation Communication & Promotions Offer

The Transformation Team's Communications and Promotions Officer post, jointly supporting Stockport NHS Foundation Trust and Tameside & Glossop Integrated Care NHS Foundation Trust, has now been active for 12 months. This role has played an important part in education and awareness training videos for patients and staff, and in communicating and promoting the wide range of improvement work taking place across both organisations. By sharing success stories, facilitating cross-organisational learning, and raising awareness of ongoing improvement initiatives, the post has strengthened collaboration and helped embed a culture of continuous improvement.

The Communications and Promotions Officer continues to support the visibility and celebration of innovation, ensuring that good practice is recognised and shared widely across teams and services.

The visual below can show the scope and scale of work that has been completed over the last 12 months.



DEVELOP
a continuous improvement culture

Our Communications and Promotions Officer is positioned to support the wider improvement work that is taking place across the organisation, in line with the Trusts Continuous Improvement Strategy. Some example areas of work include:

School Nursing - Stockport FT

The team has focused on using resources more efficiently to free capacity and reduce waiting lists. Our Communications and Promotions Officer supported this by producing videos shared with schools, parents, and new referrals to promote self-help while waiting. Since August 2024, these videos have been released in phases and in total viewed 2,259 times. In 2025, three additional classroom-focused videos launched, replacing in-person nurse sessions, and have been used 75 times cumulatively. This initiative has helped lower waiting times and allowed nurses to prioritise children needing individualised care. Further support has been requested to replicate this work for their Sex Education resources.

Endoscopy - Tameside & Glossop ICFT

The Endoscopy team noted a number of DNA's, alongside cancellations on the day, due to patients attending their appointment but being unable to proceed as they had not taken their bowel preparation treatment correctly prior to arrival. The videos focused on how to take their bowel preparation, and what to expect when they got to their appointment. To date, there has been 1925 views on this video since February 2024 and a reduction in cancellations on the day and DNA's has been noted by the service.

Each Baby Counts - Stockport FT

This campaign supported the implementation of the national Each Baby Counts toolkit to enhance communication and reduce incidents leading to foetal loss. Following GM's directive for all Maternity staff to complete mandatory training on the toolkit. A four-month campaign was launched in collaboration with the fetal monitoring and patient safety lead.

Key initiatives included:

- A training video played during the launch week at every team meetings and daily huddles.
- Creation of a Team of the Shift board in each ward, a core component of the toolkit.
- Informational displays placed in staff areas.
- Trust-wide communication via social media and internal bulletins ahead of launch week.

Apprenticeships - Tameside & Glossop ICFT

This nine-month campaign aimed to increase uptake of the national apprenticeship levy by addressing barriers through staff and management surveys. Insights from the surveys highlighted the need for greater education on apprenticeships, leading to the development of:

- Two targeted videos: one encouraging staff participation and another 'myth busting' common managerial misconceptions.
- A new apprenticeship induction pack to support onboarding.
- Trust wide communications ahead of National Apprenticeship Week, culminating in a celebration event for recent apprenticeship graduates.
- This strategic approach improved understanding and participation, fostering greater engagement with apprenticeship opportunities.

ORGANISATIONAL PARTNERSHIPS

to deliver sustainable change

For improvement to happen, and be sustained, we cannot work in isolation. As has already been shown throughout our projects, our work requires support from many teams and members of our multi-disciplinary teams, to ensure improvement. Further to this, we need the wider support of our locality and further afield, to ensure to embed sustainable improvements for our patients.

We would like to extend our heartfelt gratitude to all our colleagues, partners, and patients whose dedication and collaboration have been instrumental in driving continuous improvement. Our sincere thanks go to our colleagues in Business Intelligence and Corporate Information, Patient Experience, Governance Teams, IT and Systems Development, Library Services Clinical and Operational teams, and our Consultant in Public Health, whose expertise and commitment ensure we deliver the best possible care. We are also immensely grateful for the invaluable support of our Local Authority partners, as well as our Stockport and Tameside Locality Integrated Care Board colleagues, whose contributions help shape and strengthen our services. Most importantly, we extend our deepest thanks to our patients—their feedback is essential in shaping the care we provide. We are especially grateful to those who represent the patient voice as lived experience members in our programmes, ensuring that real experiences guide our improvements.

The collective efforts of everyone make a meaningful difference to the patients and communities we serve, and we look forward to continuing this vital work together.

PEOPLE

Placed at the heart of our plans and engagements

Our strategy places people—patients, staff, and those with lived experience—at the centre of all improvement activity. To achieve this, we focus on:

- Creating opportunities for people to suggest improvements
- Co-producing initiatives with staff, service users, and those with lived or living experience
- Embedding person-centred approaches in all improvement work
- Providing visible, effective leadership to support transformation
- Growing a network of Improvement Champions

Over the past 12 months, we have taken meaningful steps to deliver on these aims. At Tameside, we trialled new engagement approaches during our Multi-Agency Discharge Event (MADE), including a "Dragon's Den"-style forum and a dedicated inbox for improvement ideas. This proof of concept encouraged innovative thinking and grassroots involvement in service improvement and will shape thinking of how we take this forward in the future, engaging our staff in ideas for improvement.

At Stockport, we partnered with the Pain Services team to deliver a programme using Evidence-Based Co-Design (EBCD) methodology. Staff received specialised training and worked closely with patients to co-design the pain management programme, laying the groundwork for future co-production initiatives.

We have also strengthened our Equality Impact Assessments (EIAs) by working with our Equality, Diversity and Inclusion (EDI) Lead to improve how we assess and embed equity in all improvement programmes. This ensures that we are making conscious decisions within our improvement work, and impact that it may have on our population.

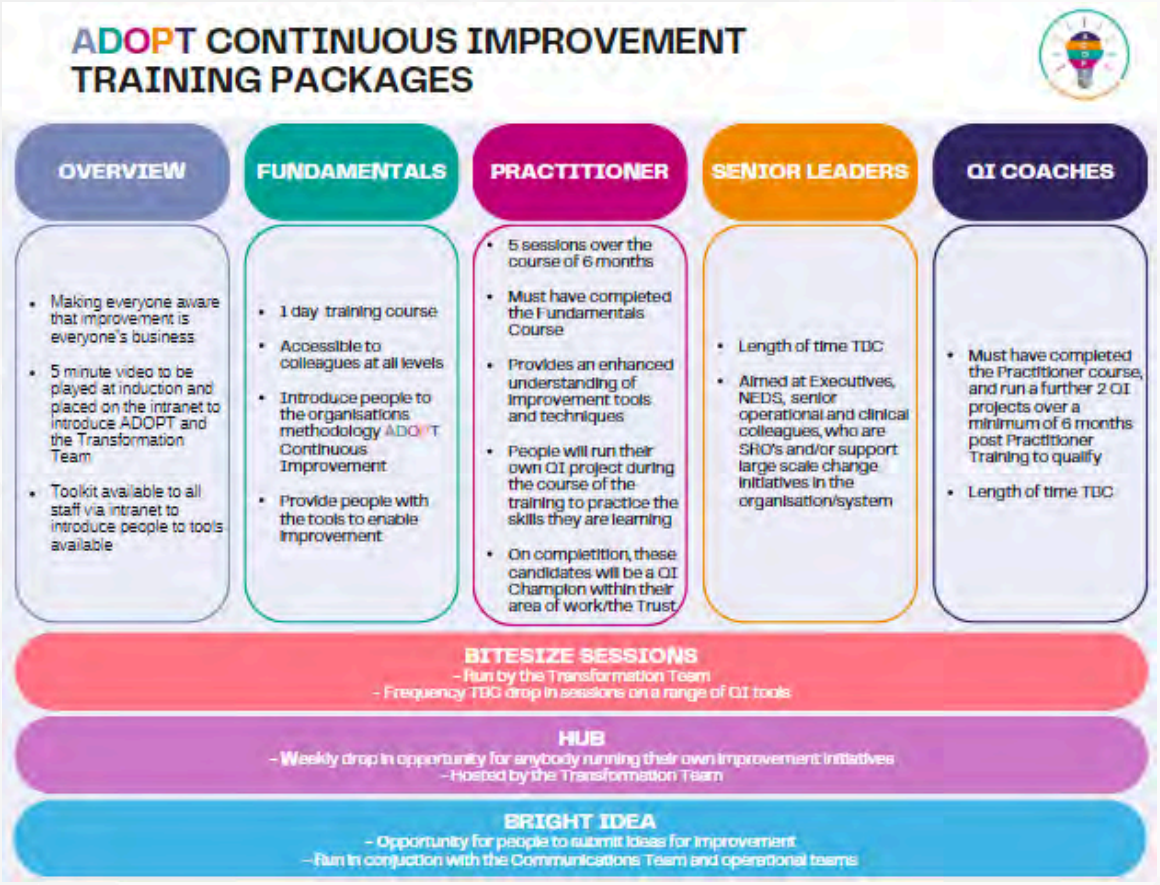
Furthermore, in collaboration with our Public Health Consultant at Stockport, we have made health inequalities a core focus. This includes new programmes targeting health literacy and alcohol-related harm, and ensuring health equity is a priority in all ongoing and future work.

Finally, with the launch of our training package in January 2025, we began building a growing network of Improvement Champions across both organisations, consisting of individuals leading change or supporting others on their improvement journeys, helping to embed a culture of continuous improvement at every level.

TRAIN

Our people to deliver improvement

Over the past 12 months, our Transformation Team has made significant progress in expanding and diversifying our training offer. We firmly believe that learning is not one-size-fits-all, and we are committed to providing a flexible suite of development opportunities to suit varying needs and preferences.



First and foremost, in line with the new Trust values, and to ensure we are supporting the Excellence domain of "we support innovation, improvement and learning" we have produced a video that can be placed in the Trust Induction, and other training sessions, to introduce the Trusts Continuous Improvement Strategy, what their role is, and how we can best support them. The aim of this is to increase the capability of our staff, increase capacity for improvement and make it everyone's business. To view the video, please scan the QR code:

SCAN ME

To further support staff, we have introduced a weekly Improvement Drop-In Hub, providing a regular space for individuals and teams to ask questions, share ideas, and seek advice on their improvement initiatives.

We are also developing a series of bite-sized training videos on a variety of topics, which is due to launch in May 2025. These on-demand resources will allow staff to learn at their own pace and at a time that suits them.

TRAIN

Our people to deliver improvement

We were proud to release a new season of our podcast, Transformation Talks, which continues to grow in reach and impact. This season features a range of practical and insightful topics, including how to start a project, tools to support improvement work, national and regional influences, and real-life examples of transformation in action. To date, our podcasts have had over 679 listens across the series.

This year we have launched the first of our face-to-face training sessions—ADOPT Continuous Improvement Fundamentals. This interactive, 3-hour workshop introduces our Trust's ADOPT methodology and gives participants hands-on experience with key improvement tools. Delivered in person and bookable via the Electronic Staff Record (ESR), this session has been extremely well received, with bookings now filled three months in advance and consistently excellent feedback from attendees.

Our focus remains on creating meaningful, accessible, and engaging learning experiences to build improvement capability across the organisation.

Training feedback:

"It was a great mix of being told information and interaction. I definitely can't wait for the rest of my team to attend. It was a great session with knowledgeable presenters, great content and the resources available look fabulous. Thank you."

"The training was very detailed and gives lots of information that is useful for everyone's teams. I didn't know anything before, and I have come away with so much."

"The training was excellent, informative and essential for the transformation happening within my team."

"It was really useful to learn about how to start a project and has given me a good starting point and guides to follow. It will help me turn ideas into actions, Thank you, I really enjoyed the session and gained a lot."

AWARDS

With all of the incredible improvement work taking place across both organisations over the last 12 months, we have had lots to celebrate. Consequently, across both organisations the Transformation Team supported the submission of 40 National Awards.

Through this, we have been shortlisted for 8 and we are awaiting an outcome on a further 27 submissions completed in March 2025.

We are extremely proud to announce, that from these submissions we were winners in 2 Health Service Journal Patient Safety Awards and we won 1st Prize for a poster we supported the production of at the National Acute Pain Symposium.

Health Service Journal Patient Safety Awards 2024 - Patient Safety, Education and Training Award Category - ME in DeMEntia Project - Tameside & Glossop Integrated Care FT

Health Service Journal Patient Safety Awards 2024 - Patient Safety in Elective Recovery Award Category - Improving Theatre Productivity to ensure our patients have timely access for surgery - Stockport FT

National Acute Pain Symposium 2024 - Reducing Opioid Use - Stockport FT

We were also incredibly proud that the Stockport FT Transformation Team were shortlisted for a Trust Making a Difference Everyday Award, as the Non-Clinical Team of the Year. We love supporting our teams to make improvements that benefit our patients and staff, and the recognition of this nomination and shortlisting we have great pride in.

ADOPT CONTINUOUS IMPROVEMENT STRATEGY YEAR 1 PROGRESS

Ambition	Objective		Success indicator	Year 1 update
Align	1.1	Ensure we remain aligned to organisational, regional and national strategies and objectives.	Meet the key milestones set out in the NHS Long Term Plan and operational planning guidance.	All documents reviewed and aligned as released.
			Key stakeholders supporting the GM Integrated Care Partnership 6 missions.	Our programmes of work have an underpinning of the 6 missions. This year has seen a particular focus in embedding financial focus in our schemes of work
Develop	2.1	Provide the tools to support change and improvement	"ADOPT" Continuous Improvement Methodology embraced across both organisations.	A new video has been developed to be played from induction to help people understand "ADOPT". Further training is then provided through our training resources.
			Interactive materials and self-help guides created and available to all, to introduce improvement tools and their use.	Podcasts live, and bitesize self-help guides developed and to be made available in May 2025. For those attending our courses, training resources are provided for future reference.
			Increased number of people accessing available materials.	We have seen rising numbers accessing our materials, including over 679 listens to our podcast, and nearly 7000 views on all videos produced.
	2.2	Develop an improvement hub, providing support and coaching to individuals and teams in implementing an improvement initiative	Frequent drop-in clinics available.	Weekly drop-in clinics established and in-situ for all staff to attend for improvement support and guidance.
			Increased number of people accessing sessions	Low numbers at present as we establish and communicate the hub.
	2.3	Promote improvement initiatives and share learning widely, celebrating successes through a range of avenues	Embedded joint working model for improvement across the two organisations with leadership infrastructure to enable this.	Joint working model now in situ.
			Annual Transformation event to be held at both Trusts to celebrate their improvement work.	A Transformation Event has been held at both organisations in the last 12 months celebrating the organisations improvement successes.
			Increased number of "Learn and Share" sessions between the 2 organisations to be held.	Further learn and shares have been held between our clinical and operational colleagues. These are also now starting to happen more organically with signposting, as our relationships mature.

ADOPT CONTINUOUS IMPROVEMENT STRATEGY YEAR 1 PROGRESS

Ambition	Objective		Success indicator	Year 1 update
			Combined annual report to be published showcasing the transformation work occurring.	Combined report produced and to be disseminated.
			Increased involvement in regional and national webinars, showcasing both organisations as at the forefront of improvement and transformation.	We have led on NHS England and GIRFT webinars in the last year for both Frailty and Urgent Emergency Care work. We have also learnt from others through these webinars.
			Increased number of award nominations.	This has been our most successful year for nominations, with 41 submissions made in the last 12 months.
	2.4	Develop a forum for improvement ideas to be submitted and reviewed.	Mechanisms developed for people to submit their ideas for improvement, and their review.	Trialled a Dragon's Den approach and trialled an improvement inbox. Both methods under review for future advancement.
			Increased number of improvement initiatives that may contribute to financial/efficiency/quality improvements received.	Across both organisations we have been involved in 46 programmes in the last 12 months, and supported others with their independent improvement work also through workshops, process mapping sessions alongside communication and promotional work via a range of media.
			Feedback loop developed to update those who have suggested improvements.	In development following trial of inbox solution.
Organisational Partnerships	3.1	Collaboration within and across both organisations to share good practice and areas for learning	Increased number of "Learn and Share" sessions between the 2 organisations to be held.	Further learn and shares have been held between our clinical and operational colleagues. These are also now starting to happen more organically with signposting, as our relationships mature.
			Maintained levels of engagement through Service Improvement Groups at both organisations.	Fantastic engagement through Service Improvement Groups on both sites.
	3.2	Engage with system-wide partners to implement and embed sustainable change for the benefits of the people living in our localities	Stakeholder checklist, including all parties, included in all transformation schemes.	Updated checklists and these are embedded in all programmes.
			Attendance as providers at all relevant meetings to improve our localities.	Relevant locality led meetings linked to improvement are attended across both localities.
	3.3	Work with our partners to support improved prevention and	Increased features of health inequalities within improvement schemes.	We have worked closely with the Stockport Public Health Consultant to improve our knowledge and approach to

ADOPT CONTINUOUS IMPROVEMENT STRATEGY YEAR 1 PROGRESS

Ambition	Objective		Success indicator	Year 1 update
		early identification for our local population		health inequalities and brought this lens into our schemes across both sites.
			Prevention and early identification workstreams to feature within all long-term health improvement schemes.	These are a feature within all existing long term condition schemes.
			Increased campaigns to improve prevention and early identification.	We have supported a Blood Borne Virus campaign and an Each Baby Counts campaign, focus on these has been dedicated to prevention and early identification.
People	4.1	Create opportunities for people to suggest improvements	Increased opportunities for patients and carers to submit improvement ideas.	In the first year, this has been using surveys in current transformation schemes.
			Increased opportunities for our workforce to submit improvement ideas.	Trialled a Dragon's Den approach and trialled an improvement inbox. Both methods under review for future advancement.
	4.2	Co-produced improvement with our staff and service users and those with lived, and living, experience	Increased visibility of patients and carers views in improvement schemes	In the first year, this has been using surveys in current transformation schemes.
			Increased training for people with lived and living experience who support our transformation meetings.	This will fall into year 2/3 of our strategy, where we will build our offer to those supporting our transformation schemes, to ensure they have the research and knowledge of improvement also and support their development whilst participating in our improvement groups.
	4.3	Person-centred approaches underpin all improvement work we carry out	Increased number of EIA and QIA completed for improvement initiatives.	The EIA has been reviewed in the last 12 months, with support from the Trust EDI lead, to provide a focused and equality lens to our scheme. Training has occurred and this is now embedded and completed in all our schemes of work.
			Increased number of improvements have considered and documented person-centred approaches.	These have been considered and documented against each of our transformation schemes.
	4.4	Effective, visible leadership to support improvement	All senior leader job descriptions to include improvement.	To be reviewed in the next 2 years of the strategy implementation.
			All senior leaders have accessed improvement training.	Senior Leader training is the next course to be developed and should be live during year 2 of the strategy.
			All transformation schemes to have an operational lead and clinical lead.	Complete.

ADOPT CONTINUOUS IMPROVEMENT STRATEGY YEAR 1 PROGRESS

Ambition	Objective		Success indicator	Year 1 update
	4.5	Grow a network of Improvement Champions	Increased number of improvement champions.	We now have an active and growing list of improvement champions across both Trusts.
			Increased number of services with an improvement champion.	This number is increasing. A full gap analysis will be completed as we head into year 3 of the strategy.
Train	5.1	Develop an in-house improvement training programme for people across all levels	Increased number of people accessing training packages.	We currently offer a training session for up to 25 people every month. These sessions are booking up quickly and are booked out 3 months in advance.
	5.2	Provide training opportunities in an array of media	Increased methods of accessing training.	We now have podcasts, face to face training, and drop-in coaching hubs. In May 2025, this will expand to videos and self-help tutorials also.
			Increased number of people accessing resources and training across the platforms.	We have seen rising numbers accessing our materials, including over 679 listens to our podcast, and 62 people attending the first 3 sessions of face-to-face training.
	5.3	Provide drop-in sessions for people, and teams, leading their own improvements	Frequent drop-in clinics available.	Weekly drop-in clinics established and in-situ for all staff to attend for improvement support and guidance.
			Increased access to coaching opportunities for improvement.	Opportunities are being provided through programmes of work, drop-in clinics and specific requests on a 1:1 basis.
	5.4	Provide bite-size improvement education sessions for people to attend	Frequent drop-in clinics available.	Weekly drop-in clinics established and in-situ for all staff to attend for improvement support and guidance.
			Increased number of people accessing sessions.	Our training sessions are booked out at present. We aim to run monthly 1 hour drop-in bitesize sessions in year 3.

TESTIMONIES

MADE AWARD 2024 - Shortlisted for Non-Clinical Team of the Year

The Transformation Team have worked tirelessly over the last 12 months, and always done so with a smile and infectious energy, that supports others to address improvement with a positive attitude. The team have supported every division with improvement work, and there have been some incredible successes.

The entire team are beyond excellent, since I joined the organisation they have been by my side supporting me to explore the services I lead and helped me deliver change, transformation and most importantly better care to our patients and the residents of Stockport.

Nothing is ever too much trouble and they are so accessible and friendly whenever I ring or email with a problem, they always have the solution. The team are always professional and always have a compassionate and kind approach to their work, they are a highly skilled and experienced team and I am grateful of their support. I couldn't do my job without them and they are a huge cog in our system that makes our clinical work so much easier.

Thank you team Transformation for everything.

This is the first time I have worked a job with such supportive staff, in such a happy environment where it was a genuine pleasure to be at work every day. Most of the places I have worked have had highs and lows, but upon reflection, this was not one of them.

From the proximity of it to my home, along with the incredible team all the way up to senior leadership, how accommodating you have all been and the beautiful culture created by the brilliant colleagues. I can truly say I have had nothing short of amazing memories during my tenure here.

Many thanks again and allow me to thank you personally for the time you gave me. I really appreciate everything and I'll be sad to say goodbye.

I have had the pleasure of working with the Service Transformation Team here at T&G NHS ICFT for many years whilst in various roles. The support and structure they have provided and continue to provide now is much like a comfort or safety blanket, you just know that they are always on hand to help, direct and motivate you to rally the troops and be get creative. The Service Transformation Team also provide a huge amount of fancy creative administration and take away a what would be a huge burden to our operational and leadership teams.

I look forward to the Service Transformation event every year, our roles in the NHS can be challenging sometimes, this event just reminds us all what a fantastic job we are doing to improve the lives and health of others.

Thank you so much, I cannot tell you how much I appreciate your support.

TESTIMONIES

The transformation team are super, always willing to help & always extremely positive

I have worked with the Service Transformation team for several years and have always found them incredibly supportive. They are fully committed to every project they lead, providing valuable guidance, advice, and support whenever needed.

Over the past three months, I have worked closely with several members of the team, all of whom are highly organised, proactive, and reliable. They consistently deliver actions on time and play a key role in ensuring effective engagement, which helps projects run smoothly with minimal challenges.

I truly enjoy collaborating with the Service Transformation team and look forward to achieving positive outcomes in the two projects I am involved in this year

We have greatly appreciated Transformation support throughout the Programme. The expertise and dedication have been invaluable in driving the service transformation, ensuring a smooth and efficient process. The teams proactive approach and commitment to excellence have significantly contributed to the success of the programme, and we are grateful for her outstanding contributions as the programme comes to a close

I just wanted to say how much I enjoyed this mornings Transformation Event, both the formal part and also meeting people informally before and afterwards.

The whole morning was so well organised and ran to clockwork! It was genuinely inspiring to hear about all the work your team is supporting, and I felt very proud to be part of T and G.

Please pass on my thanks to all your team.

It was also brilliant to see how widely the transformation work is happening across the Trust and with partners, and the impact it is having.

A massive thank you for today! I know it was a long one but it was amazing to see the energy and enthusiasm around the table in the workshop (I'm not blaming the sugary sweets) to kick start these conversations and finally getting a start on this enormous project!

Thank you for the support today! We can definitely do this!

Please can I commend your Transformation Communications and Promotions Officer as she has been so supportive, patient and flexible with our requests. The resources produced have been of a fantastic standard and we are so grateful!

CONTACT INFO

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NHS Stockport NHS Foundation Trust

				Agenda No.	
Meeting date	5 June 2025	**Public**	X	**Confidential**	
Meeting	Board of Directors				
Report Title	People Performance Committee – Alert, Advise & Assure Report				
Director Lead	Beatrice Fraenkel, Chair of People Performance Committee	**Author**	Beatrice Fraenkel, Chair of People Performance Committee Soile Curtis, Deputy Company Secretary		

Paper For:	**Information**		**Assurance**	X	**Decision**	
Recommendation:	The Board of Directors is asked to note the report from the People Performance Committee including matters for escalation to the Board of Directors.					

This paper relates to the following Annual Corporate Objectives

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

This paper relates to the following CQC domains

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

This paper relates to the following Board Assurance Framework risks

	PR1.1	There is a risk that the Trust does not deliver high quality care to service users
	PR1.2	There is a risk that patient flow across the locality is not effective
X	PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan
X	PR2.1	There is a risk that the Trust is unable to sufficiently engage and support our people's wellbeing
	PR2.2	There is a risk that the Trust does not actively participate in local collaborative programmes/neighbourhood working to improve primary and secondary health outcomes
	PR3.1	There is a risk that place-based partnership working does not effectively support delivery of Stockport ONE Health & Care (Locality) Board priorities and address health inequalities in Stockport

	PR3.2	There is a risk that partnership working in Greater Manchester do not effectively address unwarranted variation of services and improve health inequalities
X	PR3.3	There is a risk that opportunities for collaboration between Stockport NHS Foundation Trust and Tameside & Glossop Integrated Care NHS Foundation Trust are not optimised
X	PR4.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit and retain the optimal number of staff, with appropriate skills and values
X	PR4.2	There is a risk that the Trust's workforce is not reflective of the communities served
	PR5.1	There is a risk that the Trust does not implement high quality service improvement programmes
	PR5.2	There is a risk that the Trust does not implement high quality research & development programmes
	PR6.1	There is a risk that the Trust does not deliver the annual financial plan
	PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial sustainability plan
	PR7.1	There is a risk that the Trust does not implement the Digital Strategy to ensure a resilient and responsive digital infrastructure
	PR7.2	There is a risk that the estate is not fit for purpose and/or meets national standards
	PR7.3	There is a risk that the Trust does not materially improve environmental sustainability
	PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus

Where issues are addressed in the paper

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

Executive Summary

The Board of Directors has established the following Committees:

- People Performance
- Finance & Performance
- Quality
- Audit Committee

The Committees have no executive powers, other than those specifically delegated within their Terms of Reference, but they can make recommendations to the Board of Directors for approval. The Committees are to report to the Board of Directors by means of a Key Issues Report summarising business conducted by the Committee together with key actions and/or risks.

A summary is provided for the Board of Directors of the key matters and decisions from the meeting of the People Performance Committee held during May 2025, noting areas of alert, advice and assurance.

NHS
Stockport
NHS Foundation Trust

ALERT, ADVISE & ASSURE (AAA) REPORT	
Name of Committee/Group	People Performance Committee
Chair of Committee/Group	Beatrice Fraenkel, Non-Executive Director
Date of Meeting	8 May 2025
Quorate	Yes

The People Performance Committee draw the following key issues and matters to the Board of Directors' attention:

1.	**Agenda**	The Committee considered an agenda which included the following: • People Integrated Performance Report • Sickness and Attendance Management Update • Workforce Race Equality Standard (WRES) Report • Workforce Disability Equality Standard (WDES) Report • Employee Relations & Exclusions Activity • Widening Participation • Freedom to Speak Up – Q4 2024/25 • Guardian of Safe Working – Q4 2024/25 • Safer Care (Staffing) Report • Subgroups' Terms of Reference and Work Plans 2025/26 for Approval: - Equality, Diversity & Inclusion Group - Educational Governance Group • Key issues Reports: - Joint Health & Wellbeing Group - Equality, Diversity & Inclusion Group - Educational Governance Group
2.	**Alert**	No matters from this meeting to alert to the Board of Directors.
3.	**Advise**	The Committee received a Sickness and Attendance Management Update Report. A discussion took place regarding the impact of the NHS Professionals pay change on staff health and wellbeing and it was agreed to include further information about the Trust's approach in this area in the Safe Staffing Report to the Board. The Committee received and confirmed the Workforce Race Equality Standard (WRES) Report and Workforce Disability Equality Standard (WDES) Report which trusts were required to publish on an annual basis. The Committee noted the headlines, benchmarking information and actions agreed. The Committee acknowledged areas of improvement and noted that the Trust's Equality, Diversity & Inclusion (EDI) Strategy and Organisational Development Plan would continue to support improvements in WRES and WDES performance. The Committee approved the Terms of Reference and Work Plans 2025/26 of the following subgroups: - Equality, Diversity & Inclusion Group - Educational Governance Group

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4.	**Assure**	Positive assurance received around the following People metrics: • Agency expenditure as a percentage of the total pay bill remained at 2.1%, which is below the target of 3.2%. • Time to hire (measuring the time between vacancy authorisation to start date booked) decreased in March to 66 days from 79 in February, however performance remains above the Trust's revised target of 56 days. • Role essential compliance at 94.19%, which is above target. • Turnover (adjusted) has decreased in March to 10.47%, from 10.66% in February and remains under the target of 12.5%. The Committee received a Widening Participation Report and noted positive assurance regarding the widening participation and vocational learning offer, providing career opportunities for communities across Stockport, particularly from underrepresented and deprived areas. The Committee noted positive assurance regarding the growth of the Freedom to Speak Up initiative and associated learning.
5.	**Referral of Matters/Action to Board/Committee**	-
6.	**Report compiled by:**	**Beatrice Fraenkel, Non-Executive Director**
7.	**Minutes available from:**	**Soile Curtis, Deputy Company Secretary**

NHS Stockport NHS Foundation Trust

Meeting date	5 June 2025	**Public**	X	**Agenda No.**	17
Meeting	Board of Directors				
Report Title	Workforce EDI Strategy Update				
Director Lead	Amanda Bromley, Director of People and OD	**Author**	Stuart McKenna, Assistant Director of HR (Inclusion and Colleague Experience)		

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

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

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

This paper relates to the following Board Assurance Framework risks

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

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

Where issues are addressed in the paper

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

Executive Summary

This report provides an update on the progress made against the specific targets set out in the Trust's EDI Strategy 2022-25. The strategy focuses on four priority areas: 1) workforce, 2) culture, 3) assurance and compliance, and 4) health inequalities. A consolidated EDI plan was produced, bringing together the actions within the strategy, those actions from the NHS EDI delivery plan, and the actions required by the North West BAME Assembly Anti-Racist Framework.

In terms of delivering the specific metrics within the EDI strategy:

Workforce:

- Within our non-clinical workforce, we have seen increases in the proportion of BAME staff at bands 1-4 and bands 5-7 and have exceeded the strategy targets of 12.5% and 8% respectively. We have seen a small increase in the proportion of BAME staff at Band 8A+, from 3% to 4% (target 8%), although there has been no change in this figure for the last 12 months.
- Within the clinical workforce we have seen an increase in the proportion of BAME staff at bands 1-4 and bands 5-7 and have exceeded the strategy targets of 20.4% and 19.7% respectively. We have seen no change in the proportion of BAME staff at bands 8A+ in the clinical workforce since the last report and remain 1.7% away from the target of 8%.
- There has been an increase in the proportion of disabled staff across the Trust to 6.4%, although there has been no change in the proportion of disabled people on the Trust Board.
- The Trust mean gender pay gap has fallen significantly, from 22.79% to 16.96%, and is just above the target of 15.5%.
- Improvements in the proportion of disabled staff (non-clinical) have been observed at all bands, with the target of 5.2% at Band 8A and above now being reached. Within the clinical workforce the target has been achieved for bands 5-7 and 8A and above. For bands 1-4, the current figure is

0.4% below target. These represent significant improvements in the disability rates in the clinical workforce.

- There has been no change in terms of disability representation at the Board level.

Culture:

- The relative likelihood of BAME staff entering the formal disciplinary process compared to white staff is 0.75, which means that BAME staff are now less likely to entre the formal disciplinary process compared to white staff.
- There has been a significant increase in the relative likelihood of disabled staff entering the formal capability process compared to non-disabled staff. This represents a worsening position compared to the previous report. It should, however be noted, that the overall numbers are small (one disabled person and one non-disabled person, which shows the mathematical limitations of this metric when numbers are very small.
- The relative likelihood that white candidates will be appointed from a shortlist comparted to BAME candidates has increased in the last 12 months. This represents a significant decline on the previous 12 months, and the current relative ratio means that white candidates are more likely to be appointed from a shortlist compared to BAME candidates.
- There has been an increase in the proportion of BAME respondents in the staff survey reporting discrimination from managers / team leaders. This is now 15.3%, and whilst an improvement on the baseline, remain above the target of <12%
- There has been an increase in the proportion of disabled staff harassment, bullying or abuse from managers/team leaders from 14.78% to 16.80%. This is against the strategy target of less than 10%.
- At each of the AfC Bands 1-4 and 5-7 clusters, there has been growth in the proportion of BAME staff across each cluster. There has virtually no growth in the proportion of BAME staff at Band 8A and above.
- Data also shows that the distribution of BAME staff within the medical workforce is either consistent or higher than national benchmarking data.

Since October 2024, when the Board of Directors last received an update on the EDI Strategy, there has been a specific focus on the following areas:

- Inclusive recruitment
- Becoming an anti-racist organisation
- Understanding the lived experience of our colleagues
- Career progression
- Bullying and harassment

The report highlights some of the activity against these areas.

A copy of the updated consolidated action plan is provided in **appendix 1** of this report.

Highlights from our 2025 WRES and WDES performance data are included in this report, and the publishable reports are in **appendix 2** and **appendix 3** respectively.

Whilst we are making positive progress on our EDI journey it is evident that we have more work to do to fully achieve our EDI ambitions – going beyond being complaint with EDI, becoming strategic and integrating EDI into everything we do.

Our current EDI strategy has existing activity that will continue throughout 2025, in order to address the areas requiring improvement and the Board will receive a further update on progress in November 2025.

We intend to develop a new 3-year Joint EDI Strategy with Stockport FT that will run from January 2026. The strategy development work started at the Combined EDI Steering Group meeting in April 2025. Further engagement and consultation activities with key stakeholders are planned over the coming months. The Board of Directors will receive the final draft of the joint strategy in December 2025 for approval.

