

SFT Public Board Meeting - August 2025

Thu 07 August 2025, 09:30 - 12:35

Pinewood House Education Centre



Stockport
NHS Foundation Trust

Agenda

09:30 - 09:30 1. Apologies for Absence

0 min

09:30 - 09:30 2. Declaration of Interests

0 min

09:30 - 09:35 3. Patient Story

5 min

Information Nicola Firth

09:35 - 09:35 4. Minutes of Previous Meeting - held on 5 June 2025 (Paper)

0 min

Decision David Wakefield

04 - Public Board Minutes - 5 June 2025.pdf (13 pages)

09:35 - 09:40 5. Action Log (Paper)

5 min

Discussion David Wakefield

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

09:40 - 09:50 6. Joint Chair's Report (Paper)

10 min

Discussion David Wakefield

06 - Joint Chair Report - August 2025.pdf (5 pages)

09:50 - 10:00 7. Chief Executive's Report (Paper)

10 min

Discussion Karen James

07 - Chief Executive's Report - August 2025.pdf (4 pages)

FINANCE & PERFORMANCE

10:00 - 10:05 8. Finance & Performance Committee Alert, Advise & Assure Report (Paper)

5 min

Discussion Anthony Bell

08a - Finance & Performance Committee AAA Report - Front Sheet.pdf (2 pages)

08b - Finance & Performance Committee AAA Report - June & July 2025.pdf (2 pages)

10:05 - 10:25 9. Integrated Performance Report - Month 3 (Paper)

20 min

Discussion Executive Directors

09a - SFT Integrated Performance Report - Front Sheet July 2025.pdf (2 pages)

09b - SFT Integrated Performance Report - July 2025.pdf (24 pages)

Curtis Spide
07/08/2025 06:16:22

10:25 - 10:35 10. Financial Position - Month 3 (Paper)

10 min

Discussion John Graham

- 📄 10a - Financial Position Report Month 3 2025-26 Front Sheet.pdf (3 pages)
- 📄 10b - Financial Position 2025-26 M03.pdf (18 pages)

10:35 - 10:45 11. Digital Strategy Progress Report (Paper)

10 min

- 📄 11a - Front Sheet Digital Strategy Update - August 2025.pdf (2 pages)
- 📄 11b - Digital Strategy Update August 2025.pdf (14 pages)

10:45 - 10:55 12. Green Plan:

10 min

12.1. Green Plan Progress Report 2024/25 (Paper)

Discussion Laura Swann

- 📄 12.1 - SFT Green Plan Progress Report.pdf (14 pages)

12.2. Approval of Joint Green Plan (Paper)

Decision Laura Swann

- 📄 12.2a - SFT & T&G Green Plan Approval Report.pdf (22 pages)
- 📄 12.2b - Joint Green Plan Draft SFT and T&G FT Board.pdf (52 pages)

10:55 - 11:05 COMFORT BREAK

10 min

QUALITY

11:05 - 11:10 13. Quality Committee Alert, Advise & Assure Report (Paper)

5 min

Discussion Louise Sell

- 📄 13a - Quality Committee AAA Report - Front Sheet.pdf (2 pages)
- 📄 13b - Quality Committee AAA Report - June and July 2025.pdf (4 pages)

11:10 - 11:20 14. Annual Learning from Deaths Report (Paper)

10 min

Discussion Andrew Loughney

- 📄 14 - Annual Learning from Deaths Report 2024-25.pdf (6 pages)

11:20 - 11:30 15. Annual Safeguarding Report (Paper)

10 min

Discussion Nicola Firth

- 📄 15a - Safeguarding Annual Report - Front Sheet.pdf (4 pages)
- 📄 15b - Safeguarding Annual Report 202425.pdf (35 pages)

11:30 - 11:40 16. Annual Health & Safety Report (Paper)

10 min

Discussion Nicola Firth

- 📄 16 - Annual Health & Safety KPI Report.pdf (31 pages)

11:40 - 11:50 17. Annual Research, Innovation & Development Strategy Progress Report (Paper)

10 min

Curtis Soile
07/08/2025 06:56

Discussion Andrew Loughney

📄 17 - RD&I Annual Report 2024-25.pdf (29 pages)

PEOPLE

11:50 - 11:55 **18. People Performance Committee Alert, Advise & Assure Report (Paper)**
5 min

Discussion Beatrice Fraenkel

📄 18a - People Performance Committee AAA Report - Front Sheet.pdf (2 pages)

📄 18b - People Performance Committee AAA Report - July 2025.pdf (2 pages)

11:55 - 12:05 **19. People & Organisational Development Plan Progress Report (Paper)**
10 min

Discussion Amanda Bromley

📄 19 - People & OD Plan Progress Update - August 25.pdf (12 pages)

12:05 - 12:15 **20. Safer Care (Staffing) Report (Paper)**
10 min

Discussion Nicola Firth / Andrew Loughney

📄 20a - Safe Staffing Report - Front Sheet.pdf (3 pages)

📄 20b - Safe Staffing Report.pdf (30 pages)

GOVERNANCE

12:15 - 12:20 **21. Audit Committee Alert, Advise & Assure Report, including Annual Review 2024/25 (Paper)**
5 min

Decision David Hopewell

📄 21a - Audit Committee AAA Report - Front Sheet.pdf (2 pages)

📄 21b - Audit Committee AAA Report - 15 July 2025.pdf (3 pages)

📄 21c - Audit Committee Annual Review 2024-25.pdf (13 pages)

12:20 - 12:30 **22. Board Assurance Framework 2025/26 (Paper)**
10 min

Decision Karen James

📄 22a - Board Assurance Framework 2025-26 - August 2025.pdf (4 pages)

📄 22b - Appendix 1 - SFT Board Assurance Framework Q1 2025-26.pdf (25 pages)

📄 22c - Appendix 2 - Significant Risk Register - June 2025.pdf (2 pages)

CLOSING MATTERS

12:30 - 12:30 **23. Any Other Business**
0 min

DATE, TIME & VENUE OF NEXT MEETING

12:30 - 12:30 **24. Thursday 2 October 2025, 9.30am, Pinewood House Education Centre**
0 min

12:30 - 12:30 **25. Resolution:**
0 min

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".

Curtis, Steve
07/08/2025 06:36:23

Curtis Soile
07/08/2025 06:56:20

STOCKPORT NHS FOUNDATION TRUST
Minutes of a meeting of the Board of Directors held in public
Held on Thursday 5 June 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
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
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)

In attendance:

Mrs Soile Curtis	Deputy Trust Secretary
Mrs Rebecca McCarthy	Trust Secretary
Ms Victoria Rankin	Deputy IT Procurement & Business Lead (for item 54/25)
Mrs Kay Wiss	Director of Finance (for item 54/25)
Ms Hannah Silcock	Assistant Director of Transformation (for item 67/25)

Quorate: Yes

Apologies:

Mr Anthony Bell	Non-Executive Director
Mrs Karen James	Chief Executive

* indicates a non-voting member

REF No/Yr.	ITEM	ACTION OWNER
52/25	Apologies for Absence The Joint Chair welcomed everyone to the meeting. Apologies for absence were noted as above.	
53/25	Declarations of Interest There were no declarations of interest.	
54/25	Staff Story The Board watched a video regarding the Trust's Neurodiversity Network and heard that the network supported staff and patients in relation to neurodiversity and in fostering a more inclusive culture and psychological safety. Mrs Kay Wiss (Director of Finance and Executive Sponsor of the network) and Ms Victoria Rankin (Deputy IT Procurement & Business Lead and Chair of the network) provided an overview of the benefits of the network,	

	<p>including promoting acceptance, and providing a safe space, resources and support for neurodiverse employees and staff who care for neurodiverse family members, and celebrating and recognising the added strengths of neurodiverse staff.</p> <p>The Board heard about future ambitions of the network, including introduction of neurodiversity champions and ensuring reasonable adjustments were considered for neurodiverse colleagues. It was noted that there would be opportunities for Board members to speak at or recommend speakers for the network’s meetings and events.</p> <p>The Board supported the ambition of introducing neurodiversity champions and the Joint Chair agreed to liaise with the network to explore how the Non-Executive Directors could support its work.</p> <p>Mrs Beatrice Fraenkel, Non-Executive Director, welcomed the establishment of the Neurodiversity Network and highlighted the importance of an interview selection process that is fit for neurodiverse applicants. The Director of Finance advised that the network has worked with the recruitment team in this area, including ensuring applicants have advance sight of interview questions and format of interviews.</p> <p>The Board of Directors received and noted the Staff Story.</p>	
<p>55/25</p>	<p>Minutes of Previous Meeting The minutes of the previous meeting held on 3 April 2025 were agreed as a true and accurate record.</p>	
<p>56/25</p>	<p>Action Log The action log was reviewed and annotated accordingly.</p>	
<p>57/25</p>	<p>Chair’s Report The Joint Chair presented a report providing an update on national, regional and Trust developments, including:</p> <ul style="list-style-type: none"> - Operating Environment 2025/26 - Collaboration with Tameside & Glossop Integrated Care NHS Foundation Trust (T&G ICFT) - Trust Activities <p>The Board of Directors received and noted the Chair’s Report.</p>	
<p>58/25</p>	<p>Chief Executive’s Report The Deputy Chief Executive presented a report providing an update on local and national strategic and operational developments, including:</p> <ul style="list-style-type: none"> - 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 - Key Successes & Celebrations 	

	<p>In response to a question from the Joint Chair regarding the potential industrial action, the Deputy Chief Executive confirmed the Trust had contingency plans in place.</p> <p>In response to a question from Dr Marisa Logan-Ward, Non-Executive Director, querying support offered to staff following the Supreme Court ruling, the Director of People & Organisational Development (OD) advised that a message of support had been sent to all staff networks immediately following the ruling and noted that the Trust's Equality, Diversity & Inclusion Lead was supporting staff while further guidance was awaited.</p> <p>Dr Louise Sell, Non-Executive Director, referred to the draft NHS Performance Assessment Framework and queried mitigations around impact on our ability to collaborate as a system. The Joint Chair acknowledged the wide reaching implications and he and the Deputy Chief Executive briefed the Board on latest developments in this area, noting expectations for Trusts to deliver their Operational Plans.</p> <p>The Board of Directors received and noted the Chief Executive's Report.</p>	
<p>59/25</p>	<p>Final Trust Operational & Financial Plan 2025/26</p> <p>The Director of Strategy & Partnerships presented a report providing a high level summary of the material changes in the Trust's final Operational Plan submissions, including a summary plan on a page reflecting the submission made. It was noted that operational planning had previously been considered by the Board through extraordinary meetings to consider the requirements to submit a compliant plan covering operational performance, finance and workforce. It was noted that the final planning submissions were reliant upon the support outlined from the Greater Manchester Integrated Care Board (GM ICB) to achieve the revenue financial control totals.</p> <p>The Director of Strategy & Partnerships advised that additional detail to support the summary plan on a page has been developed that reflect the wider plans for 2025/26 and would be shared across the Trust.</p> <p>In response to a question from Mr David Hopewell, Non-Executive Director, querying whether the targets were ambitious enough, the Director of Strategy & Partnerships noted the need for balance between opportunities and challenges, acknowledging that there were opportunities to aim further in some areas. The Chief Nurse expressed view that the Trust should aim to be both ambitious and realistic and deploy Quality Impact Assessment (QIA) methodologies. Furthermore she highlighted the importance of acknowledging all improvement, even where targets had not been met.</p> <p>The Joint Chair suggested that the Trust's ambitions and stretch targets could be explored further as part of the Board Development programme.</p> <p>The Board of Directors received and noted the update on the final Operational Plan submission.</p>	
<p>60/25</p>	<p>Corporate Objectives and Outcome Measures 2025/26</p> <p>The Director of Strategy & Partnerships presented a report providing a year-end position against the Trust's objectives and key outcome measures for 2024/25. The report also detailed the key outcome measures aligned to the</p>	

	<p>Corporate Objectives 2025/26, which were joint ones with Tameside and Glossop Integrated Care NHS Foundation Trust (T&G).</p> <p>In response to a question from the Joint Chair querying the outcome of the virtual ward utilisation deep dive, the Director of Operations advised that an internal deep dive had been undertaken to understand areas of under-utilisation and a further review would be take place with MFT to seek best practice. The Joint Chair requested that an update on virtual wards be presented to the Board of Directors in October 2025. (ACTION)</p> <p>In response to a question from the Joint Chair regarding the Beech House data centre cooling equipment issue, the Director of Strategy & Partnerships briefed the Board on issues relating to the equipment and the Category D building, noting that a solution in relation the building was still being explored. He confirmed that the equipment issue did not impact on the Electronic Patient Record (EPR).</p> <p>In response to a question from Mrs Beatrice Fraenkel, Non-Executive Director, the Director of Strategy & Partnerships confirmed that the new Director of Estates & Facilities had commenced in post and would be meeting with Board members as part of his induction.</p> <p>The Board of Directors noted the end-of year progress against the key outcome measures for 2024/25 and approved the key outcome measures for 2025/26.</p>	<p>Director of Operations</p>
<p>61/25</p>	<p>Risk Appetite Review 2025/26</p> <p>The Deputy Chief Executive and Trust Secretary presented a report seeking Board review and approval of the Trust’s risk appetite to support development of the Board Assurance Framework (BAF) 2025/26. It was noted that in recognition of changing risk appetite 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, it was recognised that the operating environment remains one of notable financial and operational challenge, and at the onset of 2025/26, longer-term NHS reform was announced in response to these challenges.</p> <p>It was noted that 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. Dr Louise Sell, Non-Executive Director, confirmed that the Quality Committee had supported this approach in relation to the quality and outcomes risk.</p> <p>Mr David Hopewell, Non-Executive Director, noted the need to recognise both benefits and downsides of the finance risk and queried the approach for reporting risks where mitigations were unaffordable. The Joint Chair highlighted the importance of the Quality Impact Assessment (QIA) process to ensure safety is maintained, and the Trust Secretary stated that continuous monitoring of safety and harm was paramount, particularly where mitigating</p>	

Curtis, Solie
07/08/2025 09:36:43

	<p>actions were not clear.</p> <p>Mrs Beatrice Fraenkel, Non-Executive Director, noted the need to ensure shared risk is considered in the risk reporting process.</p> <p>The Board of Directors reviewed the report and supported the below risk appetite for 2025/26:</p> <ul style="list-style-type: none"> • Finance / Value for Money <ul style="list-style-type: none"> - Risk Level: Open - Risk Appetite: High • Compliance / Regulation <ul style="list-style-type: none"> - Risk Level: Cautious - Risk Appetite: Moderate • Quality & Outcomes <ul style="list-style-type: none"> - Risk Level: Cautious - Risk Appetite: Moderate • Reputation <ul style="list-style-type: none"> - Risk Level: Open - Risk Appetite: High • People <ul style="list-style-type: none"> - Risk Level: Open - Risk Appetite: High • Innovation <ul style="list-style-type: none"> - Risk Level: Seek - Risk Appetite: Significant 	
<p>62/25</p>	<p>Finance & Performance Committee Alert, Assure & Advise (AAA) Report</p> <p>Mr David Hopewell, Non-Executive Director, presented the AAA report from the Finance & Performance Committee meetings held on 17 April 2025 and 15 May 2025. He briefed the Board on the content of the report and detailed key financial and operational issues and associated key risks considered.</p> <p>The Board of Directors reviewed and confirmed the Finance & Performance Committee AAA Report, including actions taken.</p>	
<p>63/25</p>	<p>Integrated Performance Report</p> <p>The Deputy Chief Executive introduced the Integrated Performance Report (IPR), which included exception reports for areas of most significant note.</p> <p>Quality</p> <p>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), pressure ulcers, complaints and maternity due to under-achievement in month.</p> <p>The Medical Director advised that the SHMI and HSMR mortality rates continued to be low, with the Trust reported with the lowest rates across GM.</p> <p>The Board heard that timely administration of antibiotics within the necessary timescales continued to be challenging, albeit performance had improved since December 2024. It was noted that the Transformation Team were providing support to enable sustainable service improvements around antibiotic administration.</p>	

The Chief Nurse reported a deteriorating position regarding infection rates for Clostridium Difficile (CDiff) and community acquired pressure ulcers. She provided an overview of improvements around MRSA infection rates, hospital acquired pressure ulcers and timely response to complaints.

In response to a question from the Joint Chair querying the mitigating actions that had taken place in 2022 to enable a significant reduction in CDiff infection rates at that time, the Chief Nurse commented that IPC processes had developed and become more robust, however highlighted the adverse impact of deteriorating estate and increased complexity of patients requiring antibiotics.

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, however an increase in the number of 12-hour waits was reported.

The Director of Operations advised that diagnostic performance remained challenging, with actions identified to support improvement across audiology, echo, MR and endoscopy.

The Board heard that virtual ward utilisation continued to show deterioration in performance and actions were in place to improve communication and knowledge of the service.

The Director of Operations reported positive performance against most cancer metrics in month, with 62-day performance just below the trajectory. Improved performance was also noted around RTT, outpatient efficiencies and time to discharge.

In response to a question from the Joint Chair querying impact of the Emergency & Urgent Care Centre (EUCC) on 12-hour waits, the Director of Operations stated that the EUCC was expected to have a positive impact on the position, albeit noted that system flow was also a key driver in this area.

In response to a question from the Joint Chair querying the increase in patients waiting over 65 weeks, the Director of Operations highlighted patient choice and delays where the Trust relied on other organisations for diagnostic services as main factors in this area.

Dr Louise Sell, Non-Executive Director, queried the issue relating to the mental health model in the new EUCC, which was reported as a risk around 12-hour waits. The Director of Operations highlighted implementation issues on how the facility was used and staffed, noting that the issues were being explored with Pennine Care.

Curtis, Soille
07/08/2025 06:56:20

	<p>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.</p> <p>She briefed the Board on mitigating actions regarding sickness absence, highlighting a focus on short term sickness.</p> <p>Finance The Board received and noted the finance section of the IPR, noting that more detailed financial information was provided within the Finance Report.</p> <p>The Board of Directors received and noted the Integrated Performance Report.</p>	
<p>64/25</p>	<p>Finance Report The Chief Finance Officer presented a report providing an update on the financial performance for Month 1 2025/26.</p> <p>The Board heard that the Trust has agreed a balanced financial plan for 2025/26 with a Cost Improvement Programme (CIP) of £29.2m. It was noted that overall, the Trust position at Month 1 was a deficit of £1.2m which was in line with plan and at this stage in the financial year the Trust was forecasting a balanced year-end position.</p> <p>The Chief Finance Officer advised that the Trust had delivered savings of £10.1m against the in-year target, and year to date CIP was £0.7m behind the efficiency plan. The Board heard that this continued to be a key area of focus and that the Trust was expected to identify the unidentified CIP gap by the end of June 2025.</p> <p>The Chief Finance Officer advised that temporary staffing costs were £2.9m in month and further guidance was awaited from NHS England on how the required reductions would be tracked. The Board heard that reducing temporary staffing expenditure remained one of the key focus areas within the financial plan and was overseen by the Workforce Efficiency Group.</p> <p>The Board heard that the Trust's cash balance at the end of April 2025 was £35.9m.</p> <p>The Chief Finance Officer advised that the Trust had spent £2.9m on capital costs in Month 1 against a plan of £2.8m, noting that the Trust's Capital Plan for 2025/26 was £35.4m.</p> <p>In response to a question from the Joint Chair regarding CIP delivery, the Chief Finance Officer provided an overview of governance processes and due diligence with divisions to enable delivery of the year-end target, noting that CIP performance was monitored by the Finance & Performance Committee.</p> <p>The Board of Directors received and noted the Finance Report.</p>	
<p>65/25</p>	<p>Opening Budgets The Chief Finance Officer presented a report outlining the proposed budgets</p>	

	<p>for 2025/26 and the budget setting approach. He noted that the Board had approved an interim position at the April Board meeting, confirming that directors have the approved authority to operate under the standing financial instructions and scheme of delegation until the Opening Budgets could be approved.</p> <p>The Chief Finance Officer briefed the Board on the content of the report and highlighted the assumptions made in the financial plan, the key areas for investment to deliver the plan and associated risks to delivery. He advised that the Finance & Performance Committee had considered the report at its meeting on 15 May 2025 and recommended the Opening Budgets to the Board of Directors for approval.</p> <p>In response to a question from the Joint Chair querying the funding for industrial action, the Chief Finance Officer stated that there had been no indication that costs for industrial action would be centrally funded in 2025/26, and likelihood was therefore that the costs would need to be covered by the system and Trusts.</p> <p>In response to a question from the Joint Chair querying the funding for the pay award, the Chief Finance Officer stated that the national position was that the pay award would be fully funded, however a risk remained in this area as Trusts had previously been required to fund the difference between funding received and actual costs.</p> <p>The Board of Directors received the report and approved the Opening Budgets for 2025/26, recognising the inherent risks.</p>	
<p>66/25</p>	<p>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 22 April 2025 and 27 May 2025. She briefed the Board on the content of the report and detailed key quality related issues considered.</p> <p>In response to a question from the Joint Chair regarding waiting list validation, the Chair of Quality Committee advised that waiting list validation continued to be developed with the incentivised revalidation scheme, and that the process was being monitored through the Health Inequalities Group which would report to Quality Committee. Dr Samira Anane, Non-Executive Director, expressed view that it would be helpful to work across GM in this area to enable shared learning.</p> <p>The Board of Directors reviewed and confirmed the Quality Committee AAA Report, including actions taken.</p>	
<p>67/25</p>	<p>Transformation & Continuous Improvement Strategy Report The Assistant Director of Transformation presented a report providing an overview of progress made in the first year of the Trust's Continuous Improvement Strategy, and the Transformation Team Annual Report 2024/25. She briefed the Board on the content of the report, highlighting key achievements and outcomes across this Trust and Tameside & Glossop Integrated Care NHS Foundation Trust (T&G), reaffirming a shared commitment to delivering high quality, safe and sustainable services. The Board heard that one of the key achievements had been the development</p>	

	<p>and launch of an in-house Quality Improvement Training Programme, designed to build internal capability and embed continuous improvement practices across both organisations.</p> <p>It was noted that service transformation programmes were monitored through a monthly Service Improvement Group chaired by the Deputy Chief Executive.</p> <p>In response to a question from the Joint Chair querying methodology used for the projects, the Assistant Director of Transformation confirmed that the methodology allowed for project specific tools to be used to enable achievement of desired outcomes.</p> <p>The Medical Director welcomed the support provided by the Transformation Team and the Chief Finance Officer noted that the financial benefit of the projects was not always easy to articulate and that the value was often about continuous improvement.</p> <p>The Director of Operations expressed view that further work was required to embed transformational improvements as business as usual. The Assistant Director of Transformation acknowledged the comment and noted that this was addressed within the strategy, noting the launch of drop in hubs as an example.</p> <p>In response to a question from Mrs Beatrice Fraenkel, Non-Executive Director, querying how learning was encapsulated within the Trust and from other organisations, the Assistant Director of Transformation briefed the Board on horizon scanning and benchmarking against peers in GM and beyond through NHS Impact to enable wider learning.</p> <p>The Board of Directors reviewed and confirmed the Transformation Team Annual Report 2024/25 and the update on progress for year one of the Trust’s Continuous Improvement Strategy.</p>	
<p>68/25</p>	<p>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 8 May 2025. She briefed the Board on the content of the report and detailed key people related issues and associated key risks considered.</p> <p>The Board of Directors reviewed and confirmed the People Performance Committee AAA Report, including actions taken.</p>	
<p>69/25</p>	<p>Workforce Equality, Diversion & Inclusion (EDI) Strategy Report The Director of People & OD presented a report providing a progress update against each of the targets set out within the Trust’s EDI Strategy 2022-25 relating to workforce, culture, assurance and compliance and health inequalities. She noted that a consolidated EDI Plan brought together the actions within the EDI Strategy, actions from the NHS EDI delivery plan and actions required by the North West BAME Assembly Anti-Racist Framework.</p> <p>The Director of People & OD confirmed all statutory reporting had been completed for 2024/25, including submission of data relating to the annual</p>	

	<p>Workforce Race Equality Standard (WRES) Report and Workforce Disability Equality Standard (WDES) Report.</p> <p>The Director of People & OD highlighted work to develop a new three-year Joint EDI Strategy with T&G, noting the intention to present it to the Board for approval in December 2025.</p> <p>The Joint Chair acknowledged the progress made against the EDI Strategy and queried how the Trust compared with T&G in this area. The Director of People & OD stated that T&G were further along with their EDI journey, however noted that both Trusts' EDI action plans were becoming aligned.</p> <p>In response to questions from the Joint Chair, the Director of People & OD provided further clarity on actions relating to career progression, shortlisting and staff networks from an EDI perspective.</p> <p>The Joint Chair stated that each staff network would have a Non-Executive Director sponsor going forward to provide support and focus. Furthermore, he noted that it would be helpful for the staff networks to provide an update to the Board at least on an annual basis.</p> <p>The Board of Directors received the Workforce Equality, Diversion & Inclusion (EDI) Strategy Report and noted progress of the Trust's EDI Strategy 2022-25 and associated consolidated action plan.</p>	
<p>70/25</p>	<p>Safer Care (Staffing) Report</p> <p>The Chief Nurse and Medical Director presented a report providing assurances and risks associated with safe staffing, alongside actions to mitigate the risks to patient safety and quality, based on patients' needs, acuity, dependency and risks.</p> <p>The Board heard that the Trust was assessed on compliance with the triangulated approach to deciding staffing requirements described in the National Quality Board's guidance, combining evidenced based tools, professional judgement and outcomes to ensure the right staff with the right skills are in the right place at the right time.</p> <p>The Board acknowledged the ongoing high levels of operational demand within the acute and community services, which was having an impact on patient and staff experience.</p> <p>In response to a question from Dr Louise Sell, Non-Executive Director, querying medical recruitment and ensuring female consultants were supported, the Medical Director noted a positive position regarding pipeline recruitment and briefed the Board on work to recruit to hard to fill areas. He confirmed that there was generally a good spread of female and male candidates applying for consultant posts. The Director of People & OD stated that the action around supporting female consultants related to gender pay gap, identified through the Clinical Excellence Award applications.</p> <p>In response to a question from Dr Marisa Logan-Ward, Non-Executive Director, querying the impact of the NHSP pay change on staff health and wellbeing, the Chief Nurse briefed the Committee on work in this area and noted close work with T&G to ensure aligned timescales, which had also</p>	

	<p>been agreed with GM. She advised that the objective of the realignment of the NHSP pay rates was to ensure equitability and fairness across the organisation and system, noting that safety was paramount. The Chief Nurse advised that teams continued to be supported as necessary and confirmed that the pay rate change only related to NHSP pay, not to substantive pay.</p> <p>In response to a question from the Joint Chair querying the figures reported in the vacancy chart, the Chief Nurse provided further clarity and confirmed that the numbers related to recruiting to turnover.</p> <p>The Board of Directors received and noted the Safe Care (Staffing) Report.</p>	
<p>71/25</p>	<p>Freedom to Speak Up Report</p> <p>The Director of People & OD presented a report providing an overview of the Freedom to Speak Up (FTSU) Guardian's activities since the previous report.</p> <p>The Board heard that there had been an increasing trend in Freedom to Speak Up (FTSU) contacts in Quarter 4 2024/25, reflecting an increased awareness and willingness among staff to raise concerns. The Director of People & OD briefed the Board on themes and trends observed and highlighted a review of the Reflection and Planning Tool in 2025/26 to ensure it remains aligned with organisational priorities and continues to support ongoing improvement.</p> <p>In response to a question from Dr Samira Anane, Non-Executive Director, regarding FTSU training, the Director of People & OD confirmed good compliance in this area, and noted plans to incorporate this in line-management training to ensure further embedding of FTSU processes.</p> <p>In response to a question from the Joint Chair querying processes in place to monitor detriment, the Director of People & OD advised that the FTSU Guardian was working with the HR team to develop a clear and robust process for managing cases involving detriment.</p> <p>The Committee received and noted the Freedom to Speak Up Report.</p>	
<p>72/25</p>	<p>Audit Committee Alert, Assure & Advise (AAA) Report</p> <p>The Chair of Audit Committee (Mr David Hopewell, Non-Executive Director) presented the AAA report from the Audit Committee meeting held on 20 May 2025, detailing key issues considered.</p> <p>The Board of Directors reviewed and confirmed the Audit Committee AAA Report, including actions taken.</p>	
<p>73/15</p>	<p>Annual Review of Provider Trust Code of Governance</p> <p>The Trust Secretary presented a report on the Annual Review of the NHS Code of Governance. She briefed the Board on the content of the report and provided assurance that the Trust complied with the Code's provisions with two exceptions: Well-Led Review and levels of remuneration for Non-Executive Directors, and provided explanations for these.</p> <p>The Board of Directors reviewed and approved the outcome of the annual review of the Code of Governance for NHS Provider Trusts, as</p>	

	<p>recommended by the Audit Committee.</p>	
<p>74/25</p>	<p>Annual Self Certification: Continuity of Services 7 – Availability of Resources</p> <p>The Board of Directors considered the self-certification declaration for Licence Condition ‘Continuity of Services 7 – Availability of Resources’.</p> <p>The Board heard that the requirement for self-certification, previously in relation to General Condition 6 and Corporate Governance Statement FT4 of the licence, was removed from the new licence to reduce duplication with other reporting mechanisms, such as the NHS Oversight Framework, Annual Report and Annual Governance Statement. It was noted, however, that with respect to the ‘Continuity of Services 7 - Availability of Resources’ the self-certification requirement remained in place and was to be approved by a resolution of the Board of Directors.</p> <p>The Board of Directors approved the following self-certification and declaration for Licence Condition – Continuity of Services 7: Availability of Resources, as reviewed and recommended by Audit Committee:</p> <p><i>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:</i></p> <ul style="list-style-type: none"> • <i>Risk associated with planning guidance assumption on prescribed activity growth levels, noting the Trust’s continued growth position particularly in Emergency Care.</i> • <i>Potential risk to income should elective activity projections not be achieved across GM system.</i> • <i>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.</i> • <i>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.</i> • <i>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.</i> • <i>The implications on revenue on the shortage of capital funding for 2025/26 given the age and condition of the estate.</i> • <i>The Trust Board acknowledges that this is a challenging but achievable plan, on the basis that plan and funding assumptions are fully realised.</i> 	

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<p>75/25</p>	<p>Going Concern Declaration The Chief Finance Officer presented a report asking the Board to approve the recommendation from Audit Committee, and support the declaration that, in accordance with International Accounting Standard 1 and the NHS Foundation Trust Annual Reporting Manual (ARM) 2024/25, 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 2024/25.</p> <p>The Board of Directors approved the declaration that the Trust continued to adopt the going concern basis in the preparation of the accounts.</p>	
<p>76/25</p>	<p>Any Other Business There was no other business.</p>	
<p>77/25</p>	<p>Date and Time of Next Meeting Thursday 7 August 2025, 9.30am, Pinewood House Education Centre.</p>	
<p>78/25</p>	<p>Resolution <i>“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”.</i></p>	

Signed: _____ Date: _____

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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

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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
05/25	5 June 2025	60/25	Corporate Objectives and Outcome Measures	The Joint Chair requested that an update on virtual wards be presented to the Board of Directors in October 2025.	Director of Operations	October 2025

On agenda
Not due
Overdue
Closed

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

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				Agenda No.	6
Meeting date	7 th August 2025	Public	X	Confidential	
Meeting	Board of Directors				
Report Title	Joint Chair Report				
Director Lead	David Wakefield, Joint Chair	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

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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 report highlights key matters for the attention of the Board, covering national, regional and Trust matters including:

- Fit for the Future: 10 Year Health Plan for England
- Independent review of patient safety across the health and care landscape
- Tameside & Glossop Integrated Care NHS Foundation Trust (TG ICFT) and Stockport NHS Foundation Trust (SFT) Collaboration
- Key Trust Visits & Meetings

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1. **Fit for the Future: 10 Year Health Plan for England**

At the beginning of July, the Government launched its 'Fit for the Future: 10 Year Health Plan for England' (10 YHP). The plan focuses on three big shifts: analogue to digital, hospital to community and sickness to prevention, with the introduction of neighbourhood health services. It is anticipated that each of the shifts will be fundamental to securing financial sustainability.

To realise the ambition of the 10 YHP, the Government intends to reform the NHS operating model. This includes the previously announced abolition of NHS England (NHSE) and the revised role of Integrated Care Boards (ICBs) as strategic commissioners of local healthcare services. The plan also seeks to introduce a system of earned autonomy for providers and a support regime for those underperforming.

It was announced that the NHS foundation trust (FT) model was to be reinvented, with opportunity for the best performing FTs to hold the whole health budget for a defined local population as an integrated health organisation (IHO). It is anticipated that a small number of these IHOs would be designated in 2026, with a view to them becoming operational in 2027. The plan also stated that the requirement for FTs to have governors would be removed and more 'dynamic arrangements' to take account of patient, staff and stakeholder insight would be introduced.

We will continue to review and examine the detail as it emerges to determine how it impacts upon the Trust and is incorporated into our existing plans and forthcoming Joint Organisational Strategy. On a practical note, with respect to the governance of FTs, we know that legislation will need to be changed to enact elements of the plan, and further work to implement the change will be needed.

2. **Independent review of patient safety across the health and care landscape**

The Government commissioned review, led by Dr Penny Dash, Chair of NHSE, was also published in early July. The review looked at 6 bodies and how they work within the wider health and care landscape, with a particular focus on patient safety. These were the Care Quality Commission (CQC), National Guardian's Office, Healthwatch England and the Local Healthwatch network, Health Services Safety Investigations Body (HSSIB), Patient Safety Commissioner and NHS Resolution.

The review highlighted the complexity and duplication, alongside existing gaps, in the regulatory and oversight system for patient safety, and made a series of recommendations, summarised as:

- Revamp and enhance the role of the National Quality Board (NQB). The review suggests that the NQB will provide a new quality strategy by March 2026 and will provide a single determination of quality.
- Rebuild the CQC with a clear remit and responsibility.
- Continue the Health Services Safety Investigation Body's role as a discrete branch within the CQC and centre of excellence for investigations.
- Transfer the Patient Safety Commissioner functions around medicines and medical devices to the Medical and Healthcare Products Regulatory Agency (MHRA), and broader patient safety work to a new directorate for patient experience within NHSE, transferring to the Department of Health & Social Care (DHSC).
- Bring together the work of local Healthwatch, and the engagement functions of integrated care boards (ICBs), to ensure patient and wider community input into the planning and design of services.
- Streamline functions relating to staff voice.

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- Reinforce the responsibility and accountability of commissioners and providers in the delivery and assurance of high-quality care.
- Technology, data and analytics to play a more significant role in supporting the quality of health and social care.
- There should be a national strategy for quality in adult social care.

In addition, the review includes a series of next steps to support implementation, with several areas highlighted in the 10 YHP. As with the 10 YHP, legislation will need to be changed to enact several of the recommendations.

3. Tameside & Glossop Integrated Care NHS Foundation Trust (TG ICFT) and Stockport NHS Foundation Trust (SFT) Collaboration

As I commenced in post in April, both Trust Boards spent time thinking about its key challenges and opportunities for the future, acknowledging the importance of working together to maximise the opportunities joint working could bring for our local populations, patients and staff.

In July, we held our first joint TG ICFT and SFT board development session, to develop a clear vision on what will be achieved by working together and initiated the development of our Joint Organisational Strategy. We reflected on our current alignment and collectively considered areas for strategic focus, mindful of the wider NHS reform ahead. This discussion was the start of a period of broader stakeholder engagement over the coming year.

We also started to consider how our governance arrangements can support the delivery of our joint ambitions. At the session, we took time to reflect on the range of joint governance arrangements already in place across the country, as we begin to develop a joint governance model tailored to our local circumstances.

These are matters that will be discussed regularly as we move forward, including at our next joint TG ICFT and SFT board development session in September 2025.

4. Trust Activities

I have continued my visits throughout the Trust, developing my understanding of the services provided and hearing the views of our colleagues. Over recent months I have visited some of areas of our most challenged estate including Beech House (IT services), along with the Emergency Department, Clinical Decision Unity (CDU), Treehouse, Fracture Clinic and Audiology. I was pleased to attend the opening of the Acute Frailty Unit (AFU) Therapy Garden and Treehouse Celebration Event, both supported by the Trust Charity.

I attended my first Stockport Health & Well Being Board in June and have arranged to meet with the Chief Executive of Stockport Metropolitan Borough Council (SMBC), Michael Cullen, to discuss the opportunities of our place-based partnership.

I have also attended several national and regional meetings, hearing from NHS England CEO, Sir Jim Mackey, regarding the launch of the 10 YHP. As part of these meetings, I have discussed the options available for securing the capital required for the development of both Stockport and Tameside & Glossop sites and am hopeful that we will see some progress in the coming months. I have also met with the ICB Chief Executive, Mark Fisher, to discuss our operational and financial risks and the potential mitigations and help required.

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In addition, I continue to attend the Greater Manchester (GM) Providers Chairs meeting with discussion focused on opportunities and challenges we face as a system.

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				Agenda No.	7
Meeting date	7 th August 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

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

- NHS England Urgent and Emergency Care Plan (UEC Plan)
- NHS Performance Assessment Framework: Segmentation
- Greater Manchester Integrated Care Board (GM ICB): Response to ICB Blueprint
- Industrial Action
- Trust Operational Pressures
- Success & Celebrations

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1. NHS England Urgent and Emergency Care Plan (UEC Plan)

NHS England (NHSE) have set out a high-level plan to improve UEC performance and prepare for winter. It highlights seven key areas of focus. These are:

- Category 2 patients must receive an ambulance within 30 minutes
- Ambulance handovers must not exceed 45 minutes
- At least 78% A&E patients to be discharged, admitted or transferred within 4 hours
- Less than 10% patients to wait over 12 hours for admission or discharge from an ED
- Reduce the number of mental health patients waiting in EDs for over 24 hours
- Reduce the number of patients staying 21 days over their discharge-ready date
- See more children within 4 hours

For provider Trusts specifically, there is focus on improving patient flow and optimising systems to direct less urgent cases. Trusts are required to develop an organisational winter plan, completing a draft by end August and ensure preparatory actions, including staff vaccination programmes, are in progress. Preparation work is well underway on the Trust's UEC Winter Plan, which includes sign-off of a Board Assurance Statement, to be submitted to NHS England by 30th September 2025.

2. NHS Performance Assessment Framework: Segmentation

Following publication of the updated NHS England (NHSE) Performance Assessment Framework for 2025/26, the Trust has received provisional data regarding its segmentation and ranking. Publication of the data and segmentation was expected from mid-July; at the time of writing this report, data had not yet been published.

As previously reported, any organisation reporting a financial deficit would be limited to Segment 3 (but could still be placed in Segment 4 or 5).

3. Greater Manchester Integrated Care Board (GM ICB) Blueprint

As previously reported, the ICB blueprint reframes the core purpose, role and functions of ICBs in line with the forthcoming 10 Year Health Plan (10 YHP). The primary role of the ICBs will be improving population health as strategic commissioners.

All ICBs are required to submit cost reduction plans based on a revised running cost envelope of £18.76 per head of population. These reductions must be delivered 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 Trust is engaging with system partners to create a plan to meet the objectives of the ICB blueprint. GM ICB will be required to report back to the national team at the end of July/beginning of August. To date we have not formally seen the proposals.

There remains uncertainty regarding any voluntary redundancy schemes which if not available will hinder any progress toward any new desired state.

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 July, the BMA confirmed that Resident Doctors had voted in favour of strike action, with the

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first strike action taking place from 25th - 30th July. The union has a mandate for industrial action for six months, up to January 2026 and further dates are anticipated.

During the strikes held in 2023 and 2024, the Trust established an Industrial Action Planning Group and recommenced meetings in preparation for future industrial action. A verbal update regarding high-level impact of the strike for the Trust will be provided at the meeting.

The BMA is also balloting senior staff groups, including consultants and specialist doctors, and the Royal College of Nursing is currently consulting with members on this year's pay offer.

6. Trust Operational Pressures

The Trust continues to experience significant challenges with respect to urgent & emergency care where performance for both the 4 hour and 12 hour standard remains both below trajectory and the national target. We have rebranded the Multi-Agency Discharge Events to 'Focus on Flow' encompassing a broader and holistic approach that looks beyond discharge planning to every stage of the patient journey. The shift emphasises system-wide coordination, finding alternatives to hospital admission and promoting community delivered care.

With respect to elective performance, cancer performance remains on track, with further improvement required with respect to referral to treatment and diagnostics performance. Further discussion regarding operational performance will take place as part of the Integrated Performance Report.

7. Successes & Celebrations

7.1 Kings Trust Award

Annela Hussain, our Vocational Learning Lead, was invited to the Kings Trust Awards in recognition of her contribution and support of the Young Care Leavers, Kings Trust NEETs (Young people not in employment, education or training) and pre-employment programmes.

7.2 Acute Frailty Unit Therapy Garden

Our new charity-funded garden, designed to offer therapeutic support and a calming environment has now opened and is set to benefit patients with a wide range of long-term conditions, including those living with dementia and mobility issues.

The Acute Frailty Unit Therapy Garden, which has transformed a once-neglected courtyard, was funded by a £68,000 grant from the Greener Communities Fund, which exists to create and enhance green spaces and improve access to nature for NHS staff and patients.

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				Agenda No.	8
Meeting date	7 August 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 an Alert, Advise and Assure 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 June and July 2025, noting areas of alert, advice and assurance.

ALERT, ADVISE & ASSURE (AAA) REPORT

Name of Committee/Group	Finance & Performance Committee
Chair of Committee/Group	Tony Bell, Non-Executive Director
Date of Meeting	19 June 2025 and 17 July 2025
Quorate	Yes

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

1.	Agenda	<p>In June, the Committee considered an agenda which included the following:</p> <ul style="list-style-type: none"> • Operational Performance Report • Finance Report – Month 2 • Board Assurance Framework and Aligned Significant Risks • Standing Committees Alert, Advise & Assure Reports: <ul style="list-style-type: none"> - Capital Programme Management Group - Digital & Informatics Group <p>In July, the Committee considered an agenda which included the following:</p> <ul style="list-style-type: none"> • Operational Performance Report • Finance Report – Month 3 • Productivity and Stockport Trust Efficiency Programme / Cost Improvement Programme (STEP / CIP) (Verbal update) • Pharmacy Shop Update • Stockport Children's Therapy Services – Tender Outcome • Stockport Community IV Therapy Tender Bid • Contracts for Approval • Review of New Joint Green Plan to Recommend to Board • Digital Strategy Progress Report • Standing Committees Alert, Advise & Assure Reports: <ul style="list-style-type: none"> - Capital Programme Management Group
2.	Alert	<p>Concerns regarding the delivery of the 78% Emergency Department (ED) 4-hour trajectory by year-end, given historical performance in this area and the need for system flow improvement, as stated in the Trust's Operational Plan submission.</p> <p>Concerns regarding paediatric audiology and the consequent adverse impact on children, the diagnostic target and future sustainability of the service.</p> <p>Concerns regarding reduction in discharge to assess beds which is anticipated to impact on ED performance and flow, with the risk to winter performance acknowledged.</p> <p>Concerns regarding the risk of non-achievement of the Financial Plan given significant associated risks. Concerns also regarding Stockport Trust Efficiency Programme (STEP) / Cost Improvement Plan (CIP) year-end delivery.</p>
3.	Advise	<p>The Committee received the Finance Report for Month 3 and noted:</p> <ul style="list-style-type: none"> • Overall, at month 3 the Trust was reporting a break-even position against

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		<p>plan to date and a net deficit of £4.1m. At this point the forecast for year-end was in line with plan, however there are some key risks in the plan which will be monitored throughout the year.</p> <ul style="list-style-type: none"> • The STEP plan for 2025/26 was £29.2m (£20.5m recurrent). The Committee heard that STEP of £17.6m (60%) had been actioned against the in-year target, and year to date STEP was £0.3m behind the efficiency plan. • The Trust has maintained sufficient cash to operate during June. • The Capital forecast for 2025/26 was £37.4m, in line with plan. <p>The Committee received a verbal update regarding Productivity and STEP/CIP, with a written report to be presented to the September Committee meeting.</p> <p>The Committee received a Pharmacy Shop update report and noted qualitative and quantitative benefits of the service, including improved patient experience.</p> <p>The Committee received the Operational Performance Report for Month 3, 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.</p> <p>The Committee reviewed and recommended the new Joint Green Plan to the Board of Directors for approval.</p> <p>The Committee reviewed and approved the finance and performance related principal risks to be presented as part of the Board Assurance Framework 2025/26 to the Board of Directors in August 2025.</p>
4.	Assure	The Committee acknowledged positive assurance regarding ED performance in month, with performance overachieving against the trajectory, and improvements in Referral to Treatment performance.
5.	Referral of Matters/Action to Board/Committee	The Committee reviewed and recommended the new Joint Green Plan 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

Curtis, Soile
07/08/2025 06:56:20

				Agenda No.	9
Meeting date	7 th August 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	x	Assurance	x	Decision	x
Recommendation:	The Board 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.

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Integrated Performance Report

Reporting period

June 2025

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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, Incidents, and Maternity.

- Mortality rates continue to report below the expected threshold, with Stockport benchmarking well across GM.
- Sepsis performance measures are both showing deterioration in performance, with antibiotic administration below the 90% target. Delays attributed to the out-of-hours service, underutilisation of the 2222 service, and delays in prescribing.
- Reported infection rates for C. diff show improvement since the high reported in February of this year. Rates of E. coli infection show now significant changes. No additional cases of MRSA have been reported since February.
- The number of hospital-acquired pressure ulcers show sign of improvement across all categories, with total numbers below the target threshold. Community-acquired pressures ulcers do show an increase in numbers, although so far investigations have found that none are due to lapses in care.
- The Trust written complaints rate has not seen any significant changes since January 2024. Key themes include communication, clinical treatment, and patient care.
- Although patient safety incident rates do report an increasing trend, there are no reported issues in this area. All other metrics reported for incidents and risk are within local thresholds.
- Smoking during pregnancy performance is showing signs of improvement, with performance reported below the improvement trajectory for the last 3 months.

Operations Highlight

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

- Performance against the ED 4-hour standard shows strong improvement for June at 74%. June has also seen a decrease in patients waiting more than 12 hours in department.
- The number of patients with “No criteria to reside” is above the local threshold of 45. Reduced community capacity and availability of patient transport are sighted as risks affecting performance.
- Diagnostic performance shows no significant changes at Trust level. Although significant backlog reductions can be seen in Echo, Audiology and Endoscopy remain challenging areas.
- 62-day and 31-day cancer standards are reported below trajectory. Capacity in Urology Oncology, Lung, and capacity for robotic theatres procedures are key risks.
- RTT patients over 52-weeks are now reported under 1000. 65-week waits remain an area of concern, but action plans are in place to achieve 0 by October 2025.
- 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 DNA rates have shown significant improvement but remain above the target threshold.
- Performance in theatre capped touch time utilisation is improving. Productivity Improvement work continues to focus on patient flow from recovery to wards, cancellations and late starts.

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 Appraisal rates, and Mandatory training.

- Performance of monthly sickness absence rates are improving, with the latest position reported below the 5.5% target threshold.
- 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. A new process for non-compliance is to be shared with Trade Union colleagues, with an anticipated launch during September 2025.
- Agency costs are now showing no significant changes and are still reported below the Trusts local threshold of 3.2%.

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Finance Highlight

The annual plan for 2025-26 is to deliver a balance plan. At month 3 both in year and year to date, the Trust has a £4.1m deficit, which is in line with the Trust's financial plan

- The forecast at month 3 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 £17.6m (60%) of the full year CIP target has been delivered, and £11.4m (55%) of the recurrent target.
- The status of the Trust CIP delivery is being monitored on a weekly basis by NHSE. The reporting is linked to the status of PIDs. By the end of June 2025 there was a requirement for:
 - 75% of schemes to have been fully scoped, including PID approval – achieved (now 82% of £ value)
 - Zero unidentified balance – achieved
- The Trust has maintained sufficient cash to operate during June. 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 submitted a capital plan for 2025/26 of £35.4m including £1.9m for IFRS16. This increased in May by £1.3m for the approved MacMillan information centre, plus a further £0.7m in June in respect of additional PDC for an approved diagnostics request (£0.6m) and additional estates safety (£0.1m). This takes the total plan to £37.4m.

Integrated Performance Report Scorecard

	Reporting Period	Latest Target	Actual YTD	6-mth Trend	Actual Month	Current Period	1-mth Forecast
Quality Scorecard							
Mortality: SHMI	Apr-24 to Mar-25	≤ 100		→	94	●	●
Sepsis: Timely recognition	Jul-24 to Jun-25	≥ 90%		↓	95.1%	●	●
Sepsis: Antibiotic administration	Jul-24 to Jun-25	≥ 90%		↔	74.7%	▲	▲
C.diff infection rate	Jul-24 to Jun-25	≤ 40.32		↔	37.66	●	●
MRSA infection rate	Jul-24 to Jun-25	≤ 0.92		↓	0.92	●	▲
E. coli infection rate	Jul-24 to Jun-25	≤ 33.09		↔	36.29	▲	▲
Stroke: Overall SSNAP Level	Sep-24	≥ C		→	A	●	●
Pressure Ulcers: Hospital, Cat 2	Jun-25	≤ 56	8	↔	2	●	●
Pressure Ulcers: Hospital, Cat 3&4	Jun-25	≤ 18	2	↔	1	●	●
Pressure Ulcers: Community, Cat 2	Jun-25	≤ 121	37	↔	13	▲	▲
Pressure Ulcers: Community, Cat 3&4	Jun-25	≤ 54	8	↔	3	●	●
Complaints: Written Complaints Rate	Jun-25	≤ 9.3	9.6	↔	9.16	●	▲
Complaints: Timely response	Jun-25	≥ 95%	96.6%	↔	94.7%	▲	▲
Patient Safety Incident Rate	Jan-25 to Jun-25	≤ 91.92		↓	95.74	▲	▲
Patient Safety Incident Investigatio..	Jun-25		8	↔	0	●	●
Never Event Incidence	Jun-25	≤ 0	0	↔	0	●	●
Early Neonatal Deaths	Jun-25	≤ 0	1	↔	0	●	●
Registrable Stillbirth Rate	Jun-25	≤ 0	3	↔	4.88	▲	▲
Smoking In Pregnancy	Jun-25	≤ 5.2%	2.3%	↔	1.6%	●	●
Maternity Diverts	Jun-25	≤ 0	0	↔	0	●	●

Finance Scorecard							
Capital Expenditure	Jun-25	≤ 10%		↔	231.4%	▲	▲
Cash Balance	Jun-25			↔	31.7		
CIP Compliance Achievement	Jun-25	≥ 0%		↓	-5.4%	▲	▲
Financial Performance: I&E Position	Jun-25	≤ 0%		↔	-0.8%	●	●

Legend				
1-month Forecast	Current Period	6-month Trend		
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.	● target achieved	↑ strong improvement		
	▲ target not achieved	↔ improvement		
		→ no significant change		
		↔ deterioration		
		↓ strong deterioration		

	Reporting Period	Latest Target	Actual YTD	6-mth Trend	Actual Month	Current Period	1-mth Forecast
Operational Scorecard							
4hr Standard	Jun-25	≥ 68.5%	69.2%	↑	74%	●	●
Patients in department over 12hrs	Jun-25	≤ 9%	10.3%	↔	6.1%	●	●
Ambulance handover time	Jun-25	≤ 23.11		↔	21.3	●	●
No criteria to reside (NCTR)	Jun-25	≤ 45	226	↔	78	▲	▲
Adult G&A Bed Occupancy	Jun-25	≤ 92%	95.8%	↔	95.1%	▲	▲
Timely discharge	Jun-25	≥ 85%	80.9%	↔	80.9%	▲	▲
Average discharge delay	Jun-25	≤ 6.7		↔	4.5	●	●
Length of stay: Elective	Oct-24 to Mar-25	≤ 3.7		↔	2.12	●	●
Length of stay: Non-elective	Oct-24 to Mar-25	≤ 11.1		↑	10.27	●	●
Diagnostics: 6-week Standard	Jun-25	≤ 23.9%	23.6%	↔	22%	●	●
62-day standard	Jun-25	≥ 70.8%	67.7%	↔	60.3%	▲	▲
31-day standard	Jun-25	≥ 94.5%	89.9%	↔	86.8%	▲	▲
28-day standard (FDS)	Jun-25	≥ 78%	79.3%	↔	80.9%	●	●
14-day standard (2WW)	Jun-25	≥ 93%	95.4%	↔	97.7%	●	●
Incomplete pathways 18-week %	Jun-25	≥ 56.1%		↑	57.1%	●	●
52-week breaches	Jun-25	≤ 1422		↑	993	●	●
65-week breaches	Jun-25	≤ 0		↔	21	▲	▲
52-week breach %	Jun-25	≤ 4.1%		↑	2.9%	●	●
Wait for first attendance 18-week %	Jun-25	≥ 63.5%	64.5%	↑	64.6%	●	●
Virtual Ward Utilisation	Jun-25	≥ 80%	51.6%	↓	51.2%	▲	▲
Urgent Community Response	May-25	≥ 70%		↓	78.1%	●	●
Outpatient DNA rate	Jun-25	≤ 6.3%	6.7%	↑	6.8%	▲	▲
Outpatient clinic utilisation	Jun-25	≥ 90%	95.7%	↔	95.5%	●	●
Patient initiated follow up (PIFU)	Jun-25	≥ 5%	5.9%	↑	5.9%	●	●
OP First Attend and Procedure	Jun-25	≥ 43.7%	42.4%	↔	42.8%	▲	▲
Capped Touch Time Utilisation	Jun-25	≥ 85%	78.8%	↔	79.4%	▲	▲

Workforce Scorecard							
Substantive Staff-in-Post	Jun-25	≥ 90%	95.2%	↑	95.6%	●	●
Sickness Absence: Monthly Rate	Jun-25	≤ 5.5%	5.4%	↔	5.2%	●	●
Workforce Turnover	Jun-25	≤ 12.7%	11.5%	↑	11.5%	●	●
Appraisal Rate: Overall	Jun-25	≥ 95%	82.6%	↓	80.6%	▲	▲
Mandatory Training	Jun-25	≥ 95%	93.2%	↓	92.4%	▲	▲
Agency Costs %	Jun-25	≤ 3.2%	2%	↔	2.1%	●	●

Quality Sepsis

Target	Actual	6-month trend	Previous Performance					1-month Forecast
>= 90%	95.1%	↓	●	●	●	●	●	●
>= 90%	74.7%	↔	▲	▲	▲	▲	▲	▲

Sepsis: Timely recognition The number of patients who are screened for sepsis, as a percentage of those eligible patients audited.

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.

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

- 99% timely recognition in June, 12 month rolling figure 95%, ahead of trust target
- 69/70 sepsis triggers were reviewed on time
- 1 audit fail for TR: M6
 - Delay time: 8 mins, Trigger time at 09:55 – review time at 11:03
 - Had a discussion with Sr. Sarah Frost and mentioned that the doctor was attending another red flag sepsis call at the time of trigger
- Fail was a Red Flag Sepsis and happened OOH – 2222 not utilised in this occasion
- Red flag sepsis was raised on e-task

Antibiotic administration

- 60% compliance with antibiotics administration for the month of June, compared with 83% in May
- 6/10 patients screened for sepsis received antibiotics in accordance with trust guidelines.
- Red flag sepsis: 4/8 were compliant
- Amber flag sepsis: 2/2 were compliant
- 4 audit fails for antibiotic administration: M6, B2, D7, and D5
 - Ward M6 – Red Flag Sepsis trigger with BP 88/46, OOH trigger, Delay time: 270 mins – Prescribed at 15:09, administered at 15:25 with trigger time at 09:55, Escalated to ward managed with ongoing Datix
 - Ward B2 – Red Flag Sepsis trigger, OOH – 2222 not utilised, Delay time: 6 mins – Prescribed at 03:16, administered at 04:06 with trigger time at 03:00
 - Ward D7 – Red Flag Sepsis trigger, OOH – 2222 not utilised, Delay time: 17 mins – administered at 07:13, with trigger time at 05:56
 - Ward D5 – Red Flag Sepsis trigger, OOH – 2222 not utilised, Delay time: 88 mins – Prescribed at 19:30, administered at 21:06 with trigger time at 18:38, Escalated to ward manager with ongoing Datix

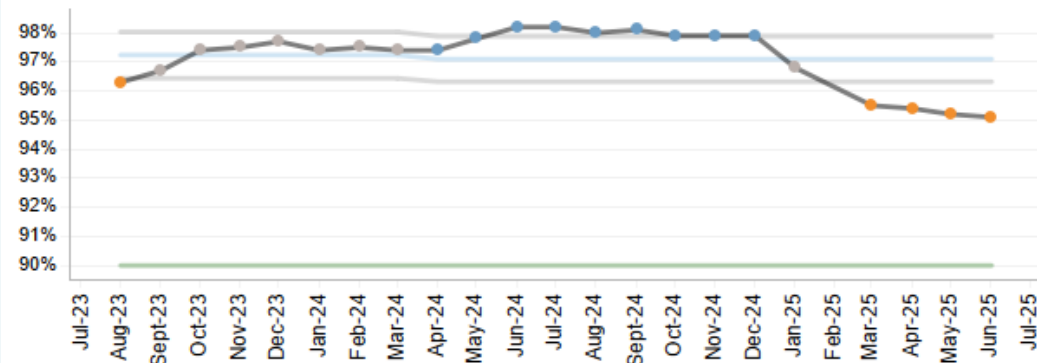
Key Events/ Ongoing Issues

- Both timely recognition and antibiotics administration delays occurred OOH
- 2222 continues to be underutilised during out of hours for red flag sepsis
- Antibiotic delays: 270 mins, 6 mins, 17 mins, and 88 mins (average: 95mins)
- A delay in prescribing, resulting in antibiotic administration being given after the 60-minute target for RFS
- Sepsis 6 assessments that were completed and finalised by clinicians: 27/96
- Wards that achieved 100% both in timely recognition and antibiotic administration for June: M4, AFU, A3, D8, A11

Target	Actual	6-month trend	Previous Performance					1-month Forecast
>= 90%	95.1%	↓	●	●	●	●	●	●
>= 90%	74.7%	↔	▲	▲	▲	▲	▲	▲

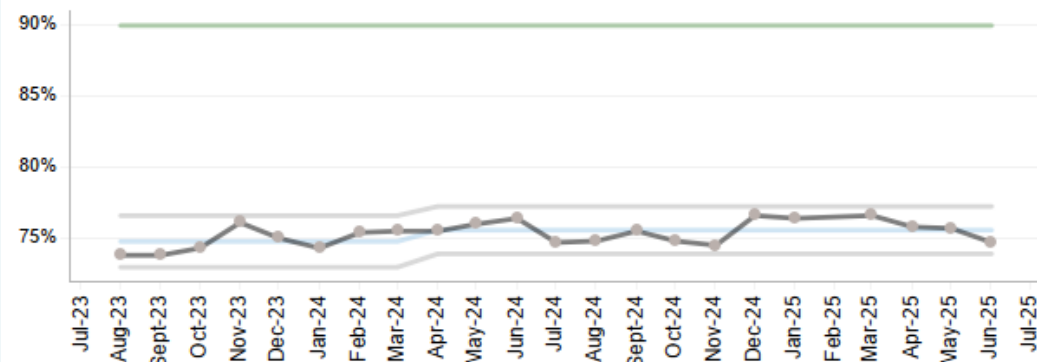
■ Performance ■ Target / Improvement Trajectory ■ Average ■ Control Limits

Performance for Sepsis: Timely recognition



The latest data point is below the lower control limits. This could be viewed as a concern.

Performance for Sepsis: Antibiotic administration



The latest data point is within the control limits. This is viewed as common cause or normal variation.

Update provided by

Christe Bolanio

Executive Lead

Andrew Loughney

Quality Infection Prevention & Control

Target	Actual	6-month trend	Previous Performance					1-month Forecast
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C.diff infection rate	The number of healthcare-associated Clostridioides Difficile (C. diff) infections per 100,000 bed days for patients aged 2 years and older.	<= 40.32	37.66	↗	▲	▲	▲	▲	●	●	●
MRSA infection rate	The number of hospital-onset Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia infections per 100,000 bed days.	<= 0.92	0.92	↘	▲	▲	▲	●	●	●	▲
E. coli infection rate	The number of Escherichia Coli (E. coli) bacteraemia infections per 100,000 bed days.	<= 33.09	36.29	↔	▲	▲	▲	▲	▲	▲	▲

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

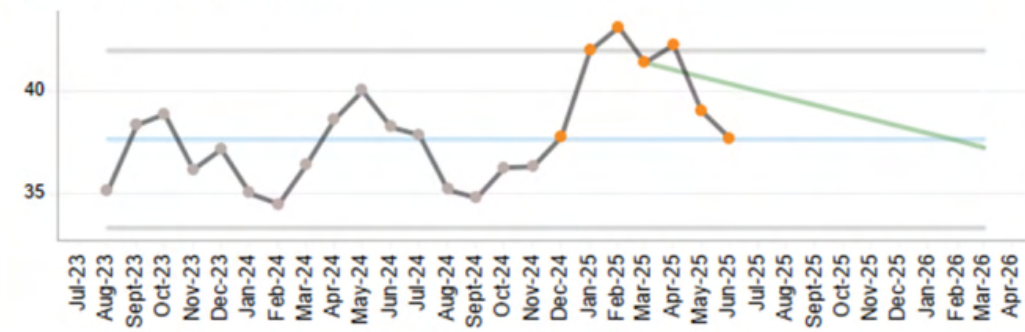
- There were 1 HOHA and 3 COHA cases in June, totalling 20 cases YTD. The Trust is under the projected threshold of 20.5 for the end of June. Of the 20 cases:
- 0 cases were attributable to the Trust due to the apportionment rule change from April 24.
- 1 HOHA case was a repeat sample of a known and continuing infection taken from a Trust location. Upon review at HCAI panel this re-sample was deemed appropriate.
- 2 COHA cases were repeat samples of known and continuing infections. 1 was taken from a GP location and 1 from a Trust location.
- 19 cases have been presented to the HCAI Panel, with 1 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 (Apr 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 case numbers and ongoing actions we are taking.
- Following the review of cases with a potential link of using co-amoxiclav in treatment of sepsis of unknown origin, the antibiotic guidelines were changed from the 1 May 2025. The impact of this will be monitored. The appropriateness of resampling known cases after 28 days is being monitored.

E. coli infection rate

- There were 3 HOHA and 3 COHA cases in June totalling 23 YTD. The Trust is over the projected threshold of 17.25 for the end of June.
- The latest National figures (Apr 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.

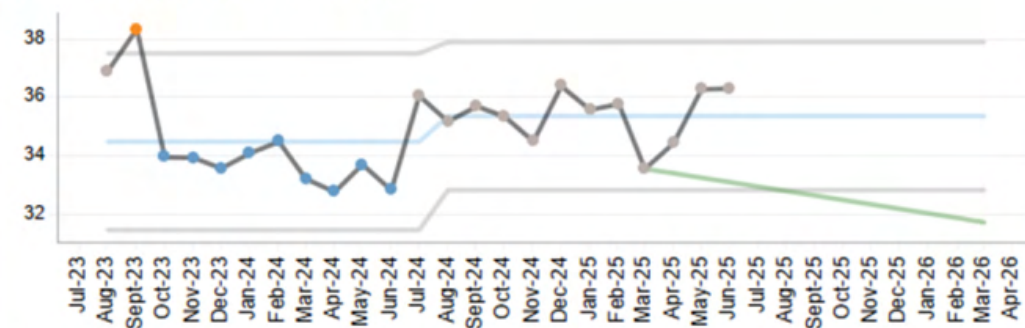
■ Performance ■ Target/Improvement Trajectory ■ Average ■ Control Limits

Performance for C.diff infection rate



There have been 7 or more consecutive data points above the mean. This shift could be viewed as a concern.

Performance for E. coli infection rate



The latest data point is within the control limits. This is viewed as common cause or normal variation.

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.	≤ 4	2	➔	● ● ● ● ● ▲ ●	●
Hospital, Category 3&4	Total number of category 3 and category 4 pressure ulcers in a hospital setting - includes device-related pressure ulcers.	≤ 1	1	➔	▲ ▲ ● ▲ ● ● ●	●
Community, Cat 2	Total number of category 2 pressure ulcers in a community setting.	≤ 10	13	➔	● ▲ ▲ ▲ ▲ ● ▲	▲
Community, Category 3&4	Total number of category 3 and category 4 pressure ulcers in a community setting - includes device-related pressure ulcers.	≤ 4	3	➔	● ● ▲ ▲ ● ● ●	●

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 (June), there have been 2 category 2 pressure ulcers reported.
- Investigations: Both of these incidents have been investigated and found no lapses in care.
- Trends: There has been a reduction in pressure ulcers reported this month which, and so we are on trajectory to meet our reduction target.
- Strategies: The pressure ulcer prevention and management policy has been updated and awaiting document approval to be re-launched. We had a successful launch of a new heel off-loading guidance within the '5in5' awareness week and updated the 7-minute briefing to a '5 in 5'

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

- Current Data: This month (June), there has been 1 category 3 pressure ulcer reported.
- Investigations: The outcome of the investigation identified no lapses in care.
- Actions: No actions were required.

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 (June), 13 category 2 pressure ulcers were reported.
- Trends: There continues to be delays in investigations into the community category 2 pressure ulcers. Of the incidents reported in June, 4 have been investigated and found no lapses, the rest remain outstanding. To date 40% of category 2 pressure ulcers are without an outcome of investigation.

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

- Current Data: This month (June), x2 category 3 and x1 category 4 pressure ulcers were reported in the community.
- Investigations: Each incident is investigated and reviewed to identify any learning or lapses in care, neither incident was found to have any lapses in care. 2 of these 3 incidents are still waiting to be heard at PSIRG, for the remaining incident no lapses in care were found.

Update provided by

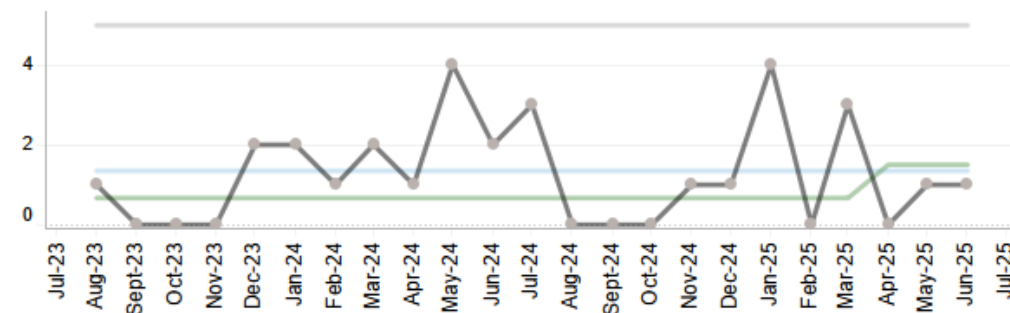
Lisa Gough

Executive Lead

Nic Firth

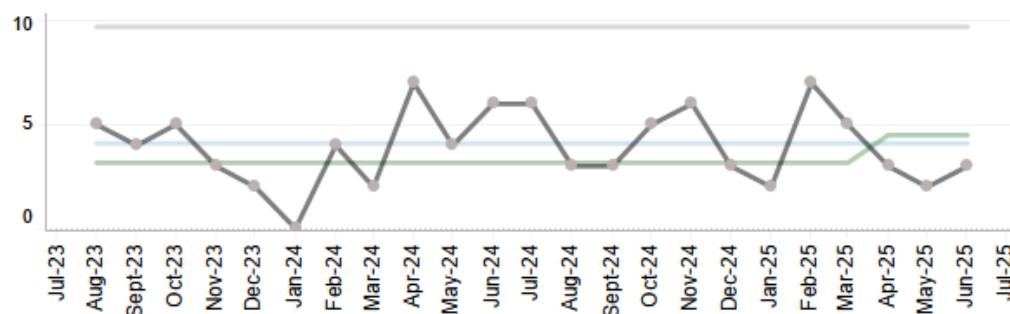
■ Performance ■ Target/Improvement Trajectory ■ Average ■ Control Limits

Performance for Pressure Ulcers: Hospital, Cat 3&4



The latest data point is within the control limits. This is viewed as common cause or normal variation.

Performance for Pressure Ulcers: Community, Cat 3&4



The latest data point is within the control limits. This is viewed as common cause or normal variation.

Quality Complaints

Target	Actual	6-month trend	Previous Performance	1-month Forecast
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Written Complaints Rate	Number of formal written complaints received, calculated as an incidence rate for every 1000 whole time equivalent staff in post.	<= 9.3	9.16	➔	▲ ● ▲ ▲ ▲ ● ▲
Timely response	The total number of formal complaints responded to within agreed timescales, as a percentage of all formal complaints responded to.	>= 95%	94.7%	➔	● ● ▲ ● ▲ ▲ ▲

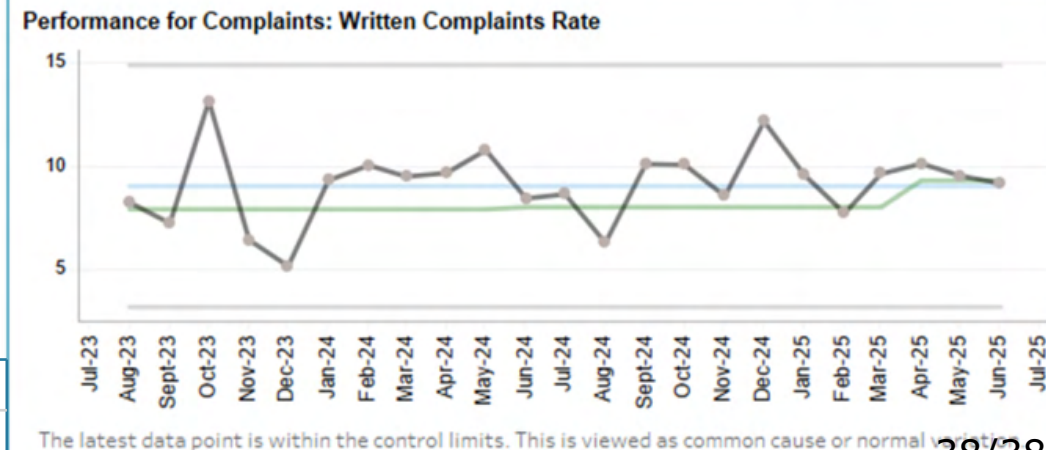
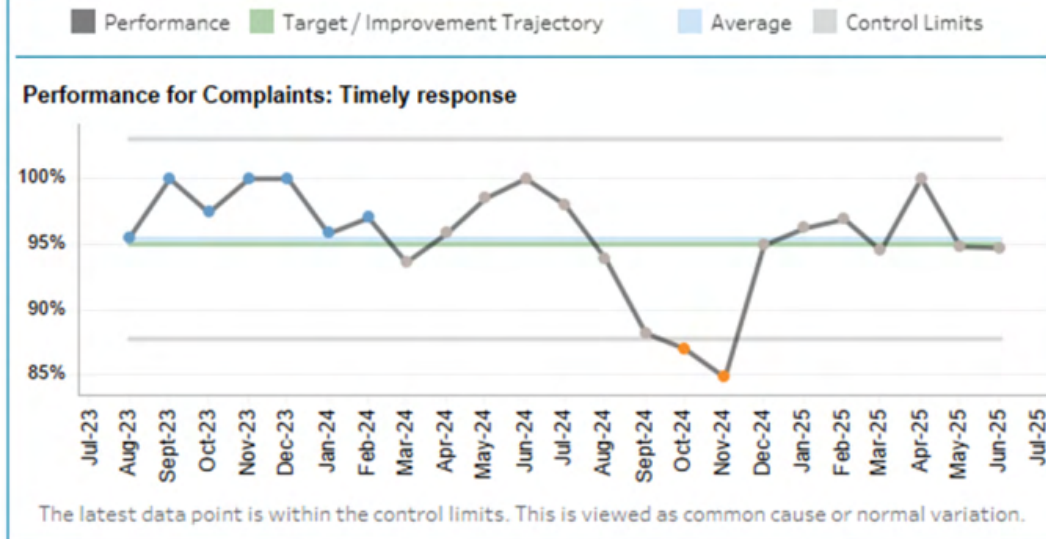
Timely response

- 38 responses were sent out in June 2025 with two being sent outside of the agreed timeframe, resulting in a 94.7% response rate. Rounded up this would be 95%, which is the Trust's target compliance.
- The organisation continues to see a high number of complaints being received and the team continue to work under significant pressure to ensure responses are as robust and timely as possible, in order to maintain a high response rate.

Written Complaints Rate

- 52 formal complaints were received in June 2025 - Clinical Support Services = 1, Integrated Care = 4, Medicine & UC = 20, Surgery = 14, Women & Children = 9, Corporate = 2, Estates & Facilities = 2.
- The team continue to focus on resolving concerns via early resolution, where appropriate, with the hope to reduce the number of formal complaints.
- Top five themes for formal complaints in June 2025 was as follows:
 - Communication
 - Clinical treatment
 - Patient care
 - Staff values and behaviours
 - Admin procedures and record management
- Top five themes for informal/early resolution concerns in June 2025 was as follows:
 - Appointments
 - Communication
 - Admin procedures and record management
 - Access to treatment or drugs
 - Patient Care

Curtis Soile
07/08/2025 06:56:20



Update provided by	Paula Bowker
Executive Lead	Nic Firth

Quality Incidents & Risk

	Target	Actual	6-month trend	Previous Performance						1-month Forecast
Patient Safety Incident Rate The number of patient safety incidents, calculated as an incidence rate for every 1000 bed days. This average is calculated using a rolling 6 months of data.	<= 91.92	95.74	↓	▲	▲	▲	▲	▲	▲	▲
Patient Safety Alert Compliance The number of national patient safety alerts not completed to deadline.	<= 0	0	→	●	●	●	●	●	●	●
Patient Safety Incident Investigations A count of the patient safety incident investigations (PSII) that have been declared in month.		0	→							
Never Event Incidence Total number of never events. Never events are serious, largely preventable patient safety incidents that should not occur.	<= 0	0	→	●	●	●	●	●	●	●

Patient Safety Incident Rate

- There are no issues related to patient incidents to report.
- The Incident Review Group meets on a weekly basis to review incidents with a focus on those where harm has been attributed, as well as other topics of interest.
- Pressure ulcer incidents are reviewed at the Pre Harm Free Care Panel on a weekly basis.
- Patient falls incidents are reviewed at the Falls Review Panel on a weekly basis.
- Security & Safeguarding Meeting takes place weekly to review Security related incidents.

Patient Safety Alerts

- There were no National Patient Safety Alert with a completion deadline in June 2025.
- At the end of June there were no overdue National Patient Safety Alerts.

Patient Safety Incident Investigations

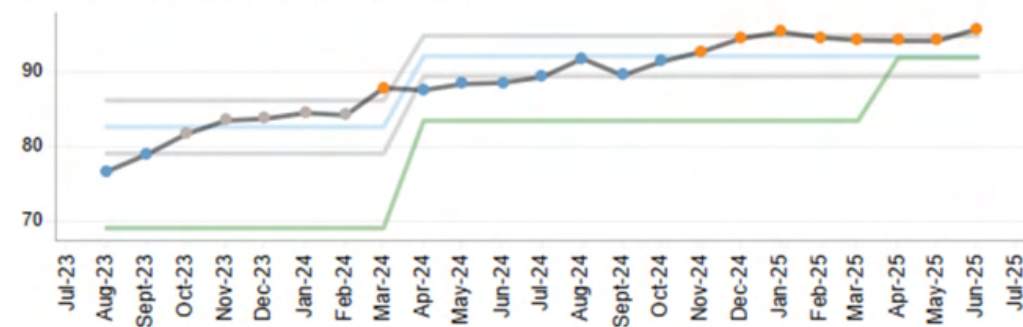
- There were no Patient Safety Incident Investigations declared in June 2025.

Never Event Incidence

- No never events were reported in June 2025.

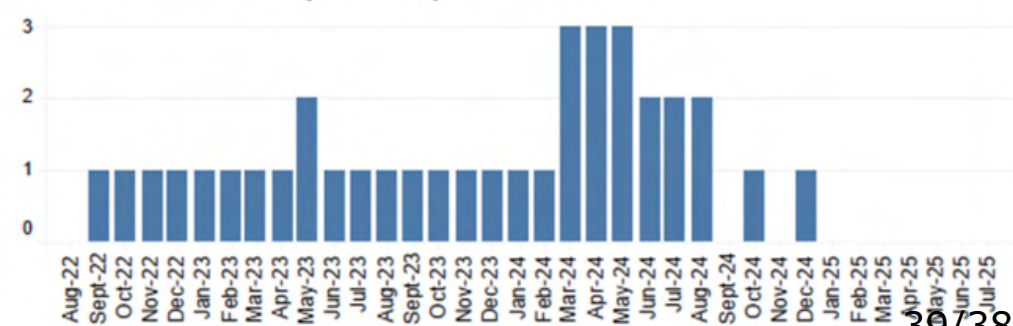
■ Performance ■ Target/Improvement Trajectory ■ Average ■ Control Limits

Performance for Patient Safety Incident Rate



There have been 7 or more consecutive data points above the mean. This shift could be viewed as a concern.

Performance for Patient Safety Alert Compliance



Curtis Soile
07/08/2025 06:56:20

Update provided by

Catherine Toksoy

Executive Lead

Nic Firth

Quality Maternity

	Target	Actual	6-month trend	Previous Performance						1-month Forecast
Early Neonatal Deaths	≤ 0	0	➔	●	●	●	●	●	●	●
Registrable Stillbirths	≤ 0	1		●	▲	●	▲	●	▲	▲
Registrable Stillbirth Rate	≤ 0	4.88	➔	●	▲	●	▲	●	▲	▲
Smoking In Pregnancy	≤ 5.2%	1.6%	➔	●	▲	▲	●	●	●	●
Maternity Diverts	≤ 0	0	➔	●	●	●	●	●	●	●

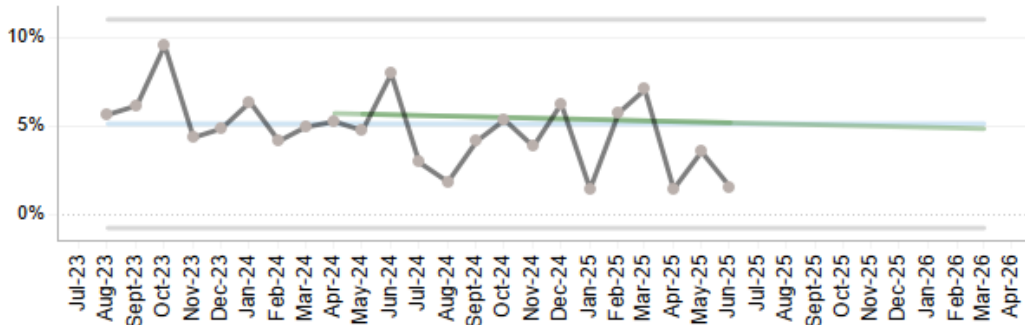
Smoking in Pregnancy: This metric excludes women whose smoking status was not known at the time of delivery, and only includes women initially booked with us who then delivered with us. Women known to be smokers at the time of delivery are defined as pregnant women who self-reported that they were smokers. 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.

- Registrable Stillbirths**
- The service had 1 Registrable stillbirth in June 2025.
 - 24+2, diagnosed as a Fetal Death in Utero (FDIU) at less than 24 weeks, but did not deliver until after 24 weeks, therefore this was classed as a registrable birth and a stillbirth certificate issued.

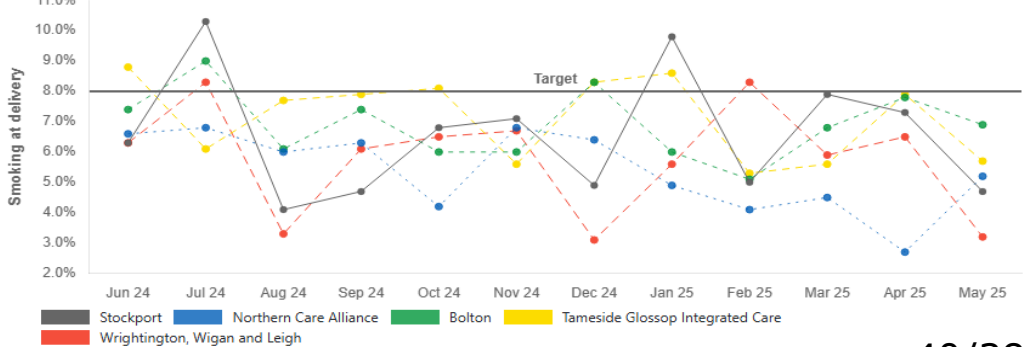
- Smoking in pregnancy**
- The percentage of women (who had initially booked and progressed to deliver with our service) who were smoking at time of delivery in June 2025 was 1.62%, which continues to be below target.



Performance for Smoking In Pregnancy



Benchmark data for Smoking at Delivery from Public View – May 2025



Curtis Soile
07/08/2025 06:56:20

Signed off by	Sharon Hyde
Executive Lead	Nic Firth

Operations Emergency Department

Target	Actual	6-month trend	Previous Performance	1-month Forecast
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4hr Standard	The number of patients who were admitted, discharged, or leave ED within 4 hours of their arrival, as a percentage of all patients attending the ED.	>= 68.5%	74%	▲▲▲●●●●	●
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.	<= 9%	6.1%	▲▲▲▲●●●	●

Performance Summary

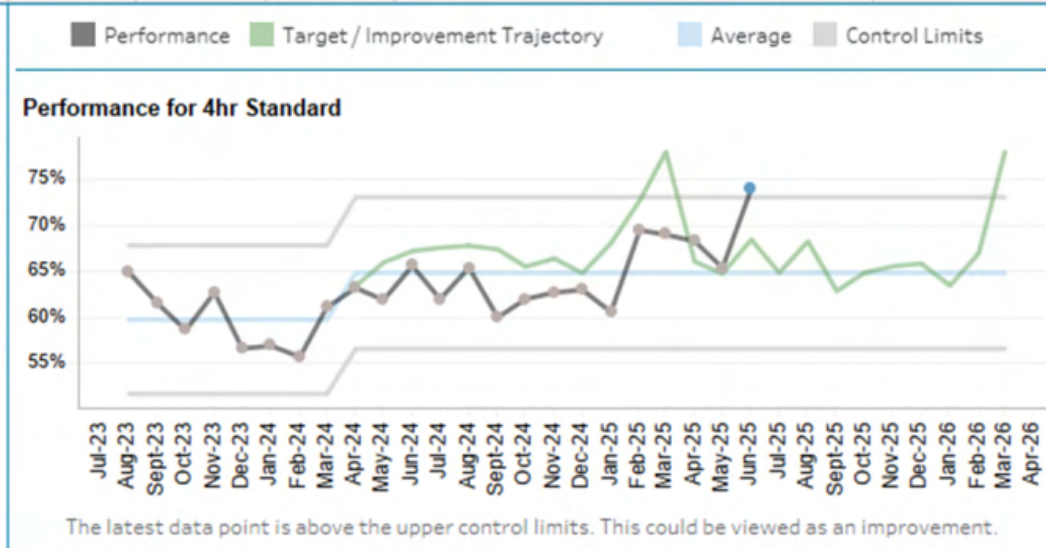
- June saw a significant decrease in patients waiting more than 12 hours in ED at 497.
- The number of patients waiting over 12 hours from the decision to admit to admission was 95 in June, a significant reduction from the previous month.
- June 2025 performance against the UEC 4hr standard was 74%.
- 9333 patients were seen in the hospital and a further 1126 patients were seen at the community UTC. The breakdown of performance was 70.9% on the hospital site, and 74% including the community UTC activity.
- Admissions to hospital from ED averaged 97 per day, a 31.3% conversion rate, this does include admissions to the SDEC pathways. Excluding SDEC admissions, the conversion rate was 25.3%.

Risks and Issues

- New medical rotas in development
- Surges in acuity and activity
- Reduction in complex discharge capacity
- Mental health long waits

Actions and Mitigations

- New programme of transformation work across UEC continues, with renewed focus on deflection, navigation and triage; Urgent Treatment Centre, Medical SDEC and Frailty streaming; long waits; pre attendance and diagnostic turnaround time
- Opening of new Medical SDEC to include frailty SDEC pathways
- Changes to the inpatient bed base with more high turnover beds
- Weekly Trust 4hr clinical standards performance group is in place with full specialty representation with actions to improve position
- Plans to implement new acuity tool to replace MTS triage model
- Collaborative work with NAWs on new ambulance handover processes
- All patients who have breached a 12hr trolley wait now discussed at site capacity meetings for additional focus across all Divisions to drive improvement
- New nursing model has seen a reduction in average times to triage



Benchmark data for 4hr Standard from Public View – June 2025



Signed off by	Ruth McNulty
Executive Lead	Jackie McShane

Operations Patient Flow

Target	Actual	6-month trend	Previous Performance	1-month Forecast
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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	78	↗	▲ ▲ ▲ ▲ ▲ ▲ ▲	▲
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%	95.1%	→	● ● ▲ ▲ ▲ ▲ ▲	▲
Timely discharge	The number of patients discharged from hospital on the same day as their discharge ready date, as a percentage of all patients patient discharges.	>= 85%	80.9%	↘	▲ ▲ ▲ ▲ ▲ ▲ ▲	▲

Performance Summary

- The average number of patients with a No Criteria to Reside in June was 78
- Adult G&A bed occupancy in May was 95.1%, which is above the 92% NHSE target.

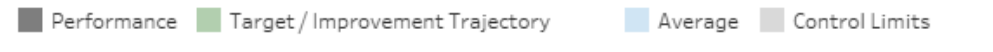
Risks and Issues

- Community capacity in Pathways 2 - 3, for Stockport. (Bramhall Manor reduced D2A bed capacity from 25 beds to 15 at the beginning of April, with further reduction of 15 end of August.)
- 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.

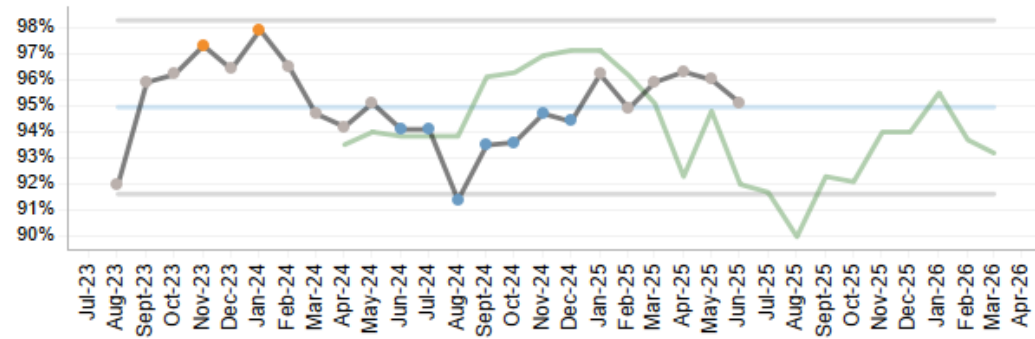
Actions and Mitigations

- Introduction of system partner meetings to support the planned reduction of 15 D2A commissioned beds and review of mitigation process around risk for the Trust and Locality.
- Twice weekly system meetings in place to review Pathway 2/3 delays over 48 hours.
- Weekly workshops in place with Stockport ASC Reablement team (REaCH) to review 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.
- Continued roll out to all wards of the Discharge Information pack to support earlier conversation under the 'Home First' ethos and session with each ward manager to support information sharing at team meetings.
- Working with Wards via 'Teams Chat' system around earlier identification of same day discharge for Pathway 1-3 and engaging with families earlier to collect patients where able.
- 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.

Signed off by	Jane Ankrett
Executive Lead	Jackie McShane

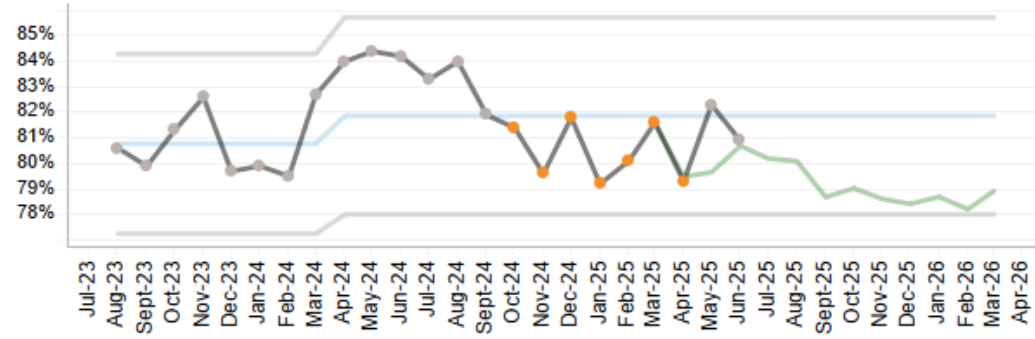


Performance for Adult G&A Bed Occupancy



The latest data point is within the control limits. This is viewed as common cause or normal variation.

Performance for Timely discharge



The latest data point is within the control limits. This is viewed as common cause or normal variation.

Operations Diagnostics Audiology

Target	Actual	6-month trend	Previous Performance	1-month Forecast
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Diagnostics: Audiology The percentage of patients referred for diagnostic tests who have been waiting for more than 6 weeks.

<= 96.3% 94.1% J F M A M J

Performance

- Performance continues to decline due to continued pause to paediatric audiology service

Risks and Issues

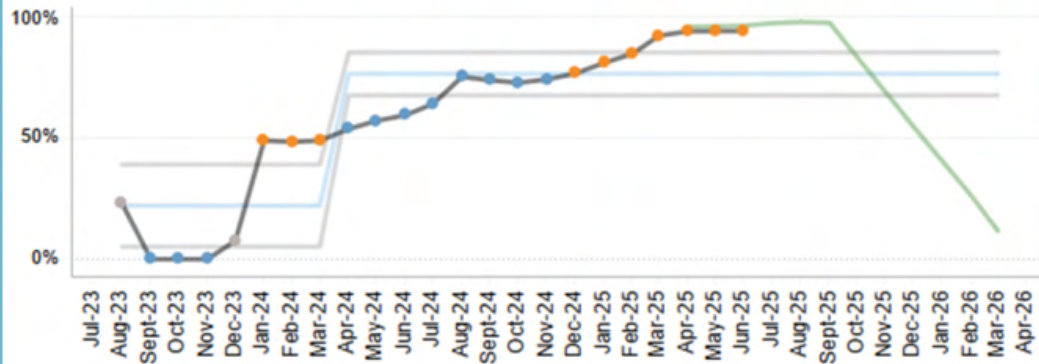
- Paediatric (5yrs and under) service remains paused
- Look back ongoing since November 2024 - resulting in further lost capacity for patients within the backlog
- Fragile workforce
- Mutual aid not available within GM
- MFT unable to offer additional support

Key Actions

- Workforce application submitted to GM STARS process
- ICB have commissioned Health Harmonie (insourcing company) to enable to service to open. Implementation plan in hand (date to be confirmed)
- Continual Monitoring of long waits , booking longest waits in order
- 2 audiologists completed their competencies, enabling some clinics for 5-year-olds and over to be booked
- Training to continue to ensure compliance with all Audiologist for over 5s
- Ongoing Strategy Meetings with ICB, Executive Team and Division

■ Performance ■ Target / Improvement Trajectory ■ Average ■ Control Limits

Performance for Diagnostics: Audiology

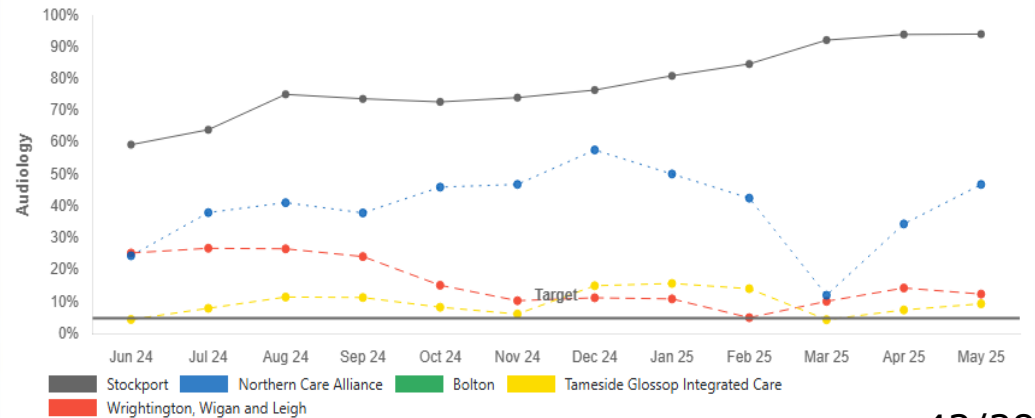


There have been 7 or more consecutive data points above the mean. This shift could be viewed as a concern.

