

ANNUAL REPORT AND

ACCOUNTS 2016/2017

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Chairman's Introduction

Welcome to the Trust's Annual Report & Accounts for 2016/17 and I sincerely hope that readers will find the content informative in describing what has been a difficult year for the Trust, in common with many other NHS organisations. It has been a challenging year, and the winter period was particularly so, and I must commend all of our staff for their sterling efforts in continuing to provide effective patient care in often challenging circumstances. These efforts have enabled us to pursue key strategic developments with our partners, to make service improvements in the process and deliver good results in key clinical areas.

Last year I used a literary reference to introduce the Annual Report, and I make no excuse for repeating myself as it accurately describes the situation over the 12-month period. It truly was 'the best of times, and the worst of times'. We were able to celebrate the opening of our new £20m Surgical and Medical Centre in October 2016 and were delighted that Mr J Rouse, Chief Executive of the Greater Manchester Health & Social Care Partnership agreed to open this state of the art facility. This major build project was completed on time, and within budget, and provides us with increased surgical capacity, an improved environment for patients and staff and the design contributes to better 'flow' through the hospital. The centre prepares us to receive additional emergency and high risk general surgery patients in 2017 as part of the Healthier Together programme. Another major development which will have a positive impact on clinical care is our Electronic Patient Record (EPR) project. We commenced work on this project in the autumn of 2016 and an expert team has been undertaking preparatory work, together with clinical engagement and training in advance of the first phase of implementation in September 2017.

We have also progressed strategic developments in the local health and care economy through our work on the 'Stockport Together' programme. This work has been undertaken in conjunction with; Stockport Clinical Commissioning Group, Stockport Metropolitan Borough Council, Pennine Care NHS Foundation Trust and Viaduct Health (a federation of Stockport General Practitioners). A key development during 2016/17 was completion by the Provider organisations of an Options Appraisal process to identify preferred organisational form for a Multi-Speciality Clinical Provider (MCP). This process concluded in November 2016 with the governing bodies of each of the four Providers agreeing that an MCP as part of an Accountable Care Trust was the preferred form. Work then followed to prepare a Business Case for this development in parallel with the MCP procurement process being conducted by a Joint Commissioning Board comprised of CCG and Local Authority commissioners. The Stockport Together programme is vital to the provision of clinically effective, efficient and sustainable services in the Stockport area and work has been undertaken concurrently with the Options Appraisal to develop 'new models of care' for the locality. These new models of care will enhance services in the community both to provide treatment closer to home and develop services to facilitate the efficient discharge of patients who no longer need to be in hospital. Preparation of the business cases commenced in 2016/17 and the documents are scheduled for consideration by the relevant governing bodies in June 2017.

The Trust has also been involved in developments across Greater Manchester, following the implementation of devolution from 1 April 2016, and we have participated fully as a Provider member of the Greater Manchester Health & Social Care Partnership. Our Chief Executive has continued in her role as Chair of the Provider Federation Board, which is an integral part of the governance arrangements, and where there has been much activity throughout the year to focus on programmes for re-design and standardisation of services across the conurbation. The

success of such approaches has been evident through the earlier reconfiguration of Hyper Acute Stroke Services in Greater Manchester which resulted in specialist services located in Stockport, Salford and Bury. Each of these services received an 'A' rating in the national stroke audit, describing the quality of care as 'world class'.

Less positive has been the continuing challenge in achieving the national performance standard for four hour waiting in the Accident & Emergency Department and this has been doubly disappointing in the context of good standards achieved against the other key national performance indicators. The factors affecting our performance in this area are described in the Performance Report but there is no doubt that addressing these factors has necessitated a multi-agency approach, as solutions cannot be implemented by the Trust alone. This was particularly the case over an extremely difficult winter period when levels of demand, combined with delays in discharge of patients who no longer needed to be in hospital, resulted in severe bed pressures and consequent delays in the A&E Department. Working constructively with partners, we opened a community unit within the hospital to ease discharge pressures and brought forward initiatives planned as part of future Stockport Together developments. As I write now, we have experienced a trend of improving performance against the A&E standard during the period from January to May 2017. We will spare no effort in ensuring that this trend continues but are under no illusion that achieving, and then maintaining, the 95% standard will be very demanding.

These efforts are being undertaken in the context of an extremely challenging financial environment. While we performed well in achieving our financial control total agreed with NHS Improvement, delivery of our financial plan resulted in a deficit position of £6.3m, despite achieving cost improvement savings of circa £14m. Our participation in the national Financial Improvement Programme coordinated by NHS Improvement did make a significant contribution to the delivery of these savings and working with an expert team from KPMG LLP resulted in much strengthened governance arrangements for efficiency identification, monitoring and delivery. Nonetheless, the Trust remains in financial deficit and achieving a sustainable breakeven position will continue to be incredibly challenging. We had to make some difficult decisions during 2016/17, such as implementation of a voluntary redundancy programme, and addressing the financial challenge will undoubtedly necessitate further difficult decisions in the coming year.

Whether our challenges are operational or financial, our commitment to providing good quality care for our patients has never wavered. The question of 'what is in the best interests of patients' will always be the first question asked by the Board in planning our response to challenging situations. The outcome of the Care Quality Commission inspection carried out in January 2016, which was published in August 2016, was really disappointing for all involved in the delivery of our services. The overall rating of 'Requires Improvement' was primarily driven by findings relating to emergency and urgent care and a number of the domains covered by the inspection such as Effective, Caring and Well-Led were assessed as 'Good'. Addressing the recommendations arising from the inspection was a key area of focus throughout 2016/17, as we commenced remedial action in advance of publication of the inspection report. A follow-up inspection was subsequently carried out by the CQC in late March 2017 and, at the time of writing, the report detailing the outcome had yet to be received. We anticipate that the follow-up will acknowledge the improvement works carried out since the initial inspection.

From a Board perspective, it is a time of change and it feels a little strange that this will be the last time that I introduce the Annual Report. I will be retiring on 31 May 2017 having worked with

the Trust for ten years, first as a Non-Executive Director then as Chairman since 2012. I am extremely proud of what we have achieved, together, in providing services to the local community and I wish my successor, Adrian Belton, every success in leading the organisation through the next stages of transformational change. We welcomed a new Non-Executive Director, Catherine Barber-Brown, who joined the Board in September 2016 as successor to John Schultz and I would like to take this opportunity to thank John for his contribution to the Board during this three years with the Trust. While there has been just one substantive change in Executive Director composition, with Sue Toal superseding James Sumner as Chief Operating Officer, there will be significant change during 2017/18 as both Ann Barnes, Chief Executive, and Judith Morris, Director of Nursing & Midwifery, will be retiring in December 2017. With regard to the Council of Governors, the Council continues to play an important role in reflecting views of members and the public on the Trust's plans and Governors' engagement activities will be an important factor in seeking feedback from the public as the Stockport Together programme progresses. Our Governors work on a completely voluntary basis and their commitment and the time they give on behalf of members is very much appreciated.

Our focus for 2017/18 and beyond has to be on the sustainable delivery of high quality services to the public in Stockport and the High Peak. We will need to do this in the context of a strategic environment characterised by increasing complexity and continuing pressure on the resources to support delivery. It will be difficult, but it is achievable and it will be achieved through commitment, dedication and collaborative working with our partners in the local health and care economy and beyond. Finally, I would like to thank our governors, volunteers and members for the difference they make to the life and work of our Trust. The Board collectively would like to thank all of our staff for their continued commitment and professionalism in providing the highest quality care to our patients. Our staff have worked tirelessly over the last 12 months, in both clinical and non-clinical areas, and it is their contribution that really does make a difference.



Gillian Easson
Chairman
25 May 2017

Performance Report

Overview of Performance

There is no escaping from the fact that 2016/17 was an extremely difficult year. Taken together, outcomes of the Care Quality Commission inspection, continued failure to achieve the 4-hour A&E standard and an extremely challenging financial position could very easily suggest a poorly performing organisation. However, it is important to view these headline factors in context and recognise that there have been examples of good performance and some significant developments over the course of 2016/17. Performance against the A&E standard has been incredibly challenging due to a combination of factors such as levels of demand, acuity of patients, delayed transfers of care and staff recruitment. Resolution, and sustainable delivery of performance levels necessitates collaborative working with our partners in the local health and care economy to implement effective solutions. While there are always ways in which we can enhance Trust practice, and we continually look to deliver improvements where possible, the ability to effect long term change is not solely within the Trust's control.

During the extremely challenging winter of 2016/17 we developed, and implemented, an Urgent Care Delivery Plan, in conjunction with partners from the Clinical Commissioning Group (CCG) and the Local Authority. This is a system plan, owned by the local health and care system, with the Trust and each of its partners taking responsibility for their elements of initiatives which aim to reduce hospital attendances through enhancing out of hospital services and improve the range and availability of care services which allow the prompt and effective discharge of patients from the hospital post-treatment. Together with improvements in practice and process within the hospital, flow of patients to the hospital, through the hospital and from the hospital will be greatly enhanced. These efforts are producing results and we have witnessed a trend of steadily improved performance against the A&E standard from January to May 2017. The lessons learned from the collaborative approach and multi-agency working bode well for the future Stockport Together developments.

The challenging financial position, as with delivery of the key performance standard, is not something that is peculiar to Stockport NHS Foundation Trust, and many NHS organisations experienced a difficult year in 2016/17. However, addressing the financial position is a matter for the Trust to resolve and we are under no illusion that a solution in terms of significant additional funding will be forthcoming. Consequently, delivery of transformation programmes to achieve the required efficiencies is pivotal to future success. Part of the solution relates to new models of care which will be implemented through the Stockport Together programme but the remainder necessitates fundamental transformation of the way in which our services are delivered, whilst maintaining high quality care. In 2016/17 we achieved our financial plan which incorporated delivery of efficiencies with a value of £14m, the highest level of annual savings achieved by the Trust, albeit that only £8m was recurrent savings. Our involvement in the nationally coordinated Financial Improvement Programme was integral to the level of savings achieved. However, we face a similar level of challenge in 2017/18 to deliver an identified cost improvement programme of £15m.

Quality of patient care is of paramount importance and the outcome of the CQC inspection was bitterly disappointing. Huge efforts have been made during 2016/17 to address shortcomings and improve the areas identified for attention by the CQC. We currently await the outcome of a follow-

up inspection undertaken in March 2017 and we will address any further recommendations with alacrity. Despite the overall rating of 'Requires Improvement' I take heart in the positive patient experience feedback which we have continued to receive throughout an incredibly challenging year both through the national Friends and Family test and numerous personal letters. This is most encouraging in terms of feedback relating to patients' experience of our A&E department and it tells me that patients do receive good, compassionate care albeit in circumstances which, at times, are acutely pressurised. Further details of Patient Experience outcomes are provided elsewhere in the report together with other quality achievements included in the Annual Quality Report.

It would be wrong to solely focus on the downside and we must remember that there have also been a series of positives during the year. A summary of key achievements during 2016/17 is included below:

- Opening of a new £20m Surgical & Medical Centre in October 2016, on time and within budget
- Reconfiguration of the Emergency Department to provide an additional seven cubicles and improve flow through to the hospital
- Introduction of primary care streaming from A&E to treat patients who do not require specialist care
- Introduction of an Ambulatory Care Unit to treat patients direct from the Emergency Department together with patients directly referred by GPs
- Implementation of a multi-agency Crisis Response Team to respond to patients at risk of hospital admission within 2 hours
- 90% of Commissioning for Quality & Innovation (CQUIN) schemes were delivered in 2016/17
- Commencement of the hospital Electronic Patient Record (EPR) project and implementation of a Community EPR
- Hyper Acute Stroke Service awarded an 'A' rating in the national stroke audit
- Decision taken by Stockport Providers on the preferred organisational form for MCP development
- Stockport ranked in the top seven in the country for cancer care
- The national Bowel Cancer Audit shows high survival rates for patients who undergo surgery and treatment at Stepping Hill Hospital
- Data from the National Joint Registry shows Stepping Hill Hospital to be one of the best places in the country for knee and hip replacement surgery
- Our pre-operative anaemia team received a Nursing Times Award for their innovative work with anaemic patients

Despite these achievements, the Trust remains in a difficult position and we must address our quality, performance and financial issues in order to meet the expectations of our patients and retain the confidence of our regulators. I am convinced that a sustainable solution will be provided by the Stockport Together programme, and this is a view shared by all participants in the local health and care economy and acknowledged by our regulators. The Trust continues to work closely with NHS Improvement and has welcomed the support provided by their Emergency Care Improvement Programme (ECIP) where a 'system' approach has been adopted to identifying initiatives to improve performance.

The Performance Report which follows, and the general content of the Annual Report, expands on overall performance during 2016/17 and will provide the reader with a good appreciation of the Trust's position.



Ann Barnes
Chief Executive
25 May 2017

Brief History of Stockport NHS Foundation Trust

The organisation was 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 provided Community Services for the populations of Stockport and Tameside and Glossop. However, the Trust's provision of these services in Tameside and Glossop ceased on 31 March 2016 when responsibility for service provision was transferred to Tameside Hospital NHS Foundation Trust.

We employ over 5,200 staff working across hospital and community premises. Our major hospital is Stepping Hill Hospital situated on the A6, south of Stockport town centre. We also provide services from the Meadows, Swanbourne Gardens, the Devonshire Centre and in peoples' homes and the community within Stockport.

The Trust is licensed to provide the following mandatory services:

Anaesthetics	Neurology
Breast Surgery	Neurosurgery
Community Services	Obstetrics
Emergency Department	Ophthalmology
Ear, Nose & Throat	Oral Surgery
General Medicine	Orthodontics
General Surgery	Paediatrics
Genito-Urinary Medicine	Rehabilitation Medicine
Gynaecology	Rheumatology
Haematology	Trauma & Orthopaedics
Medical Oncology	Urology

These services are delivered through our Business Groups which are led by a 'triumvirate' comprised of; a Business Group Director, an Associate Medical Director (AMD) and a Head of Nursing. Our Business Groups during 2016/17 were:

- Child and Family
- Community Services
- Diagnostic & Clinical Support Services
- Medicine

- Surgical & Critical Care

Our Business Groups are supported by a full range of in-house corporate services which include; Finance, Workforce & Organisational Development, Learning & Education, Estates & Facilities, Information Management & Technology and Communications.

Key Issues & Risks

The Board of Directors has identified its strategic objectives and associated principal risks in a Board Assurance Framework which is subject to regular monitoring and review by the Board. The key issues and risks that could affect the Trust in delivering its objectives are detailed in the Annual Governance Statement 2016/17 which can be found on page 94 of the report.

Performance Measurement

The Board of Directors has approved a set of key metrics to measure performance which cover; operational performance, clinical quality performance, financial performance and workforce performance. Data detailing performance against these metrics is consolidated in a comprehensive Integrated Performance Report (IPR) which is reviewed on a monthly basis by the Board of Directors. A 'kite marking' system is used to provide assurance on data quality for each indicator to identify; the source of the data, the timeframe represented, method of calculation and whether or not the data has been validated.

Performance is summarised in the IPR by means of four 'performance wheels' which denote performance by month, by quarter and year-to-date. The wheels summarise performance in the following domains:

- **Quality-** Patient Experience, Dementia FAIR, Clinical Correspondence, Discharge Summary Falls, Pressure Ulcers, Clostridium Difficile and Mortality Indicators
- **Performance-** Outpatient Waiting List, 4-hour Emergency Department Standard, Diagnostic Tests, Cancelled Operations, Cancer, Readmissions and Referral to Treatment (RTT) performance
- **Finance-** Financial Sustainability, Cost Improvement Programme, Capital Programme, In-Year Financial Performance, Expenditure Variance and Income Variance.
- **Workforce-** Appraisals, Sickness Absence, Turnover, Essentials Training, Induction and Workforce Efficiency.

The Chief Operating Officer presents the IPR to the Board under cover of a Compliance Report which details performance against the key metrics used by NHS Improvement to assess compliance with the indicators set out in the Single Oversight Framework. During 2016/17, Performance Review meetings were implemented at Business Group level and involve Executive Directors and the Business Group triumvirate. Each Business Group has a replica set of the four 'performance wheels' which allows for a more granular analysis and scrutiny of performance at operational level.

Summary of Performance

The table below summarises performance against key Single Oversight Framework metrics during 2017/18:

Metric	Standard	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Maximum time of 18 weeks from point of referral to treatment: Patients on an incomplete pathway	92%	91.2%	91.2%	92%	92.4%
Maximum waiting time of 4 hours from arrival to admission / transfer / discharge	95%	82.1%	76.7%	75.3%	75.4%
All cancers – 62 day wait for first treatment from urgent GP referral for suspected cancer	85%	90.1%	85.5%	86%	88.1%
Maximum 6-week wait for diagnostic procedures	99%	99.6%	99.7%	99.7%	99.7%

Performance Analysis

Emergency Department – 4-hour Standard

Performance against the 4-hour standard has not achieved the performance trajectory agreed with NHS Improvement since the end of Quarter 2 but has shown signs of a consistent recovery from January to March 2017. Consistent performance below the 95% standard is a national issue but one that the organisation has multiple local programmes of work to address with a commitment to return the Trust to sustained compliance by March 2018 or earlier.

Factors contributing to non-compliance with the standard include the challenges faced nationally with regard to Medical workforce supply and sustainability, as well as medically optimised patients unable to be found a place of assessment and ongoing care in the community or at home with social services support. Achieving the standard will require a collaborative with Stockport Metropolitan Borough Council and Stockport Clinical Commissioning Group providing step up and step down care in alternative settings thereby reducing the demand on the Urgent Care system and increasing the resilience to respond to future surge and seasonal pressures.

Chart 1 – A&E Performance 2016/17

Chart 2 – Delayed Discharge 2016/17

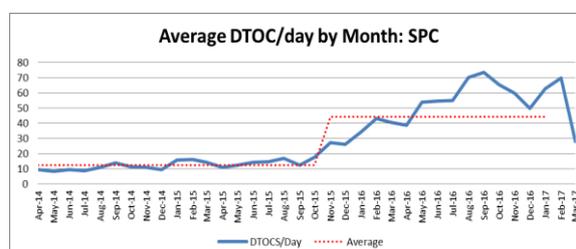
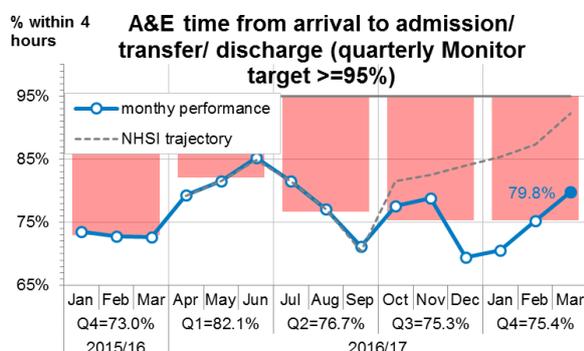
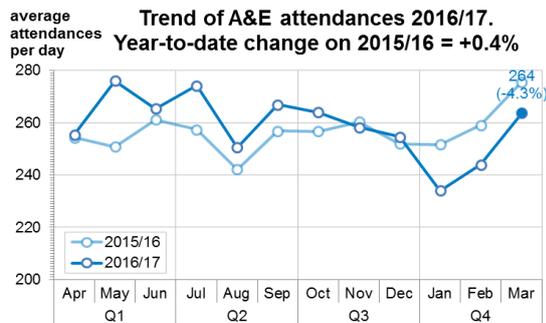
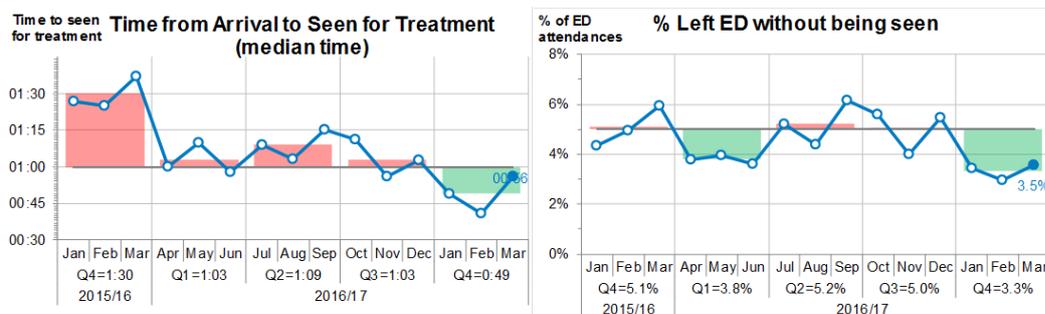


Chart 3 – A&E Attendance Levels



Continued hospital-based efforts to become more effective at seeing patients quickly and streaming them to services other than the majors department have been successful and are illustrated in the table below in terms of the time to first treatment and reduction in numbers of patients leaving the department without being seen. Expansion in our Ambulatory Care Unit (ACU) capacity and the implementation of our primary care delivered steam, Ambulatory Ill (AI) now mean that up to 33% of patient attendances are streamed away from traditional majors and minors models of care in the Emergency Department.

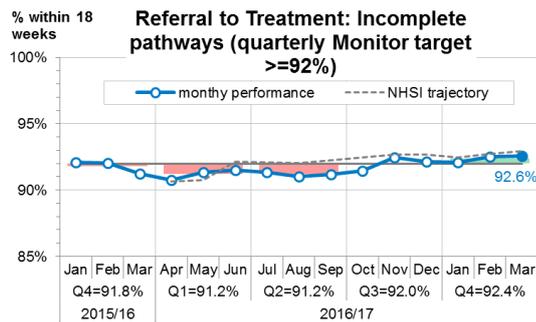


A sustainable solution to emergency department performance is a Stockport Health and Social Care system-wide issue, and the Trust is working proactively with senior leaders from Stockport Metropolitan Borough Council and Stockport Clinical Commissioning Group to develop long term, sustainable solutions to patients' increasing reliance on the Urgent Care system.

18 Week Referral to Treatment

Attainment of the 92% Referral to Treatment (RTT) target for patients on an incomplete pathway was problematic during the first half of the year as a consequence of a decision reluctantly taken to cancel routine elective activity in response to acute operational pressures during Quarter 4 2015/16. This decision was taken in order to safely manage emergency demand and capacity but resulted in a backlog of elective activity to manage in 2016/17. A compliant position against the RTT standard was achieved in November 2016, and was maintained for the remainder of year as indicated in the chart below.

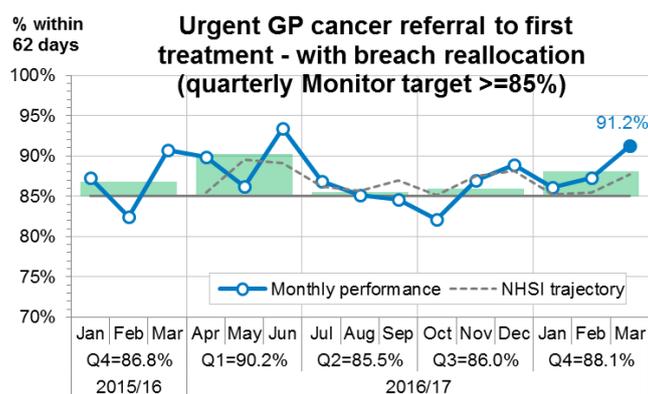
RTT Performance 2016/17



As at 31 March 2017 there were just two of our smaller specialties, Ear, Nose & Throat and Oral Surgery, where the 92% Referral To Treatment target had not been achieved. Significant improvements were made in both of these specialties during the latter months of 2016/17 and we fully expect that both will achieve a compliant position in early 2017/18. The overall number of patients waiting beyond 18 weeks on the routine waiting list continues to reduce although the Orthopaedic waiting list did increase during Quarter 4 as a result of winter bed pressures. Day-case work was actively maximised across all specialties during the winter period to allow the elective programme to continue as much as possible. Cancer and urgent cases continued to be prioritised throughout this time period.

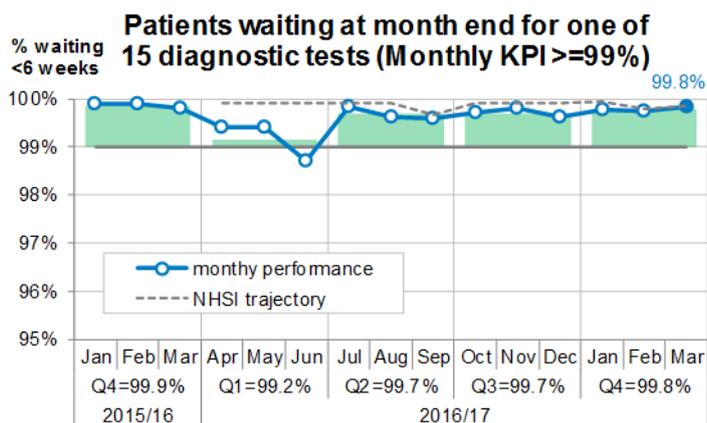
Cancer

Performance against all of the Cancer standards was strong throughout the year and resulted in full compliance against each of the required standards in 2016/17. We expect this level of performance to be maintained in 2017/18. Of particular note is the recurrent achievement of the 62 day standard in each quarter again this year. This was achieved despite the challenge of reduced bed capacity during the winter period.



Diagnostics

Performance against the 6 week diagnostic standard was strong for the majority of the year but dipped in June 2017 due to equipment issues within the cardiology department which impacted capacity. It is fully expected that compliance with this standard will continue in 2017/18.



Challenges to meeting national service standards in 2016/17

The Board of Directors has declared a forward risk of non-compliance with the Emergency Department 4-hour standard in 2017/18 as part of its governance declaration to NHS Improvement. The schemes that will provide a solution to emergency department performance within the Stockport Health and Social Care system are being implemented throughout 2017/18 and these schemes will provide the long term, sustainable solutions to patients' increasing reliance on the Urgent Care system.

Any new or significantly revised services

In October 2016 a major transfer of stroke services from East Cheshire to the Trust took place. This involved the transfer of all acute inpatient and rehabilitation services for stroke patients. The changes took effect following detailed discussions with commissioners, in order to provide a more sustainable service for stroke patients. East Cheshire patients already came to the Stepping Hill site as hyper-acute stroke centre, but were previously repatriated to Macclesfield District General Hospital. The transfer means that all care is now provided from the Stepping Hill site.

The Trust has also transferred delivery of a number of services over the past 12 months in line with our strategic intentions and agreements with partner organisations. These transfer are described below:

Tameside Community Services

As outlined in our 2015/16 Annual Report, the formal transfer of community services in Tameside & Glossop took place in April 2016. This was consistent with our Five-Year strategy and the planned transition to provision of services in Tameside by an Integrated Care Organisation (ICO).

Neurosurgery

The transfer of outpatient services to Salford NHS Foundation Trust took place in April 2016. Salford is the primary provider of specialist services and is consequently able to provide better support and a more effective and efficient pathway for patients.

Sexual Health Services

The provision of these services in Stockport, Trafford & Tameside was subject to competitive tender at the request of local authorities. The contract was subsequently awarded to Central Manchester NHS Foundation Trust and thus the Trust no longer provides services under this contract.

Paediatric Ophthalmology

The transfer of outpatient services and some elective procedures to Central Manchester NHS Foundation (CMFT) Trust was completed in September 2016. CMFT is the primary provider of specialist services in this area and is able to provide better support and a more effective and efficient pathway for patients.

Descriptions of significant partnership and alliances entered into by the Trust to facilitate the delivery of improved health care

The Trust has been actively involved in both regional and local strategic partnerships and alliances within the Health and Social Care (H&SC) system throughout 2016/17.

Regional

The Trust has been an active participant in two regional strategic programmes during 2016/17. The first is the South East Sector collaboration of providers as part of the Greater Manchester-wide Healthier Together programme. The Trust's status as the fourth Specialist Hospital site in Greater Manchester was confirmed in January 2016 and we have worked constructively with both our Sector partners and the central Healthier Together team on preparatory work to plan and design services, including revised clinical pathways in advance of Phase One implementation during 2017/18. We currently expect elective high risk general surgery to transfer from Tameside in October 2017 followed by the transfer of non-elective high risk general surgery in April 2018. Much work has been completed on the relevant business cases which are scheduled to be approved by the relevant governing bodies in the summer of 2017.

The second programme is the hugely significant Greater Manchester Health and Social Care Partnership (GM HSCP) which was established as part of the Devolution arrangements on 1 April 2016. The GM HSCP has responsibility for a £6bn budget and spending decisions in Greater Manchester to deliver its vision of the fastest and greatest improvement in the health and wellbeing of the 2.8 million people living in the conurbation. This vision was set out in the Greater Manchester strategic plan '*Taking Charge of our Health and Social Care*' which focuses on four key areas:

- A fundamental change in the way people and our communities take charge of, and responsibility for, their own health and wellbeing
- A focus on local care, and local care organisations, where doctors, nurses and other health professionals come together with social care professionals in co-located teams, in increasingly community based settings
- Hospitals across Greater Manchester working together to make sure expertise and experience can be shared widely; and
- Other changes which will make sure standards are consistently high across Greater Manchester, and will generate significant financial efficiencies, for example; sharing back office functions across organisations, making best use of the public sector estate, investing in new technology and embedding research and innovation.

The Trust is one of 37 organisations health and care organisations that participate in the GM HSCP and achievements during 2016/17 have included:

- Signing historic Transformation Fund deals with localities, totalling £60m, to deliver local plans to change the way we do things; how we organise our health and social care services to improve them and make them sustainable for the future.

- Creating GM frameworks for assurance and performance which is vital to monitor how the system is working. However, by working through a new GM Quality Board, we can focus on opportunities for improvement as a partnership and ensure that everyone in GM has access to the best possible services wherever they live.
- Identifying pressure points and agreeing partnership solutions - the establishment of the Urgent and Emergency Care Taskforce and the creation of a £5m fund to support local system resilience over winter.
- Publishing a Primary Care Reform Plan – delivering the GP Forward View in GM and supporting our ambition to ensure all patients have access to high quality, integrated care. The £41m investment over 5 years supports reform recognising the central role of primary care in a joined up health and social care system and making the best use of modern technology, investment in our buildings and bringing together staff into integrated health and care teams.
- Setting out a Social Care Transformation plan to improve and help adult social care - focusing on workforce, easing the problems of the funding gap (£176m in social care by 2020/21), and an aging population. Hospital is the right place for people who are seriously ill. But on any day in GM, around 2,500 people are in hospital who would be better receiving the treatment, care and support they need in the community through local care organisations.
- Presenting our plans for Urgent and Emergency Care reform in Greater Manchester including: ways of using data better to predict demand, using apps and websites to show in real time where people can get help, plus trialling an ‘operational hub’, open 24/7, to help co-ordinate and deploy services better.

A key part of the governance arrangements of the GM HSCP is the Greater Manchester NHS Trust Provider Federation Board. Until recently, this Board was chaired by our Chief Executive who, while no longer Chair, remains an active participant in the work of the Board to develop services across Greater Manchester. Our Chairman also participates as a member of the Greater Manchester Trusts’ Chair’s Group and Executive Directors are actively involved in the various work streams which contribute to the strategic change programme.

Local

Stockport Together

Strong relationships have been developed between providers and commissioners in Stockport to establish shared decision making processes and submit a successful bid for £19m of transformation funding to support the implementation of the locality plans. We continue to be at the forefront of change as a Vanguard site working on implementation of a Multi-Specialty Community Provider (MCP) model of delivery as part of an Accountable Care Trust in Stockport, delivering Integrated Health and Social Care (H&SC) through a transformation programme called ‘Stockport Together’.

The partners in Stockport Together; the Trust, Stockport Clinical Commissioning Group, Stockport Metropolitan Borough Council, Viaduct Health and Pennine Care NHS Foundation Trust, are beginning to transform the way in which health and social care is delivered and improve outcomes for patients. A Shadow Provider Board has been established and implementation of new services has focused on four key areas:

- **Enhanced Primary Care** - Direct Access Physiotherapy, Enhanced Pharmacy Support in Neighbourhoods and additional capacity to address low level mental health issues in Practice Populations. All three schemes were identified by Stockport GPs
- **Integrated Neighbourhood Teams** – Are beginning to work holistically to meet the health and social care needs of Neighbourhood practice populations working particularly with GP practices to identify and then intensively manage the 15% of their patients at greatest risk of future admission
- **Healthy Communities programme** - Targeted approaches in the acute setting, Intermediate Tier and Neighbourhoods to support access to community and voluntary resource, peer support, particularly for carers under pressure, increased health trainer and social prescribing capacity
- **The Intermediate Tier Hub** - Rapid Response providing a maximum 1 hour response time including mental health for those most at risk of admission through; an overnight sitting service, Intermediate Care bed and home based re-ablement and a discharge to assess model

The Trust's community service teams, specialist nurses, allied health professionals and medical staff will all play a central role in these proactive developments.

Work has been progressed during 2016/17 to prepare business cases for 'new models of care' under the following headings:

- Stockport Neighbourhoods
- Intermediate Tier
- Acute Interface
- Outpatients
- Enabler Services (Workforce, Information Technology, Estates & Facilities)

The new models of care will transform the way in which services are delivered in both community / neighbourhood settings and within the hospital and are crucial to the delivery of sustainable urgent care services. The relevant business cases are scheduled for approval by the governing bodies of the Stockport Together partners in June 2017.

In parallel with development of new models of care, the Stockport Together providers; the Trust, Stockport Metropolitan Borough Council, Viaduct Health and Pennine Care NHS Foundation Trust, completed a comprehensive options appraisal during 2016/17 to identify a preferred organisational form for the MCP. This concluded in November 2016 with unanimous agreement that incorporation of the MCP in an Accountable Care Trust would be the preferred organisational form. This option would result in the transition of Stockport NHS Foundation Trust to the Accountable Care Trust (which would remain an NHS Foundation Trust).

The Stockport Together providers commenced preparation of an Outline Business Case for this model immediately after the outcome of the options appraisal and work continued in earnest throughout Quarter 4 2016/17. Work will continue in 2017/18 in line with the requirements of the Integrated Support & Assurance Process (ISAP) which was introduced by NHS England and NHS Improvement to facilitate a comprehensive regulatory assessment of such developments. At

present, we anticipate that the process will result in establishment of an Accountable Care Trust at some point during 2018/19.

The importance of the Stockport Together programme cannot be overstated. All bodies involved in the programme; Providers, Commissioners and Regulators recognise that the programme is pivotal to the provision of sustainable, effective and efficient services in the Stockport locality. It is also recognised that services being developed through the programme will have a positive impact on patient care and experience with care being delivered closer to home.

Financial Improvement Programme

During 2016/17, the Trust was selected as a first-wave participant in a national Financial Improvement Programme (FIP) coordinated by NHS Improvement. The FIP was completed during the period May - October 2016 with the Trust working in partnership with KPMG LLP. The purpose of the programme was *“to provide support to trusts to materially reduce their 2016/17 income and expenditure deficits and improve their cash position, supporting them to deliver both their plans and control totals while maintaining delivery of safe care”*.

Participation in the programme not only made a significant contribution to the Trust’s delivery of efficiency savings totalling £14.6m for the year, but also ensured expert support in reviewing, re-designing and embedding best practice governance arrangements for management of the Trust’s cost improvement programmes. The Trust undoubtedly benefitted from the FIP and has embedded robust governance arrangements for the identification, monitoring and delivery of cost improvement schemes. These arrangements include the completion of Quality Impact Assessments to assess potential impact on the quality and safety of relevant services and ensure that any identified risks are effectively mitigated. The team from KPMG LLP supporting the Trust during the FIP was led by Mr A Burn, Financial Improvement Director, who participated as a non-voting member at Board of Directors during the period May – September 2016.

Consultation with Local Groups and Organisations

The Trust has not made any material changes to its service provision, estate or any other aspect of its establishment and operation that required formal consultation during 2016/17. However, Executive Directors regularly attend meetings of the local Health Overview & Scrutiny Committee at Stockport Metropolitan Borough Council to brief Committee members on developments at the Trust. Briefing subjects during 2016/17 included; the Trust’s Financial Improvement Programme, actions to address operational performance and presentation of the Trust’s draft Annual Quality Report 2016/17. In addition, quarterly meetings are scheduled with Stockport Healthwatch to share information on Trust developments and address any issues that may be identified by Healthwatch representatives.

Important events since the end of the Financial Year

There have been no events to report that have arisen since the end of the financial year.

Overseas Operations

The Trust did not conduct any overseas operations during 2016/17. However, the Trust is committed to providing safe nurse staffing by addressing Registered Nurse (RN) vacancies thereby

reducing reliance on temporary staffing (both bank and agency staff). Consequently, we have continued to conduct recruitment activities overseas in both European Union (EU) and non-EU countries. With regard to recruitment from EU countries, the availability of potential recruits has reduced, and we have also experienced an increase in the number of recruits returning home, as a result of both the requirement for all overseas nurses to pass the International English Language Testing System (IELTS) at Level 7 and the impact of the 'Brexit' decision in June 2016. We do, however, continue to offer video interviewing via 'Skype' to EU nurses on a regular basis to supplement our numbers of locally recruited nurses.

The impact of the IELTS requirement particularly affected our plans to recruit nurses from India. At the beginning of the year we recruited 60 Registered Nurses from India, who were expected to commence employment with the Trust in December 2016. However, many recruits now struggle to pass IELTS at the required standard and this has resulted in a significant delay to the arrival of new recruits. By 31 March 2017, only 6 of the 60 had arrived and we anticipate that 4 per month will arrive during 2017/18. This experience is not peculiar to Stockport and has affected nurse recruitment across the country. Our intention for 2017/18 is to ensure that any non-EU nurses are able to meet the IELTS standard before interview. This will avoid unnecessary delays but may also reduce the available talent pool.

We have also looked to international recruitment to address gaps in our medical workforce, particularly in shortage specialties such as emergency medicine. We have undertaken recruitment activities with some success in both India and the United Arab Emirates and look forward to welcoming new doctors at consultant and middle grade levels during 2017/18.

Vision, Strategic Priorities and Trust Strategy

In 2015/16 the Board confirmed that the Trust's strategy was fully aligned with both the Greater Manchester Sustainability & Transformation Plan and the Stockport Locality Plan. The five-year strategy approved by the Trust in May 2015 states that "*Trust strategy going forward will be focused on care of older people and people with cancer*" and set out the intention to move away from the old district general hospital model of providing 'everything to everyone' as it is no longer sustainable. This would mean that the Trust would look to provide fewer services directly (although services would continue to be provided in the Stockport locality) and focus development on services consistent with the 'care of older people and people with cancer' theme.

During 2016/17, in line with our plans for the next five years, to directly manage fewer services but to deliver these services in innovative new ways, we made a commitment to whole system integration and transformational change as the only way to ensure sustainable services within a sustainable locality. Given the significant degree of change in both the operating and strategic environment, and not least the developments to standardise acute and hospital care which will arise from the Greater Manchester Health & Social Care Partnership, the Board agreed in January 2017 to commence a fundamental 'refresh' of the Trust's strategy. This 'refresh' which has been informed by guidance published by NHS Improvement, will ensure that the Trust's Vision and Strategy will reflect the current environment and known or anticipated developments in the coming years.

We commenced the 'refresh' process towards the end of Quarter 4 2016/17 and the Board has committed to comprehensive engagement with both internal and external stakeholders to inform Strategy development, communication and implementation. This work is being progressed as a priority development and we aim to launch our refreshed strategy during the summer of 2017.

Financial Review

The Trust ended 2016/17 with a deficit of £6.3m including exceptional items against a planned deficit of £6.0m. However this includes a fixed asset impairment of £4.1m as a result of the Trust undertaking a modern equivalent asset valuation (MEAV) exercise. Excluding exceptional items, the Trust delivered an underlying deficit of £2.2m, which was £3.8m better than plan.

In 2016/17 trusts were offered Sustainability & Transformation Funding (STF) as a non-recurrent financial incentive with the condition of agreeing to deliver a 'control total' and to meet key performance criteria against agreed operational trajectories. At the end of the financial year, additional bonus payments were awarded to trusts that were able to meet their control total and a further incentive payment for exceeding the control total. Specific technical guidance was issued on eligibility for STF and which parts of a trust's accounts were included and excluded from the control total. By the end of the financial year the Trust had secured a total of £11.4m of STF and this income is included within the Trust accounts.

The annual accounts present the consolidated Trust financial position as a group, which includes the Charitable Funds and the Trust's wholly owned subsidiary, Stepping Hill Healthcare Enterprises Ltd which provides the Pharmacy Shop services. Further detail on both of these elements is provided in the annual accounts section of the report. The accounts also present the Trust position excluding both consolidations, and the following section of this report covers only the Trust position.

NHS Improvement introduced a Single Oversight Framework from 1 October 2016 which is designed to help NHS providers attain, and maintain, Care Quality Commission ratings of 'Good' or 'Outstanding'. This superseded the Monitor Risk Assessment Framework including the Financial Sustainability Risk Rating. Finance and Use of Resources (UoR) indicators now measure a provider's financial efficiency and progress in meeting its financial control total, reflecting the approach taken in "Strengthening financial performance and accountability in 2016/17." The UoR is scored from 1 to 4, where 1 is excellent and 4 is poor, for 5 different elements each with an equal weighting. An overall metric score is given with defined rules on overrides for scores.

The Trust's performance against the metrics with regard to the Use of Resources for 2016/17 compared to the annual plan can be shown in the following table:

Assurance area	Metric	Weight	2016/17 - plan		2016/17 - actual		Variance	Result
			Metric	Rating	Metric	Rating		
Financial sustainability	Capital Service cover	0.2	1.0	4	1.4	3	0.4	✓
Financial sustainability	Liquidity (days)	0.2	4.8	1	8.3	1	3.5	✓
Financial efficiency	I&E margin %	0.2	2.3	4	0.9%	3	1.4%	✓
Financial controls	Distance from plan %	0.2	-		1.4%	1		✓
Financial controls	Agency spend	0.2	(0.5)%	1	11.4%	2	12.0%	x
USE OF RESOURCES OVERALL RATING						2		

The 2016/17 financial position includes the delivery of a Cost Improvement Programme (CIP) with a total value of £14.6m. The Trust was one of a number of trusts across the country that participated in the nationally coordinated Financial Improvement Programme during the year. The expert support provided by KPMG LLP during this programme, which was undertaken during the period May – September 2016 made a significant contribution to the level of savings delivered. All efficiency schemes are subject to a Quality Impact Assessment to assess potential impact on the quality and safety of the services provided and ensure that any identified risks are effectively

mitigated. While delivery of a £14.6m cost improvement programme was a significant achievement, a proportion of the identified savings were non-recurrent in nature and this will have a consequent impact on the level of savings required in 2017/18.

Whilst achieving savings, we have continued to invest to improve services for patients, both in terms of improving the quality and safety of our services and investing in buildings and equipment. Total investment through the Capital programme in 2016/17 was £10m which included £7.1m on property and equipment schemes and £2.9m on information management and technology projects. The new state-of-the-art Surgical & Medical Centre opened on schedule in October 2016, providing additional and replacement capacity for patient services. The Trust has also continued with its development of the Electronic Patient Record (EPR) systems for both the hospital and the community services, a vital IT enabler for the Stockport Together programme.

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 Accounting Standard 1 (IAS 1). This is done by considering the information available about the future prospects of the Trust as at 31 March 2017, including the Trust's assessment of the future cost and productivity improvements required to enable it to manage through the very 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 potential loss of key personnel.

A detailed report covering all the risks and opinion drawn from this analysis was considered by the Board of Directors on 30 March 2017. The Board concluded that, whilst 2017/18 will be even more challenging than 2016/17, and despite considerable risks related to deliverability of planned savings and the Trust's overall cash position, the Trust is a going concern and the Board has taken steps to ensure that this remains the case for at least the next 12 months. The Trust will regularly review this position throughout 2017/18. The anticipated continuation of the provision of Trust services in the future, as evidenced by inclusion of financial provision for those services in published documents, is also evidence that the Trust considers it is a going concern.

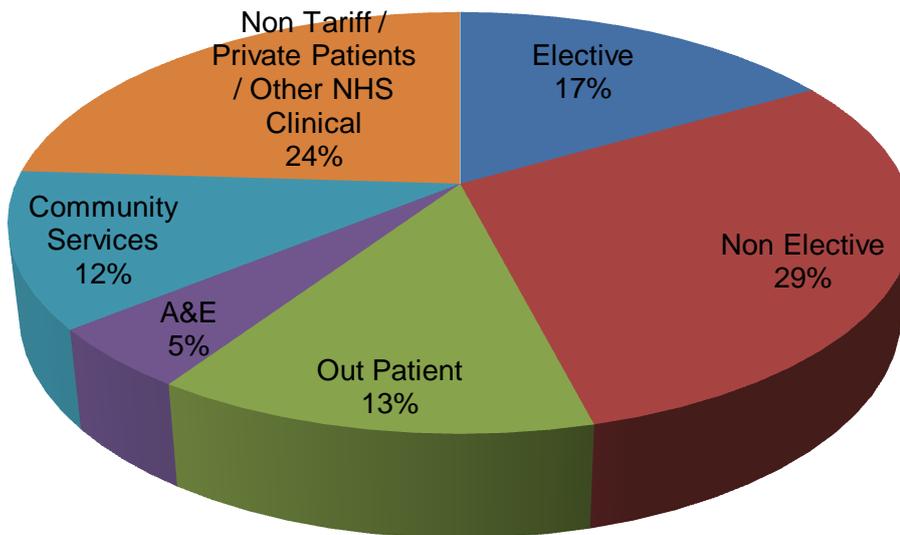
After making enquiries, the Directors have a reasonable expectation that Stockport NHS Foundation Trust has adequate resources to continue its operations on an on-going basis for the foreseeable future. For this reason, the Directors continue to adopt the going concern basis in preparing the accounts.

Income and Expenditure

In 2016/17 our overall income was £303.3m (£307.7m in 2015/16). The Trust did not receive any political donations in 2016/17.

Our operating income for 2016/17 was £256.5m and is indicated by source in the chart below:

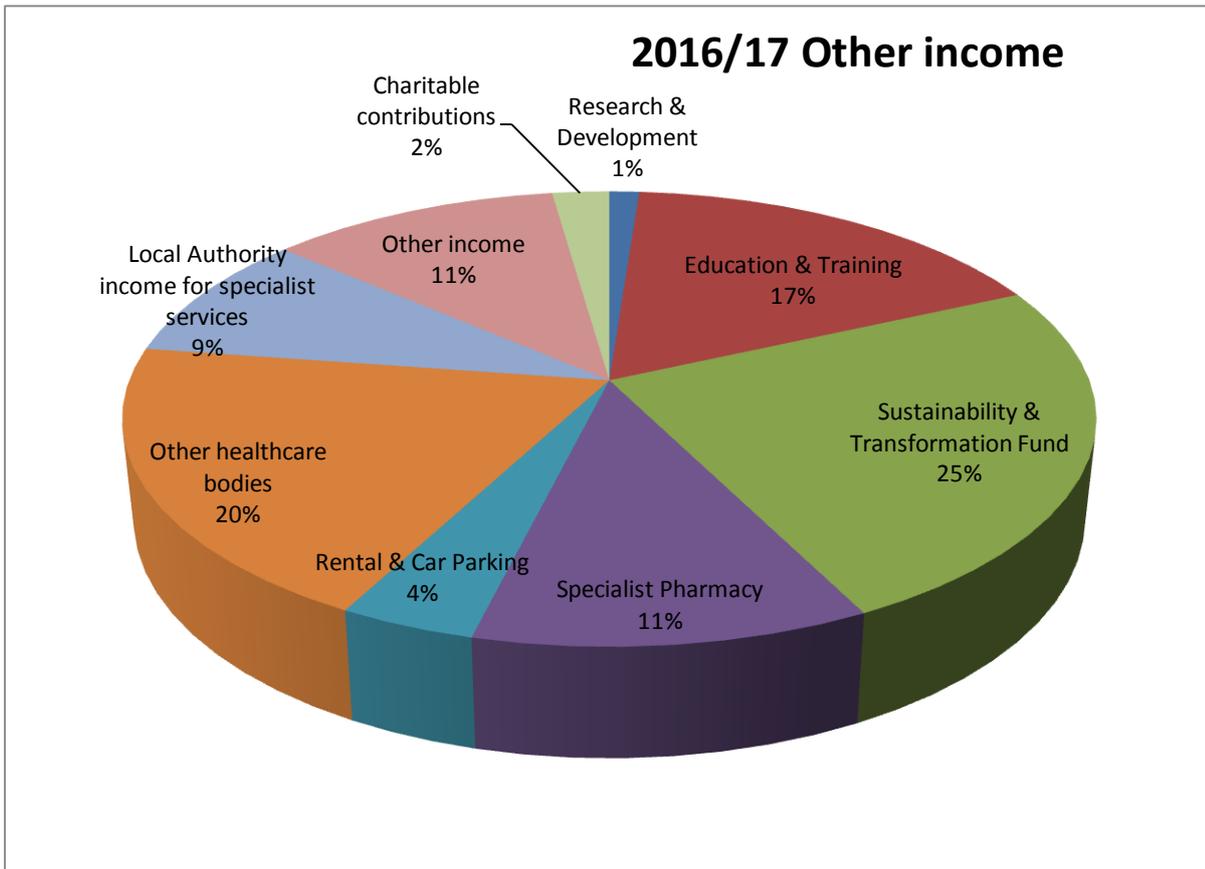
2016/17 Operating Income



Clinical income was above planned levels during 2016/17 and included the transfer of Stroke Services commissioned from Eastern Cheshire CCG which was completed in October 2016. The Trust agreed a block contract for non-elective, A&E and outpatient services with Stockport CCG for 2016/17 and therefore income was largely within plan. However there has been significant growth in the number of patients staying longer in hospital and is linked to the high levels of delayed transfers of care.

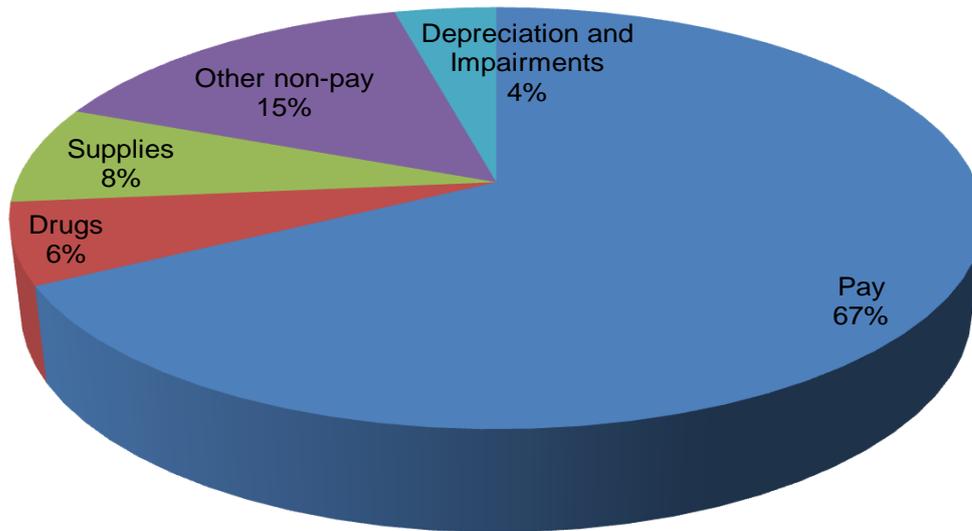
The Trust confirms that income from the provision of goods and services for the purposes of the health service in England was greater than its income from the provision of goods and services for any other purpose.

The Trust earns income from a number of different sources and a breakdown of the £46.8m 'Other Income' is provided in the chart below. The largest component of this income relates to £11.4m Sustainability and Transformation Funding described earlier. The Trust provides a number of services to other healthcare bodies via service level agreements and these include Urology, Radiology and Occupational Health services. As an Associate Teaching Hospital the Trust continues with its medical and other clinical education programmes including links with other countries. The specialist pharmaceutical services within the Trust have continued to trade and generate income, offset by manufacturing costs. The Trust also provides a number of specialist services to local authorities but predominantly Stockport Metropolitan Borough Council and this includes Health Visiting, Sexual Health, Children's Services and Mortuary storage. Other income within this category also relates to categories where additional costs have been incurred for example childcare vouchers purchased by staff and service level agreements to non-public bodies.



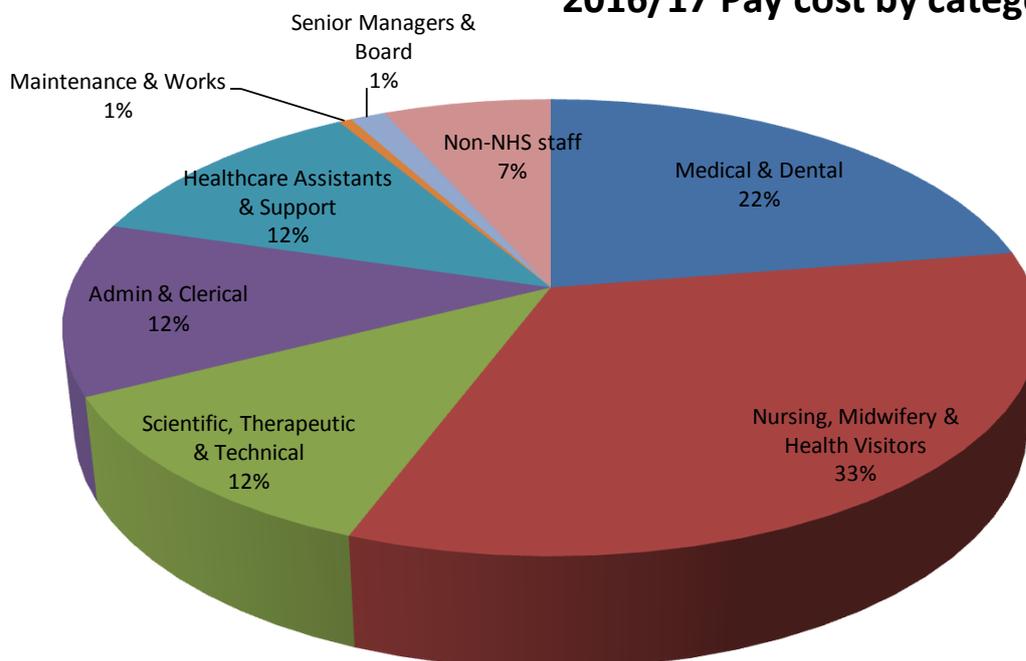
Operating expenditure was £305.4m (£315.9m in 2015/16). The main reason for the reduction in costs was the transfer of Tameside & Glossop Community Services as part of the formation of the new Tameside & Glossop Integrated Care NHS Foundation Trust which accounted for an estimated £30m reduction. The Trust's costs are divided over the following areas:

2016/17 Operating Expenditure



Pay costs account for 67% of our operating expenses, and our pay spend is split over the following categories:

2016/17 Pay cost by category

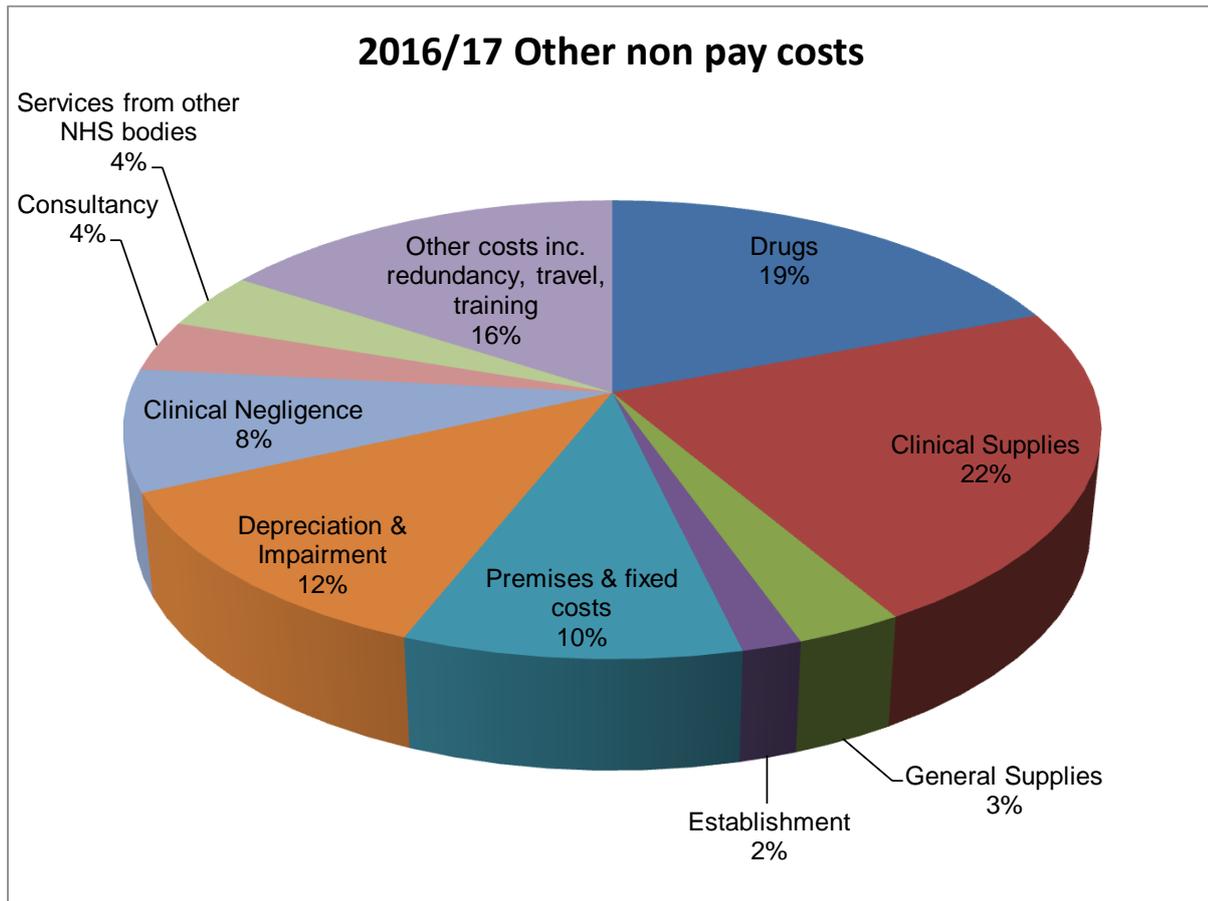


Pay costs in 2016/17 were £207.3m (£222.1m in 2015/16). The pay reduction as part of the Tameside & Glossop Community Services transfer is estimated at £16m and this reduction was offset by additional costs as a result of; the national pay award, additional investment in nursing

staff for theatres linked to the new Surgical & Medical Centre, transfer of Stroke Services and transitional investment as part of Stockport Together developments.

