

# **ANNUAL REPORT AND ACCOUNTS**

**2013/2014**



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paragraph 25(4) (a) of the National Health Service Act 2006.



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## 1. CHAIRMAN AND CHIEF EXECUTIVE'S INTRODUCTION

The year was a significant one, with a strong focus on partnership developments. We faced challenges, took opportunities, made service improvements, won awards and achieved excellent results in key clinical areas.

Our three-year transformation programme, *Building a Sustainable Future*, was launched as the year ended with our 10 year anniversary as a foundation trust. The anniversary was a proud reminder of how far we have come, and how much we have achieved, since becoming one of the first foundation trusts in the country in 2004.

Our work to build a sustainable future for the organisation was created through the ideas and innovation of our committed staff. They are at the very heart of our past, present and future, but also recognise that we can't do this alone. The need to strengthen our partnerships saw a tremendous progression of the Southern Sector Partnership and Stockport Transformation Board. Our Southern Sector Partnership with The University Hospital of South Manchester Foundation Trust, East Cheshire NHS Trust and Tameside Hospital Foundation Trust is a long-term collaboration for efficient and effective service improvements.

Over the year we received independent confirmation that we are providing the highest quality care across many areas. We had an excellent Care Quality Commission (CQC) report following an unannounced inspection of the hospital. The CQC also gave us the top ranking in its new Intelligence Monitoring Report; an authoritative assurance that we are providing safe care and treatment. National statistics ranked our hip replacement and bowel cancer surgery amongst the best in the country. We also received global coverage following a UK-first kidney cancer operation using a fluorescent dye for advanced treatment.

We met all of our national requirements, except the four-hour A&E target. Whilst our performance improved and quality remained high in this area, we along with other Trusts faced an immense struggle to achieve the 95% standard. Our failure to meet the standard, on a sustained basis, meant that we remained in significant breach of our provider licence by our regulator, Monitor. We continued our work on the unscheduled care programme, which aims to enhance the flow of patients through the hospital, and are determined to achieve the target.

We continued to implement the action plan agreed following the KPMG review of our governance arrangements. Later in the year we also began work with Deloitte's on a further governance review which is likely to result in the introduction of a revised assurance structure during 2014/15.

In terms of finance, we achieved our plans and a financial risk rating of 3 under Monitor's compliance code. This reflects our determination to scrutinise and monitor financial performance in the context of a deeply complex health care system, which is consistently challenged.

The year also saw the second anniversary of the saline contamination incident, and the conclusion of the two year police investigation with a nurse being charged.

Patients remained at the heart of all our focus and effort over the 12 months. We ran an extensive staff listening programme following the publication of the second Francis Report into Mid Staffordshire NHS Foundation Trust. This involved events with frontline teams across the Trust, the majority with the chief executive, to hear their views. The themes from the meetings have been fed into our organisational development work.

There were a number of new appointments to the Board during the year. We strengthened the composition of the Board by one executive director and one non executive director to reflect the growth of our organisation in services, staff and resources.

Jayne Shaw was appointed as Director of Workforce and Organisational Development and James Sumner took up the post of Chief Operating Officer. Dr Mike Cheshire and John Schultz, our two new Non Executive Directors, joined a strong Board team which helped ensure close scrutiny of Trust performance and strategic direction focused on putting patient care at the heart of everything we do. We also said farewell to Carole Spencer, Director of Planning and Business Development, and would like to thank Carole for her significant contribution to the development of the Trust.

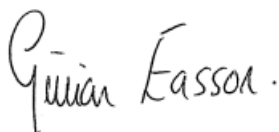
Our council of governors evolved even further over the year, playing an important role in our future plans. The governors made an excellent contribution to our organisation through their work in the community, on committees and with our board of directors. They work on a completely voluntary basis and we greatly appreciate the commitment and the time that they give on behalf of their members. We look forward to working even closer together in the future under our revised constitution.

Our lead governor David Kirk finished his term as public governor and we would like to thank him for his commitment over the years. He has now been replaced as lead governor by Les Jenkins. The year saw the retirement of a number of governors and our gratitude goes to Tricia Berry, Janet Blakeley, Cecil Brooks, Tony Johnson, David Kirk, Janet Morley and Di Readman for their contribution.

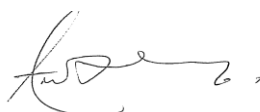
Our focus is now on building a sustainable future. Amazingly, one-in-three of the children born across England this year are likely to live to celebrate their 100th birthday. Our mission is to ensure that we are there for them throughout their lives, every step of the way.

We face the year ahead with hard-headed realism about the here-and-now, but with a sense of shared purpose and optimism. We need to continue making efficiency savings, however at all times our guiding principle will be to walk in the shoes of the people we serve.

We would like to thank our governors, volunteers, members and supporters for the difference they make to the life and work of our Trust. Finally, we would like to thank the staff for their exceptional commitment and professionalism. It is their skill and dedication which allows us to provide the highest quality care to our patients.



Gillian Easson  
**Chairman**



Ann Barnes  
**Chief Executive**

29 May 2014

## **2. DIRECTORS' REPORT**

### **2.1 OPERATING REVIEW 2013/14**

Detailed below is a review of 2013/14.

#### **Targets and ratings**

- We received an excellent report from the Care Quality Commission following a planned unannounced inspection of our emergency department, acute medical unit, ambulatory care unit, and wards B2 & E2. The report highlighted the kind and compassionate care provided to patients
- The Care Quality Commission launched its Intelligent Monitoring Tool to assess the quality and safety of patient care across the country. We were the only general hospital in Greater Manchester to achieve and then retain the top banding - ranking us as one of the safest hospitals in the country
- Despite a real effort and significant improvement through the year, we failed the 95% four hour A&E target. However quality of patient care and experience remained high
- We achieved one of the best results in the country for hip replacements, with less than 1% of our patients needing a further replacement after five years
- Our results in the national cancer patient experience survey showed an improvement, with work still to do in managing pain and giving information to patients
- Our latest PLACE inspection showed a big improvement, with positive feedback in all areas. The Patient-Led Assessment of the Care Environment looks at patient privacy and dignity, food, cleanliness and general building maintenance
- The annual Dr Foster Hospital Guide was published, focusing on mortality rates and the quality of care at weekends. The report showed a need improvements in two areas: weekend performance and emergency readmissions within 28 days of discharge
- The national Friends & Family Test was launched. We worked hard throughout the year to achieve the 20% response target
- 75% of our staff had the flu vaccination, the third best result in Greater Manchester - significantly higher than the 53% national average
- National statistics showed that Stepping Hill Hospital is the safest place in Greater Manchester to have bowel cancer surgery
- Our annual staff survey results were excellent, with a high percentage of staff recommending our organisation as a place for treatment and to work

#### **Business Development**

- The Community Healthcare business group was formed, incorporating 2,000 staff from Tameside, Glossop and Stockport
- Our new short stay older people's unit opened to help avoid unnecessary long stays in hospital for the over 70s, and improve the patient experience
- Our new Outpatients C department opened for haematology patients, giving them a one stop shop for improved care
- We continued our Stockport transformation work with the council and local partners to further integrate services
- One of the first pieces of work was the integration of the management of children's services with Stockport Council, to help remove barriers between NHS and social care, and save costs



- We launched a new integrated diabetes service in Tameside & Glossop, creating a centre of excellence in partnership with Tameside General Hospital
- The Southern Sector Partnership continued to drive collaboration between the four partners, with progress in pathology, radiology and pharmacy
- The partnership held a clinical congress to advance joint work in other clinical areas, and undertook a review of corporate services
- Ann Barnes, chief executive was invited to No 10 Downing Street where Prime Minister David Cameron thanked key leaders for their partnership work
- An 'Improvement and Innovation Academy' was launched to encourage and develop ideas for income generation and savings
- Work on our 'Building a Sustainable Future' programme began, with six strategic projects including income generation, culture & engagement and technology
- We won £1.3 million from the Department of Health, to improve energy efficiency - one of only a few hospitals in the North West to receive money, thanks to our successful track record of going green
- Ann Barnes, chief executive visited over 600 staff as part of our Francis Report listening exercise. Key feedback was put into themes and fed into the organisational development strategy

### **Patient improvements**

- We introduced new standards to reduce noise at night so that our patients can have a better night's sleep
- Our new compassion in practice strategy was launched to ensure the best possible care and outcomes with six areas of action
- We introduced top of the range trolleys to keep our patients food piping hot on its way to the wards
- We completed a major make-over of our maternity unit from Department of Health funding, which included facilities for partners to stay overnight and en-suite bathrooms
- MedEquip4Kids chose our Tree House children's unit as its main fundraising project for the year, to raise money for a new play area

### **Awards and achievements**

- Our volunteer, Charles 'Skip' Hamilton, won the regional category of the 'Pride of Britain' awards. His work entertaining children featured on Granada Reports
- We were the only Trust in the country to win three awards at the Student Nursing Times Awards - Student placement of the year (B3 ward), Mentor of the year (Stella Ross) and Partnership of the year (shared with Manchester Met University)
- Dr Philip Lewis and Maureen Holland received the international Alberto Ferrari prize for their work around blood pressure
- 26 volunteers were thanked for a total of 265 years of generous and dedicated service
- Our mortuary team was a Health Service Journal finalist in the 'Improved Partnerships between Health & Local Government' category, for their service redesign work
- Our staff gala awards celebrated excellence across our organisation
- We won a Stockport Council Young Stars Award for our work with young people - apprenticeships, work experience and volunteering
- Suren Beebakhy, Tameside community nurse was one of four finalists for a national Patient's Choice Award, organised by Nursing Standard magazine

- We retained our UNICEF baby friendly level 3 assessment, one of only a small number of units to achieve it

### **Communications and publicity**

- Nicola Hadfield, community healthcare assistant in respite care was applauded in the Daily Mail as a 'Health Hero' for her remarkable commitment to patients
- Our emergency department was applauded 'live' on national BBC news with the health correspondent praising the "calm professionalism" of our staff
- Our chairman and non-executive directors rolled up their sleeves to work on our wards, helping nurses and patients for half a day
- We received publicity across the globe for a UK first operation using fluorescent dye to remove a cancerous kidney tumour
- The stroke unit hosted its first wedding reception for one of the patients
- Our consultants gave expert opinion on national BBC news stories, commenting on the importance of post-operative care and managing A&E patients
- BBC Radio Manchester broadcasted its three hour breakfast show live from our hospital, with a wide range of features and interviews
- The National Institute for Health and Clinical Excellence chose our hospital site to host a special Question Time session
- Andrew Bingham, Conservative MP for the High Peak worked on our specialist spinal ward D4 as a healthcare assistant



A D L Barnes  
**Chief Executive**  
 29 May 2014

## 2.2 STRATEGIC REPORT

### FINANCIAL REVIEW

We are pleased that the Trust ended 2013/14 with a surplus of £0.9m, £5m ahead of plan in what was our most challenging financial year to date.

Monitor, our regulator's new Risk Assessment Framework, measures whether the financial position at a Trust could put the Continuity of Services at risk. The Continuity of Service Risk Rating (CoSRR) is scored from 1 to 4, and the Trust's 2013/14 financial position delivered a 4, which means.

The accounting regime surrounding our Charitable Funds changed in 2013/14 and now required to report them "consolidated" into our financial position. Our "Trust" financial position, excluding the charitable funds, is presented alongside in our Annual Accounts. This section of the report covers the Trust position.

Our financial position included the delivery of £9.3m of savings, known as our Cost Reduction Programme (CRP). All cost reduction schemes were assessed for the impact they might have on the quality and safety of the services we provide, to ensure that there were no adverse impacts and that costs were reduced safely. The Trust has also continued to periodically run the Mutually Agreed Resignation Schemes (MARS) under which a number of staff left the organisation during 2013/14.

The difficult economic climate is likely to continue for at least the next few years, and therefore we aim to plan ahead with our savings programmes to support this. However, in 2013/14 we still fell short of the internal savings plan we had set of £15.1m, and this will make 2014/15 even more challenging, especially as £2.2m of the £9.3m savings were non-recurrent.

Despite the difficult financial climate the Trust has continued to invest to improve services for patients, both in terms of improving the quality and safety of our services and also investments in buildings and equipment. In 2013/14, we commenced building a new state-of-the-art kitchen costing £3.8m, including investing in the newest technology available in food trolleys – to keep the food hot on its way to the wards.

The table below details our performance against the key financial performance indicators:

	2013/14 Plan	2013/14 Actual	2013/14 Variance	Result
<b>Financial Metrics (CoSRR)</b>				
Capital Service Cover (times)	1.42	2.38	0.96	✓
Liquidity (days)	24.8	32.6	7.8	✓
<b>Continuity of Services Risk Rating</b>	<b>3</b>	<b>4</b>	<b>1</b>	<b>✓</b>

<b>Financial Metrics (FRR)</b>				
EBITDA Achieved (%)	100%	162%	62%	✓
EBITDA Margin (%)	2.7%	4.2%	1.5%	✓
Net Return after Financing (%)	-2.30%	0.6%	2.9%	✓
I&E Surplus Margin (%)	-1.30%	0.3%	1.6%	✓
Liquidity (days)	52.2	59.5	7.3	✓
<b>Financial Risk Rating</b>	<b>2</b>	<b>3</b>	<b>1</b>	<b>✓</b>

<b>Prudential Borrowing Code</b>	<b>Compliant</b>	<b>Compliant</b>	<b>Nil</b>	<b>✓</b>
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## **Going Concern**

The Trust is required to assess its ability to continue as a going concern over the next 12 months, and into the future, as part of preparing the Annual Accounts and as required by International Financial Reporting Standard 1 (IFRS 1). This is done by considering the information available about the future prospects of the Trust as at the 31<sup>st</sup> March 2014, including the Trust's assessment of the future cost reduction and productivity improvements required to enable it to manage through the difficult economic climate facing it in the foreseeable future. The Financial and Governance risks assessed by Monitor are also examined as well as additional operational risks such as the loss of key personnel.

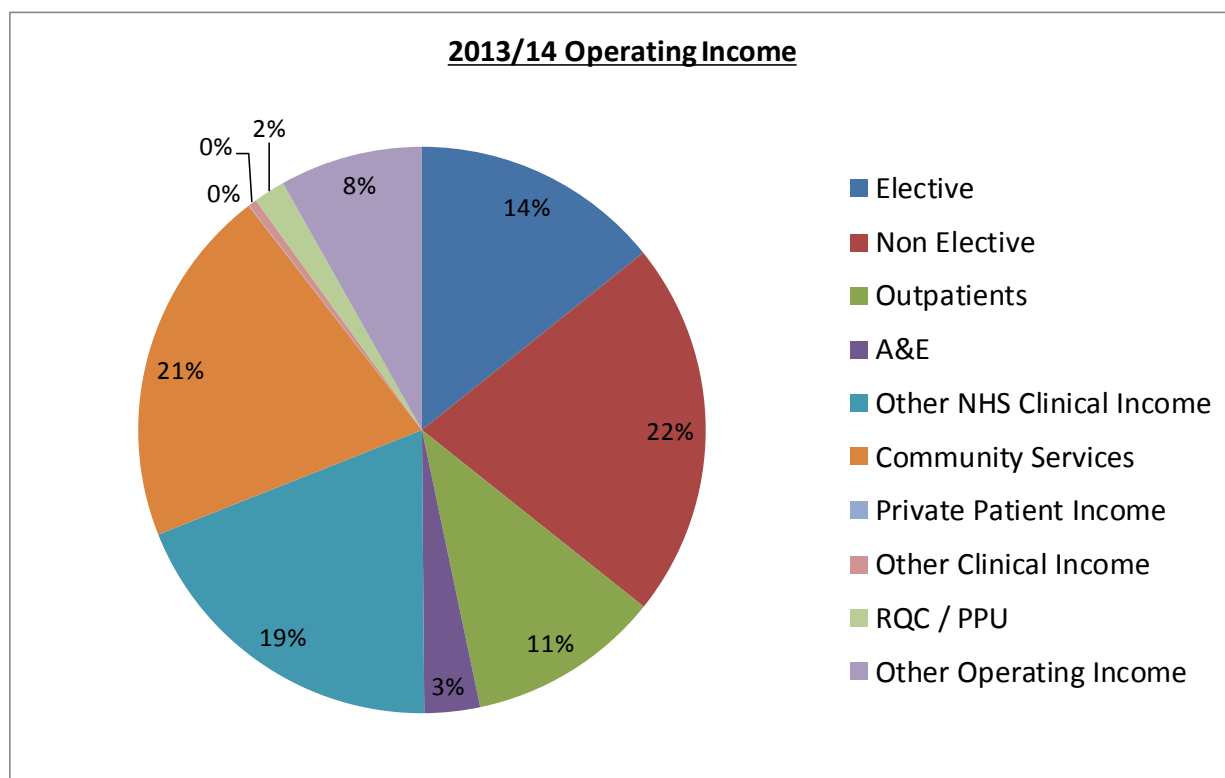
A very detailed paper covering all the risks and opinion drawn from this analysis was presented to and discussed at the Audit Committee on 20<sup>th</sup> May 2014, alongside the Annual Accounts. This paper concludes that whilst 2014/15 will be even more challenging than 2013/14 and despite considerable risks due to the size and deliverability of the required savings, that due to its strong cash and working capital position, the Trust believes it is a going concern, and has taken steps to ensure this remains the case for at least the next 12 months.

After making enquiries, the Directors have a reasonable expectation that Stockport NHS Foundation Trust has adequate resources to continue its operations on an on-going basis for the foreseeable future. For this reason, the Directors continue to adopt the going concern basis in preparing the accounts.

## **Income and Expenditure**

A £0.9m surplus was reported at the end of 2013/14.

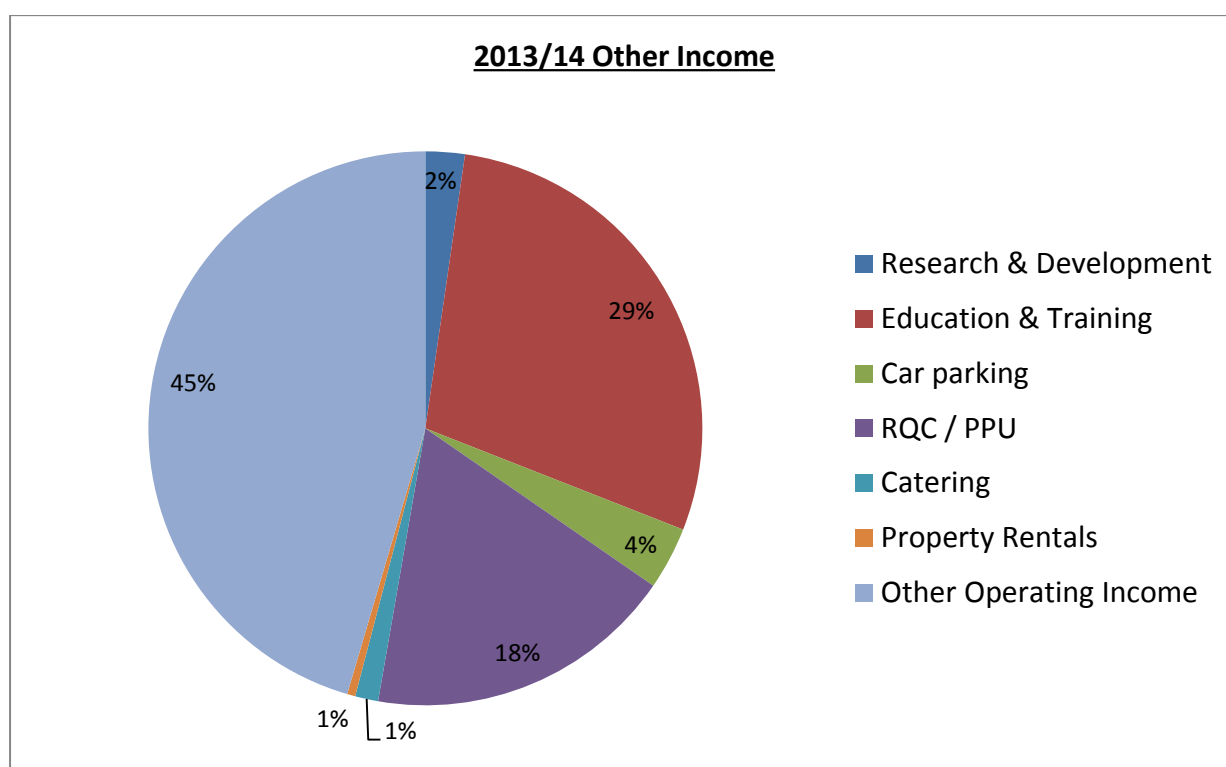
In 2013/14 our overall income was £293.8m (£290.2m in 2012/13). This comes from various sources, as shown below:



Actual income was higher than planned levels in several areas, the main reasons being outpatient income which was significantly above plan due to additional referrals following the public health cancer screening campaigns, national A&E funding, negotiated additional support for urgent care costs from our Commissioners, a planned deferred income release and several additional Community Services were commissioned in-year, such as an Integrated Diabetes Service in Tameside & Glossop.

The Trust confirms that income from the provision of goods and services for the purposes of the health service in England was greater than its income from the provision of goods and services for any other purpose.

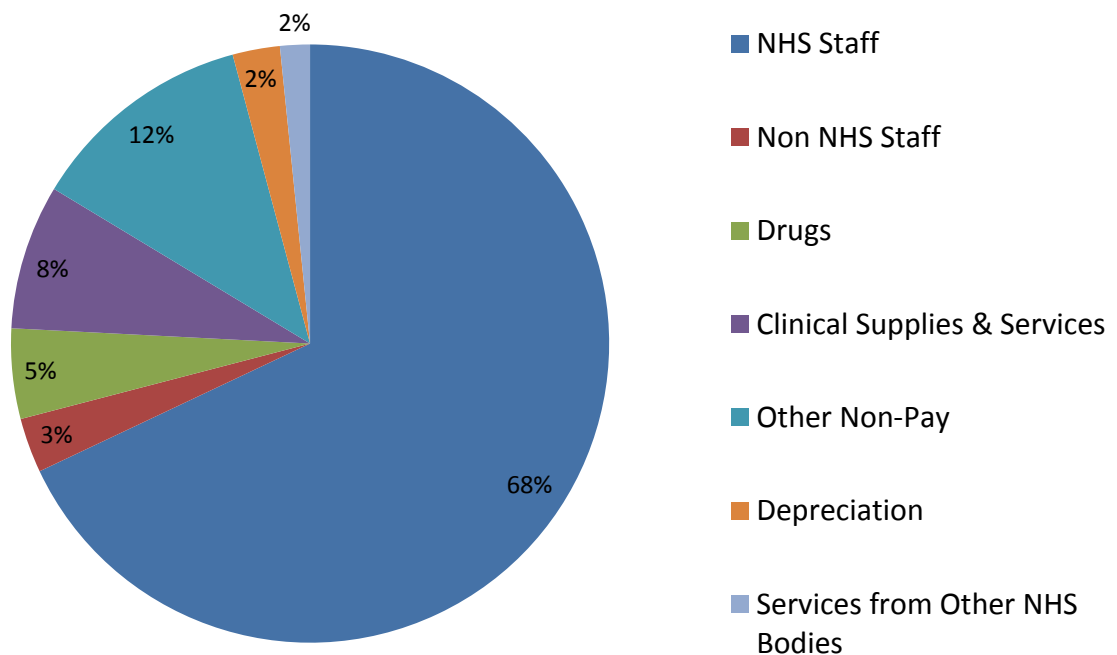
The Trust's breakdown of Other Income is shown below. Most of the income has a direct offsetting expenditure relating to the same subject as the income.



Operating expenditure was £288.8m (£283.8m in 2012/13), the increase in-year being due to the costs of additional wards and supporting costs being put in place to cover urgent care costs. The Trust also opened an Ambulatory Care Unit (ACU) and Short Stay Older People's (SSOP) Unit in year.

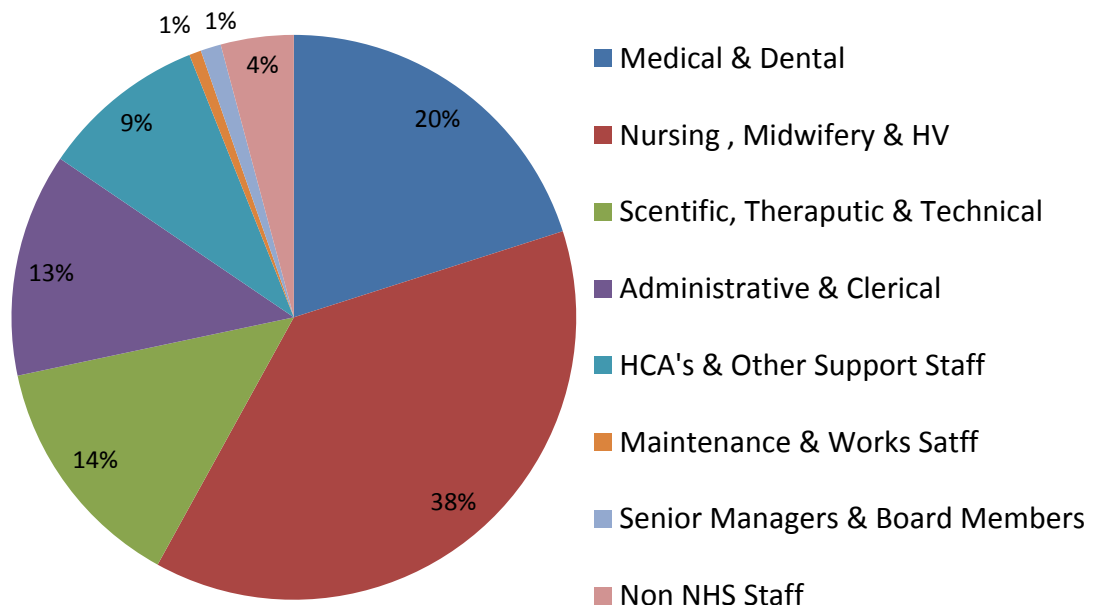
The Trust's costs are split over the following areas:

### 2013/14 Operating Expenses

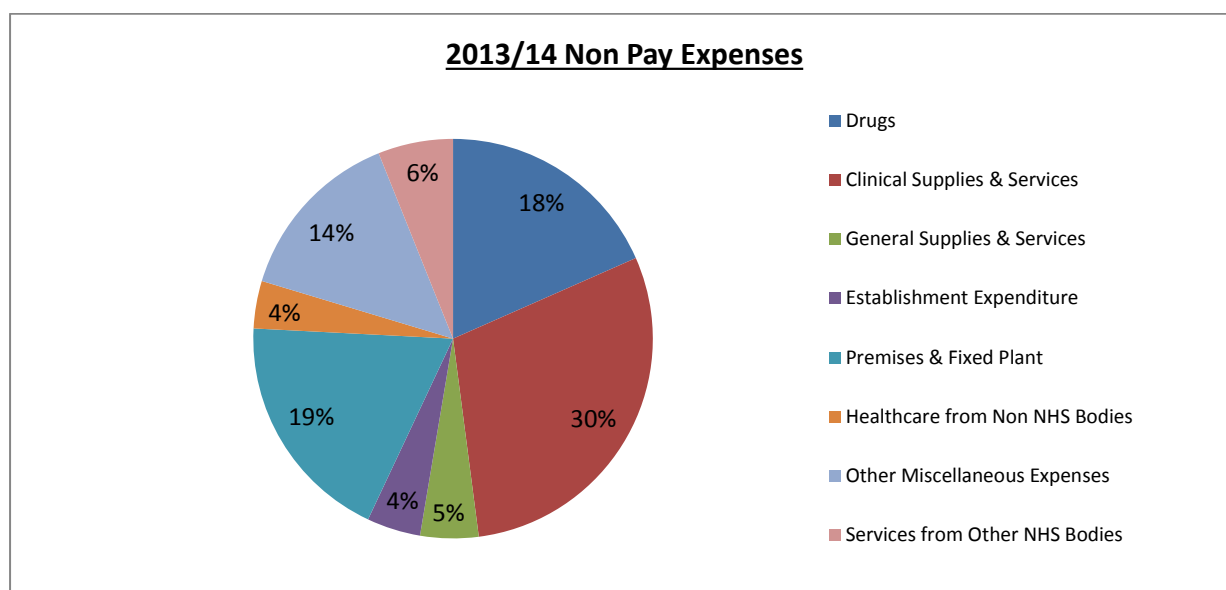


Pay is 73% of our operating expenses, and our pay spend is split over the following categories:

### 2013/14 Pay Costs



Completing the picture, we spend our non-pay on the following:



### **Balance Sheet**

In 2013/14 we spent £9.4m (£6.6m in 2012/13) on our capital programme. This included £1.2m we received from the Department of Health to improve our energy efficiency. We also invested £2.9m in improving our IT infrastructure, including electronic scanning of records and beginning the implementation of electronic whiteboards on wards to improve patient safety. £1.2m was spent on replacing and purchasing new items of medical equipment. Installing CCTV and other site security measures totalled a further £0.7m. The capital programme also included estate refurbishment, maintenance and renewal projects.

The regulations around the calculation of the Public Dividend Capital changed in-year, and therefore it is no longer worthwhile for the Trust to place commercial investments as we then pay more. Therefore we only earned £0.1m interest during 2013/14 compared with £0.3m in 2012/13.

Our year-end cash balance was £46.6m, which represents 33 days liquidity. This is a decrease from our opening cash position of £50.5m. This is mainly due to a higher than normal balance at the end of 2012/13 due to the demise of PCTs.

The Trust decided not to renew its working capital facility with Barclays Bank in March 2014, due to the Trust's strong cash position, and the requirement to have a working capital facility in place having been removed by Monitor.

### **Charitable Funds**

The Board acts as Corporate Trustee in respect of its charitable funds. During 2013/14 a detailed consideration of whether to consolidate our Charitable Funds into our group accounts, or not was undertaken and the Corporate Trustee decided to consolidate. Therefore our primary statements in our Accounts show the Consolidated or group position, including the Charitable Funds and the unconsolidated Trust position.

Copies of the separate Annual Report and Accounts for these charitable funds (Registered Charity Number 1048661) are still available on request from the Director of Finance, or from the Charities Commission website [www.charity-commission.gov.uk](http://www.charity-commission.gov.uk).

The Charitable Funds Committee oversees the management of the Charitable Funds, and their policy remains one of annual spending in line with the continuing levels of bequests and donations received in the year. This accords with the aims and objectives approved by the Charities Commission, for NHS charities in general.

In 2013/14, incoming resources for charitable funds was £0.2m and total resources expended £0.3m. The charitable funds spent £0.1m on capital equipment including £31k introducing digital signage in Stepping Hill Hospital, £18k on a scalp cooling system in the Laurel Suite and £20k on improving the Bobby Moore Unit. Additionally the funds purchased £16k of neonatal equipment, an £8k bladder scanner from the Prostrate Cancer Fund and £8k on a refractometer for Ophthalmology. Charitable Funds were also used to improve patient welfare at a cost of £51k and £24k was spent on staff welfare to support staff in their duties.

### **Regulatory Ratings**

The Trust is rated quarterly by Monitor, the NHS Foundation Trust regulator, on two aspects:

- Financial performance;
- Governance.

and given a risk rating for each of these.

The tables below identify the Trust's performance against our planned risk rating performance in 2013/14, with 2012/13 also shown as a comparison. This is shown both against the Compliance Framework Risk Ratings in place during Quarters One and Two in 2013/14, and the new Risk Assessment Framework's rating systems which came into place in Quarter Three 2014/15. Further details of the criteria used to determine these risk ratings can be found in the Risk Assessment Framework, on Monitor's website [www.monitor-nhsft.gov.uk](http://www.monitor-nhsft.gov.uk).

	Annual Plan 2013/14	Q1 2013/14	Q2 2013/14	Q3 2013/14	Q4 2013/14
<b>Under the Compliance Framework:</b>					
Financial Risk Rating	2	2	3		
Governance Risk Rating	RED	RED	RED		

<b>Under the Risk Assessment Framework:</b>					
Continuity of Service Rating				4	4
Governance Rating	RED	RED	RED	RED	RED

	Annual Plan 2012/13	Q1 2012/13	Q2 2012/13	Q3 2012/13	Q4 2012/13
<b>Under the Compliance Framework:</b>					
Financial Risk Rating	3	3	3	3	3
Governance Risk Rating	Amber Red	Amber Red	Red	Red	Red



The Trust received notification that it was in breach of its Terms of Authorisation due to our A&E performance in January 2013. On the 24<sup>th</sup> April 2013 the Trust signed Enforcement Undertakings with respect to improvements in our A&E performance reassurance on our governance structures. This can be viewed on Monitor's website. Members of the Board of Directors are currently required to meet with Monitor monthly to monitor progress on these areas, and Monitor has taken this opportunity to recently express concern about the 2014/15 CRP progress.

## **Financial Outlook**

### *Finance and Operations*

2013/14 was an incredibly difficult financial year which commenced with a planned deficit, and whilst we met our CRP target, we didn't meet our internal stretch target, and only delivered a significant proportion non-recurrently.

The challenge in 2014/15 is the larger than in 2013/14. We have a £16.9m financial gap, and have not yet fully identified savings to bridge this. We therefore have a planned £4.9m deficit for 2014/15, and a £12.0m savings challenge. In order to support us in identifying and implementing savings we have appointed a Turnaround Director.

2015/16 looks to be an equally challenging year, which after taking account of the brought forward planned deficit position from 2014/15, the CIP requirement to deliver a surplus to cover our loan payment is estimated to be £21.4m.

Whilst these are extremely challenging financial targets, the Trust has launched the "Building a Sustainable Future" (BSF) transformation programme to drive these savings safely from our cost base. The BSF programme is underpinned by an Engagement and Communication strategy, to ensure that our whole organisation is working towards the same goals.

The financial plans still include implementing some exciting developments such as Patientrack, a vital signs monitoring system which will greatly improve patient care. We are also continuing to work towards a Full Business Case for D-block, a £17m surgical and short-stay medical ward development. For this reason, the Trust's financial plans for the next three years focus on securing quality and sustainability. However, our plans do only include proposals for new developments or investments where there are distinct funding streams, they enable further efficiency schemes or there are direct links to safety and quality of patient care.

We believe that the only way for the longer term financial challenge to be met will be through closer working with our partners in the wider Stockport health economy, and through transformational change and collaboration across the Southern Sector and wider health economies.

### **Challenges to meeting national service standards**

As previously mentioned, the Trust continues to face challenges in consistently meeting the A&E 4 hour target, particularly due to difficulties in recruiting additional senior medical staff in this national shortage area. Due to this, the Board of Directors has decided to declare a forward risk of not achieving this target in 2014/15 in the Governance Declarations to Monitor, the Trust's Regulator.

Over the past few months the Trust has experienced exceptionally high levels of increased referrals in Orthopaedics, particularly for foot and ankle and knee surgery. The CCG has

reassured the Trust that it is putting in place plans to reduce referrals. Therefore the Trust is not formally declaring a forward risk on its ability to meet the 18 week Referral to Treatment (RTT) target, however this is dependent on the CCG's actions, particularly with respect to knees.

Due to the knock-on effects of the challenges faced with complex cancer pathways involving more than one provider, in meeting the Cancer target in the last two quarters of 2013/14, there is a risk that the target will be difficult to achieve in the first quarter of 2014/15. For this reason, we have declared a forward risk against this target, although we expect to meet it for the remainder of the year.

### *Capital*

We are planning to spend £11.9m on capital in 2014/15, compared to £8.8m in 2013/14.

The key investments planned for the coming year include:

- D block new ward and theatre complex (£5.1m)
- Completion of the new kitchens and associated equipment (£2.5m)
- IM&T infrastructure including implementation of Patientrack, a vital signs monitoring system (£1.9m);
- Medical Equipment replacement and advancement (£1.2m).

## **2.3 MAIN TRENDS AND FACTORS**

### **2.3.1 MAIN TRENDS AND FACTORS LIKELY TO AFFECT THE FUTURE DEVELOPMENT, PERFORMANCE AND POSITION OF THE NHS FOUNDATION TRUST**

#### **Health and Wellbeing in and around the Stockport and High Peak areas**

The populations of Stockport, High Peak and Tameside and Glossop are diverse neighbourhoods stretching from the urban borough of Stockport and the nine towns that compose Tameside, which contrast sharply with the more rural areas in High Peak and Glossop.

#### **Health inequalities - Stockport<sup>1</sup>**

Overall Stockport is similar to the national average for deprivation, although it includes some of the most affluent areas in the country; it also has some of the most deprived. Although life expectancy has improved in all areas of Stockport over the past 20 years; marked inequalities still remain.

The main causes of death are heart disease, cancer and respiratory disease, which together account for 75% of all deaths. These diseases link strongly with poor lifestyle choices: smoking, alcohol, poor diet and inactivity. There are also inequalities associated with mental wellbeing in Stockport. Reducing inequalities in health is a key priority for Stockport, and this is reflected in the priorities of the Health and Wellbeing Strategy.

#### **Health inequalities – High Peak<sup>2</sup>**

The health of the people of High Peak is generally better than the England average. Deprivation levels are low and life expectancy for men is higher than the average for England. However rural deprivation is often hidden by traditional indicators.

#### **Health inequalities – Tameside and Glossop<sup>3</sup>**

The life expectancy for men and women in Tameside and Glossop remain below the average for England. As with Stockport, some of the lowest rates of life expectancy are found in the most deprived wards in the borough.

#### **An aging population, and increasing levels of long term health conditions**

Despite improvements in health, demand for NHS services continues to rise. Many people are now living with one or more long term conditions (e.g. asthma, diabetes, dementia). All of the boroughs served by the Trust are experiencing an ageing population which is forecast to become increasingly older and an expectation of and requirement for increasing access to healthcare. This is occurring at a time when medicinal advancements are pushing the boundaries of what is achievable, but at a cost. These trends are seen clearly in the year on year rise in A&E attendances and unplanned admissions to hospital.

#### **Health and wellbeing strategies**

The three local communities that the Trust serves have developed their Health and Wellbeing Strategies, based on the analysis of the needs of the population. These Strategies set out the main focus for improving health and wellbeing and are broadly similar. This provides the one of the foundation stones of the commissioning plans of the local Clinical Commissioning Groups (CCGs).

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<sup>1</sup> Health Inequalities, A refresh April 2013, Stockport Joint Strategic Needs assessment, and 21<sup>st</sup> Annual Public Health Report for Stockport

<sup>2</sup> Profile of High Peak. Public Health contributing to the Joint Strategic Needs Assessment process 2012, Derbyshire County

<sup>3</sup> Tameside and Glossop Joint Strategic Needs Assessment 2011-12

Health and Wellbeing Strategies for populations served by the Trust			
Themes	Stockport 2012-2015	Tameside & Glossop 2013-2016	High Peak (Derbyshire) 2012-2015
	Children and families	Starting well – ensuring the best start in life for children	Improve health and wellbeing in early years
		Developing well – enabling all children and young people to maximise their capabilities and have control over their lives	
	Leisure, activity and healthy weight	Living well – creating a safe environment to build strong healthy communities and strengthening ill health prevention	Promote healthier lifestyles
	Mental wellbeing		Improve emotional and mental health
	Alcohol		
		Working well – creating fair employment and good work for all	
	Prevention and maximising independence for everyone	Being well – promoting independence and working together to make Tameside a good place to grow old	Promote the independence of people living with long term conditions and their carers
	Healthy ageing and quality of life	Dying well – ensuring access to high quality care to all who need it	Improve the health and wellbeing of older people

### Other Challenges facing the Trust and the Health Community

The UK continues to face an extremely challenging economic situation, and the recovery has been slower and more difficult than first envisaged by the Government. The NHS is also facing funding pressures, which are occurring alongside the introduction of the new 2012 Health Act that brought about a dramatic restructuring of the NHS. This includes a greater focus on clinical leadership, clinically lead commissioning and the quality of care, combined with closer integration with social care, which locally results in a planned shift of £10m of resources from health to the social care sector in 2015/16 as part of the Better Care Fund. The Trust anticipates a minimum year-on-year financial pressure of 5% to result from these conditions, and will need to implement significant changes in the way it operates to meet these challenges.

The Trust is actively involved with the transformational change that is taking place across Greater Manchester, with its Southern Sector Partners (University Hospitals South Manchester (UHSM), Tameside NHS Foundation Trust and East Cheshire NHS Trust). This work is identifying opportunities for collaboration, and in a number of cases, move to one service across providers that can improve patient care and sustainability as well as respond to the challenges identified by the Greater Manchester CCG's led review of health services across the conurbation, "Healthier Together". This is likely to lead to some changes in the configuration of services and consultation on related proposals is expected during 2014/15.

The Trust is also part of one of the eleven health economies selected by Monitor to gain additional strategic planning support in producing the five year strategic plan due to the scale of challenges faced by the four providers and six CCGs in the health economy.

The Trust has continued to experience significant pressures on its A&E and unplanned care services over the last year, and as result it has not consistently achieved the 4 hour A&E standard. Risks to other targets have also been identified and addressed during this period. Without further change to the way services are provided, these risks will remain going into the new planning period.

The number of births at the Trust have been falling over the past two years. The Trust is reviewing the reasons for this, and despite the financial pressures it has caused is investing further in this high quality service with the creation of an ambulatory labour area for women in the early stages of labour. This will be particularly helpful for women and their partners from the High Peak area, as it will reduce the number of journeys they need to make to the hospital.

The Trust has developed an on-going dialogue with Governors about its priorities and strategic plans through quarterly Council of Governors meetings and governors sub-committees for

governance, membership and patient safety and quality. The further reaching changes of the local economy plans are subject to public consultation via the CCG.

### **Planned reduction of expenditure**

2014/15 will be the most challenging year yet faced by the Trust, we expect the following three years to continue to be very challenging due to the economic environment in which we operate. This has been discussed further in the Financial Review earlier in this report.

### **Challenges to meeting national service standards**

This is covered on page 17.

### **Workforce challenges**

Whilst the Trust has an average staff turnover rate of approximately 10%, there are a small number of areas where it is harder to recruit, for example medical consultants and middle grade doctors in some specialties. These areas generally reflect the national shortage areas with the main area being emergency medicine. This has in part been exacerbated by our intention to extend the senior medical presence in the A&E department by increasing our number of consultants. Plans have been developed to respond to this challenging recruitment which should start to have a positive impact in 2014/15.

The Trust continually reviews its plans around nurse recruitment, and a programme of events will take place during 2014/15 commenced with a recruitment day for qualified nurses in April. This supports plans to reduce the requirement for temporary nursing staff, where appropriate, thus improving the continuity of care, and reducing costs while building a more sustainable workforce. However, we will consider new and innovative approaches to recruiting and retaining staff; particularly as the competition for nurses will increase following the national recommendations on staffing numbers.

### **Responding to the Challenge**

The Trust recognises the challenges it faces, and is committed to a comprehensive and solution focused approach to addressing these. The Trust's response has been developed both top down and bottom up, drawing on clinical and managerial expertise. The review of local challenges has not been introspective; instead the Trust with the local partners have considered the national policy agenda, and what this means for the local health and care economy. The actions the Trust intends to take over the next two years are broad-based and ambitious, as many require partnership working. The Trust believes our plans give the Trust the best opportunity of ensuring we "Build a Sustainable Future", and maintain a high quality service for our patients. In 2012/13 the Trust set out its three year strategic direction, which is encompassed in the four priorities:

#### **Quality**

Deliver safe, effective and compassionate care, that meets national standards and gains positive patient feedback

#### **Partnership**

Work with all our partners such as the Southern Sector Partnership trusts to provide excellent care, 24/7; sharing expertise, skills and facilities in clinical and non-clinical services

#### **Integration**

Integrate appropriate hospital and community health services with social and primary care, to provide high quality care in the community through the creation of locality teams in Stockport. The proposed model is focused on adults with complex needs and based on one referral and assessment route, one integrated care plan and record, one contact point and one pooled commissioning budget

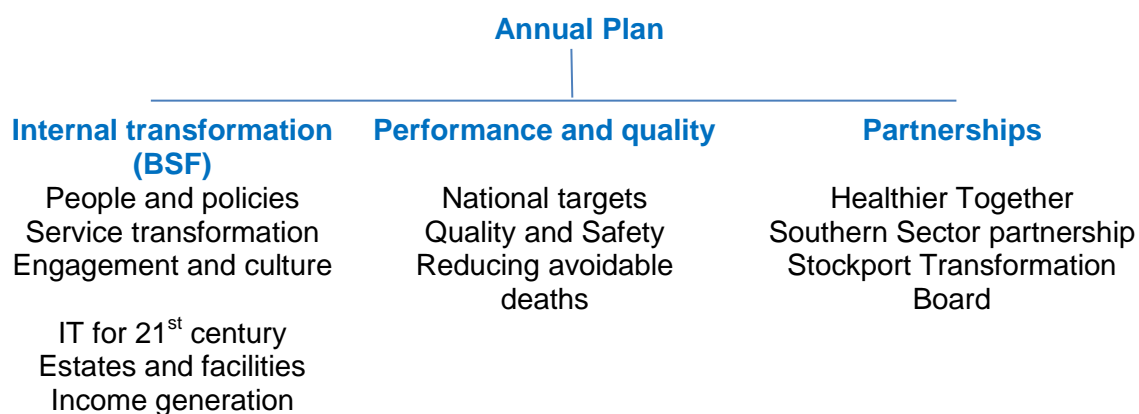
#### **Efficiency**

Achieve the required efficiency savings each year, avoiding waste and duplication whilst investing in IT, organisational development and modernising both hospital and community facilities

The difference we want to make for our service users for each strategic priority is described by two strategic outcomes, which translate the priorities into the tangible benefits we want to achieve.

Priority	Strategic outcomes
Quality	<ul style="list-style-type: none"> <li>Patients health and well-being is supported by high quality, safe and timely care</li> <li>Patients and their families feel cared for and empowered</li> </ul>
Partnership	<ul style="list-style-type: none"> <li>The Trust is an effective member of a modern and innovative health care community</li> <li>Effective and efficiently run services across the Southern Sector partnership</li> </ul>
Integration	<ul style="list-style-type: none"> <li>Patients' lives are easier because they receive their treatment closer to home</li> <li>Patients' receive better quality services through seamless health and social care</li> </ul>
Efficiency	<ul style="list-style-type: none"> <li>The Trust is able to demonstrate to Governors, local residents, partner organisations and regulators that it makes the best use of its resources</li> <li>Trust staff are enabled to deliver their best care within a high quality environment</li> </ul>

The Trust is focusing its improvement efforts on these Strategic Outcomes over the next two years. These improvement objectives will be delivered through our existing internal and externally facing work programmes. The internally focused work programmes are designed to increase efficiency and build sustainable services, as well as improving our performance. Complementing this is the predominately externally facing work programmes looking at integrating services, and the shift from acute to community based care. This includes Healthier Together review, Southern Sector Partnership collaboration, and our work within Stockport which includes the Local Authority, the CCG and other agencies.



These work programmes will be underpinned by comprehensive programme management arrangements. Through our refresh of the appraisal process, the annual objectives for all staff will be clearly linked to the delivery of these plans, and hence the Trust strategic priorities.



## Alignment of plans with local and national priorities - building a safe and sustainable service

The Trust priorities, underpinning strategic outcomes and improvement objectives for 2014-16 contribute towards the delivery of national outcomes as laid out in the three Frameworks for health, public health and social care, and supports the delivery of the Health and Wellbeing Strategies as well as the local CCGs priorities.

### Alignment of local and national improvement plans

Trust Strategic Priority	Trust Strategic Outcomes	Aligned with local health and wellbeing strategies	Aligned with Stockport CCG strategic priorities	Contributing to the delivery of the National Outcomes Frameworks	Monitor / CQC requirements
Quality	Patients health and well-being is supported by high quality, safe and timely care	✓	✓	NHS, Social Care, Public Health	✓
	Patients and their families feel cared for and empowered	✓	✓	NHS, Social Care	✓
Partnerships	The Trust is an effective member of a modern and innovative health care community		✓	NHS, Public Health	✓
	Effective and efficiently run services are available across the Southern Sector partnership		✓	Public Health	✓
Integration	Patients' lives are easier because they receive their treatment closer to home	✓	✓	NHS, Social Care	✓
	Patients' receive better quality services through seamless health and social care	✓	✓	NHS, Social Care, Public Health	✓
Efficiency	The Trust is able to demonstrate to Governors, local residents, partner organisations and regulators that it makes the best use of its resources		✓	Public Health	✓
	Trust staff are enabled to deliver their best care within a high quality environment		✓	NHS, Social Care, Public Health	✓

The detailed delivery of the 2014-16 Trust Improvement Objectives are set out in the Operational Plan, which is arranged under the four priorities of **Quality, Partnership, Integration** and **Efficiency**.

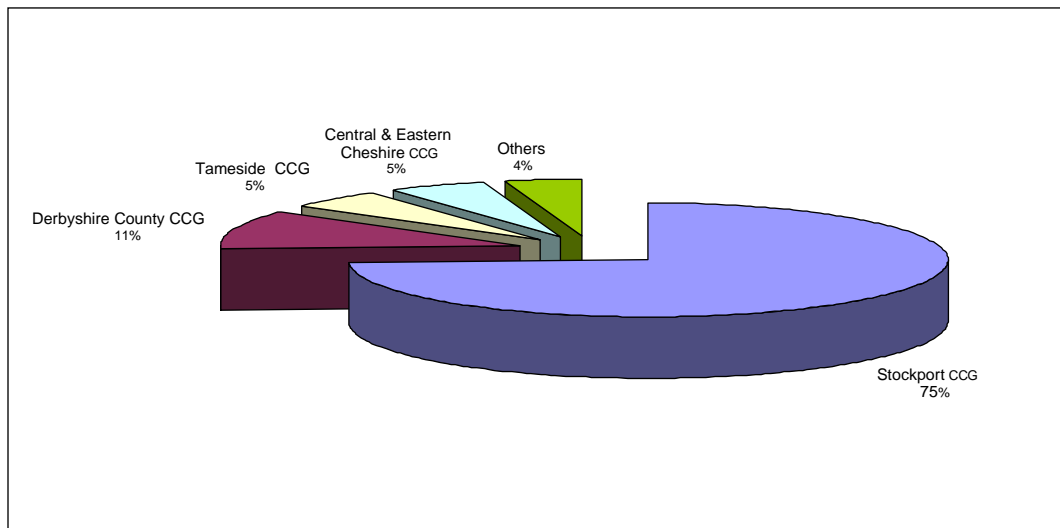
A workshop was held with our Governors to discuss our forward Operational Plan, and a further workshop is planned to be held in June 2014 prior to the submission of the Strategic Plan to Monitor to discuss this.

The Operational Plan is published on the Trust's internet site or is available upon request from the Communications department at the Trust Headquarters

### 2.3.2 REFERRALS AND ACTIVITY

The Trust continues to receive a stable level of demand across its services from its four main Commissioners.

The chart below shows the approximate 2013/14 share of Trust income on a Commissioner basis.



Overall, the year saw a steady increase from 12/13 in the number of referrals received from GP's (4.3% or 2700), creating some major demand and waiting time pressures, particularly in Orthopaedics. The overall number of Outpatient attendances increased overall by 5% above last year, with an increasing proportion of new patients being seen.

Considering the above pressure the Trust performed well against the national 18 week waiting time standards. In aggregate, consistently achieving over 95% for non-admitted care and over 90% for admitted for 10 of the 12 months.

During 2013/14, there was only a 2% increase in emergency demand, although this hides greater pressures felt in Medicine, which were 9% above plan. This skew made it a very challenging time for managing bed capacity, especially as there was increased acuity and increasing numbers of delayed discharges.

Emergency Department attendances reduced by 3% when compared to the 12/13 level. However, this reduction masked increasing pressure on ED due to the higher levels of patient acuity (as demonstrated by the HRG mix) and an increased admission rate, which resulted in the 4hr requirement not being met in year, despite best efforts.

The 2week, 31 day and 62 day complex mix of Cancer network access standards were fully met for each of the 4 quarters.

The number of births reduced (circa 4% or 150), when compared to 2012/13. This is as a result of improving levels of services in some neighbouring Units, in particular UHSM, which has led to a reduced market share for our local services.

Community services across Stockport and Tameside & Glossop delivered over almost 2 million patient contacts during the course of 13/14.



## 2.4 SUSTAINABILITY REPORT

### Background

In accordance with the Climate Change Act 2008, as amended 2009, carbon emissions for the budgetary period including the year 2020 must be such that the annual equivalent of the carbon budget for the period is at least 34% lower than the 1990 baseline.

In addition, carbon emissions for the budgetary period including the year 2050, must be such that the annual equivalent of the carbon budget for the period is lower than the 1990 baseline by at least 80%. The Foundation Trust recognises many reasons to maintain its strong commitment to reduce directly generated and consequential carbon emissions which include:

- Extreme weather events are becoming more common;
- The 10 warmest years on record have occurred since 1990;
- Warming of the climate system is unequivocal: 11 of the last 12 years rank among the 12 warmest years since records began in 1850;
- Most of the observed temperature increase is very likely to be due to the observed rise in greenhouse gas concentrations; and
- The projected global temperature increase over the next 50 – 100 years is likely to be in the range of 2 – 4.5oC, with a best estimate of about 3oC.