Number of diagnostic breaches reported by month

Diagnostic Description	31 Dec 24	31 Jan 25	28 Feb 25	31 Mar 25	30 Apr 25	31 May 25
Audiology - Audiology Assessments	846	1,039	1,196	1,318	1,357	1,377

Benchmark data from Public View – May 2025



Signed off by: Karen Hatchell

Executive Lead: Jackie McShane

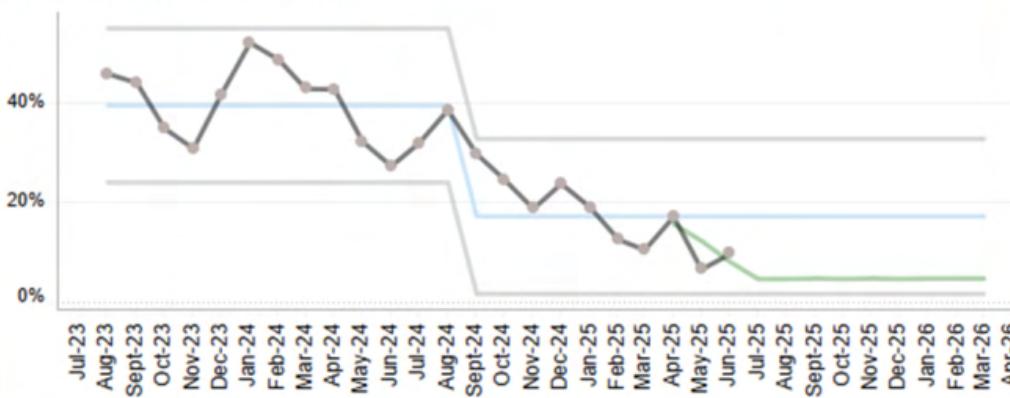
Operations Diagnostics Echo

Target	Actual	6-month trend	Previous Performance	1-month Forecast
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<= 8.2%
 9.8%
 ▲
 J
 F
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 M
 ▲

■ Performance
 ■ Target/Improvement Trajectory
 ■ Average
 ■ Control Limits

Performance for Diagnostics: Echo



The latest data point is within the control limits. This is viewed as common cause or normal variation.

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

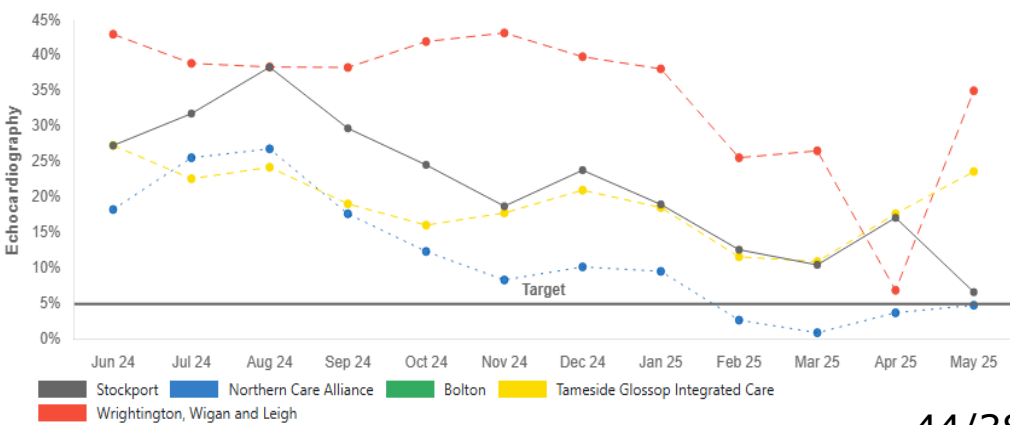
- Risks and Issues**
- DNA rates high with Stress echo
 - Stress Echo capacity
 - Stress Echo nursing support

- Key Actions**
- Locum consultant covering any cancelled stress echo list due to consultant annual leave/COW weeks, meaning 100% utilisation of capacity available.
 - DNA rates for ECG remain high at 15% – Approval now given to implement call reminder service for ECG, the development team have already started working on this and hope to be in place by the end of August.
 - Volunteer in place now supporting with call reminders which should reduce DNA rates as an interim pending text reminder service being implemented.
 - SDP being completed to increase nurse capacity with ECG to support Stress Echo meaning we can run double lists.
 - Cardiology ACP is currently completing their competencies to support Stress Echo meaning more cross cover from the nursing team and mitigating the need to reduce/cancel lists due to lack of nursing.
 - SDP being worked up for insourcing for Stress Echo due to capacity issues via SET agency.
 - Trajectory to be completed for Stress Echo to reflect the current capacity v demand gap.

Number of diagnostic breaches reported by week

Diagnostic Description	25 May 25	01 Jun 25	08 Jun 25	15 Jun 25	22 Jun 25	29 Jun 25
Cardiology - echocardiography	142	92	184	205	190	135

Benchmark data from Public View – May 2025



Signed off by: Ruth McNulty
 Executive Lead: Jackie McShane

Operations Diagnostics Endoscopy

Target	Actual	6-month trend	Previous Performance	1-month Forecast
<= 15.2%	20.9%	↓	J F M A M J	

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

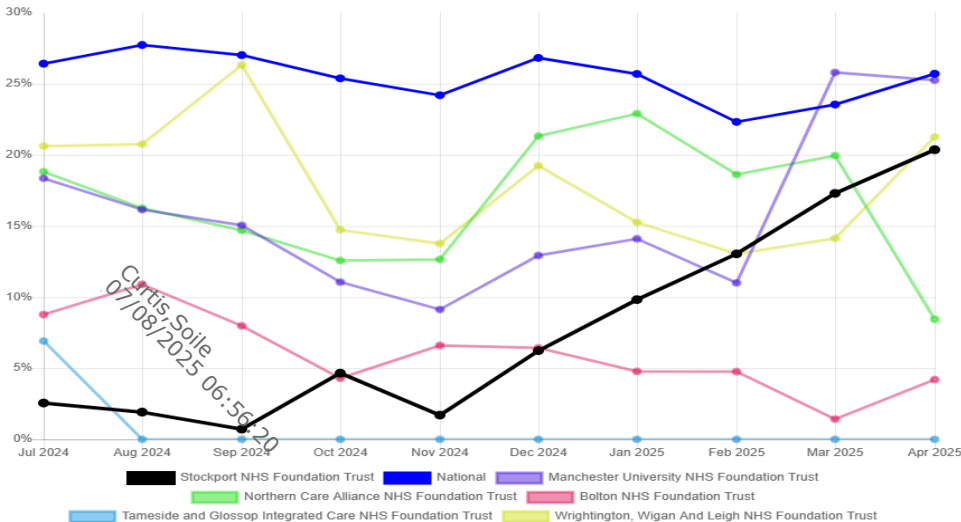
Risks and Issues

- Sustained increase in demand coupled with operator vacancies has led to an increase in patients waiting over 6 weeks.
- Patients waiting over 6 weeks peaked at 332 patients in mid-May and has since reduced to 212 patients

Key Actions

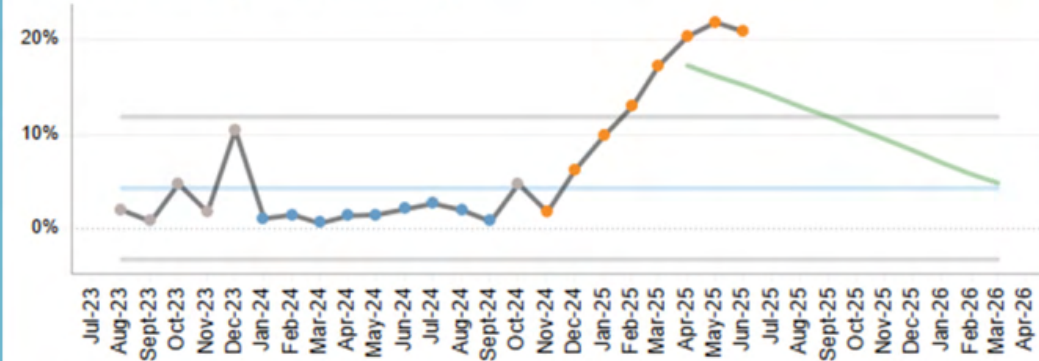
- Introduced 6-day call reminder service to try and reduce number of cancellations and DNA's.
- Introduction of cancellation on the day of procedure SOP. Regular communications to staff from Acting Matron and DND in terms of the process ongoing and actions if themes identified.
- New nurse endoscopist 1 WTE due to start end of September. Exploring opportunity for locum support in the interim.
- Additional lists have been delivered during June and July but continued high demand has meant that the waiting list has not reduced as quickly as expected.

Benchmark data from HED – April 2025



Performance	Target/Improvement Trajectory	Average	Control Limits
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Performance for Diagnostics: Endoscopy



There have been 7 or more consecutive data points above the mean. This shift could be viewed as a concern.

Number of diagnostic breaches reported by week

Diagnostic Description	25 May 25	01 Jun 25	08 Jun 25	15 Jun 25	22 Jun 25	29 Jun 25
Endoscopy	272	242	204	249	232	212
Colonoscopy	146	135	124	131	127	104
Flexible sigmoidoscopy	44	37	32	45	34	28
Gastroscopy	82	70	48	73	71	80

Signed off by	Mike Allison
Executive Lead	Jackie McShane

Operations Cancer

Target	Actual	6-month trend	Previous Performance	1-month Forecast
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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..	>= 70.8%	60.3%	↘	● ● ● ● ● ▲	▲
31-day standard	The percentage of patients on a cancer pathway that have started treatment within 31 days of their diagnosis.	>= 94.5%	86.8%	↘	▲ ▲ ▲ ● ▲ ▲	▲

Performance Summary

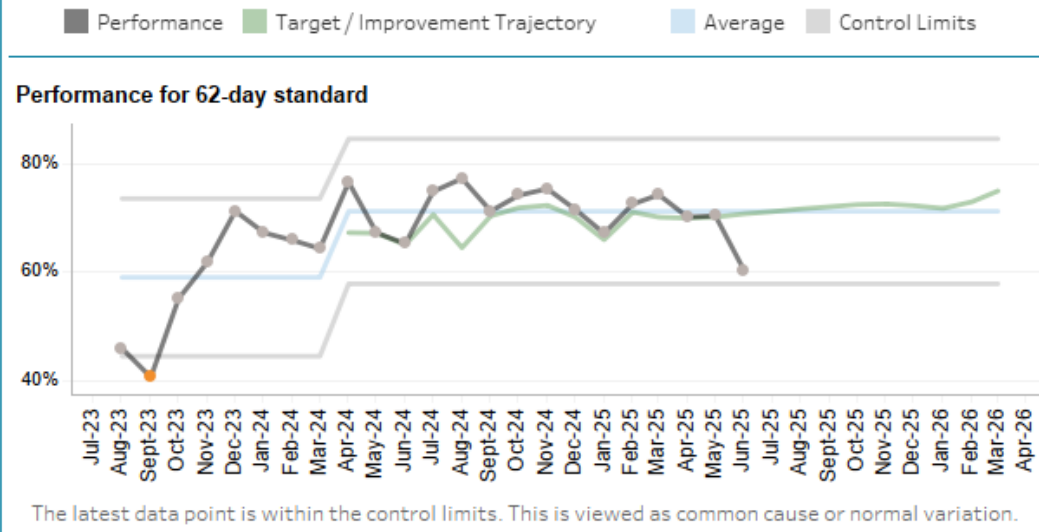
- The final 62-day performance for May is 70.4% which was above the expected trajectory target. The latest performance for June is 60.3%.
- The 31-day performance is currently below the National standard of 96%.

Risks and Issues

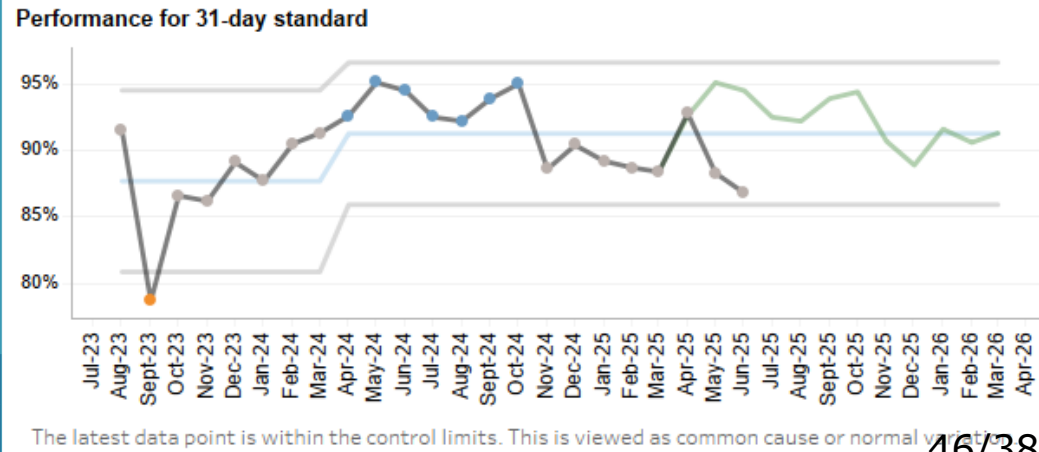
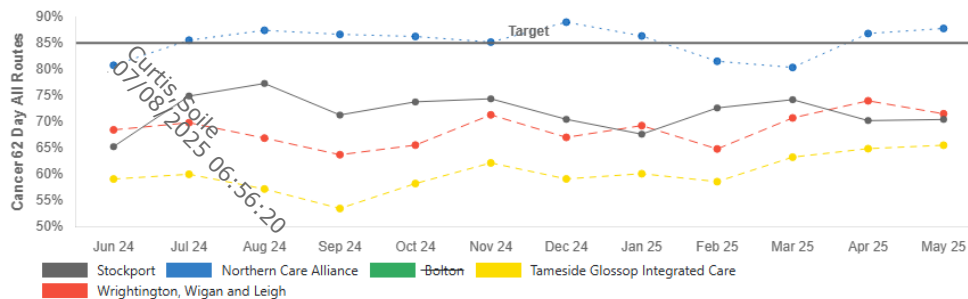
- Urology Oncology capacity deficit remains a challenge and extended appointment waits continue to impact on 62-day performance.
- Robotic theatre capacity insufficient for demand. This is the key driver of the adverse 31-day position.
- Outpatient capacity in Lung
- Bone scan capacity for prostate patients.

Actions and Mitigations

- Additional Urology Oncology clinics continue to be secured . Weekly meetings with the Christie team continue and waiting times are starting to reduce.
- SDP in development for additional Consultants in Lung.
- The Christie are supporting our Radiology team to implement a new nuclear medicine protocol for Bone Scan that will reduce overall scanning time and increase throughput.



Benchmark data for 62-day Standard from Public View – May 2025



Signed off by	Andrew Tunnicliffe
Executive Lead	Jackie McShane

Operations Referral to Treatment (RTT)

Target	Actual	6-month trend	Previous Performance	1-month Forecast
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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	21	➔	▲ ▲ ▲ ▲ ▲ ▲ ▲	▲
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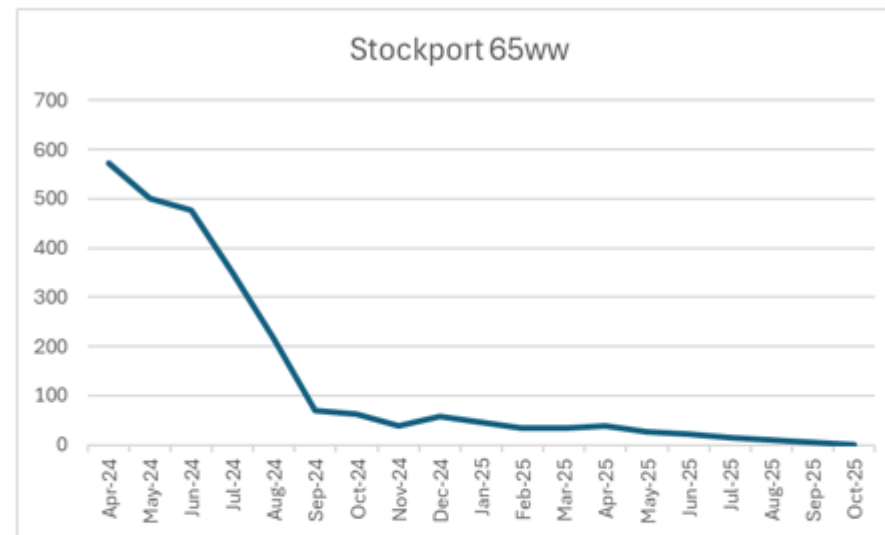
Performance Summary

- 65-week wait performance - Reduced in month to 21 breaches (26 in May-25). Some breaches are driven by patient choice and pathway complexity. There were 15 breaches attributable to capacity constraints, including 5 children awaiting paediatric audiology assessment on their ENT pathway & 7 patients awaiting elective knee surgery.

Actions & Mitigations

4 key issues to address:

- ENT**
Paediatric patients <4 years old awaiting audiology assessments. Stockport paediatric audiology service remains largely paused. No current ability to assess children under 4yrs, causing delays to progressing treatment for ENT long waiters. 5 breaches for June.
 - Action:** Tameside audiology mutual aid for 9 patients >52ww. Hearing tests booked for 9/7. Expect to clear 65ww breaches for this issue by end of August.
- Orthopaedic Knee**
Capacity pressures due to consultant vacancy and sickness. 8 breaches in June.
 - Actions:** Additional internal WLI capacity agreed throughout Jun/Jul. Bolton mutual aid offer, 16 patients accepted and agreed for transfer from >52w cohort. Expect to clear 65ww breaches for this issue by end of August.
- Gastro/General Surgery/Chemical pathology**
Long waits for external diagnostics at MFT (mainly PH manometry and SeHCAT scans for Gastro, Genetic testing for Chemical Pathology). 3 breaches in June.
 - Action:** Continue to escalate long wait patients to MFT senior leadership team on a weekly basis to expedite tests/reporting where possible. Numbers are reducing, however may continue to carry 65ww risk on small volumes during 2025-26 whilst services continue to reduce new outpatient 1st attendance wait times.
- Urology**
HOLEP procedures - short term capacity pressure due to single consultant service (at present) and combination of annual leave, paternity leave, and competing cancer pressures. 1 breach in June.
 - Actions:** GM mutual aid sought for 2-3 patients but not available. 2nd consultant currently in training to support with HOLEP service in the future. Expect to clear 65ww breaches for this issue by end of July.



Forecast Trajectory	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25
65ww	22	15	9	5	0

The Trust is currently forecasting to reduce the number of 65 week waits to single figures by August, and to reach zero by October.

Signed off by	Andrew Tunnicliffe
Executive Lead	Jackie McShane

Operations Community

Target	Actual	6-month trend	Previous Performance	1-month Forecast
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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%	51.2%	↓	▲ ▲ ▲ ▲ ▲ ▲ ▲	▲
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Performance Summary

- The number of admissions to the virtual ward was 167 in June 2025.
- The proportion of patients admitted on a step-down pathway was reported as 18.6%.

Risks and Issues

- Currently not consistently meeting the 80% trajectory and a deteriorating position.
- Cost pressure on the medical budget and a lack of substantive medical cover 7/7 (weekend cover).
- ACP vacancies; ACP workforce under review.
- Pilot of the Stockport Integrated Care Co-ordination (SICC) service continues, however, issues with the use of SFT and T&G Community EMIS IT Systems proving challenging for staff, which is also impacting on data quality.
- Delay in signing MOU/DPIA from GM Partnership resulting in delay in direct bookable appointments via Adastra to UCR/VW.

Actions and Mitigations

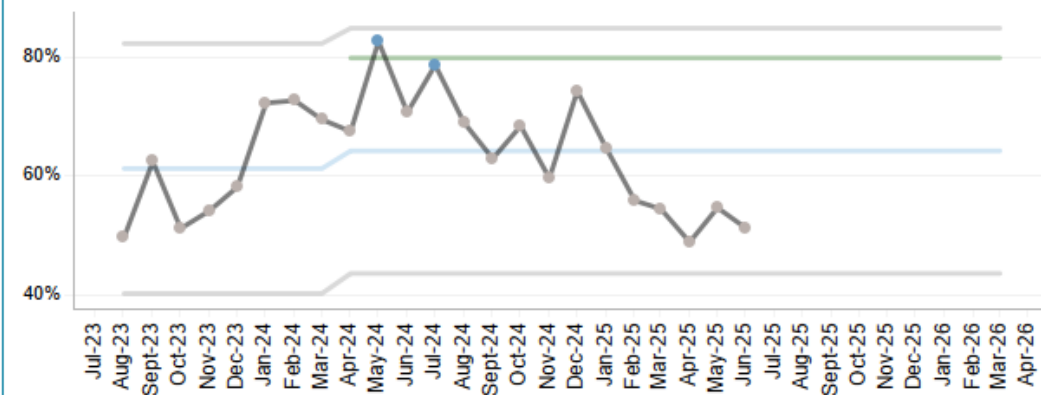
- 'Communication Campaign' commenced 30 June – 11 July 2025. There is targeted marketing to Primary Care, Community Services, Out of Hours Services and Acute Care.
- Awaiting final draft of DPIA from Mastercall Healthcare to then be able to instigate direct bookable appointments via Adastra.
- 'In-reach' instigated. VW clinician joining MSDEC Huddle and working more closely with the medic covering the Direct Advice line further identifying patients for the VW.
- Pathways identified with AFU Consultant for direct referral to VW.
- Meeting with Medical Director scheduled for July to discuss KPIs for promotion of Early Supported Discharge via VW.

Urgent Community Response

- Effective from April 2025, the way we report performance for urgent community response has changed in line with national guidance to no longer include telephone encounters. This will result in a drop from 97% to 92% performance for April 2025.
- May performance has dropped to around 78.1%. Although a drop from the usual performance level, this is still above the national target of 70%.
- Drop in performance for May due to some referrals clinically reviewed and determined safe for a next day assessment. In addition, performance also affected by a delayed ED referral due to NWAS.

■ Performance ■ Target / Improvement Trajectory ■ Average ■ Control Limits

Performance for Virtual Ward Utilisation



The latest data point is within the control limits. This is viewed as common cause or normal variation.

Signed off by	Jane Ankrett
Executive Lead	Jackie McShane

Operations Outpatient Efficiencies

Target	Actual	6-month trend	Previous Performance					1-month Forecast
≤ 6.3%	6.8%	▲	▲	▲	▲	▲	▲	▲

Outpatient DNA rate The number of appointments where the patient did not attend, as a percentage of all booked appointments.

Performance Summary

- The DNA rate for May was 6.8%, remaining below the 7% mark for the past four months.
- The Trust has recorded the lowest DNA rate in Greater Manchester and has advanced into Quarter 2 1 according to the model hospital data.

Risks and Issues

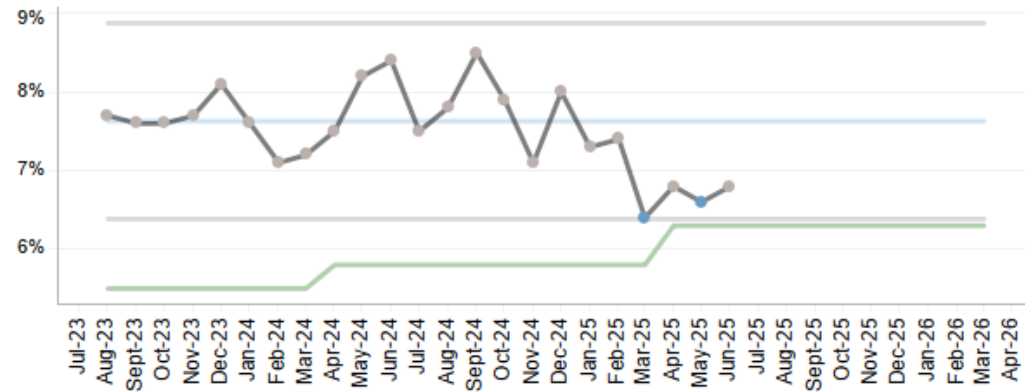
- Fluctuation in outpatient booking centre capacity could impact DNA rates. Recruitment to turnover and increased WTE from IPT funding are in progress.
- Ongoing relocation of outpatient services following OPD B closure has an inherent increased risk of DNA
- Processes relating to non-face-to-face appointments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

Actions and Mitigations

- T&F group work with medicine & paediatrics remains in place.
- Ongoing reminder reporting system review supported by prospective and retrospective audits
- Actions taken through the GIRFT Further Faster initiative
- Ongoing calls to high-risk patients continue.

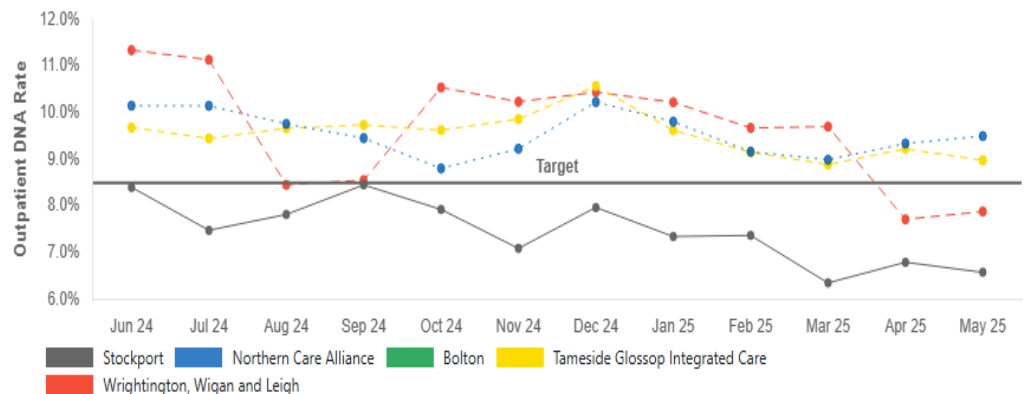
■ Performance ■ Target/Improvement Trajectory ■ Average ■ Control Limits

Performance for Outpatient DNA rate



The latest data point is within the control limits. This is viewed as common cause or normal variation.

Benchmark data from Public View – May 2025



Curtis Soile
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Signed off by	Mike Allison
Executive Lead	Jackie McShane

Operations Outpatient First and Procedures

Target	Actual	6-month trend	Previous Performance	1-month Forecast
>= 43.7%	42.8%	➔	▲ ▲ ▲ ▲ ● ▲	▲

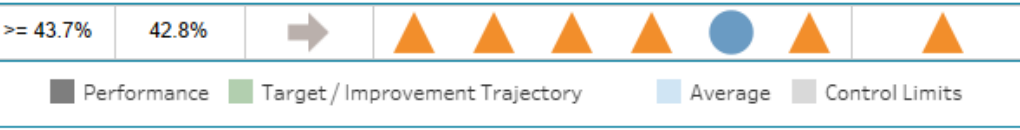
OP First Attend and Procedure The total number of outpatient attendances that are a first-attendance, or are an outpatient procedure, as a percentage of all outpatient attendances.

Risks and Issues

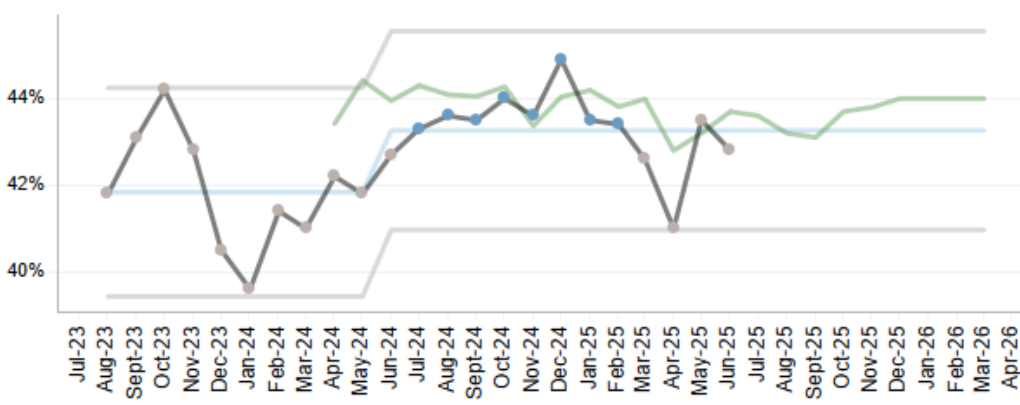
- Poor engagement by clinicians recording the procedures being undertaken in outpatient clinics. (either via paper RTT forms or within the new digital electronic outcome form (CLIO)).
- Transcription errors by administrative staff who transcribe the data into Patient Centre.
- Missing procedure codes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

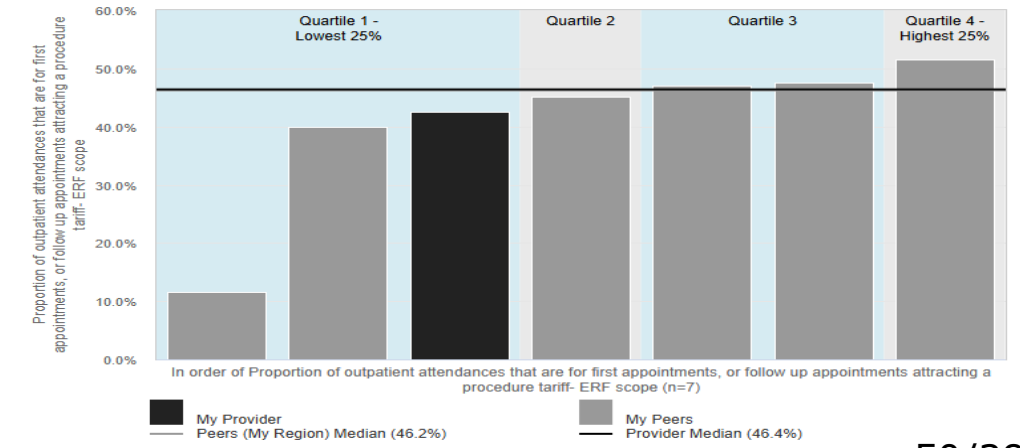


Performance for OP First Attend and Procedure



The latest data point is within the control limits. This is viewed as common cause or normal variation.

Benchmark data from Model Health – March 2025



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Updated provided by	Debbie Hope
Executive Lead	Jackie McShane

Operations Theatres

Target	Actual	6-month trend	Previous Performance	1-month Forecast
>= 85%	79.4%	↗	▲ ▲ ▲ ▲ ▲ ▲	▲

Capped Touch Time Utilisation The overall time spent operating, calculated as a percentage of the overall planned session time. Session overrun time is excluded.

Performance Summary

- 79.1% capped utilisation in June 2025. A slight increase from May 2025 which was 78.7%
- Slight increase in average late starts in June (32 mins) compared to May (30mins)
- Decrease in on the day cancellation in month
- Booking utilisation increased to 110% from 108%

Key Risks/Issues

- Late starts and early finishes.
- Challenge to backfill lists following short notice patient cancellations
- Pre-Op capacity
- Theatre staffing challenges due to leave/maternity leave/sickness.

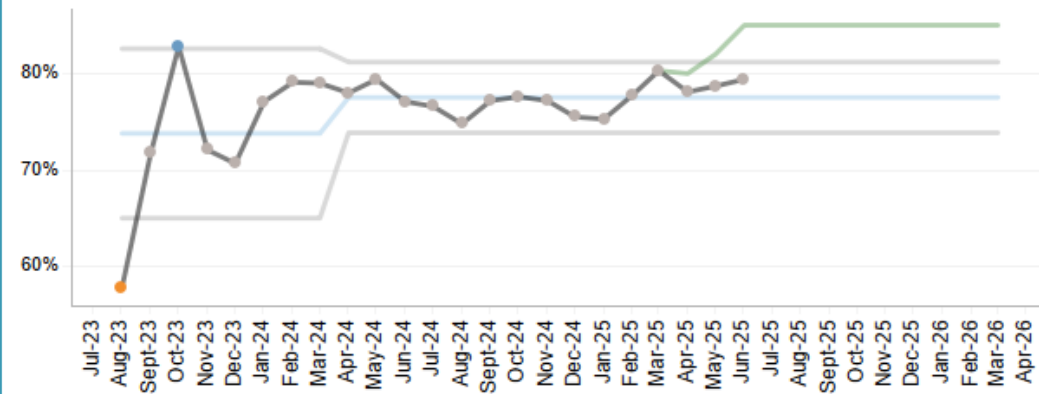
Actions and Mitigations

- Launch of 'drop in' weekly theatre session, for multi disciplinary team to report back on performance of theatre/actions and good practice
- Review of lists to prioritise urgent cases to mitigate the impact of theatre issues on patients
- Theatre Productivity Improvement work continues to focus on patient flow from recovery to wards, cancellations and late starts.
- Speciality update and challenge from the division to ensure that actions being undertaken to deliver against performance trajectory.

>= 85% 79.4% ↗ ▲ ▲ ▲ ▲ ▲ ▲ ▲

■ Performance ■ Target/Improvement Trajectory ■ Average ■ Control Limits

Performance for Capped Touch Time Utilisation

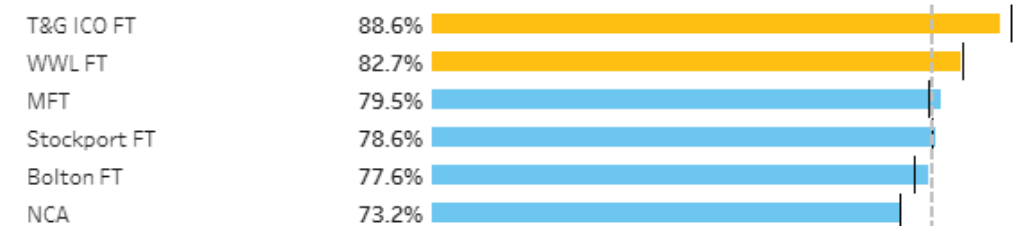


The latest data point is within the control limits. This is viewed as common cause or normal variation.

Benchmark data from GM Performance dashboard (WIP) – May 2025

Utilisation by trust

[click on trust to filter dashboard](#)



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Signed off by	Karen Hatchell
Executive Lead	Jackie McShane

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%	80.6%	↓	▲	▲	▲	▲	▲	▲	▲
--------	-------	---	---	---	---	---	---	---	---

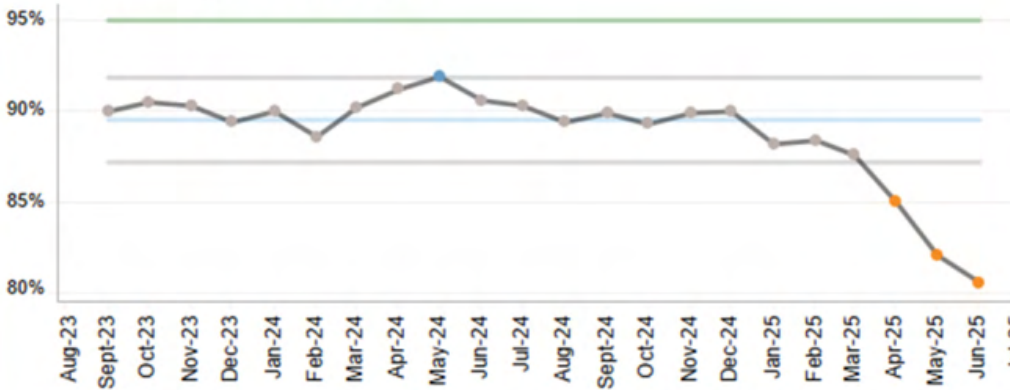
The Trust's overall appraisal compliance for June 2025 was 80.6% against the target of 95%. As highlighted in previous reports, this was expected given the move to a new appraisal window process designed to enhance the quality of appraisals by enabling a cascade approach to reinforce the Trust's corporate objectives and priorities at every level of the organisation. This means no employee has their appraisal before their appraiser has had theirs.

By the end of June, all appraisals should have been carried out to tier 4 level, which equates to team leader/supervisor level and professional leads. To provide assurance and support divisions with this cascade:

- **Appraisal Completion Reporting and Monitoring:** Workforce share detailed appraisal status reports (categorised as in date/due soon/overdue) by named employee to HR and People and OD. To strengthen local accountability, appraisal data is also shared with management teams and HR colleagues are working closely with divisions to close gaps.
- **Ongoing Communication and Support:** Communications about the new process continue across the Trust, with a particular focus on encouraging appraisees to proactively schedule their appraisal conversations. Monitoring has identified a recurring issue where appraisers forget to record completed appraisals. This has also become a key focus of internal communications to improve reporting accuracy.



Performance for Appraisal Rate: Overall



The latest data point is below the lower control limits. This could be viewed as a concern.

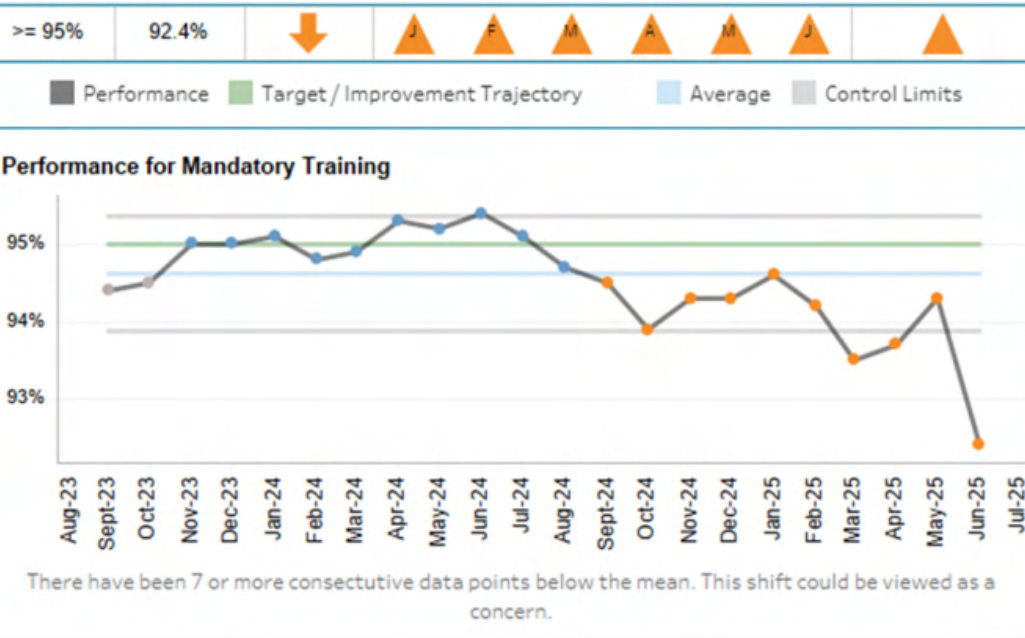
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Signed off by	Emma Cain
Executive Lead	Amanda Bromley

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.
	<p>Mandatory training for the Trust currently stands at 94.41%. Clinical Support Services (94.55%), Medicine and Urgent Care (93.45%), Surgery (91.76%) and Women & Children (94.59%) remain under target.</p> <p>In order to improve compliance, colleagues who have been outstanding in their compliance or more than 24 months have been targeted first. This has included correspondence offering support of booking onto available sessions. 'Non-compliance' emails are now being shared with key colleagues in all divisions alongside the pre-existing DNA and formal compliance reports.</p> <p>The Executive Management Team have approved the process for non-compliance which is to be shared with Trade Union colleagues and at Operational Management Group; it is anticipated that this will be launched during September.</p> <p>Mandatory training days are planned each month throughout 2025.</p>



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Signed off by	Emma Cain
Executive Lead	Amanda Bromley

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%	-0.8%	➔	▲ J ● F ▲ M ● A ▲ M ● J	●
Cash Balance	The amount of cash balance in Trust accounts. Figures displayed are millions per month.		31.7	➔	□ J □ F □ M □ A □ M □ J	
CIP Cumulative Achievement	The value of the actual CIP achievement, displayed as a percentage variance from the planned CIP achievement.	>= 0%	-5.4%	➡	● J ● F ● M ▲ A ▲ M ▲ J	▲
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%	231.4%	➔	● J ● F ● M ▲ A ▲ M ▲ J	▲

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
- Costs of industrial action related to the national pay award announced for July 2025, including cost of cover and impact of loss of activity
- The impact of any unfunded pay award
- The requirement for enhanced care
- Although we aren't currently forecasting to require revenue support funding in 2025/26 this is subject to the assumptions above.

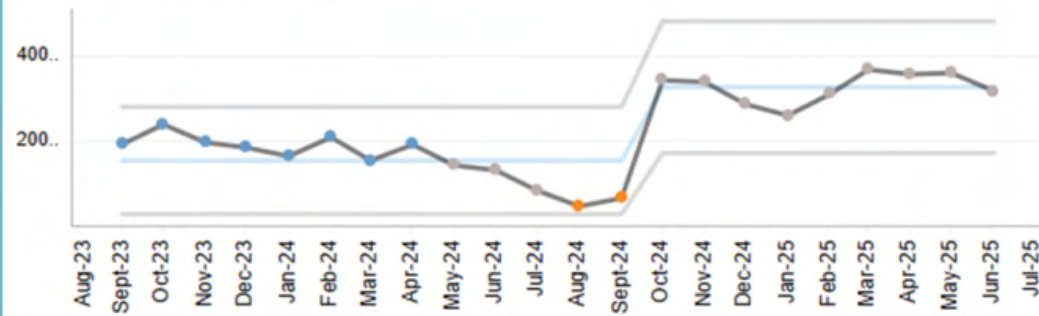
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Signed off by Kay Wiss

Executive Lead John Graham

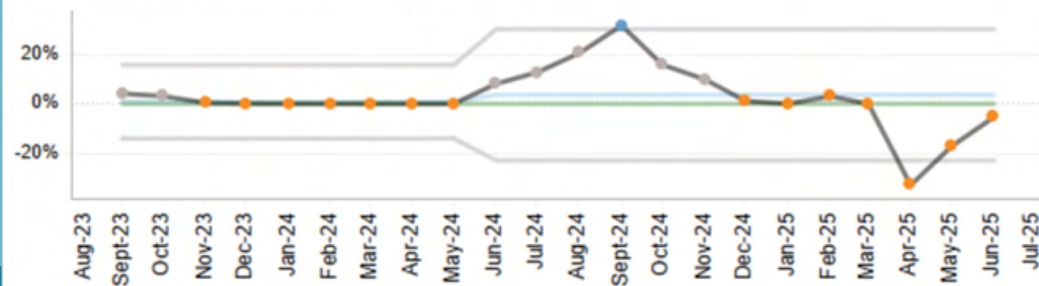
■ Performance ■ Target/Improvement Trajectory ■ Average ■ Control Limits

Performance for Cash Balance



The latest data point is within the control limits. This is viewed as common cause or normal variation.

Performance for CIP Cumulative Achievement



There have been 7 or more consecutive data points below the mean. This shift could be viewed as a concern.

				Agenda No.	10
Meeting date	5 th 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 3 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

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	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 has a planned deficit of £4.1m at the end of Q1 and the Trust was in line with this plan. A detailed finance paper was presented to the Finance & Performance Committee on the 17th July 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 £17.6m of at Month 3 which is 60% of the full year target of £29.2m. Schemes have now been identified to deliver the full target, but this is with more high risk or technical non-cash releasing schemes offsetting the current £4.0m divisional shortfall.

Agency expenditure in June was again above the target ceiling. In Q1 there has been an average reduction of 15% compared to the 30% target. Both medical and nursing agency costs increased in June above the previous run rate. 67% of agency costs are for medical staff, and 30% registered nursing. Bank costs in June continued to be below the ceiling of a 10% reduction, with an average 16% reduction achieved in Q1.

The Trust's cash balance at the end of June 2025 was £31.7m against a plan of £27.8m.

The Trust has spent £5.1m on capital costs in Q1 against a plan of £6.0m, with spend to date relating to the Emergency Care Campus and Outpatients Modular Build. The Trust's annual capital plan has increased by £2.0m to £37.4m.

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Stockport Foundation Trust

Finance Report Month 3

2025/26



John Graham - Chief Finance Officer

1.	Overall Financial Position & Drivers	Slides 3-5
2.	Income & Variable Activity Payments	Slide 6-7
3.	Workforce & Temporary Staffing	Slides 8-10
4.	Trust Efficiency Programme	Slides 11-13
5.	Cash, Capital & PFI	Slide 14-18

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Overall Financial Position

Income & expenditure Position	June 2025 (M03)			Year to Date			Forecast			Annual Plan £m
	Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m	
Total Income	42.6	42.6	(0.0)	125.6	125.9	0.3	507.7	509.7	2.0	507.7
Substantive Staff	(28.7)	(28.0)	0.7	(83.3)	(83.3)	(0.0)	(330.8)	(338.0)	(7.2)	(330.8)
Bank Staff	(2.6)	(2.4)	0.2	(7.7)	(7.2)	0.5	(30.9)	(25.7)	5.2	(30.9)
Agency Staff	(0.5)	(0.7)	(0.1)	(1.6)	(1.9)	(0.3)	(6.3)	(6.7)	(0.4)	(6.3)
Pay Costs	(31.8)	(31.1)	0.7	(92.6)	(92.4)	0.2	(368.0)	(370.4)	(2.4)	(368.0)
Drugs	(1.9)	(2.0)	(0.1)	(6.0)	(6.1)	(0.1)	(24.7)	(24.9)	(0.2)	(24.7)
Clinical Supplies & Services	(2.7)	(2.8)	(0.2)	(7.8)	(7.9)	(0.1)	(28.6)	(31.0)	(2.4)	(28.6)
Other Non Pay Costs	(5.6)	(6.2)	(0.5)	(16.7)	(17.2)	(0.5)	(57.6)	(56.7)	0.8	(57.6)
Below the Line	(2.3)	(2.1)	0.1	(6.7)	(6.4)	0.3	(29.1)	(26.9)	2.2	(29.1)
Total Expenditure	(44.2)	(44.2)	0.0	(129.8)	(130.1)	(0.3)	(508.0)	(509.9)	(1.9)	(508.0)
TRUST SURPLUS / (DEFICIT)	(1.6)	(1.6)	0.0	(4.2)	(4.2)	0.0	(0.3)	(0.2)	0.1	(0.3)
System reporting adjustments	0.0	0.0	(0.0)	0.1	0.1	(0.0)	0.3	0.2	(0.1)	0.3
Adjusted financial performance surplus/(deficit) for the purposes of system achievement	(1.6)	(1.6)	0.0	(4.1)	(4.1)	0.0	0.0	0.0	0.0	0.0
Stockport Trust Efficiency Programme (STEP)	2.0	2.4	0.4	6.0	5.7	(0.3)	29.2	29.2	-	29.2
<i>Efficiencies as % of expenditure</i>	<i>4.5%</i>	<i>5.3%</i>		<i>4.6%</i>	<i>4.4%</i>		<i>5.7%</i>	<i>5.7%</i>		<i>5.7%</i>
Capital expenditure	(1.2)	(0.9)	0.2	(6.0)	(5.1)	1.0	(37.4)	(37.4)	-	(37.4)
Cash & equivalents				27.8	32.0	4.2	31.6	31.6	-	31.6

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Key Messages

Summary of Financial Position

- At month 3 the Trust is reporting a **break-even** position against plan and a net **deficit of £4.2m**
- **STEP of £5.7m** has been delivered to date which is £0.3m behind plan. £17.6m (60%) of the full year £29.2m has been delivered, and £11.4m (55% of the recurrent requirement).

Key Metrics

- **Agency spend of £1.86m** is £0.28m worse than plan to date. This represents a **15% reduction** on 2024/25 run rate, which is less than NHSE's minimum expectation of a 30% reduction
- **Bank spend of £7.2m** is £0.5m better than plan and represents a **16% reduction** on 2024/25 run rate, which is better than NHSE's minimum expectation of a 10% reduction
- The cash balance at the end of June was **£32.9m** against a plan of £28.7m
- The Capital forecast for 2025/26 is £37.4m, in line with plan
- WTE has increased by 17 in May to 6,185, which is **66 below plan**

Forecast Outlook

- At this stage of the financial year the forecast is in line with plan.

Key Risks

The Trust financial plan for 2025/26 is break-even for system reporting purposes, including £43.2m deficit support funding. The Trust anticipates meeting its financial plan in full, however there are some key risks in the plan, which will be monitored throughout the year:

- Payments for variable activity within ICB contracts including:
 - £5.4m income assumption from Derbyshire ICB which is the value of the activity undertaken (excluding community) in 2024/25 above the 2025/26 contract offer.
 - £1.2m income assumption from GM ICB to support the work that has been undertaken on future funding flows, which will start to realign contractual payments and activity
 - £1.7m income assumption from Better Care Fund (BCF) for Discharge to Assess (D2A)
 - £1.5m revenue to capital transfers enabled by GM CDEL envelope.
- Achievement of the Trust's £29.2m efficiency plan (STEP)
- Divisional positions within budget, and all pressures are contained within funding available in the plan
- Inflationary pressures over and above those included in planning assumptions
- Costs of industrial action related to the national pay award announced for July 2025, including cost of cover and impact of loss of activity
- The impact of any unfunded pay award
- The requirement for enhanced care
- Although we aren't currently forecasting to require revenue support funding in 2025/26 this is subject to the assumptions above.

Run Rate Analysis

Run Rate Trends - Rolling 15 months - £000s

Month	Income	Non-Pay	Pay	Total
April-24	35,614	(12,688)	(27,949)	(5,023)
May-24	35,934	(11,177)	(28,174)	(3,416)
June-24	36,485	(12,846)	(28,663)	(5,024)
July-24	36,405	(12,224)	(28,578)	(4,396)
August-24	36,727	(13,039)	(28,179)	(4,492)
September-24	62,593	(12,508)	(28,303)	21,783
October-24	47,219	(14,230)	(34,307)	(1,318)
November-24	39,094	(10,436)	(29,541)	(883)
December-24	40,629	(12,165)	(28,841)	(377)
January-25	39,868	(10,340)	(29,189)	339
February-25	40,154	(10,387)	(28,820)	947
March-25	64,303	(29,909)	(51,217)	(16,823)
April-25	41,342	(12,124)	(30,458)	(1,241)
May-25	41,976	(12,483)	(30,822)	(1,328)
June-25	42,602	(13,100)	(31,095)	(1,593)
FOT 2025/26	509,701	(139,534)	(370,384)	(216)

M02 Actuals	41,976	(12,483)	(30,822)	(1,328)
M03 Actuals	42,602	(13,100)	(31,095)	(1,593)
Movement (M03 v M02)	627	(617)	(274)	(264)
% Movement	1.5%	4.9%	0.9%	

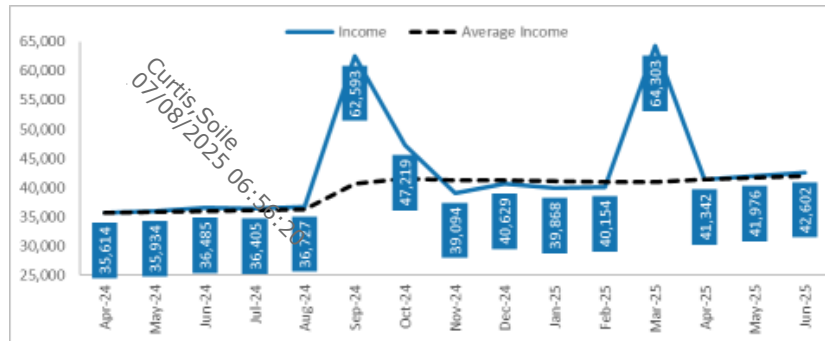
Key Movements

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

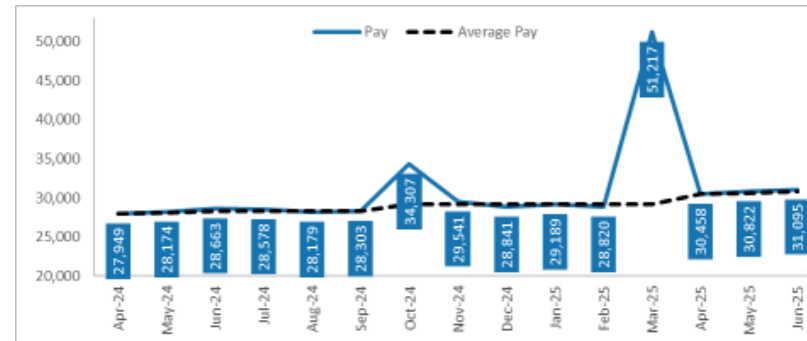
At the end of 2024-25 there was an increase in all areas, due to impairments and losses, all of which were anticipated and agreed with GMICS.

2025/26 run rate has increased for the change in national insurance rates (NI), pay award estimate and non-pay inflationary impacts. Other significant changes include MR service transfer in house cost transfer from non-pay to pay) and phase 1 transfer of neuro rehab services to NCA (medics and therapy staff TUPE).

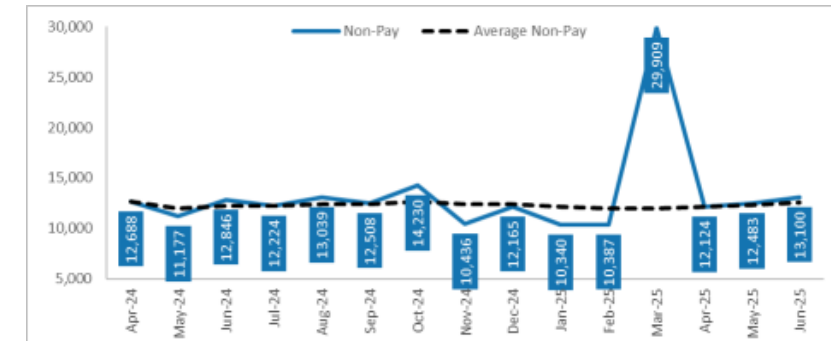
Income £000s



Pay £000s



Non-Pay £000s



Income & Variable Activity Payments

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Income Position

Income & expenditure Position	June 2025 (M03)			Year to Date			Forecast		
	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Actual	Variance
	£m	£m	£m	£m	£m	£m	£m	£m	£m
Greater Manchester ICB (Core and delegated)	32.3	32.3	(0.1)	97.2	97.2	(0.0)	388.7	388.7	(0.0)
Derby and Derbyshire ICB (Core and delegated)	3.2	3.2	(0.0)	9.5	9.6	0.1	38.2	38.2	0.0
Cheshire and Merseyside ICB (Core and delegated)	1.8	1.8	0.0	5.5	5.5	(0.0)	21.9	21.9	(0.0)
Specialised Commissioning	0.2	0.3	0.1	0.8	0.9	0.1	3.2	3.3	0.1
Low value activity	0.2	0.1	(0.1)	0.5	0.5	-	1.9	1.9	(0.0)
Local Authority	0.8	0.8	(0.0)	1.9	1.9	(0.0)	6.8	6.8	0.0
Injury cost recovery scheme	0.1	0.1	0.0	0.2	0.2	0.0	0.7	0.7	0.0
Other income from patient care	0.0	0.0	(0.0)	0.1	0.1	(0.1)	8.8	8.6	(0.2)
Clinical Income from Patient Care Activities	38.6	38.7	0.0	115.7	115.8	0.1	470.2	470.2	(0.1)
Research & Development	0.1	0.1	0.0	0.3	0.3	0.0	1.2	1.3	0.1
Education & Training	1.7	1.6	(0.1)	3.5	3.6	0.1	13.1	13.5	0.5
Pharmacy Trading Units Income	0.5	0.6	0.0	1.5	1.5	(0.0)	6.1	6.3	0.2
Other Income	1.6	1.6	0.0	4.7	4.8	0.1	17.1	18.4	1.3
Donations of cash for charitable assets	-	-	-	-	-	-	-	-	-
Other Income	4.0	3.9	(0.0)	10.0	10.2	0.2	37.5	39.5	2.1
Total Income	42.6	42.6	(0.0)	125.6	125.9	0.3	507.7	509.7	2.0

The clinical income year to date position is marginally favourable to plan by £0.1m. The Trust is forecast to be broadly in line with plan by year end. Conversations are on-going with commissioners around final contract offers for 2025/26. The values in the table above represent the latest confirmed values.

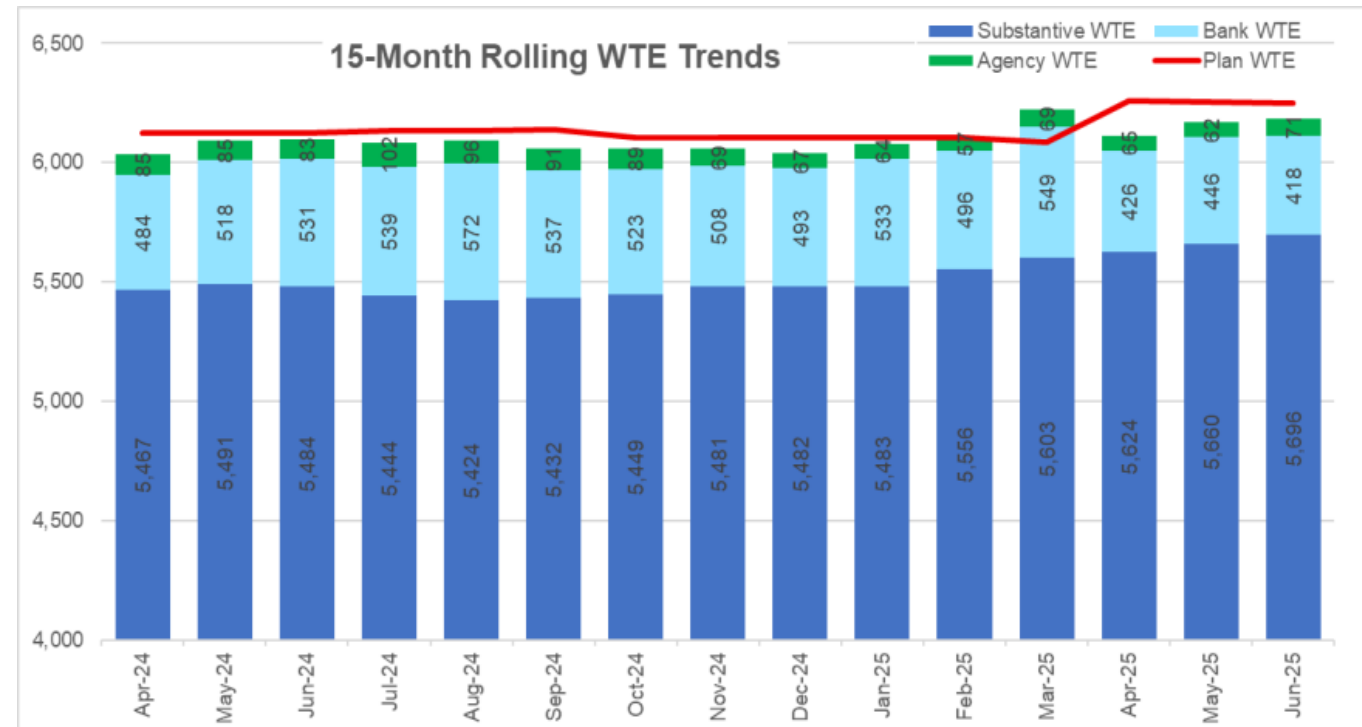
Activity and corresponding financial targets have been loaded into the Trusts Service Line Activity Monitoring (SLAM) system, aligned to the Annual Plan. The next slide shows the performance against the variable elements of the Trust's contracts. It should be noted that plans have yet to be finalised with commissioners and are still subject to change.

Workforce & Temporary Staffing

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Staff and WTE reconciliation - WTE

Month	Substantive WTE	Bank WTE	Agency WTE	Total WTE	Bank % of WTE	Agency % of WTE	Plan WTE
Apr-24	5,467	484	85	6,036	8.0%	1.4%	6,126
May-24	5,491	518	85	6,095	8.5%	1.4%	6,127
Jun-24	5,484	531	83	6,097	8.7%	1.4%	6,127
Jul-24	5,444	539	102	6,085	8.9%	1.7%	6,134
Aug-24	5,424	572	96	6,092	9.4%	1.6%	6,134
Sep-24	5,432	537	91	6,060	8.9%	1.5%	6,136
Oct-24	5,449	523	89	6,060	8.6%	1.5%	6,103
Nov-24	5,481	508	69	6,058	8.4%	1.1%	6,103
Dec-24	5,482	493	67	6,042	8.2%	1.1%	6,103
Jan-25	5,483	533	64	6,080	8.8%	1.1%	6,103
Feb-25	5,556	496	57	6,109	8.1%	0.9%	6,103
Mar-25	5,603	549	69	6,221	8.8%	1.1%	6,086
Apr-25	5,624	426	65	6,115	7.0%	1.1%	6,258
May-25	5,660	446	62	6,168	7.2%	1.0%	6,252
Jun-25	5,696	418	71	6,185	6.8%	1.2%	6,251
Movement in month	36	(28)	9	17			
Movement since April	72	(8)	6	71			

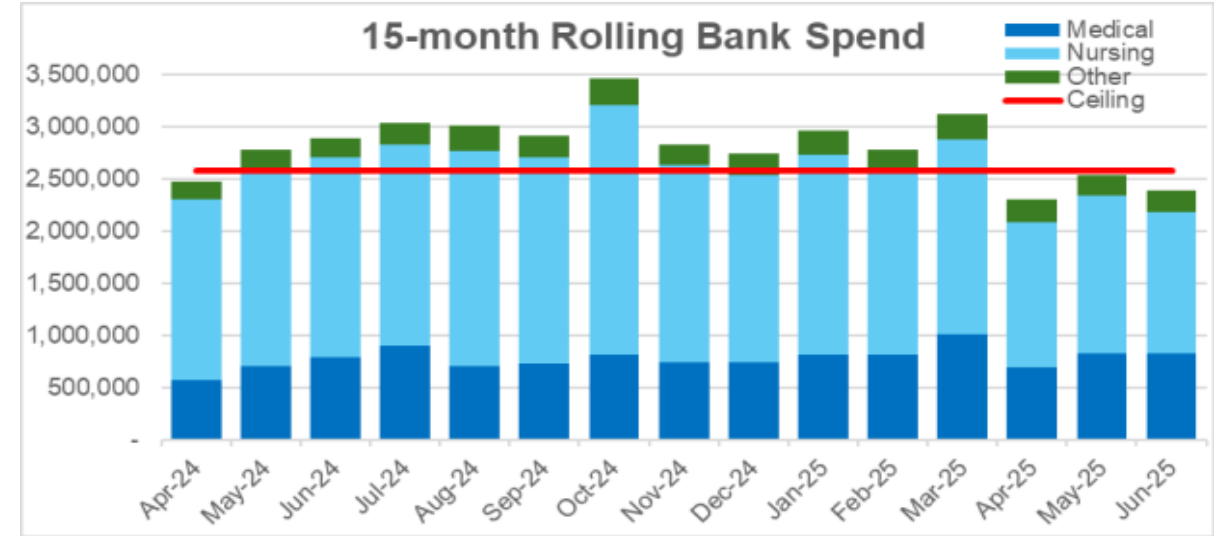
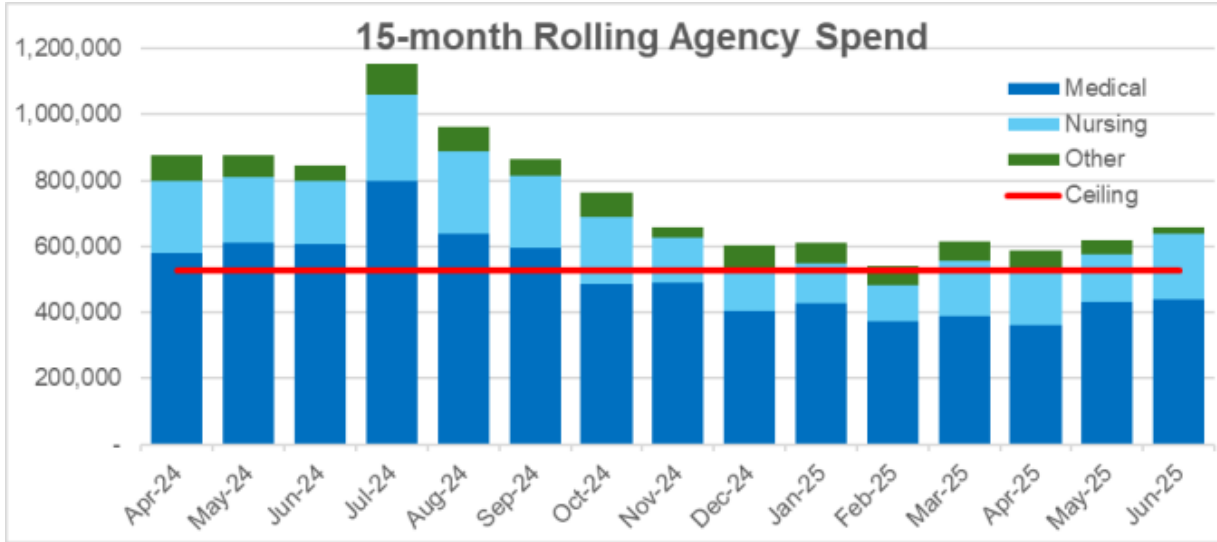


WTE Summary

Total WTE has increased by 17 between May and June 2025, a total increase of 71 since April. Recruitment into substantive posts has driven this change, with a small increase in agency mostly offset by a small reduction in bank.

Total WTE remains 66 WTE below plan in June.

Staff and WTE reconciliation - £



The Trust has submitted a compliant annual plan for 2025/26 which includes a 30% reduction in bank and a 10% reduction in agency, based on 2024/25 M08 forecast out-turn. The Trust's annual expenditure limits are therefore £30.9m for bank and £6.3m for agency. The above charts show the target reduction level as a flat line awaiting clarity from GM ICB and NHSE on reporting requirements which have yet to be received.

June agency costs are £0.7m, which is £0.13m above the ceiling. Agency nursing cost have increased again in month, which is being challenged particularly in the Surgery division for ward cover. Agency medical staff are the highest proportion of costs and have also risen in June so remain the key target for reduction.

Bank costs in June are £2.4m, which is £0.2m below the ceiling. Registered nursing bank remains low at £0.8m, linked both to the reduction in enhanced rates and increased levels of substantive staffing. Medical staffing bank costs were £0.8m in June, with a further £0.6m spent on support to clinical staff and £0.2m on non-medical non-clinical staff.

Trust Efficiency Programme

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STEP (Stockport Trust Efficiency Programme)

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 £17.6m (60%) of the full year CIP target has been delivered, and £11.4m (55%) of the recurrent target.

Schemes have now been identified to deliver the full target, but this is with more high risk or technical non-cash releasing schemes offsetting the £4.0m divisional shortfall.

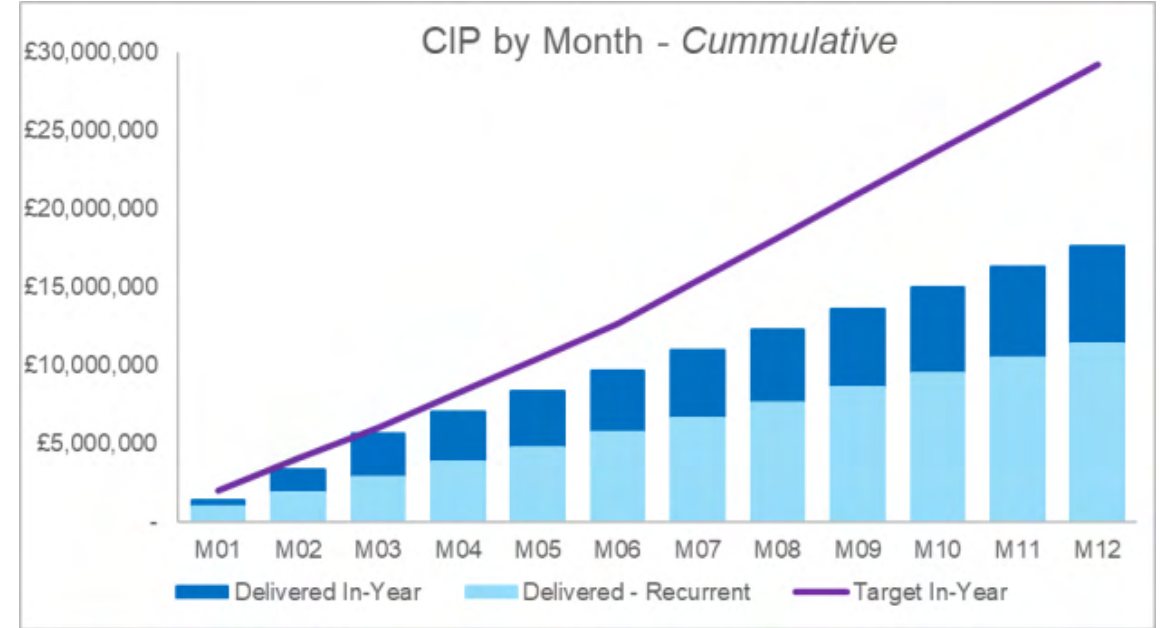
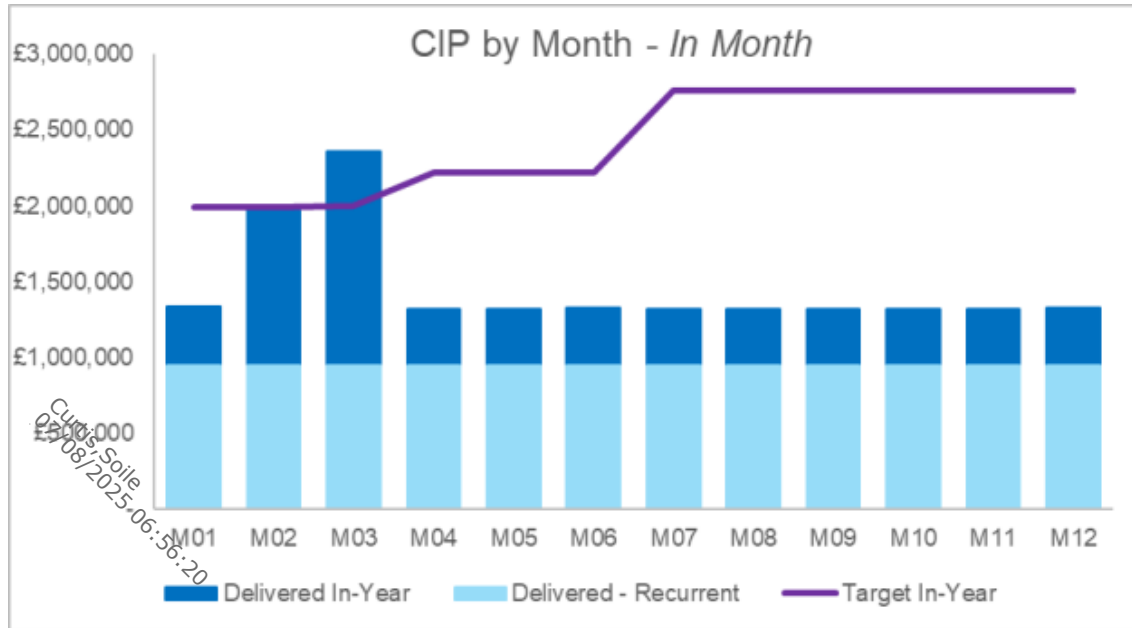
Division	Target YTD	Delivered YTD	2025/26 In Year £'000					% Identified	2025/26 Recurrent £'000					% Identified		
			Target - FYE	Delivered	Green	Amber	Red		Gap	Target Recurrent	Delivered	Green	Amber		Red	GAP
Medicine and Urgent Care	1,233	564	4,933	3,051	131	75	14	1,662	66%	3,476	2,469	337	100	75	496	86%
Surgery	972	968	3,889	1,765	260	33	751	1,081	72%	2,740	625	541	66	583	926	66%
Women & Children	482	628	2,228	1,738	318	57	306	(191)	109%	1,570	439	318	63	312	438	72%
Integrated Care	464	273	1,854	1,055	2	267	11	520	72%	1,307	373	2	271	11	650	50%
Clinical Support Services	476	454	2,305	715	1,266	234	449	(358)	116%	1,624	319	1,509	249	562	(1,015)	162%
Estates & Facilities	368	64	1,470	208	109	57	86	1,010	31%	1,036	87	81	92	169	608	41%
Corporate	407	91	1,627	850	268	253	-	255	84%	1,146	175	314	166	-	491	57%
Sub-total Divisions	4,402	3,042	18,306	9,382	2,353	975	1,616	3,980	78%	12,899	4,486	3,102	1,005	1,712	2,594	80%
General Trust	1,590	2,628	10,894	8,211	395	2,562	3,706	(3,980)	137%	7,676	6,911	-	-	2,706	(1,941)	125%
TOTAL	5,992	5,669	29,200	17,593	2,748	3,537	5,322	0		20,575	11,397	3,102	1,005	4,418	653	
TOTAL IDENTIFIED		5,669	TOTAL IDENTIFIED					29,200	TOTAL IDENTIFIED					19,922		
YTD gap		323	In Year gap		0		Recurrent gap		653							
% Identified		95%	% Identified		100%		% Identified		97%							

STEP (Stockport Trust Efficiency Programme)

£2.5m of CIP has been transacted during May to increase the total efficiencies delivered to £17.6m (60%) in year.

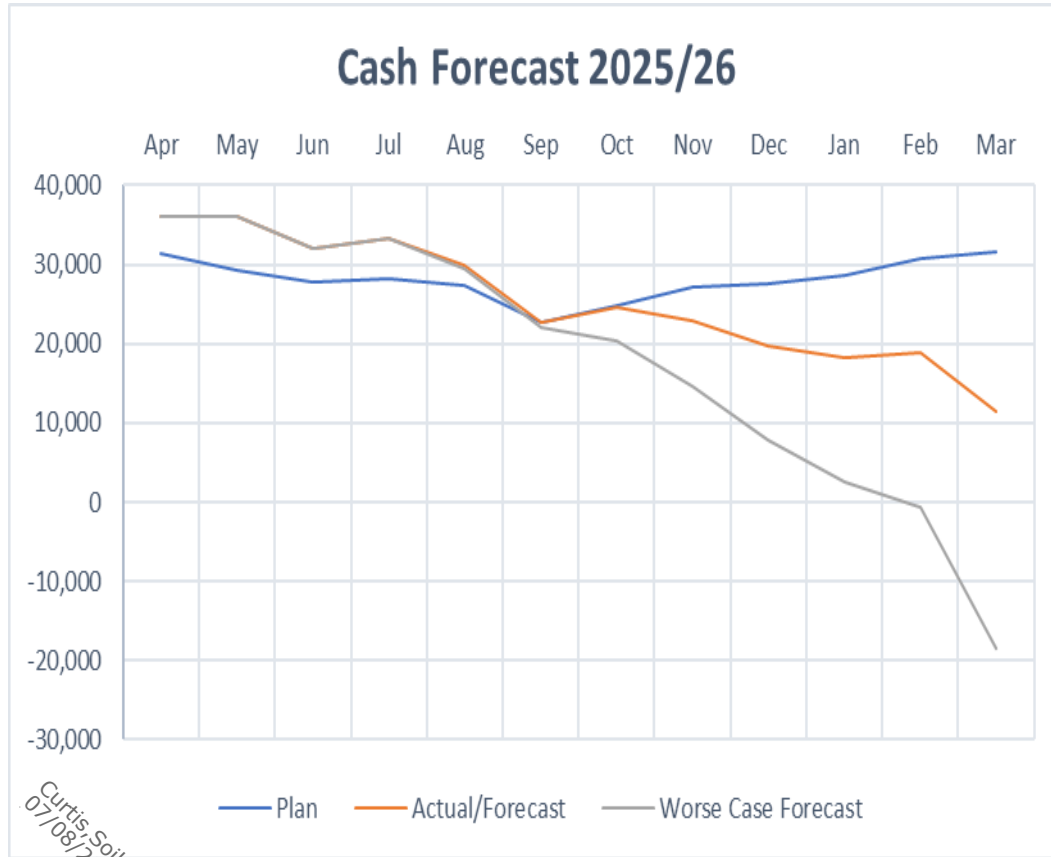
STEP of £5.7m has been delivered to date which is £0.3m behind plan, with over achievement in month partially recovering April's shortfall. The divisions are now £1.4m behind target to date; this is partially being offset by technical over-delivery, which is not cash releasing.

However, the charts below show that the pressure to deliver STEP both in year and recurrently remains high and is a key risk to delivery of the Trust's plan.



Cash, Capital & PFI

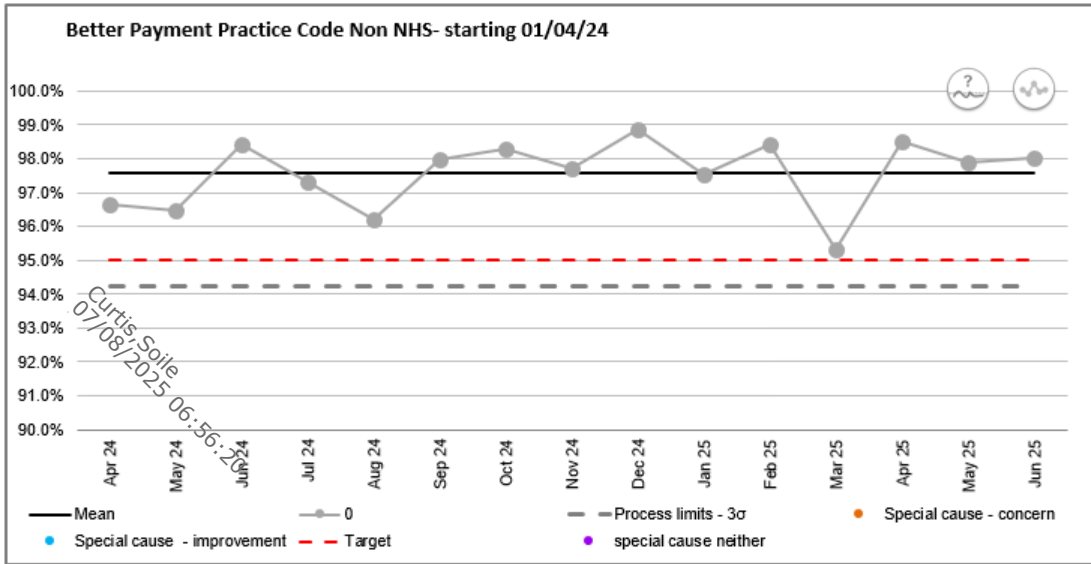
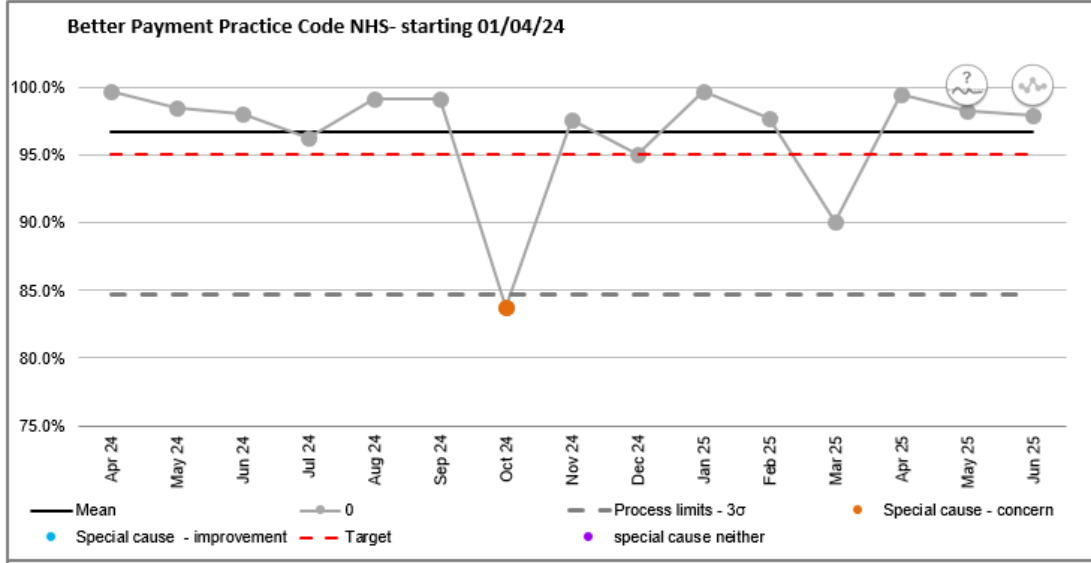
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- Cash balances at the end of June were £31.7m for the Trust and £0.3m for the Pharmacy Shop, a reduction of £4.1m from May 2025.
- Cash Annual Plan for June 2025 was £27.8m – therefore an improved cash balance of £4.2m compared to plan. This favourable balance includes the initial funding for the pay award from April 2025 which will be paid in August. The Trust will receive additional funding in August for the award.
- The cash forecast has been updated on current run rate, known cash commitments and risks. This shows that the Trust cash balances are forecasting a significant variance from Plan with a March 2026 outturn of £11.4m – which is a variance from Plan by £20m. This is an increase of £3m from the £17m reported previously due to the removal of £3m EPR revenue funding from the forecast.
- The graph includes worse case forecast which includes the risk of the removal of funding from Q3 of non recurrent deficit funding (£21.6m), Derbyshire ICS income (£5.4m), UEC D2A (£1.7m) and Future Funding Flows (£1.2m). The Trust will require cash support from the end of January through to March 2026 without these sources of funding. There are no mitigations profiled yet to offset the threat to income.
- The Cash Monitoring Group will continue to closely monitor the impact of the above risks outlined.

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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.

Better payment practice code	BPPC M01		BPPC M02		BPPC M03	
	Number	Value £000's	Number	Value £000's	Number	Value £000's
Non NHS						
Total Bills paid in the year	5079	24,496	4372	18,159	3792	17,563
Total bills paid within target	5003	24,325	4280	17,864	3716	17,480
Percentage of bills paid within target	99%	99%	98%	98%	98%	99%
NHS						
Total Bills paid in the year	855	999	458	1,132	427	956
Total bills paid within target	850	997	450	1,045	418	618
Percentage of bills paid within target	99%	100%	98%	92%	98%	65%
Total						
Total Bills paid in the year	5934	25,496	4830	19,291	4219	18,519
Total bills paid within target	5853	25,322	4730	18,909	4134	18,098
Percentage of bills paid within target	99%	99%	98%	98%	98%	98%

Capital

Division £m	June 2025 (M03)			Year to Date			Forecast		
	Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m
Estates	(0.6)	(0.7)	(0.1)	(4.8)	(4.8)	-	(13.4)	(13.4)	-
Equipment	-	-	-	-	-	-	(1.1)	(1.1)	-
Digital	(0.5)	(0.2)	0.3	(0.5)	(0.3)	0.3	(21.0)	(21.0)	-
Sub-total	(1.2)	(0.9)	0.2	(5.3)	(5.1)	0.2	(35.5)	(35.5)	-
IFRS16	-	-	-	(0.8)	-	0.8	(1.8)	(1.8)	-
Total Capital	(1.2)	(0.9)	0.2	(6.0)	(5.1)	1.0	(37.4)	(37.4)	-

Key Points

- The Trust submitted a capital plan for 2025/26 of £35.4m including £1.9m for IFRS16. This increased in May by £1.3m for the approved MacMillan information centre, plus a further £0.7m in June in respect of additional PDC for an approved diagnostics request (£0.6m) and additional estates safety(£0.1m). This takes the total plan to £37.4m.
- Capital spend to date relates to two schemes carried forward from 2024/25:
 - Emergency Care Campus £1.7m (forecast £1.4m, VAT credit of £0.3m expected in September)
 - Outpatients Modular Build £3.1m (forecast £4.3m)
- The Emergency Care Campus scheme is now finished, and no further expenditure is expected.
- There is an IFRS16 variance as the Meadows transfer has not yet been finalised and transacted, therefore the lease is not in place.

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Statement of Financial Position

	As at 31/03/2025 £000's	As at 30/06/2025 £000's
Total Non-current assets	243,326	243,342
Current assets and (Liabilities)		
<i>Inventories</i>	951	960
<i>Trade receivables and accrued income</i>	15,184	20,495
<i>Assets held for sale</i>	7,050	7,050
<i>Cash and cash equivalents</i>	36,725	31,703
<i>Current liabilities</i>	(69,480)	(74,026)
<i>Provisions</i>	(1,443)	(1,372)
Net Current Assets/Liabilities	(11,012)	(15,190)
Total Assets Less Current Liabilities	232,313	228,152
Non-current (Liabilities)		
<i>Borrowings: leases</i>	(8,040)	(8,040)
<i>Borrowings: DHSC Capital Loans</i>	(12,223)	(12,223)
<i>Provisions</i>	(2,789)	(2,789)
Total Non Current Liabilities	(23,052)	(23,052)
Total Assets Employed	209,261	205,100
Financed By Taxpayers Equity		
<i>Public dividend capital</i>	262,692	262,692
<i>Revaluation reserve</i>	59,614	59,614
<i>Income and expenditure reserve</i>	(113,046)	(117,207)
Total Taxpayers Equity	209,261	205,100

- At month 3 increased receivables include outstanding contract income from SMBC of £1.6m which was signed in June and received at the beginning of July. Increase in prepayments is £4m of which £0.72m relates to a prepayment of clinical negligence insurance to NHS Resolution, Other significant prepayments include CQC, Theatres Maintenance Contracts and IT Contracts.
- The increase in current liabilities include £2.4m of pay award which will be settled in August 2025 and £1.4m of PDC dividend which will be settled in September.
- Asset transfer and lease contracts for The Meadows Asset Held for Sale are expected to be finalised in July 2025

				Agenda No.	11
Meeting date	7 th August 2025	Public	X	Confidential	
Meeting	Board of Directors				
Report Title	Digital & Informatics Strategy Update				
Director Lead	Dr Peter Nuttall, Director of Informatics	Author	Dr Peter Nuttall, Director of Informatics		

Paper For:	Information	Assurance	X	Decision
Recommendation:	The Board is asked to note the contents of the Digital Strategy Update.			

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
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	X	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
	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
X	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

Where issues are addressed in the paper	Section of paper where covered
Equality, diversity and inclusion impacts	Not considered
Financial impacts if agreed/not agreed	Throughout
Regulatory and legal compliance	Throughout
Sustainability (including environmental impacts)	Not considered

Executive Summary

This is the update report on the delivery of Trust's Digital Strategy (2021-2026). The Strategy was approved by the Trust Board of Directors in December 2022 and five update reports have been received in October 2022, May 2023, November 2024, May/July 2024, and January 2025.

The report is structured around the seven key ambitions of the strategy and provides an update on the actions listed against each of the ambitions in the strategy document including outcomes.

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CONTENTS

1. INTRODUCTION

This is the sixth update report on the delivery of Trust's Digital Strategy (2021-2026). The Strategy was approved by the Trust Board of Directors in December 2022, and five update reports have been received in October 2022, May 2023, November 2023, July 2024, and January 2025.

The delivery of the strategy is the responsibility of the Digital and Informatics Teams, with oversight from the Digital & Informatics Group. This Group meets on a bi-monthly basis and is chaired by the Director of Informatics. Key Issues & Assurance Reports are presented to the Finance and Performance Committee.

2. REVIEW OF AMBITIONS

The report is structured around the seven key ambitions of the strategy (see diagram below) and provides an update on the actions listed against each of the ambitions in the strategy document.

3. FUNDING OPPORTUNITIES

In FY 2025/26, the Digital and Informatics department have secured £15m capital and £3.1m revenue for use against the EPR Programme procurement. This is anticipated to be drawn down in Q2 2025/26.

4. OVERALL PROGRESS ON DELIVERY

In the past 6 months, the teams have continued to progress with the delivery of the digital strategy in parallel with managing all BAU activities.



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OUR DIGITAL AMBITIONS – 2021-2024

DIGITISE Patient Care Delivery	2021 - 22	2022 - 23	2023 - 24
Acute Electronic Patient Record			
Laboratory Information Management System			
Optimise existing systems and maximise capabilities			
PATRON single point of clinical system access			
Maximise benefits of Community EPR Programme			
Expanded system integration & data sharing			
Optimise Theatreman solution			
Exploit benefits of GM PACS solution			
Specialist Ophthalmology EPR			
Explore use of AI/VR & NLP			

WHAT HAVE WE DELIVERED?

Acute EPR (Electronic Patient Record).

Stockport & Tameside digital teams have continued to work on the preparation activities for the formal procurement and implementation of a joint EPR solution. **Approval was granted for the Joint Outline Business Case on 11th December 2024 which will allow the programme to progress to procurement stage.**

The formal procurement commenced on 4th April 2025 with a final tender submission date of 15th May 2025. A total of four tenders were received, from three different suppliers.

The EPR planning team shared the relevant sections of the tenders with nominated individuals across Stockport NHS Foundation Trust and Tameside and Glossop Integrated Care Foundation Trust for evaluation and moderation. Over 150 individual members of staff have supported the paper evaluation. This element of the process is expected to be completed by Friday 20th June, at which point suppliers who have scored higher than the quality threshold of 60% will progress to system demonstrations.

System demonstrations are planned to take place between 7th July and 1st August. There are 14 clinical demonstrations and three non-clinical demonstrations for staff to evaluate. At the end of this process, it is hoped that one provider will be identified as the preferred bidder.

Outcome: £15m capital and £3.1m revenue funding has been awarded under the Frontline Digitisation Programme to support this work.

Laboratory Information Management System (LIMS).

The LIMS (Telepath replacement) programme has experienced some significant issues and there will now be a split 'go live' to take place in Q3 and Q4 2025/26. The actual dates are still being confirmed with the department and the supplier. The Team continues to support CSS providing expert advice and guidance when required.

Optimise Theatreman Solution

The Digital Projects Team will be working with the Theatreman System Manager to define and deliver an upgrade to the existing system to the new version called Aqua. This will enable additional functionality to be rolled out within Theatres. Scope of additional functionality yet to be defined. This has currently been placed on hold due to delays at the supplier side. The team is currently working through the delays to identify a new 'go live' window.

Explore use of AI/VR & NLP.

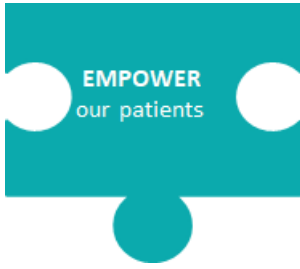
A working group has been set up to identify the ongoing requirements of dictation provision, exploring new technologies that can support operational efficiencies. Costs are being sought from the framework providers to explore whether a full procurement is required or if we can extend the scope of the BigHand solution to cover the next 3-5 years in parallel with the EPR procurement and implementation.

Outcome: £1.5m capital has been identified within the FY2025/26 capital plan to complete this work.

Digital Clinical Safety.

A robust governance structure and process have been implemented to track and progress the organisation's compliance with DCB standards to ensure the clinical safety of digital systems is assured prior to implementation. A Digital Clinical Safety Group has been established with multi-disciplinary representation and a series of templates and support packages established to enable project teams to achieve compliance. A network of Clinical Safety Officers is being established.