The Trust has continued to use agency staff at premium rates to support the level of activity in the hospital where there is not permanent staffing available. Investment has continued during the year in an international recruitment programme to fill gaps in key staff shortage areas and this will continue into 2017/18. The Trust has also invested in a specific nurse recruitment campaign.

Completing the picture, non-pay spend was incurred as follows:



Notes

1. The Trust undertook a revaluation of land and buildings during the year and this led to a net impairment charge of £4.1m, which is included with depreciation of £7.5m in the operating expenditure chart above.
2. The clinical negligence costs increased for all trusts throughout the country in 2016/17 and the impact for Stockport was an additional £0.8m, a total cost of £8.6m in year.
3. The Trust participated in the Financial Improvement Programme in year and associated costs are included in the Consultancy section.

Balance Sheet

The regulations relating to calculation of the Public Dividend Capital and current commercial interest rates mean that it is more beneficial for the Trust to keep bank balances in the government bank account. Therefore we only earned £0.1m interest during 2016/17, which is similar to that earned in 2015/16. Our year-end cash balance was £23.7m. This is a decrease from our opening cash position of £31.4m.

Charitable Funds

The Board acts as Corporate Trustee in respect of its charitable funds. 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 available on request from the Director of Finance, or from the Charities Commission website 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 is consistent with the aims and objectives approved by the Charities Commission for NHS charities in general. In 2016/17, Charitable Funds income was £436,000 with total expenditure of £1,055,000. The Trust is extremely grateful for donations of £254,000, legacies of £106,000 and fundraising of £28,000 which have been received by the Trust during the year. The Trust also received income of £50,000 from its investment of funds.

The Trust used £743,000 from its Charitable Funds to purchase a number of capital assets including £648,000 of medical equipment for the new Surgical and Medical Centre, £49,000 for a new fibro-scanner, £12,000 on a podiatry mill, £12,000 on a scalp cooling system and £12,000 on a neo-probe. Charitable Funds were also used to improve patient welfare at a total cost of £134,000 and included improvements to patient equipment in the Emergency Department. £47,000 was spent on staff welfare and this included a development post in Radiology.

Financial Outlook

Recent years have proved to be challenging financially and the Trust commenced the last two financial years with planned deficits and significant cost improvement targets to meet. In 2016/17 we delivered a deficit of £6.3m, which followed a deficit of £12.9m in 2015/16. While we successfully delivered a planned cost improvement target of £14.6m, which is the highest level of savings the Trust has achieved, a significant proportion of this total was non-recurrent which therefore adds to the challenge in 2017/18.

In achieving the financial position for 2016/17 there is a level of non-recurrent income which is not within the operational plan for 2017/18 and this includes the Sustainability & Transformation Fund. The underlying deficit for the Trust going into 2017/18 is £42.4m, before cost improvement savings of £15.0m, which results in a planned deficit of £27.4m. Delivery in full of the cost improvement programme on a recurrent basis is imperative and progress with delivery will be closely monitored by the Board of Directors.

The testing financial environment is reflected in the Trust's cash position which historically been healthy. However, whilst the Trust had a year-end cash balance of £23.7m this is reducing and it is predicted that the Trust will require working capital support in the second half of the financial year.

The Trust plans to deliver its £15m cost improvement programme through a combination of themes which include

- Optimising capacity (including use of theatres)
- Improving efficiency (including use of beds and outpatients)
- Workforce efficiency and effectiveness (including use of locum staff)
- Environment (including estate utilisation)
- Procurement (including Carter metrics)
- Medicines Management
- Corporate Services

The Trust's financial plans for the next five years focus on securing quality and sustainability. However, our plans only include proposals for new developments or investments where there are distinct funding streams, where they enable further efficiency schemes or there are direct links to safety and quality of patient care. We firmly believe that long term financial sustainability can only be achieved through closer working with our partners on the Stockport Together programme in the local health and care economy and more widely through participation with the Greater Manchester Health & Social Care Partnership.

Capital Planning 2017/18

We are planning capital expenditure of circa £12m in 2017/18, compared to £10m in 2016/17. A summary of planned investments is as follows:

Capital	Plan 2017/18 £k
Equipment	3,828
Information Management & Technology	2,021
Emergency Department and theatre expansion	4,130
Estates - Backlog Maintenance	998
Estates - Other	1,002
Total Capital Plan	11,979

Notes

1. The investment in the Emergency Department relates to extension of the resuscitation area to provide increased capacity in line with Healthier Together plans.
2. The go live dates for hospital and community electronic patient record (EPR) projects will be in the coming financial year and will be key enablers for transformational change in the Trust.
3. The equipment programme includes ongoing replacement of assets across the hospital and in 2017/18 will include upgrading of imaging equipment such as ultrasound and the replacement of essential theatre equipment such as drills and laparoscopic towers.

Environmental Matters

Introduction

As an NHS organisation, and as a spender of public funds, we have an obligation to work in a way that has a positive effect on the communities we serve. Sustainability means; spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. By making the most of social, environmental and economic assets we can improve health both in the immediate and long term even in the context of rising cost of natural resources. Demonstrating that we consider the social and environmental impacts ensures that the legal requirements in the Public Services (Social Value) Act (2012) are met.

As a part of the NHS public health and social care system, it is our duty to contribute towards the level of ambition set in 2014 of reducing the carbon footprint of the NHS, public health and social care system by 34% (from a 1990 baseline) "&" equivalent to a 28% reduction from a 2013 baseline by 2020. It is our aim to supersede this target by reducing our carbon emissions by using 2013 as the baseline year.

The Trust is constantly striving to fully understand and reduce the environmental impact created through delivering quality healthcare services. We are also looking at how sustainable principles can help provide a better organisation for staff, patients and the local and global community. Sustainability has three core elements; environmental, social and economic and Stockport NHS Foundation Trust aims to embed these sustainability themes fully throughout the whole organisation.

Our Environmental Steering Group has been tracking Trust carbon emissions since 2008, which has been a complex process. We monitor our carbon footprint to see if we are reducing emissions. Throughout this period, the Trust has continued to grow, delivering more services to more patients but we have still been able to reduce emissions based on the metrics of: carbon emission per measure of activity, turnover, number of staff and patient contacts. We are delighted that the Trust has reduced carbon emissions per patient contact by 26% over this period.

The Trust continues to be aware of and assess best practice and guidance from the across the NHS, other sectors and the NHS Sustainable Development Unit (SDU) to analyse what is applicable to the Trust. This includes details within the recent 'Sustainable Development in Health and Care Report - 2016 Health Check' by the SDU which details how the NHS has achieved the Climate Change Act 2015 target and where efforts need to be directed to work towards the 2020 carbon target of a 24% increase from the baseline. We are working towards finalising a road map to help achieve the 2020 target, which is providing a strategic and measurable plan to reduce carbon emissions below the 2020 target.

Environmental sustainability can be impacted by personal lifestyle choices and the approach taken by organisations to the way in which they conduct their business. The Trust recognises its responsibility in this area and we are committed to taking all reasonable steps to minimise our impact on the environment and to demonstrate progress on climate change adaptation, sustainable development and carbon reduction. Our Carbon Management Implementation Plan (CMIP), which has been in place since 2008, aims to reduce carbon emissions through:

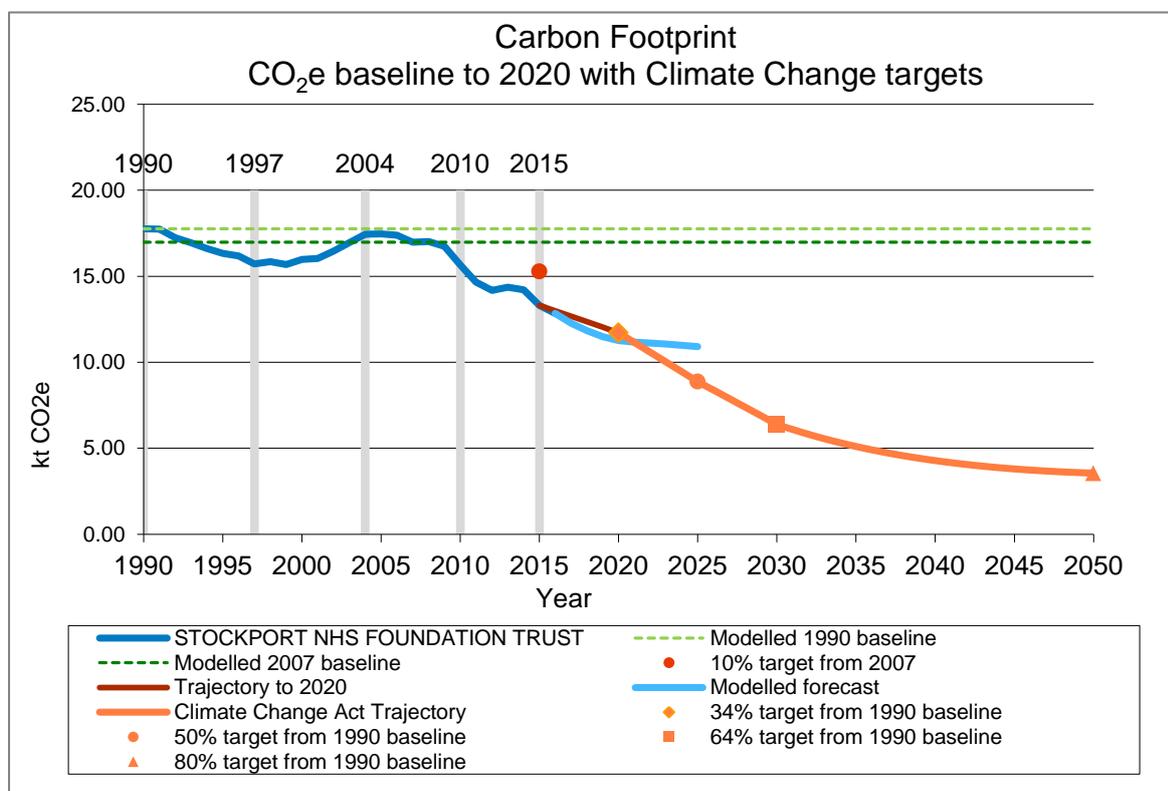
- Reduced energy use through rationalisation and efficient design
- Implementation of a green travel plan through provision of low carbon travel, transport and access

- Increased local procurement
- Reduction of waste levels and increased recycling of waste
- Reduction in water use and associated waste
- Organisational and workforce awareness and development

We continue to deliver significant 'carbon savings' through design innovation including:

1. Continued use of enzymatic food waste digestion - saving around 12,000 cubic meters of mains water per annum and reducing the level of food waste previously discharged to the mains sewer by circa 180 tonnes
2. Installation of evaporative cooling systems within our IT server rooms and other critical IT systems. This initiative has resulted in a reduction of electricity consumption whilst reducing the need for F Gas cooling.
3. Installation of LED lighting technology and controls – designed to reduce power consumed whilst delivering equivalent light lux levels in the internal and external environment.
4. Installation of Building Management Controls to set back plant and equipment when buildings are not fully occupied or been fully utilised.

We recognise that sustainability goes far beyond compliance with legislation and we believe that the development of sustainable practice is a fundamental corporate responsibility. The Trust has a Sustainable Development Management Plan (SDMP) in place in accordance with the NHS Carbon Reduction Strategy 2009. This plan sets out the Trust's commitments and actions to achieve NHS-wide carbon emission reduction targets. We achieved the target of a 10% reduction by 2015 and further carbon reduction strategies and projects are in place to achieve the target of a 24% reduction in energy use and carbon emissions by 2020. The Trust's performance to date is shown in the below carbon footprint chart.



The main actions being taken to further improve on this goal of reducing the Trust carbon footprint are summarised below.

Carbon and Energy Management

Our approach to carbon and energy management is based on; reduction in energy consumption, the supply of energy as efficiently as possible and the supply of required energy using low carbon and renewable sources. Efficient energy management necessitates close monitoring and analysis of energy consumption to enable consumption patterns and targets to be set for individual buildings across the estate. Automatic utility metering continues to be rolled out across the estate and this provides half hourly gas, electricity and water consumption data for Trust buildings. Automatic meter reading (AMR) enables rigorous scrutiny of consumption patterns to identify and address inefficiencies whilst also enabling greater financial control of energy budgets by eliminating estimated readings.

AMR is supported by a dedicated energy monitoring and targeting software tool which allows the Trust to assess building specific energy performance and compare performance with similar buildings and nationally recognised benchmarks. The information provided by these systems allows our Property Services team to produce energy performance league tables which are used to prioritise the investigation and elimination of energy waste.

During 2016/17 our Property Services team implemented a range of energy efficient initiatives which included:

- Replacement of aging inefficient gas boiler systems with appropriately designed efficient improved systems
- Next generation technology upgrades to Building Management software providing automatic control and monitoring of environmental conditions and energy efficiency within buildings.
- Installation of plate heat exchangers replacing existing old domestic hot water calorifiers – reducing gas consumption used to heat large quantities of water by only heating water as required.
- Installation of plate heat exchangers replacing existing old heating calorifiers – reducing gas consumption by reducing the volume of heated water required for existing heating circuits.
- Replacement of external lighting columns with LED equivalents
- Replacement of internal lighting with LED equivalent in office and clinical environments
- Installation of lighting control devices i.e. presence/absence detectors

Energy and Water Consumption

The Trust's consumption of Electricity, Gas and Water during 2016/17 is summarised in the table below along with comparative performance for 2015/16 and 2014/15. While the data shows a slight reduction in Electricity this is due to the construction of the new Surgical & Medical Centre, a high tech building with additional theatres and the associated running costs throughout its construction. Electricity saving schemes will continue to be identified and delivered to drive consumption down throughout 2017/18. Gas consumption reduced in 2016/17 compared to the previous year which has mainly been due to heat loss measures taken to make the existing network more efficient, although there is always an element of day degree data having an effect on overall gas consumption.

	ELECTRICITY (kWh)	GAS (kWh)	WATER m³
2014 - 2015	12,071,258	31,211,406	136,006

2015 - 2016	12,572,918	28,398,836	142,777
2016 - 2017	12,502,677	28,185,227	141,397

Water consumption also decreased in 2016/17 compared to the previous year. Reduction of consumption will continue to be an area of focus during 2017/18 with a particular focus on leak detection and other areas of waste. However, we are conscious of the need to balance water efficiency initiatives with the need to maintain robust infection control regimes and to guard against the risks of legionella contamination of water systems by regular flushing of water outlets.

Waste

The Trust has a Waste Management Policy to ensure both best use of resources and compliance with relevant environmental legislation. The policy aims to minimise waste and to maximise recovery, re-use and recycling rates. The Trust has several different waste streams and continues to recycle a range of items including general waste, batteries and oil from the kitchens. Monitoring of waste contracts and generation of revenue through recycling serves to reduce both costs and the Trust's impact on the environment.

An external audit carried out by STCS during 2016/17 confirmed compliance with current waste legislation and quarterly carriage of dangerous goods audits continue to demonstrate good waste management practice. A number of recommendations were made to further improve our disposal of waste and our environmental impact. Our environmental strategy is based on the following principles:

1. Elimination of waste where possible
2. Reduction of the waste we create
3. Reusing materials until they cannot be used again
4. Recycling the waste
5. Disposal of residual waste to landfill only when all other routes are exhausted
6. Provision of additional appropriate waste storage

The below tables summarises the improvements made by the Trust over the past four years with the overall aim of reducing its carbon footprint.

Waste		2013/14	2014/15	2015/16	2016/17
Recycling	(tonnes)	197.00	182.94	134.23	121.53
	tCO ₂ e	4.14	3.84	2.68	2.55
Other recovery	(tonnes)	5.40	3.63	71.70	692.14
	tCO ₂ e	0.11	0.08	1.43	14.53
High Temp disposal	(tonnes)	495.00	435.60	488.40	359.88
	tCO ₂ e	108.90	95.83	106.96	79.17
Landfill	(tonnes)	453.00	493.92	542.66	25.63
	tCO ₂ e	110.72	120.72	132.64	7.95
Total Waste (tonnes)		1150.40	1116.09	1236.99	1199.18
% Recycled or Re-used		17%	16%	11%	10%
Total Waste tCO ₂ e		223.87	220.47	243.71	104.21

It should be noted that there are some significant differences between 2015/16 and 2016/17 as, prior to 2016/17, all domestic waste went to landfill whereas now 95% goes to a treatment plant for waste to energy recovery.



Smoke-free Hospitals

We want to look after the health of everyone who uses our hospital and the Trust is committed to providing a clean and healthy environment for patients, visitors and staff. A complete smoking ban has been in place on Trust property since 2005 and during 2016/17 we continued to strengthen the effectiveness of this policy with a direct and honest poster campaign supplemented by security officers politely reminding people of our non-smoking policy.

In October 2016 the Trust supported the ‘Stoptober 28-day stop smoking challenge’, where everyone quits together, supported by employers, communities, charities and other partners, as well encouraging each other. Advice and information to support smokers in giving up the habit was available from promotion stands throughout the hospital.

Green Travel Plan

In November 2016 the Trust agreed a revised and updated Travel Plan with Stockport Metropolitan Borough Council. The updated Travel Plan contains specific mode share targets which will relate to an action plan of Travel Plan measures based on the results of the survey. Additionally, the Travel Plan will continue to reference the supporting work undertaken – TRICS surveys, traffic surveys and a parking study – to inform the targets and measures.

The purpose of the Travel Plan is to:

- Encourage the use of modes of transport to and from the site other than the car;
- Discourage the use of single occupancy car travel to the site;
- Make provision for staff, patients and visitors to travel to the site by modes of transport other than the car;

- Ensure that on-site car parking is effectively managed;
- Ensure that parking demand does not exceed on-site provision or place a demand on any nearby streets and car parks; and
- Ensure that the transport needs of the hospital situated within the site are met in a sustainable way.

The Trust's revised Travel Plan is a long-term strategy for a site that seeks to deliver sustainable transport objectives through positive action, and is articulated in a document that is regularly revised (DfT Good Practice Guidelines: Delivering Travel Plans through the Planning Process, 2009). It is also a package of objectives, targets and measures developed by an organisation or group of organisations to promote more sustainable means of travel and to reduce reliance on the private car.

Our Travel Plan aims to make the site more accessible to all users, whether or not they have access to a car, and helps to promote social equality within the local community. The Travel Plan for Stockport NHS Foundation Trust extends to cover both the Stepping Hill Hospital and The Devonshire Centre sites and will not only benefit staff but will improve accessibility for patients and visitors alike.

Measures to Reduce Car Use

Personalised Travel Planning

Personalised Travel Planning (PTP) involves discussion of the available transport options, and identification of a number of potential routes and modes. As appropriate, staff will be able to request a personalised journey plan from their home location to the hospital site. It is envisaged that Transport for Greater Manchester (TfGM) will use their PTP specialists to assist the Trust, as TfGM have expressed a firm interest in working with the Trust on the delivery of the Travel Plan.

Car Sharing

A car share scheme has been established at the site, by setting up a database of interested car sharers for people that work at the Hospital or the Devonshire Centre. Car sharers have been incentivised by being offered reduced rates on parking permits. In addition, dedicated car sharing spaces – at a central location within the site – are being considered by the Trust as a means to encourage car sharing.

Car Parking

Whilst paying due cognisance to the parking pressures identified at the site, it is hoped that the Trust's new Car Parking Policy, implemented in April 2016, combined with measures to promote public transport, will help to reduce parking pressures at the site. The Car Parking Policy is enforced by the site's security team, who monitor the parking areas at the site between 06:00 and 22:00, seven days a week. As part of this regime, parking tickets are issued for inappropriate parking, which includes parking without a visible and valid permit in staff only car parks.

Measures to promote Public Transport

The Trust has installed information points at each building entrance, to provide and promote public transport information. This includes public transport timetables, route maps, directions to nearest bus stops and rail stations. These points will also provide information on initiatives and events such as 'bike to work week' and 'national walking month'. These events will be supported by the Trust,

with supplementary events such as bike maintenance (provided via TfGM).

The Trust website also provides all of the above information, along with any other useful travel information for staff, patients and visitors' use. The website provides links to appropriate partner websites such as www.tfgm.com where staff will be able to find information on a range of transport modes and additional support and incentives to use sustainable transport modes.

Information packs are provided to new members of staff at the Hospital and the Devonshire Centre to make them aware of public transport provision and other sustainable travel options in the vicinity of the site. The weekly ticket for the Hazel Grove Park and Ride site is heavily promoted by the Trust, both to staff and patients / visitors, as this provides a viable way of accessing the SHH site, especially for people travelling from south of the site i.e. from the East Cheshire / High Peak areas. This has been achieved through targeted marketing to staff, patients and visitors both through internal communications and through external communications such as leaflets accompanying appointment letters.

Measures to Promote and Facilitate Cycling and Walking

Cycle parking is made available to staff to encourage cycling to the SHH site in addition to locker and shower facilities. Further promotion of these facilities will be undertaken to ensure that all staff are aware of the current provision for cyclists on the site. This promotion will be undertaken following an audit of the cycling facilities at the site, combined with consideration of the initial take up of the Cycle to Work scheme at the site.

The TPC will continue to work with SMBC and TfGM to ensure that any local initiatives to promote cycling such as the variety of cycle training that will be available to staff members free of charge. In particular, the TPC will investigate opportunities to identify cycle champions to undertake 'Ride Leader Training' to further encourage cycling by site users. TfGM also has loan bikes, which will be used to give staff the experience of commuting by bicycle as part of the launch of the Travel Plan initiatives.

Electric Vehicle Charging Points

A significant proportion of the Trust's CO₂ emissions are related to vehicles used by staff, service users and suppliers. To help address this and to enable stakeholders to consider low carbon alternatives, the Trust is installing a number of publicly accessible electric vehicle charging points across the estate. This technology will help support the operational and financial viability of electric vehicles whilst also reducing the level of CO₂ emissions attributable to the Trust.

Procurement

The Trust recognises that it has an influential role in furthering sustainable development through the procurement of buildings, goods, and services. Sustainability, environmental and social principles are embedded in our procurement processes to ensure that a balanced consideration of social, ethical, environmental and economic factors is undertaken as part of the procurement evaluation process.

Accountability Report

Directors' Report

Board of Directors and Board Committees

The Board of Directors is responsible for setting the strategic direction and managing the business of the Trust and, subject to any relevant requirements of the Trust's Constitution, exercises all the powers of the Trust. The Board of Directors therefore has an overall responsibility for delivering the activities of the Trust and is accountable for the operational performance of the Trust as well as the definition and implementation of strategy and policy.

The Board of Directors takes decisions with regard to:

- **Quality Issues** – which includes Clinical Effectiveness, performance against Quality Indicators, Infection Control, Patient Experience, Risk Management and Staff Development.
- **Strategic and Developmental Issues** – this includes decisions with regard to business planning, the Trust's annual Operational 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** – this includes decisions relating to the establishment of effective governance arrangements across the organisation.

Day to day management of the Trust is undertaken by the Chief Executive and Executive Directors who are responsible for taking decisions, particularly with regard to financial and performance issues and quality matters, subject to the levels of delegated authority set out in the Trust's Scheme of Delegation and Standing Financial Instructions.

The Board of Directors is comprised of 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 has identified no relationships or circumstances that are likely to affect, or appear to affect, their judgement. The criteria considered by the Board in determining the independence of the Non-Executive Directors were:

- Whether the individual had been an employee of the Trust within the last five years
- Whether the individual has, or has had within the last three years, a material business relationship with the Trust either directly or as a partner, shareholder, director or senior employee of a body that has such a relationship with the Trust
- Whether the individual has received, or receives, remuneration from the Trust in addition to a Director's fee, participates in a performance-related pay scheme or is a member of the Trust's pension scheme
- Whether the individual has close family ties with any of the Trust's advisers, directors or senior employees

- Whether the individual holds cross-directorships or has significant links with other Directors through involvement in other companies or bodies
- Whether the individual has served on the Board of the Trust for more than six years from the date of their first appointment
- Whether the individual is an appointed representative of the Trust's university, medical or dental school.

During 2016/17 the Board of Directors met on 14 occasions. Details of individual directors and their attendance at meetings are as follows:

Gillian Easson – Chairman

Re-appointed on 1 November 2015 until 31 October 2018

Attendance: 12/14

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. In 2012 she was appointed as Pro-Chancellor of the University of Manchester and in July 2014 she became a member of the NHS Providers Board. 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 initially appointed as Chairman of the Trust on 1 November 2012. The Chairman does not have any other significant commitments.

Malcolm Sugden – Non-Executive Director (Deputy Chairman)

Re-appointed on 1 April 2015 until 31 March 2018

Attendance: 13/14

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 North West 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.

Mike Cheshire – Non-Executive Director (Senior Independent Director)

Reappointed on 1 September 2016 until 31 August 2019

Attendance: 13/14

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 NHS 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 disestablishment, Dr Cheshire was the Medical Director for NHS North West.

John Sandford – Non-Executive Director (Chair of Audit Committee)

Re-appointed on 1 July 2014 until 30 June 2017

Attendance: 14/14

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 has developed 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.

John Schultz – Non-Executive Director

Appointed on 1 September 2013 until 31 August 2016

Attendance: 6/6

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 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.

Catherine Anderson

Appointed on 1 January 2016 until 31 December 2018

Attendance: 13/14

Background

Catherine Anderson has held senior management roles within General Electric Company, the University of Liverpool and Manchester Metropolitan University. As Head of Customer Services at Manchester Metropolitan University she established the largest department in the university by transforming and merging 10 departments. Catherine now runs her own consultancy which helps businesses to improve their performance.

Angela Smith

Appointed on 1 April 2016 until 31 March 2019

Attendance: 11/14

Background

Angela Smith has held senior human resources management roles with Virgin Management Ltd and Granada Hotels and Leisure. During her 17 years at Virgin, Angela oversaw significant organisational change and redesign at the company and ensured Virgin was an employer of choice.

Angela now runs her own consultancy firm providing strategic HR advice to organisations and entrepreneurial businesses. She is also a non-executive director for PossAbilities, a social enterprise that supports adults and children with disabilities to become more independent and experience new opportunities.

Catherine Barber-Brown

Appointed on 1 September 2016 until 31 August 2019

Attendance: 8/8

Background

Catherine Barber-Brown has held senior roles at the Britannia Building Society and Co-operative Bank since 2003. She was most recently Head of Strategy for the Co-operative Bank, whilst earlier roles spanned Change Management and Procurement. Prior to this, Catherine worked for ten years at international organisations Barclays de Zoete Wedd and Credit Suisse. Catherine left the Co-operative Bank in 2016 to set up her own consultancy. She is also a member of the University of Manchester Nominations Committee and General Assembly and a School Governor.

Ann Barnes – Chief Executive

Attendance: 14/14

Background

Ann Barnes joined Stockport NHS Foundation Trust in 2000 as Director of Operations and was appointed Chief Executive in January 2013. She has worked in the NHS since 1979 and during the past 37 years has worked both at regional and hospital level across the full spectrum of district general hospital service provision. Building on a distinguished career across the NHS, Ann has spent all of her health management career in Greater Manchester health organisations, managing a vast majority of clinical and support services in the acute, community and mental health sectors. She has a strong commitment to staff engagement and development and team working across the organisation, and is passionate to the values of the NHS and to the provision of quality healthcare for all.

James Sumner – Deputy Chief Executive (until 30 November 2016)

Attendance: 10/10

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.

Judith Morris – Director of Nursing & Midwifery / Deputy Chief Executive

Attendance: 11/14

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 Director of Nursing and Midwifery in 2004 and Director of Nursing and Midwifery in 2008.

Feroz Patel – Finance Director

Attendance: 13/14

Background

Feroz Patel began his career in the NHS as a National Financial Management Trainee in 1999 and has trained at Lancashire Teaching Hospitals NHS Foundation Trust and Salford Royal NHS Foundation Trust. Feroz qualified as a Chartered Public Finance Accountant on the scheme and since graduating he has held a number of senior finance roles across provider and commissioner organisations. Feroz joined Stockport NHS Foundation Trust in 2015 from Blackpool Teaching Hospitals NHS Foundation Trust, where he worked for eight years and held the roles of Associate Director of Finance, Acting Director of Finance and Deputy Director of Finance.

Jayne Shaw – Director of Workforce & Organisational Development

Attendance: 12/14

Background

Before joining the Trust as Interim Director of Human Resources on 1 January 2013, Jayne Shaw 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 was appointed as Director of Workforce & Organisational Development on 22 August 2013.

Sue Toal – Chief Operating Officer (from 7 March 2017)

Attendance: 13/13

Background

Sue Toal, who is also a registered nurse, joined the Trust as interim Unscheduled Care Programme Director and was previously at Salford Royal managing divisions including surgery, theatres & anaesthesia and neurosciences & renal. Sue was appointed as Acting Chief Operating Officer in May 2016 and as substantive Chief Operating Officer in March 2017.

Paul Buckingham – Director of Corporate Affairs (from 1 January 2017)

Attendance: 3/3

Background

Paul Buckingham joined the Trust in February 2015 as Company Secretary. He had previously been the Corporate Secretary at North West Ambulance Service NHS Trust since establishment of the Trust in 2006 and had undertaken procurement and contracting roles after joining the ambulance sector in 1998. Prior to working in the NHS, Paul completed a 20-year engagement as Logistics Officer in the Royal Navy. Paul was appointed as Director of Corporate Affairs with an expanded portfolio on 1 January 2017.

Donna Lynch – Acting Director of Strategy, Planning and Transformation (from 1 December 2016)

Attendance: 4/4

Background

Donna Lynch is an accountant by background and joined the NHS in 1992. She had a wealth of experience working in NHS organisations across the North West in the acute, mental health and community sectors. Donna's experience includes successfully developing commercial aspects of the NHS. She joined the Trust in 2016 from 5 Boroughs Partnership Foundation Trust in Warrington where she was Assistant Director for Strategic Development and Transformation.

Hugh Mullen – Executive Director of Support Services (from January 2017)

Attendance: 3/3

Background

Hugh Mullen joined the Trust in January 2017 on a nine-month secondment as an Executive Director of Support Services. Hugh brings 38 years extensive NHS experience, which includes senior management roles in a number of acute and community health provider organisations in this region. He was Director of Operations for six years at Salford Royal and more recently Director of Operations at Pennine Acute Hospitals Trust which runs North Manchester & Fairfield General Hospitals, The Royal Oldham Hospital, Rochdale Infirmary & community services.

Balance, Completeness and Appropriateness of the Membership of the Board

While there have been a number of changes in terms of attendees at Board meetings, there have been no changes to the composition of the Board of Directors during 2016/17 in terms of voting members. The Board considers that the skills and experience of the Non-Executive Directors (see below), aligned with the skills and experience of the Executive Directors, provides a Board of Directors which is balanced, complete and appropriate.

Skill	Responsible Non-Executive Director
Clinical	Mike Cheshire
Financial Acumen	John Sandford / Malcolm Sugden
Commercial	Catherine Anderson
Legal	Gillian Easson
Workforce	Angela Smith
Transformational	John Schultz / Catherine Barber-Brown

In accordance with statutory requirements, the Trust maintains a register of interests of the Board of Directors which is available upon request for inspection by members of the public (please contact Paul Buckingham, Director of Corporate Affairs on tel no 0161 419 5164 or e-mail paul.buckingham@stockport.nhs.uk if you wish to have access to the register).

Performance Evaluation

Six-monthly development sessions for the Board of Directors are scheduled in April and October of each year. These sessions provide the opportunity for Board members to reflect on the collective performance of the Board and undertake development activities aimed at enhancing Board and individual effectiveness. During 2016/17 these have focused on issues such as:

- Developing shared understanding of team strengths, weaknesses and preferred style of working
- Strategy – Development & Form
- Review of the Integrated Performance Report and Board Assurance Framework
- Board effectiveness and development needs
- Enhancing Board understanding of Finance & Performance metrics and accounting treatments
- Enhancing Board practice of reporting and meeting content
- Preparation for the Emergency Care Improvement Programme
- Understanding the new Acute Interface Model
- Emergency Department developments.

The Board of Directors completed a self-assessment of its effectiveness and outcomes were considered during a Board Development session held on 29 April 2016. Outcomes of the assessment informed both changes in Board practice and development activities during 2016/17.

All Directors have individual appraisals on an annual basis which are carried out by the Chairman for the Non-Executive Directors and the Chief Executive and by the Chief Executive for the Executive Directors. Appraisal of the Chairman is led by the Senior Independent Director in accordance with arrangements agreed with the Council of Governors. All Directors have individual personal development plans.

Engagement with Governors

Members of the Board of Directors are able to develop an understanding of the views of Governors and members through regular attendance at Council of Governors meetings and participation in the Annual Members Meeting. Our Non-Executive Directors also attend meetings of the various Committees of the Council of Governors and have the opportunity to further develop their understanding of Governors' views through participation in joint Governor and Non-Executive Director meetings.

Audit Committee

The Trust has an Audit Committee which meets at least five times a year. The membership of the Committee is detailed below. Attendance at meetings during 2016/17 is shown in brackets.

- John Sandford (Chair of the Audit Committee) - Non-Executive Director (attendance 6/6)
- Malcolm Sugden (Deputy Chair of the Audit Committee) - Non-Executive Director (attendance 6/6)
- Angela Smith - Non-Executive Director (attendance 5/6)
- John Schultz - Non-Executive Director (*until 31 August 2016*) (attendance 1/2)
- Catherine Barber-Brown - Non-Executive Director (*from 1 September 2016*) (attendance 2/4)

The Director of Finance, Director of Corporate Affairs, Deputy Director of Finance and the Director of Nursing & Midwifery (as executive lead on risk management) together with representatives from both Internal and External Audit are routinely in attendance at meetings. Other Directors and senior managers attend meetings by invitation.

The Audit Committee has Board-approved Terms of Reference which are available on request from the Company Secretary and are subject to annual review. Its primary purpose is to conclude upon the accuracy and effective operation of the Trust's overall control system. In performing its role, the Committee's work is predominantly focused 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 and compliance with the NHS Foundation Trust Code of Governance.

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. Regular progress reports from Internal Audit are considered, and a robust follow-up process is in place to provide the Committee with assurance on the implementation of recommendations arising from audit work. The Audit Committee has approved a policy for use where external audit are required to provide non-audit services to ensure that objectivity and independence is safe-guarded.

With regard to discussion of key matters, during the course of the year the Committee has:

- Reviewed the outcomes of internal audit reports
- Reviewed the Head of Internal Audit Opinion
- Received follow-up reports on internal audit recommendations to provide assurance that actions had been completed
- Reviewed losses and compensation payments and instances where standing financial instructions have been waived
- Approved the internal and external audit plans for the coming year
- Received technical updates and information relating to the health sector from both internal and external audit
- Completed an annual self-assessment of Committee effectiveness
- Reviewed assurance reports on the effectiveness of the risk management system
- Reviewed and, where appropriate, approved the Annual Accounts, Annual Governance Statement and Annual Report for 2015/16
- Reviewed compliance with the NHS Foundation Trust Code of Governance

- Received management assurance reports on areas where internal audit work had resulted in an assessment of limited assurance
- Obtained assurance on delivery of the Clinical Audit programme.

The External Audit Plan for audit of the financial statements for 2016/17 was considered and approved by the Audit Committee on 18 January 2017. The plan identified a number of significant audit risks as follows:

- Recognition of NHS Revenue
- Management Override of Controls
- Accounting for Property Valuations; and,
- Going Concern

The Committee received assurance on the auditor's planned approach for coverage of these risk areas and was assured that appropriate focus would be applied during the audit period. Committee members gained assurance on the effectiveness of controls in place for the risk areas through discussions with senior managers from the Trust's finance team.

The Audit Committee met on 14 March 2017 to consider significant issues and key accounting judgements related to the financial statements for 2016/17. These were:

- The overall year-end financial position;
- Consolidation of Pharmacy Shop and Charitable Funds statements;
- District Valuation of Land & Buildings;
- Surgical Centre Valuation;
- Restructuring Provision;
- Tameside & Glossop Community Services Transfer, and
- Claims against the Trust.

Internal Audit

Internal Audit services, which include an Anti-Fraud service, have been provided by Mersey Internal Audit Agency (MIAA) since 1 April 2013. The main purpose of the Internal Audit service is:

- To provide 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 organisation's agreed objectives; and
- The provision of an independent and objective consultancy service specifically to assist the Trust's management to 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. The Internal Audit plan was fully delivered during 2016/17 and the total cost of the service was £75,765.

Countering Fraud and Corruption

During 2016/17 the Trust's Anti-Fraud Specialist and the Anti-Fraud service was provided by

Mersey Internal Audit Agency (MIAA). The Trust's Anti-Fraud and Corruption Policy supports our strong anti-fraud culture and the annual work plan, agreed by the Director of Finance and approved by the Audit Committee, covered areas such as enhancing the anti-fraud culture, deterring, preventing and investigating fraud. The Anti-Fraud Specialist regularly attends Audit Committee meetings to provide updates on the progress of the annual work plan and investigations. The total cost of the service, including investigation work, in 2016/17 was £26,345.

The Trust has in place a Raising Concerns at Work Policy which outlines how staff can raise concerns, including those that may be related to fraud. Staff are reminded of their responsibility to report such matters at induction and mandatory training. The policy continues to be supplemented by the Trust's Freedom to Speak Up Guardian which was a post introduced in response to a recommendation arising from the Francis Report.

External Audit

External Audit services were provided throughout 2016/17 by Deloitte LLP following appointment as the Trust's External Audit provider by the Council of Governors with effect from 1 October 2014 following a competitive tender process. The cost of the External Audit service totalled £64,686 comprised of £48,222 for the Trust accounts, £11,760 for audit work on the Quality Report and £4,704 for Charitable Funds. All figures are inclusive of VAT.

Deloitte LLP was also appointed as the External Audit Provider for Stepping Hill Healthcare Enterprises (the Pharmacy Shop) and the fees in preparation for the accounts since the commencement, included within the consolidated accounts, is £15,000 inclusive of VAT.

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.

Directors' responsibility for preparing accounts

The Trust's Accounting Officer (Chief Executive) delegates the responsibility for preparing the accounts to the Director of Finance. Preparation of the accounts is 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. 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.

Accounting Policies

The Annual Accounts have been prepared under a direction issued by NHS Improvement 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 NHS Improvement's NHS Foundation Trust Annual Reporting Manual (ARM) and the Department of Health Group Accounting Manual.

The accounting policies for pensions and other retirement benefits are set out in note 1.3 to the accounts, and details of senior managers' remuneration can be found in the Remuneration Report on page 60. Note 7.1 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.

Better Payment Practice Code

Measures introduced as part of the Financial Improvement Programme as a result of financial constraints meant that the Trust would no longer comply with the Better Payment Practice Code which requires us 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. This decision was taken following extensive dialogue with our supplier base that was broadly understanding of the change.

All suppliers' payment terms were reviewed and the Trust continues to work with small and medium enterprises to ensure they are not disproportionately affected by the change. The Trust now has a policy of payment within 60 days and performance since its introduction in July 2016 is as follows:

	2016/17
Total number of invoices within 60 days	81.4%
Total value of invoices within 60 days	89.9%

No significant interest was paid under the Late Payments of Commercial Debts (Interest) Act 1988.

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 94 describes how this is undertaken.

Nominations Committee

The Trust has a Nominations Committee for the appointment of the Chairman and Non-Executive Directors. The Committee has a standing membership of five Governors, including the Lead Governor, the Chairman, Chief Executive and the Senior Independent Director. The Chairman of the Trust is Chairman of the Committee. Membership during 2016/17 was as follows:

Name	Position
Gillian Easson	Chairman
Les Jenkins	Public Governor (Lead Governor)
Eve Brown	Public Governor
Ron Catlow	Public Governor
Chris Wrigley	Public Governor (to 6 October 2016)

Gerry Wright	Public Governor
Lesley Auger	Public Governor (from 9 December 2016)
Ann Barnes	Chief Executive
Mike Cheshire	Non-Executive Director (Senior Independent Director)

The Committee's business during 2016/17 included recruitment of a Non-Executive Director and Chairman. The Committee commissioned the services of Veredus Ltd to support the search and recruitment process for these appointments.

Termination of Appointment of the Chairman and other Non-Executive Directors

Arrangements for any potential termination of appointment of either the Chairman or other Non-Executive Directors fall within the remit of the Council of Governors, in accordance with paragraph 26.2 of the Constitution of Stockport NHS Foundation Trust.

Council of Governors

The Council of Governors presently has 26 seats, of which 24 represent the public (20) and staff (4) and are elected by our Members. The remaining 2 are appointed by partnership organisations which include the Stockport Metropolitan Council and the education sector. The Council of Governors meets formally four times per year. Ad hoc meetings of the Council are called as required.

The responsibilities of the Council of Governors include:

- 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.
- Approval of the remuneration and allowances and the other terms and conditions of the Non-Executive Directors.
- The appointment / removal of the Trust's External Auditor.
- Receiving 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 Strategy, its policy for the composition of the Council of Governors and of the Non-Executive Directors.

The Council of Governors has established three Committees, each of which meets on a bi-monthly basis:

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

These Committees have met throughout 2016/17 and provide reports and recommendations to the Council of Governors at their quarterly meetings.

The Council of Governors work closely with the Board of Directors and during 2016/17 Directors have routinely 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 receives at each of their meetings reports from the Chief Executive on current performance and operational issues and also on strategic issues. The Trust ensures that Governors are provided with opportunities to develop their skills and knowledge and Council members are regular attendees at the North West Governors' Forum.

At a Council of Governors meeting held on 8 December 2016, Governors were given the opportunity to provide their opinions, and those of the members they represent, on the content of the draft Operational Plan 2017-19 which set out the Trust's strategy, priorities and objectives for the following year. Members of the Board of Directors were present at this meeting to hear the views expressed by Governors.

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) Receiving feedback from Trust members who have become involved with the Trust at local level including attendance at the Annual Members' Meeting, participation in member information sessions and membership recruitment activities.

Governors operate on a non-paid voluntary basis but the Trust does reimburse travel expenses. In 2016/17, Governors were reimbursed a total of £210 (£984 in 2015/16).

Elections 2016/17

Elections were held in 2016/17 in the following constituencies. The outcomes of the elections are shown in brackets:

Public:

- Bramhall & Cheadle (four Governors elected)
- Marple & Stepping Hill (four Governors elected)

Staff:

- (By-election) Other Staff (two Governors elected unopposed)

Results of these elections, which were held under the independent scrutiny of Electoral Reform Services, were announced at the Annual Members' Meeting in October 2016.

Membership of the Council of Governors

Details of our elected Governors and their attendance at meetings are provided in the following tables:

Name	Constituency	Elected Until	Attendance at formal Governors' meetings
Sharan Arkwright	Staff	Resigned December 2016	0/3
Yvonne Banham	Staff	Annual Members' Meeting 2018	2/4
Russell James	Staff	Resigned September 2016	1/2
Isabel Daniel	Staff	Annual Members' Meeting 2018	1/2
Christopher Hudsmith	Staff	Annual Members' Meeting 2018	1/2
Robert Cryer	Public – Bramhall & Cheadle	Annual Members' Meeting 2019	4/4
Charles Galasko	Public – Bramhall & Cheadle	Annual Members' Meeting 2019	2/4
Maureen Harrison	Public – Bramhall & Cheadle	Annual Members' Meeting 2019	3/4
Tony Johnson	Public – Bramhall & Cheadle	Annual Members' Meeting 2019	4/4
Linda Appleton	Public – Tame Valley & Werneth	Annual Members' Meeting 2018	2/4
Roy Driver	Public – Tame Valley & Werneth	Annual Members' Meeting 2018	1/4
Alan Gibson	Public – Tame Valley & Werneth	Annual Members' Meeting 2018	1/4
Roy Greenwood	Public – Tame Valley & Werneth	Annual Members' Meeting 2018	2/4
Lesley Auger	Public – Heatons & Victoria	Annual Members' Meeting 2017	4/4
Eve Brown	Public – Heatons &	Annual Members'	4/4

Name	Constituency	Elected Until	Attendance at formal Governors' meetings
	Victoria	Meeting 2017	
Neal Jones	Public – Heaton & Victoria	Resigned January 2017	4/4
Gerald Wright	Public – Heaton & Victoria	Annual Members' Meeting 2017	4/4
Carole Normington	Public – Marple & Stepping Hill	Annual Members' Meeting 2016	2/2
Chris Wrigley	Public – Marple & Stepping Hill	Annual Members' Meeting 2016	2/2
Ronald Catlow	Public – Marple & Stepping Hill	Annual Members' Meeting 2019	3/4
Melanie Cooke	Public – Marple & Stepping Hill	Annual Members' Meeting 2019	2/2
Les Jenkins <i>(Lead Governor)</i>	Public – Marple & Stepping Hill	Annual Members' Meeting 2019	4/4
Julie Wragg	Public – Marple & Stepping Hill	Annual Members' Meeting 2019	1/2
Lance Dowson	Public – High Peak	Annual Members' Meeting 2018	3/4
Lynne Woodward	Public – High Peak	Annual Members' Meeting 2018	3/4
Barbara Vaughan	Public – Tameside	Annual Members' Meeting 2018	0/4
Raees Khan	Public – Outer Region	Annual Members' Meeting 2018	1/4
John Pantall	Appointed – Stockport MBC	Until July 2016	0/1
Tom McGee	Appointed – Stockport MBC	Annual Members' Meeting 2019	0/2

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 Paul Buckingham, Director of Corporate Affairs, on 0161 419 5164 or paul.buckingham@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.

Membership

Eligibility requirements

Membership of the NHS Foundation Trust is open to any individual who:

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

Public Constituencies

The Trust has adopted 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 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.

Staff Constituency

The Trust has adopted an “opt-out” membership system for the staff constituency. Membership 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 the staff constituency and who:

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

shall become members.

Membership Numbers

Public Members by Constituency (as at 31 March 2017)

Area	No. of Members
Bramhall and Cheadle	2,620
Tame Valley and Werneth	2,063
The Heatons and Victoria	2,135
Marple and Stepping Hill	2,702
High Peak and Dales and Tameside and Glossop	1,447
Outer Region	984
Total	11,951

Staff Members (as at 31 March 2017)

Constituency	No. of Members
Staff	4,861

Membership Development & Involvement

In 2016/17 we continued to progress our Membership Strategy and developed a full plan detailing a number of objectives, the implementation of which is led and monitored by the Council of Governors through the Membership Development Committee.

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. Guiding principles of the Membership 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 of value to both individuals and to the Trust.
- 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.
- 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.

During 2016/17 events for members which took place in the Trust included:

- '24 hours in Accident & Emergency' - virtual tour of our emergency department – 7 June 2016
- 'Superheroes' Open Day - 9 July 2016
- Operation! - tour of our operating theatres - 15 September 2016
- Annual Members' Meeting - 6 October 2016
- Think FAST - health talk about stroke - 10 November 2016

Our regular communication with members includes:

- Our "Stepping Up" members' magazine
- A welcome pack for new members
- The members' section on the Trust's website
- Use of social media, including Twitter and Facebook
- Regular e-mail updates to members who have provided an e-mail address
- An organised programme of events aimed at both members and members of the public offering public health messages and delivered with the support of Governors
- Events will facilitate communication between Governors and members and will be

advertised in “Stepping Up”, on the Trust’s website, in the local press, on Twitter and by means of posters on Trust sites.

Member events planned to take place during 2017/18 include:

- ‘Care Closer to Home’ - a talk on the Multi-Specialty Community Provider – 4 April 2017
- ‘Cancer: Caring & Curing’ Health Talk - 4 July 2017
- Operation! - tour of our operating theatres - 12 September 2017
- Annual Members’ Meeting - 12 October 2017
- ‘Diabetes: Reduce Your Risk’ Health Talk - 7 November 2017

Performance indicators have been set for all of our engagement and these will be used by the Membership Development Committee to evaluate the success of our activities during 2017/18.

Quality Governance Reporting

The Trust has systems and processes in place to ensure the robust governance of service quality. Indicators of service quality, which include performance against national targets, as well as national and local measures on clinical quality, financial and workforce issues, are reported and monitored at business group level. The business groups are held to account by the executive team for achievement of these metrics at monthly performance reviews. Outcomes from these reviews are reported to the relevant Board assurance committees which in turn, report to the Board of Directors via key issue reports. The Board also receives a monthly compliance report which highlights the exceptions to meeting national and local indicators and this is supported by detailed data within the Integrated Performance Report (IPR). The Board of Directors also considers a ‘Patient Story’ and a Safe Staffing Report at each meeting.

Risks to quality may be identified and assessed at any level of this process and will then be monitored via business group, corporate or strategic risk registers depending on the severity of the risk. In addition to the arrangements described above, improvements in the quality of healthcare are monitored by topic specific groups such as the Strategic Heads of Nursing Group. This Group is led by the Director of Nursing & Midwifery and monitors improvements to quality of care and leadership on wards, and harm-free care via a nursing dashboard.

Quality Improvement Strategy

Improvements in the quality of healthcare and progress towards meeting national and local targets are monitored formally through the Trust’s quality governance reporting structure, from business group to Board of Directors, via performance reviews and the Board assurance committees. The Integrated Performance Report tracks the progress through this structure. During 2016/17 we have continued to deliver the Trust’s Quality Improvement Strategy 2015-20, with progress towards the objectives monitored at the Quality Governance Committee which reports to the Quality Assurance Committee. Detailed information on progress to date can be found in the Trust’s Annual Quality Report on page 103.

Clinical Audit

Clinical audit is well established in the Trust as an effective means of monitoring quality improvements. The Trust engages in a full annual programme of both local and national audits, with the results informing further improvements. Clinical audit results are shared within business groups at quarterly audit days, whilst also being reported from the Clinical Audit Steering Group through the quality governance reporting structure described above. Details of the 2016/17 clinical audit programme can be found in the Trust Annual Quality Report on page 103.

Care Quality Commission Reviews

The Trust is fully registered with the Care Quality Commission (CQC) for all its services and locations and was not subject to any enforcement actions during 2016/17. A planned review of all core services was conducted in January 2016 with the outcomes of the review being published in August 2016. Regrettably, the review resulted in an overall rating of 'Requires Improvement'. The Trust prepared a comprehensive Board-approved action plan to address the recommendations for improvement made by the CQC and progress with implementation of the actions has been regularly monitored by the Quality Governance and Quality Assurance Committees. Much of this work has focused on safety and responsiveness of urgent and emergency care as it was in this area where most concerns were raised during the inspection. At 31 March 2017 there remained just a small number of actions to be completed.

The CQC visited the Trust on three separate days in March 2017 to inspect the core services of Urgent & Emergency Care and Medicine. This was described as an unannounced responsive-focused inspection of these two core services. At the time of writing, the outcomes of this follow-up inspection had yet to be published, although we anticipate that some further actions will be required.

Commissioning for Quality & Innovation (CQUIN)

A proportion of the Trust's income in 2016/17 was conditional on achieving quality improvement and innovation goals agreed with Commissioners through the Commissioning for Quality and Innovation payment framework (CQUIN). The level of income associated with these goals in 2016/17 was £5.5m and the programme included a wide range of indicators at national and local level such as; sepsis screening, take-up of flu vaccinations, effective discharge from hospital and diabetes care bundles. We made excellent progress against all CQUIN indicators during 2016/17 and full details can be found in the Trust's Annual Quality Report on page 103.

Service improvements following staff or patient surveys

Capturing the patient and family experience has remained a key quality driver for the Trust during 2016/17. A variety of methods have been used to capture feedback including:-

- The annual national surveys e.g. the national inpatient survey
- The Friends and Family Test
- Monthly iPad surveys
- Complaints and compliments

In addition, bespoke surveys have been carried out by some of our services to help them gain a greater insight and understanding of the care and facilities they provide.

Applying these different approaches has enriched our understanding of the patient and family experience and strengthened our ability to identify themes and trends so valuable in reviewing and evaluating our services. Perhaps more importantly, it also highlights where we are getting things right, which can be a great motivator for staff. The questions we ask on our iPad surveys are reviewed annually and provide the opportunity for the Trust to monitor aspects of care or facilities where it has been considered that further monitoring or greater understanding of an issue is required. Our volunteers continue to provide essential support in carrying out these surveys with patients and who themselves receive twice-yearly updates on the changes that have taken place as a result of their dedication and hard work. Patient stories continue to be a feature at the monthly meetings of the Board of Directors and are also used to support staff training as appropriate, illustrating a particular aspect of care from the patient's point of view.

Examples of service improvements introduced as a result of feedback during 2016/17 include:-

- Extended visiting hours introduced across the Trust. This change has been well received especially by family members who have loved ones with dementia or who are very ill. Ward entrance boards have been amended to reflect the change.
- High Dependency Unit (HDU) - have introduced a support group for ex-patients to meet up along with their relatives and share their experiences with one another to help them make sense of what for many has been a frightening experience. Feedback from groups who have met so far has been very positive.
- Noise at Night Standards have been introduced and circulated Trust-wide by the night nursing team with the aim of reducing noise levels and promote a restorative sleep for patients. The standards are subject to ongoing monitoring and audit. Key features include lights being turned off by 2300, the volume on ward phones being put on a low setting and answered within 5 rings and staff wearing soft-soled shoes.
- The Acute Pain Team has carried out a number of awareness-raising sessions to assist staff in their understanding, monitoring and management of pain. In addition, the team now regularly teach on clinical skills study days and have introduced a pain link nurse on every ward. The team has also undertaken a complete review of the pain microsite in order to provide more guidance and support for staff.
- Environmental changes resulting from feedback include:-
 - o A walk-in shower room on Ward C2;
 - o A refurbished counselling room in the Antenatal Clinic;
 - o A refurbished café on the ground floor of the Women's Unit with improvements to both the environment, food selection and extended opening hours.
 - o Building work including a revision of the layout in the Emergency Department has positively impacted upon patient experience by increasing the number of cubicles available, and enhanced visibility of patients by staff while improving privacy and dignity.
- In relation to food, a review has been undertaken of patient menus. The catering team has introduced monthly inspections on wards to look at the patient mealtime experience. These include assessing the taste, temperature and quality of the food on offer whilst engaging with patients and seeking their feedback. Any information gained is reported back to the Trust Nutrition and Hydration group for action.
- Changes to help improve communication have included:-

- Telephone assessments for patients who find it difficult to attend the haematology clinic;
 - The routine issue of the mobile telephone number of district nurses for any patient who has an indwelling urinary catheter;
 - A review of processes in dermatology clinics to keep patients better informed;
 - An extension in the time slot allocation for any “new” patients attending clinics in the paediatric Outpatient Department
- Extensive work has been undertaken to develop a Dementia Café located on the hospital main corridor. The aim of this is to provide a calm ‘off the ward’ environment for patients with dementia and their families to talk, listen to music, have a drink and spend precious time together. The café will also provide opportunities to meet staff from the Alzheimer’s Society and EDUCATE (Early Dementia Users Cooperative Aiming to Educate).

Improvements in patient / carer information

Dementia packs are now readily available for the families and carers of patients with dementia. Each pack contains a copy of “This is me”, a document which provides a snapshot of an individual’s current life e.g. preferred name, likes and dislikes, which can help staff to care for the patient and develop therapeutic relationships both in and out of the hospital setting. The pack also provides information for additional support services family members may wish to access.