### Strategic Approach

Launched in 2008, our Carbon Management Implementation Plan (CMIP) continues to reduce carbon emissions through:

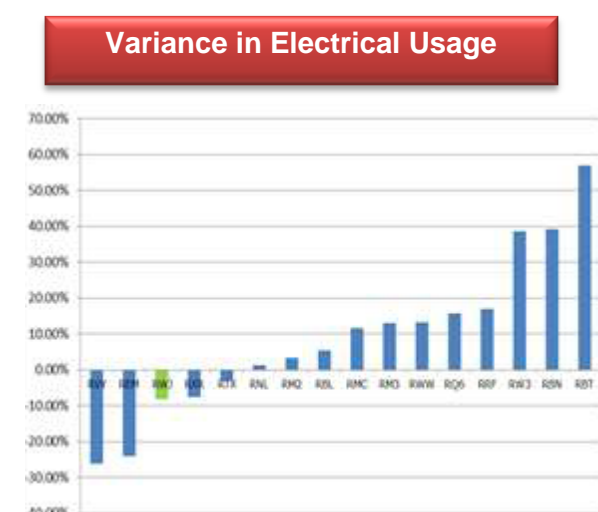
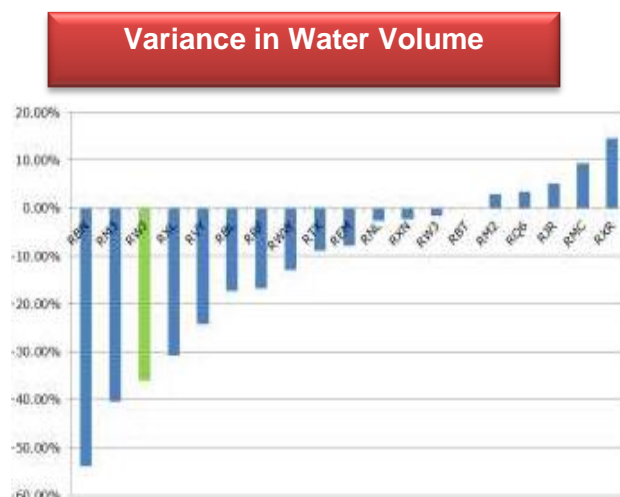
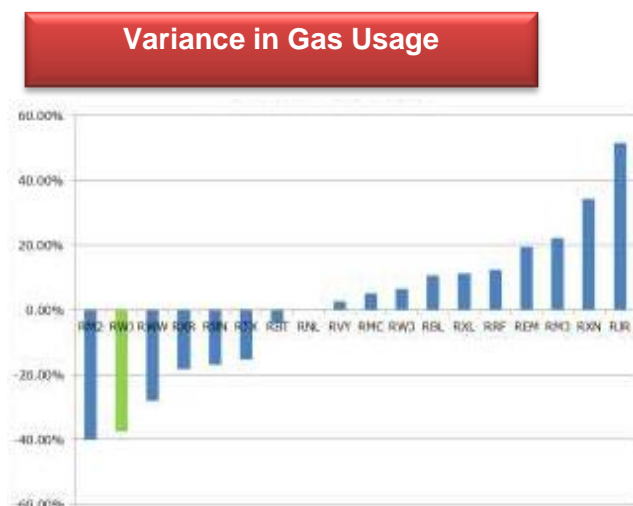
- Reduced energy use through rationalisation and efficient design
- Implementation the Green travel plan through the provision of low carbon travel, transport and access
- Local procurement and food
- Reduction in, and recycling of waste
- Reduction in water use and associated waste
- Organisational and Workforce Awareness and Development
- The Role of Partners, Stakeholders and Networks
- Governance and Assurance

The Trust's CMIP continues to deliver significant 'carbon savings' through combined traditional process and design innovation including:

1. Being first to introduce new technology including enzymatic food waste digestion (saving 8000m3 of mains water per annum – preventing 135T per year of food waste previously discharged to the sewer)
2. Installing evaporative cooling within our IT server room (saving £20,000 p.a. in electric via air conditioning). This initiative has shown the potential to save nearly 10% of the Trusts electric bill and considerable gas usage when fully implemented.
3. Installation of carbon dioxide sensors – designed to minimise the actual air changes needed whilst being fully compliant with patient need

## Energy and Carbon Reduction

Our ongoing Trust wide cultural change is demonstrable in quantifiable evidence that we have delivered recurring reduced gas consumption by 30.3%, water consumption by 30% and electricity by 9%. The financial savings relating from these actions are calculated @ £ 550,000. When benchmarked against other hospitals we are consistently one of the best performing trusts – detailed as follows (Trust in Green = Stockport):



Our proactive approach was recognised by the Department of Health during the last financial year through their award of £1.32m of government funding that allowed a wide range of schemes to be undertaken including:

1. Super low loss transformers - offering the benefit of new efficient electrical infrastructure equipment that improves the overall infrastructure supporting the long term development of the Stepping Hill
2. Pipe lagging to the underground steam main to reduce the heat loss as we transfer heat from the centralised boiler to various areas across the main hospital site
3. Replacement of numerous inefficient internal and external lights – offering significant saving and improving the overall lighting levels and ambiance of the site
4. Replacement of old inefficient air conditioning units
5. Improved ventilation and general controls to ensure we switch equipment on/off at the appropriate time

The deadline was tight in terms of the delivery of projects –allowing 6 months to spend the £ 1.32m from inception and early design through to completion and handover.

The estimated energy savings from the delivery of all the projects are calculated below

<b>9. SCHEME BENEFITS</b>  <small>The Annual Revenue Savings should be based on the ERIC calculations. Calculations should be based on the same methodology as used in the tables at items 13.2 and 13.3 of the Stage 2 submission requirements guidance.</small>	(i) Existing Energy Details (Annual):	ENERGY CONSUMPTION (kWh)	CARBON DIOXIDE EMISSION (CO <sub>2</sub> ) [ tonnes]
	Fossil:	34,942,895	6,415.5
	Electricity:	11,982,789	6,286.4
	Hot Water:	0	0
	Other (please specify):	129,046 (Fuel Oil)	34.5
	(ii) Post Project Energy (Annual):	ENERGY CONSUMPTION (kWh)	CARBON DIOXIDE EMISSION (CO <sub>2</sub> ) [ tonnes]
	Fossil:	32,747,182	6019.4
	Electricity:	8,958,701	4830.7
	Hot Water:	0	0
	Other (please specify):	129,046 (Fuel Oil)	34.5
	Confirmation of what exact period of returns are projected. (Years)	<small>This should be supported in the completed and attached Annex B</small> <b>Set out within Annex B</b>	

The financial savings resulting from the significant investment are estimated at circa £ 400k that will be released over the next 2 years, reinvested via the capital programme into front line clinical services including:

- First Impression Projects – clinical staff led initiatives that create real front line improvements to the physical layout of a ward or patient facing environment
- Small Area Painting Programme – focussing on change to environments that aid the recovery of patients
- Place Inspection/Healthwatch/Governor Interventions – investing in schemes as a result of the inspection regime of public representatives
- Purchase of Equipment - Ongoing replacement medical equipment replacement programme

### Implement the Green travel plan

Our sustainable green travel plans continue to play an active part in reducing our carbon footprint through:

- The improvement in public transport access to the hospital. Many of the buses are state-of-the-art hybrid buses using an electric/diesel hybrid engine using approximately 30% less fuel and produce around 35% less CO<sub>2</sub> than diesel engine vehicles.
- Provision of secure cycle shelters across the site
- Various cyclist changing facilities

### Reduce and recycle waste

The Trust have adopted the following waste strategy, the principles of which are included within the Department of Health's guidance.



Underpinning the above strategy we work on the following principles:

1. **Elimination** of waste if we can
2. **Reduction** of waste we create
3. **Reusing** materials until we can't use them again
4. **Recycling** the waste
5. **Disposal** of the waste to landfill if all other protocols are exhausted

The concept of energy reduction is explained above

The ongoing plan to reduce physical waste streams includes:

**Recycling** – we recycle the majority of cardboard and circa 70% of our paper waste. Work is to be developed with all users to separate the paper waste at source for collection, especially in office areas where it will be easier to implement

**Food Waste** – Work continues to reduce the amount of food sent to the waste stream. All food waste is then converted into fluid using the enzyme equipment and disposed of as liquid waste

**Clinical Waste** – The Trust is rolling out its strategy to reduce circa 70% of its designated clinical waste into new waste streams that attract both reduced costs and recycling once treated. Working with its waste stream partner, the Facilities team are working with all front lines clinical services in its implementation of the new process

**'Black Bag' General Waste** – Work continues to persuade staff to segregate general waste and recyclable materials. Recognising the difficulties in implementing this strategy due to limited space for the provision of numerous recycling bins we are seeking support from the commercial market via a tender to recycle circa 70% black bag waste. This will be done at commercial recycling centres rather than at the point of waste development.

## Moving Forward

We intend to continue to embed our sustainability credentials by:

- Encouraging that all business cases consider their sustainability impact;
- Concentrating efforts to reduce carbon emissions in those areas with the largest carbon footprints;
- Demonstrable leadership on reducing carbon
- Including the concept of sustainability into all Trust policy and operational decisions
- Ensuring all new buildings meet BREEAM Excellent or Very Good standards so far as is practicable ('BREEAM' – a leading design assessment method for sustainable buildings);
- Including Climate Change resilience as an explicit factor in decision making for new affordable capital investments;
- Testing the Trust's resilience across all services highlighting, within their operational risk management systems, any major vulnerabilities to extreme weather impacts.

## 2.5 PATIENT CARE (See also Annual Quality Report, Section 4)

- **How the foundation trust has had regard to Monitor's quality governance framework in arriving at its overall evaluation of the organisation's performance, internal control and board assurance framework and a summary of action plans to improve the governance of quality**

The Monitor quality governance framework has been utilised to guide developments in the governance arrangements of the Trust over the past year. During 2012/13, the Trust had taken part in a review of its Board Effectiveness and Risk Management, and during 2013/14 the recommendations from this review were implemented. These included changes to the Board Assurance Framework, the Corporate Risk Register and other risk management processes, all of which have strengthened the Trust's quality governance.

- **Descriptions of how the NHS foundation trust is using its foundation trust status to develop its services and improve patient care**

The Trust Governors, through both the Council of Governors and its sub-committees, play an active part in developing Trust services.

- **Performance against key healthcare targets**

Healthcare Associated Infections:

2013-14 was another challenging year for the Infection Prevention service. The Trust's Clostridium difficile trajectory of 38 was achieved as there were 32 cases of acquired Clostridium difficile. The Trust also achieved 807 days without a Trust Apportioned MRSA bacteraemia and although the zero trajectory was not achieved, the 1 case in March was unavoidable.

- **Arrangements for monitoring improvements in the quality of health care and progress towards meeting any national and local targets, incorporating CQC assessments and reviews and the NHS foundation trust's response to any recommendations made.**

Monitoring of healthcare improvements at Stockport takes many forms, from steering groups or committees looking at a specific topic, to the reporting within business groups or to sub board committees on progress and any areas of concern. The key committees for this are the Clinical Effectiveness (CE) and the Clinical Quality and Safety (CQ&S), which both include commissioner attendance. At the end of 2013 a new assurance committee was introduced where the Associate Director of a business group reports to the executive team on the topics relating to their business group and to explain any areas of concern and the actions that are in place to address these concerns. A monthly Quality board report is submitted to the board to highlight any areas where we are not achieving the target and the subsequent actions. A RAG rating table is produced to demonstrate progress against CQUINs and this is shared at the CE and CQ&S committees, loaded onto the Trust Corporate Information System (CIS) and included in the quality board report which is also uploaded to CIS for managers.

Many quality topics are corporate and in addition to the above committees will also be discussed at Heads of Nursing meetings and at Business group quality board meetings. This will include items such as Infection prevention for which we have made significant improvements and we continue to remain focused on these areas.

Nursing care indicators enable each ward to see how they are performing; this data is downloaded for use by ward managers and is included in the Quality board report.

The Trust has a Matron for Quality Improvement who is also the lead on monitoring CQC compliance, working closely with the Risk and Safety Assurance Manager and liaising with Ward managers and Heads of Nursing regarding requirements. Our current registration status is Registered, we have no conditions associated to us and have not had any enforcement action during 2013/14. The Trust has not been involved in a special review in the past however the Trust was involved in a routine inspection with the inspection report published on 06 August 2013 and the Trust met all the standards inspected. (Outcomes 1, 4, 13, 14 and 21)

The Trust has a Programme of audits which are undertaken not only to demonstrate assurance but to provide opportunity to deliver improved care for patients. Findings are shared with peers at planned Quarterly audit days and the process of the audit is captured on a Health Assure system. Audit continues to evolve as it is now recognised as a quality improvement tool by the Healthcare Quality Improvement Partnership and NHS England.

- **Progress towards targets as agreed with local commissioners, together with details of other key quality improvements.**

The CQUIN programme for 13/14 included some very challenging areas. Teams worked well to deliver to the milestones each quarter and some significant improvements were delivered. We have either achieved or partly achieved against the majority of the CQUIN Indicators in the CQUIN programme to secure approximately 80% of the finance associated with the programme. The National CQUINs were challenging however we exceeded the target for the Friends and Family response rate, the work that has taken place to address the pressure ulcer prevalence captured in Safety Thermometer has delivered a better result than we believed we could achieve at the start of the CQUIN and we have achieved the Dementia FAIR by the end of the year, although the sustainability of this remains a challenge in the coming year. We achieved the VTE Indicator in both risk assessment and root cause analysis.

We were successful with all the Greater Manchester CQUINs. For the local programme we were able to achieve most of the quarterly milestones however there remained a couple where we did not achieve the very stretching end of year target, for example the numbers of mothers who live in deprived areas who breastfeed after birth and are still breastfeeding six weeks later. We introduced new pathways successfully for long term conditions COPD and Heart Failure during the year however did not meet the percentage required in the Q4 audit, these both remain topics of the 14/15 CQUIN programme and work will continue to embed the pathway and make the improvements required. A key outcome from the CQUIN programme is the improved joint working between teams and across business groups and improved communications with primary care and other health organisations.

- **Any new or significantly revised services**

The establishment of the Integrated Prevention Service was a key achievement for 2013/14; this brought together services for children in Stockport across health and social care, with the appointment of fully integrated teams and joint management structures.



- **Service improvements following staff or patient surveys/comments and Care Quality Commission reports:**

A new role, the Matron for Patient Experience, started in post in October 2013, with her primary function being to focus on listening to patients and their families, championing patient feedback and initiating improvements as a result. We have expanded our capacity to capture patient feedback with the introduction of the Friends and Family Test on our inpatient wards, A+E and maternity services.

There has been major investment to replace all patient meal trollies with the aim of improving temperature control and reduce food waste. In addition the Trust has increased the number of volunteers trained to give assistance to patients at mealtimes.

A number of environmental improvements have also been made. A sample of these include new floor covering on Wards D1, D2, HDU and HDU, redecoration of Ward E2, a review of the nurse call bell system on Ward B6 and a new sensory garden established at Swanbourne Gardens with the help of the MedEquip4Kids Charity. In addition a new maintenance operator was introduced by the Estates Department in November to help address ward maintenance issues in a timelier manner. The Trust also invested to replace ward waste bins with a quieter soft closing version following complaints from patients about the noise generated by the previous bins, especially at night.

Our night nurse managers have developed and launched standards to help reduce noise at night, following concerns raised by patients. As part of this initiative, staff on Ward A1 now offer earplugs to patients. The standards will be monitored to ensure compliance.

- **Improvements in patient/ carer information.**

A number of initiatives have been introduced during the last year with the intention of improving information to patients and carers. These include the revision of the Trust's site map, improved signage in a number of areas and the introduction of a parent's newsletter by the Continuing Care Team at Swanbourne Gardens.

The Trust also reviewed its guidelines to assist staff in the development of patient information, and work is ongoing to update literature in both our hospital and community services.

A new "Discharge Leaflet" has been introduced which provides additional information to supplement that provided by ward staff concerning medication, transport, follow up appointments and contact numbers.

All inpatient bedside information booklets have been reviewed and replaced. Holders have been attached alongside every inpatient bed to ensure the booklets are housed safely and are readily available. So far, feedback from patients and visitors has been positive, with the wealth of information concerning hospital services well received and appreciated by all.

- **Information on complaints handling**

The Trust recognises the importance of feedback because learning from patient experience is an essential component in our commitment to improve the services we provide to our patients.



During 2013/2014 the Trust received 708 formal complaints compared to 633 during 2011/12. The slight increase in complaints is currently being monitored via the new quarterly complaints report, which also monitors themes and trends.

The quality of responses following a complaint is important to us; one of the markers used to monitor our success in this area is the number of complaints which are upheld by the Parliamentary & Health Service Ombudsman. Only one was upheld in 2013/2014 following a complaint received in 2011 and a full action plan has been completed in relation to the Ombudsman's decision.

In terms of themes arising from complaints, the top issues related to staff attitudes, appointments, communication and nursing care on the wards. Ward complaint numbers are monitored via the Trust Nursing Dashboard and are used as part of the programme of mock CQC inspections currently in progress.

## 2.6 STAKEHOLDER RELATIONS

### Health Service Provider Trust Partners – Southern Sector

Since 2011/12, Stockport FT has been party to a collaborative agreement with East Cheshire NHS Trust, signified by a formal memorandum of understanding (MOU). In October 2012, University Hospital South Manchester also signed the MOU, creating a three-way partnership, later joined by Tameside FT.

Having established the Southern Sector Partnership, the Boards of all three Trusts share a commitment to work together to create a configuration of services across the Southern Sector of Greater Manchester and Cheshire that will conform to the standards to be set out as a result of the “*Healthier Together*” review in Greater Manchester. The partners’ shared aims and associated anticipated benefits are outlined in the table below.

Developing a shared service vision – Southern Sector, Greater Manchester

East Cheshire £176m 3500 staff 450,000 people	Stockport £275m 5300 staff 396,000 people	UHSM £400m, 5500 staff + contracted-out services 750,000 people (inc 3 flows)	Outline strategic benefits
Developing an alternative and compelling vision for healthcare in the South including the full integration of community and acute care			<ul style="list-style-type: none"><li>• Building on existing patient flows to improve patient pathway and accelerate de-hospitalisation – reaping clinical and financial gains from care closer to home</li><li>• Collaborating in the provision of clinical services to offer South Sector access to local tertiary services and bolstering the provision of all secondary care services, delivering clinically compliant and financial benefit</li><li>• Positioning the South Sector as a hub within the AHSN and hooked into MAHSC, offering leveraged gains from a large patient footprint, delivering clinical and financial benefit</li><li>• Offering the opportunity for local healthcare (and other organisations) to lever financial and qualitative gains from different models of support function</li></ul>
Meeting the challenge of ‘Healthier Together’ in all domains– stronger together – Maintaining high quality community, secondary and tertiary services across the Southern Sector			
Linking into AHSN, MAHSC and LETB to protect Teaching and Associate Teaching status, maximising research activity to the benefits of patients across the Southern Sector			
Exploring shared corporate functions, to offer mutually beneficial financial efficiencies			

At the end of 2012/13, Tameside Foundation Trust declared its interest in joining the collaboration and is planning to sign the MOU in due course. Early re-planning took place during the first quarter of 2012/13 to assimilate Tameside FT’s aims into the partnership’s strategic goals. Formal and shared programme management arrangements have been established.

### Southern Sector plans

The three-way Partnership has so far established plans for collaborative services in a number of specialties. No “one-size fits all” configuration is expected and services are encouraged to respond to local conditions and establish partnership arrangements that suit their individual circumstances. A framework of principles surrounds service collaboration, including:

- Services remain local, maintaining current patient flows, where possible
- Where service location change is inevitable, early involvement of stakeholders, including patients, is required
- Specialist skills should be shared to improve the patient offer at partner Trusts
- Revised financial and contractual arrangements will be required to enable the partnership to work effectively.

On behalf of all three boards, the partnership steering group, chaired by chief executives in turn, remains mindful of Monitor's provider license conditions regarding competition and cooperation and will ensure that service plans are compliant.

In March 2013, a high level Clinical Congress was arranged for senior clinicians and management teams of the respective Trusts in order to chart progress, clarify objectives and strengthen momentum across the Southern Sector partnership. The Congress considered initial joint developments the planning of clinical support services, children's services and potential for specific areas of collaboration in non-clinical areas. A joint IT systems procurement has also been agreed. We look forward to sharing innovative solutions with our partners in the Southern Sector. One fruitful growth area is our developing plan to create a Research and Development network, led by UHSM, which will further increase Stockport FT's capability to undertake clinical trials and take part in clinical research.

Southern Sector joint working has, more recently, been involved in the national "Challenged Health Economies" initiative which has targeted intensive analysis and support in 11 health economies (including East Cheshire) in order to develop workable plans for sustainable services in these areas. Since there is a close relationship between services in East Cheshire and the rest of Southern Sector the approach has embraced commissioners and providers across the area.

### **"Healthier Together" – Greater Manchester-wide Review of Service Provision**

The "Healthier Together" exercise was established in 2011 by the combined Greater Manchester commissioners. It is aimed at developing a Greater Manchester-wide plan for the future of services which will both improve quality and consistency and reduce the projected burgeoning cost of health and social care across the conurbation in the next five to ten years. The "Case for Change" published by "Healthier Together" highlights variation in the quality and accessibility of services and describes the predicted future demand for care as a result of the changing profile of the population and changes in patterns of medical treatment. The models of care for the future that have been developed under the "Healthier Together" banner, embrace primary, community and hospital services. Options for the future configuration of hospital services have been analysed and debated and a shortlist of options will go to formal public consultation in June 2014.

Throughout the "Healthier Together" process the Trust has been keen to ensure that its clinicians and other members of staff have been fully involved in the various work groups and relevant governance arrangements that have been established to support and oversee the work. The Trust is also planning the wide-ranging involvement of staff, patients and others during the consultation period.

## **Development of services involving other local services and involvement in local initiatives**

Guided by a need to balance resilience and quality, the Trust's strategy for clinical services is founded on a determination to:

- Provide a range of services locally, easily accessible for local people
- Ensure services meet the requirements of best practice with regard to quality and safety
- Aim for a positive financial contribution from all services by driving efficiency. Where this is not possible, the underlying financial impact will be understood and under-written by remaining services.

We are working with local partners in all the health economies we serve to deliver these undertakings. Formal joint governance arrangements and programme management support has now been established, recognising the scale of the effort and the level of change which the partners have committed to, aimed at enabling many more people in Stockport to be supported at home, and avoiding in future the level of reliance on hospital care that is currently the case. Of particular note are:

- The *Stockport One* service in which we are working with partners in primary and social care to establish an integrated service model in a CCG locality for patients who have high, complex needs. This model will be replicated in other localities, adjusted to suit target populations.
- In Tameside and Glossop, 2013/14 saw the end of Stockport FT's provision of intermediate care services at the Lakes Nursing Home. The community assessment and rapid access (CARA) team remains in place and is a valued contributor to smooth patient flow in and out of Tameside hospital.

We are also proud of our record for service innovation. During 2013/14 we have:

- Introduced an electronic emergency department patient record, creating a paperless emergency department
- Introduced a workforce scheduling and diary management system for district nurses
- Continued digitisation of paper patient records – the e-record system
- Introduced the wheelchair service standard, "Child in a Chair in a Day"

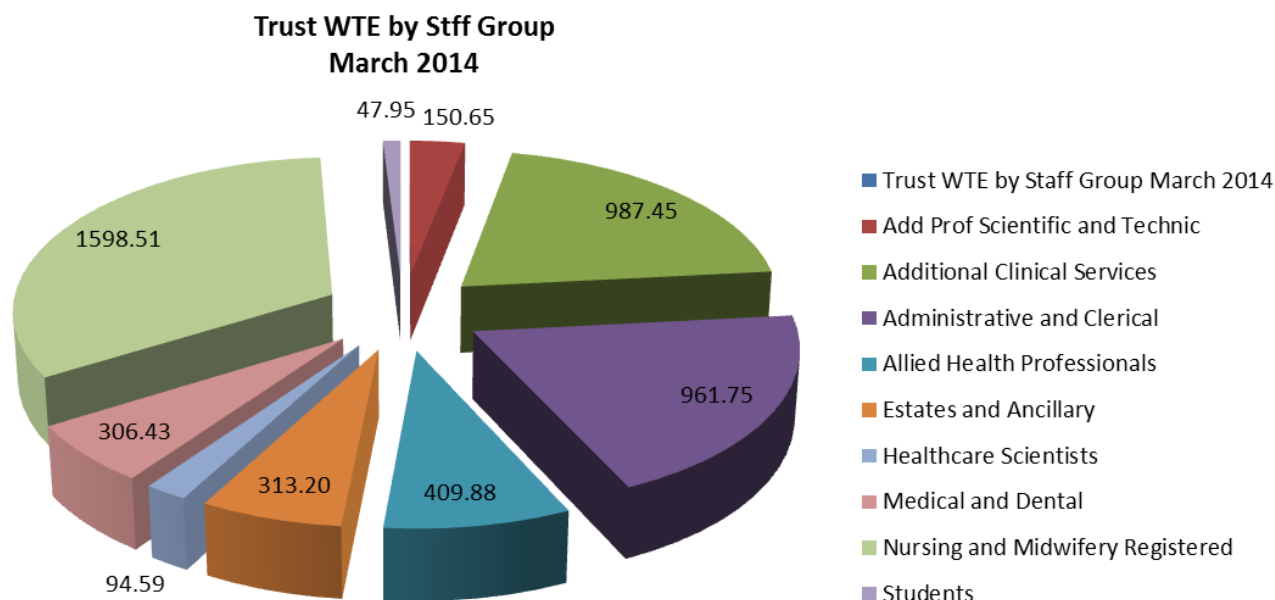
## **Healthwatch**

During the year, new arrangements came into place for representing the voice of the patient in the NHS. "Healthwatch" was established, with the local remit held by Stockport Healthwatch. This represents a key source of advice, involvement, and public scrutiny for our services. Bi-monthly consumer review meetings have been established with Healthwatch, involving the Chief Executive, Governors and the Trust's Patient Experience leads.

## 2.7 OUR WORKFORCE

The Trust recognises the valuable contribution of its workforce who provide a range of clinical and non-clinical services across hospital and community sites as well as patients homes.

Services are delivered by our committed workforce of 4870.41 WTE staff (headcount 5,857) The breakdown of all Trust staff, as at the end of March 2014, is shown below:



Over the last three years staff from both Tameside and Glossop Community and Stockport Community has transferred to the Trust. Following the integration, the Human Resources team has continued to work closely with staff side colleagues to review and implement HR policies that become the standard for all staff employed by the Trust.

### Profile:

The breakdown by gender of our 5857 staff is as follows:

- 83% female; and 17% male

A more detailed breakdown is provided in the table below:

Gender Headcount	Male	Female
Directors	8	5
Other Senior Managers	7	12
Other Employees	975	4850

### Workforce wellbeing

Supporting our staff to maintain their own health and wellbeing is a priority area for us and we know that a healthy and engaged workforce delivers better outcomes for patients. That's why we have worked with NHS Employers and a team of Trust staff, to review what we have done to date and our work plan for the future. This work will be progressed during 2014/15 and will include the development of a comprehensive Health and Wellbeing Strategy that will build on the work undertaken to date and prioritise areas for action.

Our in-house occupational health service is active in assisting employees remain well by promoting health and wellbeing and seeing employees who have been off on sick leave promptly at the request of their managers to assist early and safe return to work. A new IT system for OH activity monitoring is now running and further configuration to get the best intelligence from the system is being done.

A range of health promotion support services are available including assistance with stopping smoking and raising awareness to prevent workplace incidents. Vaccinating health care staff against influenza is recognised as an important measure to protect vulnerable patients from the illness. The occupational health service with assistance from link nurses within the Trust achieved a commendable staff flu vaccination uptake of 75%, compared with a national average of half that level.

The OH service is active in providing comprehensive OH care for the employees of the Trust but also in offering the specialist services to other employers in Stockport and further afield. The service was successful in winning a tender to provide service to the North West NHS Ambulance Service and works with its NHS partners in occupational health to provide a region wide service for this employer.

A confidential one to one counselling service is available on a self-referral basis to provide additional support for staff.

The Trust is also exploring potential service reconfiguration of OH services with local Trusts to maintain and enhance the services provided for NHS staff.

Work to reduce levels of sickness absence is ongoing and the Trust introduced a new Attendance Management Policy in June 2013. Implementation of the Policy was supported by a robust training programme for managers. Whilst it is still yet to be fully embedded we have seen the lowest sickness rates in the organisation for five years and are confident that we can continue to reduce this further. The year end sickness absence figure was 4.15% against a target of 4.00% and Human Resources will continue to work with managers to support staff and improve absence levels further.

## **Listening to our workforce**

Following the publication of Robert Francis's report of the Public Inquiry into Mid Staffordshire NHS Foundation Trust the Trust held a programme of 28 staff 'listening to you' events, involving 639 staff, to achieve the following objectives:

- I. To help the chief executive meet staff, especially frontline and off-site staff, to hear views about their work and the organisation
- II. To listen and understand staff views about what we can learn from the Francis report and need to address
- III. Promote and model our Trust values on 'quality & safety', 'communications' and 'service'
- IV. Obtain feedback about how we can better support a culture of responsibility, accountability and 'duty of candour', and connect this to the development of the workforce and organisational development strategy and plan 2013 to 2015.

Staff applauded the approach of face-to-face meetings with time to discuss issues in depth, and especially appreciated the participation of the chief executive.

Through running the 'listening to you' events, we have achieved each of the four objectives set out. They have enabled the chief executive to meet staff, especially frontline and off-site staff, as the newly appointed chief executive of the organisation to hear views about their work and the organisation, specifically what we can learn from the Francis report. They have helped to promote the Trust's values of 'quality & safety', 'communications' and 'service'.

We have obtained feedback about the behaviours and things which need to be different in the Trust to enable a culture of responsibility, accountability and duty of candour; in order to inform the further development of the 2013 – 2015 workforce and organisational development strategy and other specific programmes of work. The behavioural framework will be included as part of our recruitment and appraisals processes in the future.

### **Working in Partnership**

The Trust recognises the importance of working in partnership with staff side colleagues and well established consultation and negotiation mechanisms are in place. Meetings are attended by Executive Directors, senior managers and staff side representatives. We continue to work in partnership with staff side colleagues to update employment policies and where necessary harmonise policies and procedures, following the transfer of community services into the Trust.

### **Team Brief and Start the Year**

The Trust has comprehensive cascade communication system which is initiated through a monthly Team Brief by the Chief Executive. Key messages are shared with all staff across the organisation. It is designed to ensure that all staff are aware of the very latest developments and are kept abreast of the Trust's performance across all areas including any financial issues. Staff are encouraged to feed information back up the organisation using the normal management channels.

At the start of each year a formal presentation is delivered, again by a cascade system, to all staff. This sets out key achievements and milestones over the previous year, recognising good practice together with any learning opportunities. It also includes priorities for the forthcoming year. The programme is launched via a series of presentations led by the Chief Executive, supported by other Executive Directors and the Chairman. These are followed up with local presentations within Business Groups to ensure as many staff as possible are included.

### **Work Experience**

The Trust works hard to encourage young people to take up work experience opportunities at the trust and in 2013/14 we hosted 183 students who were placed in various wards and departments across the Trust, to increase their understanding of working in the NHS and the career opportunities available.

## **2.7.1 Putting Equality, Diversity and Inclusion at the heart of everything we do**

### **Commitment**

The trust recognises that having a commitment to the Equality and Diversity agenda speaks to the principles that we hold true in the NHS Constitution and we recognise that if we get equality and diversity right, we get the environment right for our staff and a high quality service. This year the Trust has set out a four year strategy for the promotion of Equality, Diversity and Human Rights in our service provision and employment practices. This strategy outlines the approach and actions to be taken to ensure that Stockport NHS Foundation Trust is able to move beyond mere baseline compliance with Government equalities legislation and becomes an exemplar organisation in reference to Human Rights, Equality and Diversity with clear and visible leadership at Board level.



We have much to celebrate and much achieved with many examples of good practice, some of which are highlighted in our Equality Delivery System (EDS) audit. The audit also demonstrates how the Trust is complying with the Equality Act 2010 and how our decision making processes include equality reference. Workforce and service monitoring reports have also been produced for 2013 and are published on our website alongside the audit. Together, these reports ensure that the Trust is best placed to meet the statutory equality duties and in keeping with the Government's transparency agenda they allow the public to judge our progress.

## **Communication**

Throughout 2013/14, our diversity matters newsletter continued to inform and enlighten our staff. Themes varied from key changes to legislation to detailed articles around Learning Disabilities, the 2011 Census results, Men's Health, Autism, religious festivals and many more.

In addition a number of events were organized during the year including a "Raising Aspirations for 5-16 Year olds." At this event staff from the Trust worked with two local youth groups; one of which is children from Walthew House (age 5 to 13) who are hard of hearing, deaf, visually impaired or blind. The second youth group is children from My Community UK (age 7-13) who are mostly from a Muslim background. There were around 30 children in total. The session provided a safe environment for the two youth groups to mix together, learn from each other and also gave them the opportunity to learn about the work that takes place here at the Trust. The session was also an opportunity for staff to make a positive impact on the children involved whilst gaining an insight into the lives of both groups of children.

## **Capability**

In 2013/14 the Trust further developed its Human Rights, Equality & Diversity training portfolio, with new interactive sessions delivered at all corporate welcome days and inclusive leadership presentations for our senior team and Trust Board. In addition we have also recorded a number of patient stories to use in staff training, including stories around dementia, autism, homelessness and cancer. Stands outside our canteen have also helped to bring important issues to the attention of staff and patients including World Aids Day and International Day Against Homophobia (IDAHO).

The Emergency Department User Group has continued to provide important contributions to the way we deliver our services during 2013/14. This group has representation from Age UK, Disability Stockport, Signpost for Carers, patient representatives, Stockport College, and the African / Caribbean Community Association (ACCA).

Also for the fifth year running, the Trust took part in the Pride Parade through Manchester. With a strong NHS North West presence the Trust is keen to reinforce our commitment to fair and accessible healthcare and employment for LGB staff and service users.

The forthcoming year brings further challenges for the NHS. Achieving sustainable improvement will mean taking on the challenge of service change; to provide services closer to patients wherever appropriate, to create centralised networks of clinical care where necessary, and to improve integration between services. The equality agenda sits at the very heart of these challenges and is key to delivering a quality service for all.

Work around this important agenda is supported by our Equality and Diversity Policy for staff which reflects our ambition to be an organisation that values diversity and promotes equality of opportunity, regardless of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation. The Trust values diversity as well as promoting equality of opportunity and we recognise that talent and potential are distributed across the population; by ensuring that our workforce reflects the local population we will increase the quality of service provided to patients. We aim to create a



working environment in which there is no bullying, harassment or discrimination; all people have the opportunity to realise their full potential; and all decisions are based on merit. We also aim to provide services in a safe environment where all people are able to access high quality services; there is no bullying, harassment or discrimination; and all care decisions are based on clinical need. This commitment is further reflected in our new Equality, Diversity and Human Rights Strategy which was approved by the Board of Directors in April 2014. Implementation of the Strategy will be closely monitored and reported to the Board of Directors on a regular basis.

The Trust produces an annual Equality Report which is published on our website. This includes information around a range of performance measures.

In January 2014, we launched a new Reasonable Adjustment Policy and Procedure to support disabled staff to remain in employment with the Trust and also to support disabled individuals who choose to apply for posts with us.

## **2.7.2 NHS STAFF SURVEY – A CULTURE OF ENGAGEMENT**

A national staff opinion survey is conducted each year by the Trust. The survey comprises questions relating to the four pledges to staff in the NHS Constitution together with additional themes of staff satisfaction and equality & diversity.

A review of the 2013 staff survey findings show the Trust's score for Staff Engagement continues to rise, with the score for 2013 being 3.86 out of 5 (1 indicating that staff are poorly engaged and 5 indicating that staff are highly engaged), which was significantly better than the national average. Also, of particular significance is KF 24; staff recommending the Trust as a place to work or receive treatment which has risen from 3.71 in 2012 to 3.83 in 2013 (on a scale of 1 to 5). This is above the national average of 3.68.

Overall in the 2013 staff survey, of the 28 key findings set out in CQC Report, the Trust has been placed:

- In the top 20% of acute trusts in 12 areas;
- Better than average (i.e. ranked in the top 34 acute trusts) in a further 6 areas
- Average in 7 areas
- Worse than average in 3 areas.

The areas where the Trust has been ranked in the best 20% of acute trusts were:

- KF8 Having well-structured appraisals in last 12 months
- KF9 Support from immediate managers
- KF14 Percentage reporting errors, near misses or incidents witnessed in last month
- KF15 Fairness and effectiveness of incident reporting procedures
- KF18 Experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months
- KF19 Percentage experiencing harassment, bullying or abuse from staff in last 12 months
- KF21 Reporting good communication between senior management and staff
- KF23 Staff job satisfaction
- KF24 Staff recommendations of the trust as a place to work or receive treatment;
- KF25 Staff motivation at work
- KF27 Percentage believing the trust provides equal opportunities for career progression or promotion
- KF28 Experiencing discrimination at work in the last 12 months.

The 3 areas where the Trust has scored worse than average are:

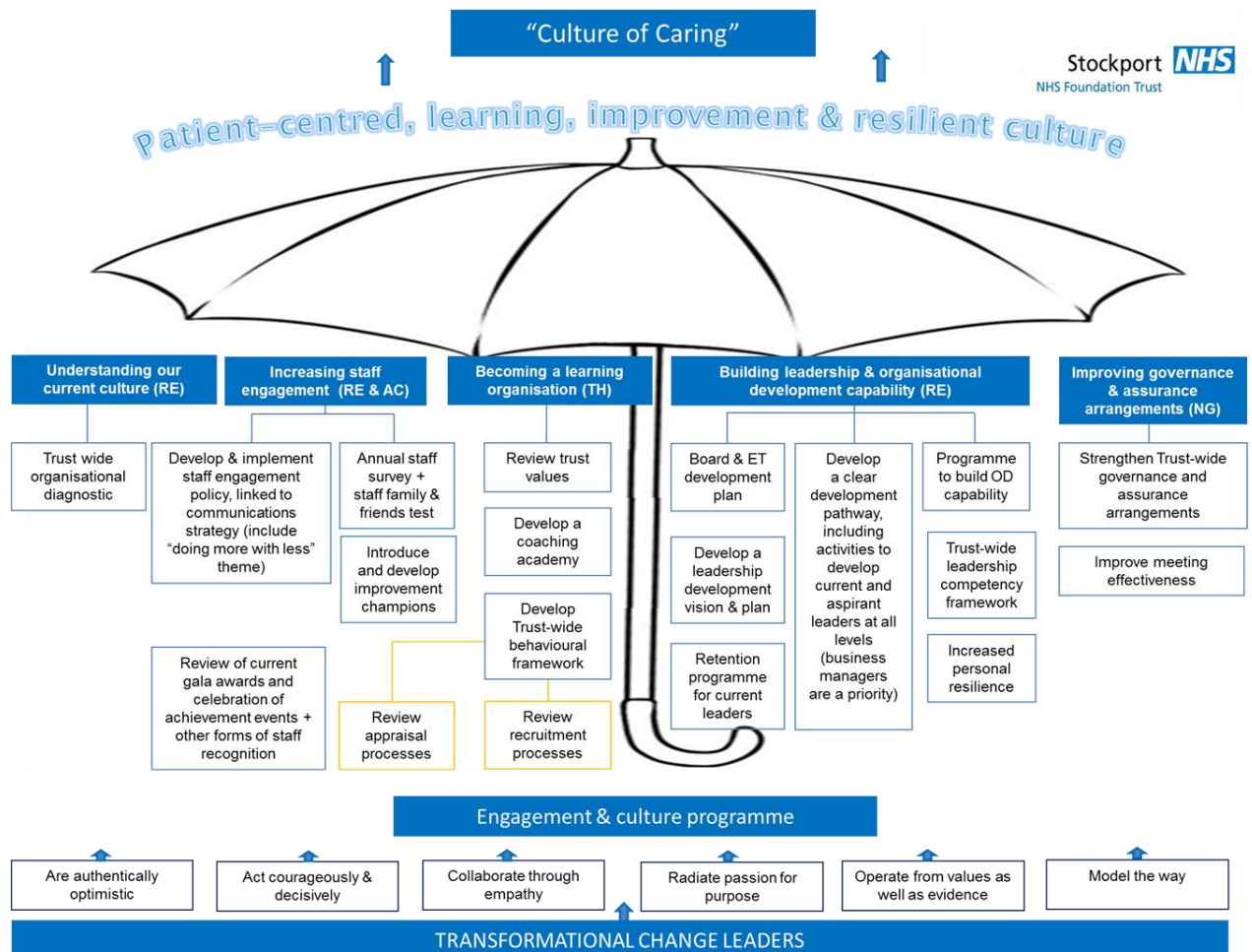
- KF2 Agreeing that their role makes a difference to patient care that they are able to deliver
- KF20 Feeling pressure in the last 3 months to return to attend work when feeling unwell
- KF10 Receiving health and safety training in the last 12 months.

The largest local changes since the 2012 staff survey are:

- KF12 Percentage of staff saying that handwashing materials are always available has reduced by 8% (from 69% to 61%)
- KF10 Percentage of staff receiving health and safety training in the last 12 months has reduced by 6% (76% to 70%) *Note: Health and safety training is included in mandatory training and the Trust's compliance rate is consistently over 85%.*

A proposed 2014/15 Trust action plan has been developed to incorporate the 2013 survey findings. This plan continues to build on the 4 key areas of focus in the 2012/13 action plan and work already being undertaken as part of the Trust-wide Engagement and Culture Programme (which forms part of the Building a Sustainable Future Programme).

The Engagement and Culture Programme started in February 2014 by the initiation of five core projects that are aligned with existing initiatives, which are shown in the 'umbrella diagram' below:



The governance and accountability for the staff survey will from part of the Engagement and Culture Programme Steering Group and the staff survey activity will be part of the 'increasing staff engagement' project.

The proposed four key areas of focus for the 2013/14 action plan are:

1. Quality of care Increase the percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver
2. Appraisals Increase the number of staff who have a quality annual appraisal and regular personal development discussions
3. Staff resilience Increase the ability of staff to perform under pressure, bounce back from difficult circumstances and manage their health, wellbeing and, ultimately performance
4. Staff engagement Increase staff involvement and engagement in service improvements and delivering exceptional patient care.

Local actions plans are being developed by all Business Groups and Directorates based on the 2013 outcomes and will focus on issues that staff identified as being of real importance to them and that will improve future levels of engagement and satisfaction. Progress against these action plans will be monitored and scrutinised through forums including the Engagement and Culture Programme Steering Group, Patient Experience and Workforce Assurance Committee, Business Group Boards. The proposed action plan will be presented to the Board of Directors for sign-off in Q1 and a progress report presented in September 2014.

## 2.7.2.1 Summary of performance – NHS Staff Survey

### 2.7.2.1.1 Response rates

#### Response rates

2013/14		2012/13		Trust Improvement / Deterioration
Trust	National Average	Trust	National Average	
54%	49%	50%	50%	4% improvement from previous year and 5% higher than the national average for other acute trusts

### 2.7.2.1.2 Top 5 ranking scores for 2013 / 2014

The table below highlights the five key findings for which the Trust compares most favourably with other trusts in England.

	Trust	National Average	Trust	National Average	
<b>KF 14:</b> Staff reporting errors, near misses or incidents witnessed in the last month (percentage) (higher score is better)	97%	90%	94%	90%	3% improvement (significant change)
<b>KF 19:</b> Staff experiencing harassment, bullying or abuse from staff in last 12 months (percentage) (lower score is better)	17%	24%	21%	24%	4% improvement (significant change)

<b>KF 15:</b> Fairness and effectiveness of incident reporting procedures (1-5 scale) (higher score is better)	3.67	3.51	3.61	3.50	0.06 improvement (not a significant change)
<b>KF 18:</b> Staff experiencing harassment, bullying or abuse from patients, relatives of public in last 12 months (percentage) (lower score is better)	23%	29%	28%	30%	5% improvement (significant change)
<b>KF 25:</b> Staff motivation at work (1-5 scale) (higher score is better)	3.98	3.86	3.86	3.84	0.12 improvement (not a significant change)

#### 2.7.2.1.3 Bottom 4 ranking scores for 2013/2104

The table below highlights the four key findings for which the Trust compares least favourably with other acute trusts in England.

	2013/14		2012/13		Trust Improvement / Deterioration
	Trust	National Average	Trust	National Average	
<b>KF 1:</b> Staff feeling satisfied with the quality of work and patient care they are able to deliver (percentage) (higher score is better)	79%	79%	78%	78%	1% improvement (not a significant change)
<b>KF 2:</b> Staff agreeing that their role makes a difference to patients (percentage) (higher score is better)	90%	91%	92%	89%	2% deterioration (significant change)
<b>KF 7:</b> Percentage of staff appraised in last 12 months (percentage) (higher score is better)	85%	84%	83%	84%	2% improvement (significant change)
<b>KF 10:</b> Staff receiving health and safety training in last 12 months (percentage) (higher score is better)	70%	76%	77%	74%	7% deterioration (significant change)
<b>KF 20:</b> Staff feeling pressure in last 3 months to attend work when feeling unwell (percentage) (lower score is better)	29%	28%	28%	29%	1% deterioration (not a significant change)

### 2.7.2.2 Future priorities and targets

It is proposed that the Trust will focus on 4 corporate key priority areas to improve overall levels of engagement / satisfaction and improve results in the 2014 survey. We are keen that where possible, each of these areas are aligned with existing initiatives and programmes to fully realise the synergistic benefits. The priority areas are outlined below:

1. **Quality of care** – *increase the percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver*

Action	Expected outcomes
Introduce staff family and friends test	For each member of staff to have the opportunity to complete the test at least once during 2014/15 (year 1)
Align the staff survey with activity under the BasF Engagement and Culture Programme	Minimum response rate of 33% in year 1 (50% in year 2)
Responsibility for staff survey to sit with the BasF Engagement and Culture Programme Steering Group	Create greater synergy between the staff survey action plan and other areas of work
Continue to provide dignity and respect training as part of induction / mandatory training	Improve numbers of people completing the survey & responses in 2014 staff survey  100% of eligible staff attending corporate welcome / essentials training

2. **Appraisal** - *increase the number of staff who have a quality annual appraisal and regular personal development discussions*

Action	Expected outcomes
Form a task and finish group to review documentation and ensure it is fit for purpose	Achieve 95% of eligible staff receiving a quality annual appraisal
Ensure all appraisals have learning needs and PDP identified	Improved responses in 2014 staff survey
Ensure that electronic recording systems for managers to have direct access to current appraisal information	Coaching academy infrastructure established by March, 2015.
Introduce a coaching academy, to support on-going performance development conversations and annual appraisals	Evidence that coaching conversations and formal 1:1 coaching are taking place

3. **Personal resilience** – *increase the ability of staff to perform under pressure, bounce back from difficult circumstances and manage their health, wellbeing and, ultimately performance.*

Action	Expected outcomes
Business groups / directorate to continue to conduct annual stress risk assessments	Full compliance of completed and actioned risk assessments
Support managers to encourage	Achieve attendance figure of 96%

involvement and communication within their teams	Reduce number of workplace stress cases
Ensure all relevant staff have undertaken conflict resolution training	Improved responses in 2014 staff survey
Introduce 'increasing personal resilience' development options i.e. as part of the management and leadership development programmes, stand-alone programme and during 1:1 coaching	Evidence of impact on productivity and quality of care

**4. Staff engagement – to increase staff involvement in service improvements**

Action	Expected outcomes
Hold further listening events with all staff groups as part of a cultural audit	26 events held during Q1 & Q2
Each transformational change and service improvement programme to include a communications and engagement plan to ensure that staff at all levels feel involved and able to contribute	Communications and engagement plan in place for each programme
Consult with staff about all proposed changes at early stages	Improved responses in 2014 staff survey
Produce and implement a staff engagement policy produced (linked to the communications strategy & includes "the doing more with less theme")	New format for staff recognition and achievement event delivered in Q3 i.e. Pride of Trust Awards
Produce and implement a toolkit for staff engagement (based on current NHS best practice e.g. Listening into Action, Wigan, Wrightington and Leigh approach)	Stockport NHS FT staff engagement toolkit implemented & embedded by March 2015
Develop leadership capability to lead change and engage teams	
Introduce and develop improvement champions	
Review current gala awards and celebration of achievement events and other forms of recognition	



### **3. CORPORATE GOVERNANCE**

#### **3.1 BOARD OF DIRECTORS**

During 2013/14 the Board of Directors comprised the following:

##### **Executive Directors**

- Ann Barnes – Chief Executive
- James Catania – Medical Director
- Bill Gregory – Director of Finance
- Judith Morris – Director of Nursing and Midwifery
- Jayne Shaw – Director of Workforce and Organisational Development (from 22.08.2013)
- Carole Spencer – Director of Planning and Business Development (Non-Voting) (until 31.01.2014)
- James Sumner – Chief Operating Officer (from 13.09.2013).

##### **Non Executive Directors**

- Gillian Easson – Chairman
- Mike Cheshire (from 01.09.2013)
- Carol Prowse – Senior Independent Director  
Deputy Chairman
- John Sandford – Chairman of Audit Committee
- John Schultz (from 01.09.2013)
- Malcolm Sugden
- Leslie Wilcock

Further details on the Board of Directors can be found in Section 3.6.

## 3.2 MEMBERSHIP

### 3.2.1 ELIBILITY REQUIREMENTS

Our Membership is open to any individual who:

- is over 11 years of age, and
- is entitled under our Constitution of to be a member of one of the public constituencies or of one of the classes of the staff constituency (as below).

### 3.2.2 PUBLIC CONSTITUENCIES

We use an “opt-in” membership system for our public constituency which is open to individuals who:

- are not a member of another public constituency
- complete an application form in whatever form the Council of Governors specifies, and
- are not eligible to be members of any of the classes of the staff constituency
- live within one of the six geographic areas set out below:

The areas of the Trust are as detailed below.

**Four areas covered by Stockport Metropolitan Borough Council as follows:**

- 1) **Bramhall and Cheadle – containing the following Local Authority wards:**  
Bramhall North, Bramhall South, Cheadle Hulme South, Cheadle and Gatley, Cheadle Hulme North and Heald Green.
- 2) **Tame Valley and Werneth– containing the following Local Authority wards:**  
Brinnington and Central, Reddish North, Reddish South, Bredbury and Woodley, Bredbury Green and Romiley
- 3) **The Heatons and Victoria – containing the following Local Authority wards:**  
Heatons North, Heatons South, Davenport and Cale Green, Edgeley and Cheadle Heath, Manor
- 4) **Marple and Stepping Hill – containing the following Local Authority wards:**  
Marple North, Marple South, Hazel Grove, Offerton, Stepping Hill

**One area covering the High Peak and Dales and Tameside and Glossop:**

- 5) **High Peak and Dales and Tameside and Glossop – which covers the following wards**
  - **The wards that fall within the Metropolitan Borough Council of Tameside**
  - **The following wards in High Peak:**  
Barms, Blackbrook, Burbage, Buxton Central, Chapel East, Chapel West, Corbar, Cote Heath, Hayfield, Limestone Peak, New Mills East, New Mills West, Sett, Stone Bench, Temple, Whaley Bridge, Dinting, Gamesley, Hadfield North, Hadfield South, Howard Town, Old Glossop, Padfield, Simmondley, St John’s, Tintwistle, Whitfield.



One area covering a wider district around our hospital:

6) **Outer Region – the areas covered by the metropolitan councils / districts of:**

Cheshire East, Manchester, Trafford, Salford, Oldham, Rochdale, Bury, Bolton, Wigan and those wards in High Peak not covered under 5) above.

### 3.2.3 STAFF CONSTITUENCY

We use an “opt-out” membership system for the staff constituency which is divided into the following classes:

- Community Staff
- Other Staff.

Membership of one of the classes of the staff constituency is open to individuals:

- who we employ under a contract of employment and who either
  - are under a contract which has no fixed term or a fixed term of at least 12 months, or
  - have been continuously employed for at least 12 months, or
- who are not employed by us but who are employed by some other body and who exercise functions for the purposes of the Trust; and who have exercised these functions for a continuous period of at least 12 months. For the avoidance of doubt, this does not include those who assist or provide services to the Trust on a voluntary basis.

All individuals who are entitled to become members of one of the classes of the staff constituency, and who:

- have been invited by us to become a member of the appropriate class, and
- have not informed us that they do not wish to do so

shall become members of that class.

The Secretary makes the final decision about the class to which an individual is eligible to be a member.

### 3.2.4 MEMBERSHIP NUMBERS PUBLIC MEMBERS PER CONSTITUENCY (as at 31 March 2014)

Area	No. of Members
Bramhall and Cheadle	2,854
Tame Valley and Werneth	2,142
The Heatons and Victoria	2,307
Marple and Stepping Hill	2,828
High Peak and Dales and Tameside and Glossop	1,325
Outer Region	625
<b>Total</b>	<b>12,081</b>

### STAFF MEMBERS PER CONSTITUENCY (as at 31 March 2014)

Staff constituency	No. of Members
Community staff	1,455
Other staff	3,896
<b>Total</b>	<b>5,351</b>

### 3.2.5 MEMBERSHIP DEVELOPMENT AND INVOLVEMENT

One of our key objectives is to build and maintain a vibrant and engaged membership. In 2012/13 we set out our three-year membership development strategy, recognising that the process of building meaningful membership structures takes a serious commitment to time and resources. In 2014/15 we continue to work to this strategy, and have developed a full plan detailing a number of objectives, the implementation of which is led and monitored by the Council of Governors.