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OUR DIGITAL AMBITIONS – 2021-2024

EMPOWER our patients	2021 - 22	2022 - 23	2023 - 24
Delivery of a patient portal			
Support increased use of video consultations			
Support the introduction of Patient Apps			
Deliver the Digital Maternity Record			
Explore Virtual Visiting platform			
Investigate options for telemedicine and telehealth			

WHAT HAVE WE DELIVERED?

Delivery of the digital maternity record.

Delivery against the National Patient Safety alert completed on 11th December 2024 with a small system upgrade and new functionality delivered to show a full maternity summary report. Discussions taking place with W&C Divisional Director about the future direction of digital maternity, and whether a new standalone system is required to meet the needs of our patients, or if this can be built into the EPR Programme. Work being done in parallel with colleagues at TGICFT to understand and identify any commonalities in strategic direction and potential for economies of scale.

Explore virtual visiting platform.

No updates.

Investigate options for telemedicine and telehealth.

No updates.

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OUR DIGITAL AMBITIONS – 2021-2024

SUPPORT our staff	2021 - 22	2022 - 23	2023 - 24
Deliver and refine PATRON			
Support agile working			
Embed flexible digital training model			
Clinical equipment investment and replacement programme			
BYOD/UYOD			

WHAT HAVE WE DELIVERED?

Clinical equipment investment and replacement programme.

Digital Clinical Ward Rounds continue Trust wide, with representation from IT and the Digital Nursing Team, to ensure digital equipment in clinical areas continues to enable care as required and that staff have the equipment which they need to fulfil their clinical roles and responsibilities. The Team is working with the supplier to undertake a device review following a number of incidents with ePMA trolleys shearing from their base plate. This work completed in May 2025 and a plan of action for fix/replacement put in place.

Outcome: To date eight carts have been fixed (replacing the struts and base plates).

BOYD/UYOD (Bring/ Use Your Own Devices).

No updates.

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OUR DIGITAL AMBITIONS – 2021-2024

INVEST in our Infrastructure	2021 - 22	2022 - 23	2023 - 24
Complete delivery of the Unified Communications Programme	[Green bar spanning 2021-22, 2022-23, and 2023-24]		
Introduction of Virtual Desktop Infrastructure & Office 365	[Green bar spanning 2021-22, 2022-23, and 2023-24]		
Review and rationalise our desktop estate	[Green bar spanning 2021-22, 2022-23, and 2023-24]		
Replacement of Beech House Data Centre	[Green bar spanning 2021-22, 2022-23, and 2023-24]		
Review external partners IT support arrangements	[Green bar spanning 2021-22, 2022-23, and 2023-24]		
Digital Equipment Tracking System	[Green bar spanning 2021-22, 2022-23, and 2023-24]		
Review Patient 'Info-tainment' solution	[Green bar spanning 2021-22, 2022-23, and 2023-24]		
Centralised printing solution	[Green bar spanning 2021-22, 2022-23, and 2023-24]		
Maintain security against cyber attacks	[Green bar spanning 2021-22, 2022-23, and 2023-24]		

WHAT HAVE WE DELIVERED?

Optimisation of Unified Communications (UC) Programme.

Since the last update, a further 220 Softphones have been deployed, displacing an equivalent number of physical handsets. The initial seven-year UC contract is coming to an end in June 2026 and, whilst it was originally our intention to invoke at least one of the three one-year contract extension options that were built into the initial tendering process, licensing changes for Cisco and Virgin Media mean that this is now not possible. The underlying infrastructure of the UC solution is primarily on premise, but we are unable to retain this configuration beyond the current contract end in June 2026. Pre-market procurement activities are underway to explore alternatives.

Outcome: Since the last update, a further 220 Softphones have been deployed, displacing an equivalent number of physical handsets.

Implementation of Vocera Communications System.

Investments have been made, but the programme remains on hold. Following the wireless/cabinets programme completion, funding was requested to restart the programme for inclusion in the 25/26 capital programme, but other priorities had higher risk classifications meaning that this was not included in the Trust’s plans. External funding opportunities continue to be explored. There is a definitive communications capability gap and with a need to ultimately replace traditional bleeps (Vocera is intended to do this), activities are underway to support a small-scale pilot within ED/Urgent care to provide meaningful information and real-life use cases for inclusion in an updated business case.

Introduction of Virtual Desktop Infrastructure (VDI).

Following completion of rollout of the new VDI solution across all community locations, the acute rollout has also completed. Further upgrades and a move to Windows 11 for both acute and Community deployment is underway along with the full Windows 11 device upgrade programme. This programme has fully commenced and is planned for completion in November 2026.

Windows 11.

Significant preparatory works, including the introduction of automatic deployment options, have been completed, ahead of the commencement of the Windows 11 upgrade programme. This will upgrade the Trust’s 4,500+ Windows-10 based laptops and PCs with a newer, more efficient, and secure operating system ahead of the end of support date for Windows 10 (14th October 2025). Significant numbers of end-user devices will not run Windows 11 and a business case for investment was submitted through the trust governance processes and subsequently approved. All required hardware has been delivered, and the rollout is underway. The programme will ultimately replace or upgrade over 5,500 Laptops/PCs.

Outcome: Funding to replace 5,500 laptops/ PCs.

EOL Phones / Tablets

Concurrently to the Windows 11 programme, a major refresh of older tablets, and mobile phones that are approaching end of life, has also commenced. The programme will ultimately replace over 1200 tablets/phones with current, secure models.

Outcome: Funding to replace 1,200 tablets/ phones.

Office 365 / Microsoft Teams / Co Pilot / Exchange Online

All staff have been 'onboarded' to Office 365 from a basic- capabilities perspective to remove Cisco Webex as our primary meetings platform. Further programmes have commenced around piloting the introduction of Microsoft Co Pilot with over 50 staff across multiple specialties being provided AI-driven Co Pilot to enhance productivity and efficiency. Operational Management Group and the Executive Team are to be consulted on migration of all Trust email accounts to Exchange Online. This, along with Microsoft 365 and Co Pilot, will improve efficiency and accessibility of core productivity solutions.

Outcome: Pilot of CoPilot underway.

Review and rationalise/optimisation of all end-user devices.

A full end-user device rationalisation programme (tablets, PCs, and laptops) has commenced as part of the Windows 11 upgrade programme. Piloting of new, more capable, Microsoft-Surface and Lenovo Yoga hybrid laptops continues in Community and these devices are planned to replace the Samsung tablets. This programme is aligned to the Windows 11 / EOL Tablets programme of work.

Replacement of Beech House data centre.

Due to significant challenges with the current 'end of life' cooling systems in the Beech House server room and the overall deterioration of the Beech House building, a programme has commenced in conjunction with Estates & Facilities to look at all options, including a data centre "pod". Architects have been appointed and have produced several options for consideration. A further, more comprehensive, assessment of the Beech House building has concluded and resulted in Beech being assigned a Category D status. A full business case is being developed with Estates & Facilities to determine the most suitable option, given the deterioration of the building and the critical nature of it for the Trust's digital and technology solutions/systems.

Review external partners IT support arrangements.

GM Shared Services provides our connectivity to community sites and the wider HSCN network. A three-year extension to this contract was put in place in 2023-24, which avoided any annual increase in the cost. An options appraisal is planned for quarter 4 of 2024-25 and this will determine what the approach will be for connectivity requirements at the end of this contract. A migration to alternative connectivity will take in the region of 12 months.

Digital equipment tracking system.

Investments have been made, but the programme is on hold. Now that the wireless/cabinets programme has concluded, a revised business case for restarting the programme will be submitted for consideration through the Trust governance process for inclusion in the 26/27 capital plans.

Review patient 'infotainment' system.

The free "proof of value" programme to replace all existing Hospedia patient infotainment units was completed in April 2025. This programme has replaced all existing Hospedia bedside units (over 700) with the latest, tablet-based models. This upgrade was provided at zero cost to the Trust, and, over the coming twelve months, we will be looking to build a business case to determine in what form we are to retain this capability, along with assessing the financial impact of extending the capability out to those inpatient areas that do not have it. The new tablets can be used for Trust applications such as meal ordering, observations, and any EPR we might select. This has obvious benefits for allowing staff to have access to the right systems/tools at the bedside.

Centralised printing solution.

A fully- managed print solution has been deployed across all Trust departments/divisions, including community, which provides for scanning and locked/secure print. This comes with significant reporting/intelligence on the type of printing being undertaken. Whilst this programme represented a c£45k cost saving over the previous printing arrangements, further changes have been made in November 2024 around disabling colour printing for all staff with a process for enabling it on a case-by case basis. This had resulted in a colour printing dropping from around 20 – 25% of total monthly volume to less than 12%. Volumes have been increasing slightly since November 2024. Monthly reporting that provides a full breakdown, down to individual users is provided to Finance and Divisional leadership.

Outcome: 50% reduction in colour- printing contribution.

Maintain security against cyber- attacks.

Significant progress in regular software updating/patching has been made, backed by robust and structured change control processes. Palo Alto cyber- security capabilities have been deployed, providing threat detection and remediation for our network (referred to as East- to- West traffic).

A business case was fully approved for investment in next-generation firewalls, providing for the best possible perimeter security. These have been fully deployed ahead of the existing firewalls' end- of- support date.

Major improvements/governance changes are planned for cyber security including the introduction of a five- year Cyber- Security Strategy, the formation of a Security Operations Centre (SOC), and the production of an overarching business case for consideration to address our people-centric cyber- security deficiencies.

As part of other, core infrastructure programmes underway and funded via the Capital programme, a further tier of internal firewalls, with AI-driven threat detection and defence, is being considered to further enhance our internal cyber- security defences.

Replace acute wireless infrastructure.

The wireless and cabinets programme formally concluded in November 2024. Some elements remain to be completed, namely TIF and EUCC, which will be completed under Business as Usual (BAU).

Infrastructure replacement/enhancement 5-year Investment Plan.

A five- year Infrastructure upgrade/replacement roadmap and plan is being produced that will outline the technical priorities for the next five years.

Outcome: Core Infrastructure Uptime Target of 99.999% (excludes planned downtime/maintenance). Latest data: May 99.701%.

Deliver an effective information governance framework and maintain accreditations and certifications that demonstrate information security best practice.

Outcome: Achieving "Standards Met" for all mandatory requirements of the Data Security and Protection Toolkit Assessment 2023/24. Maintaining ISO 27001 (Information Security Standard). Maintaining accreditation to the Secure Email Standard (DCB 1596), which allows the Trust to send secure (encrypted) email to other accredited organisations.

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OUR DIGITAL AMBITIONS – 2021-2024

ENGAGE clinical leaders to improve quality	2021 - 22	2022 - 23	2023 - 24
Establish a robust clinical engagement framework			
Digital comorbidity capture to improve clinical data quality			
Modernise our Clinical Coding Departments & raise its profile			
Clinical coders working more closely with Clinical Teams			
Data provision for clinical audit and research teams			

WHAT HAVE WE DELIVERED?

Establish a robust clinical engagement framework.

Efforts are currently underway to design a Trust Digital Champion Programme that will increase the presence and impact of digitally- enthused clinicians across the organisation to promote pipeline projects and to garner momentum and interest in the digital and informatics specialties.

Digital comorbidity to capture to improve clinical data quality.

Accurate and timely clinical coding of activity is important for monitoring the quality of clinical services, to ensure accurate benchmarking, and for appropriate reimbursement under national payment regimes. The Clinical Coding Team continues to access the Greater Manchester Care Record in order to view patients’ comorbidities as documented on primary care systems, use of this system alongside hospital clinical documentation of comorbidities, and the ongoing use of ClearView, a clinically driven digital coding validation and audit system which highlights potential missed comorbidities, has helped to improve the quality and depth of clinical coding.

Outcome: The benefits of the implementation of ClearView can be seen with a 10% increase in net tariffs per patient spell (+£1.1m across 12 months) and an increase in the average co-morbidity per spell (SHMI) from 4.53 to 5.54 (the national mean is 4.96).

Modernise our clinical coding department and raise its profile.

Clinical coding is a highly skilled task that requires considerable training and extensive knowledge. Stockport and Tameside share a joint Head of Clinical Coding, who works collaboratively across both Trusts. A cross-organisational training team is in place to support staff development. Recent recruitment includes a trained coder working across both sites to support national coding deadlines. The management team continues to attend regular clinical meetings and clinical coding presentations are delivered to new junior doctors. A close eye is being kept on national developments around AI coding solutions.

Clinical coders working more closely with clinical teams.

See previous point.

Data provision for clinical audit and research teams.

The Business Intelligence team continues to support with ad-hoc data provision; however, to support direct access to data for clinical audit and research in the future, the following detail has been included in the draft EPR output-based specification and will be a requirement of a future EPR supplier.

Outcome: ‘The EPR solution must also allow for effective clinical audit by providing functionality to easily identify cohorts of patients and subsequently supply a standard set of information and ad- hoc reports to assess clinical practice. A combination of specific clinical audit reports and alerts are expected to be provided by the bidder to support the clinical audit function for each discipline.’



OUR DIGITAL AMBITIONS – 2021-2024

ENHANCE performance and operational service delivery	2021 - 22	2022 - 23	2023 - 24
Optimise capabilities of the Data Warehouse	[Progress bar]		
Modernise internal operational and performance reporting	[Progress bar]		
New informatics portal for access to all reports	[Progress bar]		
Expand range of clinical reports & clinical quality dashboards	[Progress bar]		
Programme of work with our community based services	[Progress bar]		
Support developments in Population Health delivery	[Progress bar]		
Increase our data science skills	[Progress bar]		

WHAT HAVE WE DELIVERED?

Optimise capabilities of the data warehouse.

The Trust's Data Warehouse centralises data from seventeen different clinical and administrative digital systems. Having data in one central place makes reporting, analytics, and external data submissions easier and more comprehensive. Data held in the data warehouse continues to be used for elective recovery projects, including SMS validation of the Trust's waiting lists, the benefit of which is shown below. During 25/26 the data engineering team will be working on expanding SMS text reminders to include Radiology, Echocardiography, and Community appointments in order to help continue to drive down DNA rates and avoid appointment slots being wasted. Also, during 25/26, data from the warehouse will feed into the new machine learning RTT validation tool as part of a new project being undertaken with MBI Healthcare to deploy the LUNA ROVA tool which will help reduce the manual effort involved in validation of patient RTT and non-RTT pathways, improving the visibility and accuracy of our patient pathways. Data from the Trust warehouse continues to feed into high-profile NHS England improvement programmes, including the Federated Data Platform (FDP), Model Hospital, and GIRFT, as well as to the Integrated Care System supporting their System Control Centre and OPEL framework, GM tableau dashboards, and locality board reporting. This data is driving decision making so particular attention is paid to data quality with an established Trust Data Quality Review Group providing assurance and recommending improvements to ensure that data quality remains consistently high.

Outcome: In 24/25, there were 74,192 validation texts delivered for patients on hospital waiting lists, 87% of these were responded to, this resulted in 5,148 patients being removed from the waiting lists. That is a removal rate of 8%.

Modernise internal operational and performance reporting.

The Business Intelligence (BI) team continues to develop and improve internal reporting by providing enhanced visualisation of data to support operational teams. With a focus on efficiency and productivity this year, reports on outpatient clinic and operating theatre utilisation have been reworked and improved to provide additional intelligence to operational teams. Reports focused on cancelled theatre operations now allow teams to identify key themes and trends, enabling them to take steps to mitigate, or reduce unused capacity.

By working closely with our pre-operative assessment service, BI is now able to produce patient lists that support our elective booking teams with scheduling more operations with a view to improving utilisation of available operating time. Further analysis in this area is underway that will allow clinical teams to use peer-to-peer comparison and identify performance outliers, with a view to enhancing patient experience and reducing wait times for elective theatre operations.

Significant work has taken place to make data more accessible for our diagnostic services. A new Radiology dashboard is being piloted with the service, with an emphasis on DNA rates and utilisation to ensure that the Trust can maximise the use of available capacity. The team is also supporting collaborative projects with our Tameside

colleagues that will see both hospitals work closer together to support one another and keep patient waiting times at a minimum.

New informatics portal for access to all reports.

The BI team continues to review and develop centralised menus within Tableau for access to groups of similar reports.

Expand range of clinical reports and clinical quality dashboards.

The BI team continues to support the Trust with data and dashboards that enable monitoring of compliance and identify areas of good practice and those that require focus. Updated patient observation timeliness reports pre- and post- ward transfer, in line with requirements, have resulted in improvements towards the 80% Trust target going from 60% in January 2025 to 75% in June 2025 for post- transfer timeliness. Compliance performance is reported monthly to the Quality & Safety Improvement Strategy Group (QSISG). A new tissue- viability dashboard has been developed with performance improving across all KPIs, with May 2025 seeing the best performance for timeliness of reviews. The weight- loss- alert email has been expanded to include patients who have had changes of +/- 10% MUAC (Mid-Upper Arm Circumference) and the development of the nutrition- assessment alert, which sends a list of patients to each ward, when the patient's nutrition assessment was done over six hours from admission time, has resulted in reviewed focus and improved compliance.

Outcome: In May 2025, MUST (nutrition assessment) compliance across inpatient areas, achieved the Trust target set at 90% for the first time. This ensures patients have a nutritional assessment undertaken within the first six hours of admission/transfer to each new clinical area.

Programme of work with our community- based services.

Work continues on transitioning community data into a single Trust data warehouse, developing the underlying reporting structure, and developing new national reporting (Faster Data Flows). Re-development of local reporting from the data warehouse continues with a transition of performance reporting into Tableau. Other Tableau dashboards have been developed to manage the patients requiring a school- transition meeting, and to identify the category of need of patients through the transfer- of- care hub to aid future planning of D2A (Discharge to Assess) requirements.

Support developments in population- health delivery.

The BI team continues to support the work of the Integrated Care System with their population health delivery tools and health inequalities and prevention agenda.

Increase data- science skills.

By employing the use of data science and machine learning methodologies, the team is now working to support the improvement of outpatient DNA rates by developing more accurate forecasting models with a view to helping teams better direct supporting services – such as text and call reminders to those cohorts of patients most in need.

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OUR DIGITAL AMBITIONS – 2021-2024

COLLABORATE with our partners	2021 - 22	2022 - 23	2023 - 24
Link closely with Tameside digital teams			
Digitally support the Joint Clinical Strategy with East Cheshire			
Explore options for joint digital working			
Review internal & external technical interoperability capabilities			
Alignment of ambitions with Stockport and Greater Manchester			

WHAT HAVE WE DELIVERED?

Link closely with Tameside digital teams.

Stockport and Tameside continue to work closely on a joint EPR Programme. Early discussions are taking place on the future of the endoscopy and maternity solutions used at both sites, due to significant supplier- side issues affecting operational care delivery.

The teams are exploring opportunities to collaborate to provide cross cover and upskill members of the team across both sites.

Digitally support the joint clinical strategy with East Cheshire.

No update.

Review internal and external technical interoperability capabilities.

No updates.

Alignment of ambitions with Stockport and Greater Manchester.

The Trust’s Chief Information Officer (CIO) and Chief Clinical Information Officer (CCIO) attend the Stockport Digital Leaders’ Meeting each month.

The CIO also attends the weekly meeting of GM Provider CIOs. Attendance at both forums ensure that Stockport’s ambitions and delivery plans are aligned to external plans.

SUMMARY

Delivery of the Digital Strategy is continuing to progress well, supported by the significant external investment that the team managed to secure. In addition, the Trust’s major digital ambition of a new EPR solution is also progressing, which is a positive step for the Trust. The team is working hard to keep procurement and preparedness activities on track and ensure close collaboration with Tameside. It should also be acknowledged that the Digital and Informatics Team also continues to deliver the day- to- day activities (e.g. answering helpdesk calls; maintaining digital systems; securing clinical engagement; ensuring good data governance; and responding to ad hoc data requests).

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GLOSSARY

AI:	Artificial Intelligence
BAU:	Business as Usual
BI:	Business Intelligence
CIO:	Chief Information Officer
CSS:	Clinical Support Services
DCB:	Data Coordination Board
DNA:	Did Not Attend
EPaCCS:	Electronic Palliative Care Coordination Systems
ePMA:	Electronic Prescribing and Medications Administration
EPR:	Electronic Patient Record
ERF:	Elective Recovery Funding
EUCC:	Emergency and Urgent Care Campus
GIRFT:	Getting It Right First Time
GMCR:	Greater Manchester Care Record
GMSS:	Greater Manchester Shared Services
HSCN:	Health and Social Care Network
ISO:	International Organization for Standardization
LIMS:	Laboratory Information Management System
NLP:	Natural Language Processing
OPEL:	Operational Pressures Escalation Levels
PTL:	Patient Target List
RTT:	Referral to Treatment
SHMI:	Summary Hospital-level Mortality Indicator
SOC:	Security Operations Centre
TGICFT:	Tameside and Glossop Integrated Care Foundation Trust
TIF:	Targeted Investment Fund
UC:	Unified Communications
VDI:	Virtual Desktop Infrastructure
VR:	Voice Recognition

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				Agenda No.	12.1
Meeting date	7 th August 2025	Public	X	Confidential	
Meeting	Board of Directors				
Report Title	Green Plan Progress Update				
Director Lead	John Graham, Executive Chief Finance Officer	Author	Laura Swann, Sustainability Manager		

Paper For:	Information	X	Assurance	X	Decision	
Recommendation:	The Board is asked to receive the attached Green Plan Progress report. The report provided is the 'Environmental Matters' section of the Trust Annual Report, that describes the progress made in relation to the delivery of the Trust Green Plan in 2024/25.					

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
	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	10
Financial impacts if agreed/not agreed	N/A
Regulatory and legal compliance	4,13 and 14
Sustainability (including environmental impacts)	Throughout

Executive Summary

This report provides an update on progress made in relation to each of the 10 Green Plan Workstreams during 2024/25. Key achievements this year include:

- The establishment of a Joint Green Plan Delivery Group with Tameside and Glossop Integrated Care NHS Foundation Trust
- Engagement with Divisions to ensure the new Green Plan aligns with the targets in the Clinical Strategy
- Staff Travel Survey conducted
- Funding awarded by the Department for Energy, Security and Net Zero (DESNZ) to produce a Heat Network Readiness Report and Heat Decarbonisation Plan for the trust
- Improved clinical waste segregation performance
- Capped the nitrous oxide manifold system and moved to the use of cylinders where still required, with less wastage
- 1490 walking aids refurbished and reused
- 10% social value weighting included in all tenders

- Introduced blue plates to serve meals to patients and in the restaurant to reduce food waste
- Adapted the menu in the restaurant and for patients to introduce lower carbon dishes
- 8 large new trees planted around the hospital site
- Funding received from the Centre for Sustainable Healthcare for a Nature Recovery Ranger from April 2026 for 2 years

The Green Plan aims to drive progress towards the NHS net zero targets by continuing to reduce carbon emissions. The performance data in the report shows that carbon emissions have reduced from the baseline year of 2019/20, but we still have some way to go to achieve net zero. Gas and electricity usage is responsible for a large proportion of the emissions the Trust directly controls and the decarbonisation of our estate therefore needs to be a key area of focus in 2025. The Heat Decarbonisation Plan and Heat Network Readiness Report produced this year will help to look at how we achieve this, and the Trust have now engaged with the Carbon and Energy Fund (CEF) who will develop the brief to support the procurement of a contract to decarbonise the hospital estate and to explore associated funding options.

A new Joint Green Plan is currently in development with Tameside and Glossop Integrated Care NHS Foundation Trust and will cover the period 2025 to 2028. The plan will set out where we are now in relation to the delivery of each workstream and the planned actions over the next 3 years.

This report will be presented to the Trust Board on 7th August 2025, along with a report to request the adoption of the new Joint Green Plan.

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Environmental Matters 2024/25

The Trust recognises that the climate emergency is a health emergency, and we must act fast to reduce our carbon emissions and the associated health inequalities. The Trust is committed to the delivery of the Green Plan to drive progress to become a net zero-carbon organisation by 2040 for the emissions we control directly, and by 2045 for the emissions we can influence. Although the NHS national target for net zero is 2040, we seek to align with the GMCA target of 2038.

The Trust continues to embed the necessary long-term transformation and culture shift to see sustainable healthcare as the norm rather than the exception. We continue to be committed to reducing the environmental impact of the Trust's activities, protecting our natural environment, empowering staff to undertake their duties responsibly, and enhancing social value.

Our current Green Plan has now reached the end of its three-year duration, and we have been undertaking extensive work with key stakeholders to develop a new Joint Green Plan in partnership with Tameside and Glossop Integrated Care NHS Foundation Trust. This new plan will cover the period 2025 to 2028 and is scheduled for publication in summer 2025.

Following the appointment of a Joint Sustainability Manager (with Tameside and Glossop Integrated Care NHS Foundation Trust), in February 2024, the Trust has had more capacity to support the delivery of the Green Plan actions. The following information provides key updates for 2024/25 in relation to each Green Plan workstream.

1. Workforce and System Leadership

A Joint Green Plan Delivery Group was established in 2024 and is comprised of Workstream leads overseeing the delivery of specific areas of the Green Plan, to review performance and enable progress. The group has approved Terms of Reference and is chaired by the Director of Estates and Facilities.

Earlier this year 82 staff participated in a presentation and question and answer session relating to the delivery of the Green Plan at Stockport Foundation Trust, discussing what the organisation is doing and how they can contribute to the delivery of the joint plan.

The Sustainability Manager has attended a careers event at Stockport College this year to showcase NHS careers in environmental sustainability and promote opportunities in this field, specifically showcasing opportunities in healthcare to young people.

2. Net Zero Clinical Transformation

Significant progress has been made in 2024 to understand our current position in relation to this workstream and to identify how further progress can be achieved. Colleagues working within Strategy and Partnerships have closely aligned this workstream with the concurrent development of the Joint Trust Clinical Strategy during 2024/25. This means the new Green Plan will include a Net Zero Clinical Transformation Action Plan for each Division that directly speaks to targets within the Divisional Clinical Strategy.

Over the past 12 months, the Trust has made positive progress to promote Net Zero Clinical Transformation. This includes ongoing engagement in several Provider Partnership workstreams to address health inequalities in collaboration with local system stakeholders, supporting a preventative approach. Similarly, there have been several examples of enhanced provision introduced for early intervention through local community services for children and young people. The Trust has continued the rollout of Patient Initiated Follow Up (PIFU), which empowers patients to choose when to request outpatient follow up. To further enable patient-self-care and support in the community with the help of technology, we have seen development of Virtual Ward pathways to prevent hospital inpatient admission where possible; increased utilisation of remote outpatient consultations; and the opening of the Community Diagnostic Centre (CDC) in Denton. These developments also help to reduce carbon emissions linked to patient travel to the hospital.

3. Digital transformation

All redundant IT equipment in the Trust is collected by a contractor for recycling. In 2024/25 this has resulted in a carbon savings for the Trust of 11.07 tCO₂e (tonnes of carbon dioxide equivalent).

4. Travel and transport

To understand how staff commute to work the Trust conducted a travel survey in September 2024 using questions developed by the Integrated Care Board (ICB) in conjunction with Transport for Greater Manchester (TfGM). The ICB requested that this survey was used to create consistency in data across Greater Manchester.

The survey was conducted electronically and recorded on the Modeshift STARS for Healthcare platform. The results of the survey have now been analysed, and an action plan has been produced to try and reduce car usage and encourage cycling and walking, along with increasing the use of public transport.



The Trust has engaged with Modeshift STARS with a view to using this platform to support work relating to sustainable travel initiatives. Modeshift STARS is an accreditation program that is based on a simple 5-step process that empowers organisations to enhance everyday journeys. Organisations are supported to create, deliver, and track the effectiveness of their Travel Plans, whilst working towards national accreditation by delivering a variety of engaging and effective sustainable and active travel initiatives.

Travel wise week took place from 16th to 22nd of September. During this week the Trust promoted the staff travel survey to maximize and promote engagement.

5. Estates and facilities

The current heating system for Stepping Hill Hospital is primarily run on gas and this is the main source of carbon emissions in the trust (approximately 48% of emissions). To meet the NHS target to reach net zero by 2040 we need to decarbonise our heat source and District Heat Networks are one mechanism to do this.

Stockport Metropolitan Borough Council is developing a project for a District Heat Network (DHN) based in the town centre and extending south to Stepping Hill Hospital. They have progressed this work through the feasibility and detailed design phase this year and work on the detailed project development has confirmed there is a technological and financially viable scheme, with good potential for the hospital site to be connected to a heat network. New infrastructure and pipework would be needed on site to achieve this, along with measures to improve the fabric of the buildings.

The scale, cost, and opportunities for funding to support the works required at the Trust needed to be assessed and this year the Trust received funding for this work to take place from the Department for Energy, Security and Net Zero (DESNZ), as part of the Advanced Zoning Program for Stockport. Work to produce the plan commenced in September and the final report will be presented to the Trust in April 2025.

In February 2025 the Trust approved the signing of a contract with the Carbon and Energy Fund (CEF). This will enable work to commence through the CEF framework to develop the brief to support the procurement of a contract to decarbonise the hospital estate and to explore associated funding options.

The delivery of key capital schemes throughout the last year has contributed to sustainability through improved efficiencies and reduced energy consumption, which has been achieved using Modern Methods of Construction (MMC). This is demonstrated through the construction of the new Outpatients Department which has achieved a MMC score of 79%. The high score is representative of the modular

building, its offsite manufacture and the high proportion of pre-manufactured components used.

The capital project team seek to embed sustainability considerations and principles into the design stages of all schemes where appropriate, working collaboratively with supply chain partners to support them to reduce their carbon footprint. A key achievement in this area has been working with Tilbury Douglas to tap into the local supply chain and thus reducing the impact of the transport of materials, ensuring careful consideration of the type of materials/products utilised on site and the use of alternative powered vehicles, plant and tools (electric or hydrogenated vegetable oil (HVO)).

To reduce carbon emissions from waste there has been a focus on introducing waste stickers and posters across the trust to ensure clear guidance for staff on the use of the different waste streams. This has been accompanied by training to ensure teams throughout the trust have a good understanding of correct waste segregation.

The clinical waste contractor has been on site this year working with the Waste Manager to provide training to wards and departments on the correct segregation of waste. On 19th June they provided an activity-based training session for staff to in support of Estates and Facilities day and they also attended the Trust transformation event in October to promote the correct segregation of waste.

The Trust monitors performance against the NHS Clinical Waste Strategy segregation target of 20% incineration (HTI), 20% alternative treatment (AT), and 60% offensive waste (OW) (20:20:60). The table below shows the stepped change achieved since 2022/23. There is still some way to go to meet the target, but the recent progress has been significant and carbon emissions from clinical waste alone have reduced from 321tCO₂e in 2022/23 to 265tCO₂e in 2024/25 (a reduction of 56tCO₂e which equates to 17.5%).

Year	Incineration (Target 20%)	Infectious (Target 20%)	Offensive (Target 60%)
2022/23	31%	35%	34%
2023/24	28%	33%	39%
2024/25	23%	28%	49%

Work will continue to support improved segregation, which will lead to improvements in financial and environmental performance and lower the Trust carbon emissions from waste. In addition, the Trust clinical waste contract will treat more waste through Alternative Treatment, which will reduce carbon emissions further.

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6. Medicines

The Chief Pharmacist led a project to reduce wastage from the nitrous oxide manifold system. As a result, the Trust took the decision this year to cap the manifold system for nitrous oxide and use portable cylinders where still required. The Trust was successful in gaining funding from the Nitrous Oxide Waste Fund to do this work, which was completed in December 2024.

The nitrous oxide data has been compared between December – February 2023 and December – February 2024 in the table below. This data shows we are already seeing a reduction in usage and resultant carbon emissions as a result of capping the manifold system in December 2024.

Year	Nitrous Oxide used (litres)	Emissions from Nitrous Oxide (tCO ₂ e)
December – February 2023	54,000	26.41tCO ₂ e
December – February 2024	18,000	16 tCO ₂ e

The Trust are supporting the promotion of a GM wide campaign to encourage patients to bring their own medication when they come to hospital. Asking patients to bring in their medicines is not new, however only 12% of patients (GM Provider Trust audit October 2024) do so when they are admitted. The “Your medicines matter” campaign has been initiated in all Provider Trusts in Greater Manchester to encourage patients to bring in their medicines, for nursing staff to use Patients’ Own Drugs (PODs) which supports safety, patient care, waste reduction and carbon footprint reduction. There have been incidents where patients have missed their Time Critical Medicines, and using the PODs reduces the likelihood of this.

7. Supply chain and procurement

A total of 1,711 walking aids were returned in 2024/25 as part of the walking aid reuse scheme and 1,490 (87%) of them were cleaned, refurbished, and reissued. This has resulted in a carbon saving of 24.23 tCO₂e over the year.

Sustainability and the social value of all tenders are scored at a minimum of 10% of the overall available tender. This includes specific accountability for environmental and sustainability responsibilities and must include criteria around carbon reduction.

Examples of tenders issued this year that included the 10% social value / sustainability weighting are:

- Enteral feeds
- Taxis
- Disposable Products

- IT end user devices
- Blood Sciences

8. Food and nutrition

The catering team continue to review the restaurant and patient menu to identify opportunities to make menu options healthier and lower carbon. Examples this year include:

- On 19th August 2024 the restaurant celebrated a plant based themed menu, with 4 plant-based options available to staff and visitors.
- At the start of February 2025, the restaurant changed from serving Irish Stew to Venison Cobbler. Around 135 portions are served each fortnight, and this has resulted in a reduction in carbon emissions for 2 months in 2024/25 (February and March) of 481 kgCO₂e. Annually this will equate to a saving of 3.1 tCO₂e.

Irish Stew



Venison Cobbler



- Venison is now an established part of the menu for patients, offered twice on week one and once on week 2. Venison dishes have proven to be popular and have replaced lamb-based dishes as a more sustainable option.
- The trust has introduced Eat Curious mince to the menu this year. Eat Curious mince is a healthy option, textured vegetable protein (pea protein) that can be used to replace meat. The Trust has replaced some of the mince in the cottage pie recipe for the restaurant and patient menu each week, which reduces the carbon emissions from the dish by nearly half per serving and will save 29.77tCO₂e per year.

The Trust actively monitor food waste produced on site from the restaurant and patient menu and adjust the menus accordingly to ensure there is as little waste as possible. Work has taken place in 2024/25 to explore options to digitise the food

waste weighing process to improve accuracy. New scales have been ordered to do this and will be in place April / May 2025.

Following a trial last year, the Trust introduced blue plates to serve patient and restaurant meals from 5th September 2024. This decision was made following a trial based on the theory that blue crockery makes the food more appealing to patients and food waste is reduced as a result. During the trial the Trust found that the blue crockery enhanced our patient experience around mealtimes, with particular interest relating to patients with Dementia and the contrast provided by the plate. A reduction in overall average waste of 9.2% was seen across both wards involved in the trial on the blue-plate vs standard plate, and hence the decision was taken to introduce the use of blue plates in the Trust.

The Trust are now working with a local supplier for the purchase of milk. The milk is delivered daily, and the new local supplier has reduced the number of delivery miles for the milk from 58 miles per day to 4.4 miles per day. This will be a saving of 3,245 miles per year, which results in a carbon saving of 3.2 kgCO₂e.

9. Climate Change Adaptation

We are working closely with colleagues at the Integrated Care Board (ICB) to consider how we can adapt to the impacts of climate change to ensure we can effectively manage the increasing summer temperatures, storms and high rainfall. The Trust has a Heatwave Plan for managing extremes in summertime temperatures arising as a consequence of climate change impact. A GM Climate Change Adaptation Plan will be completed this year, and we will then look to adopt this plan for Stockport Foundation Trust, with a Trust specific action plan for local risks.

10. Nature Recovery

In March 2025 8 large trees were planted around the hospital site. The planting was funded through Defra's Northern Forest programme and supported with additional investment from Stericycle, the trust's clinical waste partner, as part of their Social Value commitment. The trees are a mixture of native and ornamental trees, making sure the right tree is planted in the right place to thrive. It is estimated that when the trees reach maturity, they will capture around 320,000kg of CO₂ gas over their lifetime, equivalent to the emissions caused by an average car driving more than 15,000 miles.

Performance Update

Whilst it is not a mandated requirement to publish performance data in our annual report, it is considered good practice. The data has been produced using the new carbon reporting tool for the Northwest that has been developed to ensure consistency with the production of emissions data. Data for 2019/20 (baseline year)

has been inputted into the tool, along with the available data for the years that followed to allow comparison year on year. Performance data for 24/25 is not yet fully available and hence assumptions have been made for the months of the year where the data is not yet available. As a result, the 2024/25 data is subject to minor change once final figures are received.

The data is reported by emissions source, rather than scope and includes scope 3 emissions associated with each source. This is in line with Greener NHS guidelines, as it allows us to understand the total emissions from each source that we can control.

Emissions Source	Total tCO ₂ e						Trend from 2019/20 to 2024/25
	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	
Electricity	3874	3488	3815	3368	3722	3783	↓
Gas	6877	6525	7033	6638	6034	6274	↓
Other Energy	0	383	383	237	2	237	↔
Refrigerant Gases	0	0	1	22	6	15	↔
Waste	322	335	361	336	298	270	↓
Water	190	197	97	107	126	112	↓
Medical Gases	1280	1296	1148	1179	1105	875	↓
Inhalers	No Data			151	149	129	↓
Business Travel	Awaiting Data						
Fleet	62	81	60	44	46	38	↓
Total	12605	12306	12897	12083	11486	11732	↓

The data shows a downward trend in the total emissions measured.

Gas and electricity usage is responsible for a large proportion of the Trust emissions and the decarbonisation of our estate therefore needs to be a key area of focus. The work outlined earlier in the report to produce a Heat Decarbonisation Plan for the site, and to the work with CEF to consider the connection to a Heat Network and other options to decarbonise will be a huge step forward for the Trust in 2025/26.

Work is in progress to collate the missing data for all years in relation to emissions from business travel.

The Trust do not currently record data in relation to emissions from our supply chain. This will be a significant source of emissions, and we will be using the new NHS North West tool during 2025/26 to collate data so the impact of changes can be measured and action can then be taken to target reductions.

Priorities for 2025/26

The following high-level priorities have been identified for 2025/26:

- Publication of the new Joint Green Plan with Tameside and Glossop Integrated Care NHS Foundation Trust
- Consult and communicate in relation to the new Joint Green Plan

- Appointment of a Sustainability Officer to support the Sustainability Manager and provide additional resource across both Trusts
- Work with the Carbon and Energy Fund to assess the viability of decarbonising Stepping Hill Hospital
- Continue to work with Stockport Council to assess the potential for a Heat Network to heat Stepping Hill Hospital
- Establish a process to integrate Green Plan requirements into broader strategic priorities and plans e.g. through Quality Improvement Project and Business Case templates
- Working with the linen service provider to target reductions in linen ending up in the domestic and clinical waste stream
- Seek to understand if there are options to reduce the use of Entonox, without impacting patient care
- Revise Travel Plans in line with the NHS Net zero Travel and Transport Roadmap
- Digital scales to be introduced to monitor the tonnages of food waste produced in the trust
- Explore further options to widen the use of Eat Curious Mince into the menu as a lower carbon alternative to meat
- Introduce the monitoring and publication of data for Supply Chain emissions
- Introduce recycling collections in line with Simpler Recycling guidance
- During 2024 the Trust applied for funding through the Centre for Sustainable Healthcare and the National Lottery for a Nature Recovery Ranger to work across Tameside Hospital and Stepping Hill Hospital. In January 2025 it was confirmed that our application was successful, and a post will be funded for two years from April 2026. The Ranger will seek to engage staff, patients and visitors in our green spaces.

Task Force on Climate-related Financial Disclosure (TCFD)

As required by the Annual Reporting Manual (ARM), we have adopted a phased approach to incorporating the TCFD recommended disclosures as part of sustainability annual reporting requirements for NHS bodies, stemming from HM Treasury's TCFD aligned disclosure guidance for public sector annual reports. TCFD recommended disclosures as interpreted and adapted for the public sector by the HM Treasury TCFD aligned disclosure application guidance, will be implemented in sustainability reporting requirements on a phased basis up to the 2025/26 financial year.

The phased approach incorporates the disclosure requirements of the governance, risk management and metrics and targets pillars for 2024/25. These disclosures are provided below and will also be detailed in our new Green Plan 2025/2028 (Joint plan with Tameside and Glossop Integrated Care NHS Foundation Trust), which can be cross referenced once published.

Governance: The Board is informed about climate-related issues through the annual Green Plan Progress update and the Trust Annual report.

The Finance & Performance Committee (subcommittee of the Board) has delegated responsibility to provide oversight and ensure appropriate governance mechanisms are in place to deliver the Trust's digital, estate, and sustainability-related strategies and plans. It oversees the development and delivery of sustainability requirements as per national NHS guidance. A Green Plan Progress Report is presented biannually to the Finance & Performance Committee.

The delivery of the Green Plan is the responsibility of the Estates and Facilities Directorate and the Director of Estates and Facilities. It is led by the Sustainability Manager. Progress is overseen by the Joint Green Plan Delivery Group (Joint with Tameside and Glossop Integrated Care NHS Foundation Trust), chaired by the Director of Estates and Facilities. A Non-Executive Director sits on the Joint Green Plan Delivery Group to offer support, leadership and guidance. The group is scheduled to meet every eight weeks and is comprised of leads for each of the ten workstreams, who are invited to provide updates on progress at each meeting. This work then feeds into the Green Plan Progress reports and Annual reports.

The trust objectives include using our resources efficiently, effectively and sustainably. This highlights the commitment of the Trust to embed sustainability in everything we do and that everyone across the Trust should work to improve sustainability regardless of their role.

The Sustainability Manager is required to regularly attend the Trust Health and Wellbeing Group to formally update on those items that support the delivery of sustainability along with health and wellbeing. This ensures joined up working across this agenda.

The Trust plays an active part in the Greater Manchester Operational Sustainability Leads group to share good practice, networking and learning.

Risk Management: Failure to deliver the Green Plan and Net Zero targets and prepare for impact of climate change is a Board Assurance Framework (BAF) risk.

The Joint Green Plan Delivery Group is responsible for identifying and managing programme level risks and ensuring they are reflected in the BAF risk updates as required.

The BAF risk was updated this year to include failure to prepare for the impacts of climate change. Progress updates in relation to the BAF risk are presented quarterly to the Finance and Performance Committee and provide further oversight of progress in relation to actions to mitigate this risk.

Metrics: Whilst disclosure of scope 1, scope 2 and scope 3 carbon emissions is not yet mandatory for NHS bodies, it is considered best practice. The Trust currently reports on scope 1 and scope 2 carbon emissions and a small amount of scope 3

emissions. However, we do not yet have a robust methodology or process for reporting our scope 3 carbon emissions. The Carbon Footprint, as defined within 'Delivering a Net Zero NHS' is provided in the Environmental Sustainability Update disclosure. We aim to continually improve data quality and accuracy and will be looking to include supply chain data during 2025/26.

A new Joint Green Plan is currently in development across the Trust and Tameside and Glossop Integrated Care NHS Foundation Trust. The plan will contain clear actions with associated leads and timescales, metrics and targets. This will allow progress against the actions to be monitored at the Joint Green Plan Delivery Group and through the governance process using a traffic light system to identify areas where there is a lack of progress.

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				Agenda No.	12.2
Meeting date	7 th August 2025	Public	X	Confidential	
Meeting	Board of Directors				
Report Title	Approval of Joint Green Plan 2025 - 2028				
Director Lead	John Graham, Executive Chief Finance Officer	Author	Laura Swann, Sustainability Manager		

Paper For:	Information	Assurance	Decision
Recommendation:	The Board is asked to approve: <ul style="list-style-type: none"> the attached Joint Green Plan between Tameside and Glossop NHS Foundation Trust and Stockport NHS Foundation Trust the publication of the Plan on the Trust web site and for the link to be shared with NHS England, to confirm compliance with Green Plan Guidance. 		

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
	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	Appendix 4
Financial impacts if agreed/not agreed	NA
Regulatory and legal compliance	Introduction
Sustainability (including environmental impacts)	Throughout

Executive Summary

Green Plans are a mandatory requirement for all Trusts (Health and Care Act 2022) and provide a structured way to set out carbon reduction initiatives that are underway and to detail actions to reduce emissions for the period covered by the plan.

They set out how the Trust will meet the NHS net zero carbon targets:

- **For the emissions we control directly (the NHS Carbon Footprint), we will reach net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032;**
- **For the emissions we can influence (our NHS Carbon Footprint Plus), we will reach net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.**

Tameside and Glossop Integrated Care NHS Foundation Trust and Stockport NHS Foundation Trust both produced Green Plans in January/ February 2022, and the plans expired in January / February 2025.

Following the appointment of a Joint Sustainability Manager across both trusts, it was agreed in August 2024 that a Joint Green Plan Delivery Group should be established and that a new Joint Green Plan would be produced for 2025, covering a 3-year period.

This report details the consultation and engagement process that has been undertaken to develop the new Joint Green Plan and outlines the Guidance from NHS England that has been followed.

The new Joint Green Plan 2025-28 is presented for approval and sets out the current position in each trust, along with the detail of the planned actions that will need to take place to reduce our emissions and enable the trust to meet the net zero targets.

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1. INTRODUCTION

Green Plans are a mandatory requirement for all Trusts (Health and Care Act 2022) and provide a structured way to set out carbon reduction initiatives that are underway and to detail planned actions to reduce emissions for the period covered by the plan.

They set out how the Trust will meet the NHS net zero carbon targets:

- **For the emissions we control directly (the NHS Carbon Footprint), we will reach net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032;**
- **For the emissions we can influence (our NHS Carbon Footprint Plus), we will reach net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.**

To align with the Greater Manchester Five-Year Environment Plan target, we will seek to exceed the net zero NHS target (net zero by 2040) and aim to reach net zero by 2038.

Tameside and Glossop Integrated Care NHS Foundation Trust and Stockport NHS Foundation Trust both produced Green Plans in January/ February 2022, and the plans expired in January / February 2025.

2. PRODUCING A JOINT GREEN PLAN 2025-2028

Following the appointment of a Joint Sustainability Manager across both trusts, it was agreed in August 2024 that a Joint Green Plan Delivery Group should be established and that a new Joint Green Plan would be produced for 2025, covering a 3-year period.

NHS England were due to produce new Green Plan Guidance for Trusts in Autumn 2024, but the guidance was not published until 4th February 2025. As a result, the agreed deadline for the production of new Green Plans for NHS Trusts was set as 31st July 2025.

Work has been taking place since August 2024 to establish workstream leads to support the delivery of the plan and to consider the status in each Trust. In addition, the focus has been on establishing the agreed actions for each workstream that need to take place over the next 3 years to drive progress towards net zero.

To ensure deliverability of the plan and achieve the targets it is essential that the plan is owned by all Divisions across both Trusts and that it aligns with other key strategies.

The plan has therefore been developed in consultation with a wide range of stakeholders across the Trusts and with support from the Sustainability Team at the Integrated Care Board (ICB).

3 CONSULTATION

3.1 Consultation with Divisions

All Divisional Directors were contacted to discuss the Green Plan and how it aligns with their Clinical Strategy. Consultation included attendance at Divisional meetings to discuss the plans and the creation of a 1-page summary for each Division to show how the Clinical Strategy aligns with the Green Plan. These plans are detailed in the Joint Green Plan in Appendix 2.

3.2 Consultation with other Trust Groups

Sustainability is an agenda item at a number of regular Trust meetings and the development of the new Joint Green Plan has been reported and discussed at these groups. Groups include:

- Joint Health and Wellbeing Steering Group
- The Catering Operations Group at each Trust
- Estates and Facilities Compliance, Risk and Assurance Group (Tameside) and the Estates and Facilities Risk and Governance Group (Stockport)
- Waste Management Meetings at each Trust

3.3 Workstream Leads

The Joint Green Plan Delivery Group was established in August 2024 and Workstream leads were appointed for each of the 10 action areas of the Plan. The Workstream Leads are responsible for leading the development and delivery of their workstream, with the support of the Sustainability Manager and the Joint Green Plan Delivery Group. Workstream leads have therefore kept the teams involved in their workstream updated and consulted on the development of the workstream actions (see Appendix 1 in the Joint Green Plan).

The roles responsible for leading each of the 10 Workstreams are detailed below:

Theme Group	Tameside and Glossop Foundation Trust Lead	Stockport Foundation Trust Lead
1. Workforce and system leadership	Deputy Director, Organisational Development	
2. Net Zero Clinical Transformation	Strategy and Partnerships Manager	Assistant Directorate Manager – Women and Children’s
3. Digital Transformation	Chief Information Officer	Head of IT
4. Travel and Transport	Head of Facilities	Head of Facilities
5. Estates and Facilities	Head of Estates Head of Capital Projects	Head of Estates Head of Capital Projects
6. Medicines	Deputy Director of Pharmacy	Chief Pharmacist
7. Supply chain and procurement	Head of Procurement	Head of Procurement
8. Food and nutrition	Head of Facilities	Head of Facilities
9. Climate Change Adaptation	EPRR Manager Sustainability Manager	
10. Nature for Health	Contract Performance Manager	Head of Estates

3.4 Workstream Consultation

Feedback from early engagement was used to develop a draft of the Workstream section of the Green Plan. Wider consultation then took place during May / early June through a feedback survey, communicated through the Weekly Digest update at each Trust, and through workstream leads with their stakeholders.

The general feedback was that the document was easy to understand, visually pleasing and had very clear and specific actions. Suggestions for additions / improvements were also received, and full details of the feedback are detailed in Appendix 1, along with details of the outcome / resulting changes made.

3.5 Consultation with the ICB

To ensure alignment with the GM Green Plan, the Workstream draft was shared with the Integrated Care Board Sustainability Team and their comments have been incorporated into the final plan (See Appendix 2).

3.6 Local Authority Consultation

It is essential that the Joint Green Plan aligns with the wider work taking place in the locality. The plan has been shared with the Climate teams at Stockport Council and Tameside Council.

4. GREENPLAN GUIDANCE CHECKLIST

NHS England have issued a guidance checklist to help Trusts to ensure they have covered the essential areas when refreshing Green Plans. This checklist has been considered in the development of the document and a copy of the checklist is provided in Appendix 3 for information.

5. EQUALITY IMPACT ASSESSMENT

An Equality Impact Assessment (EIA) has been completed and can be seen in Appendix 4.

The Green Plan focuses on reducing carbon emissions and it therefore has a positive impact in in most areas of the assessment as it improves health outcomes. However, the following actions will be delivered to address any negative impacts as a result of the plan:

- Ensure communication with vulnerable groups so they understand the risks associated with climate change e.g. heat waves
- Support engagement with young people around climate change to reduce climate anxiety and explore ways to involve children and young people in the delivery of the Green Plan to ensure their voice is heard.
- Consider communicating the Green Plan in a number of ways e.g. a plan on a page, infographics and film clips
- Ensure any actions relating to digital transformation are subject to individual EQIAs

6. RECOMMENDATIONS

The Board is asked to approve:

- the attached Joint Green Plan between Tameside and Glossop NHS Foundation Trust and Stockport NHS Foundation Trust
- the publication of the Plan on the Trust web site and for the link to be shared with NHS England, to confirm compliance with Green Plan Guidance

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Appendix 1 – Workstream Consultation Feedback

SFT & TGH Joint Green Plan Feedback			
How easy did you find the document to understand			
TGH	SFT		
90% provided 4/5 (5 being very easy)	90% provided 4/5 (5 being very easy) It's a really good user-friendly document that describes our green journey over the next three years. More detailed than we have seen in previous plans. Very clear specific actions, and visually pleasing It's a great document overall – so good to see sustainability being actively promoted and lots of great ideas		
Green Plan Workstreams			
Workforce and Systems leadership			
TGH	Outcome	SFT	Outcome
<ul style="list-style-type: none"> · Is there an opportunity to promote the use of flexible working, as a mechanism to promote sustainability, within the workforce element of the strategy. Home working, for example can reduce an individual's carbon footprint. · I think it's a good plan - there is specific QI training available (or there was) through the GM ICB which is pretty good if some champions or the transformation team wanted to do it · Set up a team to embark on Regenerative Health Campaign. This will help create awareness on sustainable health through attitudinal change and reduce over dependence of medicine. 	<p>Will be explored alongside HR Policy</p> <p>QI projects added to actions</p> <p>To form part of communications planning</p>	<ul style="list-style-type: none"> · Could create a staff committee that works with the workstreams to discuss ideas and help broaden engagement in their areas with the green plan. This would help empower the workforce. · Create "Green leads" Champions in departments/areas. · Home working would reduce an individual's carbon footprint, possible opportunity to promote / encourage the use of flexible working for those staff able to. Allowing office space to be condensed, which has been underutilised - this point was echoed several times. · Remote Working Support - We're enabling secure, effective remote working to cut commuting emissions and support a more sustainable work model. 	<p>Added as an action</p> <p>Will look for champions to be part of the Sustainability Group /Committee</p> <p>Will be explored alongside HR Policy</p> <p>Included in Digital workstream</p>

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Net Zero Clinical Transformation			
TGH	Outcome	SFT	Outcome
<ul style="list-style-type: none"> · Imaging pathways - we grossly overuse CT scans (I've only audited a couple of pathways yet but for pulmonary embolism pathways alone we could probably save 8000 - 11000 tonnes of CO2. I think it's significant enough it should be considered for inclusion.) 	<p>Will be picked up with directorate under Net Zero Clinical Transformation</p>	<ul style="list-style-type: none"> · Education of patient care/self-care is a big step in helping reach net zero (also good for helping reduce waits/hospital visits!) 	<p>To form part of communications planning</p>
Digital Transformation			
TGH	Outcome	SFT	Outcome
<ul style="list-style-type: none"> · The use of AI to detect the exact energy used by equipment 	<p>Added to the first action</p>	<ul style="list-style-type: none"> · Eco-Friendly Deliveries - We've requested suppliers reduce packaging waste by removing oversized individual boxes and instead shipping devices stacked in bulk packaging · Softphone Adoption - We're replacing desk phones with softphones to reduce electronic waste and energy use, leveraging existing IT equipment. · AI-Augmented Operations - We're leveraging AI to streamline processes, reduce resource waste, and optimise operations for greater environmental efficiency. 	<p>Added as action in Supply Chain</p> <p>Will be picked up under digital printer and desktop hardware rationalisation</p> <p>Added</p>
Medicines			
TGH	Outcome	SFT	Outcome
<ul style="list-style-type: none"> · We are doing the (very necessary) work on inhalers we need to remember that a lot of the prescribing will occur in ED/ AMU/ UCT & SDEC - I've tried to follow GMMH guidance and start powder inhalers, however, have been overruled. Often, we focus on respiratory but acute care pathways can be problematic. 	<p>Will be picked up under action: Drive a move to high quality, low carbon respiratory care in line with clinical guidelines</p> <p>Added as an</p>		

<ul style="list-style-type: none"> · What about promoting safe disposal e.g. not flushing down the toilet as environmental impact is significant e.g. on food chain. 	<p>action</p>		
<p style="text-align: center;">Travel and Transport</p>			
<p style="text-align: center;">TGH</p>	<p style="text-align: center;">Outcome</p>	<p style="text-align: center;">SFT</p>	<p style="text-align: center;">Outcome</p>
<ul style="list-style-type: none"> · Promote sustainable travel options for the workforce, such as car sharing, and provide priority car parking spaces for those in a car sharing arrangement. · Improved facilities for those who cycle to work, such as secure storage and staff shower facilities. · Electric vehicle charging to be more available, but i also have a home charger so not a deal breaker. · We do have an issue where if I need a follow up blood test, I can't get them done anywhere else so bring patients from all over Tameside and Glossop - addressing this could have a decent impact on indirect carbon footprint as well as being a quality improvement for patient experience. · Trust can consider 	<p>Will be picked up under: Create an action plan following each staff travel survey and work with partners to increase Active Travel, the use of Public transport and car sharing</p> <p>Added</p> <p>Will be considered under Estates action: Ensure that sustainability is integral to the transformation of the NHS estate</p> <p>Will be picked up with directorate under Net Zero Clinical Transformation</p>	<ul style="list-style-type: none"> · Promote sustainable travel options for the workforce, such as car sharing, and provide priority car parking spaces for those i a car sharing arrangement. · Local people cycling to work, numbers may increase if the local council created more local bike lanes. Personal experience given of the danger felt when cycling to work on the roads due to vehicle traffic distances. · Improve onsite facilities for those who cycle to work, such as secure storage and staff shower facilities, to encourage staff. · Additional electric vehicle charge points on site, to the 4 already installed. Personal experience given of using them, they were always busy, staff member has since given up their carpark pass due to congestions of parking on site. · Would like to know more about Modeshift · Greater integration with 	<p>Will be picked up under: Create an action plan following each staff travel survey and work with partners to increase Active Travel, the use of Public transport and car sharing</p> <p>Will be picked up under work with partners</p> <p>Added</p> <p>Will be considered under Estates action: Ensure that sustainability is integral to the transformation of the NHS estate</p> <p>Will publicise as part of communications Will be picked up under work</p>

<p>establishing discounted Electric Vehicle scheme for staff and invest in subsidised bikes for staff.</p> <ul style="list-style-type: none"> · We could mention we have a salary sacrifice scheme for bikes 	<p>Available through Vivup - will publicise</p>	<p>local public transport, example the 394-bus route comes onto SFT site but only every two hours - every hour or half hour would make this option more viable for visitors/patients and staff.</p>	<p>with partners</p>
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Supply Chain and Procurement

TGH	Outcome	SFT	Outcome
<ul style="list-style-type: none"> · The Trust should carry out routine audit of all facilities and systems. This will help keep track of the Trust carbon emission budget. · Ensure procurement of modern energy efficient systems to help reduce carbon emissions. · Procurement of renewable energy certificate (To install RE within the facility) · Ensure suppliers incorporate climate risk plans in their documentation. 	<p>Will be considered</p> <p>The 10% net zero social value weighting will do this along with training</p> <p>Renewable energy generation is an estates and facilities workstream action</p> <p>This will be explored further in the future</p>	<ul style="list-style-type: none"> · Encourage staff for look for ways to reduce plastics, paper, and other greener ideas through the supplies they need. 	<p>The 10% net zero social value weighting will do this along with training</p>

Food and Nutrition

TGH	Outcome	SFT	Outcome
<ul style="list-style-type: none"> · Consider locally sourced produce were available to reduce the carbon footprint of food transport. · Would be interesting to see how reliable food waste data is - may also help work on nutrition and hydration which is a patient safety priority. · What about considering anaerobic food digester on site 	<p>Added</p> <p>Introducing electronic weighing will improve accuracy</p> <p>Added</p>	<ul style="list-style-type: none"> · Consider locally sourced produce were available to reduce the carbon footprint of food transport. 	<p>Added</p>

Estates and Facilities			
TGH	Outcome	SFT	Outcome
<ul style="list-style-type: none"> · Consider the use of limited green spaces to plant wildflowers, to attract natural pollinators. · Utilise any opportunities within new builds to incorporate solar power initiatives and heat pumps. · Ensure usage of resource efficient systems · Invest in Carbon offset projects · Ensure contractors submit Carbon management plan · Incorporate natural lighting system in the buildings (new / renovated buildings) · Ensure the use of combined heat pumping system for heat · Dual Automated lights and manual lights (currently baking in the Macmillan unit TGH where lights just add to the heat and we have no control over them. There must be a financial and environmental cost to this?) · Recycling of plastics · Installing more LED lights 	<p>Added under Nature for Health</p> <p>Covered under: Ensure sustainability is a key consideration on all new build</p> <p>Green Plan Checklist says not to include carbon offsetting</p> <p>Ensure sustainability is a key consideration on all new build and refurbishment projects delivered</p> <p>Added to LED</p> <p>Covered in Action 2</p> <p>Action 5</p>	<ul style="list-style-type: none"> · Modernise lighting and sensor driven lights where appropriate. · Consider the use of the limited green space to plant wildflowers, to attract natural pollinators. · Utilise any opportunities within new builds to incorporate solar power initiatives and heat pumps. · Seek opportunities/funding to replace decaying, substandard Victorian infrastructure, and reduce the carbon emissions/utility bill costs, and create a better environment for staff and patients. 	<p>Added to LED</p> <p>Added under Nature for Health</p> <p>Covered under: Ensure sustainability is a key consideration on all new build and refurbishment projects delivered</p> <p>Considered in capital programme</p>
Adaptation			
TGH	Outcome	SFT	Outcome

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<ul style="list-style-type: none"> · Create more green space · Ensure contractors incorporate climate risk plans · Incorporate natural lighting system in buildings (new / renovated buildings) 	<p>Added action 6 and see Nature for Health</p> <p>projects and new builds to ensure building and infrastructure supports adaptation</p>		
Nature for Health			
TGH	Outcome	SFT	Outcome
<ul style="list-style-type: none"> · Creating natural habitats that will attract plants and animals · Creating more green space that will be easily accessible for staff, patients and visitors · Planting attractive flowers within green spaces where patients and staff can relax around · Bricks made for Swifts to nest in, on the side of buildings 	<p>Action 3</p> <p>Action 2 and 5</p> <p>Action 3</p>	<ul style="list-style-type: none"> · When planning new builds or refurbishments embrace greener buildings, become a "garden hospital", by adding greenery around site; trees, grass, gardens, including roofs, at the start of building design. Taller buildings to allow for green space, at ground level or roof. This would mean radical building changes so I don't expect the buildings to change but perhaps the site could be greener with its gardens (also creates a more peaceful environment which research has proven to aid recovery). 	<p>Action 1 and 3 and see Climate Adaptation action 6</p>
Further Feedback			
TGH	Outcome	SFT	Outcome
<ul style="list-style-type: none"> · I think there is something relevant about making sure sustainability becomes a core part of everything we do rather than a "nice to have" in some people's minds. 	<p>Workforce and Systems Leadership actions designed to support this change.</p>	<ul style="list-style-type: none"> · It's a great document overall- so good to see sustainability being actively promoted and lots of great ideas. 	<p>No action needed</p>
<ul style="list-style-type: none"> · There's a quality improvement movement that suggests all significant improvement pieces should consider a sustainability measure - whether that is an outcome, something measured in the process or a balancing measure. 	<p>Workforce and System Leadership Action 1</p>	<ul style="list-style-type: none"> · Lots to be achieved through the health inequalities piece. You'll be aware that Medical Director is exec lead for this, and we now have a health inequalities sub-group that reports into Quality Committee. Might be early days but I do know that 	<p>Look to join up with group</p>

<p>A good example: The QI team did with district nurses in my previous role at the NCA - the work was focused on streamlining district nurse rounds to save time - but the work also delivered significant reduction in miles driven which could be equated to a clear carbon saving.</p> <p>The team went on the get electric cars and access to charging and further drove down the carbon footprint.</p> <p>There is probably unmeasured work going on like this - helping people measure their carbon reduction (or mitigate an increased carbon footprint) can then be a source of pride and success - which is highly motivating for further improvement work.</p> <p>Even access to a simple CO2 calculator and asking part of the in-house QI training offer to cover this would be important and there are available resources.</p> <p>Generally incorporating it into QI projects is often more accessible to shop floor clinicians and can help them see how their contribution can make a difference, whereas high level strategies are often harder to personalise.</p>		<p>whilst we are talking about addressing health inequalities across all areas it's not often we talk about how environmental sustainability plays a key role in this.</p> <ul style="list-style-type: none"> · Given how extensive engagement has been across the Trusts it might be worth adding this to the plan showing how it was developed. 	<p>Detailed in the above report and referenced in the plan</p>
<ul style="list-style-type: none"> · I believe the Trust so far has set various strategies in place to achieve the net zero target. 	<p>No action needed</p>		

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Appendix 2 – Consultation Feedback from the ICB

SFT & TGH Joint Green Plan Feedback From ICB	
Comments:	Outcome:
The "where are we now" speaks to the commitments that were made in the original Green Plans, e.g. producing a sustainability annual report/disclosure is a mandatory requirement and wouldn't need to be an objective.	Annual report reference removed
(Agree with actions 1, 3, 4) Action 2 – not clear what you mean by increasing sustainability resources. Also ensure support from all departments may be picked up by the other objectives around training, and the first action.	Removed the resource reference and changed training objective to: Introduce appropriate training for staff at all levels in the organisation e.g. GM 'Plan It' training for senior leaders
Action 4 – This could consider being expanded to have something specific around senior leadership, e.g. rolling out the Plan It training. You could also consider introducing a Sustainability Impact Assessment to support the first objective.	Changed training objective to: Introduce appropriate training for staff at all levels in the organisation e.g. GM 'Plan It' training for senior leaders Added
Action 5 – the concept of Sustainability Champions feels quite dated now, and these programmes haven't really delivered the intended change, unless they are accompanied by a structure that requires those individuals to do something tangible.	Amended to: Establish a staff Sustainability Group / Committee
Action 6 – suggest this could become more specific around having a rolling communications programme in place with specific campaigns etc, sharing case studies etc.	Amended
Slide 1 – Question: 'Do we do 3 or 5 year - gm feedback? – we were originally going to do a 5-year plan but were advised to go with 3 years due to alignment with broader organisation strategy expiry date. I would have a think about whether better to go with 3 years as this is the first joint strategy for the two orgs and there is likely to be considerable learning from this.	Decision made to produce 3-year plan
Slide 2 – It would be useful to set out the interim 80% emissions reduction goals for the Net Zero Targets, so the focus isn't just on 2040 and 45 targets, also would advocate alignment with GMCA date for carbon neutrality for your carbon footprint which is 2038 rather than 2040.	Included
Slide 4 – Covers the Greener NHS 10 workstreams. Are there any cross-cutting areas, such as comms, finance etc with specific actions included?	Included after the workstream section
Slide 5 - Workforce MH - Establish a network of Sustainability Champions – establishing a network of champions doesn't have a good track record on delivering change. Could look at a Staff sustainability group or committee (like Master Call), which has time to commit to trackable actions, with	Amended to explore the introduction of a staff sustainability Group

<p>at least one representative from each directorate.</p>	
<p>Slide 6 – Net zero clinical transformation: I think you could include more around virtual healthcare here, I know, for example, Tameside, we're running remote assessments for care homes (I think UEC) , which has several co-benefits such as quicker assessment, less disruption for residents, reduced admissions. Graphic – there is an updated model from CSH with 5 principles.</p>	<p>Covered in individual divisional plans.</p> <p>Considered but decision take to keep original as Estates considered in other section</p>
<p>Actions – under prevention there is one about continued engagement, can this just be assumed rather than called out as an action? Could the second action under prevention be expanded on a bit? Similar comment in relation to this wording used elsewhere. For each action need to think about how you will report and measure progress.</p>	<p>Included in coms</p>
<p>Slide 7 - Just a reflection, we have descoped measuring Carbon savings for virtual healthcare, as there was no available data, so it became an unachievable action – unless you have a way of measuring this?</p>	<p>Removed</p>
<p>Slide 8 - Digital – Have a look at the Greener Digital NHS presentation, bentongue-nhsengland.pdf and guidance Greener Digital - How to Guide - Greener Digital - Futures new guidance will also be released next year through Greener by Design Greener by Design - Greener Digital - Futures. We are improving strategic links with our digital leads to ensure that sustainability and the above guidance is considered in their agenda and strategies. The way some of these actions are worded, such consider, look to etc is going to make it very difficult to measure and report progress. <i>It might be easier to talk through this on a call.</i></p>	<p>Updated section to consider guide</p>
<p>Slide 9 – Medicines – Recycling blister packs is a micro level action, could you include something more high level about reducing medicinal packaging (e.g. see toolkit)</p> <p>Consider the Greener Pharmacy toolkit Greener Pharmacy this will help with some of the actions listed.</p>	<p>Greener Pharmacy Toolkit added as an action and will now report on recycling of blister packs as part of toolkit action.</p>
<p>Slide 10 – Travel and Transport – Could include something on active travel and the co-benefits for health in the intro.</p> <p>Travel survey – required biannually as a minimum.</p> <p>In the where are we now, anything on fleet you can</p>	<p>Included</p> <p>Will still look to complete survey annually</p> <p>Added number of electric</p>

include?	vehicles
<p>Slide 11 – Supply chain and Procurement: Consider increasing the 10% net zero and social value weighting to 20%, over time.</p> <p>Rather than stating compliant with Evergreen, as this is voluntary could you commit to increasing uptake?</p> <p>Do you have a budget/process for monitoring supply chain emissions? We'd advocate delivering interventions rather than focus on measurement to any great depth.</p> <p>Is the CRP action necessary as this is a nationally mandated process/template?</p> <p>Could the first action include something about strengthening contract management?</p>	<p>Discussed with procurement and will not be included at this time.</p> <p>Amended to increase number of suppliers compliant with</p> <p>Left in as will be able to measure but added to enable targeted interventions.</p> <p>Removed</p> <p>Added</p>
<p>Slide 12 – Food and Nutrition – Consider locally grown produce – Link with Green Space e.g. kitchen gardens.</p> <p>Overuse of the word 'explore' in the actions</p> <p>Coffee grounds – micro level action</p>	<p>Added locally grown as priority and added develop the relationship between the restaurant and the green space on site to grow items e.g. herbs</p> <p>Amended</p> <p>Removed</p>
<p>Slide 13 – Estates and Facilities – No specific mention of on-site renewables</p> <p>Simpler recycling – mandated via legislation so doesn't need to be included unless you are going beyond requirements</p> <p>Can the first action be expanded – e.g. progressively working towards 60:20:20 for clinical waste segregation?</p>	<p>Added</p> <p>Left in as lots of comments from staff wanting to see the introduction of recycling and feel it needs to be highlighted as an action</p> <p>Amended</p>
<p>Slide 14 -Climate change adaptation - Review Major Incident and Business Continuity Plans.</p> <p>Consider how extreme weather alerts fit in with staff and service planning.</p>	<p>Amended</p> <p>Added to the Business continuity action</p>
<p>Slide 15 - Nature for Health – think about making green space on site accessible.</p> <p>Consider co-benefits of greenspace for adaptation.</p>	<p>Added</p> <p>Added</p>

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Appendix 3 – Green Plan Guidance Checklist

Greener NHS



Green plan checklist

This checklist is designed to help systems (slides 2-3) and trusts (slides 4-5) ensure they have covered essential areas when refreshing their green plans in 2025. It is for optional use and should be read alongside the updated [green plan guidance](#).

Further resources to support green plan development – including FAQs, a template structure and branding – are available on the [Greener NHS Knowledge Hub](#)

Trust green plan checklist (1)



Theme	Action required	What does good look like
Developing the plan	<ul style="list-style-type: none"> Review progress to date 	<ul style="list-style-type: none"> <input type="checkbox"/> Clear summary of progress to date across green plan focus areas, quantified where possible and celebrating key achievements
	<ul style="list-style-type: none"> Engage with key stakeholders about refreshing priorities, in particular <u>clinical</u> and staff groups who underpin green plan delivery 	<ul style="list-style-type: none"> <input type="checkbox"/> Evidence of engagement undertaken to refresh the plan, including with staff and clinicians; patient and community groups; wider system partners where relevant <input type="checkbox"/> Concise summary of what was heard and how the plan responds to this
	<ul style="list-style-type: none"> Comply with any applicable legal duties, including the duty to reduce inequalities, the Public Sector Equality Duty and the duty to have regard to all likely wider effect of decisions 	<ul style="list-style-type: none"> <input type="checkbox"/> Evidence that equalities, health inequalities and other relevant legal duties have been considered when developing the plan
	<ul style="list-style-type: none"> Plan covers the next three years, at minimum 	<ul style="list-style-type: none"> <input type="checkbox"/> Plan contains timebound actions for at least the subsequent three years
Working with partners	<ul style="list-style-type: none"> Where relevant, plan considers: <ul style="list-style-type: none"> the role of the local system and provider collaboration in supporting delivery, such as through the spread and standardisation of best practice opportunities for collaboration with wider system partners to reduce emissions engagement with research and innovation activities to support the transition to a net zero NHS 	<ul style="list-style-type: none"> <input type="checkbox"/> Evidence of collaboration (existing or planned) with system, provider, research and innovation, and/or wider partners
Areas of focus	<ul style="list-style-type: none"> At minimum, plan includes relevant actions outlined in the latest Green plan guidance (see Areas of focus) Each action should be SMART (specific, measurable, achievable, relevant and time-bound), with associated key performance indicator(s) Organisations should not consider offsetting but instead should focus all efforts on reducing emissions 	<ul style="list-style-type: none"> <input type="checkbox"/> Plan is structured in line with the areas of focus in updated Green plan guidance <input type="checkbox"/> Plan covers all relevant actions included in the updated guidance <input type="checkbox"/> Actions are tailored to the local context, timebound and include key performance indicators to monitor progress <input type="checkbox"/> Plan does not include offsetting

Trust green plan checklist (2)



Theme	Action required	What does good look like
Governance	<ul style="list-style-type: none"> Delivery of green plans overseen by a designated board-level net zero lead, generally an existing executive director, with clearly identified operational support 	<ul style="list-style-type: none"> Board-level net zero lead in place to lead plan development and delivery Operational support in place to coordinate plan development and delivery
	<ul style="list-style-type: none"> Appropriate governance arrangements in place to co-ordinate delivery, such as a regular green plan delivery board chaired by the organisation's board-level net zero lead and attended by relevant directors 	<ul style="list-style-type: none"> Evidence of robust green plan governance arrangements, including senior representation from functions responsible for green plan delivery Annual agenda item at trust board, with net zero lead presenting on progress
	<ul style="list-style-type: none"> Plans should be reviewed and updated annually to consider progress made and any new priorities, guidance, technology and other enablers 	<ul style="list-style-type: none"> Commitment to review the plan annually and update it as required
Tracking and reporting progress	<ul style="list-style-type: none"> Report an annual summary of progress on delivery of green plans to the board and publish this in the annual report, including actions taken and planned, with quantitative progress data. This should include: <ul style="list-style-type: none"> narrative updates on progress to date and key achievements delivery of key milestones and risks to future delivery quantitative assessment of progress against defined targets 	<ul style="list-style-type: none"> Clear articulation of arrangements to track and report on progress, in line with the updated Green plan guidance Makes use of national data and analytics tools, such as Greener NHS dashboard, where relevant and beneficial
Approval and publication of plans	<ul style="list-style-type: none"> Refreshed green plans should be approved by the organisation's board or governing body, published in an accessible location on the organisation's website and shared with NHS England by 31 July 2025 	<ul style="list-style-type: none"> Plan is board-approved Plan is published in an accessible location on the organisation's website Plan is easy to read and in an accessible format – a free design template and branding is available on the Greener NHS Knowledge Hub Hyperlink to the plan is shared with Greener NHS regional leads by 31 July 2025 Plan and next steps are widely communicated, including to staff and local partners

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Appendix 4 – Equality Impact Assessment (EIA)

Group	Is there a potential for positive or negative impact? (positive, negative, neutral or unknown)	Please explain and give examples of any evidence/data used	Action to address any negative impact (e.g. adjustment to the policy)
Age	Positive	<p>The Green Plan focuses on reducing carbon emissions, reducing the impact on the climate and human health and therefore has a positive impact.</p> <p>However, extremes of temperature disproportionately affect older people, increasing the risk of cardiovascular events. Climate change and healthy ageing: An assessment of the impact of climate hazards on older people - PMC</p> <p>There is evidence that an increasing number of young people are affected by climate anxiety. Climate anxiety in children and young people and their beliefs about government responses to climate change: a global survey - The Lancet Planetary Health</p> <p>Children and adults in care – Impacts of climate change on facilities and services. Health and Social Care Sector Briefing - UK Climate Risk</p> <p>Children and Young people have not been involved in the development of the strategy</p> <p>Digital Transformation is relevant to all people who are not digitally enabled or require adjustments to communicate effectively. Exploring the UK's digital divide - Office for National Statistics</p>	<p>Ensure communication with vulnerable groups so they understand the risks associated with climate change e.g. heat waves</p> <p>Support engagement with young people around climate change to reduce climate anxiety and explore ways to involve children and young people in the delivery of the green plan to ensure their voice is heard.</p> <p>Ensure any digital transformation projects that could have a negative impact on those who cannot access technology consider alternatives</p>
Disability	Positive	The Green Plan focuses on reducing carbon emissions,	Provide targeted communication to

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		<p>reducing the impact on the climate and human health and therefore has a positive impact.</p> <p>However, the Impact of climate change on vulnerable groups and how best to communicate to those groups. I.e. Learning Disabilities, Autism, and increased vulnerability from health issues (e.g. post-stroke, dementia, mental health difficulties).</p> <p>Climate change and the right to health of people with disabilities - The Lancet Global Health</p> <p>Digital Transformation is relevant to all people who are not digitally enabled or require adjustments to communicate effectively.</p> <p>Exploring the UK's digital divide - Office for National Statistics</p> <p>The Green Plan is a strategic technical document which may reduce accessibility for some people. As we know, the average UK reading age is 9 to 11 years old.</p> <p>What do adult literacy levels mean? National Literacy Trust</p>	<p>vulnerable groups so they understand the risks associated with climate change e.g. heat waves</p> <p>Consider communicating the Green Plan in a number of ways e.g. infographics and film clips</p> <p>Ensure any actions the plan that could have a negative impact on those with a disability are subject to individual EQIAs e.g. digital transformation projects, changes to buildings, installation of LED lighting etc.</p>
Gender reassignment, gender identity/gender expression	Neutral	NA	NA
Marriage/Civil partnership status	Neutral	NA	NA
Pregnancy and maternity	Positive	<p>There is evidence that pregnant women are more vulnerable to extreme heat Hot weather and high body temperature during pregnancy NCT.</p> <p>However, the Green Plan focuses on reducing carbon emissions, reducing the impact on the climate and human health and therefore has a positive impact</p>	NA
Race (incl. Ethnicity. Colour and nationality)	Positive	Individuals from ethnic minority communities who live in low-income households and those already facing health disparities	NA

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		<p>are especially vulnerable to the effects of the climate and nature crises.</p> <p>The Green Plan focuses on reducing carbon emissions, reducing the impact on the climate and human health and therefore has a positive impact.</p> <p>ECO4 Flex is a fully funded government scheme to provide whole-house energy efficiency improvements to low-income households or those otherwise vulnerable to the effects of living in a cold home due to medical conditions. The plan includes communication this scheme to maximise NHS referrals to support vulnerable household.</p>	
Religion or belief	Neutral	NA	NA
Sex	Positive	<p>There is evidence that women are more vulnerable to climate change; for instance, the risks to pregnant women increase in hotter weather.</p> <p>Hot weather and high body temperature during pregnancy NCT</p> <p>Climate change and gender ActionAid UK</p> <p>Explainer: How gender inequality and climate change are interconnected UN Women – Headquarters</p> <p>New Report: Why Climate Change Impacts Women Differently Than Men UNFCCC</p> <p>The Green Plan focuses on reducing carbon emissions, reducing the impact on the climate and human health and therefore has a positive impact.</p>	NA
Sexual orientation	Positive	<p>There is research to suggest that LGBTQ+ individuals could be disproportionately affected due to societal inequalities and discrimination. LGBTQ+ individuals experience greater rates of homelessness, mental health challenges, substance abuse and, in some societies,</p>	NA

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		<p>are more likely to be excluded from family networks. 'Climate change will exacerbate these inequalities, making it an LGBTQ+ issue of concern.'</p> <p><u>Queering Climate Change: Exploring the Influence of LGBTQ+ Identity on Climate Change Belief and Risk Perceptions* - Whitley - 2023 - Sociological Inquiry - Wiley Online Library</u></p> <p>The Green Plan focuses on reducing carbon emissions, reducing the impact on the climate and human health and therefore has a positive impact.</p>	
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Green Plan 2025 - 2028

Stockport Foundation Trust and
Tameside and Glossop Integrated
Care NHS Foundation Trust



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About Us

Tameside & Glossop Integrated Care NHS Foundation Trust is responsible for the running of Tameside Hospital and provides a wide range of hospital and community services. The Trust provides services to a population of approximately 250,000 residents across Tameside and Glossop.

The Trust has 524 hospital beds, employs over 4,000 staff and has an annual turnover of around £370 million.



Image shows: Tameside & Glossop Integrated Care NHS FT Building Façade

Stockport NHS Foundation Trust is responsible for running Stepping Hill Hospital and other specialist centres, as well as community health services for Stockport. The Trust provides services to a population of approximately 350,000 residents in and around the Stockport area and the hospital also provides some specialist services to the residents of East Cheshire and the High Peak in North Derbyshire.

The Trust has 742 hospital beds, employs around 6,300 staff and has an annual turnover of around £530million.



Image shows: Stockport NHS FT Building Façade

Foreword

As the net zero board lead for Tameside and Glossop Integrated Care NHS Foundation and Stockport NHS Foundation Trust I am pleased to publish our first Joint Green Plan.

The Trusts recognises that the climate emergency is the health emergency, and we must reduce our carbon emissions in order to reduce the associated health inequalities.

This Plan builds on the commitments made in the previous individual Green Plans and joins up thinking across both organisations, to share best practice and drive progress towards our net zero target.

Lord Darzi highlighted the urgency of this agenda last November,

‘The World Health Organisation has described the climate crisis as the “single biggest threat facing humanity”. Given the global health imperatives, the NHS must stick to its net zero ambitions. There is no trade-off between climate responsibilities and reducing waiting lists. Indeed, often health and climate are mutually reinforcing goals: cleaner air is good for the environment and good for respiratory health.’

This Plan has been developed to detail the actions we will take over the next 3 years to progress this agenda. However, we will need to be flexible in our approach to ensure we consider innovation and to review the actions in our plan each year to ensure they will still deliver the best possible outcomes and progress.



Net Zero Board Lead: John Graham,
Executive Chief Finance Officer

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Our Vision



Tameside and Glossop
Integrated Care
NHS Foundation Trust

Tameside and Glossop NHS Foundation Trust has a vision to improve health outcomes for our population and influence the wider determinants of health, through collaboration with the people of Tameside and Glossop and our health and care partners.



Stockport
NHS Foundation Trust

This aligns with the vision for Stockport Foundation Trust to work with partners to improve health and wellbeing outcomes for the communities we serve.

The Values of the two organisations are now aligned and over the past few years, both Trusts have been exploring ways to improve the lives of our local populations through partnership working. An example of the joint working can be seen in the community setting, where a recently opened Community Diagnostic Centre in Denton serves the populations of both Trusts.

There is a joint Executive Team in place across the two organisations and several Executive Directors and other senior staff now work across both organisations. These joint roles include a Sustainability Manager and Sustainability Officer to drive progress towards the NHS net zero targets. The decision was therefore taken to create a Joint Green Plan for 2025 to 2028 and work together to share best practice and reduce our impact on the environment. In turn this will lead to improved health outcomes for our populations and the communities we serve.



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Green Plan Progress

Figure 1 shows the progress made at Stockport NHS Foundation Trust and Tameside and Glossop Integrated Care NHS Foundation Trust since the last Green Plans were published in 2022.

Tameside and Glossop Integrated Care NHS Foundation Trust	Stockport NHS Foundation Trust
<p>248tCO₂e less emissions in 2024/25 compared to 2023/24, due to reductions in electricity due to:</p> <ul style="list-style-type: none"> - 85% of lighting now LED - IT data centre now closed and shared with Tameside Council <p>The equivalent to a bus driving round the world 59.5 times*</p> <p><small>*Defra emissions figures from 2019.</small></p>	<p>Decommissioned the nitrous oxide manifold system and saved over 30tCO₂e in just 3 months, the equivalent to a bus driving round the world 7.2 times*.</p> <p><small>*Defra emissions figures from 2019.</small></p>
<p>Awarded £14.4million Public Sector Decarbonisation Funding to remove the old gas boilers and replace with air source heat pumps alongside other decarbonisation works</p> <p>2188tCO₂e will be saved per year</p>	<p>Received a grant for £68,000 for a new Acute Frailty Unit therapeutic garden</p>
<p>Fleet includes 3 electric cars and 2 electric tug vehicles</p> <p>23tCO₂e less emissions in 2024/25 than in 2019/20</p>	<p>9.2% decrease in food waste during blue plate trial</p>
<p>Joint Green Plan delivery Group in Place and Joint Sustainability Manager and Officer appointed</p> <p>In every tender the Trust procures 10% net zero social value weighting is included. An example this have delivered is the redeveloped staff garden near Aspen House at Stockport Foundation Trust and tree planting at Tameside and Glossop Integrated Care NHS Foundation Trust</p> <p>Heat Decarbonisation plans in place to identify how we can reduce fossil fuel consumption</p> <p>2,241 Walking aids were cleaned, refurbished and reissued during 2024/25</p>	



The Climate Crisis and Health

Climate change is the greatest global health threat of the 21st century, affecting individuals, communities, and healthcare systems. Globally, temperatures have risen, due to the release of carbon dioxide and other greenhouse gases into the atmosphere and we have seen an increase in extreme weather events across the world.

More locally, across Greater Manchester we have experienced increased temperatures, flooding, wildfires and storms and these have impacted the most vulnerable residents the hardest.

Climate change impacts the health of our population in several ways:

- **Air Pollution & Respiratory Diseases** – Increased pollution leads to a rise in asthma, lung infections, and cardiovascular conditions. Long-term exposure contributes to premature deaths and health inequalities.
- **Heatwaves & Vulnerable Populations** – Excessive heat exacerbates conditions like heart disease and diabetes. Older adults and young children face heightened risks of dehydration and heatstroke.
- **Extreme Weather & Healthcare Strain** – Floods, storms, and wildfires disrupt healthcare services, damage infrastructure, and increase the spread of infectious diseases.
- **Food Security & Nutrition** – Climate change affects food production, leading to malnutrition and diet-related diseases, particularly among lower-income populations.
- **Mental Health Consequences** – Anxiety, depression, and PTSD are on the rise due to climate-related disasters and displacement.

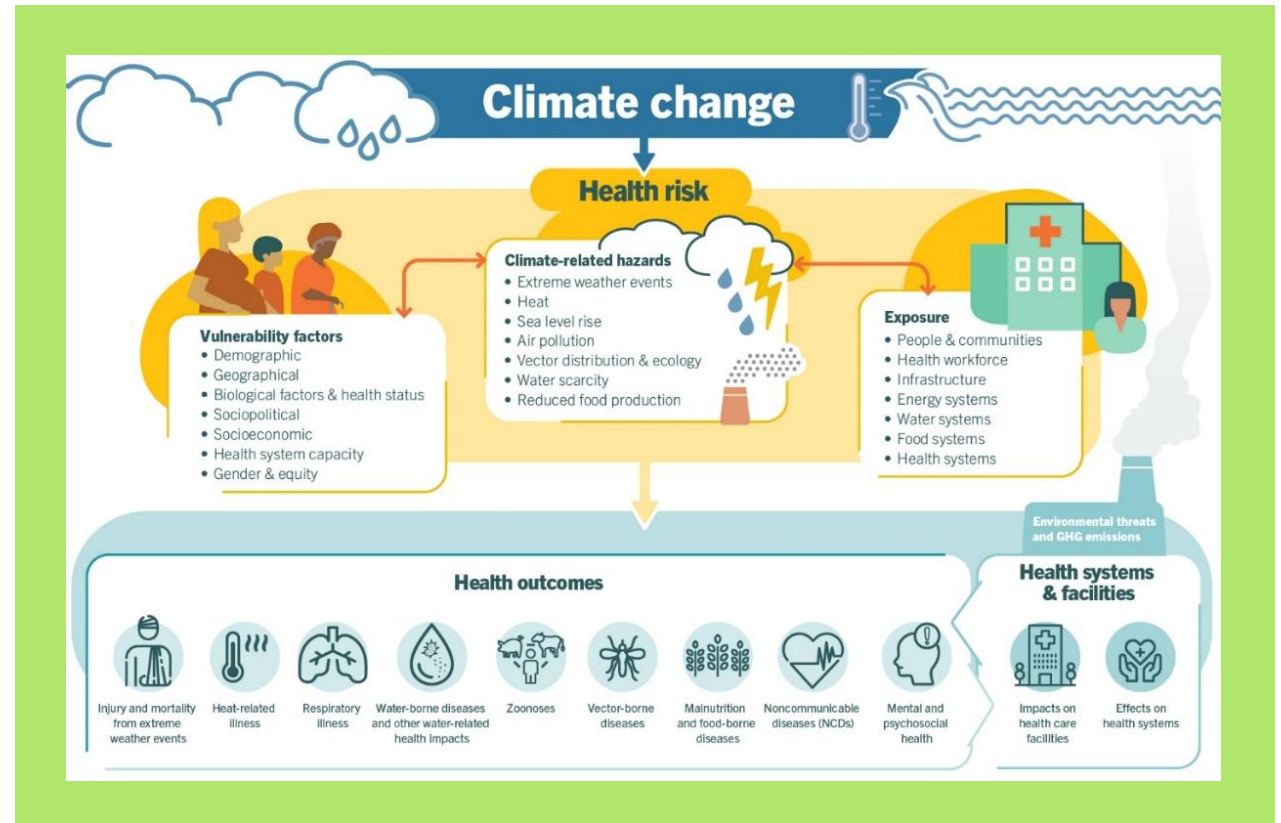


Figure2: An overview of climate-sensitive health risks, their exposure pathways and vulnerability factors (World Health Organisation)

Greater Manchester Green Ambition

Greater Manchester launched a [Five-Year Environment Plan](#) in December 2024 which aims to achieve carbon neutrality by 2038 through collaborative actions across the city-region, focusing on reducing carbon emissions and promoting nature recovery.

The Plan outlines a **comprehensive** strategy to tackle environmental challenges and promote sustainability in the region and emphasises the need for collective action from organisations, communities, and individuals to create a greener Greater Manchester. Figure 3 shows the eight key aims detailed in the plan for the city region.



The Trust Green Plan outlines the role that Stockport NHS Foundation Trust and Tameside and Glossop Integrated Care NHS Foundation Trust will play in supporting the delivery of the Five-Year Environment Plan. The Trusts will seek to exceed the net zero NHS target and strive to be carbon neutral by 2038, to align with the with the Five-Year Environment Plan ambition.

The Trusts are part of the NHS Greater Manchester Integrated Care System (ICS), which leads integration across the NHS, supporting the creation of the conditions for a thriving city region where everyone can live a good life. We have collaborated with the ICS on the development of this Plan to ensure it aligns with the NHS Greater Manchester Green Plan 2025-28. The NHS Greater Manchester Green Plan focuses on interventions that reduce the organisational carbon footprint of NHS Greater Manchester, for example, through the strategic commissioning process. NHS Greater Manchester lead on collaboration with the GMCA, Transport for Greater Manchester and other city region and national stakeholders to co-ordinate and amplify climate action, maximising the opportunities presented by devolution. The plan also seeks to enable the conditions for change and coordinate a set of impactful ‘do once’ actions.

To align with the wider work taking place in the locality, the plan has been shared with the Climate teams at Stockport Council and Tameside Council.

It is essential that we take a system wide approach to tackling climate change and joint working with our partners will be the key to successful delivery. Throughout the life of this plan, we will seek to strengthen relationship with our partners and to collaborate on projects where appropriate.



Figure 3: Commitments of the GM Five-Year Environment Plan

Delivering a Net Zero National Health Service

On 1 July 2022, the NHS became the first health system to embed net zero into legislation, through the [Health and Care Act 2022](#). The [Delivering a Net Zero National Health Service report](#) was produced and issued as statutory guidance. The Delivering a 'Net Zero' National Health Service report sets out the following targets:

- For the emissions we control directly (the NHS Carbon Footprint), we will reach net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032;
- For the emissions we can influence (our NHS Carbon Footprint Plus), we will reach net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

To align with the Greater Manchester Five-Year Environment Plan target, we will seek to exceed the net zero NHS target and aim to be carbon neutral by 2038.

If we look at the wider scope of the NHS Carbon Footprint Plus, Figure 4 shows that the greatest areas of opportunity for change are in the supply chain, estates and facilities, pharmaceuticals and medical devices, and travel.

The targets set are as ambitious as possible, while remaining realistic; and are supported by immediate action and a commitment to continuous monitoring, evaluation and innovation.