1. Introduction

1.1 This report provides an update on the progress made against the specific targets set out in the Trust's EDI Strategy 2023-26, and an update on the actions contained within the consolidated action plan. The strategy focuses on four priority areas: 1) Workforce, 2) Culture, 3) Assurance and compliance, and 4) Health inequalities.

1.2 Additionally, we are required to produce annual Workforce Race Equality Standard (WDES) and Workforce Disability Equality Standard (WDES) reports, and Gender Pay Gap reports. The People Performance Committee received the Trust's 2024 WRES and WDES reports in May 2025 which evidenced the progress being made on our EDI agenda.

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

1.4 A single consolidated EDI action plan was developed and includes local recommendations to ensure the success and sustainability of the work and to address local-specific issues. A copy of the consolidated plan is provided in **appendix 1**.

2. Areas of focus

2.1 Since the last update on the EDI strategy and associated actions, we have had a specific focus on the following areas to help accelerate the progress of our EDI journey:

2.1.1 Inclusive recruitment

Progressing the collaborative work we are doing with Tameside ICFT we have:

- Created stronger links with local community groups and are continuing to enhance our reach around recruitment.
- Enabled candidates to apply for a job vacancy using an alternative method to Trac.
- Started to provide all candidates with additional information about the interview they are invited to attend and supplied the questions that will be asked, prior to the day of the interview. The aim is to help individuals with a neurodivergent condition to prepare meaningful responses to the questions and alleviate any feelings of anxiety about the interview. So far we have received positive feedback from candidates about this approach.
- Continued to maximise our social media presence to promote careers and job vacancies.
- Introduced processes to enable our job adverts to reach marginalised groups.
- Enhanced the support for volunteers who are seeking paid employment.

2.1.2 Becoming an anti-racist organisation

Through the actions incorporated in the consolidated plan, relating to becoming an anti-racist organisation, we have:

- In conjunction with the RESN network, we have developed an organisational anti-racism statement, which was approved by the Executive Management Team and has been published on the Trust's website.

- Appointed an Executive level anti-racism champion, combining the role with our RESN sponsor.
- Established a cross divisional WRES working group, in order to examine divisional level data, and to provide appropriate challenge, and develop local actions.
- Submitted our evidence to the NW BAME Assembly for achieving the Bronze level of the NW Anti-Racist Framework. Both Trusts have now been accredited as Bronze by the NW BAME Assembly Anti-Racist framework. Two other Trusts within Greater Manchester are Bronze award holders and 10 in the NW region.

2.1.3 **Understanding the lived experience of our colleagues**

Recognising that the staff survey data provides us with largely quantitative data in relation to the lived experience of our colleagues, we have:

- Held listening events with all our staff networks. Their feedback has shaped the focus/theme of their network meetings for the 12 months ahead.
- Continued to deliver the Trust's Big Conversation Programme to elicit additional information about the lived experience of our colleagues. This is triangulated with data from the staff survey, FTSU reports and other workforce metrics.
- Continued to roll out training on workplace adjustments to improve the lived experience of disabled colleagues.

2.1.4 **Career progression**

Recognising the career progression remains an area of inequality that requires addressing, we have:

- Established a Career Progression Task Group to add additional pace to this element of our work.
- Developed a mechanism to identify specific inequality within promotion and progression. This data will routinely be reported in the annual EDI monitoring report and is being proactively used by the career progression for all working group, to ensure that interventions are appropriately targeted.
- Trained a small pool of internal qualified coaches to provide career coaching support.

2.1.5 **Bullying and harassment**

Recognising that sadly some individuals are on the receiving end of unacceptable behaviour and the negative impact that has on them and others, we have:

- Launched the Trust's refreshed values and behaviours – Compassion, Accountability, Respect and Excellence – and embedding them into everything we do.
- Reviewed our internal conduct process, which incorporates learning from an internal review, peer review and insights from legal services. This is a collaborative development with Tameside ICFT.
- Appointed six FTSU champions to support the work of the FTSU Guardian.
- Held curiosity cafes with employees that provided the opportunity for individuals to share their experiences of bullying, harassment and incivility.

3. Progress against our EDI Performance Targets

3.1 Workforce

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

Objective	Baseline	Target	May 2023	Oct 2023	May 2024	Oct 2024	May 2025	Progress
Increase in the BAME diversity (non-clinical)								
Bands 1-4	10.5%	12.5%	12.5%	13.1%	13.9%	15%	16.5%	Target exceeded
Bands 5-7	6.9%	8%	9.3%	11.1%	10.5%	10%	10.2%	Target exceeded
Bands 8A+	3%	8%	3.8%	4.8%	4.5%	4.0%	4.0%	Improvement on baseline, however no change in 12 months
Increase BAME diversity (clinical – non M&D)								
Bands 1-4	18.4%	20.4%	24.7%	29.2%	29.8%	30.6%	35.1%	Target exceeded
Bands 5-7	17.7%	19.7%	20.5%	26.7%	27.3%	28.4%	30.4%	Target exceeded
Bands 8A+	5.1%	8%	6.4%	6.3%	5.7%	6.4%	6.3%	Improvement on baseline
Increase disabled/LTC diversity								
Whole Trust	3.2%	8.2%	3.4%	4.7%	5.2%	6.1%	6.4%	Improvement on baseline
Increase disabled/LTC diversity (non-clinical)								
Bands 1-4	4.4%	8.8%	5.2%	6.3%	6.7%	7.3%	8.0%	Improvement on baseline
Bands 5-7	3.7%	7.4%	3.5%	4.0%	5.0%	6.5%	6.8%	Improvement on baseline
Bands 8A+	2.6%	5.2%	1.4%	5.8%	4.5%	6.3%	7.1%	Target achieved
Increase disabled/LTC diversity (clinical – non M&D)								
Bands 1-4	3.4%	6.8%	3.7%	4.5%	5.5%	6.1%	6.4%	Improvement on baseline
Bands 5-7	2.9%	5.8%	3%	4.9%	5.3%	5.8%	6.3%	Target achieved
Bands 8A+	2%	4%	1.4%	3.6%	4.0%	3.4%	4.6%	Target achieved
Increase in disabled representation on the Board								
Min 1 person	0%	6.1%	0%	0%	0%	0%	0%	No improvement
Address gender pay gap (GPG)								
Reduce mean GPG in line with public sector economy	23.77%	GPG as per 2026, or 15.5% whichever is smaller	22.79%	22.79 %	16.96%	19.96 %	17.8%	Significant reduction on baseline figure
Reduce mean bonus GPG	51.45%	<10%	53.08%	53.08 %	31.31%	31.31 %	34.0%	Significant reduction on baseline figure

3.1.2 Within our non-clinical workforce, we have seen increases in the proportion of BAME staff at bands 1-4 and bands 5-7 and have exceeded the strategy targets of 12.5% and 8% respectively. We have seen a small increase in the proportion of BAME staff at Band 8A+, from 3% to 4% (target 8%), although there has been no change in this figure for the last 12 months.

3.1.3 Within the clinical workforce we have seen an increase in the proportion of BAME staff at bands 1-4 and bands 5-7 and have exceeded the strategy targets of 20.4% and 19.7% respectively. We have seen no change in the proportion of BAME staff at bands 8A+ in the clinical workforce since the last report and remain 1.7% away from the target of 8%.

3.1.4 There has been an increase in the proportion of disabled staff across the Trust to 6.4%, although there has been no change in the proportion of disabled people on the Trust Board.

3.1.5 The Trust mean gender pay gap has fallen significantly, from 22.79% to 16.96%, and is just above the target of 15.5%.

3.1.6 Improvements in the proportion of disabled staff (non-clinical) have been observed at all bands, with the target of 5.2% at Band 8A and above now being reached. Within the clinical workforce the target has been achieved for bands 5-7 and 8A and above. For bands 1-4, the current figure is 0.4% below target. These represent significant improvements in the disability rates in the clinical workforce.

3.1.7 There has been no change in terms of disability representation at the Board level.

3.2 Culture

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

Objective	Baseline	Target	Oct 2023	May 2024	Oct 2024	May 2025	Progress
Reduced relative likelihood disparity regarding entry into disciplinary processes (BAME) to parity							
	1.14	1	1.14	1.85 (*taken from our 2024 WRES submission)*		0.75	Target exceeded
Reduced relative likelihood disparity regarding entry into capability processes (disabled / LTC) to parity							
	1.22	1	4	9 (*taken from our 2024 WRES submission)*		13.9	Worsening position compared to baseline[1]
Reduced relative likelihood disparity regarding shortlisting and being appointed from shortlisting (BAME)							
	2.43	<1.5	2.49	1.24 (*taken from our 2024 WRES submission)*		1.62	Target was achieved in 2024, but since fallen below target
Reduced disparity regarding discrimination from managers / team leaders in staff survey (BAME)							
	18.1%	<12%	15.4%	13.5% (*taken from our 2024 WRES submission)*		15.3%	Worsening position from the previous year
Reduced disparity regarding harassment, bullying or abuse from managers/team leaders in staff survey for (disabled / LTC)							
	24%	<10%	19.9%	14.78% (*taken from our 2024 WRES submission)*		16.8%	Improved position on baseline, but worsening over the last 12 months
Proportion of BAME staff across each of the AfC clusters (All AfC staff)[2]							

[1] It should be noted that a figure of 13.9 is a result of 1 disabled person and one non-disabled person entering capability, and demonstrates the mathematical limitations of this metric with such small numbers

	Jan 2022	May 2023	Oct 2023	May 2024	Oct 2024	May 2025	Progress
Bands 1-4	15.6%	21.1%	21.0%	21.7%	22.6%	25.9%	Since the start of the strategy, there has been a 10.3% growth in the proportion of BAME staff in this group
Bands 5-7	19.3%	25.2%	25.2%	25.7%	26.7%	28.6%	Since the start of the strategy, there has been a 9.3% growth in the proportion of BAME staff in this group
Bands 8A+	5.3%	5.6%	5.8%	5.3%	5.8%	5.7%	Since the start of the strategy, there has been 0.4% growth in the proportion of BAME staff in this group
Proportion of BAME staff across the medical workforce							
	Jan 2022	**May 2023**	**Oct 2023**	**May 2024**	**Oct 2024**	**May 2025**	**National data sets**
Foundation Trainees	27.3%	42.1%	43.4%	41.6%	48.1%	47.4%	46.2%
Specialist and Associate Specialists	70.9%	76.8%	77.3%	60.3%	76.1%	80.1%	57.5%
Consultants	45.5%	44.7%	44.2%	45.6%	46.3%	45.2%	39.0%

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

- The relative likelihood of BAME staff entering the formal disciplinary process compared to white staff is 0.75, which means that BAME staff are now less likely to entre the formal disciplinary process compared to white staff.
- There has been a significant increase in the relative likelihood of disabled staff entering the formal capability process compared to non-disabled staff. This represents a worsening position compared to the previous report. It should, however be noted, that the overall numbers are small (one disabled person and one non-disabled person, which shows the mathematical limitations of this metric when numbers are very small.
- The relative likelihood that white candidates will be appointed from a shortlist comparted to BAME candidates has increased in the last 12 months. This represents a significant decline on the previous 12 months, and the current relative ratio means that white candidates are more likely to be appointed from a shortlist compared to BAME candidates.
- There has been an increase in the proportion of BAME respondents in the staff survey reporting discrimination from managers / team leaders. This is now 15.3%, and whilst an improvement on the baseline, remain above the target of

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

<12%

- There has been an increase in the proportion of disabled staff harassment, bullying or abuse from managers/team leaders from 14.78% to 16.80%. This is against the strategy target of less than 10%.
- At each of the AfC Bands 1-4 and 5-7 clusters, there has been growth in the proportion of BAME staff across each cluster. There has virtually no growth in the proportion of BAME staff at Band 8A and above.
- Data also shows that the distribution of BAME staff within the medical workforce is either consistent or higher than national benchmarking data.

3.3 Assurance and Compliance

All statutory reporting, including WRES, WDES, Gender Pay Gap and the Annual EDI Monitoring Report were completed for 2023/24 and approved by the People Performance Committee.

4. Our WRES Performance Highlights

4.1 The following summarises our WDES performance since last year:

- As of March 2025, within the non-clinical workforce, 84.4% of staff were White, and 14.4% of staff were from Black & Minority Ethnic backgrounds (an increase from 1.4% in the previous year).
- There has been little movement across the majority of AfC pay bands for non-clinical staff, with small increases of BAME representation at band 1, 2, 3, 7, 8A and 8B.
- Within the clinical workforce, 67.9% of staff are White, and 29.9% are from BAME backgrounds (a decrease of 0.01% on the previous year).
- There has been little movement across the majority of AfC pay bands for clinical staff, with small increases of BAME representation at band 1, 2, 3, 7, 8A and 8B.
- There has been little change in the distribution of white staff in Consultant grades, where roughly an even split. There has been a small increase in the proportion of BAME staff in career grade roles, and a similar reduction on the proportion of white staff in these roles. There has been an increase in the proportion of BAME trainees compared to the previous 12 months.
- Analysis of recruitment data there has been a small increase in the relative likelihood that White staff are appointed from shortlisting compared to BAME staff. A figure of 1.62 shows that White candidates are still slightly more likely to be appointed from a shortlist than BAME candidates.
- BAME employees are less likely to enter into formal disciplinary processes than White employees. This is a reversal of the situation from 12 months ago.
- There has been no significant change in the 2024 and 2025 relative likelihood scores, showing there remains no difference in the ratios between White and BAME staff accessing non-mandatory training and CPD.
- In terms of the 2024 NHS staff survey metrics, there has been an increase (3.5%) in the proportion of BAME respondents who report bullying or abuse from patients, relatives or the public in the last 12 months.

- The proportion of BAME staff reporting harassment or bullying from staff has increased from 21.6% to 26.0%.
- There has been an increase in the proportion of BAME respondents who reported that they had experienced discrimination at work from either their manager, team leader or other colleagues, from 13.5% to 15.3%.
- The proportion of BAME respondents who believed that that the organisation provides equal opportunities for career progression or promotion has decreased by 2.2% compared to the previous year.

5. Our WDES Performance Highlights

5.1 Our 2025 WDES performance shows that we are making some progress which supports the findings of the recent national staff survey results that evidenced that we are improving the working lives of disabled employees.

5.2 The following summarises our WDES performance since last year:

Within the non-clinical workforce:

- There has been an increase in the proportion of staff self-reporting disability across bands 1-4 (1%), bands 5-7 (2%), and bands 8a and 8b (4%).
- There has been an improvement in declaration rates in 2025 in bands 1-4 and bands 8c to VSM, which has shown that there are no staff with a disability in bands 8c to VSM.

Within the clinical workforce:

- There has been a small increase in the proportion of disabled staff in clusters 1 and 2 and medical clusters 6 and 7 (SAS grade doctors and trainee grade).
- There has been small reduction in the proportion of unknown data, in AfC clinical staff (clusters 1,2 and 3.
- There has been a significant increase in the proportion of unknown data, in medical clusters (particularly clusters 5 and 6).

5.3 Disabled staff are equally likely to be appointed from shortlisting as non-disabled staff. There is no statistical difference in the likelihood of disabled staff being appointed from a shortlist compared to non-disabled staff. This a small decline on the metric from last year.

5.4 There has been a significant increase in the relative ratio of disabled staff entering the capability procedure, compared to the previous 12 months. It should be noted that the figures represent 1 disabled people and 1 non-disabled people entering the process. When numbers are this small, it demonstrates the mathematical limitations of this metric.

5.5 From the 2024 NHS staff survey results:

- There has been a small increase in the proportion of disabled staff experiencing harassment, bullying or abuse from either patients/relatives (0.39%), but a larger increase in the proportion reporting harassment from managers (2.03%). The largest increase is the proportion of disabled staff experiencing harassment, bullying or abuse from colleagues (4.19%). Similarly, there was an increase in the proportion of non-disabled staff experiencing this treatment from colleagues (3.24). The increases are larger for disabled staff across all questions.
- There has been a large increase in the proportion of disabled staff reporting any abusive treatment when it had occurred (5.39%).

- Disabled staff are still positive than non-disabled staff in relation to believing that the Trust provides equal opportunities for career progression or promotion. The score for disabled staff has increased slightly in the last 12 months, whereas the score for non-disabled staff has decrease by 1.40%.
- Disabled staff are less positive than non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties. There has been a small increase in this metric for both disabled and non-disabled staff.
- Disabled staff are less positive than non-disabled staff when asked if they are satisfied with the extent to which their organisation values their work. There has been an improvement in this score for both disabled staff and non-disabled staff in the last 12 months, particularly for disabled staff.
- 78.05% of disabled staff say that the organisation has made adequate adjustments to enable them to carry out their work. This is a decrease of 1.65% in the previous 12 months.
- The engagement score for disabled staff is lower than that of non-disabled staff (7.00 compared to 6.50 respectively).

6. Conclusion and Next Steps

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

6.2 Whilst progress is being made it is clear from our action plan and some of the results that there is more to do. Our aim is to go beyond being complaint with EDI, becoming strategic and integrating EDI into everything we do.

6.3 Our current EDI strategy has existing activity that will continue throughout 2025, in order to address areas requiring improvement. We intend to develop a new Joint EDI Strategy with Tameside ICFT. The strategy development work started at the Combined EDI Steering Group meeting in April 2025. Further engagement and consultation activities with key stakeholders are planned over the coming months. The Board of Directors will receive the draft joint EDI strategy in December 2025 for consideration and approval.

7. Recommendation

7.1 The Board of Directors is asked to:

- Note the progress of the Trust's EDI Strategy 2022-25 and associated consolidated action plan.

Appendix 1: Our Consolidated EDI Action Plan

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

Original Plan(s)	Action	Lead(s)	Original Deadline	Revised Deadline	Progress	RAG Rating	Theme
S1	Build relationships with local organisations supporting people into employment to ensure our vacancies reach a diverse audience, with a particular focus on disability/long term condition (LTC).	Recruitment team	23-Jun	Jun-23	Ongoing attendance at recruitment fairs including 'one Stockport' and help to arrange in-house recruitment events; Initial meetings held with Job Centre whom we have shared our role profiles for distribution across our local job seekers and Disability Stockport who have reviewed our new inclusive interview process with positive feedback.	Blue	**Recruitment**
S2	Routinely share our vacancies to ensure our advertising efforts for new vacancies reach people with protected characteristics such as Job Plus, GM EDI Network, RNIB, Black History Recruitment, Pink News and Voice.	Recruitment team	23-Jun	Jun-23	Adverts and inclusivity statements have been reviewed. Recruitment materials and links available through events such as Stockport Pride.	Blue	**Recruitment**

S3	Undertake mandatory implicit and association bias awareness training as part of the recruitment training for all managers with responsibility for current and future recruitment and selection.	Recruitment team/Inclusion and Colleague Experience	23-Oct	Jun-24	A cross site training programme is being developed across Stockport and Tameside to offer a suite of protected characteristic insight training options for managers and the wider organisation. Unconscious bias training course is available for deployment.	Amber	**Training and Development**
S4	Review and draw up role descriptions which are more accessible and user friendly and therefore targeted to a wider audience.	Recruitment team	23-Jun	Jun-23	Role profiles have now been created for HCAs, Domestics, Porters and Catering Assistants.	Blue	**Recruitment**
S5	Work with 'Pure Innovations', those on apprenticeships and Guaranteed Interview schemes to ensure people with protected characteristics can transition to employment following initial work experience and training programmes.	Recruitment Team	23-Jun	Jun-23	Working with Pure Innovations, providing info for upcoming vacancies as well as coaching on the application process. We have held initial meetings about how to formalise the recruitment process. We are reviewing other supported internship models across GM and process mapping to enable robust and dedicated supported internship employment pathway and a quantifiable conversion rate from supported intern to employee. Role profiles have now been created for HCAs, Domestics, Porters and Catering Assistants.	Blue	**Recruitment**
S6	Work with our recruiting managers to identify existing talent and proactively develop staff for internal promotion and progression opportunities for with protected characteristics when appropriate new vacancies arise towards equality of opportunity and support development and succession planning.	Recruitment team/ Talent, Leadership & OD Consultancy Team	23-Dec	Sept-24	Work is underway to develop our approach which will be presented to EMT in July 2024.	Amber	**Talent Management**

S7	Develop staff conducting interviews and selection for all Band 7 and above vacancies by providing appropriate toolkits for recruiting managers. E.g. offering maternity / paternity and returner's scheme support packages; more flexible work patterns: part-time; job share or compressed hours.	Recruitment team/ Talent, Leadership & OD Consultancy Team	23-Dec	Sept-24	Inclusive Recruitment training is currently being rolled out across the site. Both attendance and feedback have been positive to date. This should be concluded by January 2025. A group has been set up by the Dep Dir of OD to review recruitment practices across both sites for band 8a+ roles and a further meeting is to be arranged to progress initial thoughts and ideas.	Amber	**Resources and guidance**
	Offer coaching to female consultants for Clinical Excellence Award.	Talent, Leadership & OD Consultancy Team			A meeting with one of the female AMDs at Stockport has been convened for 1 Nov to explore what the Trust might need to consider should coaching for female consultants be required and to identify any other additional support to consider.		
S8		Talent, Leadership & OD Consultancy Team	23-Nov	Jul-24	The offer will form part of the Trust's new Coaching Plan.	Amber	**Talent Management**
S9	Reasonable adjustment training.	Inclusion and Colleague Experience Team	22-Dec	Dec-22	As part of Disability History Month 2022, new disability guidance documents were launched for staff and managers. Disability Awareness Training rolled out from Jan 2024 onwards.	Blue	**Training and Development**
S10	Establish a Reverse Mentoring Scheme.	Talent, Leadership & OD Consultancy Team	24-Mar	Mar-24	A Reverse Mentoring Scheme has been launched. To date 2 employees have put themselves forward to be a mentor (1 disabled employee & 1 BAME employee). We currently have 2 NEDs that have agreed to be a mentee and we are seeking more Board Members and staff to take part in the scheme.	Blue	**Talent Management**

S11	Undertake focus group sessions with female specialist grade doctors to understand the potential barriers to promotion, as a means of reducing the gender pay gap.	Talent, Leadership & OD Consultancy Team	23-Sep	Sep-24	Not yet started due to competing priorities. Meeting planned for 4/6/24 should focus priorities for this piece of work. Wait outcome of meeting with AMD on 1 Nov prior to confirming next steps		**Engagement**
S12	Profiling recently promoted/appointed female consultants who can describe their professional journey.	Inclusion and Colleague Experience Team/Talent, Leadership & OD Consultancy Team	23-Sep	Sep-24	Not yet started due to competing priorities & absence within the EDI Team. Arrangements will be put in place to progress this action in line with the new consolidated & re-prioritised EDI action plan. Information relating to recently promoted female consultants now available. Need to build into conversation and agree next steps where appropriate		**Talent Management**
S13	Positive action on development programmes to female, ethnically diverse, and disabled staff.	Talent, Leadership & OD Consultancy Team	24-Mar	Dec-24	Not yet started. This work needs to start once we understand the barriers so that we can establish the most appropriate development programmes.	Amber	**Talent Management**
S14	Actively create development opportunities, leadership courses, secondments, shadowing and work experience for ethnically diverse and disabled staff.	Talent, Leadership & OD Consultancy Team	24-Mar	Dec-24	A series of Curiosity Cafes were conducted across both sites over July & August 2024. The theme was focused on staff's lived experience of Career Progression within the Trust. Despite the disappointing take up rate we have gained some helpful insights which is now informing the action plan of a Career progression Task & Finish Group.	Amber	**Talent Management**
S15	Review staff networks, identify improvements, refresh process, brief managers, and relaunch.	Inclusion and Colleague Experience Team	23-Jun	Jun-23	Review of staff networks undertaken. Network dates to be rolled out using thematic approach, promoted through staff EDI newsletter, and reminder comms throughout the year through social media, and all established comms channels	Blue	**Engagement**

S16	Review existing programmes and incorporate Anti-Racist Framework. Develop process and implement.	Inclusion and Colleague Experience Team	23-Oct	Oct-23	The Anti-Racist Framework was presented to the EDI Steering Group for assurance. Relevant actions incorporated into this plan.	Green	**Governance and reporting**
S18	Create an inclusion calendar of events and awareness days/months.	Inclusion and Colleague Experience Team/Comm s Team	22-Dec	Dec-22	Calendar in place and promoted.	Blue	**Resources and guidance**
S19	Establish a process for completing the WRES, WDES and GPG ensuring governance assurance meet reporting deadlines.	Inclusion and Colleague Experience Team	23-Apr	Apr-23	The Trust's 2023 WRES, WDES and GPG reports were produced on time and presented to the EDI Steering Group & People Performance Committee.	Blue	**Governance and reporting**
S20	Define system and process for all EDI grievances and or concerns raised to ensure reported appropriately either informally or formally e.g., equality champion network are logged; for the purposes of identifying trends throughout the organisation.	Employee Relations Team	23-Dec	Sept-24	The EDI details are collated for all staff going through a formal ER process. The details are reported through PPC to Trust Board and to ET. A peer review process has been established with T&GICFT where cases are reviewed to establish joint learning and good practice. The last review had a focus on staff from an ethnic minority. From these reviews actions are agreed and where applicable processes changed.	Blue	**Workforce**

S21	WRES – Workforce Race Equality Standard.	Inclusion and Colleague Experience Team	31 May 2024 - data and action plan submitted; 31 October 2024 - external report published	31 May 2024 - data and action plan submitted ; 31 October 2024 - external report published	NHS WRES and WDES Team brought the reporting period deadline forward to 31 May 2023. The Trust's 2024 WRES report was presented to the EDI Steering Group in April 2024 and People Performance Committee in May 2024.	Green	**Governance and reporting**
S22	WDES – Workforce Disability Equality Standard.	Inclusion and Colleague Experience Team	31 May 2024 - data and action plan submitted; 31 October 2024 - external report published	31 May 2024 - data and action plan submitted ; 31 October 2024 - external report published	NHS WRES and WDES Team brought the reporting period deadline forward to 31 May 2023. The Trust's 2024 WRES report was presented to the EDI Steering Group in April 2024 and People Performance Committee in May 2024.	Green	**Governance and reporting**
S23	GPG – Gender Pay Gap	Inclusion and Colleague Experience Team	23-Mar	Mar-23	The Trust's 2023 Gender Pay Gap Report has been presented to the EDI Steering Group and People Performance Committee.	Blue	**Governance and reporting**
S24	Annual PSED Report – Public Sector Equality Duty Report	Inclusion and Colleague Experience Team	23-Mar	Mar-23	The Trust's annual PSED Report has been presented to the EDI Steering Group and People Performance Committee.	Blue	**Governance and reporting**

S25	Establish position on maturity matrix for Equality Delivery System (EDS)	EDS task and finish group	24-Feb	Jun-24	New EDS22. Initial meeting taken place with NHS Greater Manchester Shared Services to discuss the new EDS 2022 and the changes to the outcomes. Data collection completed	Amber	**Health Inequalities**
AFS5, AFG2, NPRace2	Develop and EDI dashboard, including relevant WRES/WDES metrics for managers to use in their areas, and for the Board to review progress.	SM & IH	New / Combined action	May-24	EDI dashboard developed and approved by EDI steering group. Data requirements shared with People analytics for dashboard build. It is anticipated the standard dashboard will be prepared by Q3, in readiness for new metrics identified in the EDI strategy development. Amber Data	Red	**Data**
NPDis1	Demonstrate year-on-year improvement in disability declaration rates so that ESR data is accurate about people with a disability, as measured by the WDES.	SM, JP & IH	New / Combined action	Dec-24	Current data shows increasing trend in disability declarations. The appointment of our Disability Advisor will promote this work.	Green	**Data**
NPRel1	ESR and qualitative data should be tracked to highlight the experience of people with different faiths or no faith through all stages of the employment journey. For example, NHS organisations can track turnover data by religion to identify and address trends.	SM	New/Combined action	Apr-24	Currently faith data is routinely analysed in the annual EDI report. Metrics include workforce composition, recruitment, leavers and turnover. Any disparity will result in additional actions being undertaken. Data will be triangulated with 2023 staff survey data on faith.	Blue	**Data**

NPLGBT 2	Review organisational data for LGBT+ staff across multiple sources such as ESR, TRAC, NHS Staff Survey and local qualitative and quantitative data from LGBT+ staff networks and communities. This will inform the key areas of concern that need to be addressed.	SM	New / Combined action	May-24	Currently LGB data is routinely analysed in the annual EDI report. Metrics include workforce composition, recruitment, leavers and turnover. Any disparity will result in additional actions being undertaken. Data will be triangulated with 2023 staff survey data on sexual orientation. Additionally evidence will be drawn from the staff survey listening events, and published in a full report to coincide with International day against homophobia biphobia & transphobia (IDAHOBiT).	Blue	**Data**
AFG5	The organisation should bring together annually Black, Asian and Minority Ethnic staff to review EDI progress and any learning be built into the following year's plans. WRES and anti-racism action plans to be co-produced with staff networks.	SM	New / Combined action	Oct-24	As part of the WRES publication for 2025, an event will be conducted to bring together BAME colleagues to review and present challenge to the EDI progress. This will be used to coincide with ongoing consultation of the future joint EDI strategy.	Amber	**Engagement**
NPDis5	NHS organisations should take steps to address the disproportionate levels of bullying and harassment experienced by disabled staff. Progress can be measured by the annual NHS staff survey results.	TE	New / Combined action	May-25	The findings of the Trust's 2023 staff survey results have been utilised to identify areas to focus. Data identified shows divisions and services where the Trust shows a higher score for the bullying and harassment for disabled staff. Divisions are aware of the resources available such as FTSU, Civility Saves Lives, HR etc. Joint work currently underway with Tameside and Glossop IC NHS FT regarding unwanted behaviours and anonymous reporting process.	Green	**Engagement**

AFG4	The organisation can evidence diverse representation within their disciplinary and grievance processes. Freedom to Speak Up Champions within the organisation to support in incidents involving racial discrimination.	TE/FTSUG	New / Combined action	Jan-25	The Trust Board, through the relevant updates from EDI steering group and workforce committee are routinely informed of the diversity of the staff going through formal ER processes. We have a regular wider HR meeting with FTSUG, OD and SPAWS to review any areas of concern and highlight any issues, working together to find resolution.	Green	**FTSU**
AFB2	An anti-racism statement to be produced and published detailing organisational commitment to racial equity.	SM	New / Combined action	Jun-24	Anti-racism statement approved by EMT and published on the Trust external facing website.	Green	**Governance and Reporting**
AFB3	Implementation of equality and inclusion KPIs with a focus on addressing race-based disparities.	SM	New / Combined action	Feb- 24 *(and reviewed annually through the WRES and Annual EDI monitoring report)*	Trust EDI Strategy contains explicit stretch targets in relation to race-based disparity.	Blue	**Governance and Reporting**
AFG3	Creation of a cross-departmental WRES actions working group to support and challenge progress on WRES data.	NB/LR	New / Combined action	Jun-24	Cross departmental WRES working group established to examine differentials in WRES data.	Green	**Governance and Reporting**

AFB4	The organisation can demonstrate working in partnership to reduce a specific health inequality through an anti-racism lens and publish progress within the organisational annual report. (Within the last 12 months).	EDS Task & Finish Group	New / Combined action	Mar-24	Project: Maternity services for asylum seeker/refugee residents of the Brittania Hotel.	Green	**Health Inequalities**
AFS2	All leaders at Band 8A and above must have an appraisal/ personal development plan goal agreed around equality, diversity and inclusion, and a process to report annually the percentage of these goals that have been met.	KR & JS	New / Combined action	Apr-25	The Let's Talk conversation toolkit and guides were launched on 1 June 2024 across both Trusts. The guides do already highlight the need for band 8a staff to have an objective set around EDI. Further work to enhance the quality and rigor of SMART objectives is the focus of the appraisals in 2025 and a particular objective would include EDI objectives. The second aspect of this action would need some further consideration prior to operationalising	Amber	**Leadership**
AFS3	Further education for leaders, including inclusive recruitment, cultural awareness / competency, inclusive leadership, equality strategy and direction. 75% of Executive and Non-Executive Directors and their direct reports have been part of a racial equality reverse mentoring programme over the past three years.	KR & SM	New / Combined action	Dec-24	Inclusive recruitment training undertaken with managers. Implicit bias session incorporated into the Leading with Impact Leadership Development Programme. The 1-day Introduction to Compassionate & Inclusive Leadership continues to be delivered on a monthly basis. A review of our current reverse mentoring scheme will be taking place with the aim to increase the number of mentors to enable more of our non-executive and executive leaders to be able to participate in this scheme. A review of our current reverse mentoring scheme will be taking place with the aim to increase the number of mentors to enable more of our non executive and executive leaders to be able to participate in this scheme.	Amber	**Leadership**

AFS4	A reciprocal arrangement with Black, Asian and Minority Ethnic staff network chair to attend and contribute to committee/ board meetings.	Board secretary	New / Combined action	Dec-24	A review of our current reverse mentoring scheme will be taking place with the aim to increase the number of mentors to enable more of our non executive and executive leaders to be able to participate in this scheme.	Amber	**Leadership**
NPH1	Chief Executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable. Board members should demonstrate how organisational data and lived experience have been used to improve culture (by March 2025). NHS boards must review relevant data to establish EDI areas of concern and prioritise actions. Progress will be tracked and monitored via the Board Assurance Framework (by March 2024).	Board secretary	New / Combined action	Mar-25	EDI specific objectives are incorporated into the new Board appraisal framework. Reporting through WFC and Board, including WRES, WDES, Gender Pay Gap, Ethnicity Pay Gap, Annual EDI monitoring report, strategy update reports, FTSU reports, staff survey reports, staff exclusion report. There is a relevant risk within the BAF.	Green	**Leadership**
NPDis2	Promote the visibility of leaders with a disability through effective campaigns alongside providing leadership and career development opportunities tailored to disabled staff, such as the Calibre Leadership programme or Disability Rights UK development programmes. Progress can be measured by tracking the number of disabled staff in leadership roles.	DAWN and Coll Exp & Inclusion Team	New / Combined action	Dec-24	DAWN network undertook a variety of events for Disability History Month (Nov 16-Dec 16, 2024), to include profiling of disabled people in leadership roles. Progression data made available in relation to disability for the career progression group, which will inform positive action for disabled colleagues into talent pools.	Amber	**Leadership**