The Membership Development Committee oversees:

- The development and implementation of the membership development strategy and plans.
- Membership recruitment and development.
- Communication with members, including the ongoing development of the Trust's internet and membership newsletter.

The Membership Strategy sets out a framework to deliver and develop the benefits of membership. The document sets out how we intend to sustain and build on our membership numbers and sets out the relationship we seek to have with our membership body and what benefits both parties can expect to derive from that relationship.

Some of the guiding principles of the Membership Involvement Strategy are that:

- We should regularly check to determine that we are seeking representation from all aspects of our local society within our membership.
- The activities of membership should be valuable to both individuals and to the Trust.
- Membership should help people to live a healthy and productive life.
- Membership is a natural extension to existing patient & family engagement, volunteer, and patient focus group activities.
- Activities undertaken should be prioritised to ensure achievability both in terms of time and resources.

We feel that the Trust can derive significant benefits from its membership body in the following ways:

- Engaged ambassadors who will support the Trust through good and not so good times.
- A base of volunteers.

- The future workforce could be found within a strong young person membership.
- Future governors will be found here.
- Through listening to our members in local constituencies, we can ensure we have plans to satisfy their perceptions of what it means to be a good neighbour and to contribute to the community.
- We can deliver our Care Quality Commission responsibilities for a public health agenda through our work with members.

Information will continue to flow outwards to our members through the quarterly Foundation Trust newsletter and the Trust's Annual Members' Meeting.

During 2014/15 we intend to:

- Continue to focus on under-represented groups, including members from Tameside and Glossop and socio economic groups (specifically C2, D, E).
- Our target is to increase the number of members from Tameside and Glossop to 660 members. It is intended that this will be achieved through:
  - Working closely with Tameside Healthwatch and third sector partners
  - Attendance at colleges in Tameside specifically to sign up health and social care students
  - Working closely with community based staff
- Younger people. We will continue to work closely with young people through our work with our three 'youth ambassadors', seeking to ensure that their opinions are incorporated into young member communications such as our website and social media.
- Socio-economic Groups C2, D, E. We recognise that membership should be seen as relevant to all sections of the community. We will seek to ensure that our membership is socially inclusive and our aim is to increase the number from these groups to 1,640 by March 2015. We will use the offices of those relevant Appointed Governors to help us achieve this, together with working with staff and volunteers to sign up members across our sites and in the community.
- Natural attrition. Annually, the Trust loses approximately 600 members per annum. Our aim is to maintain current membership levels, through recruiting from the under represented groups above.
- All new members recruited will want to be actively 'engaged' with the Trust – i.e. those who will be more likely to take part in surveys, attend events and potentially be interested in becoming governors.
- Implement 'membership week' during week commencing 29<sup>th</sup> September, when we will focus on membership activities such as recruitment drives and a focus on membership social media.
- Host an open day for members and the public to join us for entertainment and information, and tours of the hospital.

The overall plan is, therefore, to maintain our current public membership of 12,000 by March 2015. It is important that our engagement with the membership encourages to feel a part of the membership community through the provision of regular information.

Information flowing outwards to our members will include:

- Our newsletter “Stepping Up”
- Our Annual Members’ Meeting
- A welcome pack for new members
- The members’ section on the Trust’s website
- Use of social marketing, including Twitter and Facebook
- An organised programme of events aimed at members and the public offering public health messages and delivered with the support of Governors and staff experts. Events will allow for communication between Governors and members and will be advertised in Stepping Up, website, Twitter, through the local newspaper, the council newsletters and on posters.

Events for 2014 are:

- ‘Forget-me-not’ – dementia health talk – 25 March 2014
- ‘24 hours in A&E’ – health talk – 17 June 2014
- ‘Road to recovery’ - Tour of therapies – 16 September 2014
- Annual Members’ Meeting – 2 October 2014
- ‘Infection prevention – everybody’s business’ health talk – 18 November 2014

We will call on our membership to take part in focus groups where relevant.

The Annual Review and other key Trust communications will be styled to communicate key messages in an easy to understand consumer friendly format.

All the plans highlighted have been set clear performance indicators which will be used to evaluate success throughout 2014/15 by the Governors’ Membership Development Committee.

### **3.3 BACKGROUND INFORMATION**

#### **3.3.1 BRIEF HISTORY OF STOCKPORT NHS FOUNDATION TRUST**

We were established as an NHS Foundation Trust on 1 April 2004, pursuant to Section 6 of the Health and Social Care (Community Health and Standards) Act 2003. The Trust provides acute hospital care for children and adults predominantly across Stockport and the High Peak area of Derbyshire. With effect from 2011/12, the Trust also provides Community Services for the populations of Stockport and Tameside and Glossop.

We employ over 5,800 staff working across hospital and community premises. Our major hospital is Stepping Hill Hospital located on the A6, south of Stockport town centre. We also provide services from the Meadows and Devonshire Centre within Stockport.

We are authorised to provide the following mandatory services (more information can be found in our Terms of Authorisation):

- Anaesthetics
- Breast Surgery
- Neurology
- Neurosurgery

- Community Services
- Dermatology
- Emergency Department
- ENT
- General Medicine
- General Surgery
- Genito Urinary Medicine
- Gynaecology
- Haematology
- Medical Oncology
- Obstetrics
- Ophthalmology
- Oral Surgery
- Orthodontics
- Paediatrics
- Rehabilitation Medicine
- Rheumatology
- Trauma & Orthopaedics
- Urology

These services are delivered through our Business Groups which have an Associate Medical Director, Clinical Directors and an Associate Director. These Business Groups have been reviewed following the acquisition of Community Health Stockport.

During 2013/14 our Business Groups were:

- Surgical and Critical Care
- Medicine
- Child and Family
- Diagnostic and Clinical Support Services
- Community Services

Our Corporate Services are:

- Finance
- Human Resources
- Information Management and Technology
- Estates and Facilities

Overall responsibility for delivering the activities of the Trust rests with the Board of Directors, who are accountable for operational performance as well as the definition and implementation of strategy and policy. More detailed information on our Board of Directors can be found later in this report.

As a Foundation Trust, we also have a Council of Governors, who are the voice of our local community and the majority of whom are elected from our public membership.

The Council of Governors:

- Represents the interests of Stockport NHS Foundation Trust members and partner organisations in the local health economy;
- Feeds back information about the Trust, its vision and its performance to the constituency they represent;
- Appoints the Non Executive Directors, including the Chairman, of the Trust;
- Appoints the Trust's External Auditor;
- Works with the Board of Directors to produce plans for the future development of the Trust;
- Receives, at a public meeting, copies of the Trust's annual accounts, auditor's reports and annual report.

The role of the Governor will be developed as the Health and Social Care Act 2012 is gradually implemented.

A joint Board of Directors / Council of Governors development session was held in November 2013 and has resulted in a joint action plan aimed at introducing the changes arising from the Health and Social Care Act and closer working between the Council of Governors and the Board.

More detailed information on our Council of Governors and membership can be found later in the report.

### **3.4 MONITOR CODE OF GOVERNANCE**

The NHS Foundation Trust Code of Governance (the Code of Governance) was first published in 2006. It was most recently updated in December 2013 with the new version taking effect from 1 January 2014 and being applicable for 31 March 2014 year-end.

The purpose of the Code of Governance is to assist NHS Foundation Trust Boards in improving their governance practices by bringing together the best practice of public and private sector corporate governance. The Code is issued as best practice advice but imposes some disclosure requirements.

NHS Foundation Trusts are required to provide a specific set of disclosures to meet the requirements of the NHS Foundation Trust Code of Governance which should be submitted as part of the Annual Report (as referenced in the NHS Foundation Trust Annual Reporting Manual). Schedule A to the Code of Governance specifies everything that is required within these disclosures.

Schedule A is divided into six categories:

- i) Statutory requirements of the Code of Governance. This supersedes the “comply or explain” requirements of the Code.

There is, however, no need to report on these provisions in the Code disclosure.

- ii) Provisions which require a supporting explanation even in the case that the NHS Foundation Trust is compliant with the provision. Where the information is already contained within the Annual Report, a reference to its location is sufficient to avoid unnecessary duplication.
- iii) Provisions which require supporting information to be made publicly available even in the case that the NHS Foundation Trust is compliant with the provision. This requirement can be met by making supporting information available on request and on the NHS Foundation Trust’s website.
- iv) Provisions which require supporting information to be made available to Governors, even where the NHS Foundation Trust is compliant with the provision.
- v) Provisions which require supporting information to be made available to members of the Trust, even where the NHS Foundation Trust is compliant with the provision.
- vi) Other provisions where there are no special requirements as per i) to v) above. For these provisions the basic comply or explain requirement stands. The disclosure should therefore contain an explanation in each case where the Trust has departed from the Code explaining the reasons for the departure and how the alternative arrangements continue to reflect the main principles of the Code.

A disclosure is only required for departures from the Code. Trusts are welcome but not required to provide a simple statement of compliance with each individual provision. This might be useful in ensuring the disclosure is comprehensive and may help to ensure that each provision has been considered in turn.

Attached as an appendix to this document are the disclosures being made by this Trust with regard to each of the six categories.

## DISCLOSURE OF CORPORATE GOVERNANCE ARRANGEMENTS

NHS Foundation Trusts are required to provide a specific set of disclosures to meet the requirements of the *NHS Foundation Trust Code of Governance*, which should be submitted as part of the Annual Report (as referenced in the *NHS Foundation Trust Annual Reporting Manual*). The following list specifies everything that is required within this separate disclosure.

- Below are the statutory requirements that we have highlighted in the Code. This supersedes the “comply or explain” requirements of the Code. **However, there is no need to report on these provisions in the Code disclosure.**

For the purposes of completeness, the Trust will comment upon each requirement.

Reference	Statutory requirement:
A.2.2	<p>The roles of chairperson and chief executive must not be undertaken by the same individual.</p> <p><b><i>The Trust meets this requirement.</i></b></p>
A.5.10	<p>The council of governors has a statutory duty to hold the non-executive directors individually and collectively to account for the performance of the board of directors.</p> <p><b><i>The Board of Directors and the Council of Governors comply with this requirement.</i></b></p>
A.5.11	<p>The 2006 Act, as amended, gives the council of governors a statutory requirement to receive the following documents. These documents should be provided in the annual report as per the <i>NHS Foundation Trust Annual Reporting Manual</i>:</p> <ul style="list-style-type: none"> <li>(a) the annual accounts;</li> <li>(b) any report of the auditor on them; and</li> <li>(c) the annual report.</li> </ul> <p><b><i>The Trust meets this requirement.</i></b></p>
A.5.12	<p>The directors must provide governors with an agenda prior to any meeting of the board, and a copy of the approved minutes as soon as is practicable afterwards. There is no legal basis on which the minutes of private sessions of board meetings should be exempted from being shared with the governors. In practice, it may be necessary to redact some information, for example, for data protection or commercial reasons. Governors should respect the confidentiality of these documents.</p> <p><b><i>The Trust meets this requirement.</i></b></p>
A.5.13	<p>The council of governors may require one or more of the directors to attend a meeting to obtain information about performance of the trust’s functions or the directors’ performance of their duties, and to help the council of governors to decide whether to propose a vote on the trust’s or directors’ performance.</p> <p><b><i>The Trust meets this requirement.</i></b></p>
A.5.14	<p>Governors have the right to refer a question to the independent panel for advising governors. More than 50% of governors who vote must approve this referral. The council should ensure dialogue with the board of directors takes place before considering such a referral, as it may be possible to resolve questions in this way.</p>



Reference	Statutory requirement:
	<b><i>The Trust is aware of this requirement.</i></b>
A.5.15	Governors should use their new rights and voting powers from the 2012 Act to represent the interests of members and the public on major decisions taken by the board of directors. These are outlined in full at A.5.15.  <b><i>The Trust meets this requirement.</i></b>
B.2.11	It is a requirement of the 2006 Act that the chairperson, the other non-executive directors and – except in the case of the appointment of a chief executive – the chief executive, are responsible for deciding the appointment of executive directors. The nominations committee with responsibility for executive director nominations should identify suitable candidates to fill executive director vacancies as they arise and make recommendations to the chairperson, the other non-executives directors and, except in the case of the appointment of a chief executive, the chief executive.  <b><i>The Trust meets this requirement.</i></b>
B.2.12	It is for the non-executive directors to appoint and remove the chief executive. The appointment of a chief executive requires the approval of the council of governors.  <b><i>The Trust meets this requirement.</i></b>
B.2.13	The governors are responsible at a general meeting for the appointment, re-appointment and removal of the chairperson and the other non-executive directors.  <b><i>The Trust meets this requirement.</i></b>
B.4.3	The board has a duty to take steps to ensure that governors are equipped with the skills and knowledge they need to discharge their duties appropriately.  <b><i>The Trust meets this requirement.</i></b>
B.5.8	The board of directors must have regard for the views of the council of governors on the NHS foundation trust's forward plan.  <b><i>The Trust meets this requirement.</i></b>
B.7.3	Approval by the council of governors of the appointment of a chief executive should be a subject of the first general meeting after the appointment by a committee of the chairperson and non-executive directors. All other executive directors should be appointed by a committee of the chief executive, the chairperson and non-executive directors.  <b><i>The Trust meets this requirement.</i></b>
B.7.4	Non-executive directors, including the chairperson should be appointed by the council of governors for the specified terms subject to re-appointment thereafter at intervals of no more than three years and subject to the 2006 Act provisions relating to removal of a director.  <b><i>The Trust meets this requirement.</i></b>
B.7.5	Elected governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years.  <b><i>The Trust meets this requirement.</i></b>



Reference	Statutory requirement:
C.1.4	<p>a) The board of directors must notify Monitor and the council of governors without delay and should consider whether it is in the public's interest to bring to the public attention, any major new developments in the NHS foundation trust's sphere of activity which are not public knowledge, which it is able to disclose and which may lead by virtue of their effect on its assets and liabilities, or financial position or on the general course of its business, to a substantial change to the financial wellbeing, health care delivery performance or reputation and standing of the NHS foundation trust.</p> <p><b><i>The Trust meets this requirement.</i></b></p> <p>b) The board of directors must notify Monitor and the council of governors without delay and should consider whether it is in the public interest to bring to public attention all relevant information which is not public knowledge concerning a material change in:</p> <ul style="list-style-type: none"> <li>• the NHS foundation trust's financial condition;</li> <li>• the performance of its business; and/or</li> <li>• the NHS foundation trust's expectations as to its performance which, if made public, would be likely to lead to a substantial change to the financial wellbeing, health care delivery performance or reputation and standing of the NHS foundation trust.</li> </ul> <p><b><i>The Trust meets this requirement.</i></b></p>
D.2.4	<p>The council of governors is responsible for setting the remuneration of non-executive directors and the chairperson.</p> <p><b><i>The Trust meets this requirement.</i></b></p>
E.1.7	<p>The board of directors must make board meetings and the annual meeting open to the public. The trust's constitution may provide for members of the public to be excluded from a meeting for special reasons.</p> <p><b><i>The Trust meets this requirement.</i></b></p>
E.1.8	<p>The trust must hold annual members' meetings. At least one of the directors must present the trust's annual report and accounts, and any report of the auditor on the accounts, to members at this meeting.</p> <p><b><i>The Trust meets this requirement.</i></b></p>

2. The provisions listed below require a supporting explanation, even in the case that the NHS foundation trust is compliant with the provision. **Where the information is already contained within the annual report, a reference to its location is sufficient to avoid unnecessary duplication.**

Reference	Statutory requirement:
A.1.1	<p>This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by each of the boards and which are delegated to the executive management of the board of directors.</p> <p><b><i>Please see Annual Report paragraphs 3.3.1, 3.5 and 3.6.1 to 3.6.3.</i></b></p>
A.1.2	<p>The annual report should identify the chairperson, the deputy chairperson (where there is one), the chief executive, the senior independent director (see A.4.1) and the chairperson and members of the nominations, audit and remuneration committees. It should also set out the number of meetings of the board and those committees and individual attendance by directors.</p> <p><b><i>Please see Annual Report Section 1, Section 3.1, Section 3.6, paragraphs 3.6.6 and 3.6.7 and Section 3.7.</i></b></p>
A.5.3	<p>The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor.</p> <p><b><i>Please see Annual Report Section 3.5.1.</i></b></p>
B.1.1	<p>The board of directors should identify in the annual report each non-executive director it considers to be independent, with reasons where necessary.</p> <p><b><i>Please see paragraph 3.6.2 (Balance, completeness and appropriateness of the membership of the Board)</i></b></p>
B.1.4	<p>The board of directors should include in its annual report a description of each director's skills, expertise and experience. Alongside this, in the annual report, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS foundation trust.</p> <p><b><i>Please see paragraphs 3.6.1 to 3.6.3</i></b></p>
B.2.10	<p>A separate section of the annual report should describe the work of the nominations committee(s), including the process it has used in relation to board appointments.</p> <p><b><i>Please see paragraph 3.6.7</i></b></p>
B.3.1	<p>A chairperson's other significant commitments should be disclosed to the council of governors before appointment and included in the annual report. Changes to such commitments should be reported to the council of governors as they arise, and included in the next annual report.</p> <p><b><i>Please see paragraph 3.6.5</i></b></p>

Reference	Statutory requirement:
B.5.6	<p>Governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.</p> <p><b><i>Please see paragraph 3.3.1</i></b></p>
B.6.1	<p>The board of directors should state in the annual report how performance evaluation of the board, its committees, and its directors, including the chairperson, has been conducted.</p> <p><b><i>Please see paragraph 3.6.4</i></b></p>
B.6.2	<p>Where an external facilitator is used for reviews of governance, they should be identified and a statement made as to whether they have any other connection with the trust.</p> <p><b><i>Please see paragraph 3.6.4</i></b></p>
C.1.1	<p>The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy. There should be a statement by the external auditor about their reporting responsibilities. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report).</p> <p><b><i>Please see Section 5 (Directors and Auditors Statement)</i></b></p>
C.2.1	<p>The annual report should contain a statement that the board has conducted a review of the effectiveness of its system of internal controls.</p> <p><b><i>Please see Annual Governance Statement</i></b></p>
C.2.2	<p>A trust should disclose in the annual report:</p> <ul style="list-style-type: none"> <li>a) If it has an internal audit function, how the function is structured and what role it performs; or</li> <li>b) If it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes.</li> </ul> <p><b><i>a) Applies to this Trust. There is reference in the Annual Report, paragraph 3.6.6, 3.6.9.1, Statement of Directors' responsibilities in respect of the quality report.</i></b></p>
C.3.5	<p>If the council of governors does not accept the audit committee's recommendation on the appointment, reappointment or removal of an external auditor, the board of directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the council of governors has taken a different position.</p>

Reference	Statutory requirement:
	<b><i>Non applicable</i></b>
C.3.9	<p>A separate section of the annual report should describe the work of the audit committee in discharging its responsibilities. The report should include:</p> <ul style="list-style-type: none"> <li>• the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed;</li> <li>• an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and</li> <li>• if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.</li> </ul> <p><b><i>Please see paragraph 3.6.6</i></b></p>
D.1.3	<p>Where an NHS foundation trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.</p> <p><b><i>Not applicable</i></b></p>
E.1.5	<p>The board of directors should state in the annual report the steps they have taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, for example through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.</p> <p><b><i>Please see paragraph 3.6.4</i></b></p>
E.1.6	<p>The board of directors should monitor how representative the NHS foundation trust's membership is and the level and effectiveness of member engagement and report on this in the annual report.</p> <p><b><i>Please see paragraph 3.6.4 and 3.2.5 which describes the work of the Governors' Membership Development Committee which includes Non Executive Directors within its membership.</i></b></p>

3. The provisions listed below require supporting information to be made **publicly available** even in the case that the NHS foundation trust is compliant with the provision. This requirement can be met by making supporting information available on request and on the NHS foundation trust's website.

***The information described below is available upon request from the Trust Secretary and will also be placed on the Trust's website.***

Reference	Statutory requirement:
A.1.3	The board of directors should make available a statement of the objectives of the NHS foundation trust showing how it intends to balance the interests of patients, the local community and other stakeholders, and use this as the basis for its decision-making and forward planning.
B.1.4	A description of each director's expertise and experience, with a clear statement about the board of director's balance, completeness and appropriateness.
B.2.10	The main role and responsibilities of the nominations committee should be set out in publicly available, written terms of reference.
B.3.2	The terms and conditions of appointment of non-executive directors.
C.3.2	The main role and responsibilities of the audit committee should be set out in publicly available, written terms of reference.
D.2.1	The remuneration committee should make available its terms of reference, explaining its role and the authority delegated to it by the board of directors. Where remuneration consultants are appointed, a statement should be made available as to whether they have any other connection with the NHS foundation trust.
E.1.1	The board of directors should make available a public document that sets out its policy on the involvement of members, patients and the local community at large, including a description of the kind of issues it will consult on.
E.1.4	Contact procedures for members who wish to communicate with governors and/or directors should be made clearly available to members on the NHS foundation trust's website.

4. The provisions listed below require supporting information to be made **available to governors**, even in the case that the NHS foundation trust is compliant with the provision. This information should be set out in papers accompanying a resolution to re-appoint a non-executive director

***This information has been supplied to the Council of Governors in each report during 2013/14 seeking the reappointment of a Non Executive Director.***

Reference	Statutory requirement:
B.7.1	In the case of re-appointment of non-executive directors, the chairperson should confirm to the governors that following formal performance evaluation, the performance of the individual proposed for re-appointment continues to be effective and to demonstrate commitment to the role.

5. The provisions listed below require supporting information to be made **available to members**, even in the case that the NHS foundation trust is compliant with the provision. This information should be set out in papers accompanying a resolution to elect or re-elect a governor.

***This information is included within the election material circulated to members by the Electoral Reform Services who managed the elections on the governor elections on behalf of the Trust.***

Reference	Statutory requirement:
B.7.2	The names of governors submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to take an informed decision on their election. This should include prior performance information.

6. For all provisions listed below there are no special requirements as per 1-5 above. For these provisions, the basic “comply or explain” requirement stands. The disclosure should therefore contain **an explanation in each case where the trust has departed from the Code, explaining the reasons for the departure and how the alternative arrangements continue to reflect the main principles of the Code (page 13-16).**

A disclosure is only required for **departures** from the Code for the provisions listed in this section. NHS foundation trusts are welcome but not required to provide a simple statement of compliance with each individual provision. This may be useful in ensuring the disclosure is comprehensive and may help to ensure that each provision has been considered in turn.

In providing an explanation for any variation from the *NHS Foundation Trust Code of Governance*, the NHS foundation trust should aim to illustrate how its actual practices are consistent with the principle to which the particular provision relates. It should set out the background, provide a clear rationale, and describe any mitigating actions it is taking to address any risks and maintain conformity with the relevant principle. Where deviation from a particular provision is intended to be limited in time, the explanation should indicate when the NHS foundation trust expects to conform to the provision.

The table below provides a summary of the provisions – the full provisions as listed in the document should be used for reference. In this summary “the board” refers to the board of directors, “the council” to the council of governors, and “trust” refers to the NHS foundation trust.

Reference	Statutory requirement:
A.1.4	<p>The board should ensure that adequate systems and processes are maintained to measure and monitor the NHS foundation trust's effectiveness, efficiency and economy as well as the quality of its health care delivery</p> <p><b><i>The Trust is declaring compliance.</i></b></p>
A.1.5	<p>The board should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and delivery of performance</p> <p><b><i>The Trust is declaring compliance.</i></b></p>
A.1.6	<p>The board should report on its approach to clinical governance.</p> <p><b><i>The Trust is declaring compliance.</i></b></p>
A.1.7	<p>The chief executive as the accounting officer should follow the procedure set out by Monitor for advising the board and the council and for recording and submitting objections to decisions.</p> <p><b><i>The Trust is declaring compliance.</i></b></p>
A.1.8	<p>The board should establish the constitution and standards of conduct for the NHS foundation trust and its staff in accordance with NHS values and accepted standards of behaviour in public life.</p> <p><b><i>The Trust is declaring compliance.</i></b></p> <p><b><i>A Task and Finish Group of Governors and Directors has been established by the Board and is presently reviewing the Trust's Constitution with a view to submitting an updated version to the Board and Governors for approval in July 2014.</i></b></p>
A.1.9	<p>The board should operate a code of conduct that builds on the values of the NHS foundation trust and reflect high standards of probity and responsibility.</p> <p><b><i>The Trust is declaring compliance but a revised Code of Conduct for the Board and Council will be prepared as part of the work described at A.1.8.</i></b></p>
A.1.10	<p>The NHS foundation trust should arrange appropriate insurance to cover the risk of legal action against its directors.</p> <p><b><i>The Trust is not yet compliant with this provision. An overarching tender for Trust assurance arrangements is being prepared and will include Directors' insurance.</i></b></p>
A.3.1	<p>The chairperson should, on appointment by the council, meet the independence criteria set out in B.1.1. A chief executive should not go on to be the chairperson of the same NHS foundation trust.</p> <p><b><i>The Trust is declaring compliance.</i></b></p>
A.4.1	<p>In consultation with the council, the board should appoint one of the independent non-executive directors to be the senior independent director.</p> <p><b><i>The Trust is declaring compliance.</i></b></p>



Reference	Statutory requirement:
A.4.2	<p>The chairperson should hold meetings with the non-executive directors without the executives present.</p> <p><b><i>The Trust is declaring compliance.</i></b></p>
A.4.3	<p>Where directors have concerns that cannot be resolved about the running of the NHS foundation trust or a proposed action, they should ensure that their concerns are recorded in the board minutes.</p> <p><b><i>The Trust is declaring compliance.</i></b></p>
A.5.1	<p>The council of governors should meet sufficiently regularly to discharge its duties.</p> <p><b><i>The Trust is declaring compliance.</i></b></p>
A.5.2	<p>The council of governors should not be so large as to be unwieldy.</p> <p><b><i>The Trust is declaring compliance. The composition of the Council of Governors is under further review by the Task and Finish Group described at A.1.8 above.</i></b></p>
A.5.4	<p>The roles and responsibilities of the council of governors should be set out in a written document.</p> <p><b><i>The Trust is declaring compliance.</i></b></p>
A.5.5	<p>The chairperson is responsible for leadership of both the board and the council but the governors also have a responsibility to make the arrangements work and should take the lead in inviting the chief executive to their meetings and inviting attendance by other executives and non-executives, as appropriate.</p> <p><b><i>The Trust is declaring compliance.</i></b></p>
A.5.6	<p>The council should establish a policy for engagement with the board of directors for those circumstances when they have concerns.</p> <p><b><i>The Trust is declaring compliance.</i></b></p>
A.5.7	<p>The council should ensure its interaction and relationship with the board of directors is appropriate and effective.</p> <p><b><i>The Trust is declaring compliance.</i></b></p>
A.5.8	<p>The council should only exercise its power to remove the chairperson or any non-executive directors after exhausting all means of engagement with the board.</p> <p><b><i>The Trust is declaring compliance.</i></b></p>
A.5.9	<p>The council should receive and consider other appropriate information required to enable it to discharge its duties.</p> <p><b><i>The Trust is declaring compliance.</i></b></p>



Reference	Statutory requirement:
B.1.2	<p>At least half the board, excluding the chairperson, should comprise non-executive directors determined by the board to be independent.</p> <p><b><i>The Trust is declaring compliance.</i></b></p>
B.1.3	<p>No individual should hold, at the same time, positions of director and governor of any NHS foundation trust.</p> <p><b><i>The Trust is declaring compliance.</i></b></p>
B.2.1	<p>The nominations committee or committees, with external advice as appropriate, are responsible for the identification and nomination of executive and non-executive directors.</p> <p><b><i>The Trust is declaring compliance.</i></b></p>
B.2.2	<p>Directors on the board of directors and governors on the council should meet the “fit and proper” persons test described in the provider licence.</p> <p><b><i>The Trust is declaring compliance.</i></b></p> <p><b><i>During 2013/14 the Trust has introduced DBS testing for Directors and Governors.</i></b></p>
B.2.3	<p>The nominations committee(s) should regularly review the structure, size and composition of the board and make recommendations for changes where appropriate.</p> <p><b><i>The Trust is declaring compliance. During 2013/14, the Nominations Committee has reviewed the structure, size and composition of the Board and appointed an additional Executive and Non Executive Director.</i></b></p>
B.2.4	<p>The chairperson or an independent non-executive director should chair the nominations committee(s).</p> <p><b><i>The Trust is declaring compliance.</i></b></p>
B.2.5	<p>The governors should agree with the nominations committee a clear process for the nomination of a new chairperson and non-executive directors.</p> <p><b><i>The Trust is declaring compliance.</i></b></p>
B.2.6	<p>Where an NHS foundation trust has two nominations committees, the nominations committee responsible for the appointment of non-executive directors should consist of a majority of governors.</p> <p><b><i>The Trust is declaring compliance. During 2013/14 the Nominations Committee has appointed the Trust Chief Executive as a member of the Committee.</i></b></p>
B.2.7	<p>When considering the appointment of non-executive directors, the council should take into account the views of the board and the nominations committee on the qualifications, skills and experience required for each position.</p> <p><b><i>The Trust is declaring compliance.</i></b></p>

Reference	Statutory requirement:
B.2.8	<p>The annual report should describe the process followed by the council in relation to appointments of the chairperson and non-executive directors.</p> <p><b><i>The Trust is declaring compliance.</i></b></p>
B.2.9	<p>An independent external adviser should not be a member of or have a vote on the nominations committee(s).</p> <p><b><i>The Trust is declaring compliance.</i></b></p>
B.3.3	<p>The board should not agree to a full-time executive director taking on more than one non-executive directorship of an NHS foundation trust or another organisation of comparable size and complexity.</p> <p><b><i>The Trust is declaring compliance.</i></b></p>
B.5.1	<p>The board and the council governors should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make.</p> <p><b><i>The Trust is declaring compliance.</i></b></p>
B.5.2	<p>The board and in particular non-executive directors, may reasonably wish to challenge assurances received from the executive management. They need not seek to appoint a relevant adviser for each and every subject area that comes before the board, although they should, wherever possible, ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis.</p> <p><b><i>The Trust is declaring compliance.</i></b></p>
B.5.3	<p>The board should ensure that directors, especially non-executive directors, have access to the independent professional advice, at the NHS foundation trust's expense, where they judge it necessary to discharge their responsibilities as directors.</p> <p><b><i>The Trust is declaring compliance.</i></b></p>
B.5.4	<p>Committees should be provided with sufficient resources to undertake their duties.</p> <p><b><i>The Trust is declaring compliance.</i></b></p>
B.6.3	<p>The senior independent director should lead the performance evaluation of the chairperson.</p> <p><b><i>The Trust is declaring compliance.</i></b></p>
B.6.4	<p>The chairperson, with assistance of the board secretary, if applicable, should use the performance evaluations as the basis for determining individual and collective professional development programmes for non-executive directors relevant to their duties as board members.</p> <p><b><i>The Trust is declaring compliance.</i></b></p>
B.6.5	<p>Led by the chairperson, the council should periodically assess their collective performance and they should regularly communicate to members and the public</p>

Reference	Statutory requirement:
	<p>details on how they have discharged their responsibilities.</p> <p><b><i>The Trust is declaring compliance.</i></b></p>
B.6.6	<p>There should be a clear policy and a fair process, agreed and adopted by the council, for the removal from the council of any governor who consistently and unjustifiably fails to attend the meetings of the council or has an actual or potential conflict of interest which prevents the proper exercise of their duties.</p> <p><b><i>The Trust is declaring compliance.</i></b></p>
B.8.1	<p>The remuneration committee should not agree to an executive member of the board leaving the employment of an NHS foundation trust, except in accordance with the terms of their contract of employment, including but not limited to service of their full notice period and/or material reductions in their time commitment to the role, without the board first having completed and approved a full risk assessment.</p> <p><b><i>The Trust is declaring compliance.</i></b></p>
C.1.2	<p>The directors should report that the NHS foundation trust is a going concern with supporting assumptions or qualifications as necessary.</p> <p><b><i>The Trust is declaring compliance.</i></b></p>
C.1.3	<p>At least annually and in a timely manner, the board should set out clearly its financial, quality and operating objectives for the NHS foundation trust and disclose sufficient information, both quantitative and qualitative, of the NHS foundation trust's business and operation, including clinical outcome data, to allow members and governors to evaluate its performance.</p> <p><b><i>The Trust is declaring compliance.</i></b></p>
C.3.1	<p>The board should establish an audit committee composed of at least three members who are all independent non-executive directors.</p> <p><b><i>The Trust is declaring compliance.</i></b></p>
C.3.3	<p>The council should take the lead in agreeing with the audit committee the criteria for appointing, re-appointing and removing external auditors.</p> <p><b><i>The Trust is declaring compliance.</i></b></p>
C.3.6	<p>The NHS foundation trust should appoint an external auditor for a period of time which allows the auditor to develop a strong understanding of the finances, operations and forward plans of the NHS foundation trust.</p> <p><b><i>The Trust is declaring compliance.</i></b></p>
C.3.7	<p>When the council ends an external auditor's appointment in disputed circumstances, the chairperson should write to Monitor informing it of the reasons behind the decision.</p> <p><b><i>The Trust is declaring compliance.</i></b></p>
C.3.8	<p>The audit committee should review arrangements that allow staff of the NHS</p>

Reference	Statutory requirement:
	<p>foundation trust and other individuals where relevant, to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters.</p> <p><b><i>The Trust is declaring compliance.</i></b></p>
D.1.1	<p>Any performance-related elements of the remuneration of executive directors should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels.</p> <p><b><i>The Trust did not have a performance-related element of remuneration for Executives during 2013/14.</i></b></p>
D.1.2	<p>Levels of remuneration for the chairperson and other non-executive directors should reflect the time commitment and responsibilities of their roles.</p> <p><b><i>The Trust is declaring compliance.</i></b></p>
D.1.4	<p>The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination.</p> <p><b><i>The Trust is declaring compliance.</i></b></p>
D.2.2	<p>The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments.</p> <p><b><i>The Trust is declaring compliance.</i></b></p>
D.2.3	<p>The council should consult external professional advisers to market-test the remuneration levels of the chairperson and other non-executives at least once every three years and when they intend to make a material change to the remuneration of a non-executive.</p> <p><b><i>The Trust is declaring compliance.</i></b></p>
E.1.2	<p>The board should clarify in writing how the public interests of patients and the local community will be represented, including its approach for addressing the overlap and interface between governors and any local consultative forums.</p> <p><b><i>The Trust is declaring compliance.</i></b></p>
E.1.3	<p>The chairperson should ensure that the views of governors and members are communicated to the board as a whole.</p> <p><b><i>The Trust is declaring compliance.</i></b></p>
E.2.1	<p>The board should be clear as to the specific third party bodies in relation to which the NHS foundation trust has a duty to co-operate.</p> <p><b><i>The Trust is declaring compliance.</i></b></p>
E.2.2	<p>The board should ensure that effective mechanisms are in place to co-operate</p>

Reference	Statutory requirement:
	<p>with relevant third party bodies and that collaborative and productive relationships are maintained with relevant stakeholders at appropriate levels of seniority in each.</p> <p><b><i>The Trust is declaring compliance.</i></b></p>

### 3.5 THE COUNCIL OF GOVERNORS

The Council of Governors presently has 30 places, of which 24 represent the public and staff and are elected by our Members. The remaining 6 are appointed by partnership organisations which include Stockport Metropolitan Borough Council, Stockport and Derbyshire County Primary Care Trusts, the voluntary sector, the education sector and other local bodies. The Governor positions of partnership organisations are presently under review as part of a joint Board / Council Task and Finish Group established as a result of the joint development day in November 2013.

The Council of Governors meet formally four times per year. Ad hoc meetings of the Council are called as required.

The Council of Governors takes decisions with regard to:

- The appointment / removal of the Chairman and other Non Executive Directors.
- The approval of the appointment (by the Non Executive Directors) of the Chief Executive.
- The remuneration and allowances and the other terms and conditions of the Non Executive Directors.
- The appointment / removal of the Trust's External Auditor.
- The Annual Accounts, any report of the External Auditor on the Annual Accounts and the Annual Report.
- The provision of views to the Board of Directors when the Board of Directors is preparing the document containing information about the Trust's forward planning.
- Responding as appropriate when consulted by the Board of Directors in accordance with the Constitution.
- Undertaking such functions as the Board of Directors shall from time to time request.
- Preparing and reviewing the Trust's Membership Development and Involvement Strategies, its policy for the composition of the Council of Governors and of the Non Executive Directors.

The Council of Governors has three Committees:

- Governance Committee
- Membership Development Committee
- Patient Safety and Quality Standards Committee.

These Committees have met throughout 2013/14 and provide reports and recommendations to the Council of Governors at their quarterly meetings.

Each of the Governor Committees include Non Executive Director involvement and in the case of the Governance Committee, direct involvement by the Chairman.

Each of the Committees have a core membership but all Governors receive copies of agendas and papers and are welcome to attend meetings of the Committees.

The Council of Governors works closely with the Board of Directors. During 2013/14 Directors have attended meetings of the Council of Governors.

The Governors have not exercised their power under paragraph 10.C of Schedule 7 of the NHS Act to require one or more Directors to attend a Governors' meeting.

The Council of Governors receive at each of their meetings reports from the Chief Executive on current performance and operational issues and also on strategic issues. A joint Board of Directors / Council of Governors development session to discuss issues arising from the Health and Social Care Act and the KPMG review took place in November 2013 with an agreed action plan which is now being implemented.

Directors and Governors have been involved in the following areas of membership engagement:

- a) The Trust produces a newsletter for all its members which is circulated three times per year. The publication provides members with details of what is happening within the Trust with regard to developments in services and other topical issues such as infection control. The newsletter also provides details of Governors and how they can be contacted and has a section that invites members to contact the Trust if they have any issues or comments that they wish to raise with us.
- b) The Trust's internet site provides details of Governors and how they can be contacted. The website also provides information about developments within the Trust and provides a link for members to communicate either with the Governors or with the Trust. Board papers are also posted on the Trust's internet site.
- c) A number of membership engagement events have been held during 2013/14. These were described within the Chairman's Foreword. A programme of membership engagement events for 2014/15 has been prepared and is identified in the section on membership development (3.2.5).
- d) Receiving feedback from Trust members who have become involved with the Trust at local level including:
  - Being used as "mystery shoppers" to measure the level of customer care given by Departments
  - Taking part in Ward audits and surveys
  - Reading and reviewing Trust patient information leaflets
  - Commenting on patient information, planned for patients taking part in clinical trials
  - Receiving appropriate divisional and departmental newsletters

- Participating in seminars and training events and specific research and development training
- Participating in patient and carer groups
- Undertaking visits to areas of the hospital
- Being kept informed of local, regional and national consultation exercises so that they can offer their views.
- Providing their views on a number of specific topics of interest to the Trust by completion of regular questionnaires.

There have been four formal meetings of the Council of Governors during 2013/14 and the attendance of Governors at these meetings are detailed below.

Governors operate on a non-paid voluntary basis. In 2013/14, Governors were reimbursed £0.7k (£1.2k in 2012/13).

### **3.5.1 Elected Governors**

Elections were held in 2013/14 in the following constituencies. The results of the elections are shown in brackets:

#### Staff:

- (By-election): Community Staff (1 Governor elected unopposed)

#### Public:

- Bramhall and Cheadle (4 Governors elected)
- Marple and Stepping Hill (4 Governors elected)
- (By-election) Tame Valley and Werneth (no Governors elected, leaving 3 vacancies)
- (By-election): Tameside (no Governor elected, leaving 1 vacancy)

Results of these elections were announced at the Annual Members' Meeting in October 2013.

The above elections were held under the independent scrutiny of the Electoral Reform Services.

The following lists our elected Governors:



<b>Name</b>	<b>Constituency</b>	<b>Elected Until</b>	<b>Attendance at formal Governors' meetings</b>
<b>Janet Blakeley</b>	Community Staff	Annual Members' Meeting 2015 (resigned in September 2013)	1/2
<b>Stuart Clensy</b>	Community Staff	Annual Members' Meeting 2015	n/a
<b>Jean Rogers</b>	Other Staff	Annual Members' Meeting 2015	3/4
<b>Kay Wiss</b>	Other Staff	Annual Members' Meeting 2015	4/4
<b>Simon Plevin</b>	Other Staff	Annual Members' Meeting 2015	4/4
<b>Patricia Berry</b>	Public – Bramhall & Cheadle	Annual Members' Meeting 2013	1/3
<b>Tony Johnson</b>	Public – Bramhall & Cheadle	Annual Members' Meeting 2013	3/3
<b>David Kirk</b>	Public – Bramhall & Cheadle. Lead Governor until October 2013	Annual Members' Meeting 2013	2/3
<b>Robert Cryer</b>	Public – Bramhall & Cheadle	Annual Members' Meeting 2016	1/1
<b>Charles Galasko</b>	Public – Bramhall & Cheadle	Annual Members' Meeting 2016	1/1
<b>Maureen Harrison</b>	Public – Bramhall & Cheadle	Annual Members' Meeting 2016	1/1
<b>Margaret Nabb</b>	Public – Bramhall & Cheadle	Annual Members' Meeting 2016	3/4
<b>Evelyn Brown</b>	Public – Tame Valley & Werneth	Annual Members' Meeting 2015	4/4
<b>Lesley Auger</b>	Public – Heatons & Victoria	Annual Members' Meeting 2014	4/4
<b>Gerald Wright</b>	Public – Heatons & Victoria	Annual Members' Meeting 2014	3/4
<b>Diana Readman</b>	Public – Heatons & Victoria	Annual Members' Meeting 2014 (resigned in October 2013)	1/3



<b>Name</b>	<b>Constituency</b>	<b>Elected Until</b>	<b>Attendance at formal Governors' meetings</b>
<b>Janet Morley</b>	Public – Heaton & Victoria	Annual Members' Meeting 2014	4/4
<b>Cecil Brooks</b>	Public – Marple & Stepping Hill	Annual Members' Meeting 2013	3/3
<b>Ronald Catlow</b>	Public – Marple & Stepping Hill	Annual Members' Meeting 2016	1/1
<b>Les Jenkins</b>	Public – Marple & Stepping Hill. Lead Governor from December 2013.	Annual Members' Meeting 2016	4/4
<b>Carole Normington</b>	Public – Marple & Stepping Hill	Annual Members' Meeting 2016	1/1
<b>Chris Wrigley</b>	Public – Marple & Stepping Hill	Annual Members' Meeting 2016	4/4
<b>Tim Norton</b>	Public – High Peak	Annual Members' Meeting 2015	1/4
<b>Lynne Woodward</b>	Public – High Peak	Annual Members' Meeting 2015	4/4
<b>Terence Moore</b>	Public – Outer Region	Annual Members' Meeting 2015	3/4

### 3.5.2 Appointed Governors

<b>Name</b>	<b>Appointed By</b>	<b>Appointed Until</b>	<b>Attendance at formal Governors' meetings</b>
<b>John Pantall</b>	Stockport MBC	Annual Members' Meeting 2014	3/4
<b>Anand Dutta</b>	Stockport Community and Voluntary Services	Annual Members' Meeting 2014	3/4
<b>Fiona Fox</b>	Stockport College	Annual Members' Meeting 2014	2/4

In accordance with the statutory requirements, we keep a register of interests of the Council of Governors which is available upon request for inspection by members of the public (please contact John Pierse on 0161 419 5164 or [john.pierse@stockport.nhs.uk](mailto:john.pierse@stockport.nhs.uk) if you wish to have access to the register). The same contact point can be used for members wishing to communicate with Governors.

### 3.6. BOARD OF DIRECTORS AND BOARD COMMITTEES

The Board of Directors is responsible for managing the business of the Trust and, subject to the Constitution, exercises all the powers of the Trust. Board of Directors therefore has overall responsibilities for delivering the activities of the Trust and are accountable for the operational performance of the Trust as well as the definition and implementation of strategy and policy.

The Board of Directors therefore takes decisions with regard to:

- **Quality Issues** – which includes Clinical Effectiveness and the Trust's Quality Dashboard, Infection Control, Patient Experience and Staff Development and Assurance Risk.
- **Strategic and Developmental Issues** – this includes decisions with regard to business planning, the Trust's Annual Plan, decisions to invest in additional capacity and site development, the Trust's Capital Programme and other strategic issues affecting the Trust as they arise.
- **Finance and Performance** – this includes taking decisions with regard to the Trust's financial performance as well as its performance against all key performance indicators.
- **Governance Issues**

The day to day management of the Trust rests with the Chief Executive and Executive Directors who are responsible for taking decisions, particularly with regard to financial and performance issues and day to day quality matters, subject to the Trust's Scheme of Delegation and Standing Financial Instructions.

The Board of Directors comprises a Chairman, six Non-Executive Directors and six Executive Directors. The Board considers each of the Non-Executive Directors to be independent in character and judgement and have identified no relationships or circumstances that are likely to affect or appear to affect their judgement. During 2013/14 the Board of Directors met on eight occasions and attendance by Directors at these meetings is given below. The composition of the Board during 2013/14 was:

#### 3.6.1 Chairman

##### **GILLIAN EASSON**

Appointed on 01.11.2012 until 31.10.2015 (Previously Non Executive Director / Deputy Chairman)

##### Declared interests

- Pro-Chancellor of the University of Manchester and Chairman of the Nominations Committee
- Board member of the University of Manchester Global Leadership Board
- Annuitant Sandison Easson & Co.

##### Background

Following graduation from Cambridge University, Gillian Easson qualified as a solicitor in Stockport and became one of the North West's first female prosecuting solicitors. In 2000, she was appointed a Non Executive Director of the Christie Hospital, a governor of UMIST

and in 2004, a founder governor of the University of Manchester, becoming the first Deputy Chair in 2007. Gillian has over a decade's public sector experience in both the NHS and higher education sectors, together with significant experience of regulation and strategic oversight of organisational risk and change. Gillian was appointed as a Non Executive Director of Stockport NHS Foundation Trust on 1 January 2007 and was also Deputy Chairman until 31 October 2012. She was appointed as Chairman of the Trust on 1 November 2012.

#### Attendance at formal meetings of the Board of Directors

8/8

### **3.6.2 NON EXECUTIVE DIRECTORS**

#### **MIKE CHESHIRE**

Appointed on 01.09.2013 until 31.08.2016

#### Declared interests

- Clinical Adviser, Kings Fund
- Senior Clinical Adviser, Haelo, patient safety organisation based at Salford Royal FT
- Unpaid Medical Adviser to Broughton House home for veterans
- Patron ME Trust.

#### Background

Dr Mike Cheshire is a hugely experienced clinician, having worked as a consultant physician, specialising in geriatric and general medicine for many years, including nearly three decades working at Central Manchester Hospitals Foundation Trust. He was Clinical Vice President at the Royal College of Physicians, London from 2007 to 2010. Dr Cheshire has also held a number of other important management and regional responsibilities, including Director of Post Graduate Education (1997-2001) and clinical head of intermediate care for Central Manchester Primary Care Trust (2004-2007). From 2009 until recently, Dr Cheshire was the Medical Director for NHS North West, which was our regional health authority.

#### Attendance at formal meetings of the Board of Directors

5/5

#### **CAROL PROWSE**

Re-appointed on 01.04.2014 until 31.03.2015.

Appointed as Senior Independent Director in December 2009.

Re-appointed as Deputy Chairman on 02.04.2014

#### Declared interests

- Works with the Kinder Children's Choirs.

#### Background

Carol Prowse currently works with the High Peak Theatre Trust as a Director and Company Secretary. Carol has a strong interest in the performing arts, and also works with the Kinder Children's Choirs of the High Peak. Carol Prowse worked for a number of years for the High Peak Borough Council. For five years she was a Non Executive Director on the High Peak and Dales Primary Care Trust Board and was their appointed Governor with this Trust.

#### Attendance at formal meetings of the Board of Directors

7/8

### **JOHN SANDFORD**

Appointed on 01.07.2011 until 30.06.2014. Reappointed by Council of Governors in April 2014 for a further period of three years 01.07.2014 – 30.06.2017.

#### Declared interests

- Partner / Director KPMG / KPMG Audit PLC / KPMG LLP 1989 – 31/12/2010
- Director Epworth Investment Management Ltd
- Chair of Trustee Edward Mayes Trust (Charity)
- Council Member Central Finance Board of the Methodist Church
- Partner McKellens Outsourcing LLP
- Non Executive Director – Johnnie Johnson Housing Trust
- Non Executive Director at the Chorley Building Society
- Director of Cheadle Golf Club Trading Ltd

#### Background

John Sandford has a degree and is a chartered accountant who worked for many years with KPMG. He was an audit partner/director responsible for audit opinions, managing teams and setting audit strategy, until his retirement from the organisation on 31 December 2010. Following his retirement from KPMG, Mr Sandford has established a joint venture with a local firm of chartered accountants and is developing a financial consulting business in Stockport. Mr Sandford lives in Bramhall, Stockport, and is married with two children. He has a range of local community interests, together with being a keen cricketer and golfer.

#### Attendance at formal meetings of the Board of Directors

8/8

### **JOHN SCHULTZ**

Appointed on 01.09.2013 until 31.08.2016

#### Declared interests

- Non-Executive Director (Vice Chair) and trustee, Disability Stockport Ltd
- Chair, Trafford Integrated Care Redesign Board (to end of December 2014). Client: Director of Commissioning, Trafford Clinical Commissioning Group
- Senior adviser (local government), Newton Europe Ltd (operational improvement specialists)
- Member of General Assembly, University of Manchester.

#### Background

John Schultz CBE was Chief Executive of Stockport Council for 16 years until his retirement in 2010. Under his leadership, the Council reached the Audit Commission's top performance category. John was instrumental in setting up the Greater Manchester Health Commission, and jointly chaired the Greater Manchester Public Health Network. He is currently the independent chair of an NHS board overseeing the development of integrated care in Trafford (the Trafford Clinical Commissioning Group's Integrated Care Redesign Board).

John also assists with the governance of a number of educational establishments and charities, as well as carrying out management consultancy work. He was recognised for services to local government and appointed CBE in 2010.

Attendance at formal meetings of the Board of Directors

5/5

**MALCOLM SUGDEN**

Appointed on 01.04.2012 until 31.03.2015

Declared interests

- Nil

Background

Before his appointment as Non Executive Director of Stockport NHS Foundation Trust, Malcolm was a Non Executive Director at Tameside and Glossop Primary Care Trust from July 2010 and took an active role sitting on finance and audit committees. Previously Malcolm had worked as an Executive Finance Director for Electricity Northwest which held the licence to distribute electricity across the North West of England. The business had a turnover approaching £350 million providing services to around 2.4 million customers and this work provided excellent experience in dealing with large scale accounting and other strategic financial matters. Malcolm lives in Ashton Under Lyne.

Attendance at formal meetings of the Board of Directors

8/8

**LESLIE WILCOCK**

Re-appointed on 01.07.2012 until 30.06.2015.

Declared interests

- Director Opening Doors Ltd.
- Co-Director – Cream Loyalty LLP
- Co-Director – Cream Loyalty CRM Ltd
- Possible joint working / co-operation with Comprehensive Communications, known as Comp Comms, who are a not-for-profit PR organisation based in the clinical research facility at the University Hospital of South Manchester.

Background

Leslie Wilcock graduated with an honours degree in Computer Science and holds a diploma in marketing and in management studies. He is the Managing Director of Opening Doors, a full service marketing agency based in Congleton. He has been with the company for nine years and previously also held a senior position at professional services, KPMG. But it is the four years he spent with a fire and flood restoration company looking after the Stockport, High Peak and East Cheshire area that Les feels really benefits him in his role as a Non Executive Director of Stockport NHS Foundation Trust.

Attendance at formal meetings of the Board of Directors

7/8

## **BALANCE, COMPLETENESS AND APPROPRIATENESS OF THE MEMBERSHIP OF THE BOARD**

There have been two Non Executive Director appointments during 2013/14. The process adopted for these appointments took into account the requirement for the membership of the Board of Directors to be balanced, complete and appropriate.

<u>Skill</u>	<u>Responsible Non-Executive Director</u>
Clinical	Mike Cheshire
Financial Acumen	John Sandford / Malcolm Sugden
Marketing / Commerce	Leslie Wilcock
Legal	Gillian Easson
Patient Advocate / General Board Experience	Carol Prowse
Transformational	John Schultz

A joint statement by the Chairman and Chief Executive will be made to confirm the balance, completeness and appropriateness of the full Board of Directors and will be published on the Trust's Website.

During 2013/14, Directors were reimbursed expenses totalling £7k (£4.2k in 2012/13).

In accordance with the statutory requirements, we keep a register of interests of the Board of Directors which is available upon request for inspection by members of the public (please contact John Pierse on 0161 419 5164 or [john.pierse@stockport.nhs.uk](mailto:john.pierse@stockport.nhs.uk) if you wish to have access to the register). The same contact point can be used for members wishing to communicate with Directors.

### **3.6.3 EXECUTIVE DIRECTORS**

#### **CHIEF EXECUTIVE - ANN BARNES**

##### Declared interests

- Husband has hand crafted card business that has supplied the Nursing Directorate with material. The value is less than £200 per year.
- Member of the General Assembly of the University of Manchester (1.9.2013 for 3 years)

##### Background

Ann Barnes has worked in the NHS since 1979 and during the past 35 years has worked both at regional and hospital level across the full spectrum of district general hospital service provision.