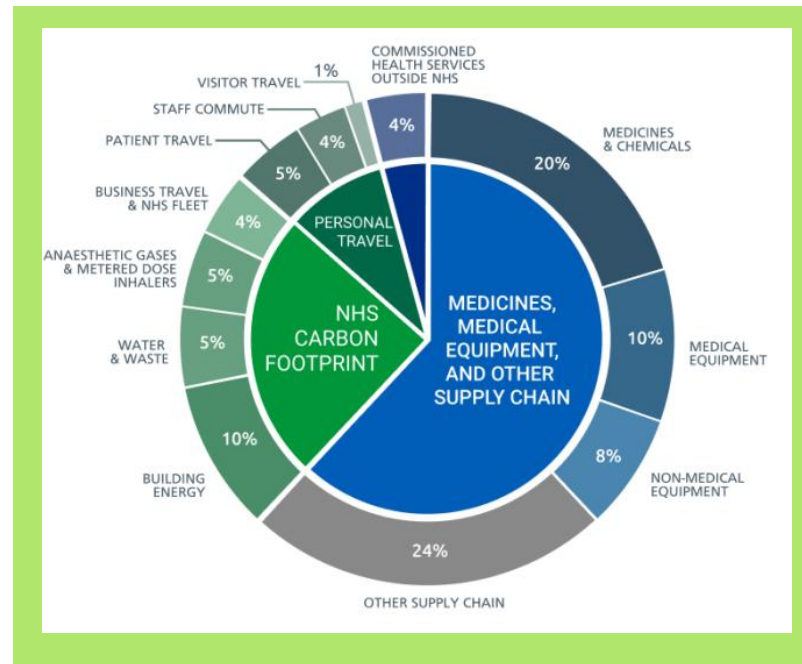
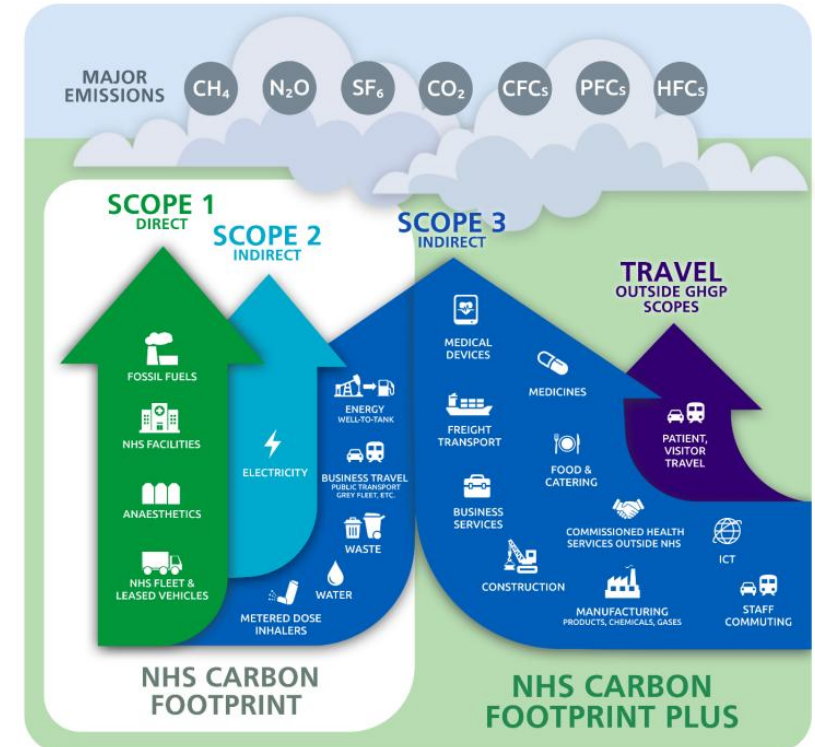


Figure 4: Sources of carbon emissions by proportion of NHS Carbon Footprint Plus

Figure 5: Greenhouse Gas Potential scopes in the context of the NHS



A Net Zero NHS is **not just about reducing carbon footprints, it's about delivering healthier, more resilient healthcare for future generations**. By embedding sustainability into every aspect of operations, NHS Trusts can safeguard public health while tackling climate change head-on.

Our Carbon Footprint

The Delivering a Net Zero NHS report defined 2019/20 as the baseline year for NHS carbon footprint reporting. The tables below show the emissions associated with the NHS Carbon Footprint for each Trust from 2019/20 to 2024/25, to show the reductions that have been achieved over this period.

Figure 6: Tameside and Glossop Integrated Care NHS Foundation Trust Carbon Footprint (tCO₂e)

Emissions Source	Total tCO ₂ e						Trend from 2019/20 to 2024/25
	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	
Electricity	3,301	3,015	3,415	2,559	3,057	2,809	↓
Gas	5,096	5,075	5,293	4,506	5,511	4,263	↓
Other Energy	2	89	3	3	2	268	↑
Refrigerant Gases	No Data	No Data	No Data	No Data	21	146	unknown
Waste	267	158	146	122	127	108	↓
Water	98	80	49	52	51	47	↓
Medical Gases	1,209	1,276	1,377	1,513	1,705	1,396	↑
Inhalers	63	No Data	No Data	140	112	118	↑
Business Travel	279	No Data	No Data	177	138	214	↓
Fleet	83	79	74	No Data	93	62	↓
Total	10,398	9,772	10,357	9,072	10,817	9,431	↓

Figure 7: Stockport NHS Foundation Trust Carbon Footprint (tCO₂e)

Emissions Source	Total tCO ₂ e						Trend from 2019/20 to 2024/25
	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	
Electricity	3,874	3,488	3,815	3,368	3,722	3,911	↔
Gas	6,877	6,525	7,033	6,638	6,034	6,596	↓
Other Energy	0	383	383	237	2	171	↑
Refrigerant Gases	No Data	No Data	No Data	22	6	15	unknown
Waste	322	335	361	336	298	265	↓
Water	190	197	97	107	126	106	↓
Medical Gases	1,280	1,296	1,148	1,179	1,105	859	↓
Inhalers	No Data	61	No Data	151	114	103	unknown
Business Travel	No Data	197	No Data	No Data	361	340	unknown
Fleet	62	81	60	46	36	24	↓
Total	12,605	12,564	12,896	12,085	11,803	12,391	↓

* Please note there are unfortunately some gaps in data, but the tables show the overall trends experienced. Please note that the 2024/25 data is still subject to validation.

The data for Tameside and Glossop Integrated Care NHS Foundation Trust shows a reduction in emissions from 2019/20 to 2024/25 of 9.3%. Reductions in the use of electricity and gas account for the largest reductions, along with waste and water. The data for Stockport Foundation Trust is more difficult to compare as there is some data missing for 2019/20. However, a decrease in emissions can still be seen and the biggest reduction is due to medical gasses.

The workstream actions detailed later in this plan are designed to make progress at each Trust over the next 3 years and priority will be given to the changes that will result in the largest reductions in emissions.

Going forward we will be looking to expand the emissions data collected to include the reporting of our carbon footprint plus (see Figure 4). This will include measuring the carbon footprint of our supply chain, including medicines, medical equipment and visitor travel.

Our Carbon Footprint

Figure 8 and 9 show the carbon budget for the period of this green plan in order to reach the NHS England target of an 80% reduction by 2028-32, from the 1990 baseline. This equates to a 47% reduction in carbon emissions from 2019/20. The graphs assume net zero by 2038, to exceed the NHS targets and align with the Greater Manchester 2038 net zero target.

Figure 8: Tameside and Glossop Integrated Care NHS Foundation Trust Carbon Footprint Trajectory to Net Zero

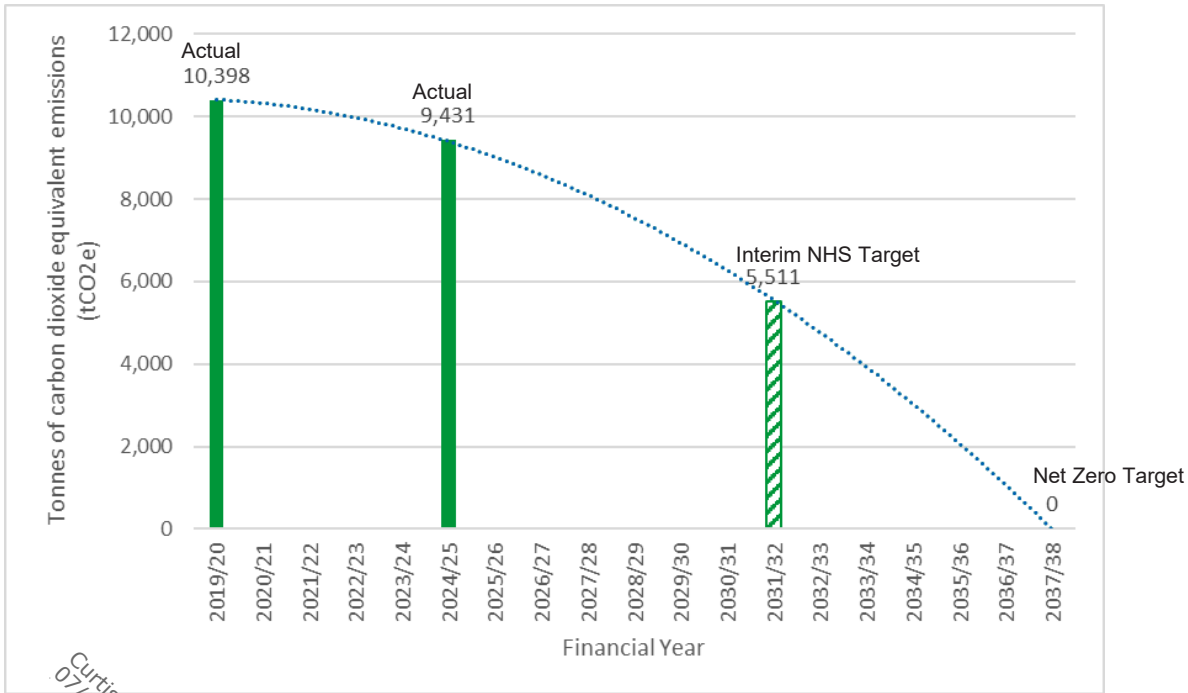
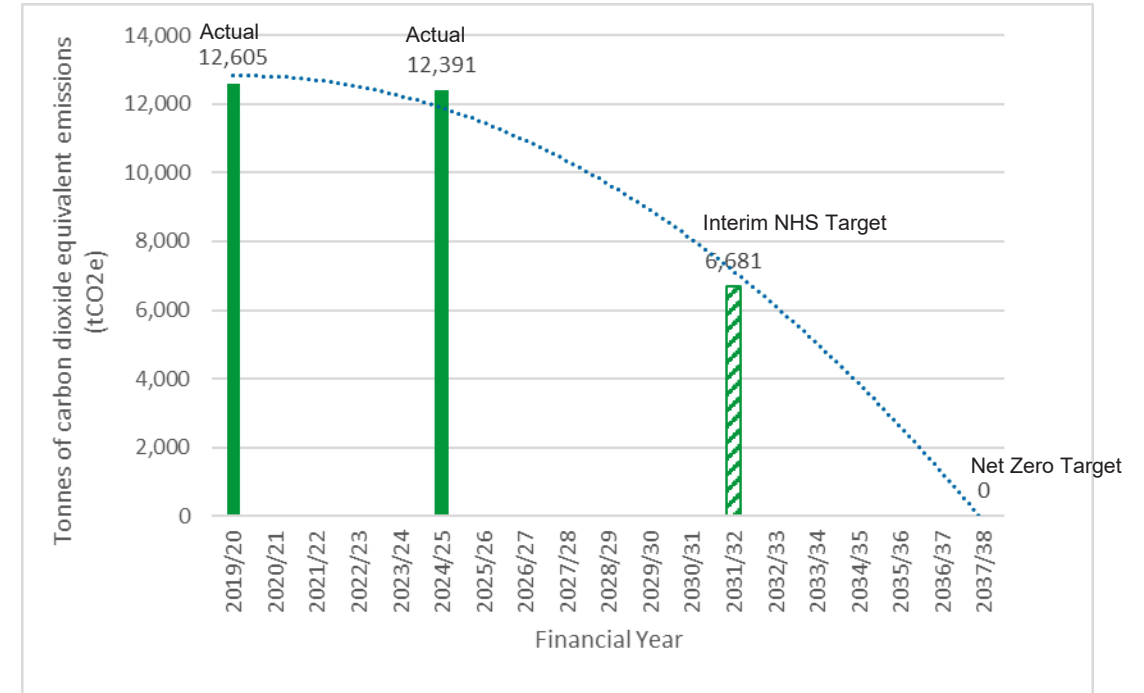


Figure 9: Stockport NHS Foundation Trust Carbon Footprint Trajectory to Net Zero



The 2028-2032 interim target will only be achieved through significant progress to decarbonise emissions from building energy (gas, electricity and other energy (oil)) and from medical gasses. Tameside and Glossop Integrated Care NHS Foundation Trust have recently received £14.4 million of Public Sector Decarbonisation Funding that will enable a reduction in building energy emissions of over 2,000 tCO₂e per year once the project is completed. At Stockport Foundation Trust we now have a heat Decarbonisation Plan in place, and we are progressing a solution to decarbonise our heat source as a priority.

Workstreams

There are 10 key workstreams that make up the Green Plan. For each workstream the plan outlines the current position 'Where we are now' and the actions we will deliver over the next 3 years 'Actions 2025 – 2028'.

Workforce and Systems Leadership

Net Zero Clinical Transformation

Digital Transformation

Travel and Transport

Estates and Facilities

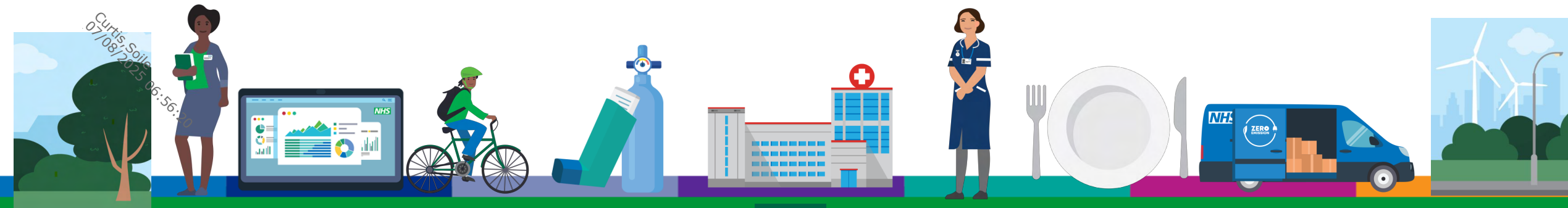
Medicines

Supply Chain and Procurement

Food and Nutrition

Climate Change Adaptation

Nature for Health



Workforce and Systems Leadership

To address climate change we need to empower our workforce and provide them with the tools to change behavior. Education and training will improve understanding about how the way we work and the services we provide impact the environment.

Sustainability must become a core part of everything we do and by incorporating sustainability into decision making processes and mobilising staff to adopt sustainable practices, we will see reduced carbon emissions, alongside wider benefits such as reduced health inequalities and improved care.

Where we are now	Actions 2025 - 2028
<ul style="list-style-type: none"> • Net zero Board lead appointed • Joint Green Plan Delivery Group established to track and challenge progress • Leads identified for all Green Plan Workstreams 	<ul style="list-style-type: none"> • Establish a process to integrate Green Plan requirements into broader strategic priorities and plans e.g. through Quality Improvement Projects, Business Case templates and Sustainability Impact Assessments • Net Zero targets and sustainability to be built into new job descriptions and appraisal process • Introduce appropriate training for staff at all levels in the organisation e.g. GM 'Plan It' training for senior leaders • Establish a staff Sustainability Group / Committee • Ensure the Trust Green Plan is widely communicated and that a rolling communications plan is in place



Image shows: Example of a staff meeting/discussion

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Net Zero Clinical Transformation

Every interaction with the NHS generates a carbon footprint. If we aim to reach the NHS net zero emissions targets, it is critical that we reflect on the end-to-end patient journey through the healthcare system. We must seek opportunity to transform services at all stages of the care pathway, actively incorporating environmental sustainability within our mission to deliver high quality and equitable care.

A significant transformation we can make is to address the broader determinants of health through a focus on prevention. By engaging and involving people in their own health and wellbeing, we can empower patients with the tools to self-manage their health and reduce growing pressures on healthcare services. Strengthening the provision of services within communities with an emphasis on tackling health inequalities, as well as streamlining our systems to minimise unnecessary waste, fortifies this effort to prevent unnecessary hospital visits and increase access to early intervention. Furthermore, by embedding a prioritisation of treatments and technologies with a lower environmental impact within processes, we can continue to support the journey to net zero as part of the work to enhance care delivery (see Figure 10).

Where we are now	Actions 2025-2028
<ul style="list-style-type: none"> • Collaboration efforts with our locality partners aimed at addressing health inequalities • Introduced enhanced provision of early intervention through local community services for children and young people • Initial rollout of Patient Initiated Follow Up, empowering patients to choose when to request outpatient follow up • Opening of the Community Diagnostic Centre in Denton • Development of Virtual Ward pathways to prevent hospital inpatient admission where possible and increasingly deliver care at home • Remote Outpatient consultations following the pandemic 	<ul style="list-style-type: none"> • Delivery of the actions detailed in the Directorate Plans on a Page (Appendix 2) • Support the delivery of the Greater Manchester Combined Authority ECO4 Flex programme for energy efficient housing retrofit

This workstream actions have been developed in close consultation with Directorates across the Trust to ensure they align with the clinical strategies for both Stockport and Tameside for 2026-28.

Figure 10: Principals of Net Zero Clinical Transformation



Prevention
Promoting health and preventing disease by tackling the causes of illness and inequalities.

Patient Self-Care
Empowering patients to take a greater role in managing their own health and care



Principles of Net-Zero Clinical Transformation



Lean Service Delivery
Streamlining care systems to minimise wasteful activities.

Low-carbon Alternatives
Prioritising treatments and technologies with a lower environmental impact.



Digital Transformation

Digital transformation is a powerful catalyst for driving sustainability within the NHS, helping to reduce carbon emissions, streamline operations, and improve patient care. By embracing digital solutions such as paperless systems, virtual wards, remote consultations and AI diagnostics, the NHS can significantly lower its environmental impact while enhancing efficiency and accessibility. However, we must ensure that digital literacy and inclusion are considered in all decision making to ensure access for all.

There is still a significant amount of paper used everyday in the NHS and the potential to move away from paper-based systems to digital technology / communications remains vast.

Where we are now	Actions 2025 - 2028
<ul style="list-style-type: none"> IT equipment reuse and recycling in place Infrastructure in place to enable remote working for staff Virtual wards Restriction on printing <p>Tameside and Glossop Integrated Care NHS Foundation Trust</p> <ul style="list-style-type: none"> Data centre now shared with the council – reduced electricity usage Now purchasing refurbished laptops, desktops and monitors 	<ul style="list-style-type: none"> Use AI to streamline processes, detect energy used by equipment, reduce resource waste and optimise operations Embed Greener Digital Guidance into digital strategies and processes Increase the availability of virtual wards to support people to receive safe and effective care in their home, with a reduced carbon footprint Printer and desktop/ hardware rationalisation (Printers/ PCs / Phones) <p>Tameside and Glossop Integrated Care NHS Foundation Trust</p> <ul style="list-style-type: none"> Digitalisation of pathways for Medical Records

Note: All actions relating to digital transformation will be subject to an Equality Impact Assessment to ensure they consider those that are not digitally enabled.

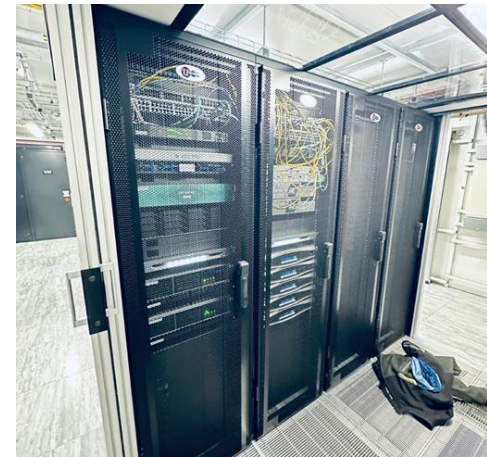


Image shows: New shared data centre with Tameside Council

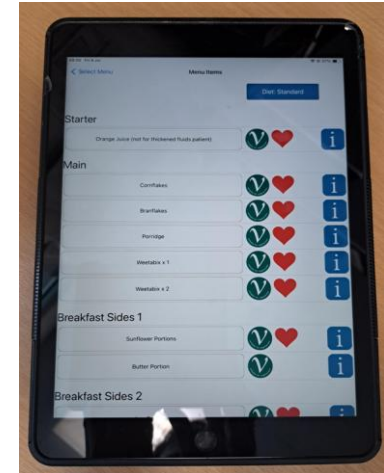


Image shows: Example of the Facilities Catering online Menu



Image shows: Example of the Estates Maintenance electronic system MiCAD



Medicines

Medicine are responsible for a quarter of the NHS Carbon Footprint plus emissions. Emissions arise from the supply chain during manufacture and distribution. Reducing medicine usage, and therefore the required production of medicines, will reduce emissions. Some emissions from medicines also occur at the point of use e.g. from inhalers and anesthetic gasses and there are actions we can take to reduce these emissions and to measure the impact.

Where we are now	Actions 2025 - 2028
<ul style="list-style-type: none"> The use of Desflurane has been eliminated Work ongoing to promote the use of dry powder inhalers (DPI) over metered dose inhalers (MDI) where clinically appropriate. <p>Stockport FT</p> <ul style="list-style-type: none"> Nitrous oxide manifold systems have been decommissioned 	<ul style="list-style-type: none"> System wide campaign to encourage patients to bring their own medicine into hospital Ensure the systems in place to return unused medicines from wards are effective and enable medicines to be reused Continue to improve systems to ensure medicines are only supplied on a need basis on discharge, to avoid duplicating medicine at home Complete the Greener Pharmacy Toolkit and work through the accreditation process Seek to understand if there are options to reduce the use of Entonox, without impacting patient care Drive a move to high quality, low carbon respiratory care in line with clinical guidelines Encourage patients to return their unused or expired inhalers for appropriate disposal Campaign to promote safe disposal of medicines <p>Tameside and Glossop Integrated Care FT</p> <ul style="list-style-type: none"> Reduce nitrous oxide waste from medical gas pipeline systems and decommission the manifold system where possible.

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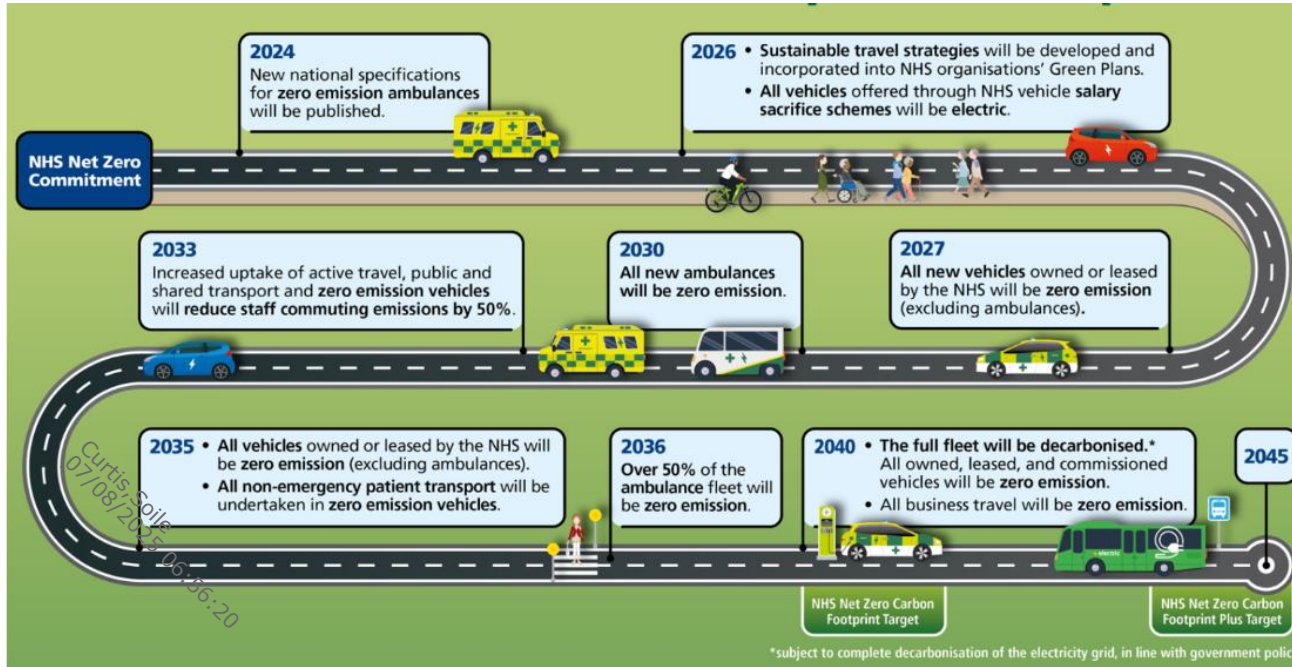


Travel and Transport

The transport of goods, services, staff, patients and visitors has a significant impact on air quality, congestion and health. The NHS has developed a Net Zero Travel and Transport Roadmap that describes the interventions and commitments the NHS will deliver and the associated timelines. The Trust will deliver the roadmap and adopt the transport hierarchy in the delivery of our services. Promoting the use of public transport and active travel is key to reduce congestion on our hospital sites. Active travel is also a valuable tool to improve both the mental and physical health of staff and visitors and will be a key area of focus.

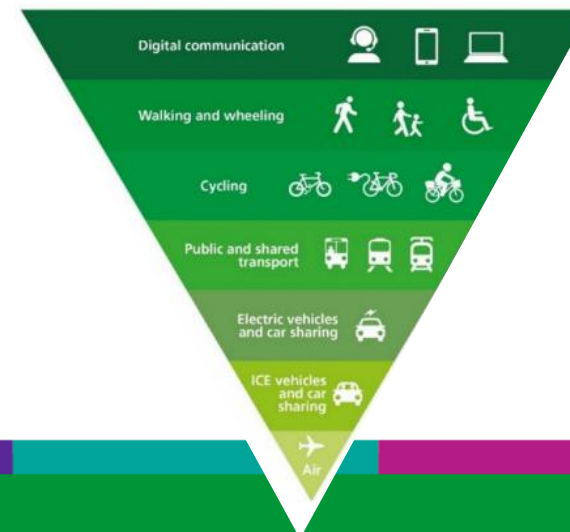
To improve travel to and from the hospitals we will need to work in partnership with the Local Authorities and Transport for Greater Manchester.

Figure 11: NHS Net Zero Travel and Transport Roadmap



Where we are now	Actions 2025 - 2028
<ul style="list-style-type: none"> 2024 Staff travel survey complete Signed up to Modeshift STARS accreditation programme 2 electric vehicle charge points in place for staff at Stepping Hill Hospital Reduced the number of deliveries to sites Fleet includes 3 electric vans and 2 electric tug vehicles at Tameside, and 4 small electric vans at Stockport 	<ul style="list-style-type: none"> Revise Travel Plans in line with the NHS Net zero Travel and Transport Roadmap Ensure all new vehicles owned or leased by the Trust meet the requirements of the NHS Net zero Travel and Transport Roadmap Carry out the staff travel survey annually and report on changes in travel patterns Progress through Modeshift STARS Travel Plan accreditation process Create an action plan following each staff travel survey and work with partners e.g. Transport for Greater Manchester to increase active travel and the use of public transport Improve facilities for those who cycle, walk or run to work e.g. safe storage and showers

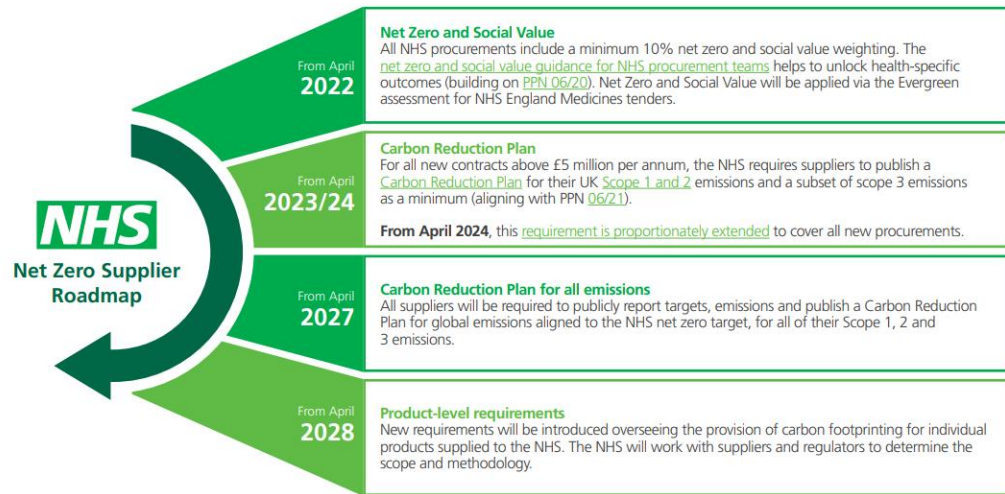
Figure 12: Transport Hierarchy



Supply Chain and Procurement

Emissions associated with our supply chain account for the largest proportion (nearly two thirds) of the overall NHS Carbon Footprint Plus. The Trusts use a network of suppliers to produce and transport the products and services we need to deliver effective healthcare. Emissions are generated throughout the process from the extraction of the raw materials to the production, packaging, and transportation of the goods. Whilst the Trusts do not have direct control over these emissions, we do have significant purchasing power and influence. The NHS Net Zero Supplier Roadmap sets out the steps suppliers must take to align with the NHS net zero ambition through to 2030.

NHS Net Zero Supplier Roadmap



Published November 2023 | [england.nhs.uk/greenernhs](https://www.england.nhs.uk/greenernhs)

Figure 13: NHS Net Zero Supplier Roadmap

Where we are now	Actions 2025 - 2028
<ul style="list-style-type: none"> • 10% net zero and social value weighting included in every tender • We include Carbon Reduction Plans and Net Zero Commitments in all relevant procurements and frameworks • Walking Aid reuse schemes in operation 	<ul style="list-style-type: none"> • Develop a set of standard Key Performance Indicators (KPIs) for Sustainability and ensure they are monitored through a strengthened contract management approach • Increase number of suppliers that are compliant with the Evergreen Assessment • Introduce the monitoring and publication of data for Supply Chain Emissions to enable targeted intervention to reduce supply chain emissions • Ensure Carbon Reduction Plans include all scope 1,2, and 3 emissions in line with Net Zero Supplier Roadmap • Integrate circular economy and value-based procurement principles into procurement policy and ensure alignment with the Procurement Act • Reduce packaging waste generated from the supply chain



Food and Nutrition

Ensuring patients are provided with a nutritious and well-balanced diet is essential to support patient recovery, benefit patient experience and improve health. By providing seasonal menus that are high in fruit and vegetables and contain minimal processed foods, we will also provide low carbon menus and reduce our impact on the environment. Ensuring the restaurant menus for staff and visitors follow the same principals will also support a healthy workforce and improve staff wellbeing.

By focusing on the food wasted in the trust and measuring this accurately we can target our menus to reduce waste and ensure we are providing high quality foods that meet the needs of our customers.



Image shows: Salad bar at Tameside Hospital restaurant



Image shows: Dining with dignity example before and after meal of sausage, mash and beans



Image shows: Fresh fruit stall at Stockport NHS FT restaurant

Where we are now	Actions 2025 - 2028
<ul style="list-style-type: none"> Manual recording of food waste tonnages Single use plastics removed from the restaurant and replaced with biodegradable containers and wooden cutlery Water available in reusable cups in the restaurant <p>Stockport FT</p> <ul style="list-style-type: none"> Improvements made to texture modified meals to enable moulding to appear as the food it is, improving appeal and reducing food waste Electronic menu ordering system in place Blue plates introduced for patients and in the restaurant to reduce food waste 	<ul style="list-style-type: none"> Introduce and electronic system to monitor food waste produced and use the data to target food waste reduction Introduce the monitoring of Carbon Emissions from patient and restaurant menu Continue to reduce the carbon footprint of the menu, to prioritise locally grown and seasonal food, to increase plant-based options and to promote health eating through regular menu reviews Develop the relationship between the restaurant and the green space on site to grow items e.g. herbs Introduce reusable containers in the restaurant for take aways Explore an upgrade of the electronic meal ordering system at Stockport and the introduction of electronic meal ordering at Tameside <p>Tameside and Glossop Integrated Care FT</p> <ul style="list-style-type: none"> Introduce blue plates for patients and in the restaurant to reduce food waste

Please note: Blue plates reduce food waste by making food appear more appealing to patients and therefore increasing the amount of food consumed.



Estates and Facilities

Energy usage across the NHS estate is the largest source of direct emissions that the Trust can control. Creating a sustainable future for healthcare starts with the spaces we work in and the resources we use. We need to transform the built environment, energy consumption, and overall infrastructure to align with ambitious net zero targets. There is a need to prioritise energy efficiency, decarbonise our buildings and prioritise the management of waste in line with the Waste Hierarchy and the NHS Clinical Waste Strategy, while maintaining the highest standards of patient care and operational efficiency.

Where we are now	Actions 2025 - 2028
<ul style="list-style-type: none"> Heat Decarbonisation Plans in place New clinical waste contract in place to support reductions in carbon emissions 90% of lighting at Tameside Hospital is LED and 27% of lighting at Stepping Hill Hospital is LED £14.4 million of Public Sector Decarbonisation Scheme (PSDS) funding secured to decarbonise Tameside Hospital 	<ul style="list-style-type: none"> Delivery of the NHS Clinical Waste Strategy targets Introduce recycling collections in line with Simpler Recycling guidance Continue to deliver waste segregation training Produce an Energy management Policy Improve energy metering and monitoring across the sites 100% of lighting across the Trusts to be LED and increase the amount of sensor driven lights Ensure that sustainability is integral to the transformation of the NHS estate, as detailed in the GM Estates Infrastructure Strategy. Implementation of a site wide heat decarbonisation project for Tameside Hospital in line with the £14.4 million of PSDS4 funding awarded Increase the amount of on-site renewable energy generation Implementation of a site wide decarbonisation project for Stepping hill hospital with the aim of connecting to the Stockport Heat Network if commercially viable Explore the potential to introduce Hydrogen fuel cells at Tameside Hospital (innovation project) Ensure sustainability is a key consideration on all new build and refurbishment projects delivered

Figure 14: A simplified four step approach to decarbonising NHS Estates

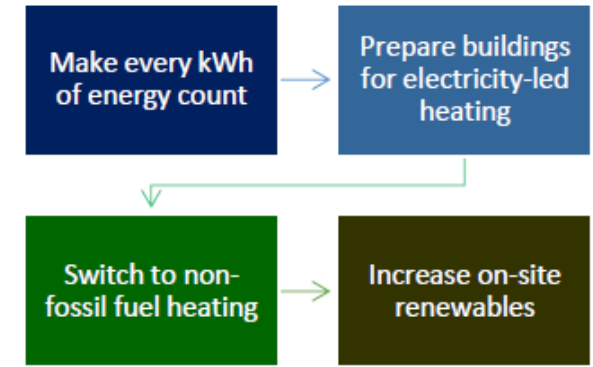
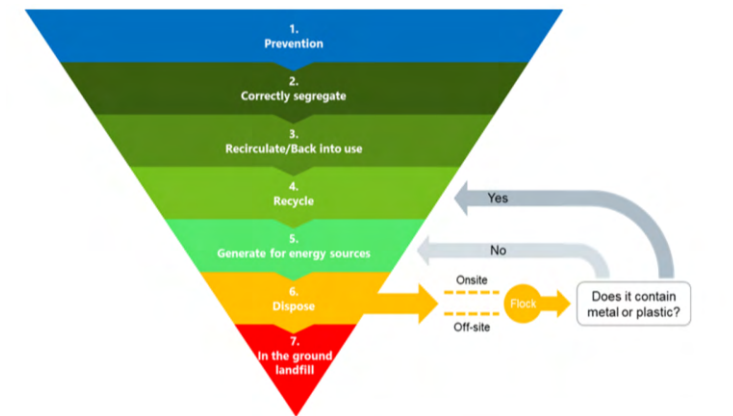


Figure 15: The Waste Hierarchy (Adapted for Clinical Waste)



Climate Change Adaptation

Climate adaptation focuses on building resilience against the impacts of climate change while ensuring continued high-quality patient care. It is essential that as climate change accelerates the Trust adapts its estates and services to mitigate and manage the risk associated with global warming. Within Greater Manchester we are experiencing increasing temperatures and heavy rain and storms have caused disruption to people, travel, homes and businesses. Periods of extreme weather are increasing and have wider implications for population health, with a rise in vector born disease, a pollen crisis and spring temperature. This in turn leads to wider health inequalities, with the most vulnerable in society being impacted the greatest.

By preparing healthcare facilities for extreme weather events and integrating sustainable infrastructure we can reduce environmental harm. By adopting nature-based solutions, enhancing supply chain sustainability, and reducing reliance on carbon-intensive resources, the NHS can safeguard its operations against climate-related disruptions. Additionally, fostering awareness and training among healthcare professionals ensures that adaptation measures are effectively implemented, contributing to a more sustainable and climate-resilient health service for the future.

Where we are now	Actions 2025 - 2028
<ul style="list-style-type: none"> Greater Manchester Climate Change Risk Assessment in place (produced by GMCA) Heatwave plans in place Major Incident plans in place 	<ul style="list-style-type: none"> Production of Climate Adaptation Plan for Greater Manchester with a Trust specific action plan to identify local risks. This will be informed by the GMCA Climate Change Risk Assessment Review Major Incident Plans and Business Continuity Plans in line with UK climate projections and extreme weather alerts Review Heatwave plans in line with up climate projections Improve understanding of climate adaptation through training Ensure the Climate Adaptation is considered in all major redevelopment projects and new builds to ensure building and infrastructure supports adaptation Identify where nature-based solutions could contribute to climate change adaptation





	2030s	2050s	2080s	
 Summer Average Air Temperature (°C)	+0.9 to +1.9	+1.4 to +3.3	+2.6 to +6.4	↑
Summer Maximum Air Temperature (°C)	+0.9 to +2.2	+1.6 to +3.8	+2.9 to +7.4	↑
 Winter Average Air Temperature (°C)	+0.7 to +1.7	+1.1 to +2.6	+1.7 to +4.5	↑
Winter Minimum Air Temperature (°C)	+0.7 to +1.7	+1.2 to +2.8	+1.7 to +4.9	↑
 Annual Average Air Temperature (°C)	+0.8 to +1.5	+1.2 to +2.5	+2.0 to +4.7	↑
 Summer Precipitation Rate (%)	-2 to -21	-11 to -35	-19 to -52	↓
Winter Precipitation Rate (%)	+2 to +11	+4 to +18	+9 to +32	↑

Figure 16: Predicted Climate Impacts for Manchester



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Nature for Health

Access to nature and green space plays an important role in both mental and physical health. Integrating nature into healthcare is therefore a vital component in promoting patient wellbeing and access to green spaces on hospital sites can also impact on staff and visitor wellbeing. By incorporating nature into care strategies such as therapeutic gardens, social prescribing and sustainable hospital design, the NHS can help foster a healthier population. It has been calculated that the NHS could save an estimated £2.1billions every year in treatment costs if everyone had access to good quality green space.

Green space can also act as a noise buffer and reduce air pollution, and the planting of trees benefits the environment as it increases the removal of carbon dioxide from the atmosphere.

People living in areas with greater access to greenspace tend to have a higher life expectancy than those living in deprived areas, which can lead to health inequalities.

Greenspaces also have a role to play in Climate Change Adaptation. Trees can lower local temperatures by providing shade and vegetated area absorb rainwater, reducing the risk of flooding and surface water.



Image shows: Patient Garden on the Acute Frailty Unit at Stockport NHS FT

Where we are now	Actions 2025 - 2028
<ul style="list-style-type: none"> • Tree registers and surveys • Bat boxes and birdboxes <p>Tameside and Glossop Integrated Care FT</p> <ul style="list-style-type: none"> • Wildflower meadow • Ancient woodland • Tree protection orders <p>Stockport FT</p> <ul style="list-style-type: none"> • Acute Frailty Unit Therapy Garden – funded by Greener Communities grant 	<ul style="list-style-type: none"> • Support the delivery of the GMCA Local Nature Recovery Strategy across the NHS estate • Nature Recovery Ranger to be employed in April 2026 for 2 years to improve access to greenspace and increase engagement with staff, patients, visitors and the community in nature-based activities • Look for opportunities to improve biodiversity through new initiatives such as hedgehog houses, swift bricks, wildflowers, composting and the creation of natural habitats. • Look at use of herbicides and pesticides on the hospital sites and seek more environmentally friendly alternatives where possible. • Work with the local council and voluntary groups to promote access to neighbouring green spaces close to the hospital sites



Image shows: Newly planted trees on site at Tameside and Glossop Integrated Care NHS FT



Communications and Engagement

The success of the Trust Green Plan is reliant on engagement and support from all teams across the Trust and it is key that staff, patients and visitors are aware of the plan and the work taking place to achieve net zero. It is important that we communicate that the climate emergency is the health emergency and that people understand the impacts climate change has on health.

The Trusts will use existing communications channels such as the Intranet, Weekly Digest communication to all staff, staff facebook page, Catch up with Karen (Fortnightly communication's from the CEO) and All-Star monthly team brief to promote our work. Throughout the delivery of the plan will strive to make this agenda visible to all staff.

The Trusts will seek to publicise the key areas of progress, so the work taking place is visible in the locality. This will be achieved through press releases, social media, presentations at events and updates on the Trust web sites.

This Plan was developed in consultation with key stakeholders across both Tameside and Glossop Integrated Care NHS Foundation Trust and Stockport Foundation Trust to ensure awareness and ownership of the plan and to achieve support with delivery. Feedback received was considered and incorporated within the plan where appropriate. Workstream leads have been appointed across both Trusts to drive delivery of each action area, and they have supported the development of the plan.

An **Equality Impact Assessment** was undertaken during the development of this Green Plan to assess the impact on people from protected characteristic groups or at known disadvantage. This identified several actions relating to communications and engagement, which will minimise any adverse impacts. The following communication actions will therefore be delivered alongside the workstream action plans:

- Ensure communication with vulnerable groups so they understand the risks associated with climate change e.g. heat waves.
- Support engagement with young people around climate change to reduce climate anxiety and explore ways to involve children and young people in the delivery of the Green Plan to ensure their voice is heard.
- Consider communicating the Green Plan in a number of different ways to adhere to accessible information standards and consider protective characteristics e.g. through a plan on a page, infographics and film clips and making large print copies available upon request.

Share your views to help the Trust reach net zero

We are currently developing a new Joint Green Plan, with Stockport NHS Foundation Trust, to describe how we will improve environmental sustainability over the next three years.

The plan focusses on 10 key workstreams and we are seeking feedback from staff.

Please look at [the consultation document](#) and [leave feedback here](#).

Alternatively, if you would like to make an appointment to discuss the plan with our Sustainability Manager Laura Swann or would like her to attend your team meeting to discuss,



Governance

Clear governance arrangements are in place to ensure the delivery of the Green Plan:

- The Board at each Trust is informed about climate-related issues through the Annual Green Plan Progress update and the Trust Annual Report. These reports include highlights of actions taken and detail quantitative progress data.
- The Finance & Performance Committee (subcommittee of the Board) has delegated responsibility to provide oversight and ensure appropriate governance mechanisms are in place to deliver the Trust's sustainability-related strategies and plans. It oversees the development and delivery of sustainability requirements as per national NHS guidance. A Green Plan Progress Report is presented biannually to the Finance & Performance Committee.
- A Joint Green Plan Delivery Group is in place, chaired by the Director of Estates and Facilities. The group is comprised of leads for each of the ten workstreams, who are invited to provide updates on progress at each meeting. This group meets every 2 months and will be responsible for tracking delivery progress for the actions detailed in this plan and reporting to the Finance and Performance Committee.
- Subgroups of the Joint Green Plan Delivery Group are set up as required to progress actions.
- The delivery of the Green Plan is the responsibility of the Net Zero Board Lead (Executive Chief Finance Officer), with the support of the Director of Estates and Facilities. Green Plan progress is coordinated and monitored by the Sustainability Manager, with the support of a Sustainability Officer.
- A Non-Executive Director sits on the Joint Green Plan Delivery Group to offer support, leadership and guidance around this agenda across the two trusts.
- The Trust is committed to updating the actions in the Green Plan on an annual basis to allow for new initiatives. A review of the action plan take place each year and any changes will be approved via the annual Green Plan Progress Report to Finance and Performance Committee and Board.
- The Trusts will ensure that all actions delivered in plan consider the equality impact they could have on different groups of people, particularly those with protected characteristics under equality legislation.
- The Trust plays an active part in the Greater Manchester Operational Sustainability Leads Group to share good practice, networking and learning and representatives sit on the Greater Manchester Sustainable Procurement Forum, The Greater Manchester Pharmacy Sustainability Group and the Greener Inhaler Steering Group. Progress This feeds into the work of the Joint Green Plan Delivery Group.

Figure 17: Governance Process



Monitoring Our Progress

To track the progress in relation to the delivery of the green plan the following data collection arrangements are in place. This ensures compliance with local, regional and national requirements. Please note this data is often not available until a number of months after the month end.

Quarterly	Six Monthly	Annually
Emissions from: <ul style="list-style-type: none"> • Waste • Medical gases • Inhalers • Gas • Electricity • Water • Refrigerant gasses • Fleet • Business Travel Greener NHS Data Collection	Green Plan Progress Report to Finance and Performance Committee	Trust Annual Report Green Plan Progress Report to Board Annual Staff Travel Survey Greener NHS Fleet Estates Return Collection Information NHS Premises Assurance Model

Options to quantify further emissions data relating to our supply chain, patients and visitor travel etc are being explored and this data will be monitored in future years.

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Risk

To ensure the successful delivery of the Green Plan we need to effectively manage the associated risks.

Failure to deliver the Green Plan and Net Zero targets and prepare for impact of climate change which may lead to worsening population health is a Board Assurance Framework Risk (BAF). This risk is scored as a 12 (Impact 3 – Moderate and Likelihood 4- likely). The Joint Green Plan Delivery Group is responsible for identifying and managing programme level risks and ensuring they are reflected in the BAF risk updates as required.

Progress updates in relation to the BAF risk are presented quarterly to the Finance and Performance Committee which provides further oversight of progress in relation to the progress of actions to mitigate this risk.

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

Figure 18: Risk Matrix

Finance

The delivery of the Green Plan and our Net Zero ambition presents significant financial challenges. However, the Trusts have been successful in securing funding to support decarbonisation in recent years and will continue to apply for opportunities where available. Examples of recent funding secured include:

- £14.4 million Public Sector Decarbonisation Funding – Tameside Hospital
- £719,000 for replacement of lighting with LEDs – Tameside Hospital
- £479,000 for upgrades to the BMS at Tameside Hospital
- Production of a Heat Decarbonisation Plan and Heat Network Readiness Report – Stepping Hill Hospital
- A Nature Recovery Ranger funded from April 2026 for 2 years – Joint, Tameside Hospital and Stepping Hill Hospital
- Planting and establishment of 10 large trees at Tameside Hospital and 8 at Stepping Hill Hospital
- £6,000 for Stepping Hill Hospital and £25,000 for Tameside Hospital to decommission the Nitrous Oxide manifold system

To ensure we are well-positioned to secure future funding it is essential that we maintain a high-level pipeline of costed projects, both estates and non-estate related, as funding availability is often last minute with a tight application period. We will also seek to work with our partners to maximise access to funding opportunities.

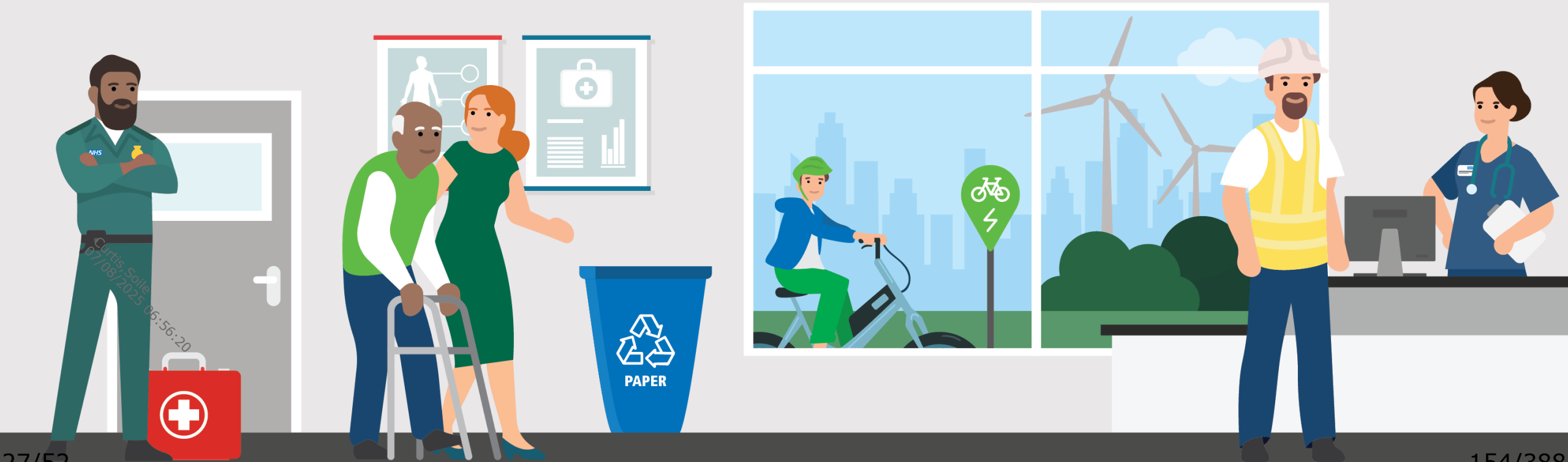
Conclusion / Next Steps

The impacts of climate change are being felt by individuals, communities, and healthcare systems. This Green Plan sets out the actions that Tameside and Glossop Integrated Care NHS Foundation Trust and Stockport NHS Foundation Trust intend to deliver over the next 3 years.

Progress against the actions will be closely monitored through our governance arrangement and reported to drive change and to identify delivery risks. The actions will be reviewed on an annual basis and adjusted accordingly.

The delivery of the plan is set against a backdrop of significant financial challenge, but we must remember that climate change and health are deeply connected and that by reducing the emissions of greenhouse gasses we will see improved health outcomes for our populations and less reliance on our services.

To embed the delivery of the Green Plan across all areas of the organisation we need to work together and educate staff and to empower them to think about sustainability in all aspects of their work.



Abbreviations

NHS:	National Health Service
ICS:	Integrated Care System
GMCA:	Greater Manchester Combined Authority
GM:	Greater Manchester
PIFU:	Patient Initiated Follow Up
BAF:	Board Assurance Framework
KPIs:	Key Performance Indicators
CDC:	Community Diagnostic Centre
DPI:	Dry Powder Inhaler
MDI:	Metered Dose Inhaler
BMS:	Building Management System
LED:	Light Emitting Diode
tCO₂e:	Tonnes of Carbon Dioxide Equivalent
PSDS:	Public Sector Decarbonisation Scheme
MDT:	Multi Disciplinary Team
PTSD	Post-Trauma Stress Disorder
FT:	Foundation Trust



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Appendix 1

Appendix 1 expands on the Actions detailed in each of the workstreams by providing details of the role responsible for the delivery of the action, the delivery timeframe and how progress will be measured.



Workforce and Systems Leadership

Area of Focus	Action	Lead	Timeframe	Reporting Measure
Workforce and Leadership	Establish a process to integrate Green Plan requirements into broader strategic priorities and plans e.g. through Quality Improvement Projects, Business Case templates and Sustainability Impact Assessments	Director of Strategy and Partnerships	Dec 2025	Included in Quality Improvement Project template, Business Case template and QI projects
Workforce and Leadership	Net Zero targets and sustainability to be built into new job descriptions and appraisal process	Deputy Director, Organisational Development	March 2026	Job descriptions and appraisal process amended to include sustainability
Workforce and Leadership	Introduce appropriate training for staff at all levels in the organisation e.g. GM 'Plan It' training for senior leaders	Deputy Director, Organisational Development / Sustainability Manager	March 2026	Training plan in place and monitor number of staff that have received training
Workforce and Leadership	Establish a staff Sustainability Group / Committee	Sustainability Manager	Dec 2025	Staff Sustainability Group / Committee in place
Workforce and Leadership	Ensure the Trust Green Plan is widely communicated and that a rolling communications plan is in place	Head of Communications / Sustainability Manager	Oct 2025	Record of communications activity

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Net Zero Clinical Transformation

Area of Focus	Action	Lead	Timeframe	Reporting Measure
Net Zero Clinical Transformation	Delivery of the actions detailed in the Directorate Plans on a Page (see Appendix 2)	Divisional Directors	Updated annually in line with Clinical Strategy	Actions delivered in Divisional Plans on a Page - Through clinical Strategy
Net Zero Clinical Transformation	Support the delivery of the GMCA ECO4 Flex programme for energy efficient housing retrofit	Sustainability Manager	March 2027	Number of referrals

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Digital Transformation

Area of Focus	Action	Lead	Timeframe	Reporting Measure
Digital Transformation	Use AI to streamline processes, detect energy used by equipment, reduce resource waste and optimise operations	Chief Information Officer (Tameside) Head of IT (Stockport)	December 2026	Tbc
Digital Transformation	Embed Greener Digital Guidance into digital strategies and processes	Chief Information Officer (Tameside) Head of IT (Stockport)	Ongoing	Embedded into strategies and processes
Digital Transformation	Increase the availability of virtual wards to support people to receive safe and effective care in their home, with a reduced carbon footprint	Divisional Directors	Updated annually in line with Clinical Strategy	Actions delivered in Divisional Plans on a Page - Through clinical Strategy
Digital Transformation	Printer and desktop/ hardware rationalisation (Printers/PCs/Phones)	Chief Information Officer (Tameside) Head of IT (Stockport)	March 2026	Project completed
Digital Transformation	Tameside and Glossop Integrated Care FT <ul style="list-style-type: none"> Digitalisation of pathways for Medical Records 	Chief Information Officer (Tameside)	March 2027	Project completed

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Medicines

Area of Focus	Action	Lead	Timeframe	Reporting Measure
Medicine	System wide campaign to encourage patients to bring their own medicine into hospital	Chief Pharmacist	March 26	Audit
Medicine	Ensure the systems in place to return unused medicines from wards are effective to enable medicines to be reused	Chief Pharmacist	Dec 25	Reporting measure
Medicine	Continue to improve systems to ensure medicines are only supplied on a need basis on discharge, to avoid duplicating medicine at home	Chief Pharmacist	Dec 25	Audit
Medicine	Complete the Greener Pharmacy Toolkit and work through the accreditation process	Chief Pharmacist / Sustainability Manager	March 27	Accreditation status
Medicines	Seek to understand if there are options to reduce the use of Entonox, without impacting patient care	Chief Pharmacist	March 26	Entonox usage data
Medicine	Drive a move to high quality, low carbon respiratory care in line with clinical guidelines	Inhaler working Group	March 26	Inhaler data
Medicine	Encourage patients to return their unused or expired inhalers for appropriate disposal	Inhaler working Group	March 26	System in place
Medicine	Campaign to promote safe disposal of medicines	Chief Pharmacist	March 26	Campaign completed
Medicines	Tameside and Glossop FT only <ul style="list-style-type: none"> Reduce nitrous oxide waste from medical gas pipeline systems and decommission the manifold system where possible. 	Tameside Medical Gasses Working Group	March 2026	System decommissioned

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Travel and Transport

Area of Focus	Action	Lead	Timeframe	Reporting Measure
Travel and Transport	Revise Travel Plans in line with the NHS Net zero Travel and Transport Roadmap	Sustainability Manager / Head of Facilities	Dec 2025	Plan in place
Travel and Transport	Ensure all new vehicles owed or leased by the Trust meet the requirements of the NHS Net zero Travel and Transport Roadmap	Head of Facilities	As per travel and transport roadmap	Requirements met
Travel and Transport	Carry out the staff travel survey annually and report on changes in travel patterns	Sustainability Manager	Annual	Staff Travel Survey results
Travel and Transport	Progress through Modeshift STARS Travel Plan accreditation process	Sustainability Manager / Head of Facilities	Annual	Accreditation status
Travel and Transport	Create an action plan following each staff travel survey and work with partners to increase Active Travel, the use of Public transport and car sharing	Sustainability Manager / Head of Facilities	Annual	Action Plan with red/amber/green reporting matrix
Travel and Transport	Improve facilities for those who cycle, walk or run to work e.g. safe storage and showers	Sustainability Manager / Head of Facilities	Annual	New facilities in place

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Supply Chain and Procurement

Area of Focus	Action	Lead	Timeframe	Reporting Measure
Supply Chain and Procurement	Develop a set of standard Key Performance Indicators (KPIs) for Sustainability and ensure they are monitored through a strengthened contract management approach	Head of Procurement / Sustainability Manager	Sept 25	KPIs
Supply Chain and Procurement	Increase number of suppliers that are compliant with the Evergreen Assessment Ensure Suppliers are compliant with the Evergreen Assessment	Head of Procurement	Ongoing	Number of suppliers compliant
Supply Chain and Procurement	Introduce the monitoring and publication of data for Supply Chain Emissions to enable targeted intervention to reduce supply chain emissions	Head of Procurement / Sustainability Manager	Dec 2025	Supply Chain emissions data
Supply Chain and Procurement	Integrate circular economy and value-based procurement principles into procurement policy and ensure alignment with the Procurement Act	Head of Procurement	March 26	Procurement Policy
Supply Chain and Procurement	Integrate circular economy and value-based procurement principles into procurement policy and ensure alignment with the Procurement Act	Head of Procurement	March 26	Procurement Policy
Supply Chain and Procurement	Reduce packaging waste generated from the supply chain	Head of Procurement / Sustainability Manager	March 2027	Reductions achieved

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Food and Nutrition

Area of Focus	Action	Lead	Timeframe	Reporting Measure
Food and Nutrition	Introduce and electronic system to monitor food waste produced and use the data to target food waste reduction	Head of facilities	March 25	Electronic system in place
Food and Nutrition	Introduced the monitoring of Carbon Emissions from patient and restaurant menu	Head of facilities	March 26	Carbon emission monitoring in place
Food and Nutrition	Continue to reduce the carbon footprint of the menu, to prioritise seasonal food, to increase plant base options and to promote healthy eating through regular menu reviews	Head of facilities	Annual update	Evidence of regular menu reviews
Food and Nutrition	Develop the relationship between the restaurant and the green space on site to grow items e.g. herbs	Head of facilities Sustainability Manager	Ongoing	Items grown on site and used in the catering
Food and Nutrition	Introduce reusable containers in the restaurant for take aways	Head of facilities	March 26	Scheme tested and introduced if successful
Food and Nutrition	Explore an upgrade of the electronic meal ordering system at Stockport and the introduction of electronic meal ordering at Tameside	Head of facilities	March 26	System in pace at each trust
Food and Nutrition	Introduce blue plates for patients and in the restaurant to reduce food waste - Tameside only	Head of facilities	Dec 25	Blue plates introduced

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Estates and Facilities

Area of Focus	Action	Lead	Timeframe	Reporting Measure
Estates and Facilities	Delivery of the NHS Clinical Waste Strategy Targets	Sustainability Manager / Head of Facilities	As per strategy	Targets in Strategy met
Estates and Facilities	Introduce recycling collections in line with Simpler Recycling guidance	Sustainability Manager / Head of Facilities	March 2026	Tonnage of waste collected for recycling
Estates and Facilities	Continue to deliver waste segregation training	Sustainability Manager / Head of Facilities	Ongoing	Number of staff trained each year
Estates and Facilities	Produce an Energy management Policy	Sustainability Manager	Dec 2025	Policy in place and approved
Estates and Facilities	Improve energy metering and monitoring across the sites	Sustainability Manager / Head of Estates / Head of Capital	March 2027	Improvements in metering achieved
Estates and Facilities	100% of lighting across the Trusts to be LED and increase the amount of sensor driven lights	Sustainability Manager / Head of Estates / Head of Capital	March 2028	Percentage of lighting that is LED
Estates and Facilities	Ensure that sustainability is integral to the transformation of the NHS estate, as detailed in the GM Estates Infrastructure Strategy	Head of Estates	Ongoing	Considered in all transformation projects
Estates and Facilities	Implementation of a site wide heat decarbonisation project for Tameside Hospital in line with the £14.4 million of PSDS4 funding awarded	Deputy Director of Estate and Facilities / Head of Estates /	March 2028	Project completed
Estates and Facilities	Increase the amount of onsite renewable energy generation	Sustainability Manager / Head of Estates / Head of Capital	March 2028	Amount of renewable energy generation
Estates and Facilities	Implementation of a site wide decarbonisation project for Stepping hill hospital with the aim of connecting to the Stockport Heat Network if commercially viable	Associate Director of Estates and Facilities	TBC	Project completed
Estates and Facilities	Explore the potential to introduce Hydrogen fuel cells at Tameside Hospital	Head of Estates	March 2028	Agreement reached on project
Estates and Facilities	Ensure sustainability is a key consideration on all new build and refurbishment projects delivered	Head of Capital	Ongoing	Considered in all projects as they arise

Climate Change Adaptation

Area of Focus	Action	Lead	Timeframe	Reporting Measure
Climate Change and Adaptation	Production of Climate Adaptation Plan for Greater Manchester with a Trust specific action plan to identify local risks. This will be informed by the GMCA Climate Change Risk Assessment	Sustainability Manager	Dec 2025	Plan produced
Climate Change and Adaptation	Review Major Incident Plans and Business Continuity Plans in line with UK climate projections and extreme weather alerts	EPRR Manager	Annually in line with planned reviews	Annual Update
Climate Change and Adaptation	Review Heatwave plans in line with up climate projections	EPRR Manager	Annually in line with planned reviews	Annual Update
Climate Change and Adaptation	Improve understanding of climate adaptation through training	Sustainability Manager	Dec 2026	Number of staff trained
Climate Change and Adaptation	Ensure the Climate Adaptation is considered in all major redevelopment projects and new builds to ensure building and infrastructure supports adaptation	Head of Capital Projects	Ongoing	Project reports
Climate Change and Adaptation	Identify where nature-based solutions could contribute to climate change adaptation	Head of Capital Projects Sustainability Manager	Ongoing	Solutions Implemented

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Nature for Health

Area of Focus	Action	Lead	Timeframe	Reporting Measure
Nature for Health	Support the delivery of the GMCA Local Nature Recovery Strategy across the NHS estate	Sustainability Manager / Contract Performance Manager / Head of Estates	Annual Update	Actions delivered
Nature for Health	Nature Recovery Ranger to be employed in April 2026 for 2 years to improve access to greenspace and increase engagement with staff, patients, visitors and the community in nature-based activities	Sustainability Manager / Contract Performance Manager / Head of Estates	March 2028	Details of projects delivered
Nature for Health	Look for opportunities to improve biodiversity through new initiatives such as hedgehog houses, swift bricks, wildflowers, composting and the creation of natural habitats.	Sustainability Manager / Contract Performance Manager / Head of Estates	Annual Update	Initiatives introduced
Nature for Health	Look at use of herbicides and pesticides on the hospital sites and seek more environmentally friendly alternatives where possible.	Sustainability Manager / Contract Performance Manager / Head of Estates	March 2027	Environmentally friendly alternatives used
Nature for Health	Work with the local council and voluntary groups to promote access to neighbouring green spaces close to the hospital sites	Sustainability Manager / Contract Performance Manager / Head of Estates	Annual Update	Activity

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Appendix 2 – Divisional Plans on a Page

Appendix 2 provides a plan on a page for each Directorate across Stockport NHS Foundation Trust and Tameside and Glossop Integrated Care NHS Foundation Trust. The plans have been developed in consultation with each of the Directorates to ensure alignment with their Clinical Strategy. The Plans on a page set out how each directorate will contribute to the delivery of Net Zero Clinical Transformation and the timeframes in which this will take place.

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Net-Zero Clinical Transformation – Divisional Plan on a Page - Tameside and Glossop Integrated Care NHS Foundation Trust

Division	Clinical Support Services	Divisional Overview		
Divisional Director	Katherine Cullen		The Clinical Support Services Division manages administration teams, diagnostics, pathology, and pharmacy.	
Principle	Activities	Timescale	Intended outcomes	
Prevention	Implementing an AI solution to evaluate chest x-rays.	Year 1	Improve early diagnosis rates and outcomes for lung cancer.	
Patient Self-Care	Deliver a digital patient portal for patients to view their clinical documentation, and improved utilisation of the existing portal to view appointments.	Years 1-3	Greater empowerment of patients to take control of their own care. Reduction in paper usage Decreased postal and courier emissions Reduced energy use in printing Promotion of digital transformation	
Lean Service Delivery	Improving radiology referral practices from the front door.	Year 1	Reduced demand for scanning.	
	Redesigning the radiology department to improve flow.	Years 2-3	Reduction in length of stay.	
	Utilisation of Community Diagnostic Centre.	Year 1	Reduction in travel demand to acute site.	
	Review clinic start times and introduce ‘golden patient’ on each clinic list to ensure optimisation and reduce delays.	Year 1-2	Improved clinic utilisation.	
	Fully embed the single unit of blood policy for top up transfusions and theatre cases	Year 1	Improved blood utilisation and reduce waste. Reduce transport costs and carbon emissions.	
Low-Carbon Alternatives	Reuse of patient’s own medication from the community in the acute setting.	Years 1-3	Reduction in consumables.	
	Reduction in use of anaesthetic gases, specifically nitrous oxide and entonox	Years 1-3	Reduction in consumables.	
	Transferring to e-referral system Trust-wide.	Years 1-2	Trust-wide reduction in paper consumption.	
	Work with the Health Information team to expand the digital patient information leaflet platform.	Years 1-2	Trust-wide reduction in paper consumption.	
	Review the use of single use tourniquets in phlebotomy.	Years 1-2	Reduction in consumables and plastic waste Lower carbon emissions from manufacturing and disposal. Promote reusable or sustainable alternatives. Financial and environmental benefits.	
	“Oplift” Current MR scanner, instead of fully replacing.	Year 1	Reusing suitable components from the scanner will result in lower carbon footprint, reduced wate and cost.	

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Net-Zero Clinical Transformation – Divisional Plan on a Page - Tameside and Glossop Integrated Care NHS Foundation Trust

Division	Intermediate Tier Services	Divisional Overview	The Intermediate Tier Services Division manages care across community and home settings, as well as the Stamford Unit.	
Divisional Director	Grace Wall			
Principle	Activities	Timescale	Intended outcomes	
Prevention	Proactive, preventative care plans with strong health promotion in respiratory physiotherapy.	Years 1-3	Reduction in acute admission and reliance on secondary care.	
	Pilot Postural Stability classes in the community	Years 1-3	Reduction in falls and readmissions.	
	Stamford Unit working with the Trust Patient Safety team in new initiatives on reducing patient falls and medicines optimisation.	Year 1	Reduction in falls and problematic polypharmacy.	
Patient Self-Care	Targeted campaigns and reasonable adjustments to support patients from minority backgrounds throughout the community rehab service.	Years 1-3	Greater proportion of local residents managing their own conditions.	
Lean Service Delivery	Implement patient-initiated reviews for appropriate patients to aid patient flow through the Community Dietetics service.	Years 1-2	Streamlined care pathways.	
	Develop new pathways for urgent patients to avoid delays in Community Dietetics	Years 1-2	Reduction in urgent admissions.	
	Develop new Crisis Response Service staffing model to accept referrals from General Practice and new pathways.	Year 1	Reduction in demand on acute services.	
	Increasing referrals to the Extensive Care service.	Year 1-2	Reduced ED attendances for those with complex long-term conditions.	
	Develop a one-stop outpatient model to provide speech therapy for Laryngectomy patients	Years 1-3	Streamlined pathways.	
Low-Carbon Alternatives	Liaise with Nutricia and Estates re options to recycle plastic feed and ONS bottles throughout Acute Dietetics.	Years 2-3	Reduction in consumables.	
	Further embed Virtual Ward in GPs and the Acute Trust.	Year 1	Reduced length of stay.	

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Net-Zero Clinical Transformation – Divisional Plan on a Page - Tameside and Glossop Integrated Care NHS Foundation Trust

Division	Medicine & Urgent Care	Divisional Overview	Medicine & Urgent Care is Tameside & Glossop ICFT's second largest division and delivers a wide range of services, including Acute Medicine, Cardiology, Care of the Elderly, Dermatology, Gastroenterology, Palliative Care, Respiratory Medicine, Rheumatology, Stroke & TIA, and Urgent Care (composed of the Emergency Department, Same Day Emergency Care, and the Urgent Treatment Centre).
Divisional Director	Kathryn Gasko Do Carmo		

Principle	Activities	Timescale	Intended outcomes
Prevention	Increasing OT/PT support in Care of the Elderly, including implementing a falls clinic with MDT input.	Years 1-3	Reduction in falls and secondary fractures.
	Explore options for an obesity service to support patients.	Years 1-3	Reducing unnecessary complications from diabetes and supporting rehabilitation in the community.
	Moving CURE smoking cessation programme to within Respiratory medicine, increasing capacity and expertise.	Years 1-3	Reduced 30-day readmissions and increasing number of inpatients quitting smoking.
	Establishing a fracture liaison service.	Years 1-3	Reduction in secondary fractures and admissions.
	Working with PCNs to understand why patients end up in urgent care and develop the out of hospital offer to better meet needs.	Years 1-3	Reduction in ED attendances and non-elective admissions.
Patient Self-Care	PIFU across all specialities.	6 months	Patients can decide when to have their follow-up, based on their needs and with better access to their care, reducing unnecessary hospital trips.
	Implementing pacemaker monitoring at home.	12 months	Enable a hybrid clinic model that will reduce travel to the hospital and empower patients at home.
Lean Service Delivery	Community Diagnostic Centre utilisation.	6 months	Patients undergo their investigations closer to home.
	Community clinics for Diabetes and Dermatology.	12 months	Clinic provision in locally accessible centres will improve attendance rate and patient experience, whilst reducing travel to the hospital site.
	Developing in-house diagnostics for chronic stable angina, including CTCA and cardiac MRI.	6 months	Investigations conducted at the Trust, reducing patient travel to central Manchester.
	Developing a 'one-stop' model in Cardiology and Rheumatology.	6 months	Streamlined patient pathways allowing for same-day investigations, minimising need for further attendances.
	Direct NWS admission to SDEC, including 'trusted assessor model' to increase direct referrals.	6 months	Streamlined pathway, reduced consumables and time spent in ED.
	Digital streaming solutions to facilitate patient streaming in ED.	6 months	Digital transformation to enable patients to be streamed to most appropriate area at the earliest opportunity, therefore reducing consumables and time spent in ED.
Low-Carbon Alternatives	Remote consultation model throughout outpatient activity.	6 months	Improved patient experience, reduced hospital visits and patients are less likely to cancel or not attend their appointment.
	Utilisation of Virtual Ward across all inpatient specialities.	6 months	Effective streaming to VW will relieve pressure on the emergency department and ward capacity, as well as reducing hospital consumables and length of stay.

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Net-Zero Clinical Transformation – Divisional Plan on a Page - Tameside and Glossop Integrated Care NHS Foundation Trust

Division	Surgery, Women & Children (TGICFT)	Divisional Overview	The division provides a diverse range of services both on the Tameside acute site and across the community footprint of Tameside and Glossop. This includes Elective and Emergency Surgery, Maternity Care, Women’s Services, CYP and acute paediatric services
Divisional Director	Zoe Turner		

Principle	Activities	Timescale	Intended outcomes
Prevention	Expansion of family hubs	Years 1-3	Improved health outcomes for children
	Securing increased funding to expand medical, nursing and administrative staff for care for children.	Years 1-3	Help meeting 16 key legislations, standards and guidance supporting CFC statutory responsibilities, thereby improving their health outcomes.
	Developing an integrated service for children and young people with bladder and bowel problems	Year 1	Improved health outcomes for children and young people.
	Progression of a 0-19 ages service in neighbourhood family hubs that provide core services, and ensuring every child has a named health visitor until age 5 years.	Year 1	Reduction of health inequalities in children.
	Developing the role of Health Mentors to deliver quality public health support in Schools	Years 1-2	Improving health outcomes for school children
	Work with ICB colleagues to redesign the pathway for Paediatric Phlebotomy	Years 1-3	
Patient Self-Care	Further Faster Work steams of efficiency	Year 1	Patients can decide when to have their follow-up, based on their needs and with better access to their care, reducing unnecessary hospital trips.
	Increased utilisation of PIFU across all specialties	Year 1	
Lean Service Delivery	Moving maternity services back into the community through GPs and combining midwifery and health visitor appointments.		Places maternity care in the community and reduces travel to the hospital site.
	Expansion of surgical SDEC	Year 1	Streamlined front door pathways.
	Work with primary care and ICB colleagues to revisit referral and follow-up pathways, including conditions that can be treated outside of hospital	Years 2-3	Reduced hospital attendances.
	Implementing a Stock Management system in Theatres	Year 1	More efficient stocking of supplies
	Relocation of diagnostic gynaecology	Year	Remove waste within pathways
	Redesign of triage area	Year 1	Streamlined flow
	Maternity Theatre build	Year 1	Streamlined pathway for EL/NEL C-Sections
Low-Carbon Alternatives	Virtual Ward utilisation, including gynaecology patients.	Year 1	Effective streaming to VW will relieve pressure on ward capacity, as well as reducing hospital consumables and length of stay.
	Introduction of virtual appointments for preop.	Year 1	Reduced travel to hospital site.
	Low carbon inhalers and inhaler recycling scheme	Year 1	Reduce carbon footprint and waste.
	New NICE guidelines rolling out DPI	Year 1	Reduce carbon footprint
	Revisit usage if virtual appointments	Year 1	Reduce unnecessary travel to hospital

Net-Zero Clinical Transformation – Divisional Plan on a Page – Stockport NHS Foundation Trust

Division	Surgery and Critical Care	Divisional Overview	The Division of Surgery is one of the Trust’s largest teams, employing 1,114 WTEs to deliver a wide range of surgical services, covering: Anaesthetics, Critical Car, ENT & Audiology, Gastroenterology, General Surgery, Ophthalmology, Oral Surgery, Orthodontics, Pain Management, Theatres, Trauma & Orthopaedics and Urology.
Divisional Director	Karen Hatchell		

Principle	Activities	Timescale	Intended outcomes
Prevention	Develop bone anchored hearing device (BAHA) service to reduce requirement for follow-up appointments	Years 3-5	Reduce patient travel to hospital Reduce wait times for follow up
	Implement early AHP assessment and treatment within Pain Management services	Years 1-2	Reduce pressure on consultant led pathways Reduce wait times for first appointment Faster diagnosis and earlier intervention
Patient Self-Care	Expand use of PIFU across ENT; Audiology; Gastroenterology; Chronic Pain Management	Year 1	Patients in charge of deciding when to request follow up if needed, reducing unnecessary hospital trips and potential DNAs
	Progress experience-based co-design within Pain Management	Year 1	Enable patient involvement in shaping future change to better meet service user needs and preference, encouraging patient self-management approach
Lean Service Delivery	Develop a one stop clinic model for LUTS within Urology based at Basquil House	Years 3-5	Streamlined service delivery with better patient experience and minimised need for multiple attendances which reduces travel to SFT
	Develop a one stop neck lumps pathway within ENT		Streamlined service delivery with better patient experience and minimised need for multiple attendances which reduces travel to SFT
	Explore increasing referral to community rehab for fractured neck of femur to enable faster discharge within Orthopaedics		Moving care closer to home Reduced length of stay in hospital, supporting better patient flow and patient experience
	Implement a Surgical SDEC model	Year 1	Reduce ED wait times and need for admission, supporting better patient flow Reduce LOS
	Joint Consultant and Audiologist clinics	Year 1	Reduce number of appointments and visits to hospital site
	Implement XprESS sinus surgery to convert more cases from General to Local Anaesthetic	Years 3-5	Reduce LOS
	Develop a joint Robotics Suite at Stockport with opportunities for collaboration with neighbouring trusts	Years 3-5	Reduce LOS Improved patient experience and outcomes
Low-Carbon Alternatives	Explore Wide-Awake Local Anaesthesia No Tourniquet (WALANT) surgery	Year 2	Improved recovery times with reduced LOS Reduced use of general anaesthetic provision
	Reduce high environmental impact medications and IV therapy	Year 1	Reduced contribution to annual carbon production
	Greater use of virtual appointments in Ophthalmology and Orthoptics	Year 1	Reduced wait times Reduced number of patient hospital visits
	Continue to deliver innovative electronic pain management programme (ePMP)	Year 1	Reduced number of patient hospital visits Increased access to support
	Adapt Virtual Fracture Clinic to improve operational and financial sustainability	Year 1	Reduced number of patient hospital visits Reduced wait times
	Explore opportunities to further reduce FU appointments through MyRecovery App	Year 1	Reduced number of patient hospital visits Empower patients to self-manage recovery
	Expand the use of robotic surgery within Urology to include: female urology; urethral reconstruction; kidney surgery.	Years 3-5	Reduced emergency readmissions within 30 days Reduced LOS
	Invite Andrologists from MFT to regular session at Stepping Hill as part of erectile dysfunction clinic to support current nurse led service	Years 3-5	Reduced travel for patients

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Net-Zero Clinical Transformation – Divisional Plan on a Page - Stockport NHS Foundation Trust

Division	Clinical Support Services	Divisional Overview	The Clinical Support Services division was established in October 2022 bringing together diagnostic and support services from the other operational divisions.
Divisional Director	Mike Allison		The division has 911 staff and an expenditure budget of £46m to deliver the following services across five main areas of radiology, endoscopy, pathology, pharmacy and patient access. As support services, the teams work closely with all of the other Divisions from booking people into appointments, to diagnostics testing, providing test results, dispensing medication to ensure a smooth patient journey through their hospital care.

Principle	Activities	Timescale	Intended outcomes
Prevention	Implementation of Bowel Cancer Screening Lists	Years 1-2	<ul style="list-style-type: none"> • Increased chances of early diagnosis and treatment • Reduced waiting times for direct access to investigation
Patient Self-Care	Enhance patient centred care within Pharmacy by implementing self-administration of Medicines	Years 1-2	<ul style="list-style-type: none"> • Greater patient control over medication • More timely administration of drugs • Strengthening patient knowledge of appropriate use of medication
	Continue to promote PIFU as an option for outpatient pathways	Years 1-2	<ul style="list-style-type: none"> • More control for patients over their outpatient pathway
Lean Service Delivery	Community Diagnostic Centre implementation and expansion	Years 1-2	<ul style="list-style-type: none"> • Reduced wait times for investigations which take place closer to home
	Within Pathology, centralise specialist test referrals to remain within Greater Manchester	Years 1-2	<ul style="list-style-type: none"> • Ensuring focus and delivery of processes is localised • Reduction in travel and transportation.
	Pacemaker MR service provision on site.	Years 1-2	<ul style="list-style-type: none"> • Reduction in patient transfers and travel time off site • Decreased length of stay in hospital
	Explore Lung BPTP and maintain prostate BPTP.	Years 2-3	<ul style="list-style-type: none"> • Reduction in patient transfers • Decreased length of stay in hospital
	Explore opportunity for direct access colonoscopy	Years 1-2	<ul style="list-style-type: none"> • Faster access to treatment with reduced waiting times
	To collaborate with Partners across GM to determine possibility of joint working on ERCP Pathway	Years 2-3	<ul style="list-style-type: none"> • Reduced wait times and improved patient flow
Low-Carbon Alternatives	Increase in-house reporting within Radiology including MR service	Years 5-10	<ul style="list-style-type: none"> • Reduction in patient transfers • Decreased length of stay in hospital

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Net-Zero Clinical Transformation – Divisional Plan on a Page - Stockport NHS Foundation Trust

Division	Medicine and Urgent Care	Divisional Overview	Medicine & Urgent Care is the Trust's largest Division, employing 1,025 WTEs to deliver care across 11 specialities including: Acute Medicine & Frailty; Cardiology; Diabetes & Endocrinology; Haematology; Older People & General Medicine; Oncology; Respiratory Medicine; Rheumatology; Stroke and Urgent Care.	
Divisional Director	Ruth McNulty			
Principle	Activities	Timescale	Intended outcomes	
Prevention	Improved collaboration with primary care across Cardiology, Respiratory, Rheumatology and Haematology services, including masterclasses to enhance the quality GP information	Year 1	Reduced unnecessary referrals and travel to hospital site Delivery of care closer to home	
	Maintain Christie Hotline for out of hours advice to Stockport Chemotherapy patients	Year 1	Reduced patient travel to hospital site for advice Faster route to advice, prevent urgent concerns becoming more serious	
	Meet national care standards for the Stroke service including CTA performed within 15 minutes to enhance patient outcomes and need for longer term hospital intervention	Years 2-3	Reduced length of stay	
	Provide more Holter monitors for patients to identify and manage AF post stroke	Years 2-3	Reduced incidence of recurring strokes and repeat hospital attendance/admission	
Patient Self-Care	Expand use of PIFU across the division	Year 1	Patients in charge of deciding when to request follow up if needed. Reduced unnecessary hospital trips and potential DNAs	
	Embed Diabetes TYA project informed by patient co-production enabling more flexible access to support for long-term condition	Years 1-2	Empower greater self management and diabetes education to prevent emergency admission/development of long-term health complications	
Lean Service Delivery	Strengthen the Lymphoma pathways within Haematology through collaborative working with specialities	Years 1	Faster diagnosis and treatment Reduced wait times	
	Offer community spirometry for Respiratory patients through the Community Diagnostic Centre	Years 1-3	Reduced wait times for diagnosis/treatment	
	EBUS and CPET on site for Respiratory Services, also developing Pleural procedure room into a formal elective day case list.	Years 1-3	Reduced length of stay Reduced number of patient journeys during diagnosis and treatment Faster route to diagnosis and treatment	
	Review accommodation at the Devonshire Centre to support clinical need of patients accessing acute frailty service	Years 1-2	Reduced delayed discharges and LOS, moving patients closer to home quicker	
	Redesign pathway for MPN patients within Haematology – bloods prior to appointment and timeliness of prescriptions	Year 1	Faster route to diagnosis and treatment	
Low-Carbon Alternatives	Develop virtual ward pathways to support early discharge for the Acute Medicine and Frailty service	Years 1-2	Reduced length of stay	
	Virtual clinics for Cardiology	Years 1-3	Reduced number of patient hospital visits Reduced wait times	
	Roll-out use of Rheumatology patient information application	Years 1-3	Reduced printing	
	Trial app for self-reported 6-monthly arthritis disease activity score within Rheumatology	Years 1-3	Reduced patient travel to hospital site Reduced wait times for diagnosis	
	Stroke Service to use E-patch to identify AF	Year 1	Reduced patient travel to hospital site Reduced wait times for diagnosis	

Net-Zero Clinical Transformation – Divisional Plan on a Page - Stockport NHS Foundation Trust

Principle	Activities	Timescale	Intended outcomes
Division	Integrated Care (SFT)	Divisional Overview	
Divisional Director	Jane Ankrett	Integrated Care employs 870 whole time equivalent (WTE) staff to provide a diverse range of services including: community nursing; specialist community services, integrated therapy services, discharge to access and administrative services (clinic receptions and single point of access). Community care is delivered across multiple health centres in Stockport, as well as in care homes and in peoples' own homes. Integrated Care supports people with acute care needs, long-term conditions, moderate to severe frailty and those recovering from surgery to prevent hospital admissions and recover at home, achieving their optimum rehabilitation and reablement potential.	
Prevention	Implementation of frailty end-to-end pathway for T&O service users. Closer working partnerships with Stockport Community Services to improve the prevention agenda	Years 1-2	Early identification and intervention to prevent admissions
	To re audit COPD caseload to reflect the identified shift from COPD early supported discharge to more acute management in the community	Year 1	Admission avoidance Keeping care in the community Reduction in need for patient travel to hospital site
	Adapt cardio renal metabolic pathways in line with national diabetes guidelines	Years 1-3	Reduced risk of complications with early interventions
	Strengthen links with primary care and upskill GP, PN and other relevant health care staff to manage diabetes care at primary care with regular education sessions and mentorship for primary care staff	Year 1	Strengthen primary care support and prevent the need for secondary care intervention Keeping care within community setting to avoid patient travel to hospital site
	Assessment of suspected heart failure patients with a BNP > 2000 by ECHO and with HF review within 2 weeks	Year 1	Early identification and intervention
	Quality improvement project for follow up of patients with preserved Ejection (approximately 40% of Heart Failure admissions)	Year 1	Early identification and intervention Readmission avoidance
	To develop FEES service further through training of staff and explore the initiation of an Outpatient FEES service	Years 1-3	Facilitate care without needing inpatient admission, keep patients at home
	To collaborate with ENT for a joint Voice clinic with Specialist Speech and Language Therapist to support tailored therapy through diagnostic assessment and meet best practice guidance.	Year 1	Early intervention and reduced number of appointments via multidisciplinary appointment
	To enhance the first contact therapy input for patients presenting to the urgent care setting with MSK conditions, to reduce system pressures on outpatient therapies if self-management can be achieved successfully.	Year 1	Early identification of malnutrition and intervention to reduce risk of further complications
	Establish nutrition assessment and intervention at the front door by enhancing awareness and support in Emergency Department of malnutrition.	Years 2-3	Early identification of malnutrition and intervention to reduce risk of further complications
Patient Self-Care	To ensure a Home First ethos is adopted by all inpatient therapy staff through induction, trusted assessor training and a robust rolling in-service training programme.	Years 1-3	Faster discharge that empowers patient to self-manage at home quicker
	Develop expert patient steering group to enhance patient co-collaboration and incorporation of feedback within Diabetes service	Years 1-3	Patient coproduction of services to increase engagement and opportunity for self-care
	Review of referral pathways into MSK Physiotherapy, including the development of a self-referral pathway.	Year 1-2	Empower patients to directly refer for care
	OP Therapies: Develop and implement strategic plan for the Hydrotherapy service, including scoping the potential to move the service into a community setting	Years 1-3	Moving care closer to home Reduction in travel to hospital site
	Review and further develop rehab and preventative pathways for discharge services, including use of self-care and self-based models – eg. re-design of D2a/ICaH / ACTT pathways in conjunction with UCR and OOA SPOA (Tameside) and co-location of community therapy teams.	Year 1-2	Empowering patient self-care
	Discharge team collaboration with stakeholders including: ACTT to develop self-management process/ tools; REACH to support self-management and referrals from neighbourhood services; ASC to support with flow of patients for appropriate packages of care in a timely manner.	Year 1-3	Promoting patient self-management care model Promoting person-centric approach of care delivered at the right place, time and by the right person
	New enteral feeding contract to be established with a plan to increase patient/care agency ownership and responsibility.	Years 1-3	Empowering patient self-management and autonomy
Lean Service Delivery	Implementation of frailty end-to-end pathway for MSK and OP services. Closer working partnerships with other Stockport Community Services to enhance care for patients living with frailty and also improve the prevention agenda.	Year 1	Streamlined route to timely, specialised care
	Complete service review of the current pelvic health physiotherapy offer to include an integrated model and implementation of GM standardise Perinatal Pelvic Health Pathway (PPHS) for women to access first line conservative care within specialist physiotherapy services, from pregnancy to 12 months postnatally.	Year 1	Improved access
	Develop process for Pathway Two patients to be triaged and discharged within 48 hrs	Year 1	Faster discharge and route home Reduced length of stay
	Podiatry: Input into the project around harmonising podiatry services across Manchester and Trafford Local Care Organisations.	Years 2-3	Coordination of services regionally Reduced duplication
	To maximise service delivery to adopt a 24-hour rehab approach across stroke pathways. Collaborative working with community neuro rehab services to support patients into the community as soon as possible	Years 1-2	Reduced length of stay
	To create and employ standardised and effective direct pathways from the Emergency Department to Community Services.	Years 1	Reduced length of stay

Net-Zero Clinical Transformation – Divisional Plan on a Page - Stockport NHS Foundation Trust

Division	Integrated Care (SFT)	Divisional Overview	Integrated Care employs 870 whole time equivalent (WTE) staff to provide a diverse range of services including: community nursing; specialist community services, integrated therapy services, discharge to access and administrative services (clinic receptions and single point of access). Community care is delivered across multiple health centres in Stockport, as well as in care homes and in peoples' own homes. Integrated Care supports people with acute care needs, long-term conditions, moderate to severe frailty and those recovering from surgery to prevent hospital admissions and recover at home, achieving their optimum rehabilitation and reablement potential.	
Divisional Director	Jane Ankrett			
Principle	Activities	Timescale	Intended outcomes	
Low-Carbon Alternatives	Identify and optimise referral pathways into the UCR and VW through the UEC Single Point of Access, including new pathway for care of males with acute urinary retention	Years 1-2	Reduction in travel to hospital site instead delivering care at home, with trajectory of 50 beds occupancy met over the 12months	
	Improve digital connectivity for Community Enhanced Clinical Practitioners to enable real-time consultations using EMIS Web in patients' homes	Years 1-2	Delivery of care in the community, reduced need for patient travel to hospital site	
	Within Community Admin, implement hybrid mail to reduce stationary costs and support efficiencies.	Year 1-2	Reduced stationary will support reduce carbon production and waste	
	Explore a 'Bladder and Bowel Service' (BABS) which incorporates trial without catheters (TWOCs)	Years 2-3	?reduction in use of catheters	
	To reduce unused oxygen equipment holdings within patient properties	Year 1	Reduction in energy/maintenance equipment?	
Maintain the sustainability walking aid project, improve collection rates of walking aids and the percentage recycled back into circulation	Years 1-3	Promoting recycling to reduce waste of walking aids		

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Net-Zero Clinical Transformation – Divisional Plan on a Page - Stockport NHS Foundation Trust

Principle	Activities	Timescale	Intended outcomes
Prevention	Develop Women Health Hubs and deliver masterclasses for patients with certain conditions	Years 1-3	Increased delivery of care in the community, reducing patient travel to hospital site
	Maternity Service workplans to align to local population priorities and deprivation index	Years 1-3	Address health inequalities and deliver intervention to more excluded groups, in turn reducing the number of patients developing service health needs
	To develop neonatal outreach	Years 1-3	Increased accessibility Reduced patient travel to hospital site?
	Develop a framework for the prevention and early identification of Foetal Alcohol Syndrome Disorders (FASD) including a clear Alcohol Exposed Pregnancies pathway.	Year 1	Increased access to care Faster diagnosis and treatment
	Develop a robust Mental health team, which includes an ADHD nurse specialist, as well as a dedicated Children's mental health practice educator	Year 1	Increased access to care Faster diagnosis and treatment
	Focus work towards improving school attendance, ensuring a multidisciplinary approach to this including primary care and working to the new attendance strategy in the LA	Year 1-2	Increased early intervention in the community
	To deliver interventions to address the increasing teenage pregnancy rate in Stockport	Year 1	Earlier intervention to reduce overall numbers of teenage pregnancy
Patient Self-Care	Expand use of PIFU and advise and guidance for Gynaecology service	Years 1-3	Empower patients with the autonomy to initiate follow up when needed. Reduced unnecessary hospital visits to hospital site.
	Therapy services to be available in family hub/place based with link therapists to ensure easier access for all to support tackling inequalities	Years 1-3	Improved access closer to home. Reduced patient travel to hospital site.
Lean Service Delivery	Business case for SDEC service model emergency gynaecology in line with NHS England guidance and internal clinical review expectations	Years 1-3	Increased access with faster route to assessment and treatment. Reduced risk of more serious complications. Reduced length of stay as a result.
	Develop a one stop ovarian pathway	Years 1-3	Reduced number of patient visits to hospital site by combining within a single appointment.
	Implement a walk-in walk out (WIWO) model in paediatrics	Year 1	Reduced length of stay

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Net-Zero Clinical Transformation – Divisional Plan on a Page - Stockport NHS Foundation Trust

Division	Women and Children's	Divisional Overview	The Women and Children's Division employs 720.71 whole-time equivalent staff to deliver a wide range of services both in hospital and in the community, including Maternity Services; Neonatal Care; Health Visiting; Paediatrics and Obstetrics & Gynaecology. We have dedicated paediatric facilities in the Tree House Building, and women's health services in the Jasmine Unit. Community services are delivered across the community in a range of community hubs, neighbourhood clinics, GP Practices, schools and people's homes. Services are modelled around the life cycle to meet the changing health needs of women and children at different points throughout their lives.
Divisional Director	Janine Cartner		

Principle	Activities	Timescale	Intended outcomes
Low-Carbon Alternatives	Review the opportunity to offer a Hysteroscopy service under sedation, delivered in Maple Suite.	Years 1-3	Reduced use of general anaesthetic provision Reduced length of stay
	Expand the use of robotic surgery for gynaecology	Years 1-3	Reduced length of stay?
	Digital solution for Maternity records	Years 1-3	Reduced use of paper/printing
	To continue to roll out the early years app after success full pilot so parent can access support and complete assessments of their child's development, only requiring home visits where required	Years 1-3	Reduced use of paper Reduced patient and family travel to hospital site Reduced staff travel for home visits
	To work with outpatient bookings team to digitalise appointment letters and reminders to support DNA rates for 0-19 nursing service	Years 1-3	Reduced use of paper

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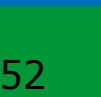
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Stockport

NHS Foundation Trust



Tameside and Glossop
Integrated Care

NHS Foundation Trust



				Agenda No.	13
Meeting date	7 August 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 an Alert, Advise & Assure 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 June and July 2025, noting areas of alert, advice and assurance.