Work has been undertaken to review and update the patients’ bedside booklet, a copy of which is available at every bedside in the Trust. The latest version is due to be circulated early in 2017/18. Concerns raised by families unhappy and unclear with the process for Child Protection Medicals on being asked to attend hospital with their injured child, resulted in the safeguarding team developing a leaflet. The leaflet explains the process, tests undertaken and next steps and has been well received by families, resulting in no further concerns or complaints.

Complaints Handling

The Trust received 687 formal complaints in 2016/17 compared with 787 in 2015/16 and 773 in 2014/15. The reduction in numbers of complaints is, in part, due to a particular emphasis put on resolving informal complaints in a timelier manner. The main themes of complaints received in 2016/17 related to:

- Treatment;
- Communication;
- Appointment / Admission;
- Standard of Nursing Care; and
- Complaints about staff

These themes are monitored by means of a quarterly Patient Experience Report which is reviewed by Quality Governance Committee and includes details of improvements to practice as a result of patient feedback.

One significant change introduced during 2016/17 was the appointment of two new case handlers to work solely in the management of informal complaints. By visiting patients in wards and departments they are able to help resolve issues with the staff at the time. This not only improves the patient and family experience but also prevents many minor concerns from becoming formal complaints.

In 2016/17 nine cases were accepted for review by the Parliamentary & Health Service Ombudsman (PHSO); four remain ongoing, three were not upheld and two were partially upheld. Reasons for upholding a complaint included the lack of an appropriate apology, inadequate complaint responses, missing records, delayed medication and poor communication with a family. Responses to upheld complaints include apology and financial restitution, and an action plan is developed to prevent any reoccurrence.

Remuneration Report 2016/17

Remuneration and Appointments Committee

The Board of Directors has established a Remuneration and Appointments 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 and appointments to Executive Director positions.

Chairman's Statement

The Remuneration and Appointments Committee met on six occasions during the reporting period to consider the following business:

- Medical Director remuneration
- Salary review
- Director of Workforce & Organisational Development remuneration
- Secondment appointment – Financial Improvement Director
- Appointment and portfolio of Deputy Chief Executive
- Appointment of Director of Corporate Affairs
- New temporary Executive Director post.

In determining and reviewing remuneration for Executive Directors, the Committee takes into account relevant benchmarking with other NHS and public sector organisations, guidance from NHS Improvement, national inflationary uplifts recommended for other NHS staff, and any variation or change to the responsibilities of Executive Directors. With regard to remuneration, the one major decision taken by the Committee in respect of senior managers' remuneration during 2016/17 was to agree that Executive Directors and other senior managers covered by the Committee would receive the national 1% inflationary pay award for the period April 2016 to March 2017. All Executive Directors are subject to an annual appraisal which is completed with the Chief Executive. The appraisal for the Chief Executive is completed with 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.

Membership of the Committee and attendance at meetings during 2016/17 is detailed in the table below:

Name	Title	Attendance
Mrs G Easson	Chairman	6/6
Mr M Sugden	Deputy Chairman	5/6
Mrs C Anderson	Non-Executive Director	5/6
Mrs C Barber-Brown (from 1 Sep 16)	Non-Executive Director	3/3
Dr M Cheshire	Non-Executive Director	5/6
Mr J Sandford	Non-Executive Director	6/6
Mr J Schultz (until 31 Aug 16)	Non-Executive Director	2/3
Ms A Smith	Non-Executive Director	4/6

The Chief Executive and Director of Workforce & Organisational Development attend meetings

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

The contracts of employment of all Executive Directors, including the Chief Executive, are permanent and are subject to a six month notice period. 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, Business Group Directors for example, are employed on a local pay scale agreed by the Remuneration and Appointments 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.

Gillian Easson

Gillian Easson
Chairman
25 May 2017

Business Expenses

As with all staff, the Trust reimburses the business expenses of Non-Executive Directors and Executive Directors that are necessarily incurred during the course of their employment, including sundry expenses such as car parking and transport costs such as rail fares.

The expenses paid to Directors during the year were:

	2016/17	2015/16
Total number of Directors in office	18	16
Number of Directors receiving expenses	8	9
Aggregate sum of expenses paid to Directors	£3,373	£4,735

Off-Payroll Arrangements

As part of the remuneration report, we are 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 staff that are paid the equivalent of more than £220 per day and have an engagement lasting longer than six months. It is Trust policy that employees are paid via the Trust's payroll and therefore these arrangements apply to staff contracted through an agency which then pays the individual via their own personal service company or via the agency payroll. The arrangements apply to a number of interim managers but not to medical agency staff.

Table 1

	2016/17	2015/16
No of existing arrangements as of 31 March 2016	Nil	Nil
Of which:		
Less than one year at time of reporting	-	-
Between one and two years at time of reporting	-	-
Between two and three years at time of reporting	-	-
Between three and four years at time of reporting	-	-
Four or more years at time of reporting	-	-

Table 2

	2016/17	2015/16
No of new engagements, or those that reached 6 months duration, between 1 April 2016 and 31 March 2017	1	8
Number of the above which include contractual clauses giving the trust the right to request assurance in relation to income tax and national insurance obligations	1	8
Number of whom assurance has been requested	1	1
Of which:		
Number for whom assurance has been received	1	1
Number for whom assurance has not been received	-	-
Number that have been terminated as a result of assurance not being received	-	-

Table 3

	2016/17	2015/16
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	Nil	Nil
Number of individuals that have been deemed "board members and/or senior officials with significant financial responsibility". This figure should include both off-payroll and on-payroll engagements.	18	16

Exit Packages

Redundancy and other departure costs are paid in accordance with the provisions of the NHS Scheme and Trust policies. Any exit packages exceeding contractual amounts, and outside the terms of the normal pension scheme provisions, require Treasury approval before they are offered. The Trust offered a Mutually Agreed Resignation Scheme in Spring 2016 and relevant staff left the Trust in the first quarter of 2016/17.

As one of the actions within the Financial Improvement Programme, a Voluntary Redundancy Scheme was run in the autumn of 2016 which resulted in 45 staff leaving the Trust. The following tables show the exit packages for 2016/17 and comparator to 2015/16:

2016/17

Exit package cost band (including any special payment element)	Number of compulsory redundancies 2016/17	Number of other departures agreed 2016/17	Total number of exit packages 2016/17
<£10,000	-	9	9
£10,001 - £25,000	-	18	18
£25,001 - £50,000	1	7	8
£50,001 - £100,000	-	12	12
£100,001 - £150,000	-	3	3
£150,001 - £200,000	-	-	-
>£200,000	-	-	-
Total number of exit packages by type	1	49	50
Total resource cost	£47,437	£1,862,198	£1,909,634

Comparator to previous year

Exit package cost band (including any special payment element)	Number of compulsory redundancies 2015/16	Number of other departures agreed 2015/16	Total number of exit packages 2015/16
<£10,000	1	-	1
£10,001 - £25,000	1	3	4
£25,001 - £50,000	2	-	2
£50,001 - £100,000	1	-	1
£100,001 - £150,000	-	-	-
£150,001 - £200,000	-	-	-
>£200,000	-	-	-
Total number of exit packages by type	5	3	8
Total resource cost	£167,000	£57,000	£224,000

The non-compulsory elements are further broken down in the following table:

	2016/17		2015/16	
Exit packages: other non-compulsory departure payments	Payments agreed number	Total value of agreements £000	Payments agreed number	Total value of agreements £000
Voluntary redundancies including early retirement contractual costs	45	1,663	-	-
Mutually agreed resignations (MARS contractual costs)	3	110	1	10
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	-	-	2	47
Exit payments following Employment Tribunals or court orders	1	89	-	-
Non-contractual payments requiring HMT approval	-	-	-	-
Total	49	1,862	3	57

Consultancy Costs

The Trust purchases expert advice in order to deliver key projects where the Trust does not have internal expertise or in some circumstances may not have the capacity. The consultancy costs for 2016/17 are summarised as follows:

Consultancy area	£000	Note
Strategy: The provision of objective advice and assistance relating to corporate strategies, appraising business structures, value for money reviews, business performance measurement, management services, product design and process and production management	2,976	(a)(b)
IT/IS: The provision of objective advice and assistance relating to IT/IS systems and concepts, including strategic studies and development of specific projects. Defining information needs, computer feasibility studies and making computer hardware evaluations. Including consultancy related to e-business	54	
Human Resource, training and education: The provision of objective advice and assistance in the formulation of recruitment, retention, manpower planning and HR strategies and advice and assistance relating to the development of training and education strategies	18	
Programme and Project Management: The provision of advice relating to ongoing programmes and one-off projects. Support in assessing, managing and or mitigating the potential risks involved in a specific initiative; work to ensure expected benefits of a project are realised	352	
Property and Construction: The provision of specialist advice relating to the design, planning and construction, tenure, holding and	1	

disposal strategies. This can also include the advice and services provided by surveyors and architects		
Finance: The provision of objective finance advice including advice relating to corporate financing structures, accountancy, control mechanisms and systems. This includes both strategic and operational finance.	3	
Technical: The provision of applied technical knowledge. To aid understanding, this can be sub-divided into: - Technical Studies: Research based activity including studies, prototyping and technical demonstrators	131	(c)
Procurement: The provision of objective procurement advice including advice in establishing procurement strategies	49	(d)
Total cost 2016/17	3,584	

- (a) The Trust worked in partnership with KPMG LLP to complete a Financial Improvement Programme in 2016/17 and the costs associated are allocated to this category in full, even though there were elements of the work undertaken which related to Human Resources and Procurement advice.
- (b) The Trust has received income of £14k to match the consultancy costs for Stockport Together (Vanguard) incurred in this category.
- (c) The Trust has explored options in year with regards to site reconfiguration and the accounting treatment with respect to modern equivalent asset valuation and consultancy on this specialist area was sought from specialist land valuers.
- (d) The Director of Finance is the lead for Procurement as part of the Greater Manchester Health & Social Care Partnership and an additional £49k was incurred in relation to work in this area.

Fair pay multiple / Median pay

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 2016/17 was £205k - £210k (2015/16 £170k-£175k). In 2016/17 this was 9.4 times the median remuneration of the workforce which was £22,168, in 2015/16 the fair pay multiple was 7.2 times and the median remuneration was £24,055. In 2016/17 the Trust has appointed a new part time medical director; however for the basis of the calculation his full salary for his medical director role and his clinical role are included. By increasing the basis of this calculation the ratio has increased overall by 1.2 times, whilst the median remuneration is marginally lower.

In 2016/17 no employees (2015/16 10 employees, all senior doctors) received remuneration in excess of the highest paid director. The Trust has paid three directors in excess of the annual equivalent of £142,500 which is the threshold used by the Civil Service as a comparison to the Prime Minister's ministerial and parliamentary salary. The Remuneration Committee has satisfied itself that the salaries are reasonable and in line with other Foundation Trusts of a similar size.



Ann Barnes, Chief Executive, 25 May 2017

Salary and Pension Entitlements of Senior Managers

Remuneration

Name	Start Date of Office	Salary and allowances (in bands of £5,000) 2016/2017	Salary and allowances (in bands of £5,000) 2015/2016	Pension Related Benefits (in bands of £2,500)	Real increase/decrease during the reporting year in the pension at pension age (in bands of £2,500)	Real increase/decrease during the reporting year in related lump sum at pension age (in bands of £2,500)	Value at the end of the reporting year of the accrued pension at pension age (in bands of £5,000)	Value at the end of the reporting year of related lump sum at pension age (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)	Employer's contribution to stakeholder pension
		£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Executive Directors												
Mrs A Barnes	01.03.2013	170 - 175	165 - 170	40.0 - 42.5	2.5 - 5.0	8.0 - 10.5	80 - 85	245 - 250	0	0	0	
Dr C Wasson	01.04.2016	205 - 210	-	332.5 - 335.0	15.0 - 17.5	32.5 - 35.0	55 - 60	150 - 155	683	252	935	
Mrs J Morris	01.07.2008	115 - 120	110 - 115	60.0 - 62.5	2.5 - 5.0	10.0 - 12.5	45 - 50	140 - 145	960	106	1,066	
Mrs J Shaw	01.01.2013	110 - 115	100 - 105	82.5 - 85.0	2.5 - 5.0	12.5 - 15.0	40 - 45	130 - 135	720	101	821	
Mr J Sumner*	26.11.2012	80 - 85	120 - 125	85.0 - 90.0	2.5 - 5.0	2.5 - 5.0	25 - 30	70 - 75	308	59	367	
Mr M Patel	03.08.2015	115 - 120	75 - 80	50.0 - 55.0	2.5 - 5.0	2.5 - 5.0	25 - 30	65 - 70	293	42	335	
Mr P Buckingham	01.01.2017	20 - 25	-	50.0 - 55.0	2.5 - 5.0	7.5 - 10.0	15 - 20	50 - 55	313	54	367	
Ms S Toal	01.12.2016	95 - 100	-	60.0 - 65.0	2.5 - 5.0	10.0 - 12.5	45 - 50	135 - 140	817	92	909	
Ms D Lynch	01.12.2016	25 - 30	-	85 - 90	2.5 - 5.0	7.5 - 10.0	15 - 20	45 - 50	207	59	266	
Mr A Burn* (KPMG Financial Improvement Director)		265 - 270										
Non Executive Directors												
Mrs G Easson		40 - 45	45 - 50									
Mr J Sandford		15 - 20	15 - 20									
Mr M Sugden		15 - 20	10 - 15									
Mr J Schultz		5 - 10	10 - 15									
Dr M Cheshire		15 - 20	10 - 15									
Mrs A Smith		10 - 15	0 - 5									
Mrs C Anderson		10 - 15	0 - 5									
Mrs C Barber-Brown		5 - 10	-									
		2016/2017	2015/2016									
		£000	£000									
Band of Highest Paid Director's Total		205 - 210	170-175									
		£	£									
Median Total		22,168	24,055									
Remuneration Ratio		9.4	7.2									

*In 2016-2017 Andrew Burn was seconded onto the Board of Directors as Financial Improvement Director for 73 days between May and October 2016. The cost reported in the Remuneration Report was the KPMG cost to the organisation for this secondment and not the direct salary of the Financial Improvement Director.

Dr Colin Wasson was appointed Medical Director from the 1st April 2016. His remuneration reflects his full salary which is split 65% for his executive director role and 35% for his clinical role.

Dr Colin Wasson was appointed Medical Director from the 1st April 2016. On the 30th November 2017 James Sumner left his post as Chief Operating Officer and the Remuneration Report reflects the salary paid to that date. Sue Toal was appointed as acting Chief Operating Officer from the 1st May 2016. Donna Lynch was appointed acting Director of Strategy and Planning on the 1st December 2016 and Paul Buckingham was appointed as Director of Corporate Affairs from the 1st January 2017. There are no prior year comparisons for these directors.

For Mrs A Barnes no cash equivalent transfer value (CETV) is shown at the 31st March 2017 as this is no longer applicable on reaching pension age in the 1995 scheme.

Median Pay

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 2016/2017 was £205k - £210k (2015/2016, £170k - £175k). This was 9.4 times (2015/2016 7.2) the median remuneration was £22,168 (2015/2016, £24,055).

In 2016-17, 0 (2015-16, 10) employees received remuneration in excess of the highest paid director.

Total remuneration for the median pay calculation includes salary, non consolidated performance related pay and benefits in kind. It does not include severance payments, employer pension contributions, employer national insurance and the cash equivalent transfer value of pensions.

Staff Report

Our Workforce

We recognise the valuable contribution of our workforce who provide a range of clinical and non-clinical services across the hospital and community sites as well as in patient's homes. We are committed to engaging with our workforce and ensuring that they feel valued through our on-going dialogue, this has been further enhanced through a range of opportunities including embedding the role of Freedom to Speak Up Guardian originally introduced in February 2016. We have continued with implementation of our Health & Wellbeing Strategy to support our staff with their work-life balance and resilience. The wellbeing programme of initiatives is complemented by a coaching programme which further assists to ensure openness, transparency and candour across the Trust, providing strong leadership and supporting the development of a performance culture.

Our services are delivered by our committed workforce and the average number of whole time equivalent (WTE) staff, employed on both a permanent and other basis, is detailed in the table below:

Category	Permanent	Other	2016/17	2015/16
Medical & dental	453	-	453	424
Administration & estates	804	-	804	864
Healthcare assistants & other support staff	1,009	135	1,144	1,213
Nursing, midwifery & health visiting staff	1,618	66	1,684	1,947
Scientific, therapeutic & technical staff	628	-	628	763
Agency & contract staff	-	121	121	157
Bank staff	-	4	4	16
Total average numbers	4,512	326	4,838	5,384
Of which:				
Number of employees (wte) engaged on capital projects	8	-	8	-

The TUPE transfer of staff from Tameside and Glossop Community Healthcare, Sexual Health Services, and Stockport Healthier Together account for the majority of the decrease in number of employees from 2015/16 and 2016/17.

Staff costs for the year, with comparative 2015/16 costs, were as follows:

Category	Permanent £000	Other £000	2016/17 £000	2015/16 £000
Salaries & wages	151,901	934	152,835	166,949
Social security costs	13,216	-	13,216	11,094
Employer's contributions to NHS pensions	17,646	-	17,646	19,433
Pension cost - other	-	-	-	49
Agency / contract staff	-	23,627	23,627	24,590
Total staff costs	182,763	24,561	207,324	222,115
Of which:				
Costs capitalized as part of assets	400	-	400	-

Our employee workforce of 4,387 whole time equivalent staff relates to a headcount of 5,171 staff as at 31 March 2017 and the profile of these staff can be shown by gender which is 81% Female and 19% Male; of which:

Gender Headcount	Male	Female	Total
Directors	5	10	15
Other Senior Managers	5	3	8
Other Employees	997	4,174	5,171

In 2016/17 we made successful appointments to 24 Consultant positions (17.96 WTE) and 249 Qualified Nurses (216.92 WTE) during the year up to 31 March 2017.

Recruiting and retaining our people

We recognise that staff are fundamental to our success, both now and in securing our future. Consequently, there is a need for us to attract and retain staff of the highest calibre and to do this we ensure that our values and behaviours are inherent in our workforce and that we recruit the very best staff who are able to continually demonstrate high levels of skill and competence.

Employing nearly 5,200 staff in extremely diverse roles, we aim to ensure that there are opportunities for career development in each and every part of the business. This is important in retaining and developing the skills that our staff bring to us. All staff complete both corporate and local induction which includes raising awareness of relevant Trust policies such as Anti-Fraud & Corruption (see page 45). We have an average staff turnover rate of approximately 14%. During Quarter 4 of 2015/16 the Board of Directors approved a Recruitment & Retention Strategy. The strategy sets out the many challenges facing the Trust in achieving its aim of recruiting and retaining a workforce with the requisite skills, within an environment which supports flexible and healthy working practices and professional development to make the Trust an employer of choice.

Despite implementation of the Recruitment & Retention Strategy, we continued to experience difficulties in recruiting suitable candidates to a number of consultant vacancies. These difficulties reflect the national position and the affected areas include Radiology, Emergency Medicine and Acute physicians. As a result we are continuing to explore alternative recruitment options including international recruitment and the use of specialist recruitment consultants. In addition, we are also experiencing difficulty in recruiting experienced Radiographers and specialist IT roles.

During 2016/17 we continued to look to address the shortages for qualified nurses from non-EU countries. Whilst there has been some success, we have experienced significant delays in nurses arriving due to challenges with the English Language Test (IELTS). The plans for 2017/18 to compensate for the low numbers of nurses being secured through this route is to commence an adaptation course to convert non-EU nurses qualified overseas that are resident in the UK to Registered Nurses. We will also maintain our commitment to support the recruitment of local people in order to encourage growth and prosperity in Stockport. We have enhanced our recruitment strategy with an improved social media campaign supported by centralised

recruitment days and an improved nursing university recruitment collaboration which has begun to improve our domestic recruitment activity.

Whilst the challenges are significant, we are confident that with the participation and commitment of every member of staff at every level, the Trust will achieve and maintain a skilled and dedicated workforce representative of the local community, and capable of delivering high quality and compassionate patient care to the people of Stockport and beyond. In summary our strategy covers both recruitment and retention and the short, medium and long term objectives of the Trust, in relation to how it attracts, develops and retains our workforce. Plans have been reviewed and refined in the context of recruitment challenges which we anticipate will have a positive impact in 2017/18.

Health and Wellbeing

Our commitment to the Health and Wellbeing of our staff is an area of priority and focus. We believe that the way to provide the best experience for our patients is to provide the best experience for our staff. We know that **Healthy Staff = Better outcomes for our patients**. As an NHS Foundation Trust, health and wellbeing applies as much to our employees as it does to our patients, their carers and families and our local population. We want to do as much as we can to support our staff to enable them to be at their best, be energised, be motivated and committed to their work and to reach their full potential.

Our 'Workforce Health & Wellbeing Strategy' brings together multiple strands with the aim of improving the health and wellbeing of staff. The key themes of this strategy are aimed at:

- Engaging all staff to identify, develop and improve their health and wellbeing, including; physical activity, smoking cessation, alcohol consumption, weight management and mental health;
- Encouraging staff to better recognise their physical and emotional needs and to feel more resilient, committed and able to contribute to the development of the Trust; in support of this resilience training for all staff is underway
- Improving the health and wellbeing of staff by promoting the benefits of a healthy and supportive working environment;
- Recognising the importance of wellbeing and ensuring assistance is provided to help staff to remain and return to work.

We have demonstrated our commitment to supporting our staff through facilities such as the availability of dedicated staff counselling support services, in-house Occupational Health services and access to staff fast-track physiotherapy, together with a number of other initiatives including:

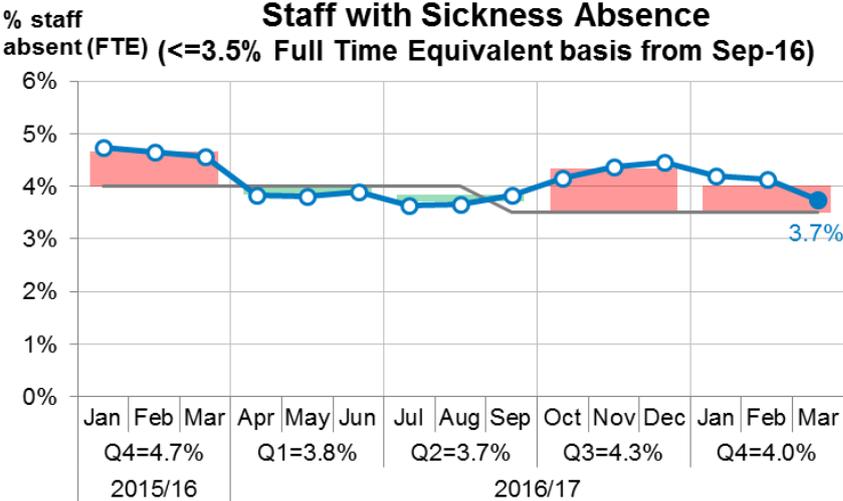
- Programme of health and wellbeing campaigns
- Spiritual and pastoral care
- Preventive interventions e.g. stress risk assessments and facilitated team working
- Coaching and guidance for managers
- Personal resilience and mindfulness workshops
- Staff benefits and incentives
- Smoking cessation support and advice

Our Occupational Health Service is designed to maximise the physical, psychological and social health of all staff and to support managers by undertaking health interventions and providing advice on medical issues. In addition to core services of new employee health assessments, management referrals and immunisation / vaccination programmes, other services offered to staff include fast track physiotherapy, counselling, and lifestyle health advice. A range of health promotion support services are provided for staff including smoking cessation and raising awareness to prevent workplace incidents, such as sharps injuries. Vaccinating health care staff against potential workplace infections will protect staff from infection and mitigate the risk of transfer to patients. The Occupational Health service leads on the delivery of the staff flu vaccination each autumn with the assistance of many link nurses and achieved an uptake of 80% of clinical staff (12th in the country) during 2016/17.

The Occupational Health service is active in providing care for the employees of the Trust but also in offering specialist services to other employers in Stockport and further afield. For example, we work with NHS partners in occupational health to provide a comprehensive region-wide service to North West Ambulance Service NHS Trust. Our service continues to be successful in retaining accreditation of the national quality assurance scheme called Safe, Effective, Quality Occupational Health Service (SEQOHS) providing assurance of quality and effectiveness and allowing the service to continue to bid for new occupational health work in the region. The Trust continues to explore potential service reconfiguration of Occupational Health services with local Trusts to maintain and enhance the services provided for NHS staff.

Sickness Absence Data

The chart below details our sickness absence performance during 2016/17.



We have reviewed our sickness absence policy and supporting procedures, in partnership with our trade union colleagues, to enable staff and managers to better address the challenges presented by staff ill health. Progress towards a revised internal target of 3.5% absence will continue to be a key objective for the Trust during 2017/18 (the revised target was introduced in September 2016). There has been an intensive programme of attendance management throughout 2016/17 to ensure that our staff and managers have the appropriate support to manage sickness absence.

Working in Partnership

We take a partnership approach to working with staff through our Joint Consultative and Negotiating Committee (JNCC) and Local Negotiation Committee (LNC). Both of these forums are attended by members of our Executive Team and include representatives from our staff side colleagues and trade union representatives. These meetings focus upon consulting with staff in a constructive manner in relation to key service changes across the Trust, as well as discussing and seeking approval of policies and procedures. Both forums share chairing arrangements between staff and management, and executive directors and senior managers regularly attend. Major project developments will also include a local staff representative, as part of steering groups to ensure positive levels of union engagement.

Staff Engagement - Team Brief and Start the Year

The Trust has a 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, with an opportunity for staff to ask questions. 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. Staff are encouraged to feed information back up the organisation using the normal management channels which include regular 'drop-in' sessions with the Chief Executive.

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.

In recognition of the scale and pace of change in the strategic environment, the Trust has developed a comprehensive internal Communication and Engagement Plan for implementation in 2017/18. This plan, which seeks to maximise staff involvement and increase opportunities for 'face to face' discussion, will enhance and improve internal communications and engagement to support successful transformational change. As well as helping to support people through change by keeping them well informed, the plan will play a key role in engagement and productivity; enhancing a culture of openness, honesty and trust.

At a time of significant transformation and challenge, maintaining an engaged workforce is more important than ever. Our staff have a valuable perspective on what is happening within the Trust and their teams. Their views of how their service is operating provide an important perspective to inform service delivery and to deliver transformation.

Equality, Diversity and Inclusion

During 2016/17 we have continued on our journey to create a working culture where everyone is included. A culture of inclusion means that everyone enjoys the opportunity of doing work that is valued, and maximises the use of their skills in an environment where they are treated well. Our Equality, Diversity & Inclusion Annual Report and Workforce Report published on our website reaffirm our commitment to the principles of equality and diversity. They set out an ambitious agenda for action, ensuring that we meet our general and specific duties for equality, as required by legislation, and that we work effectively to meet the needs of our diverse workforce, patient population and the communities served by the Trust.

Governance

In addition to our Public Sector Equality Duty reporting, our Equality, Diversity and Inclusion policy gives clear guidance around how to raise concerns and sets out our commitment to tackling discrimination in all areas of the Trust, from recruitment and employment policies through to access to our services. Our Reasonable Adjustments policy identifies what managers and staff need to know to support them in making decisions about applying for and considering requests for reasonable adjustments in the workplace and discussing requests from patients about how they could receive more accessible services across a range of different settings. Our employment policies are subject to regular review and update, in partnership with our staff side colleagues, to ensure that they continue to reflect best practice.

All new or revised policies are also subject to an equality impact assessment to ensure that our policies support the advancements of equality and do not have any negative effects upon any particular groups. Completion of the assessments also serves to ensure that we comply with our duties under the Equality Act 2010.

Workforce Race Equality Standard (WRES)

NHS England introduced the Workforce Race Equality Standard (WRES) in 2015 to ensure employees from black and ethnic minority (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. In 2016/17 the Trust continued to focus on training interview panel members to recognise unconscious bias in decision making whilst ensuring that a fair shortlisting process can be demonstrated. You can download a copy of the Trust's performance against the WRES standard, along with our action plan, from the Trust website.

Raising the profile of Equality, Diversity and Human Rights

During Equality & Diversity Week in May 2016 the Trust hosted an Inter-Faith event attended by around 100 local people, including representatives from faith groups, health service commissioners, consultants, doctors, nurses, healthcare assistants, teachers, police, social workers, occupational therapists and support staff. The event included speakers on the topics of; Christianity, Islam, Judaism, Hinduism and Sikhism, who shared information about their faith, culture and customs and how this can impact on health services.

A staff guide was developed which sets out; legal rights, religion and employment, religion and service provision, as well as an overview of different faiths. Attendees were offered blood pressure testing, undertook the Stockport String test of healthy weight, and took part in Public Health England's 'One You' healthy lifestyle survey.

Additionally, representatives from the Trust again took part in Manchester's annual lesbian, gay, bisexual and transgender (LGBT) festival, held traditionally and annually over the August bank holiday weekend. Manchester PRIDE celebrates LGBT lives and works for greater mutual support and co-operation. The 2016 event was a great success and a fantastic opportunity for the Trust to lend support and raise awareness, both in terms of being an inclusive employer and health care provider.

During 2016/17 we continued to develop our Supported Internship Programme for young people with learning disabilities. The main aim of this project is to secure paid work either with the Trust or with an external employer. The course accommodates 10 people on 3 rotational placements throughout an academic year. The trainees have classroom based activity at the beginning and end of the day and by the end of the 12 months will gain a City and Guilds Entry 3 qualification – ‘Personal progression through employment’.

In July 2016 we became one of the main recruitment and therapy sites for the pre-school autism communication trial (PACT), which is the largest long-term follow-up study of more severe autism (known as core autism) treatment ever undertaken internationally. The speech and language therapists worked individually with parents to sensitively adapt their communication and interaction specifically to match the child’s individual level of social communication.

The Trust was awarded the Disability Confident Employer kite mark by the Department of Work and Pensions in August 2016. This replaced the previous two-tick kite mark. As a Disability Confident Employer we:

- Have undertaken and successfully completed the Disability Confident self-assessment.
- Are taking all of the core actions to be a Disability Confident employer.
- Are offering at least one activity to get the right people for our business and at least one activity to keep and develop our people.

Our aim during 2017/18 is to work towards the next level of the standard and become a Disability Confident Leader and to continue to apply our policies to provide training, career development and advancement of disabled employees, including employees who may become disabled during the course of their employment.

For the fifth consecutive year, the Trust was awarded a Stockport Young Stars award in the category of ‘Working with Young People’ in the annual awards presented by Stockport Metropolitan Borough Council. We were recognised for our volunteering opportunities, career events, cadetships, and apprenticeship schemes, which allow young people to train while working on the job in both hospital and community health settings.

Equality and Diversity Training

During 2016/17, two full day disability awareness training sessions were delivered to the Trust’s Dignity and Respect Champions. Supporting resources were provided to enable the delegates to cascade the training to teams and colleagues. A similar approach will be adopted in 2017/18 to continue to cascade this training. One-off transgender awareness training sessions have also been delivered in specific areas of the Trust and we have developed a training DVD for use in 2017/18 in order to reach more staff members. Face to face essentials training for those staff unable to access e-learning has ensured an inclusive approach to delivery.

Our bi-monthly Diversity Matters newsletter has continued to inform and enlighten our staff throughout 2016/17 and themes during the year have varied from key changes to legislation to detailed articles around disabilities, depression, Black History Month, homophobia and religious festivals.

Summary of our Equality Monitoring Statistics 2016

A diverse and culturally aware workforce is better placed to understand and respond to the needs of everyone in our community. Our staff are:

- 81% women;
- 26% aged under 34 years and 22% aged over 55 years;
- 11.1% are from black and minority ethnic communities (plus a further 4.8% from white minority ethnic backgrounds);
- 3% declared themselves to be disabled; 76% declared themselves to be non-disabled and the disability status of the remainder is not known / not declared;
- 70% disclosed as heterosexual, 1.4% as lesbian, gay or bisexual;
- 51% declared Christianity as their religion;
- The average age of our Board members is 50; none declared a disability; the make-up of the Board is 93% White British and 53% are female.

Remuneration

Information relating to exit packages, off-payroll arrangements and consultancy costs is included in the Remuneration Report on page 60.

2016 National Staff Survey

The annual staff survey is a vital component in finding out the views of staff and helping to identify where improvements can be made at corporate, business group and staff group levels to improve staff experience and further enhance engagement and staff satisfaction. In 2016, all our staff were invited to complete the survey and were given the option to use either an online survey form or a hard copy survey form. In total, 1,976 staff completed the survey, a response rate of 39%. This is a 5% increase from the 2015 survey and compares with a national average of 39% for combined acute and community trusts.

The staff engagement score decreased from 3.82 in 2015 to 3.75 in 2016. This compares with a national average of 3.80. Our Communication and Engagement plan and associated activities is seen as a key initiative to improve outcomes in this area.

The tables below provide an overview of the best and worst scores when compared to all acute and community trusts.

Top 5 Ranking Scores for 2016

Five questions we scored BEST in	2016	
	Our Trust	National Average
Percentage of staff appraised in last 12 months.	89%	86%
Percentage of staff experiencing physical violence from staff in the last 12 months (the lower the score the better)	1%	2%
Percentage of staff experiencing discrimination at work in the last 12 months (the lower the score the better)	8%	10%
Percentage of staff experiencing harassment, bullying or abuse	21%	23%

from staff in the last 12 months (the lower the score the better)		
Percentage of staff experiencing harassment, bullying or abuse from patients, relative or the public in the last 12 months (the lower the score the better)	24%	26%

Bottom 5 Ranking Scores for 2016

Five questions we scored WORST in	2016	
	Our Trust	National Average
Staff satisfaction with the quality of work and patient care they are able to deliver	3.87 (out of 5)	3.92
Percentage of staff reporting most recent experience of harassment, bullying or abuse.	43%	45%
Staff satisfaction with resourcing and support.	3.25 (out of 5)	3.28
Organisation and management interest in and action on health and wellbeing.	3.55 (out of 5)	3.61
Percentage of staff satisfied with the opportunities for flexible working patterns.	49%	51%

In order to address outcomes of the survey, we plan to hold Trust-wide and Business Group-specific focus groups and engagement events to promote the results of the staff survey and to gain feedback from staff on how to improve the staff experience. A key tool in this process will be the Trust's internal Communication and Engagement Plan which will be implemented in 2017/18. The plan seeks to maximise staff involvement and increase opportunities for 'face to face' discussion and will enhance and improve our internal communications and engagement. Action plans to drive improvements will be monitored by the Workforce Efficiency and Engagement Forum with support from the Head of Organisational Development and Learning and progress will be regularly reported to the Board of Directors through the People Performance Committee.

Values-based Behaviours Framework

We continued to embed our Trust values and behaviours framework during 2016/17. Our values are closely aligned with our strategic priorities specifically in the areas of; collaborative working, teamwork, staff health and wellbeing, innovation and improving the quality of patient care. The values-based behaviours underpin our values, provide a clear framework for 'living our values' and support the ongoing development of our organisational culture. The overall aim of our engagement and culture programme is to strengthen our 'culture of caring' through fully engaging our workforce to consistently deliver safe and high quality care through continuous learning, improvement and 'putting patients at the heart of everything we do'".

Our values are fully embedded into our recruitment process, our new performance appraisal framework, leadership development programmes and team development sessions. Our values-based behaviours framework will continue to be promoted at every opportunity to all staff as a guide for how we expect one another to behave in all that we do and how we hold each other to account. The approach will be further enhanced through the introduction of a Performance Management Framework from 1 April 2017.

Leadership Development

In order to meet the challenges facing the Trust and to achieve our vision, we need leadership of the highest calibre. To help us achieve this, a leadership strategy and associated leadership and management development framework was implemented during 2016/17. The leadership strategy will create a leadership culture in which staff are fully engaged at all levels, accepting responsibility for outcomes, create opportunities for others to learn and lead, create space for innovation and share best practice supporting a culture of continuous high quality compassionate care. To achieve this requires leadership behaviours and attitudes of the highest order, where leadership is supported and enabled at all levels of the organisation, both individually and collectively. This means developing a leadership culture that supports new ways of sharing power, thinking, being and doing and by working closely with one another to collectively achieve goals and objectives. It means that distribution and allocation of leadership power to wherever expertise, capability and motivation sits within our Trust.

Apprenticeships

The government has a core manifesto commitment to create and support three million apprenticeships by 2020. It also wants to give employers greater involvement, control and investment and to ensure apprenticeships become integral to the education and development of the workforce. We participate in an Apprenticeship Framework that provides relevant training which is tailored to meet the demands of the workforce requirements within the Trust. The learner is supported throughout the programme, both on and off the job, and the scheme provides relevant staff with the opportunity to earn while they learn.

The programme contributes to improved retention and productivity and the opportunity to 'grow' a highly committed, skilled and competent workforce. The Trust's Apprenticeship Scheme Development Plan will ensure that the benefits of the changes to the apprenticeship scheme are fully realised and will be monitored closely by the Trust to ensure full advantage is taken of opportunities that will ensure the continued improvement of attracting and developing the very best talent

Workforce Design

Developments in the way that our services are delivered will require a new approach for some of our staff and we will respond to these challenges by working with our staff to develop the skills necessary to deliver quality services in new ways. The establishment of new roles such as the Trainee Nurse Associate (TNA) and changes to the Apprenticeship Scheme will result in a change to the skill mix within services and departments.

We are also working to develop the following roles, which we anticipate will be introduced during 2017/18:

- Advanced Practitioners in Urgent Care, Geriatrics, Community Nursing, Trauma & Orthopaedics and Integrated Practice.
- Advanced Pharmacist roles in our Emergency Department & Acute Medical settings
- Advanced Radiographer
- NHS Non-Medical Endoscopists (NMEs)
- Generic workers through collaboration between health and social care
- Extended Health Care Assistant roles in Emergency Medicine
- Pharmacy Technicians working directly in the ward setting.

NHS Foundation Trust Code of Governance

The NHS Foundation Trust Code of Governance (the Code of Governance) was first published in 2006 and was most recently updated in 2014. 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. Stockport NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance is based on the principles of the UK Corporate Governance Code issued in 2012.

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 and the disclosures being made by the Trust for each of these categories are detailed below.

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 purpose 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><i>The Trust complies with this requirement.</i></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><i>The Board of Directors and the Council of Governors comply with this requirement.</i></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"> (a) The annual accounts; (b) Any report of the auditor on them; and (c) The annual report. <p><i>The Trust complies with this requirement.</i></p>

Reference	Statutory requirement:
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><i>The Trust complies with this requirement.</i></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><i>The Trust is aware of this requirement. This situation did not arise during 2016/17.</i></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> <p><i>The Trust is aware of this requirement. This situation did not arise during 2016/17.</i></p>
A.5.15	<p>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.</p> <p><i>The Trust complies with this requirement.</i></p>
B.2.11	<p>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.</p> <p><i>The Trust complies with this requirement.</i></p>
B.2.12	<p>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.</p> <p><i>The Trust complies with this requirement.</i></p>
B.2.13	<p>The governors are responsible at a general meeting for the appointment, re-appointment and removal of the chairperson and the other non-executive directors.</p> <p><i>The Trust complies with this requirement.</i></p>

Reference	Statutory requirement:
B.4.3	<p>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.</p> <p><i>The Trust complies with this requirement.</i></p>
B.5.8	<p>The board of directors must have regard for the views of the council of governors on the NHS foundation trust's forward plan.</p> <p><i>The Trust complies with this requirement.</i></p>
B.7.3	<p>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.</p> <p><i>The Trust complies with this requirement.</i></p>
B.7.4	<p>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.</p> <p><i>The Trust complies with this requirement.</i></p>
B.7.5	<p>Elected governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years.</p> <p><i>The Trust complies with this requirement.</i></p>
D.2.4	<p>The council of governors is responsible for setting the remuneration of non-executive directors and the chairperson.</p> <p><i>The Trust complies with this requirement.</i></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><i>The Trust complies with this requirement.</i></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><i>The Trust complies with this requirement.</i></p>

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>The schedule of matters reserved for the Board of Directors should include a clear statement detailing the roles and responsibilities of the Council of Governors. 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>See Annual Report page 37 and page 48.</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>See Annual Report pages 38, 43, 47 and 60.</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>See Annual Report page 50.</p>
FT ARM	<p>The annual report should include a statement about the number of meetings of the council of governors and individual attendance by governors and directors.</p> <p>See Annual Report page 50.</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>See Annual Report page 37.</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>See Annual Report page 42.</p>
FT ARM	<p>The annual report should include a brief description of the length of appointments of the non-executive directors and how they may be terminated.</p> <p>See Annual Report pages 37 and 48.</p>

Reference	Statutory requirement:
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>See Annual Report page 47.</p>
FT ARM	<p>The disclosure in the annual report on the work of the nominations committee should include an explanation if neither an external search consultancy nor open advertising has been used in the appointment of a chair or non-executive director.</p> <p>See Annual Report page 47.</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>See Annual Report page 38.</p>
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>See Annual Report page 49.</p>
FT ARM	<p>If, during the financial year, the Governors have exercised their power under paragraph 10C of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report.</p> <p>See Annual Report page 49.</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>See Annual Report page 43.</p>
B.6.2	<p>Where there has been external evaluation of the board and/or governance of the trust, the external facilitator should be identified in the annual report and a statement made as to whether they have any other connection to the trust.</p> <p>No external evaluation was undertaken during 2016/17.</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. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report).</p> <p>See Annual Report pages 46 and 97.</p>

Reference	Statutory requirement:
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>See Annual Governance Statement on page 101.</p>
C.2.2	<p>A trust should disclose in the annual report:</p> <ol style="list-style-type: none"> a) If it has an internal audit function, how the function is structured and what role it performs; or 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. <p>See Annual Report page 45.</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> <p>This situation did not arise during 2016/17.</p>
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"> • the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed; • 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 • 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. <p>See Annual Report page 43.</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>This situation did not arise during 2016/17.</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>See Annual Report page 43.</p>

Reference	Statutory requirement:
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>See Annual Report page 51.</p>
FT ARM	<p>The annual report should include:</p> <ul style="list-style-type: none"> • A brief description of the eligibility requirements for joining different membership constituencies, including the boundaries for public membership; • Information on the number of members and the number of members in each constituency; and • A summary of the membership strategy, an assessment of the membership and a description of any steps taken during the year to ensure a representative membership including progress towards any recruitment targets for members. <p>See Annual Report page 51.</p>
FT ARM	<p>The annual report should disclose details of company directorships or other material interests in companies held by governors and/or directors where those companies or related parties are likely to do business with the NHS foundation trust. As each NHS foundation trust must have registers of governors' and directors' interests which are available to the public, an alternative disclosure is for the annual report to simply state how members of the public can gain access to the registers instead of listing all the interests in the annual report.</p> <p>See Annual Report pages 43 and 51.</p>

'FT ARM' indicates that the disclosure is required by the NHS Foundation Trust Annual Reporting Manual rather than the Code of Governance.

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 detailed below is available on request from the Director of Corporate Affairs and will also be placed on the Trust's website.

Reference	Statutory requirement:
A.1.3	<p>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.</p>
B.1.4	<p>A description of each director's expertise and experience, with a clear statement about the board of director's balance, completeness and appropriateness.</p>
B.2.10	<p>The main role and responsibilities of the nominations committee should be set out in publicly available, written terms of reference.</p>

Reference	Statutory requirement:
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.

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.

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.

There was just one instance of a Non-Executive Director seeking re-appointment during 2016/17. Relevant information was provided to the Council of Governors by the Chairman in relation to the re-appointment of Mr M Cheshire with effect from 1 September 2016.

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.

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.

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

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.

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.

Provision	Summary:
A.1.4	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 <i>The Trust is declaring compliance.</i>
A.1.5	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 <i>The Trust is declaring compliance.</i>
A.1.6	The board should report on its approach to clinical governance. <i>The Trust is declaring compliance.</i>
A.1.7	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. <i>The Trust is declaring compliance.</i>
A.1.8	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. <i>The Trust is declaring compliance.</i>
A.1.9	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. <i>The Trust is declaring compliance.</i>

Provision	Summary:
A.1.10	<p>The NHS foundation trust should arrange appropriate insurance to cover the risk of legal action against its directors.</p> <p><i>The Trust is declaring compliance.</i></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><i>The Trust is declaring compliance.</i></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><i>The Trust is declaring compliance.</i></p>
A.4.2	<p>The chairperson should hold meetings with the non-executive directors without the executives present.</p> <p><i>The Trust is declaring compliance.</i></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><i>The Trust is declaring compliance.</i></p>
A.5.1	<p>The council of governors should meet sufficiently regularly to discharge its duties.</p> <p><i>The Trust is declaring compliance.</i></p>
A.5.2	<p>The council of governors should not be so large as to be unwieldy.</p> <p><i>The Trust is declaring compliance.</i></p>
A.5.4	<p>The roles and responsibilities of the council of governors should be set out in a written document.</p> <p><i>The Trust is declaring compliance.</i></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><i>The Trust is declaring compliance.</i></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><i>The Trust is declaring compliance.</i></p>
A.5.7	<p>The council should ensure its interaction and relationship with the board of directors is appropriate and effective.</p> <p><i>The Trust is declaring compliance.</i></p>

Provision	Summary:
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><i>The Trust is declaring compliance.</i></p>
A.5.9	<p>The council should receive and consider other appropriate information required to enable it to discharge its duties.</p> <p><i>The Trust is declaring compliance.</i></p>
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><i>The Trust is declaring compliance.</i></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><i>The Trust is declaring compliance.</i></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><i>The Trust is declaring compliance.</i></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><i>The Trust is declaring compliance.</i></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><i>The Trust is declaring compliance.</i></p>
B.2.4	<p>The chairperson or an independent non-executive director should chair the Nominations committee(s).</p> <p><i>The Trust is declaring compliance.</i></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><i>The Trust is declaring compliance.</i></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><i>The Trust is declaring compliance.</i></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><i>The Trust is declaring compliance.</i></p>

Provision	Summary:
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><i>The Trust is declaring compliance.</i></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><i>The Trust is declaring compliance.</i></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><i>The Trust is declaring compliance.</i></p>
B.5.1	<p>The board and the council of governors should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make.</p> <p><i>The Trust is declaring compliance.</i></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><i>The Trust is declaring compliance.</i></p>
B.5.3	<p>The board should ensure that directors, especially non-executive directors, have access to independent professional advice, at the NHS foundation trust's expense, where they judge it necessary to discharge their responsibilities as directors.</p> <p><i>The Trust is declaring compliance.</i></p>
B.5.4	<p>Committees should be provided with sufficient resources to undertake their duties.</p> <p><i>The Trust is declaring compliance.</i></p>
B.6.3	<p>The senior independent director should lead the performance evaluation of the chairperson.</p> <p><i>The Trust is declaring compliance.</i></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><i>The Trust is declaring compliance.</i></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 details on how they have discharged their responsibilities.</p> <p><i>The Trust is declaring compliance.</i></p>

Provision	Summary:
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><i>The Trust is declaring compliance.</i></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><i>The Trust is declaring compliance.</i></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><i>The Trust is declaring compliance.</i></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><i>The Trust is declaring compliance.</i></p>
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) 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"> i. The NHS foundation trust's financial condition; ii. The performance of its business; and/or iii. 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. <p><i>The Trust is declaring compliance.</i></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><i>The Trust is declaring compliance.</i></p>

Provision	Summary:
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><i>The Trust is declaring compliance.</i></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><i>The Trust is declaring compliance.</i></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><i>The Trust is declaring compliance.</i></p>
C.3.8	<p>The audit committee should review arrangements that allow staff of the NHS 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><i>The Trust is declaring compliance.</i></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><i>The Trust did not have a performance-related element of remuneration for Executive Directors during 2016/17.</i></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><i>The Trust is declaring compliance.</i></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><i>The Trust is declaring compliance.</i></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><i>The Trust is declaring compliance.</i></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><i>The Trust is declaring compliance.</i></p>

Provision	Summary:
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><i>The Trust is declaring compliance.</i></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><i>The Trust is declaring compliance.</i></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><i>The Trust is declaring compliance.</i></p>
E.2.2	<p>The board should ensure that effective mechanisms are in place to co-operate 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><i>The Trust is declaring compliance.</i></p>

Regulatory Ratings

On the 24 April 2013 the Trust signed Enforcement Undertakings with Monitor in relation to the Trust's breaches of the A&E 4 hour target and potential weaknesses in Governance processes. Monitor's concerns were such that this was superseded on 4 August 2014 by imposition of an additional licence condition under section 111 of the Health and Social Care Act 2012 (a copy of which is available on Monitor's website).

The licence condition stipulated additional governance requirements relating to functioning of the Board and its committees, the need to address concerns arising from the independent governance review completed by Deloitte LLP in May 2014 and actions necessary to ensure compliance with the A&E 4-hour waiting time standard. Much work was completed during 2014/15 to address identified weaknesses in governance arrangements and the outcomes of a follow-up review reported by Deloitte LLP in March 2015 provided independent assurance that necessary actions had been taken. Consequently, the element of the additional licence condition relating to Board effectiveness and governance was formally rescinded by Monitor on 1 June 2015.

However, sustainable delivery of the A&E 4-hour waiting time standard has continued to be a major challenge, despite the considerable efforts made by the Trust to achieve this target. This has continued to be a feature of our progress review meetings with NHS Improvement and, at a Quarterly Review Meeting held on 6 March 2017, the Trust was advised that NHS Improvement intended to conduct a review of the Enforcement Undertakings. This review is scheduled to take place during May / June 2017. The Trust's aim is to take the necessary actions to provide NHS Improvement with assurance that the Trust is returning to full and sustainable compliance with the terms of its licence. This has been identified by the Board as a strategic objective for the Trust in 2017/18.

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 NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Stockport NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. 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 Department of Health Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement, 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 (and the Department of Health Group Accounting 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 the NHS Foundation Trust Accounting Officer Memorandum.



Ann Barnes
Chief Executive

25 May 2017

Annual Governance Statement 2016/17

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 2017 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

Leadership and management of the risk management process is provided through:

- The Board of Directors 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 Risk Management Committee, a sub-committee of the Quality Assurance Committee, which has responsibility for organisation-wide co-ordination and prioritisation of risk management issues. The Committee adopts a 'peer review' approach to provide guidance and encourage learning from best practice.
- An assessment of the level of risk management training that is required for staff and its delivery
- Review of the Risk Management Training Needs Audit matrix by the Risk Management Committee, which strengthens assurance that risk management training is effective, inclusive of a monitoring and review process
- Ensuring that employees with specific responsibilities for co-ordinating and advising on aspects of risk management have adequate training and development to fulfil their role
- The Trust's Risk Management Strategy, which clearly defines managers' levels of authority to manage and mitigate risks, according to risk scored ratings.

The risk and control framework

The Trust has a Board-approved Risk Management Strategy which sets out our approach to the

management of risk and the system which assists in the identification, assessment, control and monitoring of risk. Risk management is recognised as a fundamental part of the Trust's culture and is firmly embedded in our philosophy, practices and business plans by means of appropriate training and development for employees with specific responsibilities for coordinating and advising on risk management.

Our risk assessment process, incident reporting and investigation and matters arising from complaints and claims are the principal sources of risk identification. The Trust has an open and accountable reporting culture and staff are encouraged to identify and report incidents by means of an online incident reporting tool. 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, resources and reputation. The policy 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 use equality impact assessments and quality impact assessments is embedded in the Trust's business arrangements with the outputs of such assessments being used to inform risk mitigation activities where appropriate.

We use a '5x5 matrix' to assess and rate risks on both the likelihood and consequence to generate a risk score of between 1 and 25. The risk score then determines an appropriate level of escalation, management and scrutiny. The Risk Assessment process applies to all types of risk; clinical, financial, and operational, and risk registers are maintained by each of our Business Groups with registers subject to regular review at Business Group Quality Board meetings. Any risks with a residual risk score of 15 or above are placed on the Corporate Risk Register which is monitored on a monthly basis by the Risk Management Committee, Board-level Committees and the Board of Directors. Practice was enhanced during 2016/17 through the introduction of a 'peer review' approach to the assessment of risks by the Risk Management Committee.

The Board Assurance Framework details risks associated with delivery of the Trust's principal objectives. Control measures and sources of assurance are clearly detailed in the Board Assurance Framework, together with details of any gaps in either control or assurance, and each entry has an associated action plan. The Board Assurance Framework is reviewed by the Board of Directors on a bi-monthly basis and the Board considers developments in the external environment in relation to inform Board Assurance Framework content. An Internal Audit assessment completed in March 2017 confirmed that "*The organisation's Assurance Framework is structured to meet the NHS requirements, is visibly used by the Board and clearly reflects the risks discussed by the Board*".

Management capability, in terms of leadership, the availability of knowledgeable and skilled staff and adequate financial and physical resources, to ensure that processes and internal controls work effectively is routinely monitored by the Executive Team. The Board monitors and reviews the system of internal control and, where necessary, will identify improvements to accountability arrangements, processes or capability in order to deliver better outcomes. In 2016/17 this included further development of the Board's Committee arrangements which involved merger of previous Committees to result in three Assurance Committees, each of which is chaired by a Non-Executive Director and report directly to the Board. These Committees are:

- Finance & Performance Committee
- Quality Assurance Committee
- People Performance Committee

Reports from the Assurance Committees which detail key issues considered by the Committees and associated risks are presented by the Committee chairs at each Board of Directors meeting.

The foundation trust is fully compliant with the registration requirements of the Care Quality Commission. Further information on this area is included on page 97.

Key Organisational Risk in 2016/17 and 2017/18

The risks to the principal objectives of the Trust, as identified in the Board Assurance Framework for 2016/17, were:

- Risk 1 - Emphasis on day to day operational delivery, in response to environmental pressures, results in lack of focus on strategic change programmes with consequent impairment or failure to deliver the Trust's Five Year Strategy
- Risk 2 - Failure to plan, resource and engage effectively with strategic change programmes impairs level of control and influence with a consequent detrimental impact on patient services.
- Risk 3 - Failure to achieve sustainable delivery of the 4-hour A&E target impairs quality of patient care and results in further regulatory intervention.
- Risk 4 - Inability to maintain and improve compliance with Care Quality Commission standards impairs patient experience, damages Trust reputation and results in regulatory intervention.
- Risk 5 - Failure to deliver the required level of cost improvement to deliver the agreed control total and receipt of Sustainability & Transformation Funding (STF) with a consequent impact on patient services, increasing the likelihood of regulatory intervention.
- Risk 6 - Failure to prepare and deliver effective workforce plans supported by continuous professional development impairs the availability of workforce resources with a consequent impact on the delivery of patient services.
- Risk 7 - Failure to ensure efficient management of the EPR Project results in data loss from current systems and the inability to realize the benefits expected to accrue from implementation of a comprehensive electronic system.

The principal risks to compliance with condition FT4 of the Trust's provider licence ('the FT governance condition') are as follows:

- 4-hour emergency department waiting time (target breached in all four Quarters during 2016/17)

The Trust remained in breach of its provider licence throughout 2016/17 as a result of failure to achieve the 4-hour Emergency Department target and Board members have continued to meet with NHS Improvement representatives at regular intervals to discuss the effectiveness of measures being taken to address weaknesses in performance. Clearly, the Trust's performance against the 4-hour emergency department standard has continued to be a key area of scrutiny due to non-achievement of the target in any Quarter during 2016/17. Delivery of this standard remains a risk in 2017/18. The Trust implemented initiatives to manage patient flows, which included the provision of additional bed capacity over and above winter plan levels and the outsourcing of activity to create capacity. However, a combination of increased levels of high acuity patients and difficulties experienced in managing the effective discharge of patients with

social care needs, had a significant impact on capacity. It is evident that delivery of the standard on a sustainable basis is reliant on a local health economy approach to ensure that processes are efficient and effective at each point in the patient journey. The Trust has worked proactively with partners from; Stockport CCG, Stockport Metropolitan Borough Council, Viaduct Healthcare and Pennine Care NHS Foundation Trust to identify collaborative solutions to address pressures throughout the year and to progress new models of care through as part of the development of a sustainable, resilient solution through the Stockport Together programme.

On 30 March 2017, the Board of Directors formally reviewed the Board Assurance Framework for 2016/17 and agreed that the principal risks detailed above remained relevant for 2017/18 subject to an amendment to Risk 5 as follows:

- Failure to achieve the required level of cost improvement to deliver the Trust's financial plan with a consequent impact on patient services, increasing the likelihood of regulatory intervention.

The governance framework described above will ensure that risks are identified and, where necessary, escalated for action from Business Groups to Executive Team, Committees and the Board of Directors. Risks or developments that may have a consequent impact on quality of care will be identified through completion of quality impact assessments for business cases and cost improvement schemes. The outcomes of quality impact assessments are subject to validation by the Medical Director and Director of Nursing & Midwifery. The Trust will seek to engage proactively with public stakeholders in the management of any risks which may impact upon them.