##### Attendance at formal meetings of the Board of Directors

8/8

#### **MEDICAL DIRECTOR - JAMES CATANIA**

##### Declared interests

- Honorary President Stockport Parkinson's Disease Society.

##### Background

James Catania has been a Medical Director for the last 12 years and is a specialist in the care of older people, for which he has retained his clinical commitments. He has worked as a consultant physician for the last 21 years and has been involved in management for over 19 years.

##### Attendance at formal meetings of the Board of Directors

7/8

#### **DIRECTOR OF FINANCE - BILL GREGORY**

##### Declared interests

- Governor, Stockport College

##### Background

Bill Gregory joined the Trust on 1 June 2007, from Sherwood Forest NHS Foundation Trust where he had been Executive Director of Finance since November 2003. He has worked in a variety of finance and commercial roles within the public and private sectors. Having trained as an Accountant with Coopers and Lybrand, he joined the NHS in 1993 and has previously held the post of Director of Finance at two NHS Trusts in northwest England, and Head of Business Development for BUPA Hospitals.

##### Attendance at formal meetings of the Board of Directors

7/8

#### **DIRECTOR OF NURSING AND MIDWIFERY - JUDITH MORRIS**

##### Declared interests

- Nil.



### Background

Judith Morris began her career at Manchester Royal Infirmary and became one of the first intake to study for the new Bachelor of Nursing qualification at the University of Manchester. She became a Nursing Tutor in 1987 and went on to work in various nursing specialist roles, being appointed as Assistant Director of Nursing with the then Stockport Healthcare Trust. She continued in that role when the Stockport Trusts merged in 2000 and became Deputy of Director of Nursing and Midwifery in 2004 and Director of Nursing and Midwifery in 2008.

### Attendance at formal meetings of the Board of Directors

8/8

## **DIRECTOR OF WORKFORCE AND ORGANISATIONAL DEVELOPMENT - JAYNE SHAW**

### Declared interests

- Nil.

### Background

Before joining the Trust as Interim Director of Human Resources on 1 January 2013, Jayne spent twelve months as the Interim Director of Workforce at Mid Cheshire NHS Foundation Trust. Prior to this, she was the Director of Human Resources and Organisational Development at Alder Hey Children's NHS Foundation Trust for five years. Jayne's experience in human resources spans a range of roles and organisations across the NHS. Jayne Shaw was appointed as Director of Workforce and Organisational Development on 22 August 2013.

### Attendance at formal meetings of the Board of Directors

6/8

## **DIRECTOR OF PLANNING AND BUSINESS DEVELOPMENT (NON VOTING) - CAROLE SPENCER**

(Until 31.01.2014)

### Declared interests

- Governor of Stockport Technical School.

### Background

Carole Spencer began her career with a ten year spell in the private sector, working in investment and the stock market and subsequently in management consultancy with a focus on business improvement.

Her first role in the health service was as Director of Business Planning at Alder Hey, Royal Liverpool Children's NHS Trust where she worked for two years. After taking up a post with the then Regional Health Authority, Carole worked at the Countess of Chester Hospital as Director of Service Development and Planning.

### Attendance at formal meetings of the Board of Directors

5/6

## CHIEF OPERATING OFFICER - JAMES SUMNER

### Declared interests

- Nil.

### Background

James Sumner joined the NHS in 1999. James started at our Trust as Associate Director on 1 September 2009. His background is a mix of primary, secondary care and service improvement work. Prior to starting here, James was General Manager for the Surgical Care Group at St Helens & Knowsley NHS Teaching Hospitals Trust. He was Acting Director of Operations and Performance from November 2012 before being appointed as Chief Operating Officer with effect from 13 September 2013.

### Attendance at formal meetings of the Board of Directors

8/8

The remuneration disclosures in relation to Executive and Non Executive Directors are included in the Remuneration Report.

## 3.6.4 PERFORMANCE EVALUATION

The Board of Directors has regular scheduled “time outs” to discuss both the operational and strategic performance of the Trust. Following the appointment of the Assistant Director – Organisational Development and Learning, these sessions are now facilitated internally with external presenters as appropriate. They offer the opportunity to reflect on the collective performance of the Board and personal needs to develop or strengthen particular areas. During 2013/14 these have focused on issues such as:

- Strategic Priorities
- Review of Board Effectiveness and Assurance Arrangements
- Development of Partnership Working with other Trusts
- Annual Objectives 2013/14
- Workforce and Organisational Development Issues

Links between the Board of Directors and Governors are strengthened by regular attendance by Directors at the Governors’ meetings including their Committees. There is also an annual questionnaire which considers the overall leadership of the Boards and the management of meetings. Individual competence and performance are addressed through annual personal appraisals for both Executive and Non Executive Directors together with associated development plans.

During 2013/14, the Trust has continued to implement its action plan following the KPMG review of governance and follow up review during the year. The updates against the action plan have been on the public agenda of the Board of Directors at each of its meetings.

In February 2014, the Trust commissioned Deloitte’s to undertake a further review of its governance against the proposed governance review arrangements being consulted upon at that time by Monitor. The outcome of that review and any action taken will be included in the Trust’s 2014/15 Annual Report.

### **3.6.5 COMMITMENTS OF THE CHAIRMAN**

The Chairman of the Trust has no further significant commitments to record.

### **3.6.6 AUDIT COMMITTEE**

The Trust has an Audit Committee which meets at least 4 times a year.

The membership of the committee is as detailed below. Attendance at meetings during 2013/14 is shown in brackets.

- John Sandford (Chair of the Audit Committee) – Non Executive Director (attendance at 6/6)
- Malcolm Sugden (Deputy Chair of the Audit Committee) – Non Executive Director (attendance at 6/6)
- Carol Prowse – Non Executive Director (member until 11 September 2013) (attendance at 2/4)
- John Schultz – Non Executive Director (member from 13 November 2013) (attendance at 3/3)
- Leslie Wilcock – Non Executive Director (attendance at 5/6)

The Director of Finance, Trust Secretary and either the Deputy Director of Finance or Associate Director of Finance, the Director of Nursing and Midwifery (as executive lead on risk management) and representatives from both Internal and External Audit are in attendance. Other Directors and members of the Senior Management team attend by invitation.

The Audit Committee has approved Terms of Reference which are available on request from the Trust Secretary and are regularly reviewed. Its primary purpose is to conclude upon the accuracy and effective operation of the Trust's overall control system. In performing this role the Committee's work predominately focuses upon the framework of risks, controls and related assurances that underpin the delivery of Trust objectives.

The Committee reviews the disclosure statements that flow from the Trust's assurance processes, in particular, the Annual Governance Statement.

The Audit Committee also independently monitors, reviews and reports to the Board on the processes of governance and, where appropriate, facilitates and supports, through its independence, the attainment of effective processes. Audit reports from Internal Audit are considered, and the implementation of actions plans, where necessary to improve assurance levels are also considered. The Audit Committee has approved a policy for use where external audit are required to provide non-audit services to ensure objectivity and independence is safeguarded.

The Chair and Deputy Chair of the Audit Committee met the Director of Finance, Deputy Director of Finance and Associate Director of Finance – Operational Finance on the 16<sup>th</sup> April 2014 to review and significant issues and key accounting judgements proposed to be included in the Annual Accounts. This review included detailed discussions on:

- The overall year-end financial position;
- Restructuring provision;
- Serious incident (saline tampering) costs;
- Disclosures in the accounts relating to exit packages;
- Disclosures in the accounts relating to off-payroll engagements.

This meeting was minuted, and the minutes presented to the full Audit Committee alongside the Annual Accounts, on the 20<sup>th</sup> May 2014.

During 2012/13 the Trust undertook a tender process for Internal Audit Services, and as a result Mersey Internal Audit Agency (MIAA) took over from Audit North West as the Trust's Internal Auditors and Counter Fraud Specialists from 1<sup>st</sup> April 2013.

Our Internal Audit service's purpose is:

- to provide the provision of an independent and objective opinion to the Accountable Officer, the Board, and the Audit Committee on the degree to which risk management, control and governance support the achievement of the organisations agreed objectives; and
- the provision of an independent and objective consultancy service specifically to help line management improve the organisation's risk management, control and governance arrangements.

MIAA deliver a risk-assessed audit plan, which is approved each year by the Audit Committee. This is delivered by appropriately qualified and trained Internal Auditors led by a nominated Audit Manager.

### **Directors' responsibility for preparing accounts**

The Trust's Accounting Officer (Chief Executive) delegates the responsibility for preparing the accounts to the Director of Finance. These are undertaken by the finance team, comprising qualified accountants and support staff, appropriately trained to produce professional accounts.

The Audit Committee has delegated authority from the Board of Directors to review and approve the Annual Accounts.

## **3.6.7 NOMINATIONS COMMITTEE**

The Nominations Committee for the appointment of the Chairman and Non Executive Directors has a standing membership comprising five Governors, including the Lead Governor, the Chairman, Chief Executive and Senior Independent Director of the Trust. The Chairman of the Trust is Chairman of the Committee.

During the year the Nominations Committee has overseen the appointment of two new Non Executive Directors for the Trust. The Trust commissioned Odgers Berndtson to support in the recruitment process.

### **1. June 2013**

The Nominations Committee managed the process and appointment of two new Non Executive Directors with the direct involvement of the following individuals in the interview process:

- Gillian Easson (Chairman)
- Carol Prowse (Senior Independent Director)
- Les Jenkins (Public Governor)
- Eve Brown (Public Governor)
- Kay Wiss (Staff Governor)

The Nominations Committee used the services of an external search consultancy.

The selection process took place on 17 June 2013 and resulted in the recommendation that Dr Mike Cheshire and John Schultz be appointed as Non Executive Directors.

These appointments were confirmed by the Council of Governors at their meeting on 3 July 2013. Dr Cheshire and Mr Schultz took up their posts with effect from 1 September 2013.

The Nominations Committee for the appointment of Executive Directors has been involved in the appointment of two Executive Directors during 2013/14. The Trust used open advertising in filling these posts.

On 19 June 2013 the selection process for the position of Chief Operating Officer was held. This included a focus group discussion involving a wide range of Executives, Non Executives and senior managerial and medical staff. The Interview Panel was:

- Gillian Easson (Chairman)
- Ann Barnes (Chief Executive)
- Karen James (Assessor – South Manchester)
- Les Wilcock (Non Executive Director)

Following this process, James Sumner was appointed as Chief Operating Officer and took up the position with effect from 13 September 2013.

On 18 July 2013 the selection process for the position of Director of Workforce and Organisational Development was held. This included a focus group discussion involving a wide range of Executives, Non Executives and senior managerial and medical staff. The Interview Panel was:

- Gillian Easson (Chairman)
- Ann Barnes (Chief Executive)
- Rachel Charlton (Assessor – East Cheshire)
- John Sandford (Non Executive Director)

Following this process, Jayne Shaw was appointed as Director of Workforce and Organisational Development and took up the position with effect from 22 August 2013.

### **3.6.8 TERMINATION OF APPOINTMENT OF CHAIR AND NON EXECUTIVE DIRECTORS**

Arrangements for any potential termination of appointments of the Chairman or another Non Executive Director are within the remit of the Council of Governors, in accordance with paragraph 13.6. of the Constitution of the Stockport NHS Foundation Trust.

### **3.6.9. PUBLIC INTEREST DISCLOSURES**

(Equality & Diversity)

Our Equality Delivery System (EDS) audit for 2013 demonstrates how the Trust is complying with the Equality Act 2010 and how our decision making processes include equality reference. Workforce and service monitoring reports have also been produced for 2013 and are published on our website alongside our new Equality and Diversity Strategy for 2014-2018. Together, these reports and audits ensure that the Trust is best placed to meet the statutory equality duties and in keeping with the Government's transparency agenda they allow the public to judge our progress.

#### **3.6.9.1 COUNTERING FRAUD AND CORRUPTION**

In 2013/14 the Trust's Local Counter Fraud Specialist (LCFS) and service is provided by Mersey Internal Audit Agency (MIAA). The Trust's Counter Fraud and Corruption Policy supports our strong anti-fraud culture, and the annual work plan is agreed by the Director of

Finance and the Audit Committee, covering areas such as enhancing the anti-fraud culture, deterring, preventing and investigating fraud.

The LCFS regularly attends the Audit Committee to provide updates on the progress of the annual work plan and investigations.

The Trust has a policy on Standards of Business Conduct with a group chaired by a Non-Executive Director that meets twice a year to consider declarations.

There is also a Raising Concerns at Work Policy that outlines how staff can raise concerns including those relating to fraud. Staff are reminded of their responsibility to report such matters at induction and mandatory training.

### **3.6.9.2 PAYMENT PRACTICE CODE**

The Trust aims to comply with The Better Payment Practice Code which requires us to aim to pay all valid non-NHS invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later. No significant interest was paid under the Late Payments of Commercial Debts (interest) Act 1988.

The Trust is an accepted signatory of the Institute of Credit Management's Prompt Payment Code. Further details about this code can be found on the Institute of Credit Managements website [www.promptpaymentcode.org.uk](http://www.promptpaymentcode.org.uk).

The Trust takes its responsibility to assist smaller organisations seriously and has a procedure in place whereby small and medium sized (SME) businesses can apply to be eligible for faster payment terms, to support these businesses maintaining their cashflow.

### **3.6.9.4 EXTERNAL AUDIT**

The Trust's external auditors are KPMG.

In September 2012, following a formal evaluation, the Council of Governor's accepted the recommendation to extend the external auditor's contract for a further two years. This KPMG's current audit engagement therefore extends until September 2014. A tender process has commenced in order to ensure the Trust has an External Audit Contract in place for the 1<sup>st</sup> October 2014.

Statutory audit work is carried out in accordance with the "Audit Code for NHS Foundation Trusts" at a cost of £66k including VAT for the Trust accounts and £10k for the Charitable Funds accounts. During 2013/14 KPMG also provided assurance on the Quality Accounts (£19k), and undertook follow up work on the Trust governance review which commenced in 2012/13 (£10k). As part of the collaboration with the South Sector Partnership, KPMG were commissioned via a procurement process led by South Manchester University Hospitals Foundation Trust to review back office services and the Trust's share of this was £104k.

So far as the Directors are aware, there is no relevant audit information of which the Auditors are unaware and the Directors have taken all of the steps that they ought to have taken as Directors in order to make themselves aware of any relevant audit information and to establish that the Auditors are aware of that information.

### **3.6.9.5 ACCOUNTING POLICIES**

The Annual Accounts have been prepared under a direction issue by Monitor under the National Health Service Act 2006.



They have also been prepared in accordance with International Financial Reporting Standards (IFRS) and under the direction of Monitor's NHS Foundation Trust Annual Reporting Manual (ARM).

The accounting policies for pensions and other retirement benefits are set out in note 1.8 to the accounts, and details of senior managers remuneration can be found in page 60 of the remuneration report. Note 6.5 to the Accounts provides further information about employees who have retired early on ill-health grounds during the year.

The Trust has complied with the cost allocation and charging mechanisms set out in HM Treasury and Office of Public Sector Information guidance.

### **3.6.9.6 REVIEW OF THE EFFECTIVENESS OF THE SYSTEM OF INTERNAL CONTROL**

The Accounting Officer has responsibility for reviewing the effectiveness of the system of internal control. The Annual Governance Statement on page 93 describes how this is undertaken.

### **3.6.9.7 PREPARATION OF ACCOUNTING OFFICER'S RESPONSIBILITIES**

The Accounting Officer has responsibility for preparing the Annual Accounts, the detail of which is undertaken by the Director of Finance and his team.

The Directors consider the Annual Report and Accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS Foundation Trust's performance, business model and strategy.

## **3.7. REMUNERATION AND TERMS OF SERVICE COMMITTEE**

The Board of Directors has established a Remuneration and Terms of Service Committee. Its responsibilities include the review and consideration of remuneration and conditions of service of the Chief Executive, Executive Directors and a small number of other senior managers.

The Remuneration and Terms of Service Committee met once during the reporting period on 26 September 2013 to determine the salary levels for the newly appointed Chief Operating Officer and the Director of Workforce and Organisational Development and also to review the remuneration of the Executive Directors following a review of portfolio responsibilities undertaken by the Chief Executive. Membership of the Committee and attendance at meetings is detailed in the table below:

		Attendance at Meetings
Mrs Gillian Easson,	Chairman	1/1
Mrs Carol Prowse	Senior Independent Director/Deputy Chairman	1/1
Mr John Sandford	Non-Executive Director	1/1
Mr Malcolm Sugden	Non-Executive Director	1/1



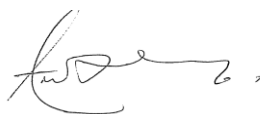
Mr Les Wilcock	Non-Executive Director	1/1
Dr Mike Cheshire	Non-Executive Director	1/1
Mr John Schultz	Non-Executive Director	1/1

The Chief Executive and Director of Human Resources attend meetings other than when matters being discussed would result in a conflict of interest. Minutes of meetings are recorded by the Trust Secretary. The Committee did not receive any external advice or services during the period covered in this report.

In determining and reviewing remuneration for Executive Directors, the Committee takes into account relevant benchmarking with other NHS and public sector organisations, guidance from Monitor, the national inflationary uplifts recommended for other NHS staff, and any variation in or change to the responsibility of Executive Directors. In addition to determining the salaries for the Chief Operating Officer and the Director of Workforce and Organisational Development the Committee also considered the salaries for other Executive Directors, including a review of salaries for the Director of Finance/Deputy Chief Executive, Director of Nursing and the Director of Strategic Developments and Partnerships. It was agreed that the CEO, Executive Directors and other senior managers covered by the terms of this Committee would not receive an inflationary pay award for the period, April 2013 to March 2014. Performance bonuses are not payable to individuals or teams. All Executive Directors are subject to annual appraisal by the Chief Executive who is herself appraised by the Chairman. As with all other staff in the organisation, performance against agreed objectives is discussed at appraisal meetings together with objectives for the forthcoming year. The Trust will review its remuneration policy for Executive Directors and senior managers in 2014/15 to ensure this is robust and reflects best practice.

The contracts of employment of all Executive Directors, including the Chief Executive, are permanent and are subject to six months notice of termination. No performance-related pay scheme (e.g. pay progression or bonuses) is currently in operation within the Trust and there are no special provisions regarding early termination of employment. The Foundation Trust has not released an Executive Director to serve as a Non Executive Director elsewhere. Pension entitlements are included in the Remuneration Table and there are no special provisions regarding early termination of employment. No early termination payments were made during the year, to any Executive Director or previous Executive Director.

A small number of other senior staff for example, Associate Directors is employed on a local pay scale agreed by the Remuneration Committee. All other terms and conditions reflect those set out in Agenda for Change. All other staff are employed on national terms and conditions or terms that mirror Agenda for Change.



Mrs A D L Barnes  
**Chief Executive**  
 29 May 2014

Salary and Pension Entitlements of Senior Managers											
Remuneration											
Name	Start Date of Office	Salary and allowances (in bands of £5,000) 2013/2014	Total (2012/2013)	Pension Related Benefits (in bands of £2,500)	Real increase/decrease during the reporting year in the pension (in bands of £2,500)	Real increase/decrease during the reporting year in related lump sum at age 60 (in bands of £2,500)	Value at the end of the reporting year of the accrued pension (in bands of £5,000)	Value at the end of the reporting year of related lump sum at age 60 (in bands of £5,000)	Value of cash equivalent transfer value at the beginning of the reporting year (to the nearest £1,000)	Real Increase/Decrease in Cash Equivalent Transfer Value during the reporting year (to the nearest £1,000)	Value of the cash equivalent transfer value at the end of the reporting year (to the nearest £1,000) <sup>1</sup>
		£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
<b>Executive Directors</b>											
Mrs A Barnes	01.03.2013	215-220	200-205	600.0-602.5	25.0-27.5	80.0-82.5	75-80	225-230	1,020	641	1,683
Mr W Gregory	01.06.2007	175-180	160-165	125.0-127.5	5.0-7.5	17.5-20.0	40-45	130-135	624	130	768
Dr J Catania	02.04.2002	215-220	215-220	(7.5-10.0)	0.0-2.5	0.0-2.5	70-75	215-220	1,531	60	1,625
Mrs J Morris	01.07.2008	135-140	115-120	112.5-115.0	5.0-7.5	15.0-17.5	40-45	120-125	692	138	845
Mrs C Spencer*		115-120	130-135	57.5-60.0	2.5-5.0	5.0-10.0	20-25	70-75	396	69	474
Mrs J Shaw	01.01.2013	120-125	25-30	77.5-80.0	2.5-5.0	10.0-12.5	30-35	100-105	521	71	604
Mr J Sumner	26.11.2012	125-130	50-55	(10.0-12.5)	(0.0-2.5)	5.0-7.5	15-20	50-55	178	36	218
<b>Non Executive Directors</b>											
Mrs G Easson		50-55	25-30								
Mrs C Prowse		15-20	15-20								
Mr LWilcock		15-20	10-15								
Mr J Sandford		15-20	15-20								
Mr M Sugden		10-15	15-20								
Mr J Schultz (7 months in 2013/2014)		5-10									
Dr Cheshire (7 months in 2013/2014)		5-10									
		2013/2014	2012/2013								
		£000	£000								
<b>Band of Highest Paid Director's Total</b>		170-175	170-175								
		£	£								
<b>Median Total</b>		23,885	24,841								
<b>Remuneration Ratio</b>		7.2	6.9								

\*Mrs C Spencers amount is reflective of a 10 month period in 2013/2014

In 2013-14, 1 (2012-13, 1) employee received remuneration in excess of the highest paid director.

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce. The banded remuneration of the highest paid director in Stockport NHS Foundation Trust in the financial year 2013/2014 was £170k - £175k (2012/2013, £170k - £175k). This was 7.2 times (2012/2013 6.9) the median remuneration was £23,885 (2012/2013, £24,841).

Total Pensions Related Benefits is a new disclosure new in 2013/2014 and is a calculation of the increase to the total sum of the executive directors accrued pension and lump sum entitlements taking account of an additional year of service and multiplying by a factor of 20 as per the prescribed HMRC method.

Notes to the table:

1 - In the budget of the 22 June 2010 it was announced that the uprating of public sector pensions would change from the Retail Prices Index (RPI) to the Consume Prices Index (CPI) with the change expected from April 2011. As a result the Government Actuaries Department undertook a review of all transfer factors. The new CETV factors have been used in this year's calculations and are lower than the previous factors used. The value of the CETVS have, therefore, fallen since 31/03/2010.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 2004/5 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV - This reflects the increase in CETV funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Non-Executive Directors do not receive pensionable remuneration.

As part of the remuneration report, we are also required to present the following tables showing the numbers of staff employed through other means than the payroll, classed as off-payroll staff. These are shown below:

<b>Table 1</b>	
No of existing engagements as of 31st March 2014	0
Of which:	
Less than one year at time of reporting	0
Between one and two years at time of reporting	0
Between two and three years at time of reporting	0
Between three and four years at time of reporting	0
Four or more years at time of reporting	0

<b>Table 2</b>	
No. of new engagements, or those that reached 6 months duration, between 1.4.13 and 31.3.14	10
No. of the above which include contractual clauses giving the Trust the right to request assurance in relation to income tax and National Insurance obligations	10
No. for whom assurance has been requested	2
Of which..	
No. for whom assurance has been received	2
No. for whom assurance has not been received	0
No. that have been terminated as a result of assurance not being received	0

<b>Table 3</b>	
No. of off-payroll engagements of board members and/or senior officials with significant financial responsibility, during the financial year	0
No. of individuals that have been deemed "board members and/or senior officials with significant financial responsibility" during the financial year. This figure should include both off-payroll and on-payroll engagements	14*

**STATEMENT OF ACCOUNTING OFFICER'S RESPONSIBILITIES FOR STOCKPORT NHS  
FOUNDATION TRUST ANNUAL ACCOUNTS 2013/2014**

**STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTING OFFICER  
OF STOCKPORT NHS FOUNDATION TRUST**

The National Health Service Act 2006 states that the Chief Executive is the Accounting Officer of Stockport NHS Foundation Trust. The relevant responsibilities of Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by Monitor.

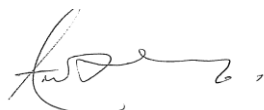
Under the NHS Act 2006, Monitor has directed Stockport NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Stockport NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

*In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Annual Reporting Manual and in particular to:*

- *observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;*
- *make judgements and estimates on a reasonable basis;*
- *state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual have been followed, and disclose and explain any material departures in the financial statements;*
- *ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance; and*
- *prepare the financial statements on a going concern basis.*

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of Stockport NHS Foundation Trust and to enable her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of Stockport NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in Monitor's *NHS Foundation Trust Accounting Officer Memorandum*.



Mrs A D L Barnes  
**Chief Executive**  
29<sup>th</sup> May 2014

## **Annual Governance Statement 2013/14**

### **Scope of Responsibility**

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accounting Officer Memorandum*.

### **The purpose of the system of internal control**

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Stockport NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Stockport NHS Foundation Trust for the year ended 31 March 2014 and up to the date of approval of the annual report and accounts.

### **Capacity to handle risk**

The Trust manages its risk management process through:-

- The Assurance Risk Committee as the Board of Directors sub-committee with responsibility for overseeing all aspects of risk management.
- The Audit Committee whose role is to receive and review assurance on the systems in place to manage risk.
- The Chief Executive and the designated Executive Directors with responsibility for specific aspects of risk management.
- The Assurance Risk Committee's responsibility includes organisation-wide co-ordination and prioritisation of risk management issues.
- An assessment of the level of risk management training that is required to staff and its delivery.
- The Trust Risk Management Training Needs Audit matrix is reviewed at the Risk Management Committee, which strengthens assurance that risk management training is effective, inclusive of a monitoring and review process.
- Employees with specific responsibilities for co-ordinating and advising on aspects of risk management having adequate training and development to fulfil their role.

- The Trust Risk Management Strategy and Policy, which clearly defines managers' levels of authority to manage and mitigate risks, according to risk scored ratings.

### **The risk and control framework**

Risk management is recognised as a fundamental part of the Trust's culture, and an integral part of good practice. It is integrated into the Trust's philosophy, practices and business plans. Risk management is the business of everyone in the organisation.

The Trust Risk Assessment process, investigating incidents, complaints and claims procedures are the principal sources of risk identification. The Risk Assessment process identifies the criteria for risk scoring both likelihood and consequence on a scale of 1 to 5, with the highest risk being accorded a score of 25 (5x5). The risk assessment process also requires an appropriate risk management plan.

The Risk Assessment process clearly states the escalation of management seniority to monitor management and mitigation of the risk according to its overall likelihood and consequence, particularly for risks with an overall score of 12 or above.

The Risk Assessment process is applied to all types of risk, clinical, financial, operational, capital, and strategic. The Trust Risk Register procedure requires Business Groups to maintain and monitor their own Risk Registers. All risks with a score rating of 15 or above are placed on the Trust, or Corporate, Risk Register.

The Assurance Framework is reported quarterly to the Board of Directors. This includes the risks associated with our objectives.

The Trust Risk Register comprises a review of the 'current' high risks and these are reviewed on a monthly basis at the Risk Management Committee, the Assurance Risk Committee and the Board of Directors.

All business cases have to be supported with a risk assessment. The scored risk rating strongly influences priorities within the Trust Capital Programmes.

The Trust's Assurance Framework helps provide assurance to internal and external stakeholders in relation to meeting the Trust objectives. Assurance of the system is also supported by independent assurance processes – internal and external, and achievement of satisfactory outcomes or results. The Trust has done a great deal of work reviewing its assurance processes recently. In 2012/13 the Trust appointed external advisers, KPMG, to undertake a governance review to assure itself that our processes were robust. Towards the end of 2013/14, a further review was commissioned from Deloitte's which is being carried out in line with Monitor's proposed tri-annual governance review process. This will include a refresh of the board committee structure and reporting lines to the Board.

The Assurance Framework identifies Stockport NHS Foundation Trust's principal objectives and their associated principal risks and is developed in consultation with the Executive Team and Business Group representation. The control systems which are used to manage these risks are identified together with the evidence for assurance that these are effective. During 2013/14 we have been working with Mersey Internal Audit Agency to review our Business Assurance Framework.

The Executive Team and the Board of Directors monitors management capability, (leadership, knowledgeable and skilled staff, adequate financial and physical resources), to ensure the processes and internal controls work effectively.



The Board monitors and reviews the system of internal control and where necessary, improves the accountability arrangements, processes or capability in order to deliver better outcomes. In 2013/14 this has included strengthening the Cost Improvement Programme accountability.

The Board ensures effective communication and consultation at all levels within the organisation and with external stakeholders. Engagement with stakeholders at various forums such as the Council of Governor's Meetings and patient forums provides an opportunity for risk related issues to be raised and discussed.

The Board obtains sufficient independent and objective assurance as to the robustness of its processes in key areas.

The reporting of incidents is actively encouraged via an electronic reporting system open to all staff; the Trust's Incident Reporting and Management Policy aims to ensure that when a serious event or incident occurs, there are systematic measures in place for safeguarding patients, property, NHS resources and reputation. This procedure ensures that a thorough investigation is undertaken and that any lessons learned are disseminated throughout the Trust; and if applicable to other agencies to reduce the likelihood of a reoccurrence.

The Board regularly reviews the external and competitive environment as part of its work in reviewing and setting the Trust's strategy.

### **Key Organisational Risk in 2013/14 and 2014/15**

This section describes the principal operational risks to compliance with the NHS Foundation Trust Condition 4 (FT governance) and our plan to mitigate these risks. This document has described the work ongoing to improve the effectiveness of governance structures, and clarify our accountabilities. The Board of Directors receive monthly reports on the Trust's performance and formally review this and the risks to compliance quarterly in line with the Risk Assessment Framework's declaration process.

The organisation's key risks are recorded in the Assurance Framework and Trust Risk Register. Forward risks and mitigation plans are also considered in the Trust's Annual Plan submission.

In 2014/15 key Operational risks include:

- Sustainable achievement of the A&E 4 hour wait target continues to present challenges. The Trust has struggled with this target and as a result was placed in significant breach of its terms of authorisation by Monitor, the Independent Regulator. During 2013/14 the Trust has made significant improvements in the patient journey including establishment of a new Ambulatory Care Unit, increased Acute Physician coverage and implementation of a ground-breaking iPad based patient management system.

However, despite the significant progress made, the Trust remains concerned about its ability to consistently achieve the target whilst the difficulties in securing substantive senior medical cover persist. The Board of Directors have therefore decided to declare a forward risk to the A&E 4 hour target in 2014/15.

- Delivery of the Referral to Treatment Target (RTT) at specialty level. The Trust is continuing to be an increasingly popular choice for orthopaedic patients. The Trust has found it challenging to keep up with the pace of this growth; and as a result some waiting time standards were not met during parts of last year. This problem was exasperated by the unavailability of another CCG commissioned provider during the year. The Trust identified the scale of the problem across the Orthopaedics specialties quickly, and in order to improve waiting times for the

greatest number of patients, planned to treat some patients sooner, which then resulted in the target being proactively breached. Monitor was notified of this decision.

The Trust is determined to improve the quality and timeliness of its elective care, and in 2014-15 we will improve waiting times for patients. The CCG have also indicated that they are putting in place alternative triage and service provision arrangements for foot and ankle surgery, to return Orthopaedic referrals to 2013-14 planned levels. However, the Trust remains concerned regarding the high levels of referrals for knee surgery, and the ability of the CCG to control these referrals, and this is where the main area of risk to the Trust lies.

The Trust's main commissioner, Stockport Clinical Commissioning Group (CCG), has not planned to commission the level of level of orthopaedic activity we believe is required to secure the 18 week target; however given the waiting time pressures and referrals to this service, the Trust is putting in place plans to undertake this level of work.

Challenges have also been experienced in ophthalmology, and we have been successful in appointing a new Consultant which should help ease these pressures. We are also redesigning pathways across community and acute teams; to ensure the 18 week referral to treatment standards are met in key pressure areas.

The Board of Director's have discussed the overall RTT position, and have decided not to formally declare a forward risk to the RTT 18 weeks target, however this is dependent on the CCGs ability to control referrals.

- The Trust has seen ever increasing numbers of patients referred for cancer treatments, and is expanding its capacity to ensure patients have low waits and a high quality of service. Due to the knock-on effects of the challenges faced with complex cancer pathways, in meeting the Cancer target in the last two quarters of 2013-14, there is a risk that the target will be difficult to achieve in the first quarter of 2014-15. For this reason, we have declared a forward risk against this target, although we expect to meet it for the remainder of the year. Over the coming year we will work with partner organisations to improve the more complex cancer pathways, that require patients to be treated at more than one hospital, allowing quicker access to diagnostics and treatment at Stepping Hill and other hospitals.
- In 2013/14 the Trust was successful in meeting the *C-Difficile* and MRSA. Over the last year the Trust has introduced new methodologies around testing for the presence of infection and trialing new technological advances in the cleaning of clinical areas. We will continue to pursue these methods over the next year, and strive to maintain the rates, as the 2014/15 target is broadly the same as in 2013/14.

The Trust has been upgrading the e-prescribing system to enhanced antibiotic stewardship, and will support increased antibiotic ward rounds and contribute towards minimising the risk that patients become susceptible to *C-Difficile* infection or ventilator acquired pneumonia (VAP).

In 2014/15 key Clinical risks include:

- The Trust's response and on-going response to the saline tampering incident as the case proceeds to trial will be kept under review. The Trust is very conscious of the impact that it may have on our staff and patients, and organisational reputation, and will do everything it can to mitigate against this.

- Service reconfiguration is planned across Greater Manchester in the Healthier Together programme and we anticipate seeing the first elements of this take shape in 2014/15. This is likely to impinge on cancer, trauma, emergency and stroke services. The Trust will need to plan carefully to respond to these changes when they impact on local service provision and configuration.
- The financial challenges facing the Trust are significant (see next section). There are many examples where improvements in quality and safety go hand in hand with reducing cost e.g. avoidance of healthcare acquired infections. However, the Trust will need to safeguard its drive to address financial pressures from coming into conflict with quality and safety and the need to implement improvements outlined in the Francis and Keogh reports. The Medical Director and Director of Nursing and Midwifery are involved in the development and implementation of efficiency programmes that affect clinical areas to mitigate this risk.

In 2014/15 key Financial and Business risks include:

- Delivery of the £12.0m cost improvement programme (CIP), which is underpinned by a programme management approach. The Trust has appointed a Turnaround Director and is investing significantly in a programme office and service improvement team to support this. The CIP is currently overseen by the Trust's monthly Productivity and Efficiency Board (PEB), chaired by the Chief Executive and attended by two Non-Executive Directors. This Board also has the responsibility for ensuring that all savings plans are assessed for impact on quality and safety.

The scale of the challenges faced has also been shared with the CCG, Associate Medical Directors, Joint Consultative Committee (JCT), Local Negotiating Committee (LNC) and wider Consultant body and staff across the hospital and community elements of the Trust via the "Start the Year Conference". Each month the Trust's team brief updates on the progress in finding the required savings.

- Despite the requirement of a £12.0m CIP, the Trust still has a budget deficit of £4.9m for 2014/15. The Trust has had long discussions with the CCG highlighting the risks, particularly due to the costs within urgent care. The Trust is instigating a turnaround regime to further strengthen financial controls and robust budgetary management to ensure budgets do not overspend.
- In 2013/14 the Trust incurred £0.4m in contract penalties and lost c.£0.8m in CQUIN monies that could have been earned. In 2014/15 it is currently estimated that we may incur c.£0.6m in financial contract penalties and may lose c.£1.1m of available CQUIN monies.
- The NHS reforms have created new strategic partners for the Trust in CCGs, Specialist Commissioning, Local Authorities, amongst others. The Trust is working hard to develop these relationships, but inevitably the transition into the reforms are likely to create uncertainties for policy making and decisions on service provision and finances.
- The work being undertaken with our three colleagues in the Southern Sector Partnership provides many opportunities to improve patient care, quality and reduce costs, there are also costs and risks associated with these relationships, and the Trust needs to be mindful of these.
- In 2013/14 there has been a significant increase in the amount of project work and collaboration work due to initiatives such as Southern Sector, Healthier Together,

Challenged Health Economy, and the Trust is also mindful of the impact in terms of management time due to this.

## **Quality Governance Framework**

Stockport NHS Foundation Trust has effective arrangements for monitoring and continually improving the quality of care provided to its patients. It achieves this by reference to its overarching quality improvement strategy together with a regular review of the Monitor Quality Governance Framework.

The Trust quality objectives are shared widely with staff and governors, monitored at the Clinical Quality and Safety Committee and reported monthly at the Board of Directors.

Assurance on compliance with the CQC registration requirements is gained through a system of 'mock' CQC inspections framed around a comprehensive audit programme which in turn is based on the five questions of whether a service is safe, well-led, caring, effective and responsive to patients' needs. As a result of each audit, action plans are developed and return visits arranged, the frequency of which is determined by the level of compliance. This process is monitored by the Clinical Quality and Safety Committee.

The foundation trust is fully compliant with the registration requirements of the Care Quality Commission.

## **Information Risks**

Specific risks relating to information governance and data quality are overseen and co-ordinated by the Information Governance Steering Group (IGSG). As well as adopting proactive measures to prevent loss of data and improvements in data quality and security, the IGSG adheres to specific procedures for detecting, reporting and dealing with any issues of data loss. Other steps taken to safeguard against risks to information include:

- IT security controls for the encryption of all laptops and mobile devices including restriction on the use of removable media.
- On-going review of Information flows of person identifiable data internally and externally within the Trust and ensuring appropriate actions to maintain secure transfer of data.
- Review and continued focus on security policies and guidance issued around handling and sharing of personal data.
- Internal audit of Information Governance and Data Security undertaken providing significant assurance to Trust Board of Directors.
- Trust's IT systems subjected to external penetration test, to ensure security levels would withstand attempts to hack into system.
- Information Commissioner review of systems. Some examples of best practice shared and action plans developed to implement.
- Board level Senior Information Risk Owner (SIRO) with lead responsibility for ensuring that information risk is properly identified, managed and that appropriate assurance mechanisms exist. This role is undertaken by the Director of Finance.

- Information Governance Training session is undertaken by all staff as part of their mandatory training.

The overall Information Governance Self-Assessment Toolkit score achieved was a credible 71% with 42 of the 45 requirements being met at level 2 or more. All of the previous 22 Key requirements were achieved. Action plans are in place to further improve performance during 2013/14.

No reportable Serious Untoward Incidents occurred involving personal data during the year.

## **Other risk areas**

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. The Trust has completed the Equality Delivery System (EDS) audit for the second time and will involve public and other stakeholders in our third assessment during 2014. Our EDS audit for 2013 demonstrates how the Trust is complying with the Equality Act 2010 and how our decision making processes include equality reference. Workforce and service monitoring reports have also been produced for 2013 and are published on our website alongside our new Equality and Diversity Strategy for 2014-2018.

The foundation trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

## **Review of economy, efficiency and effectiveness of the use of resources**

The Board draws on a range of evidence sources and material in its on-going review of economy, efficiency and effectiveness of the use of resources.

In 2013/14, with our Southern Sector partners we commissioned KPMG to undertake benchmarking of our back-office functions and develop options for future collaborative ways of working and savings. The initial findings from this are being evaluated and will feed into cost improvement plans. The Trust also participated in procurement benchmarking, facilitated by Deloitte.

Analysis of Stockport NHS Foundation Trust's costs, in comparison to national tariff levels of funding, is undertaken at speciality and point-of-delivery level. National tariff prices are based on average NHS costs in the immediate preceding financial year. Issues arising from this analysis are reported to the Board and sign-posted for further investigation.

The Trust has a well-developed patient level costing and service level costing system which allows individual service, procedure and patient costs to be compared with the income received. Specific project areas for focussed deep dives are developed from this information and then clinical, business management and finance teams work together to identify areas for efficiency gains and change behaviours to achieve this. The Trust also subscribes to a benchmarking club, and is beginning to evaluate the outcomes from this.

The annual internal audit programme together with the individual audit reports arising provide assurance to the Audit Committee on the operational arrangements to secure economy, efficiency and effectiveness in the use of resources, deriving from a systematic review of key areas of operation over time.

The Trust has reviewed the resource requirements to support delivery of its cost improvement programme and has appointed Nick Graham as a temporary management consultant, and a Turnaround Director Phil Church to support this.

### **Monitor Review of Trust Position**

On the 24<sup>th</sup> April 2013 the Trust signed Enforcement Undertakings with Monitor (a copy of which is on Monitor's website) in relation to the Trust's breaches of the A&E 4 hour target and highlighted potential weaknesses in Governance processes.

The Trust has been required to attend monthly meetings with Monitor to explain progress against the detailed requirements stipulated in the Enforcement Undertakings.

The Trust was also required to commission a further follow-up governance review from KPMG to examine the implementation of the initial governance review action plan. Subsequently, the Trust has also commissioned Deloitte to undertake a further review.

The Trust has ensured that Monitor has been kept fully informed of all performance challenges particularly around the decision to proactively breach the RTT target in Q3, the challenges we faced with C-Diff and the resultant action plan earlier in the year, and the precarious cancer target position we have faced in Q3 and Q4.

Whilst Monitor's interest has primarily been regarding the A&E target breaches and governance, the monthly meetings have allowed them to explore other areas of the Trust's performance, and in particular they have recently focussed on the Trust's performance against its Cost Improvement Programme targets in 2013/14, 2014/15 and 2015/16 especially given the financial challenges facing the whole of the NHS. They also are interested in the impact the saline-tampering incident is having on the Trust, and also how the Trust learns lessons from incidents and complaints.

The Trust is currently required to meet with Monitor on a monthly basis and will continue to do so until Monitor is assured that the Trust is returning to full and sustainable compliance with the terms of its Licence.

### **Annual Quality Report**

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS Foundation Trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the *NHS Foundation Trust Annual Reporting Manual*.

The steps the Board has taken to assure itself that the Quality Report presents a balanced view and that there are appropriate controls in place to ensure the accuracy of data include:

- Annual development of a set of corporate objectives, agreed with the Board of Directors, aimed at consistently improving clinical quality and patient experience. An executive director is assigned responsibility for each objective and progress is reported through the Trust assurance structure, with progress and exceptions reported to the Board of Directors at each Board meeting in its monthly quality report.



- Corporate Quality objectives are cascaded to business groups, wards and departments, and used to set objectives for teams and development priorities for individuals.
- The data used for reporting quality metrics is regularly reviewed and triangulated against other performance measures, using a variety of different methods, including internal audit review and a number of local and regional audits. The Trust also engages with national coding audits and uses external benchmarking to compare its performance with similar organisations.
- The development of underpinning policies and procedures to embed and sustain quality improvement, thereby enhancing longer-term achievement of quality objectives.

## **Review of effectiveness**

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and other committees that form part of the Trust's assurance structures and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by:

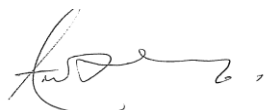
- Assurances obtained from external reviews such as the Care Quality Commission.
- Internal audit programmes as agreed each year on the basis of risk assessment, the outcome of which gave a "significant" assurance opinion on the system of internal control, management and governance. Where individual audits identify areas for improvement, the audit committee oversees the implementation of recommendations.
- The independent Governance Review work undertaken by KPMG and Deloitte provided a range of external assurances.
- The independent work undertaken by Mersey Internal Audit Agency on our Business Assurance Framework provided a range of external assurances.
- The content of the Quality Report attached to this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports.
- Clinical audit within the Trust and reported to the Board as an annual programme, with resulting actions and changes in service.
- The process that has been applied in maintaining and reviewing the effectiveness of the system of internal control includes:



- The involvement of the Board of Directors and individual Executive and Non-Executive Officers who approve, review and monitor the Assurance Framework, Trust Risk Register, Key Performance Indicators and receive reports from all sub-committees of the Board.
- The Audit Committee, which reviews risk and gains assurance on controls from external and internal audit and approves the annual audit programme.
- The Assurance Risk Committee and its supporting committee structure which approves and validates policies to manage clinical and non-clinical risk and reports on outcomes and issues relating to risk.

## **Conclusion**

I have undertaken my review on the basis of the information provided above, and conclude that I am aware of no significant internal control issues.



Ann Barnes  
Chief Executive

Date: 29 May 2014



## **Independent Auditor's Report to the Council of Governors of Stockport NHS Foundation Trust on the Quality Report**

We have been engaged by the Council of Governors of Stockport NHS Foundation Trust to perform an independent assurance engagement in respect of Stockport NHS Foundation Trust's Quality Report for the year ended 31 March 2014 (the "Quality Report") and certain performance indicators contained therein.

### **Scope and subject matter**

The indicators for the year ended 31 March 2014 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- Clostridium Difficile – all cases of Clostridium Difficile positive diarrhoea in patients aged two years or over that are attributed to the Trust; and
- 62 Day cancer waits – the percentage of patients treated within 62 days of referral from GP.

We refer to these national priority indicators collectively as the "indicators".

### **Respective responsibilities of the Directors and auditors**

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* issued by Monitor.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*;
- the Quality Report is not consistent in all material respects with the sources - specified in the *Detailed Guidance for External Assurance on Quality Reports*; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual* and the six dimensions of data quality set out in the *Detailed Guidance for External Assurance on Quality Reports*.

We read the Quality Report and consider whether it addresses the content requirements of the *NHS Foundation Trust Annual Reporting Manual*, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes for the period April 2013 to May 2014;
- Papers relating to Quality reported to the Board over the period April 2013 to May 2014;
- Feedback from the Commissioners dated May 2014;
- Feedback from local Healthwatch organisations dated May 2014;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, 2013/14;

- The latest national patient survey;
- The latest national staff survey;
- Care Quality Commission quality and risk profiles/intelligent monitoring reports 2013/14; and
- The 2013/14 Head of Internal Audit's annual opinion over the Trust's control environment.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the "documents"). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Stockport NHS Foundation Trust as a body, to assist the Council of Governors in reporting Stockport NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2014, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Stockport NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

### **Assurance work performed**

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators.
- Making enquiries of management.
- Testing key management controls.
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation.
- Comparing the content requirements of the *NHS Foundation Trust Annual Reporting Manual* to the categories reported in the Quality Report.
- Reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.



## Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*.

The scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Stockport NHS Foundation Trust.

## Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2014:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*;
- the Quality Report is not consistent in all material respects with the sources specified above; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual*.



KPMG LLP

Chartered Accountants  
St James' Square  
Manchester  
M2 6DS

29 May 2014

## INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF STOCKPORT NHS FOUNDATION TRUST

We have audited the Group and the Trust financial statements of Stockport NHS Foundation Trust for the year ended 31 March 2014 on pages 2 to 54. These financial statements have been prepared under applicable law and the NHS Foundation Trust Annual Reporting Manual 2013/14.

This report is made solely to the Council of Governors of Stockport NHS Foundation Trust in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

### Respective responsibilities of the accounting officer and the auditor

As described more fully in the Statement of Accounting Officer's Responsibilities on page 92 the accounting officer is responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practice's Board's Ethical Standards for Auditors.

### Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of whether the accounting policies are appropriate to the Group's and the Trust's circumstances and have been consistently applied and adequately disclosed, the reasonableness of significant accounting estimates made by the accounting officer and the overall presentation of the financial statements.

In addition we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

### Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the state of the Group's and the Trust's affairs as at 31 March 2014 and of the Group's and the Trust's income and expenditure for the year then ended; and



- have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2013/14.

#### Opinion on other matters prescribed by the Audit Code for NHS Foundation Trusts

In our opinion the information given in the Strategic Report and the Directors' Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

#### Matters on which we are required to report by exception

We have nothing to report where under the Audit Code for NHS Foundation Trusts we are required to report to you if, in our opinion, the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2013/14, is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements.

We are not required to assess, nor have we assessed, whether all risks and controls have been addressed by the Annual Governance Statement or that risks are satisfactorily addressed by internal controls.

#### Certificate

We certify that we have completed the audit of the accounts of Stockport NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.



Timothy Cutler for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants  
St James Square  
Manchester  
M2 6DS

29 May 2014







## Stockport NHS Foundation Trust Annual Quality Report 2013/14



**Your Health. Our Priority.**

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## Part 1 Chief Executive's Statement

Stockport NHS Foundation Trust remains fully focussed on its commitment to putting patients, carers and families first. This means that, both in the hospital and community we strive each and every day to provide the very best, safest and most effective care and experience to our patients and their families. Each of our services aims to:

- Deliver safe, high quality care in clean and safe environments.
- Communicate in a clear, open and transparent way and treat people with dignity and respect.
- Provide effective, efficient and timely care – right care, right place right time.

The integration of the community services in Tameside and Glossop and Stockport, with the respective hospitals and across all of the community services remains a key priority for the organisation working in partnerships with Clinical Commissioning Groups and Primary Care.

Quality is the thread throughout the business and service delivery of the Trust. Each Business Group has a Quality Board and the Board of Directors undertakes an in-depth review of quality, safety, harm, mortality and experience at the start of each meeting. This follows hearing a patient story to ensure appropriate focus to discussion and decisions later in the meeting. Our strategic goals reflect this importance of quality, with improvement objectives which address issues of Patient Safety, Clinical Effectiveness, and the Patient and Family Experience.

In 2013/14 quality initiatives focussed on the Commissioning for Quality and Innovation (CQUIN) standards, as agreed with Commissioners, and national standards. A main area of concentration was in Unscheduled Care where access standards remain a challenge. The Trust remains committed to continual improvements in quality of care and experience as well as improvements in access standards for our unscheduled care patients.

In addition the Trust has worked hard on its Southern Sector partnerships to maintain and improve service resilience, efficiency and quality of care. This work has largely been with the three provider organisations of East Cheshire, South Manchester and Tameside and Glossop but, in the latter part of the year has involved Commissioners at local and regional level. Service transformation and improvement across the Southern Sector has looked at clinical services including those within the Healthier Together portfolio plus orthopaedics, urology, pathology and radiology. In addition, non-clinical support services have been reviewed with a view to quality and efficiency within the infrastructure services for the clinical services.

Patient Safety objectives included meeting the challenging national targets for infection prevention, reducing patients' falls and pressure ulcers. Good progress has been made and work continues to develop still further improvement.

Clinical effectiveness objectives included further reduction in patient mortality, delivery of evidence based care such as the Advancing Quality bundles and meeting national targets such as Venous Thromboembolism (VTE). Further work is required in some of the Advancing Quality areas – such as heart failure which continues to challenge the Trust. Plans have been mobilised to make sustainable improvements in 2014/15.

Patient and Family Experience objectives included the development of nursing care indicators in our wards, learning from patient complaints and stories, feedback from carers and families and improving the care of people at the end of life.

The Trust is looking forward to refreshing its Clinical Quality Strategy and to improving reporting on quality standards; their themes and areas for development. The quality improvement agenda will never be completed but will always be continuously refreshed,

reviewed and developed. The staff throughout the organisation are highly talented, committed and passionate in their pursuit of quality improvement for each and every one of our patients. I am immensely proud of their work and achievements. This does not mean I am complacent and do not wish to ever stop the improvement, learning and development of the workforce in pursuit of continuous quality improvement. Our past record on safety and quality is good but it is the present and the future which is our focus now.

Contributors I have to thank in the preparation and review of this report include Trust Directors, Senior Manager and Clinical Directors of the Trust's Business Groups and departments, the Trust's Council of Governors, NHS Stockport, members of Healthwatch and the Stockport Overview and Scrutiny Committee.

Ann Barnes  
Chief Executive

10 April 2014



## Part 2 Priorities for improvement and statements of assurance from the board

### 2.1 Quality improvement priorities for 2013/14

The quality and safety priorities identified by the Trust during 2012/13 for clinical improvement in 2013/14, agreed by the Board of Directors and by the Council of Governors as part of the Annual Plan, were:

#### 2.1.1. Patient Experience


- a. Implement all elements of Friends and Family Test and act on feedback
- b. Improve the experience of care for patients with dementia and their carers
- c. Improve care provided at end of life (see 2i)
- d. Identify, record and support patients' carers

#### 2.1.2. Safe, effective care

- a. Improve weekend mortality rate
- b. Reduce pressure ulcer prevalence
- c. Complete VTE assessment for eligible patients and analyse root cause of any subsequent hospital-associated thrombosis
- d. Provide appropriate care for patients admitted with myocardial infarction
- e. Provide appropriate care for patients admitted with heart failure
- f. Provide appropriate care for patients admitted for hip and knee replacement
- g. Provide appropriate care for patients admitted with pneumonia
- h. Provide appropriate care for patients admitted with a stroke
- i. Improve transfers of care between teams and organisations
- j. Improve uptake of adult safeguarding training
- k. To develop an open and transparent communication channel between the Foundation Trust and Commissioner in respect of Quality Monitoring
- l. Improve Identification and signposting for patients whose alcohol consumption is unhealthily high
- m. Safety thermometer medication errors
- n. Increase the number of mothers who choose and sustain breastfeeding
- o. Reduce cancellations of community contacts and appointments
- p. Participate in Greater Manchester's Academic Health Science network
- q. Improve communication between primary, secondary and community care clinicians
- r. Reduce avoidable short-stay admissions
- s. Work with community Nursing Teams to reduce attendances at the Emergency Department for people with Chronic Obstructive Pulmonary Disease (COPD) and Heart Failure by improving personalisation of care plans and community support
- t. Reduce number of patients admitted to hospital from nursing homes where primary cause of admission is dehydration

Please note the above are all CQUINS for Stockport only.