ALERT, ADVISE & ASSURE (AAA) REPORT

Name of Committee/Group	Quality Committee
Chair of Committee/Group	Louise Sell, Non-Executive Director
Date of Meeting	24 June 2025 and 22 July 2025
Quorate	Yes

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

<p>1. Agenda</p>		<p>In June, the Committee considered an agenda which included the following:</p> <ul style="list-style-type: none"> • Board Assurance Framework 2025/26: Draft Principal Risks • Paediatric Audiology Service Update • CQC Update Report • Quality Strategy Progress Report • Quality & Safety Integrated Performance Report • Newly Progressing and Newly Developed CIP High Level Plans • Annual Research, Development & Innovation Report 2024/25 • Annual Health & Safety Report • Clinical Audit Annual Report 2024/25 and Forward Programme 2025/26 • Annual Infection Prevention Control Report 2024/25 • Standing Subgroup Alert, Advise & Assure Reports: <ul style="list-style-type: none"> - Patient Safety Group - Patient Experience Group • Revised Quality Committee Work Plan & Attendance 2025/26 <p>In July, the Committee considered an agenda which included the following:</p> <ul style="list-style-type: none"> • Matters Arising: <ul style="list-style-type: none"> - Paediatric Audiology – Update regarding exit criteria • Learning from Deaths – Q4 • Trust Health Inequalities Report • Quality & Safety Integrated Performance Report • Newly Progressing and Newly Developed CIP High Level Plans • Annual Complaints Report • Annual Safeguarding Report • Standing Subgroup Alert, Advise & Assure Reports: <ul style="list-style-type: none"> - Trust Integrated Safeguarding Group - Patient Safety Group - Patient Experience Group - Clinical Effectiveness Group • Quality Committee Work Plan & Attendance 2025/26
<p>2. Alert</p>	<p><i>Curtis Soile 07/08/2025 06:56:20</i></p>	<ul style="list-style-type: none"> • Paediatric Audiology Service Update <p>In June the committee received assurance that the Chief Nurse is engaged with the Integrated Care Board (ICB) and regional colleagues in resolving this issue. Achievement of the national standards requires investment and a request to allow the expenditure is with the ICB. A request has gone to the ICB for clarity on the exit criteria from the pause to referrals. Arrangements are in place for a</p>

		<p>response to urgent referrals at another provider and communication has gone to GPs to direct routine referrals elsewhere. Support is being given to the team in terms of professional development and well-being. 1700 people remain on our list, consisting of follow up and new non-urgent referrals received before the list closed. 400 cases need to be reviewed by another provider. To date 30 have been completed. Harm is assessed according to NHSE harm guidance. This process identified 14 children where there was a level of harm and 16 where there was no harm. Children who have suffered harm are being supported via schools, specialist voluntary sector agencies and speech and language therapy (SLT). Further work is ongoing to assess the increased demand on SLT as this cohort of children grow up. Duty of Candour has been applied in all cases. The committee requested an update on progress with the actions to resolve the issue, to identify and to mitigate the harm. The committee recognised and sincerely regret the significant impact on this cohort of children.</p> <p>In July some elements of the service had been restarted but the exit criteria to fully restart the service were still awaited, the request for funding of a senior post had been rejected and only a further 3 children had undergone a harm review. The committee recommended that the Board receive an update at its next meeting, which includes a risk / benefit assessment of the full range of options available to us as an organisation to make acceptable and timely progress on this matter.</p> <ul style="list-style-type: none"> • Annual Research, Development & Innovation Report 2024/25 The committee received this report which gave a clear account of excellent work in delivering good quality and clinically relevant research activity. However the committee noted significant red flags including high levels of long term sickness and dependence on commercial and research network funding to maintain the team. There is a need for tangible organisational support to ensure our research activity remains resilient. The committee recommend that further work is undertaken to enable collaboration between SFT and T&G within the Trusts' strategic collaboration. • Quality & Safety Integrated Performance Report and Quality Strategy Progress Report Pressure ulcers remain an area of under-performance. The committee heard that this remains a focus in the current quality strategy and that a programme of work is underway focussing on cultural attitudes, nutrition and hydration, community services and support to care homes. • Quality & Safety Integrated Performance Report The committee noted the ongoing pressure on bed occupancy and the plans to replace commissioned discharge to assess beds with a spot purchasing arrangement. The committee refers this to the Finance & Performance Committee and notes that this position will inform our winter planning process.
<p>3. Advise</p>	<p>Curtis Soile 07/08/2025 06:56:20</p>	<ul style="list-style-type: none"> • Annual Infection Prevention Control Report 2024/25 The committee noted the ongoing work to prevent and manage outbreaks of infection. The committee discussed the unhelpfully low rates of flu and covid vaccination in the community and in staff groups. We are engaged with public health colleagues and await national guidance on vaccination protocols. The committee requested that we take an active approach in Stockport on all fronts, starting as soon as possible, given what is known about vaccination clinical effectiveness in reducing morbidity and mortality and about cost effectiveness of

		<p>vaccination. The committee has requested an update and has referred the staff ambition to the People Performance Committee. The committee has agreed changes to the monthly reporting of infections to increase the visibility of our performance against the new improvement trajectory. Rates of E Coli infection are above target and improvement is expected from implementation of a new urinary catheterisation policy.</p> <ul style="list-style-type: none"> • Board Assurance Framework 2025/26: Draft Principal Risks The committee reviewed the document and welcomed the amendment to separate safety, experience and effectiveness. The target risk scores were confirmed after discussion and the committee requested some redrafting to ensure gaps in controls or assurance were matched with actions and vice versa. • Trust Health Inequalities Report The committee noted ongoing work to progress the action plan. Much of the work revolves around ensuring that operational teams have the correct data to drive decision making and that Board has visibility of this. The group will align the use of data with that available from GM. There is a need to ensure the health inequalities work continues to be led at an executive level and to have the right resource to play our part alongside partners, in the reduction of health inequalities. • Annual Complaints Report The committee noted a maintenance of response rates despite increased activity. There was comprehensive analysis of themes and a planned action by the deputy director of nursing and deputy medical director to improve communication about treatment. The committee agreed changes to the monthly reporting and requested further information about the organisational response to this rich source of information. • Quality & Safety Integrated Performance Report Performance remains below target for antibiotic administration. The committee received assurance that no harm had occurred and noted that the transformation work continues. • Standing Subgroup Alert, Advise & Assure Reports: <ul style="list-style-type: none"> - Patient Safety Group reported that noise at night remains an issue and the committee requested that consideration is also given to the use of headphones with patient entertainment systems.
<p>4.</p>	<p>Assure</p>	<ul style="list-style-type: none"> • CQC Update Report The committee were assured that we have good systems and processes to manage CQC requests and engagement. There were no matters not already covered in our workplan. • Annual Health & Safety Report The committee commended the clarity of this report along with the evidence of year on year improvement in our compliance with health and safety requirements. Notwithstanding the risk to health and safety which arises from our aging estate, this report provides assurance about the monitoring and preventative processes which are within our control.

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		<ul style="list-style-type: none"> • Clinical Audit Annual Report 2024/25 and Forward Programme 2025/26 The committee noted this comprehensive report and paper which gives good assurance about our audit programme which is focussed on national requirements / expectations and local work linked to the agenda of this committee. • Annual Safeguarding Report The report gives assurance about our compliance with statutory responsibilities and a comprehensive account of a broad range of activity. We continue to engage actively as an organisation to mitigate unintended adverse consequences from the GMP "Right Care Right Person" initiative. We engage in system reviews leading to learning and improvement. • Learning from Deaths – Q4 The committee remains assured that we have a robust process and that themes identified are addressed through the appropriate governance routes. • Quality & Safety Integrated Performance Report Our mortality data continues to report a positive benchmarked position. • Quality Impact Assessment deep dive In July the committee received two newly progressing schemes and was assured about the rationale for the decisions made.
5.	Referral of Matters/Action to Board/Committee	<p>Audiology - The committee recommended that the Board receive an update at its next meeting, which includes a risk / benefit assessment of the full range of options available to us as an organisation to make acceptable and timely progress on this matter.</p> <p>Vaccination - The committee has referred the request for assurance that we have active, early and local forward planning to improve vaccination rates to the People Performance Committee.</p> <p>Patient flow - The committee has referred the ongoing pressure on bed occupancy and the plans to replace commissioned discharge to assess beds with a spot purchasing arrangement to the Finance & Performance Committee, requesting that this committee seeks assurance about the adequacy of provision.</p>
6.	Report compiled by:	Dr Louise Sell (Chair of Quality Committee / Non-Executive Director)
7.	Minutes available from:	Mrs Soile Curtis (Deputy Company Secretary)

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Stockport NHS Foundation Trust

Meeting date	7 August 2025	X	Public	Confidential	Agenda item
Meeting	Board of Directors				14
Title	Learning from Deaths Annual Report: 2024 to 2025				
Lead Director	Andrew D. Loughney Medical Director	Author	Suzy Collins Learning from Deaths Lead		

Recommendations made/ Decisions requested

The Board of Directors is invited to receive this report on activity around Learning from Deaths in the Trust, to note the processes that the Trust has in place that allow it to learn from deaths, to consider whether the actions arising from that process have been appropriate and thereby to take assurance.

This paper relates to the following Corporate Annual Objectives

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

The paper relates to the following CQC domains

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

This paper is related to these BAF risks	X	PR1.1	There is a risk that the Trust delivers sub-optimal quality services and fails to meet regulatory standards
	X	PR1.2	There is a risk that the Trust fails to reduce harm against agreed baseline
		PR1.3	There is a risk that patient flow plans are not effective leading to decline in &E performance
		PR1.4	There is a risk that inclusive restoration plans to address elective backlog are not delivered
		PR2.1	There is a risk that the Trust fails to support and engage its workforce
		PR2.2	There is a risk that the Trust's services do not reliably support neighbourhood population health and future care needs
		PR3.1	There is a risk that effective partnership & accountability arrangements are not in place at ICS and locality provider level
		PR4.1	There is a risk that there is insufficient capacity and capability to deliver Trust, locality and system wide transformation
		PR5.1	There is a risk that robust plans to recruit, train and retain the right staff to meet service needs are not implemented
		PR5.2	There is a risk that the Trust does not deliver the Equality, Diversity & Inclusion Strategy
		PR6.1	There is a risk that the Trust fails to deliver its agreed 2021/22 financial position
	PR6.2	There is a risk that the Trust fails to develop a multi-year financial recovery plan to secure financial sustainability	
	PR7.1	There is a risk that the estate is not fit for purpose and does not meet national standards	

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

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

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

With respect to process:

- Around 32% of all in-hospital deaths received a review in this last year.

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

- The over-investigation of some dying patients impeded the provision of high quality care.
- An increasing number of deaths taking place in the Emergency Department was noted, possibly relating to difficulties with patient flow throughout the organisation but more particularly because of an inappropriate transfer into hospital for some patients at the end of their life.
- Poor documentation was an acknowledged theme, albeit not apparently directly affecting the quality of patient care or clinical outcomes.

The responses to these issues have been described in the body of this report.

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1 Purpose

- 1.1 The purpose of this annual report is to provide assurance to the Board of Directors around the Learning from Deaths function of the Trust
- 1.2 The report therefore outlines the Trust's Learning from Deaths process, presents the high level themes identified during the last quarter and describes the Trust's response to those findings. Current benchmarking data are also provided to add context to the report.

2. Background and Links to Previous Papers

- 2.1 The Trust's Learning from Deaths policy is based on the recommendations of the National Quality Board (2017). The purpose of the process is to ensure that opportunities are taken to learn from the care received by patients dying in the Trust so that actions can be taken to improve the quality and safety of patient care.
- 2.2 The Trust uses a data collection form based on the Structured Judgement Review (SJR) methodology, which is published in conjunction with the National Mortality Case Record Review programme.
- 2.3 Cases are selected from a number of sources including: deaths where families, staff or the Medical Examiners have raised concerns, maternal deaths, surgical deaths, paediatric deaths, deaths from the LEDER programme, deaths in critical care, theatres or recovery, deaths in the Emergency Department, cardiac arrest deaths and deaths due to epilepsy, asthma or diabetic ketoacidosis.
- 2.4 Additional cases can be added if capacity allows and/or following an extraordinary event.
- 2.5 In keeping with national guidance, all reviewed deaths are graded according to the following scheme, based on the opinion of the reviewer:

Outcome 1: Evidence of serious failings in care, which are likely to have affected the outcome – these are all referred for a second opinion from the Trust LFD Lead and if confirmed are escalated to the Serious Incident Review Group for consideration of formal detailed investigation.

Outcome 2: Evidence of suboptimal management unlikely (on the balance of probabilities) to have affected outcome – referred for departmental M&M review.

Outcome 3: Satisfactory care, no lessons to be learned – no further action.

Outcome 4: Exemplary management – feedback to team.

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

- 2.7 Where changes in practice are thought to be worth considering following publication of this quarterly report, the relevant bodies are informed via the Patient Safety Group (eg) advice may be given to the Transformation Team or the originating Division.

- 2.8 The Mortality Review Group also provides data and leads discussion at the Deteriorating Patient Group meeting monthly and provides the Patient Safety Group with a quarterly report for consideration.
- 2.9 The Quality Committee receives a quarterly report on LFD activity in the Trust and has the ability to escalate any concerns to the Board via AAA reporting mechanisms.
- 2.10 A Learning from Deaths Newsletter is produced and circulated widely across the Trust to promote learning and findings are also considered and disseminated at divisional level. The last newsletter was published in May 2025.

3. Matters under consideration

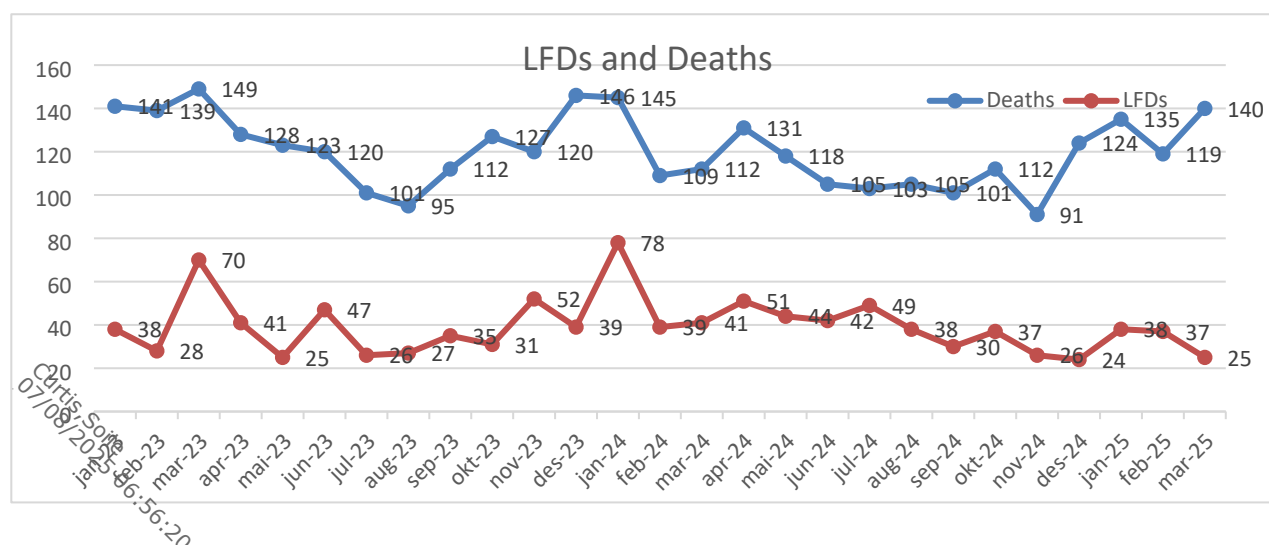
3.1 Regarding SHMI and HSMR:

The Summary Hospital-level Mortality Indicator (SHMI) is the ratio between the actual number of patients who have died following hospitalisation in the Trust and the expected number on the basis of average figures for England, given the characteristics of the patients treated in the Trust. It includes data from patients within 30 days of discharge. The SHMI at SFT is better expected.

The Hospital Standardised Mortality Ratio (HSMR) is the ratio between the actual number of patients who have died in hospital in the Trust and the expected number using a limited basket of 56 diagnoses, which are known to account for around 80 % of hospital deaths. The HSMR at SFT is slightly better than expected.

3.2 Regarding Trust processes:

There were 438 LFD report completions from 1384 deaths (31.6%) in the year to March 2025. The following graphs shows the number of reviews month by month since January 2023.



3.3 Regarding clinical practice:

3.3.1 In the currently reported year the outcome judgements were as follows across the Trust:

Outcome 1	x0
Outcome 2	x53
Outcome 3	x339
Outcome 4	x46.

Several themes were highlighted and responded to throughout the year:

3.3.2 In one quarterly report it was noted some patients continued to receive investigations such as blood tests and CT scans inappropriately as the end of life approached. This was seen as having a negative impact upon quality of care, as well as being a poor use of hospital resources.

3.3.3 In another quarterly report it was noted that if a patient had recently undergone a surgical procedure, there was a reluctance amongst clinical staff to acknowledge that the end of life may be approaching for the patient and to move them onto a palliative care pathway.

3.3.4 The need to acknowledge that the end of life is approaching for some patients and to tailor care appropriately became the theme of several newsletters and educational events in the Trust during the course of the year. In addition, the Patient Safety Group has commissioned a deep dive into the Trust's end of life care provision, to determine whether the opportunities for clinically appropriate end of life care discussions are taking place in a timely manner throughout the organisation. This will be reported through to the Patient Safety Group before the end of the calendar year 2025.

3.3.5 Some areas of poor documentation were highlighted during the year.

3.3.6 The documentation around DNA-CPR was one such area of scrutiny, with variable practice being noted. LFD reviewers recognised that although any agreed DNA-CPR should be formally documented in a patient's notes by a senior clinical decision maker at the earliest opportunity, that 'earliest opportunity' step did not always seem to be adhered to.

3.3.6 In addition, the communication of a DNA-CPR decision was not always communicated clearly and rapidly to the whole team looking after the patient.

3.3.7 Finally around documentation, several LFD reviewers commented upon the poor standard of handwriting in some of the medical notes and poor documentation around the identification of attending clinicians during various clinical reviews.

3.3.8 These documentation shortfalls have been communicated throughout the Trust. They are also the subject of continued work on the Trust's clinical audit forward plan and the Trust's Deteriorating Patient Group is considering how best to improve performance in this area, beyond the educational elements that have already been delivered.

3.3.10 Improved clinical documentation is also a key feature of the Trust's current EPR programme.

3.3.9 In an additional theme, the care of dying patients in the Emergency Department raised some concerns during the year. It was found, for example, that some patients were having to wait for a long time in the Emergency Department for a bed on the wards to be made available, following a decision to admit. Delays in specialties taking responsibility for those patients was apparent, leading to delays in transfer and delays in clinical decision making.

3.3.12 In response, the Trust produced a set of standards in which the expectations of each specialty have been set out. These define the point at which the specialty should take ownership of a patient's care and are resulting in earlier specialist advice and intervention being achieved for patients having an acute admission to hospital.

3.3.13 LFD reviewers also felt that more patients were dying within the Emergency Department than has been the case in previous years, rather than in a more peaceful and appropriate setting. Although poor flow through the hospital was a contributing factor, inappropriate transfer of dying patients into the hospital setting from their own homes or care homes was also highlighted in some cases.

3.3.14 The work of the Stockport-wide and Trust-specific mortality review groups therefore continues to focus on the delivery of care at the end of life that complies with the patient's wishes. This includes reducing unwarranted transfers into hospital for some dying patients.

3.3.15 Additional learning from the LFD process can be found in previous quarterly reports that have been presented to the Quality Committee over the last year.

4 **Areas of Risk**

4.1 Although the Trust's mortality ratios have improved markedly in this last year, the need for continued focus is acknowledged.

4.2 Whilst trying to improve the quality of care provided people who are known to be approaching the end of their life, there must be no let-up in the drive to maintain or improve the wider standards of care the Trust provides so that there is no resurgence of Outcome 1 events.

5 **Recommendations**

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

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				Agenda No.	15
Meeting date	07/08/2025	Public	X	Confidential	
Meeting	SFT Board of Directors				
Report Title	Integrated Safeguarding Team Annual Report 2024/25				
Director Lead	Nic Firth Chief Nurse Executive Lead for Safeguarding	Author	Mags Deakin Head of Safeguarding		

Paper For:	Information	Assurance	Decision
Recommendation:	The Board is asked to note the contents of the Integrated Safeguarding Annual Report for 2024/25 and support the continued prioritisation of safeguarding across all areas of strategic and operational delivery.		

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		Use of Resources

This paper relates to the following Board Assurance Framework risks

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

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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
	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

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

Executive Summary

This report provides an overview of safeguarding activity across the organisation during the reporting year, highlighting key achievements, areas of focus and ongoing challenges in meeting statutory and regulatory safeguarding responsibilities.

Key highlights include:

- Compliance with revised safeguarding contractual standards, following national updates.
- Increased safeguarding training compliance across staff groups, with targeted improvements in identified areas
- Implementation of revised referral pathways aligned with local safeguarding partnerships and national best practice
- Enhanced oversight of complex safeguarding concerns through improved multi-agency collaboration and internal governance.
- Contribution to learning reviews and safeguarding audits to inform service improvement and mitigate risk.

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Stockport
NHS Foundation Trust

Safeguarding Annual Report



April 2024 – March 2025

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Foreword

Safeguarding is at the heart of everything we do. It is our shared responsibility to protect the most vulnerable members of our communities - children, young people and adults at risk, from harm, abuse and neglect. This annual safeguarding report reflects our continued commitment to ensuring that every patient in our care is treated with dignity, respect and compassion.

Over the past year, our Trust has faced both new and ongoing challenges, including increasing complexity in safeguarding needs, rising demand on services and the ongoing impact of societal and economic pressures. Despite this, our teams have worked tirelessly to uphold high standards of care, ensuring that safeguarding remains a core priority across all services.

This report provides an overview of the progress we have made, the lessons we have learned, and the actions we are taking to improve. It highlights the dedication of our staff, the strength of our partnerships, and our relentless focus on creating safe environments for all who use our services.

I would like to extend my sincere thanks to everyone across the Trust who plays a role in safeguarding—from frontline clinicians to corporate teams, volunteers, and partner agencies. Your vigilance, compassion, and professionalism are vital in supporting those who may not have a voice.

We remain steadfast in our commitment to continuous improvement, learning, and transparency. Together, we will keep working to ensure that safeguarding is not just a policy or a process—but a culture embedded in every aspect of care we provide.

Nic Firth

Chief Nurse/DIPC and Executive Lead for Safeguarding



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1. Introduction

This report is the Stockport NHS Foundation Trust Safeguarding Annual Report for the reporting period April 2024 – March 2025.

Safeguarding means protecting a citizen's health, wellbeing and human rights; enabling them to live free from harm, abuse and neglect. It is an integral part of providing high-quality health care and is a collective responsibility.

The foundations of safeguarding are held within the United Nations Convention on the Rights of the Child [UN Convention on Rights of a Child \(UNCRC\) - UNICEF UK](#) for children, and for adults, the European Convention on Human Rights [European Convention on Human Rights](#) as well as the Convention on the Rights of Persons with Disabilities [Convention on the Rights of Persons with Disabilities | OHCHR](#)

Those most in need of protection include:

- Children and Young People
- Adults at risk, such as those receiving care in their own home, people with physical, sensory and mental impairments, and those with learning disabilities.

It is the responsibility of every NHS funded organisation, and each individual healthcare professional to ensure that the principles and duties of safeguarding children and adults are holistically, consistently and conscientiously applied with the wellbeing of these children and adults at the heart of what we do.

1.1 Purpose

The purpose of this paper is to provide assurance to the board that Stockport NHS Foundation Trust is compliant with statutory requirements outlined in legislation, including Section 11 of The Children Act (2004), Working Together to Safeguard Children (2023), The Care Act (2014), Mental Capacity Act (2005), Domestic Abuse Act (2021) and the Care Quality Commission Regulation 13.

It will:

- Provide an overview of the Stockport NHS Foundation Trust safeguarding teams activity on 2024/25.
- Provide accountability for the Trust's safeguarding responsibilities.
- Identify emerging risks and trends related to safeguarding.
- Outline the key safeguarding priorities for 2025/26.

2. Executive Summary

The Stockport NHS Foundation Trust (SFT) Annual Safeguarding Report details the systems and processes in place to safeguard children, young people and adults receiving SFT services. The report demonstrates the Trust's commitment to the safeguarding of children, young people and adults, in accordance with its statutory responsibilities, and covers the period from 1st April 2024 until 31st March 2025.

Statutory Responsibilities and Assurance

- Lead adult, child and maternity professionals are in place, meeting the statutory requirements identified in Section 11 of The Children Act 2004, Working Together to Safeguard Children (2023), The Care Act (2014), NHS England Safeguarding Accountability and Assurance Framework (2024) and the Mental Capacity Act (2005).
- The Chief Nurse is the Board Executive Lead for safeguarding. Alongside the Deputy Chief Nurse and Head of Safeguarding they provide strategic leadership and oversight of safeguarding.
- Safeguarding governance arrangements are in place, with oversight from the Trust Integrated Safeguarding Group chaired by the Deputy Chief Nurse.
- There is active SFT involvement with the Local Safeguarding Adult and Children Partnership Boards in Stockport with membership of a range of partnership sub-groups.
- SFT has contributed to several learning reviews, incorporating Safeguarding Adults Reviews (SAR), Child Safeguarding Practice Reviews (CSPR) and Domestic Abuse Related Death Reviews (DARDR) – formerly known as Domestic Homicide Reviews (DHR).
- There is a safeguarding training programme in place to ensure SFT staff have received the requisite 'essential to role' safeguarding training, including Safeguarding Adults, Safeguarding Children, Children in Our Care (otherwise known as Looked After Children), Mental Capacity Act (MCA)/Deprivation of Liberty Safeguards (DoLS) and Prevent training. Work continues to improve uptake of Level 3 safeguarding training.
- Policies, protocols and processes are in place to support the assessment of need and vulnerability of children, young people and adults accessing SFT services.
- Safeguarding supervision, (mandatory and ad-hoc) is delivered by the safeguarding teams to support staff in decision making and prioritising the needs and wishes of children, young people and adults, where there is a high level of complexity, risk and vulnerability.
- Robust recruitment processes are in place, with pre-employment clearance for all new staff. SFT complies with guidance in relation to modern day slavery and human trafficking and undertakes enhanced Disclosure and Barring (DBS) checks for staff working with children and adults.

Safeguarding 2024/25

Integrated Safeguarding System

This reporting year has seen the introduction of a new safeguarding application across the FT which has made the safeguarding systems for Adult Safeguarding, Childrens Safeguarding, Children in Our Care, Maternity and Neonates more accessible for staff providing care for patients in clinical areas. This new system has made a particular difference our adult patients as, for the first time, practitioners are able to access key safeguarding information in real time whereby in previous reporting years information regarding open safeguarding cases has been obtained via the adult safeguarding team with no function available to provide updates out of hours.

Provision of Staff Support

The Safeguarding Practitioners respond to all enquiries or requests for support and advice made

by Trust staff. This contact may be requested via email or telephone. Requests vary in subject matter and can be basic requests such as support to open or exit a safeguarding form to more specialised and detailed requests for support and/or consultation.

We provide relevant signposting information to staff and offer specialised advice in cases where staff have less knowledge such as for cases of cuckooing, human trafficking, and modern-day slavery.

The Safeguarding Practitioners attend meetings whereby it is deemed that safeguarding oversight and support is required. This includes attending Multi-Disciplinary Team meetings, Complex Case Management, and professionals' meetings. This reporting year, the adult safeguarding team have also introduced daily walk rounds in key areas such as ED, AMU, AFU and wards where there is a high acuity of patients with complex needs.

Key Achievements

During this reporting period we have:

- Responded to emerging safeguarding issues and concerns.
- Launched an electronic safeguarding platform to enhance communication, improve information sharing and streamline processes between Trust staff and the safeguarding teams.
- Co-located the community and acute safeguarding children's teams.
- Re-established safeguarding children team supervision and provided a robust model for community public health nursing case holders, acute paediatric teams, joint health visitor/midwife supervision and Family Nurse Partnership (FNP) supervision.
- Maintained a regular safeguarding training offer alongside other safeguarding activities.
- Successfully launched and widely disseminated an All-Age Safeguarding Newsletter across the Trust.
- Introduced 'Safeguarding Practice Awards' to recognise outstanding safeguarding practice demonstrated by individuals, clinical areas and/or divisions.
- Launched our Trust Domestic Abuse Champions initiative to improve awareness raising and support our workforce in recognising and responding to patients, staff and visitors who may be experiencing domestic abuse.
- Implemented an annual integrated audit plan to monitor and assess safeguarding practice and outcomes.



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- Launched a maternity specific Learning Disability passport to enable individual needs to be communicated in an easy-to-read document.
- Established an Adult Safeguarding “Hub” in one of our community locations.

Priorities for 2025/26

The following areas are set as priorities for 2025/26:

- To commit to becoming a Trauma Informed Organisation.
- To embed MCA and Best Interests processes in line with national guidance and best practice across the Trust.
- To improve the experience for patients with a Learning Disability and/or Autism, particularly in unscheduled care settings.
- To roll out ‘Section 42 Enquiry Train the Trainer’ sessions to equip Matrons and Ward Managers to lead safeguarding enquiries within the Trust.
- The roll out of the Giving HOPE Project, aimed to minimise the trauma experienced by mothers and babies who are separated close to birth due to safeguarding concerns.
- To roll out a mandatory domestic abuse training offer for all staff as per The Domestic Abuse Act 2021 statutory guidance.
- Integration of community and acute safeguarding children team to enable all nurses to be proficient with both acute and community safeguarding challenges, ensuring equitable skill acquisition.

3.0 Progress against 2023/24 Priorities

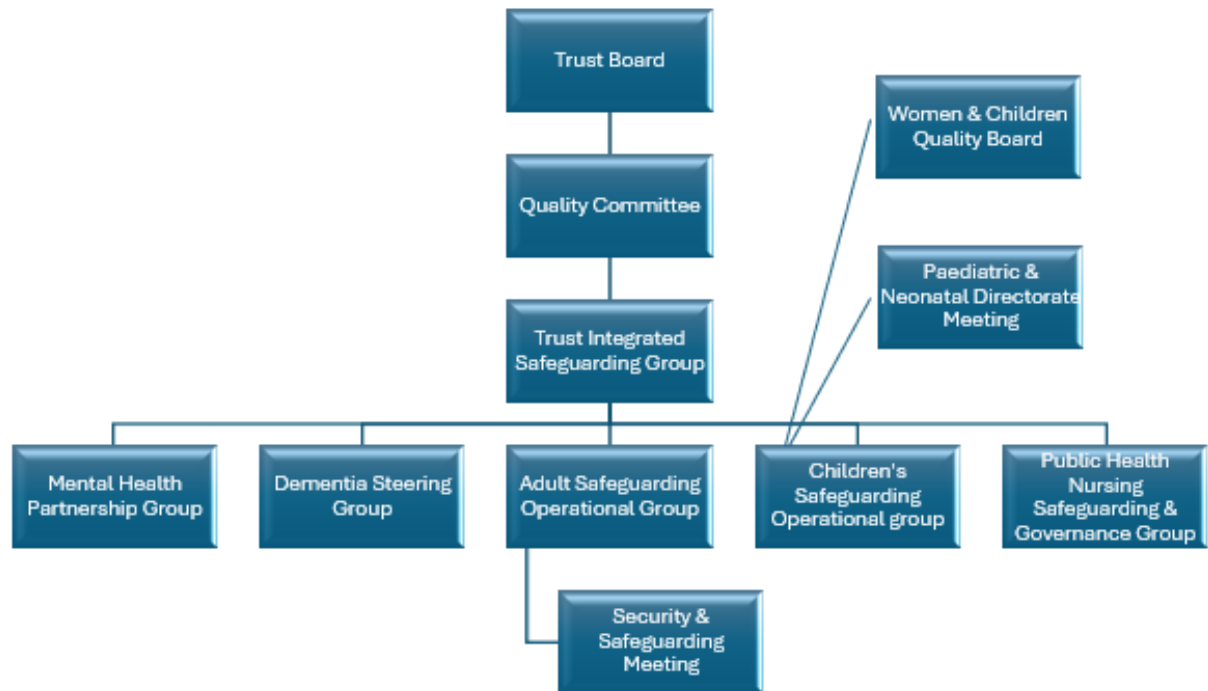
The safeguarding team is proud of its progress against priorities set last reporting year, despite the ongoing challenges of operating as a small team whilst maintaining visibility and impact across the acute Trust and Community settings.

Safeguarding Priorities for 2024/25		
	Action	Outcome
1	Achieve 95% compliance for Safeguarding Adults L3 training.	Training compliance continues an upward trajectory from 2023/24 and is consistently above ICB targets of 85%.
2	Regularly conduct audits on MCA compliance, safeguarding training and care for patients with a Learning Disability and/or Autism.	Monthly audits are now embedded across the FT and demonstrating high levels of compliance across the divisions.
3	Contribute to the Safeguarding Children Team transformation process.	Community and Acute safeguarding children’s teams have now integrated and are co-located at the Acute Trust.
4	Incorporate and report L3 training for Children in Our Care into safeguarding training.	L3 Children in Our Care training now embedded into L3 offer and compliance consistently above Trust and GM standards.
5	Launch Integrated Safeguarding IT System	System launched and rolled out across FT throughout Q3.

4. Governance and Accountability

4.1 Safeguarding Governance Structure

Safeguarding governance and assurance are monitored by the Integrated Safeguarding Group, chaired by the Deputy Chief Nurse. This group has been established as a sub-committee of the Quality Committee.



The Integrated Safeguarding Group meets bi-monthly to ensure that all safeguarding commitments and responsibilities for both adults and children are fulfilled. It oversees the work of the Operational Groups and verifies that appropriate processes are in place for the regular review and updating of safeguarding arrangements.

The following Operational Groups report to the Integrated Safeguarding Group:

- Mental Health Partnership Group
- Dementia Steering Group
- Adult Safeguarding Operational Group
- Children's Safeguarding Operational Group
- Public Health Nursing Safeguarding & Governance Group

4.2 Reporting Framework

A bi-monthly exception report is provided to the Quality Board.

Reports include:

- Mandatory training and supervision performance
- Updates on partnership working

- Safeguarding activity
- Policy development
- Audit planning
- Risk management

4.3 Safeguarding Contractual Standards

The NHS Safeguarding Contractual Standards are a set of requirements that all NHS providers must meet to ensure they have robust safeguarding practices in place for both children and adults. These standards are embedded within NHS contracts and align with national safeguarding legislation and guidance.

In 2024/25 there were 38 standards aligned with 9 Key Lines of Enquiry:

- Leadership and Organisational Accountability
- Safeguarding Processes
- Safeguarding Policies and Duties
- Supervision, Training and Development
- Safeguarding Children
- Safeguarding Adults at Risk
- Looked After Children (Children in Our Care)
- Mental Capacity Act (MCA)
- Child Death Review

This was a reduction from the 63 standards reported on in 2023/24 and has improved clarity, relevance and oversight as well as reflecting broader NHS efforts to integrate systems post Clinical Commissioning Groups (CCG), emphasise outcome-based assurances and simplify contractual requirements.

Stockport NHS Foundation Trust was fully compliant in **37** out of the 38 contractual standards for 2024/25 with work ongoing to agree a mandatory domestic abuse training offer to all Trust staff which, once identified, will evidence full compliance with all standards.

4.4 Roles and Responsibilities

The Chief Nurse is the Executive Lead for safeguarding children, young people and adults at risk.

Their responsibilities include:

- Providing strategic leadership on all aspects of the Trust's contributions to safeguarding.
- Ensuring the Trust is represented at Local Safeguarding Adult and Children's Partnerships.
- Ensuring that appropriate safeguarding processes are in place, complying with all legal, statutory and best practice requirements.

4.5 Statutory Safeguarding Responsibilities

Lead adult and child safeguarding professionals are in place, meeting the statutory requirements as identified in Section 11 of the Children Act 2004, Working Together to Safeguard Children (2024), The Care Act (2014), NHS England Accountability and Assurance Framework (2022) and the Mental Capacity Act (2005).

Safeguarding structures are established within the organisation, including the following designated roles:

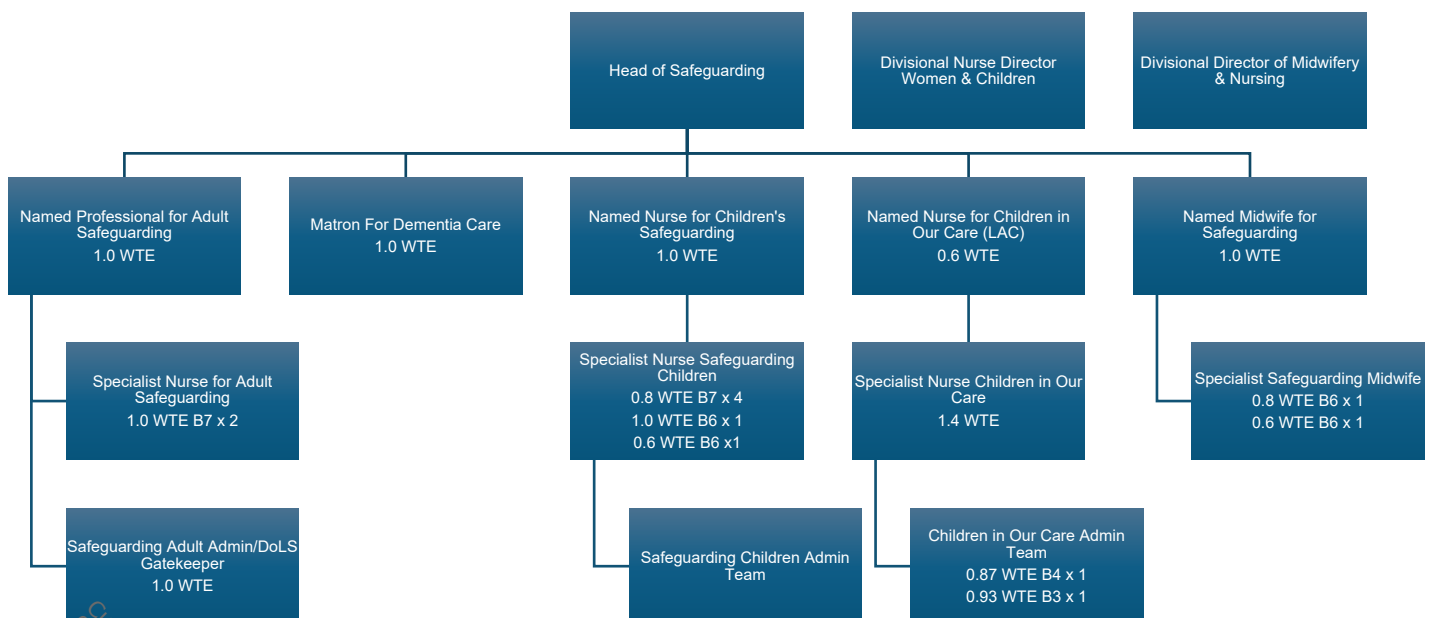
- Executive Lead
- Named Doctor for Safeguarding Children
- Named Nurse for Safeguarding Children
- Named Midwife for Safeguarding Children
- Named Nurse for Children in Our Care
- Named Professional for Safeguarding Adults

Named and lead professionals play a crucial role in promoting good practice within the organisation. They provide advice and expertise to fellow practitioners and ensure that safeguarding training is effectively implemented.

The safeguarding team collaborates to:

- Identify children and adults at risk of harm and implement measures to protect them
- Ensure that the welfare of the child or adult at risk is paramount, with their voices central to all interventions
- Ensure compliance with local and national safeguarding procedures
- Implement national and local guidance related to safeguarding children and young people, children in care and safeguarding adults
- Actively participate in the Stockport Safeguarding Adult and Children Partnerships and their sub-groups
- Promote best practice across Stockport NHS Foundation Trust

Safeguarding Structure 2025



5 Safeguarding Policies

Stockport NHS Foundation Trust collaborate with and align their practices to partnership policies across Greater Manchester and nationally. Trust-specific policies address the needs

of the organisation and are regularly updated to reflect changes in legislation as well as local and national learning.

During 2024/25 the Safeguarding Adults at Risk and Domestic Abuse policies were reviewed and updated and the Enhanced Observation of Care policy, to support staff caring for patients displaying behaviour that challenges, was approved. A Missing Patient Policy was also introduced to strengthen the FT response to the GMP Right Care Right Person model which was rolled out in Stockport in Q3. The Trust Safeguarding Children Supervision Policy is currently under review.

There are seventeen approved and current safeguarding policies that can be accessed via the safeguarding teams' microsites via the following links:

[Safeguarding Adults](#)

[Safeguarding Children](#)

6. Training and Development

Safeguarding training is guided by the Intercollegiate Documents published by the Royal College of Nursing on behalf of multiple stakeholders. These documents outline the roles and responsibilities associated with safeguarding and specify the level of training required for various positions.

[Adult Safeguarding: Roles and Competencies for Health Care Staff](#)

[Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff](#)

[Looked After Children: Roles and Competencies of Healthcare Staff | Royal College of Nursing](#)

Each level of training mandates that staff complete a minimum number of training hours over a three-year period. These training hours can be fulfilled through a variety of different training interventions. Training is accessible through the Trust ESR system.

2.1 Safeguarding Training Requirements

Children and Young People

Level	Staff Group	Method
Level 1	All Staff	Mandatory e-learning
Level 2	Clinical and non-clinical staff who have contact with children, young people or their parents/carers	e-learning via the national programme
Level 3	All clinical staff who are working with children and young people and who could potentially contribute to assessing, planning, intervening and evaluating the safeguarding needs of a child and their families.	Blended face to face/virtual and e-learning
Level 4	Named Professionals and safeguarding specialists.	This is usually multi-agency training.

Safeguarding Adults and MCA

Level	Staff Group	Method
Level 1	All Staff	Mandatory e-learning
Level 2	All staff who have regular contact with patients, their families or carers, or the public	e-learning via the national programme
Level 3	All staff who engage in assessing, planning and intervening and evaluating the needs of adults where there are safeguarding concerns	Blended face to face/virtual and e-learning
Level 4	Named Professionals and safeguarding specialists	This is usually multi-agency training

6.1 Training Compliance

The standard for safeguarding and Prevent training is locally agreed with the ICB at 85%, in alignment with national standards.

While 2024/25 compliance is detailed in the table below, current activity reflects strong compliance at Levels 1 and 2, with a positive trajectory for Level 3 as staff work towards completing the required 8 hours of competency.

The Trust is actively working with Divisions to support staff in achieving compliance. A hybrid training model is available, including e-learning, face-to-face sessions, and safeguarding supervision, to help staff complete self-declarations and meet training requirements.

Safeguarding Adults Training	2024-25			
	Q1	Q2	Q3	Q4
Level 1 (Target 85%)	97.93%	97.69%	97.32%	96.48%
Level 2 (Target 85%)	96.79%	95.66%	95.52%	93.96%
Level 3 (Target 85%)	86.72%	86.79%	85.88%	82.61
Mental Capacity Act (Target 85%)	95.58%	94.46%	94.59%	95.65%
Deprivation of Liberty Safeguards (Target 85%)	95.58%	94.46%	94.59%	95.65%
Prevent WRAP 3 (Target 90%)	96.84%	95.22%	94.71%	92.93%
Prevent Basic Awareness (Target 90%)	97.58% ⁵⁸	96.61%	96.61%	96.44%

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Safeguarding Children Training	2024-25			
	Q1	Q2	Q3	Q4
Level 1 (Target 85%)	97%	96%	96%	96.13%
Level 2 (Target 85%)	96%	95%	95%	94.25%
Level 3 (Target 85%)	92.5%	92%	89%	88%
Children in Our Care	94.99%	94.36%	95.76%	96.42%

Of note, the Intercollegiate Document for Safeguarding Children, Young People and Looked After Children is currently under review with a recommendation of a competency-based approach to training rather than minimum hours of training attended. This will provide an opportunity for the safeguarding team to review the current training offer across the FT in the forthcoming year and develop a model to meet the needs of individual divisions.

6.2 Oliver McGowan Training

The Oliver McGowan Mandatory Training on Learning Disability and Autism is named after Oliver McGowan, whose tragic death highlighted the urgent need for improved training for health and social care staff. The Health and Social Care Act 2022 introduced a statutory requirement that regulated service providers to ensure their staff receive training on learning disability and autism appropriate to their roles.



Oliver McGowan Training Requirements

Tier 1: Tier 1 of The Oliver McGowan Mandatory Training on Learning Disability and Autism is designed for individuals who require a general awareness of the support autistic individuals and those with learning disabilities may need. This e-learning component must be completed by everyone, regardless of their role. This training has been developed by Health Education England and is available via the ESR training portal. The uptake of this important training package has been extremely positive, and the Trust is able to demonstrate consistently high levels of compliance throughout the reporting year.

Oliver McGowan Training	2024-25			
	Q1	Q2	Q3	Q4
Tier 1 (Target 85%)	93.38%	93.14%	94.32%	94.36%

Tier 2: Tier 2 training is intended for those who may need to provide direct care and support to autistic individuals or those with a learning disability. It includes the Tier 1 training, along with a 1-day face-to-face training session co-delivered by a facilitating trainer, and expert

with lived experience co-trainers. Trainers undergo standardised training prior to being approved to deliver the sessions. The safeguarding team are currently working with Learning and Education on a delivery model for the Tier 2 training.

7. Safeguarding Activity

7.1 Supervision

Safeguarding supervision is offered widely across the Trust, both in acute and community services and according to role requirements.

Case Holding Practitioners and Acute Specialist Nursing Roles

Safeguarding children supervision for Health Visitors and School Nurses is delivered with a revised model, with the aim to spend longer on those cases which are presenting the most difficulties for practitioners. This enables quality reflection, learning and development which is transferable to other cases within their caseload.

Compliance by Cohort	2024-25			
	Q1	Q2	Q3	Q4
Health Visitors	76.3%	86.2%	94.1%	75%
School Nurses	100%	76.4%	41.3%	85.7%
Children's Learning Disability Team	100%	100%	100%	100%
Children's Diabetes Team	100%	100%	100%	100%
Children's Epilepsy Team	100%	*0%	100%	100%

Compliance remains high and of significant importance within the community provision. Non-compliance is recorded as due to sickness or maternity leave at the time of the session.

Children's Therapy Services – Non-Case-Holding Practitioners

The delivery of safeguarding supervision for this cohort of staff is provided by the therapy team leads, who have completed training in delivering safeguarding supervision, in group format. The team leads receive safeguarding supervision facilitated by the safeguarding children team to provide oversight of case management.

Compliance by Cohort	2024-25			
	Q1	Q2	Q3	Q4
Therapy Service	86.67%	80.5%	86.3%	88%
Therapy Leads	100%	100%	100%	100%

Acute Paediatric Teams

The provision of safeguarding children supervision to the acute staff is delivered in group format and the data collated demonstrates the sessions offered. This has been well received by the service leads and will be supported in the year ahead.

Compliance by Cohort	2024-25			
	Q1	Q2	Q3	Q4
Children's CCNT	86.67%	80.5%	86.3%	88%
Treehouse and Out Patients Dept	100%	100%	100%	100%
Neonates	100%	100%	100%	100%
Children's Emergency Dept	100%	100%	100%	100%

To assist with the delivery of this model there have been several practitioners within the women and children's division who have completed training in delivering safeguarding supervision to support the service provision. This aim is to enhance the team experience by having one of the safeguarding children team support the implementation and development of the supervisor skills and enhance the application of theory to practice.

Ad-hoc supervision continues to be provided daily, supporting current / active case management; some of which is delivered in a coaching method whereby the specialist nurse works directly alongside the member of staff to guide them through the process as well as telephone advice that results in a reflection and staff actions with regards to the case. Due to the increase in visibility across the Trust and the developments in working within other areas, there has been a noted increase in this activity which has been extremely well received especially in adult service areas.

Maternity

Required frequency of maternity safeguarding supervision is determined by role. Case loading midwives, such as community midwives require supervision on a quarterly basis. Midwives who work in the acute Trust are required to receive supervision on a yearly basis and this is facilitated via the Public Health Study Day. Compliance with this is currently 85.45%.

Compliance by Cohort	2024-25				Total
	Q1	Q2	Q3	Q4	
Acute Maternity	28.48%	13.94%	29.09%	30.30%	69.09%
Community Midwifery	58%	15.79%	30.51%	30.30%	39.66%

Safeguarding supervision is currently delivered to case-holding midwives either one-to-one with a member of the maternity safeguarding team, or as a group session. Group supervision is delivered by community team leaders who have received the necessary training in delivering safeguarding supervision, and the Named Midwife for Safeguarding. Group supervision is most appropriate for community-based midwives who do not case manage significant numbers of families with safeguarding concerns, whereas one-to-one sessions are most valuable to midwives working with more vulnerable families, or in areas of high social deprivation

Adult Nursing

The provision of safeguarding supervision across the Trust was expanded in 2024/25 to include an offer for safeguarding adults' supervision for colleagues who attend the safeguarding adult level 3 training.

The offer was rolled out at the end of Quarter 1 and uptake has been positive despite reduced capacity within the adult safeguarding team due to staff who had received the requisite training to deliver the sessions being limited to one member of the team.

Attendees By Division	2024-25				Total
	Q1	Q2	Q3	Q4	
Medicine and Urgent Care	15	0	14	15	44
Integrated Care	8	0	0	8	16

The remaining two members of the team have since received the requisite training, a plan is in place to expand the offer to the divisions of Surgery and Clinical Services and dates have been agreed for sessions to be delivered throughout 2025/26.

7.2 Managing Allegations Against Staff

The Trust has a statutory duty to investigate allegations against staff working with children and with adults at risk. This includes activity relating to a staff member's conduct in their personal as well as their professional life.

Allegations are managed in accordance with the Stockport NHS Foundation Trust policy, with monthly oversight led by the head of Safeguarding and Head of Human Resources. The response to an allegation will vary according to the nature of the allegation and may include referral to the police and/or local authority.

The Managing Safeguarding Allegations Against Staff Policy applies when it is alleged that a person who works with children or any adult at risk has:

- Behaved in a way that has harmed a child/adult at risk or may have harmed a child/adult at risk
- Possibly committed a criminal offence against or related to a child/adult at risk
- Behaved towards a child or children/adult at risk in a way that indicates they will pose a risk of harm if they work regularly or closely with children/adults at risk

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- Behaved or may behave in a way that indicates they may not be suitable to work with children/adults at risk

The senior safeguarding leads collaborate closely with the Stockport Local Authority Designated Officers (LADO) to assess risks and determine actions when a staff member may pose a risk to children.

Managing allegations against staff is a complex and sensitive area of the Trust's work, requiring a thorough process that involves close collaboration between the Human Resources department and the safeguarding team, as well as, when applicable, temporary staffing, the police and local authorities.

During 2024/25 there were 18 new allegations against staff of which 9 cases involved individuals working with children and young people.

7.3 FGM Mandatory Reporting

Female Genital Mutilation (FGM) is illegal in England and Wales under the FGM Act (2003). It is classified as a form of child abuse and violence against women. Regulated health professionals in England and Wales are required to report any known cases of FGM in individuals under 18 that they identify in the course of their professional work to the police. This reporting requirement came into effect on 31 October 2015.

During the year 2024/25 there were 18 reported cases of FGM, with 0 mandatory referrals for individuals under the age of 18.

7.4 Child Protection Medicals

During a child protection enquiry, a child protection medical report may be requested by Children's Social Care and the Police to support a Section 47 Investigation.

This service is provided by Stockport NHS Foundation Trust and the clinic is situated within the Treehouse Children's Unit.

Where possible it is best practice to ensure sibling groups are seen together. This ensures that the children remain together as a sibling cohort, and it assists with continuity and the ability to reduce the need for multiple histories to be obtained if the children are reviewed by the same practitioner. This can however have a direct impact on the clinic capacity and workload within the department which can result in time slots being extended to accommodate.

Comparative Data	Child Protection Medical reports				Total
	Q1	Q2	Q3	Q4	
2024/25	23	22	36	30	111
2023/24	31	36	17	21	105

There is little variation in comparative data, other than heightened activity at the beginning and end of the reporting years.

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7.5 Learning from Child Deaths

The death of a child is a devastating loss that profoundly affects the family and all those involved. Our process for reviewing the deaths of children is grounded in our respect for the rights of children and their families. Our intention is to learn what happened and why and prevent future child deaths.

Child Death Overview Panels (CDOPs) are a multi-disciplinary sub-group of Local Safeguarding Children Partnerships that work across Local Authority boundaries based on population numbers. CDOP reviews the deaths of all children aged from birth up to the age of 18 years old (excluding still births and planned terminations carried out under the law) who normally reside within the geographical boundaries of that CDOP area. There are four CDOPs across Greater Manchester, three of which function as a 'tri-partite' such as Stockport, Tameside and Trafford (STT).

The table below details the Stockport child deaths during 2024/25

CDOP	2024/25				Total
	Q1	Q2	Q3	Q4	
Expected	2	3	2	3	10
Unexpected	2	0	1	2	5

Child Death Overview Panels review every death of a child, whatever the circumstances, to find out if there's anything we can learn. We identify any concerns that the death suggests for other people and that contributes to wider understanding of the causes of childhood mortality.

Child deaths in Stockport are reviewed by a panel covering Stockport, Tameside and Trafford. Our panel includes:

- Doctors
- Other healthcare professionals
- Public health professionals
- Child safeguarding professionals
- Greater Manchester Police

CDOP is a statutory requirement. The panel seeks to understand the circumstances of each child's death by reviewing paperwork, such as clinical records and policing records. While the panel will ask for the information it needs from organisations who have responsibility for a child's care, it does not conduct police investigations or interviews. CDOP panel meetings are held in private, and the child's parents do not attend.

All child deaths must be reported by an appropriate professional to the CDOP panel and reports are made through the eCDOP online portal.

Learning from unexpected child deaths is incorporated into safeguarding training. Key messages on topics such as neglect, working with fathers and non-birthing partners, exploitation, safe sleeping and child mental and emotional health are shared as part of this training.

7.6 Prevent

Prevent is part of the Government's Counter Terrorism Strategy called "CONTEST". As part of this strategy, all healthcare staff receive mandatory training, and this must be updated every 3 years (training figures are contained within this report). The Named Professional for Adult Safeguarding is our operational Lead for Prevent and regularly attends Stockport's Channel panel.

Channel Panel provides support to those who may be vulnerable to being drawn into terrorism.

Channel uses existing collaboration between partners, to support individuals and protect them from being drawn into terrorism. Stockport NHS FT has had **100%** attendance at Channel Panel this year.

All staff have a responsibility to raise concerns where they believe that a patient is at risk of being drawn into terrorist activity or committing a terrorist act. Concerns are reported to the Prevent Lead who refer to Greater Manchester Channel Team. These concerns will be investigated and if felt to be appropriate the individual will be offered the option of being supported by the Channel Panel.

We made **3** referrals to Channel panel throughout 2024/25 but were able to assist in sharing information, where we received **8 requests** to provide information by the Channel panel at meetings with statutory and non - statutory partners.

Quarterly reports are also shared with NHS England on the Prevent activity per quarter and data includes information on volume of referrals received within the Trust and training compliance within the organisation. (*Compliance can be seen in the Training section of this report*).

7.7 Safeguarding Adults Referrals

The Trust has a statutory duty to contribute to safeguarding enquiries and reviews. Throughout the reporting period, the Adult Safeguarding Team has actively participated in Section 42 Enquiries under the Care Act (2014), attending Strategy Meetings, Case Conferences, and, where appropriate, undertaking investigations at the request of the Local Authority.

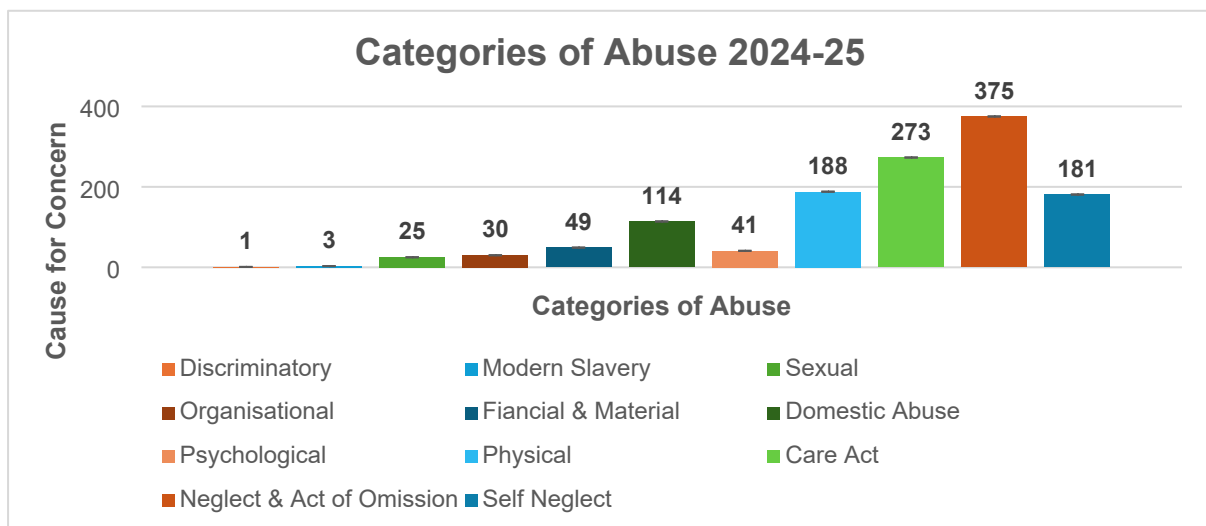
A clear reporting pathway is in place for staff to escalate safeguarding concerns via an electronic "Cause for Concern" form, accessible through the Adult Safeguarding microsite. All referrals are reviewed, with patient records assessed where necessary to support decision-making, escalate immediate risks, and ensure appropriate guidance is provided. Actions are recorded on a safeguarding dashboard to support monitoring and reporting.

During this reporting year, **1,670** referrals were received - a consistent pattern compared to the previous year. This reflects sustained awareness among staff regarding safeguarding processes and reporting mechanisms. Data indicates an embedded culture of reporting within the Trust, with staff demonstrating confidence in raising concerns and seeking advice. Notably, referral activity has stabilised at a significant level following the increase observed post- the Covid pandemic (2020/21).

Year	Safeguarding Cause for Concern				Total
	Q1	Q2	Q3	Q4	
2024/25	373	449	415	433	1670
2023/24	372	441	425	436	1674
2022/23	307	363	333	334	1337

Categories of Abuse

The primary reasons for consultation with the Safeguarding Adults Team relate to Neglect and acts of omission, Care Act needs, and physical abuse (see table below). Domestic abuse remains a significant concern also, with 116 cases referred to the team. DASH assessments and MARAC referrals for high-risk cases are completed promptly, with ongoing training and support for staff to ensure high-quality assessments. Further work is planned for 2025/26 to enhance domestic abuse training, aligned with the recently updated Trust policy and current legislation.



7.8 Safeguarding Children Referrals

The safeguarding children team act as subject experts with regards to providing advice and oversight when required with Stockport NHS Foundation Trust staff; staff are empowered to complete MASSH referrals when concerns arise. The safeguarding children team will support with escalating immediate concerns and ensuring the right practitioners are in receipt of the right guidance and support. How to complete a MASSH referral form is included in the training that the safeguarding children team delivers.

In October 2024 there was a change to process whereby the local authority MASSH platform no longer supports the print option. This means staff are required to note the MASSH reference number in the health records instead of uploading a printed copy to the records.

The change has also meant that MASSH referrals are sent directly to MASSH via their electronic system and the safeguarding children team no longer receive a printed copy, instead liaison has increased from the MASSH health representative who will report trends and flag any quality assurance problems with the safeguarding children team.

Most children’s social care referrals are generated within the Emergency Department (ED) by the Paediatric and adult nursing teams. The safeguarding children team continues to work with the ED to ensure that safeguarding children’s training remains a priority within the department. This in addition to the team being included as part of the doctor’s induction program to raise further awareness and ensure that the need to safeguard the child / young person is integrated within the medical assessment for children, young people, and adult presentations.

ED Attendances with a MH Presentation 0-15 years	2023/24	2024/25
Q1	111	65
Q2	75	38
Q3	77	56
Q4	101	78
ED Attendances with a MH Presentation 16-17 years		
Q1	51	34
Q2	32	23
Q3	31	39
Q4	44	28

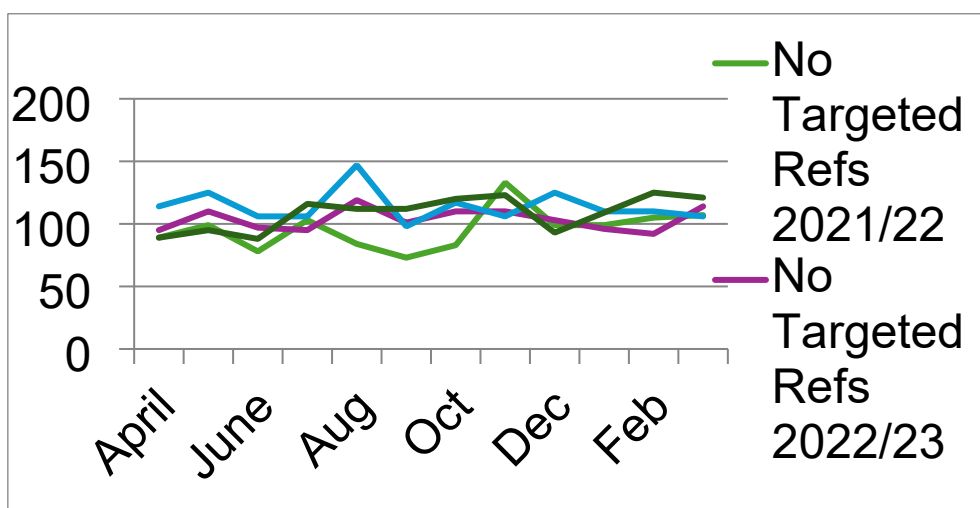
Year	Safeguarding Children Referrals				Total
	Q1	Q2	Q3	Q4	
2024/25	610	528	643	623	2404

7.9 Maternity Safeguarding Referrals

The Maternity Safeguarding IT system went live in January 2025 and the numbers of Enhanced Maternity Care Pathway referrals received over the past 24 months have been consistent with an upward trend. This indicates that the process for identifying vulnerable women is well embedded and staff feel confident using the new system.

During the reporting period, there were 1306 Enhanced Maternity Care Pathway referrals received. This equates to 43.78% of all women booked to give birth at Stockport FT being identified as vulnerable or having unmet needs. The most common indication for referral was due to perinatal mental health issues, which is consistent with national trends.

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Although this year's Q1 data indicates a reduction in referrals as compared to previous years Q1 data. The average number of referrals per month increased with the use of the well embedded Risk Resilience matrix with monthly average of 113 referrals being made in Q2. Q3 & Q4 have seen similar upward trends with an average of 110 EMPs completed monthly in Q3 and an average of 118 in Q4. This trend will continue to be closely monitored by the Maternity Safeguarding Team

8. Partnership Working

Safeguarding Partnerships refer to statutory arrangements between agencies focused on protecting children and vulnerable adults from harm, abuse and neglect. The Trust has a duty to engage with the Safeguarding Children and Safeguarding Adult Partnership arrangements in our local authority and is actively involved in the work of the sub-groups.

8.1 Local Safeguarding Partnership Meetings

A representative from the safeguarding team attends the following strategic and operational multiagency safeguarding meetings.

Safeguarding Adults	Safeguarding Children	Joint Safeguarding
Stockport Safeguarding Adult Partnership Board	Children's Practice Improvement and Assurance Partnership	Stockport Joint Safeguarding Adults Partnership Board
Adults Practice Improvement Partnership	Integrated Looked After Children Board	Safeguarding Children Partnership Executive Meeting
Adults Quality Assurance Partnership		Domestic Abuse Partnership Board
		Domestic Abuse Operational Meeting
		Channel Panel
Safeguarding Adult/Domestic Abuse Related Death Review (SAR/DARDR) Consideration Panel	Rapid Review & Child Safeguarding Practice Review Panel and Process	Domestic Abuse Related Death Review Consideration Panel
		Training & Workforce Development

The safeguarding team contribute to support the functioning of the Multi-Agency Daily Risk meeting. This function is shared with Greater Manchester Police to ensure health information is shared to inform assessment of high-risk domestic abuse cases.

9.0 Domestic Abuse

9.1 Multi-Agency Risk Assessment Conferences (MARAC)

The safeguarding team attend the bi-weekly MARAC to share and gather relevant information in high-risk domestic abuse cases to support risk assessment and planning for practitioners who have case holding responsibilities. Information, such as the MARAC alert flag, is recorded on the electronic patient record to alert practitioners providing care that the patient is experiencing domestic abuse so that this can be considered during their care episode.

9.2 Risk Assessment and Notifications

During 2024/25, funding for the Independent Domestic Abuse Advisor (IDVA) service ended in Quarter 3 and the function of completing the DASH Risk Assessment and responding to disclosures of domestic abuse and onward signposting/referrals absorbed by the safeguarding team. The table below illustrates MARAC activity for the reporting year, including activity generated by the FT.

It is important to note that each case is reviewed to ascertain if there are any children associated with the victim and / or alleged perpetrator so information can be shared to ensure that the child/ren are considered and included as part of the wider risk assessment.

Once the cases are heard at the panel, action plans are developed and communicated accordingly by the safeguarding team to the case holding professional and the relevant GP practice, so the practitioners involved with the family are clearly cited on the level of risk and the requirements to provide support to the child and family. This is also a key trigger for GP practices to review the GP coding / flagging system so appropriate safeguards can be put in place if the parent / child presents. Of note, there can be many GP practices, practitioners and services involved in one incident which can be a challenge to ensure that the right teams are alerted.

MARAC 2024/25						
	Q1	Q2	Q3	Q4	Total	2023/2024 Total
Cases Heard	192	181	151	180	704	730
Cases With children	157	129	101	120	507	551
Total Number of Children	404	316	222	295	1237	1366
Cases Involving Pregnancy	12	6	9	7	34	21
Total DA Referrals (Trust Generated)	34	18	25	39	116	101
Total DA Notifications	292	321	456	596	1665	1544

In addition, due to the noted national increase in domestic abuse notifications there has been a need to review the data in relation to this activity. The final row of the table presented notes the domestic abuse notifications received by Greater Manchester Police (GMP). Each case is reviewed, and clarity secured regarding the case holding practitioners so the information can be shared effectively, and immediate support can be made available for the family. These figures remain high, and the team are currently reviewing the systems and processes in place to support this function.

9.3 Routine Enquiry and Training

Routine enquiry, recognition and reporting of domestic abuse is included in Level 3 Safeguarding Adults training and the Public Health study day with toolbox training provided in clinical areas as an additional offer. The Domestic Abuse Act 2021 recommends that all staff working in NHS settings are required to receive training in domestic abuse and the safeguarding team are currently working with Education and Learning on an offer to be rolled out in 2025/26.

This reporting year has also seen the introduction of 10 Domestic Abuse Champions across the FT who will be collaborating with champions across the Safeguarding Partnership, to receive specialist training and development to assist them in their roles. Stockport FT have been influential in the development and roll-out of this exciting initiative and are collaborating with the local authority in developing the training package.

10. Statutory Reviews

10.1 Safeguarding Adult Reviews (SAR)

A Safeguarding Adult Review must be conducted where “there is reasonable cause for concern about how the Safeguarding Adults Partnership, members of it or others worked together to safeguard the adult and death, or serious harm arose from actual or suspected abuse” (Care Act 2014). A review may also be commissioned in other circumstances where it is felt one would be useful, including learning from “near misses”.

This report is prepared by Stockport Safeguarding Adults Partnership.

In 2024/25 the Partnership received 7 SAR referrals, 2 of which were not deemed to have met the threshold. This is compared with 15 referrals the previous reporting year

	SAR Referrals received	Referrals progressing to mandatory SAR	Referrals progressed to discretionary SAR / LLR / other review	Inappropriate referrals	Referrals not progressed	Main themes							
						Self-neglect	Substance misuse	Physical health	Care Leaver / complex	Suicide / sudden death	Mental health	DA / DV	Other
Quarter 1	1	0	0		1			1					1
Quarter 2	2	0	0	1	2	1				1			
Quarter 3	2	0	0		1		1		1	1			1
Quarter 4	2	0	0	1	2								1
Notes One SAR referral received in Q3 is the subject of a learning review (PSII) and the Partnership is reviewing whether a discretionary SAR would support with this learning.													

SAR 8

MM lived alone and had a learning disability and autism. He experienced difficulties with his physical health and there have been long-standing concerns around his alcohol consumption. He was taken to hospital to drain his stomach and due to concerns regarding his health and presentation a safeguarding referral was raised. He was admitted to hospital on 14th February 2023 and passed away on 18th February 2023.

His cause of death was detailed as pneumonia, alcoholic liver disease, and severe malnutrition.

Stockport FT actively contributed to the review, its published report, and the resulting action plan. This included participating in the multi-agency self-neglect audit, supporting the delivery of learning circles for the Partnership Board, and presenting improvements made to support patients with a learning disability and/or autism within the Trust.

SAR 9

This referral concerned the death of a 76-year-old woman with mixed Alzheimer's and vascular dementia, who was living in a Stockport residential care home until her passing. Due to restricted mobility, she developed moisture lesions that progressed to grade 2 pressure ulcers, becoming ungradable. She sadly died with the cause recorded as vascular dementia, with osteomyelitis from the pressure ulcer likely contributing to her death.

SFT played an active role in the review, published report, and action plan. This included supporting learning circles for the Partnership Board and presenting actions taken to strengthen relationships and enhance collaborative working between community nursing teams and independent care home providers.

SAR 10

This referral is a thematic SAR concerning the deaths of patients at Cheadle Royal Hospital is ongoing at the time of the report. A panel meeting is planned for Quarter 1 of 2025/26 to consider the draft report which Stockport FT has contributed to.

10.2 Safeguarding Child Practice Reviews (SCPR)

Local authorities in England must notify the National Child Safeguarding Practice Review Panel within 5 working days of becoming aware of a serious incident. This is whereby a local authority in England knows or suspects that a child has been abused or neglected, the local authority must notify the Child Safeguarding Practice Review Panel if –

- The child dies or is seriously harmed in the local authority's area
- While normally resident in the local authority's area, the child dies or is seriously harmed outside England.

Safeguarding Partners must undertake a rapid review into all serious child safeguarding cases promptly and complete this within fifteen working days of becoming aware of the incident.

The table below demonstrates the number of agency check / rapid review responses submitted for children and young people who have died or have suffered significant / serious harm. The safeguarding children team have responded to all requests within the required time frame and submitted the evidence accordingly.

Child Safeguarding practice Review/Learning Review Agency Report Submissions/Partnership Audits 2024/25	
Quarter 1	2
Quarter 2	1
Quarter 3	3
Quarter 4	4

10.3 CSPR's Commissioned in 2024/25

The Smith Family

In November 2023 a relative of a 13-year-old girl told health professionals that he had sexually abused the child in the past, and that this abuse was known about by her parents. The police visited the family and identified significant concerns about the state of the home. The police officers removed the children using their powers, reporting that the conditions were 'horrific' and 'the worst they had seen in a very long time'.

Stockport FT contributed to this CSPR, submitted a single agency action plan and will be undertaking an audit to provide further assurance.

TC

TC was brought to the Emergency Department (ED) of Stepping Hill Hospital via ambulance on 20th November 2024, accompanied by his mother and grandmother. He presented with bruising to head, torso and legs. Bloods were taken to see if the bruising was linked to illness such as sepsis.

A CT of his abdomen and Chest X-Rays revealed a laceration to the liver, injury to the pancreas, bruising around the kidney, recent buckle fractures of the ribs as well as old rib fractures.

TC was transferred to Royal Manchester Children's Hospital on the 21/11/2024.

A safeguarding children rapid review meeting took place on the 16/11/24 to determine if the threshold for a CSPR has been met.

The panel decision was split and after lengthy discussions the decision to proceed to a CSPR was made and agreed by the national panel in January 2025.

A learning event has been scheduled for the 18th of June 2025 and panel meetings continue while the CSPR report is being written.

Key Themes



10.4

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Domestic Abuse Related Death Reviews (DADR) – Formerly Referred to As Domestic Homicide Review (DHR)

A Domestic Abuse Related Death Review is carried out when a person has died because of abuse, violence or neglect by a relative, intimate partner, or member of the same household. These reviews are conducted to understand the circumstances surrounding such deaths and to identify areas for improvement in preventing domestic abuse related fatalities.

The term was changed from Domestic Homicide Review following calls to better recognise deaths from domestic abuse related suicide.

There were 2 ongoing Domestic Abuse Related Death Reviews in 2024/25

DARDR 22

The report is currently going through Quality Assurance with the Safer Stockport Partnership and is awaiting submission to the Home Office.

DARDR 23

This review has been delayed due to a criminal investigation and the coronial process. A learning event is being convened to share the learning.

Key Themes



11.0 Deprivation of Liberty Safeguards (DoLS) Applications

The adult safeguarding team review, manage and administer the DoLS process for the Trust. Each authorisation is reviewed and sent to the patients Local Authority.

The team review authorisations prior to submission to ensure:

- A relevant mental capacity assessment is document
- Accurate, appropriate and comprehensive DoLS applications are received
- The appropriate use of the Mental Capacity Act

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11.1 DoLS Activity

There were **1855** Dols authorisations made during the year, compared to **2012** the previous year, a decrease of **8% (157)**. This is a reduction although figures from previous years during the pandemic would suggest we have seen an increase in staff awareness on the DoLS process as applications have increased by 40% since the recovery of the pandemic.

DoLS Applications	
Financial Year	Total
2024-25	1855
2023-24	2012
2022-23	2526
2021-22	1689
2020-21	1193

11.2 DoLS Performance Activity

Each DOLS application is reviewed by the safeguarding adult's team prior to the safeguarding administrator sending to the appropriate DOLS supervisory office.

An administrative and clinical review is undertaken prior to the submission of the DOLS application form. This ensures a relevant mental capacity assessment is documented accurate, appropriate, and comprehensive DOLS is in place.

2024-2025	Q1	Q2	Q3	Q4	Total
Authorised (Urgent)	523	401	498	433	1855
Trust Compliant-AMAT	86.7%	95.0%	93.5%	94.9%	92.3%
Rejected	35	1	0	0	36

DoLS Applications Sent to Local Authority

Local Authority	Q1	Q2	Q3	Q4	Total
Stockport	327	296	324	320	1267
Derbyshire	39	40	45	42	166
Cheshire East	30	18	15	18	81
Tameside	11	6	12	4	33
Manchester	6	4	1	0	11
Other	3	3	2	2	10
Trafford	2	1	3	1	7
Rochdale	0	1	2	0	3
Oldham	0	2	1	0	3
Bury	0	1	0	0	1
Total	418	372	405	387	1582

A Standard Operating Procedure (SOP) was introduced to guide Divisions on the standards and expectations for DoLS authorisations, resulting in significant improvements in the quality and detail of submissions, and increased staff awareness. Trust-wide compliance for

2024/25 stands at **92.3%**, with only **36** authorisations returned for further information. Supporting tools, resources, and learning materials are available via the Adult Safeguarding microsite. Monthly audits demonstrate consistently high and improving compliance, with ongoing feedback and the new SOP further strengthening practice.

12.0 Children in Our Care (Looked After Children)

This reporting year has seen a change in terminology from Looked After Children to ensure staff are aware of the importance and power of language used by professionals in assessments.

The Trust is commissioned to provide a dedicated resource for Children in Our Care which sits alongside universal services. Together these fulfil the aim of reducing inequalities and ensuring the health needs for Children in Our Care are met, in accordance with statutory guidance.

The vision across Stockport is that Children in our Care will access universal health services in the same way as other children and young people. Additional needs will be met through targeted interventions and specialist services. Furthermore, children and young people who are cared for by any Local Authority, but living in Stockport, will receive the same opportunities to access health services within the borough irrespective of their originating ICB. It should however be acknowledged that this can cause difficulties due to commissioning arrangements for these children within some services.

Stockport can and does provide care to Children in Our Care from outside the Local Authority due in part to the high number of private residential provisions. Placements here from other local authorities have a significant impact on the whole health economy.

12.1 Placements

In addition to Stockport's 153 mainstream foster carers there are 73 connected carers for Stockport children living in Stockport, in addition to this there are numerous different IFA (Independent Fostering Agency) carer's registered in Stockport. Stockport also has many children who are looked after but continue to be placed at home with their parents.

The large number of children placed in Stockport by other areas are accommodated in a variety of settings, including private agency foster carers, residential homes, 16+ provision, therapeutic placements and specialist provisions. Currently Stockport has 58 homes providing accommodation for some of the most complex and vulnerable young people in Stockport, who access a variety of provision across the health economy.

The Specialist Children in Our Care health team ensure that information is shared timely and appropriately to support access to services while here in Stockport.

Children in Our Care placed here from outside the Greater Manchester (GM) area face further challenges as they are not provided with any on-going therapy they may require. The current commissioning arrangements would mean that following assessment it would be up to the placing ICB to find and commission something privately.

There are currently 248 children from other local authorities placed in Stockport with a further 202 moving into the area during the year. For Stockport Local authority there were

497 Children in Our Care at the end of Q4 with an additional 254 children starting their journey into care over the year.

A new dataset has been created this reporting year, in line with the new NHSE statutory reporting requirements. The new data requirements from both NHSE and GM ICB are placing further emphasis on children placed from both GM and further away.

12.2 Specialist Children in Our Care Team Activity

The Specialist Children in Our Care health team provides a specialist resource to address the health needs of children and young people who are looked after by Stockport Local Authority, and young people who are living in Stockport who are looked after by other LAs. The delivery model for Children in Our Care is that services will primarily be delivered through existing primary and community services (such as health visitors, school nurses), with additional targeted support provided by the Specialist nursing team for those children and young people who either do not fall within the remit of, or find it difficult to access, local services. The team coordinate health assessment requests and provide support and guidance to professionals completing assessments. They also provide quality assurance for health assessments completed both in and out of area.

Most Stockport children that are placed out of area remain within Greater Manchester (GM) meaning many of the children living on the borders of Stockport remain on Stockport caseloads. The Specialist nursing team is currently working with a caseload of 160 young people, in addition to this the team coordinates the health requests for those children placed out of area and provides clinical oversight for those children with additional complexities and risk.

Information including safeguarding information, placement moves and requests for this year's 633 health assessments comes through the Specialist team, activity is captured through the quarterly activity reports and will need considering in terms of capacity, delivery and the commissioning of future service requirements.

2024/25	Q1	Q2	Q3	Q4
Placement change in Stockport	66	96	84	77
Stockport movements out	62	54	53	42
Other LA movements in	81	46	61	27
New into care	80	68	54	52

12.3 Emotional Health and Wellbeing

There is a significant challenge for looked after children to access appropriate mental health provision, with the reduction of tier 2 services, looked after young people are required to meet the threshold for tier 3 to receive specialist support. The health and wellbeing team commissioned by the LA are providing consultation to Social Workers and supporting carers and schools with interventions. There is hope in the future that they will be able to offer 1:1 work with young people. All children between the ages of 4-16years have an SDQ (strengths and difficulties questionnaire) completed to inform the health assessment. Health professionals completing the review health assessment (RHA) also complete an age-

appropriate assessment of emotional well-being; this provides a basis for discussion, support and on-going referral.

Children placed locally from other authorities outside of GM experience further challenge with emotional health support as currently Stockport CAMHS do not provide therapeutic support for these children.

12.4 Initial Health Assessments (IHA)

The Foundation Trust is commissioned to deliver 52 clinics a year which has been the capacity required to meet the statutory requirement.

There have continued to be challenges with the timeliness of receiving IHA requests which is having an impact meaning only 49% were seen within timescales in across the year. While this is an improvement on the percentage from last year, the change in the reporting requirements for NHSE and GM ICB will affect this percentage considerably in the future. As a team we will continue to monitor the trusts performance and will provide exception reports to provide understanding for those things outside our control.

There has been some further analysis into the impact of the delayed requests which has been shared with the local authority. Stockport NHS FT will continue to work in partnership in fulfilling the statutory health assessment and works proactively in trying to meet the challenging timescales.

Over the reporting year the trust delivered 52 clinics which provided 210 appointment slots. There were 31 appointments not attended, all of which were offered another appointment. Of these 9 had a decliner pathway completed which included the offer of a home visit from the specialist nursing team.

The team have had a continued focus to try and further decrease Did Not Attend (DNA)/Was Not Brought (WNB) rate and have identified a variety of factors. There needs to be continued work highlighting the importance of the appointment, alongside some continued communication out to placements and SW's to both support attendance and reduce the perceived flexibility and non-importance of these appointments.

12.5 Review Health Assessments (RHA)

Review Health Assessments are completed by the caseload holder. In Stockport the Health Visitor completes the under 5's and the School Nurse would complete any 5-16's in mainstream education. Any 16–18-year-olds or young people in specialist educational provision would be completed by the Specialist Children in Our Care health team.

The challenges in meeting these KPI's have previously been monitored within a dashboard. There are now different reporting expectations, but the data will continue to provide oversight to managers and will feed into continuous service review.

The table below shows the comparison in completed assessments over the last 5 years.

Completed by	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024	2024-2025
IHA	181	185	128	173	185	163
Specialist team	105	84	102	105	128	120
School Nursing	222	276	299	269	268	276
Health Visiting	96	113	133	154	132	104

12.6 Missing from Home

Children in Our Care make up a significant proportion of all children that go missing in Stockport. Ensuring that they have a multiagency plan for support is key when considering their safeguarding needs.

The team ensure that the appropriate professional receives the notification so they can review and support appropriately. This has a significant impact on the work of both the specialist health team alongside the wider health economy with 631 missing notifications processed during the reporting year. This data shows a decrease from the 768 missing notifications processed during 2023/24.

13.0 GMP Right Care Right Person Initiative

GMP Right Care, Right Person (RCRP) is a strategic approach adopted by Greater Manchester Police (GMP) to ensure that individuals experiencing mental health crises or other vulnerabilities receive the most appropriate support — from the right agency, at the right time.

Originally developed by Humberside Police and endorsed by the College of Policing and National Police Chiefs' Council, RCRP aims to shift the focus of certain non-crime and welfare-related incidents away from policing and toward health and social care professionals, who are better equipped to handle them.

GMP began implementing the RCRP model in response to:

- Increased police time spent dealing with mental health and social vulnerability calls
- Recognition that policing alone cannot provide the best outcomes for vulnerable people
- National direction to refocus police efforts on crime prevention and public safety

The key principles of the model are:

- **Appropriate Response:** Ensuring people in mental health crisis are supported by clinical experts, not defaulted to police intervention
- **Partnership Working:** Collaborating with NHS, local authorities, ambulance services and social care
- **Reducing Risk of Criminalisation:** Avoiding un-necessary criminal justice involvement for those with health or social needs.

Impact and benefits of the model include:

- Reduced inappropriate police deployments
- Improved response for genuine emergencies
- Better health and social care outcomes
- More efficient use of police resources

The phased roll-out of RCRP began in 2023 in Manchester and Salford and extended to Stockport at the beginning of Q3 in 2024.

Whilst positive in aiming to ensure that people in crisis are supported by the most appropriate agency, the RCRP initiative poses several challenges for the FT and wider health and social care systems, particularly regarding walkouts from Emergency

Departments where police would previously have attended to support in returning patients identified as vulnerable to the department.

The FT developed a Missing Patient policy in partnership with GMP colleagues to ensure that thresholds were aligned for patients identified as “High Risk” however there remains some ambiguity around processes, in defining whether the responsibility for performing welfare checks is a health or police responsibility.

The FT continues to work collaboratively with Police and Mental Health colleagues in addressing any issues with the RCRP initiative and provides representation at the weekly multi-agency oversight meetings.

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14. Conclusion

Over the past year, the safeguarding team has continued to play a vital role in promoting the safety, wellbeing, and rights of the most vulnerable individuals across our Trust. Despite operating within a complex and evolving healthcare landscape, and often with limited capacity, the team has remained committed to delivering high-quality safeguarding practice, strengthening multi-agency partnerships, and supporting staff through training, advice, and supervision.

Key achievements against the priorities set last year demonstrate the team's dedication, adaptability, and collaborative spirit. The continued visibility and influence of safeguarding across the Trust reflects the strength of our shared commitment to a culture where safeguarding is everyone's responsibility.

Looking ahead, we will continue to build on this foundation, responding to emerging risks, learning from national developments, and ensuring that safeguarding remains embedded in every aspect of care. With the support of our colleagues and partners, we remain focused on ensuring that every person we serve is protected from harm and empowered to live safely.

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15. Supporting Documents

Working Together to Safeguard Children (DfE 2024) [Working together to safeguard children - GOV.UK](#)

Safeguarding Children and Young People – Intercollegiate Document (2019) [Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff | Royal College of Nursing](#)

Section 11, Children’s Act (2004) <http://www.legislation.gov.uk/ukpga/2004/31/section/11>

Children in Care [Promoting the health and wellbeing of looked-after children - GOV.UK](#)

Safeguarding accountability and assurance framework 4th ed (June 2024) [NHS England » Safeguarding children, young people and adults at risk in the NHS](#)

The Care Act (2014) [Care Act 2014](#)

Mental Capacity Act (2005) [Mental Capacity Act 2005](#)

Adult Safeguarding – Intercollegiate Document (2024) [Adult Safeguarding: Roles and Competencies for Health Care Staff | Publications | Royal College of Nursing](#)

Looked After Children – Intercollegiate Document (2025) [Looked After Children: Roles and Competencies of Healthcare Staff | Royal College of Nursing](#)

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				Agenda No.	16
Meeting date	7th August 2025	Public		Confidential	
Meeting	Board of Directors				
Report Title	Health & Safety Annual Key Performance Indicators (KPI) Report 2024/2025				
Director Lead	Chief Nurse	Author	Mike Craven Health & Safety and Risk Manager		

Paper For:	Information	X	Assurance		Decision	
Recommendation:	Members to note the Key Performance Indicators for health and safety within Stockport NHS Foundation Trust during 2024/2025.					

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
	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
	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
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
	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

Where issues are addressed in the paper	Section of paper where covered
Equality, diversity and inclusion impacts	Not applicable
Financial impacts if agreed/not agreed	Not applicable
Regulatory and legal compliance	Throughout the Report
Sustainability (including environmental impacts)	Not applicable

Executive Summary

This report provides provide the Group with a summary of principal activity and outcomes relating to the Key Performance Indicators (KPI) for health and safety within Stockport NHS Foundation Trust during 2024/2025.

Data is reported via the standing quarterly reports.

Assurances are provided to the Quality Committee, quarterly, by submission of a key issue and assurance report

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Health & Safety Joint Consultative Group (H&S JCG)

Annual KPI Report – 2024/2025 (Presented to the meeting on 7th May 2025)

Executive Summary

This report provides provide the Group with a summary of principal activity and outcomes relating to the Key Performance Indicators (KPI) for health and safety within Stockport NHS Foundation Trust during 2024/2025.

Data is reported via the quarterly reports submitted to the H&S JCG meeting in May, August, November and February.

Assurances are provided to the Quality Committee, monthly, by submission of a Key Issues and Assurance Report.



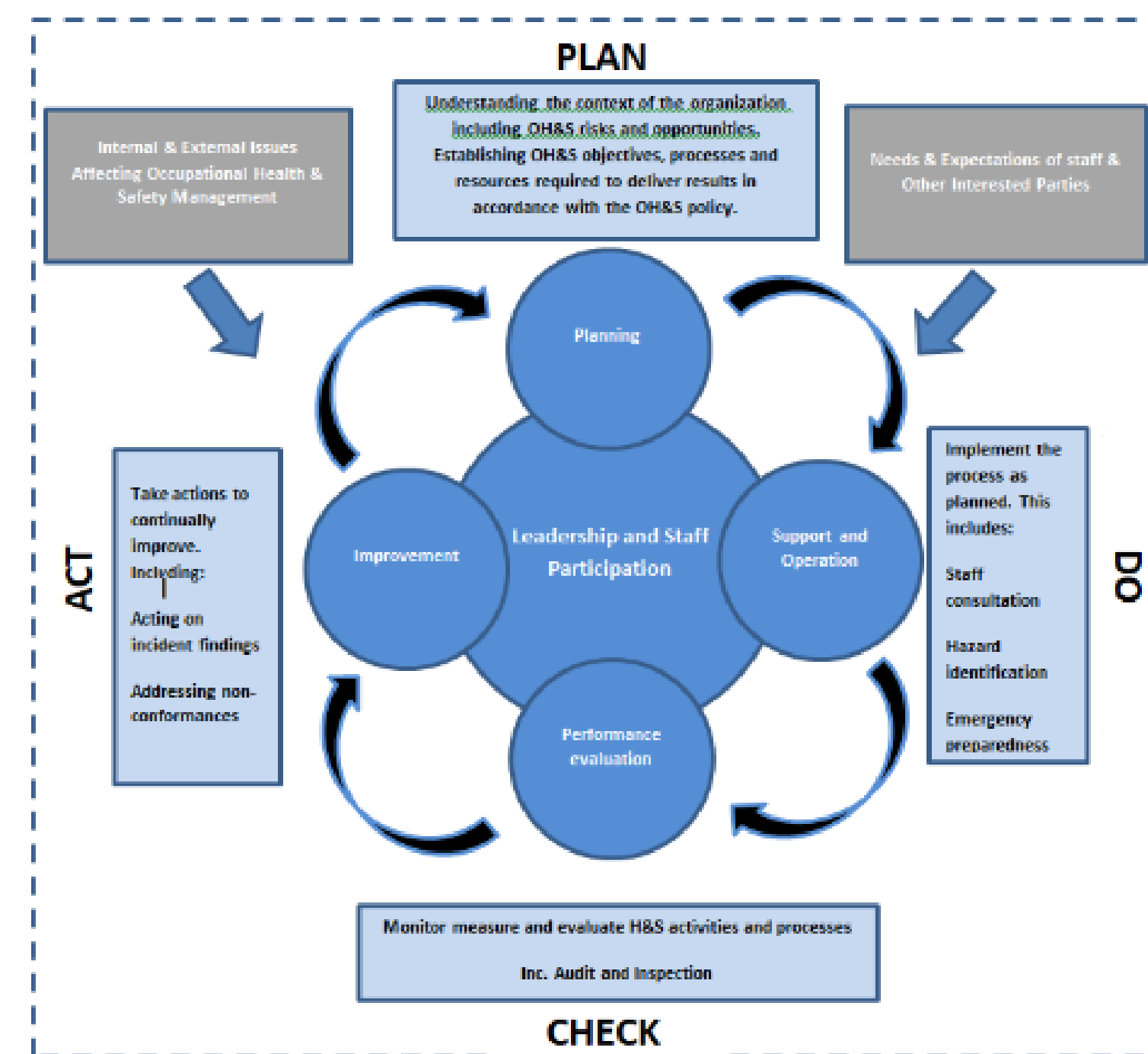
1. Introduction

This report provides analysis of the delivery of KPI's for Health and Safety Management throughout the Trust for the financial year 1st April 2024 to 31st March 2025. The Health and Safety at Work etc. Act 1974 provides a legislative framework to promote, stimulate and encourage excellent health and safety at work standards with delegated responsibility through the Chief Executive to implement systems that ensure Trust staff and contractors, work in a safe and compliant manner to protect themselves, patients and visitors from significant or avoidable harm.