NPRace1	Boards should be able to demonstrate their understanding of and progress towards race equality, an essential criterion in job descriptions for board members and all very senior manager (VSM) grades. Appraisals of senior executives will include a focus on EDI, as recommended by the Messenger Review.	Board secretary	New / Combined action	Dec-24	Demonstration of understanding of Board members should be through the new Board appraisal framework	Amber	**Leadership**
NPRace3	To tackle race discrimination effectively Boards must give due consideration to national policies and recommendations from other arms-length bodies such as the Equality and Human Rights Commission inquiry and General Medical Council. In addition, Boards must proactively raise awareness of their commitment with patients and public.	Board members	New / Combined action	On-going	The Trust Board, through the relevant updates from EDI steering group and workforce committee are routinely informed of any national policies, strategies or recommendations from arms length bodies in relation to equality, diversity and inclusion.	Green	**Leadership**
NPRace4	Boards should ensure concerns raised about race discrimination are dealt with in a proactive, preventative, thorough and timely manner, including encouraging diversity in Freedom to Speak Up Guardians.	Board members/ FTSUG	New / Combined action	On-going	Board receives updates of complaints reported through the FTSU process bi-annually. FTSU meets regularly with the Chief Executive.	Green	**Leadership**
NPRel3	Boards should ensure concerns raised about religious discrimination are dealt with in a proactive, preventative, thorough and timely manner, including by encouraging diversity in Freedom to Speak Up	Board members/FTSUG	New / Combined action	On-going	Board receives updates of complaints reported through the FTSU process	Green	**Leadership**

	guardians.						
NPLGBT 4	Executive teams within the organisations should actively talk about the benefits of allyship as well as champion, and sponsor LGBT+ staff networks. They should also build the concept of allyship into existing and new development programmes.	Board sponsors	New / Combined action	On-going	An Executive Director is the sponsor of the LGBT+ staff network. .Board members/Executives attend Stockport Pride as an act of allyship, as well as supporting events such as LGBT History month, Trans awareness day and Trans day of remembrance.	Green	**Leadership**
NPAge3	NHS organisations should work in partnership with local educational institutions and voluntary sector partners to support social mobility by improving recruitment from local communities, and by considering alternative entry routes to the NHS, such as apprenticeships and volunteering.	IH & JM	New / Combined action	On-going	An Inclusive Recruitment Improvement Action Plan has been implemented which covers this specific action. Additionally, the Trust runs a 'Pathways into Employment' Group with representatives for local community organisations. The group's terms of reference & membership is currently being reviewed. Collaborative working with locality partners including SMBC and FEIs is embedded offering T-Levels, Cadets, work experience, pre-employment and alternative routes into NHS roles. We have expanded place based placements with our social care partners from September 24 to support the cadet and T Level programmes. We are expanding the T level offer by promoting other industry pathways in addition to Health and Social Care which is aligned to the GM MBacc	Blue	**Recruitment**

NPDis3	Implement recommendations from the inclusive recruitment and promotion practices programme, and ensure each stage of the recruitment pathway is accessible, does not discriminate and encourages people with disabilities to apply for roles in the NHS. This can be tracked via the WDES, using Trac data.	Recruitment Team	New / Combined action	Sept-23	Inclusive interview practices now implemented - providing candidates with details of all stages of interview (venue, equipment, facilities, expectations of day/times etc, interview questions - prior to interview date). Full guidance for managers is now in place to complete template document with info about interview days and questions prior to interview.	Blue	**Recruitment**
NPDis6	NHS organisations should ensure that their reasonable adjustments policy is effectively and efficiently implemented and achieves year-on-year improvement in NHS Staff Survey metrics relating to reasonable adjustments at work.	SM	New / Combined action	Mar-23 and annually thereafter through staff survey responses	Reasonable adjustment guidance implemented. Workplace adjustments training rolled out. The most improved question score in the 2024 staff survey was in relation to disabled colleagues being given reasonable adjustments to be able to do their job. Reasonable adjustments policy updated, and submitted for approval.	Green	**Resources and guidance**

AFB1	This senior director level EDI sponsor has a clear role description, including annual personal development performance goals related to advancing anti-racism. Must report as a minimum into an executive director and / or chief executive officer and be considered a part of the wider senior leadership team to facilitate and enable change on racial equity.	EDI Sponsor	New / Combined action	TBA	Sponsor appointed as part of the Bronze ARF submission, with specific role profile outlining their responsibilities in relation to progressing the work on anti-racism.	Green	**Talent management**
AFS1	Ensure Black, Asian and Minority Ethnic talent is intentionally included across organisational talent programmes. Numbers should reflect the need for positive action to increase diversity within leadership roles. Must have set targets and a published talent trajectory for Black, Asian and Minority Ethnic representation across every level of the organisation. An organisation should have a dedicated positive action secondment or stretch projects programme in place to give Black, Asian and Minority Ethnic colleagues the chance to gain experience to support with career progression.	KR & JS	New / Combined action	Dec-24	All of our leadership development offers are open to all leaders at the appropriate level of the organisation regardless of their sex, disability or ethnicity. Equaity monitoring to be undertaken of the newly launched Leading with Impact program, to ensure equitable access.	Amber	**Talent management**

AFG1	Creation and implementation of talent development and pipeline plan for Black, Asian or Minority Ethnic directors or associate non-executive director programme. Partner with the North West Black Asian and Minority Ethnic Assembly to create a mentorship programme for Black, Asian or Minority Ethnic talent within the organisation.	KR & JS	New / Combined action	Dec-24	Not yet started due to competing demands and limited staffing resource	Amber	**Talent management**
NPH2	Create and implement a talent management plan to improve the diversity of executive and senior leadership teams (by June 2024) and evidence progress of implementation (by June 2025). Implement a plan to widen recruitment opportunities within local communities, aligned to the NHS Long Term Workforce Plan. This should include the creation of career pathways into the NHS such as apprenticeship programmes and graduate management training schemes (by October 2024).	KR & JS	New / Combined action	Jun-24	Not yet started due to competing priorities. A Working Group is in place that involves Trust reps and colleagues from local agencies/organisations working together to improve pathways into employment from underrepresented groups. Since September 2024 both Trusts are supporting 3 GMTS trainees - 2 operational trainees in Year 2 and 1 HR/OD trainee in Year 1	Amber	**Talent management**
	Impact should be measured in terms of social mobility across the integrated care system (ICS) footprint.						

NPH3	Implement the Mend the Gap review recommendations for medical staff and develop a plan to apply those recommendations to senior non-medical workforce. Analyse data to understand pay gaps by protected characteristic and put in place an improvement plan. This will be tracked and monitored by NHS boards. Reflecting the maturity of current data sets, plans should be in place for sex and race by 2024, disability by 2025 and other protected characteristics by 2026. Implement an effective flexible working policy including advertising flexible working options on organisations' recruitment campaigns.	Employee relations, SM, TH	New / Combined action	Mar-24	Gender pay gap and actions published annually. Ethnicity pay gap calculated and published for 2025. Flexible working recommendations implemented through new policy. Career progression actions passed to career progression task group. Gender pay gap report and ethnicity pay gap report were presented to EDI steering group in December 2024 (rather than March 2025) to formulate specific plans to address any inequality. New flexible working policy and resources have now been implemented	Green	**Talent management**
NPAge1	Line managers should have meaningful conversations with their teams, to align personal aspirations with job roles and requirements. This should include the option of phasing retirement and exploring alternative work patterns.	KR & JS	New / Combined action	Sep-24	The Trust is introducing on 1st June 2024 the new 'Let's Talk' Toolkit which provides managers and staff with templates & guidance to help them to have more meaningful conversations including 121/check-ins, annual appraisals and 6-month appraisal reviews. The toolkit is supported by briefing sessions and 1-day course skills course for managers.	Blue	**Talent management**
NPDis4	Commissioners and providers of talent management and career development programmes must ensure that these are fully accessible and inclusive. Progress can be measured by tracking the number of disabled	KR & SM	New / Combined action	On-going	All of our leadership development offers are open to all leaders at the appropriate level of the organisation regardless of their sex, disability or ethnicity. Monitoring data required to monitor uptake and conduct necessary positive action for any inequality identified.	Green	**Talent management**

	people in leadership roles.						
NPLGBT 3	Organisations to ensure that diversity training on gender reassignment and sexual orientation is included within mandatory training.	SM	New / Combined action	Jan-24	LGBTQ+ training forms part of the Trust's mandatory EDI training. Compliance is monitored on a monthly basis.	Blue	**Training and Development**
NPLGBT 5	Organisations to ensure that LGBT+ staff are closely involved in the development and delivery of its LGBT+ training and educational interventions and its health & wellbeing programmes so that these are fully inclusive.	SM	New / Combined action	Jan-24	LGBT+ employees are routinely engaged in the development and quality assurance of LGBTQ+ training programmes.	Blue	**Training and Development**
AFB5	Explicit processes for addressing instances of racist abuse, discrimination and harassment should be developed within or in addition to current organisational disciplinary procedures.	Employee relations	New / Combined action	Jan-24	Explicit processes exist to address racial harassment, through the Trust's Respect Policy and Reduction in Violence and Aggression Strategy.	Blue	**Workforce**

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

NPH5	Before they join, ensure international recruits receive clear communication, guidance and support around their conditions of employment ; including clear guidance on latest Home Office immigration policy, conditions for accompanying family members, financial commitment and future career options. Create comprehensive onboarding programmes for international recruits, drawing on best practice. The effectiveness of the welcome, pastoral support and induction can be measured rom, for example, turnover, staff survey results and cohort feedback. Line managers and teams who welcome international recruits must maintain their own cultural awareness to create inclusive team cultures that embed psychological safety. Give international recruits access to the same development opportunities as the wider workforce. Line managers must proactively support their teams, particularly international staff, to access training and development opportunities. They should ensure that personal development plans focus on fulfilling potential and opportunities for career progression.	JM / KR	New / Combined action	25-Jan	IR package was previously provided to IR nurses. The information will be reviewed and amended to be more generic to suit any international recruits. Internationally recruited nurses undertake the full preceptorship programme. All internationally recruited colleagues are able to access training and development opportunities and funding to support their career progression. ACCEND International Programme - 5 International Nurses to develop cancer knowledge and skills.	Amber	**Workforce**

NPH6a, S10a	Review data by protected characteristic on bullying, harassment, discrimination and violence. Reduction targets must be set (by March 2024) and plans implemented to improve staff experience year-on-year.	SM	New / Combined action	Apr-24	Explicit targets for reduction in bullying/harassment by protected characteristic are included in the Trust EDI strategy. Data is reviewed within the annual staff survey. Improvements in data triangulation to be used to identify potential areas of focus throughout the year.	Blue	**Workforce**
NPH6b	Review disciplinary and employee relations processes. This may involve obtaining insights on themes and trends from trust solicitors. There should be assurances that all staff who enter into formal processes are treated with compassion, equity and fairness, irrespective of any protected characteristics. Where the data shows inconsistency in approach, immediate steps must be taken to improve this.	Employee relations team	New / Combined action	Mar-24	The EDI details are collated for all staff going through a formal ER process. The details are reported through PPC to Trust Board and to ET. Each potential disciplinary case is reviewed by a conduct review panel to ensure consistency and allow for alternatives to formal investigations are considered. A peer review process has been established with T&GICFT where cases are reviewed to establish joint learning and good practice. The last review had a focus on staff from an ethnic minority. From these reviews actions are agreed and where applicable processes changed.	Blue	**Workforce**
NPH6c	Ensure safe and effective policies and processes are in place to support staff affected by domestic abuse and sexual violence (DASV). Support should be available for those who need it, and staff should know how to access it.	Employee relations team	New / Combined action	25-Jan	The Trust has signed up to the Sexual Safety Charter and has an action plan for the promotion and communication. A regional policy has been developed and a member of the team is on the working group for implementation. Training for staff to deal with instances of sexual abuse disclosures and the wider awareness is currently being rolled out across the Trust. A confidential reporting process is being developed and the policy is going through the approval process. The Trust has guidance in place for supporting staff dealing with Domestic abuse.	Green	**Workforce**

NPH6d	Create an environment where staff feel able to speak up and raise concerns, with steady year-on-year improvements. Boards should review this by protected characteristic and take steps to ensure parity for all staff.	FTSUG	New / Combined action	On-going	Year-round promotion of FTSU as a mechanism to raise concerns. FTSU Guardian has attended staff network meetings to promote the services. 13 FTSU champions appointed. Significant promotion activity throughout FTSU month (Oct 2024).	Blue	**Workforce**
NPH6f	Provide comprehensive psychological support for all individuals who report that they have been a victim of bullying, harassment, discrimination or violence. Have mechanisms to ensure staff who raise concerns are protected by their organisation.	SPAWS	New / Combined action	Mar-24	All individuals who raise concerns formally are signposted to SPAWS. Ensure that FTSU Guardian, HRBMs and teams are signposting to effective psychological programs where an individual has made an allegation of bullying/harassment.	Blue	**Workforce**
NPAge2	Organisations should encourage flexible working as part of local attraction, recruitment, retention and return plans. The plan should embed the NHS Pension Scheme and highlight its value across the career journey, with special focus on flexible retirement for staff in late stage careers.	Recruitment Team	New / Combined action	On-going	This is included in applicant packs attached to all adverts. The information will be reviewed regularly to ensure it is up to date and relevant	Blue	**Workforce**

NPRel2	NHS organisations should review their policies and processes to ensure they are supportive of religious expression in the workplace. This includes access to facilities for prayer, understanding of cultural differences, including religious clothing, and flexibility around religious observances such as the Sabbath and Ramadan.	SM	New / Combined action	On-going	Flexible working policy and guidance is explicit in reference to religious expression. Prayer facilities are available on the main Trust site for staff to utilise. The chaplaincy service is available to all staff. Significant religious and cultural holidays are celebrated across the Trust. Guidance on religious expression is available on the inclusion and colleague experience SharePoint site.	Green	**Workforce**
NPSex1	NHS organisations to focus on closing the gender pay gap and improving the experiences of the lowest paid people, extending the Mend the Gap Review recommendations for medical workforce to the wider workforce.	SM, NB & LR	New / Combined action	Dec-24	Our latest ethnicity pay gap has been calculated, and the gender pay gap report was presented to the Combined EDI Steering Group and Workforce Committee in March 2025. Flexible working recommendations implemented through new policy. Career progression actions passed to career progression task group.	Green	**Workforce**
NPSex2 (cross ref NPH3)	NHS organisations should ensure that their flexible working policy is easily accessible and suitable for all their staff; supporting their work–life balance, management of caring responsibilities, health and wellbeing, and enabling continued professional development.	Employee relations	New / Combined action	Sep-24	Flexible working is part of of our recruitment campaign and is detailed on adverts. We also have a policy in place to support staff with flexible working requests. The process is done electronically and is monitored with regard to approvals and is proving successful. We also have a retirement policy which promotes the various types of retirement options available to staff. The Trust provides information sessions for staff approaching retirement.	Blue	**Workforce**

NPSex3 (cross ref NPH3)	NHS organisations are encouraged to adapt NHS England's policy on menopause awareness as applicable to their local workforce. They should also adopt and implement the Supporting our NHS people through menopause: guidance for line managers and colleagues. This will ensure they fully support colleagues experiencing menopause, maximising their wellbeing and allowing them to work for as long as they wish to contribute.	Employee relations, LP	New / Combined action	Sep-24	Staff Menopause service in place, aligned with the NHSE policy, including guidance for line managers and staff is widely communicated and available on the intranet. Progressing application to become menopause accredited employer. Successfully achieved Menopause Accreditation in September 2024.	Blue	**Workforce**

Workforce Race Equality Standard (WRES) Report 2025

Introduction

The NHS Workforce Race Equality Standard (WRES) was made available to the NHS from April 2015, following sustained engagement and consultation with key stakeholders including a widespread of NHS organisations across England. The WRES is included in the NHS standard contract, and since July 2015, NHS trusts have been producing and publishing their WRES data on an annual basis.

The main purpose of the WRES is:

- to help local, and national, NHS organisations (and other organisations providing NHS services) to review their data against the nine WRES indicators,
- to produce action plans to close the gaps in workplace experience between white and Black and Ethnic Minority (BME) staff, and,
- to improve BME representation at the Board level of the organisation.

This document reports on Trust's activity between 1st April 2024 and 31st March 2025 against the WRES, in accordance with the three workforce themes: workforce diversity (indicators 1 – 4), staff experience (indicators 5 – 8) and leadership diversity (indicator 9).

In addition to reporting the metrics required of the WRES, this report also sets out actions that will be undertaken to address the inequalities identified.

The WRES Indicators

Workforce indicators

Indicator	Descriptor
1	Percentage of staff in each of the AfC Bands 1-9 and Very Senior Managers (VSM) (including executive Board members) compared with the percentage of staff in the overall workforce Note: organisations should undertake this calculation separately for non-clinical and for clinical staff
2	Relative likelihood of staff being appointed from shortlisting across all posts
3	Relative likelihood of BAME staff entering the formal disciplinary process compared to that of White staff
4	Relative likelihood of staff accessing non-mandatory training and continuous professional development (CPD).

National NHS Staff Survey indicators

Indicator	Descriptor
5	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
6	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
7	KF 21. Percentage believing that the trust (or organisation) provides equal opportunities for career progression or promotion
8	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? Manager/team leader or other colleagues

Board representation indicator

Indicator	Descriptor
9	Percentage difference between the organisation's Board voting membership and its overall workforce disaggregated: • By voting membership of the Board • By executive membership of the Board

Performance against the WRES indicators

Indicator 1: Percentage of staff in each of the AfC Bands 1-9 and Very Senior Managers (VSM) (including executive Board members) compared with the

percentage of staff in the overall workforce Note: organisations should undertake this calculation separately for non-clinical and for clinical staff

Non-clinical workforce

31st March 2024		**31st March 2025**	
White	1457	White	1418
BAME	215	BAME	242
Unknown	23	Unknown	21
Total	1695	Total	1681

As of March 2025, within the non-clinical workforce, 84.4% of staff were White, and 14.4% of staff were from Black & Minority Ethnic backgrounds (an increase from 1.4% in the previous year).

Clinical workforce

31st March 2024		**31st March 2025**	
White	3051	White	2861
BAME	1383	BAME	1261
Unknown	128	Unknown	92
Total	4562	Total	4214

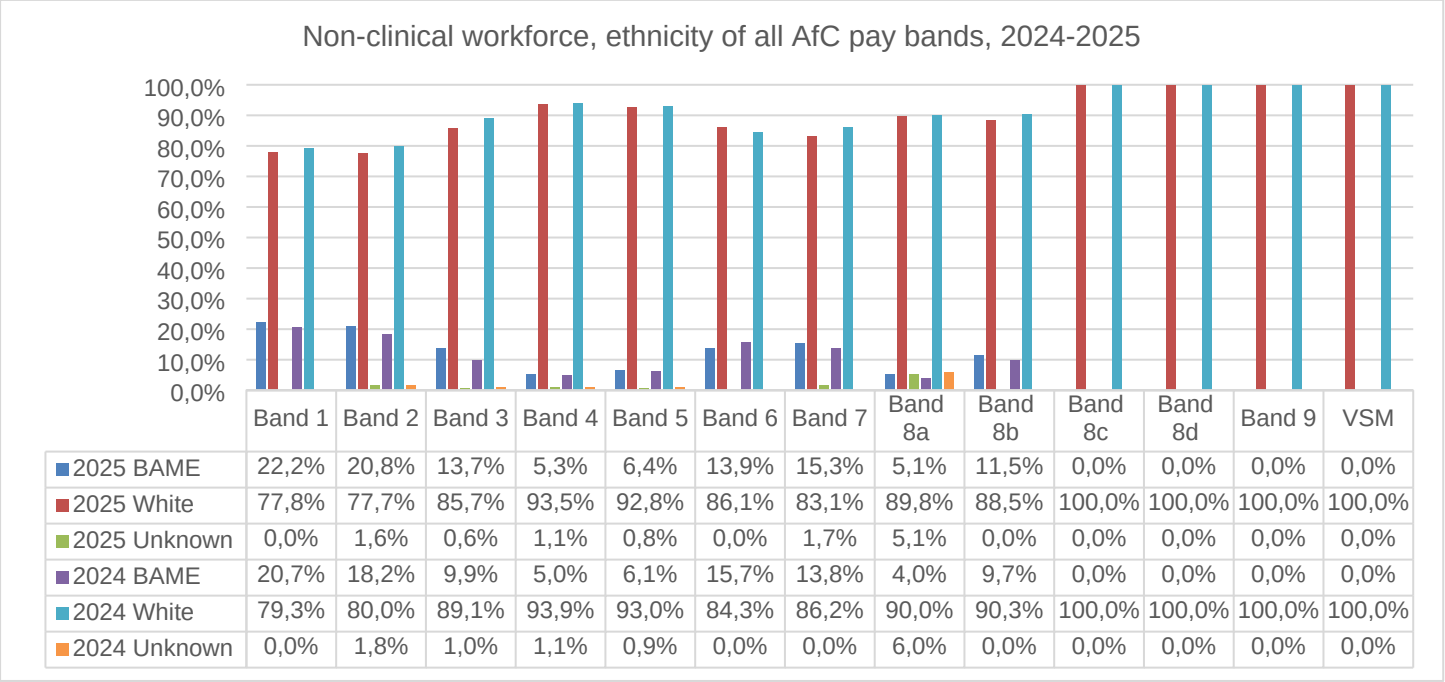
As of March 2025, within the clinical workforce, 67.9% of staff are White, and 29.9% are from BAME backgrounds (a decrease of 0.01% on the previous year).

Figure 1 (*overleaf*) shows the proportion of White and BAME staff in each of the AfC pay bands within the non-clinical workforce.

In summary the data shows:

- There has been little movement across the majority of pay bands, with small increases of BAME representation at band 1,2,3, 7, 8A and 8B.

Figure 1

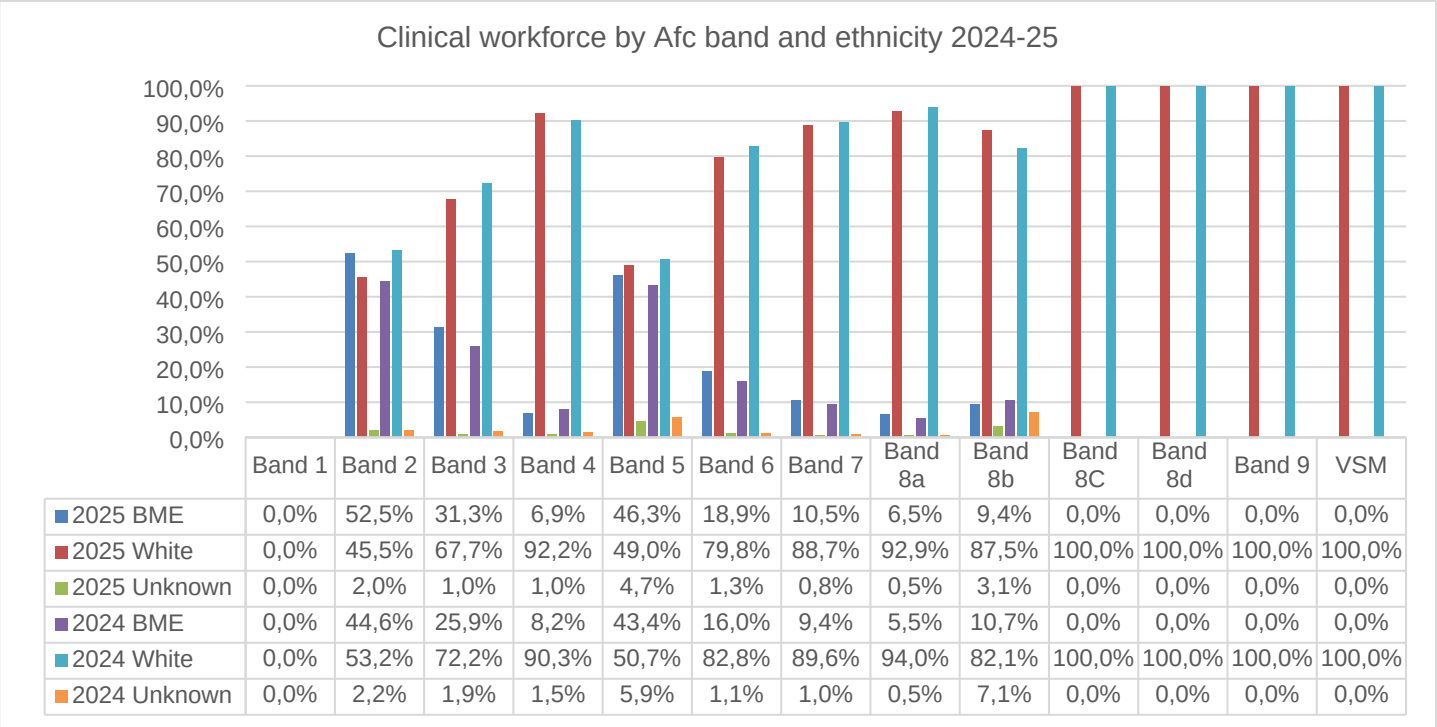


	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8c	Band 8d	Band 9	VSM
2025 BAME	22,2%	20,8%	13,7%	5,3%	6,4%	13,9%	15,3%	5,1%	11,5%	0,0%	0,0%	0,0%	0,0%
2025 White	77,8%	77,7%	85,7%	93,5%	92,8%	86,1%	83,1%	89,8%	88,5%	100,0%	100,0%	100,0%	100,0%
2025 Unknown	0,0%	1,6%	0,6%	1,1%	0,8%	0,0%	1,7%	5,1%	0,0%	0,0%	0,0%	0,0%	0,0%
2024 BAME	20,7%	18,2%	9,9%	5,0%	6,1%	15,7%	13,8%	4,0%	9,7%	0,0%	0,0%	0,0%	0,0%
2024 White	79,3%	80,0%	89,1%	93,9%	93,0%	84,3%	86,2%	90,0%	90,3%	100,0%	100,0%	100,0%	100,0%
2024 Unknown	0,0%	1,8%	1,0%	1,1%	0,9%	0,0%	0,0%	6,0%	0,0%	0,0%	0,0%	0,0%	0,0%

The table below shows the changes at each AfC band between 2024 and 2025.

	% movement per band		
AfC Band	**White 2025**	**BAME 2025**	**Unknown 2025**
Band 1	-2%	2%	0%
Band 2	-2%	3%	0%
Band 3	-3%	4%	0%
Band 4	0%	0%	0%
Band 5	0%	0%	0%
Band 6	2%	-2%	0%
Band 7	-3%	2%	2%
Band 8A	0%	1%	-1%
Band 8B	-2%	2%	0%
Band 8C	0%	0%	0%
Band 8D	0%	0%	0%
Band 9	0%	0%	0%
VSM	0%	0%	0%

Figure 2 (below) shows the proportion of White and BAME staff in each of the AfC pay bands within the clinical workforce.



	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a	Band 8b	Band 8C	Band 8d	Band 9	VSM
2025 BME	0,0%	52,5%	31,3%	6,9%	46,3%	18,9%	10,5%	6,5%	9,4%	0,0%	0,0%	0,0%	0,0%
2025 White	0,0%	45,5%	67,7%	92,2%	49,0%	79,8%	88,7%	92,9%	87,5%	100,0%	100,0%	100,0%	100,0%
2025 Unknown	0,0%	2,0%	1,0%	1,0%	4,7%	1,3%	0,8%	0,5%	3,1%	0,0%	0,0%	0,0%	0,0%
2024 BME	0,0%	44,6%	25,9%	8,2%	43,4%	16,0%	9,4%	5,5%	10,7%	0,0%	0,0%	0,0%	0,0%
2024 White	0,0%	53,2%	72,2%	90,3%	50,7%	82,8%	89,6%	94,0%	82,1%	100,0%	100,0%	100,0%	100,0%
2024 Unknown	0,0%	2,2%	1,9%	1,5%	5,9%	1,1%	1,0%	0,5%	7,1%	0,0%	0,0%	0,0%	0,0%

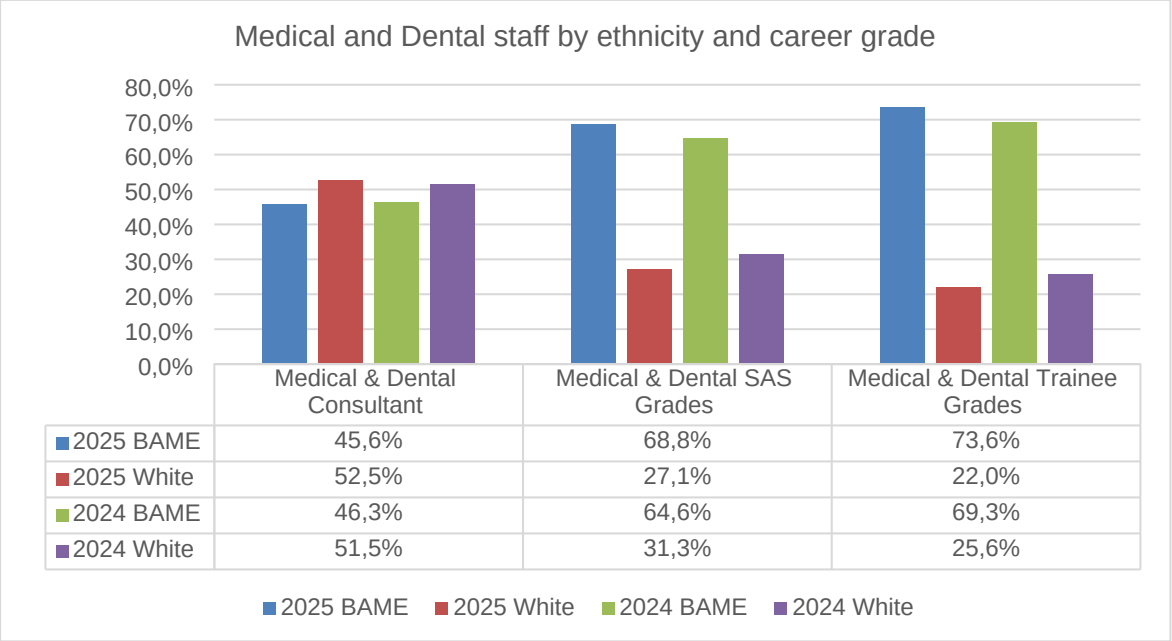
The table below shows the changes at each AfC band between 2024 and 2025.

	% movement per band		
AfC Band	**White 2025**	**BAME 2025**	**Unknown 2025**
Band 1	0%	0%	0%
Band 2	-8%	8%	0%
Band 3	-5%	5%	-1%
Band 4	2%	-1%	-1%
Band 5	-2%	3%	-1%
Band 6	-3%	3%	0%
Band 7	-1%	1%	0%
Band 8A	-1%	1%	0%
Band 8B	5%	-1%	-4%
Band 8C	0%	0%	0%
Band 8D	0%	0%	0%
Band 9	0%	0%	0%
VSM	0%	0%	0%

In summary the data shows:

- There has been little movement across the majority of AfC pay bands in relation to ethnicity. The largest change is across band 2 whereby there is an 8% decrease in white staff and an 8% increase in BAME staff.

Figure 3 below shows the distribution of White and BAME staff over each of the career grades for the medical workforce.



	Medical & Dental Consultant	Medical & Dental SAS Grades	Medical & Dental Trainee Grades
2025 BAME	45,6%	68,8%	73,6%
2025 White	52,5%	27,1%	22,0%
2024 BAME	46,3%	64,6%	69,3%
2024 White	51,5%	31,3%	25,6%

The table below shows the changes between 2024 and 2025:

	% Movement between grades	
	White 2025	BAME 2025
Medical & Dental Consultant	1%	-0.7%
Medical & Dental Career Grade	-4.2%	4.2%
Medical & Dental Trainee Grades	-3.6%	4.3%

There has been little change in the distribution of white staff in Consultant grades, where roughly an even split. There has been a small increase in the proportion of BAME staff in career grade roles, and a similar reduction on the proportion of white staff in these roles. There has been an increase in the proportion of BAME trainees compared to the previous 12 months.

Indicator 2: Relative likelihood of staff being appointed from shortlisting across all posts

	Relative likelihood in 2024	Relative likelihood in 2025	Difference +/-
Relative likelihood of White staff being appointed from shortlisting compared to BAME staff.	1.24	1.62	+0.38

Analysis of recruitment data there has been a small increase in the relative likelihood that White staff are appointed from shortlisting compared to BAME staff. A figure of 1.62 shows that White candidates are still slightly more likely to be appointed from a shortlist than BAME candidates.

Indicator 3: Relative likelihood of BAME staff entering the formal disciplinary process compared to that of White staff

	Relative likelihood in 2024	Relative likelihood in 2025	Difference +/-
Relative likelihood of BAME staff entering the formal disciplinary process compared to that of White staff.	1.85	0.75	-1.1

The relative likelihood of BAME staff entering the formal disciplinary process compared to that of White staff has decreased significantly in the last 12 months (from 1.85 to 0.75), and now BAME staff are less likely to enter into the formal disciplinary process than White staff, compared to 12 months ago.

Indicator 4: Relative likelihood of staff accessing non-mandatory training and continuous professional development (CPD)

	Relative likelihood in 2024	Relative likelihood in 2025	Difference +/-
Relative likelihood of staff accessing non-mandatory training and continuous professional development (CPD).	0.99	0.97	-0.02

There has been no significant change in the 2024 and 2025 relative likelihood scores, showing there is no disparity between white staff and BAME staff accessing non-mandatory CPD opportunities.

Indicators 5-8: The figure below summarise the staff survey data that is used to inform the WRES submission

Measure	2023 Score	2024 Score

% of BAME staff reported experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	23.1%	26.6%
% of BAME staff reported experiencing harassment, bullying or abuse from staff in last 12 months	21.6%	26.0%
% of BAME staff said they had experienced discrimination at work from either their manager, team leader or other colleagues	13.5%	15.3%
% of BAME staff believed that the organisation provides equal opportunities for career progression or promotion	50.6%	48.4%

There has been an increase (3.5%) in the proportion of BAME respondents who report bullying or abuse from patients, relatives or the public in the last 12 months.

The proportion of BAME staff reporting harassment or bullying from staff has increased from 21.6% to 26.0%.