The Trust's performance in 2013/14 against these Quality Improvement objectives has been reported on a monthly basis in the Board of Directors' Quality Board Report. The priorities chosen are the Trust objectives for Quality which includes the CQUIN programme whose overall aim is to improve patient care and experience through delivering improvements. The annual performance for 2013-2014 is detailed below.


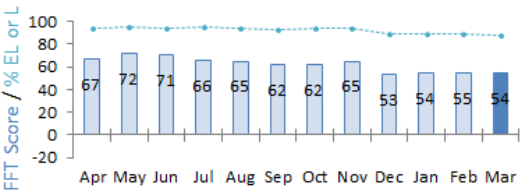
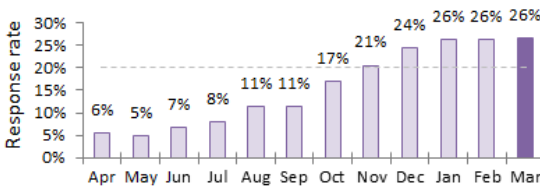
	<p><b>Key:</b> Indicates the direction of travel/performance for 2013/2014</p> <ul style="list-style-type: none"><li>■ = Performance achieved or exceeded trajectory for 2013/14</li><li>■ = Performance improved but not achieved trajectory for 2013/14</li><li>■ = Performance not achieved trajectory for 2013/14</li></ul>
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## Achievements against quality improvement priorities 2013/14


\*All objectives are reported monthly to the Trust Board of Directors, Clinical Effectiveness and Clinical Quality & Safety and discussed if an area for concern. All CQUINs are reported to local commissioners on a quarterly basis as part of CQUIN monitoring.

All data reported is considered correct however some data is collected from third party organisations / web sites.


### 2.1.1. Patient Experience

Priority 1a.		Patient Experience
Implement all elements of Friends and Family Test (FFT) and act on feedback		
Aim: Achieve a response rate of at least 20% each quarter		
2013/14	26.5% (March 2014)	
Progress, Monitoring and Reporting*		
<ul style="list-style-type: none"> <li>This is the first year Friends and Family has been introduced, therefore there is no comparable data</li> <li>This began as a challenge; with continuous improvement over the year the Trust's response rate is now at 26.5% (March 2014) against the target of 20% for inpatients and Emergency Department.</li> <li>In October 2013 it was rolled out to maternity patients (Maternity end of year response 20%)</li> <li>The increase in response from December was a result of introducing SMS texting, and work is being undertaken to improve the FFT score</li> <li>There is a Friends and Family Steering Group to drive, promote and monitor progress.</li> <li>The Trust reviews the comments and takes pro-active actions.</li> </ul>		
<div>   </div> <p>In addition to the above this question is asked of Staff as part of the Staff Survey (the Staff Survey incorporates both hospital and community staff). The aim of this element of the CQUIN was to deliver an improvement on last year's score, as this was included in 2012. Following the results of the staff survey in 2012 the Trust developed an action plan to address specific areas. In 2013 an improvement has been delivered for this question as show below.</p> <p><b>Q12d</b></p> <p>If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation (% agree or strongly agree):</p> <ul style="list-style-type: none"> <li><b>2012</b> Survey = <b>66.4%</b></li> <li><b>2013</b> Survey = <b>72.5%</b></li> </ul> <p>The Trust uses a third party, Capita, to capture and report the data for the friends and family test.</p>		




<b>Priority 1b.</b>	<b>Patient Experience</b>
<b>Improve the experience of care for patients with dementia and their carers</b> <b>Aim to achieve 90% in each element of the FAIR assessment (Find, Assess and Investigate, Refer)</b>	
	
<b>Progress, Monitoring and Reporting*</b>	
<ul style="list-style-type: none"> <li>• The Trust struggled for the first three quarters to complete the Dementia FAIR assessments for appropriate patients, a new process was introduced and the Trust is now achieving in quarter 4.</li> <li>• Following the success of the named nurse an advert was placed for a Dementia Matron. Recruitment has now taken place. This post will be an increase in hours than the named nurse undertook and therefore work on embedding the process with clinicians will be part of the remit.</li> <li>• Training – 40% (2329) of staff have undertaken dementia care training as appropriate for their role. A monthly training programme continues throughout 2014/15.</li> <li>• The results of the monthly carer's survey are discussed at the Dementia steering group.</li> <li>• The comments gathered from the Survey are used with other data intelligence to support learning for staff and to improve process to enable carers to be supported as well as patients.</li> <li>• The highest negative result (63%) was regarding being offered information on local carers support services. This will be addressed by the introduction of the Carers Information Point which will be opened on the Stepping Hill site in June 2014 (see 1d).</li> <li>• Communication had the most positive feedback (86%) however is regarded as an area that can always be improved upon therefore is the theme of the patient experience CQUIN for 2014/15.</li> <li>• Feedback was mainly positive for carers' role being recognised by staff (71%) and carers being involved in the patients' care and treatment in hospital (81%). Comments are considered along with other data intelligence regarding patient experience to support the build of action plans.</li> </ul>	

### Priority 1c is included in 2i


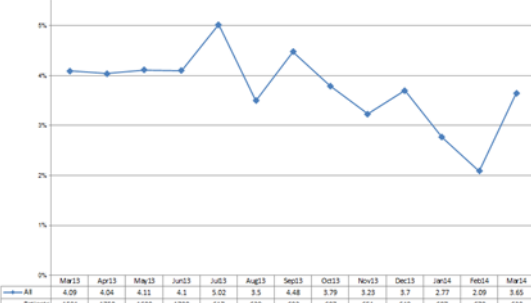
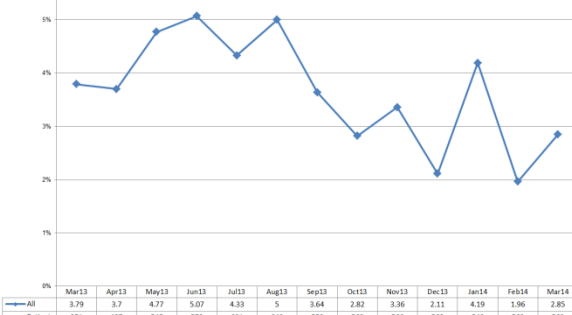
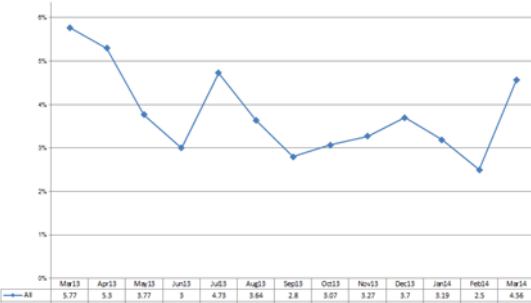
<b>Priority 1d.</b>	<b>Patient Experience</b>
<b>Identify, record and support patients' carers</b> <b>Aim: Carers and their essential role are identified at first contact or as soon as possible afterwards and are referred to appropriate support services</b>	
	
<b>Progress, Monitoring and Reporting*</b>	
<ul style="list-style-type: none"> <li>• A field has been adapted within the Trust's Patient Administration System to capture carer data. Work continues to promote the capture of carer details.</li> </ul>	

- Community data is captured in Dominic and I-soft Patient Manager (IPM) systems (electronic record systems used by Stockport and Tameside community staff respectively to record contacts, appointments, brief information regarding contacts, produce schedules of visits etc. Dominic is used by the Stockport District Nurses and IPM is used by all clinicians in Tameside community). Reports are available from the Dominic system however at the current time we are not able to extract the data from IPM. This is with our IT department to address.
- A room has been identified within the Trust in a central location which is to be developed into an information point for carers. The information point will be a joint venture with Signpost and other organisations under the Anchor umbrella.
- The identification of carers and providing an Information point is to ensure Carers are aware of what support is available and to ensure they know where to go for further help or advice. This may vary for carers of patients with different conditions but should be a resource that will help to provide clear information at a time that may be a stressful and emotional. It has been demonstrated that support groups who understand the implications of the individual conditions are a valuable asset to others.
- A delay to the information point being established was due to the Trust wishing to provide a fit for purpose environment and therefore £10,000 will be invested in building works to create an area that will be able to supply a good service and have the appropriate resources and access. This will be in place by June 2014.

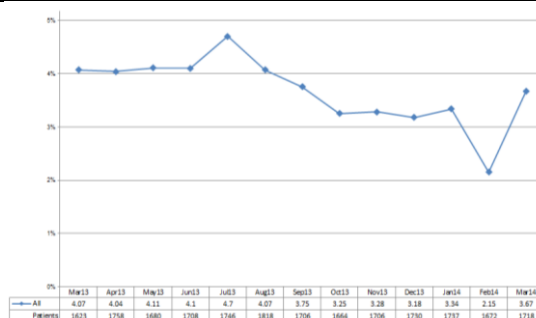
### 2.1.2. Safe, effective care

Priority 2a.		Safe, effective care																																																						
Improve weekend mortality rate																																																								
2010/11	110.3 (HSMR*)																																																							
2011/12	103.7 (HSMR)																																																							
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2013/14 (From November report)	109 (HSMR)																																																							
Progress, Monitoring and Reporting*																																																								
<ul style="list-style-type: none"><li>Mortality is reported by several sources:<ul style="list-style-type: none"><li>Summary Hospital-level Mortality Indicator (SHMI) from Health and Social Care Information Centre (HSCIC) (includes deaths outside of hospital within 30 days of discharge)</li><li>HSMR (*Hospital Standardised Mortality Ratios) from Dr Foster (adjusts for coding of palliative care)</li><li>Risk Adjusted Mortality Index (RAMI) from CHKS (Caspe Healthcare Knowledge System) (excludes palliative care and non-elective zero length of stay)</li></ul></li></ul>																																																								
	<table><tr><th colspan="4">RAMI (CHKS)</th><th colspan="4">SHMI (HSCIC)</th></tr><tr><th></th><th colspan="2">weekend</th><th colspan="2">weekday</th><th colspan="2">weekend</th><th colspan="2">weekday</th></tr><tr><th>year</th><th>SMR</th><th>Mortality rate</th><th>SMR</th><th>Mortality rate</th><th>SMR</th><th>Mortality rate</th><th>SMR</th><th>Mortality rate</th></tr><tr><td>2011/12</td><td>86.1</td><td>4.3%</td><td>88.5</td><td>3.3%</td><td>106.4</td><td>3.8%</td><td>91.3</td><td>2.7%</td></tr><tr><td>2012/13</td><td>82.4</td><td>4.5%</td><td>79.6</td><td>3.1%</td><td>101.2</td><td>3.6%</td><td>90.9</td><td>2.7%</td></tr><tr><td>2013/14</td><td>83.3</td><td>3.9%</td><td>83.1</td><td>2.8%</td><td></td><td></td><td></td><td></td></tr></table>			RAMI (CHKS)				SHMI (HSCIC)					weekend		weekday		weekend		weekday		year	SMR	Mortality rate	SMR	Mortality rate	SMR	Mortality rate	SMR	Mortality rate	2011/12	86.1	4.3%	88.5	3.3%	106.4	3.8%	91.3	2.7%	2012/13	82.4	4.5%	79.6	3.1%	101.2	3.6%	90.9	2.7%	2013/14	83.3	3.9%	83.1	2.8%				
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<p>SMRs coloured according to 99.8% Poisson confidence intervals (amber = within expected range), expected range proportional to number of deaths weekend/weekday derived from date of admission models differ in spells being included, and factors used in calculation of risk of mortality SHMI shown with benchmark at 100</p>																																																								
<ul style="list-style-type: none"><li>The working party set up in 2012/13 created an action plan which has been updated throughout the year. 19 of the 24 actions are now complete.</li><li>Improving the weekend mortality rate has been led by the Medical Director who discusses the progress with the commissioners on a quarterly basis.</li></ul>																																																								

- In October 2013 the Trust moved from Dr Foster data to CHKS, in line with other Southern Sector partners. As per table above improvements made in both weekday and weekend mortality rates from 12/13 to 13/14.
- The Trust is within the expected range and below the National average (see SHMI chart at 2.3 12a).
- As at November the Trust's HSMR figures were 98 for weekday mortality and 109 weekend mortality with an overall figure of 101.
- The Trust has a Consultant in Palliative Care Medicine and a combined Stockport Community and Hospital Specialist Palliative Care Team. 7 day working was introduced in January 2014.
- Two Macmillan nurses are on site as a result of the action plan.
- The action plan is reported at the Clinical Effectiveness and Clinical Quality & Safety Committees and commissioners attend.

Priority 2b.		Safe, effective care																																											
Reduce pressure ulcer prevalence																																													
Aim: To reduce the overall prevalence of pressure ulcers across Stockport health economy by 25% from 3.7% to 2.7%.																																													
2013/14 – Overall		3.9%																																											
2013/14 – Acute		4.05%																																											
2013/14 – Community		3.65%																																											
																																													
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## All



Results for:	Jan	Feb	March	Q4	Median for the past 6 months
Acute	2.77%	2.09%	3.65%	2.84%	3.44%
Stockport Community	4.19%	1.96%	2.85%	3.0%	2.84%
Tameside & Glossop Community	3.19%	2.5%	4.56%*	3.42%	3.80%
Acute and Community combined	3.4%	2.03%	3.37%	2.93%	3.28%

**Combined result:** Q2: 4.4% Q3: 3.2% Q4: 2.93%

\*This figure includes an exceptional admission of five patients to the Shire Hill Intermediate Care Unit with the agreement of our Commissioners. Without these patient admissions the figure would have been 3.6%

The Trust knew this would be a challenging CQUIN as our baseline was 3.7% when the national baseline was 6.6%. Although we have not achieved the target set significant improvements have been made this year as evidenced in the quarterly combined results above. Our mean prevalence is 3.9%, this CQUIN measures the number of new pressure ulcers that develop and existing pressure ulcers i.e. pressure ulcers that occurred before admission to hospital. In order to address this challenge a proposal has been submitted to local commissioners which looks at engaging all care providers to work collaboratively to implement a standardised Pressure Ulcer Prevention and Management strategy across the Stockport health economy.


We are unable to compare with previous years as this is now measured differently, in previous years we reported on incidence and now we report on prevalence.

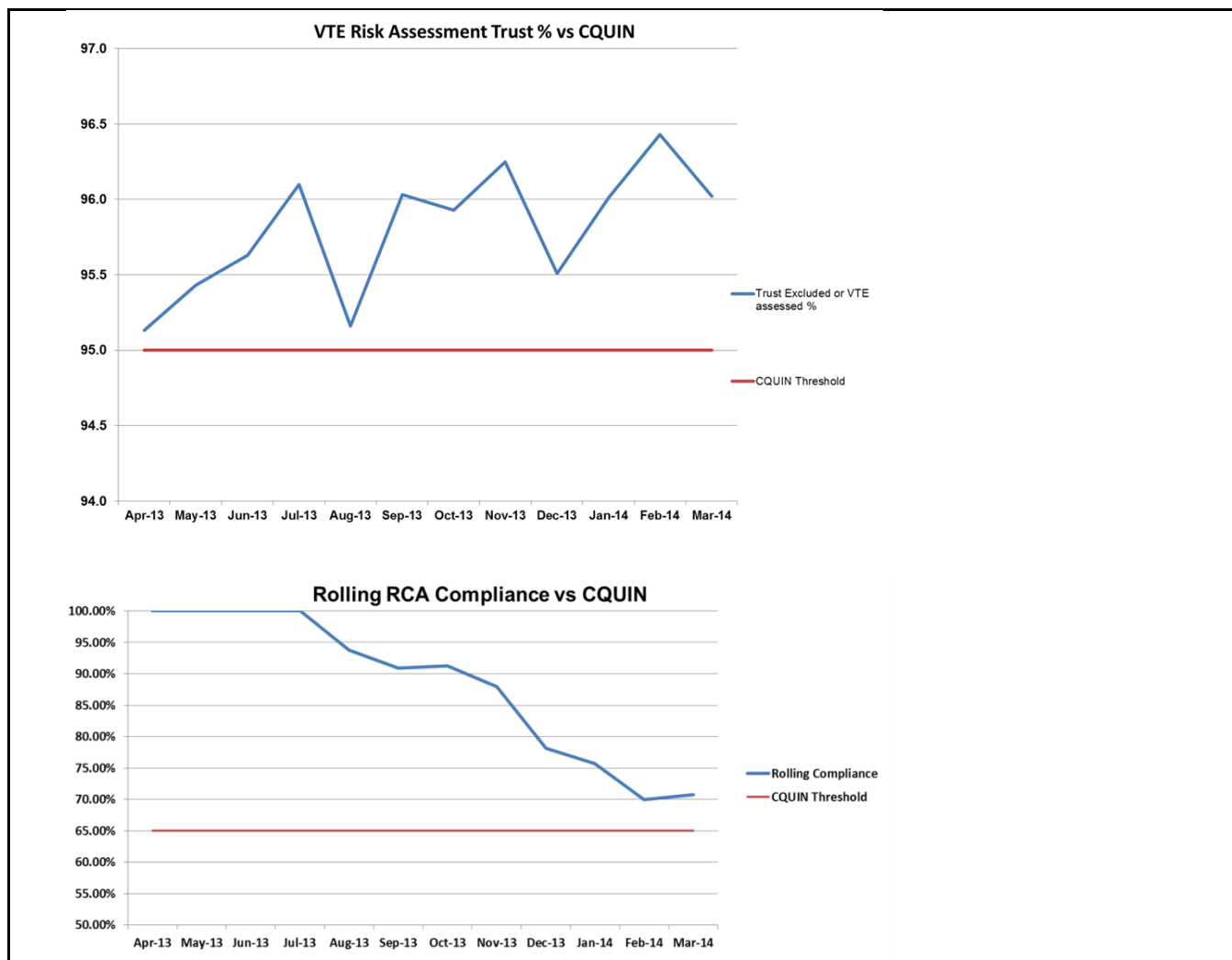
The initiatives that have contributed to the Trust's sustained improvements relating to pressure ulcer prevention in the last year include:

- In September the Director of Nursing became the chair of the monthly Pressure Ulcer Assurance Meetings. All ward managers where pressure ulcer harm has occurred in the last month are invited to this meeting. The purpose is to identify trends in pressure ulcer occurrence and identify what support wards require in order to continue to achieve a reduction in pressure ulcer incidence.
- A new pressure ulcer screening tool has been introduced for the Emergency Department (ED) to ensure that all patients in the department for more than 4 hours have their risk of pressure damage identified and a plan of care for pressure ulcer prevention implemented.
- The nursing assessment documentation now includes the pressure ulcer prevention and management plan alongside the Waterlow risk assessment. This ensures that a plan of care is instigated as soon as a patient's risk of pressure sores is identified.
- Red Rules for the prevention and management of pressure sores have been introduced which reinforce the main elements of the Trust's Pressure Sore Prevention Strategy that must be adhered to by all clinical staff.
- A Ward round check list label has been introduced, that can be inserted into the patients' medical records to improve multi-disciplinary communication, as it includes a prompt for Doctors to consider their patient's risk of or actual pressure damage in the scope of the patient's medical management plan.
- Processes are now in place ensuring that clinical areas have access to heel off-loading devices out of hours.
- A Patient Information Leaflet to raise awareness of pressure sores has been devised.
- The anti-embolic stocking pathway has been re-launched. There is now an alert on the electronic prescribing system that ensures that doctors and nurses are prompted to refer to the guidance at the point of prescribing stockings to ensure that it is safe and appropriate to

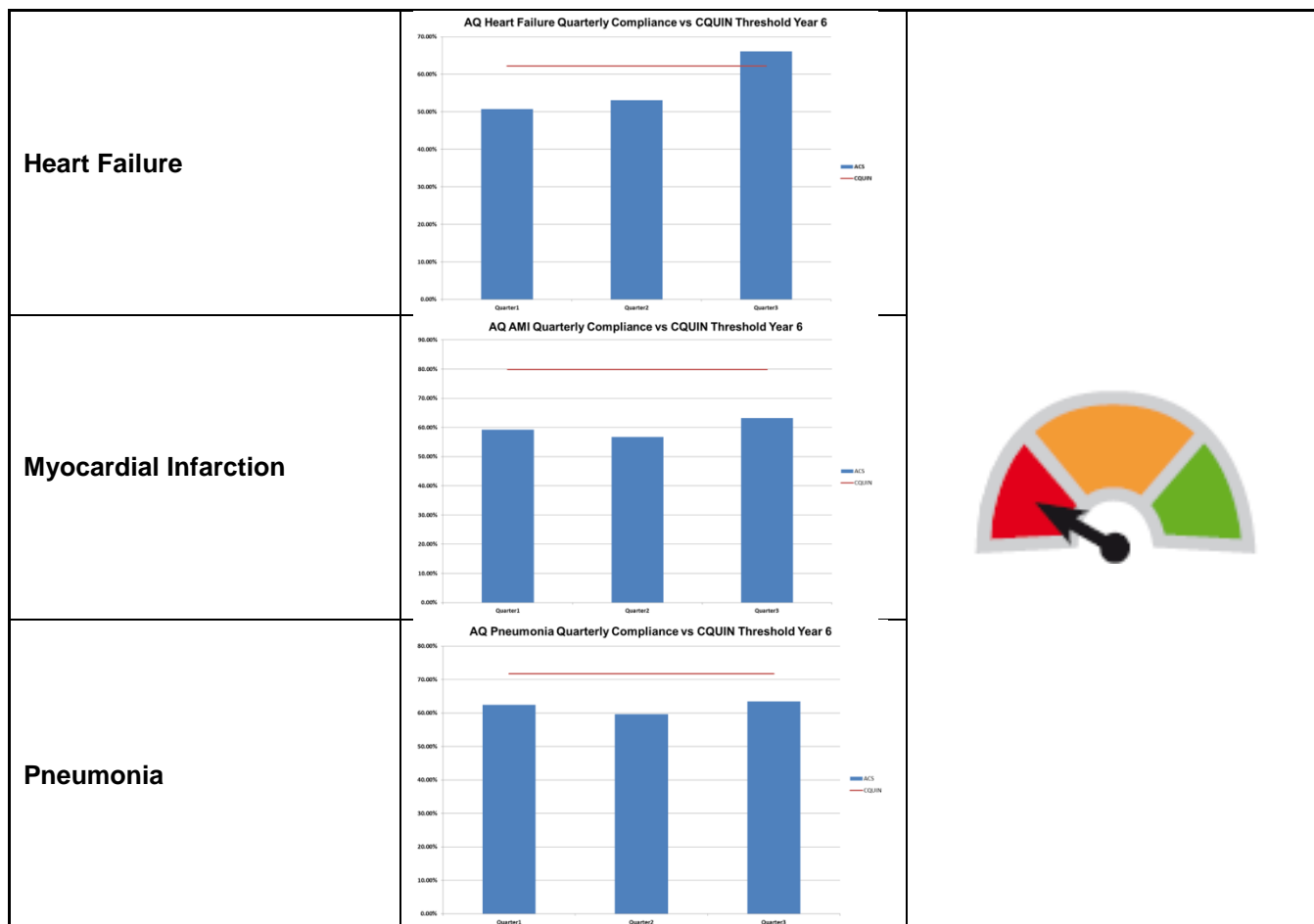
do so.

- Dermal pads used to redistribute pressure and protect critical areas/ bony prominences from the effects of pressure /shear forces and stop skin breaking down have been introduced.
- A pressure ulcer task and finish group meets on a monthly basis. This collaborative includes both commissioners and providers of healthcare, both statutory and non-statutory and is looking at how pressure ulcer prevention strategies can be standardised across all care settings.

Priority 2c.			Safe, effective care
Complete Venous Thromboembolism (VTE) risk assessment for eligible patients and analyse root cause of any subsequent hospital-associated thrombosis			
Aim: to reduce patient harm			
	Risk assessment	Root Cause Analysis	
2012/13	94.28%	47.73% (not a CQUIN)	
2013/14	95.81%	70.73%	
Progress, Monitoring and Reporting*			
<ul style="list-style-type: none"><li>• The Trust has achieved the target for VTE risk assessment completed for all eligible patients</li><li>• The target of 65% for root cause analysis of any subsequent hospital-associated thrombosis has been achieved</li></ul>			
Actions include: <ul style="list-style-type: none"><li>• Created an electronic database to capture re-admissions with confirmed VTE.</li><li>• Electronic process for undertaking root cause analysis (RCA) on identified patients</li><li>• Thrombosis committee meetings to discuss findings of RCA</li></ul>			
Lessons learned: <ul style="list-style-type: none"><li>• Trust realised we require more Intermittent Compression Stockings</li><li>• Introduced pathway for patients with Lower limb fractures requiring subcutaneous chemical thromboprophylaxis</li><li>• Revised need to do blood monitoring for patients on Clexane who have undergone colorectal surgery</li><li>• Introduced a pre-op electronic database to perform a risk assessment of patients on anticoagulants that are listed for a surgical procedure.</li></ul>			
(see 2.3 number 23 for further information)			



Priority 2d - h.		Safe, effective care												
Provide care according to the Advancing Quality Improvement programme for patients admitted for Acute Myocardial Infarction (AMI), Heart Failure, Hip And Knee Replacement, Pneumonia and Stroke														
Aim: deliver Advancing Quality Alliance (AQuA) target levels of clinical interventions for these patients														
Hip & Knee Replacement	<p>AQ Hip &amp; Knee Quarterly Compliance vs CQUIN Threshold Year 6</p> <table><thead><tr><th>Quarter</th><th>ACS</th><th>CQUIN</th></tr></thead><tbody><tr><td>Quarter1</td><td>88.50%</td><td>88.00%</td></tr><tr><td>Quarter2</td><td>93.50%</td><td>88.00%</td></tr><tr><td>Quarter3</td><td>92.50%</td><td>88.00%</td></tr></tbody></table>	Quarter	ACS	CQUIN	Quarter1	88.50%	88.00%	Quarter2	93.50%	88.00%	Quarter3	92.50%	88.00%	
Quarter	ACS	CQUIN												
Quarter1	88.50%	88.00%												
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Stroke	<p>AQ Stroke Quarterly Compliance vs CQUIN Threshold Year 6</p> <table><thead><tr><th>Quarter</th><th>ACS</th><th>CQUIN</th></tr></thead><tbody><tr><td>Quarter1</td><td>58.00%</td><td>55.00%</td></tr><tr><td>Quarter2</td><td>65.00%</td><td>55.00%</td></tr><tr><td>Quarter3</td><td>60.00%</td><td>55.00%</td></tr></tbody></table>	Quarter	ACS	CQUIN	Quarter1	58.00%	55.00%	Quarter2	65.00%	55.00%	Quarter3	60.00%	55.00%	
Quarter	ACS	CQUIN												
Quarter1	58.00%	55.00%												
Quarter2	65.00%	55.00%												
Quarter3	60.00%	55.00%												



Data is captured 3 months following discharge so Quarter 3 is the latest data.

#### Progress, Monitoring and Reporting\*

- AQuA changed the scoring mechanism from Composite Process Score (CPS) to Appropriate Care Score (ACS) from April 2013. This means each patient has to meet every measure.
- The Trust achieved the targets for Hip & Knee replacements and Stroke
- Heart Failure and AMI. Although the Trust is not achieving ACS scoring, improvement each quarter has been demonstrated for CPS scoring and work continues to address areas requiring further improvements.
- Pneumonia and Heart Failure continue to be challenging areas and in order to address this from 1<sup>st</sup> April 2014 the aim is to collect data within 2 weeks of a patient's discharge with timely feedback to clinicians.

Priority 2i.	Safe, effective care
<p><b>Improve transfers of care between teams and organisations</b></p> <p><b>To reduce harm and improve care in line with best clinical practice for vulnerable patient groups during transfers of care</b></p> <p><b>Improve care provided at end of life - to increase the number of end of life care plans recorded and increase the number of patients who die in their place of choice.</b></p>	




## Progress, Monitoring and Reporting\*

- Clinical peer reviews have been undertaken on fractured neck of femur, Non-Invasive Ventilation, Stroke and Intermediate Care. As a result action plans were produced. A report on the methodology and outcomes has been created.
- End of Life – 77% of patients died in their preferred place of care. Liverpool Care Pathway is no longer used. Therefore the CQUIN indicator and information required was amended which is why there is no comparative baseline data. Advanced Care Plans are required for all patients and are discussed when appropriate. The Trust participated in the National Care of the Dying audit; the report for this is not due until after May 2014.

The Stockport Inview/District Nurse Dashboard is to be re-written in light of District Nurse Service Review and also new targets for 2014 in order to make reporting more robust and more accessible for staff to input.


89.24% of patients known to the Tameside and Glossop Macmillan Nursing service died in their preferred place of care.


- Homelessness - the 2013/14 CQUIN target for the Trust around homelessness (transfer of care) focused attention and extra resources into this important area of health inequalities. An action plan was created working closely with local authority to improve services. Key items include:
  - Engaging GPs – questionnaire sent to all GPs and results discussed at GP masterclass – as a result a new guide for registering homeless patients at practices was developed
  - New protocol and easy read guidance issued to wards with awareness raising sessions
  - Two local charities (Wellspring Centre and H3) awarded funding from Department of Health to improve discharge plans for homeless patients. Homelessness Nurse Practitioner, Hospital Advocate and Peer Mentors now in place.
  - Set up a new alert process through Advantis ED to flag attendance of homeless patient to the Homelessness Nurse Practitioner and Equality & Diversity Manager which allows follow up to ensure protocol has been used.
  - Presentation to Junior Doctors by Homelessness Nurse Practitioner, Hospital Advocate and a patient who was previously homeless.


Priority 2j.			Safe, effective care
Improve uptake of adult safeguarding training			
Aim: to train 85% of all eligible staff in the four levels of safeguarding adults training			
2013/14	Level 1	100%	
	Level 2	52.7%	
	Level 3	84%	
	Level 4	100%	
Progress, Monitoring and Reporting*			
<ul style="list-style-type: none"><li>The Trust has an ongoing programme to capture new starters; level 1 training is given at the Trust induction session with a video and leaflet.</li><li>Level 2 training is delivered by several methods – e-learning, classroom based and at ward level, supported by a printed booklet for reference. During the year it was difficult to monitor the numbers trained as it was manual collation of numbers from the various training methods. Mental Capacity Act and Deprivation of Liberty Safeguards training has also taken place and this had been counted in the results each quarter however from Q3 the commissioners advised this was not to be counted and has been removed. This explains why the result</li></ul>			


above will be lower than published results during the year.


- A data base has now been established by the Training team and more accurate reporting is available and is visible to managers to be able to monitor compliance within the teams.
- Level three has been a focus in quarter four. The staff eligible for this training are fully aware of actions to take and who to contact should a situation or concern arise. The baseline of who requires this training has been revisited as at the start of the year it had been done on job title rather than actual role. Official training is now captured in the database as above.


<b>Priority 2k.</b>		<b>Safe, effective care</b>
<b>Early Warning System</b>		
<b>Aim</b>	To develop an open and transparent communication channel between the Trust and Commissioner in respect of Quality Monitoring	
<b>Progress, Monitoring and Reporting*</b>		
<ul style="list-style-type: none"> <li>• An early warning system was agreed with the Commissioners to which reports are provided within timescales. This includes providing the commissioners with timely updates on incidents and complaints and is undertaken by verbal and written communications, reports and commissioners attending sub-board committees.</li> </ul>		


<b>Priority 2l.</b>		<b>Safe, effective care</b>
<b>Reducing alcohol abuse</b>		
<b>Aim: Improve Identification and signposting for patients whose alcohol consumption is unhealthily high</b>		
		
<b>Progress, Monitoring and Reporting*</b>		
<ul style="list-style-type: none"> <li>• 90% of eligible ED and Acute Medical Unit (AMU) staff have been trained in how to undertake screening</li> <li>• 100% of the Heart Failure and Contraceptive and Sexual Health Community team have been trained in screening</li> <li>• The Trust has exceeded the referral rate of 150 set by Commissioners</li> <li>• 75% of patients accepted a brief intervention following screening</li> <li>• 100% of patients screening in Maternity, 10.5% received Brief Intervention Advice</li> <li>• 71% of maternity staff attended training</li> <li>• Mandatory screening has been incorporated into the Advantis ED system.</li> </ul>		


<b>Priority 2m.</b>	<b>Safe, effective care</b>
<b>Safety thermometer medication errors</b>	
<b>Aim: introduce safety thermometer for monitoring medication errors</b>	
	
<b>Progress, Monitoring and Reporting*</b>	
<ul style="list-style-type: none"> <li>• The Trust has participated in the pilot organised by Academic Health Science network (AHSN), for capturing medication errors as part of the Safety Thermometer tool. This included both community District Nursing services. Staff from AHSN visited Tameside and Glossop District Nurses early in the pilot to develop the community tool.</li> <li>• The Trust has submitted data for the pilot as per the CQUIN requirements</li> <li>• The Trust was one of the first to provide feedback and changes were made as a result of the feedback.</li> <li>• The Matron for Quality Improvement has trained staff on the wards to collect data.</li> <li>• Progress has been reported and discussed at the Safe Medicines Management Group</li> </ul>	


<b>Priority 2n.</b>	<b>Safe, effective care</b>
<b>Increase the number of mothers who choose and sustain breastfeeding</b>	
	
<b>Progress, Monitoring and Reporting*</b>	
<p>Initiation (Acute)</p> <ul style="list-style-type: none"> <li>• The Clinical Commissioning Group (CCG) has revisited baseline data and we have achieved the Stockport target of 72% delivering 74.5%.</li> <li>• We have not achieved the target of 65.3% for deprived areas, we reached 64.1%</li> </ul>	
<p>Maintenance (Community)</p> <ul style="list-style-type: none"> <li>• Target has been reset to 48.7% for Stockport and we achieved 48.5%.</li> <li>• For deprived areas the target was 40.6% and we achieved 38%.</li> <li>• Specialist community infant feeding co-ordinator is in post</li> <li>• Baby friendly initiative – the Trust has met the standards and maintained level three</li> </ul>	



<b>Priority 2o.</b>		<b>Safe, effective care</b>
<b>Percentage of appointments or contacts cancelled by Community Health Stockport in the contract month for out of hospital care services</b>		
<b>Aim: Reduce cancellations of community contacts and appointments</b>		
<b>2013/14</b>	Quarter 1 = 1.1% Quarter 2 = 0.9% Quarter 3 = 0.9% Quarter 4 = 0.9%	
<b>Progress, Monitoring and Reporting*</b>		
<ul style="list-style-type: none"> <li>• The Trust is achieving against this CQUIN target of less than 1.8%.</li> <li>• Several small services are easily impacted by staff absence.</li> <li>• Tameside &amp; Glossop community services also met their local target of less than 1.3%</li> </ul>		

<b>Priority 2p.</b>		<b>Safe, effective care</b>
<b>Participate in Greater Manchester's Academic Health Science network</b>		
		
<b>Progress, Monitoring and Reporting*</b>		
<ul style="list-style-type: none"> <li>• Engagement – the Trust has participated as requested</li> <li>• Foundation Trust leads were identified.</li> <li>• Requirements of AHSN were amended in December 2013 due to delayed set up of the structure for the organisation</li> <li>• Over 1% of our Foundation Trust members signed up as 'citizen scientists'. Members' names are available if required.</li> <li>• The website link where we are promoting the AHSN statement: <a href="http://www.stockport.nhs.uk/84/Who-we-are-and-what-we-do">http://www.stockport.nhs.uk/84/Who-we-are-and-what-we-do</a></li> <li>• The Trust participated in the Stakeholder governance work in January</li> <li>• The Trust met with AHSN reps and discussed their agenda detail and provided information to support the survey activities in February.</li> <li>• In principle we are ok with the Data Sharing protocols; to date nothing specific has been requested by the AHSN</li> </ul>		

<b>Priority 2q.</b>	<b>Safe, effective care</b>
<b>Improve communication between primary, secondary and community care clinicians</b>	
	
<b>Progress, Monitoring and Reporting*</b>	
<ul style="list-style-type: none"> <li>• Workshops are held quarterly</li> <li>• Agenda items have covered referral and discharge communication.</li> <li>• Changes have been made as a result of these discussions including clearer instruction between all for example when GP referring a patient to hospital or hospital sending discharge information to GPs to avoid duplication and provide clarity. This work is to continue throughout 2014/15.</li> <li>• A rollout programme is looking at the quality of the out-patient clinics letter, led by an Associate Medical Director.</li> <li>• The Health Care Record is being reviewed to be specialty specific with mandatory fields</li> <li>• This has been RAG (red/amber/green) rated as green as all four workshops were held and positive outcomes achieved. However the CQUIN was not fully met due to not always having the full complement of attendees as specified in the indicator.</li> <li>• Medical Director organised for GPs to shadow a whiteboard round.</li> </ul>	

<b>Priority 2r.</b>	<b>Safe, effective care</b>
<b>Reducing avoidable admissions by implementation of ambulatory pathways</b>	
<b>Aim: Reduce avoidable short-stay admissions &lt;25hours</b>	
	
<b>Progress, Monitoring and Reporting*</b>	
<p>Introduction of new pathways for ambulatory care:</p> <ul style="list-style-type: none"> <li>• Adults with Isolated Upper Limb Fracture requiring Orthopaedic Opinion</li> <li>• Ambulatory Care Cellulitis</li> <li>• Possible Pulmonary Embolism in Pregnancy</li> <li>• Community Acquired Pneumonia</li> <li>• COPD</li> <li>• DVT</li> <li>• Pulmonary Embolism</li> <li>• First seizure in adults</li> <li>• Heart Failure</li> </ul> <p>As the Trust implemented the pathways by quarter 2, quarters 3 and 4 milestones were changed to work on the Chest Pain pathway.</p>	

<b>Priority 2s.</b>	<b>Safe, effective care</b>
<b>Managing long term conditions</b>	
<b>Aim: Work with community Nursing Teams to reduce attendances at the Emergency Department for people with COPD and Heart Failure by improving personalisation of care plans and community support</b>	
	
<b>Progress, Monitoring and Reporting*</b>	
<ul style="list-style-type: none"> <li>• The CQUIN was not finalised until June/July 2013</li> <li>• Met the milestones of 1<sup>st</sup> three quarters but have failed to meet compliance of audit as required in quarter 4 for both COPD and HF. This is due to the time it takes to embed new pathways</li> <li>• New pathways covering admission and discharge were introduced for both specialties. COPD pathway was built on the evidence based standards as issued by AQuA.</li> <li>• COPD will continue as the topic for the reducing admissions CQUIN for 2014/15, the Trust will participate in the AQ programme for COPD measures.</li> <li>• Heart Failure will continue as an AQ topic in which the Trust will participate in 2014/15 in addition to the National Heart Failure audit. The Trust is recruiting 4 cardiologists to underpin the Heart Failure team.</li> <li>• During the year, in Tameside, a pilot was commenced with the Local Authority. A health and social care Integrated Response Intervention Service (IRIS) was established to keep people out of the hospital. Early indications are that the project is having a significant impact on admission avoidance.</li> </ul>	

<b>Priority 2t.</b>	<b>Safe, effective care</b>
<b>Reducing avoidable admissions</b>	
<b>Aim: Reduce number of patients admitted to hospital from nursing homes where primary cause of admission is dehydration</b>	
 <p><b>Project Milestone</b></p>	 <p><b>Project Outcome</b></p>
<b>Progress, Monitoring and Reporting*</b>	
<ul style="list-style-type: none"> <li>• The Trust achieved the CQUIN milestone each quarter; however the project did not deliver the outcomes hoped for.</li> <li>• The outcomes that were not achieved were due to not taking into account the patients who had other comorbidities when agreeing the baseline. The project has raised awareness in Nursing Homes.</li> <li>• Training was delivered to nursing homes involved in the project; there were varying levels of engagement from GPs.</li> <li>• The largest nursing home withdrew from the project.</li> <li>• Staff in nursing homes are now trained in administering subcutaneous fluids which may enable patients to have a reduced length of stay in hospital.</li> </ul>	

### 2.1.3 Priorities for quality improvement in 2014/15

The priorities for quality improvement will be covered in the CQUINs agreed with the Trust's commissioners.

For the coming year 2014/15 the Trust will be giving assurance that quality is being driven forward by being fully engaged in the CQUIN process. To date the following are the indicators that the Trust is committed to achieve.

National	Greater Manchester	Local Stockport	Local Tameside	Specialised Services	Public Health
Friends & Family	Lessons Learned Once	Improve communication	Clinical Leadership Adults	Breast milk in preterm infants	Health Inequalities Stocktake
Safety Thermometer	Clinical Effectiveness	Patient/Carer empowerment	Clinical Leadership Children & Transition		Secondary Dental
Dementia	Ambulatory Care	Improve Clinical Leadership	Frail elderly		
	Learning Disability	Patient Experience	Medicine Management: Antibiotic education and Prescribing		
		LTC Diabetes	Medicine Management: Medication Safety Thermometer		
		AQ Programme			

Goal Name	Objectives/Outcomes
<b>Friends &amp; Family Test</b>	<ul style="list-style-type: none"> <li>implementation of the staff FFT</li> <li>implementation of the patient FFT in outpatient and day case departments,</li> <li>Increasing or maintaining response rates in acute inpatient services.</li> </ul>
<b>Safety Thermometer</b>	<ul style="list-style-type: none"> <li>Reduction in the prevalence of pressure ulcers as measured using the NHS Safety Thermometer for Acute</li> <li>Prevalence data for Catheters</li> </ul>
<b>Dementia</b>	<ul style="list-style-type: none"> <li>case finding for at least 90 per cent of patients aged 75 and over admitted as an emergency for &gt;72 hours; are appropriately assessed; and where appropriate, referred on to specialist services.</li> <li>Ensuring sufficient clinical leadership of dementia within providers and appropriate training of staff.</li> <li>Ensuring carers of people with dementia feel adequately supported.</li> </ul>
<b>Lessons Learned Once</b>	To use change improvement methodology to improve and sustain change in a Lessons Learned Theme identified and agreed with CCG. Focus area Falls.
<b>Clinical Effectiveness</b>	Improve care of the deteriorating patient by focusing on earlier recognition and treatment.
<b>Ambulatory Care - Reducing emergency admissions through integration</b>	To reduce emergency admissions for known COPD patients for Stockport CCG and Left Ventricular Systolic Dysfunction for Tameside CCG. This CQUIN will require acute and community services to work collaboratively i.e. right care, right time, right place to deliver a seamless pathway that reduces emergency admissions.
<b>Improving Learning Disability User Experience</b>	Uniformity within GM for the approach taken in the implementation of Traffic Light Passports (TLP) or a similar approved communication tool, for patients identified with Learning Disabilities (LD). Improved access and reduced inequalities for patients with LD.
<b>Medications Safety Thermometer</b>	Prevalence data for Tameside only. To avoid harm from medication errors



<b>Communication workshops</b> (Development of 12/13 CQUIN)	4 workshops to be held to improve communication and training of GPs and Trust Clinicians in identified topics. Stockport only
<b>Patient / Carer empowerment</b> (Development of 12/13 CQUIN)	Raise awareness within the Trust acute and community settings Roll out identification process to other wards Effectively empower patients and carers by improving support systems
<b>Improve Clinical Leadership</b>	Improve ward leadership and demonstrate quality improvements at ward level. Use and develop nursing dashboard to measure improvement. Tameside CQUINS: Adults; Children & Transition.
<b>Improving Patient experience focus on Communication</b>	Increase patient experience scores relating to communication with patients on specific wards. Improve feedback about patient experience of district nursing care
<b>Long Term Conditions (LTC) – Diabetes</b>	Reducing the number of deaths / readmissions Ensure all patients on podiatry caseload with diagnosis of diabetes are identified, improve care and treatment of foot ulcers
<b>Frail Elderly</b>	Improve the management of frail and elderly patients across community and hospital services. (Tameside only)
<b>Antibiotic education and prescribing</b>	Audit and training on antibiotics in intermediate care homes. Tameside only
<b>Advancing Quality CQUINs</b>	COPD, HF, Pneumonia, Stroke Annual audits for other AQ indicators; Hip & Knee, Sepsis, diabetes, fractured neck of femur, acute kidney injury, alcoholic liver disease and AMI discharge advice (not covered by the Myocardial Ischaemia National Audit Project (MINAP)).
<b>Specialised Services: Breast milk in preterm infants</b>	Improve access to breast milk for preterm infants
<b>Public Health: Health inequalities Stocktake</b>	Data gathered by health visitors for vulnerable and deprived groups
<b>Public Health: Dental</b>	To implement consistent coding.

This CQUIN programme was agreed with the Commissioners to address areas identified for improvement and many which are built on the work already undertaken in 2013/14. The programme was agreed by the Trust Board.

To agree the expected outcome and milestones to achieve for each indicator workshops were held with the commissioners, senior management and speciality leads to create a stretching but achievable indicator. In January 2014 an event took place to review all proposed CQUINs and this was attended by the majority of CQUIN leads, speciality clinicians, business group managers and Health watch to represent the public perspective in addition to representatives from the Clinical Support Unit and Clinical Commissioning Group.

Data from key priority areas, such as pressure ulcers has been reviewed to support learning and assist the next steps required to make further improvements, for 2014/15 this involves healing rates.

Benchmark data from 13/14 was considered for some Indicators to set realistic improvement goals.

Other Indicators involve collecting data as part of the early milestones for 2014/15.

CQUINS are risk rated at the start of the year and project plans created for how they will be delivered by the CQUIN lead. These are monitored by either data from Information systems, updates to action plans and project plans and discussions at various forums from business group Quality boards to sub committees of the board. In 2014/15 this will also form part of the transformation agenda.

A monthly Internal CQUIN meeting takes place with the CQUIN Programme lead, CQUIN Executive lead, Finance and Information to monitor progress.

A quarterly report and supporting evidence is submitted to the CCG. Discussion on any queries takes place between the Commissioning Support Unit and the Trust CQUIN Programme lead. All CQUINS are monitored monthly and reported to various sub committees of the Board with an overview RAG rating to the Trust Board where exceptions and areas of concern are raised.

## 2.2 Statements of assurance from the board

During 2013/14, Stockport NHS Foundation Trust provided and/ or sub contracted the following health services. During 2013/14 a restructure separated Integrated Care into Medicine and Community Health Services (combining Stockport Community and Tameside & Glossop Community Healthcare):

Integrated Care	Diagnostics and Clinical Support
Accident & Emergency General Medicine Medicine for Older People Community Medicine Genito-Urinary Medicine Haematology Dermatology Neurology District Nursing Rehab at home ME/CFS Diabetes COPD and Heart Failure Palliative Care	Diagnostics Clinical Support Pharmacy Therapies Nutrition and Dietetics –Stockport Community Direct Access Physiotherapy Children Therapy Teams
	Surgery and Clinical Care
<b>Child and Family</b> Obstetrics Gynaecology Paediatrics Health Visiting School Nursing	Anaesthetics General Surgery Trauma & Orthopaedics Urology Ear, Nose and Throat Ophthalmology Oral Surgery Breast Surgery Musculo-Skeletal Tier 2 Orthotics Podiatry
Tameside and Glossop Community Health Care	
Acute and Community Adult and Paediatric Nutrition Adult SALT CARA Community and MSK Physio Community Neuro Rehab Team Continence Diabetes District Nursing Early Attachment Health Visiting Integrated Transfer Team Integrated Services for Children with additional needs	IRIS Language Interpretation Service Learning Disabilities Lifestyles Long Term Conditions Macmillan and Palliative Care Orthotics Podiatry School Nursing Sexual Health Shire Hill Intermediate Care Wheelchairs

Stockport NHS Foundation Trust has reviewed all the data available to them on the quality of care in all of these relevant health services through a variety of methods including Clinical Audit, Business Group Assurance meetings, and Business Group Quality Boards.

The income generated by the relevant health services reviewed in 2013/14 represents **89.9** per cent\* of the total income generated from the provision of relevant health services by Stockport NHS Foundation Trust for 2013/14.

\*Please note that these figures are subject to approval of the Trust accounts by our external auditors. Total clinical income in 2013/14 was £264,146,000. Total income was £293,791,000. Therefore the % of clinical income is 89.9%

## 2.2.1 Participation in clinical audits and national confidential enquiries

During 2013/14 30 national clinical audits and 3 national confidential enquiries covered relevant health services that Stockport NHS Foundation Trust provides.

During that period Stockport NHS Foundation Trust participated in 94% of national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Stockport NHS Foundation Trust was eligible to participate in during 2013/14 are as follows (see table below).

The national clinical audits and national confidential enquiries that Stockport NHS Foundation Trust participated in during 2013/14 are as follows (see table below).

The national clinical audits and national confidential enquiries that Stockport NHS Foundation Trust participated in, and for which data collection was completed during 2013/14, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry (see table below).

The reports of 20 national clinical audits were reviewed by the provider in 2013/14 and Stockport NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided - to share the report with the Medical Director and clinical lead for the specialty for perusal, consideration and sharing with appropriate groups the findings and where appropriate develop local action plans.

The reports of 186 local clinical audits were reviewed by the provider in 2013/14 and Stockport NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

- Action plans and a report is produced for each audit and submitted to the clinical audit team for recording, these are owned by the specialty for implementation of actions.
- An outcome report of assurance and areas of concern is sent to the Trust board quarterly.

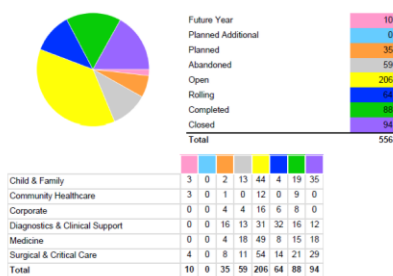
### Clinical Audit End of Year Dashboard (7 April 2014)

#### Clinical Audit: Trust Dashboard

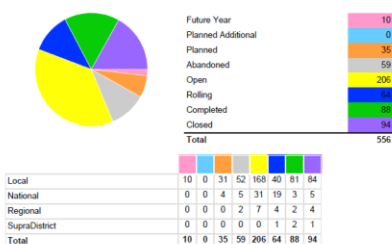
Dashboard showing the total number of audits; planned, open, closed, completed and abandoned by Business Group, Directorate, Audit Type and Year Registered.

Stockport  
NHS Foundation Trust

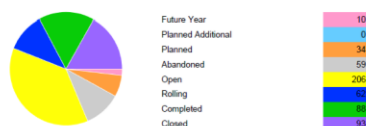
##### Business Group



##### Audit Type



##### Speciality



## National clinical audits and national confidential enquiries

Category	Name of audit / Clinical Outcome Review Programme	Applicable to participate	Trust Participation	Sample size		Comment	Action
				Sent	Approx		
Acute	Case Mix Programme (CMP)	Yes	Yes		100% est		
Acute	Emergency use of oxygen	Yes	No	0	0		
Acute	Medical and surgical clinical outcome review programme: National confidential enquiry into patient outcome and death	Yes	Yes		100%	Contributed in all studies.	
Acute	National Audit of Seizures in Hospitals (NASH)	Yes	Yes		100%		Report awaiting presentation
Acute	National emergency laparotomy audit (NELA)	Yes	Yes	52		Started January 2014	
Acute	National Joint Registry (NJR)	Yes	Yes	849			
Acute	Paracetamol overdose (care provided in emergency departments)	Yes	Yes		100%		
Acute	Severe sepsis & septic shock	Yes	Yes	30			
Acute	Severe trauma (Trauma Audit & Research Network, TARN)	Yes	Yes	305		Up to end February	
Blood and Transplant	National Comparative Audit of Blood Transfusion programme	Yes	Yes		100%		
Cancer	Bowel cancer (NBOCAP)	Yes	Yes	187		185 expected	
Cancer	Head and neck oncology (DAHNO)	Yes	Yes	37			
Cancer	Lung cancer (NLCA)	Yes	Yes	210		145 expected	
Cancer	Oesophago-gastric cancer (NAOGC)	Yes	Yes	55		<51 expected	
Heart	Acute coronary syndrome or Acute myocardial infarction (MINAP)	Yes	Yes	621		Up to end February	
Heart	Cardiac Rhythm Management (CRM)	Yes	Yes		100%		

Category	Name of audit / Clinical Outcome Review Programme	Applicable to participate	Trust Participation	Sample size		Comment	Action
				Sent	Approx		
Heart	Congenital heart disease (Paediatric cardiac surgery) (CHD)	No	N/A				
Heart	Coronary angioplasty	No	N/A				
Heart	National Adult Cardiac Surgery Audit	No	N/A				
Heart	National Cardiac Arrest Audit (NCAA)	Yes	Yes	42	35%	Up to end February	
Heart	National Heart Failure Audit	Yes	Yes				
Heart	National Vascular Registry*	No	N/A				
Long term conditions	Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)*	Yes	Yes		100%	Diabetes inpatient day	
Long term conditions	Diabetes (Paediatric) (NPDA)	Yes	Yes	150	100%		
Long term conditions	Inflammatory bowel disease (IBD)*	Yes	Yes	0	0		
Long term conditions	National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme*	Yes	Yes	N/A	N/a	Audit started February 2014	
Long term conditions	Paediatric bronchiectasis	Yes	No	N/A	N/A		
Long term conditions	Renal replacement therapy (Renal Registry)	No	N/A				
Long term conditions	Rheumatoid and early inflammatory arthritis	Yes	Yes			Started 1 <sup>st</sup> February 2014	
Mental Health	Mental health clinical outcome review programme: National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH)	No	N/A				
Mental Health	National audit of schizophrenia (NAS)	No	N/A				
Mental Health	Prescribing Observatory for Mental Health (POMH)	No	N/A				

Category	Name of audit / Clinical Outcome Review Programme	Applicable to participate	Trust Participation	Sample size		Comment	Action
				Sent	Approx		
Older People	Falls and Fragility Fractures Audit Programme (FFFAP)	Yes	Yes		100% est	Data collection only for NHFD this year	
Older People	Sentinel Stroke National Audit Programme (SSNAP)	Yes	Yes	566		Jan 13 – Dec 13	
Other	Elective surgery (National PROMs Programme)	Yes	Yes		92%		
Women's & Children's Health	Child health clinical outcome review programme (CHR-UK)*	Yes	TBC			Await reply from C Cooper	
Women's & Children's Health	Epilepsy 12 audit (Childhood Epilepsy)	Yes	Yes		100%		
Women's & Children's Health	Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	Yes	Yes		100%		
Women's & Children's Health	Moderate or severe asthma in children (care provided in emergency departments)	Yes	Yes	50		Audit period ended January 2014	
Women's & Children's Health	Neonatal intensive and special care (NNAP)	Yes	Yes		100%		
Women's & Children's Health	Paediatric asthma	Yes	Yes	22			
Women's & Children's Health	Paediatric intensive care (PICANet)	No	N/A				



Below are examples of improvements to care based on audit results:

## SURGICAL AND CRITICAL CARE

### Perioperative Anticoagulation Audit

#### Background

The management of patients requiring temporary discontinuation of warfarin or any newer oral anticoagulants for surgery is complex. The risk of thromboembolism should be weighed against the risk of bleeding. This is now managed by outpatient-based use of low molecular weight heparin. It is worth noting that management of VTE is a CQUIN target.