In progressing the Health and Safety strategy throughout the Trust, the Health, Safety and Risk Manager continues to work to the Health & Safety Executive (HSE) guidance, HSG65 – “Managing for health and safety” – and observe the ISO 45001:2018 – Occupational Health & Safety Management System – Standard as a framework for our organization to document and improve our operational practices in order to prevent work-related injury and ill-health.

Working to HSG65 helps the Trust to achieve its objectives and demonstrate that its Health and Safety Management System (HSMS) is effective. The management system will help to translate its corporate objectives to prevent incidents into a systematic and ongoing set of processes that are supported by the use of appropriate methods and tools that can reinforce commitment to proactively improving performance.

The figure to the right illustrates HSG65 for the development of the HSMS, which uses the plan, do, check and act cycle to implement the process approach that delivers management system objectives, stakeholder requirements and staff safety.



2. The Trust's Health & Safety Objectives (1)



Stockport

NHS Foundation Trust

Historically, objectives up to 2023-2024 were to:

- Develop and implement a robust Health and Safety Management System that delivers continuous improvement
- Ensure a Healthy and Safe working environment for staff, patients and visitors
- Develop and maintain a culture of safety that promotes; openness, continuous improvement, research, innovation and positively acts upon learning

The objectives were reviewed by the incoming Health & Safety & Risk Manager, in consultation with divisional governance leads, and with staff-side partners, for 2024-2025, thus:

Key General Objectives:

1. To keep our employees safe and healthy at work
2. To keep those affected by what we do protected from harm caused by our activities
3. To protect the Trust and its people from the potential threat of legal (both, criminal – enforcement – and, civil – liability claims) action and financial loss.
4. To build and enhance a positive Health & Safety Culture
5. To ensure that Health & Safety aligns with the Trust values that, “We Care, We Respect, We Listen”

Specific Objectives (to support the above)

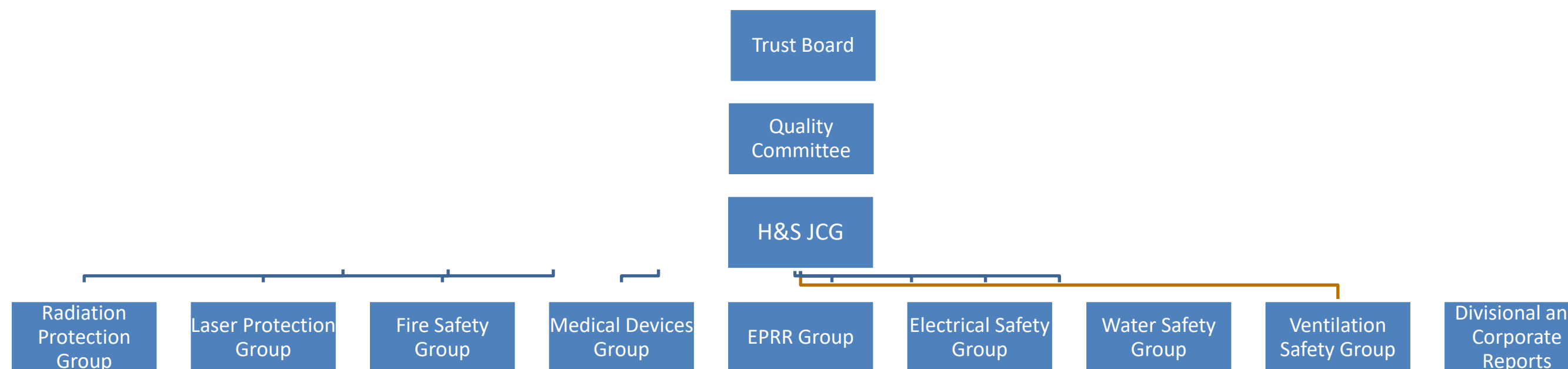
- Provide effective governance and oversight of Health & Safety.
- Maintain a safe and healthy working environment for all.
- Provide and maintain safe equipment, plant and machinery.
- Minimise the number of RIDDOR-reportable, lost-time, and foreseeable / avoidable workplace accidents.
- Provide effective Health & Safety training.
- Increase the level of staff involvement in Health & Safety
- Maintain (and enhance) an effective Health & Safety Management System
- Reduce incidence of, and harm (actual and potential) caused by identified key challenges

3. Health and Safety Joint Consultative Group (H&S JCG) and Supporting Groups

The H&SJCG has been established to plan, manage and monitor organisational compliance with statutory health and safety requirements and specific NHS duties. In this way, compliance with external organisational requirements such as the HSE are managed.

The H&SJCG receives reports from its sub-committees and ratifies policies approved at sub-committee level.

The H&S supporting committees are structured as follows:



4.1 Delivery of the KPIs within the Health & Safety Strategy – Audit & Inspection (1)

An annual programme was developed to identify what audit activity is required for the forthcoming year, and to ensure any areas of concern are addressed as soon as possible and that all regulatory requirements are met. The following methods of audit and inspection were to be carried out:

Safety Management System (HSMS)

An annual audit of the HSMS was carried out and presented by the Health and Safety and Risk through regular progress reports, with a final, closing report being submitted to H&S JCG in March 2024. This audit is a methodical and documented assessment of the trust's systems and processes relating to Health and Safety Management. It is be measured against the ISO 45001 criteria. And addresses the following factors:

- The strengths and weaknesses of the current system
- How the system performs within the aims of the trust
- If the trust is fulfilling its legal obligations
- If a proper performance review system is in place

A report on the annual audit was presented at the 2025 Annual Meeting of the H&S JCG, with quarterly progress reports being presented to H&S JCG throughout the 2024/25 year.

4.1 Delivery of the KPIs within the Health & Safety Strategy – Audit & Inspection (2)



Stockport

NHS Foundation Trust

Monthly inspections commenced from Q1 2021/22. These are completed by each ward/department and captured using the AMaT system currently being used for clinical audit, fire safety etc. Following consultations, and discussions at the H&S JCG, these inspections moved to quarterly with effect from 01/10/2023 (Q3, 2023/24).

The KPI for all Divisions and Corporate function was to achieve 100% proactive monitoring in accordance with agreed plan. Commencing Q1 2021/22. The compliance rates for financial year 2024-2025 – compared in the table below with compliance rates for the previous three years - for each Division and Corporate function were as follows:

	Audits Completed 2024/25	% Completion 2024/25	% Completion 2023/24	% Completion 2022/23	% Completion 2021/22
Trust Level	453/545	83.11%	78.49%	63.90%	51.07%
Corporate Services	38/60	63.33%	59.56%	65.55%	70.00%
Estates & Facilities	67/68	98.53%	90.44%	81.00%	81.00%
Integrated Care	95/118	80.51%	69.23%	43.90%	43.30%
Medicine & Urgent Care	98/112	87.50%	87.05%	75.22%	45.06%
Surgery	64/76	84.21%	92.50%	76.66%	49.70%
Women & Children	43/55	78.18%	75.00%	68.88%	50.10%
Clinical Support Services	48/56	85.71%	70.14%	N/A	N/A

The overall Trust compliance of completion of the audits was 83.11%, a further increase on 78.49% in 2023/24, in addition to the previous significant increases on 63.90% in 2022/23 and 51.07% in 2021/22.

Audit completions will remain as a KPI within the 2025-2026 Health and Safety Strategy.

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4.2 Delivery of the KPIs within the Health & Safety Strategy – Safety Metrics (1)

By the end of Quarter 4 2023/24, target reductions of 10% in incidents of ‘harm’ to staff were required for all Divisions and Corporate functions in relation to slips, trips and falls, needle-stick/sharps, physical assaults, moving and handling and collision/contact with objects.

In seeking to prioritise reductions in the categories of accident statistically most likely to be reportable under the Reporting of Injuries, Diseases & Dangerous Occurrences Regulations (RIDDOR) 2013, these reductions were reviewed for 2024-2025 as follows:

- slips, trips and falls (10%)
- needle-stick/sharps (10%)
- physical assaults (25%)
- moving and handling (20%)
- collision/contact with objects (10%).

By the end of Quarter 4 a target to ‘achieve a year-on-year reduction in the Injury Incidence Rate (“IIR”).

4.2 Delivery of the KPIs within the Health & Safety Strategy – Safety Metrics (2)

Study and Comparison of Injury / Incident Incidence Rate (IIR) Statistics 2021 to 2025

IIR = Injury / Incident Incidence Rate. Number of Injuries / Incidents X 1,000 ÷ Average number of employees (monthly).
 Example: If there were 17 incidents/injuries in the Division and “Workforce Central” advises that the number of employees (FTE) at month-end was 925. 17 X 1,000 = 17,000. Divided by 925, gives an IIR of 18.38 for that month. When using IIR for Injuries, the lower the IIR the better. The “Injuries” figure comes from Datix reports where the level of harm is greater than “None”. Details of Trust and Divisional performance – average monthly IIR – as follows:

Division	IIR – 2021/22 (Average)	IIR – 2022/23 (Average)	IIR – 2023/24 (Average)	IIR – 2024/25 (Average)
Trustwide	7.04	7.60	5.80	6.87
Surgery	13.92	13.43	9.70	10.22
Estates & Facilities	10.38	11.39	7.02	10.57
Medicine & UC	6.32*	9.87*	7.35*	8.27
Integrated Care	5.20	5.50	3.97	6.65
Women & Children	4.81	4.19	3.55	3.81
Clinical Support Services	Division not formed at this time	4.40	4.47	2.95

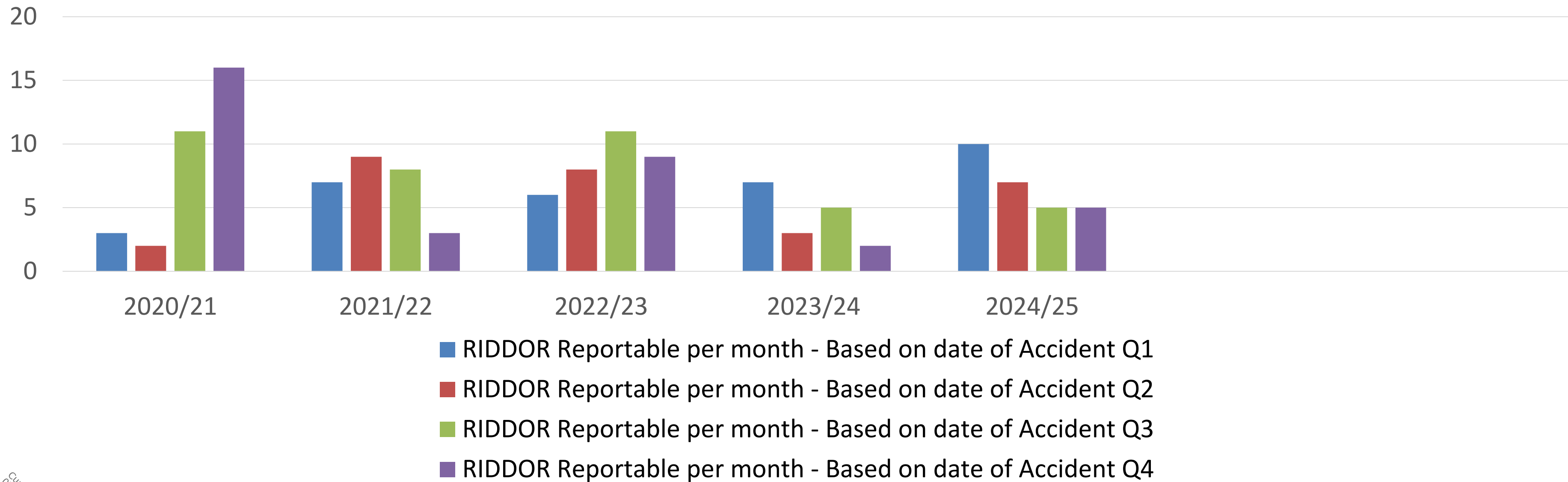
* The ED was a separate division at this time.

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4.3 Delivery of the KPIs within the Health & Safety Strategy – RIDDOR Reporting (1)

In financial year 2024-2025 there were 27 incidents reported under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). This compares to 17 for 2023-2024 and 35 for 2022/23.

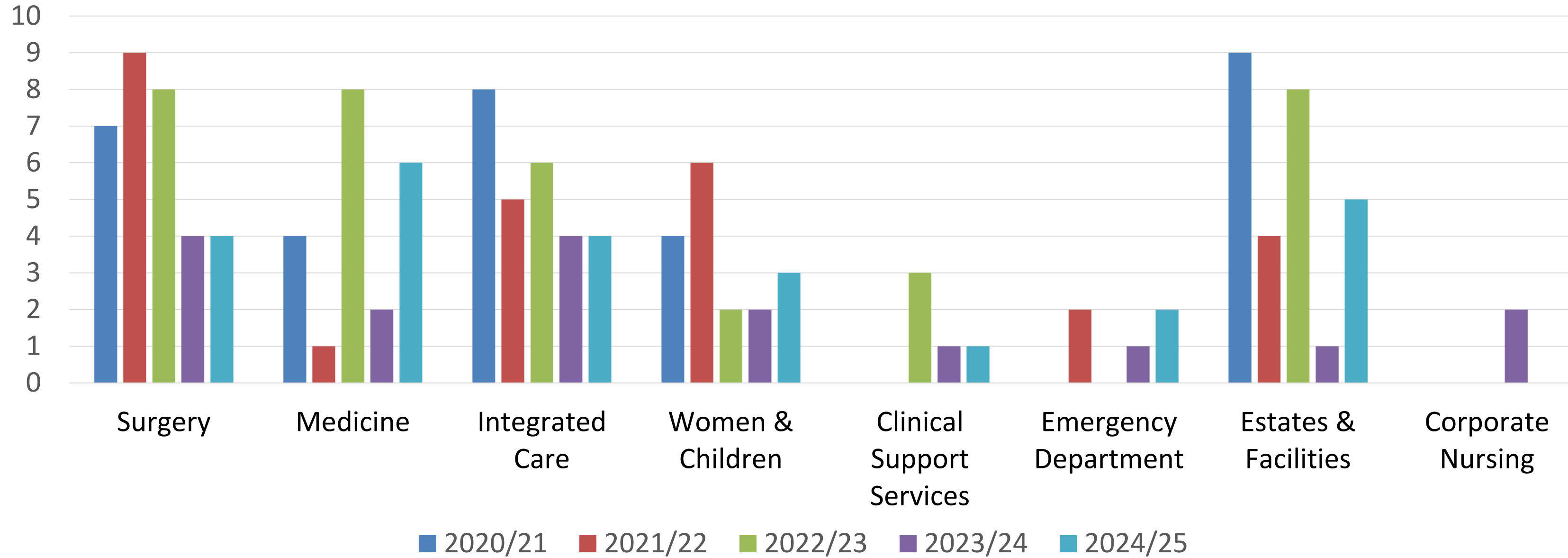
RIDDOR Reportable per month - Based on date of Accident



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4.3 Delivery of the KPIs within the Health & Safety Strategy – RIDDOR Reporting (2)

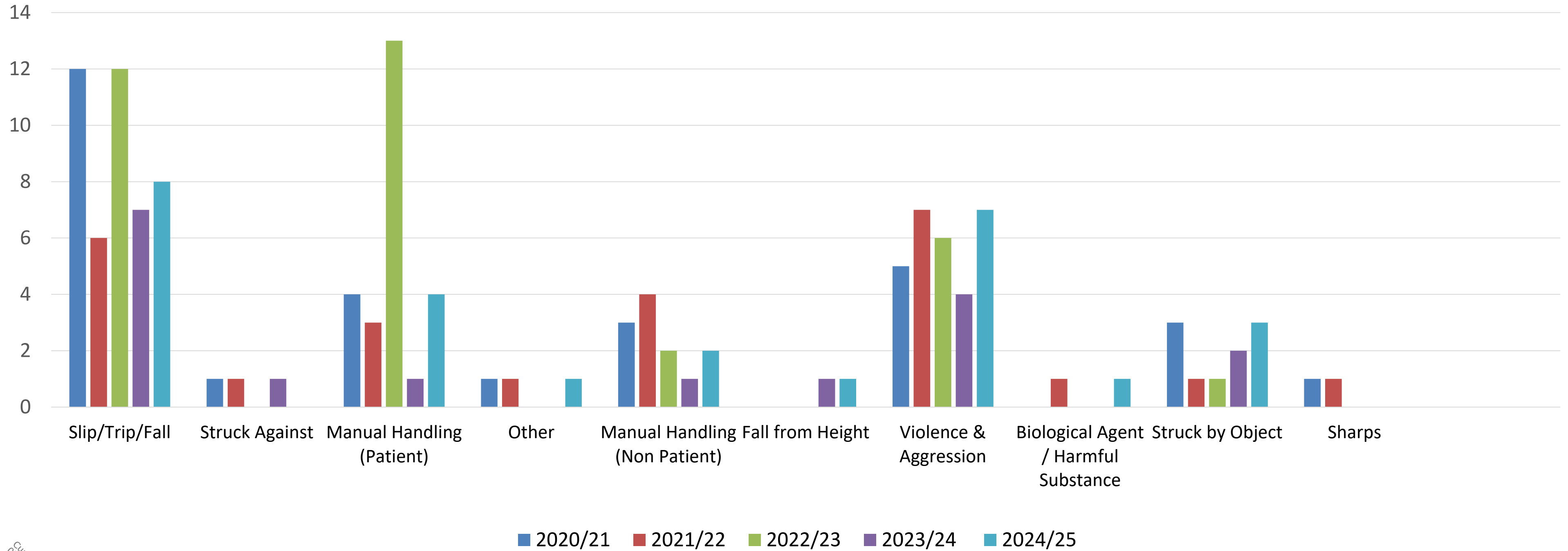
RIDDOR Reportable by Division



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4.4 Delivery of the KPIs within the Health & Safety Strategy – RIDDOR Reporting (3)

RIDDOR Reportable by Accident Classification



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4.4 Delivery of the KPIs within the Health & Safety Strategy – RIDDOR Reporting (4)

By the end of Quarter 4, a target to ensure ‘*All serious incidents (RIDDOR and potential claims) are investigated within agreed timescales and lessons learned are communicated*’. At the time of writing this report there were 4 RIDDOR investigations overdue. All RIDDOR reportable incidents had been investigated at Level 1 and lessons learned communicated within their respective Divisions and at the H&SJCG via Divisional and Corporate function reports.

(Note: The Level 1 reporting format was geared towards to investigation of patient incidents. The process and format was reviewed during 2023/24, and RIDDORs related to employees are now reported in a more appropriate manner and format.)

By the end of Quarter 4, a target to ensure “*All RIDDOR reports are submitted to the Health & Safety Executive (HSE) within the timescales set out within the Regulations*” (i.e. *within 10 days of the accident for “specified injuries” and within 15 days for “over seven-day incapacitation”*). Of 27 RIDDORs reported in 2024/25, 14 (52%) were reported within the required timescales; this compares with 59% in 2023/24, 23% in 2022/23 and 37% in 2021/22.

4.5 Delivery of the KPIs within the Health & Safety Strategy – Insurance Liability Claims

Claims

By the end of Quarter 4, a target to *achieve a reduction of EL and PL claims relating to workplace safety*. In 2023-2024, 7 Employers Liability claims and 3 Public Liability claims had been received by the Trust. In 2024-2025, 8 Employers Liability claims and 2 Public Liability claims were received. An overall increase/decrease of zero claims received by the Trust for 2024-2025.

Accident categories resulting in Employers Liability claims for 2024/25 were: Slips/Trips/Falls (3), Violence & Aggression (2), Manual Handling (2) and Exposure to Environmental Hazards (1).

Accident categories resulting in Employers Liability claims for 2023/24 were: Manual Handling (3), Violence & Aggression (2), Entrapment (1) and Contact/Collision with an Object (1).

4.6 Delivery of the KPIs within the Health & Safety Strategy – Significant Hazards

By the end of Quarter 4 a target to ensure all significant Health and Safety Hazards identified within the Trusts Duty Holders Matrix to be included within the Trusts Risk Register.

Assurances were sought from Duty Holders during 2024-2025, with the updates provided being added to the Matrix. In order to get a better understanding of assurance, and because many of the duties previously identified have been completed and/or require a review and/or update, the Health & Safety & Risk Manager will meet with Duty Holders in early 2025-2026 to complete a full review of the Matrix.

One area of risk included:

COSHH – The Trust COSHH Policy was been reviewed and updated. A new “COSHH Working Party” was been set up to replace the defunct “COSHH Committee”. The working party has met on seven occasions during 2024/25 – all meetings have been quorate - and reports back to the H&S JCG via a key issues report. The following areas have been represented and attended meetings:

- Health & Safety
- Occupational Health
- Pathology
- Surgery
- Estates & Facilities
- Procurement
- Pharmacy
- Theatres
- Medicine & Urgent Care
- Infection Prevention & Control
- Clinical Support Services
- Maternity
- Quality Control North-West (QCNW)
- Women & Children
- Integrated Care

4.7 Delivery of the KPIs within the Health & Safety Strategy – Legal Compliance

A target to provide assurance that the trust is either fully compliant with H&S legal requirements or has a SMART action plan in place to address non-compliance.

The Trust subscribed to a legal (and updates) register, which was being populated with evidence of compliance against respective legislation and for E&F HTM compliance, and where gaps are identified actions are put in place to rectify. The register was not used or updated during 2024/25; very few legal updates were forthcoming – largely as a result of the dissolution of Parliament in May 2024, the General Election of July 2024, and the general absence of many changes to Health & Safety legislation by the new, incoming Government; and E&F HTM compliance was measured and reported on via a separate, quarterly HTM Compliance report submitted to the H&S JCG. It was also noted that evidence of legal compliance was partly covered through use of the Trust's Health & Safety Management System (HSMS).

A decision was taken to cancel the annual subscription to the Legal Update Service, and to extend use of the HSMS and quarterly HTM reports to measure and provide assurance on legal compliance.

4.8 Delivery of the KPIs within the Health & Safety Strategy – Consultation & Communication

Safety, including monitoring of the Duty Holder's Matrix is a continuous standing agenda item on Divisional and Directorate governance meetings. Formal meetings between staff-side representatives and the Health, Safety and Risk Manager are held quarterly via the "Health & Safety – Staff Side Representatives Collaborative Forum", and the Health & Safety & Risk Manager has established a strong working relationship with Staff-Side Representatives, which includes regular informal meetings. Bulletins and briefings are sent out periodically to all staff to raise awareness of specific Health and Safety topics.

Health & Safety messages have been shared via the Trust's "Risky Business" publication, with the following topics being published in 2024/25.

- Faulty or Damaged Furniture and Moving & Handling Equipment
- Kitchen Safety
- Risk Training Sessions
- Violence & Aggression – 7 Minute Briefing

4.9 Delivery of the KPIs within the Health & Safety Strategy – H&S JCG (1)

For 2024-2025 the following targets were set in relation to the H&SJCG;

1. 100% (12) Quarterly H&S JCG or Collaborative Forum meetings held according to Terms of Reference.
2. 100% (Quorate) staff side representation at all JCG meetings.
3. 80% membership attendance at H&SJCG.
4. 100% Senior Management representative attendance for all business groups.

1. Achieved – 100% of meetings were held, with the full JCG meeting in May 24, August 24, November 24 and February 25, and the two Collaborative Forums meeting in-between.
2. Not achieved – 75% of meetings were quorate, with only one Staff-Side Representative attending the November 24 meeting.
3. Not achieved – May 24 (13/20 = 65%); August 24 (14/21 = 67%); November 24 (11/20 = 55%); February 25 (12/20 = 60%). However, the non-attendees do include four delegates who did not attend any meetings, and the Terms-of-Reference for 2025/26 have been reviewed to consider the ongoing Group membership.
4. Not achieved – 75% compliance – the Senior Management Representative was unable to attend the August 24 meeting. However, the Representative is a single, named person, and the Terms-of-Reference for 2025/26 have been reviewed to consider whether or not this position might be shared to allow other Senior Managers to experience the meetings.

4.9 Delivery of the KPIs within the Health & Safety Strategy – H&S JCG (2)

A significant review of the H&S JCG Terms of Reference had been carried out at the end of 2023/2024. For 2024-2025, the main H&S JCG meetings moved from monthly to quarterly (May, August, November and February), with an AGM in March. These quarterly JCG meetings were supported by two “Collaborative Forums” – one attended by the Health & Safety & Risk Manager and Divisional Governance, the other attended by the Health & Safety & Risk Manager and Staff Side representatives – both meeting on a quarterly basis. The main aims of the Collaborative Forums were to increase staff side involvement and practical involvement in Health & Safety issues.

All meetings (eight) of the Collaborative Forums took place in 2024/25 and each meeting was quorate. An annual report from each Forum was presented to the JCG AGM (actually held one week later than planned on 2nd April 2025) and the overwhelming view was that the above aims had been achieved.

4.10 Delivery of the KPIs within the Health & Safety Strategy – Health & Safety Training (1)

As of March 2024, the compliance of mandatory Health and Safety training was as follows:

	Fire Safety	Health, Safety and Welfare	Moving and Handling - Level 1	Moving and Handling - Level 2	Conflict Resolution
Stockport NHS Trust	98.05%	96.75%	95.52%	91.22%	96.52%
Clinical Support Services	98.99%	98.49%	98.15%	92.68%	98.49%
Corporate Services	98.93%	97.33%	97.24%	92.59%	96.79%
Emergency Department	96.48%	95.59%	91.14%	79.05%	96.48%
Estates & Facilities	94.27%	94.47%	94.26%	100.00%	95.45%
Integrated Care	98.88%	98.11%	96.03%	93.44%	97.68%
Medicine & Urgent Care	96.84%	94.35%	88.82%	91.75%	94.80%
Surgery	98.41%	96.08%	94.31%	88.35%	95.33%
Women & Children	99.53%	98.46%	98.14%	95.17%	97.39%

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4.10 Delivery of the KPIs within the Health & Safety Strategy – Health & Safety Training (1)

As of March 2025, the compliance of mandatory Health and Safety training was as follows:

	Fire Safety	Health, Safety and Welfare	Moving and Handling - Level 1	Moving and Handling - Level 2	Conflict Resolution
Stockport NHS Trust	97.68%	96.70%	95.63%	91.13%	96.05%
Clinical Support Services	98.21%	97.83%	96.87%	92.31%	97.70%
Corporate Services	98.08%	98.43%	97.09%	93.33%	97.20%
Estates & Facilities	98.38%	97.16%	96.54%	100.00%	97.36%
Integrated Care	98.59%	97.61%	97.28%	95.70%	96.63%
Medicine & Urgent Care	97.05%	94.79%	91.25%	91.81%	94.18%
Surgery	96.65%	95.65%	92.16%	89.10%	95.15%
Women & Children	97.97%	97.73%	97.43%	85.78%	96.53%

Further progress has been made on an already high level of compliance, in that, using the RAG-rating system, 75% of the indicators were green at the end of March 2025 – compared with 64% at the end of March 2024.

4.11 Delivery of the KPIs within the Health & Safety Strategy – Health & Safety Action Plan (1)

An independent audit of the health and safety arrangements of the Trust was carried out in September 2020. The aim was to assess compliance of current health and safety arrangements in place and to carry out a gap analysis and identify areas for improvement. The methodology used was to compare against a recognised ISO standard for Health & Safety (ISO45001). From the findings of the audit a Health and Safety Plan was developed to address gaps identified. A summary of the progress of the Health and Safety Plan and Roadmap since its adoption in 2022 is as follows:

Indicator	Update
Develop a Health and Safety Manual using ISO45001 as a foundation.	The Health and Safety Manual was partially written by the previous Health & Safety & Risk Manager and continues to be progressed as a “working document” by the current post-holder.
Initiate a triannual independent audit of safety management in line with ISO 45001	This was intended to be looked at in 2024/25 when new initiatives and arrangements had been implemented and bedded-in, and the Health & Safety Joint Consultative Group (guided by the Health & Safety & Risk Manager) was satisfied that the Trust was completely ready for an independent audit. This will be looked at by the H&S JCG again during 2025/26, including a further assessment of what the likely benefits (versus costs/time/effort) would be.
Carry out a gap analysis of Trust compliance against the NHS Workplace Health and Safety Standards 2022.	Work is ongoing and a good deal of progress has been made through use of the Trust’s Health & Safety Management System (HSMS), and will continue in 2025/26, with the H&S JCG receiving regular progress reports. The two newly formed H&S Collaborative Forums - H&S & Staff-Side, and H&S & Divisional Governance - have had a greater practical involvement.

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4.11 Delivery of the KPIs within the Health & Safety Strategy – Health & Safety Action Plan (2)



Stockport

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Indicator	Update
Populate the trust legal register.	<p>The Trust subscribed to a legal (and updates) register, which was being populated with evidence of compliance against respective legislation and for E&F HTM compliance, and where gaps are identified actions are put in place to rectify. The register was not used or updated during 2024/25; very few legal updates were forthcoming – largely as a result of the dissolution of Parliament in May 2024, the General Election of July 2024, and the general absence of many changes to Health & Safety legislation by the new, incoming Government; and E&F HTM compliance was measured and reported on via a separate, quarterly HTM Compliance report submitted to the H&S JCG. It was also noted that evidence of legal compliance was partly covered through use of the Trust’s Health & Safety Management System (HSMS).</p> <p>A decision was taken to cancel the annual subscription to the Legal Update Service, and to extend use of the HSMS and quarterly HTM reports to measure and provide assurance on legal compliance.</p>
Raise awareness of the Health & Safety Policy using a campaign targeting at all levels to: Engage with duty holders, accounting officers and front-line teams so that they know their individual and collective responsibilities:- Clarify expectations of all employees, visitors and contractors	The trust Health and Safety Policy was reviewed, updated and re-issued in February 2024.
Safety audit and inspection: - Update the Health and Safety audit matrix in this document.	Health and Safety audits are now embedded. Frequency of the audits was changed from monthly to quarterly from October 2024, with additional “H&S walkabouts” promoting increased staff-side and trade union involvement being promoted.

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4.11 Delivery of the KPIs within the Health & Safety Strategy – Health & Safety Action Plan (3)

Indicator	Update
Update and approve a Safety Management Strategy to: - Shape the Board's goals and ambition for safety management; - Support the adoption of a proactive, anticipatory safety culture; - Drive demonstrable improvement in safety outcomes.	The Health and Safety Strategy was written and approved.
Review the Duty Holders Matrix setting out (for each identified hazard arising from the Trust's undertakings and primary activities undertaken by the Trust and contractors): - The hazard, who might be harmed and how: - Who the duty holder is; - Who the responsible person for implementation is; - How the hazard is controlled; - Updated evaluation of risk; and - Who to contact for advice.	The Duty Holder's Matrix was embedded and updated quarterly. During 2024/25, it became clear that many issues within the Matrix had been completed, did not necessarily require any further review or update, and/or may potentially require replacement In 2025/26, the Matrix will be reviewed and further questions asked on assurance.
Obtain written confirmation from new Duty Holders and responsible officers that confirm they: - understand and agree to the responsibilities assigned to them for the oversight and management of specific safety hazards; - are clear on their obligations for planning, implementation, monitoring and assurance for each duty assigned to them	As above
Undertake specific 'safety climate survey' to assess and evaluate safety culture and benchmark results with other NHS Trusts and the IOSH Healthcare Group.	This was not completed due to having an agreed method of delivery. This will remain on the Health and Safety Plan 2025-2026. The Health & Safety Manager has regularly attended meetings of the IOSH Healthcare Group, although opportunities for benchmarking have been extremely limited to date.
Explore ways to make safety more prominent within the Trust's organisational values and behaviours	This is an ongoing piece of work that will remain on the Health and Safety plan indefinitely.

4.11 Delivery of the KPIs within the Health & Safety Strategy – Health & Safety Action Plan (4)



Stockport

NHS Foundation Trust

Indicator	Update
Review and confirm responsible persons/Manager training provision for safety management. Where any gaps are identified a personal development plan is developed and agreed with relevant line managers	This is an ongoing piece of work that will remain on the Health and Safety plan indefinitely.
Review the role and contribution of the Health & Safety Consultative Group, using this opportunity to: - Secure operational representation at senior level; - Secure involvement of Communications Officer; - Secure input from Service Improvement Specialist; - Develop, review and approve safety management plan; and - Oversee safety management performance	This was carried out within an annual review of the Terms of Reference in both March 2023 and March 2024. The 2024 review changed the Group meetings frequency from monthly to quarterly, whilst introducing an AGM, and two quarterly “collaborative forums” (H&S & Staff Side Reps, and H&S & Divisional Governance)
Develop, approve and establish an annual Safety Management Plan subject to annual review that: - Flows directly from the safety risks incorporated into the Duty Holders Matrix above; - Identifies resource requirements for implementation and records the Board’s decision on those resource requirements; - Sets clear safety management goals and objectives for the year ahead as prioritised within the Safety Management Strategy - Annual Safety Management Plan is based on a systematic review of safety performance using a balanced mix of leading and lagging key performance measures	This was completed in 2022-2023, was reviewed annually, and will require a further review for 2025-2026.
The following leaders to undertake and successfully complete accredited IOSH training commensurate with their role in effective safety management: - Board of Directors - Deputy Director of Quality Governance - Business Group Directors - Directors of major corporate functions	This was delivered, however this will need to be repeated to ensure newly appointed leaders are trained.

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4.11 Delivery of the KPIs within the Health & Safety Strategy – Health & Safety Action Plan (5)

Indicator	Update
Develop, agree and implement a suite of suitable leading and lagging safety performance measures in to test specific risks control strategies and procedures	Complete - annual reviews required.
Identify and implement a system which links staff absence reported as work related to incident investigation and Occupational Health activity.	Workforce and OD now supply data relating to work-related absence and costs.
With the contribution of the Health & Safety Consultative Group, HR, Occupational Health and Health and Wellbeing Group explore ways to reduce; • Work-related stress within the Trust. • Violence and aggression to staff • Sharps injuries • Moving and Handling Injuries • Slips and Falls	This is ongoing.

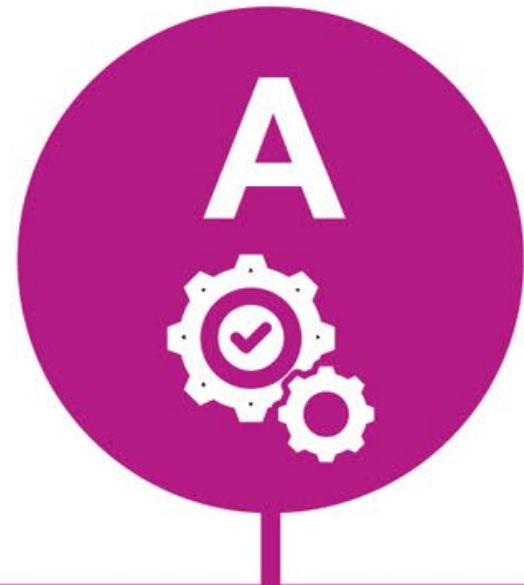
The Plan will be fully reviewed in 2024/2025

4.11 Delivery of the KPIs within the Health & Safety Strategy – Conclusion

This report highlights the significant level of H&S focussed activity that has been undertaken during the 2024-2025 period, to improve the management of health and safety in the Trust.

The H&SJCG continues to promote every facet of the Trusts H&S Strategy while measuring each outcome against the declared objectives and associated metrics. This essential Group is supported by the Trust Executive Management while also relying heavily upon the frequency and quality of the reports received from its key subgroups, in support of a safe and compliant Health and Safety management system.

Our Values



Compassion

Accountability

Respect

Excellence

We show kindness, caring and willingness to help others.

We take responsibility for our actions, behaviours, performance and decisions.

We value people's lived experience, feelings, qualities and views.

We support research, innovation, improvement and learning.



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IF YOU HAVE ANY QUERIES OR

REQUESTS PLEASE CONTACT

**Mike Craven
Health & Safety & Risk Manager**

				Agenda No.	17
Meeting date	7 August 2025	Public	X	Confidential	
Meeting	Board of Directors				
Report Title	Research, Development and Innovation Annual Report 2024/25				
Director Lead	Dr Andrew Loughney and Mr Dilraj Sandher, Medical Directors and RD&I Executive Leads	Author	Wiesia Woodyatt, Stockport RD&I Manager Rebecca Roberts, Tameside Research Governance Manager		

Paper For:	Information	x	Assurance	x	Decision
Recommendation:	<p>The Board of Directors is asked to confirm they have received assurance from this report that the RD&I departments across Stockport NHS Foundation Trust (SNHSFT) and Tameside and Glossop Integrated Care NHS Foundation Trust (TGICFTFT) have:</p> <ul style="list-style-type: none"> - Delivered appropriately throughout 2024/25 with the limitations in resource available and in alignment with the joint RD&I strategy. - Identified and managed risks appropriately. - Demonstrated effectiveness, adherence and progress to their respective 'Terms of Reference' for RD&I Committee activity. - Provided assurance that we have delivered research that has had a positive impact on patients, staff and the population. 				

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
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

	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
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	2.4
Financial impacts if agreed/not agreed	3.2, 4.1
Regulatory and legal compliance	3.1.1, 3.5.2, 4.2-3
Sustainability (including environmental impacts)	N/A

Executive Summary

<p>The purpose of this report is to inform on RD&I performance across both our trusts for 2024/25, focusing on:</p> <ul style="list-style-type: none"> - Organisational changes including staffing, engagement and the significant, ongoing risks/implications of an under-resourced workforce. - Annual financial summary focusing on: <ul style="list-style-type: none"> o Income received to support the research delivery workforce from the National Institute for Health and Care Research (NIHR).
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- Re-investment of RD&I generated income to sustain the local research workforce and embed a 'research active' culture throughout our organisations.
- Key Performance Indicators (KPIs) from the NIHR Northwest Research Delivery Network and internally for research study set-up, recruitment delivery and research participant experience.
- General assurances for research delivery conduct and risk mitigation including an assessment of the effectiveness of our joint RD&I Committee.
- General assurances that we have delivered research that has had a positive impact on our patients, staff and the populations we serve including performing research to address health inequalities across populations served for both trusts.
- Progress update on the delivery of our joint RD&I strategy and recommendations to ensure this continues to be delivered, acknowledging the significant regional financial and resourcing challenges we are currently operating within.

This report has been reviewed and confirmed by the joint SNHSFT and TGICFT RD&I Committee, then SNHSFT CEG before passing on to the SNHSFT QC/ TGICFT SQAG and finally the joint Board of Directors for consideration.

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1. Purpose

1.1 The purpose of this report is to provide:

- an annual review for 2024/25 of our RD&I activity across SNHSFT and TGICFT
- focusing on KPIs for study set-up, delivery targets, participant recruitment and experience, finances, staffing and engagement.

A summary is provided of the current gaps in the RD&I service and the proposal for addressing these over the year ahead to minimise risk, (albeit impacted by chronic, limited resourcing). There is an update on the progress made on delivery of our joint RD&I strategy, which was launched in Oct-2022, and an assessment of the effectiveness of our now fully merged SNHSFT/ TGICFT RD&I Committee.

1.2 It is a request that the RD&I teams have delivered effectively throughout 2024/25 despite the limited resource available, with a focus on relevant, high-quality, inclusive research to meet our population's needs, with an acknowledgement that full strategic delivery success is unlikely without further staffing investment.

2. Introduction/ background

2.1 Our trusts are committed to RD&I as a driver for improving the quality of care we provide for our patients. It provides the evidence base to answer key questions that help us tackle health and care issues in our population.

2.2 It makes a real difference to patient experience, organisational reputation, tackling healthcare inequalities as well as staff satisfaction, development, recruitment and retention.

2.3 Embedding and maintaining an active research ethos across SNHSFT and TGICFT is vital to fostering a better future for our patients and staff.

2.4 Research is enabled in our trusts through:

- research-active healthcare professionals, the delivery staff and service department (i.e. imaging, laboratories and pharmacy) funding support received from the NIHR, coupled with income linked to specific research projects.
- The NIHR supports the infrastructure for research delivery in the NHS. Support is offered regionally and from Oct-2024, SNHSFT and TGICFT became part of the newly formed Northwest Research Delivery Network (NW RDN), encompassing a population of 7 million and 33 NHS Trusts, with Manchester University NHS Foundation Trust acting as the regional host. This was formed from a merger of the previous Greater Manchester and Northwest Coast Clinical Research Networks.

2.5 The formation of the NW RDN in 2024/25 has seen a new vision and mission being launched, which our trusts are to align with. This vision is for the UK to

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be a global leader in the delivery of high-quality research that is inclusive, accessible and improves health and care. Their mission builds on this, which is to enable the health and care system to attract, optimise and deliver research across England. Their purpose further reinforces the importance of having a robust, appropriately staffed RD&I infrastructure in our trusts to ensure its prioritisation. It focuses on ensuring successful delivery of high-quality research and increasing the capacity and capability of the research delivery infrastructure for the future. In early Apr-2025, our Prime Minister stressed the importance of fast-tracking clinical trial set-up, a key focus of the UK Clinical Research Delivery (UKCRD) delivery programme ([Prime Minister turbocharges medical research - GOV.UK](#)), coupled with the key government changes of hospital to community, analogue to digital and sickness to prevention. Locally, these changes have necessitated our service to reflect and consider how we can keep pace for the year ahead. This report demonstrates that we are a flexible workforce, covering many specialties, but our alignment to this new UK vision is hampered by inadequate staffing levels across our RD&I teams, with vulnerabilities on the governance side.

2.6 In 2024/25, there has been a national focus on increasing the diversity of people taking part in research. The Health Research Authority (HRA) has worked with other regulators to introduce guidance on this, as well as a question set being part of the regulatory submission process for new studies, to encourage researchers to design projects where people underserved by research are not overlooked. Supporting projects that positively address **healthcare inequalities** has continued to be a focus of our 2024/25 research activity.

- TGICFT continue to be the only trust in the NW RDN to be open to the 'Born and Bred in' study (BaBi Tameside), gathering data from pregnant women and their children to improve the health and wellbeing of people in the locality. SNHSFT have delayed this to 2025/26.
- SNHSFT has opened TRANSFORM, a study mapping the difference in treatment patterns and improving support for black men with advanced prostate cancer.
- Both trusts have also successfully delivered the REMORA-2 study, looking at transforming outpatient consultations for rheumatology patients by integrating regular symptom tracking into clinic care, with a focus on looking to better understand and overcome digital exclusions.

2.7 In summary, the national and regional changes in 2024/25 have been vast, with local staffing challenges this has decelerated our progress on strategic delivery.

2.8 Despite these challenges and difficulties, we hope this report showcases the successes of 2024/25, what we have managed to achieve despite resource limitations and provides a vision of the 'art of the possible' should these limitations be overcome in the years ahead.

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3. Matter under consideration

3.1 Organisation/ staff, funding and engagement

3.1.1 Organisation/ staff: The RD&I team:

There have been some significant achievements across our trusts in 2024/25 due to the effectiveness of our delivery teams:

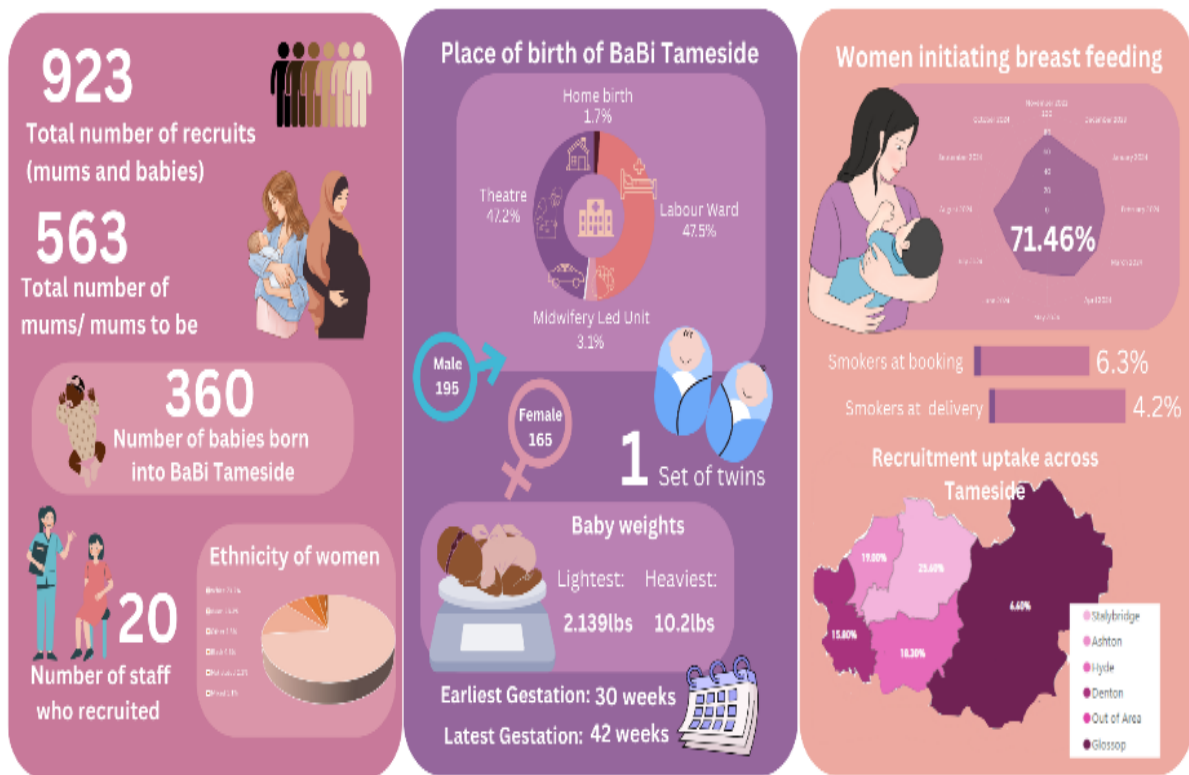
- UnCorked saw ~200 patients at SNHSFT and 132 patients at TGICFT enrolled to understand escalation area and corridor care in UK emergency departments. Through its results, the national coordinating team hope to advise NHS organisations if being cared for in a temporary escalation area has any impact on the care delivered.
- SNHSFT delivered several 'UK first recruits' for commercially sponsored studies, including x2 for paediatric migraine, and x1 each for studies focusing on adults with chronic rhinosinusitis with nasal polyps and a new treatment for patients with moderately to severely active Crohn's disease.
- Our TGICFT sponsored diabetes diagnosis study FIND-IT, has seen >1,275 service users enrolled in this project through attendance in our emergency department. The study has recently marked the recruitment milestone of 5,000 participants, making it one of the largest studies of its kind in the UK. The study continues to attract UK-wide interest and could be used as the precursor to roll out of a national screening programme to identify diabetes/ pre-diabetes at an early stage.
- SNHSFT has strategically focused on research projects that can integrate into established clinical care pathways, so there is a service wide approach to research delivery. This model has been successful in 2024/25 in anaesthetics with PQIP (Improving peri-operative care through using quality data), COLO-COHORT (colorectal cancer cohort study), aligning with the '2-week wait' bowel cancer pathway, and in rheumatology with IMID (Immune-Mediated Inflammatory Diseases bioresource). ~700 patients engaged in these projects.

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- o TGICFT marked the first anniversary of 'BaBi' at Tameside, a large-scale data study recruiting pregnant patients to hopefully improve health, care and services through research planning in the locality and beyond. Every pregnant patient is asked if they'd like to take part in the project, with >900 recruited in 2024/25.

BaBi Tameside First Year

Data from: 01/11/23 - 22/10/24



(Data Source, Euroking)

Rebecca Smyth, Corporate Information and Jean Kinder, Research and Development



Key achievements have happened:

- o Our second successful showcase of research activity across both trusts in a celebration event in Oct-2024, coordinated by the RD&I governance teams, themed around 'breaking boundaries' with research.

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- Consolidation of our joint RD&I Committee across both trusts.
- Although limited, development and roll-out of part of our shared QMS, with the following documents launched and education sessions provided in 2024/25: Standard Operating Procedures (SOPs) for informed consent in research, research study amendments and research study closure and archiving activities.
- Shared monthly audit programme for general study conduct, delegation logs and informed consent, to highlight good clinical practice and also share areas for improvement. These audits have been successful and provided assurance on the quality of study conduct for those projects with limited input from external study sponsors.
- Successful promotion of #Red4Research in May and Sep-2024. Its aim was to get as many people as possible wearing red to show their support for all those participating, undertaking and supporting research.



3.2 Departmental funding

3.2.1 Team complements in 2024/25 compared to 2023/24 were:

Role	SNHSFT WTEs		TGICFT WTEs	
	2023/4	2024/25	2023/24	2024/25
Administration	4.60	5.45	3.85	3.67

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Governance	3.00	3.00	1.40	1.40
Research Delivery (Nurse, Practitioners, Fellows)	13.40	13.40	6.54	6.25
Totals	21.00	21.85	11.79	11.53

For both trusts, our teams are reliant on continued NIHR annual service support funding to sustain these workforces (including dedicated funding for imaging, laboratories and pharmacy), with some of the SNHSFT posts reliant on continued growth/ delivery of a commercial portfolio as well (the non-recurrent income funding held at present will help sustain the current SNHSFT team to Mar-2029 but only if other income generated remains at 2024/25 levels). SNHSFT does have this financial risk on the risk register (Datix 2583) as our team are not currently generating enough income year-on-year to sustain the above staffing model. The clinical team are continually reviewing the portfolio and bidding for new commercial work to help mitigate this risk.

3.2.1 RD&I staff funding is also currently linked to achieving NIHR performance metrics for study recruitment/ delivery, as well as regular invoicing for specific study work. The figures below demonstrate the NIHR NW RDN's commitment in supporting our trusts with the infrastructure needed to sustain our study portfolios and are commensurate to funding levels received in the previous financial year. 2023/24 figures are provided as a comparator:

Year	Trust	NIHR Service Support/ Research Capacity Funding	Other Research Income	Totals
2023/24	SNHSFT	£556,610.11	£184,167.09	£740,777.20
2024/25		£585,530.64	£248,930.76	£834,461.40
2023/24	TGICFT	£452,441.91	£15,254.98	£467,696.89
2024/25		£515,856.56	£100,558.53	£616,415.09

If NIHR performance metrics aren't achieved, there is a potential financial risk to both trusts. NIHR funding may not be renewed to the same level or funding may not be available from income generation in future financial years, which could result in redeployment or redundancy of RD&I staff. This would be an unpalatable outcome, as the safety of our study portfolios requires the staffing levels we currently have across both trusts as a minimum to manage risk.

In 2024/25, both trusts demonstrated a strong recruitment record with 1,672 participants enrolled and 2,552 participants enrolled at TGICFT. We hope these track records will support future funding being secured around the level needed for our current staffing infrastructure.

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Aligned with our RD&I strategy, securing future commercial work, increased trust investment, robust service department support and a similar or elevated level of NIHR funding from 2026/27 will be key to future continuity of these staffing structures. Our NIHR service support funding for 2025/26 has been confirmed as a 'flat rate' to match 2024/25 levels, but beyond this, we do not have certainty in the NIHR funding model. We have actively been contributing to national surveys to help shape the future of NIHR funding, but like all other trust nationally, we don't yet know what this will be for 2026/27 onwards.

3.2.2 Continued assurance can be provided that all RD&I invoicing is up to date with clear funding distributions at SNHSFT to minimise the financial risk to our trust around lost income from late or missed invoices. TGICFT are still working on adopting SNHSFT established tracking systems, to ensure a consistent approach across both trusts. In Apr-2024, NHS England published 'Managing Research Finance in the NHS' guidance, and when capacity allows in the RD&I governance team in 2025/26, this will be formulated into a local SOP for full consistency in the financial management of research studies across both organisations.

3.2.3 The joint trust infrastructure still requires further evaluation to ensure healthcare professionals have the time/ funding to truly embed research into clinical care and attract staff who wish to improve treatment options for our patients. Discussions continue through the RD&I Committee and with key stakeholders as we deliver on our 5-year strategic plan.

3.3 Staff and public engagement and impact

3.3.1 2024/25 has seen increased and sustained engagement with clinical research delivery from a range of staff, including nurses, advanced clinical practitioners, clinicians, specialty trainees and other allied healthcare professionals. This has led to the following positive impacts for our staff and patients.

- Our RD&I portfolio has been maintained to cover 21 specialties with 89 research studies open at SNHSFT. For TGICFT, the RD&I portfolio covered 15 specialties with 42 research study opportunities open.
- SNHSFT introduced 29 new studies and TGICFT 18 new studies, including commercial and non-commercially sponsored work, interventional and observational projects.
- Both trusts had significant success in delivering 'snapshot' studies such as UnCorked (see Section 3.1.1), as well as PANDOS (**P**ain **AND** **O**pioids after **S**urgery). At SNHSFT 84 patients were enrolled in a 2-week period in May-2024 and TGICFT recruited 12 patients during the recruitment period. This

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was investigating use of pain relief in the month before patients had surgery, whilst they were in hospital after surgery, then a year after their surgery, to understand opioid use patterns and hopefully improve patient care in the future.

- Multi-disciplinary delivery approach models have thrived in specialties such as stroke at SNHSFT, where clinicians and allied health care professionals (e.g. speech and language therapists) have worked together to offer a variety of research options to our patients. In 2024/25, these projects have ranged from testing neuromuscular stimulation devices to hopefully prevent venous thromboembolism in stroke, a treatment trial aiming to prevent secondary complications post-stroke, pharyngeal electrical stimulation to potentially improve dysphagia symptoms and a speech after stroke recovery project. Similarly for TGICFT, a multi-disciplinary approach in critical care has resulted in several new research opportunities for patients, varying from comparing 'Airway Pressure Release Ventilation' with conventional ventilation, to helping define the platelet count below which critically ill patients should receive a platelet transfusion prior to an invasive procedure and awake prone positioning for patients with respiratory failure. This has resulted in an 'Intensive Care Society Road to Research' funding award and created the opportunity for local staff to collaborate with external parties to develop new research proposals.
- We have just over 200 staff with up-to-date Good Clinical Practice (GCP) training at SNHSFT and over 80 staff at TGICFT.
- A recent survey conducted by the RD&I department investigated the enablers and barriers for staff to become research active. Out of the 102 respondents, 39% were actively involved supporting the delivery of research at our trusts. Based on these responses, the primary reason for getting involved with research was due to their belief that research opportunities are important for patient care or treatment (45%), followed by 35% of respondents who cited personal interest as their motivation for supporting research. In contrast, the main barrier to supporting research cited by the 61% of respondents who were not currently research active, was due to a lack of time (27.4%), closely followed by 25.8% who were unsure how to get involved. We will look to see how we can improve communications around research involvement in the year ahead, perhaps through research being incorporated in some way into corporate inductions. Furthermore, 88.2% of respondents felt research was extremely important to advance healthcare, demonstrating strong support from local healthcare staff.
- The RD&I team have really focused on staff and patient engagement with clinical research throughout 2024/25, effectively using patient stories to highlight the variety of work being undertaken from helping to improve a patient's sense of smell (https://www.stockport.nhs.uk/news_23259), a teenager being the first in the UK to be part of a research trial for a new children's migraine medication ([Teenager proud to be part of research trial](#))

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[for new children's migraine medication | NIHR RDN](#)) through to a podcast to help raise research awareness, on the community radio station Tameside Talks ([Episode 21: Raising Research Awareness - Tameside Talks! | Podcast on Spotify](#)). We are excited to also be embarking on a collaboration with Stockport County Football Club in the year ahead to further educate our local community on the research studies available to them.



- We also saw 3 of our allied healthcare professionals (2 physiotherapists and a speech and language therapist) completing the 'NIHR Integrated Clinical Academic Programme', which has supported them to shape their clinical academic research careers and focus on evidence-based practice. The RD&I team were fully supportive of these staff members and it has been fantastic to see some go on to NIHR pre-application supporting funding bids to potentially complete a PhD in the future.
- TGICFT successfully received its first NIHR Research for Patient Benefit award to conduct a study exploring new ways of working for adult social care workers, in collaboration with Manchester Metropolitan University. The trust also received NIHR funded INSIGHT awards for two members of the speech and language therapy team to complete their Masters' degrees in collaboration with UCLAN and the University of Liverpool.

3.3.2 The RD&I teams have also continued with research publicity from many different angles in 2024/25, some of which have already been touched upon earlier in this report. Our focus has remained on ensuring that clinical research is seen as part of 'business as usual' and inclusive for everyone. Other key examples include:

- Quarterly release of joint research publication bulletins and newsletters to publicise all research related activities in our trusts.
- Regular posting on staff intranet news and RD&I microsites to publicise new studies opening, training, seminar, conference and funding opportunities.

Press releases on high profile studies (see Section 3.3.1).

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- Presentations in local specialty areas (e.g. gut club, critical care) to educate and engage the wider multi-disciplinary team in supporting research project delivery.

The above summary is to provide assurance that the RD&I team has been committed to engaging participants and staff across our healthcare system to deliver the studies that best aligned with the needs of our population, with a focus on inclusivity for all.

3.4 Key Performance Indicators (KPIs) for research

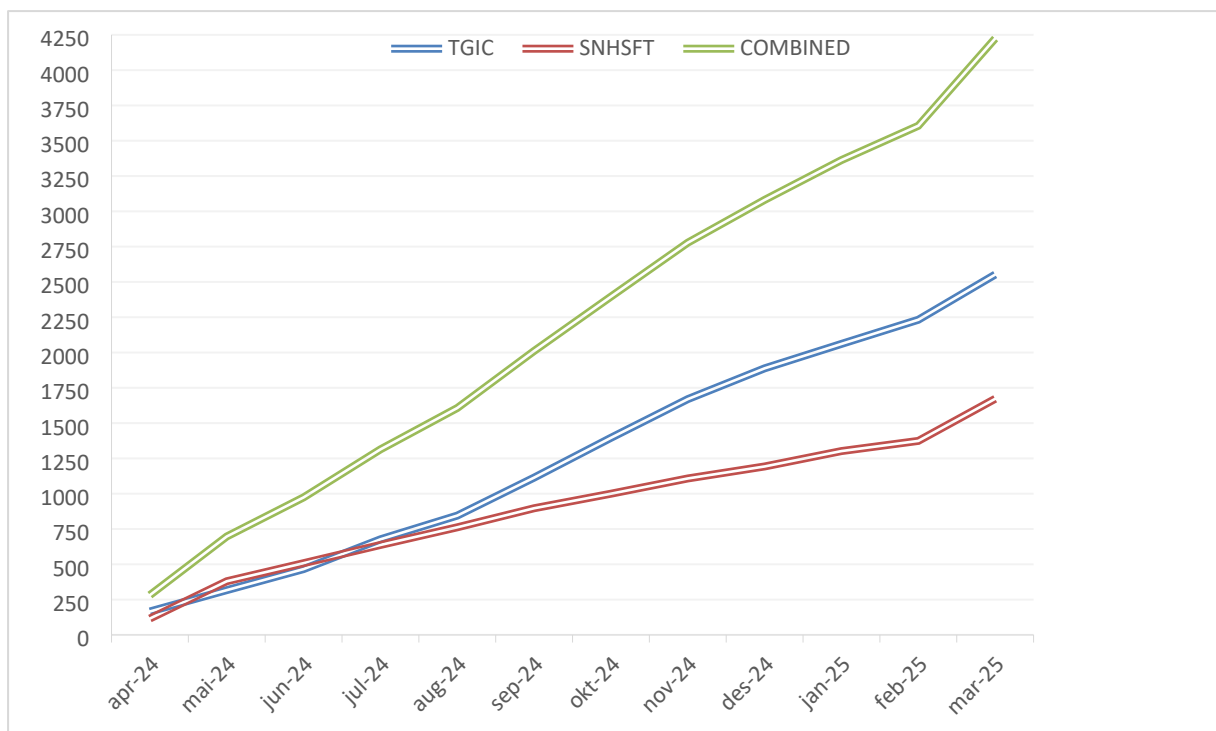
3.4.1 Department of Health and Social Care (DHSC) KPIs for research

- Previously the DHSC requested that NHS providers publish their performance on the initiation and delivery of clinical research. The aim was to increase the number of patients who had the opportunity to participate in research and to enhance the nation's attractiveness as a host for research. Up to 2022/23 SNHSFT and TGICFT posted these performance reports on our external-facing website pages.
- In late Mar-2025, we received a DHSC briefing letter to confirm that new KPIs will start to be rolled out in 2025/26, starting with study-set-up, to include the proportion of commercial studies open to recruitment within 60 days of the HRA approval letter and also the proportion of these studies that recruit their first participant within 30 days of sites opening to recruitment.
- Due to this, we will provide our first year of these new metrics in our 2025/26 report.

3.4.2 NIHR and local KPIs for research study recruitment and set-up

- Recruitment: The number of patients receiving relevant health services provided or subcontracted by SNHSFT and TGICFT in 2024/25, that were recruited during that period to participate in research approved by a Research Ethics Committee (REC) and/ or the HRA was 1,672 and 2,552 respectively. There were no NIHR targets set in 2024/25 due to the transition into the new NW RDN taking place. These research studies had undergone strict ethical review and had received favourable opinions from the REC (where required) and HRA, signifying robust scientific quality and risk assessment. Our trusts excelled in their recruitment, with commercially linked work also prominent in both trusts (10 studies open at SNHSFT and 3 studies open at TGICFT in 2024/25).

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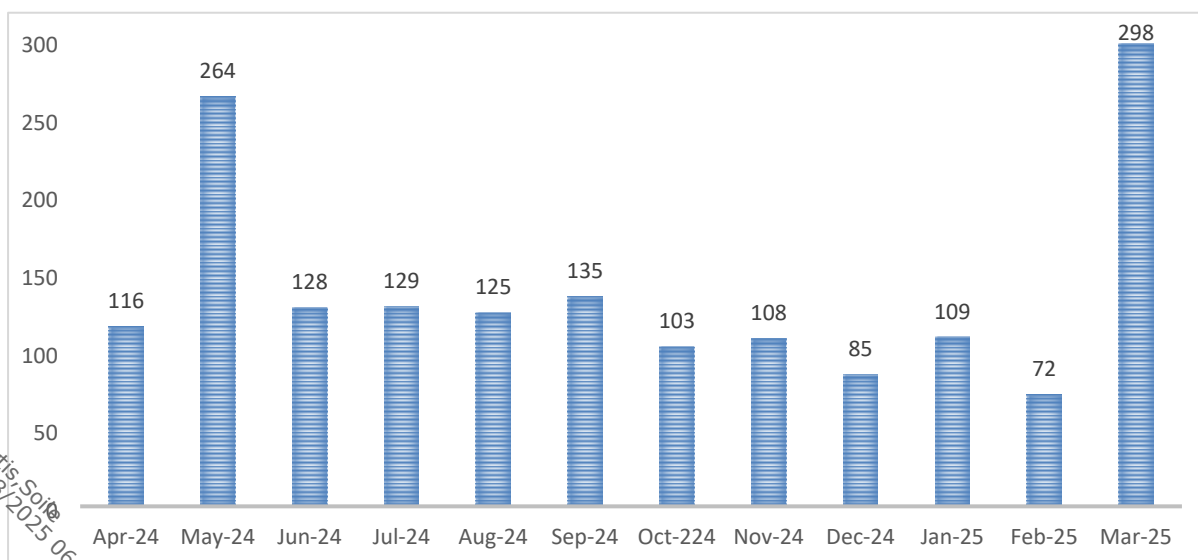
Specialty with open study	SNHSFT Participant recruitment numbers		
	2023/24	2024/25	Difference
Ageing	21	4	-17
Anaesthesia	91	156	65
Cancer	22	23	1
Cardiovascular	97	68	-29
Children	587	8	-579
Critical Care	19	20	1
Diabetes	35	66	31
Ear, Nose, Throat	4	13	9
Gastroenterology	431	422	-9
Health Services	32	60	28
Hepatology	5	5	0
Infectious Disease	2	22	-20
Musculoskeletal	226	424	198
Ophthalmology	23	0	-23
Primary Care	105	0	-105
Public Health	0	0	0
Renal Disorders	4	4	0
Reproductive Health	186	26	-160
Stroke	60	75	15
Surgery	11	29	18
Trauma and Emergencies	206	247	41
Totals	2,167	1,672	-495

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Specialty with open study	TGICFT Participant recruitment numbers		
	2023/24	2024/25	Difference
Anaesthesia	87	49	-38
Cancer	10	18	8
Cardiovascular	24	0	-24
Children	28	5	-23
Critical Care	53	28	-25
Dermatology	2	12	10
Diabetes	1,655	1278	-377
Infectious Disease	13	17	4
Mental Health	1	0	-1
Musculoskeletal	11	20	9
Primary Care	110	0	-110
Public health	436	910	474
Reproductive Health	26	38	12
Stroke	19	2	-17
Surgery	30	21	-9
Trauma and Emergencies	19	154	135
Totals	2,524	2,552	28

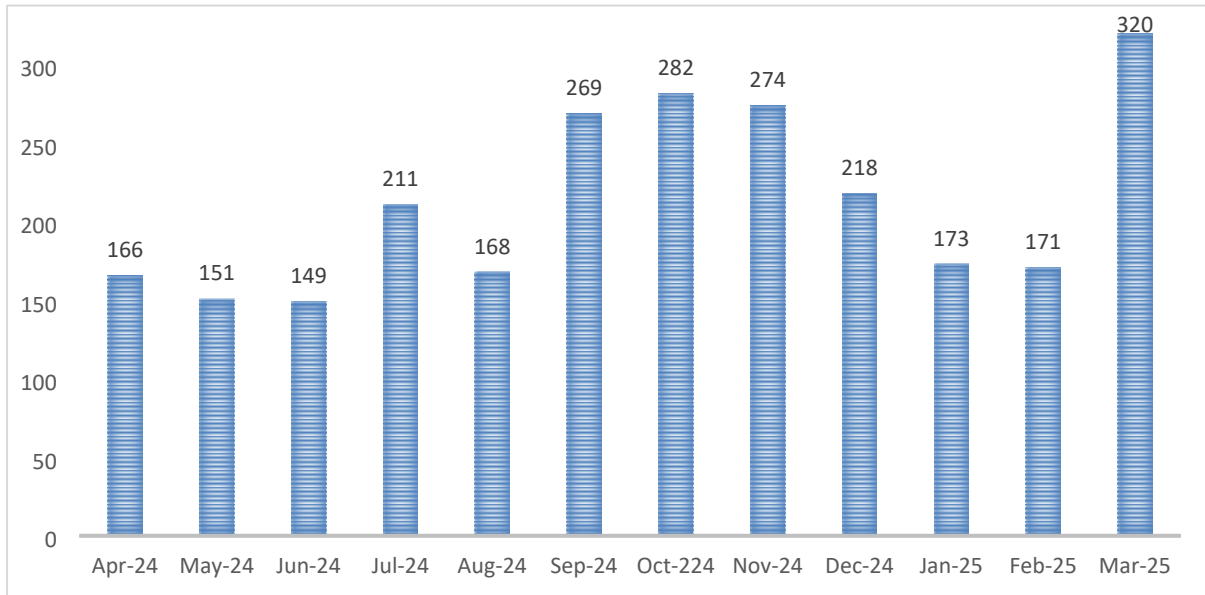
- The above summary shows our 2024/5 recruitment summaries, compared to 2023/24, demonstrating the maintenance of a balanced portfolio, covering multiple specialties. Some areas have seen lower recruitment, others higher, highlighting the continuing flow of research projects, as some have closed out and new studies have been taken on. In Greater Manchester, our combined recruitment total sees our trusts at 6th overall and in the NW RDN 7th out of 30 trusts.

Month-by-month recruitment activity: 1,672 participants for SNHSFT

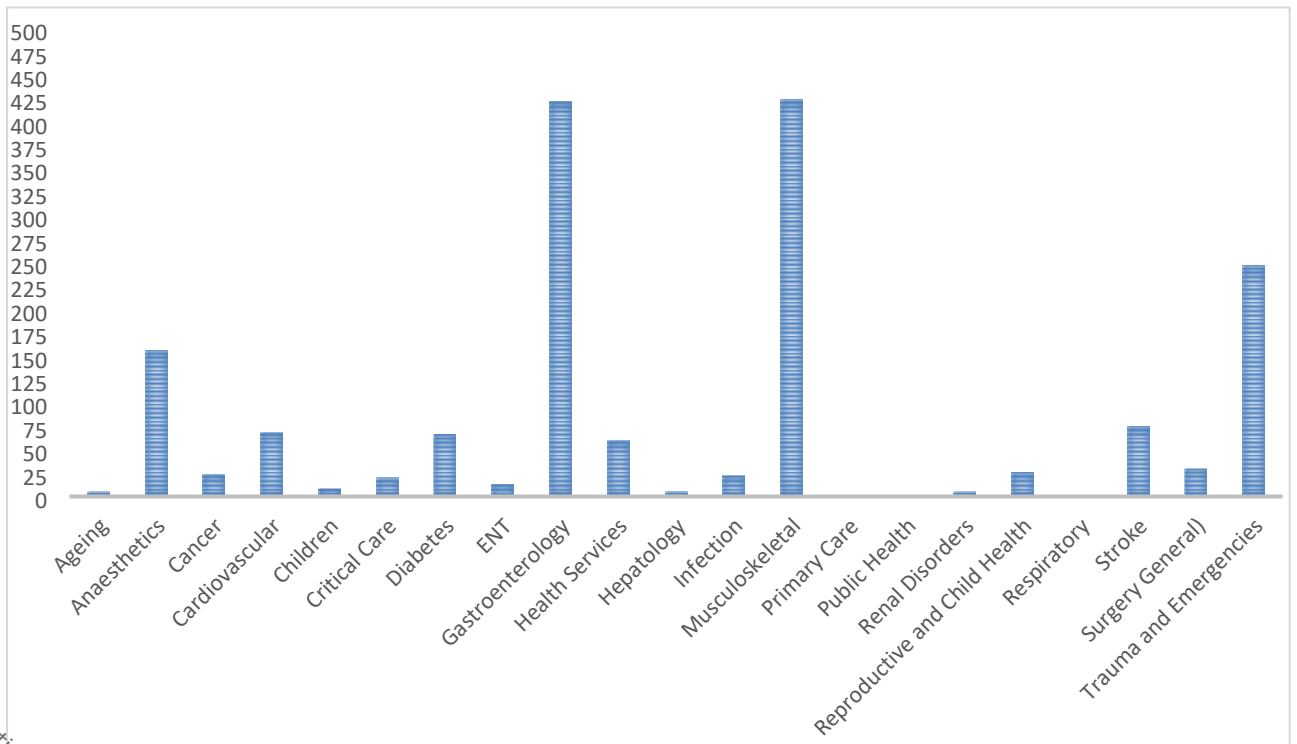


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Month-by-month recruitment activity: 2,552 participants for TGICFT

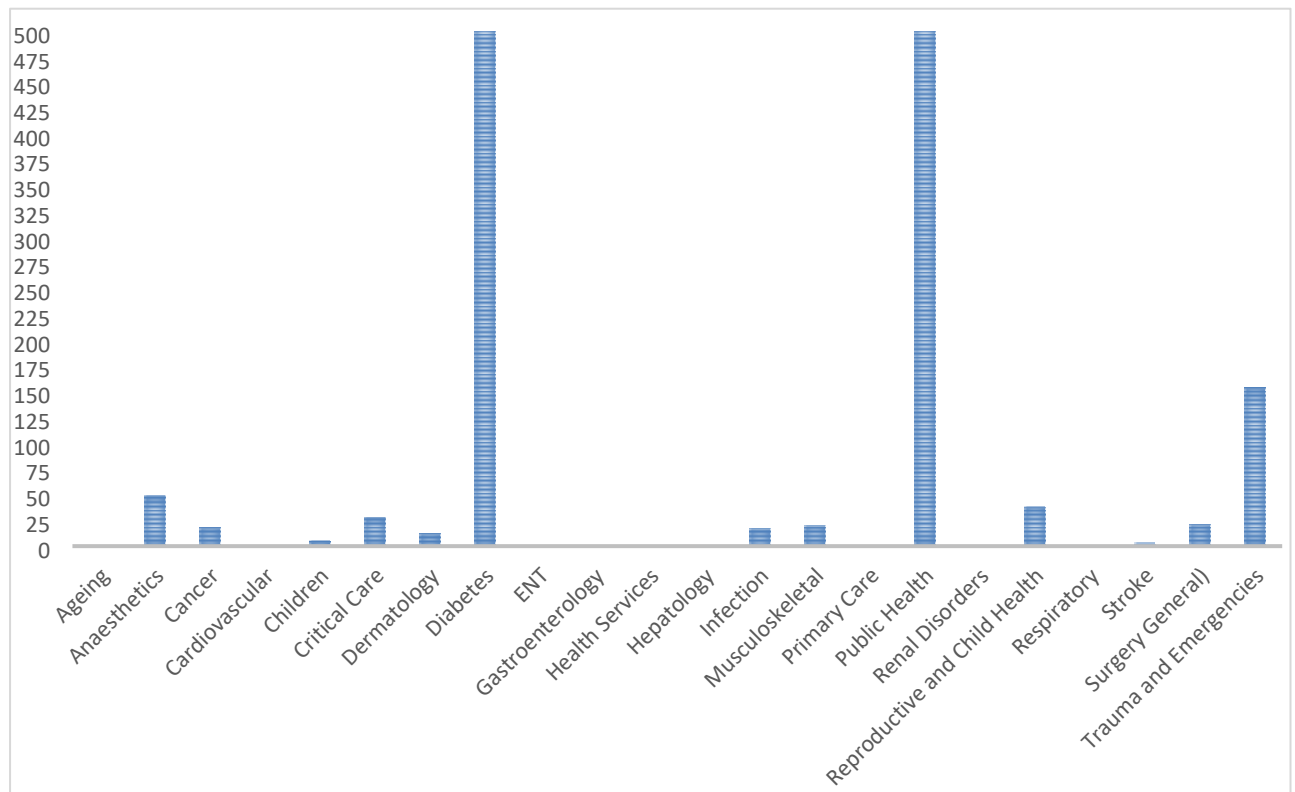


Recruitment activity across specialties at SNHSFT



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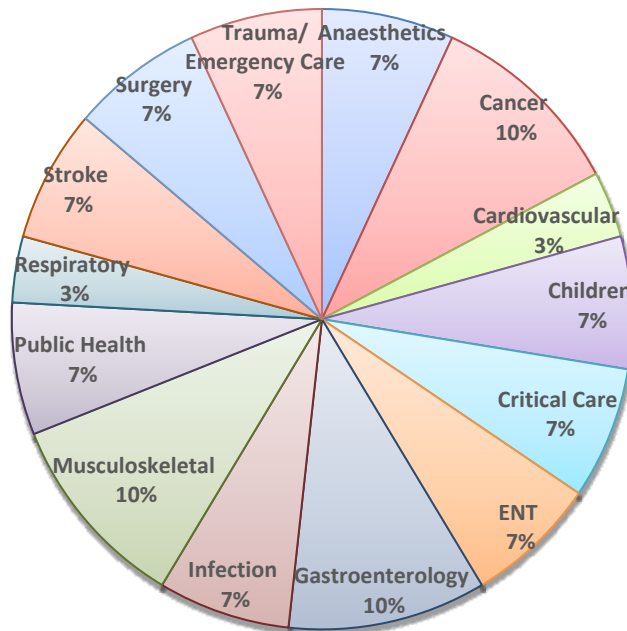
Recruitment activity across specialties at TGICFT



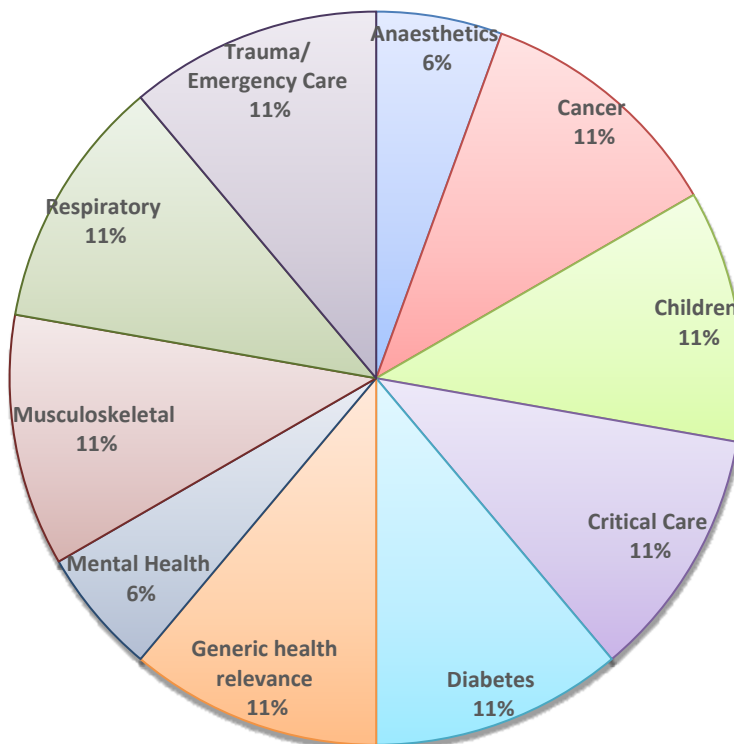
- Study set-up:** In 2024/25, 29 studies were locally assessed, with capacity and capability confirmed (compared to 39 in 2023/24) at SNHSFT, with 18 studies at TGICFT (compared to 21 in 2023/24). This decrease is predominantly due to studies coming into the portfolio with increased complexity compared to the previous year (i.e. more interventional, treatment trials), more limited staffing in the RD&I office to support the project management around an increased volume of new study set-up opportunities (due to long-term sickness) as well as continuation of several high recruiting studies, which limits capacity for new studies within the research delivery team.

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SNHSFT: Specialty distribution for new studies issued with local capacity/ capability confirmation in 2024/25



TGICFT: Specialty distribution for new studies issued with local capacity/ capability confirmation in 2024/25

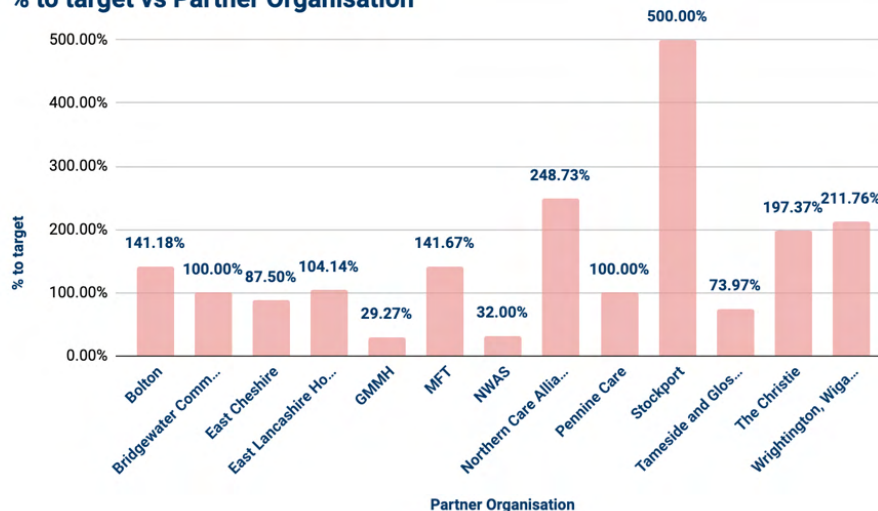


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3.4.3 Participant research experience survey (PRES)

- A NIHR survey to capture the experience of participants in health research has run annually since 2015/16. It is carried out to help improve the experience of those taking part in research, giving a chance to feedback on what went well and what could be improved. From 2019/20, this survey was made a priority by the DHSC. The elevation of the PRES's profile increases appreciation of the importance of access to research being routinely promoted in health care provision.
- In 2024/25, SNHSFT and TGICFT combined received one of the highest response rates to the PRES in Greater Manchester (279 surveys completed, NIHR target was 118). This provides assurance that we are actively seeking feedback on how we are performing in this area and what we need to focus on in future to ensure exceptional experiences for our research participants. Themes identified were fantastic knowledge, professionalism and great communication from our research delivery staff.

% to target vs Partner Organisation



- The critique on how we can improve has also continued to be reviewed and integrated into how we run future studies. Key improvements made from 2024/25 feedback included continued logging of maintenance jobs with the estates teams to ensure areas where patients are seen remain fit for purpose, flexibility in appointment times and providing patient information in different formats to suit the needs of individual patients. A recurring regional theme still stands on how results of research studies are shared. We continue to report this back to study sponsors to ensure this is

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considered at appropriate study milestones. It is also now in our study closure checklist to ensure this is addressed before a study is archived.

3.5 RD&I committee meeting overview and effectiveness

3.5.1 During 2024/25, SNHSFT and TGICFT consolidated our joint RD&I committee to align with our strategic direction. The committee met on 23-Apr-2024, 24-Jul-2024, 23-Oct-2024 and 21-Jan-2025. Core membership and paper circulation is shown in Appendix 1, as well as a summary of effectiveness in Appendix 2. To summarise, these reports provide assurance that the procedural aspects of the committee’s operations have been effective, and that some further progress has been made in establishing/ maintaining a research active culture across both trusts. This will continue to be developed in 2025/26, working with each other and the NIHR NW RDN to increase research activity and patient recruitment into studies. The RD&I committee have complied with their ‘Terms of Reference’ during 2024/25 and have made progress to improve the research processes and procedures at both sites, despite the RD&I core governance team staffing challenges outlined previously.

3.5.2 In 2023/24, we found that TGICFT, but not SNHSFT reported on an annual research audit programme through committee and this annual report. In 2024/25, a joint audit programme was rolled out across both trusts, led by the RD&I governance staff to help drive quality improvement and consistency in our research delivery approaches. In 2024/25, the following planned study audits were completed, with all corrective and preventative measures now in place from the findings:

Study title	Trust	Findings
The STARFISH Trial: A randomised controlled trial of STeroid Administration Routes For Idiopathic Sudden sensorineural Hearing loss	SNHSFT Jul-2024	Minor findings all resolved: Some missing or duplicate annotations, documents, letters, minor delegation log errors, missing training evidence, general check through to tidy up site file.
RECOVERY: Randomised Evaluation of COVID-19 Therapy	TGICFT Aug-2024	Minor findings all resolved: Some missing filing to demonstrated principal investigator/ service department oversight on set-up, safety reporting, some visits taking place outside of the specific protocol time frame, missing consent form being uploaded to patient record.
FIND-IT: Diabetes diagnosis during hospital presentations	TGICFT Sep-2024	Minor findings all resolved around delegation log: Some missing GCP/ CVs or updates needed, incorrect end date for staff member.
IMID: Immune-Mediated Inflammatory Diseases BioResource	SNHSFT Sep-2024	Minor findings all resolved around delegation log: Incorrectly supplied log template from sponsor so transfer onto correct version needed, some log duplications, incorrect date formats, missing end dates, some missing GCP/ CVs and incorrect delegation of some tasks.

Study title	Trust	Findings
COLO-COHORT: Colorectal Cancer Cohort Study	SNHSFT Oct-2024	Minor findings all resolved around consent: Out of date local contacts on some patient information, some instances where consents had been corrected but not following good documentation practice, incorrect date formats and file note needed to confirm why consentor and consentee dates were different in some instances.
UK-ROX: Intensive Care Unit Randomised Trial Comparing Two Approaches to Oxygen Therapy	TGICFT Oct-2024	Minor findings all resolved around consent: Missing consents in some patient files, missing staff member on delegation log, missing CVs/ GCP, no evidence for a patient to re-consent after regaining capacity, some consent boxes ticked not initialled, some delays in a consent form being fully signed off and some documents missed as being uploaded to patient record.
MAPS-2: The Metoclopramide for Avoiding Pneumonia after Stroke trial - a single-blind, randomised controlled trial of metoclopramide for the prevention of pneumonia in patients with dysphagia after an acute stroke.	SNHSFT Nov-2024	Major finding and various minor findings now resolved: Delegation log sign delays by Principal Investigator, with a staff member being incorrectly being delegated clinical activities when they have an administrative role, lack of clarity for who should be on the delegation log, general check through/ tidy up of electronic site file needed as various missing documents throughout and some missing eligibility information in patient files/ medical records to be added in.
GenOMICC: Genetics of Susceptibility and Mortality in Critical Care	SNHSFT and TGICFT Dec-2024	Minor findings now resolved: Some missing localised documents in the site file, minor lapses in 3-yearly renewal of GCP training by some key delivery staff, some missing GCP/ CVs, some missing patient facing documents to be added to electronic records, some updates to old contacts on patient facing documents, some patients missed in re-consenting after regaining capacity.
STIMULATE: A multi-centre, cluster randomised trial of an integrated care pathway with a nested, PIII, open label, adaptive platform randomised drug trial in individuals with Long COVID	TGICFT Jan-2025	Minor findings now resolved: Missing prescription copy in a patient file, missing contract/ regulatory documents in site file, version control log not updated, delay in Principal Investigator signing staff onto delegation log, some missing GCP/ CVs, training records and monitoring reports to add to site file.
WHITE PRESSURE-3: World Hip Trauma Evaluation Appendix 14 - Pressure Ulcer Prevention 3: A randomised clinical trial assessing early heel specific adjunct devices for heel pressure ulcer prevention in people with a fractured hip	SNHSFT and TGICFT Feb-2025	Minor findings now resolved: Some missing superseded patient facing documents in the electronic site file, missing evidence to confirm a consenting staff member had been delegated this activity, some patients missing their information sheets or withdrawal date being uploaded to the electronic patient record.
RAPID-RESCUE: Supported rescue packs post-discharge in chronic obstructive pulmonary disease: An open-	SNHSFT Mar-2025	Minor findings, currently being resolved as audit was 25-Mar-2025: Some electronic site file folders to be updated to align with sponsor index, some missing documents to be acquired and added to site file,

Study title	Trust	Findings
label multi-centre randomised controlled trial		delegation log queries around those assigned to safety reporting causality/ severity assessment, paper GCP/ CV copies to be destroyed as duplicates of those held electronically.

4. Areas of risk

- 4.1 Performance, business and financial: Reacting to the national changes outlined in Section 2 has been challenging this year. However, working within the structure of our 5-year RD&I strategy has enabled both teams to focus on the key priorities for our staff and the populations we serve.

It is critical that both trusts maintain a robust level of NIHR participant recruitment, given the likely transformation of NIHR funding models from 2026/27. It is important to note that the Band 7 senior research nurse posts rely on this NIHR funding. RD&I income generation can also only support the SNHSFT Band 8a lead research nurse post for another 3-4 years. Work also needs to take place to ensure we have the right skills mix in our research delivery teams to help with financial sustainability and support a more expansive commercial portfolio.

The set-up of new studies has continued to be staggered until the RD&I governance teams return to full complement. In the future team will look at how we share the set-up resource better across both organisations, to avoid duplicating set-up work for studies running at both sites (accounting for the nuances around the two trusts remaining as separate legal entities, with separate IT systems etc.).




Finally, the available support from key service departments (imaging, laboratories and pharmacy) and having an appropriate estates footprint is integral to the research portfolio expanding locally. This links to Ambitions 3 and 4 of our key strategic themes of RD&I integration into service development and increasing research funding.

- 4.2 Clinical, quality and reputational (part 1): This risk has continued to be rolled over year-on-year due to the capacity reasons outlined throughout this report. Although all our RD&I staff are trained in trust essentials, research legislation and regulations, with protocols provided for each study conducted, the lack of a fully developed, joint QMS continues to be an organisational risk with reputational consequences if we were to be inspected by external regulatory authorities. It is also an important underpinning factor of our second strategic ambition to embed an inclusive research active culture within our trust community. At both trusts, we currently don't sponsor any studies which fall under the MHRA's remit, so the risk of inspection is low (it would only come from a hosted study if triggered due to recurrent safety issues at site or if the study drug was coming close to licensing and our site is randomly selected out of all


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participating sites). However, the lack of a fully launched QMS and appropriate staffing support means that it would not be prudent for our RD&I service to expand into more complex study sponsorship until this is in place. This is appropriately documented on our risk registers. This is a key strategic step for our Trust as ‘home-grown’ ideas and development of these locally is really important to our clinical staff. Due to the long-term sickness in the core RD&I governance team in SNHSFT across 2023/24 and 2024/25, this work programme is behind schedule but has moved on a little in the last year (see 3.1.1). The aspiration would be to complete this in 2025/26 so that we have fully standardised processes across SNHSFT and TGICFT, which will support a more cohesive work force across both trusts, driving improved quality standards. However, without additional resource being added into the RD&I governance infrastructure, it is going to be a challenge to achieve this. There is some work needed in improving clinicians input and enthusiasm in commencing new trials.

4.3 Strategic update: Finally, with the launch of our joint RD&I strategy in Oct-2022, we do provide a quarterly, detailed summary to our RD&I committee on our key achievements against our 4 high level ambitions, broken down into 15 objectives. The themes below are evident throughout this report

Ambition	Objective
 <p>Ambition 1: High quality research of direct patient benefit, tackling health and care inequalities</p>	<p>1.1 Increase participation and diversity in NIHR studies</p> <p>1.2 Increase patient and public involvement in research studies</p> <p>1.3 Improve clinical research facilities</p> <p>1.4 Deliver NIHR targets</p> <p>1.5 Support grant application development</p>
 <p>Ambition 2: Embed an inclusive research active culture within our community</p>	<p>2.1 Protected research time</p> <p>2.2 Researcher career pathways</p> <p>2.3 Increase understanding of RD&I role in clinical care</p> <p>2.4 Quicker uptake of new techniques and therapies</p> <p>2.5 Data and resources to support research delivery</p>
 <p>Ambition 3: Integrate RD&I into service development</p>	<p>3.1 Maximise RD&I potential for translational and applied health services</p> <p>3.2 Collaboration to improve health outcomes</p>

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 <p>Ambition 4: Increase research funding</p>	4.1	Maximise external income opportunities
	4.2	Fiscal transparency
	4.3	increase research infrastructure funding

5. Summary

- 5.1 Both trusts continue with a strong tradition of research which is diversifying to address inequalities.
- 5.2 SNHSFT and TGICFT have recruited 1,672 and 2,552 respectively.
- 5.3 Total income for SNHSFT is £834461.40 and TGICFT is £616415.09.
- 5.4 Staffing is stable but due to sickness, there has been pressure on starting new studies. Business cases for joint appointments is planned for 2025/26.
- 5.5 Feedback from participants is overwhelmingly positive.
- 5.6 There is good governance around continuing research and continued engagement with NW Research Delivery Network. We need to develop QMS across both trusts in 2025/26. This will help improve governance and help set up more studies to increase the trusts income from research.
- 5.7 During the year, 3 allied health professionals were supported to achieve higher degrees whilst conducting research within the trusts.

6. Recommendations

- 6.1 It is requested that this report is noted and research and development to be supported. There are excellent opportunities for recruitment, retention and quality improvements by investment into RD&I expansion for our patient population.
- 6.2 It is requested for the board to accept assurance provided.