There has been an increase in the proportion of BAME respondents who reported that they had experienced discrimination at work from either their manager, team leader or other colleagues, from 13.5% to 15.3%.

The proportion of BAME respondents who believed that that the organisation provides equal opportunities for career progression or promotion has decreased by 2.2% compared to the previous year.

Indicator 9: Percentage difference between the organisation's Board voting membership and its overall workforce disaggregated.

	White	BAME	Unknown
Board Membership	10	2	1
Of which; Voting Board Members	9	2	1
Non-voting Board Members	1	0	0
Board Membership	11	2	1
Of which; Exec Board Members	7	0	0
Non-Exec Board Members	3	2	1
Number of staff in overall workforce	4479	1822	130
Overall Workforce % by ethnicity	69.65%	28.33%	2.02%
Total Board members by ethnicity (%)	76.92%	15.38%	7.69%
Difference Board membership to overall workforce	7%	-13%	6%

Appendix 3: 2025 WDES Submission

Workforce Disability Equality Standard (WDES) Report 2025

Introduction

The Workforce Disability Equality Standard (WDES) is a set of ten specific measures (metrics) which enables NHS organisations to compare the workplace and career experiences of Disabled and non-disabled staff. NHS trusts use the metrics data to develop and publish an action plan. Year on year comparison enables trusts to demonstrate progress against the indicators of disability equality.

The WDES is important, because research shows that a motivated, included and valued workforce helps to deliver high quality patient care, increased patient satisfaction and improved patient safety.

The WDES enables NHS organisations to better understand the experiences of their Disabled staff and supports positive change for all existing employees by creating a more inclusive environment for disabled people working and seeking employment in the NHS.

This report summarises the Trust position, and progress against the 10 indicators of the NHS Workforce Disability Equality Standard.

This document reports on the Trust's workforce data and activity between 1 April 2024 and 31 March 2025.

The WDES Indicators

Workforce indicators

Indicator	Descriptor
1	Percentage of staff in each of the AfC Bands 1-9, Medical and Dental and VSM staff groups compared by: • Non-Clinical staff & Clinical staff
2	Relative likelihood of staff being appointed from shortlisting across all posts
3	Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.

National NHS staff survey indicators

Indicator	Descriptor
4	a) Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from: i. Patients/Service users, their relatives or other members of the public ii. Managers iii. Other colleagues b) Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.
5	Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.
6	Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.
7	Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.
8	Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.
9	a) The staff engagement score for Disabled staff, compared to non-disabled staff. b) Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? (Yes) or (No)

Board representation indicator

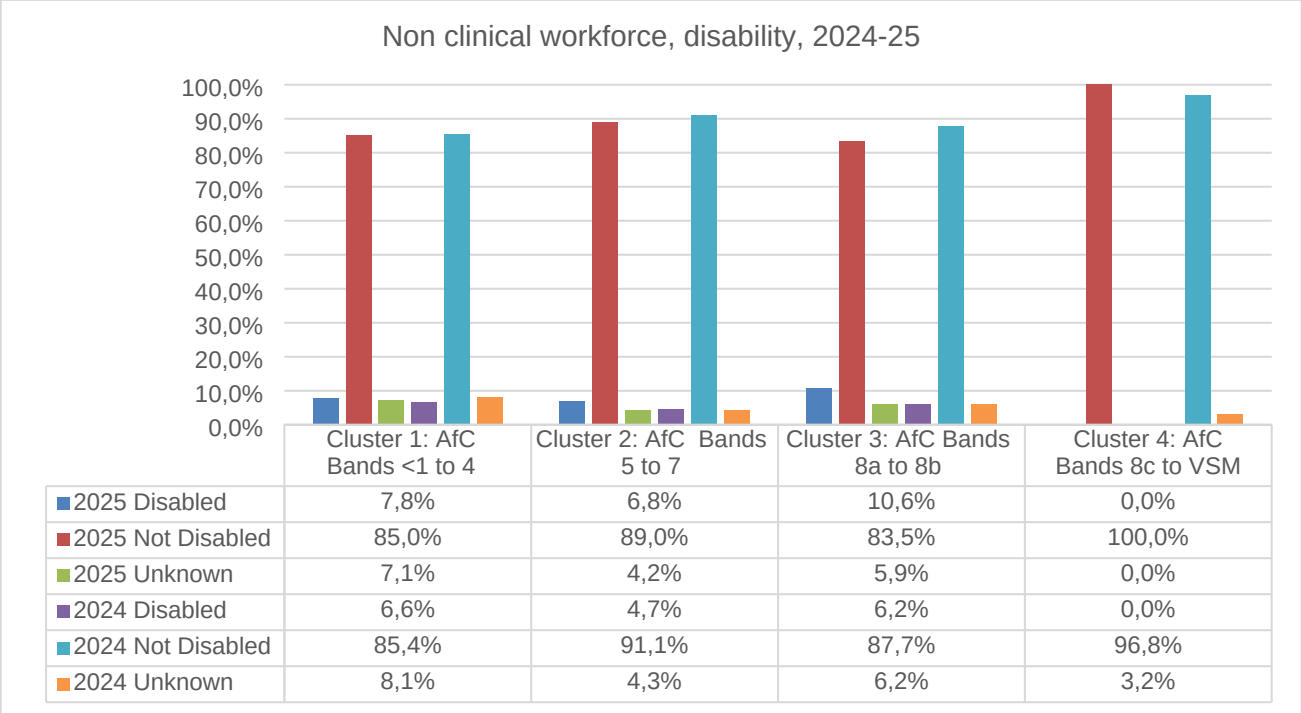
Indicator	Descriptor
10	Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated: • By voting membership of the Board. • By Executive membership of the Board.

Reporting against the WDES indicators

Indicator 1: Percentage of staff in each of the AfC bands 1-9, medical and dental and VSM staff groups compared by: non-clinical staff & clinical staff.

Figure 1 (below) shows the distribution of disabled/non-disabled staff across the AfC pay bands in the non-clinical workforce, for both 2024 and 2025.

Figure 1



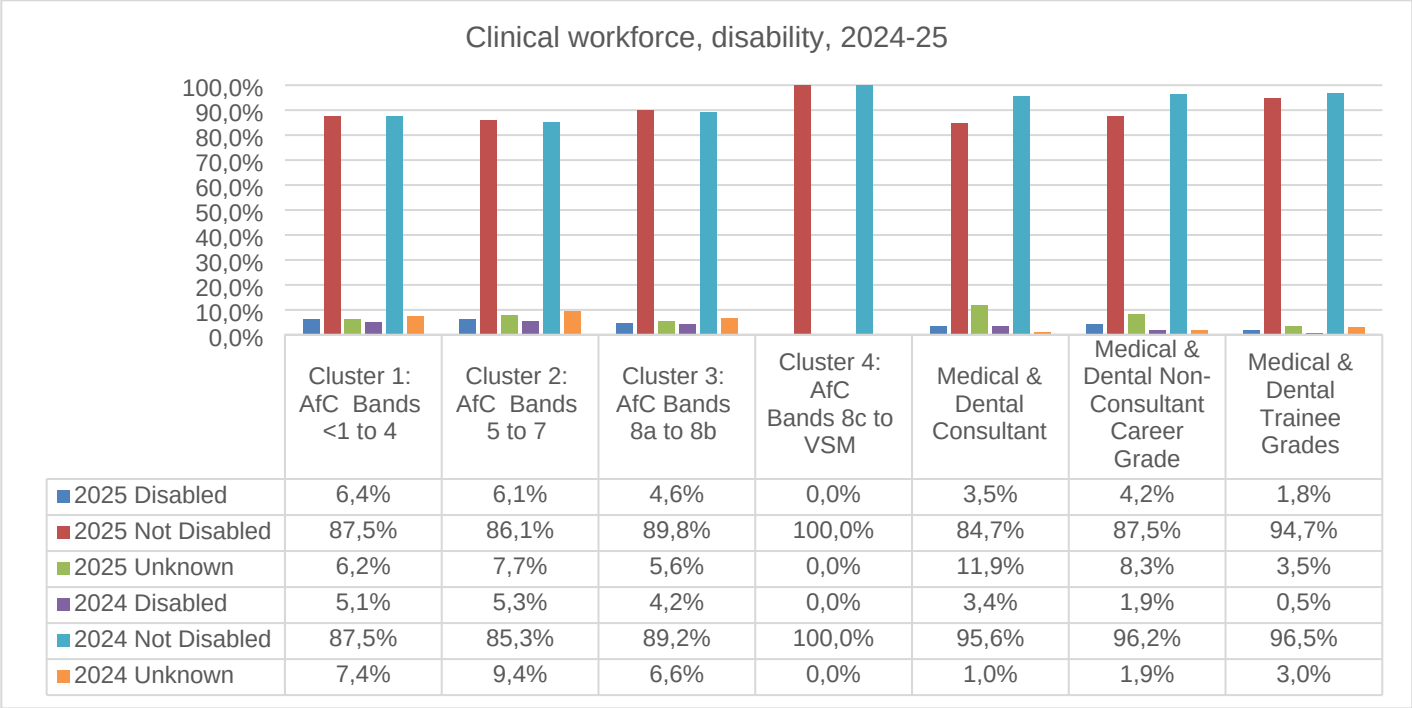
	Cluster 1: AfC Bands <1 to 4	Cluster 2: AfC Bands 5 to 7	Cluster 3: AfC Bands 8a to 8b	Cluster 4: AfC Bands 8c to VSM
2025 Disabled	7,8%	6,8%	10,6%	0,0%
2025 Not Disabled	85,0%	89,0%	83,5%	100,0%
2025 Unknown	7,1%	4,2%	5,9%	0,0%
2024 Disabled	6,6%	4,7%	6,2%	0,0%
2024 Not Disabled	85,4%	91,1%	87,7%	96,8%
2024 Unknown	8,1%	4,3%	6,2%	3,2%

	Change 2024-2025		
	Disabled	**Not Disabled**	**Unknown**
Cluster 1: AfC Bands <1 to 4	1%	0%	-1%
Cluster 2: AfC Bands 5 to 7	2%	-2%	0%
Cluster 3: AfC Bands 8a to 8b	4%	-4%	0%
Cluster 4: AfC Bands 8c to VSM	0%	3%	-3%

Summary analysis shows that:

- There has been an increase in the proportion of staff self-reporting disability across bands 1-4 (1%), bands 5-7 (2%), and bands 8a and 8b (4%).
- There has been an improvement in declaration rates in 2025 in bands 1-4 and bands 8c to VSM, which has shown that there are no staff with a disability in bands 8c to VSM.

Figure 2 (below) shows the distribution of disabled/non-disabled staff across the AfC pay bands in the clinical workforce, for both 2023 and 2024.



	Cluster 1: AfC Bands <1 to 4	Cluster 2: AfC Bands 5 to 7	Cluster 3: AfC Bands 8a to 8b	Cluster 4: AfC Bands 8c to VSM	Medical & Dental Consultant	Medical & Dental Non-Consultant Career Grade	Medical & Dental Trainee Grades
2025 Disabled	6,4%	6,1%	4,6%	0,0%	3,5%	4,2%	1,8%
2025 Not Disabled	87,5%	86,1%	89,8%	100,0%	84,7%	87,5%	94,7%
2025 Unknown	6,2%	7,7%	5,6%	0,0%	11,9%	8,3%	3,5%
2024 Disabled	5,1%	5,3%	4,2%	0,0%	3,4%	1,9%	0,5%
2024 Not Disabled	87,5%	85,3%	89,2%	100,0%	95,6%	96,2%	96,5%
2024 Unknown	7,4%	9,4%	6,6%	0,0%	1,0%	1,9%	3,0%

The table below shows the changes in the last 12 months:

	Change 2024-25		
	Disabled	**Not Disabled**	**Unknown**
Cluster 1: AfC Bands <1 -4	1%	0%	-1%
Cluster 2: AfC Bands 5 to 7	1%	1%	-2%
Cluster 3: AfC Bands 8a to 8b	0%	1%	-1%
Cluster 4: AfC Bands 8c to VSM	0%	0%	0%
Cluster 5: Med&Den Staff, Consultants	0%	-11%	11%
Cluster 6: Med&Den Staff, Career grade	2%	-9%	6%
Cluster 7: Med&Den Staff, Trainee grade	1%	-2%	1%

Summary analysis shows that:

- There has been a small increase in the proportion of disabled staff in Clusters 1 and 2 and medical clusters 6 and 7 (SAS grade doctors and Trainee Grade).
- There has been small reduction in the proportion of unknown data, in AfC clinical staff (Clusters 1,2 and 3.
- There has been a significant increase in the proportion of unknown data, in medical clusters (particularly clusters 5 and 6).

Indicator 2: Relative likelihood of staff being appointed from shortlisting across all posts.

	Relative likelihood in 2024	Relative likelihood in 2025	Difference +/-
Relative likelihood of disabled staff being appointed from shortlisting across all posts	1.03	1.17	+ 0.14

Disabled staff are equally likely to be appointed from shortlisting as non-disabled staff as there is no statistical difference in the likelihood of disabled staff being appointed from a shortlist compared to non-disabled staff. This a small decline on the metric from last year but it is still statistically insignificant.

Indicator 3: Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.

	Relative likelihood in 2024	Relative likelihood in 2025	Difference +/-
Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure	9	13.9	+4.9

There has been a significant increase in the relative ratio of disabled staff entering the capability procedure, compared to the previous 12 months. **It should be noted that the figures represent 1 disabled people and 1 non disabled people entering the process. When numbers are this small, it demonstrates the mathematical limitations of this metric.**

Indicator 4: a) Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from:

i. Patients/Service users, their relatives or other members of the public
ii. Managers
iii. Other colleagues

b) Percentage of disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.

	2023		2024		Change	
	Disabled staff	Non-disabled staff	Disabled staff	Non-disabled staff	Disabled staff	Non-disabled staff
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	26.03%	20.47%	26.42%	20.44%	+0.39%	-0.03%
Percentage of staff experiencing harassment, bullying or abuse from managers in last 12 months	14.78%	6.60%	16.81%	7.18%	+2.03%	+0.58%
Percentage of staff experiencing harassment, bullying or abuse from other colleagues in last 12 months	19.15%	10.77%	23.34%	14.01%	+4.19%	+3.24%
Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	44.26%	45.72%	49.65%	46.96%	+5.39%	+1.24%

There has been a small increase in the proportion of disabled staff experiencing harassment, bullying or abuse from either patients/relatives (0.39%), but a larger increase in the proportion reporting harassment from managers (2.03%). The largest increase is the proportion of disabled staff experiencing harassment, bullying or abuse from colleagues (4.19%). Similarly, there was an increase in the proportion of non-disabled staff experiencing this treatment from colleagues (3.24%). The increases are larger for disabled staff across all questions.

There has been a large increase in the proportion of disabled staff reporting any abusive treatment when it had occurred (5.39%).

Indicator 5: Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.

	2023		2024		Change	
	Disabled staff	Non-disabled staff	Disabled staff	Non-disabled staff	Disabled staff	Non-disabled staff
Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.	51.10%	60.19%	52.12%	58.79%	+1.02%	-1.40%

Disabled staff are still positive than non-disabled staff in relation to believing that the Trust provides equal opportunities for career progression or promotion. The score for disabled staff has increased slightly in the last 12 months, whereas the score for non-disabled staff has decrease by 1.40%.

Indicator 6: Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.

	2023		2024		Change	
	Disabled staff	Non-disabled staff	Disabled staff	Non-disabled staff	Disabled staff	Non-disabled staff
Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	25.45%	16.74%	26.15%	17.40%	+0.70%	+0.66%

Disabled staff are less positive than non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties. There has been a small increase in this metric for both disabled and non-disabled staff.

Indicator 7: Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.

	2023		2024		Change	
	Disabled staff	Non-disabled staff	Disabled staff	Non-disabled staff	Disabled staff	Non-disabled staff
Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.	36.19%	47.54%	37.25%	47.96%	+1.06%	+0.42%

Disabled staff are less positive than non-disabled staff when asked if they are satisfied with the extent to which their organisation values their work. There has been an improvement in this score for both disabled staff and non disabled staff in the last 12 months, particularly for disabled staff.

Indicator 8: Percentage of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.

	2023	2024	Change
Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.	79.70%	78.05%	-1.65%

78.05% of disabled staff say that the organisation has made adequate adjustments to enable them to carry out their work. This is a decrease of 1.65% in the previous 12 months.

Indicator 9: a) The staff engagement score for disabled staff, compared to non-disabled staff. b) Has your Trust taken action to facilitate the voices of disabled staff in your organisation to be heard? (Yes) or (No)

(a) Staff Engagement Scores of Disabled Staff v Non-Disabled Staff

	Trust Score	**Not disabled staff**	**Disabled staff**
Engagement Score	6.87	7.00	6.50

The engagement score for disabled staff is lower than that of non-disabled staff (7.00 compared to 6.50 respectively).

b) Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? **Yes**

The Trust has an established network for disabled staff (DAWN). The network is represented on the trust Staff Side Partnership Forum (SPF). In the last 12 months, the network and its members have been instrumental in:

(1) Development of a DAWN information Pack.
(2) Launch of a Trust wide Disability Survey.
(3) Delivery of Workplace Adjustment Training for Managers.
(4) Promotion and use of the Reasonable Adjustment Guidance Documents.
(5) Celebration of Disability History Month and International Day of Disabled People.
(6) Celebration of National Day of Staff networks.

Indicator 10: Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated:

- **By voting membership of the Board**
- **By Executive membership of the Board**

	Disabled	Not Disabled	Unknown
Board Membership	0	13	0
Of which; Voting Board Members	0	12	0
Non-voting Board Members	0	1	0

Board Membership	0	13	0
Of which; Exec Board Members	0	7	0
Non-Exec Board Members	0	6	0
Number of staff in overall workforce	401	4930	77
Overall Workforce % by disability	6.24%	86.74%	7.03%
Total Board members by disability (%)	0%	100%	0%
Difference Board membership to overall workforce	-6%	13%	-7%

NHS Stockport NHS Foundation Trust

Meeting date	5th June 2025	**Public**	X	**Agenda Item No.**	
Meeting	Board of Directors				
Report Title	Safer Care (Staffing) Report				
Director Lead	Nic Firth, Chief Nurse Andrew Loughney, Medical Director	**Author**	Helen Howard, Deputy Chief Nurse		

Paper For:	**Information**		**Assurance**	X	**Decision**	
Recommendation:	The Board of Directors are requested to review and note the assurances of this report.					

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

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

This paper relates to the following Board Assurance Framework risks

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

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

Where issues are addressed in the paper

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

Executive Summary

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

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

We continue to experience high levels of operational demand within the acute and community services which we are aware is having an impact on both patient and staff experience.

Safer Care (Staffing) Report – June 2025

Contents

Stockport NHS Foundation Trust

1. Introduction

Stockport NHS Foundation Trust

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

- Staffing assurances
- Current challenges regarding staffing levels and risk mitigations, and the actions being taken to mitigate risks and financial impacts identified
- Safer staffing governance monitoring led by evidence-based decision-making on safe and effective staffing is a requirement for all NHS organisations
- The NHS has produced a comprehensive long term workforce plan. This is a collective plan for the NHS and sets out a clear direction. The certainty of confirmed funding up to 2028 allows for actions locally, regionally and nationally to address the gaps in the current workforce and meet the challenge of a growing and ageing population
- The Trust strives to provide outstanding care whilst developing flexible approaches and innovative ways of working. This is a challenging time but brings significant opportunities for workforce development
- It is recognised that we are experiencing ongoing pressures require health systems and boards to make tough decisions to ensure services achieve the best outcomes at a time of financial challenge. Boards must ensure that this does not have an adverse impact on the quality of care, as well as patient, service user and staff experience

2. Safe Staffing

NHS Stockport NHS Foundation Trust

Introduction	**What is safe staffing?** **What are the warnings signs of inadequate staffing?** **What CQC standards are around safe staffing?**	**The National Quality Board (NQB) assess Trusts' compliance with the triangulated approach to decide staffing requirements. This combines evidence based tools, professional judgement & outcomes to ensure right staff & skills set, right place and right time.**
1 **Safe staffing levels** **How many staff do you need**	• **Decide how many staff you need** • **Plan your staffing rota** • **Put contingencies in place** • **Review your staffing levels** • **Use technology to support safe staffing**	**We use strategic staffing meetings and evidence from tools such as Datix, Harms, StARS, Safe Care , Healthroster compliance & Opel level escalation processes in place.**
2 **Safe recruitment practices** **Recruit the right staff to deliver safe care & support**	• **Plan your recruitment** • **Attract the right people** • **Review your recruitment & retention activities**	**All recruitment events are planned, organised with engagement from divisions.** **Attend regular *Thrive* workshops improve retention procedures & strategies.**
3 **Safe & competent staff** **Ensure staff are competent to deliver safe care & support**	• **Give new staff a thorough induction** • **Provide learning & development opportunities for staff** • **Support your staff**	**Advertising for a Pastoral Care Lead. The Lead will support new staff throughout the recruitment process, on joining the Trust & induction. Robust training plans are in place for new starters. Speciality areas CPFs' provide bespoke training.**

3. Workforce Safeguards

Stockport NHS Foundation Trust

To ensure the welfare & safety of staff and patient's, nurse to patient ratios were introduced :

Deploying staff effectively
This is to advise the Committee of their responsibilities in ensuring staffing arrangements are safe, sustainable and productive. It also considers emerging roles such as nursing associates (NAs), physician associates and Advanced Clinical Practitioners (ACP) who are all integral to the future NHS workforce.

Useful guidance
The National Quality Board's (NQB) guidance explicitly requires the Trust meets the following expectations :

- deploying the right staff
- with the right skills
- at the right place and time

These set the foundations on which any workforce plan should be based while not ignoring other organisational development needs such as values and behaviours.

In addition, the Cavendish Report 4 highlights that well-performing organisations use their workforce as a strategic asset. This underlines the need to deploy the workforce effectively and efficiently.

4. Guide for safe staffing

NHS Stockport NHS Foundation Trust

- A good rota assists staff in planning work-life balance, communicating with colleagues and people who need care and support. And provides evidence for the CQC inspection
- Once built the rota is approved 12 weeks in advance, this supports the staff with their work-life balance as they can request preferred pattern of shifts
- It is expected, where possible, staff schedule non-emergency appointments on days off. Staff can view shifts & request annual leave via Loop, this app can also be downloaded onto a mobile phone providing flexibility regarding planning annual leave while off-site
- Senior members of staff are allocated to build safe and efficient rotas.
- Staff creating rotas require an understanding of the financial impact and skillset of the workforce required
- Managers are expected to monitor the rota regularly and input changes such as sickness, annual leave, study days
- Healthroster is discussed at ward/unit meetings, managers proactively engage and act on staff feedback in making improvements in the building of the roster.
- The electronic system is simple to use with regular training for all staff groups.

5. Healthroster

Healthroster

24th March 2025 roster period

Annual leave:

Remains within the target at 12.4%

Roster Approval:

This has seen a further decrease in approval lead time days, due to adding Estates and Facilities on to the Dashboard. The Rostering team are working with the E&F team to review the rostering stats and put plans in to bring in line with the KPIs.

Total Unavailability:

This has continued to be well managed; this month is fully on target.

Changes since approval:

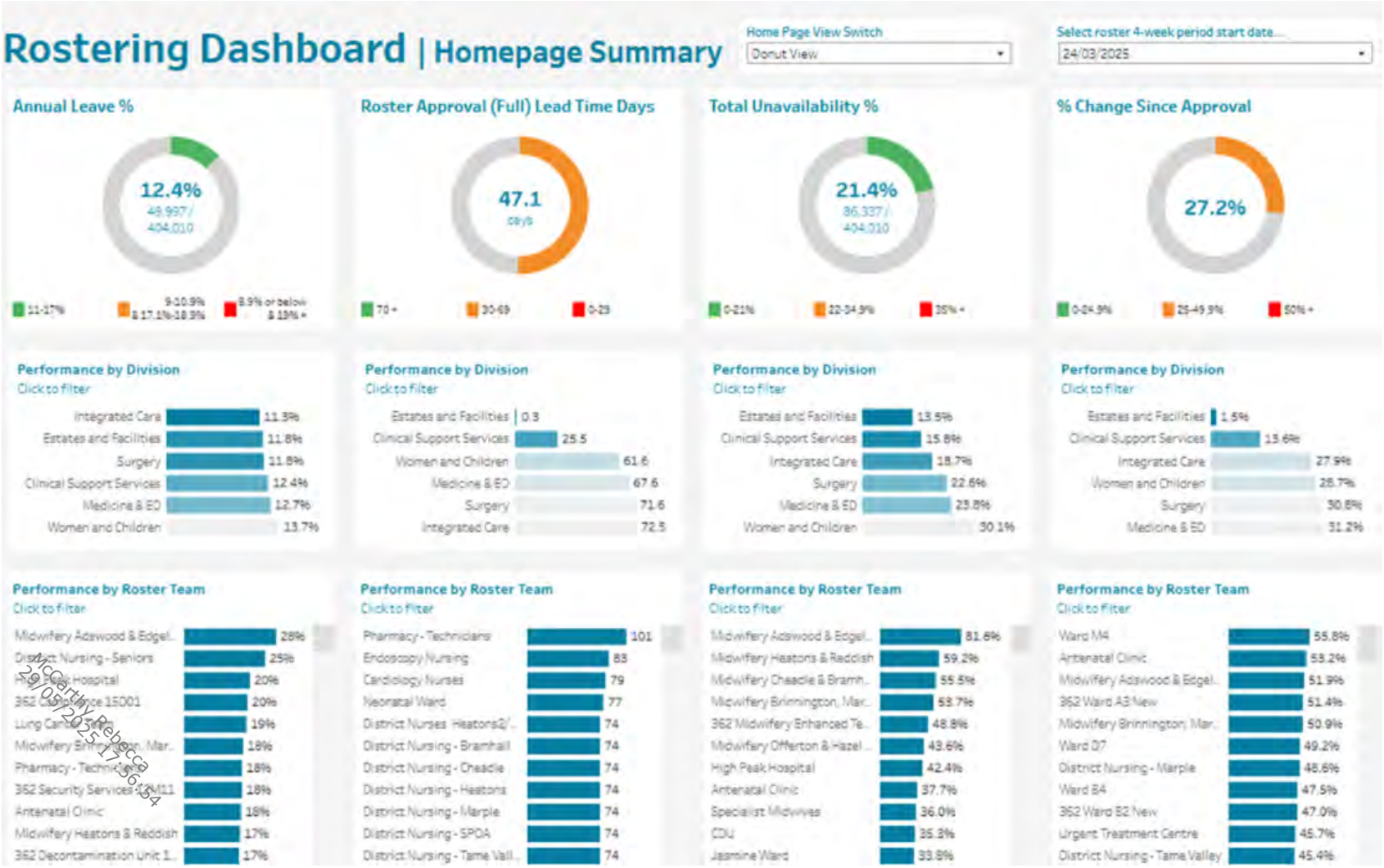
This remains high. The rostering team are working through common themes for changes, this will be feedback to Divisions.

Performance by Division:

Integrated Care has the highest full approval rates, currently at 72.5 days against the 70 day target.

5. Healthroster

NHS Stockport NHS Foundation Trust



6. Vacancies

NHS Stockport NHS Foundation Trust

The data below covers the positions of registered nurses (RNs), registered midwives (RMs), nursing associates (NAs), newly registered nurses and midwifes awaiting PINs.

Registered Nurses & Midwives	FTE Actual	Variance FTE	Post Recruited to in TRAC FTE
Clinical Support Services	63.48	5.7	7.75
Corporate Services	101.47	4.27	29.33
Integrated Care	262.3	-16.44	37.15
Medicine & Urgent Care	546.95	-51.65	64.49
Surgery	473.31	-33.2	109.4
Women & Children's	405.52	-16.66	40.28
Total	1,852.83	-107.98	288.37

In February 2025, the trust recruited a total of 33 RNs and HCAs. Currently all areas have recruited to turnover with a minimum of 10% of base numbers, with a figure of 181 WTE employees, this is to help cover the transitional period of employees leaving and new starters commencing.

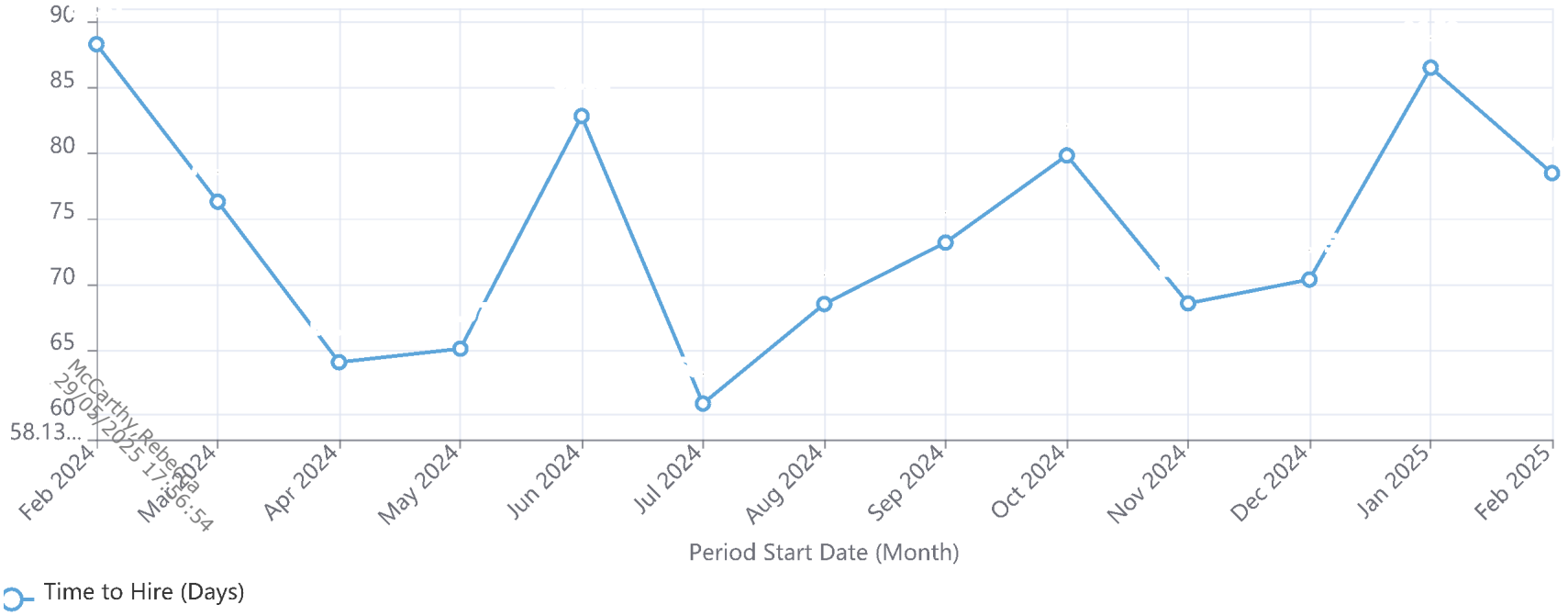
Within the Trust we have planned a Career and Job fair on 17th May 2025 which has had a lot of interest from employees, members of the public and local media. This will give the organisation a chance to promote roles not well known within the Trust, promote the careers possible, to promote why Stockport NHS is a good place to work, and to advertise any roles we have for all areas.

6. Vacancies

Stockport NHS Foundation Trust

We are still seeing long periods of time taken from being offered a post to then commencing employment. The spikes in timeframes coincide with following recruitment events.

Work is in progress to put mechanisms in place to mitigate against potential employee delays. The delays relate to the individuals and the completion of the DBS forms.



6. Vacancies

NHS Stockport NHS Foundation Trust

- We have seen a reduction in time of vacancy request to authorisation being granted
- There are still lengthy delays with shortlisting times and completion of checks

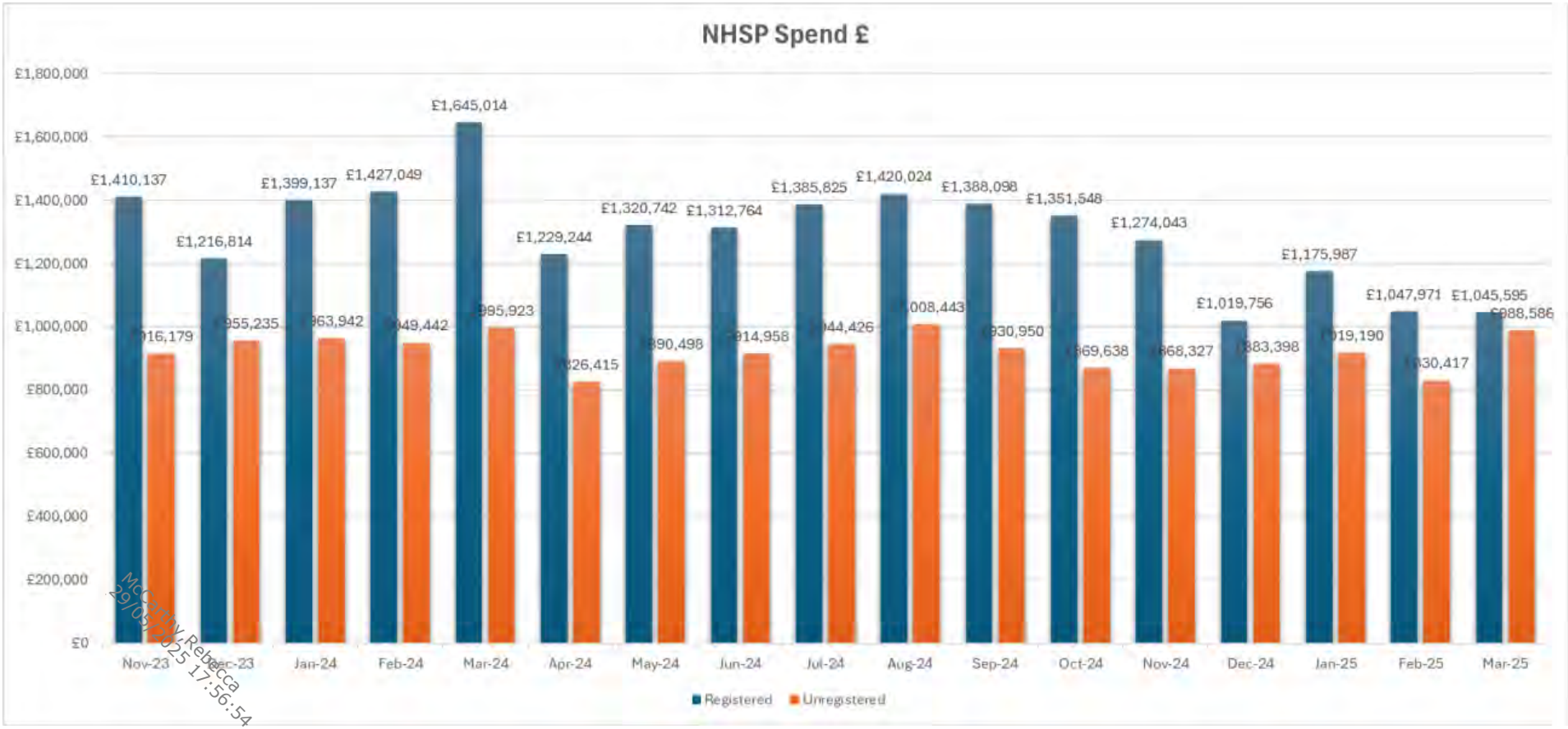
Our time-to-hire decreased by thirteen days from 79 to 66 in March and we met 4 out of the 11 targets. Recruitment activity has significantly increased since November/March due to the recruitment days, where the team have been tasked with processing an extra 182 (RN's/HCA's) new starters.
Work is ongoing to review internal processes within the Recruitment department and to work collaboratively with TGH to align our processes and improve efficiencies across both Trusts.