The practice and processes incorporated in the risk and control framework, together with those incorporated in the quality governance framework serve to provide assurance on the validity of the Trust's Corporate Governance Statement as required under NHS foundation trust condition 4(8)(b).

Quality Governance Framework

Stockport NHS Foundation Trust has effective arrangements for monitoring and continually improving the quality of care provided to its patients. The Board of Directors monitors performance against a suite of indicators relating to clinical, access and partnership and efficiency metrics through consideration of an Integrated Performance Report at each Board meeting. This report incorporates specific quality metrics relating to the following seven domains:

- Mortality & preventable deaths
- Pressure ulcers
- C Difficile
- Dementia FAIR
- Falls
- Discharge summary
- Patient experience

The Trust is fully compliant with the registration requirements of the Care Quality Commission and had been subject to a CQC inspection in January 2016. The outcome of the inspection, published in August 2016 was an overall rating of 'Requires Improvement' with the overall rating being driven by poor outcomes of the assessment of Accident & Emergency Department arrangements. The

outcomes for each area reviewed during the inspection were as follows:

- Stepping Hill Hospital (eight service areas): 5 = Good, 3 = Requires Improvement
- Community Health Services for Adults: Requires Improvement
- Community Health Services for Children, Young People and Families: Good
- Community Health Inpatient Services: Good
- End of Life Care: Good

A comprehensive action plan was prepared to address weaknesses identified during the inspection, with progress monitored by the Quality Assurance Committee and the Board of Directors. A follow-up inspection was subsequently carried out by the CQC in late March 2017 and positive observations relating to improved communication, culture change and patients being treated with kindness, dignity and respect were noted. However, there were also a number of areas where the actions taken by the Trust were considered to require further attention. The Trust submitted a further action plan to the CQC for these specific areas on 11 April 2017.

No Never Events were identified by the Trust during 2016/17. Assurance on control arrangements relating to Never Events was provided through the outcomes of a comprehensive independent review which was commissioned by the Trust during 2015/16. The review considered seven Never Event incidents which had occurred in the Trust between 2012 - 2015 to determine any systemic weaknesses and to identify learning to mitigate the risk of such incidents and the final report was considered by the Board of Directors on 30 June 2016. An action plan was prepared to address recommendations from the review which was monitored through to completion by the Quality Assurance Committee. However, it should be noted that the review concluded that *“The pattern of Serious Untoward Incidents experienced by the trust is not unusual. Furthermore, following a review of all appropriate documentation, no evidence has been found to suggest that the Trust has an unrecognised systematic patient safety problem. On the contrary, the evidence indicates that the vast majority of the activities undertaken by the Trust, with respect to patient safety meet the highest standards”*.

Information Risks

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

- IT security controls for the encryption of all laptops and mobile devices including e-mail encryption software. There is restriction on the use of removable media on all Trust computers.
- E-mail and web security controls and filters to protect against malicious software and websites
- On-going review of information flows of person identifiable data, internally and externally, and ensuring appropriate measures to maintain secure transfer of data.
- Review and continued focus on security policies and guidance issued around handling and sharing of personal data in compliance with the Data Protection Act.
- 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 Support Services.

- All staff are required to complete information governance e-learning as part of the Trust's mandatory training programme.

The overall Information Governance Toolkit self-assessment score for version 14 (2016/17) achieved 68% with all 45 of the requirements met at Level 2 standard or above. Action plans are in place to further improve performance during 2017/18. An Internal Audit review of IG Toolkit evidence resulted in an assessment of Significant Assurance.

The Trust reported one serious IG incident (level 2) to the Information Commissioner's Office (ICO) during 2016/17 which related to data loss or confidentiality breaches. The incident was subject to a full investigation, with appropriate action taken to mitigate risk of reoccurrence. No regulatory action was taken by the ICO. A summary of the incident is included below:

Date of Incident	Nature of Incident
October 2016	Failure to remove patient identifiable data in hidden cells from a Spreadsheet before it was uploaded to a secure, restricted access website.

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 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 assurance sources and material in its on-going review of economy, efficiency and effectiveness of the use of resources. The annual internal audit programme, together with the reports from individual audits, provides assurance to the Audit Committee on the operational arrangements to secure economy, efficiency and effectiveness in the use of resources.

Assurance on the effectiveness of use of resources is also provided through scrutiny of performance against objectives and targets which is achieved through a number of channels, including:

- Approval of annual budgets by the Board of Directors
- Monthly reporting to the Board on key performance indicators covering access, finance, quality and workforce targets
- Scrutiny of performance against the financial plan and monitoring delivery of strategic change projects by the Finance & Performance Committee
- Board of Directors consideration of key issues reports from its Assurance Committees
- Executive team performance review meetings with Business Groups.

During 2016/17, the Trust was selected as a first-wave participant in a national Financial Improvement Programme coordinated by NHS Improvement. The FIP was completed during the period May - October 2016 with the Trust working in partnership with KPMG LLP. Participation in the programme not only made a significant contribution to the Trust's delivery of efficiency savings totalling £14.1m for the year, but also ensured expert support in reviewing, re-designing and embedding best practice governance arrangements for management of the Trust's cost improvement programmes. Participation in the FIP had a material impact on economy, efficiency and the effective use of resources.

Compliance with the NHS Foundation Trust Code of Governance is reviewed by the Audit Committee on a six-monthly basis as a core element of the Committee's work plan. Outcomes of these reviews inform the compliance declarations included at page 78 of the report. Work of the Audit, Nominations and Remuneration committees is included on pages 43, 47 and 60 of the report.

NHS Improvement Review of Trust Position

On the 24 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. Monitor's concerns were such that this was superseded on 4 August 2014 by imposition of an additional licence condition under section 111 of the Health and Social Care Act 2012 (a copy of which is available on Monitor's website). In July 2015 the additional licence condition relating to Governance was formally removed by Monitor in recognition of the actions taken by the Trust in response to recommendations made following an independent Governance Review completed by Deloitte LLP during 2014/15.

However, sustainable delivery of the A&E 4-hour waiting time standard has continued to be a major challenge, despite the considerable efforts made by the Trust to achieve this target and this subject has been a constant theme of progress review meetings with NHS Improvement throughout 2016/17. At the initial Quarterly Review Meeting (QRM) on 6 March 2017, the Trust was advised by NHS Improvement of their intention to conduct a formal review of the Enforcement Undertakings and we anticipate that this review will be conducted during the period May-June 2017.

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.

NHS Improvement 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 that 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:

- Seeking feedback on presentation and content of the Quality Report from commissioners, governors and other key stakeholders
- 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. The Trust also engages with national coding audits and uses external benchmarking provided through CHKS 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.

However, the external testing of mandated indicators, completed by Deloitte LLP to support a limited assurance opinion on the Quality Report, identified weaknesses in data management process and practice relating to the 18-week incomplete Referral to Treatment indicator. The weaknesses resulted in a modified opinion for this specific indicator. Actions to address the identified weaknesses, including the introduction of a bespoke mandatory training programme for all staff who contact the 18-week pathway, were implemented during 2016/17 and, while some progress has been made, further action to fully resolve these issues has been initiated and assurance on the effectiveness of this action will be monitored by the Audit Committee.

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. Our Integrated Performance Report includes indicators relating to finance, performance, quality and workforce and a 'kite marking' system is used to provide assurance on data quality for each indicator to identify; the source of the data, the timeframe represented, method of calculation and whether or not the data has been validated. 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 the other committees that form part of the Trust's assurance structure and a plan to address weaknesses and ensure continuous improvement of the system is in place.

In describing the process that has been applied in maintaining and reviewing the effectiveness of the system of internal control I have detailed below some examples of the work undertaken during 2016/17.

My review has been informed by:

- The Board Assurance Framework which provides the Trust with evidence of the effectiveness of the system of internal controls that manage the principal risks to the organisation's strategic objectives. The Assurance Framework is subject to regular review by the Board of Directors.
- Internal Audit review of the Board Assurance Framework and the effectiveness of the overall system of internal control as part of the Internal Audit plan which is agreed by the Audit Committee.
- The Director of Audit Opinion which gave an overall significant assurance opinion on the system of internal control for 2016/17.
- The Trust continues to be registered with the Care Quality Commission without conditions.
- The process for the follow-up of audit recommendations which is monitored by the Audit Committee.
- Committees within the Board's committee structure having a clear timetable of meetings and a clear reporting structure which enables matters to be reported and/or escalated in a timely manner.
- Outcomes of the Financial Improvement Programme (FIP) completed during the period May – October 2016.

The Trust has a comprehensive risk-based internal audit programme in place and the programme was delivered in full during 2016/17. Outcomes of the internal audit programme are reported to the Audit Committee and appropriately led action plans are in place to address any audits which result in a limited assurance assessment.

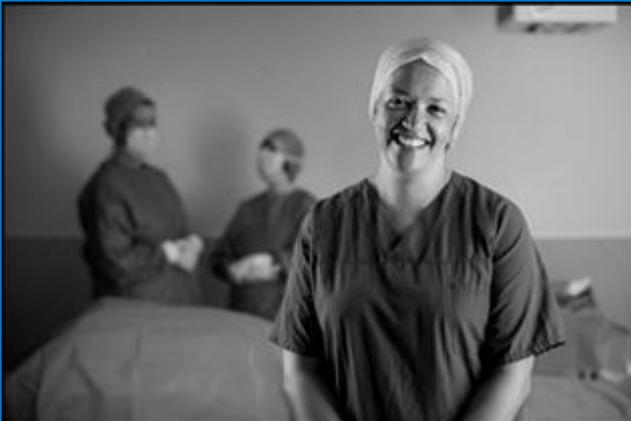
Conclusion

During 2016/17, no significant control issues have been identified by the Trust's systems of internal control. My review confirms that Stockport NHS Foundation Trust has generally sound systems of internal control that support the achievement of its policies, aims and objectives.



Ann Barnes
Chief Executive

25 May 2017



Annual Quality Accounts Report 2016 – 17

Your Health. Our Priority.



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HEALTHCARE

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MAP

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What is a Quality Account?

The Quality Account (Quality Report) is an annual report about the quality of services provided by an NHS healthcare organisation. Quality Accounts aim to increase public accountability and drive quality improvements in the NHS.

Our Quality Account looks back on how well we have done in the past year at achieving our goals. It also looks forward to the year ahead and defines what our priorities for quality improvements will be and how we expect to achieve and monitor them.

This report is presented to parliament as part of our 'Annual Report and Accounts 2016-17' and is a standalone document available on the NHS Choices website and at www.stockport.nhs.uk.



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PART 1

Statement on Quality from the Chief Executive

Part 1

Statement on Quality from the Chief Executive

We are going through a period of fundamental change to the way care is delivered, within a backdrop of immense urgent care and financial challenges. Our involvement in both regional and local health and social care partnerships throughout the year have been a central part of the quality agenda. At a regional level, we have been fully engaged in the Greater Manchester Health and Social Care Partnership throughout its first year under devolution.



Our local position aligns with the aims of the Greater Manchester five year strategic plan: improved population health, quality of care and cost control, matched by removing the boundaries between mental and physical health, primary and specialist services, health and social care. As part of the Greater Manchester strategic plan we continued to progress the Healthier Together agenda to deliver a single service approach for emergency and planned high acuity general surgery as one of four specialist hospital sites.



Our new £20 million medical and surgical centre opened in October 2016 to support this new position as the 'hub' site for the Healthier Together South East Sector of Greater Manchester. The new centre offers a vastly improved quality environment, with over 120 beds for patients, replacing facilities in old wards. It also includes four new operating theatres, three of which replace old theatres.

Locally, the Stockport Together health and social care partnership accelerated work on the multi-specialty community provider Vanguard new model of care. Stockport Together was selected as one of 15 areas nationwide to test this new model. A shadow provider board is in place for the multi-specialty community provider, with a lot of work taking place over the year to enhance primary care, integrate neighbourhood teams, roll out a healthy communities programme and establish an intermediate tier hub. The Stockport Together Vanguard plans to provide improved services closer to home, a long-term sustainable solution to help reduce the pressure on urgent care and to deliver cost efficiencies.

Despite intense work over the year however, we did not achieve the national A&E four-hour wait target, facing an especially difficult period over Christmas and the New Year. Whilst we are not alone in struggling to achieve this national standard, the Care Quality Commission and Health Education England North West raised concerns over the increased risk to quality and safety in our emergency department. Our most recent Care Quality Commission inspection resulted in a rating of 'requires improvement' due mainly to the issues in the emergency department.

Robust action plans, with additional support and oversight from Greater Manchester Health and Social Care Partnership, the Care Quality Commission and NHS Improvement

are in place to reduce emergency admissions, improve length of stay and discharge processes.

A new pathway to stream patients attending A&E with ambulatory, primary care type conditions has been successfully introduced in partnership with Mastercall, the out of hours General Practitioner (GP) service. A new transfer to assess team, recovery at home service, and crisis response team has already been put in place. In addition, we have opened new ambulatory care and community units on the hospital site and expanded both our emergency department and short stay older people's unit. We have also invested in 24 hour bed management and discharge co-ordinators.

These changes have begun to have a positive impact on the care that we deliver across health and social care, with services being community focused and improving standardisation. We will continue with changes in the next two years to transform services, improve outcomes for our population, reduce inefficiencies and provide sustainable services.



Our quality strategy 2015-2020 sets out our specific quality priorities and approach to quality improvement. It aims to improve the quality of care for patients and families by reducing harm and mortality, providing reliable care and improving the patient experience. It is underpinned by a culture of strong leadership and clinical engagement and supported by the executive leads for quality improvement, the Medical Director

and Director of Nursing and Midwifery, as well as a focus on the well-led elements of the Care Quality Commission framework.

Our quality improvement plan for the next two years comprises a broad range of local and national quality priorities which are consistent with our local sustainability and transformation plan. It includes our approach to seven day services, which is centered on the four Keogh standards directly linked with weekend mortality and on making progress in a financially challenged health economy.

Having the right numbers and types of clinical staff is an essential part of our quality agenda. The time taken to train staff, the challenging, changing landscape and the scale of the exercise, mean that our workforce planning is a complex issue and process.

Good training and development opportunities for our medical, nursing and therapy practitioners is a priority and we are working hard with Health Education England North West to make improvements. This goes hand in hand with our policy of recruiting and retaining staff for their talent and values based behaviours. Values based recruitment ensures our staff are able to provide optimal care to our patients in a positive, effective manner and style. Our staff appraisal system measures not just 'what' staff are delivering but 'how'.

We have created a learning and development and clinical skills plan in conjunction with senior clinical staff. This identifies the priorities over the next two years to support workforce transformation, including the need for greater partnership working and skills development across health and social care and the impact of 'new' roles. In addition, we have pursued the international recruitment of nursing staff, launched a nurse recruitment campaign across the region and are developing a recruitment and retention strategy. The diversity and richness of our workforce is energising and having a positive impact on patient care.

Our guiding principle for success is based on positive outcomes and feedback from patients, carers and families. We continue with our commitment to openness and transparency; ensuring everyone's voices are heard and used to help us to deliver better services. Our key measures of success are satisfied patients and staff who feel positive about what they are doing. Our staff survey this year was extremely disappointing in this respect but has provided us with further impetus to improve on staff involvement and engagement. The goal is high quality care for all, now and for future generations.

I would like to give thanks and appreciation to

our staff for their exceptional commitment and professionalism, often in challenging circumstances.

I would also like to thank our governors, volunteers, members and supporters for their tremendous support and contribution which clearly makes a positive difference to our Trust.



Mrs. Ann Barnes

Chief Executive

Stockport NHS Foundation Trust

Declaration:

There are a number of inherent limitations in the preparation of Quality Accounts which may impact the reliability or accuracy of the data reported. These include:

- *Data is derived from a large number of different systems and processes. Only some of these are subject to external assurance, or included in internal audits programme of work each year.*
- *Data collection practices and data definitions are evolving, which may lead to differences over time, both within and between years. The volume of data means that, where changes are made, it is usually not practical to reanalyse historic data.*

The Trust and its Board of Directors have sought to take all reasonable steps and exercise appropriate due diligence to ensure the accuracy of the data reported, but recognises that it is nonetheless subject to the inherent limitations noted above. Following these steps, to my knowledge, the information in the document is accurate.



.....Chief Executive

25 May 2017.....Date

PART 2

Priorities for improvement & statements of assurance from the board

Part 2

Priorities for improvement & statements of assurance

All organisations need to understand how well they are doing, and how they can develop and improve their services in the future. Our strategy for quality improvement sets out how quality improvement will contribute to the delivery of the Trust's overarching five year strategic plan.

The Trust's first priority is its commitment to putting patients, carers and families first. This means that in both the hospital and the community we strive every day to provide the best, safest and most effective care and a positive experience for our patients and their families.

Each of our services aims to:

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

As an organisation we aim to become one of the safest organisations in the NHS and to provide safe, high quality care, underpinned by evidence-based practice, whilst also providing an excellent patient experience. To achieve this we will focus on strategic outcomes which encompass the five domains of the NHS Operating Framework:

1. Preventing people from dying prematurely
2. Enhancing quality of life for people with long-term conditions
3. Helping people to recover from episodes of ill health or following injury
4. Ensuring that people have a positive experience of care
5. Treating and caring for people in a safe environment and protecting them from avoidable harm

Our strategic outcomes will be that:

Quality Accounts Report 2016-17

Patients' health and well-being is supported by high quality, safe and timely care

The Trust continues to hold patient safety as its first priority. We know that we have improved patient safety through changes to clinical practice and patient care, through adoption of evidence based guidance and compliance with care bundles.

We also know that we have a good safety culture, as demonstrated by our staff reporting high numbers of incidents (National Reporting and Learning System (NRLS) data) and by our current position in band 6 of the Care Quality Commission Intelligent Monitoring Report (CQC, July 2014), denoting the lowest risk on 150 indicators.

However all this would be worthless if we had not also improved the ways in which we measure and monitor patient safety; we now have data available to compare indicators across time and between teams and organisations. An underpinning objective for all the following patient safety goals is that the Trust continues to invest in the effective use of patient safety data and outcomes.

Patients and their families feel cared for and empowered

The Trust will build upon systems and processes already in place to strengthen the cycle of continual listening, learning and service improvement; working together with our patients, their families and our partners in care, to ensure their feedback is routinely captured and used to enhance patient experience and service improvement.

PART 2.1

Priorities for improving Quality in 2016-17

Part 2.1

Priorities for improving Quality in 2016-17

The Trust's Quality Improvement Strategy 2014-19 was approved by the Board of Directors in November 2014. It was then refreshed in light of the new Trust strategy and was re-presented to the Board as part of a suite of supporting strategies, which included a change of timescales to 2015-20, in line with all other strategies.

The current Quality Improvement Strategy closely followed the Trust's first such strategy (2008-2012) which was based on the 'Darzi' definition of quality as comprising patient safety, clinical effectiveness and the patient experience. It also incorporated findings from Trust serious incident investigations, the Francis Report (2013) and the five domains of the NHS Operating Framework as indicated on page 11.

Priorities are chosen following discussions with stakeholders and using intelligence that is gathered from various sources. Most are key topics nationally and the objective is how SFT will support improvement in those areas. The quality strategy delivery plan is regularly updated at the start of the year, to show the new or refreshed annual objectives (see page 14), and during the year to show progress to date. During the process of updating the strategy objectives for 2016-17, project leads raised a number of issues which resulted in a number of the original projects being removed.

Projects removed from the plan and rationale for exclusion is specified below.



WEEKEND MORTALITY

This has always been viewed as an integral part of the drive towards 7-day working and as such, is subject to a set of national standards. The Trust has acknowledged that it can only implement these standards working with partners in Stockport Together and it will be taken forward as part of this programme.



CARE BUNDLES

Many Greater Manchester Trusts and CCGs have now moved away from using Advancing Quality Alliance (AQuA) for this in order to make the indicators real-time and more local. Since care bundles for 2016-17 form one of the local CQUINs it was agreed that these be removed from the Quality Strategy.



REDUCE HOSPITAL READMISSIONS

This has always been viewed as an integral part of the drive towards 7-day working and as such, is subject to a set of national standards. The Trust has acknowledged that it can only implement these standards working with partners in Stockport Together and it will be taken forward as part of this programme.



PROVIDING CARE WITH DIGNITY AND COMPASSION

This is such a fundamental issue in all aspects of care and treatment and already features in the Nursing and Midwifery Strategy, the OD and Engagement Strategy and as part of the PLACE programme led by Estates and Facilities.

1. SEPSIS	To introduce sepsis screening tool
PROVIDE HARM FREE CARE:	OBJECTIVES 2016-17
2. PRESSURE ULCERS	To continue to work towards achieving a reduction in avoidable grade 3 and 4 pressure ulcers: <ul style="list-style-type: none"> • zero incidence for acute areas • 50% reduction for community (on 2015-16 outturn)
3. FALLS	<ul style="list-style-type: none"> • To reduce serious falls (major and above Datix categories) by 33% (on 2015/16 outturn) • To undertake a comprehensive review of the falls bundle and evaluation of themes • To work with Stockport CCG at the falls 'cluster' meetings to reduce falls in the whole health economy
4. VENOUS THROMBOEMBOLISM	To continue to work towards a 50% reduction of <u>avoidable</u> venous thromboembolism (VTE) by implementing lessons from VTE root cause analysis (RCA)
5. MEDICATION ERRORS	To continue with all measures designed to reduce medication incidents which cause harm
6. HEALTHCARE ASSOCIATED INFECTIONS	To achieve both local and national HCAI targets
7. DIABETES	To embed the changes made during 2015-16 and achieve zero incidence of diabetes related serious incidents
PROVIDE RELIABLE CARE:	OBJECTIVES 2016-17
8. EARLY WARNING SCORE	To continue to build on progress made during 2015-16 to further reduce cardiac arrests on wards
IMPROVE PATIENT EXPERIENCE:	OBJECTIVES 2016-17
9. CAPTURING & LEARNING FROM PATIENT & FAMILY FEEDBACK	To continue to build on progress made during 2015-16 and in particular: <ul style="list-style-type: none"> • Expand patient voices to include OPD areas • Review and strengthen community services data capture in relation to patient experience • Review and improve the Trust's systems and processes to communicate and inform patients and service users e.g. review of bedside booklets, utilising patient feedback in training and providing feedback in a variety of modalities to help inform service reviews • Further develop the triangulation of FFT results with staff FFT results to provide a more in-depth understanding of service effectiveness
10. IMPROVE CARE FOR PATIENTS WITH DEMENTIA	High level objectives: <ul style="list-style-type: none"> • Emergency Department (ED): Fast track of patients using a blue name-band for patients with a diagnosis of dementia, and further work with ED staff on support for people with dementia • Find, Assess, Investigate, Refer and Inform (FAIRI) assessments – work with medical staff to ensure it is incorporated as part of the regular clerking process • Use of the training resource, 'Barbara's Story' at all dementia training sessions • More widespread use of 'This is me' booklet in care planning and management of patients living with a diagnosis of dementia • Dementia ward: Further roll out of rooms such as the quiet room/ reminiscence room on Ward E2 and dementia space on SSOP; development of a dementia ward
11. COMPLAINTS MANAGEMENT & DUTY OF CANDOUR	To review the management of complaints against the recommendations of NHS England 'A Quality Framework for Complaints' (2015) and PHSO 'Breaking down the Barriers' (2015) for further improvement, particularly for older people

1

Sepsis

Sepsis

Sepsis is a life-threatening condition that arises when the body's own response to an infection injures its own tissues and organs. In the UK alone there are around 37,000 deaths each year. Sepsis can lead to shock, multiple organ failure and death, especially if not recognised early and treated quickly.



Following on from a patient safety alert published by NHS England in 2014, which highlighted that the prompt recognition of sepsis and the rapid initiation of treatment is key to reducing mortality rates, Stockport NHS Foundation Trust (SFT) continues to progress work undertaken to deliver further improvements in this area. Sepsis remains a priority topic for the Trust and continues as one of the National CQUIN's, which looks at patient screening and timely administration of antibiotics for patients with sepsis.

The CQUIN covers both Emergency Department and Inpatient settings. The ED system 'AdvantisED' enables 100% screening to take place; the antibiotic administration within the 1 hour timescale is challenging due to capacity issues and so the Trust is striving to improve the compliance with this timescale. Further information on the performance of this CQUIN is referred to on page 28 of this report.

It is more difficult to identify inpatients who may be at risk of developing sepsis, therefore, to help identify patients who require screening we introduced a screening tool for inpatients whose observations met the agreed criteria for sepsis and to ensure they receive the right care within the right timescales.

Patientrack, the software used to monitor patient observations and flag when assessments are required has been updated to include a flag for sepsis screening from April 2017.

The formation of the 'Sepsis Steering Group' has been key to monitoring and reviewing progress in this area.

The National Sepsis CQUIN will continue in 2017-18 and 2018-19.

2

Pressure Ulcers

Pressure ulcers are an injury that breaks down the skin and underlying tissue. They are caused when an area of skin is placed under pressure and develop over a short period of time. Pressure ulcers tend to affect people with health conditions that make it difficult to move, especially those confined to a bed or sitting for long periods of time.



For some patients, pressure ulcers require basic nursing care. For others they can be serious and lead to life-threatening

complications, such as blood poisoning or gangrene.

Even with the highest standards of care it is not always possible to prevent pressure ulcers in particularly vulnerable patients. However, 95% of pressure ulcers are completely avoidable, if the right steps are taken by our nursing teams. Our staff are taught that by turning and moving patients regularly, making sure any incontinence is well managed and that patients are well fed and hydrated, they are unlikely to develop an ulcer.

During 2016-17 there have been 21 acute grade 3+ avoidable pressure ulcers and 18 community grade 3+ avoidable pressure ulcers confirmed. With further incidents still under investigation, this is in the trust corporate risk register and an action plan to improve this position is reviewed on a monthly basis.

A new reporting process has been introduced into the acute setting which aims to determine avoidable/unavoidable status within 48-72 hours of development. When the process is fully embedded in the acute setting it will be incorporated in to the community business group.

Concerns relate to medical devices and Plaster of Paris (POP) applications which accounts for a significant number of incidents. Work is currently taking place with diagnostics and a wound care committee has been established.

3 Falls

Anyone can have a fall, but older people are more vulnerable and likely to fall, especially if they have a long-term health condition. Falls are a common, but often overlooked, cause of injury. Around one in three adults over 65 who live at home will have at least one fall a year, and about half of these will have more frequent falls.

Most falls don't result in serious injury. However, there's always a risk that a fall could lead to broken bones, and it can cause the person to lose confidence, become withdrawn and feel as if they've lost their independence increasing the risk of another fall.

In Stockport for those people in the 65+ age group we know that 47% attend the emergency department with falls and this age group are more likely to arrive by ambulance and more likely to be admitted to hospital rather than discharged. Once admitted to hospital all patients get assessed to see if they are at risk of falls and if so care plans are put in place to prevent further injury.



The Trust's target during 2016-17 for avoidable falls was ≤ 19 .

To date there have been 47 falls (major and above), of these;

- 8 are still under review
- 7 are deemed avoidable
- 32 have been deemed as unavoidable

A new process has commenced whereby all falls proformas are reviewed as soon after the fall as possible by a risk manager and the Assistant Director of Nursing to identify if further investigations are required.

A Falls Collaborative group has been set up which combines work going on in the community, as well as the hospital to prevent and reduce where possible the number of patients who fall. A number of work streams have been agreed to target the areas of the

falls bundle that need reviewing. These include:

- Review of Training required to include assessment around vision
- Documentation
- Audit of equipment required
- Designing Falls pathway that can be used across the whole health economy
- Creating a dashboard to monitor falls

National Institute for Health and Care Excellence (NICE) guidance for falls in older people has been reviewed in January 2017 and the Trust has reviewed its compliance against these standards.

4 VTE

Venous thromboembolism (VTE) is the collective term for Deep Vein Thrombosis (DVT) and Pulmonary Embolism (PE). DVT is a blood clot in one of the deep veins in the body. It can cause pain and swelling and may lead to complications, such as PE. This is when a piece of blood clot breaks off into the bloodstream and blocks one of the blood vessels in the lungs.



Each year more than 25,000 people in England die from VTE contracted in hospitals. This is more than the combined total deaths from breast cancer, AIDS and traffic accidents and more than 25 times the number who die nationally from MRSA (methicillin-resistant *Staphylococcus aureus*).

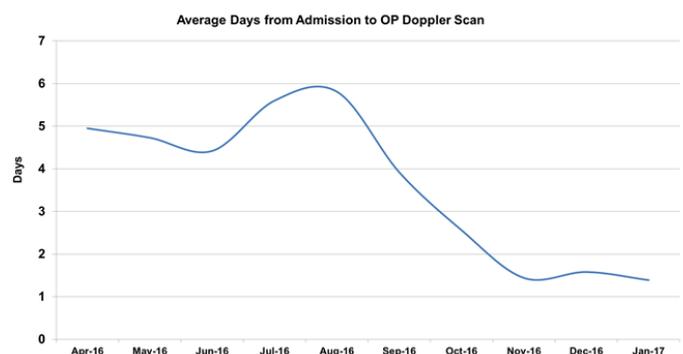
Risk assessments ensure that patients admitted to hospital are assessed for their risk of developing VTE so that appropriate preventative treatment can be given to improve health outcomes. Compliance against the 95% target for VTE risk assessment within the Trust remains high with the target being met in each month (April 2016 - March 2017).

A hospital acquired VTE is identified for any patient with a confirmed DVT or PE who had a previous admission greater than 24 hours within the last 30 days. During 2016-17 the Trust had 41 hospital acquired VTE's (compared to 48 in 2015-16). A RCA (root cause analysis) should take place to see if this could have been avoided. Root cause analysis is a key performance indicator as agreed with Stockport Commissioners.

The Trust Thrombosis committee meets bi-monthly and reviews cases that were deemed avoidable so that lessons can be learnt.

One of the improvements delivered was that in early 2016 the average wait, for a patient who had a suspected deep vein thrombosis in the leg, to have a scan to confirm this, was around 5-6 days. This was unacceptable as a patient waiting for a test was at risk of complications and was prescribed blood thinning drugs that would potentially be unnecessary.

We set ourselves a target of performing these tests within 72 hrs. Extra capacity for tests in Radiology was secured using monies saved on the non-prescribing of these drugs. This has shortened the average wait for patients to 1.4 days.



The NICE recommendation No. 144 is that we scan patients within 24 hrs and we are continually looking for ways to improve this service so that we can achieve this.

From January 2017 a new escalation process was agreed that involves the Deputy Medical Director and governance leads. It is now suggested that to improve the compliance of the RCAs the timing of the RCA needs to be brought forward and therefore a new process is being considered for 2017-18.

5 Medication Errors

In England, GPs issue more than 660 million prescriptions every year and there are an estimated 200 million prescriptions in hospitals. Prescribed medicine is the most common treatment in the NHS. Some adverse reactions are unpredictable and unavoidable, but medication errors, including mistakes or lapses, are always avoidable.



The National Reporting and Learning Systems (NRLS) defines a 'patient safety incident' (PSI) as, 'any unintended or unexpected incident, which could have or did lead to harm for one or more patients receiving NHS care.' Medication errors are any PSIs where there has been an error in the process of prescribing, preparing, dispensing, administering, monitoring or providing advice on medicines.

The core objective of this project aimed to continue with all measures designed to

reduce medication incidents which cause harm. The target is a reduction of at least 50% from the 2014-15 baseline during the five years of the current quality strategy.

	2014-15	2015-16	2016-17
Major Errors	33	22	27
Reduction	-	30%	18%

During 2016-17 the Trust has;

- Reviewed the function of the Medicines Management Committee and the Safe Medicines Practice Group, ensuring that lessons are learnt from medication incidents and changes are made to prevent them happening again through the appropriate committee
- Continued use of EPMA to reduce the number of omitted doses by reviewing stock lists throughout the hospital and highlight areas of medicine risk
- Implemented an aminoglycoside dosage calculator which has reduced the number of reported aminoglycoside incidents
- A pharmacist writing discharge prescriptions which has been shown to reduce the number of prescribing errors and also provides a comprehensive review of drug changes during admission
- Fed back medication incidents to foundation year 1 & 2 doctors which has shown to be a positive learning outcome
- Produced newsletters to highlight common medication errors and drugs that are at risk of causing potential errors such as phenytoin and opioids

6

Healthcare Associated Infections

There are several types of hospital infection; MRSA (methicillin-resistant Staphylococcus aureus), C.diff (Clostridium-difficile), device related bacteraemia and CPE (Carbapenemase producing enterobacteriaceae).

The Trust is pleased to report that it has had no incidents of MRSA bacteraemia or outbreaks of CPE during 2016-17.

The reporting arrangements for C.diff remain the same as the previous year, reporting cases that have been associated with significant lapses of care. SFT was allocated a trajectory 17 or less for 2016-2017. The Trust has so far had 15 cases identified as a result of a lapse of care.

The ultimate decision regarding associated lapses of care is taken independently by the Clinical Commissioning Group (CCG) following a root cause analysis.

SFT has had a total of 36 cases of hospital acquired C.Diff. 35 of the 36 cases have been fully investigated. 1 case still requires investigation to be completed.

The CCG have reviewed 20 and confirmed they do not have significant lapses in care and do not reach the threshold for reporting.

More information in Infection Prevention can be found on page 72 of this report.

7

Diabetes

Diabetes is a lifelong condition that affects a person's blood sugar level. Type 2 diabetes is a leading cause of preventable sight loss in people of working age and is a major contributor to kidney failure, heart attack and stroke.

In 2015/16 the Trust adopted the AQUA Diabetes care bundle and continued with this during 2016-17.

The care bundle is a CQUIN and more information can be found at page 33.

There has been 1 Serious Incident in the last year relating to hospital acquired Diabetic Ketoacidosis with sepsis.

We continue to take actions to improve care for Diabetes patients:

- New guidance for Hyperglycaemia treatment has recently been written.
- Bespoke training for the Emergency department and other assessment units is ongoing as these busy areas could be more prone to errors.
- A Hypoglycaemia treatment sticker is included in the patient record as an aide memoir; this has improved documentation and timeliness of treatment.
- To ensure lessons are learnt there is a monthly report to Pharmacy of any Insulin omission errors that may have occurred.
- Work is taking place on the requirements of the electronic patient record. This will mitigate the hazards of mis-prescription or omission which may occur as a result of paper records.
- The National Inpatient Diabetes Audit report published in March 2017 will be used to target future audit and quality improvement work.
 - Key findings show areas that have improved and some that have deteriorated.

A key improvement is that foot risk assessment within 24 hours increased from 30.5% to 74.8%.

8 Early Warning Score

The Early Warning Score or 'EWS' can be divided into three areas:

- measurement of patient parameters
- frequency of observations and calculation of the EWS
- appropriate interventions



The aim is to recognise earlier when a patient's condition is deteriorating to facilitate early interventions and treat the patient, which in turn could reduce the number of cardiac arrests on the wards.

It should be noted that an increase may not always be negative, as many patients admitted are older or more acutely unwell with a number of comorbidities.

Number of Cardiac Arrests on wards:

2014-15	2015-16	2016-17
151	122	112

'Patienttrack' is an electronic data capture system; vital signs are recorded at the point of patient care and captured electronically via hand-held devices in all Adult, Maternity and Paediatric clinical areas across the Trust. A number of assessments are also being completed electronically in Patienttrack on the medicine and surgical wards namely: MRSA, C.Diff and fluid balance charts.

Policies and training relating to taking observations and recording on Patienttrack are regularly reviewed.

- A review report with recommendations has been to the Trust quality governance committee regarding the Patient Safety Alert "Resources to support safer care of the deteriorating patient".
- A formal review and audit (random sample) on the existing cardiac arrest root cause analysis process has been completed. The recommendation is for a revised process. This will be agreed after discussions at the Resuscitation and Palliative care committee.
- In-patient Observation Policy amendments completed to include the EWS escalation pathway and patient track changes.
- Resuscitation policy has been updated and agreed.
- Compliant with standardisation of defibrillators.
- Following the latest National Cardiac arrest audit, local data analysis is awaited for quantitative data, on the number of cardiac arrests compared to previous years.
- Monthly EWS audits are to take place.

9 Capturing & Learning From Patient & Family Feedback

SFT aims to ensure that improving the patient experience is at the heart of everything we do - "Your Health, Our Priority".

Feedback is important as it allows the Trust to provide assurance that the care provided is being valued by service users, but also helps the Trust to identify where improvements or

changes need to be considered and addressed.

The Trust gathers data on patient experience from a number of sources namely:-

- iPad Inpatient Surveys
- Friends and Family Test
- National Surveys
- Complaints

In addition, many of our services ask patients to complete bespoke questionnaires with the intention of gathering local insight and understanding of care delivery.

For more information on patient and family experience please refer to page 80 of this report.

10

Improve Care For Patients With Dementia

Dementia is a syndrome associated with an on-going decline of the brain and its abilities. This includes problems with memory loss, thinking speed, mental agility, language, understanding and judgement.

According to the Alzheimer's Society, it is estimated there are around 850,000 people living with dementia in the UK, with numbers set to rise to over one million by 2025. Around 225,000 people will develop dementia this year alone – that's one every three minutes.



An early diagnosis can help people with dementia get the right treatment and support, and help those close to them to prepare and

plan for the future. With treatment and support, many people are able to lead active, fulfilled lives.

The focus for Dementia Care remains on the provision of training to clinical and non-clinical staff. Training is focused on communication and attitudes towards patients living with dementia and their families. We also want to ensure that families get the right support at the right time. This has led to the development of Dementia Carer Information Packs which is given to all families on admission. This enables family members to be informed of what support is available to them whilst the patient living with dementia is in hospital. The packs also contain a copy of the 'This is me' document for families to complete and give to ward staff with information about the patient which will inform their care.

We are also in the process of opening our Dementia Café which will enhance the wellbeing of patients living with dementia and their families whilst they are in hospital. We continue to monitor how we are doing through surveys and use feedback from these to improve our practices and services. The FAIRI assessments remain a Key Performance Indicator and our emergency department has been supporting the Matron for Dementia Care with these daily.

We are currently actively working to recruit an in house dedicated team of Dementia Enhanced Care providers who will work with the Matron for Dementia Care to provide bespoke care for our patients. We are looking to initially recruit 10 health care support staff who will be trained in communicating and engaging with patients living with dementia.

The staff will also cascade their enhanced knowledge to the wider nursing and care teams. We equally still have as a goal the development of a specialised Dementia Care ward and continue to work with our medicine group to see how this can be achieved.

11

Complaints Management
& Duty Of Candour

SFT is committed to the provision of high quality health care. As part of this objective, promoting a culture of openness and truthfulness is a prerequisite to improving the safety of patients, staff and visitors as well as the quality of healthcare systems.



This culture ensures communication is open, honest and occurs as soon as possible following a patient safety event or when a poor outcome has been experienced. It encompasses the communication between healthcare organisations, healthcare teams and patients, their families and carers.

The Trust continues to improve the complaints process based on patient and family feedback and takes account of any changes to the national guidance.

The Trust is currently working with Stockport Metropolitan Borough Council (SMBC) and Stockport Clinical Commissioning Group (CCG) on complaints management review over “no wrong door process” to include all providers of care in Stockport Health Economy. Stockport is a trial site for Department of Health (DOH) around the issues of shared complaints management.

A working party has been established with all business groups to review the complaint response template and processes to include gap analysis against recommendations from NHS England Quality Framework for

Complaints and Parliamentary and Health Service Ombudsman (PHSO).

Changes within the complaints team are taking place to improve the management of informal complaints so they can be dealt with effectively to avoid them becoming a formal complaint.

Please refer to page 78 for further information on complaints.

Part 2.1.1

Participation in CQUIN 2016-17

The Commissioning for Quality and Innovation (CQUIN) programme for 2016-17 was developed and agreed by the Trust and the Commissioners based on data intelligence from varying streams and stakeholders.

The indicator goals for the programme were agreed with the Commissioners to address areas identified for improvement and some are built on the work already undertaken in 2015-16. Progress against CQUIN's is shared internally with the Quality Governance Committee, the Finance and Performance Committee and forms part of the Integrated Performance Report. All CQUINs are reported to local commissioners on a quarterly basis as part of CQUIN monitoring.

The tables below show the performance against quarterly financial milestones for each CQUIN indicator. Indicators include those which are set nationally and those which have been agreed locally. Further information on each CQUIN indicator can be found on page 26-38 of this report.

RAG KEY: ■ Full Payment ■ Partial Payment ■ No Payment ■ Not Applicable

National Indicators

Indicator	Value	Q1	Q2	Q3	Q4	16-17
<u>Health & Wellbeing - Initiatives</u> <i>Improve the support available to NHS Staff to help promote their health and wellbeing.</i>	£581,388	100%	NA	NA	85%	88%
<u>Health & Wellbeing - Healthy Food</u> <i>Achieve a step-change in the health of the food and drink offered the premises.</i>	£532,870	100%	NA	NA	100%	100%
<u>Health & Wellbeing - Flu Vaccination</u> <i>Achieve at least 75% uptake of flu vaccinations by frontline clinical staff.</i>	£532,870	NA	NA	NA	100%	100%
<u>Sepsis - Emergency Department</u> <i>Screening for sepsis and where sepsis is identified, to provide timely and appropriate treatment and review.</i>	£242,589	100%	90%	90%	50%	83%
<u>Sepsis – Inpatients</u> <i>Screening for sepsis and where sepsis is identified, to provide timely and appropriate treatment and review.</i>	£242,589	100%	50%	90%	0%	60%
<u>Antibiotics - Consumption</u> <i>Reduction in antibiotic consumption and encouraging focus on antimicrobial stewardship.</i>	£388,142	NA	NA	NA	100%	100%
<u>Antibiotics - Review</u> <i>Encouraging focus on antimicrobial stewardship and ensuring antibiotic review within 72 hours.</i>	£97,035	100%	100%	90%	85%	94%

Local Indicators

Indicator	Value	Q1	Q2	Q3	Q4	16-17
Safety Culture <i>Development of a robust safety culture to improve safety for patients.</i>	£553,102	75%	100%	92%	58% ¹	74% ¹
Effective Discharge (Stockport) <i>Improve the patient journey and reduce delayed discharges of care.</i>	£489,301	83%	75%	66%	75%	75%
Effective Discharge (Derbyshire) <i>Improve the patient journey and reduce delayed discharges of care.</i>	£58,949	100%	100%	100%	100% ²	100% ²
Nutrition & Hydration <i>Focussing on assessments, snack provision/protected mealtimes, transfers of care and patient experience</i>	£548,250	100%	100%	100%	50%	78%
Sepsis Care Bundle <i>Alignment with the regional Advancing Quality programme, which is known to yield improved outcomes for patients.</i>	£145,553	100%	100%	100%	100%	100%
Diabetes Care Bundle <i>Alignment with the regional Advancing Quality programme, which is known to yield improved outcomes for patients</i>	£145,553	100%	100%	100%	100%	100%
Acute Kidney Injury Care Bundle <i>Alignment with the regional Advancing Quality programme, which is known to yield improved outcomes for patients</i>	£145,553	100%	100%	100%	100%	100%
Alcoholic Liver Disease Care Bundle <i>Alignment with the regional Advancing Quality programme, which is known to yield improved outcomes for patients</i>	£145,553	100%	0%	90%	0%	29%
MCP - Expert Reference Groups <i>Deliver the work-programme for the 4 Expert Reference Groups for the Stockport Together Outcomes Framework.</i>	£239,703	100%	100%	100%	100%	100%
MCP - Business Intelligence <i>Provide technical and financial leadership for the development of the Outcomes Framework.</i>	£239,703	100%	100%	100%	100%	100%
Tameside Wheelchair Service <i>Reduce inappropriate referrals to the wheelchair service and therefore improve patient experience.</i>	£284,403	100%	100%	100%	100%	100%

¹ Initial achievement only. This does not represent final outcome. Trust awaiting final achievement following appeal.

² Forecast only. Trust awaiting confirmation of final achievement.

Specialised Service Indicators

Indicator	Value	Q1	Q2	Q3	Q4	16-17
Systemic Anticancer Therapy (SACT) <i>Standardise the doses of SACT in order to increase safety, to increase efficiency.</i>	£29,908	100%	100%	100%	100%	100%
Hypothermia Prevention (Neonatal) <i>Provide a two year follow up assessment for very preterm babies.</i>	£38,453	100%	100%	100%	100%	100%
2 Year Follow Up (Neonatal) <i>Monitoring of temperature within 1 hour of admission for very preterm babies.</i>	£38,453	100%	100%	100%	100%	100%

Dental Service Indicators

Indicator	Value	Q1	Q2	Q3	Q4	16-17
Referral Management <i>Ensure systems/processes are in place to interface with any e-referral systems commissioned by NHS England.</i>	£14,892	100%	100%	100%	100% ²	100% ²
Managed Clinical Networks <i>Ensure active participation in the Managed Clinical Networks and clinical engagement groups.</i>	£14,892	100%	100%	100%	100% ²	100% ²
Consistent Coding <i>Introduction of the single operating model for the allocation of codes for oral surgery.</i>	£14,892	100%	100%	100%	100% ²	100% ²

² Forecast only. Trust awaiting confirmation of final achievement.

Total CQUIN Programme

Value	Q1	Q2	Q3	Q4	2016-17
£5,764,597	95%	89%	91%	83% ³	87% ³

³ Figures based on initial achievement only. Trust awaiting final achievement following appeal with Stockport CCG and confirmation from other commissioning bodies.

Staff Health & Wellbeing

Without staff that are well and at work the NHS could not deliver quality and effective care to patients. We need to ensure that staff are provided with an environment and opportunities that encourage and enable them to lead healthy lives and make choices that support their wellbeing.

As a result, a three-part CQUIN was introduced for 2016-17 focussing on introducing health and wellbeing initiatives (such as physical activity and mental health support), the banning of price promotions on sugary drinks and foods high in fat, sugar and salt and ensuring that healthy options are available and to encourage the uptake of flu vaccinations for frontline staff.

Part 1: Introduction of Initiatives:

Estimates from Public Health England put the cost to the NHS of staff absence due to poor health at £2.4bn a year – around £1 in every £40 of the total budget. As well as the economic benefits that could be achieved, evidence from the staff survey and elsewhere shows that improving staff health and wellbeing will lead to higher staff engagement, better staff retention and better clinical outcomes for patients.

The first element of this CQUIN required the Trust to develop a plan to introduce and actively promote three initiatives. A 'Workforce Health and Wellbeing Strategy 2015-17' was developed and covered various interventions that were being introduced in the Trust which included; physical activity, smoking, alcohol consumption, weight management and mental health. The three key initiatives agreed were; 'Personal resilience', 'Mindfulness' and 'Walk to run sessions'.

The Trust provides a variety of services aimed at promoting health and wellbeing, these include; Weight Loss Group, Healthy Eating Options (staff restaurant), Running Club, Staff Counselling Services, Cycle to Work Schemes, Stress Risk Assessments,

Childcare Vouchers and Early Access Physiotherapy.

Staff are encouraged to ensure that they take a full and proactive part in their own self-care. Due to longer working lives this increases in importance, as this proportion of staff may be required to manage long term health conditions.

The Workforce Health and Wellbeing Steering Group continue to promote and identify a wide range of support with the emphasis on good management and early detection of conditions. All staff have a responsibility to ensure they remain as well as possible. Training of managers and staff is essential to success in those aspects of the Strategy.

Part 2: Healthy Food:

Public Health England's report "Sugar reduction – The evidence for action" published in October 2015 outlined the clear evidence behind focussing on improving the quality of food on offer across the country. Almost 25% of adults in England are obese, with significant numbers also being overweight.



Treating obesity and its consequences alone currently costs the NHS £5.1bn every year. Sugar intakes of all population groups are above the recommendations, contributing between 12 to 15% of energy, tending to be highest among the most disadvantaged who also experience a higher prevalence of tooth decay, obesity and its health consequences. It is important for the NHS to start leading the

way on tackling some of these issues, starting with the food and drink that is provided and promoted in hospitals.

Part 2 of the NHS Staff Health & Well-being CQUIN for 2016-17 focussed on achieving a step-change in the health of the food offered on Trust premises. The Trust banned advertisements and price promotions on sugary drinks and foods high in fat, sugar and salt (HFSS). Checkouts now only have healthy options available and work continues to improve healthier options for night staff. Posters are in place to support healthy choices.

The Trust has complied with the requirements of the CQUIN and produced a food and drink strategy 2015-19, with implementation supported by an action plan which is monitored at the Nutrition & Hydration Steering Group.

This will remain a CQUIN for 2017-19.

Part 3: Flu Vaccination:

Influenza is an acute viral infection of the respiratory tract which is highly transmissible. It has been estimated that up to one in four healthcare workers may become infected with influenza during a mild influenza season- a much higher incidence than expected in the general population.



Focussing on the importance of the vaccination, Part 3 of the NHS Staff Health & Well-being CQUIN for 2016-17 centred on improving the flu vaccination uptake of

frontline staff. The target was to achieve a 75% uptake by frontline clinical staff by December 31st 2016 (week 13 of the flu vaccination campaign).

Regular meetings took place over the course of the year between management and nursing staff to monitor uptake and review the campaign. In order to understand why some staff did not have the vaccine in 2015, a questionnaire was sent to all staff. Reasons for not having the vaccine included “The flu vaccination will give me bad side effects / can give me flu” and “I didn’t have time / couldn’t attend a flu clinic / I couldn’t find a flu link nurse”. The survey results were deliberated and discussions ensued about how the Trust could improve on its overall uptake.

It was agreed that staff should have more information available to them and that a publication regarding safety of vaccination should disseminated, with more flu link nurses being available.

Various steps were taken to help promote the vaccination during the 2016 campaign including:

- Production of a flu vaccination FAQ (Frequently Asked Questions) leaflet
- Daily news articles added on the Trust intranet dismissing the ‘myths’ around having the vaccination
- Updates made available on the flu vaccination microsite
- Intranet updated weekly with % uptakes and updates included in monthly team brief (circulated to all staff)
- Short, snappy statements on the screensaver on the Intranet
- Weekly ‘Flu photo of the week’ published on Trust intranet
- Published a ‘Survivors Story’ highlighting the importance of being vaccinated

Flu link nurses were also present at Team Brief, Corporate Welcome and Essentials Study Days to give staff flu vaccinations.

Sepsis

Sepsis is potentially a life threatening condition and is recognised as a significant cause of mortality and morbidity in the NHS, with around 37,000 deaths in England attributed to Sepsis annually. Of these it is estimated that 11,000 could have been prevented.

This Trust undertook 3 Sepsis CQUINs in 2016-17:

- 1) Screening for Sepsis in the Emergency Department, and where sepsis is identified (screened), to provide timely and appropriate treatment and review.
- 2) Screening for Sepsis in Inpatients, and where sepsis is identified, to provide timely and appropriate treatment and review.
- 3) Sepsis Care Bundle



Emergency Department (ED):

This CQUIN was a continuation from 2015-16. A pathway and screening tool for sepsis had previously been introduced in ED and in March 2016 a mandatory sepsis screen was introduced into the ED I.T (Information Technology) system to ensure all patients were screened.

The tool asks set questions which identifies if the patient may be septic and what clinical interventions are required. Treatment begins

and more regular observations of vital signs are taken.

Performance is shown below:

Screening:

	Q1	Q2	Q3	Q4
Target	90%	90%	90%	90%
Result	100%	100%	100%	100%

Treat & Review:

	Q1	Q2	Q3	Q4
Target	N/A	50%	60%	90%
Result	40%	41.7%	48.4%	50%

Inpatients:

If a patient is considered to have sepsis, the clinical team would treat accordingly. The CQUIN is to implement screening to ensure all patients who may develop sepsis are identified as early as possible. A sepsis steering group was established to develop and monitor progress in delivering improvements in this area.

A pathway and screening tool for inpatient Sepsis were developed in quarter 1. A pilot of the tool was undertaken on 2 wards in June 2016 and extended to 4 wards in August 2016.

In October 2016, the screening tool was introduced into all adult inpatient wards except for maternity. In March 2017 a sticker for case notes was implemented to prompt a sepsis screen. An electronic prompt for relevant patients has been introduced in April 2017.

As is evidenced by the screening results, implementing a paper screen tool has been challenging. The introduction of the sepsis screen prompt being built into the 'AdvantisED' system will improve the identification of patients at risk and therefore enable quicker clinical intervention.

Performance is shown below:

Screening:

	Q1	Q2	Q3	Q4
Target	N/A	25%	25%	25%
Result	16%	0%	20.5%	4.5%

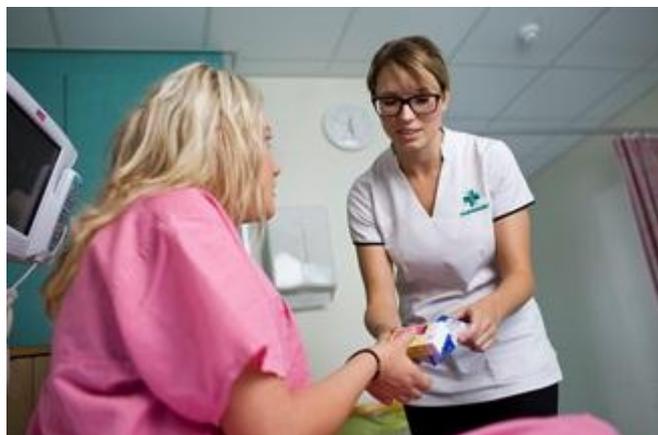
Treat & Review:

	Q1	Q2	Q3	Q4
Target	N/A	20%	10%	56.5%
Result	0%	0%	54%	55.7%

See Sepsis care bundle at page 33.

Antimicrobial Stewardship

Antibiotic resistance is one of the most significant threats to patients' safety and is driven by overusing antibiotics and prescribing them inappropriately. Infections with antibiotic-resistant bacteria increase levels of disease and death, as well as the length of time people stay in hospital. As resistance in bacteria grows, it will become more difficult to treat infection, and this affects patient care.



The World Health Organisation (WHO) has estimated that antimicrobial-resistant infections currently claim at least 50,000 lives each year across Europe and the US.

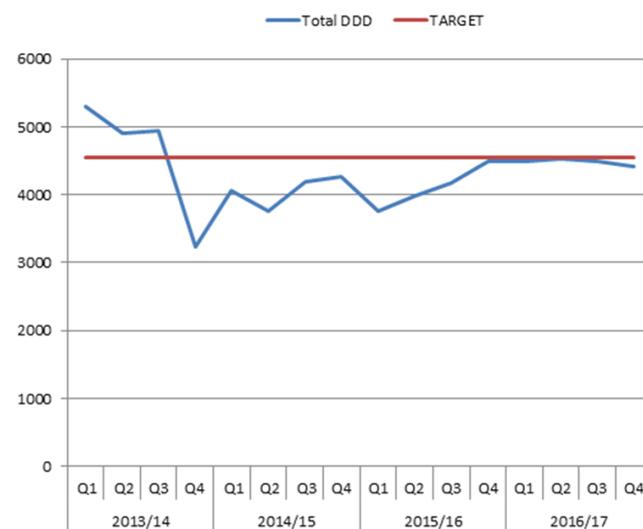
The CQUIN aims to reduce antibiotic consumption and encourage a prescribing review within 72 hours of commencing an antibiotic.

Reducing Antibiotic Consumption

This element of the CQUIN aimed to reduce antibiotic usage (defined daily dose or DDD) per 1000 admissions by 1%.

There were no targets for quarters 1-3; however the Trust achieved the target of 1% reductions by the end of quarter 4.

Graph: Defined daily dose (DDD) per 1000 admissions



72 hour reviews

This element of the CQUIN measures the percentage of patients who had their antibiotics reviewed between 24 and 72 hours. A lack of a prescribing review is considered to be a major contributor to overuse of antibiotics.

Each month the Trust audited a random sample of 50 prescriptions of patients who met the criteria.

Performance is shown below:

	Q1	Q2	Q3	Q4
Target	25%	50%	75%	90%
Result	66.7%	60.7%	67.3%	76.7%

Safety Culture

The development and nurturing of a robust safety culture has been evidenced to improve safety for patients within health organisations. A safety culture is

where staff within an organisation have a constant and active awareness of the potential for things to go wrong. Both the staff and the organisation are able to acknowledge mistakes, learn from them, and take action to put things right.

This indicator was designed to encourage the organisations to foster a culture of patient safety where incidents are seen as opportunities to learn and to consider human factors when designing and implementing systems and process.

In order to gain an understanding of areas for development and recommendation a staff survey was piloted on two medical wards. The results enabled an action plan focussing on those areas highlighted to be implemented.