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Appendix 1: Core membership and paper circulation for the RD&I committee: Always quorate

Name	Link	Specialty	23-Apr-2024	24-Jul-2024	23-Oct-2024	21-Jan-2025
Abbas Ismail	SNHSFT	Rheumatology	Present	Apologies	Apologies	Not member
Adam Armitage	TGICFT	Children	Absent	Absent	Absent	Absent
Adam Finaly	SNHSFT	AHP (Physio)	Not member	Not member	Not member	Present
Adam Pinder	SNHSFT	Finance	Present	Apologies	Present	Present
Alissa Kent	SNHSFT	RD&I	Apologies	Present	Present	Present
Al-Tahoor Butt	TGICFT	Respiratory	Absent	Apologies	Absent	Present
Amy Barratt	NIHR	NIHR	Mins only	Mins only	Mins only	Mins only
Andrew Loughney	SNHSFT	Exec Lead	Apologies	Apologies	Apologies	Absent
Appukuttan Suman	SNHSFT	Stroke	Absent	Apologies	Absent	Absent
Carole Sparks	SNHSFT	Nursing	Mins only	Mins only	Mins only	Mins only
Chris Cooper	SNHSFT	Children	Absent	Apologies	Present	Apologies
David Baxter	SNHSFT	Infection	Present	Absent	Absent	Absent
David Johnson	SNHSFT	Orthopaedics	Present	Present	Apologies	Present
Dilraj Sandher	TGICFT	Exec Lead	Present	Apologies	Apologies	Apologies
Edward Jude	TGICFT	Diabetes	Present	Present	Apologies	Present
Emma Reid	SNHSFT	Radiology	Mins only	Mins only	Mins only	Mins only
Georgina Williams	SNHSFT	AHP (SALT)	Not member	Not member	Not member	Present
Heather Savill	TGICFT	RD&I Nursing	Present	Apologies	Present	Present
Hywel Garrard	SNHSFT	Critical Care	Present	Apologies	Apologies	Absent
James Dyer	SNHSFT	Cancer	Apologies	Absent	Absent	Absent
Janette Hunt	SNHSFT	Audit	Mins only	Mins only	Mins only	Mins only
Joanna Lawrinson	TGICFT	Pharmacy	Not in post	Present	Present	Present
Justine Toole	TGICFT	Finance	Present	Present	Apologies	Present
Laura Gifford	SNHSFT	AHP (Physio)	Not member	Not member	Not member	Present
Louise Mercer	SNHSFT	Rheumatology	Apologies	Present	Apologies	Present
Madhavi Pureti	SNHSFT	Obs/ Gynae	Absent	Absent	Absent	Absent
Magda Kujawa	SNHSFT	Urology	Absent	Present	Present	Absent
Mamoona Khalid-Raja	SNHSFT	ENT	Mins only	Mins only	Mins only	Mins only

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Name	Link	Specialty	23-Apr-2024	24-Jul-2024	23-Oct-2024	21-Jan-2025
Mandy Pickersgill	TGICFT	Labs	Absent	Absent	Absent	Absent
Margaret Cooper	TGICFT	RD&I	Present	Present	Present	Present
Mary Barden	SNHSFT	Library	Apologies	Apologies	Apologies	Present
Matthew Jackson	SNHSFT	Anaesthetics	Absent	Absent	Not member	Not member
Michelle Beecroft	TGICFT	Pharmacy	Present	Absent	Absent	Apologies
Milan Rudic	SNHSFT	ENT	Apologies	Apologies	Absent	Absent
Mohammed Kamal	SNHSFT	Labs	Not in post	Not in post	Not in post	Apologies
Naomi Majek	SNHSFT	Library	Present	Mins only	Mins only	Apologies
Neil Powrie	SNHSFT	Radiology	Absent	Absent	Absent	Absent
Nicky Mandall	TGICFT	Dental	Apologies	Present	Present	Present
Nicola Hermitage	SNHSFT	Pharmacy	Present	Present	Present	Present
Paul Buckley	SNHSFT	Pharmacy	Present	Present	Apologies	Absent
Philip Lewis	SNHSFT	Cardiology	Present	Absent	Apologies	Absent
Rebecca Roberts	TGICFT	RD&I	Present	Present	Present	Present
Roxana Stanciu	SNHSFT	Respiratory	Apologies	Apologies	Absent	Present
Sajal Rai	SNHSFT	Surgery	Mins only	Mins only	Mins only	Mins only
Sandra Harrison	TGICFT	Library	Apologies	Present	Apologies	Present
Sara Benett	SNHSFT	RD&I Nursing	Present	Present	Present	Present
Sharman Harris	SNHSFT	Labs	Absent	Absent	Absent	Mins only
Slawomir Pawlik	TGIC ICB	ICB	Apologies	Absent	Left	Left
Shaun Dorey	TGICFT	Radiology	Absent	Present	Absent	Absent
Srivastavi Dukka	SNHSFT	Haematology	Apologies	Absent	Absent	Absent
Stephen Wilson	Patient	Patient	Apologies	Absent	Absent	Apologies
Sue Rothwell	TGICFT	Nursing	Present	Apologies	Present	Mins only
Suzy Collins	SNHSFT	Acute Medicine	Absent	Apologies	Absent	Absent
Tracey Stockwell	SNHSFT	Procurement	Mins only	Mins only	Mins only	Mins only
Victoria Thorne	TGICFT	Nursing	Not in post	Present	Present	Present
Wiesia Woodyatt	SNHSFT	RD&I	Present	Present	Present	Present
Wisam Jafar	SNHSFT	Gastroenterology	Absent	Absent	Absent	Apologies

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Appendix 2: Compliance with RD&I committee ‘Terms of Reference’ (ToR)

- **Compliance:** The ToR were last reviewed in Apr-2024 and are reviewed annually, unless there is the requirement to review earlier. There was no requirement for this in 2024/25.
- **Meeting frequency:** The Committee held 4 (i.e. quarterly) meetings in 2024/25, in accordance with the ToR.
- Evidence of compliance with each of the functions devolved to the RD&I committee through the ToR are as follows:

1.	Provide assurance to the Trust Executive Board(s) of managed risk, safety, quality and performance of RD&I activity through annual reporting internally and externally as appropriate (e.g. Individual Trust-sponsored studies are required to submit an annual progress report to the Research Ethics Committee).	The RD&I committee report annually on the progress they have made and on the Trust’s research activity. This annual report is produced by the RD&I governance team and ratified through the RD&I committee. It is then submitted to SNHSFT CEG, then SNHSFT QC and TGICFT SQAG who report to Trust Board. The RD&I committee also submit committee minutes to CEG and SQAG on a quarterly basis, with appropriate key issue reports and a summary of risk register entries. Individual studies report to the REC and MHRA annually, as applicable. The departments retain appropriate records of all internal/ external discussion and decisions. All communication is available in the relevant files and folders stored on the relevant Trust’s secure IT system and ink signed documents are stored within the paper RD&I filing system.
2.	Oversee achievement of RD&I performance targets and strategy.	There are standing agenda items on the RD&I committee agenda with supporting quarterly minutes that reflect on performance and strategic deliverables. This annual report summarises any significant achievements and risks, including the ongoing limited resourcing which has reduced our capacity to deliver on our strategic goals.

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3.	Provide oversight to ensure that all research being conducted complies with professional and ethical standards specified in the Department of Health and Social Care's UK Policy Framework for Health and Social Care Research, the Medicines for Human Use (Clinical Trials) Regulations and other current guidelines.	The SNHSFT RD&I manager and TGICFT research governance manager manage the annual audit programme on behalf of the RD&I committee. Audits are conducted in line with our Quality Statement of Intent and prioritisation flowcharts. A report of the internal audits conducted is presented to the RD&I committee as one of the standing agenda items (as well as a summary of any external monitoring or audit activities), to ensure there is awareness of findings and to maintain the required oversight of audit/ monitoring activity. A summary of internal audit activity is documented earlier in this report (see Section 3.5.2). Any significant risk register entries and scoring are also documented.
4.	Promote RD&I initiatives across both Trusts thereby enhancing its research reputation and activity.	This annual report provides a summary of key RD&I initiatives which have taken place across both trusts
5.	Provide RD&I training opportunities and support continued professional development of staff in research skills.	Both trusts regularly publicise training opportunities through emails, news bulletins on the staff intranet/ departmental microsites as well as advising on NIHR research related opportunities, such as GCP introductions/ 3-yearly refreshers, with regular checks on GCP training compliance through the quarterly RD&I committee.
6.	Encourage linkage, collaboration and relationship building with partners/ other organisations in our sector to maximise research opportunities for the local population we serve. To include sourcing additional funding, resources and facilities as appropriate.	<p>We have strong links with imaging, laboratories and pharmacy, as well as other relevant service departments through our hospitals, to ensure feasibility and support for the studies we conduct across both trusts. Representatives from each key supporting department are invited to the RD&I committee meetings.</p> <p>The departments have also engaged with several external collaborators, such as local universities, pharmaceutical companies, Health Innovation Manchester, the NW RDN, Stockport County and other study sponsors to maximise research opportunities for the local population we serve.</p>

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7.	Maintain links with other relevant departments and functions (e.g. finance, governance) in order to ensure the highest standards of scientific and financial probity and maximised integration into these and other mainstream functions.	<p>Our RD&I departments have maintained strong relationships with finance and other supporting departments to provide assistance for research issues such as funding posts within the Trust and improving resources. Our RD&I departments have focused on ensuring all invoices are raised and income is distributed according to the costing templates.</p> <p>The RD&I committee has maintained good relations with all departments to propel research at both trusts forward. A representative from each supporting department is invited to the RD&I committee meetings, where any issues or new procedures can be discussed.</p>
8.	Oversee appropriate review and risk assessment of new research proposals for Trust sponsorship so that only those studies that can be adequately supported by RD&I infrastructure are approved to progress (i.e. Both Trusts are NOT in a position to sponsor for Clinical Trials of Investigational Medicinal Products [CTIMPs]).	The RD&I committee has agreed to undertake the sponsorship responsibilities for a handful of new studies during 2024/25, via review of relevant study documentation and the sponsorship application form. Sponsorship oversight is maintained for existing sponsored studies by the RD&I governance team (including through the regular internal audit programme) and through regular updates to the RD&I committee. The quarterly minutes from committee meetings provide the evidence of this and the corrective/ preventative action plans from audits.
9.	Oversee appropriate review, capacity and risk assessment of any potential hosted CTIMPs, to determine whether additional Trust auditing is required (including review of the protocol and sponsor's risk assessment).	The RD&I committee has reviewed several potential hosted CTIMP studies during 2024/25, prior to confirming capacity and capability. The committee members reviewed a minimum of the study protocol. This is adequately evidenced in the quarterly, ratified minutes produced from these meetings. It has been agreed that the committee will look at studies earlier than a phase III setting.
10.	Maintain quality oversight via review of the annual audit programme activities as defined in the joint Trust 'Quality Statement of Intent'.	See point 3 for documented evidence.
11.	To provide assistance to the RD&I office and delivery teams for any research related issues (e.g. Standard Operating Procedures, Policies and training), via the below escalation process:	The RD&I committee assist with any RD&I issues, such as SOP or training compliance via the escalation process described in the committee's ToR.

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				Agenda No.	18
Meeting date	7 August 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 an Alert, Advise & Assure 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 July 2025, noting areas of alert, advice and assurance.

ALERT, ADVISE & ASSURE (AAA) REPORT

Name of Committee/Group	People Performance Committee
Chair of Committee/Group	Beatrice Fraenkel, Non-Executive Director
Date of Meeting	10 July 2025
Quorate	Yes

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

1. Agenda	<p>The Committee considered an agenda which included the following:</p> <ul style="list-style-type: none"> • People Integrated Performance Report • Organisational Development Plan • Equality, Diversity & Inclusion Strategy • Staff Survey • Safer Care (Staffing) Report • Temporary Staffing • Subgroups' Terms of Reference and Work Plans 2025/26 for Approval: <ul style="list-style-type: none"> - Joint Health & Wellbeing Group • Board Assurance Framework and Aligned Significant Risks • Alert, Advise & Assure Reports: <ul style="list-style-type: none"> - Joint Health & Wellbeing Group - Equality, Diversity & Inclusion Group - Educational Governance Group
2. Alert	<p>The Committee expressed concern regarding mandatory training compliance, specifically in relation to training relating to patient safety. The Committee heard of mitigating actions in this area, noting that the Executive Team were considering an options appraisal of consequences, and a further update would be provided to the next meeting of the Committee.</p> <p>The People Performance Committee requested that the Quality Committee review the impact of non-compliance of mandatory training from a quality and safety perspective.</p>
3. Advise	<p>The Committee received an Equality, Diversity & Inclusion (EDI) Strategy Update Report and noted the proposed priorities for the next 6 months, including the development of a joint EDI strategy with Tameside & Glossop Integrated NHS Foundation Trust (T&G).</p> <p>The Committee received a Staff Survey Report, noting actions being taken to address areas of concern highlighted in the latest Staff Survey. It was noted that planning was underway for this year's Staff Survey, which was expected to launch in September 2025, and the Committee highlighted the importance of demonstrating to colleagues the action taken in response to their feedback.</p> <p>The Committee received a Temporary Staffing Report and heard about continued work to explore alternatives to the use of bank and agency staff.</p> <p>The Committee reviewed and approved the people related principal risks to be</p>

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		<p>presented as part of the Board Assurance Framework 2025/26 to Board of Directors in August 2025.</p> <p>The Committee approved the Joint Health & Wellbeing Group Terms of Reference and Work Plan 2025/26.</p>
4.	Assure	<p>Positive assurance received around the following People metrics:</p> <ul style="list-style-type: none"> • The in-month sickness rate for May is 5.46%, which is a reduction from April of 0.45% and is below the target of 5.5%. • Agency expenditure as a percentage of the total pay bill is 2%, which is below the target of 2.1%. • Role essential compliance at 94.5%, which is above target. • Turnover (adjusted) has decreased in May to 10.37%, from 10.68% in April and remains below the target of 11.5%. <p>The Committee noted positive assurance regarding the delivery of the Organisational Development (OD) Plan and acknowledged further work required to measure the impact of the OD programmes of work.</p>
5.	Referral of Matters/Action to Board/Committee	<p>Quality Committee to review the impact of non-compliance of mandatory training from a quality and safety perspective.</p>
6.	Report compiled by:	Beatrice Fraenkel, Non-Executive Director
7.	Minutes available from:	Soile Curtis, Deputy Company Secretary

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Meeting date	7 August 2025	Public	✓	Agenda No.	19
Meeting	Board of Directors				
Report Title	People & Organisational Development Plan Progress Update				
Director Lead	Amanda Bromley, Director of People & OD	Author	Emma Cain, Deputy Director of People & OD and Lisa Gammack, Deputy Director of OD		

Paper For:	Information	Assurance	✓	Decision
Recommendation:	The Board is requested to formally note and endorse the report's key insights, which provide assurance and support informed strategic oversight.			

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

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

This paper relates to the following Board Assurance Framework risks

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

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

Where issues are addressed in the paper

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

Executive Summary

This report provides the Board of Directors with assurance on the progress made in delivering the Trust's People and Organisational Development (OD) priorities, building on the February 2025 update. It outlines key achievements, challenges, and strategic alignment with national workforce transformation goals.

Key highlights include:

- **Workforce Performance:** Positive trends in turnover (down to 10.2%), sickness absence (reduced to 5.2%), and agency spend (reduced to 2%) demonstrate early signs of sustained improvement. Mandatory and role-essential training compliance remains high.
- **Organisational Development:** Progress is on track across most priority areas, including leadership development, civility and sexual safety programmes, onboarding, coaching and mentoring, talent management, and career progression. Notable achievements include:
 - Launch of the "Our C.A.R.E. Leadership Way" framework.
 - Implementation of the Sexual Safety Training Programme.
 - Revamped onboarding and survey process for new recruits.
 - Expansion of mentoring and career progression initiatives.
- **Equality, Diversity & Inclusion (EDI):** The Trust has achieved bronze-level accreditation in the NW Anti-Racist Framework and improved WRES and WDES metrics. A joint EDI Strategy with TGICFT is in development, with final approval expected in December 2025.
- **Workforce Supply & Development:** Apprenticeships, cadet schemes, and pre-employment programmes continue to grow, with 153 apprentices supported and 92 cadets currently in placement. The Trust has secured £184k in funding to support T-Level placements and industry coordination.
- **Temporary Staffing:** Agency and bank expenditure have significantly reduced, with improved compliance against national targets. Strategic recruitment and conversion of temporary staff to substantive roles are ongoing.

- **Sickness Absence Management:** Long-term sickness and stress-related absences have declined. Enhanced support services, including menopause and MSK clinics, are contributing to improved staff wellbeing and attendance.
- **Collaboration:** Joint initiatives with TGICFT are progressing well, including shared recruitment, workforce information services, and an aligned approach to the National Statutory and Mandatory Training Programme reforms.

The Trust remains committed to delivering a compassionate, inclusive, and high-performing culture. Planning is underway for the next phase of the People & OD Plan, aligned with the NHS 10-Year Health Plan and local workforce needs.

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1. Introduction

1.1 This report provides assurance to the Board of Directors on the progress made in delivering the People and Organisational Development (OD) priorities. It builds on the update presented in February 2025, offering continued oversight of delivery against our strategic workforce objectives.

2. Impact

2.1 We remain committed to our improvement journey, with ambitious goals in a complex environment. Monitoring progress against key people metrics remains essential.

2.2 We continue to see early signs of positive change and will closely track performance, applying mitigations as needed.

2.2.1 People Key Performance Targets:

As outlined in the previous report to the Board, new workforce expenditure targets have been introduced through the NHS Operating Plan 2025-26, including revisions to existing benchmarks. Providers are expected to reduce agency spend by 30% and bank spend by 10%, with the lowest-performing Trusts required to achieve reductions of 40% and 15%, respectively. SFT has been set a target of a 30% reduction in agency spend and 15% in bank spend.

To support monitoring, the national Temporary Staffing Efficiency Team has updated its metrics:

- Agency spend ≤ 1.5% of total pay bill (national target)
- Bank spend ≤ 6.2% of total pay bill (national target)
- £0 off-framework spend for non-'break glass' usage (provider target)
- 80% compliance with price caps for Agenda for Change roles (national target)
- £0 Band 2 & 3 agency spend for non-'break glass' usage (provider target)

2.2.2 People Key Performance Indicators:

- The annualised (adjusted) turnover rate decreased to 10.2% in June 2025, down from 11.16% in June 2024.
- Reduction in agency spend as a % of pay to 2.1% in December 2024, against the new target of 3.2%. We continue to achieve no 'off framework' spend.
- Sickness absence has reduced from 6.32% in June 2024 to 5.2% in June 2025. We continue our improvement journey to reduce this level further. Our year-to-date position is 5.73%.
- We achieved our mandatory training compliance of 95.39% in June 2024, the June 2025 position is 94.7%, marginally below our 95% target.
- We achieved our role essential training compliance of 90% in June 2024 and have continued to be above target throughout 2025 – as of June 2025 it was at 94.7%.

3. Progress Update

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

Strategic Priority	Key Area of Focus	Current Status
1. Organisational Development	Board & Executive team development	On-going (BAU)
	Leadership & management development	On track
	Civility & sexual safety programmes	On track
	Onboarding	Completed
	Coaching & mentoring	On track
	Talent management & succession planning	On track
	Career progression	On track
2.	Career progression opportunities for BAME staff	On track

	Equality Diversity & Inclusion	Review of recruitment process to reduce/remove barriers	On track
		Review of disciplinary progress to reduce likelihood of BME staff entering formal process	On track
		Improving the way in which staff networks work	On track
		Disability – improvement of metrics & handling of workplace adjustments	On track
		Career progression opportunities for disabled staff	On track
3.	Place Based Programmes	Attracting the local population, partnership working as part of the One Stockport Programme.	On track
4.	Collaboration	Pilot shared recruitment service	On track
		Pilot shared workforce information service	On track
5.	Medical Staffing / Agency Expenditure	Review opportunities for increased grip/control to reduce expenditure	On track
6.	Sickness Absence	Development and implementation of person-centred absence management and wellbeing policy and approach. Reduce sickness absence.	On track

3.2 Organisational Development

Delivery of the OD Plan remains challenging due to ongoing operational pressures. Shifting priorities and limited OD expertise and capacity. Nonetheless, all actions scheduled for completion by July 2025 are either completed or underway.

The People Performance Committee received a comprehensive update on the delivery of the OD work programme in July 2025. The following provides a high-level summary to offer assurance to the Board on progress to date:

3.2.1 Leadership and Management Development

We continue to enhance our leadership and management development offer to drive organisational performance and strengthen our culture. Recent highlights include the successful relaunch of Appraisals with Impact training, the launch of two additional cohorts of the Leading with Impact programme, and a well-received celebration event recognising the achievements of the first cohort.

A new overarching framework, aligned with the Trust's C.A.R.E. values, has been developed around three interconnected strands:

- People Management Excellence – focused on everyday line management aligned with the NHS Expectations of Line Managers, supported by practical 'Know-How' sessions on systems such as ESR, TRAC, and People Analytics.
- Operational Management Excellence – developed in collaboration with Corporate Services colleagues, this strand enhances technical capabilities including data analysis, project management, financial acumen, and digital literacy.
- Leadership Excellence – includes the Leading with Impact Programme and regular development sessions for senior leaders (Band 8C+, medical leaders, and Executive Directors). A recent session (June 2025) focused on strategic alignment, collaboration, and innovation, with positive feedback and a follow-up planned for October 2025.

Development opportunities are designed to be flexible and person-centred, supported by a self-assessment tool for all managers. A development session for Band 8B leaders was held on 17 July 2025, with sessions for Band 7–8A managers starting in September 2025.

The Our C.A.R.E. Leadership Way will be launched by the end of July 2025 and will evolve to meet organisational needs. Uptake and impact will be monitored, with concerns escalated as appropriate.

3.2.2 Civility and Sexual Safety Programmes

The second phase of the Trust's Civility Saves Lives (CSL) Programme – Having the Conversation sessions – launched in May 2025. This training is designed to equip staff with the skills and confidence to address incivility in the workplace through constructive dialogue. To date, 853 colleagues have completed the course, with a further 3,353 booked to attend by March 2026.

To further embed a culture of civility, the core principles of Civility Saves Lives will be integrated into the People Management Excellence strand of the new 'Our C.A.R.E. Leadership Way', reinforcing respectful and inclusive leadership behaviours.

We have adopted and launched the national Sexual Misconduct Policy, supported by guidance materials and an anonymous reporting mechanism for unwanted behaviours. A new sexual safety e-learning package is also now available to all staff.

Following a successful pilot in late 2024, the Sexual Safety Training Programme commenced in July 2025, with sessions commissioned throughout 2025-26. The training defines unacceptable behaviours, explores their impact, and equips staff to support colleagues, challenge harassment, and foster a safe, respectful workplace. Delivery is being prioritised in areas where concerns have been raised, including through the NHS staff survey.

3.2.3 Onboarding

Since January 2025, the updated fortnightly Trust Welcome Sessions have been successfully delivered. The redesigned format is more engaging, with a stronger focus on the Trust's values, behaviours, and available staff support.

Feedback from the past six months has been overwhelmingly positive, with attendees describing the sessions as informative, welcoming, and interactive. Immediate improvements, such as providing microphones for presenters, have been implemented. An action plan is in place to address remaining suggestions, with completion expected by the end of July 2025. Participant feedback will be reviewed annually.

The Trust has historically surveyed new staff to gather feedback on the recruitment and induction experience. However, response rates have been consistently low, and the survey content no longer provides meaningful insights. To address this, we have revised both the focus and timing of the survey to better capture the early experiences of new employees. The updated survey process is scheduled for implementation from July 2025. The feedback will be triangulated with other staff feedback and monitored by the POD Leadership Team.

3.2.4 Coaching and Mentoring

Staff continue to access 1:1 coaching through the internal coaching pool, the North-West Leadership Academy, and executive coaching via our Leadership Academy membership.

The Reverse Mentoring Scheme, launched in June 2023 for BAME and disabled staff, currently involves two mentors supporting two Non-Executive Directors. Despite ongoing promotion, uptake remains low. Feedback from participants has been positive, and plans are in place to broaden the scheme to encourage wider participation.

We are also developing a formal mentoring pilot for newly appointed Band 7 and 8A nursing, AHP, and midwifery managers, with implementation expected by September 2025. Insights from the pilot will inform future expansion to other staff groups.

3.2.5 Talent Management and Succession Planning

The Head of Talent, Leadership & OD Consultancy is leading the development of an inclusive talent management and succession planning framework for implementation across SFT and TGICFT. The framework is expected to be finalised by October 2025, with phase one of the rollout planned to start in November 2025, subject to approval.

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3.2.6 **Career Progression**

The Career Progression Task Group has been invigorated, with expanded membership. The group is using data insights to drive initiatives aligned with the Trust's EDI priorities, including:

- **Application Support:** Providing guidance for staff applying for internal roles, including interview and assessment preparation.
- **Mentoring Pilot:** Pairing experienced staff with mentees to support career development across clinical and non-clinical roles.
- **Shadowing Programme:** Offering staff opportunities to observe and learn from experienced professionals to explore career pathways.
- **BAME Leadership Programme:** Exploring a targeted initiative to address leadership barriers and promote inclusivity.
- **Women's Network:** Assessing the feasibility of a network to support female staff in career progression and leadership.

The OD Service continues to support the recruitment and hosting of NHS graduate management trainees. Currently, three trainees are placed across operational management and the People & OD Directorate. Two additional trainees will join in Health Informatics from September 2025.

3.3 **Equality Diversity and Inclusion**

Over the past six months, we have maintained a strong strategic focus on delivering the Trust's consolidated EDI Action Plan. This has resulted in measurable progress across key priority areas, reinforcing our commitment to fostering an inclusive and equitable organisational culture. Key achievements include:

- **Enhanced Workforce Metrics:** We have seen demonstrable improvements in both the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) indicators, as reflected in our 2025 published reports. These improvements signal positive shifts in staff experience and representation.
- **External Recognition:** Our successful submission to the North-West BAME Assembly has secured bronze-level accreditation within the NW Anti-Racist Framework. This external validation affirms the robustness of our anti-racism initiatives and our alignment with regional best practice.
- **Inclusive Recruitment:** We have embedded a suite of inclusive recruitment practices designed to attract, engage, and appoint talent from our local communities. These practices are contributing to a more representative workforce and enhancing our employer brand.
- **Career Progression Insights:** The Collaborative Career Progression Task Group has undertaken a detailed analysis of employment data and staff survey feedback. This has enabled the identification of targeted interventions to address barriers to career progression, as outlined in section 3.2.6 of this report.
- **Strengthening Staff Networks:** We continue to invest in the development of our Staff Networks, ensuring they play a central role in shaping policy and organisational development. We have consulted with Network Leads on a proposed integration of networks across SFT and TGICFT. This approach aims to enhance collaboration, amplify staff voices, and deliver a more strategic and unified approach to inclusion. The joint staff network meetings will start from September 2025.
- **Joint EDI Strategy Development:** Work is progressing on the co-creation of a joint EDI Strategy with TGICFT. A Trust-wide staff engagement survey is underway and will close at the end of July. The draft strategy will be reviewed by the Combined EDI Strategy Group in October, the Workforce Committee in November, and presented to the Board for final approval in December. This collaborative approach will ensure alignment of strategic priorities and shared accountability for outcomes.

3.4 **Place Based Programmes**

Collaboration with system partners across Stockport remains central to our workforce strategy, enabling us to showcase diverse career pathways in health and social care. We continue to invest in work

experience, pre-employment programmes, careers events, apprenticeships, internships, and cadet schemes – prioritising engagement with underrepresented communities.

Our partnership with local social care providers has led to successful cadet placements, with four cadets now employed in care homes. We have also secured roles in primary care and are integrating cadets into the SMILE programme to expand targeted, place-based opportunities.

Aligned with our ambition to train, retain, and reform the workforce, we are strengthening inclusivity through initiatives such as Inclusive Recruitment and Neurodiversity Awareness training. Our widening access and participation approach recognises the critical link between health and employment, advocating for anchor institutions to improve life chances in deprived areas – ultimately driving better health outcomes and quality of life.

3.5 Apprenticeships

Since February 2025, we have supported 38 individuals to start an apprenticeship – 17 in the current financial year – bringing our total to 153 across 48 clinical and non-clinical programmes from Level 2 to Level 7. This reflects our continued commitment to developing a skilled, homegrown workforce.

We are actively supporting advanced clinical pathways, including Community Nurse Specialist Practitioner and Specialist Community Public Health Nurse Level 7 programmes, though national funding changes from January 2026 may impact future access. Our Registered Nurse Degree (RNDA) and Student Nursing Associate (SNA) apprenticeship programmes remain strong, with 36 learners in progress and 16 due to qualify by the end of 2025, joining the NMC register and entering the workforce as Registered Nurses or Nursing Associates.

Progress continues across allied health professions, with completions expected in Occupational Therapy, Physiotherapy, Dietetics, and Diagnostic Radiography through 2027. Three Operating Practitioners Department (OPD) apprenticeship in September 2025 with Edgehill University. Three Advanced Clinical Practitioner apprenticeships began in 2024, with completion expected in 2026, pending national funding decisions.

To further strengthen our talent pipeline, we are exploring integration of Level 2 and 3 Health Care Assistant apprenticeships into the Trust's Care Certificate framework – enhancing accessibility and maximising levy utilisation.

3.6 Cadet Programme

We have continued to build on the success of our cadet and T Level programmes since the launch of our first cohort of 10 learners. After several fruitful cohorts we set ourselves the ambitious target of 120 cadets by September 2024, a target that we comfortably met. We therefore decided to expand our capacity to work towards supporting 250 cadets in placement for 2025/26 and we are actively expanding our capacity to meet this goal. Currently, 92 cadets are on placement in various teams within the Trust. This figure is lower than the 160 confirmed for 2024/25, as many learners have now completed their placement and successfully progressed into employment, apprenticeships, or degree-level training. Our current learners are drawn from a range of educational partners and programmes, including:

- Stockport College (BTEC Health and Social Care, Transitional Level 2)
- Manchester College and Macclesfield College (Transitional Level 2 and T Level Health programmes)
- Manchester College UCEN (Higher National Certificate/Diploma in Healthcare Practice)

From September 2025, we anticipate an increased focus on supporting learners on T Level and transitional programmes, which provide a more rigorous academic pathway compared to traditional BTEC qualifications. Nonetheless, we remain committed to offering placements across a broad range of health-related programmes that support employment into entry roles within the NHS and wider health and care sector. Ongoing progress and developments will continue to be reported through the Education Governance Group and People Performance Committee.

We have recently secured funding to the value of £184,268 from the Department of Education to work alongside the Greater Manchester Combined Authority (GMCA) to host an Industry Placement Coordinator (IPCO). This role is expected to play a key part in supporting the ongoing success of the

cadet and t-Level programme at the Trust, as well as contributing to the broader Greater Manchester initiatives around clinical and non-clinical T Level programmes.

3.7 Young Care Leavers

Following the success of the King's Trust Pre-Employment Programme in October 2024, all 13 learners who completed The King's Trust (TKT) programme were offered the option of a direct interview (via a Trust recruitment day), a pre-employment placement or volunteering opportunity, as appropriate. This resulted in 8 securing roles (1 Young Care Leaver & 7 NEETs) as either Health Care Assistants or Ward Clerks. A further 3 YCL are being supported to access volunteering opportunities with the Trust whilst one YCL and one NEET have paused their placements owing to personal circumstances. In recognition of the Trust's efforts to support YCLs and NEETs, TKT extended an invitation to the Vocational Learning to their annual awards event in recognition of the successful outcomes.

A second cohort is planned for October 2025, continuing our work alongside the Stockport Council Young Care Leaving Team. In addition, we continue to offer multiple pathways, such as volunteering, work experience, and tailored pre-employment programmes, all supported by enhanced pastoral care to ensure that individuals are guided every step of the way. Similarly, the pre-employment programme will allow care-experienced learners to select from a range of entry-level roles, including Healthcare Assistant, Administration, and Estates and Facilities, with the long-term aim of securing substantive employment.

Since February 2025, we have facilitated 10 work experience placements for this cohort of learners and supported 2 volunteering opportunities. In collaboration with the council, we have committed to prioritising care-experienced learners. As part of this agreement, there is no cap on the number of placements offered to individuals from this group and therefore all requests for work experience and volunteering have been arranged.

3.8 Pre-Employment Programme/ UK Youth: Summer Jobs Programme

In February 2025, we delivered another cohort of our pre-employment programme in partnership with Trafford & Stockport College Group, as part of our ongoing rolling initiative. Following a successful open day, eight individuals were accepted onto the programme. Four participants were offered roles as Healthcare Support Workers (HCSWs), while two determined that the role was not suited to them. One participant secured a position as an Antenatal Ward Clerk, and another took up a role in employee resourcing. We remain committed to fostering equity and inclusivity throughout our programme, where individuals required significant workplace adjustments; these were implemented with the support and guidance of our Disability Lead to ensure their full participation and a successful outcome.

In place of our second pre-employment cohort this year the Trust signed up to participate in the UK Youth: Summer Jobs Programme. As part of our commitment to youth development and inclusive employment pathways, we partnered with the UK Youth: Summer Jobs Programme, a national initiative aimed at supporting young people aged 16–20 who are at heightened risk of violence or social exclusion. The programme offers paid six-week work placements during the summer, designed to build confidence, foster employability skills, and enhance wellbeing through real-world experience and wraparound support provided by youth workers.

The Trust pledged five placements including Domestic Assistant, Library Assistant, Housekeeper, and two roles in catering. These positions were advertised through UK Youth's network alongside opportunities from other participating organisations. Due to a broader trend across the programme where the number of placements exceeded applications, the Library Assistant role was the only role selected. The successful candidate is due to start their placement at the Trust in August 2025.

3.9 Work Experience

Since the last update in February 2025 our work experience programme continues to offer opportunities to engage young people and provides participants with an insight into NHS careers, and as a means of initial contact with potential employees of the future.

The offer includes learners of 16+ years onsite clinical placements in Radiology, Pharmacy, SALT, Dietetics, and the large majority in ward-based placements. Learners of 14+ years in nonclinical placements include EBME, Administration (e.g. HR, Pinewood, non-patient facing administration areas), IT, Finance and Estates and Facilities as appropriate. In conjunction with all onsite placement's

learners have access to the NHSE Creating Careers Portal which includes an introduction to a range of online e-learning modules which mirrors the mandatory training undertaken by any new member of staff, bespoke support information and guidance.

Since July 2024 to date, we have offered 229 (14–16-year-olds) on site placements with enrolments on the 14+ years 'Creating Careers portal.

We are pleased to be delivering a second bespoke Physiotherapy Taster Day in August 2025, providing 11 local learners with direct exposure to Allied Health Professional (AHP) careers. This initiative supports early engagement and insight into physiotherapy pathways within the NHS.

In parallel, our IT department is offering practical opportunities for learners to contribute to the Trust-wide rollout of Windows 11 between August and October. This hands-on experience is particularly valuable for those studying or considering a future in Information Technology, enabling a minimum of 12 local learners to participate and develop key skills in a live working

3.10 Temporary Staffing Expenditure

We continue to work to ensure appropriate oversight and grip and control on our temporary staffing use and expenditure. We know that this is an area of significant challenge and have continued to see improvement against the targets. We continue to monitor this closely at the monthly Workforce Efficiency Group (WEG) chaired by the Director of People & OD, attended by operational and clinical leaders to discuss agency expenditure and plans to further reduce this.

3.10.1 Agency Expenditure

Our work to review opportunities to reduce our agency expenditure remains a significant priority and substantial progress has been made throughout 2025/26; we have consistently achieved better than the target of 2.1% of pay spend. The YTD position, as of June 2025, is 2%, an improvement against the June 2024 YTD position of 3.1%.

There has been an in-year reduction in the nursing & midwifery spend as a % of pay, from 2.9% in June 2024, to 2% in June 2025. We have also seen positive progress with our Medical & Dental agency expenditure, across the last 12 months, reducing from 10% in June 2024 to 5.4% in June 2025. NHSE have revised their agency spend % target to 1.5%, we are responding to this by further exploring opportunities to drive down our expenditure, with a renewed focus on the longest serving agency workers during July requesting an exit plan from the divisions, as well as being supported by recruitment to a number of hard to recruit to medical posts, for example appointments have been made for Rheumatology Consultant, Stroke Consultant, Consultant in General Medicine and the GPs for the UTC.

In addition to the change in agency % spend target, NHSE have revised their approach to the price cap compliance and have adjusted this target to 80% for all non-medical use; we continue to be consistently above this target and in June 25, we were 93%.

3.10.2 Bank Expenditure

Our work to reduce our agency expenditure has been supported by converting agency workers to the bank, where possible and to also convert bank/locum workers into substantive posts.

There has been a significant in-year reduction in the nursing & midwifery spend as a % of pay, from 12.2% in June 2024, to 7.5% in June 2025. We have also seen positive progress with our Medical & Dental agency expenditure, across the last 12 months, reducing from 11.6% in June 2024 to 10.1% in June 2025.

The percentage of bank versus agency spend in June 25 was 77% bank, and the number of bank shifts compared to agency shifts was 85.33%, which is above the GM target of 75%. NHSE has a new national target for bank as a % of the total pay bill, this is set at 6.2% (excluding Medical and Dental staff), in June 25 our position was currently at 5.02%, above this target.

3.11 Sickness Absence

The managing and supporting of staff who are off due to sickness remains an on-going priority. Over 2025 we have seen an improving position, reducing from 6.32% in June 2024, to 5.11% in June 2025, which is in line with our operational planning ambitions, below the 5.5% target. However, we are mindful

of the seasonal variance of absence and during Q2 are planning our approach to the influenza vaccination programme, launching in Q3 along with our winter wellbeing programme.

The Deputy Director of People & OD continues to attend monthly meetings with each of the Divisions, focusing on the most complex and longest absence cases, which has been well received, and the benefits are being noted with a reduction in our long-term sickness absence from 4.32% in June 2024 to 3.45% in June 2025.

The menopause service continues to be a support to staff and managers. To date the service has seen 270 staff members and helped numerous managers to confidently have supportive conversations with their staff members around this topic. Regular menopause awareness sessions are held throughout the year covering topics from nutrition, physical exercise and HRT. A recent survey of staff who had attended the menopause clinic revealed that 100% would recommend the service to their colleagues.

Our MSK Physiotherapist continues to support staff with musculoskeletal issues, which is having positive impact in addressing absence due to MSK issues. Between quarter 4 FY24/25 and quarter 1 FY25/26, the number of MSK cases referred to occupational health dropped from 161 to 110 which is a 31.7% reduction. Back issues remain the most common, although they did decrease from 34.8% to 30.0%. Our MSK staff clinic supports on average 40 staff a week with a mix of clinics in occupational health and physical physiotherapy sessions in the outpatient therapies department. We held the first mini back care campaign during June 2025 which saw our MSK Physiotherapist visit numerous Wards and departments across the Trust, reminding staff in their working environments of the importance of good back care. One of the ward areas has agreed to take part in a trial staff exercise programme, which involves staff participating in a pre-shift warm up, mid shift stretches and a warm down at the end of the shift. One of the departments with high levels of MSK back care issues, has agreed to participate in a 6-12 week 'Back Strengthening Programme' to educate and provide exercises to staff to reduce the potential risk of injury. If both these pilots are successful, then the aim would be to roll-out to other areas across the Trust.

Stress-related absences remain the highest reason for sickness, we have seen a reduction in the level for this reason from 1.9% in June 2024, to 1.5% in June 2025. We continue to benefit with the support of our Staff Psychological Wellbeing Service. Individual referral rates to SPAWS continue to increase, SPAWS have met individually with over 15% of staff and service satisfaction is extremely high (4.92/5, where 5 is extremely satisfied). SPAWS deliver a range of wider activity including training, webinars and group facilitation and are supporting the delivery of the wellbeing module within our leading with impact leadership development course.

Since the introduction of our new Occupational Health system which supports the referral and reminder for staff appointments and enables managers to access the information required directly, shortening referral wait times and improving access to information to support with the management of attendance. we continue to improve our performance as demonstrated by our key performance indicators below:

- Pre-employment questionnaires triaged within 2 working days, has increased from 85% (June 2024) to 100% (June 2025) and has been 100% for the last 7 months.
- Pre-employment appointments within 10 days of triage of the questionnaire (for those who need to be seen) has increased from 28.6% (June 2024) to 93% (June 2025).
- Management referrals triaged within 2 days has remained at 100% consistently.
- New urgent referrals seen/offered an appointment within 5 days has increased from 14.3% (June 2024) to 100% (June 25).
- Reports issued within 3 days of appointment has improved from 53.6% (June 2024) to 100% (June 2025).

3.12 Collaboration

The People and OD Directorates at SFT and TGICFT continue to collaborate closely, sharing best practices, minimising duplication, and aligning policies and processes wherever feasible. Over the past six months, we have made notable strides in our joint efforts, including:

- The appointment of a joint Head of Strategic Workforce Transformation who is enhancing and harmonising our Workforce Information functions.

- A pilot initiative to jointly lead the two Recruitment Teams, currently under evaluation for permanent adoption.
- Collaborative delivery of the National Statutory and Mandatory Training Programme, ensuring alignment with the Core Skills Training Framework. This includes standardising training content, delivery methods and refresher periods.
- Implementing a coordinated and strategic approach to the nursing and midwifery role review, ensuring alignment and consistency in processes and job descriptions across both organisations, where practicable.
- Formation of a Combined Staff Health and Wellbeing Steering Group, building on the successful model of the Combined EDI Steering Group.
- Weekly meetings of a unified People & OD Leadership Team to support decision-making and ensure alignment with the GM Scaling People Services Programme.
- Exploration of how digital solutions can bring about further efficiencies continues, with learning and sharing of best practice from the RPA model being developed at TGICFT.

4. Next Steps

- 4.1 Our People and OD priorities remain central to our workforce strategy, with continued focus on improving retention, sustaining positive turnover trends, reducing temporary staffing costs, and advancing internal career development through a 'grow our own' approach.
- 4.2 We are aligning our efforts with the recently published NHS 10-Year Health Plan (July 2025), which sets a refreshed national direction for workforce transformation. This will inform our future planning and ensure our priorities remain responsive to evolving system-wide expectations.
- 4.3 Delivery of the People and OD priorities will continue alongside the Health and Wellbeing Plan 2024-25, with a new joint EDI Strategy set to launch in January 2026. Together, these will underpin our commitment to building a compassionate, inclusive, and high-performing culture.
- 4.4 Building on progress to date, we are now developing the next phase of our People & OD Plan for 2025 and beyond, ensuring alignment with national priorities and local workforce needs.

5. Recommendation

- 5.1 The Board is requested to formally note and endorse the report's key insights, which provide assurance and support informed strategic oversight.

Curtis Soile
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Meeting date	7 August 2025	Public		Agenda Item No.	20
Meeting	Board of Directors				
Report Title	Safe Staffing Report				
Director Lead	Nic Firth Chief Nurse	Author	Helen Howard Deputy Chief Nurse		

Paper For:	Information		Assurance		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.

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Safer Care (Staffing) Report – July 2025

Curtis Soile
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Report of: Helen Howard
Deputy Chief Nurse

1	Introduction
2	Safe Staffing
3	Workforce Safeguards
4	Guide for Safe Staffing
5	Healthroster
6	Vacancies
7	Recruitment Process
8	Temporary Staffing Spend
9	Agency Spend
10	Sickness / Absence
11	Risk Highlights
12	Retention
13	Reasons for Leaving
14	Recruitment Initiatives
15	Training Pathways
16	Healthcare Scientists
17	Allied Health Professionals
18	Midwifery Update
19	Medical Workforce
20	Good News
21	Going Forward

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This report provides the Committee 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.
- 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 which 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

<p>Introduction</p>	<p>What is safe staffing? What are the warnings signs of inadequate staffing? What CQC standards are around safe staffing?</p>	<p>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.</p>
<p>1 Safe staffing levels How many staff do you need</p>	<ul style="list-style-type: none"> • Decide how many staff you need • Plan your staffing rota • Put contingencies in place • Review your staffing levels • Use technology to support safe staffing 	<p>We use strategic staffing meetings and evidence from tools such as Datix, Harms, StARS, Safe Care , Healthroster compliance & Opel level escalation processes in place.</p>
<p>2 Safe recruitment practices Recruit the right staff to deliver safe care & support</p>	<ul style="list-style-type: none"> • Plan your recruitment • Attract the right people • Review your recruitment & retention activities 	<p>All recruitment events are planned, organised with engagement from divisions. Attend regular <i>Thrive</i> workshops improve retention procedures & strategies.</p>
<p>3 Safe & competent staff Ensure staff are competent to deliver safe care & support</p>	<ul style="list-style-type: none"> • Give new staff a thorough induction • Provide learning & development opportunities for staff • Support your staff 	<p>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.</p>

3. Workforce Safeguards

To ensure the welfare & safety of staff and patients, nurse to patient ratios were introduced :

Deploying staff effectively

This is to advise the Committee/Board of their responsibilities in ensuring staffing arrangements are safe, sustainable and productive. It also considers 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 highlights that well-performing organisations use their workforce as a strategic asset. This underlines the need to deploy the workforce effectively and efficiently.

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4. Guide for Safe Staffing

- A good rota assists staff in planning work-life balance, communicating with colleagues and people who need care and support. It also provides evidence for a 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.

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- **Annual leave** – currently below the Trust target
- **Roster approval** – showing at 47.9 days which is a slight increase on previous months.
- **Total unavailability** – this continues to be well managed & is within the Trust target.
- **Changes since approval** – this figure will fluctuate over the roster period but is currently within the Trust target.
- **Safecare completion** – decreased slightly in May 2025, with C3 the only ward with 100% completion. An action has been taken to identify the process used by C3 & share with other wards.

Unit	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Difference between last 2 months
Total	65.77%	67.56%	68.00%	67.06%	71.26%	70.24%	▼

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5. Healthroster

Rostering Dashboard | Homepage Summary

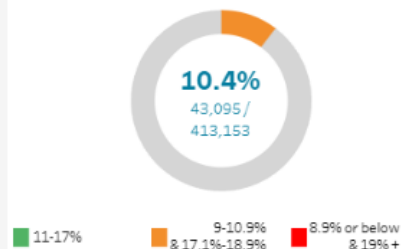
Home Page View Switch

Donut View

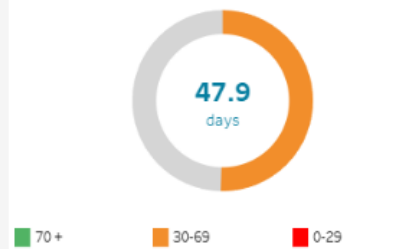
Select roster 4-week period start date...

16/06/2025

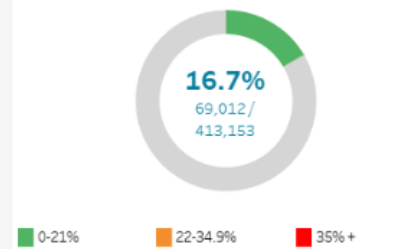
Annual Leave %



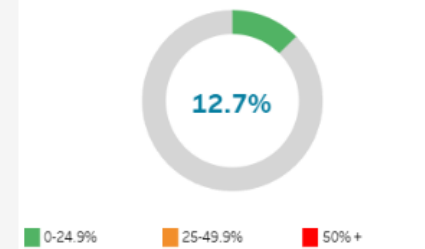
Roster Approval (Full) Lead Time Days



Total Unavailability %

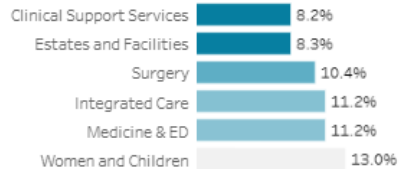


% Change Since Approval



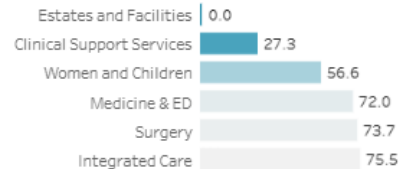
Performance by Division

Click to filter



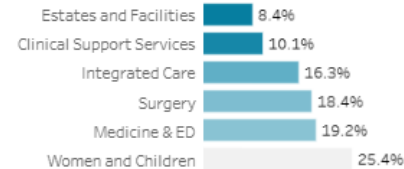
Performance by Division

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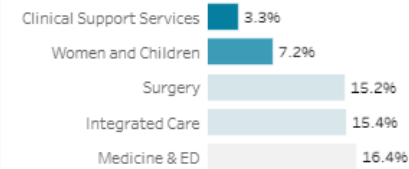
Performance by Division

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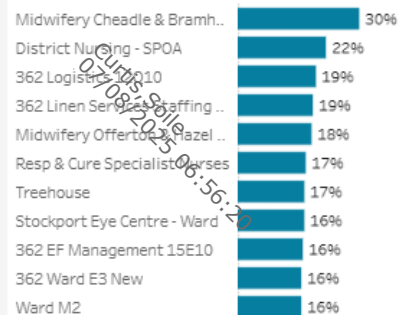
Performance by Division

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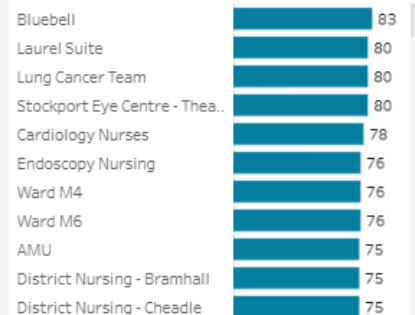
Performance by Roster Team

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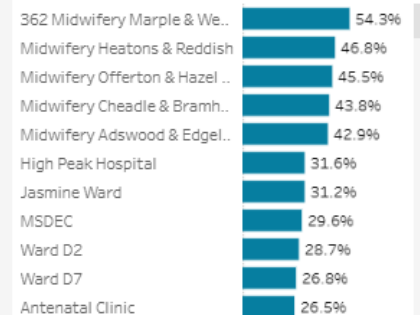
Performance by Roster Team

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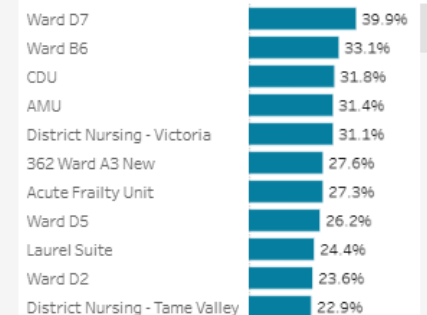
Performance by Roster Team

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Performance by Roster Team

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6. Vacancies

The data below for May 2025 :

Registered Nurses	FTE Budgeted	FTE Actual	Variance FTE	Variance %	Post Recruited to in TRAC FTE	Grand Total Variance from Establishment FTE
Clinical Support Services	81.89	84.75	2.86	3%	10.35	13.21
Corporate Services	97.15	102.71	5.56	6%	23.53	29.09
Integrated Care	281.99	269.11	-12.88	-5%	37.53	24.65
Medicine & Urgent Care	636.15	595.64	-40.51	-6%	49.01	8.50
Surgery	443.60	421.87	-21.74	-5%	45	23.26
Women & Children	423.07	400.78	-22.29	-5%	49.88	27.59
Grand Total	1963.86	1874.85	-89.00	-5%	215.3	126.30

Healthcare Support Workers	FTE Budgeted	FTE Actual	Variance FTE	Variance %	Post Recruited to in TRAC FTE	Grand Total Variance from Establishment FTE
Clinical Support Services	43.18	42.48	-0.70	-1.62%	1.97	1.27
Corporate Services	9.50	10.17	0.67	7.09%	13.64	14.31
Integrated Care	111.45	92.09	-19.36	-17.37%	8.04	-11.32
Medicine & Urgent Care	404.61	378.88	-25.73	-6.36%	7.22	-18.51
Surgery	193.40	187.43	-5.97	-3.09%	13.21	7.24
Women & Children	110.21	84.06	-26.15	-23.72%	11.59	-14.56
Grand Total	872.35	795.12	-77.23	-8.85%	55.67	-21.56

Currently services are recruiting to turnover where appropriate, hence the large number of people going through checks. This is to prevent the reliance on agency/bank when in recruitment check times. The Trust is holding staffing reviews between now and March so these figures may change in the new financial year.

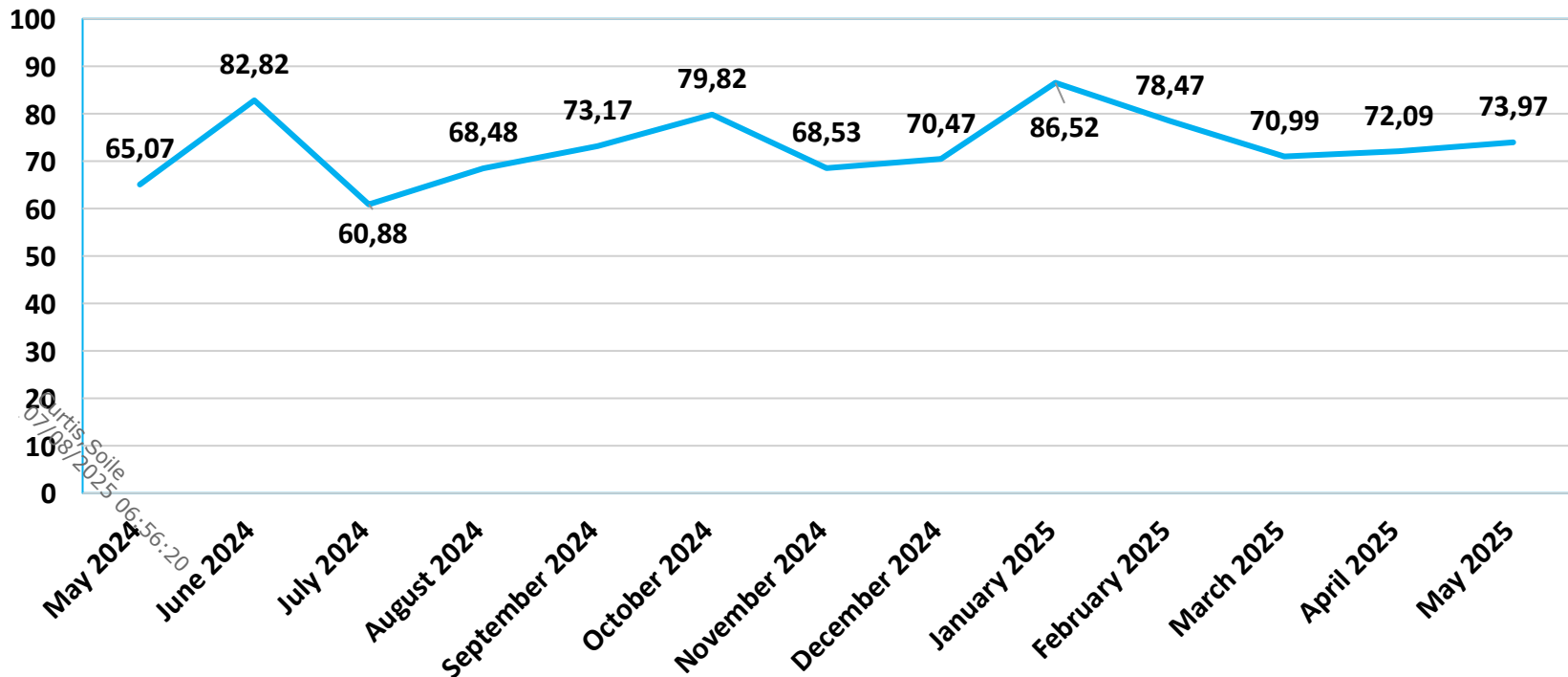
On the 17th May 2025 the Trust held a successful careers event which was well attended by employees, members of the public and local media. The event provided the opportunity for the Trust to showcase the different divisions and services, careers pathways, training & development available, and also information about the different roles not usually associated within healthcare.

7. Recruitment Process

The number of days from job offer to start date continues to increase month-on-month, with the highest spikes following on from recruitment events.

Working in conjunction with the Recruitment Team mechanisms are being implemented to mitigate against potential employee delays.

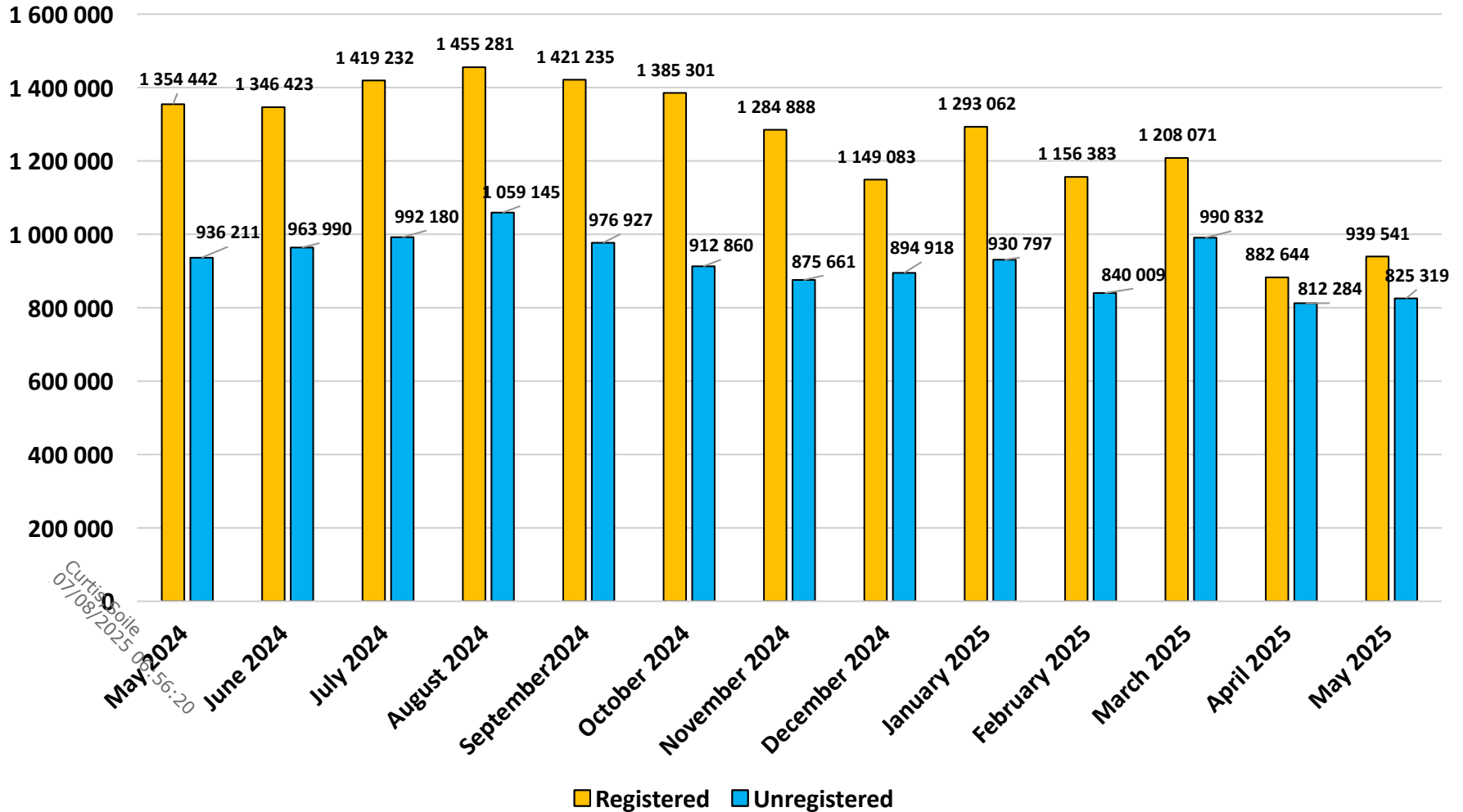
Number of days from job offer to start date



8. Temporary Staffing Spend

The table below illustrates the 'month on month' cost to the Trust of NHSP bank RNs, RMs and unregistered staff.

NHSP Spend £



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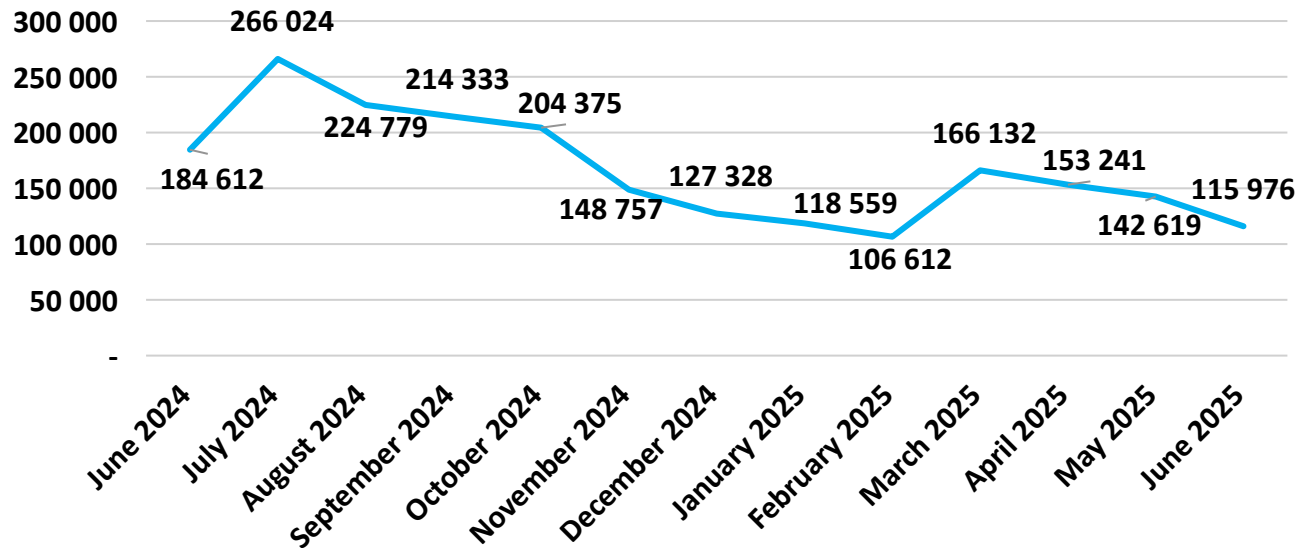
9. Agency Spend

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, and the Trust is now working towards reducing the amount of agency shifts with only a limited number of areas able to use agency workers. The plan is to be sustainably at 0% agency usage within 2 years.

From February to March there was a considerable increase in the use of agency. This has been reviewed & restrictions have been implemented & actioned. The positive outcome has been a steady decrease from March to June.

A listening event in theatres, with Executive and Divisional colleagues, took place on 8 July 2025. Good engagement and actions have been taken from the meeting and feedback will be provided.

Agency spend £



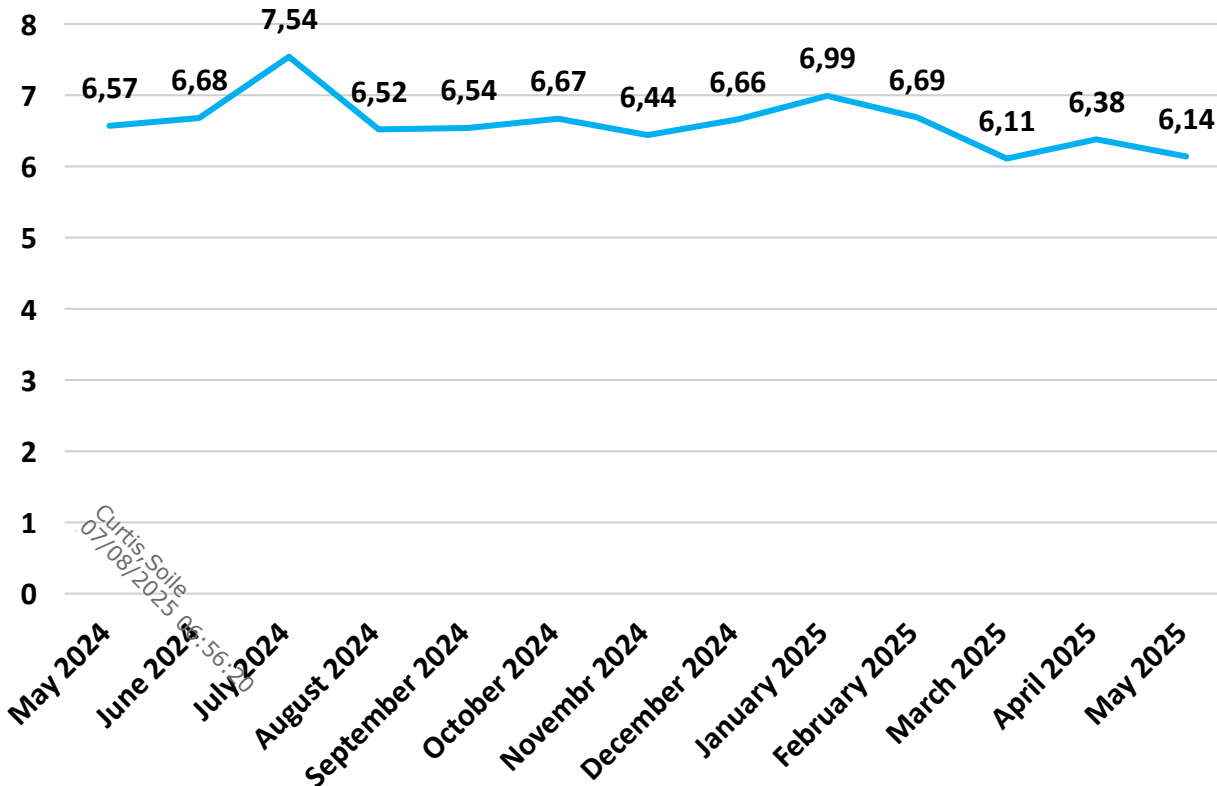
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10. Sickness / absence

The chart below illustrates the sickness percentage for registered nurses, registered midwives and AHPs workforce.

The Trust sickness/absence target is set at 5.5% and the rate for the nursing & midwifery workforce in May was above this at 6.14% but lower than in April. The Matrons, Lead Practitioners & DNDs have monthly meetings with HR to review sickness/absences.

Sickness rate %



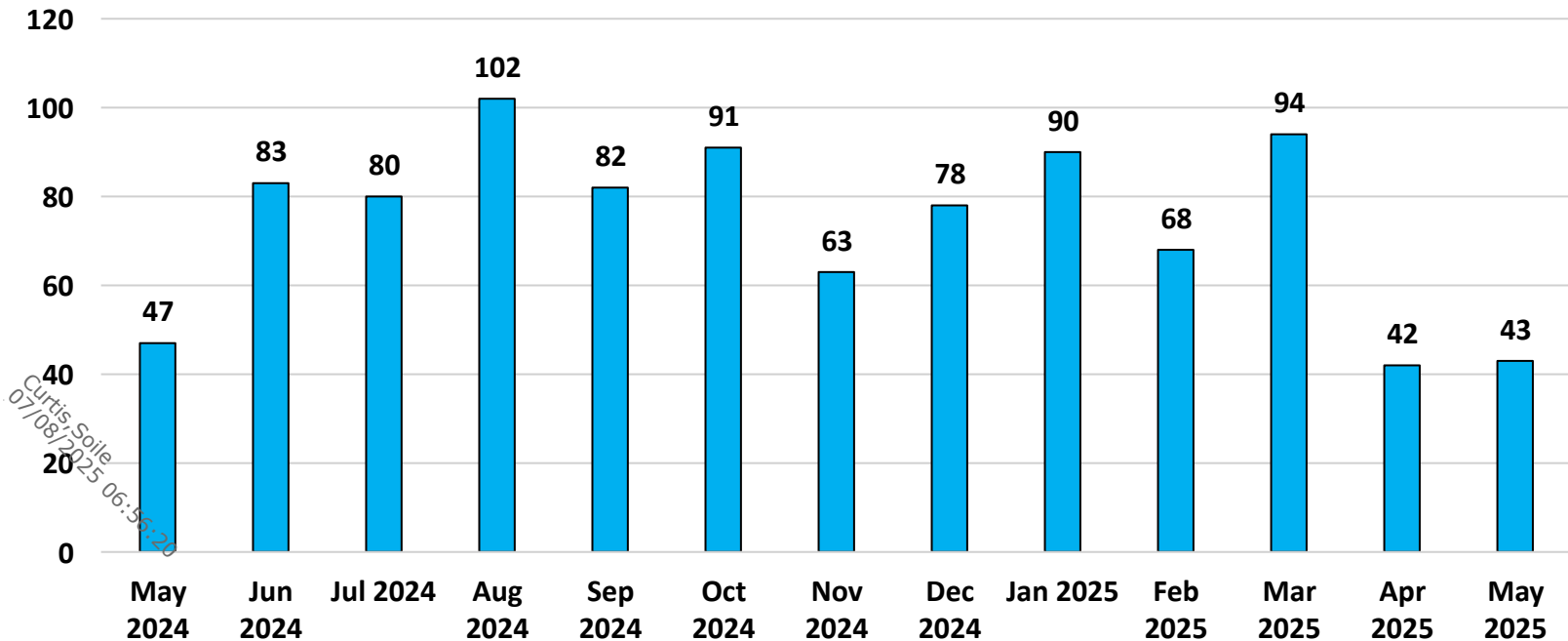
- The main reasons for absence continues to be Anxiety, Stress & Depression
- The Trust has a close working relationship with HR, Occupational Health, Professional Nurse Advocates (PNA) SPAWS & Freedom to Speak Up Champions to support the work life balance of our employees
- The introduction of pastoral support for colleagues has also been seen as a benefit and will hopefully contribute to this rate reducing.

11. 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.

There has been a noticeable reduction in the number of incidents recorded from March through to April & May. This reduction is a result of several successful recruitment events & an increased number of new starters joining the Trust, which has improved staffing numbers.

Recordings of insufficient staff numbers



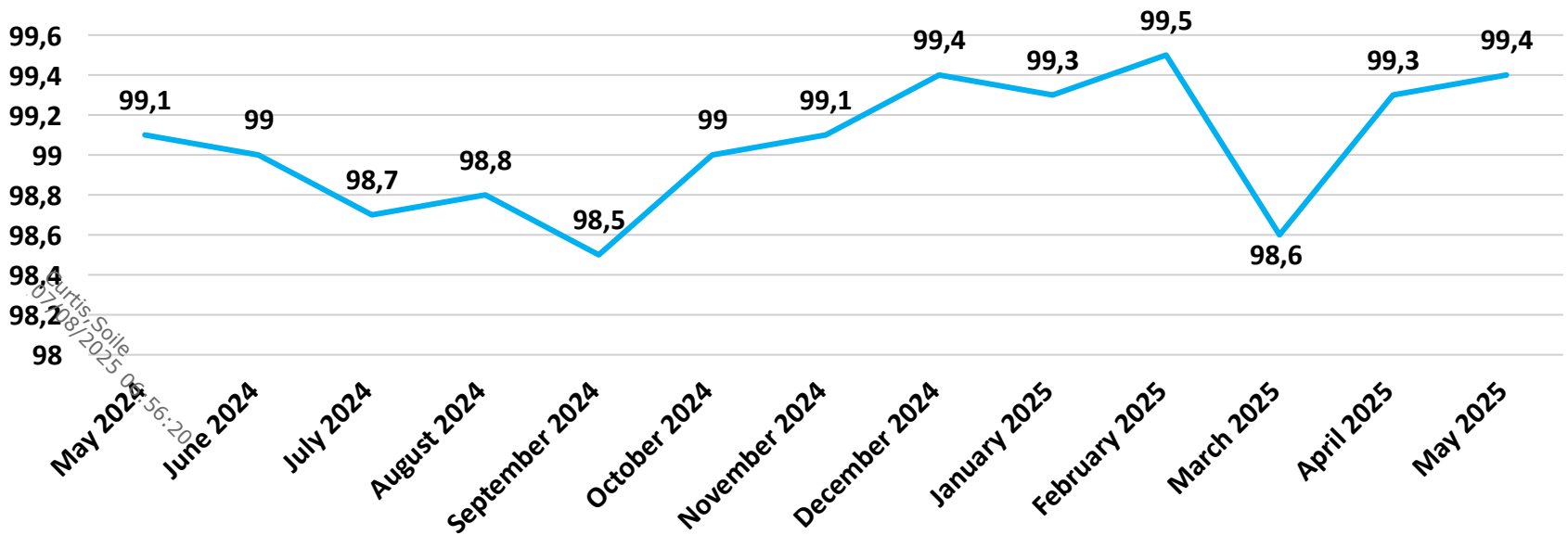
12. Retention

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 Interim Workforce Matron has been facilitating clinics providing staff with the opportunity of an open forum to discuss workforce issues including retention. These sessions have been well-received & staff have felt that their opinions are of value. Going forward more sessions will be held.

The Trust values career development and invests in staff by providing training opportunities and supporting secondments to enhance career development. This encompasses both the NHS People Plan and People Promise.

Retention rate %



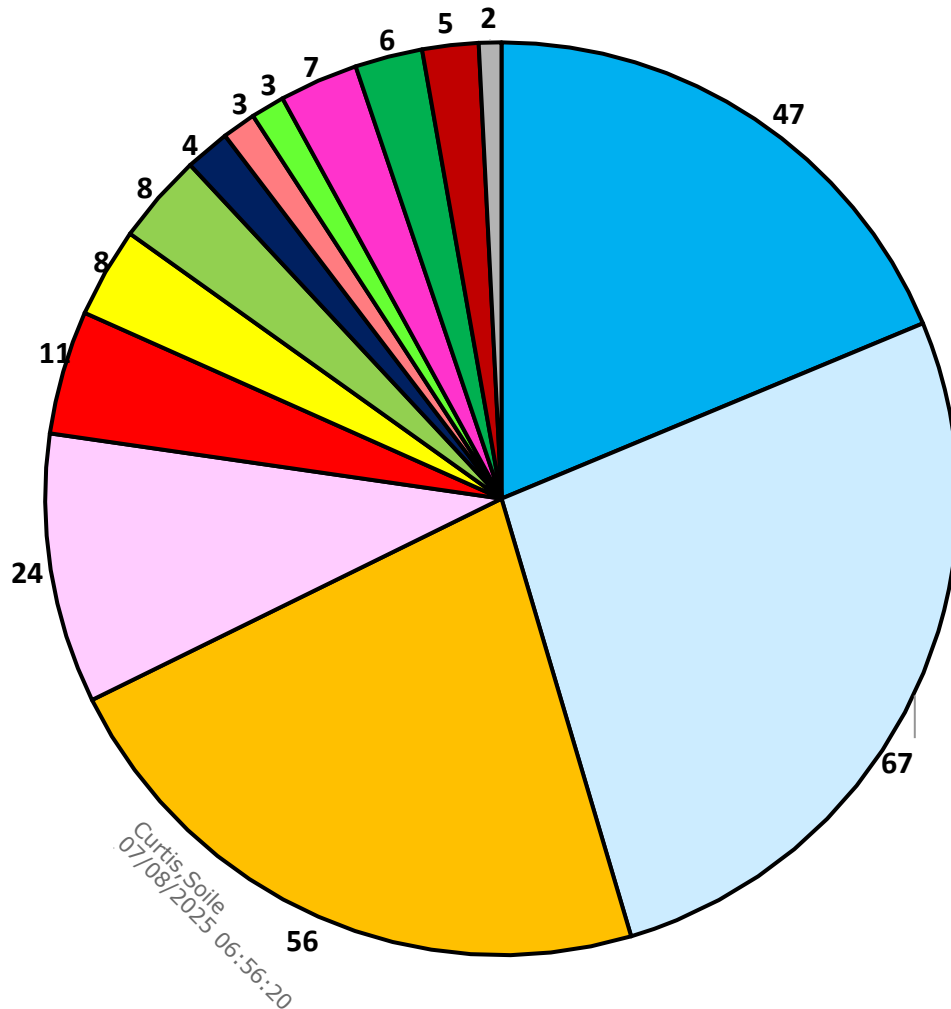
Workforce Matron feedback

Since the last report presented to the Committee :

- Further workforce clinics have been facilitated creating a safe space for staff to be listened & enhancing a sense of empowerment
- Training has been carried out in all acute areas in preparation for the launch of the Safer Care Nursing Tool (SNCT). The tool will provide data to support the annual staffing review.
- All areas been prepared for the application of the Strategic Staffing Review
- Planning in place to create a working group focusing on wellbeing. PNAs, PMAs, SPAWS and the Freedom to Speak up champion have all been invited.
- Currently the Pastoral Care Lead Nurse role to be approved by due process.
- Stockport NHS Showcase organised for November 2025.
- Discussions being held to gain sponsorship for a Family Fun Day in 2026.
- Exploring the creation of an “ask the Exec Team” microsite on the intranet and a senior leader job swap day.

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13. Reasons for Leaving – May 2025



- There has been an increase in colleagues retiring month-on-month.
- And an increase in staff leaving for promotions and relocation.

- Retirement
- Voluntary Resignation - Relocation
- Voluntary Resignation - Work Life Balance
- Voluntary Resignation - Promotion
- Voluntary Resignation - Health
- Voluntary Resignation - Lack of Opportunities
- Voluntary Resignation - To pursue further education/training
- Voluntary Resignation - Pay & Reward Related
- Voluntary Resignation - Adult Dependants
- Voluntary Resignation - Child Dependants
- Internal transfer
- End of Fixed Term Contract
- Dismissal- Capability
- Has Not Worked

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- Currently we are not holding any planned mass recruitment events within Stockport NHS at this time due to staffing levels being nearly fulfilled.
- Considering a 24 hour priority for job applications from student nurses who have completed placements at the Trust.
- We are looking to create a similar scheme for promotions to aid in retention with an email alert.
- We are holding a showcase event on 15th November to show the work done within Stockport NHS.

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Multi-Professional Cadet Programme

- We have successfully expanded the Cadet Programme for 2025 /26. Currently we have the capacity for 180 learners and will be increasing to 200 from September 2025.
- In addition, we are expanding T-Levels offers to now include Midwifery, Community and Therapies and continue to extend placement offers to BTEC, Cache and Level 2 Transition programmes.
- It is anticipated that there will be a large numbers of adult learners (with existing care experience) from UCEN college in September & they will have the opportunity to attend a new course – Foundation Degree Assistant Practitioner. These students will be actively looking to gain employment in the Trust as a Band 2/3.
- Placement expansion and relationship building continues in place-based environments, and we are working closely with the GM and ICB Workforce Development Lead, One Stockport and other external partners.
- 3 cadets from the previous cohort have secured employment within nursing homes and 2 cadets are now working as HCAs at the Trust. Collaborative working with the Workforce Matron has begun to develop recruitment and career pathways for cadets aiming to recruit and retain local young people.
- We are working with GM universities to secure interviews and “home Trust” placements for those wishing to pursue a Nursing Degree to retain young people in Stockport.
- We will continue to monitor, document and report on cadet destinations.



16. Healthcare Scientists

Laboratory Medical

- **Microbiology** consultants the position has been somewhat stabilised with the appointment of a consultant clinical scientist. A gap analysis is underway to review the service delivery against standard and best options to strengthen and improve the service provided.
- **Histopathology** consultant workforce is stable with 11 consultants. The reporting of the service is still supported with outsourcing to a private company, this will continue with 10-15% remaining the margin between reporting capacity and the departmental workload.
- **Blood sciences** there is an additional day to backfill consultant clinical scientist to provide capacity for the replacement LIMS project. There has been no additional resource for the significant increase in workload seen since Covid, with yearly increases above 10% growth. Growth continues at 6% year to date, and no additional resource has been provided.

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; recruitment of approved additional staffing is proving slow. Internal training to Band 6 for 3 staff continues as the lack of Band 6 staff in the recruitment market remains.
- **Medical Laboratory Assistants (MLA)** – Cancer Tracker post is out for advert again due to internal promotion. Staffing numbers are being recruited where additional budget and recruit to turnover has been approved.

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16. Healthcare Scientists

Blood sciences

- **Biomedical Scientists (BMS), Bands 5-8s** There is a requirement for support from the staff in terms of overtime to cover the 24/7 rota in Transfusion and Haematology; this is due to the need to grow our own rather than being able to recruit at band 6 and complicated by a number of staff on reduced duties.
- **Medical Laboratory Assistants (MLA), Bands 2-4** There is a historically a high turnover for the MLA staff in the Pathology Reception and this is seen to be continuing. This is due to it being a stepping stone entry position within laboratory services. There is a business case for a band 4 to support the transfusion practitioner and laboratory in progress for approval.

Microbiology Laboratory

- **Biomedical Scientists (BMS), Bands 5-8s.** There is a lack of sufficient staff in this area, additional budget has been provided and recruit to turnover approved with individuals in the process of recruitment. We remain reliant on overtime to address the workload presented to the department.
- **Medical Laboratory Assistants (MLA), Bands 2-4** Workload against staffing level is a significant pressure for this group. Additional budget and recruit to turnover is approved and in process, we remain reliant on overtime to address the weekend workload.

Summary

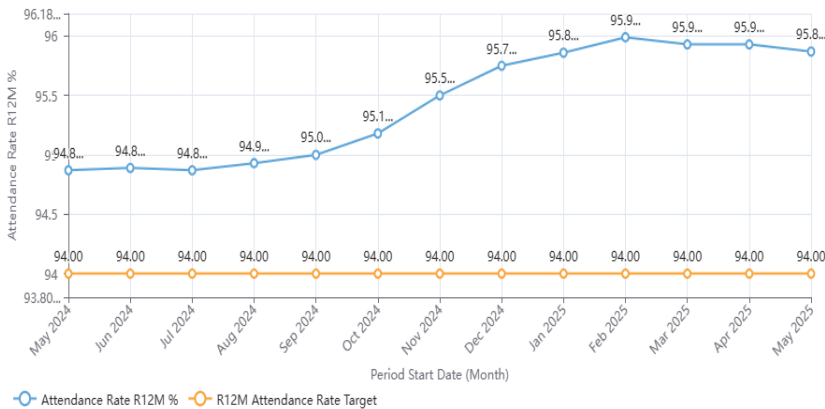
Pathology has seen a year-on-year workload increase between 6-10% across the disciplines far exceeding the annual growth prior to Covid & has past the point of saturation of the staffing resource. Recruitment remains an obstacle for experienced BMS staff and in-house training has been required to bring people to qualification and through their specialist portfolios. Additional budget and recruit to turnover has been approved; there is an additional heavy workload in terms of delivery of a new laboratory information system that has required a high input of staff time and expertise.

17. Allied Health Professionals (AHPs) – Integrated Therapies

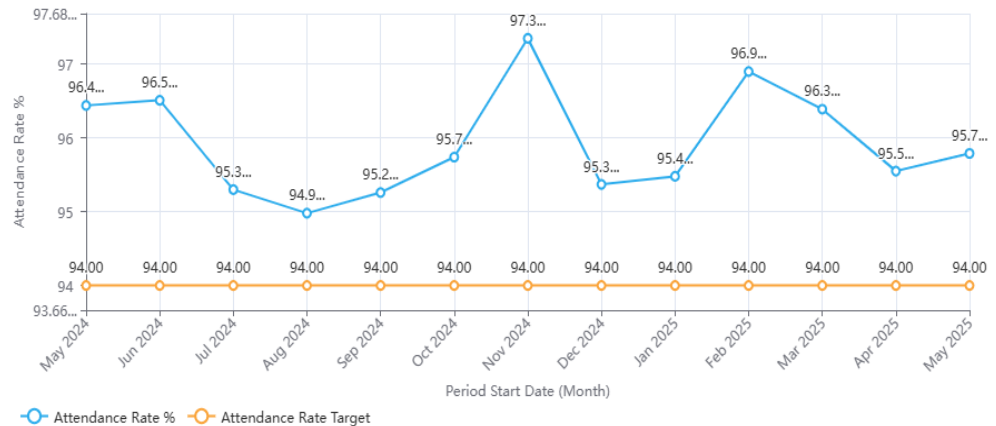
Attendance Rates

Attendance has continued to be positive & remains above the organisational target, reflecting strong engagement & commitment across the workforce. While this is encouraging, our focus remains on maintaining this trend by taking a proactive approach to employee health & wellbeing. Ongoing efforts are being made to identify & implement opportunities that further support a positive working environment, with an emphasis on early intervention, access to wellbeing resources, and promoting a healthy work-life balance.

Stockport - Rolling 12 Months Attendance Rates



Stockport - In Month Attendance Rate - Last 12 Months



We recognise that 'Anxiety/stress/depression/other psych illness' remains consistently as one of the top 2 reasons for absence. While the majority of stress-related absences are cited as being driven by personal factors rather than work-related issues, we acknowledge the clear correlation between an individual's experiences both at home & in the workplace. We recognise that personal & professional pressures often intersect. As previously mentioned, the Directorate has been piloting a work-related stress stratification tool with advice & guidance signposting embedded. This was shared with Emma Cain & Jo Black in June 2025 for review & feedback. The pilot is ongoing at present with Therapies, & a date has been agreed for presentation to the wider Division in August 2025.

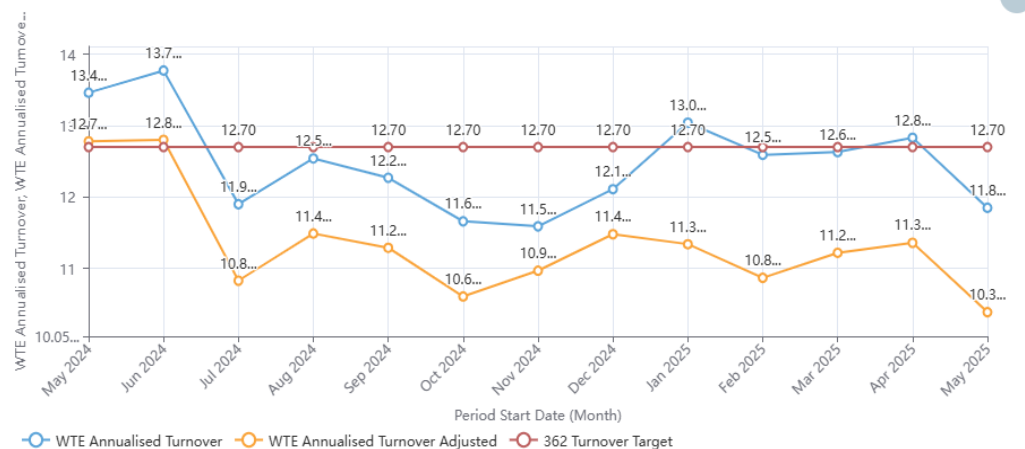
17. Allied Health Professionals (AHPs) – Integrated Therapies

Turnover

As recognised previously, in November 2024, 9 leavers (14.8%) cited work/life balance as a reason for leaving. This information, triangulated with staff survey results & reasons for sickness absence drove an informal scoping exercise. We recognised that early career staff, particularly those in rotational Band 5 roles, are more likely to experience elevated work-related stress and several reasons identified were the pressure of transition into autonomous clinical roles, high expectations and demand, relatively limited hands-on experience, and the challenges of adapting to varied clinical settings. To better support these staff, a range of measures have been implemented, including enhanced quality of appraisal and supervision training/processes, early allocation of rotation settings to allow timely preparation, and the use of the work-related stress risk stratification tool. In addition, efforts have been made to ensure that workload expectations are realistic, with a focus on manageable caseloads and protected time for development through AHP job planning.

Whilst the Directorate turnover rates remain fairly steady, rotational staff turnover is quite consistently >20%, as per expectation due to career mobility, which drives the overall Directorate figure up. A recruit to turnover paper for Rotational Band 5 is almost complete for presentation.

STK - WTE Annualised Turnover Last 12 Months



People Promise



17. Allied Health Professionals (AHPs) – Integrated Therapies

Apprenticeships

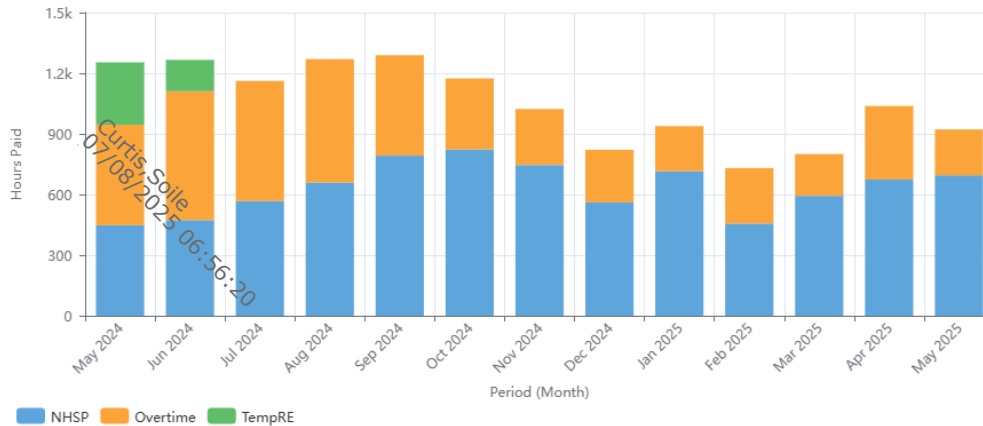
We have successfully appointed to all 5 of the Support Worker apprenticeships for 2024/25. Despite being awarded further places for 2025/26, we have declined these due to low levels of interest from our current workforce. To note, expressions of interest were also invited from W&C and CSS, as well as across Integrated Care.

We are in the process of recruiting to a Trainee Advanced Clinical Podiatry for the High-Risk Foot Team, which is an exciting step forward for Advanced Practice in Podiatry within Stockport. It reinforces our commitment to innovative workforce planning & helps maintain our position as an attractive & positive employer within the region.

Temporary Staffing

We have maintained robust oversight and control of overtime, additional, and bank hours within our Directorate. These hours are now strictly limited to those that are pre-agreed, costed, and essential for service delivery—such as covering vacancies or maternity leave, supporting the ‘escalation ward’, or fulfilling weekend working requirements in the absence of 7-day staffing levels. March and May 2025 delivered the lowest number of overtime hours within the Directorate in two years, when these figures started to be monitored. Work is underway to address the reduction in bank use targets in line with STEP.

Stockport - Overtime Cost Last 12months



Challenges:

- Number of senior clinical Dietitians & Speech and Language Therapists currently on maternity leave; WTE under control with backfill in place but recognised impact on clinical expertise within the workforce.
- Challenges recruiting to Band 6 OT post(s) due to limited supply & widespread vacancies.

18. Midwifery Update

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).

Vacancies

- WTE Actual 162.29
- Vacancies 2.05
- Maternity Leave 8.76

Challenges & Actions

- **Sickness in Maternity teams.** Being supported by managers for each area. Monthly meetings taking place with HR, ward managers & matron to ensure effective management of absence. Sickness reporting SOP devised & has been circulated to all staff.
- **High levels of Maternity leave.** Previously fixed term contracts have not been desirable & therefore not filled. Current climate in Midwifery with shortages of jobs for students may make these posts more desirable again.
- **Maternity Ultrasound Practitioner Service.** To be supported by the Ultrasound Department on a limited service awaiting new appointment to start.

Assurance

- Monthly roster reviews within division.
- Partial approval by Ward Manager.
- Full approval by Matron/DND.
- Staffing forecast weekly & daily reviews.
- All shift co-ordinators have supernumerary status & monitored daily by MOD, incorporated into monthly dashboard with 100% compliance.

19. Medical Workforce

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 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.

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19. Medical Workforce Update

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	270.00	243.00
Tier 2	113.00	99.00
Tier 1	144.00	153.00
Grand total	527.00	495.00

- Senior Medical Recruitment.** The Medical Workforce Group meets monthly and continues to monitor this position so that it can assist divisions with difficult-to-fill posts and ensure that all options are being explored.

There have been new Consultant appointments recently in General Medicine, ENT, Rheumatology, T&O and O&G. Consultant interviews are scheduled for Gastroenterology, Acute Medicine, DMOP and Anaesthetics/Critical Care.

GPs appointed to run the Urgent Treatment Centre have all joined the Trust payroll from June 2025. This will help to reduce bank and agency spend.