Division	Vacancy Request to Authorisation	Authorisation Granted to Advertising	Time to Shortlist	Time to Release Interview Invites	Notification Given to Applicants for Interview	Time to Update Interview Outcomes	Time to Send Conditional Offer	Conditional Offer to 1st Rerence Request	Time to Check References	Conditional Offer to Checks OK	Authorisation Granted to Checks OK
Clinical Support Services (3)	7	3.3	16	0	6	0	42.5	0	3.4	45	92.5
Corporate Services (3)	0	0	118	0	0	0	0	3	0	100.5	137
Medicine & Urgent Care (3)	10.5	1.8	14.9	0.1	8.3	8.6	6.9	9.9	6.8	54.4	242.6
Surgery (3)	13	16	17.3	0.3	6.7	12.5	25.4	4	1.2	43.2	100.6
Women & Children (3)	0	0	6	1	4	2	0	8	2.5	136	184.5
Total	9.9	5.4	20.4	0.2	7.3	8.6	15.8	8.3	4.6	63.5	191
KPI's	**10**	**2**	**5**	**2**	**5**	**2**	**2**	**1**	**2**	**30**	**56**

7. Temporary Staffing Spend

NHS Stockport NHS Foundation Trust

The table below illustrates the 'month on month' cost to the Trust of NHSP bank RNs, RMs and unregistered staff.



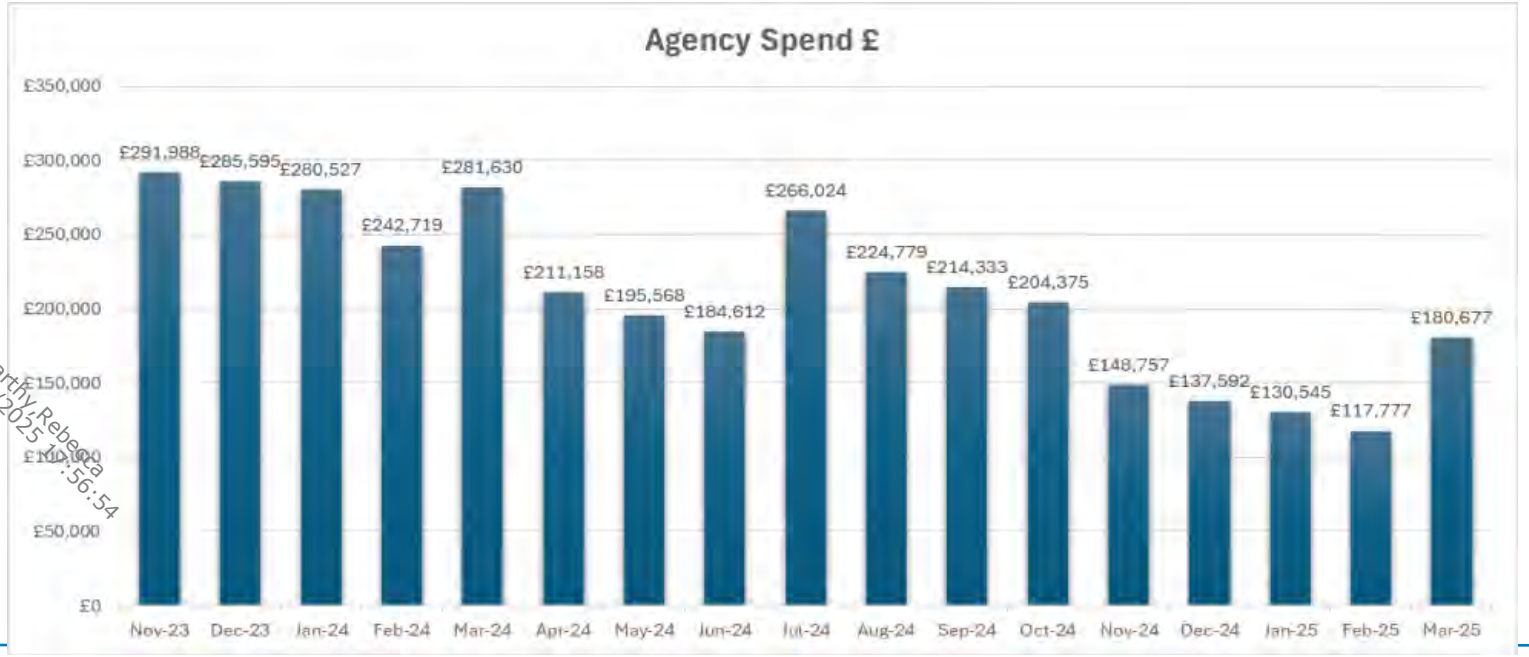
Data provided by People Analytics

8. Agency Spend

NHS Stockport NHS Foundation Trust

The Deputy Chief Nurse, DNDs and NHSP attend a weekly meeting to review agency uptake and explore strategies to reduce agency usage. Staff are encouraged to put out bank shifts as soon as possible to ensure early pick-up. The Trust has significantly reduced agency staff with a focus of reduction of NHSP usage over the next 12 months.

This has all contributed to a dramatic reduction in agency spend from July to February, but this went up in March due to staffing pressures in ED and ICU and increase sickness during the time period. This was also contributed to by the change in NHSP rate that has been agreed across GM and was communicated to NHSP staff in advance of the change. Staff in these areas have been supported the divisional and corporate teams and safety has been monitored closely to mitigate any untoward risk.



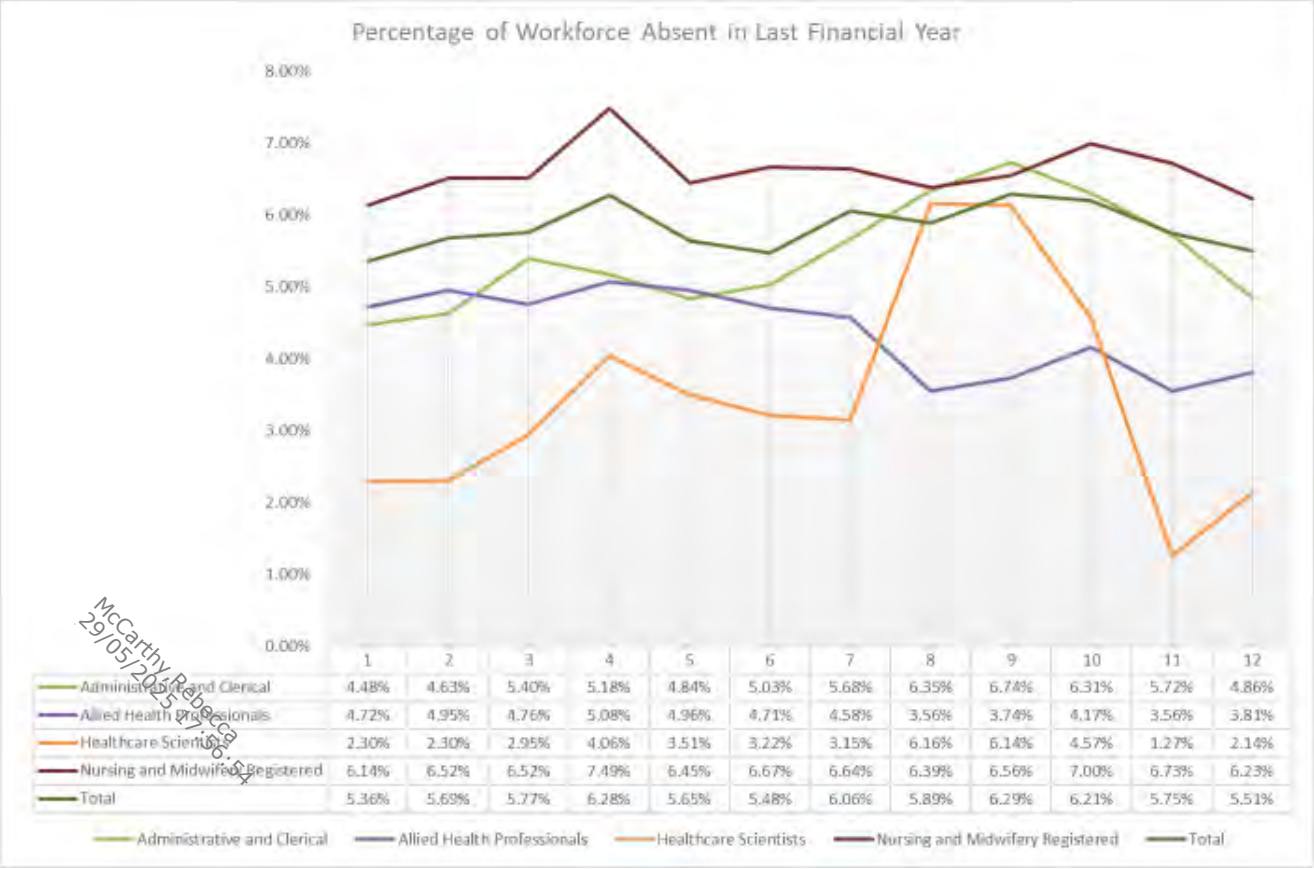
Data provided by NHS Professionals

9. Absences/Sickness

NHS Stockport NHS Foundation Trust

The chart below illustrates the sickness percentage for registered nurses, registered midwifes and AHPs workforce.

With the Trust absence target being set at 6% we are currently below this as a Trust but have further work to do with Nursing and Midwifery



	1	2	3	4	5	6	7	8	9	10	11	12
Administrative and Clerical	4.48%	4.63%	5.40%	5.18%	4.84%	5.03%	5.68%	6.35%	6.74%	6.31%	5.72%	4.86%
Allied Health Professionals	4.72%	4.95%	4.76%	5.08%	4.96%	4.71%	4.58%	3.56%	3.74%	4.17%	3.56%	3.81%
Healthcare Scientists	2.30%	2.30%	2.95%	4.06%	3.51%	3.22%	3.15%	6.16%	6.14%	4.57%	1.27%	2.14%
Nursing and Midwifery Registered	6.14%	6.52%	6.52%	7.49%	6.45%	6.67%	6.64%	6.39%	6.56%	7.00%	6.73%	6.23%
Total	5.36%	5.69%	5.77%	6.28%	5.65%	5.48%	6.06%	5.89%	6.29%	6.21%	5.75%	5.51%

- The main reasons for absence continues to be Anxiety, Stress & Depression
- The Trust has a close working relationship with HR, Occupational Health, Professional Nurse Advocates (PNA) SPAWS & Freedom to Speak Up Champions to support the work life balance of our employees
- The introduction of pastoral support for colleagues has also been seen as a benefit and will hopefully contribute to this rate reducing.

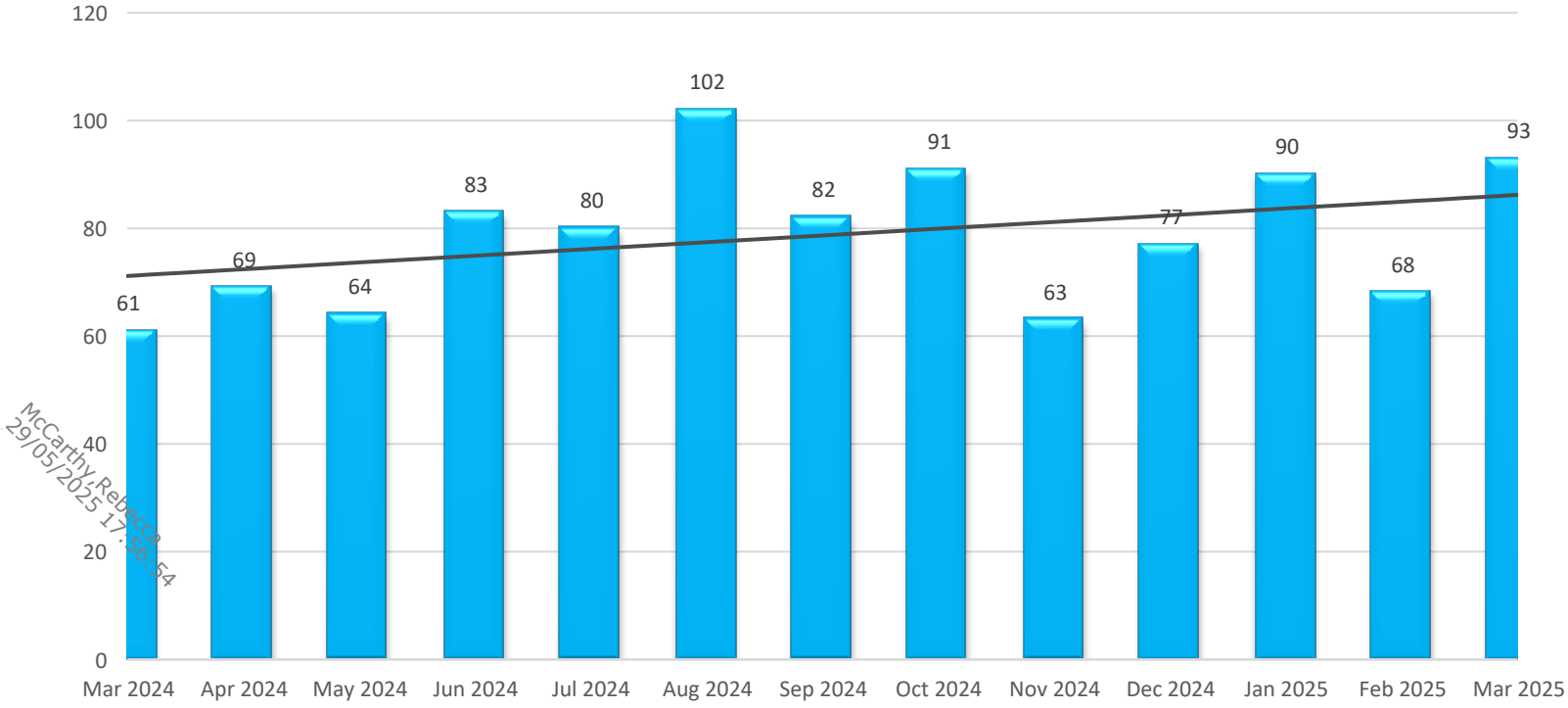
Data provided by People Analytics & Workforce

10. Risk Highlights

The Trust actively encourages all employees to report incidents of staffing shortfalls, which has increased in recent time as shown by the increase in trend line. This is also due to colleagues utilising Datix more to report the deficits.

In the last 6 months we have significantly recruited to vacancies which has caused a significant amount of workforce having to take entitled leave in March 2025. We expect to see this trend line start to decrease in the coming months.

Staffing levels / Insufficient staff numbers by month reported



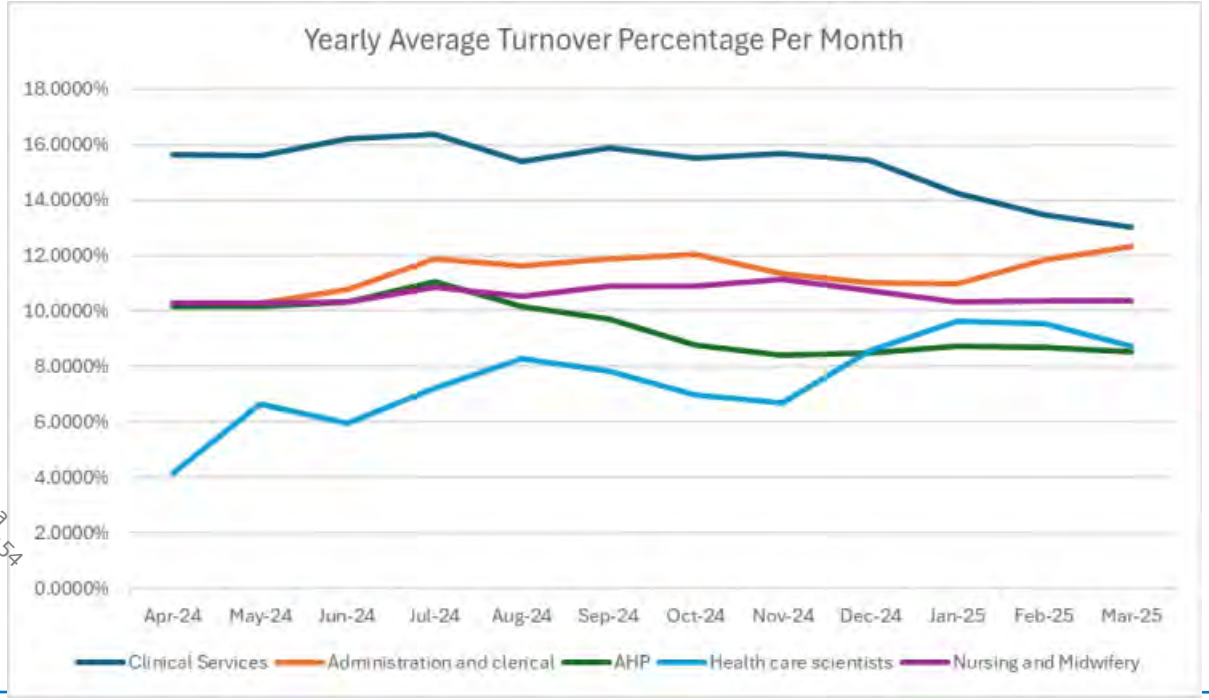
Data provided by Datix

11. Retention

NHS Stockport NHS Foundation Trust

The chart below illustrates the Trust's staff average year turnover rate 'month on month' per specialism from April 2024– March 2025.

There has been an improvement in the Trust from a Clinical Services and AHP, while there has been an increase in colleagues leaving from the Administration and Health Care Scientist sections. Nursing and Midwifery has been very consistent through the year. It is anticipated that the trends will improve for Nursing and Midwifery with the introduction of the new role of Pastoral Care Lead Nurse who will focus on supporting new starters from interview through the recruitment process, and their induction. The Workforce Matrons have also been holding clinics where discussions have been had with colleagues around their retention and issues being faced. The Trust values career development and invests in staff by providing training opportunities and supporting secondments to enhance career development.



Data provided by People Analytics

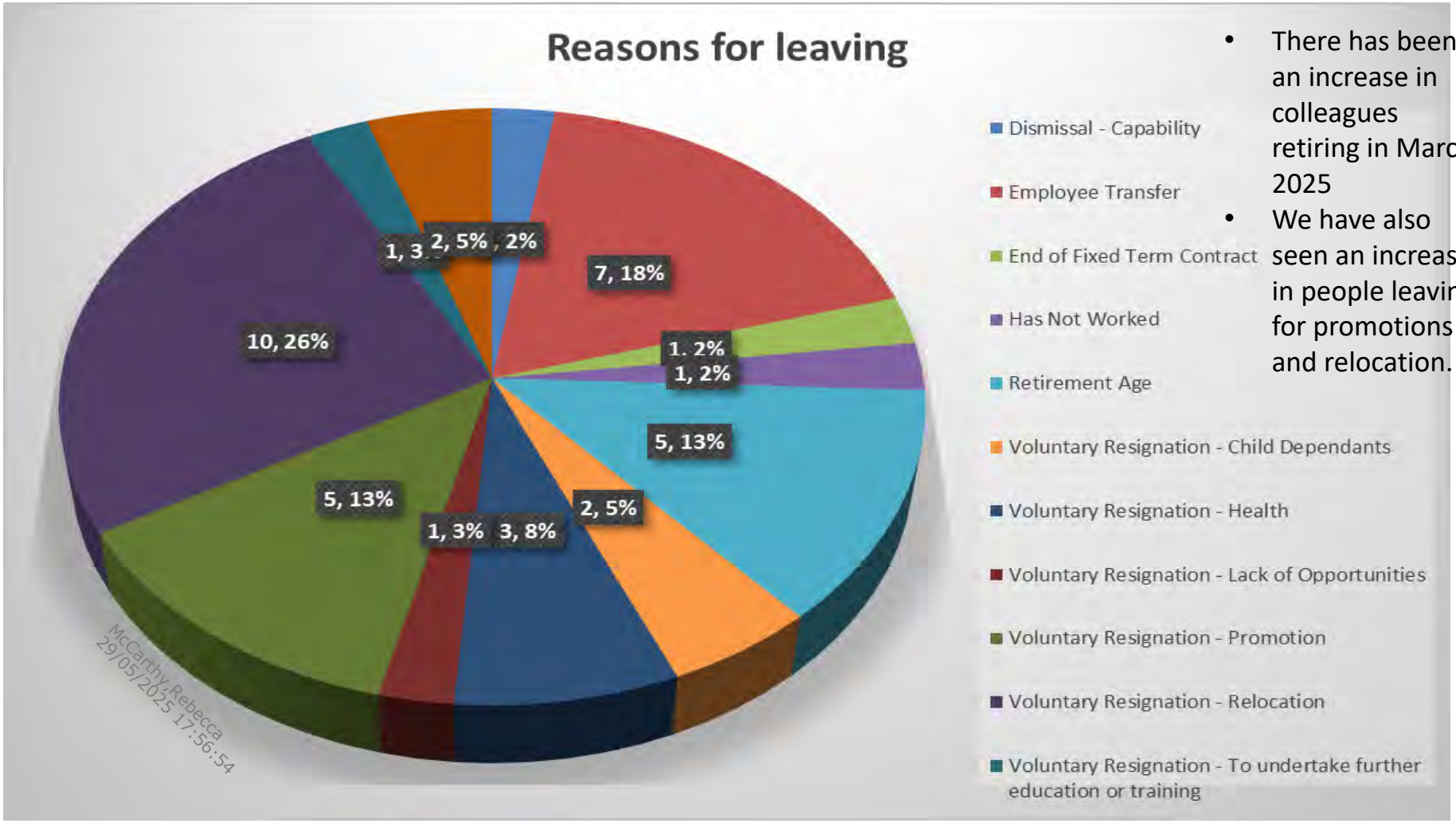
Workforce Matron feedback

Following clinics with colleagues to aid in recruitment the following common themes were fed back as affecting them;

- E-portfolio is hard to complete, too long and not user friendly – to be fed back to L+D in report
- Colleagues found appraisals to be none beneficial and found previous version more beneficial – to be fed back to T+OD for review
- Colleagues would like more green outside areas to sit on breaks – Workforce Matron linking in with Charity to see about opportunities
- Issues around food availability for within 30 minute breaks – work being done with catering to look at options, possible delivery service or preorder grab and go service
- Colleagues wanted to come to work for colleagues and patients
- Currently a retention questionnaire is live with colleagues to gather focuses for future.
- Colleagues are wanting band 5 to 6 and band 6 to 7 development courses to be created with competency framework – work being done with L+D to develop a programme.
- Session held in University of Salford with potential new colleagues to prepare them for transition to Registered Nurse that had great reviews and feedback from 300 people

12. Reasons for Leaving – March 2025

Stockport NHS Foundation Trust



- There has been an increase in colleagues retiring in March 2025
- We have also seen an increase in people leaving for promotions and relocation.

Data provided by People Analytics

13. Recruitment

Stockport NHS Foundation Trust

- HCA Recruitment Event took place in February 2025 with great support from all divisions, HR & the Training Department which resulted in recruiting to all available RN and HCA posts.

- Career and Job fair planned for 17th May 2025 which is having a big reception from ticket requests and local media.

- Career and Job fair to advertise all available posts, not limited to nursing.

14. Training Pathways

The Registered Allied Health Professional (AHP) apprenticeship programme has been a success, and 8 candidates remain on programme and are progressing well. These include Physiotherapy, Occupational Therapy, and Dietetics. Healthcare Support Worker Apprenticeship pathways for Band 2 and Band 3 Healthcare Assistants (HCAs) have also commenced, which also supports individuals in gaining their Functional Skills Level 2 - a prerequisite of advanced apprenticeships programmes.

We continue to support the Student Nursing Associate (SNA) and Registered Nurse Degree Apprenticeship (RNDA) programmes as part of our continued commitment to developing and growing our workforce. Currently on programme we have 20 RNDAs who are due to complete in either 2025 (10 learners) or 2025 (10 learners) .7 SNAs are due to complete in April 2025. 10 further SNA's were recruited in September 24 (7) and March 25 (3) for completion in 2026 and 2027 respectively.

Our Multi-Professional Cadet Program continues to expand and now includes local young people from Stockport and Cheadle College Group, Manchester College, Macclesfield College and UCEN Manchester. There are currently 110 cadets on program and numbers are expected to increase to 180 in September 25. Placement opportunities have been developed and now include Community, Maternity, Therapies, Pharmacy and Pathology in addition to Acute areas . 2 of the 7 cadets from the first cohort, who secured employment within the Trust last year remain in post. We now have cadets who commenced HEI programs in Nursing returning to the Trust for placements, with a view to gaining employment on qualification. A further 2 cadets have secured employment within social care following placements in these areas.

The Preceptorship Program, which supports newly qualified staff in their transition from learner to newly registered professional in their first year has been reviewed and aligned with National Preceptorship Standard Frameworks (including Nursing, Midwifery and AHP's) and Trust objectives/values. A new National Quality Mark application window is expected to open in September to support a multi-professional framework and we will be submitting our application.

15. Healthcare Scientists

NHS Stockport NHS Foundation Trust

Laboratory Medical

- **Microbiology** - Our first Microbiology consultant clinical scientist has started. There will be a period of acclimatisation and then they will be taking a full role in the consultant rota. Currently there is a need for support from the consultants of neighbouring trusts to cover the Microbiology on call service, in addition to this Macclesfield and Leyton have pulled out of the multi hospital cover arrangements, Tameside and ourselves will need to cover an additional 20 weekends per year between us.
- **Histopathology** consultant workforce is stable with 11 consultants all new starters now in post, the performance of the department has seen the benefit of this. The consultant body has a reporting capacity of 340 cases per week against an average workload of 400 cases per week, therefore continued outsourcing is still required.
- **Blood sciences** There has been no additional resource for the significant increase in workload seen since Covid, with last years growth 4.8%, an additional 405,000 tests.

Histology Laboratory

- **Biomedical Scientists (BMS)** We remain 2 BMS short of the required staffing to match the workload coming to the lab, Locums have been required to match this however they are not a stable resource with repeated recruitment needed. Internal training to band 6 for 3 staff continues and additional funding for 1 BMS and 1 MLA has been provided and recruit to turnover has been approved.
- **Medical Laboratory Assistants (MLA)** – Cancer tracker now in post, additional staffing of 1 band 4 for digital Pathology has been authorised and additional recruitment approved through recruit to turnover.

15. Healthcare Scientists

NHS Stockport NHS Foundation Trust

Microbiology Laboratory

- **Biomedical Scientists (BMS)** Additional posts have been approved as has recruit to turnover, this will assist in the staffing of the laboratory and free senior staff for quality management system work as well as delivering key projects.
- **Medical Laboratory Assistants (MLA)** – The approved additional recruitment will go some way to alleviate the pressure on this workforce. There are currently high levels of stress and anxiety in the workforce.

Blood Sciences Laboratory

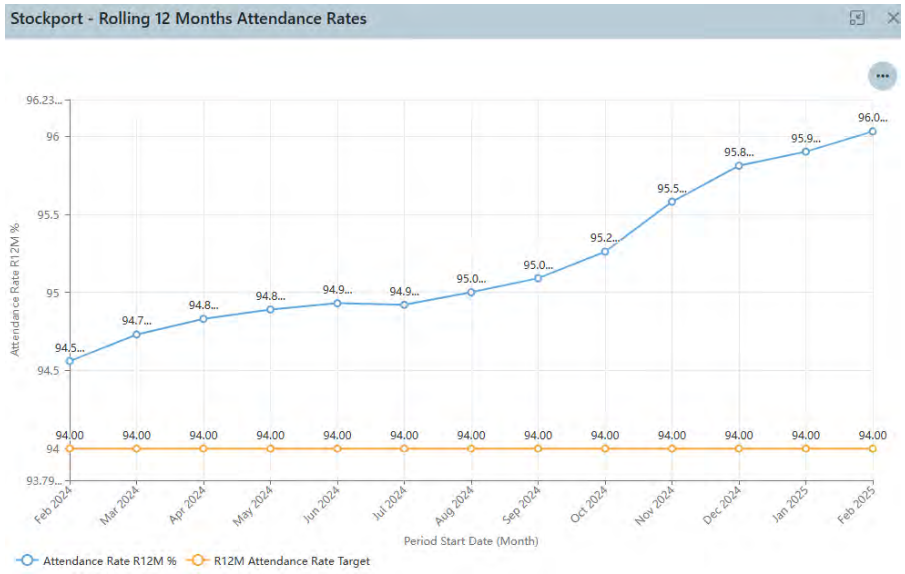
- **Biomedical Scientists (BMS)** Recruit to turnover has been approved, currently in Haematology there is a need for additional hours or overtime from staff to cover the 24/7 rota. There are a number of staff that would normally assist in this rota that are not due to OH advised restricted duties.
- **Medical Laboratory Assistants (MLA)** – The appointment of additional staffing is going through the trust financial systems for approval

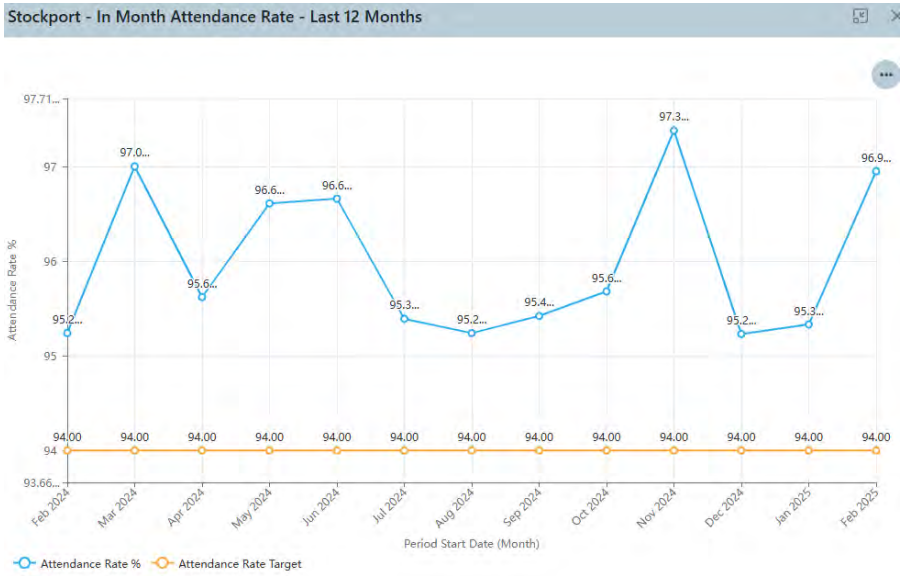
16. Allied Health Professionals (AHPs) – Integrated Therapies

NHS Stockport NHS Foundation Trust

Attendance Rates

The Directorate continues to remain above attendance target, although there have been transient pockets of higher sickness absence within specific teams which are closely monitored month on month. Cough/cold/fu remains the highest reason for non-attendance, but anxiety/stress has crept up again to the 2nd highest at the time of writing.





Further work to gain more accurate insight into opportunities for further progress are likely to fall out of the post-staff survey action planning, and we continue to consider staff health and wellbeing as one of the main priorities for our AHPs.

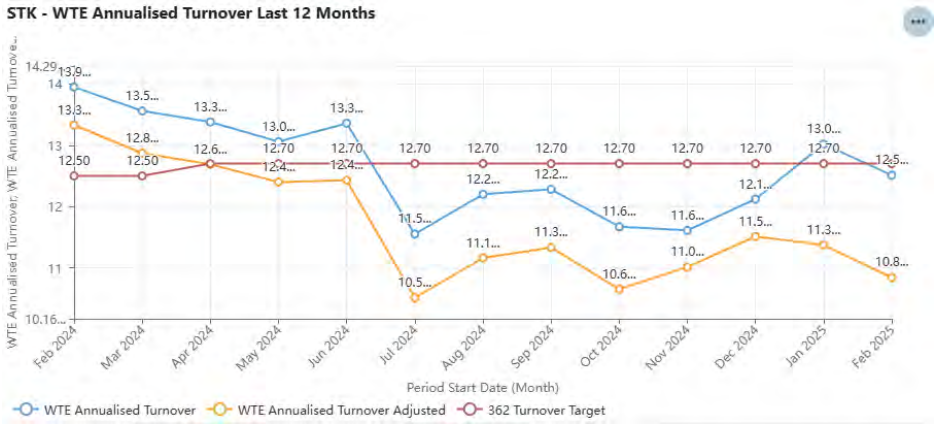
Data provided by Integrated Therapies & Boroughwide Services

16. Allied Health Professionals (AHPs) – Integrated Therapies

NHS Stockport NHS Foundation Trust

Turnover

We continue to observe adjusted turnover rates below the Trust target of 12.7%, remaining below since April 2024. We are currently working up a recruit to turnover case for one specific cost centre, 62M20 (Rotational Therapists), where we see a far higher than Directorate average turnover due to the transient nature of this predominantly new graduate workforce working towards promotion. Between Nov '23 and Nov '24 (latest data available due to People Analytics glitch), turnover of this particular workforce sat between circa 18% and 25%.