Having a robust safety culture also included a process review of Serious Incidents in the Medicine Business Group, particularly around:

- Lessons learned across the organisation
- Communication and the dissemination of learning potential
- Sharing best practice
- Lessons driven by staff engagement

As a result the SOP (Standard Operating Procedure) for Serious Incident Management in the Medicine business group has been enhanced to include expectations for shared learning, action completion, detailed roles and responsibilities for the investigation process.

Effective Discharge

This CQUIN is in support of the Stockport Together programme whose primary aim is to develop a single strategic plan to improve health and social care services involving partner organisations across the borough.

Effective discharge planning has been evidenced to improve the patient journey and reduce delayed discharges of care which can

in turn reduce the risk of harm to patients. Communication, patient involvement and a Multi-Disciplinary Team (MDT) approach are of prime importance in ensuring a safe transfer of care.



The indicator focused on the following vital functions to support an effective discharge:

1. A robust discharge planning and communication process which included the reduction of delayed transfers of care through effective planning and a MDT approach.
2. Consider the benefit of dedicated key workers and/or dedicated discharge co-ordinators.
3. Review the internal processes for discharge coordination.
4. Ensure safe transfers of patient care between agencies through robust hand-overs.

Of the many initiatives that are contributing to supporting change was the introduction of SAFER: (**S**-Senior Review, **A**-Assessment, **F**-Flow, **E**-Early Discharge, **R**-Regular Review.) The SAFER tool has helped in identifying areas where improvements can be made to processes in support of earlier discharges.

To enable the timely discharge of patients from hospital, we need a health care system that can match capacity with demand and ensure delays are minimised. Creating tailored care for each individual is key to the Trusts' ethos of getting it right for every patient, every time. 'Transfer to Assess' is a

pathway that allows for therapy and social work assessments to be carried out in the patient's own home, solving problems head on, setting up bespoke care packages and preventing hospital readmissions.

'Better at Home' is a new campaign aimed at health and social care staff and part of the SAFER initiative to raise awareness and promote timely, effective discharge from hospital. Research shows that whilst hospital is the right place for people who are seriously ill, it is better and safer for people to receive the treatment, care and support they need in their own home, the family home or a nursing/residential home.

This is ongoing work as part of the Stockport Together partnership work, and a CQUIN on proactive and safe discharge will continue for the next two years.

Derbyshire CCG - A similar CQUIN to address discharges took place. As a result an in-reach service has been established which has been positive and improved relationships which have resulted in expedited discharges of Derbyshire patients.

Nutrition & Hydration

Malnutrition is common in the UK, affecting more than three million people at any one time. Around 1 in 3 patients admitted to acute care will be malnourished or at risk of becoming so. The scale of dehydration in the UK is unknown but is associated with a number of known causes of harm to people.

Both malnutrition and dehydration have substantial adverse effects on health, disease and well-being. Better nutritional care reduces complications and length of stay and NICE cost saving calculations show that better nutritional care is achievable with substantial savings in net NHS costs (NICE, 2011). Therefore it is essential that malnutrition and dehydration problems are better recognised and treated.

NHS England recommended in Guidance – Commissioning Excellent Nutrition and Hydration (N&H) 2015 – 2018 that Commissioners ensure that the health and social care organisations for which they are responsible prevent malnutrition and dehydration from occurring, identify when malnutrition has occurred through the use of nutritional screening e.g. using the Malnutrition Universal Screening Tool ('MUST') for adults, and specifically treat those at risk from malnutrition or dehydration using appropriate care pathways. It was recommended that an assessment of current screening and provision of nutritional care be undertaken, i.e. the MUST tool.



The aims of the CQUIN were:

- To support the implementation of electronic risk assessments on 'Patienttrack'
- Improve timeliness of the MUST assessment, compliance with the food / balance chart and completion of care plans
- Support and embed snack provision and protected mealtimes
- Ensure Nutritional/ hydration issues were highlighted and documented on transfer of care
- Provide evidence of improved patient experience from Q1-Q4

Key Outcomes:

- Fluid balance charts: These were incorporated into the 'Patientrack' system for use by medical and surgical wards.
- MUST assessments, food and fluid charts and care plans: A baseline audit took place to provide evidence of compliance and a re-audit took place in order to show whether improvements had been made. Unfortunately no improvements were demonstrated and the results are to be reviewed at the Nutrition and Hydration group an action plan will be developed and results will be shared with the heads of nursing and cascaded to ward managers.
- Snack provision and protected mealtimes: Standards were implemented on 2 pilot wards C4 (medical now A3) and D1 (surgical). A plan for rolling out protected meal times and snack/drink provision across all medical and surgical wards was devised and this has begun.
- Transfers of Care: Following an audit the Nursing Patient Assessment booklet was amended to include the patient's nutritional status, MUST score and any special requirements / diet, providing information to the receiving ward.
- Patient experience: Patient stories and responses from the nutrition related questions in the iPad surveys were shared. Ward staff have been working hard to ensure patients are assisted at mealtimes if help is required. Volunteers are helping on some wards ensuring that patients have napkins at mealtimes and ensuring patients are receiving drinks etc.

Ward A1 made a change so all staff help with meals and ensure that trays are tidied away in a timely fashion. A tangible difference in the ward has been observed.

Ward M4 has a housekeeper who ensures that patients are supported with meals/snacks/drinks which works very

well. The ward focus at meal times is the patients; staff down tools to support the patients.

The inpatient catering team manager and a chef visit two wards per month. They audit the food available that day, taste, texture and temperature. They gather patient feedback, asking what they like to eat and what they like about the food available. The team acts on any negative responses and have made changes as a result of these monthly visits.

Nutrition & Hydration Week, March 2017

A number of initiatives highlighting the importance of N&H included:

- An Enteral Feeding skills session for Trust staff by the Trust's Nutrition Nurse.
- Thirsty Thursday – AKI Nurse Specialist promoting hydration. Staff and patients were encouraged to 'Make a Pledge' of how they personally could help improve hydration for patients.

Lessons Learnt:

Further improvements are required to meet patients' nutritional needs;

- Completion / quality of the MUST assessments
- Investigate reasons behind poor completion of the assessment.
- Training / engagement of all nursing staff
- Develop ward nutrition link nurses
- Consider how to utilise the imminent electronic patient record to ensure compliance of nutritional assessments, care plans, fluid balance and food & fluid intake charts.

The CQUIN has shown that patients' views are being listened to and the wards and catering department are acting on the results of the iPad surveys.



Care Bundles

For the following care bundles the performance is measured by ACS and CPS this means;

- **CPS** (Composite Process Score) is the percentage of all measures achieved.
- **ACS** (Appropriate Care Score) is the percentage of patients who receive perfect care i.e. receives all the measures of the care bundle they were eligible for.

Sepsis Care Bundle

This CQUIN focussed on timely recognition and treatment within the first 4 hours of the patient journey based on NICE clinical guidance. Many elements of the care bundle were made mandatory within the ED I.T. system meaning high compliance was achieved.

Each month the Trust audited 20 patient records that were eligible for the audit. Targets were based on a percentage improvement from baseline.

The CQUIN measures compliance against the CPS score for Q1 – 3 and against ACS for Q4. Performance is shown below;

	Q1	Q2	Q3	Q4
Target	78.3%	80.6%	82.8%	50%
Result	78.5%	89.4%	89.3%	91.6%

Diabetes Care Bundle

Since 1996 the number of people with diabetes has more than doubled from 1.4 million to 2.9 million. It is estimated 5 million people in the UK will have diabetes by 2025. Diabetes is the fifth most common reason for death in the world and is associated with serious complications including heart disease, stroke, kidney disease, blindness and amputations. Up to 70% who lose a limb as a result of diabetes will die within 5 years.

This local care bundle aimed to prompt early recognition and treatment of patients both admitted to hospital with diabetes complications and those who develop complications of diabetes during their stay.

Hypoglycaemia Stickers and Foot of the Bed Forms: Timely hypoglycaemia treatment and foot inspections were identified as areas that require improvement. As such, the Diabetes Community Team revamped the existing foot of the bed form to make it clearer and easier to use, and introduced a hypoglycaemia sticker as an aide memoir within the case notes. Previously it was thought that hypoglycaemia treatment was delivered but not always documented at the right time within the case notes. Feedback from the wards suggests that the stickers have significantly improved documentation and timeliness of treatment.

Raising Awareness/Education: A Diabetes Facebook page with the aim of raising awareness and sharing information has been created. This has been very successful. An Urdu Type 2 Diabetes session was held in June 2016. The in-patient diabetes specialist nurses have regular meetings with staff to remind them about the use of the hypoglycaemia stickers and foot of the bed forms. Monthly link nurse meetings are held where the CQUIN is discussed and promoted.

Each month the Trust audited 20 patient records that were eligible for the audit. Targets were based on a percentage

improvement from baseline. The standards for diabetes were agreed in quarter one and these results were used as a baseline.

The CQUIN measures compliance against the CPS score for Q2 and 3 and against ACS for Q4.

Performance is shown below;

	Q1	Q2	Q3	Q4
Target	N/A	58.2%	60.9%	30%
Result	55.4%	67.1%	76.1%	73.3%

ARLD Care Bundle

Liver disease causes approximately 2% of deaths in England. Whilst other major causes of death are falling the number of people who die from liver disease is rising (41% increase from 1999-2005, 450% increase since 1987) and younger age groups are disproportionately affected.

The rate of mortality from liver disease is higher and rising faster in the North West than anywhere else in the country. 12.3% of hospital admissions for alcoholic liver disease result in death.

The Trust has adopted a modified British Society of Gastroenterology (BSG) care bundle of first 24 hours care document for this cohort of patients. This local care bundle aimed to prompt early recognition and treatment of patients with alcohol related liver disease (ARLD), based on NICE clinical guidance.

Within the care bundle there are eight measures. One of these is the prescribing of Pabrinex. Pabrinex contains water soluble vitamins, specifically vitamins B and C. These vitamins can be severely depleted in patients presenting with alcoholism. As these vitamins are not produced by the body, only obtained from diet, it is essential to ensure that they are replaced. Historically delays in administering Pabrinex had been identified. ED now give patients with ARLD a first dose

of Pabrinex which supports rehydration and replaces nutrients.

Each month the Trust audited a maximum of 20 patient records that were eligible for the audit. Targets were based on a percentage improvement from baseline.

The CQUIN measures compliance against the CPS score for Q1 – 3 and against ACS for Q4.

Performance is shown below:

	Q1	Q2	Q3	Q4
Target	76.4%	78.7%	80.9%	50%
Result	78.5%	76.9%	78.7%	74.5%

AKI Care Bundle

Acute kidney injury (AKI) is the sudden damage to the kidneys that causes them to not work properly. It can range from minor loss of kidney function to complete kidney failure.

It's essential that AKI is detected early and treated promptly. Without quick treatment it affects the ability of other organs to work properly. If the kidneys shut down completely, this may require temporary support from a dialysis machine, or lead to death. In the UK around 100,000 deaths each year are associated with acute kidney injuries, and up to 30% of these could be prevented if a patient is given the right treatment.

This local CQUIN focused on the prompt recognition and treatment of AKI in accordance with NICE Guidance.

Development and Implementation of AKI Priority Care Bundle: The AKI priority care bundle was developed and implemented across the Trust in two stages: May 2016 (for medical wards) and July 2016 (for surgical wards). Aligned to NICE standards, the care bundle is a single document, providing clear guidance to ensure patients receive high quality care for all stages of AKI without

delay. The care bundle emphasises the team based approach to managing AKI patients.

Raising Awareness Campaign: Ward 'AKI Champions' were identified who received training around the causes of AKI, assessing patients at risk of AKI and using the care bundle. Presentations were given to key clinical teams including medical staff, ward managers, matrons, ANPs and AHPs using existing educational forums

I.T. Innovation: The IT team at SFT have developed an electronic AKI flagging system that can be attached to the patients' electronic record which populates all the electronic systems currently used across the Trust. The plasma screens on the wards and in the ED areas display a highly visible AKI Alert Icon. A permanent electronic record is made so if the patient attends ED again; their record is populated with 'Previous AKI' meaning staff will be instantly aware that the patient is at higher risk of AKI. Stockport is the first Trust in Greater Manchester to implement such a system.

Each month the Trust audited 20 patient records that were eligible for the audit. Targets were based on a percentage improvement from baseline.

The CQUIN measures compliance against the CPS score for Q1 – 3 and against ACS for Q4.

Performance is shown below:

	Q1	Q2	Q3	Q4
Target	42.5%	44.7%	46.6%	50%
Result	70.4%	80.4%	84.5%	86.4%

Multi-Community Provider

The 5 year forward view published by NHS England expressed a requirement to deliver care differently.

'Stockport Together' is a collaboration of four provider organisations; Stockport NHS FT, Stockport Local Authority, Pennine Care NHS FT and Viaduct, the Stockport GP Federation.

All working with Stockport Clinical Commissioning Group to change the way/where care is delivered; with the aim of improving patient care and delivering efficiencies by working together rather than as independent organisations.



As a result of the above a new organisation has been formed; multi-specialty community provider organisation (MCP).

This CQUIN was to support Stockport Together and the MCP by setting up and delivering a programme of 4 Expert Reference Groups (ERG) for the Stockport Together Outcomes Framework, which is to be included in the commissioning contract for 2017-18 and to agree and discuss current and future data availability (Business Intelligence) to support the measuring of outcomes.

Representatives from each organisation formed the ERG and quarterly meetings were established. The groups also included patient representatives, social care bodies as well as clinical and non-clinical staff from each organisation.

Business Intelligence representatives attended these meetings and held independent meetings to progress data areas. The MCP work was supported by an independent organisation that had previously undertaken a similar project. The meetings were held in the evenings to mitigate any impact on daily activity. Having perspectives from the different disciplines that formed the

group enabled meaningful discussion and debate.

Three key objectives were to establish;

- CSOMs (Clinical and Social Outcome Measures)
- PCOMs (Person-Centred Outcome Measures)
- Business Intelligence / IT options

Excellent progress was achieved during 2016-17; the work continues in 2017-18 with continued engagement from members of the ERG groups and Business Intelligence from each organisation.

Wheelchair Service

The aim of the CQUIN was to reduce inappropriate referrals to the wheelchair service and therefore improve patient experience. Understanding the reasons for the inappropriate referrals would ultimately support the CCG in the future commissioning of Wheelchair services. Ensuring eligibility criteria is clear and managing expectations of referrers, by providing clear guidance as to why not all patients referred to or seen by the service received a prescription.

A patient experience survey and audit tool were developed in quarter 1, rolled out in quarter 2 and used until the end of February 2017. Referrals received continued to be triaged as normal by the service but the reasons that patients were not accepted in the service were also recorded.

Some patients were deemed ineligible at triage and a further group of patients were accepted into the service and received an assessment but were subsequently found either to be ineligible for a wheelchair or modifications could be undertaken to their existing chair which meant that they did not require a new prescription. All patients attending clinic were provided with a questionnaire which asked them to provide feedback about the service they received and how they felt about the outcome of the

assessment. The responses were collated and shared with the CCG.

The main reasons for patients being ineligible for a wheelchair were;

- Referral was for an outdoor only use chair.
- The request was from a nursing home and not related to a specific patient.

The service specification which the service is commissioned to deliver does not include provision of either.

Overall, the patients seen were happy with the service they received and felt that their needs had been met or expectations exceeded. Where patients were unhappy it was as a result of their ineligibility for a service rather than as a result of the care received.

As a result of the CQUIN it was highlighted that a significant number of patients who were clearly ineligible for a service were being referred, resulting in the service being the 'bearers of bad news' rather than the referrers. The commissioners agreed to try to address this issue by reissuing the eligibility criteria and sending a communication to GPs advising them of the need to adhere to them.

SACT Dose Banding

This CQUIN continued on from the work undertaken during the 2015/16 CQUIN looking at a national incentive to standardise the doses of Systemic Anticancer Therapy (SACT) in all units across England.

This aims to increase safety, efficiency and to support the parity of care across all NHS providers of SACT in England. Overall, the standardisation of doses should reduce costs for providers, while releasing capacity locally to support other activities and in particular clinical trial and research.

Collection of base-line data was delivered during quarter 1 for the range of dose banded

drugs and was agreed with the local commissioner. The target banding levels were set for quarters 2, 3, and 4.

The targets were achieved based on the percentage of chemotherapy doses for a defined list of SACT drugs prescribed and administered in accordance with national banded doses, as shown below.

Percentage of Doses Dispensed / Administered Matching National Tables:

	Q1	Q2	Q3	Q4
Target	N/A	70%	80%	85%
Result	47%	92%	88%	96%

Hypothermia Prevention

This CQUIN aimed to prevent hypothermia in preterm babies (<34 weeks) by routine monitoring within 1 hour of admission, and by taking corrective action.



Hypothermia can lead to harmful side effects, which include hypoglycaemia, respiratory distress, hypoxia, metabolic acidosis, coagulation defects, delayed readjustment from foetal to new-born circulation, acute renal failure, necrotizing enterocolitis, failure to increase weight or weight loss and increased mortality especially in babies < 28 weeks.

Prevention of hypothermia is possible for babies born in the hospital delivery suite using a variety of well-established methods - (appropriate ambient temperature, avoiding

draughts, occlusive skin wrap/plastic bags, drying, removal of wet towels at resuscitation, warm blankets, use of hats, overhead heaters, trans-warmer mattresses as appropriate). These are relatively simple and inexpensive measures.

The Trust is compliant in both elements of this CQUIN as shown below.

1. The number of babies <32+0 weeks gestational age, admitted from delivery suite, whose first temperature is taken within an hour of admission.

Q1	Q2	Q3	Q4
100%	100%	100%	100%

2. The number of babies <32+0 weeks gestational age, admitted from delivery suite, whose first temperature, having been taken within an hour of admission is in the range $\geq 36^{\circ}\text{C}$.

Q1	Q2	Q3	Q4
100%	100%	100%	100%

Two Year Follow-Up

It is recommended that all preterm babies born more than 10 weeks early (<30 weeks of gestation) should have a follow up evaluation 2 years after their due date to ensure that they are developing normally.

Structured assessment at two years of corrected age is important to ensure that any effects of prematurity, e.g. visual impairment and intellectual development, are identified in a timely way to enable the appropriate management to be put in place to optimise outcomes.

This CQUIN aimed to ensure that all infants <30 weeks gestation at birth, discharged home from the Trust, whose 3rd birthday fell within the reporting period, had all the required follow up data recorded on the BadgerNet system; a paperless maternity system which allows real-time recording of core information.



The Trust is compliant in the recording of all the required data as shown below.

All infants <30 weeks gestation at birth, discharged home from SFT are assessed at their 3rd birthday within the following areas;

- Neuromotor
- Malformations
- Social
- Respiration / Cardiovascular
- Gastro-intestinal
- Renal
- Neurology
- Auditory
- Vision
- Communication

This is to ensure that they have developed accordingly.

Q1	Q2	Q3	Q4
100%	100%	100%	100%

Managed Clinical Networks

This CQUIN focused on having active participation in Managed Clinical Networks (MCNs) and clinical engagement groups. A MCN is a way of working where clinicians from all settings across a clinical pathway can focus on patients and services rather than being constrained by organisational boundaries.

Named consultants were identified to be leads in responding to and disseminating information that the network shares.

Referral Management

Ensure the Trust has the necessary IT infrastructure systems and management processes in place to interface with any electronic referral management systems commissioned by NHS England and to receive or process electronic referrals and related dental radiographs in line with NHS Information governance rules.

From 13th March 2017, the Trust has implemented a NHS net link and digital link to enable electronic referrals to take place. Images are now received electronically into the PACS system thereby improving quality of images. In order to deliver this, the Personal Computers (PC) in the department were upgraded to support the downloads.

Consistent Coding

The introduction of the single operating model for the allocation of codes for oral surgery was shared and implemented with providers during the 2015-16 CQUIN. This indicator builds on the ground work of the implementation of consistent coding.

This element links in with the electronic solution as mentioned above and the Trust provided all information required.

Part 2.1.2

Sign Up To Safety Campaign

Sign up to Safety is a national initiative to help NHS organisations and their staff achieve their patient safety aspirations and care for their patients in the safest way possible. The Trust signed up to the campaign in 2014-15 and developed a safety improvement plan to reduce avoidable harm, by reducing pressure ulcers, falls and medication incidents, and by timely treatment of sepsis and by implementing improvements in diabetes care.

Since that time, and rather than having two separate quality plans, these objectives have been pursued as part of the Trust's Quality Improvement Strategy 2015-20. The original five pledges of the campaign remain themes running through the whole of our quality improvement work. These comprise putting safety first, facilitating continual learning, being open and honest with patients and families, collaborating with partners and supporting patients and staff.



Sign up to
SAFETY
LISTEN LEARN ACT

Part 2.1.3 NHS Staff Survey

The NHS Staff Survey results are predominantly aimed to inform local improvements in staff experience and well-being. Nationally, the NHS Staff Survey results provide an important measure of performance against the pledges set out in the NHS Constitution. The Constitution outlines the principles and values of the NHS in England, setting out a number of pledges that define what staff should expect from NHS employers.

The results are also used by NHS England to support national assessments of quality and safety. The Care Quality Commission use the results to help to decide who, where and what to inspect.

For the purpose of this year's quality report the Trust was required to report on the following questions from the NHS staff survey. The results provide comparison to both the previous year and the national average.

Staff Survey Question	Value	2015	2016
Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	Trust score:	88%	86%
	National average:	87%	87%

There has been a slight reduction in the percentage of staff believing that the organisation provides equal opportunities for career progression or promotion compared to the previous year. This may be a result of the significant reorganisation that has taken place in the Trust and across the local health economy.

Staff Survey Question	Value	2015	2016
Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	Trust score:	21%	21%
	National average:	24%	23%

The percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months remains the same as the previous year. The Trust continues to be below (better than) the national average.



Part 2.1.4 Care Quality Commission (CQC) Ratings

The Care Quality Commission (CQC) carried out a review of Stepping Hill Hospital on 19–22 January 2016 as part of their comprehensive inspection of Stockport NHS Foundation Trust. The inspection was structured around the CQC’s five key questions (are services safe, effective, caring, responsive, and well-led?) for each of eight core hospital services we provide. The ratings were as follows;

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent & Emergency Services	Inadequate	Good	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement
Medical Care	Requires Improvement	Good	Good	Requires improvement	Good	Requires Improvement
Surgery	Good	Good	Good	Good	Good	Good
Critical Care	Good	Good	Good	Requires Improvement	Good	Good
Maternity And Gynaecology	Requires Improvement	Requires Improvement	★ Outstanding	Good	Requires Improvement	Requires Improvement
Services For Children & Young People	Requires Improvement	Good	Good	Good	Good	Good
End Of Life Care	Good	Good	Good	Good	Good	Good
Outpatients & Diagnostic Imaging	Good	Not Rated*	Good	Good	Good	Good
Stockport NHS Foundation Trust	Requires Improvement	Good	Good	Requires Improvement	Good	Requires Improvement

* The CQC were not confident that they collected sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging

Overall, the CQC rated Stepping Hill Hospital as ‘Requires Improvement’. In their detailed report they found that services were provided by dedicated, caring staff, and patients were treated with dignity and respect. However, improvements were needed to ensure that all services were safe, effective, well led and responsive to peoples’ needs.

Following the CQC’s report, the Trust compiled an action plan to address concerns. The action plan included 115 action areas, containing 212 individual actions to address each area. The action plan is a standing item on the agenda of each business group quality board, risk management board, quality governance committee, quality assurance committee and Trust board meetings where progress is monitored. The latest positions regarding the status of actions in this action plan are highlighted in the table on page 42 of this report.

CQC Action Plan (Position at 12th May 2017)

Blue Completed **Green** On Track **Amber** Overdue/Progressing **Red** Overdue/Concern

Service/ Specialty	Action Type	Action No.	Final Action Date	No. of Actions		Blue	Green	Amber	Red
				Must	Should				
Stockport NHS Foundation Trust	Regulation Requirement	1-5	31/12/2016	22		22			
	Should do	6-18	31/12/2016		4	3	1		
Urgent and Emergency Care	Must do	19-32	31/12/2016	35		34	1		
	Should do	33-47	31/12/2016		26	26			
Medicine	Must do	48-51	31/12/2016	10		8		2	
	Should do	52-54	31/12/2016		6	6			
Maternity and Gynaecology	Must do	55-61	01/12/2016	13		12	1		
	Should do	62-66	01/12/2016		6	6			
End of Life Care (Community)	Must do	67-71	01/12/2016	14		14			
End of Life Care (Hospital)	Must do	72-76	30/04/2017	10		9	1		
Community Adults	Must do	77-80	31/12/2016	11		8	2	1	
	Should do	81-89	31/12/2016		14	14			
Children and Young People	Must do	90-95	31/12/2016	31		28	3		
Diagnostics	Should do	96-101	31/12/2016		12	12			
Critical Care	Must do	102	31/12/2016	2		2			
	Should do	103-106	31/12/2016		2	2			
Surgery	Should do	107-115	31/12/2016		17	17			

The Trust identified 3 priorities to address from the key themes identified in the report, and work has been progressed in these areas throughout the year.

1. We need to improve the safety of patients in our Emergency Department by reducing overcrowding and improving nursing and medical staffing. We aim to reduce overcrowding by reducing Emergency Department attendances and admissions, and by enhancing capacity and flow through the hospital. These actions will not only improve patient safety, but also the care and experience of patients and families in the Emergency Department.
2. We need to continue to improve our nursing and medical staffing through effective recruitment and retention of staff, looking at new roles and continuing to reduce reliance on temporary staff. Whilst significant progress has been made, we recognise that there remains work to do in specific areas such as the Emergency Department, medical wards and Community Nursing.
3. We need to improve and maintain compliance with mandatory training and appraisals for all staff.

A follow-up inspection was carried out by the CQC in March 2017 and positive observations relating to improved communication and patients being treated with dignity and respect were noted. However, there were also a number of areas where actions taken by the Trust were considered to require further attention. An action plan for these specific areas was submitted to the CQC on 11 April 2017.

PART 2.2

Priorities for improving Quality in 2017-18

Part 2.2 | Priorities for improving Quality in 2017-18

For 2017-18 we will continue to develop and improve work around our priorities and objectives as indicated below.

REDUCE MORTALITY:	OBJECTIVES 2017-18
1. SEPSIS	To continue to embed the Sepsis Screening Tool
PROVIDE HARM FREE CARE:	OBJECTIVES 2017-18
2. PRESSURE ULCERS	To continue to work towards achieving a reduction in avoidable grade 3 and 4 pressure ulcers: <ul style="list-style-type: none"> Acute areas: 2017/18 Target =0 Community: 2017/18 Target = 9
3. FALLS	To aim for a 10% reduction on 2016/17 outturn: <ul style="list-style-type: none"> To reduce serious falls (major and above Datix categories) to \leq 17 To work with key stakeholders in the acute setting to devise a falls pathway. To improve quality of life for people in Stockport by working with key stakeholders in the community to reduce the burden of falls and fractures.
4. VTE	To continue to work towards reducing avoidable VTEs by establishing a new VTE group comprising Associate Medical Directors, to review the RCAs and determine further learning.
5. MEDICATION ERRORS	To continue with all measures designed to reduce medication incidents which cause harm
6. HEALTHCARE ASSOCIATED INFECTIONS	2016-17 15 lapses in care against trajectory of 17 <ul style="list-style-type: none"> 2017-18 trajectory remains at 17 2016-17- zero MRSA bacteraemia, <ul style="list-style-type: none"> Last hospital acquired case was December 2014 Full review of the IP service and business case <ul style="list-style-type: none"> Review of IV service and processes & ANTT especially around medics
7. DIABETES	<ul style="list-style-type: none"> To prevent hospital acquired DKA by targeted training Reduce inpatient severe hypoglycaemia below 5% Review foot ulcers within 24 hours of admission Participate and learn from National Audits and adverse incident multidisciplinary review process Support patients in empowerment for self-care
PROVIDE RELIABLE CARE:	OBJECTIVES 2017-18
8. EARLY WARNING SCORE	<ul style="list-style-type: none"> Implement the standardized trust mortality review process Embed the changes to the EWS policy Improve attendance at Resuscitation Training
IMPROVE PATIENT EXPERIENCE:	OBJECTIVES 2017-18
9. CAPTURING & LEARNING FROM PATIENT & FAMILY FEEDBACK	<ul style="list-style-type: none"> Continue to build on the progress made during 2016/17 To progress triangulation of Staff and Patient FFT
10. IMPROVE CARE FOR PATIENTS WITH DEMENTIA	<ul style="list-style-type: none"> Continue to implement the Trust's Dementia Strategy Dementia training sessions for ED staff to commence in April. Discussions on fast track of patients through ED remain on the agenda. Encourage the use of the Dementia café; Alzheimer's Society will have information and advice sessions on the last Friday of every month and EDUCATE group (Early Dementia Users Co-operative Aiming to Educate) will also run information and advice sessions on 4th Wednesday of every month. Establish a bespoke Enhanced Care Team of skilled HCAs to work with dementia patients Plans for Dementia ward remain in place going forward.
11. COMPLAINTS MANAGEMENT & DUTY OF CANDOUR	<ul style="list-style-type: none"> Continuing to redesign management of informal complaints – education of patients and families on how to get issues and concerns resolved. Work towards improving the timely completion of Duty of Candour responsibilities, with closer monitoring and support for business groups.

Part 2.2.1 Participation in CQUIN 2017-18

As in previous years, the Trust will be fully engaged in the CQUIN programme. For the first time NHS England have published a two year scheme which will provide greater certainty and stability on the CQUIN goals leaving more time for health communities to focus on implementing the initiatives. The CQUIN scheme is intended to deliver clinical quality improvements and drive transformational change. With these objectives in mind the scheme is designed to support the ambitions of the Five Year Forward View and directly link to the NHS Mandate, so now focuses on two areas:

- Clinical quality and transformational indicators:**
 These indicators aim to improve quality and outcomes for patients including reducing health inequalities, encouraging collaboration across different providers and improving the working lives of NHS staff.
- Supporting local areas:**
 Sustainability and Transformation Plans (STP) – reinforcing the critical role providers have in developing and implementing local STPs. Local financial sustainability – encouraging providers and commissioners to work together to achieve financial balance and to complement the introduction of system control totals at STP level.

The CQUIN scheme has shifted focus from local CQUIN indicators to prioritising Sustainability & Transformation Plan engagement and delivery of financial balance across local health economies. It is anticipated that this approach will free up commissioner and provider time and resource to focus on delivering critical priorities locally.

The table below highlights the indicators that the Trust is committed to achieve during 2017-18. Further detail on each indicator is provided on page 46-48 of this report.

National		STP	Specialised	Dental
NHS Staff Health & Wellbeing	e-Referrals	Sustainability & Transformation Plan Engagement	Nationally Standardised Dose Banding For SACT	Managed Clinical Networks (MCNs)
Proactive & Safe Discharge	Wound Care	Sustainability & Transformation Plan Risk Reserve	Medicines Optimisation	Referral Management
Antimicrobial Resistance & Sepsis	Personalised Care / Support Planning			
Mental Health Services A&E	Advice & Guidance			

Quarterly reports with supporting evidence are produced and submitted by the Trust to each relevant commissioning group. Discussion on any queries takes place between the Commissioners and the Head of Outcomes & Assurance for the Trust. All CQUIN's are monitored monthly and reported to various sub-committees of the Trust Board. Any areas of concern are also highlighted within the Integrated Performance Reports which are shared with the Trust Board.

Staff Health & Wellbeing

Staff Health – During 2016-17 this CQUIN focussed on the introduction of health and wellbeing initiatives covering physical activity, mental health and improving access to physiotherapy for people with MSK issues. For 2017-05-1518 the CQUIN will shift from the introduction of schemes to measuring the impact that staff perceive from the changes, via improvements to the health and wellbeing questions within the NHS staff survey.

Healthy Food –The Trust will be expected to build on the changes made during the 2016-17 CQUIN to improve its availability of healthy food and drink options and reduce sugary drinks and foods high in fat, sugar or salt while also introducing new changes to food and drink provision.

Flu Vaccinations – As undertaken in 2016-17 the Trust will continue to carry out its annual flu vaccination campaign to ensure its frontline healthcare workers receive their flu vaccination to protect staff and patients from infection.

Proactive & Safe Discharge

There is considerable evidence for the harm caused by poor patient flow. Delays lead to poor outcomes for patients, create financial pressures and impact on key NHS performance measures.

Delayed discharge has a serious impact across health and care systems, reducing the ability of emergency departments to respond to peoples' needs, and increasing costs to local health economies.

This CQUIN will look at increasing the proportion of patients admitted via non-elective route discharged from acute hospitals to their usual place of residence within 7 days of admission.

Antimicrobial Resistance & Sepsis

Sepsis Screening – Continuing on from the 2015-16 CQUIN the Trust will undertake monthly audits on the timeliness for identification of sepsis in ED and acute inpatient settings by ensuring patients who met the criteria for sepsis screening were screened.

Sepsis Treatment – Continuing on from the 2015-16 CQUIN the Trust will undertake monthly audits on the timeliness for treatment of sepsis in ED and acute inpatient settings by ensuring patients receive IV antibiotics within 1 hour of the diagnosis of sepsis.

Antibiotic Review – Continuing on from the 2015-16 CQUIN the Trust will undertake monthly audits to identify the percentage of antibiotic prescriptions documented and reviewed for patients with sepsis who are still inpatients at 72 hours.

Antibiotic Consumption – Building on the progress made in the 2015-16 CQUIN the Trust will continue to make a reduction in antibiotic consumption per 1,000 admissions.

A&E Mental Health

This CQUIN has been designed to incentivise both acute and mental health providers to contribute to improved services for people with mental health and psychosocial needs who present to A&E by ensuring these needs are met more effectively through an improved, integrated service, reducing their future attendances at A&E.

The Trust will be expected to reduce the number of attendances to A&E for those within a selected cohort of frequent attenders who would benefit from mental health and psychosocial interventions, and establish improved services to ensure this reduction is sustainable.

e-Referrals

This CQUIN is designed to encourage a move away from any paper based processes by requiring all providers to publish all of their services and make all first outpatient appointment slots available on e-referral service by 31 March 2018.

Wound Care

Research evidence demonstrates that over 30% of chronic wounds (wounds that have failed to heal for 4 weeks or more) do not receive a full assessment which is based on research evidence and best practice guidelines.

Failure to complete a full assessment can result in ineffective treatment and contributes to delays in the rate of wound healing for patients. This has significant consequences for patients in respect of their quality of life as failure to treat wounds correctly can lead to delays in healing or failure to heal.

This CQUIN will require the Trust to undertake an audit on the number of full wound assessments for wounds which have failed to heal after 4 weeks and then to increase the number assessed by undertaking a repeat audit.

Personalised Care & Support Planning

This CQUIN aims to incentivise providers to shift to a more personalised approach. A growing body of evidence now suggests that by increasing individuals' knowledge, skills and confidence to manage their health and wellbeing, there will be less reliance on clinical services, reducing demand in both primary and secondary care.

The Trust will be expected to identify the groups of patients who would benefit most from the delivery of personalised care and support planning and provide this support to them.

Advice & Guidance

The GP Forward View set out the need to improve GP access to consultant advice on potential referrals into secondary care. This indicator draws on a number of case studies from around the country where advice and guidance has already begun to be implemented.

This CQUIN requires providers to set up and operate advice and guidance services for non-urgent GP referrals, allowing GPs to access consultant advice prior to referring patients in to secondary care.

Sustainability & Transformation Plan (STP)

For 2017-18 the CQUIN scheme has shifted focus from local CQUIN indicators to prioritising Sustainability & Transformation Plan (STP) engagement and delivery of financial balance across local health economies.

The Trust will be expected to make the required contributions to the STP initiatives and demonstrate to the STP governance arrangements how it is supporting and engaging in the local STP initiatives.

Nationally Standardised Dose Banding For SACT

It is intended that all NHS England commissioned providers of chemotherapy move to prescribing a range of Systemic Anticancer Therapy (SACT) drugs, in accordance with a nationally approved set of dose tables.

This CQUIN looks to build on the progress made during 2015-16 by the implementation of nationally standardised doses of SACT across England using the dose-banding principles and dosage tables published by NHS England (developed through the Medicines Optimisation Clinical Reference Group).

Targets will be agreed for end of year achievement in relation to the % of doses standardised per drug (number of SACT doses given of selected drugs that match to the standardised doses / number of SACT doses given of selected drug).

Medicines Optimisation

Optimising the use and management of medicines is a significant and realisable opportunity for the NHS. The Carter Review has highlighted that unwarranted variation in use and management of medicines costs the NHS at least £0.8billion per year that could be re-invested to support sustainable service delivery.

This CQUIN aims to support the procedural and cultural changes required to optimise use of medicines commissioned by specialised services. This includes;

- Faster adoption of best value medicines
- Significantly improved drugs data quality
- The consistent application of lowest cost dispensing channels
- Compliance with policy/ consensus guidelines to reduce variation and waste.

Managed Clinical Networks (MCNs)

This CQUIN aims to build on the existing work undertaken during 2016-17 for secondary care dental services which are directly commissioned by NHS England North (Cheshire & Merseyside).

An MCN is a way of working where clinicians from all settings across a clinical pathway can focus on patients and services rather than being constrained by organisational boundaries.

For 2017-18 the Trust will continue to have active participation in the Managed Clinical Networks and clinical engagement groups.

Referral Management

This CQUIN aims to build on the existing work undertaken during 2016-17 for secondary care dental services which are directly commissioned by NHS England North (Cheshire & Merseyside).

The Referral Management indicator aims to ensure the Trust has the necessary IT infrastructure systems and management process in place to interface with any electronic referral management systems commissioned by NHS England. This includes the ability to receive and process electronic referrals and related dental radiographs in line with NHS Information governance rules.

For 2017-18 the Trust will continue to develop work currently being undertaken to ensure these systems are fully embedded.

PART 2.3

Statements of assurance from the Board

Part 2.3

Statements of assurance from the Board

The following section includes responses to a nationally defined set of statements which will be common across all Quality Account reports. The statements serve to offer assurance that our organisation is performing to essential standards, such as securing Care Quality Commission registration and measuring our clinical processes and performance. This includes participation in national audits and being involved in national projects and initiatives aimed at improving quality (such as recruitment to clinical trials).

1 Review of Services

This statement is to ensure that we have considered quality of care across all of our services. The information reviewed by our quality committees is from all clinical areas. Information at individual service level is considered within our divisional structure and any issues escalated to the Quality Governance Committee or to Performance and Planning Committee.



During 2016-17 SFT provided and/or subcontracted 49 NHS services.

SFT has reviewed all the data available 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 NHS services reviewed in 2016-17 represents 85% of the total income generated from the provision of NHS services by SFT for 2016-17.

2 Participation in Clinical Audit

The purpose of this statement is to demonstrate that we monitor quality in an on-going, systematic manner.

During 1 April 2016 to 31 March 2017, 38 national clinical audits and 6 national confidential enquiries covered NHS services that SFT provides.

During that period SFT participated in 97% of national clinical audits and 83% of 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 SFT was **eligible** to participate in during 2016-17 are as shown in the table on page 56.

The national clinical audits and national confidential enquiries that SFT **participated** in during 2016-17 are as shown in the table on page 56.

The national clinical audits and national confidential enquiries that SFT participated in, and for which data collection was completed during 2016-17 are listed in the table on page 56, 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.

The reports of 37 national clinical audits were reviewed by the provider in 2016-17 and SFT intends to take the following actions to improve the quality of healthcare provided. Reports are included on the quality

governance committee agenda as part of the governance framework and the Medical Director delegates to the clinical lead for the specialty for perusal, consideration and sharing the findings with appropriate groups and where appropriate develop local action plans.

The reports of 126 local clinical audits were reviewed by the provider in 2016-17 and SFT intends to take the following actions to improve the quality of healthcare provided:

- A report and action plan if appropriate is produced for each audit and submitted to the clinical audit team. Business Groups are advised of outcomes and as part of the governance framework an outcomes report is submitted to the Trust Quality Governance Committee to advise of compliance level, risk and escalation requirements.

Clinical Audit has also been an integral part of the Trust's CQUIN programme providing evidence information for a number of indicators including care bundles.

3

Participation in Clinical Research

Research engagement within the Trust is critical to meet the expectations of our patients. Polls run through the Department of Health have demonstrated public support for the NHS to offer opportunities to take part in healthcare research. The NHS Constitution summarises what staff, patients and the public can expect from the NHS: 'The NHS will do all it can to ensure that patients, from every part of England, are made aware of research that is of particular relevance to them'. Healthcare professionals therefore have a part in ensuring the NHS Constitution is upheld in their own practices at this Trust.

Participation in clinical research demonstrates the commitment of SFT to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff members stay abreast of the latest treatment possibilities and active participation in research leads to successful patient outcomes.

In 2016-17, research and innovation became a key component of Trust strategy. Research is enabled in the Trust pre-dominantly through research active healthcare professionals and the staff funding support received from the National Institute of Health Research (NIHR). The NIHR is the research delivery arm of the NHS. Support is offered in regions through the NIHR and Stockport is part of the Greater Manchester Clinical Research Network (GMCN).



The number of patients receiving NHS services provided or sub-contracted by SFT in the period 2016-17 that were recruited during that period to participate in research approved by a research ethics committee was 901, which significantly exceeds the Trust target set by the GMCN (Greater Manchester Clinical Research Network) at 555. This reflects research studies that were approved by a research ethics committee (in conjunction with the Health Research Authority), and adopted by the NIHR. This is a very large increase from 365 in 2015-16.

Participation in clinical research demonstrates SFT's commitment to improving the quality of care we offer and to making our contribution to wider health improvements. Our clinical staff stays abreast of the latest treatment possibilities and active participation in research leads to successful patient outcomes.

SFT actively recruited into 50 out of 75 open research studies in the following Trust areas during this reporting period. Of these 75 studies, 7 were sponsored by pharmaceutical companies (i.e. commercial studies) and 68

sponsored by a variety of academic institutions (i.e. universities) and other NHS Trusts in the UK.

Specialty:	Studies	Patients Recruited
Cancer	11	153
Musculoskeletal	6	62
Children	5	16
Stroke	5	43
Anaesthesia	3	203
Cardiovascular Disease	3	32
Ear, Nose, Throat	3	12
Other	14	380

Our top three recruiting studies for 2016-17 were across 3 different specialties. Further information on these studies can be found on page 55 of this report.

There were over 50 members of clinical staff participating in clinical research studies at SFT during 2016-17. These staff participated in research covering 17 specialties. Our engagement with clinical research demonstrates the Trust's commitment to testing and offering the latest medical treatments and techniques.

For 2017-18, SFT hopes to build on the success of 2016-17 by further embedding research as a front-line activity. Re-location of the team into a centralised location on the Trust footprint along with relationship building in the new Manchester healthcare landscape will enable the Trust to improve recruitment into research studies further and maximise revenue potential from commercial work.

The Trust currently has more than 10 studies in active set-up, with many more in early feasibility discussions to ensure a diverse research portfolio continues at Stockport. Our engagement with clinical research demonstrates SFT's commitment to testing and offering the latest medical treatments and techniques.

Our latest performance reports are published on the Trust website:

http://www.stockport.nhs.uk/services_895R.

4

Information on the use of CQUIN framework

The CQUIN payment framework continues to support the cultural shift towards making quality the organising principle of NHS services by embedding quality at the heart of commissioner-provider discussions.

A proportion of SFTs income in 2016-17 was conditional on achieving quality improvement and innovation goals agreed between SFT 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 2016-17 and for the following 12 month period are available on request from CQUIN@stockport.nhs.uk.

The level of the Trust's income in 2016-17 which was conditional upon the quality and innovation goals was £5.7m; in line with national rules this represented 2.5% of income.

During 2015-16 the Trust achieved a CQUIN payment of £5.2m, 88% of the £5.9m available.

5

Registration with Care Quality Commission

The Care Quality Commission (CQC) is the independent regulator of health and adult social care services in England.



SFT is required to register with the Care Quality Commission (CQC) and its current registration status is 'registered'. SFT has no conditions on its registration.

The Care Quality Commission has not taken enforcement action against SFT during 2016-17.

SFT has not participated in any special reviews or investigations by the CQC during the reporting period.

The Trust did participate in a special review by the Care Quality Commission during 2015-16 and continues to implement the actions resulting from the findings. See page 41 for inspection rating and updates on the status of the Trust's action plan.

6 Quality of Data

Data quality refers to the tools and processes that result in the creation of the correct, complete and valid data required to support sound decision-making. Good quality data underpins the effective delivery of patient care and is essential if improvements in quality of care are to be made.



SFT submitted records during 2016-17 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The patient NHS number is the key identifier for patient records. Accurate recording of the patient's General Medical Practice Code is essential to enable the transfer of clinical

information about a patient from a trust to the patient's GP.

Percentage of records published data which included a valid patient NHS number:	
Admitted Patient Care	99.80%
Out-Patient Care	99.90%
Accident & Emergency Care	98.84%

Percentage of records published data which included the patient's valid GP practice code:	
Admitted Patient Care	99.86%
Out-Patient Care	99.96%
Accident & Emergency Care	99.40%

Period: 01 April 2016 to 31 March 2017

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"

SFT 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 clinics and A&E department.
- Review and update procedures for capture and handling of patient activity data.
- Undertake work to improve timeliness of electronic recording on wards of admissions, transfers and discharges.
- During 2017-18, in view of the implementation of phase 1 of a new acute electronic patient record (Intersystems Trakcare), we will develop a wide range of data quality reports with the aim of ensuring that data quality does not drop post implementation. We have however, warned our commissioners of the

possibility of a reduction in data quality immediately post go live as this tends to be the experience of most Trusts implementing new systems. Any data quality issues will be fed back to the training team and communicated to staff to correct any unforeseen issues.

- As above, 2017-18 will see the end of phase 1 of the implementation of our new Community EPR (EMIS web). A range of new data quality reports will be developed to help improve data quality in community services. Commissioners have been made aware of the potential risk to data quality until these are implemented and actioned.
- Update training materials and amend in view of any data quality issues.
- Regular contact with consultants to highlight issues that clinical coders encounter, to improve the quality of the information regarding diagnoses and procedures in patient records and therefore continue to improve the quality of clinical coding.
- Continue to maintain compliance with all the Information Governance Toolkit requirements including health records and data quality standards.

7 Information Governance

Information governance ensures that information held about patients and staff is kept safe and secure. The information governance toolkit is the way in which we demonstrate our compliance with information governance standards. The Trust's Information Governance & Security Group oversees the annual submission.

SFT Information Governance Assessment Report overall score for 2016-17 was 68% (Level 2) and was graded green and satisfactory.

8 Clinical Coding

Clinical coding translates the medical terminology written by clinicians to describe a patient's diagnosis and treatment into standard, recognised codes. The accuracy of this coding is a fundamental indicator of the accuracy of the patient record.

SFT was not subject to the Payment by Results clinical coding audit during 2016-17 by the Audit Commission.



Part 2.3.1**Top Recruiting Studies In Clinical Research**

2016-17 reflects a significant diversification into different specialisms in the Trust, to ensure research can be a viable option across as many areas as possible for our patients. Stockport NHS Foundation Trust also acts as a participant identification area for other Greater Manchester Trusts across many of these specialisms to ensure there is choice is available to our patients for research study participation.

Our top three recruiting studies for 2016-17 were across 3 different specialisms as follows:

1. Oral and Dental Health

The TIGER TEETH study has recruited 201 participants from July 2016 to March 2017. This is a randomised controlled trial of a targeted distributed toothpaste and tooth brushing programme to reduce paediatric dental general anaesthetic operations for young children in at risk families. Families are either allocated to receive the intervention (i.e. provision of standardised sugar-acid neutraliser toothpaste, tooth brushes, a timer and an evidence based information sheet to all adults and children identified in at risk families with follow up packs administered by post at 3 month intervals for 24 months) or no additional preventative oral health advice or treatment. Recruitment is ongoing into 2017-18.

2. Anaesthesia

SNAP-2 is the second UK sprint national anaesthesia project, looking at the epidemiology of critical care provision after surgery. Recruitment for Stockport totalled 174 in 2016-17 and was run over a week's snapshot in the hospital in the last week of March 2017.

The study aimed to describe the rates and reasons for patients being admitted to critical care after inpatient surgery in the UK. A secondary aim was to estimate whether postoperative critical care admission is associated with patient benefit (a reduction in postoperative complications). The study also explored how clinicians determined the risk of death in clinical practice and whether these risk estimates are accurate. Data was collected on all patients undergoing surgery requiring overnight stay in hospital in

participating UK hospitals for one week. Data analysis is currently ongoing by the study sponsor, University College of London in association with the Royal College of Anaesthetists.

3. Health Services and Delivery

The high intensity specialist acute care (HiSLAC) project was our third top recruiter at 95 in 2016-17. This study is a survey directed at clinicians, evaluating the impact of high-intensity specialist-led acute care on emergency medical admissions to NHS hospitals at weekends. It is a 5-year study, based on research in diverse health systems demonstrating poorer outcomes for patients admitted to hospitals at weekends. In the UK, the importance of this issue has been recognised through four recent initiatives: the Academy of Medical Royal College's publications 'Benefits of Specialist Delivered Care' and the Academy's standards document 'Seven Day Specialist Present Care'; the Royal College of Physicians Future Hospital Commission to examine new ways of providing specialist care; and NHS England's (Commissioning Board) working group on implementing 7-day services.

The aim is to combine quantitative analysis with qualitative (ethnographic) research to measure quality of care and to explore cultural and behavioural aspects of a fundamental change in service delivery. The study also looks to assess the health economic impacts of improving specialist cover over weekends. This was the first year of Stockport's participation in this study.

Part 2.3.2

National Clinical Audits & Confidential Enquiries

The national clinical audits and national confidential enquiries that Stockport NHS Foundation Trust participated in during 2016-17 are as follows:

KEY: E = Eligible P = Participated

Title		E	P	% or Num. Submitted
1. Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)		Yes	Yes	430 Jan 16 - Dec 16
2. Adult Asthma		Yes	Yes	28
3. Adult Cardiac Surgery		No	NA	Not Eligible
4. Asthma (paediatric and adult) care in emergency departments		Yes	Yes	50
5. Bowel Cancer (NBOCAP)		Yes	Yes	189 (Estimate)
6. Cardiac Rhythm Management (CRM)		Yes	Yes	347
7. Case Mix Programme (CMP)		Yes	Yes	100%
8. Child Health Clinical Outcome Review Programme		No	NA	Not Eligible
9. Chronic Kidney Disease in primary care		No	NA	Not Eligible
10. Congenital Heart Disease (CHD)		No	NA	Not Eligible
11. Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)		No	NA	Not Eligible
12. Diabetes (Paediatric) (NPDA)		Yes	Yes	100%
13. Elective Surgery (National PROMs Programme)		Yes	Yes	100%
14. Endocrine and Thyroid National Audit		Yes	Yes	24 (100%) Jan 1st 2016 - 31st Dec 2016
15. Falls and Fragility Fractures Audit programme (FFFAP):	Fracture Liaison Service Database	No	NA	Not Eligible
	Falls	NA	NA	Not Applicable
	National Hip Fracture Database	Yes	Yes	100%
16. Head and Neck Cancer Audit		Yes	Yes	56
17. Inflammatory Bowel Disease (IBD) programme		Yes	Yes	141
18. Learning Disability Mortality Review Programme (LeDeR Programme)		Yes	No	Participating from April 2017
19. Major Trauma Audit		Yes	Yes	299 Apr 1st 2016 - 31st Dec 2016
20. Maternal, Newborn and Infant Clinical Outcome Review Programme:	Perinatal Mortality Surveillance	Yes	Yes	
	Perinatal mortality and morbidity confidential enquiries	Yes	Yes	
	Maternal Mortality surveillance and mortality	Yes	Yes	

Title		E	P	% or Num. Submitted
	confidential enquiries			
21. Medical and Surgical Clinical Outcome Review Programme:	Acute Pancreatitis	NA	NA	Not Applicable
	Physical and mental health care of mental health patients in acute hospitals	Yes	Yes	1
22. Medical and Surgical Clinical Outcome Review Programme: Non-invasive ventilation		Yes	NA	
23. Mental Health Clinical Outcome Review Programme:	Suicide in children and young people (CYP)	No	NA	Not Eligible
	Suicide, Homicide & Sudden Unexplained Death	No	NA	Not Eligible
	The management and risk of patients with personality disorder prior to suicide and homicide	No	NA	Not Eligible
24. National Audit of Dementia		Yes	Yes	100%
25. National Audit of Pulmonary Hypertension		No	NA	Not Eligible
26. National Cardiac Arrest Audit (NCAA)		Yes	Yes	103
27. National Chronic Obstructive Pulmonary Disease (COPD) Audit programme:	Pulmonary rehabilitation	Yes	Yes	Data collection only started 03/2017, 0 submitted to date
	Secondary Care	Yes	Yes	69
28. National Comparative Audit of Blood Transfusion - Audit of Patient Blood Management in Scheduled Surgery		Yes	Yes	
29. National Diabetes Audit – Adults:	National Footcare Audit	Yes	Yes	100%
	National Inpatient Audit	Yes	Yes	100%
	National Pregnancy in Diabetes Audit	Yes	Yes	21
	National Diabetes Transition	NA	NA	Not Applicable
	National Core	No	NA	Not Eligible
30. National Emergency Laparotomy Audit (NELA)		Yes	Yes	160 Dec 15 - Nov 16
31. National Heart Failure Audit		Yes	Yes	484 Jan 16 - Dec 16
32. National Joint Registry (NJR):	Knee replacement	Yes	Yes	100%
	Hip replacement	Yes	Yes	100%
33. National Lung Cancer Audit (NLCA)		Yes	Yes	195 (Estimate)
34. National Neurosurgery Audit Programme		No	NA	Not Eligible
35. National Ophthalmology Audit		Yes	No	Significant delays as we have required a lot of information signed off by Medisoft before we have been able to progress with this audit. We are aiming to start this in March 2017 in order that we can look prospectively at this activity
36. National Prostate Cancer Audit		Yes	Yes	350 (Estimate)

Title	E	P	% or Num. Submitted
37. National Vascular Registry	No	NA	Not Eligible
38. Neonatal Intensive and Special Care (NNAP)	Yes	Yes	100%
39. Nephrectomy Audit	Yes	Yes	103
40. Oesophago-gastric Cancer (NAOGC)	Yes	Yes	75 (Estimate)
41. Paediatric Intensive Care (PICANet)	No	NA	Not Eligible
42. Paediatric Pneumonia	Yes	Yes	0
43. Percutaneous Nephrolithotomy (PCNL)	Yes	Yes	100% (Estimate)
44. Prescribing Observatory for Mental Health (POMH-UK)	No	NA	Not Eligible
45. Radical Prostatectomy Audit	Yes	Yes	240
46. Renal Replacement Therapy (Renal Registry)	No	NA	Not Eligible
47. Rheumatoid and Early Inflammatory Arthritis	NA	NA	Not Applicable
48. Sentinel Stroke National Audit programme (SSNAP)	Yes	Yes	100%
49. Severe Sepsis and Septic Shock – care in emergency departments	Yes	Yes	50
50. Specialist rehabilitation for patients with complex needs	Yes	Yes	100%
51. Stress Urinary Incontinence Audit	Yes	Yes	90%
52. UK Cystic Fibrosis Registry	No	NA	Not Eligible

Part 2.3.3

Local Clinical Audits

Clinical audit is a way to find out if healthcare is being provided in line with standards and allows care providers and patients know where their service is doing well, and where there could be improvements. The aim is to enable quality improvement to take place where it will be most helpful and will improve outcomes for patients.

Once an audit has been undertaken it is given a level of assurance by calculating the individual ratings against its standards as follows;

 **95% and above**  **75% to 94%**  **74% and below**

Once each standard has been rated an overall level of assurance for the audit project can be determined using the matrix below.

During 2016-17 the reports for **115** audits or re-audits were submitted to quarterly Quality Governance Committee meetings. The assurance levels reported are highlighted below.

Assurance Level	Calculation of assurance	Number of audits reported
Full	To be used when each standard has achieved a score of 95% or above and is rated Green	16
Significant	To be used when there are only Green and Amber rated findings (although where there are a significant number of Amber rated findings, consideration will be given as to whether in aggregate the effect is to reduce the assurance level given)	21
Limited	To be used when there is a small ratio of Red and Amber to Green rated findings	39
Very Limited	To be used when the ratio of Red rated findings are greater than the Amber and Green	39

The majority of audits are undertaken where it is perceived that there is room for improvement therefore it is anticipated that the level of assurance will often be limited or very limited. Once the assurance level is given the project lead will then advise on the risk level (not all failed measures present a risk).

During the course of the year quarterly outcome reports are submitted to the Trust's Quality Governance Committee (QGC) as part of the governance framework advising on the level of assurance that an audit provided. The report also advises on the risk level and whether action is required by the committee. Where an audit required the committee's input, full details of the measures and compliance were submitted. Following an audit, action / improvement plans are put in place to support the delivery of improvements.