This process of risk analysing this group of patients is still complex. In preop, we have implemented an electronic database, which provides a simple, user-friendly way of performing risk analysis. A comprehensive patient care plan is generated based on the operation and individual comorbidities. The plan directs anticoagulation treatment from the time patient is seen in the pre-op-assessment to the discharge of the patient. This was proved beyond doubt in our last audit

(Reference: Perioperative Anticoagulation: Consultant Survey: Presented on 12th January 2013)

#### The aim of this audit:

1. Quality control of this process
2. Ensure safety, standardisation and consistence
3. Minimise adverse events

#### Objectives:

1. Improved efficiency of the patient journey and satisfaction
2. Standardisation of perioperative anticoagulation pathway enhancing patient care.
3. Reduction in pre-op bed days by 2-3 days.
4. Reduction in postoperative bed days by 3-5 days.
5. Reduced our reliance on multiple specialties.
6. No increase in morbidity and mortality related to anticoagulation management

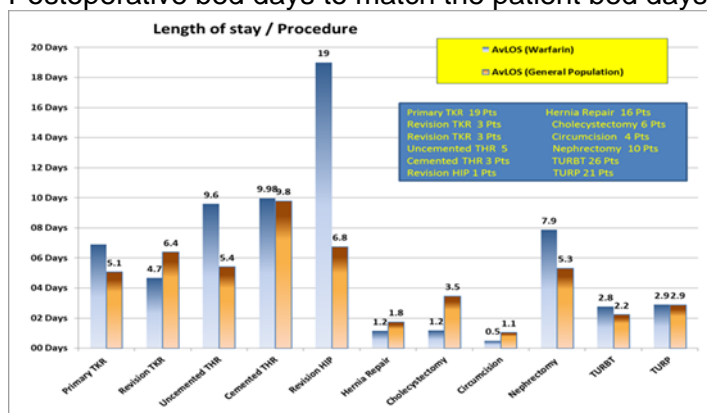
The criteria came from American College of Chest Physicians (ACCP) 9th Edition guideline, National Institute for Health and Care Excellence (NICE) guidelines, and other multiple evidence based papers.

#### Findings

We have been using the database for the past 12 months

#### Improvements to date:

1. Efficiency of the patient journey and satisfaction
2. Standardisation of perioperative anticoagulation pathway enhancing patient care. (98.6% accuracy of prediction of plan to match patient need)
3. Reduction in pre-op bed days by 2-3 days. All the patients are admitted on the day of surgery.
4. Postoperative bed days to match the patient bed days in similar procedures



5. Reduced our reliance on multiple specialties. 98 Cardiologist / Haematologist referrals saved
6. 2.3% bleeding (Estimated Risk of Bleeding for Oral Anticoagulant is 4.5%-5%)
7. 1 DVT / 302 Root cause analysis confirmed best standard of care.
8. No increase in morbidity and mortality related to anticoagulation management.

## Outcomes

The database is standardised, safe and secure, user- friendly, paperless and cost effective.

## Actions

1. On-going audit to get more robust data
2. Further analysis of post op plan to standardise postop care & discharge
3. Update database to include newer oral anticoagulants

## SURGICAL & CRITICAL CARE

### Critical Care Patients: who is reviewing them?

The main aim of the audit was to ascertain how frequently patients admitted to critical care were reviewed by their referring parent specialty as per gold standards defined within the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) report of 2005 and the Academy of Medical Royal Colleges (AOMRC) report of 2012: that all admissions to critical care are consultant-to-consultant; that all critical care admissions are reviewed daily by their parent specialty; that all critical care admissions are reviewed within 12 hours by the consultant intensivist. The methodology used was a retrospective analysis of 80 admissions to the critical care unit selected pseudo-randomly (40 medicine, 40 surgery) resident for a minimum of five days between April 2012 – March 2013.

The principle findings, based on documentation found in the hospital notes, were:

1. 67.5% medical patients were referred on a consultant-to-consultant basis compared with 87.5% surgical patients ( $p=0.06$ ).
2. 50% medical patients were reviewed by a medical consultant in person immediately before referral (within the preceding four hours) compared with 87.5% surgical patients ( $p=0.0006$ ).
3. 25% medical patients were reviewed within 24 hours of critical care admission by their parent specialty compared with 62.5% surgical patients ( $p=0.001$ ).
4. 42.5% medical patients were never reviewed by their parent specialty over a minimum stay of five days compared with 10% surgical patients ( $p=0.002$ ).
5. 0% medical patients were reviewed daily by their parent specialty compared with 22.5% surgical patients ( $p=0.002$ ).
6. 0% medical patients were reviewed on at least alternate days by their parent specialty compared with 82.5% surgical patients ( $p<0.0001$ ).
7. 100% medical patients were reviewed on a less than alternate day frequency by their parent specialty compared with 17.5% surgical patients ( $p<0.0001$ ).
8. 82.5% patients were reviewed by the consultant intensivist within 12 hours of admission. The large majority of patients not seen within this time frame were surgical patients admitted directly from theatre.
9. 98.8% patients were reviewed by the consultant intensivist within 24 hours of admission.
10. 100% patients were reviewed at least once daily by the consultant intensivist.

Although there was certainly a significant improvement in consultant-to-consultant referral compared with data from a similar audit undertaken in 2005 by Dr Rigg and Dr Stevens, the main results are of some significant concern. This concern was expressed after presenting the data during the discussion which followed. Clearly, patients are not being reviewed on a daily basis by either medicine or surgery as the parent specialty. Whilst this is a published gold standard, it is perhaps a counsel of perfection and unrealisable in the real world. However, when we consider an alternative standard of at least alternate day review by the parent specialty, this was also never achieved by the medical teams compared with the large majority of surgical teams, which did achieve it. A completely unacceptable proportion of medical patients were never reviewed at all during a critical care stay of at least five days by their parent specialty.

The conclusion of the audit meeting was that steps were urgently required to increase the proportion of patients who are reviewed on the critical care unit by a member of the medical parent specialty (not necessarily the consultant). The proposed minimum standards were defined as:

1. All patients should be reviewed by their parent specialty within 24 hours of critical care

admission.

2. All patients should be reviewed by their parent specialty at least twice per week – this could easily occur during the scheduled consultant-led ward rounds.
3. A robust system of identifying the relevant medical consultant responsible for the patient whilst resident in critical care needs to be implemented. As an interim measure, it was decided that at the time of referral, the consultant intensivist would speak personally to the relevant responsible medical consultant at that time and inform him/her that the patient would remain their responsibility throughout the duration of the stay in critical care until/unless that medical consultant referred the patient to a colleague and also informed critical care of that fact.
4. A re-audit should take place to assess the results of this action plan.

The details were presented to the Medicine business group at the quarterly audit day in January 2014. This was to raise awareness of the outcome of the audit and advise on the correct use of the e-referral system. This will be re-audited by junior doctors in quarter 3 to allow time for the embedding of the process to take place.

This is an operational concern not a clinical risk.

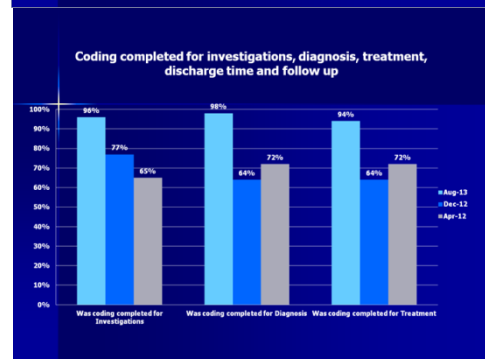
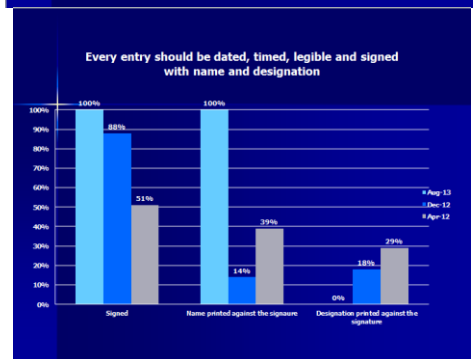
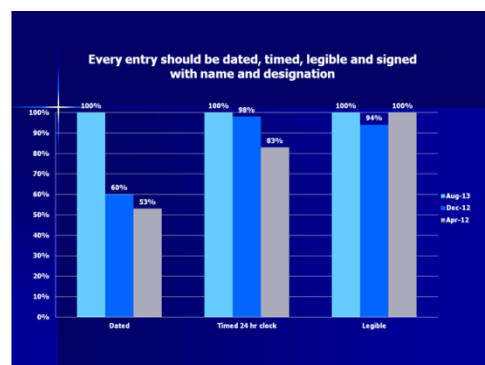
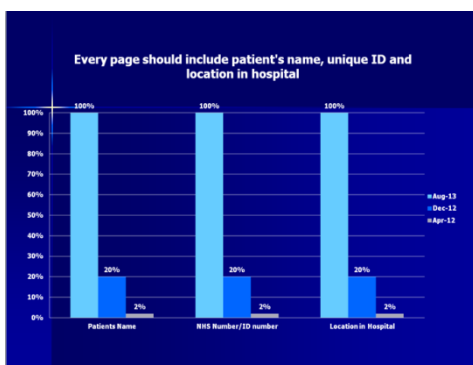
## MEDICINE

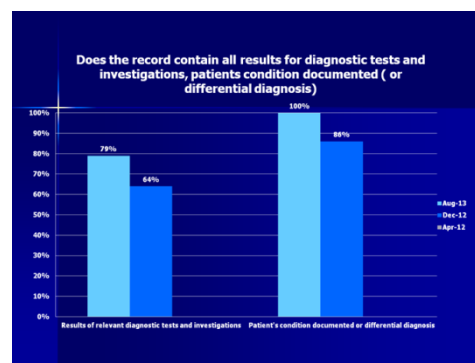
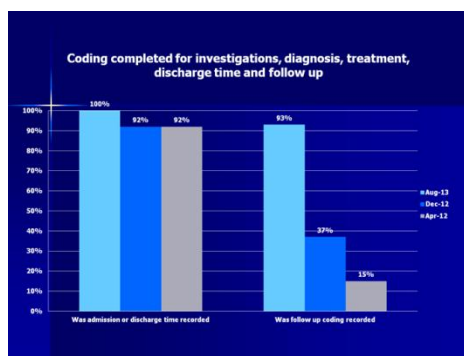
### Emergency Department Documentation Audit

National standards have been introduced for documentation in hospital notes. Several of these standards were not applicable to episodes purely involving an attendance at the Emergency Department. We therefore applied the relevant standards and devised further standards specifically applicable to the Emergency Department Record.

We were performing very poorly in several areas. We managed to improve performance tenfold with the introduction of patient identification stickers to be used on the paper record. However, an enormous amount of work was done by Paula Bennett, ED Nurse Consultant, and Dr Henry Morriss, ED Consultant, with the Trust IT Department to develop an electronic Emergency Department Record (AdvantisED).

AdvantisED was launched in June 2013 and has produced a dramatic effect in compliance with record keeping standards. Many areas have now improved from 2% in April 2012 to 100% in August 2013.





#### Action plan following re-audit

1. Include designation with each electronic signature. This is being addressed by IT and will give 100% performance against this standard once implemented.
2. Consider whether the patient identifier number should be the NHS rather than hospital number, as this is truly unique.
3. Explore improvements to the treatments page of AdvantisED to improve coding in this area.
4. Re-audit with a change of focus: specifically look at the accuracy of recording of treatments, investigations and diagnoses.

## MEDICINE

### Pulmonary Embolism in Pregnant Women

Pregnant ladies with a possible Pulmonary Embolism (PE) are normally managed by medical team. There were no set guidelines available to guide the way they are investigated. The aim of the audit was to identify how this cohort of patients were investigated and to compare it with the guidelines from the Royal College of Obstetricians and Gynaecologists.

#### Criteria and results

- All patients should have a Chest X Ray (CXR) or a clear reason given if not - 82% had CXR, 5/33 (15%) patients refused.
- All patients should have bilateral Doppler Ultrasound leg - 27% - poor compliance
- D-dimer is not indicated unlike in non-pregnant patients - 58% had D-dimer
- When CXR is normal – ventilation/perfusion lung (VQ) scan is the preferred investigation - 75% had VQ scan
- All patients should be treated while waiting investigations - 96%
- Low Molecular Weight Heparin (LMWH) dose is based on pre-pregnancy weight - Only 50% had correct dose based on weight
- LMWH should be given twice a day - 75% received this
- Pregnant patients with suspected PE should not be managed as ambulatory - 45% managed as ambulatory

This audit clearly showed that initial diagnosis of suspected PE is not very accurate as only 3% of this cohort of patients had confirmed PE. But the aim of this audit was to identify how this group of patients were investigated / treated and not to challenge the how this working diagnosis of suspected PE is made by the clinician who made the initial assessment.

#### Actions

The formulation of a pathway in how to investigate pregnant women with suspected PE, and recommendations were taking place during the audit period, action plans were in place at the time of completion of the audit and a pathway chart and how to manage pregnant women with suspected PE is available on the acute medical and ambulatory care web pages.

## CHILD & FAMILY

### Care of Women in Labour

**Aim of the audit** - To audit care provided against Trust guidelines and provide evidence for Clinical Negligence Scheme for Trusts (CNST) Standard 2 – Criterion 1: Care of Women in Labour

According to the CNST guidelines “*Care in labour should be aimed towards achieving the best possible outcome for the woman and baby. All maternity services should have in place approved documentation to support the staff who care for women in labour.*”

**Criteria** – CNST / Trust Guidelines Care of Women in Labour

**Standard** for each was  $\geq 75\%$

**Sample** = 38 (1% of all women who delivered in 2012)

**Methodology** – data extraction from women’s maternity notes using proforma and results presented at Obstetrics & Gynaecology Audit meeting in May

**Results** - the results of the audit showed that only three of the nine criteria met the standard set of  $\geq 75\%$ .

#### Actions following first audit:

- Disseminate findings to the maternity team - on Intranet, results emailed to all relevant staff including Ward Managers and medical staff, at meetings including Labour Ward Forum & Quality Board
- Intrapartum records updated to ensure minimum standards are recorded
- Snapshot audits to monitor progress and raise awareness amongst staff (results discussed with teams)– three completed - overall average results increased
- Re-audit

#### Learning Points:

From this and other audits the Obstetric department learnt that it was important to involve the whole maternity team in the audit (Ward managers, clinical midwives, management team and medical staff contributed). The discussion of results on the ‘shop floor’ had a big impact. The first audit provided a benchmark for them to build on. It identified areas for improvement and areas where the team ‘celebrated’ good results.

#### Re-audit

Following completion of the actions agreed as a result the first audit it was agreed to complete a re-audit to see if those actions had made any improvements.

**The aim** of the audit is to see whether or not improvements have been made following the implementation of actions agreed after the first audit.

#### Re-audit Objectives

- To see if improvements have been made where standards were not previously met and that these are now achieving above 75%
- To ensure that the other criteria & standards are still being met as per the original audit
- To monitor the Trust guideline and ensure that it is being followed.

**Method** - 40 sets of women’s records were reviewed (women who had delivered between June 2013 – January 2014)

**Results** - all 9 criteria achieved the standard of  $\geq 75\%$ , 8 of the 9 achieved 100% and the other achieved 98%. This is the first cycle where all criteria achieved above the standard.

The re-audit was presented at the Obstetrics & Gynaecology audit meeting on 30 April 2014, as all criteria achieved the standards there were no concerns and actions were therefore to disseminate the excellent results with all relevant staff, discuss at the Quality Board meeting and re-audit in 3 years as per the Care of Women in Labour guideline (unless for some other reason this needs to be sooner).

## CORPORATE

### Trust Record Keeping Audit

#### Background

Good record keeping is necessary to comply with NHS Litigation Authority (NHSLA) as well as contributing to patient safety and staff professionalism. It is essential that staff provide a clear legible record of a patient's treatment. Good record keeping protects the professional, providing evidence of treatment given, when and by whom (essential at a coroner's court). The Trust Record Keeping audit has been running in its current format since May 2012, the current Trust standards were updated and launched in April 2012.

#### Aim

To demonstrate current position of compliance against standards and to provide regular and current focus to support improvements.

#### Objective

To raise the compliance against standards to at least the minimum expected by the NHSLA.

- Use a unique patient identifier on every page
- All entries must be written in ink
- All entries must be dated and signed
- Entries should be in chronological order, if not then a reason must be given
- When making an alteration use a single line cross out and date & sign the alteration

#### Methodology





Each business group was expected to complete 25 submissions each month. The proformas consisted of questions to demonstrate compliance with the Trust agreed standards.

The auditors could be anyone from any staff group within the business group. The notes were selected randomly and had to be the most recent episode/appointment or visit during the last month. Data was extracted from case notes onto a web or paper proforma. The data was then transferred to Excel, analysed and a report created.

Community Services collect data for a different service each month therefore we may not see a continuous improvement month on month.

Regular feedback on findings was given to each Business Group via a monthly report to enable them to produce an action plan; a monthly report of progress was given to the Health Records Committee and a quarterly report of findings given to Clinical Effectiveness. Results were presented back at each specialty's Quarterly Audit Meetings by the Clinical Directors and key messages reiterated to staff.

Results were scored using a traffic light system:

Gold		>95%	Excellent
Green		86 – 95%	Good
Amber		75 – 85%	Acceptable
Red		<75%	Poor

#### Results

Results were variable every month. The monthly report provided business groups with data for all questions for all of the audit's standards, giving prominence to the five basic standards required by NHSLA. Certain standards have continued to remain seemingly unachievable. The percentage of questions that achieved an acceptable rating or above ( $\geq 75\%$ ) was also reported on.

#### Examples of actions:

- Discuss the outcomes with ward areas during observational audits and with clinical audit lead. Clinical Audit lead to discuss the need for consultants to lead by example on their ward rounds and challenge junior doctors who are not following practice which fall below the expectations.
- Each member of the Business Group Management Team will undertake 2 case note audits



following their weekly walk rounds and each non-compliance will be highlighted to the staff at the time of the audits.

- Review of documentation to ensure it covers record keeping standards such as information regarding dependants, patient name and id number on every page etc.
- Making certain fields on Electronic Patient Record mandatory (Sexual Health, Community)
- Using stickers to ensure every page has patient details recorded (Macmillan Team, Community)

### **Achievements**

The audit has raised the profile of record keeping throughout the Trust. Improvements have been made since the audit started however results have plateaued. Therefore we are currently revisiting the audit methodology to enable business groups to concentrate on failing areas. The final month of data collection for the audit in its current form was March 2014.

## **DIAGNOSTICS & CLINICAL SUPPORT**

### **Faeces Sample Audit – Infection Prevention Team and Microbiology Laboratory**

#### **Reasons for the audit**

The Trust was over trajectory for *Clostridium difficile* cases – while looking into the possible causes for this it was noticed that many faeces samples sent to the microbiology laboratory for testing were sent inappropriately.

An audit of faeces sample requesting was undertaken to understand the following issues; how big a problem inappropriate faeces sample requesting is, for what reasons inappropriate faeces samples are being sent to the laboratory. The aim of the audit was to prevent inappropriate requesting of faeces samples as the results may be misleading and lead to inappropriate management.

#### **Methods and Results**

- 37 consecutive patients who had had faeces samples sent from within the Trust over a 6 day period in Sept 2013 were examined for appropriateness of testing for faecal pathogens
- 22 should have been submitted and tested – 2 *Clostridium difficile* toxin positive and 1 *Clostridium difficile* GDH (Glutamate dehydrogenase) positive in this group
- 15 should not have been sent (9 laxative induced; 3 not diarrhoea; 1 Gastro-Intestinal bleed; 1 definitely condition related; 1 went home as so well) – no *Clostridium difficile* toxin or *Clostridium difficile* GDH positives in this group

#### **Actions as a result of the audit**

- Advise Health Care Workers about appropriate faeces sample submission
- Plan for Faeces Sample Requests to be assessed for appropriateness for microbiological analysis before testing

#### **Outcomes of audit and actions**

- Infection Prevention Team have continued visiting patients from whom faeces samples have been taken before testing. This takes up to 2hrs each morning.
- 40% samples from patients assessed approximately 12-18 hours after submission are deemed not appropriate to test.
- For those that are tested that generate positive results the results are felt to be more clinically significant and “true” positives than before the clinical assessment process.
- Easier to formulate clear management and isolation plans for patients.
- Less unnecessary testing – less costly in terms of both time and consumable resources. This is especially important now *C difficile* Polymerase Chain Reaction PCR is in the testing algorithm.
- Reduced incidence of *C difficile* disease in the Trust.



## **2.2.2 Participation in Clinical Research**

The number of patients receiving NHS services provided or sub-contracted by Stockport NHS Foundation Trust in the period 2013/14 that were recruited during that period to participate in research approved by a research ethics committee was 680 (2012/13 835).

Participation in clinical research demonstrates Stockport NHS Foundation Trust's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stays abreast of the latest treatment possibilities and active participation in research leads to successful patient outcomes.

Stockport NHS Foundation Trust was involved in conducting and/or recruiting to 163 research studies in the following Trust strategic priority areas during the reporting period:

- Cancer – 44
- Musculoskeletal – 25
- Paediatrics and neonatal – 27
- Vascular (stroke and cardiology) – 24
- Workforce development and management – 6
- Other – 37

Of these, 134 were National Institute for Health Research portfolio adopted studies.

There were over 50 members of the clinical staff participating in research approved by a research ethics committee at Stockport NHS Foundation Trust during 2013/14. These staff participated in research covering 43 medical specialties

Our engagement with clinical research demonstrates Stockport NHS Foundation Trust's commitment to testing and offering the latest medical treatments and techniques.

### 2.2.3 Commissioning for Quality and Innovation (CQUIN)

A proportion of Stockport NHS Foundation Trust's income in 2013/14 was conditional on achieving quality improvement and innovation goals agreed between Stockport NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2013/14 and for the following 12 month period are available electronically at [www.stockport.nhs.uk/110/summary-of-cquin-programme](http://www.stockport.nhs.uk/110/summary-of-cquin-programme)

#### **For 2012/13 the Trust received:**

Stockport

Acute £4.7m of which Trust achieved £4.1m

Community £0.7m (100% guaranteed through Business Transfer Agreement\*)

Total £4.8m

Tameside Community £0.7m

**Total CQUIN 2012/13 achieved £5.5m**

#### **For 2013/14 the Trust is forecast to receive:**

Stockport

Acute £4.7m of which Trust forecast £3.5m

Community £0.7m of which Trust forecast £0.5m

Total £4m

Tameside Community £0.7m

**Total CQUIN forecast 2013/14 £4.7m**

Stockport NHS Foundation Trust achieved 100% CQUIN for Specialist £246k, 85% NHS England £213k, 100% Public Health i.e. Local Authority £175k for 2013/14 (Stockport Acute, Community and T&G Community).

\*As part of the Business Transfer Agreement for Stockport Community services the Trust was guaranteed 100% CQUIN payment for 2012/13 by the PCT. In recognition that it would be unfairly penalised as it wouldn't have time to embed CQUIN whilst the service transfer was taking place.

#### **2.2.4 Registration with the Care Quality Commission (CQC)**

Stockport NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is Registered. Stockport NHS Foundation Trust has the following conditions on registration There is no condition on its registration.

The Care Quality Commission has not taken enforcement action against Stockport NHS Foundation Trust during 2013/14.

The Trust has not been involved in a special review in the past however the Trust was involved in a Routine Inspection with the inspection report published on 06 August 2013 and the Trust met all the standards inspected. (Outcome 1,4,13,14 and 21)

## 2.2.5 Information on the quality of data

Stockport NHS Foundation Trust submitted records during 2013/14 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:

Which included the patient's valid NHS number was:

99.92% for admitted patient care;

99.98% for out-patient care; and

99.74% for accident and emergency care

Which included the patient's valid General Medical Practice Code was:

99.99% for admitted patient care;

100% for out-patient care; and

99.99% for accident and emergency care

Period: 01 April 2013 to 31 March 2014

1. Upon checking GP Practice codes, all were valid. Those showing as invalid have the default code of "Practice Code is Not Known"

2. NHS Numbers include where patient identity has been withheld - invalid codes relate to "Trace attempted and no Match" or "Trace needs to be resolved"

Stockport NHS Foundation Trust Information Governance Assessment Report overall score for 2013/14 was 75% and was graded green.

Stockport NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2013/14 by the Audit Commission.

Stockport NHS Foundation Trust has been and will continue to take the following actions to improve data quality:

- continue to monitor data quality under a variety of Key Performance Indicators and report on these;
- continue to undertake spot checks of patient recording activities in clinic, departments and wards;
- review and update procedures for capture and handling of patient activity data;
- update training materials and amend in view of any data quality issues;
- deliver training and refresher training to staff responsible for data capture including ward clerks and clinical coders;
- continue the good progress on developing procedures and data quality checks for community services in Stockport;
- regular contact with lead clinician in each specialty, highlighting issues that clinical coders encounter, to improve the quality of the content of patients' records;
- promote good filing and reduction of the size of casenote folders – ward clerks and health records staff;
- introducing a new structure for Business and Performance management led by the Chief Operating Officer, supported by Director of Performance managing a team comprising of Business & Performance Manager, Clinical Performance Manager and Transformation Manager;
- continue to maintain compliance with all the Information Governance Toolkit requirements including health records and data quality standards.

## 2.3 Reporting against core indicators

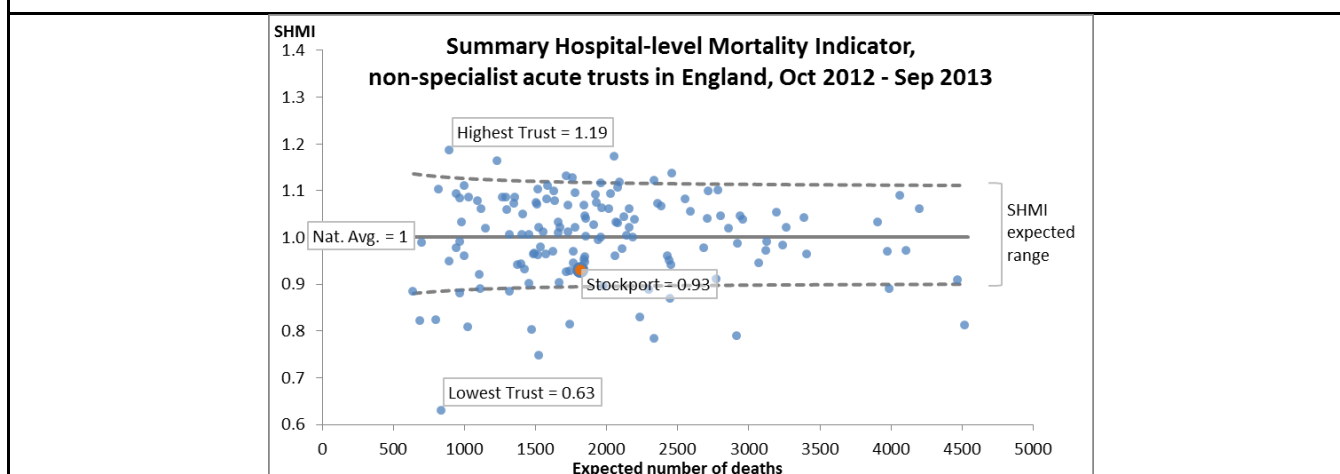
### 12. (a) The value and banding of the summary hospital-level mortality indicator ("SHMI") for the Trust for the reporting period

	October 2011 – September 2012	October 2012 – September 2013
<b>Stockport NHS Foundation Trust</b>	0.95	0.93
<b>National Average</b>	1	1
<b>Lowest NHS Trust</b>	0.68	0.63
<b>Highest NHS Trust</b>	1.21	1.19

Stockport NHS Foundation Trust considers that this data is as described for the following reasons this is the latest data available and Stockport are pleased to report they continue to be below the national average.

Stockport NHS Foundation Trust has taken the following actions to improve this indicator, and so the quality of its services, by having a comprehensive weekend mortality action plan which includes:

- Introducing 2 Macmillan nurses on site
- Extended hospital and community palliative care expertise over 7 days a week
- Increased antibiotic pharmacists
- Implemented changes to medical rotas
- Regular meetings held with commissioners



### 12. (b) The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust for the reporting period

	October 2011 – September 2012	October 2012 – September 2013
<b>Stockport NHS Foundation Trust</b>	12%	17%
<b>National Average</b>	19%	21%
<b>Lowest NHS Trust</b>	0%	0%
<b>Highest NHS Trust</b>	43%	45%

Stockport NHS Foundation Trust considers that this data is as described for the following reasons: The percentage for October 2011 – September 2012 is low compared to national average because specialist palliative care was often not documented in the casenotes so could not be coded.

Stockport NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by the Medical Director encouraging clinicians to document palliative care more clearly in casenotes. In addition, the Clinical Coding Manager and Medical Director have made an agreement as to what constitutes specialist palliative care. This has brought the Trust's percentage more in line with the national average as shown by the higher figure in the 12 months October 2012 to September 2013.

<b>18. The Trust's patient reported outcome measures scores for:</b>									
	<b>2011/12</b>			<b>2012/13*</b>			<b>April – Dec 2013*</b>		
	Groin hernia surgery	Hip replacement surgery	Knee replacement surgery	Groin hernia surgery	Hip replacement surgery	Knee replacement surgery	Groin hernia surgery	Hip replacement surgery	Knee replacement surgery
<b>Stockport NHS Foundation Trust</b>	46.8%	90.3%	84.8%	48.4%	90.3%	84.0%	52.6%	96.4%	78.4%
<b>National Average</b>	49.9%	87.3%	78.4%	49.4%	87.9%	79.7%	50.2%	87.8%	81.0%
<b>Lowest NHS Trust</b>	12.5%	63.6%	63%	10%	67%	33%	18.8%	50%	54.5%
<b>Highest NHS Trust</b>	88.9%	100%	100%	83%	100%	100%	83.3%	100%	100%

Stockport NHS Foundation Trust considers that this data is as described for the following reasons: this is the latest data available from The Health and Social Care Information Centre as at May 2014, the figures are based on the patients' responses to questionnaires completed before and after surgery and is the percentage of respondents who had improved health. The EQ-5D Index captures in a single value a range of generic health issues in a broad but clearly defined way.

Stockport NHS Foundation Trust has taken the following actions to improve these scores, and so the quality of its services, by:

**Hips and Knees** – the Trust continues to review them on a regular basis, along with publishing the figures within and outside the Trust. No other specific action required.

**Groin Hernia Surgery** - more are being done laparoscopically especially if the patients are younger with small hernias and need to return to work quicker. We have calculated that if we do them laparoscopically and do them as day case then the costs incurred are favourable for us and the patient feedback is obviously better.

The other change has been an agreement amongst the surgeons that all groin hernias should be listed as day cases on the listing proformas with an aim to go home the same day. This seems to be working better but we still need to improve on this.

As you can see that the most recent year's figures in the data reflect that our PROM has got better than the national average. Obviously we still need to go quite a way forward to catch up with the best NHS figures

\*Most recent data released May 2014

<b>19. The percentage of patients readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period aged:</b>				
	<b>2010/11</b>		<b>2011/12*</b>	
	<b>0 to 15</b>	<b>16 or over</b>	<b>0 to 15</b>	<b>16 or over</b>
<b>Stockport NHS Foundation Trust</b>	<b>10.5%</b>	<b>12.5%</b>	<b>10.9%</b>	<b>11.8%</b>
<b>National Average</b>	<b>10.0%</b>	<b>11.4%</b>	<b>10.0%</b>	<b>11.5%</b>
<b>Lowest NHS Trust</b>	<b>0%</b>	<b>0%</b>	<b>0%</b>	<b>0%</b>
<b>Highest NHS Trust</b>	<b>16.1%</b>	<b>22.8%</b>	<b>14.9%</b>	<b>41.7%</b>

Stockport NHS Foundation Trust considers that this data is as described for the following reasons this is the latest available from The Compendium of Population Health Indicators.

Stockport NHS Foundation Trust along with the commissioners has taken the following actions to improve this percentage, and so the quality of its services, by undertaking audits to look at readmitted cases and identify the root causes and key themes to use as learning points.

\*Please note that the latest data is for 2011/12 released in March 2014.

**20. The Trust's responsiveness to the personal needs of its patients during the reporting period.**

	2011/12	2012/13	2013/14*
<b>Stockport NHS Foundation Trust</b>	61.4	63.3	
<b>National Average</b>	67	68	
<b>Lowest NHS Trust</b>	57	57.4	
<b>Highest NHS Trust</b>	85	84.4	

Stockport NHS Foundation Trust considers that this data is as described for the following reasons; the result shown is calculated as the average of five questions taken from the inpatient survey.

Stockport NHS Foundation Trust is:

- Adding the question regarding worries and fears to the local iPad survey in order that we can identify and target specific areas to ensure this is addressed
- Has already produced a discharge leaflet that advises patients on actions to take if they have concerns once home
- Have produced a medications leaflet for discharge advising patients of side effects and the actions to take
- The other questions form part of a Trust action plan that also addresses Care Quality Commission (CQC) and Picker findings. This plan is discussed at Trust committee meetings to improve the score, and so the quality of its services, by monitoring the progress of the above.

\*2013-14 figures for NHS Outcomes Framework indicator 4.2 (Responsiveness to inpatients' personal needs) will be released in the next publication on the 22nd May 2014.

**21. The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.**

	2012	2013
<b>Stockport NHS Foundation Trust</b>	66%	73%
<b>National Average (median)</b>	63%	66%
<b>Lowest NHS Trust</b>	35%	40%
<b>Highest NHS Trust</b>	94%	94%

Stockport NHS Foundation Trust considers that this data is as described for the following reasons it is taken from the results of the national staff survey.

Stockport NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services by having a Trust action plan to address the findings from the staff survey. This element has been included in the staff survey Trust action plan. A mid-year sample survey has been carried out.

**23. The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.**

	2012/13	2013/14
<b>Stockport NHS Foundation Trust</b>	94.28%	95.81%
<b>National Average</b>	94%	95.7%
<b>Lowest NHS Trust</b>	80.2%	65.3%
<b>Highest NHS Trust</b>	10%	100%

Stockport NHS Foundation Trust considers that this data is as described for the following reasons it is captured via the Trust's IT systems.

Stockport NHS Foundation Trust has taken the following actions to improve this percentage (although compliance has been consistently high), and so the quality of its services, by:

- Undertaking root cause analysis within Business Groups in months where the percentage fell



- Risk assessment added to Trust's electronic prescribing, and prescribers are unable to prescribe chemical prophylaxis without having completed it
- In Child and Family business group, who had the lowest compliance in 2013/14, the Associate Medical Director contacted all first on call doctors and sent memos regarding the importance of completing VTE risk assessment in the Gynaecology Documentation and met with each ward manager personally to ensure that VTE Risk Assessment completed by midwives in all Maternity wards.
- Following audit of missed patients in Trauma & Orthopaedics implemented the following:
  - No procedure - Role of Trauma Nurse Team to remind
  - Procedure – Don't leave ward until VTE Risk Assessment done
- Audits in both Obstetrics & Gynaecology and Trauma & Orthopaedics showed many of the patients who failed should have been excluded, therefore actions have been included to ensure all patients who should be excluded are actually recorded as excluded.

**24. The rate per 100,000 bed days of cases of C.difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period**

	2011/12	2012/13	2013/14*
<b>Stockport NHS Foundation Trust</b>	30.9	21.9	13
<b>National Average</b>	22.2	17.3	12
<b>Lowest NHS Trust</b>	0.0	0.0	0
<b>Highest NHS Trust</b>	58.2	30.8	31

Stockport NHS Foundation Trust considers that this data is as described for the following reasons it is captured by the Infection Prevention team.

Stockport NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services, by developing, implementing and monitoring an action plan, including:

- Ward deep cleans and exploration of alternative methods of deep cleaning
- Polymerase Chain Reaction (PCR) testing commenced on 7th October 2013 following a trial, this reduces the risk of false positive samples.
- Procalcitonin introduced on a trial basis
- Monthly antibiotic stewardship audits started in September 2013.
- Capability within electronic prescribing system considered. Current version allows for various alerts for prescribers when prescribing antibiotics. Adding an automatic request for a clinical review for intravenous antibiotics after 48 hours. Negotiating to implement further enhancements to promote antibiotic stewardship. In particular a mandatory requirement for the prescriber to put the clinical indication for antibiotic prescription and duration of the course of antibiotics.
- November 2013 surveillance of faeces sampling commenced following a pilot.

\* April 2013 – February 2014

**25. The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.**

	2011/12			2012/13			April – Sept 2013		
	rate of patient safety incidents*	number and percentage that resulted in severe harm or death		rate of patient safety incidents*	number and percentage that resulted in severe harm or death		rate of patient safety incidents*	number and percentage that resulted in severe harm or death	
<b>Stockport NHS Foundation Trust</b>	8.3	72	1.01%	10.0	81	0.94%	10.0	73	1.69%
<b>National Average (Acute Trusts)</b>	6.5	6895	0.75%	7.1	6629	0.65%	7.5	3023	0.56%
<b>Lowest NHS Trust</b>	2.6	0	0.00%	2.5	0	0.00%	3.5	0	0.00%
<b>Highest NHS Trust</b>	20.8	254	4.57%	27.8	212	3.34%	27.9	106	4.05%

Stockport NHS Foundation Trust considers that this data is as described for the following reasons as captured in the Trust's Datix system for reporting incidents. The Trust reports all cardiac arrests via the Datix reporting system as a new requirement, these by their nature are catastrophic however the reporting of them does not mean that an incident or near miss occurred. Reporting is simply to ensure full investigation / root cause analysis is undertaken to ensure any learning is identified. Approximately 25% of the number reported as severe harm or death is due to cardiac arrests.

Stockport has good reporting, above the national average. The rate of incidents has remained the same since 2012/13 however the percentage that resulted in severe harm or death has increased.

Stockport NHS Foundation Trust has taken the following actions to improve this percentage/number, and so the quality of its services, by continued review of incidents, patterns and trends and development of relevant action plans when issues are highlighted. This is done through the Risk Management Committee, quarterly report and new risk management dashboard. Business groups continue to monitor patterns and trends through their own quality meetings.

\*As rate per 100 admissions

## Part 3 Other Information

### 3.1 Overview of the Quality of Care

Since Stockport NHS Foundation Trust began its explicit quality improvement strategy in 2008/09, a number of the quality issues covered by our quality goals have remained fairly constant, and were included in the Trust's 2012/13 annual quality report. These include:

#### Patient Safety:

- Infection Prevention – MRSA (meticillin-resistant staphylococcus aureus) bacteraemia and C. Difficile infections
- NHS Safety Thermometer focusing on pressure ulcers
- Nursing Care Indicators

#### Clinical Effectiveness:

- Advancing Quality (reliable care)
- VTE Risk Assessment
- Mortality

#### Patient & Family Experience:

- Friends & Family
- Complaints / Serious Events
- Learning From Patient and Family Experience
  - Dignity
  - I Pad Surveys
  - Feedback Leaflets

This section will demonstrate progress over time and wherever possible, the Trust's performance compared to other providers.

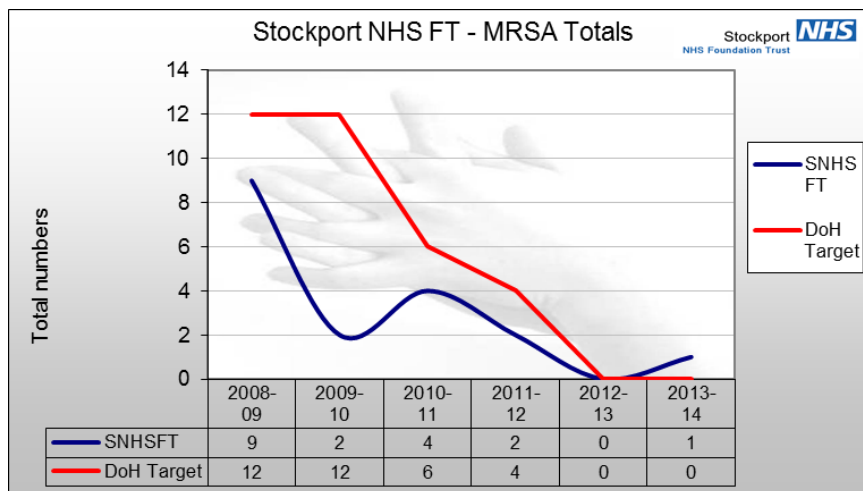
### Performance against relevant indicators and performance thresholds

#### 3.1.1 Patient Safety

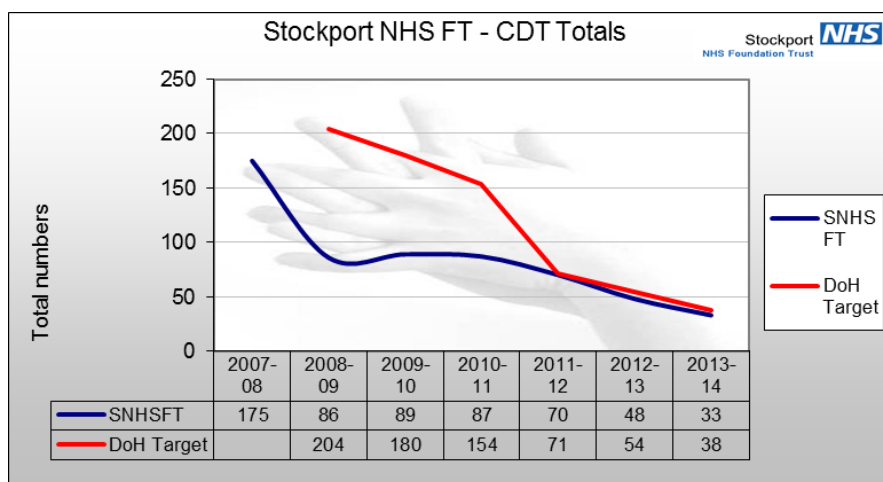
##### Infection Prevention – MRSA bacteraemia and C. Difficile infections

##### a) Hospital acquired MRSA Bacteraemia: national target of Zero

Since trajectories were introduced for MRSA bacteraemia in 2008, the Trust has met the trajectory presented despite the challenges. 2013-14 year was another extremely challenging year with a target of zero cases, this year we were unable to meet the trajectory by having one hospital acquired case after 807 days without. This case has subsequently gone to arbitration as the Trust believes this should not be attributed to Trust as the patient was already ill before their episode at Stockport, the Trust is awaiting the results of the arbitration at the time of this report.



**b) Hospital acquired Clostridium difficile Infections: Have fewer or no more than the National Target (38)**

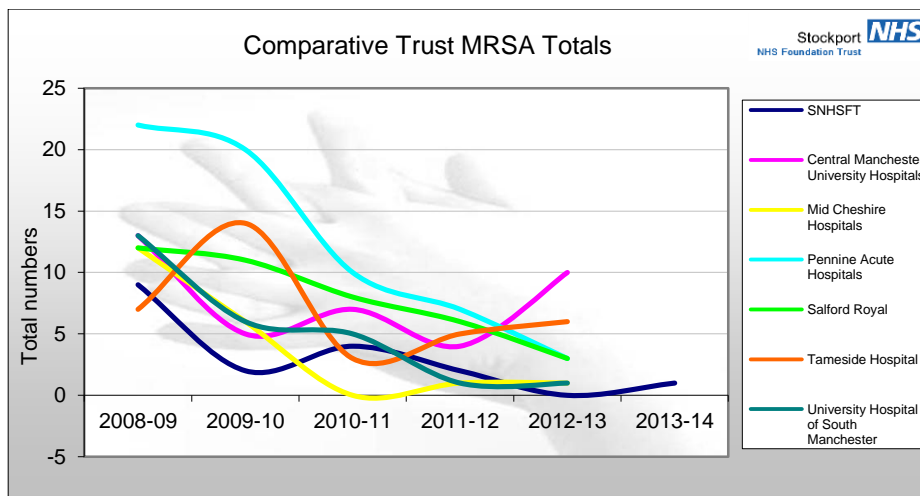
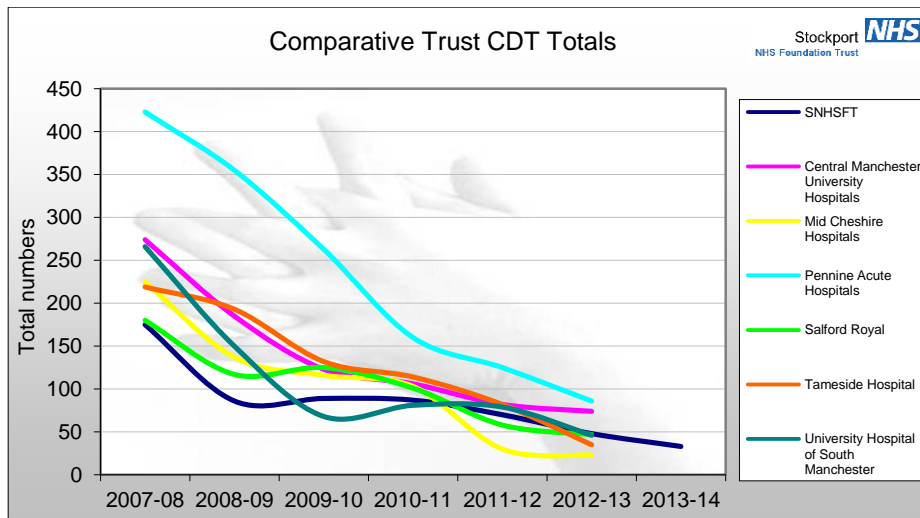


Since trajectories were introduced in 2008, the Trust has always met them although at times this has been challenging. 2014-15 year will be no exception with a challenging trajectory of 39 cases.

33 patients acquired Clostridium difficile during 2013/14. The Trust had fewer infections than the target of 38 set by the Department of Health.

Comparison with other trusts across the North West for both Clostridium difficile and MRSA bacteraemia continues to remain difficult due to many variables. The two main areas being:

- The starting points for all trusts were variable
- All trusts data collection is slightly different even though they meet the guideline



Publication of 2013-14 data is due out within the next 3 months.

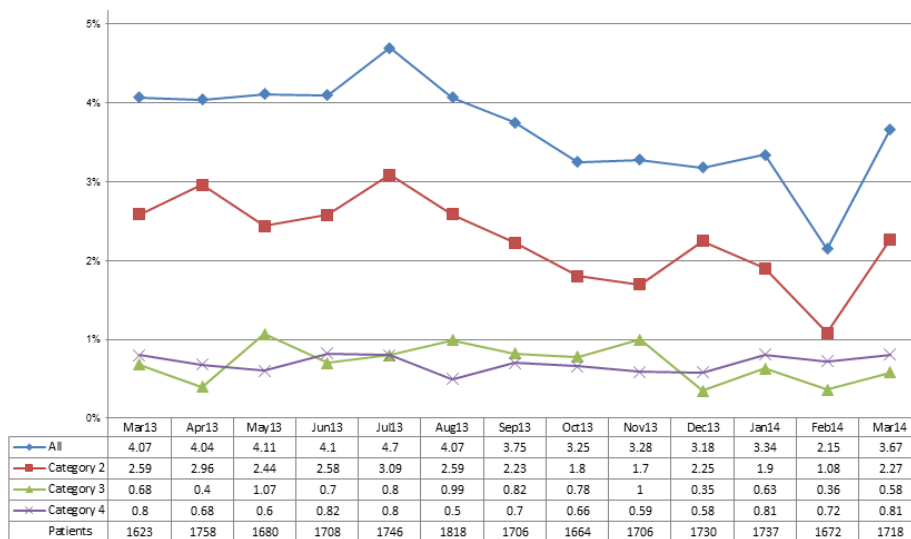
However, what we can say is:

- During 2007-2013 all the above Trusts have reduced *Clostridium difficile* across the North West by between 72-89%. Stockport NHS Foundation Trust by 72%
- During 2008-2013 all the above trusts have reduced MRSA bacteraemia cases across the North West by between 14-100%. Stockport NHS Foundation Trust by 100%

## NHS Safety Thermometer focusing on pressure ulcers

### Prevalence

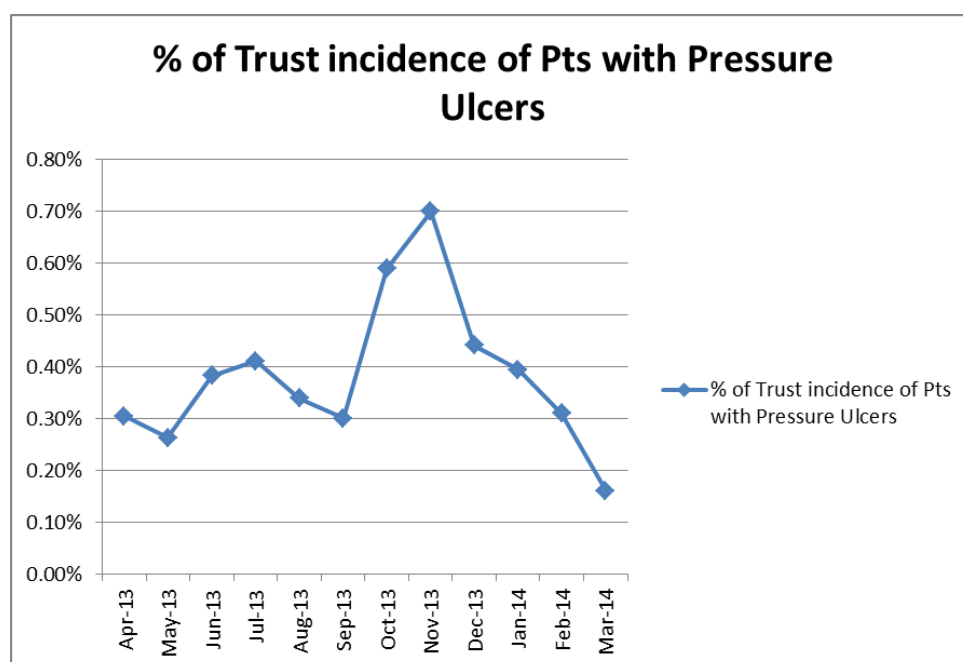
Pressure Ulcers All: patients with an old or new pressure ulcer



Stockport Acute; Stockport Community & Tameside Community.

## Pressure Ulcers - Incidence

Incidence is new Pressure Ulcers only. The graph below shows that the incidence of pressure ulcers for hospital in patients has reduced. In February there were 5 new pressure ulcers that occurred

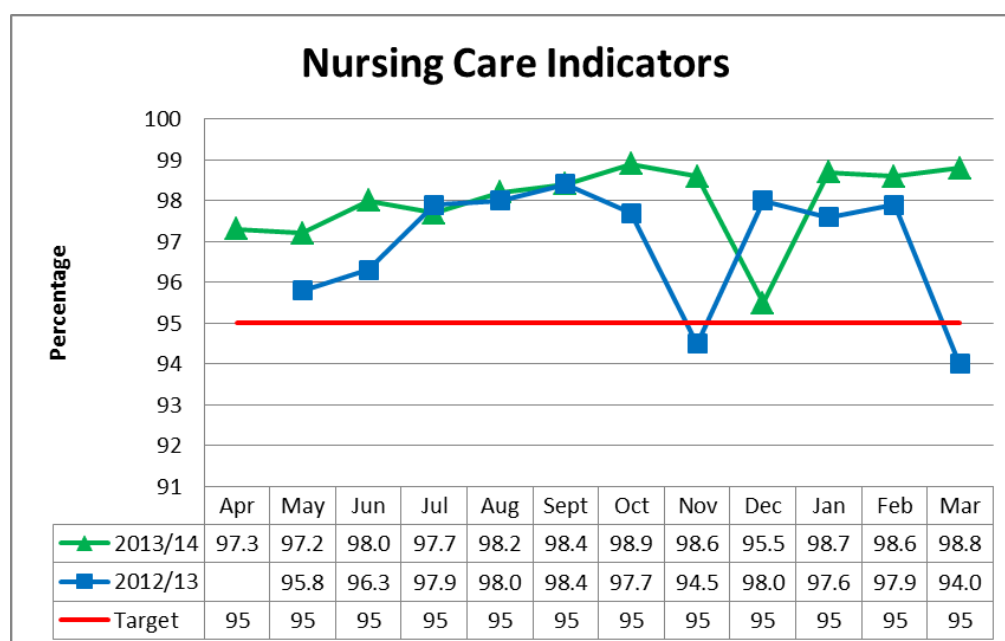


Significant work has been undertaken this year which has supported the reduction in pressure ulcer incidence and prevalence, see Part 2 – 2b for further details.