Health Roster

Work is progressing well to move AHPs forwards with regards to Heath Roster KPI compliance, utilisation and effectiveness, having identified several areas of process and system adherence which were not previously implemented / implemented well across our Directorate. We are now reporting on KPI compliance for our Directorate, which we were not included on previously, with robust action plans to improve any areas of achievement.

Data provided by Integrated Therapies & Boroughwide Services

16. Allied Health Professionals (AHPs) – Integrated Therapies

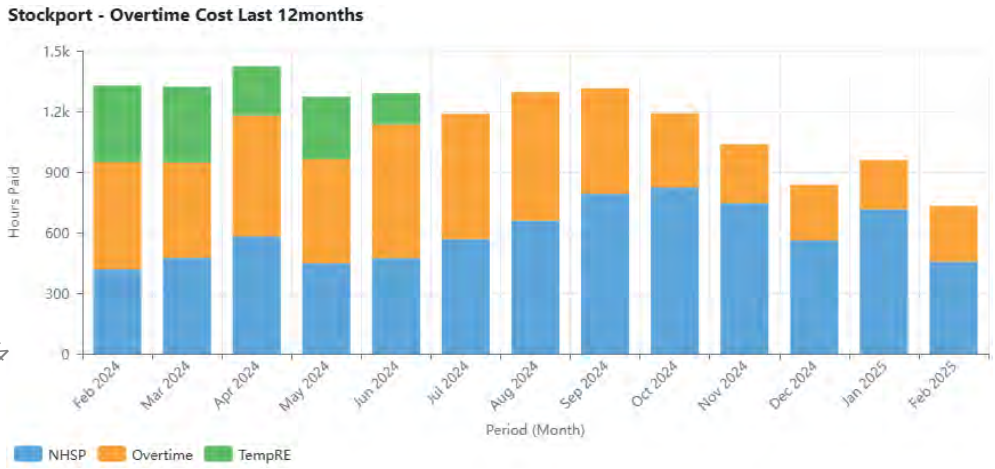
NHS Stockport NHS Foundation Trust

Apprenticeships

We have successfully appointed to all 5 of our Support Worker apprenticeships for 2024/25. Our Level 3 apprentice started in November 2024, and our Level 5 apprentices started their programmes in February 2025. All Level 6 apprentices remain on programme and are progressing well. The next step is to review and evaluate this workstream and propose a revised programme of AHP and AHP Support Worker apprenticeship offers for 2026/27 onwards.

Temporary Staffing

As discussed in previous papers, temporary staffing and overtime costs have been areas of focus for Integrated Therapies. The process for requesting and approving additional hours has been implemented and we are seeing the impact of the additional rigor and standardisation. As a result, we have seen overall hours paid at the lowest it has been in well above 12 months. Further workstreams are reviewing our weekend therapy position / opportunities.



Data provided by Integrated Therapies & Boroughwide Services

17. Midwifery Update

NHS Stockport NHS Foundation Trust

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

February 2025	WTE Actual	Number of WTE vacancies	Post WTE recruited to TRAC
Registered	167.6 2 Matrons 1 band 8a Safeguarding Lead Total 162.2	24/02/2025 Vacancy -4.84 WTE Maternity Leave 9.36 WTE Notices: 3 WTE (Retirementsx2, 1x leaver)	

Challenges

- Current registered vacancy inclusive of Inpatient and outpatient area's is none (over established by -4.84), however, there is currently a gap **of 9.36 WTE** on Maternity leave. Currently discussing with finance ability for recruiting to turnover and maternity leave.
- MSW – have now recruited and once onboarded will be at establishment.

Actions

- Weekly planned roster scrutiny meetings/E-Roster training sessions continue
- Recruiting to turnover and maternity leave- review of finance currently ongoing. Jobs to be added to trac
- Engaging in pre-employment programme for MSW and ward clerk vacancies.

Assurance

- All shift co-ordinators have supernumerary status & monitored daily by MOD, incorporated into monthly dashboard with 100% compliance March 2025
- February showed we achieved 95.7 % one to one care in labour (3 BBA, 1x fully dilated on admission)
- Fully engaged with MSW Framework Working Group
- We have continued to support trust pre-employment programme for MSW and ward clerks.

Data provided by the Division of Women & Children's

18. Medical Workforce

Stockport NHS Foundation Trust

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

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

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

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

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

18. Medical Workforce

Stockport NHS Foundation Trust

The table below gives a general overview of the directly employed Medical Workforce position within the Trust:

Medical Staff	FTE Budgeted	FTE Actual
Tier 3	267.01	238.11
Tier 2	150.21	115.8
Tier 1	139.18	154.2
Grand Total	**556.40**	**508.11**

N.B. See next slides for further information.

18. Medical Workforce

Stockport NHS Foundation Trust

Medical Workforce Group General Update

1. **Senior Medical Recruitment**. The group continues to monitors this at Medical Workforce Group so that it can seek to assist divisions with e.g. those difficult to fill specialties and ensure that all options are being explored.

   *There have been a number of positive appointments recently including Consultants in Ophthalmology and a number of GPs in the Urgent Treatment Centre, and with upcoming interviews scheduled in Gastro, Surgery, Anaesthetics/Critical Care, Acute, Rheumatology and DMOP.

2. **Senior Medical Locum Expenditure**. This is also being monitored by the group so that it can actively seek to assist divisions in reducing costs to the Trust, whilst also focusing on ensuring ensure safe staffing levels and patient safety. This exercise has already demonstrated significant financial savings and cost avoidance for the Trust.

3. **GMC Survey and Mandatory Training**. The group have placed great emphasis on improving the GMC Survey Results and the Mandatory Training compliance rates in 2024/25. This will help with attracting substantive doctors to the Trust.

4. **Portfolio Pathway and Workforce Planning**. The group continues to explore providing support for those Doctors wanting to undertake this route so that they can become eligible for Consultant posts to help with workforce planning, particularly in those difficult to fill areas.

Data provided by Medical Staffing

19. Good news

Stockport NHS Foundation Trust

- Continuing to work with NHSP to create a pathway enabling NHSP HCAs to apply directly to vacancies within the Trust, this ensures a quicker more efficient recruitment process
- All areas now recruited to turnover which will assist in maintaining safe staffing levels for all divisions.
- As a result of a highly successful recruitment event, we are now recruited to most establishments and have resulted in the recruit to turnovers being fulfilled.
- There had been a steady reduction in the use of agency from July to February
- There are currently minimal vacancies for registered staff.
- Colleagues been actively partaking in the Workforce Clinics which have had very good feedback.
- The retention rates continue to increase with staff leaving on a continual downward trajectory.
- Student visit at University of Salford by Workforce Matron was successful to 300 students with positive feedback

20. Going forward

Stockport NHS Foundation Trust

- To continue to focus on retention with employing of the Pastoral Care Lead Nurse
- To host a career and job event on 17th May 2025
- To continue to hold colleague clinics to assess trends in the workforce views and to work to improve retention.
- To continue reducing agency and NHSP use.

NHS Stockport NHS Foundation Trust

Meeting date	5th June 2025	**Public**	**X**	**Confidential**	19
Meeting	Board of Directors				
Report Title	Freedom to Speak Up Report				
Director Lead	Amanda Bromley, Director of People and OD	**Author**	Nadia Walsh – Freedom to Speak Up Guardian		

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

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

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

This paper relates to the following Board Assurance Framework risks

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

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

Where issues are addressed in the paper

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

Executive Summary

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

Overview of FTSU Role Activities: The Freedom to Speak Up (FTSU) Guardian supports a culture of openness by encouraging staff to raise concerns safely. The Guardian regularly meets with senior leaders, including the CEO, Chair, and Non-Executive Lead for FTSU, to keep leadership engaged with FTSU priorities. Fortnightly one-to-one meetings with their line manager provide further support. Each month, the Guardian also conducts site walkabouts and visits teams across departments to maintain direct engagement.

FTSU Case Data Overview: Since submitting the committee report, the data has been reviewed and validated, and the report details the data for the last 12 months

Culture: Freedom to Speak Up (FTSU) is one of several routes available for staff to raise concerns, but it does not represent the entirety of the speaking up culture. I am one of multiple avenues available, and ideally, FTSU should be seen as a supportive safety net or last resort. However, there is a growing perception that all speaking up activity is directed solely to me with referrals seen from those we are telling staff to contact in the first instance such as managers and Human resources, which places unintended pressure on the FTSU service.

While we communicate to staff that there are multiple channels available to raise concerns, in practice, only a few lead to meaningful outcomes. This presents an opportunity to re-evaluate our messaging and consider

streamlining our approach, ensuring staff are clear about how to raise concerns effectively and where their voices can make the most impact. Work on this will commence in 2025/2026 with key individuals.

To genuinely improve the speaking up culture I recommend conducting an audit of speaking up processes across departments to help identify common patterns, highlight inconsistencies. Data on the culture of speaking up within the trust will be collected as part of our Speaking up in Bloom event. Although not an audit, this will still provide insights into the culture of speaking up within the organisation.

Learning: To ensure the learning from FTSU cases is captured and shared effectively, I collaborate with HR and governance teams to triangulate data and identify any emerging patterns or systemic issues. Additionally, I engage in informal discussions with union representatives, fraud teams, EDI and leadership to share insights and trends that arise from FTSU concerns.

Staff Survey Results: The recent staff survey shows a decrease across all four questions related to speaking up, with question 25f — "If I spoke up about something that concerned me, I am confident my organisation would address my concern" — showing a 3.3% decline. While this may initially appear disappointing, it offers an opportunity to reflect and improve.

FTSU Champions: This quarter, no cases were raised directly to the FTSU champions. However, my own caseload has risen significantly, which may explain why fewer cases were directed to the champions. This suggests that staff have been more inclined to raise concerns with me directly.

Next Steps: We will revisit the Reflection and Planning Tool in 2025/2026 to ensure it remains aligned with organisational priorities and continues to support ongoing improvement. Section 8 provides the detail along with the action plan at appendix 1.

Looking ahead, we are preparing for the Speaking Up in Bloom event in May. This will include targeted engagement in identified hot spot areas from the staff survey.

I am also working with HR to develop a clear and robust process for managing cases involving detriment.

As part of ongoing improvements to accessibility and engagement, I am working with the Transformation Team to produce three animated Freedom to Speak Up videos.

Feedback: Out of 18 feedback forms distributed, only 3 were returned. While the response rate was low, all 3 individuals who responded expressed satisfaction with how the Guardian handled their concerns. 2 people were happy with how the wider organisation responded, while 2 were not—though no reasons were provided for the dissatisfaction, which limits opportunities for reflection and improvement.

Equality and Diversity Data: 25 EDI forms were sent to staff as part of the FTSU process with 2 completed form returned. Both forms were completed by White, Christian women who both identified as having a disability.

Capacity Overview: The issue of capacity within the Freedom to Speak Up (FTSU) process is regularly monitored, though it has not always been clearly defined. In line with the Reflection and Planning Tool, I have reviewed and set an optimal caseload capacity of no more than 60 concerns per quarter across both Trusts. This equates to approximately 4 to 5 cases per week, or around 20 cases per month, factoring in case complexity, engagement activities, and reporting responsibilities. Total of cases raised between both Trusts for Q4 70

1. Introduction

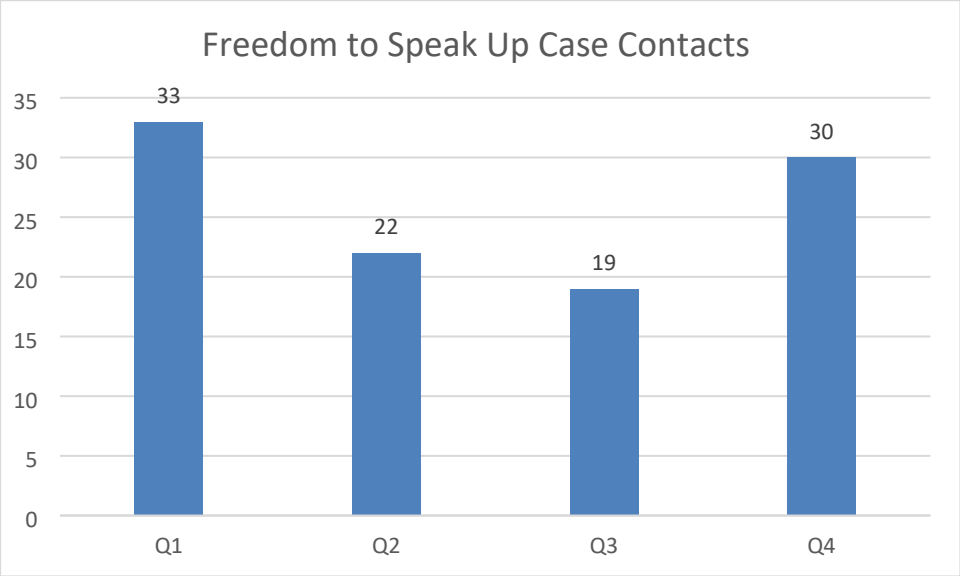
The purpose of this report is to provide the Board of Directors with an update on the Trust position in relation to the Freedom to Speak Up (FTSU) agenda and assurance on the approach and activities of the Freedom to Speak Up Guardian (FTSUG).

2. Overview of FTSU Role Activities

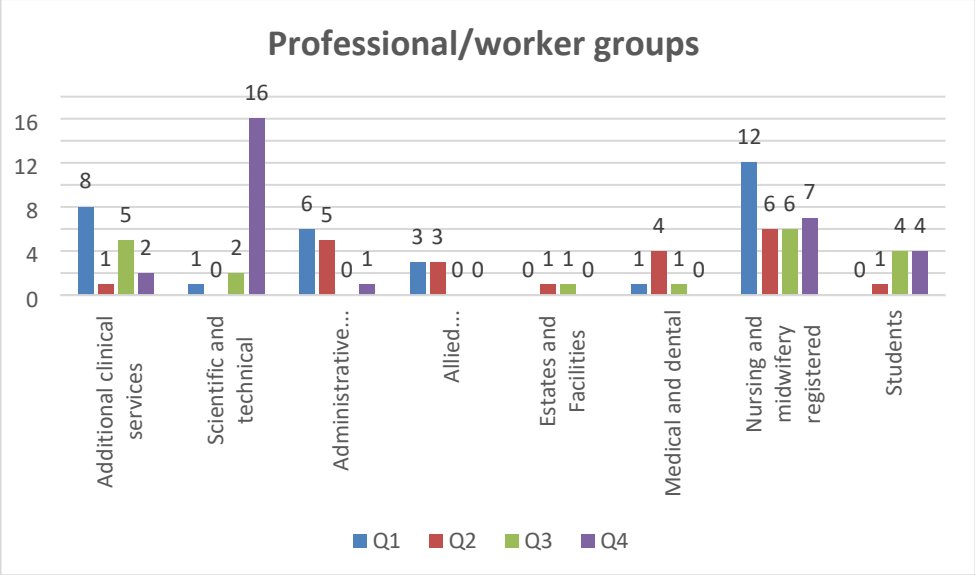
The Freedom to Speak Up (FTSU) Guardian supports a culture of openness by encouraging staff to raise concerns safely. The Guardian regularly meets with senior leaders, including the CEO, Chair, and Non-Executive Lead for FTSU, to keep leadership engaged with FTSU priorities. Fortnightly one-to-one meetings with their line manager provide further support. Each month, the Guardian also conducts site walkabouts and visits teams across departments to maintain direct engagement, fostering trust and approachability.

3. FTSU Case Data Overview

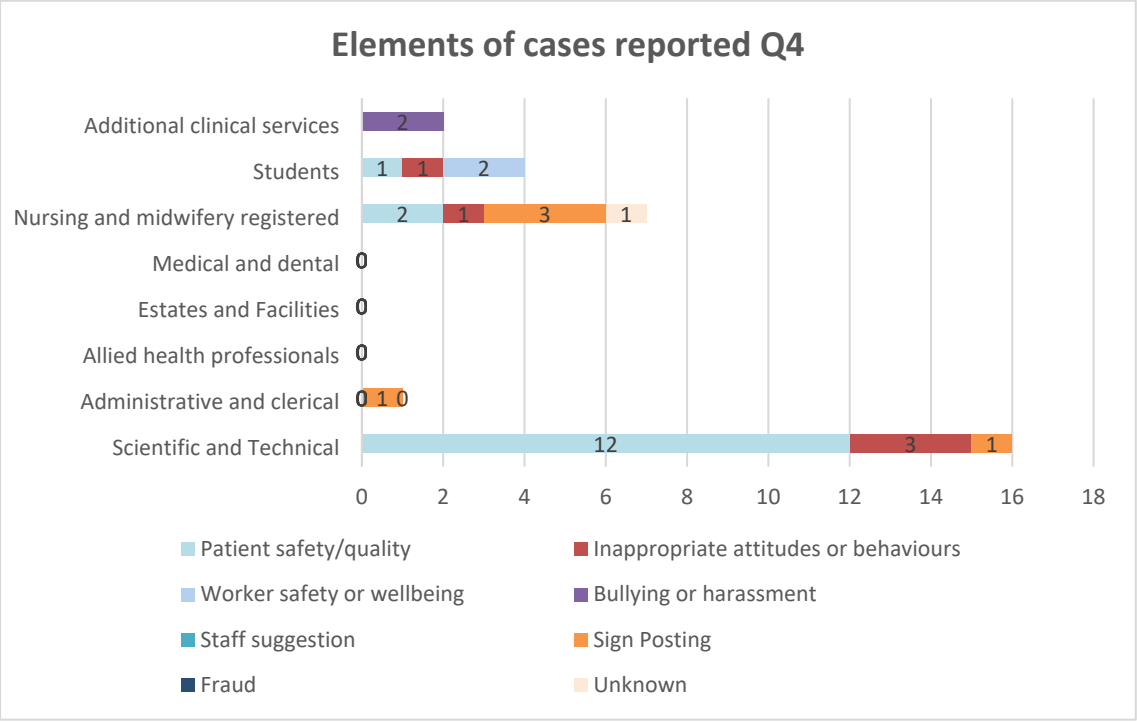
The table below details the number of cases received through the Freedom to Speak Up channel per quarter. During Q4, a total of 30 concerns were raised, an increase from 19 in Q3. contributing to a total of 104 cases for the year.



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



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



3.1 Open Cases

15 cases remain open and await investigation/outcomes. 11 are in relation to 1 department.

3.2 Key Trends:

In Q4, students raised 4 concerns: one regarding sexual inappropriate behaviour, one related to patient safety, and two concerning wellbeing. All concerns were responded to promptly.

Scientific and Technical Services saw a particularly sharp increase in concerns, rising from 2 in Q3 to 16 in Q4. Notably, most patient safety concerns—11 in total—originated from a single department, where staff reported feeling overwhelmed and unsupported. While these concerns are being actively addressed, the pace of response has at times, been slow, contributing to ongoing staff anxiety. Nevertheless, senior leaders are engaged, and efforts are underway to resolve the issues.

Nursing and Midwifery continued to report concerns, with 7 cases in Q4 compared to 6 in Q3. These reports centred around staff wellbeing and inappropriate behaviours, pointing to persistent cultural and interpersonal challenges. In contrast, concerns from Additional Clinical Services fell from 5 in Q3 to 2 in Q4.

Other staff groups reported little or no concerns in Q4. Administrative and Clerical staff submitted 1 concern, while Allied Health Professionals, Estates and Facilities, Medical and Dental did not raise any. Targeted outreach in these areas could help strengthen staff confidence and ensure that everyone feels able to raise concerns safely.

A key trend this quarter is the increasing number of staff being directed to the FTSU Guardian by managers and human resources. While this shows recognition of the FTSU Guardian's role, it raises a significant concern. These are the individuals and teams responsible for managing and resolving concerns at a local level, yet staff are being signposted to the FTSG instead. This suggests a gap in the confidence or capability of these leaders to address the issues themselves, despite having the authority to make meaningful changes. It raises the question: if the people responsible for leading and resolving concerns are deferring to the FTSU Guardian, how can we ensure that concerns are addressed effectively at the first point of contact?

3.3 Key Cases in Q4:

Individual cases of concern were discussed at Mays Committee meeting

4. FTSU and the Speaking Up Culture

Freedom to Speak Up (FTSU) is one of several routes available for staff to raise concerns, but it does not represent the entirety of the speaking up culture. I am one of multiple avenues available, and ideally, FTSU should be seen as a supportive safety net or last resort. However, there is a growing perception that all speaking up activity is directed solely to me with referrals seen from those we are telling staff to contact in the first instance such as managers and Human resources, which places unintended pressure on the FTSU service.

While we communicate to staff that there are multiple channels available to raise concerns, in practice, only a few lead to meaningful outcomes. This presents an opportunity to re-evaluate our messaging and consider streamlining our approach, ensuring staff are clear about how to raise concerns effectively and where their voices can make the most impact.

To genuinely improve the speaking up culture, we must first understand how concerns are currently raised and managed across the organisation. Conducting an audit of speaking up processes across departments could help identify common patterns, highlight inconsistencies, and reveal areas for improvement. It would also provide a clearer picture of what's working

and where additional support is needed. Data on the culture of speaking up within the trust will be collected as part of our Speaking up in Bloom event. Although not an audit, this will still provide insights into the culture of speaking up within the organisation.

5. Staff Survey Results

The recent staff survey shows a decrease across all four questions related to speaking up, with question 25f — "If I spoke up about something that concerned me, I am confident my organisation would address my concern" — showing a 3.3% decline. While this may initially appear disappointing, it offers an opportunity to reflect and improve.

Insights drawn from Freedom to Speak Up (FTSU) casework and staff conversations suggest that contributing factors may include fear of detriment, slow or absent communication and concerns being minimised by the individuals they were raised with.

In the interest of transparency, I have highlighted both areas of celebration and areas requiring attention. While there are positive examples where staff feel supported in speaking up, there remain key hot spots where individuals report feeling less safe or confident. These areas, which do not align with concerns raised through formal FTSU routes, will require targeted focus and sustained engagement moving forward.

Question	Staff response selected	Organisation		Change from 2023 to 2024
		2023	2024	
	Description	Score	Score	Score
20a I would feel secure raising concerns about unsafe clinical practice.	Satisfied/Very satisfied	73.6%	70.9%	-2.7%
20b I am confident that my organisation would address my concern.	Agree/Strongly agree	58.7%	56.9%	-1.8%
25e I feel safe to speak up about anything that concerns me in this organisation.	Agree/Strongly agree	63.8%	62.4%	-1.4%
25f If I spoke up about something that concerned me I am confident my organisation would address my concern.	Agree/Strongly agree	52.3%	49.0%	-3.3%

Key	
	Score > 3% increase
	Score in between
	Score > 3% decline

Celebration Areas		HotSpots
Active Recovery	School Nursing & Immunisations	Clinical Coders
Continuing Care, Community Learning Disabilities Team & Long-Term Vent Team	Specialist Midwives & Saving Babies Lives	Histopathology Staffing
Employee Relations	Ward A3	Microbiology Staffing
Medicine Management	Ward D1 Gastro	Radiology Admin & Clerical
Midwifery Community Team & High Peak Hospital	Ward D2	RTT Team
Obs & Gynae Medical Staff		Ward B6
Radiology Medical Staffing		Ward D7 – Urology & ENT

6. FTSU Champions

This quarter, no cases were raised directly to the FTSU champions. However, my own caseload has risen significantly, which may explain why fewer cases were directed to the

champions. This suggests that staff have been more inclined to raise concerns with me directly.

While the number of cases raised to champions remains low, they continue to provide an important support role. To further strengthen this, I propose merging the FTSU champions from both Tameside and Glossop Integrated Care and Stockport NHS Foundation Trust, increasing the group to 26 champions. This would enhance support, offer another independent avenue for concerns, and bring greater diversity to the team, aligning with the growing collaboration between the trusts.

This proposal has been shared with our current champions, and it has been welcomed by those who have responded so far, showing a positive reception to this idea.

7. Learning

Learning from concerns raised through the FTSU route are effectively shared within the organisation. I provide direct feedback to staff who raise concerns, ensuring they are informed about the actions taken as a result. However, the confidential nature of many FTSU cases can limit the level of detail that can be shared, which may impact staff's understanding of the outcomes and their confidence in the speaking-up process.

To ensure the learning from FTSU cases is captured and shared effectively, I collaborate with HR and governance teams to triangulate data and identify any emerging patterns or systemic issues. This ensures that key learning is shared across relevant departments and informs improvements in processes. Additionally, I engage in informal discussions with union representatives, fraud teams, EDI and leadership to share insights and trends that arise from FTSU concerns.

In the previous report, I outlined several key learning points that emerged from the concerns raised through the FTSU process. It would be helpful to revisit these learning points as part of the reflection and planning process to assess whether they can be implemented or further developed. Reviewing these points will ensure that we continue to build on the insights gained and explore how they can contribute to enhancing the speaking-up culture and addressing ongoing issues.

8. Next Steps

Moving forward, we will continue to focus on refining our approach to FTSU. Please see updates from the action at appendix 1 for specific details on the Reflection and Planning Tool.

We will revisit the Reflection and Planning Tool in 2025/2026 to ensure it remains aligned with organisational priorities and continues to support ongoing improvement.

Looking ahead, we are preparing for the Speaking Up in Bloom event in May. This will include targeted engagement in identified hot spot areas from the staff survey, with a focus on encouraging staff to raise concerns without fear of retribution.

As part of ongoing improvements to accessibility and engagement, I am working with the Transformation Team to produce three animated Freedom to Speak Up videos:

- One will explain the FTSU Guardian role, clarifying expectations and responsibilities.

- Another will support the promotion and recruitment of FTSU Champions, encouraging wider participation.
- The third will highlight the Trust's FTSU strategy and policy, making key messages easier to understand and access.

These animations are being designed with inclusivity in mind, offering alternative ways to connect with staff who may not engage with traditional formats. This work is part of a broader commitment to ensuring the FTSU message is clear, visible, and reaches all areas of the workforce in ways that are meaningful to them.

9. Feedback

Out of 18 feedback forms distributed, only 3 were returned. While the response rate was low, all 3 individuals who responded expressed satisfaction with how the Guardian handled their concerns. 2 people were happy with how the wider organisation responded, while 2 were not—though no reasons were provided for the dissatisfaction, which limits opportunities for reflection and improvement. Gathering feedback once a case is closed remains a challenge, as individuals often disengage. This is not seen as a trust issue; the Northwest Guardian network has shared similar concerns about low response rates and difficulties in gathering meaningful feedback after cases are closed.

"Nadia was an immense support to me in navigating my concern and also her genuineness in her empathy and the kindness that she offered me. She demonstrated the knowledge to understand not only my concern but the psychological effects of what I have been experiencing. Following our conversations, I was also confident of her ability to effectively discuss my concern with a relevant colleague."

10. Equality and Diversity Data

Over the past quarter, 25 EDI forms were sent to staff as part of the FTSU process with 2 completed form returned. Both forms were completed by White, Christian women who both identified as having a disability. I recognise the critical importance of capturing this data to ensure inclusive and representative insights.

To address the low response rate and improve the data collection process, I am actively looking at ways to make the process more seamless and integrated. My plan is to begin collecting EDI data during the initial engagement with staff, where possible, rather than relying on post-case follow-up. By incorporating the EDI questions earlier in the workflow, I aim to increase response rates and capture more accurate data, which will ultimately help in identifying trends and improving outcomes related to equality, diversity, and inclusion within the FTSU process.

It is worth noting that incidents relating to race or discrimination are shared with the EDI Team.

11. Capacity Overview

The issue of capacity within the Freedom to Speak Up (FTSU) process is regularly monitored, though it has not always been clearly defined. In line with the Reflection and Planning Tool, I have reviewed and set an optimal caseload capacity of no more than 60 concerns per quarter across both Trusts. This equates to approximately 4 to 5 cases per week, or around 20 cases per month, factoring in case complexity, engagement activities, and reporting responsibilities. With over 10,500 staff across the two organisations, I am currently the sole Guardian

responsible for holding and managing all concerns, while supported by departmental Champions who help raise awareness but do not handle casework.

Operating at this new defined capacity ensures high-quality support, timely case resolution, and meaningful engagement. However, exceeding this limit introduces risks, including burnout, delays in response, and reduced time for proactive work in low-uptake areas. If demand increases, we may need to prioritise high-risk concerns, review the scope of the role, or consider additional support. Total of cases raised between both trust Q4 70.

It is worth noting that a bench marking exercise completed 2023 by the NW Guardian Network recommended the ratio of one FTE Guardian per 1000 staff suggesting our scale would benefit from two full-time FTSU Guardians.

12. Resources

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

Currently in the absence of the Guardian, staff raise concerns with the Director of People and OD or one of our 18 Freedom to speak up Champions, the Trust also highlights the various mechanisms within which staff can raise concerns which includes their line manager, their line manager's line manager and any Executive Director.

13. Recommendations

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

Appendix 1

Development areas to address in the next 6–12 months	Comments
Development of a Communications Plan	The 2023/2024 communications plan has been fully delivered. The 2025/2026 plan is in development and currently complete up to June 2025, incorporating key themes, awareness campaigns, and engagement activities. Delivery is ongoing in partnership with the communications team.
Develop relationships with the Assistant Director of HR and Governance team to further develop triangulation of data and a support network	This action is complete. Six-weekly triangulation meetings are now established between the Assistant Director of HR and the Governance team. I also attend the HR Business Partner (HRBP) meetings every six weeks, supporting joined-up working and data alignment.
Attend PELG to meet managers and talk about themes, responses, response times and learning/good practice etc	PENDING: A presentation covering key themes, response times, learning, and good practice has been created and will be delivered at the next PELG meeting 26th June 2025.
Review website and ensure updated information is on there	Complete. The FTSU webpage has been reviewed and is now routinely updated by myself and the Communications team to ensure all information is accurate, accessible, and reflective of current work.
Review Strategy Document	Complete. The updated FTSU Strategy is now in place and aligned to national guidance and organisational priorities. It includes a focus on culture change, accessibility, learning from themes, and strengthened visibility across both Trusts.
Review time allocated to FSU role and how it is utilised across both Trusts and any benchmark data of recommended practice	Complete. A review of the current 30-hour allocation across both Trusts indicates that while the role is being delivered safely, there is limited capacity for proactive culture work. Benchmarking shows varied models across the system, and locally, it remains important to prioritise and utilise time effectively to maintain a safe and responsive service.
Explore the development of anonymous reporting mechanisms, building into comms plan and potential development	This will be delivered at Trust level as part of the wider sexual safety anonymous reporting system. The FTSU Guardian will form a supporting role in the process but will not lead its development or implementation.
Explore mechanisms to capture barriers and potential barriers to reporting, linking in with fellow FTSUGs as required.	Complete. Mechanisms such as case analysis, feedback from engagement sessions, and informal staff reflections are now being used to identify barriers to speaking up. Regular contact with regional Guardians has supported the identification of themes such as fear of detriment, lack of feedback, and uncertainty about what constitutes a concern. These insights are feeding into ongoing improvement work

NHS Stockport NHS Foundation Trust

				Agenda No.	
Meeting date	5 June 2025	**Public**	X	**Confidential**	
Meeting	Board of Directors				
Report Title	Audit Committee – Alert, Advise & Assure Report				
Director Lead	David Hopewell, Chair of Audit Committee	**Author**	Lisa Byers, Assistant Director of Finance		

Paper For:	**Information**		**Assurance**	X	**Decision**	
Recommendation:	The Board of Directors is asked to note the report from the Audit Committee including matters for escalation to the Board of Directors.					

This paper relates to the following Annual Corporate Objectives

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

This paper relates to the following CQC domains

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

This paper relates to the following Board Assurance Framework risks

	PR1.1	There is a risk that the Trust does not deliver high quality care to service users
	PR1.2	There is a risk that patient flow across the locality is not effective
	PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan
	PR2.1	There is a risk that the Trust is unable to sufficiently engage and support our people's wellbeing
	PR2.2	There is a risk that the Trust does not actively participate in local collaborative programmes/neighbourhood working to improve primary and secondary health outcomes
	PR3.1	There is a risk that place-based partnership working does not effectively support delivery of Stockport ONE Health & Care (Locality) Board priorities and address health inequalities in Stockport

	PR3.2	There is a risk that partnership working in Greater Manchester do not effectively address unwarranted variation of services and improve health inequalities
	PR3.3	There is a risk that opportunities for collaboration between Stockport NHS Foundation Trust and Tameside & Glossop Integrated Care NHS Foundation Trust are not optimised
	PR4.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit and retain the optimal number of staff, with appropriate skills and values
	PR4.2	There is a risk that the Trust's workforce is not reflective of the communities served
	PR5.1	There is a risk that the Trust does not implement high quality service improvement programmes
	PR5.2	There is a risk that the Trust does not implement high quality research & development programmes
X	PR6.1	There is a risk that the Trust does not deliver the annual financial plan
X	PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial sustainability plan
	PR7.1	There is a risk that the Trust does not implement the Digital Strategy to ensure a resilient and responsive digital infrastructure
	PR7.2	There is a risk that the estate is not fit for purpose and/or meets national standards
	PR7.3	There is a risk that the Trust does not materially improve environmental sustainability
	PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus

Where issues are addressed in the paper

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

Executive Summary

The Board of Directors has established the following Committees:

- People Performance
- Finance & Performance
- Quality
- Audit Committee

The Committees have no executive powers, other than those specifically delegated within their Terms of Reference, but they can make recommendations to the Board of Directors for approval. The Committees are to report to the Board of Directors by means of a Key Issues Report summarising business conducted by the Committee together with key actions and/or risks.

A summary is provided for the Board of Directors of the key matters and decisions from the Audit Committee held in May 2025, noting areas of alert, advice and assurance.

