Greater Manchester
Mental Health
NHS Foundation Trust

Annual Report 2019-20

Greater Manchester Mental Health
NHS Foundation Trust

Improving Lives

Greater Manchester Mental Health NHS Foundation Trust

Annual Report 2019-20

Presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a)
of the National Health Service Act 2006

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Performance Report

Message from the Chair and Chief Executive

Welcome to our Annual Report for the year ended 31 March 2020. Each year our Annual Report provides opportunity to reflect on our achievements over the last twelve months and to also look towards the future.

Our Response to the Coronavirus (COVID-19) Pandemic

When work began on this Annual Report, the scale of the challenge about to face us all as a result of the coronavirus (COVID-19) pandemic was unclear. We could not have anticipated the speed and way in which our national life was about to transform. We are immensely proud of our organisational response to the crisis. We have worked together as one team to find and implement solutions at a relentless pace, taking decisions (big and small) that would previously have seemed inconceivable. Our frontline clinical teams and corporate support services have adapted quickly, going the extra mile to ensure that we continue to safely meet service users' needs. Examples include:

- The introduction of a 24/7 helpline for all our service users and carers early in the crisis, staffed by mental health practitioners and offering life-saving support to vulnerable adults and young people in our community
- Our IAPT (Improving Access to Psychological Therapies) services and other community services, including substance misuse services, adopting digital solutions to provide care and treatment
- Provision of on-site and on-call mental health liaison psychiatry services to the North West NHS Nightingale Hospital
- Provision of psychosocial support for all staff working at the Nightingale Hospital and in critical care teams as part of the Greater Manchester Resilience Hub
- Mobilisation of Mental Health Urgent Care Centres at our inpatient units in Bolton, Salford and Manchester, providing a much-needed alternative to A&E in those areas
- Implementation of a range of COVID-19 care bundles including those relating to end of life care, community care and overall holistic health care
- Providing increased access to RADAR (Rapid Access Detoxification Acute Referral) beds at out Chapman Barker Unit for inpatient detoxification

Our back-office teams have also stepped up to very different ways of working to maintain essential business functions and support clinical service delivery, whilst our volunteers (old and new) have provided invaluable support to our service users.

We activated Gold Command arrangements in early March 2020 to lead our emergency planning and response. We also linked into command structures in each of our four localities and at a Greater Manchester level at an early stage, as well as participating in national arrangements and discussions. The exchange of ideas and support via these routes has proved useful throughout the crisis. It is hoped that, once the crisis has passed, we will adopt or adapt some of these new ways of working which cut across traditional organisational boundaries and bureaucracy.

The health and wellbeing of our staff has been a primary concern. We are continuing to do everything we can to enable our staff to look after themselves and their colleagues. This includes providing access to PPE (Personal Protective Equipment), testing and broader health, wellbeing and resilience resources, and also giving daily briefings to help staff stay up to date and informed on COVID-19 and our response. We have also made resources available to patients, service users, carers and the wider public via our website. We will continue with these measures for as long as they are needed. Clearly, the coronavirus pandemic will have a lasting effect into the future, with the mental health impact expected to extend beyond the physical health impact. We are now beginning to plan our recovery, including how we will manage any increases in demand for our services once the immediate crisis has passed and what our longer-term support offer for both service users and staff might look like.

We would like to take this opportunity to thank everyone for their efforts during this unprecedented period of change and for the dedication and spirit you have shown.

Our Achievements

Though the effectiveness of our response to the coronavirus pandemic was our over-riding organisational priority at the end of 2019/20, we had grown our organisation both in terms of the services provided and our shared goals during the previous months. These achievements are recognised here.

Our New Five-Year Strategy

We launched our new five-year Strategy (*'Delivering Excellent Care and Supporting Wellbeing')* in October 2019, following engagement with a range of stakeholders. Our strategy reflects the ambitions set out in the NHS Long Term Plan, the Greater Manchester Health and Wellbeing Strategy and local commissioning priorities. It clearly describes what we will do over the next five years (2019 to 2024) to improve our care offer and support wellbeing. Achieving our vision – *Working Together to Improve Lives and Support Optimistic Future* – will require close and effective working across our workforce and with our partners, service users and carers.

Improving Quality

Quality improvement is a key strand of our new Strategy. The launch of phase one of our Quality Improvement Strategy in early 2019/20 marked the continuation of our journey to provide high quality, safe and clinically effective care for our service users. By building quality improvement capacity and capability across our workforce over the last twelve months, and introducing a standardised approach to continual quality improvement and learning, we are now in a strong position to deliver our quality improvement priorities for 2020/21. Further information can be found on this in our Quality Account 2019/20.

Following a thorough Care Quality Commission (CQC) inspection of our services in early 2019/20, we were pleased to maintain our overall 'Good' rating for quality of services. The CQC visited four of our core services and also completed a well-led review. Our substance misuse services, which expanded

to include the provision of a new integrated treatment and recovery system in Bury in September 2019, retained their 'Outstanding' rating following this inspection. 'Achieve Bury' follows our successful delivery model in Bolton, Salford and Trafford and is delivered in partnership with The Big Life Group and Early Break.

Positives highlighted by the CQC included our staff treating service users with compassion and kindness, respecting privacy and dignity, seeking feedback and also involving service users in care planning and risk assessment. As co-production is at the heart of our approach to care, we were extremely pleased that the CQC recognised this. The CQC also commented on our constructive engagement with staff, our open and transparent culture, our active research profile and our work with housing providers to support service users into appropriate housing to promote and maintain recovery.

We have responded quickly to the improvement opportunities identified by the CQC, including through the implementation of a more robust system for ensuring supervision compliance and by progressing our plans to build the new Park House development on the North Manchester General Hospital Site.