## Nursing Care Indicators

Delivering high quality and appropriate care to patients is of paramount importance. The Trust must account for the quality of care we deliver and that care should be evidence based and appropriate to the needs of the patient.

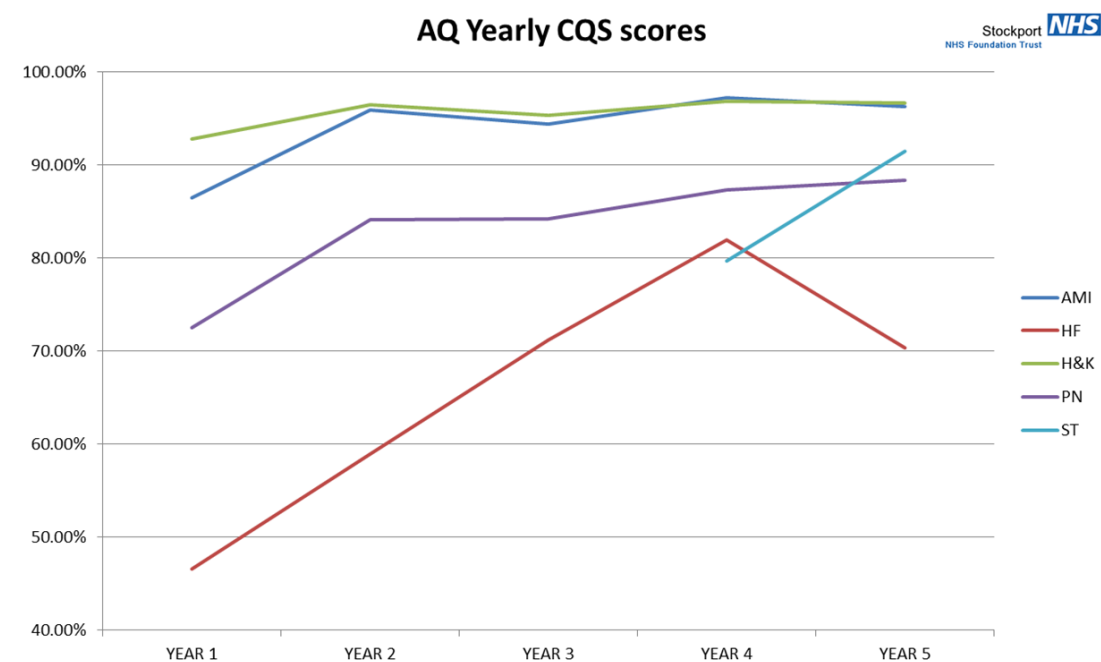
The Nursing Care Indicators (NCI's) are designed to support nurses and midwives in practice to understand how they deliver care, and where improvements are needed. The figures include the Intermediate Care wards at Shire Hill in Tameside and Glossop. This is carried out on a monthly basis where between 7-10 clinical indicators are measured by undertaking an audit of 50% of patients' records. The Trust target is that 95% has to be achieved. The figures for April 13-March 14 are as follows:





### 3.1.2 Clinical Effectiveness:

#### Advancing Quality (reliable care)

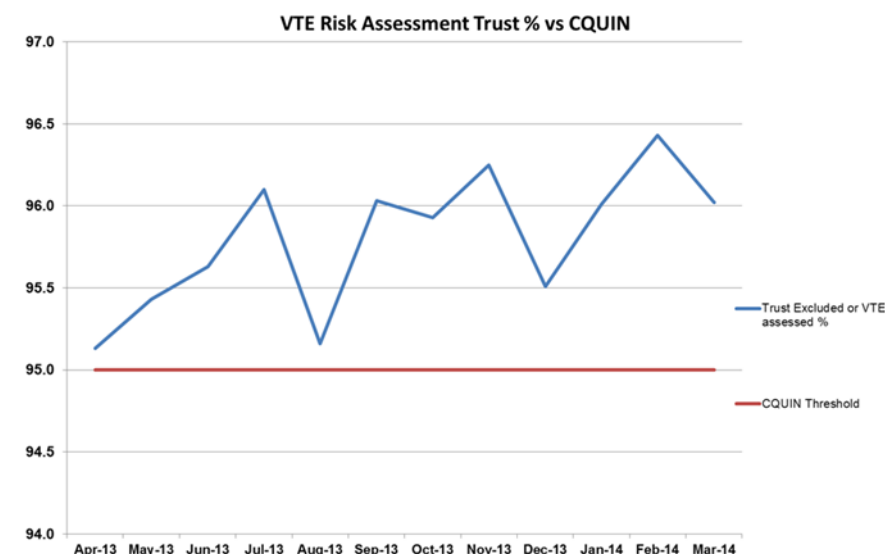


	YEAR 1		YEAR 2			YEAR 3			YEAR 4			YEAR 5		
MEASURE GROUP	CQS	NW AVG	CQS	% IMP	NW AVG	CQS	% IMP	NW AVG	CQS	% IMP	NW AVG	CQS	% IMP	NW AVG
AMI	86.48%	92.55%	95.86%	10.85%	97.39%	94.40%	-1.53%	97.58%	97.23%	3.00%	97.83%	96.33%	-0.93%	98.53%
HF	46.52%	63.21%	58.96%	26.74%	70.65%	71.19%	20.74%	76.84%	81.99%	15.17%	80.54%	70.33%	-14.22%	81.78%
H&K	92.80%	88.96%	96.44%	3.93%	93.39%	95.31%	-1.18%	94.88%	96.90%	1.67%	95.67%	96.70%	-0.21%	96.81%
PN	72.52%	79.09%	84.11%	15.98%	81.38%	84.18%	0.09%	85.68%	87.31%	3.72%	85.05%	88.37%	1.21%	87.91%
ST									79.64%	N/A	85.86%	91.52%	14.92%	89.98%

The Trust continues to perform above thresholds in both Stroke and Hip & Knee measure groups. The Trust has not achieved the ACS score for AMI and Heart Failure; however we have improved on 5 out of 8 indicators for AMI and 5 out of 6 for Heart Failure and will continue to address the measures we have not improved on in 2014/15. Pneumonia continues to be a challenge and this is a CQUIN for 2014/15.

#### VTE Risk Assessment

The graph below shows the Trust performance of VTE risk assessment against the National target of 95%. It can be seen there has been sustained performance since April 2013 when this target was introduced. Prior to this the Trust had achieved target of 90% since October 2011.



## Mortality

The Summary Hospital-Level Mortality Indicator (SHMI) as published by the Information Centre April 2014.

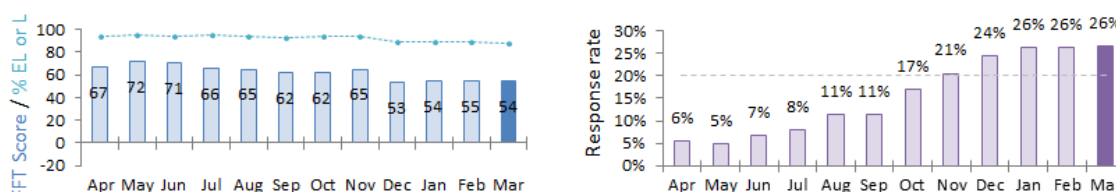
SHMI value for the Trust – 0.93% (See section 2.3 12a for dates and data).

Palliative Care: 17% (See section 2.3 12b for data dates and explanation of change to reporting and rationale for increase).

## 3.3 Patient & Family Experience:

### Friends & Family

Friends and Family began in April 2013; continuous improvements have been demonstrated to date.



The Trust rolled out Friends & Family to Maternity in October 2013 and introduced SMS texting from December 2013 to patients who attended ED. Individual ward managers receive a report and data is available on the Trust Corporate Information system. Any negative feedback is collated and assessed to monitor trends. Results are discussed at business group quality boards and at Trust board sub committees

### Complaints / Serious Events

In 2013/2014 the Trust received 712 formal complaints compared to 619 during 2012/13. The slight increase in complaints is currently being monitored via the new quarterly complaints reports this report also monitors themes and trends.

The quality of responses that we provide following a complaint is important to us; one of the markers used to monitor our success in this area is the number of complaints which are upheld by the Parliamentary & Health Service Ombudsman. Only one was upheld in 2013/2014 following a complaint received in 2011 a full action plan has been completed in relation to the Ombudsman's decision.

In terms of themes arising from complaints, the top issues related to nursing care on the wards, staff attitudes, appointments and communication. Ward complaint numbers are monitored via the care indicators and also as part of the mock CQC inspections which are currently in progress.

For the first 11 months of 2013/14 our compliance with the 25 working days response rate is only 70.3% (2012/13 was 84.1%) this is due to the Medicine Business group being at 46.5%. This is being monitored internally and by the CCG and a risk assessment and action plan are in place.

### Learning From Patient and Family Experience

The Trust is supported by Capita to collate responses to the iPad survey. The results of the surveys are shared with the wards and the graphs are a good visual aid to support understanding of ward performance.

Patient Experience is a key topic for the Trust and data is gathered from several sources including iPad, Friends and Family, and Patient and Carers feedback leaflets as well as the national Inpatient surveys.

The CQUIN for 14/15 has a specific indicator for Patient Experience in which there will be a focus on the medical wards regarding the results on communication questions from the iPad survey. Patient and Carer Experience is also covered in several other CQUINs

### **Service improvements following staff or patient surveys/comments and Care Quality Commission reports:**

We have expanded our capacity to capture patient feedback with the introduction of the Friends and Family Test on our inpatient wards, ED and maternity services.

There has been major investment to replace all patient meal trollies with the aim to improve temperature control and reduce food waste. In addition the Trust has increased the number of volunteers trained to give assistance to patients at mealtimes.

A number of environmental improvements have also been made. A sample of these include new floor covering on Wards D1, D2, and HDU; redecoration on ward E2, a review of the nurse call bell system on B6 and a new sensory garden established at Swanbourne Gardens. In addition a new maintenance operator was introduced by the Estates Department in November to help address ward maintenance issues in a timelier manner.

The Trust also invested to replace ward waste bins with a quieter soft closing version following complaints from patients about the noise generated by the old ones.

The matron for patient experience started in post in October. The primary function of the role is to focus on championing patient feedback, and initiate change as a result of issues raised.

Our night nurse managers have developed and launched standards to help reduce noise at night, following concerns raised by patients. The standards will be monitored to ensure compliance. In addition staff on A1 now offer earplugs to patients.

### **Improvements in patient/ carer information**

A number of initiatives have been introduced with the intention of improving information to patients and carers including the revision of the Trusts site map; improved signage in a number of areas, and the introduction of a parents newsletter by the Continuing Care Team at Swanbourne Gardens.

The Trust also reviewed its guidelines to assist staff in the development of patient information, and work is ongoing to update literature in both our hospital and community services.

A new "Discharge leaflet" has been introduced which provides additional information to supplement that provided by ward staff concerning medication, transport, follow up appointments and contact numbers.

All inpatient bedside information booklets have been reviewed and replaced. Holders have also been attached at the side of every inpatient bed area to ensure the booklets are housed safely and readily available. So far feedback from patients and visitors has been positive, with the plethora of information concerning hospital services enclosed, well received.

### 3.2 Performance against indicators and performance thresholds 2013/14

Indicator	Threshold	Weighting					Result
			Quarter 1	Quarter 2	Quarter 3	Quarter 4	2013/14
Maximum time of 18 weeks from point of referral to treatment in aggregate – admitted	90%	1.0	92.3%	92.1%	89.7%	91.0%	91.3%
Maximum time of 18 weeks from point of referral to treatment in aggregate – non-admitted	95%	1.0	97.1%	96.8%	95.9%	95.5%	96.3%
Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway	92%	1.0	96.7%	95.9%	94.5%	93.7%	95.2%
A&E: maximum waiting time of four hours from arrival to admission/ transfer/ discharge	95%	1.0	92.8%	93.1%	94.8%	91.1%	93%
All cancers: 62-day wait for first treatment from:		1.0					
urgent GP referral for suspected cancer	85%		89.3%	89.4%	85.1%	86.1%	87.5%
NHS Cancer Screening Service referral	90%		100.0%	100.0%	No applicable patients	80.0%	92.3%
All cancers: 31-day wait for second or subsequent treatment, comprising:		1.0					
surgery	94%		100.0%	100.0%	100.0%	100.0%	100%
anti-cancer drug treatments	98%		100.0%	100.0%	100.0%	100.0%	100%
radiotherapy	94%						NA

All cancers: 31-day wait from diagnosis to first treatment	96%	1.0	98.1%	98.9%	97.2%	97.1%	97.9%
Cancer: two week wait from referral to date first seen, comprising:		1.0					
all urgent referrals (cancer suspected)	93%		95.4%	96.2%	96.3%	96.2%	96.0%
for symptomatic breast patients (cancer not initially suspected)	93%		94.0%	94.3%	94.6%	95.5%	94.6%
Clostridium (C.) difficile – meeting the C. difficile objective	DM*	1.0	16	25	29	33	33
Data completeness: community services, comprising:		1.0					
referral to treatment information	50%		84.8%	84.0%	85.4%	85.0%	84.8%
referral information	50%		94.3%	96.2%	98.3%	98.1%	96.7%
treatment activity information	50%		96.9%	97.9%	97.6%	97.2%	97.4%

## **Annex 1: Statements from Commissioners, local Healthwatch organisations and Overview and Scrutiny Committees**

### **Statement from Scrutiny Committee 9<sup>th</sup> May 2014**

The Scrutiny Committee, having had the opportunity to consider the Quality Report and to question the Director of Nursing & Midwifery, is satisfied with the Quality Report for 2013/14. The Trust was able to demonstrate that progress and improvement was being made on areas identified in previous quality reports and that they recognised areas where further improvement was needed.

The Scrutiny Committee continued to receive updates from the Trust about their on-going efforts to improve performance in relation to waiting times for admissions at the Emergency Department, and has been satisfied that the Trust have taken steps to address these issues, but recognise that performance in part reflects national challenges.

### **Statement from Governors 9<sup>th</sup> May 2014**

The Council of Governors welcomes the opportunity to comment on the Trust's Annual Quality Report for 2013/2014 and on the Trust's program for change and improvement in care.

The Governors receive regular reports from the Trust of its medical, clinical and community health performance via Board papers; presentations at full Council and at Governor Committee Meetings; and by specific briefings. Governors appreciate the breadth and depth of the material made available to them.

The Trust has much of which to be proud in the many awards and accolades both collective and individual which have been gained, and in its overall performance amongst peer groups. Equally the Trust will accept that the Governors have a duty to voice concerns, to seek assurance, and to look to measurable improvements where standards are falling short or flagging.

We note and welcome the Trust's published plans to ensure it provides harm free, high quality, safe and timely care to all patients in both the hospital and community care setting. The Board of Directors have made the decision to continue using CQUIN (Commissioning for Quality and Innovation) as its framework for prioritising the quality improvement plan, which links a proportion of the Trust's income from providers to the achievement of local and national improvement goals. The Governors are kept abreast of performance and financial outcomes and whilst targets have been broadly met there are areas where problems appear intractable.

The Governors appreciate the support given by the workforce to the ongoing Unscheduled Care Programme, and look forward to it becoming further embedded in the year to come and to its resulting in the overall improvements in Trust performance to which it is directed.

In the Report section on Safe Effective Care the Governors view with concern the position in respect of patients admitted with myocardial infarction, heart failure and pneumonia and welcome the aims and objectives relating to reducing hospital related mortality; hospital acquired pressure ulcers; reduction in the incidence of falls; and the early detection of urinary tract infection and deep vein thrombosis. Equally welcome are the plans to improve the standard of Dementia Care and assurance that 90% of appropriate patients will be assessed on admission.

In relation to the Report section headed 'Surgical and Clinical Care' we applaud the fact that the Trust did not flinch from calling attention to the alarming shortcomings identified in the review of patients admitted to critical care. We are assured that a robust system is being recommended for implementation and so the Governors will await with particular interest the results of the planned 6-month re-audit.

The Trust remains in breach of the national Emergency Department target of 95% of arrivals being afforded a 4-hour passage, and it is of cold comfort that numerous Trusts around the country are now in the same position. The Governors are kept up to date on the situation and of the reporting lines to Monitor and we are very supportive of the tremendous efforts which have been made by management and medical staff to remedy and stabilise the position. We recognise the difficulties in recruiting and retaining appropriately qualified consultants and other grades and the dedicated work and commitment of those in post. The position is exacerbated by the gaps in primary and social care

provision, compounded by the trivial nature of some of the conditions presented by all too many of those attending of their own volition at the Hospital. The need for a better and more joined-up pathway in Accident and Emergency Care is widely recognised, and much debated on the national stages, but remains only an aspiration on the horizon of realisation at local level.

The Governors will always be fully supportive of the Trust's aims and objectives, but equally we are mindful of our duty to the public in being vigilant and objective in our scrutiny of performance.

## **Stockport CCG Commissioner Response to Stockport NHS Foundation Trust's Quality Report 9<sup>th</sup> May 2014**

Stockport Clinical Commissioning Group (CCG) commends the Trust on significant achievement of the 2013/14 CQUIN targets.

The CCG is encouraged to see that patient safety has improved with a reduction in pressure ulcer prevalence, better reporting of serious incidents and a focus on reducing weekend mortality. The CCG acknowledges the scale of the challenge of continuous quality improvement and welcomes the further improvements to move towards NHS 7 Day Services will inevitably require. Key areas of focus for patient safety in the year ahead are full compliance with safeguarding training requirements and dementia assessments and embedding learning from serious incidents.

The Trust has successfully implemented the Friends and Family Test (FFT) and is, in the main, achieving the required response rates. Learning from the FFT scores and comments and from all patient and staff surveys is important in improving quality.

The CCG and Foundation Trust have worked together to improve quality across primary and secondary care. Forums have taken place to share the learning from the Francis Review. Regular workshops take place to bring together GPs and hospital doctors and nurses to improve communication and reform pathways for better care. Stockport CCG is keen to develop a whole system approach to quality across Stockport in association with Stockport Foundation Trust and other key stakeholders.

In the future the CCG would recommend extending this report beyond CQUIN to include the broader quality agenda, including improvements identified as important through staff and patient experience.



## **Healthwatch Stockport response to the Stockport NHS Foundation Trust Quality Account 2013/14**

### **About Healthwatch Stockport**

Healthwatch is the new independent consumer champion created to gather and represent the views of the public, patients, relatives and carers. Healthwatch plays a role at both national and local level and makes sure that the views of the public and people who use services are taken into account.

Healthwatch Stockport is a membership organisation run by volunteers with an interest in health & social care. They are supported by a team of staff to offer help to members carrying out activity on behalf of the organisation.

The Stockport NHS Foundation Trust subgroup of Healthwatch Stockport has recently established bi-monthly review meetings with senior executives of the Trust.

Healthwatch Stockport has, amongst others, the following responsibilities;

- Promote and support local people to be involved in monitoring, commissioning and provision of local care services
- Obtain local people's views about their needs for and experience of local care services
- Tell agencies involved in the commissioning, provision and scrutiny of care services about these views
- Produce reports and make recommendations about how local health and care services could or should be improved

### **Introduction**

Healthwatch Stockport welcomes the opportunity to comment on this Annual Quality Report (as seen in draft and with incomplete data) in a manner that hopefully will be helpful to the general public and to highlight the key areas where the public are seeking assurance within the framework of this increasingly prescriptive report.

Healthwatch Stockport commends the Trust on the many areas where, through hard work and dedication quality improvements have been demonstrated.

### **Priorities for improvement and statements of assurance from the board**

In 2013/14 the Trust's quality initiatives focused on the Commissioning for quality and innovation (CQUIN) standards as agreed with Commissioners and national standards. The Trust has continued this approach in setting the priorities for improvement in 2014/15.

The commissioning for quality and innovation (CQUIN) payment exists to encourage NHS organisations to sharpen their focus on quality by making a proportion of income conditional upon quality and innovation.

The key aim of the CQUIN framework for 2014/15 is to support improvements in the quality of services and the creation of new, improved patterns of care. The framework stipulates that Commissioners must set out clearly in contracts the proportion of payment associated with each CQUIN indicator and the basis upon which payment will be made.

Healthwatch Stockport believes that the setting out of this information in this report (the amount of monies and the basis of achievement of each standard) would be extremely helpful to the public understanding of this incentive for quality improvement.

In the current report the comparative CQUIN income (draft) for the years 2012/13 and 2013/14 needs greater clarity as there is a concern that the 2013/14 achievement is below that of the previous year.

Healthwatch Stockport recommends there should be a financial reconciliation between the CQUIN income and the reported achievements (see below).

Looking back at the improvement priorities for 2013/14, Healthwatch Stockport can only comment on the incomplete draft report it has seen and the Trust is reporting that it has:

- a) Achieved or exceeded trajectory on 17 of its objectives (green rating);
- b) Improved performance but not achieved trajectory on 3 objectives (amber rating)
  - Priority 2j. Improve uptake of adult safeguarding training
  - Priority 2n. Increase the number of mothers who choose and sustain breastfeeding
  - Priority 2s. Managing long term conditions;
- c) Not achieved trajectory on 4 objectives (red rating)
  - Priority 2b. Reduce pressure ulcer prevalence
  - Priority 2d. Provide appropriate care for patients admitted with myocardial infarction
  - Priority 2e. Provide appropriate care for patients admitted with heart failure
  - Priority 2g. Provide appropriate care for patients admitted with pneumonia

Healthwatch Stockport would like to have seen a more comprehensive comment in a form understandable by the general public on the priorities rated red and amber.

Healthwatch Stockport notes the Trust states that 40% of staff (as appropriate for their role) has received dementia awareness training (priority 1b). It recognises the importance of dementia awareness training in ensuring the best possible care for dementia patients and their timely discharge. *"Many patients may not be able to communicate that they are pain, in need of help, hungry, thirsty or simply uncomfortable. This is why it is vital that all staff from porters to nurses and doctors are aware of dementia and trained in how they can meet the complex needs of those with the condition". (Jeremy Hughes, Chief Executive of Alzheimer's Society).*

Healthwatch Stockport urges the Trust to become exemplar by escalating its training (hospital and community) throughout 2014/15 and this is incorporated in its priorities for 2014/15. We fully support the recent mandate to Health Education England regarding the provision of training.

Regarding the rating of amber for priority 2j (Improve uptake of adult safeguarding training), Healthwatch Stockport is concerned that the aim of this priority is to train 85% of all eligible staff in the four levels of safeguarding adults training. Within many voluntary sector organisations, 100% of volunteers and staff are required to attend safeguarding adults training and we would expect the same from the Trust. We believe it is paramount that the recording and documentation of this priority is accurate.

In respect of 2s (Managing long term conditions), we welcome the continuation of this work into the next year.

#### Participation in clinical audits and national confidential enquiries

The Trust is required to report on clinical audits in this report. Clinical audit is a way to find out if healthcare is being provided in line with standards and lets care providers and patients know where their service is doing well and where there could be improvements. The aim is to allow quality improvement to take place where it will be most helpful and will improve outcomes for patients.

This report includes examples of improvements to care based on audit reports and the findings in some cases raises serious concerns particularly in critical care and record keeping. Over the coming twelve months Healthwatch Stockport will be seeking assurance that standards improve in line with the actions identified. Members particularly raised concerns over the record keeping audit in the context of patient safety. Whilst it is acknowledged that the NHS Litigation Authority (NHSLA) is

undergoing a review of its current standards it was felt that the objective to raise compliance to the minimum expected by the NHSLA was a particularly unambitious target.

The draft report was incomplete in respect of the Trust's performance and the intended actions for improving performance against some core indicators. However Healthwatch Stockport is concerned that the Trust was below the national average in 2012/13 for Core Indicator 20 (Responsiveness to the personal needs of patients) and Core Indicator 25 (Percentage of safety incidents that resulted in severe harm or death).

## Conclusion

Alongside safety and clinical effectiveness, the consumer (public, patient, family and carers) experience is integral to the provision of high quality care and it is encouraging to see patient experience reported on within this account.

Healthwatch Stockport has long been concerned about the Trust's performance in respect of the discharge of patients and is concerned that the current and past national inpatient surveys, and Healthwatch research (including the Discharge From Hospital to Nursing Homes research carried out as Stockport LINK), continue to indicate that there is room for improvement. The Healthwatch Stockport discharge procedures group will be reconvening in the near future to look at these issues. There is also concern that the latest national inpatient survey continues to show that the Trust performs "about the same" as other Trusts on 65 of 70 areas surveyed and performing worse than other Trusts on 5 areas. When, for example, Salford Foundation Trust performs "better" than other Trusts on 25 of the questions and worse on none.

Healthwatch Stockport welcomes the prioritisation of communication, patient and carer empowerment with continuing improvements for patients with physical or learning disabilities, improving clinical leadership and the patient experience, in the local CQUIN's for quality improvement. Healthwatch Stockport will seek to work with the Trust to understand in greater detail how it intends to achieve these standards.

It would have been useful to see within this Quality Account a comprehensive report on the Trust's management of its complaints and how the complaints process is considered to be working. It would also have been beneficial for this Quality Account to report on waiting times by specialty as well as the aggregate time.

Healthwatch Stockport will also continuously challenge the use of acronyms within reports and request that the meanings of acronyms are detailed in all cases.

The Quality Account is particularly hospital-centric and Healthwatch Stockport would have liked to have seen more detailed reporting on the community services provided by the Trust.

Healthwatch Stockport would like to take this opportunity to thank the Trust for their support in a number of pieces of work throughout 2013/14.

- The audiology department supported the Healthwatch Stockport It's in the Drawer Task & Finish Group in identifying and circulating the questionnaires to patients. The Task & Finish Group are now working with both providers and commissioners on their recommendations arising from the research.
- Healthwatch Stockport members have been involved in the A&E Redesign at Stepping Hill Hospital including the D Block Redevelopment, Emergency Department User Group and the Unscheduled Care Strategy.
- Healthwatch Stockport contacted Monitor to support the Trust's complaints around the lack of consultation on plans for cancer services.
- Healthwatch Stockport members have been involved in the current integration work involving the Trust, including Healthier Together and the Integrated Locality Hubs.

- Healthwatch Stockport hosted the first meeting of the District Nurse User Group alongside the Trust's community services and will work with the Trust in the continuation of this group.
- A subgroup of Healthwatch Stockport has recently established bi-monthly review meetings with senior executives of Stockport NHS Foundation Trust.
- Healthwatch Stockport members sit on a number of the Trust's groups including the Foundation Trust Patient Representative Group: Division of Medicine, the Medicines Management Committee, Stockport CCG Unscheduled and Scheduled Care Working Groups.

Healthwatch Stockport thanks the Trust for the opportunity to comment on this document and request consistency in reporting next year to enable a direct comparison of the information.

If members of the public have any queries or questions or concerns resulting from this report or annex, Healthwatch Stockport can be contacted by e-mail at [info@healthwatchstockport.co.uk](mailto:info@healthwatchstockport.co.uk), telephone on 0161 477 8479 or you can visit our website at [www.healthwatchstockport.co.uk](http://www.healthwatchstockport.co.uk).

### **Healthwatch Stockport**

## Annex 2: Statement of directors' responsibilities for the quality report

The directors are required under the Health Act 2009 and the National Health Service Quality Accounts Regulations to prepare quality accounts for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2013/14;
- the content of the quality report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2013 to June 2014
  - papers relating to Quality reported to the Board over the period April 2013 to June 2014
  - feedback from commissioners dated 09/05/2014
  - feedback from governors dated 09/05/2014
  - feedback from local Healthwatch organisations dated 15/05/2014
  - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 25/07/2013
  - national patient survey April 2014
  - national staff survey February 2014
  - the head of internal audit's annual opinion over the Trust's control environment dated 20/05/2014
  - CQC quality and risk profiles - the intelligent monitoring report dated 13/03/2014.
- the quality report presents a balanced picture of the NHS foundation Trust's performance over the period covered;
- the performance information in the quality report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- the quality report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts Regulations) as well as the standards to support data quality for the preparation of the quality report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.

By order of the Board

NB: sign and date in any colour ink except black

.....Date.....Chairman

.....Date.....Chief Executive



# **CONSOLIDATED ANNUAL ACCOUNTS 2013-14**

## **Foreword to the Accounts**

### **Stockport NHS Foundation Trust**

These accounts for the year ended 31 March 2014 have been prepared by Stockport NHS Foundation Trust pursuant to Schedule 7, paragraph 24 and 25 of the National Health Service Act 2006, in the form which Monitor, the Independent Regulator of NHS Foundation Trusts, with the approval of the Treasury, directed.

Signed .....

Mrs A Barnes – Chief Executive

Date: 29<sup>th</sup> May 2014



## Consolidated Statement of Comprehensive Income for the Year Ended 31 March 2014

	Notes	Trust		Group	
		2013-14 £000s	2012-13 £000s	2013-14 £000s	2012-13 £000s
<b>Operating Income</b>	3	<b>293,821</b>	290,194	<b>293,744</b>	289,871
<b>Operating Expenses</b>	4-7	<b>(288,848)</b>	<b>(283,779)</b>	<b>(288,848)</b>	<b>(283,779)</b>
<b>Operating Surplus /(Deficit)</b>		<b>4,973</b>	6,415	<b>4,896</b>	6,092
<b>Finance Costs</b>					
Finance income	8	<b>134</b>	295	<b>188</b>	353
Finance expense	9	<b>(855)</b>	<b>(905)</b>	<b>(855)</b>	<b>(905)</b>
Finance expense - unwinding of discount on provisions		<b>(45)</b>	<b>(51)</b>	<b>(45)</b>	<b>(51)</b>
PDC Dividends payable	21	<b>(3,251)</b>	<b>(3,135)</b>	<b>(3,251)</b>	<b>(3,135)</b>
<b>Net Finance Costs</b>		<b>(4,017)</b>	<b>(3,796)</b>	<b>(3,963)</b>	<b>(3,738)</b>
Movement in fair value of investments		-	-	<b>10</b>	112
<b>Surplus/(Deficit) for the Year</b>		<b>956</b>	2,619	<b>943</b>	2,466
<b>Other comprehensive income</b>					
Gain/(loss) from asset transfer by absorption*		<b>346</b>		<b>346</b>	
Revaluations - Property, Plant and Equipment (PPE)		<b>(27)</b>	<b>(837)</b>	<b>(27)</b>	<b>(837)</b>
<b>Total Comprehensive Income for the Period</b>		<b>1,275</b>	1,782	<b>1,262</b>	1,629

In 2013-14 the Trust has prepared its financial statements as a consolidated group with its associated charitable fund. The primary statements are presented for both Trust and Group.

\* Asset transfers are from the demise of primary care trusts as detailed in Note 1.3 and are accounted for under modified absorption accounting.

The notes on pages 9 to 55 form part of these accounts. All income and expenditure is derived from continuing operations.

## Trust Statement of Financial Position (SoFP) as at the 31 March 2014

	Notes	2013-14 £000s	2012-13 £000s
<b>Non-Current Assets:</b>			
Intangible assets	11	1,356	1,067
Property, Plant and Equipment	12.1	132,738	131,021
Trade and other receivables	14.1	714	943
<b>Total non-current assets</b>		<b>134,808</b>	<b>133,031</b>
<b>Current Assets:</b>			
Inventories	13	2,258	2,302
Trade and other receivables	14.1	9,867	7,338
Cash and cash equivalents	22.3	46,559	50,523
<b>Total current assets</b>		<b>58,684</b>	<b>60,163</b>
<b>Current Liabilities:</b>			
Trade and other payables	15	(25,541)	(25,346)
Borrowings	15.2	(1,096)	(1,130)
Provisions	18	(2,682)	(2,750)
Other liabilities	15.1	(1,595)	(2,588)
<b>Total current liabilities</b>		<b>(30,914)</b>	<b>(31,814)</b>
<b>Total Assets less Current Liabilities</b>		<b>162,578</b>	<b>161,380</b>
<b>Non-Current Liabilities:</b>			
Borrowings	15.2	(17,184)	(18,282)
Provisions	18	(2,072)	(1,938)
Other liabilities	15.1	(648)	(961)
<b>Total non-current liabilities</b>		<b>(19,904)</b>	<b>(21,181)</b>
<b>Total Assets Employed</b>		<b>142,674</b>	<b>140,199</b>
<b>Financed by:</b>			
<b>Taxpayers' Equity</b>			
Public Dividend Capital	20	82,901	81,701
Revaluation reserve	19	45,711	47,439
Income and expenditure reserve		14,062	11,059
<b>Total Taxpayers Equity</b>		<b>142,674</b>	<b>140,199</b>

## Consolidated Statement of Financial Position (SoFP) as at the 31st March 2014

		Group		
	Notes	2013-14 £000s	2012-13 £000s	Restated 1 April 2012
<b>Non-Current Assets:</b>				
Intangible assets	11	1,356	1,067	1,598
Property, Plant and Equipment	12.2	132,738	131,021	132,236
Other Investments	10	1,225	1,215	1,103
Trade and other receivables	14.3	714	943	905
<b>Total non-current assets</b>		<b>136,033</b>	<b>134,246</b>	<b>135,842</b>
<b>Current Assets:</b>				
Inventories	13	2,258	2,302	2,305
Trade and other receivables	14.3	9,318	6,845	6,976
Non – current assets for sale and assets in disposal groups	12.8	-	-	225
Cash and cash equivalents	22.3	47,391	51,322	49,142
<b>Total current assets</b>		<b>58,967</b>	<b>60,469</b>	<b>58,648</b>
<b>Current Liabilities:</b>				
Trade and other payables	15	(25,541)	(25,346)	(24,528)
Borrowings	15.2	(1,096)	(1,130)	(1,162)
Provisions	18	(2,682)	(2,750)	(3,100)
Other liabilities	15.1	(1,595)	(2,588)	(3,348)
<b>Total current liabilities</b>		<b>(30,914)</b>	<b>(31,814)</b>	<b>(32,138)</b>
<b>Total Assets less Current Liabilities</b>		<b>164,086</b>	<b>162,901</b>	<b>162,352</b>
<b>Non-Current Liabilities:</b>				
Borrowings	15.2	(17,184)	(18,282)	(19,412)
Provisions	18	(2,072)	(1,938)	(1,785)
Other liabilities	15.1	(648)	(961)	(1,515)
<b>Total non-current liabilities</b>		<b>(19,904)</b>	<b>(21,181)</b>	<b>(22,712)</b>
<b>Total Assets Employed</b>		<b>144,182</b>	<b>141,720</b>	<b>139,640</b>
<b>Financed by:</b>				
<b>Taxpayers' Equity</b>				
Public Dividend Capital	20	82,901	81,701	81,250
Revaluation reserve	19	45,711	47,439	48,695
Income and expenditure reserve		14,062	11,059	8,021
<b>Others' Equity</b>				
Charitable Fund Reserves	30	1,508	1,521	1,674
<b>Total Taxpayers Equity</b>		<b>144,182</b>	<b>141,720</b>	<b>139,640</b>

Mrs A Barnes  
Chief Executive  
29<sup>th</sup> May 2014

### Trust Statement of Changes in Taxpayers' Equity as at 31 March 2014

	Total	Public Dividend Capital (PDC)	Revaluation reserve	Income and Expenditure Reserve
	£000s	£000s	£000s	£000s
Taxpayers' Equity at 1 April 2013	140,199	81,701	47,439	11,059
Surplus/(Deficit) for the year	956	-	-	956
Transfers by Modified absorption: Gains/(losses) on 1 April transfers from demising bodies.	346	-	-	346
Transfers by Modified absorption: transfers between reserves	-	-	1	(1)
Revaluations - Property, Plant and equipment	(27)	-	(27)	-
Public Dividend Capital received	1,200	1,200	-	-
Movements on other reserves	-	-	(1,702)	1,702
<b>Taxpayers' Equity at 31 March 2014</b>	<b>142,674</b>	<b>82,901</b>	<b>45,711</b>	<b>14,062</b>

### Trust Statement of Changes in Taxpayers' Equity as at 31 March 2013

	Total	Public Dividend Capital (PDC)	Revaluation reserve	Income and Expenditure Reserve
	£000s	£000s	£000s	£000s
Taxpayers' Equity at 1 April 2012	137,966	81,250	48,695	8,021
Surplus/(Deficit) for the year	2,619	-	-	2,619
Revaluations - PPE	(837)	-	(837)	-
Public Dividend Capital received	451	451	-	-
Movements on other reserves	-	-	(419)	419
<b>Taxpayers' Equity at 31 March 2013</b>	<b>140,199</b>	<b>81,701</b>	<b>47,439</b>	<b>11,059</b>

**Consolidated Statement of Changes in Taxpayers' Equity as at 31 March 2014**

	Total	NHS Charitable Funds Reserve	Public dividend capital (PDC)	Revaluation reserve £000	Income and Expenditure Reserve £000
	£000s	£000s	£000s	£000s	£000s
<b>Taxpayers' Equity at 1 April 2013</b>	<b>141,720</b>	<b>1,521</b>	<b>81,701</b>	<b>47,439</b>	<b>11,059</b>
Surplus/(Deficit) for the year	943	296	-	-	647
Transfers by Modified absorption: Gains/(losses) on 1 April transfers from demising bodies.	346	-	-	-	346
Transfers by Modified absorption: transfers between reserves	-	-	-	1	(1)
Revaluations	(27)	-	-	(27)	-
Public Dividend Capital received	1,200	-	1,200	-	-
Movements on other reserves	-	-	-	(1,702)	1,702
Other reserves movements - charitable funds consolidation adjustment	-	(309)	-	-	309
<b>Taxpayers' Equity at 31 March 2014</b>	<b>144,182</b>	<b>1,508</b>	<b>82,901</b>	<b>45,711</b>	<b>14,062</b>

**Consolidated Statement of Changes in Taxpayers' Equity as at 31 March 2013**

	Total	NHS Charitable Funds Reserve	Public dividend capital (PDC)	Revaluation reserve	Income and Expenditure Reserve
	£000s	£000s	£000s	£000s	£000s
<b>Taxpayers' Equity at 1 April 2012</b>	<b>137,966</b>	<b>-</b>	<b>81,250</b>	<b>48,695</b>	<b>8,021</b>
Prior Period adjustment	1,674	1,674	-	-	-
Surplus/(Deficit) for the year	2,466	303	-	-	2,163
Revaluations	(837)	-	-	(837)	-
Public Dividend Capital received	451	-	451	-	-
Movements on other reserves	-	-	-	(419)	419
<b>Taxpayers' Equity at 31 March 2013</b>	<b>141,720</b>	<b>1,521</b>	<b>81,701</b>	<b>47,439</b>	<b>11,059</b>

## Statement of Cashflows for the Year Ended 31 March 2014

		Trust		Group	
	Notes	2013-14 £000's	2012-13 £000's	2013-14 £000's	2012-13 £000's
<b>Cash flows from operating activities</b>					
Net cash generated from/utilised in operations	22.1	<b>8,044</b>	13,197	<b>8,023</b>	13,199
<b>Cash flows from investing activities</b>					
Interest received		170	297	170	297
Purchase of financial assets*	10	10,000	32,000	10,000	32,000
Sale of financial assets*	10	(10,000)	(32,000)	(10,000)	(32,000)
Purchase of intangible assets	11	(537)	(90)	(537)	(90)
Purchase of Property, Plant and Equipment		(7,736)	(6,391)	(7,736)	(6,391)
Sale of Property, Plant and Equipment		30	-	30	-
NHS Charitable funds - net cash flows from investing activities		-	-	54	58
<b>Net cash generated from/(used in) investing activities</b>		<b>(8,073)</b>	<b>(6,184)</b>	<b>(8,019)</b>	<b>(6,126)</b>
<b>Cash flows from financing activities</b>					
Public dividend capital received	20	1,200	451	1,200	451
Loans repaid	15.2	(1,071)	(1,071)	(1,071)	(1,071)
Capital element of Private Finance Initiative obligations	16	(59)	(92)	(59)	(92)
Interest paid		(847)	(902)	(847)	(902)
Interest element of Private Finance Initiative obligations	9.2	(17)	(20)	(17)	(20)
PDC Dividend paid	21	(3,141)	(3,258)	(3,141)	(3,258)
<b>Net cash generated from/(used in) financing activities</b>		<b>(3,935)</b>	<b>(4,893)</b>	<b>(3,935)</b>	<b>(4,893)</b>
<b>Increase/decrease in cash and cash equivalents</b>		<b>(3,964)</b>	<b>2,120</b>	<b>(3,931)</b>	<b>2,180</b>
<b>Cash and Cash equivalents at 1 April 2013</b>	22.2	<b>50,523</b>	48,403	<b>51,322</b>	49,142
<b>Cash and Cash equivalents at 31 March 2014</b>	22.2	<b>46,559</b>	50,523	<b>47,391</b>	51,322

\*Relates to short-term cash investments.

## NOTES TO THE ACCOUNTS

### 1. ACCOUNTING POLICIES AND OTHER INFORMATION

Monitor has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual (FT ARM) which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2013/14 NHS Foundation Trust Annual Reporting Manual issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

#### Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain assets and financial liabilities.

#### 1.1 Relevant International Finance reporting Standards

Listed below are the extant International Accounting Standards adopted in the preparation of these accounts in so far as they are applicable to the Foundation Trust:

##### International Financial Reporting Standards (IFRS)

IFRS 3 (Revised) Business combinations  
 IFRS 5 Non-current assets held for sale and discontinued operations  
 IFRS 7 Financial Instruments: Disclosures  
 IFRS 8 Operating Segments

##### International Accounting Standards (IAS)

IAS 1 Presentation of Financial Statement  
 IAS 2 Inventories  
 IAS 7 Statement of Cash Flows  
 IAS 8 Accounting policies, changes in accounting estimates and errors  
 IAS 10 Events after the reporting period  
 IAS 12 Income taxes  
 IAS 16 Property, plant and equipment  
 IAS 17 Leases  
 IAS 18 Revenue  
 IAS 19 Employee benefits  
 IAS 20 Accounting for Government grants and disclosures of Government assistant  
 IAS 21 The effects of changes in foreign exchange rates  
 IAS 23 Borrowing costs  
 IAS 24 Related party disclosures  
 IAS 27 Consolidated and separate financial statements  
 IAS 28 Investments in Associates  
 IAS 31 Interests in Joint Ventures  
 IAS 32 Financial instruments: Presentation  
 IAS 36 Impairment of assets  
 IAS 37 Provisions, contingent liabilities and contingent assets  
 IAS 38 Intangible Assets



IAS 39 Financial Instruments: Recognition and measurements  
IAS 40 Investment Property

#### IFRIC Interpretations

IFRIC 1 Changes in Existing Decommissioning, Restoration and Similar Liabilities  
IFRIC 4 Determining whether an arrangement contains a lease  
IFRIC 9 Reassessment of Embedded Derivatives  
IFRIC12 Service concession arrangements  
IFRIC14 IAS 19 – The limit on a defined benefit asset, minimum funding requirements and their interaction

#### SIC Interpretations

SIC 12 Consolidation – Special Purpose Entities  
SIC 13 Jointly Controlled Entities – Non-Monetary Contributions by Venturers  
SIC 15 Operating Leases – Incentives  
SIC 27 Evaluating the Substance of Transactions Involving the Form of a Lease  
SIC 29 Disclosure – Service Concession Arrangements  
SIC 31 Revenue – Barter Transactions Involving Advertising Services  
SIC 32 Intangible Assets – Web Site Costs

### **1.2 Acquisitions and discontinued operations**

Activities are considered to be ‘acquired’ only if they are taken on from outside the public sector where they are accounted for in accordance with IFRS 3. Activities are considered to be ‘discontinued’ only if they cease entirely. They are not considered to be ‘discontinued’ if they transfer from one public sector body to another. The Trust has no transactions falling into these categories in 2013-2014.

### **1.3 Transfers of functions to/from other NHS bodies/local government.**

For functions that have been transferred to the Trust from another NHS body or local government body, the assets and liabilities transferred are recognised in the accounts as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. For 1 April 2013 transfers from Primary Care Trusts (PCTs) the net gain/loss corresponding to the net asset or liability is transferred from the relevant PCT body and is recognised within the income and expenditure reserve.

For property, plant and equipment assets and intangible assets, the Cost and Accumulated Depreciation/Amortisation balances from the transferring PCT's accounts are preserved on recognition in the Trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the Trust makes a transfer from its income and expenditure reserve to its income and expenditure reserve to maintain transparency within public sector accounts.

On the 1st April 2013 property, plant and equipment assets transferred from Stockport Primary Care Trust and Tameside Primary Care Trust to Stockport NHS Foundation Trust. The Financial Reporting Manual does not require retrospective adoption so prior year transactions have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector.

## 1.4 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates. Underlying assumptions and estimates are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods. In 2013-2014 the Audit Committee has challenged the draft Annual Accounts before submission as part of its additional duties as required under the FT ARM.

The most significant areas where judgements and estimates are made are as follows:

- The Provision for Restructurings includes estimated costs associated with the workforce elements of the Trust's future plans, in light of the recent economic downturn. This includes the provision for the Mutually Agreed Voluntary Resignation Scheme (MARS). The actual costs will depend upon uptake to the schemes, value for money and ability to flex the staffing profile.

## 1.5 Consolidation

### Stockport NHS FT Charitable Funds

The Trust is the corporate trustee to Stockport NHS Foundation Trust Charitable Fund, Charity Commission Registration 1048661. The Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary due to the way in which its financial and operating policies are discharged so as to obtain benefits from its activities for itself, its patients or its staff.

Prior to 2013-2014 the FT ARM, on the direction of the Treasury, permitted the Trust not to consolidate its charitable funds. However, in 2013-2014 this direction has been removed and IAS 27 requires that consolidated accounts are prepared. The Trust has considered the materiality of its charitable fund in 2013-2014 and the Board has approved, on the Audit Committee's recommendation, it is appropriate to consolidate. From 2013-2014 the Trust has consolidated the charitable fund and has applied this as a change in accounting policy.

The charitable fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended practice (SORP) which is based on UK Generally Accepted Accounting principles (UK GAAP). On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

- Recognise and measure them in accordance with the Trust's accounting policies;
- Eliminate intra-group transactions, balances, gains and losses.

### Other Subsidiaries

Subsidiary entities are those over which the Trust has the power to exercise control or a dominant influence so as to gain economic or other benefits. Where this is applicable the income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. In 2013-2014 the Trust has no other subsidiaries under its control.

## 1.6 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of healthcare services.

The Trust is entitled to recognise income for partially completed spells of activity at the 31st March 2014. As the individual National Tariff price and procedure code is not known for partially completed spells the Trust has based its calculation of such income based on the average length of stay and the cumulative activity. In 2013/14 partially completed spell activity is not material for inclusion in the financial results of the Trust. This principle will be reviewed on an annual basis.

Where income is received for a specific activity which is to be delivered in future financial years, that income is deferred. NHS deferred income is agreed with other NHS bodies through the agreement of balances.

The Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating individuals to whom personal injury compensation has subsequently been paid e.g by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensations claims and bad debts.

Income from the sales of goods and services is recognised after deduction of any price reductions, quantity discounts or cash discounts. Sales are recognised in the income statement in the year in which the risks and rewards of ownership related to the goods have passed to the customer or in which the service is rendered, and the amounts can be reliably measured and are expected to be recovered.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

## 1.7 Expenditure on Employee Benefits

### Short-term Employee Benefits

Salaries, wages and employment related payments are recognised in the period in which the service is received from employees. The Trust is entitled to recognise in the financial statements the cost of annual leave entitlement earned but not taken by employees at the end of the period to the extent that employees are permitted to carry-forward leave into the following period. The Trust will assess the movement in carry forward annual leave at the end of each financial year for materiality for inclusion in the financial statements. This principle will be reviewed on an annual basis.

## 1.8 Pension Costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at [www.nhsbsa.nhs.uk/pensions](http://www.nhsbsa.nhs.uk/pensions). The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the HM Treasury FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”. An outline of these follows:

a) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2014, is based on valuation data as 31 March 2013, updated to 31 March 2014 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant HM Treasury FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes were suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision due in 2015.

The Scheme Regulations were changed to allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next formal valuation, to be used for funding purposes, was carried out at as at March 2012 and will be used to inform the contribution rates to be used from 1 April 2015.

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a “final salary” scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as “pension commutation”.

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) has been used and replaced the Retail Prices Index (RPI).

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

## **1.9 Expenditure on other goods and services**

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

### **1.10 Property, Plant and Equipment**

#### Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust;
- it is expected to be used for more than one financial year; and
- the cost of the item can be measured reliably.

#### Capitalisation

Property, plant and equipment is capitalised if it:

- individually has a cost of at least £5,000; or
- forms a group of assets which individually have a cost of more than £250, collectively have a cost of at least £5,000, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- forms part of the initial equipping and setting-up cost of a new building or refurbishment of a ward or unit irrespective of their individual or collective cost.
- Where a large asset, for example a building, includes a number of components with significantly different asset lives e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

## Measurement

### Valuation

All property, plant and equipment are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently at fair value. The carrying value of property, plant and equipment are reviewed for impairment annually if events or changes in circumstances indicate the carrying value may not be recoverable. Land and buildings used for the Trust's services or for administrative purposes are stated in the Statement of Financial Position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. All land and buildings are restated to current value using professional valuations in accordance with IAS 16 every five years. A three yearly interim valuation is also carried out. Fair values are determined as follows:

- Land and Buildings - market value for existing use
- Specialised buildings - depreciated replacement cost

The depreciated replacement cost of specialised buildings has been valued on a modern equivalent asset basis. Valuations are carried out by the District Valuer, who is external to the Trust, and in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. The last full land and building asset valuation, using the modern equivalent asset methodology, was undertaken in March 2010 as part of the Trust's year end and to comply with HM Treasury requirements. A further assessment of valuations with updated indices was completed as at the 31st March 2013, in line with the requirement for an interim three yearly valuation.

Assets in the course of construction for service or administration purposes are valued at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are valued by professional valuers on the next occasion when all assets of that class are revalued unless there is an indication that initial cost is less than fair value.

Fixtures and equipment are valued at depreciated historical cost as this is not considered to be materially different from fair value. Equipment surplus to requirements is valued at net recoverable amount.

### Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

### Depreciation

Items of Property, Plant and Equipment are depreciated over their remaining useful economic life in a manner consistent with the consumption of economic or service delivery benefits. Depreciation is charged using the straight line method. Freehold land is considered to have an infinite life and is not depreciated.

Property, Plant and Equipment which has been classified as 'Held for Sale' ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Buildings and fittings are depreciated on their current value over the estimated life of the asset as assessed by the NHS Foundation Trust's Professional Valuers.

Plant and Equipment are depreciated evenly over the estimated life of the asset, as follows:

Medical equipment, engineering plant and equipment	5 to 15 years
Furniture	10 years
Information technology installations	8 years
Soft furnishings	7 years
Office and information technology equipment	5 years
Set-up costs in new buildings	10 years
Vehicles	7 years

### Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

### Impairments

In accordance with the FT ARM, impairments that are due to a loss of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.



An impairment arising from a loss of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income.'

#### De-recognition

Assets intended for disposal are reclassified as 'Held for Sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable i.e :
  - management are committed to a plan to sell the asset;
  - an active programme has begun to find a buyer and complete the sale;
  - the asset is being actively marketed at a reasonable price;
  - the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale';
  - and the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

#### **1.11 Donated, government grant and other grant funded assets**

Donated and grant funded property, plant and equipment are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor imposes a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

#### **1.12 Service Concessions / Private Finance Initiative (PFI) transactions**

Property transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'On-Statement of Financial Position' by the Trust. The underlying

assets are recognised as Property, Plant and Equipment at their fair value. An equivalent financial liability is recognised in accordance with IAS 17.

The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for the services. The finance cost is calculated using the effective interest rate for the scheme.

The service charge is recognised in operating expenses and the finance cost is charged to Finance Costs in the Statement of Comprehensive Income.

### **1.13 Intangible Assets**

#### Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

#### Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customers lists and similar items are not capitalised as intangible assets.

#### Recognition

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the Trust intends to complete the asset and sell or use it;
- the Trust has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
- the Trust can measure reliably the expenses attributable to the asset during development.

#### Software

Software which is integral to the operation of hardware e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software is capitalised as an intangible asset.

#### Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at fair value. Revaluation gains and losses and impairments are treated in the same manner as for Property, Plant and Equipment.

Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

#### Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

### **1.14 Revenue government and other grants**

Government grants are grants from Government bodies other than income from Primary Care Trusts or NHS Trusts for their provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

### **1.15 Inventories**

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the First In First Out (FIFO) method.

### **1.16 Financial instruments and financial liabilities**

#### **Recognition**

Financial assets and financial liabilities which arise from contracts for the sale or purchase of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.

Regular way purchases or sales are recognised and de-recognised, as applicable, using the trade date.

All other financial assets or liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

#### **De-recognition**

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

#### **Classification and measurement**

Financial assets are all classified as loans and receivables.

Financial liabilities are all classified as other financial liabilities.