NHS
Stockport
NHS Foundation Trust

ALERT, ADVISE & ASSURE (AAA) REPORT	
Name of Committee/Group	Audit Committee
Chair of Committee/Group	David Hopewell
Date of Meeting	20th May 2025
Quorate	Yes

The Audit Committee draw the following key issues and matters to the Board of Director's attention:

1.	**Agenda**	The Committee considered an agenda which included the following: • Risk Management Committee Key Issues Report • Feedback from Board Committees • Internal Audit Progress Report • Internal Audit Plan 2025/26 • Internal Audit Charter • Anti-Fraud Annual Report 2024/25 • Internal Audit Annual Report and Head of Internal Audit Opinion • Declaration of Interests Annual Review • Accounting Policies update • Review of Waivers • Standing Financial Instructions Breaches • Annual Self Certification: Continuity of Services • Review of NHS Code of Governance • Review of Draft Annual Report 2024/25 • Review of Draft Annual Governance Statement 2024/25 • Annual Accounts 2024/25 • Key Accounting Issues Report • Review of Going Concern Basis of Preparation 2024/25 • External Audit Strategy Memorandum 2024/25
2.	**Alert**	No matters from this meeting to alert to the Board of Directors.
3.	**Advise**	The Committee received a Risk Management Committee Key Issues Report, following meetings held in February and March 2025, providing an overview of ongoing oversight of risk management and detailing the significant risks. The Committee discussed how emergent risks are tracked; having noted new risks with a 15 + score where none previously were recorded. The Committee reviewed the Internal Audit Plan 2025/26 and approved the final version. There will be an update with days added in the next Audit Committee report. The Committee received and noted the Anti-Fraud Annual Report 2024/25. The Committee received and noted the Internal Audit Charter. The Committee approved the updated Accounting Policies, subject to any subsequent updates during the audit of the Annual Accounts. The Committee received and noted the Review of Waivers and Standing

		Financial Instructions Breaches reports. The Committee received draft versions of the following for 2024/25: • Draft Annual Governance Statement; • Draft Annual Report; • Draft Annual Accounts; • Going Concern Basis of Preparation of Accounts The Committee reviewed and noted the above reports and were asked to feedback any amendments or comments by the 23rd May 2025. The Committee received and noted the External Audit Strategy Memorandum for the 2024/25 Annual Accounts and Annual Report. The strategy is consistent in scope with previous years with four significant risks highlighted as revenue recognition, management override of controls, risk of fraud in revenue and expenditure and the valuation of property, plant and equipment.
4.	**Assure**	The Committee were assured that the Internal Audit Plan for 2024/25 was almost complete with five reports finalised (see below) and the Quality Spot Checks report at final stages with the Draft Report issued. Performance indicators all rated green. The Committee received the final reports for: • ESR/Payroll – Substantial Assurance • EPPR Declaration – Substantial Assurance • Risk Management Core Control – High Assurance • Key Financial Systems – Position Statement • Board Assurance Framework Review The Committee asked for assurance on the substantial ratings for ESR and EPPR when considering the follow up recommendations and were assured that these were judged securely as substantial in the overall process. The latter two reports were opinions and position statements and did not require an assurance rating. The Key Financial Systems statement provided assurance that recommendations from the last internal audit report were carried out. The following review are in progress and will conclude by the end of June: • Quality Spot Checks • PSIRF Incident Management • Data Protection and Security Toolkit (DPST) The Committee were assured that a detailed report on DPST will be presented to July Committee and will address the IT recommendations on the Follow Up tracker. The Committee received positive progress regarding follow up actions on previous internal audits. The Committee received the Internal Audit Annual Report and Draft Head of Internal Audit opinion. It reported that this will give substantial assurance that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently. There were

		no concerns that this opinion will change once the final reports for Quality Spot Checks, PSIRF and DPST are issued. The Committee received a report of the Annual Review of Conflicts of Interest and received positive assurance of continued compliance with the completion of declarations of interest remaining at 98% in 2024/25. The Committee received a Key Accounting Issues report and considered and noted the significant points relating to the 2024/25 Accounts. Further assurance was provided in the meeting on the accounting treatment specifically related to the purchase of The Meadows land and building.
5.	**Referral of Matters/Action to Board/Committee**	In considering the Risk Management report the Committee also discussed if further review was required of the Trust's risk appetite. It was confirmed that this would be considered at the June 2025 Board meeting. The Committee received a report to consider the self-declaration on the availability of resources with respect to Continuity of Services. It considered the report and supported a recommendation to the Board of Directors that the Trust will have the required resources available noting specific risks surrounding this declaration. The Committee received a report on the Annual Review of the NHS Code of Governance. It was assured that the Trust complied with the Code's provisions with two exceptions: well led review and levels of remuneration for non-executive directors and explanations detailed for these. The Audit Committee recommend to the Board of Directors to approve.
6.	**Report compiled by:**	David Hopewell, Chair of Audit Committee (Non-Executive Director)
7.	**Minutes available from:**	Soile Curtis, Deputy Company Secretary

NHS Stockport NHS Foundation Trust

				Agenda No.	21
Meeting date	5 June 2025	**Public**	X	**Confidential**	
Meeting	Board of Directors				
Report Title	Annual Review of Provider Trust Code of Governance				
Director Lead	Karen James, Chief Executive	**Author**	Rebecca McCarthy, Trust Secretary		

Paper For:	**Information**		**Assurance**	X	**Decision**	X
Recommendation:	**The Board of Directors is asked to review and support the outcome of the annual review of the Code of Governance for NHS Provider Trusts as recommended by Audit Committee.**					

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

	Safe		Effective
	Caring		Responsive
X	Well-Led		Use of Resources

This paper relates to the following Board Assurance Framework risks

	PR1.1	There is a risk that the Trust does not deliver high quality care to service users
	PR1.2	There is a risk that patient flow across the locality is not effective
	PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan
	PR2.1	There is a risk that the Trust is unable to sufficiently engage and support our people's wellbeing
	PR2.2	There is a risk that the Trust does not actively participate in local collaborative programmes/neighbourhood working to improve primary and secondary health outcomes
	PR3.1	There is a risk that place-based partnership working does not effectively support delivery of Stockport ONE Health & Care (Locality) Board priorities and address health inequalities in Stockport

	PR3.2	There is a risk that partnership working in Greater Manchester do not effectively address unwarranted variation of services and improve health inequalities
	PR3.3	There is a risk that opportunities for collaboration between Stockport NHS Foundation Trust and Tameside & Glossop Integrated Care NHS Foundation Trust are not optimised
	PR4.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit and retain the optimal number of staff, with appropriate skills and values
	PR4.2	There is a risk that the Trust's workforce is not reflective of the communities served
	PR5.1	There is a risk that the Trust does not implement high quality service improvement programmes
	PR5.2	There is a risk that the Trust does not implement high quality research & development programmes
	PR6.1	There is a risk that the Trust does not deliver the annual financial plan
	PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial sustainability plan
	PR7.1	There is a risk that the Trust does not implement the Digital Strategy to ensure a resilient and responsive digital infrastructure
	PR7.2	There is a risk that the estate is not fit for purpose and/or meets national standards
	PR7.3	There is a risk that the Trust does not materially improve environmental sustainability
	PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus

Where issues are addressed in the paper

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

Executive Summary

The Code of Governance for NHS Provider Trusts (the Code) sets out principles to help trusts deliver effective corporate governance. It includes provisions with which trusts should comply, or explain how the principles have been met in other ways. There are several statutory requirements, where compliance is mandatory. The provisions are drawn together in a disclosures section, which must be reported against in Trust's Annual Report.

In May 2025, the Audit Committee considered a management review and compliance checklist with each of the Code provisions (provided at Appendix 1 for information) and confirmed that the Trust complies with the Code's provisions, except for the below.

- **Explain: Provision C.4.7** – All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the well-led framework every three to five years, according to their circumstances.

Explanation: The Trust has not had a formal externally facilitated developmental review in recent years. However, the Trust has had two CQC Well Led Inspections in 2018/19 and 2019/20 (Requires Improvement), and subsequently an NHS England (NHSE) governance review was conducted. In

2021/22, having implemented several recommendations from the NHSE governance review, a self-assessment was completed and an independently facilitated Well Led Mapping Review by AQuA was commissioned. The Well Led Mapping Review provided an overview of the Trust's evidence against the Key Lines of Enquiry (KLOEs) and developmental actions for the purpose of continuous improvement. Additionally, internal audit has also been utilised to provide independent assurance on several elements of the Well Led Framework.

During 2024/25, the NHSE Well Led Framework Key Lines of Enquiry (KLOEs) were mapped to the new CQC Well Led Quality Statements, and a self-assessment was completed, including a position statement, supporting evidence, rating and developmental actions. Furthermore, recognising that the Trust has not had an externally facilitated well led developmental review in recent years, the Board of Directors determined that an options appraisal would be presented to the Board of Directors in 2025/26, exploring options to support the Trust on its well-led journey.

- **Explain: Provision E.2.2** – Levels of remuneration for the chair and other non-executive directors should reflect the Chair and non-executive director remuneration structure.

Explanation: In February 2022, the Council of Governors agreed that all new Non-Executive Director positions would be remunerated in line with 'NHS England Chair and non-executive director remuneration structure'. This decision has subsequently been implemented. Furthermore, the Council of Governors agreed that existing non-executive directors, who are reappointed for a further term of office, would remain at the level of remuneration to which they were originally appointed, subject to a robust performance appraisal and confirmation that performance continues to be effective, thereby differing to the 'NHS England Chair and non-executive director remuneration structure'. The Chair's remuneration is in line with the NHS England remuneration structure.

The Board of Directors is asked to review and support the outcome of the annual review of the Code of Governance for NHS Provider Trusts as recommended by Audit Committee.

Section A: Board leadership and purpose

Provision	Code Provision	Current Position	Comply or Explain
A.2.1	Board of Directors (BoD) should assess the basis on which the trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB, and place-based partnerships. BoD should ensure the trust actively addresses opportunities to work with other providers to tackle shared challenges through entering into partnership arrangements such as provider collaboratives. Trust should describe in its annual report how opportunities and risks to future sustainability have been considered and addressed, and how its governance is contributing to the delivery of its strategy.	• Annual Operational Plan (including activity, workforce, and finance), developed in line with national planning guidance and agreed, as part of the GM ICS Plan. • Trust's Corporate Objectives & Outcomes Measures are developed based on the agreed operational plan, incorporating national, system and locality based measures. This includes the corporate objective to 'Develop effective partnerships to address health and wellbeing inequalities' and is reflected in the five year strategy as one of the key strategic objectives to 'Work with others for our patients and communities.' • Implementation of corporate objectives monitored by Board and established Board subcommittees throughout the year, alongside holistic mid-year review. Regular review by Board and Board Committees of: Integrated Performance Report, Finance, Operational Performance, People and Quality & Safety Dashboards and suite of reporting, including relevant benchmarking with GM. • Executive Directors are part of key governance arrangements within GM ICS and Stockport including Trust Provider Collaborative and Director Groups, Locality Board and Place-Based Provider Partnership. Executive Directors and senior leaders meet regularly with local health and social care economy leaders to discuss and respond to challenges within the system. • Executive Directors are engaged in the GM System Improvement meetings, developing workstreams in response to the enforcement undertakings. Trust engaged in work to develop GM financial sustainability plan. • 'ONE Stockport' Health & Care Plan developed bringing together all parts of the borough. The One Stockport Health & Care Board (Locality Board) and Stockport Provider Partnership (led by SFT) established. • Stockport Provider Partnership has identified a series of population health focused workstreams (Diabetes, Frailty, Alcohol related Admissions, Cardiovascular Disease) to support improved population health outcomes. • Board level review of Place/Locality Developments reporting initiated in 2024/25. • Improving Economy, Efficiency & Effectiveness reviewed via External Audit. For 2023/24, the audit recognised the need for the Trust to work with the system to reach a sustainable balanced position, however, did not identify a significant weakness in the Trust's arrangements in relation to improving economy, efficiency and effectiveness. • Annual Report to include information in line with Annual Reporting Manual.	Comply
A.2.2	BoD should develop and articulate a clear vision and values for the trust, with reference to the ICP's integrated care strategy and the trust's role within system and place-based partnerships, and provider collaboratives.	• The Trust acknowledges that the Trust Strategy 2020-2025 was developed prior to legal establishment of ICS and publication of GM ICP Strategy and Joint Forward Plan to set the direction of the system. • However, the current Trust Strategy clearly articulates vision and	Comply

Provision	Code Provision	Current Position	Comply or Explain
	Agreed statement of the organisation's purpose and intended outcomes, and the behaviours used to achieve them.	values/behaviours of the Trust and recognises the role the Trust plays a key partner within GM & Stockport. • Annual corporate objectives and key outcomes measures include vision to work with partners to improve health and well-being outcomes for communities served and development of effective partnerships to address health and well-being inequalities. • Refreshed set of Trust Values launched, following engagement exercise undertaken in 2024/25, in partnership with T&G. Part of Appraisal Process.	
A.2.3	BoD should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the trust's vision, values and strategy, it should seek assurance that management has taken corrective action. Annual Report should explain the board's activities and any action taken, and the trust's approach to investing in, rewarding and promoting the wellbeing of its workforce.	• Board approved Organisational Development (OD) Plan to further build awareness of organisational values, identify situations not aligned to those values and implement series of interventions aimed at changing behaviour, hearts and minds. OD Plan implementation, monitored via People Performance Committee and Board. • Freedom to Speak Up Guardian and Guardian of Safe Working Hours in place, with regular report to the People Performance Committee and Board, including themes and action taken. • Staff engagement activities in place as part of the OD Plan, include Big Conversations, Schwartz Rounds, Walkabout Wednesday, Civility Saves Lives Programme. • Approved Health & Wellbeing Plan in place, aligned to the NHS Health and Wellbeing Framework; implementation and outcome reported to People Performance Committee. • Trust Disciplinary Policy and Just Culture guide in place to ensure that any disciplinary matter is dealt with fairly. Board review Staff Exclusions Report, which provides insight into colleagues entering the disciplinary process. • Suite of quality-based reports that includes lessons learned and improvements to practice further to thematic review of incidents, inquests, claims and complaints reported via the Trust's incident reporting system. Reviewed by Quality Committee. • NHS Staff Survey Results utilised to review progress within SFT. Outcomes reported to People Performance Committee and action plans developed and monitored via Divisions to support improvement. • Staff Report section of Annual Report prepared in line with Annual Reporting Manual.	Comply
A.2.4	BoD should ensure that adequate systems and processes are maintained to measure and monitor the trust's effectiveness, efficiency and economy, the quality of its	See A.2.1 and A.2.2 • Reporting schedules of the Board and Board Committees allow quality, operational performance, financial performance objectives, set as part of system	Comply

Provision	Code Provision	Current Position	Comply or Explain
	healthcare delivery, the success of its contribution to the delivery of the five-year joint plan for health services and annual capital plan agreed by the ICB and its partners (This may also include working to deliver the financial duties and objectives the trust is collectively responsible for with ICB partners, and improving quality and outcomes and reducing unwarranted variation and inequalities across the system), and that risk is managed effectively. BoD should regularly review the trust's performance in these areas against regulatory and contractual obligations, and approved plans and objectives, including those agreed through place-based partnerships and provider collaboratives.	& locality planning, to be reported, reviewed and challenged. • Key operational systems and processes in place to support the above and the Trust in its duty to exercise functions effectively, efficiently and economically, and have regard to likely effects of the decision in relation to the quality of services provided to individuals and on quality of care delivery. Including (but not limited to: Staffing Approval Group, cost improvement planning, QIA & EIA, business case approval process. • Executive Directors and senior leaders fully engaged in processes with partners in Stockport locality to manage current and future performance and take steps to implement new ideas to improve services, as reported in the Place Report to Board of Directors. • Executive Directors and senior leaders fully engaged in processes at GM to addressing the challenges faced across finance, performance and quality and population health. In developing the GM Sustainability Plan, the financial and performance position of all providers considered.	
A.2.5	BoD should ensure relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and performance, ensuring performance reports are disaggregated by ethnicity and deprivation where relevant. Where appropriate and particularly in high risk or complex areas, the BoD should commission independent advice, e.g. from the internal audit function, to provide an adequate and reliable level of assurance.	• An Integrated Performance Report (IPR) is reviewed by the Board on a bimonthly basis to ensure any relevant action required is taken to improve performance. The IPR is supplemented by a suite of assurance reports, alongside progress with respect to key strategic developments, partnership & collaboration. • Trust has developed performance reporting more broadly in recent years, with Board subcommittee performance reports / dashboards and data packs supporting the Trust's governance and assurance processes and the approach of 'measurement for improvement'. • Divisional Performance Review process established. • Self-assessment undertaken against NHS Providers Reducing Health Inequalities tool to assess the Trusts current response to addressing health inequalities and inform next steps and an action plan to support and evidence this work. • Independent advice commissioned by Board, as appropriate.	Comply
A.2.6	BoD should report on its approach to clinical governance and its plan for the improvement of clinical quality. BoD should record where in the structure of the organisation clinical governance matters are considered.	• Board approved Quality Strategy in place. Development of Joint Quality Strategy with T&G being progressed. • Oversight of clinical governance and quality established through Board's Quality Committee, and onward to Board as required. • Quality Accounts produced annually.	Comply
A.2.7	Chair and BoD should regularly engage with stakeholders, including patients, staff, the community and system	• Number of stakeholder engagement processes and practices in place for Board to engage with patients, public and staff engagement, including Site Visits, Staff	Comply

Provision	Code Provision	Current Position	Comply or Explain
	partners, in a culturally competent way to understand their views on governance and performance. Committee chairs should engage with stakeholders on significant matters related to their areas of responsibility. Chair should ensure that the BoD as a whole has a clear understanding of the views of all stakeholders including system partners. NHS foundation trusts must hold a members' meeting at least annually.	Networks, governor and membership meetings/seminars. • Board members engage with system partners via number of GM and Locality forums/meetings. • Chair and Chief Executive Report provide high-level overview of engagement at Board (& CoG for Chair) • Annual Members Meeting held each year.	
A.2.8	BoD should describe in the annual report how the interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision-making, and set out the key partnerships for collaboration with other providers into which the trust has entered. BoD should keep engagement mechanisms under review so that they remain effective.	• Performance Report, Directors Statements and Annual Governance Statement included in Annual Report incorporating all required statements. • Annual Report, subject to external audit, to be prepared in line with Annual Reporting Manual.	Comply
A.2.9	Workforce should have a means to raise concerns in confidence and – if they wish – anonymously. BoD should routinely review this and the reports arising from its operation. It should ensure that arrangements are in place for the proportionate and independent investigation of such matters and for follow-up action.	• Freedom to Speak Up (FTSU) Guardian in post to act in an independent and impartial capacity to support staff who raise concerns. Reporting to People Performance Committee & Board. Self-assessment undertaken in line with national planning tool. • FTSU Policy revised in line with new national policy, and national training packages for all staff adopted. • Guardian for Safe Working Hours in place, reporting regularly to People Performance Committee and annual report to Board. • Annual review via Audit Committee of 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 and proportionate investigation • Regular counter-fraud update reports received by Audit Committee	Comply
A.2.10	BoD should take action to identify and manage conflicts of interest and ensure register available to the public in line with Managing conflicts of interest in the NHS: Guidance for	• Conflicts of Interest Policy in place in line with NHS England guidance. • Annual review of Board Register of Interest via Board and annual review of trust-wide Register of Interests undertaken by Audit Committee.	Comply

Provision	Code Provision	Current Position	Comply or Explain
	staff and organisations.	• Board minutes fully record any interests raised during Board/Board Committee meeting, and action taken. • Public register available via SFT website.	
A.2.11	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. • No concerns received from Directors that have stood down in 2024/25.	Comply

Section B: Division of Responsibilities

Provision	Code Provision	Current Position	Comply or Explain
B.2.1	Chair responsible for leading agenda setting for board and council of governors, and ensuring time for discussion, on strategic issues.	• Chair leads agenda setting for BoD and CoG in line with work plan, which considers balance of operational, regulatory, and strategic matters.	Comply
B.2.2	Chair responsible for ensuring that directors and, for foundation trusts, governors receive accurate, timely and clear information that enables them to perform their duties effectively. A foundation trust chair should take steps to ensure that governors have the necessary skills and knowledge to undertake their role.	• Relevant information made available to BoD and CoG regarding finance, quality of care, operational performance and people performance, alongside key strategic developments. • Suite of reports, including background information provided to BoD and CoG. • Standardised front sheet, with executive summary and recommendation section to ensure clarity and appropriate review of paper. • Training and development programme established for governors, including both internal and external opportunities. Information included in Annual Report.	Comply
B.2.3	Chair should promote a culture of honesty, openness, trust and debate by facilitating the effective contribution of non-executive directors in particular and ensuring a constructive relationship between executive and non-executive directors.	• Evidence of openness and debate and contribution of both executive and non-executive directors via Board and Board Committee minutes.	Comply
B.2.4	A foundation trust chair is responsible for ensuring that the board and council work together effectively.	• Mechanism in place to resolve disagreements between the Board and CoG as stated within Constitution. • Executive and Non-Executive Director attendance at CoG meetings, and informal meetings between governors and Non-Executive Directors and Chair. • Senior Independent Director (SID) supports CoG and Board relationships as required. Annual Report describes how Board and CoG operate.	Comply
B.2.5	Chair should be independent on appointment. The roles of chair and chief executive must not be exercised by the same individual. A chief executive should not become chair of the same trust. BoD should identify a deputy or vice chair who could be the senior independent director. Chair should not sit on the audit committee. The chair of the audit committee, ideally, should not be the deputy or vice chair or senior independent director.	• Chair recruitment process ensured Joint Chair independent on appointment. • Board states its reasons if it determines that a director is independent despite relevant circumstance/criteria • Role of Chair and Chief Executive are not exercised by same individual. • Deputy Chair in place. • Audit Committee established by Board. Membership includes only independent NEDs and does not include the Chair. Trust Chair attends Audit Committee by invitation only. Deputy Chair / SID do not Chair Audit Committee.	Comply

Provision	Code Provision	Current Position	Comply or Explain
B.2.6	BoD should identify in the annual report each non-executive director it considers to be independent based on circumstances that are likely to impair, or could appear to impair, a non-executive director's independence include.	• Board undertakes annual review of independence and states 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.	Comply
B.2.7	At least half the BoD, excluding the chair, should be non-executive directors whom the board considers to be independent.	• There are currently 12 voting members of the Board, this includes 6 Executive Directors and 6 NEDs, plus the Joint Chair. • All current NEDs considered to be independent (as above)	Comply
B.2.8	No individual should hold the positions of director and governor of any NHS foundation trust at the same time.	• 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.2.9	The value of ensuring committee membership refresh and no undue reliance placed on individuals should be taken into account in deciding chairship and membership of committees. Council of governors should take into account the value of appointing a non-executive director with a clinical background and appointing diverse range of non-executive directors.	• Annual review of all Board committees, including membership and chairship. Also considered on appointment of new non-executive directors. • 2 NEDs with clinical experience. Selection and recruitment process for NEDs designed to encourage applicants with range of skill sets, backgrounds and lived experience.	Comply
B.2.10	Only the committee chair and committee members are entitled to be present at nominations, audit or remuneration committee meetings, but others may attend by invitation of the particular committee.	• Terms of reference for Audit, Nominations, and Remuneration Committees set out membership and those who may attend by invitation.	Comply
B.2.11	BoD to appoint Senior Independent Director (SID), in consultation with the Council of Governors. Led by the SID, the foundation trust non-executive directors should meet without the chair present at least annually to appraise the chair's performance.	• Current SID - Dr Louise Sell. CoG consulted on proposed appointment in February 2022, appointment confirmed by Board in April 2022 • SID presents process for appraisal of the Chair to CoG annually and leads appraisal process seeking feedback from Non-Executive Directors (and other stakeholders), reporting to Nominations Committee and CoG.	Comply
B.2.12	Non-executive directors have a prime role in appointing and removing executive directors. They should scrutinise and hold to account the performance of management and individual executive directors against agreed performance objectives. Chair should hold meetings with the non-executive directors	• Remuneration Committee established for this purpose, as set out in Terms of Reference. Annual performance evaluation of each Executive Director presented to Remuneration Committee. • Throughout 2024/25 Interim Chair held regular meetings with Non-Executive Directors, without Executive Directors present.	Comply

Provision	Code Provision	Current Position	Comply or Explain
	without the executive directors present.		
B.2.13	Responsibilities of the chair, chief executive, senior independent director, board and committees should be clear, set out in writing and publicly available. Annual Report should give the number of times the board and its committees met, and individual director attendance.	• Job Description and Role Specifications set out the role of Chair, Chief Executive and Senior Independent Director. Role of Board, Board Committees set out in Constitution, Scheme of Reservation & Delegation (SoRD) and terms of reference. Publicly available via Trust Secretary. • Annual Report, subject to external audit, prepared in line with Annual Reporting Manual.	Comply
B.2.14	When appointing a director, the BoD should take into account other demands on their time. Prior to appointment, the individual should disclose their significant commitments with an indication of the time involved. They should not take on material additional external appointments without prior approval of the BoD, with the reasons for permitting significant appointments explained in the annual report. Full-time executive directors should not take on more than one non-executive directorship of another trust or organisation of comparable size and complexity, and not the chairship of such an organisation.	• Job description for directors covers time commitment and availability in times of emergency. Considered as part of appointment process to ensure no significant commitments that would interfere with the demands of the role. • Joint leadership appointments considered by Remuneration Committee and reported to the Board. • No Executive Director holds NED or chair role in another trust.	Comply
B.2.15	All directors should have access to the advice of the company secretary. Appointment and removal of the company secretary should be a matter for the board.	• All directors have access to advice of Company Secretary. • Constitution sets out the appointment/removal of Company Secretary is a matter for BoD.	Comply
B.2.16	All directors have a responsibility to constructively challenge during board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy. Non-executive directors should scrutinise the performance of the executive management in meeting agreed goals and objectives, request further information if necessary. They should satisfy themselves as to the integrity of financial,	• Effective challenge and request for further information, and input to strategic developments demonstrated at Board and Board Committees – evidenced within relevant minutes and action log. • Board Assurance Framework established and reviewed via Internal Audit as compliant 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	Comply

Provision	Code Provision	Current Position	Comply or Explain
	clinical and other information, and make sure that financial and clinical quality controls, and systems of risk management and governance, are robust and implemented.	established by management that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee and Board.	
B.2.17	BoD should meet sufficiently regularly to discharge its duties effectively. A schedule of matters should be reserved specifically for its decisions. For foundation trusts, this schedule should include a clear statement detailing the roles and responsibilities of the council of governors. Statement should describe how any disagreements between the council of governors and the BoD will be resolved. The annual report should include this schedule of matters or a summary statement of how the BoD and the council of governors operate, including a summary of the types of decisions to be taken by the board, the council of governors, board committees and the types of decisions that are delegated to the executive management of the BoD.	• Board meets sufficiently regularly to fulfil responsibilities, in public bimonthly, within additional private meetings as required and board development. Attendance register held by Company Secretary. • Approved Constitution, Standing Orders (SO)s and SoRD in place setting out decisions reserved for the Council of Governors (CoG) includes role and responsibilities of CoG and decisions reserved for the BoD 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. • Annual Report, subject to external audit, to be prepared in line with Annual Reporting Manual.	Comply

Section C: Composition, Succession and Evaluation

Section	Code Provision	Current Position	Comply or Explain
C.2.1	Nominations committee/s responsible for the identification and nomination of executive and non-executive directors and consider succession planning. Best practice is that a selection panel includes at least one external assessor from NHS England and/or a representative from relevant ICB and engage with NHS England to agree approach.	• Nominations Committee established by CoG in place for NED appointments. For Joint Chair appointment, a Joint Nominations Committee established by Council of Governors of both T&G and SFT. • Remuneration Committee established by BoD in place for Executive Director appointments • Membership of selection panels, including external assessor, considered as part of each recruitment and selection process and agreed by respective nominations committee. NHS England and ICB engaged in appointment process of Joint Chair in 2024/25.	Comply
C.2.2	There may be one or two nominations committees. If there are two, one will be responsible for considering nominations for executive directors and the other for non-executive directors (including the chair). Nominations committee(s) should regularly review the structure, size and composition of the BoD and recommend changes where appropriate. In the light of this evaluation, describe the role and capabilities required for appointment of both executive and non-executive directors, including the chair.	• As above (C.2.1) • Remuneration Committee reviews the structure, size and composition of the Board and, where appropriate, make recommendation/s to the Board or CoG as appropriate. • Job Description & Person Specifications prepared including specific expertise, background, skills and qualities (as agreed) for each vacancy, and the balance of skills/experience on the board.	Comply
C.2.3	Chair or an independent non-executive director should chair the nominations committee(s).	• Chair identified as chair for both nominations committees. • For Joint Chair position, the Senior Independent Director was nominated as the Co-Chair (with Senior Independent Director, T&G) of the Joint Nominations Committee.	Comply
C.2.4	Governors should agree with the nominations committee a clear process for the nomination of a new chair and non-executive directors. Once suitable candidates have been identified, the nominations committee should make recommendations to the Council of Governors.	• Nominations Committee agree process for recruitment of NEDs and Chair, including final recommendation to the CoG. See above re Joint Chair.	Comply
C.2.5	Open advertising and advice from NHS England's Non-Executive Talent and Appointments team is available for use by nominations committees to support the council of governors in the appointment of the chair and non-executive directors. If an external consultancy is engaged, it should be identified in the Annual Report alongside a statement about any other connection it has with the Trust or individual directors.	• External consultancy engaged for Joint Chair appointment. Information to be included in Annual Report as per Annual Reporting Manual.	Comply
C.2.6	Where an NHS foundation trust has two nominations committees, the nominations committee responsible for the	• Trust has separate Nominations Committee for appointment of NEDs. Only governors and the Chair are members of the Nominations Committee, as set out	Comply

Section	Code Provision	Current Position	Comply or Explain
	appointment of non-executive directors should have governors and/or independent members in the majority. If only one nominations committee exists, when nominations for non-executives, including the appointment of a chair or a deputy chair, are being discussed, governors and/or independent members should be in the majority on the committee and also on the interview panel.	in Terms of Reference.	
C.2.7	When considering the appointment of non-executive directors, the Council of Governors should take into account the views of the BoD and the nominations committee on the qualifications, skills and experience required for each position.	• Nominations Committee receives recommendation via Remuneration Committee and Board regarding future NED appointments.	Comply
C.2.8	Annual Report should describe the process followed by the Council of Governors to appoint the chair and non-executive directors. Main role and responsibilities of the nominations committee should be set out in publicly available written terms of reference.	• Information to be included in Annual Report as per Annual Reporting Manual includes section about the Nominations Committee and details appointment processes. • Nominations Committee Terms of Reference publicly available via Trust Secretary.	Comply
C.2.9	Elected governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The names of governors submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to make an informed decision on their election. This should include prior performance information.	• Elected governors' term of office set at no more than three years. Biography details and relevant information published during election.	Comply
C.2.10	The chair, the other non-executive directors and – except in the case of the appointment of a chief executive – the chief executive are responsible for deciding the appointment of executive directors. The nominations committee with responsibility for executive director nominations should identify suitable candidates to fill executive director vacancies as they arise and make recommendations to the chair, the other non-executives directors and, except in the case of the appointment of a chief executive, the chief executive.	• Chair, NEDs and CEO approval of all Executive Director appointments (CEO does not approve a CEO appointment). Responsibilities set out in Remuneration Committee Terms of Reference.	Comply

Section	Code Provision	Current Position	Comply or Explain
C.2.11	Non-executive directors appoint and remove the chief executive. The appointment of a chief executive requires the approval of the council of governors.	• Process followed for current CEO appointment.	Comply
C.2.12	Governors are responsible at a general meeting for the appointment, re-appointment and removal of the chair and other non-executive directors.	• CoG Nominations Committee (Joint Nominations Committee for Joint Chair appointment) oversees the processes leading to CoG fulfilling its responsibility to appoint, reappoint or remove chair and other Non-Executive Directors. Formal appointment takes place at CoG meeting.	Comply
C.2.13	Non-executive directors, including the chair, should be appointed by the council of governors for the specified terms subject to re-appointment thereafter at intervals of no more than three years and subject to the 2006 Act provisions relating to removal of a director.	• Term of office for NEDs and Chair considered and agreed by Nominations Committee, in full consideration of NHS England guidance of terms of no more than three years and any term beyond six years requiring rigorous review. • Chair confirms to governors, via Nominations Committee, that performance of any NED proposed for re-appointment continues to be effective or otherwise.	Comply
C.2.14	Terms and conditions of appointment of non-executive directors should be made available to the council of governors. The letter of appointment should set out the expected time commitment. Non-executive directors should undertake that they will have sufficient time to do what is expected of them. Their other significant commitments should be disclosed to the Council of Governors before appointment, with a broad indication of the time involved, and the Council of Governors should be informed of subsequent changes.	• NED (including Chair) terms and conditions outlined in recruitment pack and role description, considered by Nominations Committee. • Commitments reviewed by Nominations Committee during appointment process to ensure no significant commitments that would interfere with the demands of the role. • Letter to NED/Chair on appointment – confirms expected time commitment Changes in commitments would be reported to CoG if they arise.	Comply
C.3.1	NHS England is responsible for appointing chairs and other non-executive directors of NHS trusts. A committee consisting of the chair and non-executive directors is responsible for appointing the chief officer of the trust. A committee consisting of the chair, non-executive directors and the chief officer is responsible for appointing the other executive directors. NHS England has a key advisory role in ensuring the integrity, rigour and fairness of executive appointments at NHS trusts. The selection panel for the posts should include at least one external assessor from NHS England.	*N/A (NHS Trust specific)*	
C.4.1	Directors on the BoD and, for foundation trusts, governors on the council of governors should meet the 'fit and proper' persons test described in the provider licence.	• Compliance regime in place for Fit and Proper Persons requirement – reviewed annually by Board. • Directors sign Annual Fit and Proper Person Self-Attestation. • At election, governors self-declare eligibility in line with fit and proper person	Comply