PART 2.4

Reporting against core indicators

Part 2.4 Reporting against core indicators

SUMMARY HOSPITAL-LEVEL MORTALITY INDICATOR (SHMI)

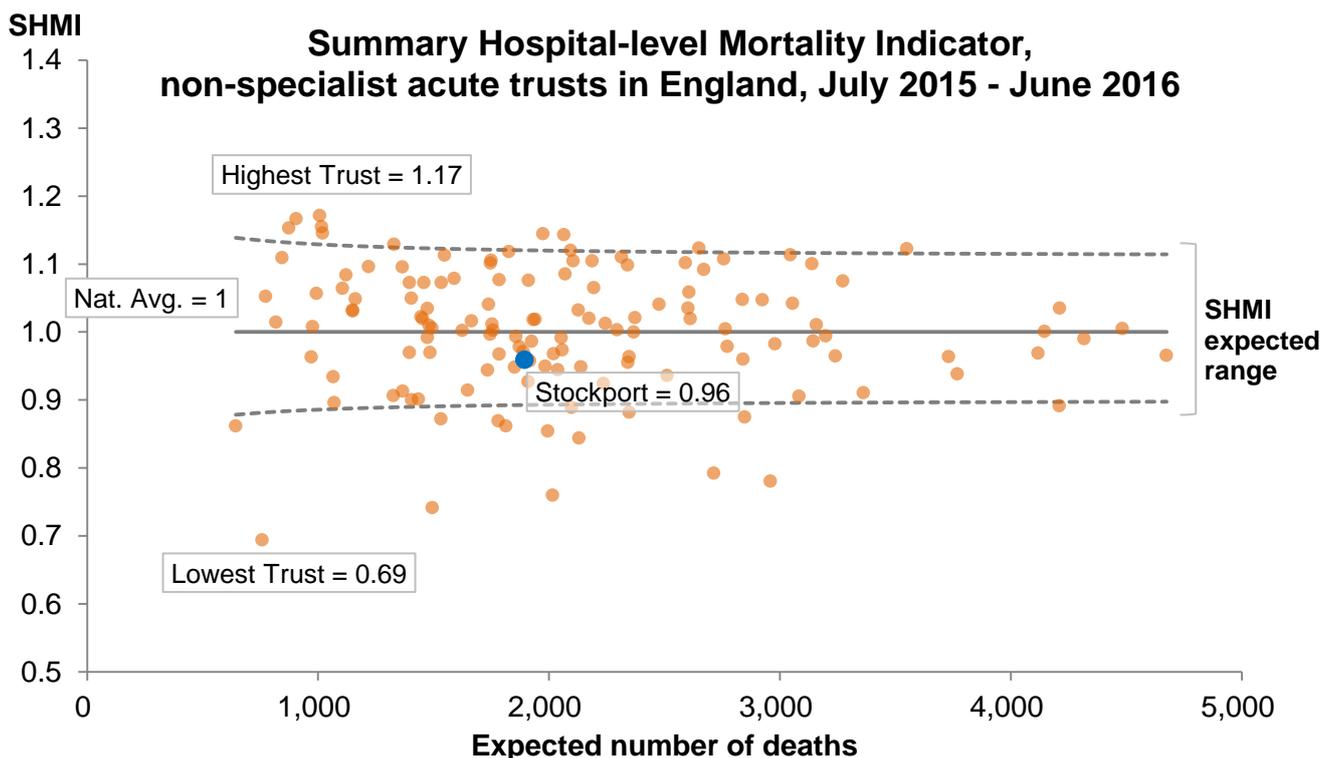
The value and banding of the summary hospital-level mortality indicator (“SHMI”) for the trust for the reporting period*

Value	2012-13	2013-14	2014-15	2015-16
Trust score:	0.95	0.90	0.94	0.96
National average:	1.00	1.00	1.00	1.00
Highest national:	1.16	1.20	1.21	1.17
Lowest national:	0.63	0.54	0.66	0.69

*Reporting period is from July to June

SFT considers that this data is as described for the following reasons; it is the latest data available from NHS Digital. We perform better than the national average (a lower score is better) and continue to focus upon accurate coding of patients to ensure that our population is accurately represented by their data. Please note that figures differ from that reported in last year’s report due to a change in the reporting period.

SFT has taken the following actions to improve this indicator, and so the quality of its services: reviewing case studies at Morbidity and Mortality quarterly meetings within specialties to support learning



PATIENT DEATHS WITH PALLIATIVE CARE CODED

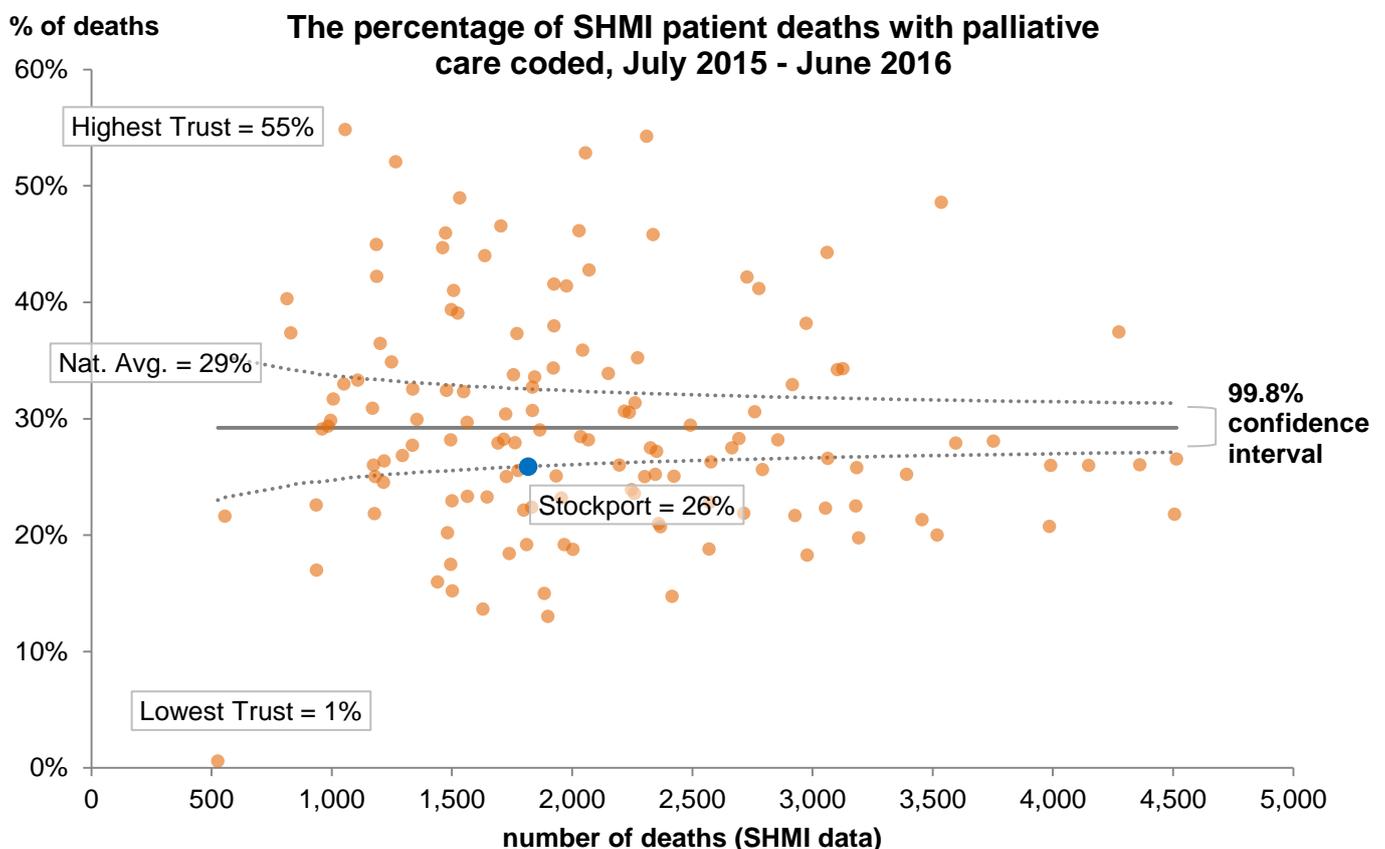
The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period*

Value	2012-13	2013-14	2014-15	2015-16
Trust score:	17%	22%	24%	26%
National average:	21%	25%	27%	29%
Highest national:	45%	49%	54%	55%
Lowest national:	0%	0%	0%	1%

*Reporting period is from July to June

SFT considers that this data is as described for the following reasons; this is the latest data available. We continue to move closer to the national average. The Trust is currently within the expected range and is not an outlier.

SFT has taken the following actions to improve this indicator, and so the quality of its services: monthly reviews of deaths, root cause analysis where appropriate, discussions and shared learning at appropriate forums.



PATIENT REPORTED OUTCOME MEASURES SCORES (PROMS)

The trust's patient reported outcome measures scores ("PROMS") for the reporting period				
Measure	Value	2013-14	2014-15	2015-16*
Groin hernia surgery	Trust score:	56%	52%	45%
	National average:	50%	50%	49%
	Highest national:	88%	75%	100%
	Lowest national:	21%	11%	0%
Hip replacement surgery	Trust score:	92%	91%	75%
	National average:	88%	88%	86%
	Highest national:	100%	100%	100%
	Lowest national:	67%	74%	0%
Knee replacement surgery	Trust score:	84%	88%	85%
	National average:	80%	80%	81%
	Highest national:	100%	100%	100%
	Lowest national:	40%	54%	0%

*April 2015 to September 2016 provisional results, published February 2017

SFT considers that this data is as described for the following reasons: this is the latest data available from NHS Digital as of as at September 2016, final figures will be available in August 2017. The figures are based on patients' responses to questionnaires, completed before and after surgery and are 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.

SFT 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 results on a regular basis, along with publishing the figures within and outside the Trust. See article on page 90.

Groin Hernia Surgery – The Trust continues to review results on a regular basis.

READMISSIONS WITHIN 28 DAYS OF DISCHARGE

The percentage of patients readmitted to a hospital within 28 days of being discharged from a hospital which forms part of the trust during the reporting period					
CHKS Data	Value	2013-14	2014-15	2015-16	2016-17*
Patient readmitted to hospital within 28 days of being discharged aged: 0-15	Trust score:	8.2%	8.7%	8.6%	9.1%
	National average:	9.2%	9.3%	9.4%	9.3%
	Highest national:	15.4%	15.4%	18.2%	15.5%
	Lowest national:	0.0%	0.0%	0.0%	0.0%
Patient readmitted to hospital within 28 days of being discharged aged: 16+	Trust score:	8.3%	8.8%	8.3%	8.0%
	National average:	7.3%	7.5%	7.5%	7.5%
	Highest national:	11.2%	11.2%	10.6%	10.4%
	Lowest national:	0.0%	0.0%	0.0%	0.0%

*2016-17 data for April to Dec for Trust, April to Nov for Peer

SFT considers that this data above as described for the following reason: this is the latest available from Comparative Health Knowledge System (CHKS).

SFT has taken the following actions to improve this percentage, and so the quality of its services by undertaking extensive reviews in specialties where readmissions were above national average. These cases were managed by the Trust Optimising Capacity Board and were monitored at the Optimising Capacity Steering Group.

NATIONAL INPATIENT SURVEY

The trust's responsiveness to the personal needs of its patients during the reporting period				
Value	2013	2014	2015	2016
Trust score:	63	63	68	68
National average:	68	69	69	70
Highest national:	84	85	86	86
Lowest national:	57	54	59	60

This indicator is based on data from the National Inpatient Survey – an average weighted score of 5 questions relating to responsiveness to inpatients' personal needs (score out of 100).

SFT considers that this data is as described for the following reason: the result shown is calculated as the average of five questions taken from the national inpatient survey.

SFT has taken the following action to improve this percentage and so the quality of its services, the Matron for Patient experience is highly visible on the wards supporting ward managers. The iPad survey continues to be used and the questions are reviewed annually to ensure targeted focus.

NATIONAL STAFF SURVEY

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.				
Value	2013	2014	2015	2016
Trust score:	73%	65%	73%	66%
National average:	67%	65%	71%	69%
Highest national:	94%	93%	93%	95%
Lowest national:	40%	38%	46%	48%

SFT considers that this data is as described for the following reason: it is taken from the results of the national staff survey.

SFT has taken the following actions to improve this percentage, and so the quality of its services by introducing a health and wellbeing programme of activities for all staff to have access to a wide range of staff benefits. As a Trust we are proud of the quality of care we provide for our patients. We know that good quality care is delivered by staff who feel recognised and valued and we strive to improve our staff experience through investment in learning and development.

We have introduced local and Trust wide listening events and Chief Executive Drop in sessions to enhance staff engagement. We continue to hold monthly Team Brief sessions to disseminate key messages which forms part of our communications and engagement plan. One of our key values statements includes “we deliver safe, high quality compassionate care” and these continue to be promoted extensively throughout our Trust.

VENOUS THROMBOEMBOLISM RISK ASSESSMENT

The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period

Value	2013-14	2014-15	2015-16	2016-17*
Trust score:	95.8%	95.9%	95.7%	95.5%
National average:	95.8%	96.1%	95.7%	95.6%
Highest national:	100.0%	100.0%	100.0%	100%
Lowest national:	66.7%	88.6%	79.93	82.8%

**Data refers to April 2016 to December 2016 only*

SFT considers that this data is as described for the following reason: it is an embedded process and is captured via the Trust's IT system.

SFT has taken the following actions to improve this percentage, and so the quality of its services by continuing to focus on improvements within lowest performing business groups.

CASES OF C.DIFFICILE INFECTION (PER 100,000 BED DAYS)

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				
Value	2013-14	2014-15	2015-16	2016-17*
Trust score:	14.8%	10.9%	23.4%	16.4%
National average:	14.7%	15.1%	14.9%	13.7%
Highest national:	37.1%	62.2%	66.0%	77.1%
Lowest national:	0.0%	0.0%	0.0%	0.0%

**Data refers to April 2016 to January 2017 only*

SFT considers that this data is as described for the following reason; the data above is captured by the Infection Prevention team. The team continues with prudent testing to understand how many patients with loose stools of any duration and causation were carrying C difficile bacteria capable of spreading to others and the environment, even if not clinically causing disease in a particular individual. This continues to ensure we know exactly which patients should be managed with infection prevention precautions, including being isolated in side rooms. This remains critical to reducing C difficile disease in the Trust in the long term despite meaning more patients are being tested for carriage of C difficile.

SFT continues to progress on actions undertaken last year to improve this rate and the quality of its services by every case of C difficile undergoing a root cause analysis and where there have been concerns of possible patient harm as a result of failures in practice an investigation has been undertaken. The lessons learnt from the investigations have been acted on and measures put in place to prevent avoidable harm. The lessons and changes to practice have had wide discussion within the Trust and lessons and changes in practice have been communicated widely throughout the Trust to ensure education.

PATIENT SAFETY INCIDENTS

The number and, where available, rate of patient safety incidents reported within the trust the reporting period and the number and percentage of such patient safety incidents that resulted in severe harm or death

Value	April 2014 - March 2015				April 2015 - March 2016			
	Number of patient safety incidents / as a rate per 1,000 bed days		Number resulting in severe harm or death / as a % of all incidents		Number of patient safety incidents / as a rate per 1,000 bed days		Number resulting in severe harm or death / as a % of all incidents	
Trust score:	10,986	49.5	189	1.7%	10,752	47.2	91	0.4%
National average:	1,248,175	35.9	6,122	0.5%	1,331,343	38.7	5,436	0.2%
Highest national:	24,804	101.5	193	4.2%	23,990	130.0	162	0.9%
Lowest national:	85	17.4	0	0.0%	681	16.0	0	0.0%

SFT considers that this data is as described for the following reason: The figures show that SFT has a higher than average number of patient safety incidents reported within the Trust and the National Reporting and Learning System (NRLS) report from October 2015 to March 2016 reflects this as it shows SFT as being in the highest 25% of reporters across Acute NHS organisations; however 98% of the incidents reported in this period resulted in either no or low harm.

The NRLS state that Organisations that report more incidents usually have a better and more effective safety culture and we actively encourage our staff to record all patient safety incidents, including near misses, to ensure learning takes place.

The reduction in the number of incidents resulting in severe harm may be due to a change in the reporting processes of cardiac arrests on the Trust's local reporting system. Previously these incidents were all reported as patient safety incidents however it was recognised that this was prior to Trust investigations and did not indicate lapses in care.

PART 3

Other information

Part 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 2015-16 annual quality report.

For the purpose of this report, SFT is required to provide an overview of the quality of care offered, based on performance in 2016-17 against indicators selected by the board that require continuous improvement.

The indicators selected cover 3 key areas; patient safety, clinical effectiveness and patient experience. Each key area includes 3 indicators selected by the board which refer to historical data to demonstrate progress and performance over time.



1	PATIENT SAFETY	2	CLINICAL EFFECTIVENESS	3	PATIENT & FAMILY EXPERIENCE
1.	Infection Prevention <i>Data Source: Internal</i>	1.	Care Bundles <i>Data Source: Internal</i>	1.	Complaints <i>Data Source: Datix</i>
2.	Pressure Sores <i>Data Source: NHS Safety Thermometer</i>	2.	VTE Risk Assessment <i>Data Source: Internal</i>	2.	Friends & Family Test <i>Data Source: Healthcare Communications</i>
3.	Nursing Care Indicators <i>Data Source: Internal</i>	3.	Mortality <i>Data Source: SHMI</i>	3.	Learning From Patient & Family Experience <i>Data Source: Internal</i>

Part 3.1.1 Infection Prevention

Our infection prevention nurses work across all the wards and departments in the hospital and at local GP Surgeries and clinics, giving practical advice and support in the fight against health care acquired infections.

Prevention of infection practitioners and assistants, work on each ward and department, with up to date knowledge and experience to daily assist their colleagues.

1 Clostridium Difficile

Clostridium difficile, also known as C. difficile or C. diff, is a bacterium that can infect the bowel and cause diarrhoea. The infection most commonly affects people who have recently been treated with antibiotics, but can spread easily to others.



C. difficile infections are unpleasant and can sometimes cause serious bowel problems, but they can usually be treated with another course of antibiotics.

These infections can be passed on very easily but the risk can be reduced by practicing good hygiene, both at home and in healthcare settings.

C. Difficile Incidence:		
2014-15	2015-16	2016-17
24	53	36

2 MRSA

MRSA is a type of staphylococcal bacteria that has developed resistance to a number of widely used antibiotics.

Staphylococcal ("staph") bacteria are relatively common. About 1 in 3 people carry staph bacteria harmlessly on their skin, usually inside their nose and on the surface of their armpits, groin and buttocks. This is known as being "colonised" by staph bacteria.

Up to 1 in every 30 people are colonised by MRSA bacteria. Like other types of staph bacteria, it's usually harmless and not a cause for concern for most healthy people. However, it can cause problems if it's able to enter the body or it infects someone in poor health.

Mandatory MRSA Screening came into effect from 1 April 2009 and affects all patients attending the hospital for elective or emergency admissions. The Trust's MRSA Screening patient information leaflet is available upon request.

MRSA Incidence:		
2014-15	2015-16	2016-17
4	0	0

Part 3.1.2 Pressure Sores

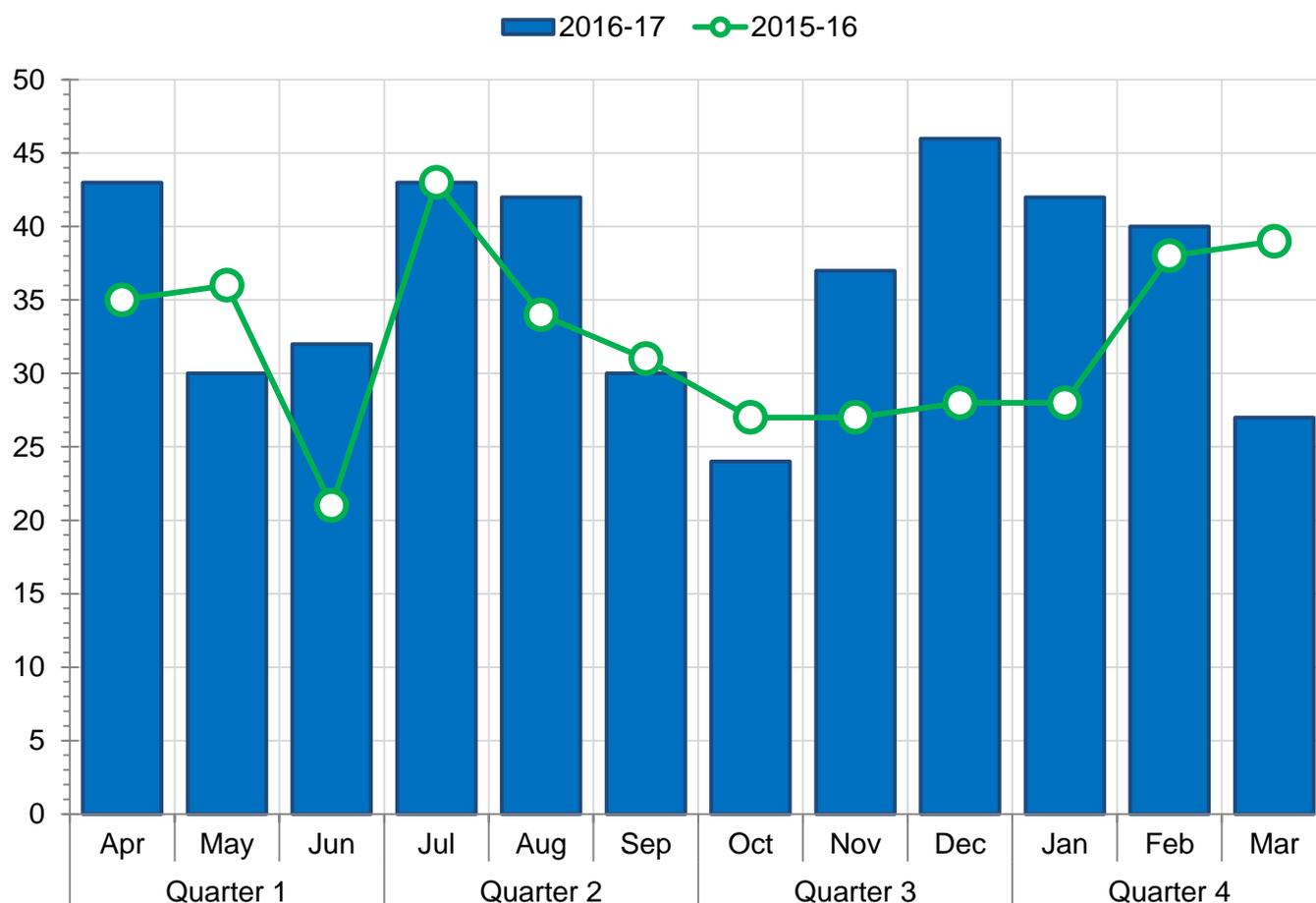
The total number of new pressure ulcers has increased in the last financial year, with the steepest rise occurring in quarter 3 and quarter 4. This in part correlates directly to the effects of the recent winter pressures experienced across the organisation however, it does not account for the increase in isolation. A number of work streams have been established as part of a wider detailed pressure ulcer risk assessment and action plan that has been formulated, and a 3 year pressure ulcer reduction strategy has been devised and agreed by the Director of Nursing and midwifery.

The last month of quarter 4 has seen a marked reduction in the number of pressure ulcers reported, which suggests progress with these recent interventions is starting to make some impact. Over the next 12 months there will be continued emphasis on reducing the number of pressure ulcers across the organisation, and a new pressure ulcer prevention and management pathway is to be developed and implemented as part of the Trusts optimising care and capacity project.

HOSPITAL & COMMUNITY ACQUIRED PRESSURE SORES

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015-16	35	36	21	43	34	31	27	27	28	28	38	39
2016-17	43	30	32	43	42	30	24	37	46	42	40	27

*Excludes Shire Hill



Part 3.1.3 Nursing Care Indicators

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 (NCIs) are designed to support nurses and midwives in practice to understand how they deliver care, and where improvements are needed.

An audit is carried out on a monthly basis where clinical nursing indicators are measured by undertaking an audit of 50% of patients' records, with each indicator covering several measures. As a Trust we aim for compliance of 95% in each indicator.

Each business group or ward can view their own results and can then take any actions if performance against any of the criteria requires improvement.

RAG KEY: ■ ≤89% ■ 90%-94% ■ ≥95%

	Falls	Medication	EWS	Tissue Viability	Infection prevention	Nutrition	Pain	Catheter Care	Discharge	Privacy & Dignity
Apr-16	97.9	97.9	98.9	98.1	99.4	97.4	99.7	98.7	84.0	99.3
May-16	97.8	98.2	98.8	97.3	99.4	97.2	98.7	99.2	82.8	99.8
Jun-16	97.8	98.4	98.1	98.8	99.1	98.6	97.1	95.2	93.7	99.6
Jul-16	97.5	98.4	99.7	98.0	99.6	96.9	98.9	98.7	97.4	99.6
Aug-16	97.5	95.8	99.6	98.6	98.7	96.3	98.4	100.0	93.9	99.7
Sep-16	96.9	98.0	99.5	96.8	98.6	95.8	99.1	98.4	97.6	99.0
Oct-16*	98.3	97.2	97.7	99.1	99.3	97.9	90.8	98.2	96.1	98.6
Nov-16	96.6	97.1	98.7	96.2	96.6	92.3	92.8	97.7	88.1	99.3
Dec-16	96.7	99.1	99.2	96.6	99.6	95.0	97.7	97.2	85.6	99.5
Jan-17	95.6	92.9	97.5	92.1	96.7	91.0	94.6	93.2	80.9	98.5
Feb-17	97.8	97.7	99.0	98.3	98.8	94.5	98.1	95.9	93.2	99.7
Mar-17	96.0	98.1	99.1	98.2	99.5	94.8	97.2	99.4	96.3	99.3

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014-15	98.7	99.2	98.1	99.2	98.8	98.6	98.8	98.7	98.4	98.7	97.6	98.5
2015-16	88.2	94.9	95.4	96.0	96.6	96.9	94.4	95.8	97.4	94.3	97.2	98.2
2016-17	98.3	98.1	98.4	98.5	97.9	97.8	97.5*	96.1	97.7	94.4	97.8	97.7

*October 2016 data incomplete due to Ward moves

Part 3.1.4 Care Bundles

During 2016-17, Stockport NHS Foundation Trust moved away from using AQuA (Advancing Quality Alliance) to report on its care bundle audits. The rationale behind this was to make the indicators more local and to enable access to real-time data. This would allow earlier reporting of data and therefore enable the prompt implementation of any actions required.

As in 2015-16 the Trust continued to undertake monthly audits which formed part of the 2016-17 CQUIN programme. This year covered 4 key measure groups which comprised of Acute Kidney Injury (AKI), Diabetes, Alcohol Related Liver Disease (ARLD) and Sepsis.

The results for each of the measure groups which the Trust undertook during 2016-17 are detailed below. For Quarter 1-3 the Trust target was based on the CPS (Composite Process Score) which is the percentage score of all measures achieved across all patients. For Quarter 4 the Trust target was based on the ACS (Appropriate Care Score) which is the percentage score where a patient receives all measures.

RAG KEY: ■ Missed Target ■ Met or Exceeded Target ■ Not Applicable

Composite Process Score (CPS) Results:

	Acute Kidney Injury		Diabetes		Alcohol Related Liver Disease		Sepsis	
	Target	Result	Target	Result	Target	Result	Target	Result
Quarter 1.	42.5%	70.4%	n/a	55.4%	76.4%	78.8%	78.3%	78.6%
Quarter 2.	44.7%	80.4%	58.2%	60.4%	78.7%	76.9%	80.6%	89.4%
Quarter 3.	46.6%	84.5%	60.9%	76.1%	80.9%	78.7%	82.8%	89.3%
Quarter 4.	n/a	86.4%	n/a	73.3%	n/a	74.5%	n/a	91.6%

Appropriate Care Score (ACS) Results:

	Acute Kidney Injury		Diabetes		Alcohol Related Liver Disease		Sepsis	
	Target	Result	Target	Result	Target	Result	Target	Result
Quarter 1.	n/a	42.6%	n/a	10.0%	n/a	29.4%	n/a	60.0%
Quarter 2.	n/a	55.8%	n/a	23.6%	n/a	22.2%	n/a	70.0%
Quarter 3.	n/a	75.6%	n/a	41.2%	n/a	31.4%	n/a	70.0%
Quarter 4.	50.0%	58.7%	30.0%	31.5%	50.0%	25.0%	50.0%	68.8%

For further information on the care bundles specified above, please refer to page 33.

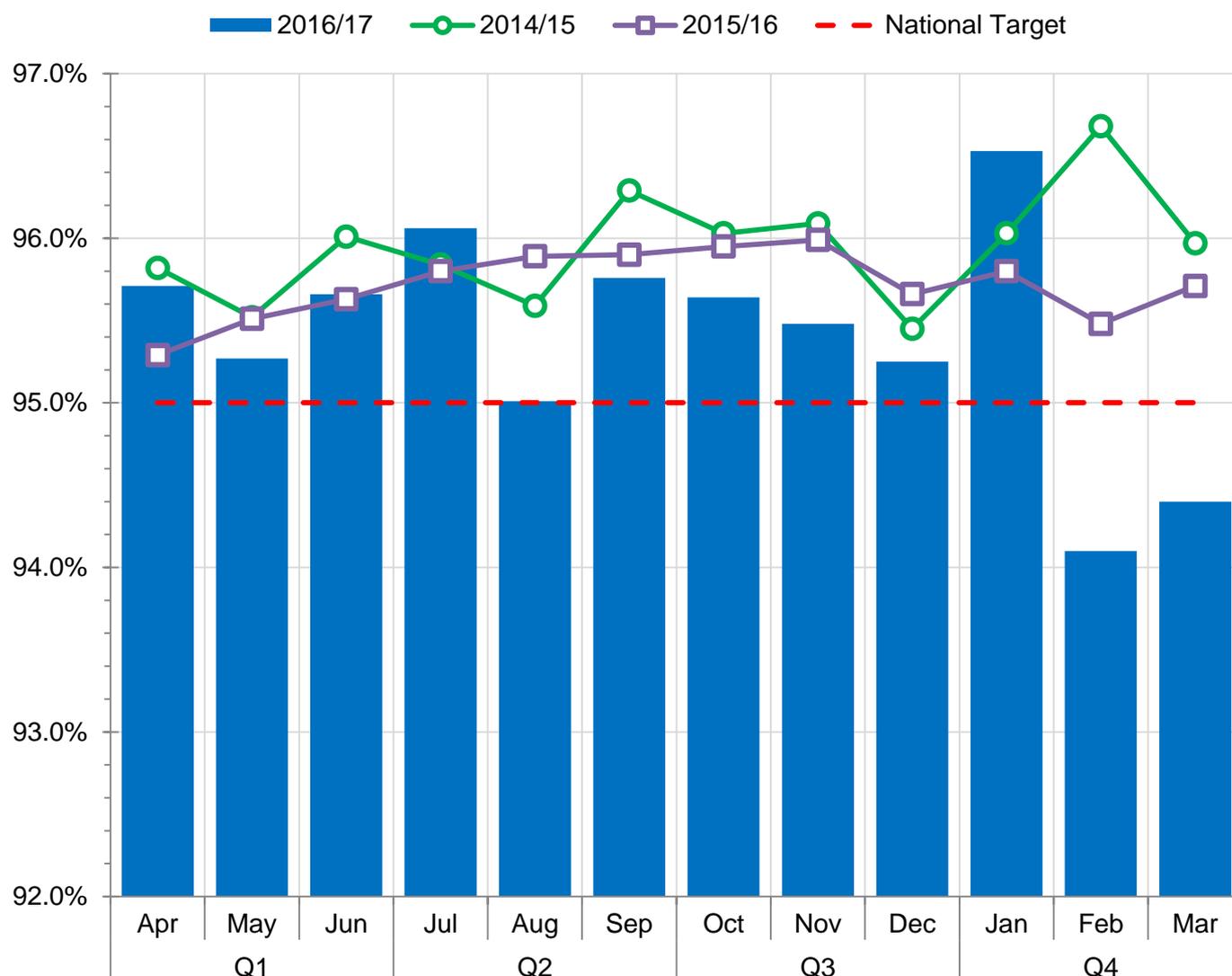
Part 3.1.5 VTE Risk Assessment

The Trust continues to be compliant with our national target to ensure that at least 95% of our patients are assessed for their risk of VTE within 24 hours of admission to hospital. There has been an issue in February and March with the reporting of these due to a staff change. The VTE nurse validates the data, unfortunately due to a vacancy not all validation has taken place. A replacement VTE nurse has now been recruited.

The data below shows the Trust's percentage of patients risk assessed for VTE across multiple years. Further information on VTE is referred to on page 17 of this report.

RAG KEY: ■ Missed Target ■ Met or Exceeded Target

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014-15	95.8	95.5	96.0	95.8	95.6	96.3	96.0	96.1	95.5	96.0	96.7	96.0
2015-16	95.3	95.5	95.6	95.8	95.9	95.9	96.0	96.0	95.7	95.8	95.5	95.7
2016-17	95.7	95.3	95.0	96.1	95.0	95.8	95.6	95.5	95.3	96.5	94.1	94.4



Part 3.1.6

Mortality

As an Acute Trust, serving a large and aging population, it is inevitable and entirely appropriate that some patients will die in our hospital. Our focus is on recognising those deaths that might have been avoided, ensuring that these cases are thoroughly reviewed and that lessons are learnt.

Where deaths are considered as unavoidable, we focus upon ensuring that these patients have received the best possible end of life care. Once again, by reviewing these cases, important learning can be had. Finally, consideration must be given to the support our health system offers to those patients who understand that they are dying, but prefer to be cared for with support in their own home. Improving the support offered to such patients in the community will be one of the benefits of the 'Stockport Together' initiative.



Data from the Summary Hospital-Level Mortality Indicator (SHMI), as published by the Health and Social Care Information Centre, is referred to on pages 61 and 62 of this report. The chart of pages 61 and 62 show the mortality rates at trusts vary greatly. Some of this variation may be explained by different populations, different areas of specialism between hospitals, and variations in how patients' diagnoses and previous health problems are recorded (coded); however, the standardised mortality index gives a useful estimate of relative mortality risk.

Stockport is pleased to have a mortality rate below the national average, but we continue to strive to reduce this further. We take the subject of mortality very seriously and

continue to develop our process for reviewing cases following the death of a patient. These are presented to peer groups so that meaningful discussion and challenge can be given to the care and treatment provided, and actions identified that could have been taken that would have altered the outcome or improved patient care. These discussions support learning and can on occasion highlight where changes to process or practice can be implemented to improve future patient care.

A major cause of avoidable death in hospitals is delays in treatment for sepsis from a serious infection. Early diagnosis is paramount to a good outcome and ensures key treatments are not delayed. This year we have introduced a new tool for screening patients for early signs of sepsis on our wards. Our electronic patient monitoring system has also been adapted to alert to the possibility of early signs of sepsis. We are confident that these two measures will ensure that early treatment of sepsis will ensure consistent early treatment of this serious condition.

In recent years there have been reports in the national media regarding mortality linked to hospital admissions at a weekend. To understand this further NHS England now undertake an audit twice a year, to capture any variance between weekday and weekend working. Stockport has fully participated in each round and considers the findings of the audit to deliver further improvements.

The development of '7 day services' is a key focus area for the Board and features regularly on the agenda of many of the sub board committee meetings. This work is already delivering earlier consultant reviews of emergency cases across the whole week, and is working towards more consistent senior medical input and availability of investigations and procedures for all hospital in-patients over the weekend. We anticipate this project to be a major focus of the trust for the next four years.

Part 3.1.7 Complaints

Every NHS organisation has a complaints procedure. We encourage feedback because it is used to improve the services we provide.

In 2016-17 (Quarter 1-3), we received 520 formal complaints. We had received 787 in 2015-16 and 773 in 2014-15. The main subjects of complaints continue to be treatment, communication, appointments, admissions and complaints about staff and nursing care on the wards. These themes are monitored in the quarterly patient experience and complaints report at the Quality Governance Committee, this includes changes to practice and improvements to patient experience.

The introduction of three levels of response time in September 2014 has continued to ensure that robust and timely responses are provided to complainants.

Percentage of timely responses:

Q1	Q2	Q3	Q4
95%	91.6%	91.6%	*

*Data not available until 7th June 2017.

This gives an overall 92.7% (Quarter 1-3) of complainants responded to in the time we targeted, which is an improvement on 2015-2016 which was 87.6% (full year).

In January 2017 a meeting was held with the Trust Patient and Customer Services (PCS) team and Business Groups to review complaint response processes. This was to facilitate consistent patient experience in line with Parliamentary Health Service Ombudsman (PHSO) and Healthwatch recommendations.

A meeting was held with Stockport CCG, Stockport NHS FT, SMBC and Pennine Care Trust Complaints Teams in January 2017 to discuss ways of joint working to meet Quality Framework recommendations. In February 2017 a meeting was held with NHS England to discuss possible implementation of a

Patient Survey across care organisations to audit patient and service user experience of complaints processes.



In 2016-17 (Quarter 1-3) there has been 1 complaint fully upheld by the PHSO. The complaint was upheld in relation to delayed diagnosis.

There have also been 8 complaints partly upheld by the ombudsman in relation to:

- Documentation
- Clinical treatment delay (2 cases)
- Lack of continuity of care
- Complaint handling
- Poor community follow-up care
- Poor discharge
- Data protection breach

In all of the above cases apologies have been issued and action plans developed by the relevant business group to reduce the likelihood of reoccurrence.

All action plans are shared with the PHSO on completion.

Part 3.1.8 Friends & Family Test

The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience.

It asks people if they would recommend the services they have used and offers a range of responses. When combined with supplementary follow-up questions, the FFT provides a mechanism to highlight both good and poor patient experience. This kind of feedback is vital in transforming NHS services and supporting patient choice. Results are reviewed to monitor trends and are discussed at business group quality boards and at Trust board sub-committees. In addition, monitoring of response rates forms part of the Nursing Dashboard which is reviewed monthly.

During 2016-17 the Trust received a total of 57,223 responses to the FFT question. It is encouraging to note that 92% of patients who did respond stated they were either 'likely' or 'extremely likely' to recommend Trust services.

Issues where patients have responded less positively continue to show long waiting times to be seen in A&E, and poor or conflicting communication and information.

The children's emergency department continues to be a challenge in obtaining FFT feedback and this continues to be monitored by the business group. A new Matron for Patient Experience has been recruited and part of her role will be to review current areas of poor performance with FFT returns and work with staff and teams to increase response rates.

'Patient voices' continues to include those patients attending A&E, outpatient departments and parts of community services and has been positively received. Patients contacted via landline are asked for their verbal feedback at the point of discharge, and comments are available to the business group for review and sharing with staff.

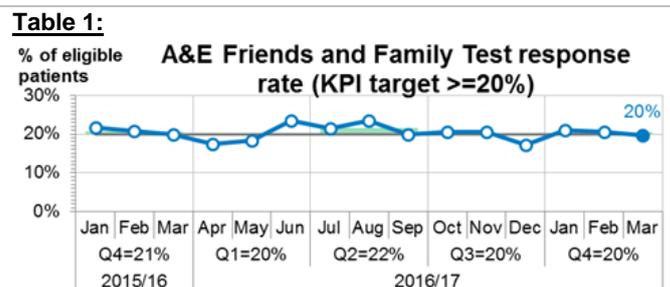


Table 1 shows the position of A&E in relation to the required national response rates.

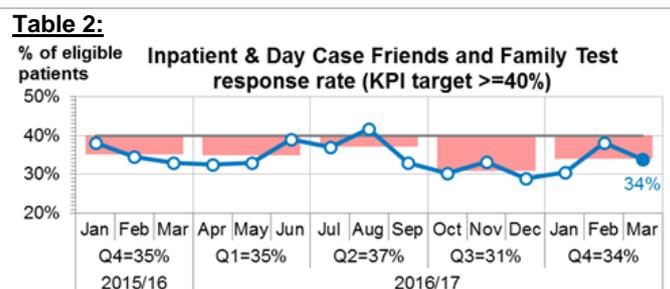


Table 2 shows the position of hospital inpatient and day case wards in relation to the required national response rates.

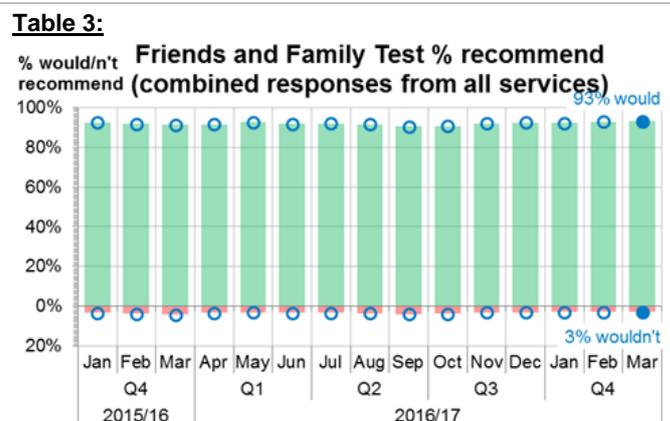


Table 3 shows the percentage of respondents who would recommend the service to their friends and family.

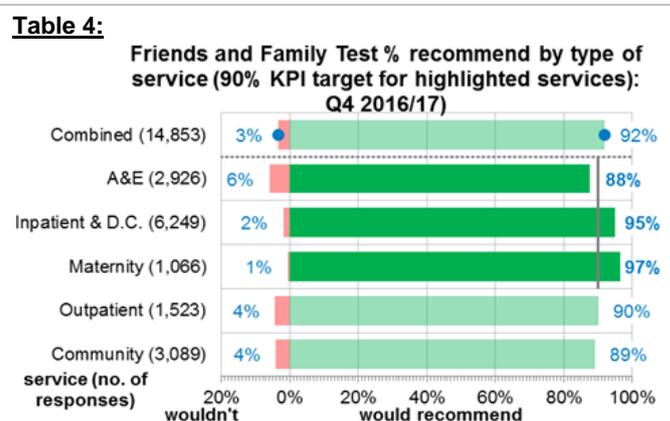


Table 4 shows the percentage recommended by type of service over the quarter.

Part 3.1.9

Learning from Patient & Family Experience

Learning from Patient & Family Experience

The trust continues to capture patient feedback in a variety of ways including:

- The annual national surveys (e.g. the National Inpatient Survey)
- The Friends and Family Test
- Complaints and compliments
- Monthly iPad surveys



In addition, many of our services ask patients to complete bespoke questionnaires with the intention of gathering local insight and understanding of care delivery.

Applying these different approaches facilitates a more informed understanding of patient or service user experience and identifies the themes and trends which are then considered in service or process evaluations and reviews.

An annual appraisal of our iPad questions provides the opportunity for the trust to monitor aspects of care where it has been identified more surveillance, or understanding of an issue, is required. Our volunteers continue to provide fantastic support in carrying out these surveys and who themselves receive updates twice a year of the changes taken place as a result of their dedication and support.

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

The monitoring of noise levels at night continues to be undertaken by the night sisters. This includes ensuring staff are aware of the “*standards to reduce noise levels and promote a restorative night for patients*” and advocate: lights being turned off by 23.00hrs; the volume on ward phones being put on a low setting and answered within 5 rings; and staff wearing soft soled shoes.

Extended visiting hours have been introduced across the Trust. This change has been well received especially by family members who have loved ones with dementia or who are very ill.

High dependency / intensive care units (HDU/ICU) have introduced a support group for ex patients to meet up along with their relatives and share their experiences with one another in the hope that it will help them make sense of what has been for many a frightening experience. Feedback from those who have met so far has been very positive.

The Acute Pain Team have carried out a number of awareness raising sessions to assist staff in their understanding, monitoring and management of pain. In addition, the team now regularly teach on Trust clinical skills days, have introduced pain link nurses on every ward and undertaken a complete review of the pain microsite.

Environmental changes that have resulted from feedback include: a walk in shower room on ward C2, a refurbished counselling room in the antenatal clinic, a new play specialist introduced into the paediatric outpatient department and a new look café on the ground floor of the Women’s Unit with improvements to both the environment and food selection. The opening hours have also been extended to 18.00hrs.

Substantive work has also been undertaken in the Emergency Department which has positively impacted upon amongst other things patient privacy and dignity.

In relation to food, a review has been undertaken of patient menus. In addition the catering team have introduced monthly inspections on wards to look at the patient mealtime experience. These include assessing the taste, temperature and quality of the food on offer in addition to engaging with patients and seeking their feedback. Any information gained is then reported back to the Trusts Nutrition and Hydration group.

To help improve communication, a number of changes have been introduced including: telephone assessments for patients who find it difficult to attend the haematology clinic, the routine issuing of the mobile telephone number of district nurses for any patient who has an indwelling catheter, a review of processes in dermatology clinic to keep patients better informed and an extension in the time slot allocation for any “new” patients attending clinics in the paediatric Outpatient Department.



Improvements in patient / carer information

Following concerns raised by families unhappy with the process for Child Protection Medicals, especially in relation to not understanding what they were for or why they were being asked to attend hospital with their injured child.

As a result the safeguarding team produced a patient information leaflet explaining the process, tests undertaken and next steps. This information has been well received and has resulted in no further complaints.



Dementia packs for carers/family of people with dementia are now readily available. Each pack contains a copy of “*This is me*” (a document about the patient to help communication between the patient and healthcare staff) and information for additional support services family members may wish to access.

Work has also been undertaken to review the ward bedside booklet with an updated version due to be circulated shortly.

Part 3.2

Performance against other indicators

The table below provides data against the relevant indicators and performance thresholds set out in the risk assessment framework.

Indicator	Threshold	Q1	Q2	Q3	Q4	2016-17
18 weeks referrals:						
Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway	92%	91.2%	91.2%	92.0%	92.4%	91.7%
A&E waiting times						
A&E: maximum waiting time of four hours from arrival to admission/ transfer/ discharge	95%	82.1%	76.7%	75.3%	75.4%	77.4%
All cancers: 62-day wait for first treatment from pre breach re-allocation:						
Urgent GP referral	85%	90.8%	88.0%	90.3%	90.9%	90.1%
NHS cancer screening service referral	90%	100.0%	100.0%	100.0%	80.0%	95.0%
All cancers: 62-day wait for first treatment from post breach re-allocation:						
Urgent GP referral	85%	90.2%	85.5%	86.0%	88.6%	87.7%
NHS cancer screening service referral	90%	100.0%	100.0%	100.0%	80.0%	95.0%
All cancers: 31-day wait for second or subsequent treatment, comprising:						
Surgery	94%	100.0%	98.2%	100.0%	100.0%	98.9%
Anti-cancer drug treatments	98%	100.0%	100.0%	100.0%	100.0%	100.0%
Radiotherapy	94%	n/a	n/a	n/a	n/a	n/a
All cancers: 31-day wait from diagnosis to first treatment	96%	97.9%	98.8%	98.1%	97.4%	98.0%
Cancer: two week wait from referral to date first seen, comprising:						
all urgent referrals (cancer suspected)	93%	97.1%	96.8%	96.7%	97.3%	97.0%
for symptomatic breast patients (cancer not initially suspected)	93%	98.3%	98.9%	98.2%	96.4%	97.9%
Data completeness: community services, comprising:						
Referral to treatment information	50%	90.0%	96.4%	98.0%	99.6%	95.8%
Referral information	50%	98.3%	99.3%	98.2%	97.9%	98.4%
Treatment activity information	50%	95.5%	95.7%	96.8%	94.7%	95.7%
Clostridium difficile (C. diff):						
C. diff due to lapses in care	<= 17	3	8	9	15	15
Total C. diff (year to date)	<39	7	19	25	36	36

Data source: Open Exeter

Part 3.3

Other Quality Initiatives

There have been a significant number of quality initiatives which have been happening during the course of 2016-17, some of which have been covered in this report. This section covers just a snapshot of some of the other great quality initiatives which have happened during 2016-17.



NEW £20M MEDICAL AND SURGICAL CENTRE OPENS AT STEPPING HILL HOSPITAL

A new £20 million medical and surgical centre was opened at Stepping Hill Hospital.

The new centre includes spacious, modern facilities and a cleaner environment for better infection control. It houses over 120 beds for patients, replacing facilities in old wards. The hospital has around 800 beds in total.

It includes four new operating theatres, three of which replace old theatres, bringing the hospital's total from 17 to 18. It supports Stepping Hill Hospital's new status as one of four specialist centres in Greater Manchester for emergency and high risk abdominal surgery. More than 30,000 operations per year are carried out on the hospital site.

The acute medical ward in the new centre will look after 13,000 patients a year. A new primary care receiving unit for patients referred by their GP will also open which is designed to reduce pressure on the hospital's A&E.

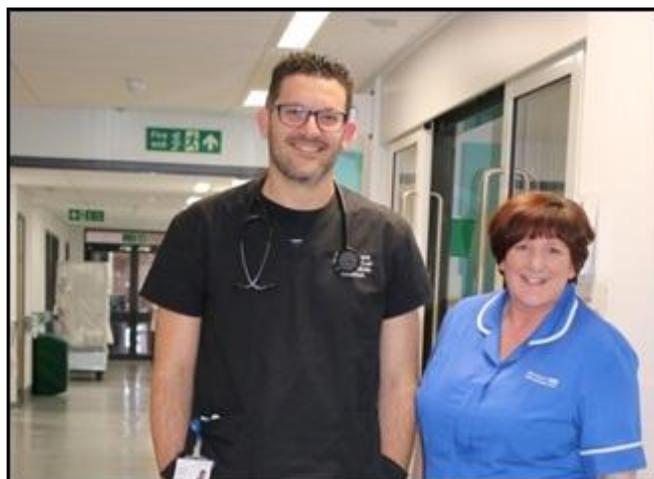
Ann Barnes, Chief Executive for Stockport NHS Foundation Trust, which runs Stepping Hill Hospital, said, "This has been a major investment, but one which is absolutely necessary to make our services fit for the future and provide the extra capacity we need for specialist surgery.

"It is also more cost-effective in the long term to have an effective care environment, rather than having to maintain old and outdated wards. The new wards and operating theatres will make a huge and positive difference to the patient experience, provide an excellent environment for staff to work in, and enhance our services for the future."

NEW ALERT SYSTEM HELPS BOOST KIDNEY TREATMENT

A computer alert system is helping healthcare teams provide faster and better care for acute kidney injury patients at Stepping Hill Hospital.

The IT alert system, the only one of its kind in Greater Manchester, will help save local lives by ensuring patients get specialist care and treatment as soon as they arrive at hospital to prevent them from developing chronic kidney disease.



It is estimated that one in five patients taken into hospital for an emergency will be suffering from an acute kidney injury, a sudden reduction in a person's kidney function. In the UK around 100,000 deaths each year are associated with acute kidney injuries, and up to 30% of these could be prevented if a patient is given the right treatment.

Wendy Oakes joined Stepping Hill Hospital in March 2016, working as a specialist nurse for acute kidney injury. She is working with Dr Karl Bonnici, clinical director for acute medicine, to raise awareness about the condition with staff and provide new care plans and guidance for these patients.

When a patient comes to the A&E department, a blood test is taken which determines whether a patient has an acute kidney injury. When the doctor or nurse updates the patient's electronic record the IT system then sends an immediate colour-coded alert about the patient to the computer screens where doctors and nurses first view lists of patients. This information is particularly useful in the fast-moving environment of A&E, acute medical and surgical assessment units.

The alert system helps highlight the diagnosis of acute kidney injury. Earlier recognition and timely intervention is fundamental in reducing the possible complications associated with acute kidney injury.

Since the introduction of the system and care plan, very strong improvements had been made in the care patients receive. For patients with the most severe acute kidney injuries, 40% more acute kidney injury patients have received an initial urine test and a kidney scan within the first 24 hours. There has also been a 10% improvement in stopping earlier any medication which may be harmful to these patients. A full critical care evaluation has also been carried out within 12 hours on 30% more acute kidney injury patients.

Wendy Oakes said "The prevention and management of acute kidney injury is not rocket science. It's about getting the basics right, especially in the first 24 hours. The new alert system, together with the new care plan, will really help ensure patients get the treatment they need as soon as they possibly can. If we continue to improve the care we deliver, over the long term this will have a positive effect on patient outcomes, and in some cases save lives."

SAFE FOR BOWEL CANCER TREATMENT

New statistics confirm that Stepping Hill Hospital in Stockport is delivering some of the most successful and safest bowel cancer treatment in the country.

The National Bowel Cancer Audit, which is published nationally, shows high survival rates for bowel cancer patients who undergo surgery and treatment at Stepping Hill Hospital.



The 90 day mortality figure for patients treated by Stepping Hill is 1.9%, well below the national average of 3.6%, and among the top ratings in the country. The two year mortality figure is 13.8%; again much lower than the national average and the lowest rating in the north west.

The audit follows a NHS England report, in October 2016, which ranked Stockport as the 7th best area in England for cancer treatment in terms of prompt diagnosis and treatment, one-year survival rates and the overall patient experience. It also follows 100% satisfaction rates for the hospital's cancer outpatient services in the Friends and Family Test.

Despite moves to increase the early diagnosis of bowel cancer about 30% of patients have to have treatment as an emergency. The recent National Emergency Laparotomy Audit (NELA) audit looking at emergency surgery showed that Stepping Hill was in the top 10 for safety in the country and second only to Bristol University for large units.

Bowel cancer is the most common cancer in non-smokers and second most common cause of death from cancer. Over 40,000 people in the UK are diagnosed with bowel cancer each year.

Stepping Hill treats around 200 bowel cancer patients each year, with cases being similar to other hospitals in terms of complexity and risk. It has a specialist bowel cancer team which includes surgeons, oncologists, cancer nurses and stoma therapists, as well as state-of-the-art critical care facilities. This ensures each patient has the highest quality advice, support and care throughout their time with the hospital.

Ed Clark, a consultant surgeon at Stepping Hill Hospital, who specialises in bowel cancer, said, "Surgery is the main curative treatment for bowel cancer and we are delighted that this independent audit confirms the high quality and safety of our care."

The whole team is constantly striving to improve our care and results as well as staying up to date with the latest technology. Over the last few years we were the first in Manchester to introduce new techniques for both advanced and early rectal cancer.

For patients to know how safe it is for them to come to this hospital is a huge message and it's a great tribute to the team here. Our results are constantly improving thanks to the multi-disciplinary team work and improved post-operative care. Having cancer surgery is always a stressful experience, but patients at Stepping Hill can be assured that they are in the very best hands."



TOP NATIONAL RATING FOR STROKE UNIT

Stepping Hill Hospital's stroke unit has received the top 'A' rating again in the latest national stroke audit.

This Sentinel Stroke National Audit Programme (SSNAP) from the Royal College of Physicians gives 'A' ratings to services rated as 'world class' in their quality of care. It has now given Stepping Hill Hospital's services the highest possible rating twice over the last twelve months.

The hospital is one of only three specialist stroke centres in Greater Manchester, alongside Salford Royal and Bury Hospital. All three units have now achieved an 'A' rating, putting the region's performance well above the national average.

In October 2016, Stroke Association findings showed that Stepping Hill had the fourth best performing stroke unit in the country for patients receiving a brain scan within an hour (75.2% of patients), and for patients accessing a stroke unit within four hours (83.3% of patients.)

Adele Trenholme-Rolfe, 46, from Brinnington, Stockport had a stroke in mid-January this year. After being taken to Stepping Hill Hospital's A&E for emergency treatment she was then transferred to the hyper-acute stroke unit, and since then went to the stroke rehabilitation unit, where has been taking part in activity rehabilitation therapy since then. Adele is progressing well and will soon be able to go home to husband Mark.

Adele said, "Having a stroke is scary, but the staff on the stroke unit have been fantastically supportive. They work closely with your family too, so that Mark will be able to support me once I'm back at home as well. The rehab has taken weeks and it's been hard, but things like the treadmill in the physio gym is helping me to get back on my feet ready for the outside world. The staff have given me my life back and I can't thank them enough."

LAUNCHED THE 'BETTER AT HOME' CAMPAIGN

The 'Better at Home campaign' was launched for health and social care staff in Stockport.



Whilst hospital is the right place for the seriously ill, it is better and safer for people to receive treatment, care and support in their own home, family home or nursing/residential home. Through Better at Home, we aim to raise awareness of the emotional and physical benefits of people feeling confident and supported at home, as well as the new services in primary care, integrated neighbourhood teams, intermediate tier and the healthy communities programme.

This campaign supports our SAFER initiative which aims to promote timely, effective discharge from hospital. It strongly supports the work we're doing in the Stockport Together partnership and will also be launched to the public in March 2017.