#### **Loans and receivables**

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets.

The Trust's loans and receivables comprise: current investments, cash and cash equivalents, trade receivables, accrued income and other receivables.

Loans and receivables are recognised initially at fair value, net of transaction costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive income.

### **Cash and cash equivalents**

Cash and bank balances are recorded at the current values of these balances in the Trust's cash book. Account balances are only set off where a formal agreement has been made with the bank to do so. Interest earned on bank accounts is recorded as interest receivable in the periods to which it relates. Bank charges are recorded as operating expenditure in the periods to which they relate.

### **Other financial liabilities**

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

The Trust's financial liabilities include trade creditors, accruals and other creditors. They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

### **Determination of fair value**

For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from quoted market prices and discounted cash flow analysis as appropriate to the financial asset or liability. Where cashflows are discounted this is at the Treasury discount rate of 2.2% except for finance leases and on-Statement of Financial Position PFI or service concession transactions, which use the interest rate implicit in the agreement.

### **Impairment of financial assets**

At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure' are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of

Comprehensive Income and, in the case of trade receivables, the carrying amount of the asset is reduced directly or through the use of a provision for irrecoverable debts.

The carrying value of financial assets is recognised directly where it is acknowledged that all available avenues to recover the asset's full value have been exhausted. A provision for impairment of receivables<sup>7</sup> is utilised where the likelihood of full recovery is probable but not yet fully approved to write down directly.

## **1.17 Leases**

### **Finance Leases**

Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS Foundation Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property, plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

### **Operating Leases**

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

### **Lease of land and buildings**

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately. Leased land is treated as an operating lease.

## **1.18 Provisions**

The Trust provides for legal or constructive obligations that are of uncertain timing or amount at the Statement of Financial Position on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rate of 2.2% in real terms, except for early retirement provisions and injury benefit provisions which both use the HM Treasury's pension discount rate of 1.80% in real terms.

### **Clinical negligence costs**

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at note 18 but is not recognised in the Trust's Accounts.

## **Non-clinical risk pooling**

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

### **1.19 Contingencies**

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the Trust's control) are not recognised as assets, but are disclosed in note 25 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised but are disclosed in note 25 unless the probability of a transfer of economic benefits is remote. Contingent liabilities are disclosed as:

- Possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the Trust's control; or
- Present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amounts of the obligation cannot be measured with sufficient reliability.

### **1.20 Public dividend capital**

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of the establishment of the original NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the forecast cost of capital utilised by the NHS Foundation Trust, is paid over as Public Dividend Capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets (including lottery funded assets), (ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short term working capital facility, (iii) for 2013-2014 only, net assets and liabilities transferred from bodies which ceased to exist on 1 April 2013, and (iv) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

### **1.21 Value Added Tax**

Most of the activities of the NHS Foundation Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

### **1.22 Corporation Tax**

Health Service bodies, including Foundation Trusts, are exempt from taxation on their principal healthcare income under section 519A ICTA 1988. The Government introduced legislation in section 148

of the Finance Act 2004 to ensure that significant commercial non-core healthcare activities of NHS Foundation Trusts are taxable. Accordingly, the Trust is potentially within the scope of Corporation Tax in respect of its activities which are not related to, or are ancillary to, the provision of healthcare, and where the profits therefrom exceed £50,000 per annum.

HMRC have been in consultation on the implementation of a corporation tax regime for Foundation Trusts and it has been announced that Ministers have decided to defer the planned implementation of legislation. As a result there is no tax liability arising for Stockport NHS Foundation Trust in respect of the current financial year 2013-2014.

### **1.23 Foreign Exchange**

The functional and presentational currencies of the Trust are sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items (other than financial instruments measured at 'fair value through income and expenditure') are translated at the spot exchange rate on 31 March;
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation of the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

### **1.24 Third Party Assets**

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since Stockport NHS Foundation Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements HM Treasury's Financial Reporting Manual.

### **1.25 Losses and special payments**

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).



However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

## 2. Segmental Reporting

In line with IFRS 8 on Operating Segments, the Board of Directors, as Chief Operating Decision Maker, have assessed that the Trust continues to report its Annual Accounts on the basis that it operates as a single entity in the healthcare segment only. The accompanying financial statements have consequently been prepared under one single operating segment. This decision was made following a paper to the March 2014 Audit Committee meeting, and the rationale for this decision is explained below.

All of the Foundation Trust's activities are in the provision of healthcare, which is an aggregate of all the individual specialty components included therein, and the very large majority of the healthcare services provided occur at the one geographical main site. Similarly, the large majority of the Foundation Trust's revenue originates with the UK Government. The majority of expenses incurred are payroll expenditure on staff involved in the production or support of healthcare activities generally across the Trust together with the related supplies and overheads needed to establish this production. The business activities which earn revenue and incur expenses are therefore of one broad combined nature and therefore on this basis one segment of 'Healthcare' is deemed appropriate.

The operating results of the Foundation Trust are reviewed monthly by the Trust's Chief Operating Decision Maker which is the overall Foundation Trust Board and which includes senior professional non-executive directors. The Board of Directors review the financial position of the Foundation Trust as a whole in their decision making process, rather than individual components included in the totals, in terms of allocating resources. This process again implies a single operating segment under IFRS 8.

The finance report considered monthly by the Board of Directors contains summary figures for the whole Trust together with graphical line and bar charts relating to different total income activity levels, and expenditure budgets with the overall cost improvement position. Likewise only total Statement of Financial positions, cashflow forecasts, Monitor Risk ratings and performance against the capital programme are considered for the whole Foundation Trust. The Board as Chief Operating Decision Maker therefore only considers one segment of healthcare in its decision-making process.

The position on segmental reporting has been reviewed by the Board of Directors and the Trust's view remains unchanged. The Board as Chief Operating Decision Maker does not receive separate information routinely as described within IFRS 8 Operating Segments for any of its internal business groups and continues with its integrated business group structures with services aligned across all the clinical business groups. Following the transfer of Stockport Community Services there has been a restructuring of business groups with the largest change being the transfer of community services from within the Integrated Care group to a newly formed Community business group. This change will not be effective until the 1<sup>st</sup> April 2014 and financial reporting and information received by the Chief Operating Decision Maker, before and after the integration of Stockport Community Services, remains unchanged.

In consolidating the charitable funds the Trust has considered the level of its charitable funds and has considered them immaterial to report as a separate operating segment as the charitable funds revenue are not 10% or more of the combined assets of all operating segments.

### 3. Income and Activity

#### 3.1 Operating Income by type

	Foundation Trust and Group	
	2013-14 £000s	2012-13 £000s
NHS Foundation Trusts	302	-
NHS Trusts	36	-
Strategic Health Authorities	-	-
Clinical Commissioning Groups and NHS England	254,053	-
Primary Care Trusts*	-	257,511
Local Authorities**	8,247	-
NHS Other	112	146
Non NHS:		
- Private Patients	99	190
- Overseas Patients (non-reciprocal)	60	16
- NHS Injury Scheme***	1,249	1,411
- Non NHS: Other	78	84
<b>Total Income from activities</b>	<b>264,236</b>	<b>259,358</b>

The table reflects the updated restructure of NHS Bodies as at the 1st April 2013. This also reflects the change in commissioning responsibilities from Primary Care Trusts to Local Authorities (including public and sexual health).

#### 3.2 Income from Activities

	Foundation Trust and Group	
	2013-14 £000s	2012-13 £000s
Elective Income*	41,767	41,772
Non elective Income*	63,053	65,564
Outpatient Income*	32,243	33,351
A&E Income*	9,279	9,039
Other NHS Clinical Income*	56,084	47,558
<b>Total Contract Income</b>	<b>202,426</b>	<b>197,284</b>
<b>Community Trusts</b>		
Income from PCTs*	-	60,373
Income from CCGs and NHS England*	53,135	-
Income from Local Authorities*	7,189	-
Private patient income	99	206
Other clinical income including NHS Injury Scheme	1,387	1,495
<b>Total Income from Activities</b>	<b>264,236</b>	<b>259,358</b>

The notes on Income from Type and Activities are Trust figures and are unaffected by Group numbers.

\*Income received related to Commissioner requested services.

### 3.3 Other Operating Income

	Trust 2013-14 £000s	Trust 2012-13 £000s	Group 2013-14 £000s	Group 2012-13 £000s
Research and Development	697	708	697	708
Education and Training	8,375	7,994	8,375	7,994
Charitable contributions to expenditure	309	416	-	-
Profit on disposal of other tangible fixed assets	30	-	30	-
Stockport Pharmaceuticals/Regional Quality Control	5,294	5,276	5,294	5,276
NHS Bodies	6,818	7,124	6,818	7,124
Non NHS bodies	223	502	4,431	502
Rents, car parking & telephone income	1,208	1,116	1,208	1,116
Catering Sales	393	398	393	398
Other operating income*	6,238	7,302	2,030	7,262
NHS Charitable Funds: Incoming Resources excluding investment income	-	-	232	133
	<u>29,585</u>	<u>30,836</u>	<u>29,508</u>	<u>30,513</u>
<b>Total Operating Income</b>	<u><b>293,821</b></u>	<u><b>290,194</b></u>	<u><b>293,744</b></u>	<u><b>289,871</b></u>

\*Examples of other operating income include income from Local Authorities, the Hospital retail outlets, specific projects and funded posts, the release of deferred income, clinical excellence awards and income from occupational health services.

For Group Accounts elimination adjustments have been made to remove Trust income received from its charitable fund for reimbursement of purchases and management fees. The consolidated numbers include income received by the Charity from donations, legacies and fundraising.

#### 4. Operating Expenses

##### 4.1 Operating expenses comprise:

	Foundation Trust and Group	
	2013-14 £000s	2012-13 £000s
Services from Foundation Trusts	2,882	2,763
Services from NHS Trusts	808	574
Services from Primary Care Trusts	-	1,687
Services from CCGs and NHS England	822	-
Services from other NHS bodies	-	1
Purchase of healthcare from non NHS bodies	2,945	3,211
Employee Expenses - Executive Directors	812	869
Employee Expenses - Non-Executive Directors	134	129
Employee Expenses – Staff	204,363	199,569
Drugs Costs (non-inventory drugs only)	1,351	978
Drug Inventories consumed	12,728	11,947
Supplies and services - clinical	22,621	21,379
Supplies and services - general	3,599	3,452
Establishment	1,789	2,634
Research and Development (Not included in employee expenses)	26	54
Research and Development (Included in employee expenses)	658	764
Transport (other)	303	69
Transport (Business travel only)	1,227	1,308
Premises	10,479	9,701
(Decrease) / Increase in bad debt provision	52	(345)
Increase in other provisions	344	171
Change in provisions discount rate(s)	108	-
Rentals under operating leases – minimum lease receipts	4,063	4,068
Depreciation on property, plant and equipment	6,697	6,293
Amortisation of intangible assets	692	621
Impairment of property, plant and equipment	-	741
Impairments of intangible assets	11	-
Audit Services - statutory audit	63	59
Other auditors remuneration – further assurance services	31	21
Other auditors remuneration – other services	104	18
Audit fees payable to external auditor of charitable fund accounts	10	6
Loss on disposal of other property, plant and equipment	-	87
Clinical negligence	4,892	4,913
Legal fees	186	189
Consultancy costs	627	678
Training, courses and conferences	780	799
Patient travel	99	101
Car parking and security	169	339
Redundancy	131	704
Other Services including internal audit	104	118
Insurance	356	337
Losses, ex gratia & special payments, injury benefits provision	42	15
Other **	1,740	2,757
	<b>288,848</b>	<b>283,779</b>

The consolidation of charitable fund numbers does not affect the operating expenses note as resources expended by the Charity with Stockport NHS Foundation Trust are already reflected in the above numbers. The consolidation adjustment is, therefore, within the Charity Accounts expenses note.

\*Other operating expenses include the Radiology IT System costs, quality control services, CQC, AQUA and other subscription costs and FT membership costs.

## 4.2 Arrangements containing an operating lease

### 4.2.1 Operating expenses include:

	Foundation Trust and Group	
	2013-14 £000s	2012-13 £000s
Lease payments	4,063	4068
<b>Total</b>	<b>4,063</b>	<b>4,068</b>

### 4.2.2 Arrangements containing an operating lease:

	Foundation Trust and Group			
	2013-14 Buildings £000s	2013-14 Other £000s	Total 2013-14 £000s	Total 2012-13 £000's
Future lease payments due:				
- not later than one year;	3,841	222	4,063	3,951
- later than one year and not later than five years;	1,152	20	1,172	2,980
- later than five years.	127		127	158
<b>Total</b>	<b>5,120</b>	<b>242</b>	<b>5,362</b>	<b>7,089</b>

## 5. Operating Liabilities

### 5.1 The Late Payment of Commercial Debts (Interest) Act 1998

There were no significant claims (greater than £500) for interest as a result of the late payment of commercial debt.

### 5.2 Limitation on Auditor's Liability

As determined in the engagement letter with KPMG, external auditors to Stockport NHS Foundation Trust, the liability of either Party under or in connection with the contract, whether arising in contract, tort, negligence, breach of statutory duty or otherwise shall not exceed the sum of £5 million in any one year.

### 5.3 Audit Remuneration

	Foundation Trust and Group	
	2013-14 £000s	2012-13 £000s
Further Assurance Services	21	21
Other	124	24
<b>Total</b>	<b>145</b>	<b>45</b>

In 2013/14 the Trust required additional assurance work from its external auditor consultancy arm unrelated to its duties as statutory auditor. Other remuneration covers the statutory audit of the charitable funds and quality accounts work.

## 6 Staff costs and Numbers

### 6.1 Staff costs

	Foundation Trust and Group			
	Total 2013-14 £000s	Permanently Employed £000s	Other £000s	Total 2012-13 £000s
Salaries and wages	166,559	160,680	5,879	164,058
Social Security Costs	10,947	10,947	-	10,713
Employer contributions to NHSPA	18,790	18,782	8	18,370
Termination Benefits	1,113	1,113	-	441
Bank and Agency Staff	8,555	-	8,555	8,324
	<b>205,964</b>	<b>191,522</b>	<b>14,442</b>	<b>201,906</b>
<b>Analysed into Operating Expenditure</b>				
Employee Expenses - Staff	204,363	189,921	14,442	199,569
Employee Expenses - Executive directors	812	812	-	869
Research & development	658	658	-	764
Redundancy (arising in year)	131	131	-	704
<b>Total Employee benefits excl. capitalised costs</b>	<b>205,964</b>	<b>191,522</b>	<b>14,442</b>	<b>201,906</b>

## 6.2 Directors Remuneration

	Foundation Trust and Group	
	Total 2013-14	Total 2012-13
	£000s	£000s
Directors remuneration	834	900
Employer contributions to the pension scheme	117	126
	2013-14	2012-13
	Number	Number
Total number of directors to whom benefits are accruing under:	7	7

## 6.3 Average number of persons employed – WTE basis

	Foundation Trust and Group			
	Total 2013-14	Permanently Employed	Other	Total 2012-13
	WTE	WTE	WTE	WTE
Medical and dental	406	406	-	393
Administration and estates	886	886	-	879
Healthcare assistants and other support staff	1,064	1,064	-	1,044
Nursing, midwifery and health visiting staff	1,835	1,835	-	1,833
Scientific, therapeutic and technical staff	753	753	-	731
Bank and agency staff	119	-	119	117
Total	<u>5,063</u>	<u>4,944</u>	<u>119</u>	<u>4,997</u>
Number of employees (WTE) engaged on capital projects	<u>2</u>	<u>-</u>	<u>2</u>	<u>2</u>



## 6.4 Employee benefits

	Foundation Trust and Group	
	2013-14 £000s	2012-13 £000s
Childcare subsidies & arrangements	57	56
Staff Counselling Service	93	72
Occupational Health staff flu campaign*	21	18
Hospitality & Staff Health Initiatives*	20	21
	<b>191</b>	<b>167</b>

\* Offset by direct income sources.

## 6.5 Retirements due to ill-health

This note discloses the number and additional pension costs for individuals who retired early on ill-health grounds during the year. There were 9 retirements due to ill-health during 2013-14 (8 in 2012-13) at an additional cost of £546,949 (£490,899 in 2012-13). These costs were met by the NHS Pension scheme. This information has been supplied by NHS Pensions.

## 6.6 Staff Exit Packages: reporting of other compensation schemes

Exit Package Cost Band	Foundation Trust and Group			
	Number of Compulsory Redundancies 2013-14	Number of Other Departures Agreed 2013-14	Total Number of Exit Packages 2013-14	Total Number of Exit Packages 2012-13
< £10,000	-	8	8	15
£10,001 - £25,000	2	11	13	10
£25,001 - £50,000	3	6	9	8
£50,001 - £100,000	-	4	4	3
£100,001 - £150,000	-	-	-	-
£150,001 - £200,000	-	-	-	1
<b>Total number of exit packages by type</b>	<b>5</b>	<b>29</b>	<b>34</b>	<b>37</b>
<b>Total resource cost £000s</b>	<b>142</b>	<b>743</b>	<b>884</b>	<b>883</b>

'Other departures' were under phases of an approved Mutually Agreed Resignation scheme.

## 6.7 Staff Exit Packages: other departures

Exit Packages - other (non-compulsory) 2013/14	Foundation Trust and Group	
	Payments agreed	Total Value of agreements 2013-14 £000s
Mutually agreed resignation (MARS)		
contractual costs	28	723
Contractual payments in lieu of notice	1	20
<b>Total resource cost</b>	<b>29</b>	<b>743</b>

## 7 Profit or Loss on Disposal of Property, Plant and Equipment

During 2013 -14 the Trust has recorded income of £30,109 on disposal of fully depreciated equipment of which £25,373 was for medical equipment. (In 2012-13 the Trust recorded a net loss on disposal of equipment of £87,280).

## 8 Foundation Trust Finance Income

	2013-14 £000s	2012-13 £000s
Interest receivable	134	295
<b>Total</b>	<b>134</b>	<b>295</b>

### 8.1 Group Finance Income

	Foundation Trust and Group	
	2013-14 £000s	2012-13 £000s
Interest receivable	134	295
NHS Charitable Funds Investment Income	54	58
<b>Total</b>	<b>188</b>	<b>353</b>

## 9 Group Finance Costs

### 9.1 Interest expense

	Foundation Trust and Group	
	2013-14 £000s	2012-13 £000s
Interest on Loans from the NHS Financing Facility	838	886
<b>Total</b>	<b>838</b>	<b>886</b>

## 9.2 Finance Costs in PFI Obligations

	<b>Foundation Trust and Group</b>	
	<b>2013-14</b>	<b>2012-13</b>
	<b>£000s</b>	<b>£000s</b>
Main Finance Costs	17	20
<b>Combined total (notes 9.1 &amp; 9.2)</b>	<b>855</b>	<b>905</b>

## 10 Investments

In 2013-14 the Trust placed a short-term deposit account investment with its commercial bank Barclays PLC. At the 31 March 2014 the Trust held no short-term investments and all monies were placed with the Trust's Citibank account via the Government Banking Service (GBS). The Trust has decided to cease activity in short term investments following the changes to the calculation of PDC Dividend. Surplus cash now remains within the Trusts GBS Citibank account for interest receivable purposes.

For the Consolidated Accounts the Group has reported investment income of £54,000 from charitable fund investments in fixed interest and equity common investment funds and a charitable funds deposit account.

For 2013-14 the details of the short-term deposit investment utilised by the Trust are listed below:

	<b>2013-14</b>	<b>2012-13</b>
	<b>£000s</b>	<b>£000s</b>
<b>Foundation Trust Investments</b>		
Investments at 1 April 2013	-	-
Acquisitions in year - short term cash investments	10,000	32,000
Disposals in year - short term cash investments	(10,000)	(32,000)
<b>Carrying Value at 31 March 2014</b>	<b>-</b>	<b>-</b>

For 2013-14 the details of the Consolidated Group Investments are listed below:

	<b>2013-14</b>	<b>2012-13</b>
	<b>£000s</b>	<b>£000s</b>
<b>NHS Charitable Funds: Other Investments</b>		
Carrying Value at 1 April 2013	1,215	1,103
Fair value gains taken to I&E	10	112
<b>Carrying Value at 31 March 2014</b>	<b>1,225</b>	<b>1,215</b>

## 11 Intangible Fixed Assets

	Foundation Trust and Group		
	Software Licences £000s	Other Purchased	Total 2013-14 £000s
Gross cost at 1 April 2013	4,676	20	4,696
Additions purchased	537	-	537
Reclassifications	455	-	455
<b>Gross cost at 31 March 2014</b>	<b>5,668</b>	<b>20</b>	<b>5,688</b>
Amortisation at 1 April 2013	3,629	-	3,629
Provided during the year	692	-	692
Impairment charged to operating expenses		11	11
<b>Amortisation at 31 March 2014</b>	<b>4,321</b>	<b>11</b>	<b>4,332</b>
<b>Net book value</b>			
Purchased at 31 March 2014	1,347	9	1,356
<b>Total at 31 March 2014</b>	<b>1,347</b>	<b>9</b>	<b>1,356</b>

The Trust has reclassified £455,000 IT equipment assets from the Property, Plant and Equipment category to Software Licences above.

Under the Carbon Reduction Commitment Energy Efficiency Scheme the Trust has settled its 2013-14 liability and has remaining a £9k unused allowance to carry forward into the 2014-15 financial year. This is shown within Other Purchased Intangible Assets.

Economic Life of Intangible Assets	Min Life Years	Max Life Years
Software licences and trademarks	5	5

## 12 Property, Plant and Equipment 2013-14

### 12.1 Foundation Trust and Group Property, plant and equipment at the Statement of Financial Position date comprise the following:

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000 s
Cost or valuation at 1 April 2013	18,891	95,812	1,697	1,453	33,666	474	10,858	1,653	164,504
Transfers by absorption - MODIFIED	-	-	-	-	288	-	304	145	737
Additions purchased	-	2,327	-	1,666	2,339	57	2,147	14	8,550
Impairments charged to the revaluation reserve	-	-	-	-	-	-	-	-	-
Reclassifications	-	550	-	(1,037)	33	-	(1)	-	(455)
Revaluations	-	36	(63)	-	-	-	-	-	(27)
Disposals	-	-	-	-	-	-	-	-	-
<b>At 31 March 2014</b>	<b>18,891</b>	<b>98,725</b>	<b>1,634</b>	<b>2,082</b>	<b>36,326</b>	<b>531</b>	<b>13,308</b>	<b>1,812</b>	<b>173,309</b>
Accumulated Depreciation at 1 April 2013	-	-	-		23,413	427	8,035	1,608	33,483
Transfers by absorption - MODIFIED	-	-	-		184	-	124	83	391
Provided during the year	-	3,413	48		2,337	20	852	27	6,697
Impairments	-	-	-		-	-	-	-	-
Revaluations	-	-	-		-	-	-	-	-
<b>Depreciation at 31 March 2014</b>		<b>3,413</b>	<b>48</b>		<b>25,934</b>	<b>447</b>	<b>9,011</b>	<b>1,718</b>	<b>40,751</b>

### Group Property, Plant and Equipment Financing

	Land £000	Buildings £000	Dwellings £000	Assets Under Construction £000	Plant and Machinery £000	Transport £000	Information Technology £000	Furniture & Fittings £000	Total
<b>Net book value</b>									
- Purchased at 31 March 2014	18,891	94,545	1,586	2,082	10,392	84	4,297	94	131,971
- PFI obligations at 31 March 2014	-	767	-	-	-	-	-	-	767
<b>Net Book Value Total at 31 March 2014</b>	<b>18,891</b>	<b>95,312</b>	<b>1,586</b>	<b>2,082</b>	<b>10,392</b>	<b>84</b>	<b>4,297</b>	<b>94</b>	<b>132,738</b>

## 12. Foundation Trust Property, Plant and Equipment

### 12.2 Property, plant and equipment at the Statement of Financial Position date comprise the following elements:

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Cost or valuation at 1 April 2013	18,891	95,812	1,697	1,453	33,666	474	10,858	1,653	164,504
Transfers by absorption - MODIFIED	-	-	-	-	288	-	304	145	737
Additions purchased	-	2,307	-	1,666	2,248	57	2,147	14	8,550
Additions – grants/donations of cash to purchase assets	-	20	-	-	91	-	-	-	111
Reclassifications	-	550	-	(1,037)	33	-	(1)	-	(455)
Revaluations	-	36	(63)	-	-	-	-	-	(27)
Disposals	-	-	-	-	-	-	-	-	-
<b>At 31 March 2014</b>	<b>18,891</b>	<b>98,725</b>	<b>1,634</b>	<b>2,082</b>	<b>36,326</b>	<b>531</b>	<b>13,308</b>	<b>1,812</b>	<b>173,309</b>
Accumulated Depreciation at 1 April 2013	-	-	-		23,413	427	8,035	1,608	33,483
Transfers by absorption - MODIFIED	-	-	-		184	-	124	83	391
Provided during the year	-	3,413	48		2,337	20	852	27	6,697
Impairments	-	-	-		-	-	-	-	-
Revaluations	-	-	-		-	-	-	-	-
<b>Depreciation at 31 March 2014</b>		<b>3,413</b>	<b>48</b>		<b>25,934</b>	<b>447</b>	<b>9,011</b>	<b>1,718</b>	<b>40,751</b>

### Trust Property, Plant and Equipment Financing

	Land £000s	Buildings £000s	Dwellings £000s	Assets Under Construction £000s	Plant and Machinery £000s	Transport £000s	Information Technology £000s	Furniture & Fittings £000s	Total
<b>Net Book Value</b>									
- Purchased at 31 March 2014	18,891	93,765	1,586	2,082	10,293	84	4,297	94	131,092
- PFI obligations at 31 March 2014	-	767	-	-	-	-	-	-	767
- Government Granted at 31 March 2014	-	-	-	-	-	-	-	-	-
- Donated at 31 March 2014	-	780	-	-	99	-	-	-	879
<b>Net Book Value Total at 31 March 2014</b>	<b>18,891</b>	<b>95,312</b>	<b>1,586</b>	<b>2,082</b>	<b>10,392</b>	<b>84</b>	<b>4,297</b>	<b>94</b>	<b>132,738</b>

## 12.4 Assets held at open market value

There were no assets held at open market value at the 31 March 2014.

## 12.5 The net book value of land, building and dwellings at 31 March 2014 comprises:

	Foundation Trust and Group	
	2013-14 £000s	2012-13 £000s
Freehold	115,789	116,400
<b>Total</b>	<b>115,789</b>	<b>116,400</b>

## 12.6 Impairment of assets

	Foundation Trust and Group	
	2013-14 £000s	2012-13 £000s
Tangibles	-	741
Intangibles (CRC Allowance)	11	-
	<b>11</b>	<b>741</b>

## 12.7 Economic Life of property, plant and equipment

	Foundation Trust and Group	
	Min Life Years	Max life Years
Buildings excluding dwellings	3	55
Dwellings	20	40
Plant & Machinery	5	15
Transport Equipment	7	7
Information Technology	8	8
Furniture & Fittings	7	10



### 13. Inventories

#### 13.1 Inventory Movements – 2013-14

	Foundation Trust and Group	
	2013-14 £000s	2012-13 £000s
Drugs	544	484
Consumables	1,558	1,626
Energy	156	192
<b>Total at 31 March 2014</b>	<b>2,258</b>	<b>2,302</b>

#### 13.2 Inventory Movements – 2013-14

	Foundation Trust and Group	
	2013-14 £000s	2012-13 £000s
Inventories recognised in expenses	12,728	13,647
<b>Total at 31 March 2014</b>	<b>12,728</b>	<b>13,647</b>

## 14. Receivables

### 14.1 Trust Trade and Other Receivables

	2013-14 £000s	2012-13 £000s	01-Apr-12 £000s
<b>Current:</b>			
NHS receivables	4,172	1,975	2,291
Provision for impaired receivables	(638)	(582)	(964)
Receivables due from NHS Charities	552	493	175
Other receivables with related parties	911	587	151
Prepayments	1,038	720	988
Interest receivable	10	46	48
VAT receivable	402	412	465
PDC Dividend Receivable	13	123	-
Other receivables	3,410	3,564	3,997
<b>Sub Total</b>	<b>9,867</b>	<b>7,338</b>	<b>7,151</b>
<b>Non-Current:</b>			
Provision for impaired receivables	(117)	(121)	(84)
Prepayments	91	105	119
Other receivables	740	959	870
<b>Sub Total</b>	<b>714</b>	<b>943</b>	<b>905</b>
<b>Total</b>	<b>10,581</b>	<b>8,281</b>	<b>8,056</b>

### 14.2 Provision for impairment of receivables

	Foundation Trust and Group	
	2013-14 £000s	2012-13 £000s
<b>At 1 April 2013</b>	<b>703</b>	<b>1,048</b>
Increase in provision	139	212
Amounts utilised	-	-
Unused amounts reversed	(87)	(557)
<b>At 31 March 2014</b>	<b>755</b>	<b>703</b>

### 14.3 Group Trade and Other Receivables

	2013-14 £000s	2012-13 £000s	01-Apr-12 £000s
<b>Current:</b>			
NHS receivables	4,172	1,975	2,291
Provision for impaired receivables	(638)	(582)	(964)
Other receivables with related parties	911	587	151
Prepayments	1,038	720	988
Interest receivable	10	46	48
VAT receivable	402	412	465
PDC Dividend Receivable	13	123	-
Other receivables	3,410	3,564	3,997
<b>Sub Total</b>	<b>9,318</b>	<b>6,845</b>	<b>6,976</b>
<b>Non-Current:</b>			
Provision for impaired receivables	(117)	(121)	(84)
Prepayments	91	105	119
Other receivables	740	959	870
<b>Sub Total</b>	<b>714</b>	<b>943</b>	<b>905</b>
<b>Total</b>	<b>10,032</b>	<b>8,281</b>	<b>7,881</b>

### 14.4 Provision for impairment of receivables

	2013-14 £000s	2012-13 £000s
<b>At 1 April 2013</b>	703	1,048
Increase in provision	139	212
Amounts utilised	-	-
Unused amounts reversed	(87)	(557)
<b>At 31 March 2014</b>	<b>755</b>	<b>703</b>

#### 14.5 Foundation Trust and Group Analysis of impaired receivables

	2013-14	2013-14	2012-13	2012-13
	Trade	Other	Trade	Other
	Receivables	Receivables	Receivables	Receivables
	£000s	£000s	£000s	£000s
<b>Ageing of impaired receivables</b>				
0 - 30 days	-	-	-	33
90 - 180 days	4	-	-	-
Over 180 days	196	556	212	458
<b>Total</b>	<b>199</b>	<b>556</b>	<b>212</b>	<b>491</b>
<b>Ageing of non-impaired receivables past their due date</b>				
0 - 30 days*	5,684	-	3,385	-
30 - 60 days	409	-	556	-
60 - 90 days	128	-	142	-
90 - 180 days	146	-	268	-
Over 180 days**	153	3,519	177	3,631
<b>Total</b>	<b>6,519</b>	<b>3,519</b>	<b>4,528</b>	<b>3,631</b>

\* The Trust non-impaired receivables under 30 days include charitable funds receivables of £551,412.

\*\* Receivables aged over 180 days include the total value of NHS Injury Scheme receivables for which the Trust is awaiting the settlement of compensation claims.

## 15. Foundation Trust and Group Trade and other payables

15.1 Trade and other payables at the Statement of Financial Position date are made up of:

	Foundation Trust and Group	
	2013-14 £000s	2012-13 £000s
<b>Current:</b>		
NHS payables	3,004	2,260
Other trade payables – revenue	3,300	4,641
Other trade payables – capital	1,476	662
Amounts due to other related parties –revenue*	4,154	3,075
Social security costs	1,724	1,701
Other taxes payable	1,783	1,866
Other payables	258	228
Accruals	9,842	10,913
<b>Total Current Trade and other payables</b>	<b>25,541</b>	<b>25,346</b>

### Other Liabilities

	Foundation Trust and Group	
	2013-14 £000s	2012-13 £000s
<b>Current :</b>		
Deferred income	1,595	2,588
<b>Total Other Current Liabilities</b>	<b>1,595</b>	<b>2,588</b>
<b>Non-Current:</b>		
Deferred income	648	961
<b>Total Other Non-Current Liabilities</b>	<b>648</b>	<b>961</b>
<b>Total Other Liabilities</b>	<b>2,243</b>	<b>3,549</b>

\* Includes £2.5 million outstanding pensions contributions at 31 March 2014 (31 March 2013 £2.3 million), which have been settled in April 2014 in accordance with the NHS Pensions Agency payment dates.

The Trade Payables note is unaffected by Group numbers for charitable funds 2013-14 and 2012-13. At 1<sup>st</sup> April 2012 the Trust Trade Payables included £7,782 payables to the charitable funds. This is not included in Group numbers.

## 15.2 Borrowings and other long-term financial liabilities

At the balance sheet date 31 March 2014, Stockport NHS Foundation Trust had repaid £1.1 million in-year of a £25.0 million loan to the NHS Financing Facility (£7.2 million to date). This loan was utilised for the purposes of constructing the Cardiac and Surgical Unit and Orthopaedic Theatre and ward block. The outstanding balance of the loan at the 31 March 2014 is £17.8 million.

	<b>Foundation Trust and Group</b>	
	<b>2013-14</b>	<b>2012-13</b>
	<b>£000s</b>	<b>£000s</b>
<b>Current:</b>		
Loans from Foundation Trust Financing Facility	1,071	1,071
Obligations under Private Finance Initiative contracts	25	59
<b>Total</b>	<b>1,096</b>	<b>1,130</b>
<b>Non- Current:</b>		
Loans from Foundation Trust Financing Facility	16,748	17,821
Obligations under Private Finance Initiative contracts	436	461
<b>Total</b>	<b>17,184</b>	<b>18,282</b>

## 16. PFI obligations on SoFP

	<b>Foundation Trust and Group</b>	
	<b>2013-14</b>	<b>2012-13</b>
	<b>£000s</b>	<b>£000s</b>
Gross PFI liabilities	583	659
of which liabilities are due		
- not later than one year;	40	76
- later than one year and not later than five years;	161	161
- later than five years.	382	422
Finance charges allocated to future periods	(122)	(139)
Net PFI liabilities	461	520
- not later than one year;	25	59
- later than one year and not later than five years;	111	107
- later than five years.	325	354
	461	520

The Trust is committed to make the minimum following payments for on-SoFP PFIs obligations during the next year in which the commitment expires:

Later than five years	461	520
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## 17. Prudential Borrowing Limit (PBL)

The Prudential Borrowing Code requirements in section 41 of the NHS Act 2006 were repealed with effect from the 1<sup>st</sup> April 2013 by the Health and Social Care Act 2012. The financial statements disclosures that were provided previously are no longer required.

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**18. Provisions for liabilities and charges**

	Foundation Trust and Group			
	2013-14	Current	2013-14	Non-Current
	£000s	2012-13	£000s	2012-13
		£000s		£000s
Pensions relating to other staff	150	142	2,072	1,938
Other legal claims	135	114	-	-
Restructurings	1,172	688	-	-
Redundancy	595	1,372	-	-
Other	630	434	-	-
<b>Total</b>	<b>2,682</b>	<b>2,750</b>	<b>2,072</b>	<b>1,938</b>

	Pensions relating to other staff	Legal claims	Restructurings	Redundancy	Other	Total
	£000s	£000s	£000s	£000s	£000s	£000s
At 1 April 2013	2,080	114	688	1,372	434	4,688
Change in the discount rate	108	-	-	-	-	108
Arising during the year	137	93	1,465	131	284	2,109
Utilised during the year – cash	(110)	(55)	(981)	(425)	(12)	(1,583)
Utilised during the year - accruals	(39)	-	-	-	-	(39)
Reversed unused	-	(17)	-	(482)	(76)	(575)
Unwinding of discount	45	-	-	-	-	45
<b>At 31 March 2014</b>	<b>2,222</b>	<b>135</b>	<b>1,172</b>	<b>595</b>	<b>630</b>	<b>4,753</b>

**Expected timing of cashflows:**

Within one year	150	135	1,172	595	630	2,682
Between one and five years	574	-	-	-	-	574
After five years	1,498	-	-	-	-	1,498
<b>Total</b>	<b>2,222</b>	<b>135</b>	<b>1,172</b>	<b>595</b>	<b>630</b>	<b>4,753</b>



The provision for 'Pensions relating to other staff' is for the reimbursement of injury benefit allowances to the NHS Pensions Agency.

The provision for 'Legal Claims' provides for the Liability to Third Parties Schemes (LTPS) and Public & Employers Liability Scheme (PES). This provision covers the excess amount payable by the Trust and not the full liability of claims which are covered by the NHSLA under the non-clinical risk pooling scheme.

£45.0 million is included in the provisions of the NHS Litigation Authority Accounts at 31 March 2014 (£25.2 million at 31 March 2013) in respect of clinical negligence liabilities of the Trust.

The provisions for 'Restructurings' and 'Redundancy' include costs associated with the workforce elements of the Trust's future plans, in light of the recent economic downturn. Examples of this include the provision for the current phases of the Mutually Agreed Voluntary Resignation Scheme (MARS) and other staff exit costs.

Within other provisions the Trust has provided for costs of the trial relating to the saline tampering incident. These are based on current estimates but a risk exists that this may be significantly more as final arrangements are confirmed.

## 19. Revaluation Reserve

	Foundation Trust and Group	
	Property, plant & equipment	Total
	£000s	£000s
At 1 April 2013	47,439	47,439
Transfer by absorption – Modified	1	1
Revaluations	(27)	(27)
Other reserve movements*	(1,702)	(1,702)
<b>At 31 March 2014</b>	<b>45,711</b>	<b>45,711</b>
At 1 April 2012	48,695	48,695
Revaluations	(837)	(837)
Other reserve movements	(419)	(419)
<b>At 31 March 2013</b>	<b>47,439</b>	<b>47,439</b>

\*In 2013-14 the Trust has released revaluation reserve balances for fully depreciated assets to the income and expenditure reserve of £1,702,000 and made a small revaluation adjustment to its buildings valuation.

## 20. Movement in Public Dividend Capital

	Foundation Trust and Group	
	2013-14	2012-13
	£000s	£000s
Public Dividend Capital as at 1 April 2013	81,701	81,250
New Public Dividend Capital*	1,200	451
<b>Public Dividend Capital as at 31 March 2014</b>	<b>82,901</b>	<b>81,701</b>

In 2013-14 the Trust received £1,200,000 from the Department of Health for two capital schemes: £1,156,000 for Energy Efficiency and £44,000 for Better Maternity Care Settings (In 2012-13 it received £451,000 for a nationally funded scheme for maternity refurbishment).

## 21. Public Dividend Capital Dividend

The Trust is required to pay a dividend to the Department of Health at a rate of 3.5% of forecast average relevant net assets. The actual rate is calculated as the percentage that dividends paid on public dividend capital, totalling £3.2 million (£3.1 million in 2012-13), bears to the average relevant net assets of £92.9 million (£89.6 million in 2012-13).

## 22. Notes to the Cash flow Statement

### 22.1 Reconciliation of operating surplus to net cash flow from operating activities

	Foundation Trust 2013-14 £000s	Group 2013-14 £000s
Total operating (deficit) / surplus	4,973	4,896
Depreciation and amortisation charge	7,389	7,389
Fixed asset impairments and reversals	11	11
Gain/(Loss) on disposal	(30)	(30)
Interest accrued and not paid	0	0
(Increase)/decrease in Inventories	44	44
(Increase)/decrease in trade and other receivables	(2,446)	(2,390)
Increase/(decrease) in trade and other payables	(609)	(609)
Increase/(decrease) in other liabilities	(1,306)	(1,306)
Increase/(decrease) in provisions	20	20
NHS Charitable Funds - net adjustments for working capital movements, non-cash transactions and non-operating cash flows		(2)
Other movements in operating cashflows	(2)	
<b>Net cash inflow from operating activities</b>	<b>8,044</b>	<b>8,023</b>

### 22.2 Reconciliation of operating surplus to net cash flow from operating activities

	Foundation Trust 2012-13 £000s	Group 2012-13 £000s
Total operating (deficit) / surplus	6,415	6,092
Depreciation and amortisation charge	6,914	6,914
Fixed asset impairments and reversals	741	741
Gain/(Loss) on disposal	87	87
Interest accrued and not paid	46	46
(Increase)/decrease in Inventories	3	3
(Increase)/decrease in trade and other receivables	(92)	226
Increase/(decrease) in trade and other payables	702	702
Increase/(decrease) in other liabilities	(1,315)	(1,315)
Increase/(decrease) in provisions	(197)	(197)
NHS Charitable Funds - net adjustments for working capital movements, non-cash transactions and non-operating cash flows	-	7
Other movements in operating cashflows	(107)	(107)
<b>Net cash inflow from operating activities</b>	<b>13,197</b>	<b>13,199</b>

## 22.3 Cash and Cash Equivalents

	Foundation Trust and Group			
	2013-14 Cash and Cash Equivalents excluding charitable funds £000s	2013-14 Charitable Fund Cash Equivalents £000s	2012-13 Cash and Cash Equivalents excluding charitable funds £000s	2012-13 Charitable Fund Cash Equivalents £000s
At 1 April 2013	50,523	799	48,403	739
Net change in year	(3,964)	33	2,120	60
<b>At 31 March 2014</b>	<b>46,559</b>	<b>832</b>	<b>50,523</b>	<b>799</b>
Broken down into:				
Cash at commercial banks and in hand	131	5	235	25
Cash with the Government Banking Service	46,428	-	50,288	-
Other current investments	-	827	-	774
<b>Cash and cash equivalents as in SoFP</b>	<b>46,559</b>	<b>832</b>	<b>50,523</b>	<b>799</b>

## 23. Capital Commitments

The Trust has contractual capital commitments at the 31<sup>st</sup> March 2014 of £3.364 million comprising of £411,000 of intangible capital investment in a vital signs information system (Patient track) and £2.953 million ongoing tangible fixed asset schemes; predominantly investment in a new catering building and facilities.

## 24. Events after the Reporting Period

There are no significant events to report after the 31<sup>st</sup> March 2014.

## 25. Contingencies

	Foundation Trust and Group	
	2013-14 £000s	2012-13 £000s
NHSLA Contingent Liabilities:	(64)	(68)

Net contingent liability

(64)

(68)

## 26. Foundation Trust and Group Related Party Transactions

Stockport NHS Foundation Trust is a body corporate authorised by Monitor, the Independent Regulator of NHS Foundation Trusts, in exercise of the powers conferred by the National Health Service Act 2006.

During the year none of the Board of Directors or members of the key management staff or parties related to them has undertaken any material transactions with Stockport NHS Foundation Trust.

The Trust has 22 members of the Council of Governors; 19 representing public and staff and a further 3 appointed by partner organisations including Stockport Metropolitan Borough Council and Stockport College. None of the Council of Governors or parties related to them has undertaken any material transactions with Stockport NHS Foundation Trust.

	Income £000s	Expenditure £000s	Receivables £000s	Payables £000s
▪ Stockport CCG	159,684	(44)	1,438	(5)
▪ North Derbyshire CCG	20,545	-	-	-
▪ Eastern Cheshire CCG	9,794	-	-	-
▪ Tameside & Glossop CCG	34,761	(1,952)	82	(149)
▪ Stockport MBC	8,738	(1,440)	793	(30)

### 26.1 Related Parties: Key Management Personnel

	Total 2013-14 £000s	Total 2012-13 £000s
Key management personnel compensation in total for short-term employee benefits *	1,116	1,126
Key management personnel compensation in total for other long-term benefits *	117	126

\* Key management personnel comprises the Executive Directors of the Trust.

## **27. Financial Instruments**

IFRS 7 Financial Instruments Disclosure requires declaration of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. Financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies to which IFRS 7 mainly applies. Stockport NHS Foundation Trust has powers to borrow or invest surplus funds, and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Foundation Trust in undertaking its activities.

### **Liquidity risk**

Stockport NHS Foundation Trust receives its income from annually agreed contracts with local Clinical Commissioning Groups, NHS England and Local Authorities and in accordance with the Payments by Results regime which is intended to match the income received in year to actual activity delivered by reference to the 2013-14 National Tariff procedure costs. The Trust receives cash each month based on annually agreed level of contract activity and there are quarterly payments or repayments made to adjust for performance against planned activity.

The Trust finances its capital expenditure from internally generated funds or funds made available from the Department of Health as Public Dividend Capital. The Trust has also borrowed commercially from the Department of Health NHS Financing Facility within approved borrowing limits to finance strategic capital schemes.

Stockport NHS Foundation Trust has in place a Treasury Management Policy that covers the short-term investment of surplus operating cash. It provides a clearly defined risk management framework and was developed with reference to best practice guidance issued by Monitor, the Independent Regulator. This policy ensures the efficient management of liquidity and financial risk. Due to the changes in 2013-2014 in the calculation of the annual PDC dividend the Trust no longer engages currently in short term money market investments and retains its surplus cash for interest receivable within the Government Banking Service.

At the 31 March 2014 the Trust's cash balances were held solely in its Government Banking Services bank accounts and Barclay's current accounts as per note 22.2. Stockport NHS Foundation Trust is, therefore, not exposed to significant liquidity risk.

### **Market and Interest Rate Risk**

At the 31 March 2014 the Trust's financial liabilities carried either nil or fixed rates of interest. The Trust's financial assets relate to loans and receivables and its cash balances held within its Government Banking Service bank accounts and commercial current account. Interest on cash balances are set by HM Treasury through Citibank. Stockport NHS Foundation Trust is not, therefore, exposed to significant interest rate risk.

### **Credit Risk**

As the Trust receives most of its income from its commissioners based on annual contracts adjusted quarterly. It operates a robust debt management policy and, where necessary, provides for the risk of particular debts not being discharged by the applicable party. Stockport NHS Foundation Trust is, therefore, not exposed to significant credit risk.

### **Foreign Currency Risk**

The Trust has negligible foreign currency income or expenditure.

## Charitable Funds

The Group accounts include the financial statements of the Stockport NHS Charitable Fund. The charitable fund places its short term cash in bank accounts with the Trust's commercial bank, Barclays PLC.

The Charity invests monies of £2 million for longer term investment with CCLA Investment Management Ltd. It holds two common investment funds in fixed interest and equity funds of £1.2 million and one cash deposit account holding £0.8 million. The Charity receives quarterly updates on the performance of its investments and allocates gains and losses when realised to its charitable funds. This policy is reviewed on an annual basis to mitigate for any possible market losses on the valuation of its equity common investment fund.

### 27.1 Financial Assets by category

	<b>Foundation Trust and Group</b>	
	<b>Total</b>	<b>Loans and receivables</b>
	<b>£000s</b>	<b>£000s</b>
<b>Assets as per Statement of Financial Position 2013-14</b>		
Trade and other receivables excluding non-financial assets at 31 March 2014	<b>8,279</b>	<b>8,279</b>
Cash and cash equivalents at bank and in hand at 31 March 2014	<b>46,559</b>	<b>46,559</b>
NHS Charitable Fund financial assets	<b>2,057</b>	<b>2,057</b>
<b>Total at 31 March 2014</b>	<b>56,895</b>	<b>56,895</b>
<b>Assets as per Statement of Financial Position 2012-13</b>		
NHS Trade and other receivables excluding non-financial assets at 31 March 2013	6,497	6,497
Cash and cash equivalents at bank and in hand at 31 March 2013	50,523	50,523
Cash and cash equivalents at bank and in hand at 31 March 2012	2,014	2,014
<b>Total at 31 March 2013</b>	<b>59,034</b>	<b>59,034</b>

## 27.2 Financial Liabilities by category

	Foundation Trust and Group	
	Total £000s	Other financial liabilities £000s
<b>Liabilities as per SoFP</b>		
Borrowings excluding Finance lease and PFI liabilities at 31 March 2014	17,820	17,820
Obligations under Private Finance Initiative contracts at 31 March 2014	461	461
Trade and other payables excluding non-financial assets at 31 March 2014	25,541	25,541
Provisions under contract at 31 March 2014	2,471	2,471
<b>Total at 31 March 2014</b>	<b>46,293</b>	<b>46,293</b>
Borrowings excluding Finance lease and PFI liabilities at 31 March 2013	18,892	18,892
Obligations under Private Finance Initiative contracts at 31 March 2013	520	520
NHS Trade and other payables excluding non-financial assets at 31 March 2013	4,653	4,653
Non NHS Trade and other payables excluding non-financial assets at 31 March 2013	17,126	17,126
Provisions under contract at 31 March 2013	2,434	2,434
<b>Total at 31 March 2013</b>	<b>43,625</b>	<b>43,625</b>

## 27.3 Fair Values

Set out below is a comparison, by category, of book values and fair values of the Trust's financial assets and liabilities as at 31 March 2014.

### 27.3.1 Fair value of financial assets at 31 March 2014

	Foundation Trust and Group		
	Book Value £000s	Fair Value £000s	Basis of Fair Valuation
<b>Financial assets</b>			
At 31 March 2014			
Receivables over one year	623	623	*
NHS Charitable Funds – non-current investments	1,175	1,225	
<b>Total</b>	<b>1,798</b>	<b>1,848</b>	
At 31 March 2013			
Receivables over one year	838	838	*

NHS Charitable Funds – non-current investments	1,175	1,215
<b>Total</b>	<b>2,013</b>	<b>2,053</b>

### 27.3.2 Fair value of financial liabilities at 31 March 2013

	Foundation Trust and Group		
	Book Value	Fair Value	Basis of Fair
	£000s	£000s	Valuation
<b>Financial liabilities</b>			
At 31 March 2013			
Provisions under contract	2,072	2,072	**
Loans	17,185	17,185	***
<b>Total</b>	<b>19,257</b>	<b>19,257</b>	
At 31 March 2013			
Provisions under contract	2,434	2,434	
Loans	18,892	18,892	
<b>Total</b>	<b>21,326</b>	<b>22,392</b>	

\* Prepayments and NHS Injury Receivables over 1 year where book value is expected to equal fair value.

\*\* Fair value is not significantly different from book value since, in the calculation of book value, the expected cash flows have been discounted by the Treasury discount rate of 2.2% in real terms.

\*\*\* Loans from the Department of Health's NHS Foundation Trust Financing Facility where it is expected that book value will equal fair value.

## 28. Third Party Assets

At the 31 March 2014 the Trust held no certified third party assets; though, if requested, the Trust does retain patient monies and belongings in sealed pouches for the duration of their stay.

## 29. Losses and Special Payments

There were 63 cases of losses and special payments totalling £42,694 during 2013-14 (55 cases totalling £19,872 in 2012-13). There were no payments made by the Trust for clinical negligence, fraud, personal injury or compensation cases under legal obligation in 2013-14. The majority of losses and special payments made in 2013-14 related to payments for bad debts, overpayments of salary and claims abandoned or ex-gratia payments for loss of personal effects.

The total costs included in this note are on a cash basis and will not reconcile to the amounts in the notes to accounts which are prepared on an accruals basis.



### 30. Stockport NHS Charitable Funds.

In preparing consolidated accounts the Group includes financial statements incorporating Stockport NHS Foundation Trust and its associated charitable fund, Stockport NHS Charitable Fund. This is a registered Charity with the Charity Commission under the registration number 1048861. The Charity is an umbrella Charity split between one unrestricted fund, one endowment fund and 15 restricted funds. The objects of the Charity, as set out in its governing document are:

- To provide funds for any charitable purpose, or purposes relating to the National Health Service;
- For the relief of sickness by promoting the efficient performance of their duties by staff;
- For the relief of patients treated by Stockport NHS Foundation Trust;
- For any charitable purpose which will further the aim of advancing scientific or medical research;
- To support staff training, development and improvement of staff welfare.

The financial statements for Stockport NHS Charitable Funds are prepared under UK GAAP before consolidation adjustments and are due for submission to the Charity Commission by the 31<sup>st</sup> January 2015. The following Statement of Financial Activities and Balance Sheet for 2013-2014 are estimated at the 31<sup>st</sup> March 2014 to be consolidated into Group numbers.

#### Stockport NHS Charitable Fund Statement of Financial Activities for the year ended 31 March 2014

	2013-14 £000s	2012-13 £000s
Incoming Resources	232	133
<b>Sub-total voluntary income</b>	<b>232</b>	133
Investment Income	54	58
<b>Total incoming resources</b>	<b>286</b>	191
Resources Expended	(309)	(456)
<b>Total resources expended</b>	<b>(309)</b>	(456)
<b>Net (outgoing) resources before other recognised gains and losses</b>	<b>(23)</b>	(265)
Unrealised Gains on investments assets	10	112
<b>Net Movement in Funds</b>	<b>(13)</b>	(153)

**Stockport NHS Charitable Funds Balance Sheet for the year ended 31 March 2014**

	<b>2013-14</b> <b>£000s</b>	2012-13 £000s
<b>Fixed Assets</b>		
Investments	1,225	1,215
<b>Total Fixed Assets</b>	<b>1,225</b>	<b>1,215</b>
<b>Current Assets</b>		
Debtors	2	-
Short term investments and deposits	827	796
Cast at bank and in hand	5	3
<b>Total Current Assets</b>	<b>834</b>	<b>799</b>
Creditors falling due within one year	(551)	(493)
<b>Total Net Assets</b>	<b>1,508</b>	<b>1,521</b>
<b>Funds of the Charity</b>		
Endowment Fund	10	10
Unrestricted Fund	245	268
Restricted Fund	1,253	1,243
<b>Total Funds</b>	<b>1,508</b>	<b>1,521</b>