Section	Code Provision	Current Position	Comply or Explain
	Trusts should also have a policy for ensuring compliance with the CQC's guidance Regulation 5: Fit and proper persons: directors.	requirements for governors. • Governors complete annual declaration of interests and self-assessment of compliance with fit and proper person for governor.	
C.4.2	BoD should include in the annual report a description of each director's skills, expertise and experience. Alongside this, the BoD should make a clear statement about its own balance, completeness and appropriateness to the requirements of the trust. Both statements should also be available on the trust's website.	• Annual Report detail's each director's area of expertise and statement about Board balance, completeness, and appropriateness to the Trust. Information to be included in Annual Report as per Annual Reporting Manual. • Annual Report available on website.	Comply
C.4.3	Chairs or NEDs should not remain in post beyond nine years from the date of their first appointment to the BoD and any decision to extend a term beyond six years should be subject to rigorous review. To facilitate effective succession planning and the development of a diverse board, this period of nine years can be extended for a limited time, particularly where on appointment a chair was an existing non-executive director. The need for all extensions should be clearly explained and should have been agreed with NHS England.	• Term of office for NEDs and Chair considered and agreed by Nominations Committee, in full consideration of NHS England guidance of terms of no more than nine years, and any term beyond six years requiring rigorous review.	Comply
C.4.4	Elected foundation trust governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. Best practice is that governors do not serve more than three consecutive terms to ensure that they retain the objectivity and independence required to fulfil their roles.	• Elected governors' term of office set at no more than three years. • Trust Constitution prevents governor remaining in post for more than three consecutive terms.	Comply
C.4.5	There should be evaluation of the performance of the BoD, its committees, the chair and individual directors. For NHS foundation trusts, the council of governors should take the lead on agreeing a process for the evaluation of the chair and non-executive directors. The governors should bear in mind that it may be desirable to use the senior independent director to lead the evaluation of the chair. NHS England leads the evaluation of the chair and non-executive directors of NHS trusts.	• Board Committee and individual evaluations undertaken. Remuneration Committee reviews performance evaluation of each Executive Director. Nominations Committee reviews performance evaluation of each NED and Chair. • SID leads evaluation of Chair.	Comply
C.4.6	The chair should act on the results of the evaluation by recognising the strengths and addressing any weaknesses of the BoD. Each director should engage with the process	• Board development sessions in place to support members to work together to achieve objectives. • Individual director personal and professional development objectives in place.	Comply

Section	Code Provision	Current Position	Comply or Explain
	and take appropriate action where development needs are identified.		
C.4.7	All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the well-led framework every three to five years, according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the trust or individual directors or governors.	• SFT has not had a formal externally facilitated developmental in recent years. However, the Trust has had two CQC Well Led Inspections in 2018/19 and 2019/20 (Requires Improvement), and subsequently an NHS England (NHSE) governance review was conducted. In 2021/22, having implemented several recommendations from the NHSE governance review, a self-assessment was completed and an independently facilitated Well Led Mapping Review by AQuA was commissioned. The Well Led Mapping Review provided an overview of the Trust's evidence against the Key Lines of Enquiry (KLOEs) and developmental actions for the purpose of continuous improvement. Additionally, internal audit has also been utilised to provide independent assurance on several elements of the Well Led Framework. • Well Led Self-Assessment 2024/25, including position statement, evidence ratings & developmental actions undertaken by Board in March 2025. Options appraisal to be presented to Board in 2025/26 regarding developmental review.	Explain
C.4.8	Led by the chair, foundation trust councils of governors should periodically assess their collective performance and regularly communicate to members and the public how they have discharged their responsibilities, including their impact and effectiveness on: • holding the non-executive directors individually and collectively to account for the performance of the BoD • communicating with their member constituencies and the public and transmitting their views to the BoD • contributing to the development of the foundation trust's forward plans	• Presentation to AMM about CoG performance including how they have performed statutory duties and responsibilities. • Governor observation of Board meetings. • NED attendance and interaction at CoG meetings. • Regular Chair & NED informal sessions with governors • CoG approved Chair & NED appraisal process. • CoG established Nominations Committee for detailed review of Chair and NED appraisal, with final CoG review. • CoG appoint all NEDs (& Chair) and ensures this responsibility is highlighted during selection and appointment process.	Comply
C.4.9	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.	• Approved Code of Conduct for Governors in place that details values and outlines circumstances that would result in removal of governor - agreed and signed by all governors. • Process for removal of governors included within Constitution.	Comply
C.4.10	It may be appropriate for the process to provide for removal from the council of governors if a governor or group of governors behaves or acts in a way that may be incompatible with the values and behaviours of the NHS foundation trust. Where there is any disagreement as to whether the	• As above. Process for removal of governors included within Constitution. Consideration of independent assessor would be made if situation arose.	Comply

Section	Code Provision	Current Position	Comply or Explain
	proposal for removal is justified, an independent assessor agreeable to both parties should be asked to consider the evidence and determine whether or not the proposed removal is reasonable. NHS England can only use its enforcement powers to require a trust to remove a governor in very limited circumstances.		
C.4.11	BoD should ensure it retains the necessary skills across its directors and works with the council of governors to ensure there is appropriate succession planning.	• Remuneration Committee reviews the structure, size and composition of the Board and, where appropriate, make recommendation/s to the BoD and CoG	Comply
C.4.12	Remuneration Committee 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 risk assessment.	• Remuneration Committee provide full consideration to such matters as they arise.	Comply
C.4.13	Annual report should describe the work of the nominations committee(s), including board appointments process, approach to succession planning to support the development of a diverse board, policy on diversity and inclusion, ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard (WRES) and the gender balance of senior management and their direct reports.	• Annual report describes the work of the Nominations Committee and Remuneration Committee. • Information to be included in Annual Report as per Annual Reporting Manual, including specific WRES indicators and information on EDI Strategy in relation to diversity of Board.	Comply
C.5.1	All directors and, for foundation trusts, governors should receive appropriate induction on joining the BoD or the Council of Governors and should regularly update and refresh their skills and knowledge. Both directors and, for foundation trusts, governors should make every effort to participate in training that is offered.	• Induction programmes in place for directors and governors. • Training and development plan in place to support governors in conducting roles and duties. • Training and development for Executive Directors and Non-Executive Directors agreed as part of appraisal process.	Comply
C.5.2	Chair should ensure directors and governors update their skills, knowledge and familiarity with the trust to fulfil their roles. Directors should be familiar with the integrated care system(s) that commission material levels of services from the trust.	• Training and development programme established for governors, including both internal and external opportunities. Information included in Annual Report. • Members of Nominations Committee provided with recruitment specific training prior to NED recruitment process, including EDI and unconscious bias. • All Directors required to complete mandatory training. • Directors have access to individual and collective training/development as identified. • Development needs for all directors are agreed via Chair (for NEDs) and CEO	Comply

Section	Code Provision	Current Position	Comply or Explain
	Trust should provide the resources for directors and governors to develop and update skills, knowledge and capabilities. Those involved in recruitment, should receive appropriate training, including on equality, diversity and inclusion, and unconscious bias.	(for Exec Directors) and reviewed annually. Chair aware of all development needs for individual directors via Remuneration Committee. • All directors familiar with GM ICS.	
C.5.3	All directors need appropriate knowledge of the Trust and appropriate access to its operations and staff. Directors and governors to be appropriately briefed on values and all policies and procedures adopted by the Trust.	• All directors have appropriate knowledge of the Trust and appropriate access to operations and staff. Additional knowledge requirements formally identified as part of appraisal and informally on continuing basis. • Board approved Values. • Relevant policies and procedures considered by Board, Board Committees and/or CoG during year.	Comply
C.5.4	Chair should ensure that new directors and, for foundation trusts, governors receive a induction on joining the board or the council of governors. As part of this, directors should seek opportunities to engage with stakeholders, including patients, clinicians and other staff, and system partners. Directors should also have access at the trust's expense to training courses and/or materials that are consistent with their individual and collective development programme.	• Induction programmes in place for directors and governors, including externally facilitated induction. • Number of stakeholder engagement processes and practices in place that involve patients, public and staff engagement. Directors engage with system partners via number of GM and locality forums/meetings. • Directors have access to individual and collective training/development as identified via appraisal.	Comply
C.5.5	Chair should regularly review and agree with each director their training and development needs as they relate to their role on the board.	• Development needs for all directors are agreed via Chair (for NEDs) and CEO (for Exec Directors) and reviewed annually. Chair aware of all development needs for individual directors via Remuneration Committee	Comply
C.5.6	A foundation trust board has a duty to take steps to ensure that governors are equipped with the skills and knowledge they need to discharge their duties appropriately.	• Training and development programme established for governors, including both internal and external opportunities. Information included in Annual Report.	Comply
C.5.7	Board and CoG to receive appropriate information to discharge its respective duties. Governors should be provided with information on ICS plans, decisions and delivery that directly affect the organisation and its patients.	• Relevant information made available to Board and CoG regarding finance, quality of care, operational performance and people performance, alongside key strategic developments. • CoG informed of GM ICS planning process and priorities alongside Trust plans. Decisions that directly affect Trust and/or patients raised with CoG as emerge.	Comply

Section	Code Provision	Current Position	Comply or Explain
C.5.8	Chair is responsible for ensuring that directors and governors receive accurate, timely and clear information. Management has an obligation to provide such information but directors and, for foundation trusts, governors should seek clarification or detail where necessary.	• Suite of reports, including background information provided to Board and CoG. • Standardised front sheet, with executive summary and recommendation section for Board and CoG papers to ensure clarity and appropriate review of paper. • Data Quality statement included in Annual Governance Statement reported via Audit Committee. • Board has access to all sources of information as requested.	Comply
C.5.9	Chair's responsibilities include ensuring good information flows across the board and, for foundation trusts, across the council of governors; between directors and governors; and for all trusts, between senior management and non-executive directors; as well as facilitating appropriate induction and assisting with professional development as required.	• Suite of reports, including background information provided to Board and CoG. • Non-Executive Director provide report to CoG providing high level overview of delivery against key performance metrics throughout the year. • Induction & Training see C.5.4 and C.5.5	Comply
C.5.10	BoD and, for foundation trusts, the council of governors should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make. BoD and, for foundation trusts, the council of governors should agree their respective information needs with the executive directors through the Chair. The information for boards should be concise, objective, accurate and timely, and complex issues should be clearly explained. BoD should have complete access to any information about the Trust that it deems necessary to discharge its duties, as well as access to senior management and other employees.	• Suite of reports, including background information, provided to BoD and CoG on specific matters relevant to their functions. • Relevant information made available to BoD and CoG regarding finance, quality of care, operational performance and people performance, alongside key strategic developments. Additional information requested by BoD and CoG on specific matters. • NEDs provide regular summary report to CoG regarding matters considered via Board & Board Committees. Chief Executive, Executive Directors and NEDs routinely attend CoG meetings.	Comply
C.5.11	In challenging assurances received from Executive, BoD 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.	• Effective challenge and request for further information and analysis demonstrated at Board and Board Committees – evidenced within relevant minutes, action sheet and follow-up actions. • Independent advice, information and training made available as necessary/requested.	Comply

Section	Code Provision	Current Position	Comply or Explain
	On occasion, Non-Executive Directors may reasonably decide that external assurance is appropriate.		
C.5.12	Board to ensure Non-Executive Directors 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 Non-Executive Directors Availability of independent external sources of advice should be made clear at appointment.	• Independent advice made available as necessary/requested.	Comply
C.5.13	Committees should be provided with sufficient resources to undertake their duties. The BoD of foundation trusts should also ensure that the council of governors is provided with sufficient resources to undertake its duties with such arrangements agreed in advance.	• Committees and CoG provided with sufficient resources, supported by Company Secretariat.	Comply
C.5.14	Non-Executive Directors should consider whether they are receiving necessary information in a timely manner and feel able to raise appropriate challenge of recommendations of the Board. They should expect and apply similar standards of care and quality in their role as a non-executive director of a Trust as they would in other similar roles.	• Papers, in general, disseminated in line with agreed Terms of Reference. • Standardised front sheet for Board papers to ensure clarity regarding recommendation. • NED's able to raise any concerns about the information they receive and their ability to raise appropriate challenge is routinely recorded in minutes of Board / Committee meetings.	Comply
C.5.15	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 canvas opinion of members/bodies they represent. • Views of Council of Governors sought in development of the Trust's Strategy 2020-2025. • Membership Strategy & Action Plan approved by CoG in July 2022, to support in fulfilling this duty. Governors share 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	Comply
C.5.16	Where appropriate, the BoD should in a timely manner take account of the views of the Council of Governors on the forward plan, and then inform the council of governors	• Views of Council of Governors sought in development of the Trust's Strategy. • Governors remained appraised of key strategic developments in relation to the forward plans of the Trust via the Chair's Report and identified topic	Comply

Section	Code Provision	Current Position	Comply or Explain
	which of their views have been incorporated in the NHS foundation trust's plans and explain the reasons for any not being included.	presentations, including GM & locality plans, at each meeting of the CoG and were able to provide view. • Annual discussion regarding Trust Planning at CoG regarding forthcoming year plans and priorities.	
C.5.17	NHS Resolution's Liabilities to Third Parties Scheme includes liability cover for trusts' directors and officers. There is no legal requirement for trusts to provide an indemnity or insurance for governors, where an indemnity or insurance policy is given, this can be detailed in the Trust's constitution.	• No further indemnity/insurance policy for governors.	Comply

Section D: Audit, Risk & Internal Control

Section	Code Provision	Current Position	Comply or Explain
D.2.1	Board must establish an audit committee composed of at least three independent NEDs. Chair of the trust should not chair or be a member of the audit committee but can attend by invitation as appropriate. The vice chair or senior independent director should not chair the audit committee. Board should satisfy itself that at least one member of audit committee has recent/relevant financial experience and committee should have competence relevant to the sector.	• Audit Committee established, includes 4 independent NEDs • Board has appointed Chair of Audit Committee with relevant financial experience, this is not the Deputy Chair or SID. • Trust Chair attends Audit Committee by invitation only.	Comply
D.2.2	The main roles and responsibilities of the audit committee should include: - monitoring the integrity of the financial statements of the trust and any formal announcements relating to the trust's financial performance, and reviewing significant financial reporting judgements contained in them - providing advice (where requested by the BoD) on whether the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's position and performance, business model and strategy - reviewing the trust's internal financial controls and internal control and risk management systems, unless expressly addressed by a separate board risk committee composed of independent non-executive directors or by the board itself - monitoring and reviewing the effectiveness of the trust's internal audit function or, where there is not one, considering annually whether there is a need for one and making a recommendation to the BoD - reviewing and monitoring the external auditor's independence and objectivity - reviewing the effectiveness of the external audit process, taking into consideration relevant UK professional and regulatory requirements - reporting to the BoD on how it has discharged its responsibilities.	• Terms of reference established for Audit Committee including all relevant roles and responsibilities, approved by Board. Publicly available via papers and Trust Secretary. • Chair of Audit Committee provides regular update about matters reviewed at Audit Committee to the BoD and CoG.	Comply

Section	Code Provision	Current Position	Comply or Explain
D.2.3	Trust should change its external audit firm at least every 20 years. Legislation requires an NHS trust to newly appoint its external auditor at least every five years. An NHS foundation trust should re-tender its external audit at least every 10 years and in most cases more frequently than this.	• 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 two years subject to mutual agreement. This option was exercised. • Procurement exercise undertaken in 2024/25 to select External Auditor. CoG considered the options for the procurement of external audit services and supported the preferred option of a direct award. CoG appointed Mazars for a period of three years (i.e. conducting the 2024/25, 2025/26 and 2026/27 external audit) with an option to extend for a further two years.	Comply
D.2.4	The annual report should include: - the significant issues relating to the financial statements that the audit committee considered, and how these issues were addressed. - an explanation of how the audit committee (and/or auditor panel for an NHS trust) has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor; length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans - an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services.	• Section within the Annual Report comprehensively reports on how Audit Committee has discharged its responsibilities. Information in Annual Report in line with Annual Reporting Manual and subject to external audit.	Comply
D.2.5	An NHS foundation trust's audit committee should develop and implement a policy on the engagement of the external auditor to supply non-audit services. The Council of Governors is responsible for appointing external governors.	• 'Policy for the Approval of Non-Audit and Additional Services by the Trust's External Auditors' approved by Audit Committee, February 2023. • As above re appointment of External Auditor (D.2.3)	Comply
D.2.6	Directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy.	• Directors Statements, Auditors Statements and Annual Governance Statement included in Annual Report incorporating all required statements, in line with Annual Reporting Manual, subject to external audit.	

Section	Code Provision	Current Position	Comply or Explain
D.2.7	BoD should carry out a robust assessment of the trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the annual report.	• Board Assurance Framework established and reviewed via Internal Audit as compliant with NHS requirements. • Annual Governance Statement prepared in line with Annual Reporting Manual.	Comply
D.2.8	BoD should monitor the trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The board should report on internal control through the annual governance statement in the annual report.	• Board Assurance Framework established and reviewed via Internal Audit as compliant 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 Statement (AGS) compiled by the CEO, reviewed by Auditors, Audit Committee and approved/signed by CEO	Comply
D.2.9	In the annual accounts, the BoD should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern.	• Annual review of Going Concern at Audit Committee, subsequent to Board, and relevant inclusion within Annual Report.	Comply

Section E: Remuneration

Section	Code Provision	Current Position	Comply or Explain
E.2.1	In designing schemes of performance-related remuneration of executive directors, the remuneration committee should: - consider whether the directors should be eligible for annual bonuses. If so, performance conditions should be relevant, stretching and designed to match long-term interests of the public and patients. - Payouts should be subject to challenging performance criteria reflecting objectives and relative to a group of comparator trusts. - Performance criteria and any upper limits for annual bonuses and incentive schemes should be set and disclosed and must be limited to the lower of £17,500 or 10% of basic salary. - consider the pension consequences and associated costs to the trust of basic salary increases and any other changes in pensionable remuneration, especially for directors close to retirement.	• Not currently applicable. • The Terms of Reference for the Remuneration Committee cover the requirements of this provision with responsibility for design of performance-related remuneration.	Comply
E.2.2	Levels of remuneration for the chair and other non-executive directors should reflect the Chair and non-executive director remuneration structure.	• CoG agreed all new NED positions to be remunerated in line with NHS England Chair and non-executive director remuneration structure. Existing non-executive directors, who are reappointed for a further term of office, remain at the level of remuneration to which they were originally appointed, subject to a robust performance appraisal and confirmation that performance continues to be effective.	Explain
E.2.3	Where a trust releases an executive director, e.g. to serve as a non-executive director elsewhere, the remuneration disclosures in the annual report should include a statement as to whether or not the director will retain such earnings.	• Remuneration disclosure of Annual Report will include information if required. Not applicable during 2024/25.	Comply
E.2.4	Remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise, to in the event of early termination – the aim to avoid rewarding poor performance.	• Provision covered within Remuneration Committee Terms of Reference. Not applicable 2024/25.	Comply
E.2.5	Trusts should discuss any director-level severance payment, whether contractual or non-contractual, with their NHS England Regional Director at the earliest opportunity	• To be discussed with NHS England should situation arise. Not applicable 2024/25.	Comply
E.2.6	BoD should establish a remuneration committee of independent non-executive directors, with a minimum membership of three. Remuneration Committee should make its terms of	• Remuneration Committee established including all NEDs. Annual review of NED independence confirmed. Director of People & OD attends Remuneration Committee in an advisory capacity. • Remuneration Committee Terms of Reference available for review via Trust	Comply

Section	Code Provision	Current Position	Comply or Explain
	reference available, explaining its role and the authority delegated to it by the BoD. The board member with responsibility for HR should sit as an advisor on the remuneration committee. Where remuneration consultants are appointed, a statement should be made available as to whether they have any other connection with the Trust.	Secretary • Statement re remuneration consultants would be included in relevant Annual Report where applicable – Not applicable during 2024/25.	
E.2.7	Remuneration Committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments. Remuneration Committee should recommend and monitor the level and structure of remuneration for senior management.	• Remuneration Committee Terms of Reference set out all aspects of this provision. • Remuneration of Executive Directors and VSM considered annually.	Comply
E.2.8	Council of Governors is responsible for setting the remuneration of a foundation trust's non-executive directors and the chair.	• Level of remuneration for Chair and NEDs reviewed by CoG Nominations Committee annually, in consideration of NHSE remuneration structure for NHS provider chairs and non-executive directors.	Comply

NHS Stockport NHS Foundation Trust

				Agenda No.	22
Meeting date	5 June 2025	**Public**	X	**Confidential**	
Meeting	Board of Directors				
Report Title	Annual Self Certification: Continuity of Services 7 (Licence Condition) – Availability of Resources				
Director Lead	John Graham, Chief Finance Officer	**Author**	John Graham, Chief Finance Officer Kay Wiss, Director of Finance Rebecca McCarthy, Company Secretary		

Paper For:	**Information**		**Assurance**		**Decision**	X
Recommendation:	**The Board of Directors is asked to review and confirm the self-certification for Licence Condition - Continuity of Services 7: Availability of Resources as recommended by Audit Committee.**					

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

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

This paper relates to the following Board Assurance Framework risks

	PR1.1	There is a risk that the Trust does not deliver high quality care to service users
	PR1.2	There is a risk that patient flow across the locality is not effective
	PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan
	PR2.1	There is a risk that the Trust is unable to sufficiently engage and support our people's wellbeing
	PR2.2	There is a risk that the Trust does not actively participate in local collaborative programmes/neighbourhood working to improve primary and secondary health outcomes
	PR3.1	There is a risk that place-based partnership working does not effectively support delivery of

		Stockport ONE Health & Care (Locality) Board priorities and address health inequalities in Stockport
	PR3.2	There is a risk that partnership working in Greater Manchester do not effectively address unwarranted variation of services and improve health inequalities
	PR3.3	There is a risk that opportunities for collaboration between Stockport NHS Foundation Trust and Tameside & Glossop Integrated Care NHS Foundation Trust are not optimised
	PR4.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit and retain the optimal number of staff, with appropriate skills and values
	PR4.2	There is a risk that the Trust's workforce is not reflective of the communities served
	PR5.1	There is a risk that the Trust does not implement high quality service improvement programmes
	PR5.2	There is a risk that the Trust does not implement high quality research & development programmes
X	PR6.1	There is a risk that the Trust does not deliver the annual financial plan
X	PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial sustainability plan
	PR7.1	There is a risk that the Trust does not implement the Digital Strategy to ensure a resilient and responsive digital infrastructure
	PR7.2	There is a risk that the estate is not fit for purpose and/or meets national standards
	PR7.3	There is a risk that the Trust does not materially improve environmental sustainability
	PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus

Where issues are addressed in the paper

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

Executive Summary

The NHS Provider Licence ('the licence') was introduced in 2013 for all NHS foundation trusts. It sets out conditions that providers must meet to help ensure that the health sector works for the benefit of patients, now and in the future, and serves as the legal mechanism for formal regulatory intervention. Following enactment of the Health and Care Act 2022, the licence was modified, and an amended licence came into effect on 1st April 2023.

Since April 2023, the requirement is in place for the following provision only: 'Continuity of Services 7 - Availability of Resources'. The self-certification is to be approved by a resolution of the Board of Directors. The Board must select and confirm one of the three prescribed statements as set out in the licence.

The Audit Committee reviewed the proposed statement and declaration at its meeting on 20 May 2025 And recommends the following statement and declaration for Stockport NHS Foundation Trust to the Board of Directors:

b) After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking

into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors which may cast doubt on the ability of the Licensee to have access to the required resources:

- Risk associated with planning guidance assumption on prescribed activity growth levels, noting the Trust's continued growth position particularly in Emergency Care.
- Potential risk to income should elective activity projections not be achieved across GM system.
- The national arrangements for borrowing revenue support should this be required, have not been finalised for 2025/2026. The delivery of the CIP plan is therefore crucial in order to not require revenue support. The current indication is that only in exceptional circumstances will access to revenue support be granted.
- Significant underpayment in block contracts with the GM Integrated Care Board (ICB) for activity delivered by the Trust and the outcome of the Future Finance Funding Workstream not being actioned.
- Lack of capital availability across the ICS in order to deliver a balanced capital plan and where the risk to disruption to service is high given the condition of the estate and the level of backlog maintenance required.
- The implications on revenue on the shortage of capital funding for 2025/26 given the age and condition of the estate.
- The Trust Board acknowledges that this is a challenging but achievable plan, on the basis that plan and funding assumptions are fully realised.

1. Introduction and Context

1.1 The NHS Provider Licence ('the licence') was introduced in 2013 for all NHS foundation trusts. It sets out conditions that providers must meet to help ensure that the health sector works for the benefit of patients, now and in the future, and serves as the legal mechanism for formal regulatory intervention.

1.2 Following enactment of the Health and Care Act 2022 (the Act), and a period of consultation, the licence was modified, and an amended licence came into effect on 1st April 2023 and now forms part of the oversight arrangements for NHS foundation trusts, independent sector providers and NHS trusts.

1.3 The requirement for self-certification, in relation to General Condition 6 and Corporate Governance Statement FT4, was removed from the new licence to reduce duplication with other reporting mechanisms and oversight arrangements incorporated in the NHS Oversight Framework, Annual Report and Annual Governance Statement.

1.4 However, within the new licence there remains a requirement for self-certification with respect to Continuity of Services 7: Availability of Resources. Boards should confirm that they understand clearly the declarations being made and retain copies of those declarations should they be the subject of an audit by NHS England.

2. Continuity of Services 7 (CoS 7) – Availability of Resources

2.1 An NHS Foundation Trust is required to always act in a manner calculated to secure that it has, or has access to, the required resources.

2.2 The licence continues to require Trusts, not later than two months from the end of each Financial Year, to certify as to the availability of the Required Resources for the period of 12 months commencing on the date of the certificate, including a statement approved by a resolution of the Board of Directors.

The Board of Directors must select one of the three statements, as detailed below, and provide a statement of the factors taken into account in making the relevant declaration.

2.3 The three statement options are:

a) "After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate."

Or

b) "After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the

period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors which may cast doubt on the ability of the Licensee to have access to the required resources".

Or

c) "In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate".

2.4 In considering an appropriate declaration, Board members should note that 'Required Resources' are defined as follows:

- management resources,
- financial resources and facilities,
- personnel,
- physical and other assets

3. Audit Committee Review

3.1 In May 2025, Audit Committee noted the following factors for consideration as part of the declaration include:

- In 2024/25 the Trust delivered an adjusted financial performance deficit of £2.1m, which is an improvement against plan by £0.4m.
- The Trust Board, through its Finance and Performance Committee, scrutinises the Trust's financial position and forecasts monthly.
- Assurance has been received from external auditors in relation to annual accounts and from internal auditors regarding the robustness of the Trust's financial systems and processes.
- The Trust's financial plan submission 2025/26 developed in line with national guidance and as part of the Greater Manchester Integrated Care System (GM ICS). The submission for the Trust is a break-even compliant plan (after receipt of deficit funding of £42.3m), the plan includes a cost improvement programme (CIP) of £29.2m (5%) and requires the Trust to manage a further £11.8m of risk – The Trust has examined in detail several unpalatable schemes. The financial plan assumes a level of additional CDEL cover, additional income in respect of the GM Future Funding Flows (FFF) workstream and from other ICBs. The Trust Board acknowledges that this is a challenging but achievable plan, on the basis that plan and funding assumptions are fully realised.
- The Going Concern assessment presented to Audit Committee (to be agreed by the Board in June 2025).
- The implications of any planned or potential services changes in the context of resource availability to accommodate/service such changes.
- The likelihood of any unplanned changes emerging during financial year 2025/26.
- The implications of inflation across all services, some of which may be beyond the control of the organisation to influence.

3.2 Further to the above, Audit Committee recommended to the Board of the adoption of the following statement for Stockport NHS Foundation Trust:

b) After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors which may cast doubt on the ability of the Licensee to have access to the required resources:

- Risk associated with planning guidance assumption on prescribed activity growth levels, noting the Trust's continued growth position particularly in Emergency Care.
- Potential risk to income should elective activity projections not be achieved across GM system.
- The national arrangements for borrowing revenue support should this be required, have not been finalised for 2025/2026. The delivery of the CIP plan is therefore crucial in order to not require revenue support. The current indication is that only in exceptional circumstances will access to revenue support be granted.
- Significant underpayment in block contracts with the GM Integrated Care Board (ICB) for activity delivered by the Trust and the outcome of the Future Finance Funding Workstream not being actioned.
- Lack of capital availability across the ICS in order to deliver a balanced capital plan and where the risk to disruption to service is high given the condition of the estate and the level of backlog maintenance required.
- The implications on revenue on the shortage of capital funding for 2025/26 given the age and condition of the estate.
- The Trust Board acknowledges that this is a challenging but achievable plan, on the basis that plan and funding assumptions are fully realised.

NHS Stockport
NHS Foundation Trust

				Agenda No.	23
Meeting date	5 June 2025	**Public**	X	**Confidential**	
Meeting	Board of Directors				
Report Title	Going Concern Assessment 2024/25				
Director Lead	John Graham, Chief Finance Office/r	**Author**	Lisa Byers, Associate Director of Finance – Financial Services		

Paper For:	**Information**		**Assurance**		**Decision**	X
Recommendation:	**The Board of Directors is asked to support the recommendation from Audit Committee to:** • **Support the declaration that, in accordance with International Accounting Standard 1 and the NHS Foundation Trust Annual Reporting Manual (ARM) 2024/2025, the Directors of the Trust have a reasonable expectation of the continued provision of Stockport NHS Foundation Trust's services, and, for this reason, the Directors should continue to adopt the going concern basis in preparing the accounts for 2024/2025.**					

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

	Safe		Effective
	Caring		Responsive
	Well-Led	X	Use of Resources

This paper relates to the following Board Assurance Framework risks

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

	PR2.2	There is a risk that the Trust does not actively participate in local collaborative programmes/neighbourhood working to improve primary and secondary health outcomes
	PR3.1	There is a risk that place-based partnership working does not effectively support delivery of Stockport ONE Health & Care (Locality) Board priorities and address health inequalities in Stockport
	PR3.2	There is a risk that partnership working in Greater Manchester do not effectively address unwarranted variation of services and improve health inequalities
	PR3.3	There is a risk that opportunities for collaboration between Stockport NHS Foundation Trust and Tameside & Glossop Integrated Care NHS Foundation Trust are not optimised
	PR4.1	There is a risk that, due to national shortages of certain staff groups, the Trust is unable to recruit and retain the optimal number of staff, with appropriate skills and values
	PR4.2	There is a risk that the Trust's workforce is not reflective of the communities served
	PR5.1	There is a risk that the Trust does not implement high quality service improvement programmes
	PR5.2	There is a risk that the Trust does not implement high quality research & development programmes
X	PR6.1	There is a risk that the Trust does not deliver the annual financial plan
	PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial sustainability plan
	PR7.1	There is a risk that the Trust does not implement the Digital Strategy to ensure a resilient and responsive digital infrastructure
	PR7.2	There is a risk that the estate is not fit for purpose and/or meets national standards
	PR7.3	There is a risk that the Trust does not materially improve environmental sustainability
	PR7.4	There is a risk that there is no identified or insufficient funding mechanism to support the strategic regeneration of the hospital campus

Where issues are addressed in the paper

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

Executive Summary

This paper will set out the considerations for the declaration of going concern status for Stockport NHS Foundation Trust based on the criteria set out in the NHS Foundation Trust Annual Reporting Manual 2024/25, as considered by the Audit Committee at its meeting on 20 May 2025, and recommended to the Board of Directors.

1. Purpose

1.1 The International Accounting Standard 1 (IAS 1), Presentation of Financial Statements, requires management to assess its ability to continue as a Going Concern as part of preparing the Annual Accounts.

1.2 There is no presumption of going concern status for NHS foundation trusts. Directors must decide each year whether or not it is appropriate for the NHS foundation trust to prepare its accounts on the going concern basis. The process for considering Going Concern should be proportionate in nature and depth to the risk being faced by the entity.

1.3 Consideration of risks to the financial sustainability of the organisation is a separate matter to the application of the going concern concept. Determining the financial sustainability of the organisation requires an assessment of its anticipated resources in the medium term. Any identified significant risk to financial sustainability is likely to form part of the risks disclosures included in the wider performance report but is a separate matter from the going concern assessment.

1.4 This paper will set out the considerations for the declaration of going concern status for Stockport NHS Foundation Trust based on the criteria set out in the Treasury's Financial Reporting Manual (FReM) and NHS Foundation Trust Annual Reporting Manual. It has been considered by Audit Committee at its meeting on 20th May and recommended to the Board of Directors.

2. Audit Committee Review of Going Concern

2.1 When concluding whether or not the accounts for 2024/25 should be prepared on a going concern basis, IAS1 requires that the Board of Directors will need to consider which of the following scenarios are most appropriate:

a. The Trust is a going concern, and it is appropriate for the accounts to be prepared on the going concern basis;

b. The Trust is a going concern but there are material uncertainties regarding future issues which should be disclosed in the accounts to ensure a true and fair view;

c. The Trust is not a going concern, and the accounts will need to be prepared on an appropriate alternative basis.

2.2 The NHS Foundation Trust Annual Reporting Manual (ARM) 2024/25 sets out that the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern.

2.3 The Trust has submitted final 2025/26 operational plans to NHS England in April 2025. These plans include income, activity, expenditure and workforce plans, indicate delivery of the financial control total for 2025/26 and have Board approval. The Plan has confirmed system support funding, clinical income contract offers set on commissioning

intentions and is based on a number of assumptions on delivery of Trust efficiency programmes and receipt of additional income.

2.4 The 2025/26 Plan also includes submission of a compliant capital plan including national funding for Estates Safety schemes, Constitutional standards and development of an Electronic Patient Record.

2.5 The Trust's assessment of whether the going concern basis is appropriate for its accounts should therefore only be based on whether it is anticipated that the services it provides will continue to be provided with the same assets in the public sector. This is expected to be the case for NHS foundation trusts unless exceptional circumstances indicate otherwise; these should be discussed with NHS England. Where the continued provision of services in the public sector is anticipated to apply, there will not be any material uncertainties over going concern requiring disclosure.

3. Recommendation

3.1 Based on the criteria set out in the NHS Foundation Trust Annual Reporting Manual (ARM) 2024/2025, the Audit Committee recommends to the Board of Directors support the following declaration on going concern status in accordance with option 2.1(a):

After making enquiries, the Directors have a reasonable expectation that the services provided by Stockport NHS Foundation Trust will continue to be provided by the public sector for the foreseeable future. For this reason, the Directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.