INTENSIVE CARE UNIT 'LIVE' MUSIC

Stepping Hill Hospital's intensive care unit became one of the first in the country to use live music to help patients.

The Music In Hospitals charity have been playing in patient wards across the country for many years, and are now going into intensive care and high dependency units (ICUs and HDUs) which treat severely and critically ill patients.



The new 'ICU-Hear' project uses musicians experienced in providing gentle and soothing music, and they move around the patients' beds to play at the bedside. This allows them to sensitively respond to the needs of the patients, relatives and staff and enables them to choose appropriate music for their condition and likes.

Evaluation from the charity so far shows that 99% respondents (patients, visitors and staff) on the intensive and high dependency units said they enjoyed listening to the music.

Gerol Williams, intensive care nurse ward manager at Stepping Hill Hospital said, "We do our very best to care for our patients, but if you're severely ill in an intensive or high dependency unit it can be a stressful experience, leaving you anxious and weak. Many of us know how calming and relaxing it can be to listen to a beautiful piece of music. We're so pleased that Music in Hospitals have been able to give our patients these soothing sounds to help them through difficult times."

The musicians have now visited Stepping Hill Hospital units twice, playing melodies on clarinet and kora (West African harp) respectively for patients, with plans for further visits. This is in addition to visits for over a year to other wards at Stepping Hill Hospital, including wards with patients with dementia.

Sid Richards, regional director of Music in Hospitals North said, "Since 1948 Music in Hospitals has been providing professionally performed live music sessions in all kinds of healthcare settings but it is only in the past few months that we have delivered these concerts to patients in intensive care. The feedback from patients, staff and family members has been phenomenal and the charity is working hard to take these sessions to ICUs all over the UK."

UNsung HEROES GET THE TOP PRIZE

Two hospital security guards received a national award for helping to save a young woman's life.

Ali Jallow and Andy Tobin won the 'Unsung Hero' prize from health careers company GoToJobBoard for preventing a distressed patient from jumping off a bridge.



Ali and Andy were working their shift at Stepping Hill Hospital's busy A&E department when they noticed a woman in an upset state leaving the department. Concerned for her welfare, Ali and Andy followed her, trying to convince her to return.

The woman made her way to a railway bridge, and then attempted to throw herself onto the train tracks beneath. A fight to save her life took place, with the woman attacking the security guards and landing several harsh blows. Eventually the pair managed to grab the woman's arms and legs to prevent her jumping, and escort her back to the hospital.

The GoToJobBoard 'Unsung Hero' awards are for non-nursing and non-medical NHS staff, such as porters, cleaners, receptionists and security guards who have gone the extra mile to help patients and public. Winners were honoured at a special ceremony hosted by Roy Lilley, a health policy analyst, writer, broadcaster and commentator on the NHS.

Andy Tobin has since moved on to another job outside of Stepping Hill and was unable to attend, but Ali Jallow accepted on behalf of them both, together with other award winners from across the country. Ali Jallow said, "I was so surprised when my name was announced. I will always try my best to help others, knowing fully well that the sacrifices are not in vain."

GoToJobBoard operations manager Mark Cherry said, "Every Unsung Hero Award winner represents some of the most hard working and dedicated non-medical staff in the NHS today. The NHS doesn't get enough credit, especially when it comes to non-medical staff, so it's great to host these awards and make NHS staff feel special and proud of the hard work they do every day."

Ann Barnes, chief executive of Stockport NHS Foundation Trust, which runs Stepping Hill said: "I'm delighted that Ali and Andy have won this award. They are real heroes who showed courage and compassion in doing their utmost to save this young woman's life. They are an absolute credit to our organisation, their colleagues and their families."



NURSE SHORTLISTED FOR TOP REGIONAL RESEARCH AWARD

A Stepping Hill Hospital nurse was shortlisted for the region's 'Research Nurse of the Year' award.

Sara Bennett was nominated for the title in the Greater Manchester Clinical Research Awards for her research work with children in the hospital's paediatric department.

Sara has been a research nurse at Stepping Hill Hospital for eight years, recruiting many young volunteers for research projects alongside her nursing role with children. She has recruited children and families to a range of research studies with some exceptional results, including the first volunteers for the 'Archie' study which helps vulnerable children against the flu virus.

Dr Chris Cooper, Associate Clinical Director for Child and Family Services at Stockport NHS Foundation Trust, which runs Stepping Hill Hospital, said, "Sara has a knack of recruiting patients and families to take part in studies which is due to her personable manner and enthusiasm. She always receives excellent feedback from external reviewers due to her thoroughness and conscientious approach. She would be a thoroughly deserving winner of the title of Research Nurse of the Year."

The awards are run by the Greater Manchester Clinical Research Network aimed at honouring excellence in clinical research in the region.

SAVING BABIES' LIVES!

Our maternity service has implemented 'SaBiNE' (Saving Babies Lives' in the North of England) Care Bundle.

The Saving Babies' Lives care bundle is designed to reduce stillbirth and early neonatal death. It brings together four elements of care that are recognised as evidence-based and/or best practice in improving outcomes for mothers and their babies.



The elements include; reducing smoking in pregnancy, risk assessment and surveillance for fetal growth restriction, raising awareness of reduced fetal movement and effective fetal monitoring during labour. The guidance was developed with various stakeholders including clinicians, charities and royal colleges and is based on the best available evidence. Stockport NHS FT has introduced several workstreams including;

- Introduction of the 'customised growth charts' for all women
- Monitoring fetal movements in pregnancy
- Cardiotocograph (CTG) training/assessment and 'fresh eyes' approach
- Smoking in pregnancy – Introduction of carbon monoxide (CO) monitoring

A JOINT SUCCESS!

Figures show that Stepping Hill Hospital is one of the safest and best places in the country for hip and knee replacement surgery.

The hospital carries out around 800 hip and knee replacement operations per year, mostly for patients suffering from different forms of arthritis.



The National Joint Registry (NJR) compiles figures for how frequently these artificial joints wear out and need replacing again, along with mortality rates. The latest figures show Stepping Hill Hospital as better than average for hip replacement, with 2.14% replaced again within 7 years compared to 3.59% nationally; for knee replacement the results are significantly better than average, with 0.9% replaced again within 7 years compared to 3.18% nationally. Stepping Hill's mortality figures are better than average for both hip and knee replacement, with rates for knee replacement being around half the national figure.

David Johnson, consultant orthopaedic surgeon at Stepping Hill Hospital says "It's excellent news for local people that these safety figures remain so encouraging. Hip and knee replacements can offer significant benefits to suitable patients, especially regarding reduction of pain, which often restores function and a return to activity."

Jean Ritchie, 68, a retired nurse from Marple in Stockport, suffered increasingly bad pain in her knees for four years before being diagnosed with osteoarthritis. She then underwent a knee replacement operation on each side in 2014 and 2015, giving her freedom from pain as well as improved mobility.

Jean said, "It's been a total transformation in my quality of life. Just being able to do things now which were really painful before, like walking round the shops or taking my dog for a walk, is wonderful. Both the surgical team and the support I've had afterwards from the physiotherapy team has been fantastic."

Annex 1

Statements from stakeholder organisations

Annex 1 | Statement from Stockport CCG

Date: 4th May 2017

Subsequent to receipt and review of the Annual Quality Accounts Report 2016-17, Stockport Clinical Commissioning Group (SCCG) would like to acknowledge Stockport NHS Foundation Trust (SFT) achievements against a significant proportion of the priorities for improvement for 2016-2017. We acknowledge the trust's commitment to achieving these objectives in a particularly challenging and pressured time.

SFT have continued to demonstrate commitment to the quality improvement programme of CQUINs and shown definite motivation in achieving these improvement objectives. Similarly, there has been a clear enthusiasm to improving patient experience and as a result over 90% of people surveyed said they were likely or extremely likely to recommend the Trust.

The Trust has seen challenges throughout the year, particularly around emergency department (ED) waiting times and recruitment and retention of staff across the Trust. CQC result was disappointing with ED scored 'inadequate' for safety' and an overall Trust rating of 'requires improvement'. The learning from the 12 hour breaches that have been examined as Serious Incidents in 2016-17 needs to be embedded thoroughly across the organisation in 2017-18.

Failure to achieve the performance indicators around ED has been discouraging, but the CCG acknowledge the Trusts' commitment to ensure that processes are in place to improve and maintain quality and safety and to alleviate some of the issues identified in this particularly challenging environment. The pace of the improvements needed have been slower than expected and a renewed focus needs to be applied in 2017-18 to create the changes needed.

The year has seen a 30% increase in the number of severe grade 3+ pressure ulcers compared to 2015-16 and the Trust unfortunately did not meet its 2016-17 target for hospital and community for numbers of avoidable PU's documented. SCCG acknowledge the work in progress around the standardised PU care pathway to be devised and implemented as part of the Trusts optimising capacity work stream 'Wound Care - Development Improvement Plan', the PU strategy 2016-2018 'Delivering Safe Effective Care' and PU prevention action plan.

There have been some substantial improvements reported this year that SCCG wish to commend, and some good examples of collaborative working across the health and social care economy, and a dedication to patient safety, incident reporting and implementation of lessons learned.

MRSA rates have been particularly encouraging with no cases reported, and a reduction in C. diff rates from the previous year demonstrates a clear improvement around infection prevention and control. The reduction in the number of avoidable falls from 31 in 2015-16 to 7 in 2016-17 and the safety thermometer identified a marked improvement in 'recorded falls with harm' which was lower than the National average.

The Trust has seen marked improvements and outcomes around cancer targets, achieving the 18 week waiting target and the introduction of a highly rated stroke unit from the SSNAP audit. The CCG note the clear commitment to harm free care and improvement plans around falls and pressure ulcers.

The CCG support the response of the Trust to address the CQC outcomes through its Improvement Plan. The CCG will continue to seek assurance on completion of the actions, and is committed to working with SFT on sustaining and nurturing improvements, developing areas for growth and establishing innovation in quality improvement projects in the year ahead.

SCCG recognise the achievements made over the last year and look forward to working with SFT to further improve patient experience, patient safety and clinical effectiveness for all patients accessing SFT services.

Annex 1 | Statement from Overview & Scrutiny Committee

Date: 11th April 2017

The Scrutiny Committee, having had the opportunity to consider the draft Quality Report and to question the Director of Nursing & Midwifery, is satisfied with the Quality Report for 2016-17.

The Scrutiny Committee was disappointed that the draft report did not include all the quality data, although it was explained to the Committee that this was due to the Committee's reporting timetable. However, most of the data suggested that the Trust's performance was broadly in line with expectations. The Scrutiny Committee recognised, evidenced by the CQC findings from January 2016, those areas of concern were largely those that the Scrutiny Committee had previously received updates on, such as Emergency Department performance and delayed discharges, and the Scrutiny Committee have previously recognised the wider factors in the local health economy that would impact on this performance.

The Trust was able to demonstrate its commitment to improvements being made across a range of indicators and that they recognised areas for further work. The Scrutiny Committee had previously received updates from partners, including Healthwatch Stockport, on work the Trust was engaged with to tackle issues affecting the hospital, and was pleased with the responsiveness of the Trust to feedback received.

The Scrutiny Committee continue to receive regular updates from the Trust, and other partners in the health and social care economy, about their on-going efforts to improve care and performance, particularly in relation to the Emergency Department and delayed discharges.

The Scrutiny Committee has repeatedly been given assurances that the Trust was continuing to work closely with partners in the health economy to address these issues.

Annex 1 | Statement from Trust Governors

Date: 5th May 2017

Stockport Foundation Trust Governors would like to take the opportunity to comment on the Trust's Annual Quality Report.

Throughout the last year the Trust has carried out focus groups and stakeholder activities with the intention to involve members and the community in the continuing plethora of changes which face the Trust, - such as Devolution in Manchester and Stockport Together. Governors have contributed to this process as part of their duty to represent the interests of the members who elected them.

Through regular meetings of the Patient Safety and Quality Standards Committee which is Governor chaired, as well as attendance at Board meetings, we have had the opportunity to seek assurance on the quality targets that are set to ensure that the services and procedures in the hospital and community provide consistent, high quality harm-free care.

Governors welcome the Board's initiative to help achieve more transparency by allowing the Governors and members of the public to ask questions at Board meetings.

Accident and Emergency targets are disheartening. Factors, such as a higher than average ageing population in Stockport, difficulties recruiting staff and reduced Council social services input will continue to provide a serious challenge to the hospital.

The Governors agree with the Chief Executive when, in her statement, she expresses extreme disappointment with the results of this year's staff survey which shows a reduction from last year in the numbers of staff who would recommend the Trust as a provider of care to their family or friends.

The Governors are pleased to see the implementation of sepsis screening which will hopefully lead to an improvement in treatment. It is reassuring to see that improvements in the speed of identifying venous thromboembolism (VTE) are being delivered and we look forward to further progress as a result of a new escalation process. There has been no reported incidence of MRSA; however, C.Diff still remains a challenge. It is pointed out in the report that medication errors are 'always avoidable'. There were 22 major errors last year and we have yet to see the figures for this year but the Governors would like to see a more ambitious objective than to continue with present measures.

The Governors' choice of local indicator for independent audit in last year's Quality Account was falls. That anticipated audit report from Deloitte has not been seen by the Governors. The local indicator for independent audit this year was agreed for pressure ulcers. The incidence of pressure ulcers across the Trust, but with particularly reference to the community, has been a continuing concern to the Governors. Regular reports across the year point to staff failing to adhere to policy and procedure. The Governors expect to see the outcome of the audit for pressure ulcers in the Trust's Annual Report later this year.

The Governors acknowledge the commendable work that takes place in the Trust and the dedication of staff to their patients and families. We look forward to continuing to work in partnership with the Trust.

Annex 1 | Statement from Healthwatch Stockport

Date: 18th May 2017

Healthwatch Stockport would like to thank all the hardworking staff for achieving many of the internal and external goals in terms of quality and patient experience in very challenging times.

The emergency department standard of admitting or discharging 95% of patients within four hours remains stubbornly illusive and Stockport NHS Foundation Trust continues to be subject to regulatory action.

Whilst Healthwatch Stockport recognises that this is a system wide problem Stockport NHS Foundation Trust has internal issues to resolve. It is also incumbent upon commissioners and all providers to work collaboratively and provide the leadership to solve these complex problems.

Healthwatch Stockport is concerned that as a result of the actions Stockport NHS Foundation Trust has had to take to maintain an emergency department service (particularly through the winter) this has resulted in a less than satisfactory experience for patients. The impact on elective care will potentially mean that in the current year patients will have to wait longer for their treatment and this is a matter of serious concern.

Healthwatch Stockport, through its involvement with Commissioners and Providers, continues to help challenge and encourage the achievement of the pledges to patients set out in the NHS Constitution.



Annex 2

Statements of directors' responsibilities for the quality report

Annex 2 Statements of Directors' responsibilities

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.

NHS Improvement 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 the 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 2016-17 and supporting guidance
- 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 2016 to March 2017
 - papers relating to quality reported to the Board over the period April 2016 to March 2017
 - feedback from commissioners dated 4 May 2017
 - feedback from governors dated 5 May 2017
 - feedback from the local Healthwatch organisation dated 18 May 2017
 - feedback from Overview and Scrutiny committee dated 11 April 2017
 - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated July 2016
 - the latest national inpatient survey 2016
 - the latest national staff survey 2016
 - the Head of Internal Audit's annual opinion over the Trust's control environment for 2016-17
 - Care Quality Commission (CQC) inspection report dated January 2016
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported 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 reported 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 NHS Improvement's annual reporting manual and supporting 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

25 May 2017  **G EASSON** **CHAIRMAN**

25 May 2017  **A BARNES** **CHIEF EXECUTIVE**

Glossary

Terms and abbreviations

Glossary Terms & Abbreviations

Acute – This describes a disease of rapid onset, severe symptoms and brief duration.

A&E – Accident & Emergency (or Emergency Department)

AKI - Acute kidney injury. This refers to the sudden damage to the kidneys that causes them to not work properly. It can range from minor loss of kidney function to complete kidney failure.

AQ / AQuA - Advancing Quality. Advancing Quality is the flagship programme of AQuA (Advancing Quality Alliance) the North West's health care quality improvement body.

AdvantisED – Software used to capture patient data within Emergency Department .

ARLD - Alcohol-related liver disease. This refers to liver damage caused by excess alcohol intake. There are several stages of severity and a range of associated symptoms.

Board of Directors – the powers of a Trust are exercised by the Board of Directors (also known as the Trust Board). In a foundation trust, the Board of Directors is accountable to governors for the performance of the trust.

Care Bundle - A care bundle is a set of clinical interventions that, when used together, significantly improve patient care.

Care Quality Commission (CQC) – the independent regulator of health and social care in England.

Clinical Commissioning Groups (CCGs) – Entities which are responsible for commissioning many NHS funded services under the new Health and Social Care Act 2012, established 1 April 2013.

Clostridium difficile (C.Difficile or CDIFF) – a health care associated intestinal infection

that mostly affects elderly patients with underlying diseases.

Commissioning for Quality and Innovation (CQUIN) – The CQUIN payment framework enables commissioners to reward excellent performance by linking a proportion of providers' income to the achievement of local quality improvement goals.

COPD - Chronic obstructive pulmonary disease. This refers to a collection of lung diseases including chronic bronchitis, emphysema and chronic obstructive airways disease.

DDD - Defined daily dose. This is a statistical measure of drug consumption, defined by the World Health Organization (WHO).

ED - Emergency Department (or Accident & Emergency)

EMIS Web - A clinical system for delivering integrated healthcare allows healthcare professionals to record, share and use vital information.

EPR - Abbreviation for Electronic Patient Record. A system used to access patient information electronically.

FAIRI - Find, Assess, Investigate, Refer and Inform

FFT or F&FT - Friends and Family Test. This is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. It asks people if they would recommend the services they have used and offers a range of responses.

Foundation Trust (FT) – NHS hospitals that are run as independent public benefit corporations and are controlled and run locally.

Governors - Members can become more involved by standing for election as a governor and representing their fellow members' views on the Council of Governors. Governors play an important role in the governance of the Trust. They represent the views of patients, carers and patients.

GP –General Practitioner

HDU/ICU – High dependency / intensive care unit

I.T – Information Technology

KPI – Key Performance Indicator

MRSA – Methicillin-Resistant Staphylococcus Aureus is the bacterium responsible for several difficult to treat infections.

MUST – Malnutrition Universal Screening Tool

NHS – National Health Service

NHSFT – NHS Foundation Trust

NICE -The National Institute for Health and Care Excellence (NICE) provides national guidance and advice to improve health and social care.

NRLS - National Reporting and Learning System

Primary care – the collective term for family health services that are usually the patient's first point of contact with the NHS; includes general medical and dental practices, community pharmacy and optometry.

PROM - Patient Recorded Outcome Measure

RA - Risk assessment. This is a systematic process of evaluating the potential risks that may be involved in a projected activity or undertaking.

RCA - Root cause analysis. This is a method of problem solving used for identifying the root causes of faults or problems.

Secondary care – care provided in hospitals.

SACT - Systemic Anticancer Therapy

SHH - Stepping Hill Hospital

SSNAP - Sentinel Stroke National Audit Programme

SMBC – Stockport Metropolitan Borough Council

SFT – Stockport (NHS) Foundation Trust

STP - Sustainability and Transformation Plans

SHMI – Summary Hospital-level Mortality Indicator is a new indicator which uses standard and transparent methodology for reporting mortality at hospital level.

Trust Board – another name used for the Board of Directors.

VTE - Venous Thromboembolism



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Your Health. Our Priority.

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 2017 (the 'Quality Report') and certain performance indicators contained therein.

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 2017, 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, except where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

The indicators for the year ended 31 March 2017 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement:

- Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period; and
- Percentage of patients with a total discharge time in A&E of 4 hours or less from arrival to admission, transfer or discharge.

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 NHS Improvement.

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 section 2.1 of the NHS Improvement 2016/17 Detailed requirements for external assurance for quality reports for Foundation Trusts; 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 the documents listed below:

- Board minutes for the period April 2016 to March 2017;
- papers relating to quality reported to the Board over the period April 2016 to March 2017;
- feedback from Commissioners, dated 4 May 2017;
- feedback from governors, dated 5 May 2017;
- feedback from local Healthwatch organisations, dated 18 May 2017;
- feedback from Overview and Scrutiny Committee, dated 11 April 2017;
- the trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, dated July 2016;
- the latest national patient survey 2016;
- the latest national staff survey, 2016;
- the Head of Internal Audit's annual opinion over the trust's control environment dated March 2017; and
- Care Quality Commission (CQC) inspection report dated January 2016.

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.

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; and
- 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 affect 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 of these criteria, 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 testing of indicators other than the two selected mandated indicators, or consideration of quality governance.

Basis for qualified conclusion

The annualised 18 week referral to treatment indicator is calculated as an average based on the percentage of incomplete pathways which are incomplete at each month end, where the patient has been waiting less than the 18 week target. We have tested a sample of 25 pathways which were listed as incomplete at a month end, selected on both a random and risk focussed basis.

Our sample testing identified:

- In 4 cases there was no evidence of the start date in the patient notes;
- In 2 cases there was no evidence of the stop date in the patient notes;
- In 3 cases the patient was reported as an open pathway after the end of the correct month in the monthly snapshot submissions;
- In 1 case the patient was reported as an open pathway as the start of an open pathway after the correct month;
- In 1 case the pathway was deleted incorrectly; and
- In 1 case the breach was reported one month late in the monthly snapshot submissions based on the evidence in the patient notes.

Our procedures included testing a risk based sample of cases, and so the error rates identified from that sample cannot directly be extrapolated to the population as a whole.

As a result of the issues identified, we have concluded that there are errors in the calculation of the "maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway" indicator for the year ended 31 March 2017. We are unable to quantify the effect of these errors on the reported indicator.

Qualified conclusion

Based on the results of our procedures, except for the matters set out in the basis for qualified conclusion paragraph above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017:

- 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 2.1 of the NHS Improvement Detailed requirements for quality reports for Foundation Trusts 2016/17; 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'.

Deloitte LLP

Chartered Accountants

Leeds

26 May 2017

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS AND BOARD OF DIRECTORS OF STOCKPORT NHS FOUNDATION TRUST

Opinion on financial statements of Stockport NHS Foundation Trust

In our opinion the financial statements:

- give a true and fair view of the state of the Group and Trust's affairs as at 31 March 2017 and of the Group's and Trust's income and expenditure for the year then ended;
- have been properly prepared in accordance with the accounting policies directed by NHS Improvement - Independent Regulator of NHS Foundation Trusts; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

The financial statements that we have audited comprise:

- the Group and Trust statements of Comprehensive Income;
- the Group and Trust Statement of Financial Position;
- the Group and Trust Statements of Cash Flow;
- the Group and Trust Statements of Changes in Taxpayers' Equity; and
- the related notes 1 to 45.

The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by NHS Improvement - Independent Regulator of NHS Foundation Trusts.

Going concern - Emphasis of Matter

We have considered the adequacy of the disclosure made in the financial statements in respect of the Group's ability to continue as a going concern.

The Group recorded a deficit during the year ended 31 March 2017 of £6.6m and are forecasting £27.4m deficit for the 2017/18 year end. Cash during the year under audit fell from £31.4m to £23.7m and additional working capital funding is anticipated to be required during quarter 2.

In response to this, we:

- reviewed management's controls in place over the forecasting of their financial position and cash requirements into 2017/18, and the Board paper prepared and reviewed confirming the intention to prepare accounts under the going concern assumption;
- reviewed the Trust's 2017/18 plan including cash-flow forecasts and the planned CIP for 2017/18, including the profiling of these savings. We have considered assumptions driving this forecast for 2017/18 and have reviewed management's sensitivity analysis to understand the level of risk in the forecast position;
- reviewed the potential funding arrangements available to maintain the minimum cash balance proposed by the Trust and the timing of when these would be required.

Whilst we have concluded that the Accounting officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate, these conditions indicate the existence of a material uncertainty which may cast significant doubt about the Group's ability to continue as a going concern. The financial statements do not include the adjustments that would result if the company was unable to continue as a going concern. Our opinion is not modified in respect of this matter.

Certificate

We certify that we have completed the audit of the accounts in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Summary of our audit approach

Key risks	The key risks that we identified in the current year were: <ul style="list-style-type: none">• NHS Revenue Recognition• Property Valuations• Going Concern (see the emphasis of matter above)
Materiality	The materiality that we used in the current year was £6.07m (2015/16: £4.65m) which was determined on the basis of 2% of total income (2015/16: 1.5% of total income).
Scoping	All audit work for the Group was performed directly by the audit engagement team.
Significant changes in our approach	Going concern has been upgraded to a key risk due to the worsening deficit forecast for 2017/18 when compared to the 2016/17 position.

Independence

We are required to comply with the Code of Audit Practice and Financial Reporting Council's Ethical Standards for Auditors, and confirm that we are independent of the group and we have fulfilled our other ethical responsibilities in accordance with those standards.

We confirm that we are independent of the group and we have fulfilled our other ethical responsibilities in accordance with those standards. We also confirm we have not provided any of the prohibited non-audit services referred to in those standards.

Our assessment of risks of material misstatement

The assessed risks of material misstatement described below are those that had the greatest effect on our audit strategy, the allocation of resources in the audit and directing the efforts of the engagement team.

NHS revenue recognition	
Risk Description	<p>As described in note 1.4, Income and note 1.24, Critical Accounting Judgements and key Sources of Estimation Uncertainty, there are significant judgements in recognition of revenue from care of NHS patients and in provisioning for disputes with commissioners due to:</p> <ul style="list-style-type: none"> • The complexity of the Payment by Results regime, in particular in determining the level of over performance revenue to recognise; • the judgemental nature of provisions for disputes, including in respect of outstanding over performance income for quarters 3 and 4; and • the risk of revenue not being recognized at fair value due to adjustments agreed in settling current year disputes and agreement of future year contracts. <p>Details of the Group's income, including £255m of Commissioner Requested Services, are shown in note 3 to the financial statements. NHS debtors of £4.2m are shown in note 24 to the financial statements.</p> <p>The Group earns revenue from a wide range of commissioners, increasing the complexity of agreeing a final year-end position. The majority of the Group's income comes from Stockport Clinical Commissioning Group (CCG), increasing the significance of associated judgements. The settlement of income with CCGs continues to present challenges leading to disputes and delays in the agreement of year end positions.</p>
How the scope of our audit responded to the risk	<p>We evaluated the design and implementation of key controls in relation to the invoicing process with commissioners including calculation and invoicing of over-performance.</p> <p>We performed detailed substantive testing on a sample basis of the recoverability of over performance income and adequacy of provision for underperformance through the year, and evaluated the results of the agreement of balances exercise.</p> <p>We challenged key judgements around specific areas of dispute and actual or potential challenge from commissioners and the rationale for the accounting treatments adopted. In doing so, we considered the historical accuracy of provisions for disputes and reviewed correspondence with commissioners.</p> <p>We reviewed the key changes and any open areas in setting 2016-17 contracts, and considered whether, taken together with the settlement of current year disputes, there were any indicators of inappropriate adjustments in revenue recognised between periods.</p>
Key observations	<p>We are satisfied that the NHS revenue has been appropriately recognised.</p>

Property valuations	
Risk Description	<p>The Group holds property assets within Property, Plant and equipment at a modern equivalent use valuation of £124m. The valuations are by nature significant estimates which are based on specialist and management assumptions (including the floor areas for a Modern Equivalent Asset, the basis for calculating build costs, the level of allowances for professional fees and contingency, and the remaining life of the assets) and which can be subject to material changes in value.</p> <p>As described in Note 1.24 Critical Accounting Judgements and Key Sources of Estimation Uncertainty, there are significant judgements in property valuations due to the specialist knowledge required to conduct the valuation and assumptions used. Details of the Property, Plant and Equipment can be found in note 16 of the accounts.</p>
How the scope of our audit responded to the risk	<p>We evaluated the design and implementation of controls over property valuations, and tested the accuracy and completeness of data provided by the Group to the valuer.</p> <p>We used Deloitte internal valuation specialists to review and challenge the appropriateness of the key assumptions used in the valuation of the Group's properties, including through benchmarking against revaluations performed by other Groups at 31 March 2017.</p> <p>We assessed the appropriateness of the reduced floor areas the Group has used in calculating a Modern Equivalent Asset valuation by considering the detailed justification of the differences from the current estate, and how these compared to the layout of the Group's estate compared to a modern building.</p> <p>We have reviewed the disclosures in notes 1.7, 6 and 16.1 and evaluated whether these provide sufficient explanation of the basis of the valuation and the judgements made in preparing the valuation.</p> <p>We assessed whether the valuation and the accounting treatment of the impairment were compliant with the relevant accounting standards, and in particular whether impairments should be recognized in the Income Statement or in Other Comprehensive Income.</p>
Key observations	<p>We are satisfied that the valuation of Property, Plant and Equipment has been appropriately recognised.</p>

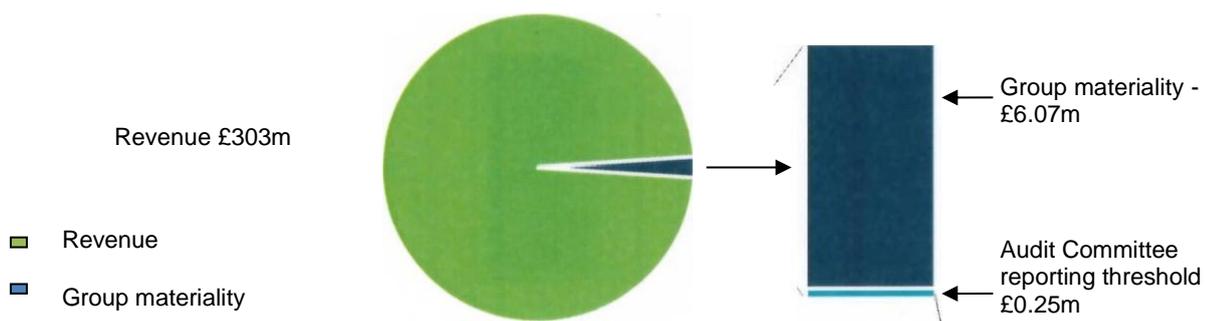
These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

Our application of materiality

We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality both in planning the scope of our audit work and in evaluating the results of our work.

Based on our professional judgement, we determined materiality for the financial statements as a whole as follows:

Group materiality	£6.07m (2015/16: £4.65m)
Basis for determining materiality	2% of total income (£2015/16: 1.5% of total income) We reassessed the percentage used from 1.5% of total income in 2015/16 in the context of our cumulative knowledge and understanding the audit risks at the Trust and our assessment of those risks for this year.
Rationale for the benchmark applied	Total income was chosen as a benchmark as the Trust is a non-profit organisation, and revenue is a key measure of financial performance for users of the financial statements.



We agreed with the Audit Committee that we would report to the Committee all audit differences in excess of £250k (2015/16: £233k), as well as differences below that threshold that, in our view, warranted reporting on qualitative grounds. We also report to the Audit Committee on disclosure matters that we identified when assessing the overall presentation of the financial statements.

An overview of the scope of our audit

Our group audit was scoped by obtaining an understanding of the Group and its environment, including internal controls, and assessing the risks of material misstatement at the Group level.

The focus of our audit work was on the Trust, with work performed at the Trust's head offices in Stockport directly by the audit engagement team, led by the audit partner.

Our audit covered the primary Trust entity within the Group which accounts for 99% of the Group's net asset and 95% of the deficit for the year.

At the Group level we also tested the consolidation process and carried out analytical procedures to confirm our conclusion that there were no significant risks of material misstatement of the aggregated financial information of the remaining components not subject to audit or audit of specified account balances.

The audit team included integrated Deloitte specialists bringing specific skills and experience in property valuations and Information Technology systems.

Opinion on other matters prescribed by the National Health Service Act 2006

In our opinion:

- The parts of the Directors' Remuneration Report and Staff Report to be audited have been properly prepared in accordance with the National Health Service Act 2006; and
- The information given in the Performance Report and the Accountability 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

Use of Resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion the NHS foundation trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Basis for qualified conclusion

We consider the following matters to be relevant to the Trust's arrangements to secure economy, efficiency and effectiveness:

- The Trust was subject to enforcement action by NHSI throughout 2016/17 in relation to its breach of the A&E 4 hour maximum waiting time target, more detail of which can be found in the Regulatory Ratings section of the Annual Report on page 92. Urgent care continues to be an area of focus for the Foundation Trust.

This matter above is evidence of weakness in proper arrangements for planning, organizing and developing the workforce effectively to deliver strategic planning priorities.

Qualified conclusion

On the basis of our work, having regard to the guidance issued by the C&AG in November 2016, with the exception of the matter reported in the basis for qualified conclusion paragraph above, we are satisfied that, in all significant respects, Stockport NHS Foundation Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

Annual Governance Statement and compilation of financial statements

Under the Code of Audit Practice, we are required to report to you if, in our opinion;

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading, or is inconsistent with the information of which we are aware from our audit; and
- proper practices have not been observed in the compilation of the financial statements.

We have nothing to report in respect of these matters.

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

Reports in the public interest or to the regulator

Under the Code of Audit Practice, we are also required to report to you if:

- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit; or
- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006 because we have reason to believe that the Trust, or a director or officer of the Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency.

We have nothing to report in respect of these matters.

Our duty to read other information in the Annual Report

Under International Standards on Auditing (UK and Ireland), we are required to report to you if, in our opinion, information in the annual report is:

- materially inconsistent with the information in the audited financial statements; or
- apparently materially incorrect based on, or materially inconsistent with, our knowledge of the Group acquired in the course of performing our audit; or
- otherwise misleading.

In particular, we are required to consider whether we have identified any inconsistencies between our knowledge acquired during the audit and the directors' statement that they consider the annual report is fair, balanced and understandable and whether the annual report appropriately discloses those matters that we communicated to the Audit Committee which we consider should have been disclosed.

We confirm that we have not identified any such inconsistencies or misleading statements.

Respective responsibilities of the accounting officer and auditor

As explained more fully in the Accounting Officer's Responsibilities Statement, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law, the Code of Audit Practice and International Standards on Auditing (UK and Ireland). We also comply with International Standard on Quality Control 1 (UK and Ireland). Our audit methodology and tools aim to ensure that our quality control procedures are effective, understood and applied. Our quality controls and systems include our

dedicated professional standards review team and independent partner reviews.

This report is made solely to the Council of Governors and Board of Directors (“the Boards”) of Stockport NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Boards 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 Trust and the Boards as a body, for our audit work, for this report, or for the opinions we have formed.

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.

Paul Thomson ACA (Senior statutory auditor)
for and on behalf of Deloitte LLP
Chartered Accountants and Statutory Auditor
Leeds
26 May 2017

Stockport NHS Foundation Trust

Annual accounts for the year ended 31 March 2017

Foreword to the accounts

Stockport NHS Foundation Trust

These accounts, for the year ended 31 March 2017, have been prepared by Stockport NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed



Name Mrs A D Barnes
Job title Chief Executive
Date 25 May 2017

Consolidated Statement of Comprehensive Income for the Year Ended 31 March 2017

	Note	Group		Trust	
		2016/17 £000	2015/16 £000	2016/17 £000	2015/16 £000
Operating income from patient care activities	3.1	256,521	271,512	256,521	271,512
Other operating income	4	46,582	35,776	46,802	36,139
Total operating income from continuing operations		303,103	307,288	303,323	307,651
Operating expenses	5, 7	(305,705)	(316,163)	(305,386)	(315,925)
Operating surplus/(deficit) from continuing operations		(2,603)	(8,875)	(2,063)	(8,274)
Finance income	10	116	149	66	94
Finance expenses	11	(939)	(824)	(939)	(824)
PDC dividends payable	20	(3,318)	(3,951)	(3,318)	(3,951)
Net finance costs		(4,141)	(4,626)	(4,191)	(4,681)
Gains/ (losses) on disposal of non-current assets	12	(59)	12	(76)	12
Movement in the fair value of investment property and other investments		165	(51)	-	-
(Deficit) for the year from continuing operations		(6,638)	(13,540)	(6,330)	(12,943)
Surplus/(deficit) on discontinued operations and the gain/(loss) on disposal of discontinued operations	14	-	-	-	-
(Deficit) for the year		(6,638)	(13,540)	(6,330)	(12,943)
Other comprehensive income					
Will not be reclassified to income and expenditure:					
Impairments	6	(16,859)	(891)	(16,859)	(891)
Revaluations	19	1,439	3,206	1,439	3,206
Other reserve movements		-	2	-	2
Total comprehensive income/(expense) for the period		(22,058)	(11,223)	(21,750)	(10,626)
(Deficit) for the period attributable to:					
the Foundation Trust		(6,638)	(13,540)	(6,330)	(12,943)
Total comprehensive (Expense) for the period attributable to:					
the Foundation Trust		(22,058)	(11,223)	(21,750)	(10,626)

The Group Accounts include the consolidated financial results of Stockport NHS Foundation Trust, its associated Charity, Stockport NHS Foundation Trust Charitable Fund (Charity Commission Number 1048661) and Stepping Hill Healthcare Enterprises Limited (trading as the Pharmacy Shop).

The Group Accounts reflect the outcome of the Trust of £6.3 million deficit in 2016/2017 (£12.9 million deficit in 2015/2016) and a profit of £128k for Stepping Hill Healthcare Enterprises Limited (£6.8k loss in 2015/2016). The Trust Charity has net movement in funds of £436k outgoing in 2016/2017 compared to net movement in funds of £547k outgoing resources in 2015/2016. The Trust's consolidated subsidiaries results are further explained at notes 43 to 45.

Included in the Trust deficit of £6.3 million are net adjustments for an impairment charge of £4.1 million following the revaluation of the Trust's land and buildings. The revaluation has also had an impact on the Trust revaluation reserve of £15.4 million charge as disclosed above in the Total Comprehensive Expense for the period at the 31st March 2017. The impairment and revaluation charges to the financial statements are explained further at notes 6 and 19.

In 2016/2017 the Department of Health's Group Accounting Manual has harmonised Foundation Trust and Trust financial reporting. This has resulted in some presentational changes to prior year numbers. In 2015/2016 the Trust reported a reversal of impairment of £2.542 million in operating income. This has now been re-presented as a net impairment operating expense. Both operating income and operating expense notes for 2015/2016 have a compensating adjustment of £2.542 million.

Group and Trust Statement of Financial Position as at the 31st March 2017

	Note	Group		Trust	
		31 March 2017 £000	31 March 2016 £000	31 March 2017 £000	31 March 2016 £000
Non-current assets					
Intangible assets	15	3,374	1,954	3,374	1,954
Property, plant and equipment	16, 17	139,450	158,599	139,450	158,599
Other investments	21	1,213	1,289	-	-
Trade and other receivables	24	782	703	782	703
Total non-current assets		144,820	162,546	143,606	161,256
Current assets					
Inventories	23	1,574	1,962	1,369	1,751
Trade and other receivables	24	16,545	11,218	17,518	12,704
Non-current assets for sale	25	315	-	315	-
Cash and cash equivalents	26	24,677	33,124	23,726	31,398
Total current assets		43,111	46,304	42,928	45,853
Current liabilities					
Trade and other payables	27	(26,283)	(28,597)	(26,490)	(28,769)
Other liabilities	28	(960)	(1,215)	(960)	(1,215)
Borrowings	29	(1,647)	(1,458)	(1,647)	(1,458)
Provisions	31	(5,072)	(3,071)	(5,072)	(3,071)
Total current liabilities		(33,962)	(34,341)	(34,169)	(34,513)
Total assets less current liabilities		153,969	174,509	152,365	172,597
Non-current liabilities					
Other liabilities	28	(416)	(570)	(416)	(570)
Borrowings	29	(25,190)	(23,628)	(25,190)	(23,628)
Provisions	31	(2,259)	(2,149)	(2,259)	(2,149)
Total non-current liabilities		(27,865)	(26,347)	(27,865)	(26,347)
Total assets employed		126,104	148,162	124,500	146,250
Financed by					
Public dividend capital (PDC)		83,390	83,390	83,390	83,390
Revaluation reserve		41,065	56,485	41,065	56,485
Income and expenditure reserve		(57)	6,145	45	6,375
Charitable fund reserves	22	1,706	2,142	-	-
Total taxpayers' and others' equity		126,104	148,162	124,500	146,250

The notes on pages 1 to 49 form part of these accounts.



Name
Position
Date

A D Barnes
Chief Executive
25 May 2017

Statement of Changes in Equity for the year ended 31 March 2017

Group	Note	Public	Revaluation	Income and	NHS	Total
		dividend capital £000	reserve £000	expenditure reserve £000	charitable funds reserves £000	
Taxpayers' and others' equity at 1 April 2016 - brought forward		83,390	56,485	6,145	2,142	148,162
(Deficit)/Surplus for the year		-	-	(7,242)	604	(6,638)
Impairments	6	-	(16,859)	-	-	(16,859)
Revaluations	19	-	1,439	-	-	1,439
Other reserve movements		-	-	1,040	(1,040)	-
Taxpayers' and others' equity at 31 March 2017		83,390	41,065	(57)	1,706	126,104

Statement of Changes in Equity for the year ended 31 March 2016

Group	Note	Public	Revaluation	Income and	NHS	Total
		dividend capital £000	reserve £000	expenditure reserve £000	charitable funds reserves £000	
Taxpayers' and others' equity at 1 April 2015 - brought forward		82,943	54,168	19,138	2,689	158,938
(Deficit)/Surplus for the year		-	-	(13,841)	301	(13,540)
Impairments	6	-	(891)	-	-	(891)
Revaluations	19	-	3,206	-	-	3,206
Public dividend capital received (PDC)		447	-	-	-	447
Other reserve movements		-	2	848	(848)	2
Taxpayers' and others' equity at 31 March 2016		83,390	56,485	6,145	2,142	148,162

Information on reserves**NHS Charitable Funds Reserves**

This balance represents the ring-fenced funds held by the NHS charitable funds consolidated within these Accounts. These reserves are classified as restricted or unrestricted.

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 establishment of the predecessor NHS trust. Additional PDC may also be issued to NHS foundation trusts by the Department of Health. A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation Reserve

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and Expenditure Reserve - Trust

The balance of this reserve is the accumulated surpluses and deficits of Stockport NHS Foundation Trust.

Income and Expenditure Reserve - Group

The balance of this reserve is the accumulated surpluses and deficits of Stockport NHS Foundation Trust and its subsidiary, Stepping Hill Healthcare Enterprise Ltd, which are consolidated into these Accounts with the Trust.

Statement of Changes in Equity for the year ended 31 March 2017

Trust	Note	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2016 - brought forward		83,390	56,485	6,375	146,250
(Deficit)/Surplus for the year		-	-	(6,330)	(6,330)
Impairments	6	-	(16,859)	-	(16,859)
Revaluations	19	-	1,439	-	1,439
Transfer to retained earnings on disposal of assets		-	-	-	-
Other reserve movements		-	-	-	-
Taxpayers' and others' equity at 31 March 2017		83,390	41,065	45	124,500

Statement of Changes in Equity for the year ended 31 March 2016

Trust	Note	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2015 - brought forward		82,943	54,168	19,318	156,429
(Deficit)/Surplus for the year		-	-	(12,943)	(12,943)
Impairments	6	-	(891)	-	(891)
Revaluations	19	-	3,206	-	3,206
Public dividend capital received (PDC)		447	-	-	447
Other reserve movements		-	2	-	2
Taxpayers' and others' equity at 31 March 2016		83,390	56,485	6,375	146,250

Group and Trust Statement of Cash Flows as at 31st March 2017

	Note	Group		Trust	
		2016/17 £000	2015/16 £000	2016/17 £000	2015/16 £000
Cash flows from operating activities					
Operating (deficit)		(2,603)	(8,875)	(2,063)	(8,274)
Non-cash income and expense:					
Depreciation and amortisation	5.1	7,996	8,629	7,996	8,629
Net impairments and reversals of impairments	6	4,152	(387)	4,152	(387)
(Increase)/decrease in receivables and other assets		(4,631)	(254)	(4,119)	394
(Increase)/decrease in inventories		388	339	381	328
Increase/(decrease) in payables and other liabilities		(1,196)	(1,855)	(1,159)	(2,694)
Increase/(decrease) in provisions		2,082	746	2,081	746
NHS charitable funds - net movements in working capital, non-cash transactions and non-operating cash flows		-	1,007	-	-
Net cash generated from/(used in) operating activities		6,187	(650)	7,269	(1,258)
Cash flows from investing activities					
Interest received		69	97	69	97
Purchase of intangible assets		(498)	(692)	(498)	(692)
Purchase of property, plant, equipment and investment property		(9,879)	(14,862)	(9,879)	(14,862)
Sales of property, plant, equipment and investment property		13	85	14	85
Investing cash flows of NHS charitable funds		308	55	-	-
Net cash generated used in investing activities		(9,987)	(15,317)	(10,294)	(15,372)
Cash flows from financing activities					
Public dividend capital received (PDC)		-	447	-	447
Movement on loans from the Department of Health		1,509	7,929	1,509	7,929
Capital element of finance lease rental payments		(1,149)	-	(1,149)	-
Capital element of PFI, LIFT and other service concession payments		(27)	(26)	(27)	(26)
Interest paid on PFI, LIFT and other service concession obligations		(13)	(14)	(13)	(14)
Other capital receipts		-	-	-	-
Other interest paid		(872)	(749)	(872)	(749)
PDC dividend paid		(4,095)	(4,166)	(4,095)	(4,166)
Net cash (used in)/generated from financing activities		(4,647)	3,421	(4,647)	3,421
Decrease in cash and cash equivalents		(8,447)	(12,546)	(7,672)	(13,209)
Cash and cash equivalents at 1 April		33,124	45,669	31,398	44,607
Cash and cash equivalents at 31 March	26.1	24,677	33,124	23,726	31,398

Notes to the Accounts

Note 1 Accounting policies and other information

Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, is responsible for issuing an accounts direction to NHS foundation trusts under the NHS Act 2006. NHS Improvement has directed that the financial statements of NHS Foundation trusts shall meet the accounting requirements of the Department of Health Group Accounting Manual (DH GAM) which shall be agreed with the Secretary of State. Consequently, the following financial statements have been prepared in accordance with the DH GAM 2016/17 issued by the Department of Health. The accounting policies contained in that manual follow IFRS and HM Treasury's FReM 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 financial assets and financial liabilities.

Going concern

These accounts have been prepared on a going concern basis.

IAS1 requires the Board of Directors to assess, as part of the accounts preparation process, the Trust's ability to continue as a going concern. As a non-trading entity in the public sector the anticipated continuation of the provision of a service in the future is normally sufficient evidence of going concern. The financial statements should be prepared on a going concern basis unless there are plans for, or no realistic alternative other than, the dissolution of the Trust without the transfer of its services to another entity.

The Directors consider the future provision of service is evidenced by the signed contracts and agreements with commissioning bodies and is sufficient evidence that the Trust will continue as a going concern for the foreseeable future.

Note 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
 IFRS 10 Consolidated Financial Statements
 IFRS 11 Joint Arrangements
 IFRS 12 Disclosure of Interests in Other Entities
 IFRS 13 Fair value measurement
 Annual Improvements to IFRS 2009-13

International Accounting Standards

IAS 1 Presentation of Financial Statements
 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 disclosure of Government assistance
IAS 21	The effects of changes in foreign exchange rates
IAS 23	Borrowing costs
IAS 24	Related party disclosures
IAS 27	Separate financial statements
IAS 28	Investments in Associates and Joint Ventures (Revised 2011)
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
IFRIC 12	Service concession arrangements
IFRIC 14	IAS 19 – The limit on a defined benefit asset, minimum funding requirements and their interaction.
IFRIC 21	Levies

SIC Interpretations

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

Standards, amendments and interpretations in issue but not yet effective or adopted

As required by IAS 8 the Trust can disclose that the following standards have been issued or amended but have not yet been adopted by the HM Treasury FReM and are therefore not applicable to DH Group Accounts in 2016/2017.

- IFRS 9 *Financial Instruments* – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 15 *Revenue for Contracts with Customers* - Application required for accounting periods beginning on or after 1 January 2017, but not yet adopted by the FReM: early adoption is not therefore permitted
- IFRS 16 *Leases* – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

Note 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.

Note 1.3 Consolidation

Stockport NHS Foundation Trust General Fund

Stockport NHS Foundation Trust is the Corporate Trustee to Stockport NHS Foundation Trust General Fund, Charity Commission Registration 1048661. The Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

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 Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

- Recognise and measure them in accordance with the foundation trust's accounting policies and
- Eliminate intra-group transactions, balances, gains and losses.

Other subsidiaries

Subsidiary entities are those over which the Trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to minority interests are included as a separate item in the Statement of Financial Position.

The amounts consolidated are drawn from the published financial statements of the subsidiaries for the year except where a subsidiary's financial year end is before 1 January or after 1 July in which case the actual amounts for each month of the trust's financial year are obtained from the subsidiary and consolidated.

Where subsidiaries' accounting policies are not aligned with those of the Trust (including where they report under UK FRS 102) then amounts are adjusted during consolidation where the differences are material. Inter-entity balances, transactions and gains/losses are eliminated in full on consolidation.

Stepping Hill Healthcare Enterprises Limited

Stepping Hill Healthcare Enterprises Limited is a limited company incorporated on the 16th September 2014 but operational from the 16th October 2014. Its principal activities are to dispense drugs to the outpatients of Stockport NHS Foundation Trust. The Company is wholly owned by Stockport NHS Foundation Trust.

The subsidiary's first accounting period was from the 16/09/2014 to the 15/10/2014 for which a set of dormant accounts were submitted. The company's second accounting period for the eighteen month accounting period to the 31st March 2016 has been prepared, audited and submitted to Companies House on the 23rd December 2016.

Note 1.4 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 health care services.

The Trust is entitled to recognise income for partially completed spells of activity at the 31st March 2017. 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 2016/17 partially completed spell activity is not material for inclusion in the financial results of the Trust. The principle to not include partially completed spells activity is agreed with the Trust's lead Commissioner, Stockport CCG as part of the income and expenditure agreement of balances exercise. These principles are reviewed on an annual basis.

Non-Contract Activity

The timing of year end processes precludes determining the final figure for non-contracted activity in February and March and full and final settlement figure for Stockport CCG. of the financial year. The year end figures are based on estimates which may be different to the final year end outturn for the year. Stockport NHS Foundation Trust includes a general non-provider specific 'provision' for non-contracted activity.

Where income is received for a specific activity which is to be delivered in future financial years, that income is deferred.

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.

Note 1.5 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 annual leave into the following period. The Trust has reviewed and updated its policy for the carry forward of annual leave in 2016/2017 and the movement in carry forward annual leave at the 31st March 2017 reflects this new policy.

Pension Costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of these Schemes can be found on the NHS Pensions website www.nhsba.nhs.uk/pensions. Both are unfunded, defined benefit schemes that covers NHS employers, general practices and other bodies, allowed under the direction of the Secretary for 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, each scheme is accounted for as a defined contribution scheme. The cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to the scheme for the accounting period.

Employer's pension contributions are charged to operating expenses as and when they become due.

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 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 the 31 March 2017, is based on valuation data as at the 31 March 2016, updated to the 31 March 2017 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant 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 payable by employees and employers

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012

The Scheme Regulations 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 actuarial valuation is to be carried out as at the 31st March 2016. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required provisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

Note 1.6 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.

Note 1.7 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 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

An item of property, plant and equipment which is surplus with no plan to bring it back into use is measured at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

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 as at the 31st March 2017 as part of the Trust's year end and to comply with HM Treasury requirements. In 2016/2017 the Trust has had an alternate site valuation of its land and buildings at the 1st April 2016 and 31st March 2017 by the District Valuer; having agreed the material change in valuation should be reflected in the 2016/2017 financial statements.

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. In 2015/2016 the Trust had an initial District Valuer valuation of the Surgical Centre asset under construction to assess impairment losses on completion of the capital scheme in September 2016 and to recognise such impairment losses in the 2015/2016 financial statements. In 2016/2017 the Trust has had the final impairment valuation and the resulting impairment reversal has been transacted in operating expenses.

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 lives in a manner consistent with the consumption of economic or service delivery benefits. Depreciation is charged using the straight life method. Freehold land is considered to have an infinite life and is not depreciated.

Property, Plant and Equipment which has been reclassified 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 10 years

Transport equipment: 7 years

Office and Information technology equipment: 5 years

Furniture & fittings: 10 years

Soft Furnishings: 7 years

Set up costs in new buildings: 10 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 gains and losses continued

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 DH GAM, impairments that arise from a clear consumption 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 that arises from a clear consumption 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 expenses 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 ie:
 - 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.

Donated, government grant and other grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed 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.

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. In accordance with IAS 17 the underlying assets are recognised as Property, Plant and Equipment together with an equivalent financial liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

Useful Economic Lives of Property, Plant and Equipment

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	24	29
Dwellings	30	40
Plant & machinery	5	10
Transport equipment	7	7
Information technology	5	8
Furniture & fittings	7	10

Finance-leased assets (including land) are depreciated over the shorter of the useful economic life or the lease term, unless the Trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.8 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, customer lists and similar items are not capitalised as intangible assets.

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, eg, 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;

Internally generated intangible assets continued

- 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 current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

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.

Useful economic life of intangible assets

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	Max life Years
Intangible assets - purchased		
Software	4	10

Note 1.9 Revenue government and other grants

Government grants are grants from government bodies other than income from commissioners or NHS trusts for the 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.

Note 1.10 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.

Note 1.11 Financial instruments and financial liabilities

Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale 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, ie, when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

Regular way purchases or sales are recognised and de-recognised, as applicable, using the trade date.

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

Note 1.11 Financial instruments and financial liabilities continued

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 categorised as loans and receivables.

Financial liabilities are classified as other financial liabilities.

Financial assets and financial liabilities at "fair value through income and expenditure"

Financial assets and financial liabilities at "fair value through income and expenditure" are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term.

These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the income and expenditure account. Subsequent movements in the fair value are recognised as gains or losses in the Statement of Comprehensive Income.

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, NHS receivables, accrued income and "other receivables".

Loans and receivables are recognised initially at fair value, net of transactions 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.

Available-for-sale financial assets

Available-for-sale financial assets are non-derivative financial assets which are either designated in this category or not classified in any of the other categories. They are included in long-term assets unless the Trust intends to dispose of them within 12 months of the Statement of Financial Position date.

Available-for-sale financial assets are recognised initially at fair value, including transaction costs, and measured subsequently at fair value, with gains or losses recognised in reserves and reported in the Statement of Comprehensive Income as an item of "other comprehensive income". When items classified as "available-for-sale" are sold or impaired, the accumulated fair value adjustments recognised are transferred from reserves and recognised in "finance costs" in the Statement of Comprehensive Income.

Cash and cash equivalents

Cash, bank and overdraft 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.

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in three months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

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 estimated 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

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.

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 is utilised where the likelihood of full recovery is probable but not yet fully approved to write down directly.

Note 1.12 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.

Leases 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.

Note 1.13 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources 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 the discount rates published and mandated by HM Treasury. Post employment benefits provisions, such as injury benefits provision, use HM Treasury's pension discount rate of 0.24% (1.37%) in 2015/2016) 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 NHS foundation trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS foundation trust is disclosed at note 31.2 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.

Note 1.14 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 32 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 32, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined 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 entity'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 amount of the obligation cannot be measured with sufficient reliability.

Note 1.15 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 establishment of the predecessor NHS trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the NHS Foundation Trust, is payable 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, and (iii) 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 of the audit of the annual accounts.

Note 1.16 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.

Note 1.17 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.

The Trust may incur corporation tax through its wholly owned subsidiary 'Stepping Hill Healthcare Enterprises Limited.

Note 1.18 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 at 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.

Note 1.19 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*.

Note 1.20 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 foundation 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.

Note 1.21 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.22 Transfers of functions to / from other NHS bodies / local government bodies

For functions that have been transferred to the Trust from another NHS 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 property plant and equipment assets and intangible assets, the cost and accumulated depreciation / amortisation balances from the transferring entity'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 revaluation reserve to maintain transparency within public sector accounts.

For functions that the Trust has transferred to another NHS or local government body, the assets and liabilities transferred are de-recognised from the accounts as at the date of transfer. The net loss / gain corresponding to the net assets/ liabilities transferred is recognised within expenses or income, but not within operating activities. Any revaluation reserve balances attributable to assets de-recognised are transferred to the income and expenditure reserve.

In 2015/2016 the Trust approved the transfer of Tameside and Glossop Community Services to Tameside and Glossop Integrated Care NHS Foundation Trust. This took place with effect from the 1st April 2016. No assets or liabilities were transferred from the Statement of Financial Position. Also in 2016/2017 the Sexual Health service transferred to Central Manchester NHS Foundation Trust with its accompanying equipment asset transferred at a value of £29.5k.

Note 1.23 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2016/17.