19. Medical Workforce Update (continued)

2. **Senior Medical Locum Expenditure.** This is also monitored by the Medical Workforce Group with a view to reducing costs across all divisions whilst ensuring that safe staffing levels and patient safety are maintained. This exercise helps generate significant financial savings and cost avoidance for the Trust.
3. **GMC Survey and Mandatory Training.** The Trust places great emphasis on its GMC Survey Results and the findings (plus initial response) are being presented to the People Committee in September 2025. Detailed specialty by specialty actions will be generated through a process of engagement. Mandatory training compliance rates are described elsewhere – there has been a general increase in compliance in 2025 with areas of deficit receiving added scrutiny and encouragement to improve.
4. **Locally Employed Doctors (Senior Clinical Fellows and Junior Clinical fellows).** From June 2025 the Trust has been appointing all new LEDs on terms & conditions (TCS) that mirror the 2016 TCS - moving us away from the 2002 TCS & bringing Stockport in line with other GM Trusts. This will help with recruitment and reduce pay queries. The Medical Workforce Group is also considering how to manage staff who are currently employed on permanent 2002 contracts.
5. **Portfolio Pathway and Workforce Planning.** The Medical Workforce Group is supporting SAS Doctors who want to become eligible for Consultant posts, particularly in difficult to fill specialties.
6. **Guardian of Safe Working.** Hywel Garrard, Critical care consultant has been appointed as the new Guardian of Safe Working.
7. **Health Roster.** Approval has been granted to procure a roster system for doctors.
8. **Strike action.** Resident Doctors took industrial action from 25 July to 30 July 2025. Additional industrial action is anticipated.



- 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.
- Career event was held with great success
- All areas prepared for staffing review
- Retainment levels and sickness levels continue to improve
- All Nurse Apprentices have gained employment within the Trust

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21. Going forward

- To continue to hold colleague clinics to assess trends in the workforce and to work to improve retention.
- The role of Pastoral Care Lead Nurse to be advertised & shortlisted.
- To continue reducing agency and NHSP usage.
- Start organising the Stockport Showcase Event to be held on the 15th November 2025 at Stepping Hill Hospital. All divisions will be attending along with local schools/colleges/universities, the Army and NWAS.
- To organise the family fun day in 2026.

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				Agenda No.	21
Meeting date	7 August 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 an Alert, Advise & Assure 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 July 2025, noting areas of alert, advice and assurance.

ALERT, ADVISE & ASSURE (AAA) REPORT

Name of Committee/Group	Audit Committee
Chair of Committee/Group	David Hopewell, Non-Executive Director
Date of Meeting	15 th July 2025
Quorate	Yes

The Audit Committee draw the following key issues and matters to the Board of Director's attention:

1. Agenda	<p>The Committee considered an agenda which included the following:</p> <ul style="list-style-type: none"> • Update Report on Data Protection Security Toolkit • Audit Committee Annual Review including ToR, Workplan & Effectiveness • Risk Management Committee Key Issues Report, ToR and Workplan • Feedback from Board Committees • Internal Audit Progress Report • Internal Audit Plan 2025/26 • Anti-Fraud Progress Report 2024/25 • Auditors Annual Report • Review of Losses and Special Payments • PAS System Risk • CliniSys Change Control Notice and Quotation
2. Alert	<p>The Committee received and noted the update report on the Cyber Assessment Framework - Data Protection Security Toolkit for ongoing discussion.</p>
3. Advise	<p>The Committee received a Risk Management Committee Key Issues Report, following meetings held in May and June 2025, providing an overview of ongoing oversight of risk management and detailing the significant risks. The Committee discussed the scoring of risk for individual Divisions not meeting recurrent CIP targets and how this aligned cumulatively for all divisions at a corporate level.</p> <p>The Committee were advised by MIAA that new fraud legislation comes into force on the 1st September 2025 which introduces a new 'failure to report' offence for organisations. MIAA will issue a client briefing on the necessary requirements, update the Fraud Policy and there will be webinars for the Senior Leadership Team and non-executives to attend.</p>
4. Assure	<p>The Committee received the Audit Committee Annual Review and were assured that its terms of reference had been reviewed and updated as required on an annual basis. The Committee discussed its self- assessment of the effectiveness of the Committee. An action has been taken to review the answers for disagree/unable to answer to isolate those that Committee members could not be expected to have the knowledge to answer and inform the next annual review.</p> <p>The Committee approved the Audit Committee Annual Review, Terms of Reference and 2025/26 Annual Work Plan and recommended to the Board of Directors for approval.</p> <p>The Committee were assured that the Internal Audit Plan for 2024/25 was almost</p>

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complete with the Quality Spot Checks report at final stages and the Draft Report issued. Performance indicators all rated green.

The Committee received the 2024/25 final reports for:

- Patient Safety and Incident Response Framework – Substantial Assurance
- Cyber Assessment Framework/Data Security & Protection Toolkit

The Committee received an update on the remaining 2024/25 audit to be completed:

- Quality Spot Checks - draft report issued.

The Committee were assured that the receipt of all reports relating to 2024/25 were in line with the Head of Internal Opinion issued.

The Committee received assurances that the 2025/26 Internal Audit Plan was on track. The following audits are in progress:

- Fit and Proper Persons Review
- Recruitment and Onboarding

The Committee asked for assurance on the follow up recommendations for IT and for separation of overdue follow ups from in progress or partially complete in future monthly reports.

The Committee received the Anti-Fraud Report for July 25 and an update on the status of current investigations.

The Committee received assurance that the Counter Fraud Functional Standard Return was submitted to the 31st May 2025 deadline.

The Committee were given assurance that the Trust had not incurred any financial losses on Fraud Prevention notices issued during May and June 25 to date.

The Committee received and noted the final version of the Auditors Annual Report for 2024/25 and were assured that the content was largely submitted in the Auditors Completion Report at the June Committee and re-iterated the unqualified rating on the Trust Annual Accounts for 2024/25, the Trust consolidation schedules were consistent with the audited financial statements and the ratings assigned to the Value for Money arrangements. The report has been submitted to NHSE by the Trust.

The Committee received and noted a report received a report from on Losses and Special Payments to the 31st March 2025. It was informed that an insurance claim was ongoing for recovery of the loss incurred on IT equipment damage.

The Committee was given verbal assurances on mitigations for the risks surrounding the Trust's PAS system with a scheduled functional update timetabled for the 12th August 2025.

The Committee received a report on plans for the rollout of the Pathology LIMS system; lessons learnt on the project implementation and mitigations for future

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		risks. It provided assurance on the costs to be incurred by the Trust in 2025/26 for the system implementation. It was assured that no future costs were to be charged to achieve the full update and that the scheduled go-live dates were on track.
5.	Referral of Matters/Action to Board/Committee	<p>The Committee received and noted the update report on the Data Protection Security Toolkit for ongoing discussion.</p> <p>The Committee approved the Audit Committee Annual Review, Terms of Reference and 2025/26 Annual Work Plan and recommended to the Board of Directors for approval.</p>
6.	Report compiled by:	David Hopewell, Chair of Audit Committee (Non-Executive Director)
7.	Minutes available from:	Soile Curtis, Deputy Company Secretary

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				Agenda No.	21
Meeting date	7 August 2025	Public	X	Confidential	
Meeting	Board of Directors				
Report Title	Audit Committee Annual Review 2024/25				
Director Lead	David Hopewell, Chair of Audit Committee	Author	Rebecca McCarthy, Company Secretary Soile Curtis, Deputy Company Secretary		

Paper For:	Information		Assurance		Decision	X
Recommendation:	The Board of Directors is asked to receive and confirm the effective operation of the Audit Committee during 2024/25, including approval of Terms of Reference and Work Plan 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

X	PR1.1	There is a risk that the Trust does not deliver high quality care to service users
X	PR1.2	There is a risk that patient flow across the locality is not effective
X	PR1.3	There is a risk that the Trust does not have capacity to deliver an inclusive elective restoration plan
X	PR2.1	There is a risk that the Trust is unable to sufficiently engage and support our people's wellbeing
X	PR2.2	There is a risk that the Trust 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
X	PR4.2	There is a risk that the Trust's workforce is not reflective of the communities served
X	PR5.1	There is a risk that the Trust does not implement high quality service improvement programmes
X	PR5.2	There is a risk that the Trust does not implement high quality research & development programmes
X	PR6.1	There is a risk that the Trust does not deliver the annual financial plan
X	PR6.2	There is a risk that the Trust does not develop and agree with partners a multi-year financial 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

Effective sub-committees can provide significant benefits to the Board, enabling the Board to make informed decisions and meet their wide-ranging governance and regulatory responsibilities. Likewise, sub-committees should play a key role in supporting directors in their strategic and oversight roles.

The Terms of Reference of the Board Committees include a requirement for the respective Committee to evaluate their own membership and review their effectiveness and performance on an annual basis.

The Audit Committee considered and confirmed the Audit Committee Annual Review 2024/25 at its meeting on 15 July 2025. The assessment included two parts; a checklist focused on Committee administration and processes; the second on how well the Committee operates over several categories. Both parts of the assessment are aligned with the HFMA NHS Audit Committee Handbook. As part of the effectiveness review, the Committee reviewed the suite of matters overseen by the Committee throughout the year in line with the responsibilities set out in the Terms of Reference, alongside meeting attendance.

Furthermore, the Committee considered what had worked well and what could be improved. The outcome of the self-assessment was largely positive and the Committee confirmed the effective operation of the Audit Committee throughout 2024/25 in line with its Terms of Reference, with opportunities for ongoing improvement to be taken forward during 2025/26, as reflected in Committee work plan and reporting. The full annual review is available from the Company Secretariat.

The Audit Committee Terms of Reference and Work Plan for 2025/26 were also reviewed and are recommended to the Board of Directors for approval:

Appendix 1 – Audit Committee Terms of Reference

Appendix 2 – Audit Committee Work Plan 2025/26

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AUDIT COMMITTEE

TERMS OF REFERENCE

1. CONSTITUTION

- 1.1. The Board of Directors hereby resolves to establish a Committee, to be known as the Audit Committee (the Committee). The Committee is a Non-Executive Committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference and by the Board.
- 1.2 It shall have terms of reference and powers delegated by the Board of Directors and is subject to such conditions, such as reporting to the Board of Directors, in accordance with any legislation, regulation or direction issued by the Trust.
- 1.3 The Audit Committee will provide report to the Council of Governors identifying any matters in respect of which it considers that action of improvement is needed and recommendation as to the action to be taken.

2. PURPOSE OF THE COMMITTEE

The overarching purpose of Audit Committee is to:

- 2.1 review the establishment and maintenance of an effective system of governance, and internal control, including risk management, across the whole of the organisation's activities (both clinical and non-clinical);
- 2.2 ensure there is an effective internal audit function established which provides appropriate independent assurance to the Committee;
- 2.3 review the findings of the External Auditor, as appointed by the Council of Governors, as part of its delegated authority from the Board of Directors and consider the implications and management's responses to their work;
- 2.4 review and approve for audit the annual report (including Annual Governance Statement), annual accounts and financial statements as part of its delegated responsibility from the Board.

3. COMPOSITION & CONDUCT OF THE COMMITTEE

3.1 Membership

- 3.1.1 Membership will comprise:

A non-executive director who should have relevant financial experience and should be appointed Chair of the Committee by the Board. A provision in the Code of Governance states that this should not be the Deputy or Vice Chair or Senior Independent Director.

- In addition to the Chair, at least three non-executive directors, to include the Chair of each of the Trust's Board assurance committees.

- 3.1.2 All statutory non-executive directors, except for the Chair, are authorised to attend as members of the Audit Committee.
- 3.1.3 The Chair of the Foundation Trust shall neither chair nor be a member of the Committee but can attend meetings by invitation of the Chair of the Committee.
- 3.1.4 There is an expectation that the membership will attend all Committee meetings during the financial year. Individual attendance levels will be monitored by the Chair of the Committee who will take appropriate measures should attendance be less than 75%.
- 3.1.5 The following shall attend the Committee meetings on a regular basis:
- Chair of the Risk Management Committee
 - Chief Finance Officer
 - Director of Finance
 - Associate Director of Finance (Financial Services)
 - Company Secretary
 - A representative of the Internal Auditors
 - A representative of the External Auditors
 - Counter-Fraud Lead
- 3.1.6 Executive Directors, including the Chief Executive, and/or senior leaders shall be invited to attend those meetings in which the Audit Committee will consider areas of risk or operation that are their responsibility.
- 3.1.7 The head of internal audit and representative of external audit have a right of direct access to the Chair of the Committee. This also extends to the local counter fraud specialist.

3.2. Chair

- 3.2.1 The Chair of the Committee will be a Non-Executive Director with relevant financial experience.
- 3.2.2 Another Non-Executive Director will deputise as the Chair of the Committee in the Chair's absence.

3.3 Quorum

- 3.3.1 A quorum will consist of at least two independent non-executive directors.
- 3.3.2 Members withdrawing from the meeting owing to a conflict of interest shall no longer count towards a quorum.
- 3.3.3 However, at the discretion of the Chair, matters and decisions deemed urgent may proceed within the absence of a quorum with any actions from that meeting being confirmed at the next full meeting.

3.4 Notice of meeting

- 3.4.1 Before each meeting, a notice of the meeting specifying the business proposed to be transacted and supporting papers for the business expected shall be sent by electronic mail to the usual place of business of each member, to be available at least five clear days before the meeting.

3.4.2 The Chair of the Committee may, at their discretion, allow additional agenda items and papers to be circulated after the notice of the meeting.

3.5 Frequency of meetings

3.5.1 Meetings shall be held at least five times per year, with additional meetings where necessary.

3.5.2 The External Auditor and Internal Auditor shall have the opportunity at least once per year to meet with the Audit Committee without executive directors present.

3.5.3 The Chair may at times convene additional meetings of the Committee to consider business that requires urgent attention.

3.6. Administration

3.6.1 The Trust Secretary will ensure appropriate administrative arrangements are in place and that minutes are recorded, confirmed and appropriately archived from each meeting.

4. DELEGATED AUTHORITY

The Audit Committee is authorised by the Board of Directors to:

4.1 Investigate any matter within these terms of reference.

4.2 Seek information from any Director, officer, or employee; and all Directors, officers and employees are directed to extend the fullest co-operation to the Committee in the discharge of its functions.

4.3 Within the procedures approved by the Board, obtain outside legal or other independent professional advice. The Committee is authorised by the Board of Directors to request the attendance of individuals and authorities from outside the Foundation Trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions.

5. RESPONSIBILITIES

5.1 Governance, risk management and internal control

5.1.1 To review provision of an effective system of governance, including systems for risk management and clinical audit, and internal control aligned to the overall governance agenda.

5.1.2 To maintain oversight of the Trust's risk management structures, processes and responsibilities, including the production and issue of any risk and control-related disclosure statements.

5.1.3 To review processes to ensure appropriate information flows to the Audit Committee from executive management and other Board Committees in relation to the Trust's overall internal control and risk management.

5.1.4 To review the adequacy of underlying assurance processes that indicate the degree of achievement of corporate objectives and the effectiveness of the management of principal risks. In respect of the controls in place to manage risks recorded on the Board Assurance Framework, each Board Committee (through its Chair) shall report regularly to the Audit Committee.

5.1.5 To review the adequacy of arrangements by which staff can raise issues in confidence about

possible improprieties in matters of financial reporting and control and related matters or any other matters of concern.

- 5.1.6 To review the adequacy of the policies and procedures in respect of all local counter-fraud services work.
- 5.1.7 To review the adequacy of policies and procedures for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications, including the NHS Code of Governance and NHS Provider Licence.

5.2 Internal Audit & Counter Fraud

- 5.2.1 To review and approve the internal audit strategy and programme, ensuring that it is consistent with the needs and priorities of the organisation.
- 5.2.2 To consider the provision of the Internal Audit service and the costs involved (and make a recommendation to the Board of Directors for award of contract where required).
- 5.2.3 To oversee on an on-going basis the effective operation of internal audit in respect of:
 - Adequate resourcing;
 - Co-ordination with external audit;
 - Meeting relevant internal audit standards;
 - Providing adequate independence assurances;
 - Having appropriate standing within the Foundation Trust; and
 - Meeting the internal audit needs of the Foundation Trust.
- 5.2.4 To consider the findings of internal audit investigations and management's response and their implications and monitor progress on the implementation of recommendations.
- 5.2.5 To evaluate performance of the internal audit service against relevant key performance indicators on an annual basis.
- 5.2.6 Receive the Head of Internal Audit Opinion.
- 5.2.7 To review and approve the Trust's annual counter-fraud workplan, ensuring that it is consistent with the needs of the organisation.
- 5.2.8 To satisfy itself that the organisation has adequate arrangements in place for anti-fraud, bribery and corruption that meets the NHS Counter Fraud Authority's (NHS CFA) standards. In doing so, the Audit Committee will refer any suspicions of fraud, bribery and corruption to the NHS CFA via its Counter-Fraud Specialist.

5.3 External Audit

- 5.3.1 To oversee the appointment of the external auditor, including the conduct of a market testing exercise at least once every ten years and, based on the outcome, make a recommendation to the Council of Governors for award of contract.
- 5.3.2 To assess the external auditor's work and fees in line with the contract award, and based on this assessment, make the recommendation to the Council of Governors with respect to the re-appointment or removal of the auditor. This assessment should include the review and monitoring of the external auditor's independence and objectivity and effectiveness of the audit process in light

of relevant professional and regulatory standards.

- 5.3.3 To discuss with the external auditor, before the audit commences, the nature and scope of the audit, and ensure co-ordination, as appropriate, with other external auditors in the local health economy.
- 5.3.4 To review all external audit reports, including the 'auditor's annual report', together with the management response, and to monitor progress on the implementation of recommendations.
- 5.3.5 To develop and implement a policy on the engagement of the external auditor to supply non-audit services.
- 5.3.6 To consider the provision of the external audit service, the cost of the audit and any questions of resignation and dismissal of the auditors.
- 5.3.7 To ensure mechanisms are in place to engage with the external auditor out with the Audit Committee as maybe required.

5.4 Annual Report & Accounts

- 5.4.1 To review and approve for audit the Annual Accounts, before they are presented to the Board of Directors, in order to determine their completeness, objectivity, integrity and accuracy. This review will cover but is not limited to:
 - The meaning and significance of the figures, notes and significant changes;
 - Areas where judgment has been exercised;
 - Adherence to accounting policies and practices;
 - Explanation of estimates or provisions having material effect;
 - The schedule of losses and special payments;
 - Any unadjusted statements; and
 - Any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved.
- 5.4.2 To review and approve for audit the Annual Report and Annual Governance Statement, before they are presented to the Board of Directors, to determine completeness, objectivity, integrity and accuracy.
- 5.4.3 To review accounting and reporting systems on a cyclical basis for reporting to the Board of Directors, including in respect of budgetary control.

5.5 Scheme of Reservation & Delegation, Standing Financial Instructions and Standards of Business Conduct

- 5.5.1 To review on behalf of the Board of Directors the operation of, and proposed changes to, including but not limited to the Standing Orders, Scheme of Reservation & Delegation and Standing Financial Instructions.
- 5.5.2 To examine the circumstances of any significant departure from the requirements of any of the foregoing, and whether those departures relate to a failing, an overruling or a suspension.
- 5.5.3 To monitor the implementation of policy of the Standards of Business Conduct (management of conflicts of interests, including gifts and hospitality) and Codes of Conduct, on behalf of the Board of Directors.

5.6 Other

- 5.6.1 To examine any other matter referred to the Audit Committee by the Board of Directors and to initiate investigation as determined by the Audit Committee.
- 5.6.2 To review each year the accounting policies of the Foundation Trust and make appropriate recommendations to the Board of Directors.
- 5.6.3 Review and approve the Annual Report, Work Plans and Terms of Reference of any group/committee that reports directly to the Committee.
- 5.6.4 To consider the outcomes of significant reviews / other significant assurance functions, both internal and external to the organisation, where relevant to the governance, risk management and assurance of the organisation. This may include, but is not limited to, any reviews conducted by regulators and inspectors within the health and social care sector and professional bodies.
- 5.6.5 In addition, the Committee will work with other Committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own areas of responsibility.
- 5.6.6 Members must consider if there are any equality and diversity implications of decisions they make.

6. RELATIONSHIP WITH THE BOARD OF DIRECTORS

- 6.1 The Committee will report to the Board of Directors by means of a report summarising business conducted by the Committee together with key actions and/or risks.
- 6.2 The report will be forwarded to the Board of Directors following each Committee meeting.

7. RELATIONSHIP WITH OTHER GROUPS

- 7.1 The Committee will receive reports from the following:
 - Risk Management Committee

8. REVIEW

- 8.1 The Committee will review its terms of reference and membership annually and recommend any changes to the Board of Directors for approval.
- 8.2 The Committee will review the effectiveness and performance of the Committee on an annual basis and report the outcome to the Board of Directors.

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		2025										2026					
Items		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	
Papers Due			9.5.	16.6	4.7.		5.9.		7.11.			6.2.					
Meeting Date			20.5.	25.6	15.7		16.9		18.11			17.2.					
Lead		Q1			Q2			Q3			Q4			Q1			
Governance																	
1.	Review the operation of, and proposed changes to, the Standing Orders, Scheme of Reservation & Delegation and Standing Financial Instructions	Chief Finance Officer										•					
2.	Board Assurance Framework Mid-Year Review	Trust Secretary							•								
3.	To review arrangements by which staff can raise issues	Director of People & OD					•										
4.	Review of waivers	Chief Finance Officer	•						•						•		
5.	SFI Breaches	Chief Finance Officer	•						•						•		
6.	Review of losses and special payments	Chief Finance Officer			•							•					
Internal Audit																	
7.	Oversee the conduct of a market testing exercise for the appointment of an internal auditor at least once every five years and, based on the outcome, make a recommendation to the Board of Directors for award of contract <i>* Current Internal Audit contract term is 1 April 2023 – 31 March 2026 (with a two-year extension option)</i>																
8.	Approval of the internal audit plan and counter fraud plan based on risk assessments	Internal Audit										• <i>Draft</i>			• <i>Final</i>		
9.	Review of internal audit plan to ensure it remains consistent with Trust priorities	Internal Audit	•		•		•		•			•			•		
10.	Review of internal audit reports issued since last meeting and major audit issues arising from audits in progress	Internal Audit	•		•		•		•			•			•		
11.	Review of internal audit follow up report including follow up of outstanding recommendations and ongoing review of key governance processes	Internal Audit	•		•		•		•			•			•		

			2025									2026					
Items			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
		Papers Due		9.5.	16.6	4.7.		5.9.		7.11.			6.2.				
		Meeting Date		20.5.	25.6	15.7		16.9		18.11			17.2.				
		Lead	Q1			Q2			Q3			Q4			Q1		
12.	Review of Local Counter Fraud specialist activities through consideration of progress reports.	Local Counter Fraud Specialist (LCFS)		•		•		•		•			•			•	
13.	Counter Fraud Annual Report	LCFS		•												•	
14.	Emerging Issues (with urgent and emergent issues reported outside of formal timetable as required)	Internal Audit / LCFS		•		•		•		•			•			•	
External Audit																	
15.	Oversee, in liaison with the Council of Governors, the conduct of a market testing exercise for the appointment of an external auditor at least once every five years and, based on the outcome, make a recommendation to the Council of Governors for award of contract <i>* External Audit contract term ends in June 2027 with an option to extend by further 2 years.</i>																
16.	Assess the external auditor's work and fees and make recommendation to the Council of Governors re re-appointment or removal of the auditor <i>* See 14. above</i>																
17.	Approval of the external audit plan , based on risk assessments, and the proposed fee for the next year	External Audit														•	
18.	External Audit Update Report including review of outstanding implementation of recommendations with significant / fundamental status as required	External Audit		•		•		•		•			•			•	
19.	Policy on the engagement of the External Auditor to supply non-audit services <i>* Next due for review in Feb 2026</i>	Trust Secretary / Director of Finance											•				
20.	Emerging Issues (with urgent and emergent issues reported outside of formal timetable as required)	External Audit		•	•	•		•		•			•			•	
21.	Private discussions with Internal and External Audit (if required)	Chair		•		•		•		•			•			•	
Year End Matters																	
22.	Review of Accounting Policies	Chief Finance Officer											• <i>Draft</i>			•	

			2025									2026					
Items			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Papers Due				9.5.	16.6	4.7.		5.9.		7.11.			6.2.				
Meeting Date				20.5.	25.6	15.7		16.9		18.11			17.2.				
Lead			Q1			Q2			Q3			Q4			Q1		
23.	Review of annual accounts progress and agreement of final accounts process and timetable	Chief Finance Officer		•												•	
24.	Annual Report and Accounts review and recommendation to the Board	Chief Finance Officer / Trust Secretary		• <i>Draft</i>	• <i>Final</i>											• <i>Draft</i>	• <i>Final</i>
25.	Review of Going Concern basis of preparation	Chief Finance Officer		•												•	
26.	Review Annual Governance Statement (AGS) and related disclosure statements and make recommendation to the Board	Chief Executive / Trust Secretary		• <i>Draft</i>	• <i>Final</i>											• <i>Draft</i>	• <i>Final</i>
27.	Receipt of Annual Internal Audit Annual Report and Head of Internal Audit Opinion	Internal Audit		•	• <i>Final HOIA</i>											• <i>Draft</i>	• <i>Final HOIA</i>
28.	Audit Completion Report including Auditor's Report	External Audit			•												•
29.	Audit Annual Report	External Audit			•												•
31.	Management Representation letter: Financial Accounts	Chief Finance Officer			•												•
32.	Review Declaration of Interests Annual Report	Trust Secretary		•												•	
33.	Review of NHS Provider Licence Compliance	Trust Secretary		•												•	
34.	Review of NHS Code of Governance	Trust Secretary		•												•	
Board Committees																	
35.	Reports from Board Committee Chairs	Committee Chairs		•		•		•		•		•				•	
Subgroups																	
36.	Risk Management Committee Key Issues Report <i>July Meeting to confirm Terms of Reference and Work Plan</i>	Chief Executive		•		•		•		•		•				•	
Committee Business																	

			2025									2026					
Items			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	Papers Due			9.5.	16.6	4.7.		5.9.		7.11.			6.2.				
	Meeting Date			20.5.	25.6	15.7		16.9		18.11			17.2.				
	Lead		Q1			Q2			Q3			Q4			Q1		
37.	Annual Review of Audit Committee, inc. review of Terms of Reference, Work Plan and Formal Committee Evaluation	Chair				•											
38.	Informal Review of Committee Effectiveness	Led by Chair		•	•	•		•		•			•			•	•

NB. Subject to NHSE financial accounting and reporting requirements for 2025/26, year-end meetings will be scheduled.

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				Agenda No.	22
Meeting date	7 th August 2025	Public	X	Confidential	
Meeting	Board of Directors				
Report Title	Opening/Q1 Board Assurance Framework 2025/26				
Director Lead	Karen James, Chief Executive	Author	Rebecca McCarthy, Trust Secretary Executive Directors		

Paper For:	Information		Assurance	X	Decision	X
Recommendation:	The Board of Directors is asked to: <ul style="list-style-type: none"> - Review and approve the Opening/Q1 2025/26 Board Assurance Framework 2025/26 - Confirm the Trust's current significant risk profile ensuring alignment between operational and principal risks. 					

This paper relates to the following Annual Corporate Objectives

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

The paper relates to the following CQC domains

	Safe		Effective
	Caring		Responsive
X	Well-Led		Use of Resources

This paper relates to the following Board Assurance Framework risks

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	N/A

Executive Summary

The Trust maintains a Board Assurance Framework as a key tool to identify and manage the principal risks that may threaten the achievement of the corporate objectives agreed by the Board. The corporate objectives 2025/26 were supported by the Board of Directors in March 2025, with outcome measures approved in May 2025, along with review and agreement of the Trust's risk appetite, enabling development of the Board Assurance Framework (BAF).

Principal risks for the Opening/Q1 BAF 2025/26 (Appendix 1) have been considered via the Lead Director and/or the relevant Board Committees at meetings held in June-July 2025. Throughout the discussions at Finance & Performance Committee, People Performance Committee and Quality Committee, the continuing operational and financial pressures were recognised as impacting or having potential to impact the breadth of strategic and operational risks.

Principal risks to achievement of the Corporate Objectives 2025/26 are prioritised as follows at end Q1 2025/26:

Risk No.	Risk Summary	Risk Score
7.2	Failure to maintain suitability of premises and environments which may lead to increased health & safety incidents, breach of regulation and suboptimal patient and staff experience.	20
1.3	Failure to achieve mandatory access standards for urgent & emergency care which may lead to suboptimal quality of care for patients and increased regulatory intervention.	16
6.1	Failure to deliver annual revenue (including cash) and capital financial plans which may lead to increased regulatory intervention.	16
6.2	Failure to achieve financial sustainability through improved productivity & efficiency and system effectiveness, which may lead to suboptimal use of resources and increased regulatory intervention.	16
7.4	Failure to identify or insufficient funding mechanism to support the strategic regeneration of the hospital campus which may lead to an adverse long-term impact on the Trust's capability to deliver modern and effective care.	15
1.1	Failure to maintain standards of patient safety which may lead to potential harm to patients receiving care and non-compliance with regulatory standards.	12
1.4	Failure to achieve mandatory access standards for elective, diagnostic & cancer care which may lead to suboptimal quality of care for patients and increased regulatory intervention.	12
3.1	Failure to recognise and manage the impacts of health inequalities on service provision, at a Trust, Locality and Greater Manchester (GM) System, which may lead to unwarranted variation of services and inequality in health outcomes for the populations served.	12
4	Failure to recruit and retain the optimal number of staff, with appropriate skills, which may lead to gaps in the workforce and suboptimal quality of care.	12
7.1	Failure to maintain and develop a resilient and responsive digital infrastructure which may lead to inability to support improvements in quality of care and compromise of data/information.	12
7.3	Failure to deliver the Green Plan / Net Zero targets and prepare for the impacts of climate change which may lead to worsening population health.	12

1.2	Failure to deliver personalised care and experience, which may lead to poorer patient outcomes and satisfaction.	9
2.1	Failure to sufficiently engage and support our people's wellbeing which may lead to low morale, higher turnover and sickness absence.	9
2.2	Failure to actively participate in and progress neighbourhood working which may lead to suboptimal improvement in primary and secondary health and well-being outcomes	9
3.2	Failure to deliver on the collaborative working opportunities that exist between Stockport NHS Foundation Trust and Tameside & Glossop Integrated Care NHS Foundation Trust which may lead to suboptimal pathways of care for the populations served and/or limited-service resilience across the footprint of both Trusts.	9
4.2	Failure to create an inclusive and equitable culture which may lead to lack of equality of opportunity and experience for the workforce.	9
5.1	Failure to ensure clinical effectiveness which may lead to poorer patient outcomes, preventable harm to patients and suboptimal use of resources.	9
5.2	Failure to implement high quality research & development programmes which may lead to poorer quality of outcomes for our patients and communities.	9

In addition, the Trust's significant risks from the corporate risk register (as presented to Risk Management Group in July 2025), are provided at Appendix 2 to ensure triangulation between operational and principal risks. The significant risks relate to the following areas: environment, IT systems, capacity and demand, compliance with regulatory/clinical standards and infection prevention & control.

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1. Introduction

- 1.1 The Trust maintains a Board Assurance Framework 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 2025/26 and Outcomes Measures were approved by the Board of Directors in June 2025, along with confirmation of the Trust's risk appetite, enabling development of the Board Assurance Framework (BAF).

2. Changes to Principal Risks from 2024/25

- 2.1 During 2024/25 Quality Committee discussed the potential to split the principal risk relating to 'quality of care' into distinct risks relating to patient safety, clinical effectiveness and patient experience. Following discussion at Quality Committee in Jun 2025, three principal risks are now included on the BAF: Principal Risk 1.1, 1.2 and 5.1, relating to patient safety, patient experience and clinical effectiveness respectively.
- 2.2 A new Principal Risk 3.1 has been added relating to the recognition of health inequalities and subsequent management of services, at a Trust, Locality and Greater Manchester (GM) System, to address inequality in health outcomes for the populations served.
- 2.3 The risk description for Principal Risk 4.2 has been expanded from the previous risk relating specifically to diversity of the Trust's workforce, to a broader risk relating to an inclusive and equitable culture.
- 2.4 All other Principal Risks from 2024/25 have been incorporated within the BAF 2025/26. These have been considered via the relevant Board Committees based on; BAF 2024/25 year-end position, key controls and assurances, any gaps, and required actions.

3. Significant Risks – Corporate Risk Register

- 3.1 The significant risks on the Trust's corporate risk register are reviewed at each meeting of the Risk Management Committee, which reports to the Audit Committee, as part of its responsibility to review of the establishment and maintenance of an effective system of integrated governance, risk management and internal control.
- 3.2 In addition, full risk rows are considered via the relevant board assurance committee, supporting triangulation between operational and principal risks. The Trust's significant risks are included at Appendix 2.
- 3.3 The significant risks primarily relate to the following areas: capacity and demand, ageing infrastructure and equipment, workforce challenges, quality and regulatory/clinical standards.

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Stockport NHS Foundation Trust

Board Assurance Framework

2025/26

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Corporate Objectives 2025/26

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.

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Board Assurance Framework Key

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

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

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

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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 or 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	

Summary: Board Assurance Framework 2025/26

Heat Map Q1

Risk Matrix					
Impact	Likelihood				
	1 - Rare	2 - Unlikely	3 - Possible	4 - Likely	5 - Certain
1 - Negligible					
2 - Minor					
3 - Moderate			1.2, 2.1, 2.2, 3.1, 4.2, 5.1	3.2, 4.1, 7.3	7.4
4 - Major			1.1, 1.4, 7.1	1.3, 6.1, 6.2	
5 - Catastrophic				7.2	

Gap Score Matrix (Difference between Target Score and Current Score)	
Gap score ≤0	
Gap score 1 - 5	1.1, 1.2, 1.4, 2.1, 2.2, 3.1, 4.1, 4.2, 5.1, 6.1, 6.2, 7.1, 7.3
Gap score 6 - 9	1.3, 3.2, 7.4
Gap score 10	7.2
Gap score > 10	

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Summary: Board Assurance Framework

Risk Ref	Risk Description	Q4 24/25 (IxL)	Q1 25/26 (IxL)	Q2 25/26 (IxL)	Q3 25/26 (IxL)	Q4 25/26 (IxL)	Target Score (IxL)	Lead Committee	Risk Appetite	Risk Gap
Objective 1. Deliver personalised, safe and caring services.										
1.1	Failure to maintain standards of patient safety which may lead to potential harm to patients receiving care and non-compliance with regulatory standards.	15 (5x3)	12 (4x3)				8 (4x2)	Quality Committee	Moderate	4
1.2	Failure to deliver personalised care and experience, which may lead to poorer patient outcomes and satisfaction.	NEW	9 (3x3)				6 (3x2)	Quality Committee	Moderate	4
1.3	Failure to achieve mandatory access standards for urgent & emergency care which may lead to suboptimal quality of care for patients and increased regulatory intervention.	16 (4x4)	16 (4x4)				8 (4x2)	Finance and Performance Committee	Moderate	8
1.4	Failure to achieve mandatory access standards for elective, diagnostic & cancer care which may lead to suboptimal quality of care for patients and increased regulatory intervention.	12 (4x3)	12 (4x3)				8 (4x2)	Finance and Performance Committee	Moderate	4
Objective 2. Support the health and wellbeing needs of our community and colleagues.										
2.1	Failure to sufficiently engage and support our people's wellbeing which may lead to low morale, higher turnover and sickness absence.	9 (3x3)	9 (3x3)				6 (3x2)	People Performance Committee	High	3
2.2	Failure to actively participate in and progress neighbourhood working which may lead to suboptimal improvement in primary and secondary health and well-being outcomes	9 (3x3)	9 (3x3)				6 (3x2)	Board of Directors	Moderate	3
Objective 3. Develop effective partnerships to address health and wellbeing inequalities.										
3.1	Failure to recognise and manage the impacts of health inequalities on service provision, at a Trust, Locality and Greater Manchester (GM) System, which may lead to unwarranted variation of services and inequality in health outcomes for the populations served.	NEW	12 (3x4)				4 (2x2)	Board of Directors	Moderate	8
3.2	Failure to deliver on the collaborative working opportunities that exist between Stockport NHS Foundation Trust and Tameside & Glossop Integrated Care NHS Foundation Trust which may lead to suboptimal pathways of care for the populations served and/or limited-service resilience across the footprint of both Trusts.	12 (4x3)	9 (3x3)				6 (3x2)	Board of Directors	Significant	3
Objective 4. Develop a diverse, talented and motivated workforce to meet future service and user needs.										
4.1	Failure to recruit and retain the optimal number of staff, with appropriate skills, which may lead to gaps in the workforce and suboptimal quality of care.	12 (3x4)	12 (3x4)				9 (3x3)	People Performance Committee	High	3
4.2	Failure to create an inclusive and equitable culture which may lead to lack of equality of opportunity and experience for the workforce.	9 (3x3)	9 (3x3)				6 (3x2)	People Performance Committee	High	3
Objective 5. Drive service improvement through high quality research, innovation and transformation.										
5.1	Failure to ensure clinical effectiveness which may lead to poorer patient outcomes, preventable harm to patients and suboptimal use of resources.	NEW	9 (3x3)				6 (3x2)	Quality Committee	Moderate	3
5.2	Failure to implement high quality research & development programmes which may lead to poorer quality of outcomes for our patients and communities.	6 (3x2)	9 (3x3)				6 (3x2)	Quality Committee	Significant	3
Objective 6. Use our resources efficiently and effectively										
6.1	Failure to deliver annual revenue (including cash) and capital financial plans which may lead to increased regulatory intervention.	12 (4x3)	16 (4x4)				12 (4x3)	Finance and Performance Committee	High	4
6.2	Failure to achieve financial sustainability through improved productivity & efficiency and system effectiveness, which may lead to suboptimal use of resources and increased regulatory intervention.	16 (4x4)	16 (4x4)				12 (4x3)	Finance and Performance Committee	High	4

Objective 7. Develop our Estate and Digital infrastructure to meet service and user needs.										
7.1	Failure to maintain and develop a resilient and responsive digital infrastructure which may lead to inability to support improvements in quality of care and compromise of data/information.	12 (4x3)	12 (4x3)				8 (4x2)	Finance and Performance Committee	Moderate	4
7.2	Failure to maintain suitability of premises and environments which may lead to increased health & safety incidents, breach of regulation and suboptimal patient and staff experience.	20 (5x4)	20 (5x4)				10 (5x2)	Quality / Finance and Performance Committee	Moderate	10
7.3	Failure to deliver the Green Plan / Net Zero targets and prepare for the impacts of climate change which may lead to worsening population health.	12 (3x4)	12 (3x4)				9 (3x3)	Finance & Performance Committee	Moderate	3
7.4	Failure to identify or insufficient funding mechanism to support the strategic regeneration of the hospital campus which may lead to an adverse long-term impact on the Trust's capability to deliver modern and effective care.	20 (4x5)	15 (3x5)				9 (3x3)	Finance & Performance Committee	Moderate	6

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Board Assurance Framework 2025/26

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score			
								Impact	Likelihood	Current	Q4 2024/25	Q1	Q2	Q3	Q4	Impact	Likelihood	Target	
Objective 1 - Deliver personalised, safe and caring services																			
Principal Risk Number: PR1.1		Risk Appetite: Moderate																	
Failure to maintain standards of patient safety which may lead to potential harm to patients receiving care and non-compliance with regulatory standards.	Quality Committee	SFT Quality Strategy: Outcome Measures 2025/26 Board established Quality Committee with responsibility for patient safety & approved Quality Committee Terms of Reference & Work Plan. Quality Committee Subgroups established including Safety & Quality Assurance / Patient Safety, Health & Safety, Safeguarding & approved Terms of Reference & Work Plans. Patient Safety Work Streams – Nutrition and Hydration, Deteriorating Patient, Resuscitation, Transfusion, Tissue Viability, Falls, Venous Thromboembolism (VTE), Sepsis, Acute Kidney Injuries (AKI) Patient Safety Incident Response Framework Policy & Patient Safety Incident Response Plan Established process for managing and learning from: - Incidents - Duty of Candour - Complaints - Legal Claims Learning from deaths process established including: - Mortality Review Policy - Learning from Deaths Review Process - Medical Examiner Team Safe staffing process established including: - Defined Nurse Establishments - Defined Medical Establishments - Healthcare Scientist Establishments - Medical Job Planning process - Medical Appraisal & Revalidation process in place including quality assessment Established Accreditation Programme (StARS) – Inpatients, Community, Theatres, Outpatients Maternity Improvement Plan in place including action plan in response to CQC Maternity Inspection and LMNS.	Indirect harm from operational pressures challenging to identify & quantify Full implementation of CQC/Maternity Action Plan Expired SFT Quality Strategy	Level 1 - Management: Divisional Governance: Quality Dashboards (Monthly) Mortality Steering Group Incident Response Group (IRG) Patient Safety Incident Response Group (PSIRG) Learning from Deaths Newsletter Quality Committee Subgroups: Patient Safety Group Health & Safety Subgroup Safeguarding Subgroup		Interrogation & triangulation of data relating to incidents due to operational pressures (Development of Patient Safety Report)	September 2025	4	3	12	15	12					4	2	8
				Level 2 – Corporate Quality Committee: - Quality & Safety Dashboard - CQC Report including CQC Action Plan Update, CQC Preparation (Biannually) - StARS Position Statement & Key Themes (Quarterly) - Patient Safety Report (Quarterly) (Incidents, PALS/Complaints, Inquests, Claims) - Intermittent Review – Long Waits in ED - Quality Strategy Progress Report (Biannually) - Maternity Services Report - Incorporates all Improvement/Action Plans - Learning from Deaths Report (Quarterly) - Management of External Visits, Inspections & Accreditations Report (Biannually) - Alert, Advise, Assure Reports: o Safety & Quality o Health & Safety o Safeguarding People Performance Committee: - Guardian of Safe Working / Freedom to Speak Up Report to Board (Quarterly) Board of Directors: - Integrated Performance Report (Quality & Safety Metrics) - Safe Care Report (Quarterly) and Bi-Annual Nursing Establishments Review - Guardian of Safe Working / Freedom to Speak Up Report to Board (Annually / Bi-annually) Annual Quality Accounts Clinical Audit Forward Programme – Local & National Audit		Development of Joint Quality Strategy (SFT and T&G) Full implementation of CQC & LMNS Action Plan	October 2025												

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score			
								Impact	Likelihood	Current	Q4 2024/25	Q1	Q2	Q3	Q4	Impact	Likelihood	Target	
Objective 1 - Deliver personalised, safe and caring services																			
		<p>Executive & Non-Executive Maternity Safety Champions in place with Visits & Meetings schedule.</p> <p>External Visits & Accreditations Policy & Register</p> <p>Freedom to Speak Up process established.</p> <p>Guardian of Safe Working process established</p> <p>Established Quality Impact Assessment (QIA) in place for Trust Efficiency Programme & Business Cases</p>		<p>Level 3 - Independent</p> <p>MIAA Internal Audits</p> <ul style="list-style-type: none"> - Quality Spot Checks 2024-25 (Limited) - PSIRF 2025-26 (Substantial) <p>LMNS & Region Visits & Report</p> <p>GM ICB Enhanced Monitoring Programme</p> <p>CNST Submission – Year 6</p> <p>Emergency Department Visit from GM ICB (Dec 2024) & Report.</p> <p>GM Clinical Quality & Effectiveness Group</p>															
Principal Risk Number: PR1.2		Risk Appetite: Moderate																	
<p>Failure to deliver personalised care and experience, which may lead to poorer patient outcomes and satisfaction.</p>	Quality Committee	<p>Patient Experience Strategy 2025-2026</p> <p>Board established Quality Committee with responsibility for patient experience & approved Quality Committee Terms of Reference & Work Plan.</p> <p>Quality Committee Subgroup established including Patient Experience with approved Terms of Reference & Work Plan.</p> <p>Subgroup of Patient Experience Group: Membership includes representation from: Divisions, Health Watch.</p> <p>Patient Experience Team with accountability and responsibility for: Patient Experience, Personalised Care, Patient and User Involvement, Communication between Services Users and Board.</p> <p>Processes in place to gather patient experience:</p> <ul style="list-style-type: none"> - Family & Friends - Carers Opinion - Patient Stories - Site Visits - Senior Nurse Walkarounds 	<p>Evidence of continued hospitalisation and investigation at end of life care (EoL) out with expressed preferences.</p> <p>Emergent themes from Complaint Analysis / Surveys</p>	<p>Level 1 - Management:</p> <p>Divisional Governance: Quality Dashboards (Monthly)</p> <p>Patient Experience Subgroup (Monthly)</p> <p>Level 2 - Corporate:</p> <p>Quality Committee:</p> <ul style="list-style-type: none"> - StARS Position Statement & Key Themes (Quarterly) - Patient Safety Report (Quarterly) (Incidents, PALS/Complaints, Inquests, Claims) - Maternity Services Report – Maternity Safety Champion Walk Rounds & Maternity Voices Partnership - Patient Experience Report (Biannual) - Annual Complaints Report - Alert, Advise, Assure Report: <ul style="list-style-type: none"> o Patient Experience <p>Board of Directors:</p> <ul style="list-style-type: none"> - Patient Story - Integrated Performance Report (Quality & Safety Metrics) <p>Council of Governors:</p> <ul style="list-style-type: none"> - Quarterly Formal Meetings 		<p>Trust EoL Committee deep dive of cause of continued EoL hospitalisation out with preference & solutions.</p> <p>Implementation of Action Plans from National Surveys & Complaints Learning</p>	<p>December 2025</p> <p>Ongoing (Action Plan includes actions spanning the year with differing dates for completion)</p>	3	3	9		9					3	2	6

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score				
								Impact	Likelihood	Current	Q4 2024/25	Q1	Q2	Q3	Q4	Impact	Likelihood	Target		
Objective 1 - Deliver personalised, safe and caring services																				
		Trust End of Life Care Committee & Stockport End of Life Care Group. Electronically assisted sharing of Care Plans across multiple organisations at Locality. Mental Health Partnership Board established with Pennine Care NHS Foundation Trust including Service User Representation Complaints Policy & established process for managing and learning from Complaints & PALS Established Accreditation Programme (StARS) includes Personalised Care assessment. Council of Governors (CoG) established, including public, staff and appointed governor from HealthWatch & attendance from Executive Directors.		- Quarterly Informal Governor & Joint Chair, Non-Executive Director, Chief Executive Meetings Level 3 - Independent Friends & Family Test National Patient Experience Surveys: - Adult Inpatient Survey - National Cancer Survey - Emergency Department Survey - Maternity Survey PLACE Assessment																
Principal Risk Number: PR1.3		Risk Appetite: Moderate																		
Failure to achieve mandatory access standards for urgent & emergency care which may lead to suboptimal quality of care for patients and increased regulatory intervention.	Finance & Performance Committee	Board approved Operational Plan 2025/26, Corporate Objectives & Outcome Measures including Activity Standards & Trajectories. Board established Finance & Performance Committee with responsibility for operational performance. Approved Finance & Performance Committee Terms of Reference & Work Plan. Established models of emergency and urgent care in place in line with national standards. Rapid ambulance handover process in place. Trust and system escalation process in place, aligned to a single OPEL system – Including divert of resource from elective activity to support flow. Virtual Ward established. Bed modelling undertaken to assess capacity gaps. Urgent & Emergency Care GIRFT Programme – Chaired by Medical Director Workforce models in place – Flexible to adapt to surges. Locality wide Urgent & Emergency Care (UEC) Delivery Board in place - Oversight of patient flow management plans.	Increased demand for urgent & emergency care Patient flow management due to: - Constraints in domiciliary & bed-based care impacting patients with NCTR - Financial constraints resulting in lack of 24/7 medical & surgical specialties to support discharge of non-elective patients. Locality Plan relating to intermediate care capacity not agreed with Trust – Reduction in capacity for Pathway 1 and Pathway 2. Financial constraints resulting in suboptimal staffing levels in Emergency Department	Level 1 - Management: Divisional Governance: Performance Weekly Performance Meetings (Urgent Care) 4 Hour Clinical Standard Improvement Group (Weekly) Urgent & Emergency Care GIRFT Meeting Level 2 – Corporate Joint Executive Team: Performance Report (Weekly) Trust Performance Meetings (Monthly) & Divisional Performance Reviews (Quarterly) Finance & Performance Committee - Operational Performance Report - Urgent & Emergency Care Metrics (Monthly) Board of Directors: - Integrated Performance Report (Operational Performance) (Bimonthly) Locality: - Urgent & Emergency Care Delivery Board - Locality Board Level 3 – Independent NHS England – Activity Returns NHS GM:					4	4	16	16	16					4	2	8
						Urgent Care Delivery Board to agree priority metrics to support improvement to 4 hour standard. Virtual Ward Deep Dive with best performing Trust – Action Plan to be developed to maximise utilisation.	July 2025 Q2 2025/26													
						NHSE Follow Up – Agree further support from ECIST to support 4 hour standard.	September 2025 Ongoing													

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score			
								Impact	Likelihood	Current	Q4 2024/25	Q1	Q2	Q3	Q4	Impact	Likelihood	Target	
Objective 1 - Deliver personalised, safe and caring services																			
				<ul style="list-style-type: none"> - Urgent & Emergency Care Oversight Meeting (Trust & Locality) - Contract Monitoring Meeting - Provider Oversight Meeting 		Escalation to ICB Commissioners via Monthly Contract Meeting & Provider Oversight Meeting													
Principal Risk Number: PR1.4																			
Failure to achieve mandatory access standards for elective, diagnostic & cancer care which may lead to suboptimal quality of care for patients and increased regulatory intervention.	Finance & Performance Committee	<p>Board approved Operational Plan 2025/26, Corporate Objectives & Outcome Measures including Activity Standards & Trajectories.</p> <p>Board established Finance & Performance Committee with responsibility for operational performance. Approved Finance & Performance Committee Terms of Reference & Work Plan.</p> <p>GIRFT Programmes in place for all Surgical & Medical Specialties.</p> <p>Escalation Process in place with Performance Team: 65+ week wait patients and any P2/cancer patients that are not dated.</p> <p>Booking & Scheduling centralisation</p> <p>Board approved Expanding Elective Care Business Case 2024/25</p>	<p>Agreed Trust sustainability plan for MR</p> <p>Agreed GM sustainability plan for Paediatric Audiology</p> <p>Ability of GM partners to provide mutual aid and fulfil service SLAs</p> <p>Increased demand for elective care, including from out of area.</p> <p>Loss of Outpatients B Department.</p>	<p>Level 1 – Management</p> <p>Divisional Governance: Performance</p> <p>Performance Meetings (Elective, Cancer & Diagnostics) (Weekly)</p> <p>Divisional Access Meetings (Weekly)</p> <p>GIRFT Meetings (Specialty Level)</p> <p>Joint Executive Team: Performance Report (Weekly)</p> <p>Level 2 – Corporate</p> <p>Trust Performance Meetings (Monthly) & Divisional Performance Review</p> <p>Finance & Performance Committee: Operational Performance Report - Elective, Cancer, Diagnostics</p> <p>Board of Directors</p> <ul style="list-style-type: none"> - Integrated Performance Report (Operational Performance) <p>Level 3 – Independent</p> <p>NHSE – Activity Returns</p> <p>GM & NHS England Productivity Benchmarking</p> <p>NHS GM:</p> <ul style="list-style-type: none"> - Contract Monitoring Meeting - Provider Oversight Meeting 		<p>Agree plan to increase forecast demand in MR capacity utilising CDC</p> <p>Agree with GM ICB plan to commission additional IQUIPS accredited capacity for Paediatric Audiology</p> <p>Review investment to right size elective care including non-recurrent investment.</p> <p>Refresh capacity & demand models for all specialties.</p> <p>Mobilisation of new Outpatients Department.</p>	<p>Q3 2025/26</p> <p>Q2 2025/26</p> <p>Q3 2025/26</p> <p>Q3 2025/26</p> <p>Q3 2025/26</p>	4	3	12	12	12					4	2	8

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Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores				Target Risk Score					
								Impact	Likelihood	Current	Q4 2024/25	Q1	Q2	Q3	Q4	Impact	Likelihood	Target		
Objective 2 - Support the health and wellbeing needs of our communities and colleagues																				
Principal Risk Number: PR2.1		Risk Appetite: High																		
Failure to sufficiently engage and support our people's wellbeing which may lead to low morale, sickness absence and higher turnover.	People Performance Committee	<p>Trust Health and Wellbeing (HWB) Plan and Strategy in place which presents delivery against ambitions / trajectories set by NHS England – Approved by Workforce / People Performance Committee and Board of Directors.</p> <p>Board established People Performance Committee with responsibility for staff wellbeing & approved Workforce / People Performance Committee Terms of Reference & Work Plan.</p> <p>People Performance Committee Subgroup established: Joint Health & Wellbeing Group. Approved Terms of Reference & Work Plan</p> <p>Approved people policies, procedures, guidelines in place including:</p> <ul style="list-style-type: none"> - Organisational Development - Flexible Working - Appraisal - Sickness Absence - Relationships at Work Policy - National Parent Support (Paternity) Policy - National Sexual Safety Policy <p>Regular sickness absence deep dive - Led by Deputy Director of People</p> <p>Collaborative Occupational Health Service with SFT & T&G – Including Staff Counselling Service & Physio Fast Track Service.</p> <p>Staff Vaccination Programme - Pertussis Influenza, Covid and MMR</p> <p>Board level Well Being Guardian (Non-Executive Director).</p> <p>FTSU Guardian and FTSU Champions Guardian of Safe Working</p> <p>Appraisal Process includes Wellbeing Discussion</p> <p>Big Conversation Programme</p> <p>Staff Side Partnerships established</p> <p>Health & Safety Mandatory Training Reasonable Adjustments Training</p> <p>Staff Survey Action Plans – Themed: Health and Well Being, Equality Diversity and Inclusion and Safety Culture</p>	<p>Impact of continuing operational & external/internal financial pressures</p> <p>Impact of ageing estate/quality of environment</p>	<p>Level 1 – Management</p> <p>Joint Health and Wellbeing Group (Bimonthly)</p> <p>Staff Side Partnership Meetings</p> <p>Industrial Action Planning Group</p>		<p>Commission further training sessions for sexual harassment in the workplace</p> <p>Health & Wellbeing Environmental Audit</p>	<p>June 2025</p> <p>Nov 2025</p>	3	3	9	9	9					3	2	6	
				<p>Level 2 – Corporate</p> <p>Divisional Performance Review / Divisional Meetings: Workforce standards, Establishments, Recruitment, Absence, Turnover & Recovery/Mitigation Actions</p> <p>NHS People Plan Self-Assessment</p> <p>People Performance Committee:</p> <ul style="list-style-type: none"> - Workforce Dashboard: Sickness Absence, Turnover (Bimonthly) - Sickness Absence Report (Biannually) - Freedom to Speak-up Report (Quarterly) - Guardian of Safe Working Report (Bi-annually) <p>Board of Directors:</p> <ul style="list-style-type: none"> - Staff Story - Integrated Performance Report: Workforce (Bimonthly) - Freedom to Speak Up (Bi-annually) - National Staff Survey 																
				<p>Level 3 - Independent</p> <p>NHS National Staff Survey</p> <p>MIAA Staff Wellbeing Review, February 2024 – Substantial Assurance.</p>																

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Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores				Target Risk Score				
								Impact	Likelihood	Current	Q4 2024/25	Q1	Q2	Q3	Q4	Impact	Likelihood	Target	
Objective 2 - Support the health and wellbeing needs of our communities and colleagues																			
		Award & Recognition Programme including Staff Awards, Long Service Awards Established partnerships with Locality & GM System e.g. Resilience Hub																	
Principal Risk Number: PR2.2		Risk Appetite: Moderate																	
Failure to actively participate and progress neighbourhood working which may lead to suboptimal improvement in primary and secondary health and well-being outcomes.	Board of Directors	Board of Directors – Place Collaboration Reporting in place. Neighbourhood profiles produced by Local Authority. Executive Director representation in established Locality Structures including: - Health & Wellbeing & Locality Board	Unfunded growth in demand for community services. Capacity & demand modelling for community services to support appropriate deployment of resources. Implications arising from the Planning Guidance 2025/26, Neighbourhood Health Guidelines and 10 Year Plan re. neighbourhood working. GM Community Service Review	Level 1 – Management Divisional Quality & Operations Group (Monthly) Performance Management Report Area Leadership Team (Monthly) Health and Care Collaborative – Delivery Group (Monthly) Children's: - Joint Public Health Oversight Group - SEND Joint Commissioning Group - CYP mental health & Well-being Partnership Board Adult and Children: - Joint Safeguarding Board	Community Services Dashboard			3	3	9	9	9					3	2	6
				Level 2 – Corporate Divisional Performance Review (Monthly) including targeted 'Deep Dives' Locality Provider Partnership (Monthly) Locality Board (Monthly)	Plans to respond to neighbourhood health guidelines Review of 10 Year Plan Outcome of GM community services review	September 2025 September 2025 TBC													
				Level 3 – Independent Children's – SEND Inspection Ofsted Report – 'Good' SALT – External multiagency review – Pathways & capacity and demand															

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Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores				Target Risk Score					
								Impact	Likelihood	Current	Q4 2024/25	Q1	Q2	Q3	Q4	Impact	Likelihood	Target		
Objective 3 - Develop effective partnerships to address health and wellbeing inequalities																				
Principal Risk Number: PR3.1		Risk Appetite: Significant																		
Failure to manage service provision in a way that reduces health inequalities at Trust, Locality and Greater Manchester (GM) level, which may lead to inequities in outcomes for the populations served.	Quality Committee	<p>Greater Manchester (GM) Integrated Care Partnership (ICP) Strategy, GM Sustainability Plan & GM Annual Plan 2025/26</p> <p>ONE Stockport One Future Plan and ONE Stockport Health and Care Plan.</p> <p>Executive Director representation in established GM & Locality Structures (Strategic & Operational) including:</p> <ul style="list-style-type: none"> - Health & Wellbeing & Locality Board - Provider Partnership - Locality System Quality Group - GM Trust Provider Collaborative - GM Health Inequalities Group - GM Medical Directors Group <p>Locality Provider Partnership chaired by CEO. Identified workstreams based on population health metrics.</p> <p>Executive Director led Health Inequalities Forum. Established programmes: Alcohol Harm, Health Literacy.</p> <p>Core20PLUS Ambassadors established. Trust employed Public Health Nurse (0.8 WTE)</p> <p>NHS Providers Health Inequalities Self-Assessment Report & Action Plan</p> <p>Executive (Medical Director) & Non-Executive Director Lead for Health Inequalities</p> <p>Patient Experience Strategy 2025-2026: Including workstreams to support health inequalities.</p> <p>Mental Health Partnership Board established with Pennine Care NHS Foundation Trust.</p> <p>Partnership and involvement with community & third sector.</p>	<p>Factors that are the primary responsibility of partner organisations (Education, Social Housing, etc.) where the Trust has less interface with the factors affecting health</p> <p>No Trust employed medical public health expertise & alcohol care team</p>	<p>Level 1 – Management</p> <p>Provider Partnership Workstream Meetings</p> <p>SFT Health Inequalities Forum</p>				3	4	12	NEW RISK	12					2	2	6	
				<p>Level 2 – Corporate</p> <p>Quality Committee</p> <ul style="list-style-type: none"> - Health Inequalities Report (Quarterly) - Annual Mortality Report - Annual Complaints Report - Annual Patient Experience Report - Annual Safeguarding Inspections and Report <p>Board of Directors</p> <ul style="list-style-type: none"> - Locality/Place Report <p>Locality Meetings</p> <ul style="list-style-type: none"> - Stockport Provider Partnership 	Lack of data provision for disadvantaged groups:	BI development underway to improve data provision as part of Health Inequalities Group key workstream	December 2025													
				<p>Level 3 – Independent</p> <p>GM Meetings</p> <ul style="list-style-type: none"> - Trust Provider Collaborative (TPC) - Relevant Directors part of GM TPC System Boards (Cancer, Elective, Urgent & Emergency Care, Diagnostics, Mental Health and Sustainable Services) - GM Medical Directors <p>Locality Meetings</p> <ul style="list-style-type: none"> - One Stockport Health & Care Locality Board 																
Principal Risk Number: PR3.2		Risk Appetite: Significant																		
Failure to deliver on the collaborative working opportunities that exist between Stockport NHS	Board of Directors	<p>Board of Directors – SFT and T&G Collaboration Reporting in place</p> <p>Clinical Service Partnership Group in place between both Trusts with Case for Change for clinical services for Radiology & Gastroenterology</p>	<p>Failure to gain key support from staff and agreement on the resulting service by service Case for Change.</p>	<p>Level 1 – Management</p> <p>Clinical Service Partnerships Group</p>		Develop case for change for clinical services for Pathology and Pharmacy	Q3 2025/26	3	3	9	12	9					3	2	6	
				<p>Level 2 – Corporate</p> <p>Executive Team - Oversight of Key Issues</p>	-	Development of Joint Clinical Strategy, based on learning from case for	Q3 2025/26													

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								Impact	Likelihood	Current	Q4 2024/25	Q1	Q2	Q3	Q4	Impact	Likelihood
Objective 3 - Develop effective partnerships to address health and wellbeing inequalities																	
Foundation Trust & T&G Integrated Care NHS Foundation Trust which may lead to suboptimal pathways of care for the populations served and/or limited-service resilience across the footprint of both Trusts		Updated Divisional Plans in place Corporate services collaborative working in place. Joint Executive Director and Senior Manager roles in place, with single Joint Executive Team. Joint Chair in post.	No current revenue or capital or recurrent funding identified to support future service changes.	Board of Directors SFT and T&G Collaboration Report		change and development of divisional plans.	Q2 2025/26										
				Level 3 – Independent			Exploration of joint governance models	Q4 2025/26									
						Development of Joint Organisational Strategy											

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								Impact	Likelihood	Current	Q4 2024/25	Q1	Q2	Q3	Q4	Impact	Likelihood	Target	
Objective 4 - Develop a diverse, capable and motivated workforce to meet future service and user needs																			
Principal Risk Number: PR4.1		Risk Appetite: High																	
Failure to recruit and retain the optimal number of staff, with appropriate skills, which may lead to gaps in the workforce and suboptimal quality of care.	People Performance Committee	<p>Approved People Plan in line with national People Strategy objectives – Including enabling approaches to Workforce Transformation (Planning); Leadership Development; Health & Wellbeing; Coaching; Resourcing; Organisational Development; Equality, Diversity & Inclusion, Talent Management & Succession planning.</p> <p>Board established People Performance Committee & approved Workforce / People Performance Committee Terms of Reference & Work Plan.</p> <p>Board approved Operational Plan 2025/26 including Workforce Plan.</p> <p>Model Hospital / NHS Productivity & Efficiency Benchmarking - Workforce</p> <p>Defined Medical and Nurse Staffing levels for all wards and departments. Safe Staffing Standard Operating Procedure deployed.</p> <p>E-rostering and Job Planning in place to support staff deployment. E-Rostering Workforce Group established.</p> <p>Weekly Staffing Approval Group (SAG)</p> <p>Temporary staffing and approval processes with defined authorisation levels</p> <p>Workforce Strategy & Divisional Workforce Plans</p> <p>Mandatory & Role Essential Training Requirements set, with a focus on persistent non-compliance to improve performance.</p> <p>Range of leadership and management development training sessions.</p> <p>Local/ Regional/National Education Partnerships - Widening Participation Programme in place - Degree Apprenticeships, Medical Support Workers, Cadet Programmes. E.g. roles identified as national shortage occupations</p> <p>Board approved Trust Values</p> <p>Appraisal Process</p> <p>Established partnerships with Locality / GM. Director of People & OD part of GM HR Directors Forum</p>	<p>National workforce shortages particularly for some medical posts exist (e.g. Radiologists, Acute/Stroke Physicians)</p> <p>Escalation areas remaining open – staffing additional areas required.</p> <p>Mandatory training compliance.</p>	<p>Level 1 - Management</p> <p>Divisional Governance: Divisional reports on workforce standards, establishments, recruitment, and retention, absence, and turnover and recovery/mitigation action plan</p> <p>Educational Governance Group</p> <ul style="list-style-type: none"> - Exception reports for Mandatory & Role Essential Training, Attendance <p>Staff Side Partnership Meetings</p> <p>Industrial Action Planning Group</p>		<p>Joint NHS England Stat Mand Programme Implementation Group - Deliver the changes for both statutory & mandatory and role essential training programmes</p> <p>Work programme focus on persistent non-compliance with mandatory training to improve participation & performance.</p>	September 2025	3	4	12	12	12					3	3	9
				<p>Level 2 – Corporate</p> <p>People Performance Committee</p> <ul style="list-style-type: none"> - Workforce Integrated Performance Report (Sickness Absence / Substantive Staff /Recruitment Pipeline / Appraisal, Turnover, Training Compliance Flexible Working Requests, Bank & Agency) - Safe Staffing Report (Bimonthly) - Biannual Nursing & Midwifery Establishments - Annual Medical Job Planning - Annual Medical Revalidation Report <p>Staffing Approval Group (Weekly)</p> <p>Workforce Efficiency Group</p> <p>Board of Directors:</p> <ul style="list-style-type: none"> - Integrated Performance Report (People Metrics) (Bimonthly) - Safer Care (Staffing) Report (Bimonthly) - Nursing & Midwifery Establishments (Biannual) - People & Organisational Development Plan Progress Report (Biannual) 															
				<p>Level 3 - Independent</p> <p>NHS National Staff Survey</p> <p>GMC Survey & NETS Survey</p> <p>Health Education Visits & Deanery Assurance Reports/Visits</p>															

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								Impact	Likelihood	Current	Q4 2024/25	Q1	Q2	Q3	Q4	Impact	Likelihood	Target	
Objective 4 - Develop a diverse, capable and motivated workforce to meet future service and user needs																			
Principal Risk Number: PR4.2		Risk Appetite: High																	
Failure to create an inclusive and equitable culture which may lead to lack of equality of opportunity and experience for the workforce.	People Performance Committee	<p>Approved People Plan in line with national People Strategy objectives – Including Equality, Diversity & Inclusion, Organisational Development (OD) Talent Management & Succession Planning</p> <p>Equality, Diversity & Inclusion Strategy & Implementation Plan.</p> <p>Board established Workforce / People Performance Committee with responsibility for equality, diversity & inclusion (EDI) & approved Workforce / People Performance Committee Terms of Reference & Work Plan.</p> <p>Workforce / People Performance Committee established Subgroup: - Joint EDI Group</p> <p>Established cross-divisional WRES/WDES Group</p> <p>Staff Networks (BAME / Disability / Carer/ LGBTQ+ and Neurodiversity) established with Board level sponsors.</p> <p>EDI Mandatory Training requirement.</p> <p>Senior medical leadership roles – Interview panel includes representation from staff with protected characteristics.</p> <p>Hate Crime Reduction Policy in place (Red/Yellow Card)</p> <p>Accessible Scheme</p> <p>Civility Saves Lives Programme established.</p> <p>Peer Review of Disciplinary Cases SFT & T&G</p>	<p>Career development programmes for staff with protected characteristics</p> <p>Formal recruitment/ disciplinary processes operating as barriers to achieving greater diversity</p>	<p>Level 1 - Management</p> <p>WRES / WDES Steering Group - Oversight of WRES / WDES Annual Report and Action Plan</p> <p>Equality, Diversity & Inclusion Steering Group - Oversight of the EDI Action Plan</p> <p>EDI metrics for applicants included in People Analytics dashboard</p> <p>Career Progression for All Task Group</p> <p>Level 2 – Corporate</p> <p>People Performance Committee</p> <ul style="list-style-type: none"> - EDI Report (Biannually) - WRES and WDES Annual Report - Gender Pay Gap - NHS Staff Survey & Action Plans - Freedom to Speak Up Report (Quarterly) <p>Board of Directors</p> <ul style="list-style-type: none"> - Annual EDI Report - NHS Staff Survey - Freedom to Speak Up Report (Biannually) <p>Level 3 - Independent</p> <p>NHS National Staff Survey</p>		EDI Action Plan Implementation	Ongoing (Action Plan includes actions spanning the year with differing dates for completion)	3	3	9	9	9					3	3	9

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Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score			
								Impact	Likelihood	Current	Q4 2024/25	Q1	Q2	Q3	Q4	Impact	Likelihood	Target	
Objective 5 – Drive service improvement through high quality research, innovation and transformation																			
Principal Risk Number: PR5.1		Risk Appetite: Significant																	
Failure to ensure clinical effectiveness which may lead to poorer patient outcomes, preventable harm to patients and suboptimal use of resources	Quality Committee	<p>SFT Quality Strategy: Outcome Measures 2025/26</p> <p>Board established Quality Committee with responsibility for clinical effectiveness. Approved Quality Committee Terms of Reference & Work Plan</p> <p>Quality Committee Subgroup established including Clinical Effectiveness Group</p> <p>Annual Clinical Audit Programme: Including national and locally prioritised audit based on risk assessment</p> <p>Assurance Programme for audit and assess their implementation of NatSSIPs and LocSSIPs</p> <p>NICE Guidance Compliance Review Process established</p> <p>Clinical Benchmarking & GIRFT Review Programme established (All Trust specialties)</p> <p>Attendance at National GIRFT Reviews for relevant Trust specialties.</p> <p>Divisional Clinical Accreditation Programmes and Royal College Audit Programmes</p> <p>Introduction of internal Professional Standards & Dispositions for ED escalation</p> <p>Clinical effectiveness interface with mental health and GP Partners in Locality via established Joint Forums</p>	Some elements of clinical effectiveness out with Trust control where interface with other organisations / professional groups	<p>Level 1 - Management:</p> <p>Divisional Governance: Quality Dashboards (Monthly)</p> <p>Incident Response Group (IRG) Patient Safety Incident Response Group (PSIRG)</p> <p>Clinical Effectiveness Subgroup (Monthly) Clinical Audit, NICE Compliance, NatSSIPs & LocSSIPs, Results Governance, Transfusion, GIRFT</p> <p>Level 2 - Corporate:</p> <p>Quality Committee: - External Visits & Inspections Register Report (Biannual) - Clinical Audit Forward Programme Report (Biannual) - Annual Clinical Audit Report - Annual Quality Account - Alert, Advise, Assure Report: o Clinical Effectiveness</p> <p>Board of Directors: - Integrated Performance Report (Quality & Safety Metrics)</p> <p>Level 3 - Independent</p> <p>National Clinical Audit</p>				3	3	9	NEW RISK	9					3	2	6
Principal Risk Number: PR5.2		Risk Appetite: Significant																	
Failure to implement high quality research & development programmes which may lead to poorer quality of outcomes for our patients and communities	Quality Committee	<p>T&G / SFT Research Team established.</p> <p>Joint Clinical Research, Development & Innovation Strategy 2022-2027 (SFT & T&G) & governance meetings in place to review work programme (as derived from strategy)</p> <p>Annual Research Programme in place.</p> <p>Annual Joint RD&I Celebration Event: Shared Learning</p> <p>RD&I – 5 year financial stability projection.</p>	<p>Recurrent staffing shortages impacting activity</p> <p>Majority of staff funded from research income therefore dependent on external funding</p>	<p>Level 1 – Management</p> <p>Joint SFT & T&G RD&I Governance Group</p> <p>Clinical Effectiveness Subgroup - Research & Innovation Progress Report - Annual Research & Innovation Report</p> <p>Level 2 – Corporate</p> <p>Quality Committee: - Annual Research & Innovation Report - Alert, Advise, Assure Report: Clinical Effectiveness</p> <p>Board of Directors:</p>				3	3	9	6	9					3	2	6

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 2024/25	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 5 – Drive service improvement through high quality research, innovation and transformation																		
				- Annual RD&I Report Level 3 - Independent DHSC KPIs for Research NIHR North West CRN KPIs for Research Participant Research Experience Survey (PRES)														

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Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score						
								Impact	Likelihood	Current	Q4 2024/25	Q1	Q2	Q3	Q4	Impact	Likelihood	Target				
Objective 6 – Use our resources efficiently and effectively																						
Principal Risk Number: PR6.1		Risk Appetite: High																				
Failure to deliver annual revenue and capital financial plans which may lead to increased regulatory intervention.	Finance & Performance Committee	<p>Financial planning processes and central Finance Team for coordination of delivery.</p> <p>Board approved Financial (Revenue & Capital) Plan 2025/26. Agreed as part of Greater Manchester Integrated Care System (GM ICS)</p> <p>Board approved Opening Budgets based on submitted Financial Plan.</p> <p>Established Trust Efficiency Programme (CIP) and oversight process</p> <p>Cash Management Plan & Forecast procedures, including sensitivity and scenario planning. Board approval of cash support applications</p> <p>Joint T&G & SFT Finance Improvement Group established, chaired by Chief Executive.</p> <p>Board established Finance & Performance Committee with responsibility for financial performance. Approved Finance & Performance Committee Terms of Reference & Work Plan.</p> <p>Key financial policies including:</p> <ul style="list-style-type: none"> Standing Financial Instructions Scheme of Delegation Budgetary systems and procedures Procurement Policy Fraud management process Treasury management policy <p>Delivery of budget holder training workshops and enhancements to financial reporting.</p> <p>Internal Audit Programme – Key Financial Controls</p> <p>Authorisation processes for recruitment and agency spend in place via Staffing Approval Group.</p> <p>Workforce Efficiency Group – Oversight of temporary staffing spend.</p> <p>NHS Productivity/Benchmarking data to support monitoring of service delivery, productivity & efficiency.</p> <p>Submission of National Cost Collection exercise (PLICS).</p>	<p>Assumptions in Financial Plan including:</p> <ul style="list-style-type: none"> Income from commissioners Pay award funding CDEL cover Non-elective care demand Inflation costs <p>Identification & implementation of recurrent CIP Plan</p> <p>System deficit funding withdrawn if Operational Plans not achieved - Quarterly Review by NHS Regional</p> <p>Condition of estate and unavailability of equipment due to failure, resulting in impact to service delivery, productivity and revenue.</p> <p>Stockport System finance deficit potentially impacting on SFT position e.g. reduction on spot purchase beds.</p>	<p>Level 1 – Management</p> <p>Divisional Governance</p> <ul style="list-style-type: none"> Finance Metrics/CIP/Forecast <p>Finance Training Group</p> <p>Cash Monitoring Group (Monthly)</p> <p>Operational Board (Monthly) – Review of business cases, emerging and new pressures and developments.</p>				4	4	16	12	16					4	3	12			
				<p>Level 2 – Corporate</p> <p>Trust Efficiency Programme Group: Delivery against Plans and Milestones, Recovery Actions and Forecast.</p> <p>Staffing Approval Group (Weekly)</p> <p>Capital Planning and Monitoring Group (Monthly): Scheme level monitoring to support capital programme</p> <p>Divisional Performance Review (Monthly) - Financial Position, CIP, Forecast, Recovery Actions.</p> <p>Joint T&G & SFT Finance Improvement Group: Reports on I&E, Run Rate, TEP, Cash and Capital.</p> <p>Finance & Performance Committee:</p> <ul style="list-style-type: none"> Finance Report (Monthly) CPMG – Capital Position (Monthly) Productivity (including national productivity benchmarking) & TEP (Quarterly) <p>Board of Directors:</p> <ul style="list-style-type: none"> Financial Position Report (Bimonthly) <p>Stockport System Financial Recovery Group (Monthly)</p>	Escalation of Commissioning/Contracting Issues & Planning Assumptions via GM Provider Oversight Meeting (POM)	Monthly																
				<p>Level 3 - Independent</p> <p>Independent assurance on 2025/26 Financial Plan by Seagry under instruction of NHS England.</p> <p>Internal Audit Reports</p> <ul style="list-style-type: none"> Key Financial Systems (Substantial) HFMA Financial Sustainability Review: Confirmation of Self-Assessment. Data Quality (High/Substantial) <p>GM ICS</p>	Independent assurance on 2025/26 Key Financial Systems & Controls	Q4 2025/26																

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 2024/25	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 6 – Use our resources efficiently and effectively																		
		<p>Divisional Performance Review Process including Finance Review</p> <p>Stockport System Finance Recovery Group established (Monthly) including Trust representation.</p> <p>GM System Efficiency Group established including Trust representation.</p> <p>GM Provider Oversight Meetings established, chaired by GM ICB CEO, attended by NHS England (NHSE).</p> <p>GM Trust Provider Collaborative (TPC) established, chaired by SFT & T&G CEO.</p>		<p>Monthly Provider Finance Return including detailed commentary on financial position and reconciliation of workforce, productivity/finance and performance data.</p> <p>Monthly Provider Oversight Meeting (Information Pack)</p> <p>NHSE NHSE - North West Region oversight and triangulation of finance, activity and workforce data including productivity metrics</p> <p>Monthly Finance Return – Detailed commentary on financial position and Oversight of GM ICS based on the GM NHS SOF Rating 3.</p>														
Principal Risk Number: PR6.2		Risk Appetite: High																
<p>Failure to improve productivity & efficiency and system effectiveness, which may lead to lack of organisational financial sustainability and increased regulatory intervention.</p>	<p>Finance & Performance Committee</p>	<p>Board established Finance & Performance Committee with responsibility for financial performance. Approved Finance & Performance Committee Terms of Reference & Work Plan.</p> <p>GM ICS and Locality Financial Planning & Oversight processes in place including GM, Local Authority & Trust representation.</p> <p>GM ICS commissioned Drivers of Deficit Review.</p> <p>Stockport System Financial Recovery Group established – Chief Finance Officer, Director of Finance & Director of Operations.</p> <p>Productivity/Benchmarking data to support monitoring of service delivery, productivity & efficiency</p> <p>GM business case assessment process in place.</p> <p>GM System Efficiency Group established including Trust representation.</p> <p>GM Provider Oversight Meetings established, chaired by GM ICB CEO, attended by NHS England (NHSE).</p> <p>GM Trust Provider Collaborative (TPC) established, chaired by SFT & T&G CEO.</p>	<p>Underlying financial deficit driven by structural drivers.</p> <p>Realignment of deficit funding from 2025/26</p> <p>Delivery / Implementation Plan to support GM Sustainability Plan.</p>	<p>Level 1 - Management Divisional Governance - Finance Metrics/CIP/Forecast</p> <p>Level 2 – Corporate Trust Efficiency Programme Group: Delivery against Plans and Milestones, Recovery Actions and Forecast.</p> <p>Finance & Performance Committee - Finance Report (Monthly) - Productivity & CIP (Quarterly) - Financial Sustainability (Quarterly)</p> <p>Joint T&G & SFT Finance Improvement Group: Productivity & Efficiency</p> <p>Stockport System Financial Recovery Group (Monthly)</p> <p>Level 3 - Independent</p> <p>Internal Audit CIP Process (Substantial Assurance)</p> <p>GM ICS Provider Director of Finance GM Meeting</p> <p>Monthly Provider Finance Return including detailed commentary on financial position and reconciliation of workforce, productivity/finance and performance data.</p> <p>GM Provider Oversight Meeting (Monthly)</p> <p>NHSE NHSE - North West Region oversight and triangulation of finance, activity and workforce data including productivity metrics</p>				4	4	16	16	16				4	3	12
						<p>Escalation of Commissioning/Contracting Issues & Planning Assumptions via GM Provider Oversight Meeting (POM)</p> <p>Locality review of contracts with particular focus on community services.</p> <p>SFT Drivers of Deficit Review - Development of Action Plan</p>	<p>Monthly</p> <p>October 2025</p> <p>October 2025</p>											

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores					Target Risk Score		
								Impact	Likelihood	Current	Q4 2024/25	Q1	Q2	Q3	Q4	Impact	Likelihood	Target
Objective 6 – Use our resources efficiently and effectively																		
				Monthly Finance Return – Detailed commentary on financial position and Oversight of GM ICS based on the GM NHS SOF Rating 3														

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Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores				Target Risk Score				
								Impact	Likelihood	Current	Q4 2024/25	Q1	Q2	Q3	Q4	Impact	Likelihood	Target	
Objective 7 - Develop our estate & digital infrastructure to meet service and user needs																			
Principal Risk Number: PR7.1		Risk Appetite: Significant																	
Failure to maintain and develop a resilient and responsive digital infrastructure which may lead to inability to support improvements in quality of care and compromise of data/information.	Finance & Performance Committee	<p>SFT Digital Strategy 2021-2026</p> <p>Capital Programme in place to support funding of Digital Strategy</p> <p>Board established Finance & Performance Committee with responsibility for digital strategy oversight. Approved Finance & Performance Committee Terms of Reference & Work Plan.</p> <p>Finance & Performance Committee established Subgroups including Digital & Informatics Group. Approved Terms of Reference & Work Plan</p> <p>Digital Team established dedicated delivery of the Digital Strategy, with project management infrastructure in place.</p> <p>Information Governance Assurance Framework (IGAF) & NHIS Cyber Security Strategy</p> <p>Information Governance mandatory training.</p> <p>Change control process in place.</p> <p>Major incident & business continuity plans in place.</p> <p>Annual penetration testing by independent organisation</p> <p>Anti-virus & spam and malware update programme in place</p> <p>Process in place to respond to Care Cert notifications</p> <p>DSPT – Submission, auditing and reporting</p>	<p>Not always sufficient capital investment to support the replacement of ageing and/or unsupported hardware & software, and for cyber- security resource meaning assets are pushed up to (sometime beyond) their 'end of life'.</p> <p>Dependencies on supplier to complete remedial actions.</p> <p>Recording of medical devices introduced on the corporate network</p>	<p>Level 1 – Management</p> <p>Digital Team Governance: Monitoring of data/incidents.</p> <p>Medical Equipment Group</p> <p>Cyber Meetings – CareCert.</p> <p>SFT Digital & Informatics Group</p> <p>Level 2 – Corporate</p> <p>Finance & Performance Committee:</p> <ul style="list-style-type: none"> - Digital Strategy Progress Report (Biannual) - Capital Programmes Management Group – Including digital capital (Monthly) - Alert, Advise, Assure Report <ul style="list-style-type: none"> o Digital & Informatics Group <p>Board of Directors:</p> <ul style="list-style-type: none"> - Digital Strategy Progress Report (Biannual) <p>Level 3 - Independent</p> <p>Business Continuity Confirm and Challenge NHSE</p> <p>ISO 27001 Information Security Management Certification</p> <p>DCB 1596 Secure Email Standard Accreditation</p> <p>MIAA Internal Audit Report June 2024 - Data Security and Protection (DSP) Toolkit Assessment 2023/24 - Achieved "Substantial Assurance" against the veracity of the self-assessment and "Moderate Assurance" against the 10 National Data Guardian Standards.</p>		External bids for capital funding.	Ongoing	4	3	12	12	12					4	2	8
Principal Risk Number: PR7.2		Risk Appetite: Moderate																	
Failure to maintain suitability of premises and environments which may lead to increased health & safety incidents, breach of regulation and suboptimal patient	Finance & Performance Committee	<p>Board established Finance & Performance Committee with responsibility for estates & facilities oversight and Quality Committee for health & safety. Approved Terms of Reference & Work Plan.</p> <p>Finance & Performance Committee established Subgroup: Estates Strategy Group. Approved Terms of Reference & Work Plan</p> <p>Quality Committee established Subgroup:</p>	<p>Inability to deliver required levels of estates backlog maintenance due to lack of funding.</p> <p>Inability to deliver required upgrades due to access limitations related to clinical activity pressures</p>	<p>Level 1 – Management</p> <p>Capital Programme Management Group:</p> <ul style="list-style-type: none"> - Compliance with agreed delivery programme - Confirmation of spend against approved budget <p>Health & Safety Group</p> <ul style="list-style-type: none"> - Compliance with regulatory standards - Health & Safety Incidents <p>Estates Strategy Group</p> <ul style="list-style-type: none"> - Site Development Strategy Progress 		Operational review of backlog maintenance funding (SFT & T&G)	Q3 2025/26	5	4	20	20	20					5	2	10

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores				Target Risk Score				
								Impact	Likelihood	Current	Q4 2024/25	Q1	Q2	Q3	Q4	Impact	Likelihood	Target	
Objective 7 - Develop our estate & digital infrastructure to meet service and user needs																			
and staff experience.		<p>Health & Safety. Approved Terms of Reference & Work Plan</p> <p>Estates and Facilities Risk Forum established, including clinical and non-clinical representation.</p> <p>Approved Capital Programme in place including backlog maintenance.</p> <p>Six-Facet Survey Process. Additional structural surveys completed for Category D and poor condition property assets by Structural Engineers, in line with Six Facet Survey.</p> <p>Premises Assurance Model (PAM) Process & Action Plan.</p> <p>HTM Compliance Assurance Groups established.</p> <p>Appointment of Authorising Engineers in accordance with the requirements of HTM00.</p> <p>Project Board and Senior Responsible Officer identified for major capital developments.</p> <p>Training and Continuing Professional Development of Estates Technical and Operational staff.</p>	<p>Delivery/Transition Plan to address highest risk capital stock and decompression of site.</p>	<p>Level 2 – Corporate</p> <p>Quality Committee</p> <ul style="list-style-type: none"> - Annual Health & Safety Report - Alert, Advise & Assure Report <ul style="list-style-type: none"> o Health & Safety Group <p>Finance & Performance Committee</p> <ul style="list-style-type: none"> - Estates & Facilities Assurance Report - Site Development Strategy Progress Report - Alert, Advise & Assure Reports: <ul style="list-style-type: none"> o Capital Programme Management Group o Estates Strategy Group <p>Board of Directors</p> <ul style="list-style-type: none"> - Site Development Strategy Progress Report <p>Level 3 - Independent</p> <p>Estates Return Information Collection (ERIC)</p> <p>Six Facet Survey</p> <p>PLACE Assessment</p>		<p>Procurement of master planning exercise for SFT & T&G to support development of estates strategy</p>	Q3 2025/26												
Principal Risk Number: PR7.3		Risk Appetite: Moderate																	
Failure to deliver the Green Plan / Net zero targets and prepare for the impacts of climate change which may lead to worsening population health.	Finance & Performance Committee	<p>Approved Green Plan in place.</p> <p>Joint SFT & T&G Green Plan Delivery Group established.</p> <p>Joint appointment of Sustainability Manager and Sustainability Officer between SFT and T&G</p> <p>Six Facet Survey Process</p> <p>Funding secured for a full Decarbonisation plan and Heat Network Readiness Report.</p> <p>Mechanisms in place to explore and develop sustainability approach across Locality.</p> <p>Engagement with GM Sustainability Group</p> <p>Nitrous Oxide manifold system capped to reduce gas wastage and associated emissions</p>	<p>Inability to deliver required levels of environmental and sustainability improvements due to lack of funding and awareness / ownership across all departments</p> <p>Climate Change Adaptation Plan</p> <p>Decarbonisation Plan and Heat Network Readiness Report - Awaiting approval</p>	<p>Level 1 – Management</p> <p>Capital Programme Management Group</p> <ul style="list-style-type: none"> - Compliance with agreed delivery programme - Confirmation of spend against approved budget <p>Joint Green Plan Delivery Group</p> <ul style="list-style-type: none"> - Monitoring of Green Plan delivery - Development of sustainability opportunities <p>Level 2 – Corporate</p> <p>Finance & Performance Committee:</p> <ul style="list-style-type: none"> - Green Plan (Sustainability) Progress Report (Biannual) <p>Board of Directors</p> <ul style="list-style-type: none"> - Annual Green Plan Report - Annual Report including Sustainability Report 		<p>Work with Carbon Energy Fund (CEF) to assess the viability of decarbonising the Stepping Hill Hospital site and connecting to the Stockport Heat Network</p> <p>Decarbonisation Plan & Heat Network Readiness Report</p> <p>Develop new joint Green Plan SFT & T&G</p>	<p>Q3 2025/26</p> <p>Q2 2025/26</p> <p>Q2 2025/26</p>	3	4	12	12	12					3	3	9

Principal Risk Description	Lead Board Committee	Key Controls	Gaps in Control	Key Assurances	Gaps in Assurance	Key Actions	Due date for action	Current Risk Score			Previous Risk Scores				Target Risk Score				
								Impact	Likelihood	Current	Q4 2024/25	Q1	Q2	Q3	Q4	Impact	Likelihood	Target	
Objective 7 - Develop our estate & digital infrastructure to meet service and user needs																			
				Level 3 - Independent Estates Return Information Collection (ERIC) ICB Contacting Requirement Annual Check		Development of a Climate Change Adaptation Plan	Q4 2025/26												
Principal Risk Number: PR7.4		Risk Appetite: Moderate																	
Failure to identify or insufficient funding mechanism to support the strategic regeneration of the hospital campus which may lead to an adverse long-term impact on the Trust's capability to deliver modern and effective care.	Finance & Performance Committee	Strategic Regeneration Framework Prospectus completed, and New Hospital Building Programme Expression of Interest produced. Site Development Strategy to support and inform immediate site development and maintenance aspirations Estates Strategy Steering Group (ESSG) established, reporting to Finance & Performance Committee. Joint working arrangements with SMBC established to explore strategic regeneration of the hospital campus.	Insufficient financial resources to enable optimum levels of investment to deliver regeneration ambitions including Project Hazel.	Level 1 - Management Level 2 - Corporate Strategic Regeneration Framework Prospectus and Expression of Interest - Reviewed by Board. Finance & Performance Committee Site Development Strategy Progress Report (Biannual) Board of Directors Site Development Strategy Report (Biannually) Level 3 - Independent		Review of funding approach with partners.	Ongoing	3	5	15	20	15					3	3	9

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Appendix 2 – Stockport NHS Foundation Trust Significant Risk Register (as at June 2025)

Risk ID	Division/Corporate Service	Risk Title	Consequence	Likelihood	Rating	Target Rating	Change since May 25
3018	Surgery	There is a risk to patients in the Stockport locality due to the pause of the paediatric audiology service	4	4	16	8	NEW
2765	Estates & Facilities	There is a risk that limitations in capital resource will impact on ability to repair, replace and retain a fully functioning site	4	5	20	4	↔
586	Estates & Facilities	There is a risk of deterioration of the hospital site due to a significant increase in Estate Backlog Maintenance	4	5	20	8	↔
2908	Corporate - IT	There is a risk that the Trust could lose all access to the PAS system due to the age of the hardware	4	5	20	8	↔
2596	Corporate – IT	There is a risk of total failure of the cooling in the Beech House Data Centre	5	4	20	8	↔
2650	Surgery	Risk of harm to pediatric patients if the audiology service does not comply with best practice recommendations	4	5	20	3	↔
2682	Estates and Facilities	There is a risk of service disruption impacting on care delivery due to standard of estate (blocks 30/31 & 52 Pathology)	4	4	16	4	↔
2949	Corporate – IT	There is a risk to the organisations cyber security from the large number of unsupported and end of life end user devices.	4	4	16	9	↔
2969	Surgery	There is a risk of harm to patients, staff and operational flow due to failure of lifts 22 and 23	4	4	16	4	↔
2452	Clinical Support Services	The risk of the pathology estate not being fit for purpose or safe	3	5	15	3	↔
2247	Estates and Facilities	There is a risk that electrical capacity could prevent future electrical schemes and electrical purchases	3	5	15	3	↔
288	Corporate Nursing	There is a risk of there being an inability to provide a robust service for the insertion of VADs	3	5	15	6	↔
2196	Estates and Facilities	Dangerous & obstructive car parking occurring across the SHH Site	3	5	15	6	↔
2971	Corporate – Learning & Education	There is risk of Health and Safety to staff and visitors from water leaks in Pinewood House	5	3	15	6	↔
2304	Medicine & Urgent Care	There is a risk of harm if patients cannot be transferred from ambulances to	4	4↓	16	8	↓

Appendix 2 – Stockport NHS Foundation Trust Significant Risk Register (as at June 2025)

		ED then there are delays in treatment					
2713	Medicine & Urgent Care	There is a risk of patient harm due to capacity not meeting demand resulting in overcrowding in ED	4	4↓	16	8	↓

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