Note 1.24 Critical accounting estimates and judgements

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.

The most significant areas where judgements and estimates are made are as follows capital expenditure, provisions, accruals, revaluations and revenue. Specifically estimates and judgements are made in the following areas:

Asset valuation and impairments: the valuation of the Trust's Land and Buildings is subject to significant estimation uncertainty, since it derives from estimates provided by the Trust's external valuers who base their estimates on local market data as well as other calculations to reflect the age and condition of the Trust's estate. In 2016/2017, the basis upon which the Modern Equivalent Asset Valuation is assessed by the external valuer, has been changed from the existing site to an alternate, theoretical site. This has had a significant impact on the value of land and building assets and on the financial statements.

- The Trust uses the District Valuer service to provide revalued amounts for its Trust, building and dwellings. These valuations are in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual.

- The Provision for Restructurings includes estimated costs associated with the workforce elements of the Trust's future plans; in light of the ongoing challenging financial environment. This includes the provision for the redundancy and restructurings. The actual costs will depend upon uptake to the Scheme, value for money and ability to flex the staffing profile.

- The timing of year end processes precludes determining the final figure for non-contracted activity in February and March of the financial year. The year end figures are based on estimates which may be different to the final year end outturn for the year. Stockport NHS Foundation Trust includes a general non-provider specific 'provision' for non-contracted activity.

Note 2 Operating Segments

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.

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 Trust's view on segmental reporting remains unchanged from its financial statements in 2015/2016. The Board, as Chief Operating Decision Maker, does not receive separate information routinely to evaluate how to allocate resources and assess performance 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 business groups.

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.

In consolidating the financial results of the Stepping Hill Healthcare Enterprises Limited Company, the Trust considers that the provision of an outpatient dispensing service to patients still falls under the healthcare operating segment. In addition its revenue streams are also not 10% or more than all the combined assets of all operating segments.

Note 3 Operating income**Note 3.1 Income from activities arising from commissioner requested services**

Under the terms of its provider licence, the Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	Foundation Trust and Group	
	2016/17	2015/16
	£000	£000
Income from services designated (or grandfathered) as commissioner requested services	255,004	269,960
Income from services not designated as commissioner requested services	1,517	1,552
Total	<u>256,521</u>	<u>271,512</u>

Note 3.2 Income from patient care activities (by nature)

	Foundation Trust and Group	
	2016/17	2015/16
	£000	£000
Acute services		
Elective income	42,611	40,007
Non elective income	75,475	72,678
Outpatient income	34,144	30,963
A & E income	12,162	11,522
Other NHS clinical income	60,054	53,978
Community services		
Community services income from CCGs and NHS England	22,612	49,743
Community services income from other commissioners	7,946	11,069
All services		
Private patient income	242	307
Other clinical income	1,275	1,245
Total income from activities	<u>256,521</u>	<u>271,512</u>

Note 3.3 Income from patient care activities (by source)

	Foundation Trust and Group	
	2016/17	2015/16
	£000	£000
Income from patient care activities received from:		
CCGs and NHS England	246,387	257,996
Local authorities	8,016	11,238
Other NHS foundation trusts	502	509
NHS trusts	14	24
NHS other	85	193
Non-NHS: private patients	242	307
Non-NHS: overseas patients (chargeable to patient)	45	39
NHS injury scheme (was RTA)	1,230	1,163
Non NHS: other	-	43
Total income from activities	<u>256,521</u>	<u>271,512</u>
Of which:		
Related to continuing operations	256,521	271,512

The notes on Income by nature and source are Trust figures and are unaffected by Group numbers.

Note 3.4 Overseas visitors (relating to patients charged directly by the NHS foundation trust)

	Foundation Trust and Group	
	2016/17	2015/16
	£000	£000
Income recognised this year	45	39
Cash payments received in-year	39	14
Amounts added to provision for impairment of receivables	11	32
Amounts written off in-year	131	-

Note 4 Other operating income - Group

	Group	
	2016/17	2015/16
	£000	£000
Research and development	545	395
Education and training	7,978	8,045
Stockport Pharmaceuticals and Quality Control	5,278	5,472
Local Authorities	4,249	4,440
Sustainability and Transformation Fund income	11,402	-
NHS Bodies	9,172	9,111
Non NHS Bodies	2,082	3,441
Rents and car parking income	1,820	1,414
Catering sales	11	278
Stockport Healthcare Enterprises Ltd Income	3,312	2,837
Incoming resources received by NHS charitable funds	387	297
Other income	346	46
Total other operating income	<u>46,582</u>	<u>35,776</u>
Of which:		
Related to continuing operations	46,582	35,776

For Group Accounts elimination adjustments have been made to remove Trust income received from its Pharmacy Shop subsidiary for purchases of drugs and services charged by the Trust for use of its facilities. The consolidated numbers include income earned by the Pharmacy Shop on its outpatient dispensing service, prescription charges and retail income from the Pharmacy Shop itself.

Note 4 Other operating income - Trust

	Trust	
	2016/17	2015/16
	£000	£000
Research and development	545	395
Education and training	7,978	8,045
Charitable and other contributions to expenditure	1,043	848
Stockport Pharmaceuticals and Quality Control	5,278	5,498
Local Authorities	4,249	4,440
Sustainability and Transformation Fund income	11,402	-
NHS Bodies	9,172	9,111
Non NHS Bodies	2,082	3,441
Rents and car parking income	1,820	1,414
Catering sales	11	278
Other income	3,222	2,669
Total other operating income	<u>46,802</u>	<u>36,139</u>
Of which:		
Related to continuing operations	46,802	36,139

In 2016/2017 the Trust has received £11.4 million Sustainability and Transformation income from NHS England. There is no prior year comparator as this is non-recurrent income received on the achievement of financial and performance quarterly targets.

In 2015/2016 the prior year reversal of impairment figure of £2.542 million is now reported within operating expenses.

Note 4.1 Profits and losses on disposal of property, plant and equipment

In 2016/2017 the Trust has a loss on disposal of assets of £76,000 (profit of £12,000 in 2015/2016) comprising of cash proceeds of £14k offset by the write off of a net book value of £90k. The cash proceeds relate to the trade in prices achieved for items of medical equipment, vehicles and fittings as they were replaced.

Note 5.1 Operating expenses

	Group	
	2016/17	2015/16
	£000	£000
Services from NHS Foundation Trusts	2,994	3,787
Services from NHS Trusts	207	127
Services from CCGs and NHS England	428	1,027
Services from other NHS bodies	358	661
Purchase of healthcare from non NHS bodies	3,851	3,833
Employee expenses - executive directors	1,382	1,065
Remuneration of non-executive directors	146	145
Employee expenses - staff	203,535	220,747
Supplies and services - clinical	22,527	22,405
Supplies and services - general	3,058	3,534
Establishment	1,711	1,578
Research and development	358	320
Transport	769	1,264
Premises	9,619	9,609
Increase/(decrease) in provision for impairment of receivables	470	186
Increase/(decrease) in other provisions	2,387	1,270
Change in provisions discount rate(s)	241	(15)
Drug costs	19,094	19,273
Rentals under operating leases	2,518	3,435
Depreciation on property, plant and equipment	7,498	8,157
Amortisation on intangible assets	498	472
Net impairments	4,152	(387)
Audit fees payable to the external auditor		
audit services- statutory audit	48	50
other auditor remuneration (external auditor only)	17	68
Clinical negligence	8,562	7,802
Legal fees	162	194
Consultancy costs	3,584	1,411
Internal audit costs	102	101
Training, courses and conferences	640	681
Patient travel	373	411
Car parking & security	201	203
Redundancy	1,663	-
Insurance	308	330
Losses, ex gratia & special payments	106	23
Other resources expended by NHS charitable funds	15	-
Other	2,123	2,396
Total	305,705	316,163
Of which:		
Related to continuing operations	305,705	316,163

In 2015/2016 the prior year reversal of impairment figure of £2.542 million is now reported within operating expenses.

Note 5.1 Operating expenses

	Trust	
	2016/17	2015/16
	£000	£000
Services from NHS Foundation Trusts	2,994	3,787
Services from NHS Trusts	207	127
Services from CCGs and NHS England	428	1,027
Services from other NHS bodies	358	661
Purchase of healthcare from non NHS bodies	3,851	3,833
Employee expenses - executive directors	1,382	1,065
Remuneration of non-executive directors	146	145
Employee expenses - staff	203,535	220,747
Supplies and services - clinical	22,527	22,405
Supplies and services - general	3,058	3,534
Establishment	1,711	1,578
Research and development	358	320
Transport	769	1,264
Premises	9,619	9,609
Increase/(decrease) in provision for impairment of receivables	470	186
Increase/(decrease) in other provisions	2,387	1,270
Change in provisions discount rate(s)	241	(15)
Drug costs	19,039	19,213
Rentals under operating leases	2,518	3,435
Depreciation on property, plant and equipment	7,498	8,157
Amortisation on intangible assets	498	472
Net impairments	4,152	(387)
Audit fees payable to the external auditor		
audit services- statutory audit	48	50
other auditor remuneration (external auditor only)	17	56
Clinical negligence	8,562	7,802
Legal fees	162	194
Consultancy costs	3,584	1,411
Internal audit costs	102	101
Training, courses and conferences	640	681
Patient travel	373	411
Car parking & security	201	203
Redundancy	1,663	-
Insurance	308	330
Losses, ex gratia & special payments	106	23
Other resources expended by NHS charitable funds	-	-
Other	1,874	2,230
Total	305,386	315,925
Of which:		
Related to continuing operations	305,386	315,925

Note 5.2 Other auditor remuneration

	Group	
	2016/17	2015/16
	£000	£000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	17	17
2. Audit-related assurance services	-	12
3. All assurance services not falling within items 1 to 2	-	39
Total	<u>17</u>	<u>68</u>

The Group auditor remuneration figure includes fees for the audit of Stepping Hill Healthcare Enterprises Limited and its subsidiary Charity, Stockport NHS Foundation Trust General Fund.

Note 5.3 Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial years 2016/17 or 2015/16.

Note 6 Impairment of assets

	Foundation Trust and Group	
	2016/17	2015/16
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Loss or damage from normal operations	-	9
Changes in market price	4,152	(396)
Other	-	-
Total net impairments charged to operating surplus / deficit	<u>4,152</u>	<u>(387)</u>
Impairments charged to the revaluation reserve	16,859	891
Total net impairments	<u>21,011</u>	<u>504</u>

In 2016/2017 the Trust has undertaken a revaluation exercise of its land, buildings and dwellings on an alternate site basis. The table above highlights the impairment charge to the revaluation reserve of £16.9 million from the valuation where an existing revaluation reserve balance exists to charge the impairment. It has also resulted in a £5.3 million impairment to the Statement of Comprehensive Income (SoCi). The District Valuer has, in addition, given a final valuation for the Trust's Surgical Centre capitalised in 2016/2017 having being held as an asset under construction in 2015/2016 at an initial impaired value (also provided by the District Valuer in 2015/2016.) The final valuation has resulted in a reversal of impairment of the Surgical Centre to the SoCI of £1.184 million. The net impact is a total impairment value of £4.1 million. Reversals of impairments reflect the increase in value of property where previous charges have been made to income and expenditure.

Note 7 Employee benefits

	Foundation Trust and Group	
	2016/17	2015/16
	Total	Total
	£000	£000
Salaries and wages	152,835	166,949
Social security costs	13,216	11,094
Employer's contributions to NHS pensions	17,646	19,433
Pension cost - other	-	49
Temporary staff (including agency)	23,627	24,590
Total gross staff costs	<u>207,324</u>	<u>222,115</u>
Recoveries in respect of seconded staff	-	-
Total staff costs	<u>207,324</u>	<u>222,115</u>
Of which		
Costs capitalised as part of assets	400	-

Note 7.1 Retirements due to ill-health

During 2016/17 there were 3 early retirements from the Trust agreed on the grounds of ill-health (8 in the year ended 31 March 2016). The estimated additional pension liabilities of these ill-health retirements is £243k (£521k in 2015/16).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 8 Pension costs

The Group offers an additional defined contribution workplace pension scheme, the National Employment Savings Scheme (NEST), to employees of both the Foundation Trust and its subsidiary, Stepping Hill Healthcare Limited. The Trust has paid £32k (£17k in 2015/2016) to NEST in employer contributions.

Note 9 Operating leases**Note 9.1 Stockport NHS Foundation Trust as a lessor**

This note discloses income generated in operating lease agreements where Stockport NHS Foundation Trust is the lessor.

Note 9.2 Stockport NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Stockport NHS Foundation Trust FT is the lessee.

	Foundation Trust and Group	
	2016/17	2015/16
	£000	£000
Operating lease expense		
Minimum lease payments	<u>2,518</u>	<u>3,435</u>
Total	<u>2,518</u>	<u>3,435</u>

Note 9.2 Stockport NHS Foundation Trust as a lessee continued

This note discloses costs and commitments incurred in operating lease arrangements where Stockport NHS Foundation Trust is the lessee.

	Foundation Trust and Group	
	31 March 2017 £000	31 March 2016 £000
Future minimum lease payments due:		
- not later than one year;	2,518	2,419
- later than one year and not later than five years;	139	139
- later than five years.	61	95
Total	<u>2,718</u>	<u>2,653</u>
Future minimum sublease payments to be received	-	-

In 2016/2017 the Trust has leasing arrangements for its community buildings with NHS Property Services Ltd for community services provided in the Stockport area. These leases are held in line with current commissioning contracts. It also has a lease arrangement for the Swanbourne Gardens Childrens Respite building. This is due to expire in January 2023.

Note 10 Finance income

Finance income represents interest received on assets and investments in the period.

	Group	
	2016/17 £000	2015/16 £000
Interest on bank accounts	66	94
Investment income on NHS charitable funds financial assets	50	55
Total	<u>116</u>	<u>149</u>

	Trust	
	2016/17	2015/16
Interest on bank accounts	66	94
Total	<u>66</u>	<u>94</u>

Note 11 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money and the unwinding of discount on injury benefit provisions.

	Foundation Trust and Group	
	2016/17 £000	2015/16 £000
Interest expense:		
Loans from the Department of Health	897	776
Main finance costs on PFI and LIFT schemes obligations	12	14
Unwinding of discount	30	34
Total interest expense	<u>939</u>	<u>824</u>

Note 11.2 The late payment of commercial debts (interest) Act 1998

The Trust and Group has no late payment of commercial debts to report in 2016/2017.

Note 12 Gains/losses on disposal/derecognition of non-current assets

	Group	
	2016/17	2015/16
	£000	£000
Profit on disposal of non-current assets	13	12
Loss on disposal of non-current assets	(89)	-
Gains/losses on disposal of non-current assets by NHS charitable funds	17	-
Net profit/(loss) on disposal of non-current assets	(59)	12

In 2016/2017 the Group Charity disposed of its CCLA Fixed Interest Interest Common Investment Fund with gain on disposal of £16,932.

	Trust	
	2016/17	2015/16
	£000	£000
Profit on disposal of non-current assets	13	12
Loss on disposal of non-current assets	(89)	-
Net profit/(loss) on disposal of non-current assets	(76)	12

In 2016/2017 the Trust has a loss on disposal of assets of £76,000 (profit of £12,000 in 2015/2016) comprising of cash proceeds of £14k offset by the write off of net book value of £90k. The cash proceeds relate to the trade in prices achieved for items of medical equipment, vehicles and fittings as they were replaced.

Note 13 Corporation Tax

The Trust had no corporation tax payable or receivable in 2016/2017 or 2015/2016.

The Group has consolidated the provisional financial results of its subsidiary, Stepping Hill Healthcare Enterprises Limited, and may have Corporation tax liability once assessment is concluded for its accounting period to the 31st March 2017.

Note 14 Discontinued operations

There were no discontinued operations during 2016/2017 or 2015/2016.

Note 15 Intangible assets - 2016/17

Foundation Trust and Group	Software licences £000	Other £000	Intangible assets under construction £000	Total £000
Valuation/gross cost at 1 April 2016 - brought forward	6,756	-	448	7,204
Additions - purchased	290	-	208	498
Additions - leased	414	-	1,006	1,420
Reclassifications	16	-	(16)	-
Gross cost at 31 March 2017	7,476	-	1,646	9,122
Amortisation at 1 April 2016 - brought forward	5,250	-	-	5,250
Provided during the year	498	-	-	498
Amortisation at 31 March 2017	5,748	-	-	5,748
Net book value at 31 March 2017	1,728	-	1,646	3,374
Net book value at 1 April 2016	1,506	-	448	1,954

In 2016/2017 the Trust entered into a capital contractual commitment for an electronic prescribing record system. It has made payments of £1,437,000 to date (£431,000 in 2015/2016) which has been recorded as an intangible asset under construction until completion of the scheme in 2017/2018.

Note 15.1 Intangible assets - 2015/16

Foundation Trust and Group	Software licences £000	Other £000	Intangible assets under construction £000	Total £000
Valuation/gross cost at 1 April 2015 - as previously stated	6,650	9	-	6,659
Additions - purchased	244	-	17	261
Additions - leased	-	-	431	431
Impairments	(11)	(9)	-	(20)
Disposals / derecognition	(127)	-	-	(127)
Valuation/gross cost at 31 March 2016	6,756	-	448	7,204
Amortisation at 1 April 2015 - as previously stated	4,907	9	-	4,916
Provided during the year	472	-	-	472
Impairments charged to operating expenses	(2)	(9)	-	(11)
Disposals / derecognition	(127)	-	-	(127)
Amortisation at 31 March 2016	5,250	-	-	5,250
Net book value at 31 March 2016	1,506	-	448	1,954
Net book value at 1 April 2015	1,743	-	-	1,743

Note 16.1 Property, plant and equipment - 2016/17

Group	Buildings excluding		Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	Land	dwelling							
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2016 - brought forward	17,386	112,240	1,869	12,705	40,823	199	12,715	861	198,798
Additions	-	4,115	(11)	1,405	2,317	35	306	161	8,328
Impairments	(6,300)	(17,189)	-	-	-	-	-	-	(23,489)
Reversals of impairments	-	351	20	2,107	-	-	-	-	2,478
Reclassifications	-	14,493	-	(14,812)	42	-	257	20	-
Revaluations	-	(2,250)	(9)	-	-	-	-	-	(2,259)
Transfers to/ from assets held for sale	(56)	-	(264)	-	-	-	-	-	(320)
Disposals / derecognition	-	-	-	-	(920)	(31)	(510)	(489)	(1,950)
Valuation/gross cost at 31 March 2017	11,030	111,760	1,605	1,405	42,262	203	12,768	553	181,586
Accumulated depreciation at 1 April 2016 - brought forward	-	-	-	-	29,412	124	9,879	784	40,199
Transfers by absorption	-	-	-	-	-	-	-	-	-
Provided during the year	-	3,654	49	-	2,598	18	1,146	33	7,498
Revaluations	-	(3,654)	(44)	-	-	-	-	-	(3,698)
Transfers to/ from assets held for sale	-	-	(5)	-	-	-	-	-	(5)
Disposals/ derecognition	-	-	-	-	(831)	(28)	(510)	(489)	(1,858)
Accumulated depreciation at 31 March 2017	-	-	-	-	31,179	114	10,515	328	42,136
Net book value at 31 March 2017	11,030	111,760	1,605	1,405	11,083	89	2,253	225	139,450
Net book value at 1 April 2016	17,386	112,240	1,869	12,705	11,411	75	2,836	77	158,599

Note 16.2 Property, plant and equipment - 2015/16

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2015 - as previously stated	17,386	109,466	1,989	5,206	38,730	207	13,401	1,821	188,206
Prior period adjustments	-	-	-	-	-	-	-	-	-
Valuation/gross cost at 1 April 2015 - restated	17,386	109,466	1,989	5,206	38,730	207	13,401	1,821	188,206
Transfers by absorption	-	-	-	-	-	-	-	-	-
Additions - purchased/ leased/ grants/ donations	-	1,546	167	10,265	3,610	18	485	27	16,118
Impairments	-	(681)	(249)	(2,107)	-	-	-	-	(3,037)
Reversals of impairments	-	2,542	-	-	-	-	-	-	2,542
Reclassifications	-	474	-	(659)	79	-	106	-	-
Revaluations	-	(1,107)	(38)	-	-	-	-	-	(1,145)
Transfers to/ from assets held for sale	-	-	-	-	-	-	-	-	-
Disposals / derecognition	-	-	-	-	(1,596)	(26)	(1,277)	(987)	(3,886)
Valuation/gross cost at 31 March 2016	17,386	112,240	1,869	12,705	40,823	199	12,715	861	198,798
Accumulated depreciation at 1 April 2015 - as previously stated	-	-	-	-	28,257	131	10,071	1,747	40,206
Provided during the year	-	4,288	63	-	2,677	19	1,086	24	8,157
Revaluations	-	(4,288)	(63)	-	-	-	-	-	(4,351)
Disposals / derecognition	-	-	-	-	(1,522)	(26)	(1,278)	(987)	(3,813)
Accumulated depreciation at 31 March 2016	-	-	-	-	29,412	124	9,879	784	40,199
Net book value at 31 March 2016	17,386	112,240	1,869	12,705	11,411	75	2,836	77	158,599
Net book value at 1 April 2015	17,386	109,466	1,989	5,206	10,473	76	3,330	74	148,000

Note 16.3 Property, plant and equipment financing - 2016/17

Group	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Net book value at 31 March 2017									
Owned	11,030	110,993	1,605	1,405	11,083	89	2,253	225	138,683
On-SoFP PFI contracts and other service concession arrangements	-	767	-	-	-	-	-	-	767
NBV total at 31 March 2017	11,030	111,760	1,605	1,405	11,083	89	2,253	225	139,450

Note 16.4 Property, plant and equipment financing - 2015/16

Group	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Net book value at 31 March 2016									
Owned	17,386	111,289	1,869	12,705	11,411	75	2,836	77	157,648
On-SoFP PFI contracts and other service concession arrangements	-	951	-	-	-	-	-	-	951
NBV total at 31 March 2016	17,386	112,240	1,869	12,705	11,411	75	2,836	77	158,599

Note 17.1 Property, plant and equipment - 2016/17

Trust	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2016 - brought forward	17,386	112,240	1,869	12,705	40,823	199	12,715	861	198,798
Additions - purchased	-	4,106	(3)	1,405	1,575	35	306	161	7,585
Additions - assets purchased from cash donations/grants	-	9	(8)	-	742	-	-	-	743
Impairments	(6,300)	(17,189)	-	-	-	-	-	-	(23,489)
Reversals of impairments	-	351	20	2,107	-	-	-	-	2,478
Reclassifications	-	14,493	-	(14,812)	42	-	257	20	-
Revaluations	-	(2,250)	(9)	-	-	-	-	-	(2,259)
Transfers to/ from assets held for sale	(56)	-	(264)	-	-	-	-	-	(320)
Disposals / derecognition	-	-	-	-	(920)	(31)	(510)	(489)	(1,950)
Valuation/gross cost at 31 March 2017	11,030	111,760	1,605	1,405	42,262	203	12,768	553	181,586
Accumulated depreciation at 1 April 2016 - brought forward	-	-	-	-	29,412	124	9,879	784	40,199
Transfers by absorption	-	-	-	-	-	-	-	-	-
Provided during the year	-	3,654	49	-	2,598	18	1,146	33	7,498
Revaluations	-	(3,654)	(44)	-	-	-	-	-	(3,698)
Transfers to/ from assets held for sale	-	-	(5)	-	-	-	-	-	(5)
Disposals/ derecognition	-	-	-	-	(831)	(28)	(510)	(489)	(1,858)
Accumulated depreciation at 31 March 2017	-	-	-	-	31,179	114	10,515	328	42,136
Net book value at 31 March 2017	11,030	111,760	1,605	1,405	11,083	89	2,253	225	139,450
Net book value at 1 April 2016	17,386	112,240	1,869	12,705	11,411	75	2,836	77	158,599

Note 17.2 Property, plant and equipment - 2015/16 Trust	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2015 - as previously stated	17,386	109,466	1,989	5,206	38,730	207	13,401	1,821	188,206
Additions - purchased/ leased/ grants/ donations	-	1,546	167	10,265	3,610	18	485	27	16,118
Impairments	-	(681)	(249)	(2,107)	-	-	-	-	(3,037)
Reversals of impairments	-	2,542	-	-	-	-	-	-	2,542
Reclassifications	-	474	-	(659)	79	-	106	-	-
Revaluations	-	(1,107)	(38)	-	-	-	-	-	(1,145)
Disposals / derecognition	-	-	-	-	(1,596)	(26)	(1,277)	(987)	(3,886)
Valuation/gross cost at 31 March 2016	17,386	112,240	1,869	12,705	40,823	199	12,715	861	198,798
Accumulated depreciation at 1 April 2015 - as previously stated	-	-	-	-	28,257	131	10,071	1,747	40,206
Provided during the year	-	4,288	63	-	2,677	19	1,086	24	8,157
Revaluations	-	(4,288)	(63)	-	-	-	-	-	(4,351)
Disposals / derecognition	-	-	-	-	(1,522)	(26)	(1,278)	(987)	(3,813)
Accumulated depreciation at 31 March 2016	-	-	-	-	29,412	124	9,879	784	40,199
Net book value at 31 March 2016	17,386	112,240	1,869	12,705	11,411	75	2,836	77	158,599
Net book value at 1 April 2015	17,386	109,466	1,989	5,206	10,473	76	3,330	74	148,000

Note 17.3 Property, plant and equipment financing - 2016/17

Trust	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Net book value at 31 March 2017									
Owned	11,030	110,558	1,554	1,405	9,981	89	2,253	225	137,095
On-SoFP PFI contracts and other service concession arrangements	-	767	-	-	-	-	-	-	767
Donated	-	435	51	-	1,102	-	-	-	1,588
NBV total at 31 March 2017	11,030	111,760	1,605	1,405	11,083	89	2,253	225	139,450

Note 17.4 Property, plant and equipment financing - 2015/16

Trust	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Net book value at 31 March 2016									
Owned	17,386	110,571	1,808	12,705	10,955	75	2,836	77	156,413
On-SoFP PFI contracts and other service concession arrangements	-	951	-	-	-	-	-	-	951
Donated	-	718	61	-	456	-	-	-	1,235
NBV total at 31 March 2016	17,386	112,240	1,869	12,705	11,411	75	2,836	77	158,599

Note 18 Donations of property, plant and equipment

In 2016/2017 the Trust received income of £743,000 (2015/2016 £509,000) from its charitable funds to purchase capital assets. These include £648,000 on medical equipment for the new Surgical and Medical theatres, £49,250 for a new Fibroscanner, £12,000 on a Podiatry mill and £11,578 on a Scalp Cooling system and £12,000 for a Neoprobe system in the Bobby Moore Unit.

Note 19 Revaluations of property, plant and equipment

In 2016/2017 the Trust undertook a full valuation of land and buildings by the District Valuer. The valuation has been undertaken at both the 1st April 2016 and the 31st March 2017. In contrast to previous valuations this valuation was prepared on an alternative site basis. The valuation was based on land on its existing site but on a much smaller footprint and buildings based on a Modern Equivalent Basis.

The impact of the revaluation was to reduce the value of land and buildings within the Trust's financial statements by £20.8 million, with £15.5 million being charged to the revaluation reserve and the remaining £5.3 million charged to the Statement of Comprehensive Income. Other movements in the reserve relate to the final valuation of the Surgical and Medical Centre and a net reversal of £100k and a transfer to asset held for sale of two residential properties.

Revaluation Reserve Movements	Foundation Trust and Group		
	Property, Plant and Equipment	Assets Held for Sale	Total Revaluation Reserve
	£000		£000
At 1 April 2016	56,485	-	56,485
Revaluations	1,439	-	1,439
Impairment	(16,859)		(16,859)
Other reserve movements	(344)	344	-
At 31 March 2017	40,721	344	41,065
At 1 April 2015	54,168	-	54,168
Revaluations	3,206	-	3,206
Impairment	(891)	-	(891)
Other reserve movements	2	-	2
At 31 March 2016	56,485	-	56,485

Note 20 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. Average relevant assets are calculated as £94.8 million (£112.9 million in 2015/2016) giving a public dividend capital dividend of £3.3 million (£3.9 million in 2015/16).

Note 21 Investments - 2016/17

Group	NHS Charitable Funds: Other investments	
	31 March 2017	31 March 2016
	£000	£000
Carrying value at 1 April 2016	1,289	1,340
Disposals	(236)	
Movement in fair value	160	(51)
Carrying value at 31 March 2017	1,213	1,289

For the Consolidated Group the Charity held investments in fixed interest and equity common investment funds. In 2016/2017 the Group reported £50,000 (£55,000 in 2015/2016) in interest receivable on these investments and a gain on valuation of £160,000 at the 31st March 2017. In 2016/2017 the Charity disposed of its holding in the fixed interest fund.

Note 22 Analysis of charitable fund reserves

The Trust has consolidated its charitable fund, Stockport NHS Foundation Trust General Fund - Charity Commission Number Registration Number 1048661, within the Group Accounts 2016/2017.

	31 March 2017 £000	31 March 2016 £000
Unrestricted funds:		
Unrestricted income funds	241	219
Restricted funds:		
Restricted income funds	1,455	1,913
Permanent endowment funds	10	10
	<u>1,706</u>	<u>2,142</u>

Unrestricted income funds are accumulated income funds that are expendable at the discretion of the trustees in furtherance of the Charity's objects. Unrestricted funds may be earmarked or designated for specific future purposes which reduces the amount that is readily available to the charity.

Restricted funds are accumulated income funds which are expendable at the Trustee's discretion only in furtherance of the specified conditions of the donor and the objects of the Charity. For Stockport NHS Foundation General Fund these funds relate to specified business groups and departments at the Trust. There is one permanent endowment fund where the monies are retained for use rather than expended.

Note 23 Inventories

	Group		Trust	
	31 March 2017 £000	31 March 2016 £000	31 March 2017 £000	31 March 2016 £000
Drugs	561	656	356	445
Consumables	928	1,228	928	1,228
Energy	85	78	85	78
Total inventories	<u>1,574</u>	<u>1,962</u>	<u>1,369</u>	<u>1,751</u>

Inventories recognised in expenses for the year were £19,394k (2015/16: £19,611k). Write-down of inventories recognised as expenses for the year were £0k (2015/16: £0k).

Inventories for the Group included £205k (£211k in 2015/16) drugs for Stepping Hill Enterprises Healthcare Limited (the Pharmacy Shop).

Note 24 Trade receivables and other receivables

	Group		Trust	
	31 March 2017 £000	31 March 2016 £000	31 March 2017 £000	31 March 2016 £000
Current				
Trade receivables due from NHS bodies	4,199	4,151	4,199	4,151
Receivables due from NHS charities	-	-	432	848
Other receivables due from related parties	1,009	448	1,009	448
Provision for impaired receivables	(1,191)	(874)	(1,191)	(874)
Prepayments (non-PFI)	791	1,131	791	1,131
Accrued income	5,972	1,349	5,972	1,349
Interest receivable	4	7	4	7
PDC dividend receivable	837	60	837	60
VAT receivable	851	1,057	851	1,057
Other receivables	4,027	3,844	4,614	4,527
Trade and other receivables held by NHS charitable funds	46	45	-	-
Total current trade and other receivables	16,545	11,218	17,518	12,704
Non-current				
Provision for impaired receivables	(168)	(180)	(168)	(180)
Prepayments (non-PFI)	217	62	217	62
Other receivables	733	821	733	821
Total non-current trade and other receivables	782	703	782	703

Consolidation adjustments within the Group have removed the £432k Trust Receivable from its charitable fund subsidiary to settle its grants expensed in 2016/2017 (£848k in 2015/2016).

Consolidation adjustment within the Group have removed intra group receivables between the Trust and its subsidiary Stepping Hill Healthcare Enterprise Limited. The Group Accounts includes £143k receivables for its Pharmacy Shop subsidiary; £141k of this being due from HMRC (£137k in 2015/2016).

Note 24.1 Provision for impairment of receivables

	Group		Trust	
	2016/17	2015/16	2016/17	2015/16
	£000	£000	£000	£000
At 1 April as previously stated	1,054	1,014	1,054	1,014
Increase in provision	498	327	498	327
Amounts utilised	(165)	(146)	(165)	(146)
Unused amounts reversed	(28)	(141)	(28)	(141)
At 31 March	1,359	1,054	1,359	1,054

The Trust provision for impaired receivables includes £738k for the NHS Injury Scheme using the nationally recommended percentage rate of write down of such debts. Other impaired receivables have been reviewed on an individual basis which includes consideration of information from its debt recovery service.

There are no provisions for impaired receivables held by the Trust Charity or Stepping Hill Healthcare Enterprises Ltd.

Note 24.2 Analysis of financial assets

Group	31 March 2017		31 March 2016	
	Trade and other receivables	Investments & Other financial assets	Trade and other receivables	Investments & Other financial assets
	£000	£000	£000	£000
Ageing of impaired financial assets				
0 - 30 days	183	-	2	-
30-60 Days	2	-	2	-
60-90 days	30	-	1	-
90- 180 days	1	-	31	-
Over 180 days	308	-	280	-
Total	524	-	316	-
Ageing of non-impaired financial assets past their due date				
0 - 30 days	11,637	1,213	5,625	1,289
30-60 Days	591	-	1,511	-
60-90 days	761	-	560	-
90- 180 days	566	-	558	-
Over 180 days	482	-	701	-
Total	14,037	1,213	8,955	1,289

Trust	31 March 2017		31 March 2016	
	Trade and other receivables	Investments & Other financial assets	Trade and other receivables	Investments & Other financial assets
	£000	£000	£000	£000
Ageing of impaired financial assets				
0 - 30 days	183	-	2	-
30-60 Days	2	-	2	-
60-90 days	30	-	1	-
90- 180 days	1	-	31	-
Over 180 days	308	-	280	-
Total	524	-	316	-
Ageing of non-impaired financial assets past their due date				
0 - 30 days	12,657	-	6,580	-
30-60 Days	591	-	1,511	-
60-90 days	761	-	560	-
90- 180 days	566	-	558	-
Over 180 days	436	-	701	-
Total	15,011	-	9,910	-

The Group has other investments held by its Charity with CCLA Investment Management Ltd. These assets are held to earn a return on its investment until disposal is requested by the Corporate Trustee.

The Trust non-impaired receivables under 30 days includes charitable funds receivables of £432k and receivables from Stepping Hill Enterprises Healthcare Limited of £454k.

As per updated DH Accounting Manual guidance the prior year Impaired (£738k) and non impaired financial assets (£3,357k) past their due date do not include receivables for the total value of NHS Injury Scheme receivables for which the Trust is awaiting the settlement of compensation claims.

Note 25 Non-current assets for sale and assets in disposal groups

Foundation Trust and Group	2016/17		2015/16	
	Land £000	Property, plant & £000	Total £000	Total £000
NBV of non-current assets for sale and assets in disposal groups at 1 April	-	-	-	-
Plus assets classified as available for sale in the year	56	259	315	-
NBV of non-current assets for sale and assets in disposal groups at 31 March	56	259	315	-

In August 2016 the Trust put on the market for sale two residential properties as part of the financial improvement programme in 2016/2017. The expected disposal period is in the following financial year 2017/2018. The value of land and buildings of these properties is detailed in the note above. There were no assets held for sale in 2015/2016.

Note 26.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	Group		Trust	
	2016/17 £000	2015/16 £000	2016/17 £000	2015/16 £000
At 1 April	33,124	45,669	31,398	44,607
Net change in year	(8,447)	(12,545)	(7,672)	(13,209)
At 31 March	24,677	33,124	23,726	31,398
Broken down into:				
Cash at commercial banks and in hand	1,324	1,773	445	117
Cash with the Government Banking Service	23,281	31,281	23,281	31,281
Other current investments	72	70	-	-
Total cash and cash equivalents as in SoFP	24,677	33,124	23,726	31,398
Total cash and cash equivalents as in SoCF	24,677	33,124	23,726	31,398

Analysis of Group Cash and Cash Equivalents

	2016/17 £000	2015/16 £000
Stockport NHS Foundation Trust	23,726	31,398
Stockport NHS Foundation Trust Charitable Funds	879	1656
Stepping Hill Healthcare Enterprises Limited	72	70
	24,677	33,124

Note 26.2 Third party assets held by Stockport NHS Foundation trust

Stockport NHS Foundation Trust held no cash or cash equivalents which relate to monies held by patients or other parties. It does, if requested, retain patient monies and belongings in sealed pouches for the duration of the individual's stay.

Note 27.1 Trade and other payables

	Group		Trust	
	31 March 2017 £000	31 March 2016 £000	31 March 2017 £000	31 March 2016 £000
Current				
NHS trade payables	1,043	4,232	1,043	4,232
Amounts due to other related parties	2,574	2,914	2,576	2,914
Other trade payables	4,283	4,752	4,281	4,752
Capital payables	1,271	2,822	1,271	2,822
Social security costs	1,951	1,762	1,951	1,762
Other taxes payable	1,603	1,727	1,603	1,727
Other payables	178	239	178	239
Accruals	13,380	10,149	13,587	10,321
Total current trade and other payables	26,283	28,597	26,490	28,769

Included in the figure for 'Amounts due to related parties' is £2.4 million outstanding pension contributions at 31 March 2017 (31 March 2016 £2.7 million), which have been settled in April 2016 in accordance with the NHS Pensions payment dates.

Consolidation adjustments by the Group have removed payables between the Trust, Charitable Fund and the Stepping Hill Healthcare Enterprises Limited subsidiaries.

The Trust and Group have no amounts in Trade payables to buy out the liability for early retirements.

Note 28 Other liabilities

	Group		Trust	
	31 March 2017 £000	31 March 2016 £000	31 March 2017 £000	31 March 2016 £000
Current				
Other deferred income	960	1,215	960	1,215
Total other current liabilities	960	1,215	960	1,215
Non-current				
Other deferred income	416	570	416	570
Total other non-current liabilities	416	570	416	570

Note 29 Borrowings

	Group		Trust	
	31 March 2017	31 March 2016	31 March 2017	31 March 2016
	£000	£000	£000	£000
Current				
Loans from the Department of Health	1,551	1,431	1,551	1,431
Obligations under finance leases	68	-	68	-
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	28	27	28	27
Total current borrowings	1,647	1,458	1,647	1,458
Non-current				
Loans from the Department of Health	24,634	23,246	24,634	23,246
Obligations under finance leases	202	-	202	-
Obligations under PFI, LIFT or other service concession contracts	354	382	354	382
Total non-current borrowings	25,190	23,628	25,190	23,628

In 2016/2017 the Trust received an additional loan of £3 million towards the construction of the new Surgical Centre. The Trust now has four individual loans with the Independent Trust Financing Facility; all having being received for capital purposes.

Note 30 Finance leases**Note 30.1 Stockport NHS Foundation Trust as a lessor**

The Trust had no future lease receipts due under finance lease agreements where Stockport NHS Foundation Trust is the lessor:

Note 30.2 Stockport NHS Foundation Trust as a lessee

Obligations under finance leases where Stockport NHS Foundation Trust is the lessee.

	Group		Trust	
	2016/17	2015/16	2016/17	2015/16
	£000	£000	£000	£000
Gross lease liabilities	270	-	270	-
of which liabilities are due:				
- not later than one year;	68	-	68	-
- later than one year and not later than five years;	202	-	202	-
Net lease liabilities	270	-	270	-
of which payable:				
- not later than one year;	68	-	68	-
- later than one year and not later than five years;	202	-	202	-

In 2016/2017 the Trust entered into an agreement to provide an electronic patients records system for its Community Services business group for a five year period. Costs relating to software have been capitalised as a finance lease on deployment.

Note 31.1 Provisions for liabilities and charges analysis

Foundation Trust and Group	Current 2016/17	Current 2015/16	Non - Current 2016/17	Non - Current 2015/16
Pensions relating to other staff	163	163	2,259	2,149
Other legal claims	112	110	-	-
Restructurings	142	1,345	-	-
Redundancy	3,317	205	-	-
Other	1,338	1,248	-	-
Total	5,072	3,071	2,259	2,149

Foundation Trust and Group	Pensions - early departure costs £000	Other legal claims £000	Re- structurings £000	Redundancy £000	Other £000	Total £000
At 1 April 2016	2,312	110	1,345	205	1,248	5,220
Change in the discount rate	241	-	-	-	-	241
Arising during the year	-	127	135	3,318	856	4,436
Utilised during the year	(161)	(70)	(227)	-	-	(458)
Reversed unused	-	(55)	(1,111)	(206)	(766)	(2,138)
Unwinding of discount	30	-	-	-	-	30
At 31 March 2017	2,422	112	142	3,317	1,338	7,331
Expected timing of cash flows:						
- not later than one year;	163	112	142	3,317	1,338	5,072
- later than one year and not later than five years;	645	-	-	-	-	645
- later than five years.	1,614	-	-	-	-	1,614
Total	2,422	112	142	3,317	1,338	7,331

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.

The provisions for 'Restructurings' and 'Redundancy' include costs associated with the workforce elements of the Trust's future plans. Examples of this include the provision for protected pay following service restructuring and other staff exit costs. It has also provided for the future costs of service restructuring for Stockport Together.

Within other provisions the Trust has provided for costs for legal costs and provisions for at risk income for penalties from commissioners.

Note 31.2 Clinical negligence liabilities

At 31 March 2017, £113,107k was included in provisions of the NHSLA in respect of clinical negligence liabilities of Stockport NHS Foundation Trust (31 March 2016: £87,475k).

Note 32 Contingent assets and liabilities

	Group		Trust	
	31 March 2017 £000	31 March 2016 £000	31 March 2017 £000	31 March 2016 £000
Value of contingent liabilities				
NHS Litigation Authority legal claims	(107)	(68)	(107)	(68)
Gross value of contingent liabilities	(107)	(68)	(107)	(68)
Amounts recoverable against liabilities	-	-	-	-
Net value of contingent liabilities	(107)	(68)	(107)	(68)
Net value of contingent assets				

The above contingent liability is the liability related to the Liability to Third Parties Schemes and Public and Employer Liability (PES) and is supplied by the NHS Litigation Authority along with its associated provision at Note 31.1.

Note 33 Contractual capital commitments

	Group		Trust	
	31 March 2017 £000	31 March 2016 £000	31 March 2017 £000	31 March 2016 £000
Property, plant and equipment	617	3,244	617	3,244
Intangible assets	5,781	7,026	5,781	7,026
Total	6,398	10,270	6,398	10,270

The Trust signed a contract in December 2015 for the provision of an Electronic Patients Record system with Intersystems Corporation. This is for a period of ten years from an effective date of the 1st June 2016 and is expected to be completed in 2017/2018. Capital commitments included within this contract are £5.8 million. The Trust has made payments to date of £1,437,000. This is shown in the accounts within the intangible asset under construction total.

Commitments arising from this contract are as follow:

	Trust £000
Software	7,000
Support and maintenance	10,200
Finance Charges	1,000
	18,200

Note 34 Defined benefit pension schemes

Neither the Trust nor the Group held any on-Statement of Financial Position Defined Benefit Pension Schemes during 2016/17 or 2015/2016.

Note 35 On-SoFP PFI, LIFT or other service concession arrangements

Under IFRIC 12 the Trust recognises a service concession arrangement with Alliance Medical for the provision of a building to perform MRI scanning services.

Note 35.1 Imputed finance lease obligations

The Trust has the following obligations in respect of the finance lease element of on-Statement of Financial Position PFI and LIFT schemes:

	Group		Trust	
	31 March 2017 £000	31 March 2016 £000	31 March 2017 £000	31 March 2016 £000
Gross PFI, LIFT or other service concession liabilities	463	503	463	503
Of which liabilities are due				
- not later than one year;	40	40	40	40
- later than one year and not later than five years;	161	161	161	161
- later than five years.	262	302	262	302
Finance charges allocated to future periods	(81)	(94)	(81)	(94)
Net PFI, LIFT or other service concession arrangement obligation	382	409	382	409
- not later than one year;	28	27	28	27
- later than one year and not later than five years;	121	118	121	118
- later than five years.	233	264	233	264

Note 35.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

The Trust's total future obligations under these on-SoFP schemes are as follows:

	Group		Trust	
	31 March 2017 £000	31 March 2016 £000	31 March 2017 £000	31 March 2016 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	14,544	16,978	14,544	16,978
Of which liabilities are due				
- not later than one year;	1,212	1,306	1,212	1,306
- later than one year and not later than five years;	4,848	5,224	4,848	5,224
- later than five years.	8,484	10,448	8,484	10,448

Note 35.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the Trust's payments in 2016/17:

	Group		Trust	
	31 March 2017 £000	31 March 2016 £000	31 March 2017 £000	31 March 2016 £000
Unitary payment payable to service concession operator	1,183	901	1,183	901
Consisting of:				
- Interest charge	12	14	12	14
- Repayment of finance lease liability	28	27	28	27
- Service element and other charges to operating expenditure	1,143	860	1,143	860
Total amount paid to service concession operator	1,183	901	1,183	901

Note 36 Financial instruments**Note 36.1 Financial risk management**

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. For the Group the Charity does hold investments and is, therefore, exposed to a degree of financial risk. This risk is carefully managed by pursuing a low risk investment strategy. The Charity holds its investments within common investment funds with a market leader provider of Charity Investments, CCLA Management Ltd.

The Trust's treasury management operations are carried out by the Finance department, within parameters defined formally within the Trust's Standing Financial Instructions and policies agreed by the Board of Directors. Similar treasury management for the Trust Charity and subsidiary, Stepping Hill Healthcare Enterprises Ltd, are also carried out by the Finance department. All treasury activity is subject to review by Internal Audit.

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 2015/16 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 2017 the Trust's cash balances were held solely in its Government Banking Services bank accounts and Barclays current accounts as per note 26 Stockport NHS Foundation Trust is, therefore, not exposed to significant liquidity risk.

Market and Interest Rate Risk

At the 31 March 2017 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 the Royal Bank of Scotland. 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 £1.7 million for longer term investment with CCLA Investment Management Ltd. It holds one common investment fund in equity funds of £1.2 million and one cash deposit account holding £0.5 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.

Stepping Hill Healthcare Enterprises Limited

The Group accounts include the financial statements of its trading subsidiary, Stepping Hill Healthcare Enterprises Limited. The subsidiary holds its cash with the Trust commercial banker, Barclays PLC, in a separate bank account. Its income is predominantly with the parent and it currently purchases drugs for its dispensing services using the Trust Pharmacy as its wholesale supplier. It is not considered, therefore, to have market or liquidity risks.

Note 36.2 Financial assets

Group	Loans and receivables	Total	Loans and receivables	Total
	31 March 2017 £000	31 March 2017 £000	31 March 2016 £000	31 March 2016 £000
Assets as per SoFP as at 31 March				
Trade and other receivables excluding non financial assets	12,368	12,368	7,591	7,591
Cash and cash equivalents at bank and in hand	23,798	23,798	31,468	31,468
Financial assets held in NHS charitable funds	2,138	2,138	2,991	2,991
Total at 31 March	38,304	38,304	42,050	42,050

Trust	Loans and receivables	Total	Loans and receivables	Total
	31 March 2017 £000	31 March 2017 £000	31 March 2016 £000	31 March 2016 £000
Assets as per SoFP as at 31 March				
Trade and other receivables excluding non financial assets	12,799	12,799	8,478	8,478
Cash and cash equivalents at bank and in hand	23,726	23,726	31,398	31,398
Total at 31 March	36,525	36,525	39,876	39,876

Prior year figures for trade and receivables no longer include receivables of £2.679 million as a financial instrument from the Injury Recovery Scheme as they arise under legislation and not contract.

Note 36.3 Financial liabilities

Group	Other financial liabilities £000	Total £000
Liabilities as per SoFP as at 31 March 2017		
Borrowings excluding finance lease and PFI liabilities	26,185	26,185
Obligations under finance leases	270	270
Obligations under PFI, LIFT and other service concession contracts	382	382
Trade and other payables excluding non financial liabilities	21,969	21,969
Provisions under contract	961	961
Total at 31 March 2017	49,767	49,767

Group	Other financial liabilities £000	Total £000
Liabilities as per SoFP as at 31 March 2016		
Borrowings excluding finance lease and PFI liabilities	24,677	24,677
Obligations under PFI, LIFT and other service concession contracts	409	409
Trade and other payables excluding non financial liabilities	25,108	25,108
Provisions under contract	818	818
Total at 31 March 2016	51,012	51,012

Trust	Other financial liabilities £000	Total £000
Liabilities as per SoFP as at 31 March 2017		
Borrowings excluding finance lease and PFI liabilities	26,185	26,185
Obligations under finance leases	270	270
Obligations under PFI, LIFT and other service concession contracts	382	382
Trade and other payables excluding non financial liabilities	22,936	22,936
Provisions under contract	961	961
Total at 31 March 2017	50,734	50,734

Trust	Other financial liabilities £000	Total £000
Liabilities as per SoFP as at 31 March 2016		
Borrowings excluding finance lease and PFI liabilities	24,677	24,677
Obligations under PFI, LIFT and other service concession contracts	409	409
Trade and other payables excluding non financial liabilities	25,280	25,280
Provisions under contract	818	818
Total at 31 March 2016	51,184	51,184

Prior year figures for provisions under contracts no longer include the provision for injury benefits of £2.312 million which is provided under legislation rather than contract. This is a change to note 36.3 Liabilities and note. 36.4 Maturity of Liabilities.

Note 36.4 Maturity of financial liabilities

	Group		Trust	
	31 March 2017	31 March 2016	31 March 2017	31 March 2016
	£000	£000	£000	£000
In one year or less	25,132	27,384	26,099	27,556
In more than one year but not more than two years	1,551	1,431	1,551	1,431
In more than two years but not more than five years	6,204	4,411	6,204	4,411
In more than five years	16,880	17,786	16,880	17,786
Total	49,767	51,012	50,734	51,184

Note 36.5 Fair values of financial assets at 31 March 2017

	Group		Trust	
	Book value	Fair value	Book value	Fair value
	£000	£000	£000	£000
Non-current trade and other receivables excluding non financial assets	565	565	565	565
Non-current financial assets held in NHS charitable funds	1,175	1,213	-	-
Total	1,740	1,778	565	565

Note 36.6 Fair values of financial liabilities at 31 March 2017

	Foundation Trust and Group	
	Book value	Fair value
	£000	£000
Loans	24,634	24,634
Total	24,634	24,634

Note 37 Losses and special payments

	2016/17		2015/16	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses: overpayment of salaries	43	22	6	3
Bad debts and claims abandoned	138	150	20	5
Total losses	181	172	26	8
Special payments				
Ex-gratia payments	36	108	32	14
Total special payments	36	108	32	14
Total losses and special payments	217	280	58	23

In 2016/2017 there were 181 cases of bad debts abandoned and approved at Audit Committee. The majority related to overseas visitors, private patients and overpayment of salaries to staff who no longer work for the Trust. From April 2017 new guidelines are to be implemented in relation to the recovery of overseas visitor debt. The Trust continues to monitor overpayments of salary at business group level each month. Other ex gratia payments include the reimbursement of patients effects and negotiated legal settlements.

Note 38 Gifts

Neither the Trust or Group made gifts of any value in 2016/2017 or 2015/2016

Note 39 Transfers by absorption

On the 1st April 2016 the Trust transferred its community services to Tameside Integrated Care NHS Foundation Trust. However, as no assets or liabilities were transferred and no exchange of cash received this has not required transfer by absorption accounting.

Note 40 Prior period adjustments

The Trust or Group made no prior period adjustments in 2016/2017 or 2015/2016.

Note 41 Events after the reporting date

The Trust has no events to report after the 31st March 2017.

Note 42 Related parties

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. The Department of Health is the parent body of all Foundation Trusts.

The Trust has 26 members of the Council of Governors; 24 representing public and staff and a further 2 appointed by partner organisations. None of the Council of Governors or parties related to them has undertaken any material transactions with Stockport NHS Foundation Trust.

During the year none of the permanent 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. In 2016/2017 the Trust engaged KPMG to provide support to the Trust as part of a Financial Improvement Programme designed by NHS Improvement. As part of this programme a Turnaround Director, Andrew Burn, was appointed on secondment as a non-voting member of the Board of Directors. The full cost of the consultancy support from KPMG is declared below in the table of significant related parties.

The Trust and Group's related parties include all Whole of Government bodies as defined by the Treasury of whom it's key transactions are with the following bodies:

Note 42.1 Related parties - Key Bodies

	Receivables		Payables	
	31 March 2017 £000	31 March 2016 £000	31 March 2017 £000	31 March 2016 £000
Stockport CCG	55	-	(4)	(500)
North Derbyshire CCG	206	82	-	-
Eastern Cheshire CCG	-	471	(65)	-
Tameside & Glossop CCG	-	173	(193)	(479)
NHS England	7,086	218	(3)	(200)
Stockport MBC	969	390	(163)	(246)
Total	8,316	1,334	(428)	(1,425)

	Income		Expenditure	
	31 March 2017 £000	31 March 2016 £000	31 March 2017 £000	31 March 2016 £000
Stockport CCG	178,038	165,966	(8)	(69)
North Derbyshire CCG	23,004	21,950	-	-
Eastern Cheshire CCG	13,418	11,438	-	-
Tameside & Glossop CCG	11,968	35,984	(84)	(1,596)
Stockport MBC	11,343	10,221	(331)	(200)
NHS England	25,258	15,731	(3)	(387)
NHS Litigation Authority (NHSLA)	-	-	(8,812)	(8,054)
Health Education England	7,930	7,942	-	(5)
	270,959	269,232	(9,238)	(10,311)

KPMG	(3,228)
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Note 43 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 Charities SORP 2015 and FRS 102 before consolidation adjustments and are due for submission to the Charity Commission by the 31st January 2018. The following Statement of Financial Activities and Balance Sheet for 2016/2017 are estimated at the 31st March 2017 to be consolidated into Group numbers.

Note 43.1 Stockport NHS Charitable Fund Statement of Financial Activities for the year ended 31st March 2017

	2016/17 £000	2015/16 £000
Incoming Resources	387	297
Sub-total voluntary income	387	297
Investment Income	50	55
Total incoming resources	437	352
Resources Expended	(1,055)	(848)
Total resources expended	(1,055)	(848)
Realised Gains on disposal of assets	17	-
Net (outgoing)/incoming resources before other recognised gains and losses	(601)	(496)
Unrealised Gains on investments assets	165	(51)
Net Movement in Funds	(436)	(547)

The Charity has accrued a £42,000 legacy (£42,000 in 2015/2016) which it is due to receive in 2016/2017.

Note 44 Stockport NHS Charitable Funds Balance Sheet at the 31st March 2017**Balance Sheet for the year ended 31 March 2017**

	31st March 2017 £000	31st March 2016 £000
Fixed Assets		
Investments	1,213	1,289
Total Fixed Assets	<u>1,213</u>	<u>1,289</u>
Current Assets		
Debtors	46	46
Short term investments and deposits	536	937
Cast at bank and in hand	343	719
Total Current Assets	<u>925</u>	<u>1702</u>
Creditors falling due within one year	(432)	(849)
Total Net Assets	<u>1,706</u>	<u>2,142</u>
Funds of the Charity		
Endowment Fund	10	10
Unrestricted Fund	241	219
Restricted Fund	1,455	1,913
Total Funds	<u>1,706</u>	<u>2,142</u>

Note 45 Disclosure of Interests in other entities**Note 45.1 Stepping Hill Healthcare Enterprises Limited**

On the 16th September 2014 the Trust formally registered its subsidiary company, Stepping Hill Healthcare Enterprises Limited. The subsidiary started trading in October 2014 in newly refurbished premises and trades under the name 'The Pharmacy Shop.' It provides an improved service to the Trust's patients by dispensing outpatient prescriptions faster than previously with improved advice. In addition it provides retail Pharmacy drugs and goods to the staff, patients and visitors to Stockport NHS Foundation Trust.

The subsidiary company's accounting period end is twelve months to the 31st March 2017 of which twelve months for 2016/2017 are consolidated in line with the accounting period of the Trust and its other subsidiary, Stockport NHS Foundation Trust General Fund. The Group Financial Statements have been prepared with estimated financial results for Stepping Hill Healthcare Enterprises Limited.

Profit and Loss Account for the year ended 31st March 2017	31st March 2017	31st March 2016
	£000	£000
Operating Income	3,312	2,837
Operating expenses	(3,184)	(2,844)
Operating Deficit	128	(7)

Statement of Financial Position for the year ended 31 March 2017	31st March 2017	31st March 2016
	£000	£000
Current Assets		
Inventories	205	211
Receivables	381	373
Cast at bank and in hand	72	70
Total Current Assets	658	654
Creditors falling due within one year	(762)	(808)
Total assets less current liabilities	(104)	(154)
Non-current liabilities		
Other liabilities	-	(76)
Total assets employed	(104)	(230)
Reserves	-	-
Income and Expenditure Reserve	(104)	(230)
	(104)	(230)