Supporting our Staff

We have maintained our focus on the four 'High Impact Areas' set out in our Workforce and Organisational Development Strategy' during the year:

1. Supply, Recruitment and Retention
2. Creating and Outstanding Place to Work
3. Transforming our Workforce
4. Outstanding Leadership and Management Development

Ensuring we have sufficient numbers of engaged, capable and motivated staff is a particular priority, given the national workforces shortages and associated risks. We have worked hard to reduce staff vacancies and improve retention, including by taking different approaches and acting on new opportunities. As a participant in NHS Improvement's National Retention Programme, we have seen our turnover reduce and by commissioning NHS Professionals to provide a temporary engagement and direct resourcing service, we have significantly reduced our reliance on agency staffing. We have also taken steps to retain the valuable skills and expertise of our EU (European Union) workforce. Going forward, we will continue to engage in regional and national workforce discussions and collaborate with other providers in the area to recruit to 'hard to fill' posts and enable new developments.

We have analysed our performance against the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) and commenced work to implement our agreed Workforce Equality Plan. We have been proud to support the growth of our BAME (Black, Asian and Minority Ethnic), LGBT+ (Lesbian, Gay, Bisexual, Transgender plus) and Disabled Staff Networks during 2019/20 and have also launched our innovative reverse mentoring scheme. Looking ahead, we are planning to refresh our approach to delivering our Workforce Strategy taking into account the

outcomes of our recent Staff Survey. We will maintain our focus on equality, diversity and inclusion, whilst also increasing our attention on health and wellbeing. The launch of our Mental Health First Aiders programme in October 2019 and our increased support for staff to work more flexibly have been positive steps. We are also now actively working with our trade unions to develop a new Wellbeing Policy for the Trust.

Becoming More Digitally-Enabled

In year one of our Digital Strategy 2019 - 2022, we have begun to embrace the adoption of new technologies that support and enhance the experience of our staff and service users and enable service transformation. We introduced the use of digital apps in our IAPT (Improving Access to Psychological Therapies) service and, by implementing MAST and Clintouch in a number of our Community Mental Health Teams (CMHTs), are aiming to help our service users become more digitally engaged. We also introduced electronic prescribing in our substance misuse services, which is patient-oriented and supports improvements in medicines safety. Our service user and carer digital advisory group have been key to the improvements delivered so far and will inform the future evolution of our Digital Strategy.

The progress made in implementing our Digital Strategy during 2019/20 laid the grounds for the rapid digitisation of our IAPT and other community services early in the COVID-19 pandemic, enabling staff to maintain video contact with vulnerable service users.

Working Together

As a specialist mental health provider, we recognise the need to collaborate with third sector and statutory partners for the benefit of our service users. We commenced work to develop our role as an expert commissioner of services through the Lead Provider Collaborative (LPC) approach in 2019/20. Working in partnership with other providers, the LPC will offer opportunities to redesign pathways of care and improve quality of services for service users. We have been nominated as Greater Manchester Lead for Adult Secure Services and, taking into account delays related to the coronavirus pandemic, are aiming to 'go live' with the LPC by the end of 2020/21.

We also remain an active partner in our local integrated care systems, supporting delivery of joined up, higher quality care for our local communities. As these integrated models embed, we have been working with our GP partners and primary care networks to deliver schemes that fill the gaps between primary and secondary care. These include the Living Well Model in Salford, the Primary Care Mental Health Wellbeing Service in Trafford and the introduction of Primary Care Mental Health Practitioners in Bolton and Salford. We have also been collaborating with commissioners in Manchester on the development of a Primary Care Service, which will be delivered in partnership with MIND.

In September 2019, we expanded our service offer to include an innovative new Greater Manchester University Student Mental Health Service. With the four Greater Manchester universities, the Royal Northern College of Music (RNCM) and third sector providers, this pilot service offers a flexible step up/step down approach that places students at the centre of their care and enables them to achieve their full potential.

We have also collaborated with NHS England and Bridgewater Community Healthcare NHS Foundation Trust over the last six months to enable the smooth transition of staff and healthcare services previously provided by Bridgewater in three prisons and two secure children's homes to this organisation on 1 April 2020. This development aligned with our successful bid to lead the provision of all healthcare services in HMPs Garth and Wymott from April 2020.

We will continue to build our external partnerships in 2020/21 to enable innovative approaches to care, deliver social value and meet the expectations set out in the NHS Long Term Plan and our own five-year Strategy.

Improving our Environments

We invested approximately £10.7million in our estate (patient and non-patient facilities) during 2019/20. Key environmental improvements included working in partnership with Manchester City Council and Manchester Health and Care Commissioning to transform Harpurhey Wellbeing Centre into a vital community resource (No. 93) for Harpurhey and the North Manchester area. No.93 hosts community activities and volunteer-led groups and offers an exercise room, creative arts space and outdoor space for use by everyone including centre users, local groups and residents in the wider community. We also provide Improving Access to Psychological Therapies (IAPT) services at No. 93 from nine dedicated therapy rooms and a group room, making the centre an inclusive space where stigma associated with mental health can be effectively challenged.

We completed an extensive refurbishment of Borrowdale Ward at our medium secure unit, Edenfield, during the year. This investment has meant that our female service users on Borrowdale Ward are cared for in one place and have improved access to therapies that promote recovery, including the sports hall, Recovery Academy, a GP for medical issues and the activity centre. All bedrooms on Borrowdale are now ensuite and quiet places, such as a sensory room and multi-faith room, have also been made available for privacy and reflection.

We were delighted to receive news, in August 2019, of a £72.3million capital award from the government to replace our Park House inpatient unit on the North Manchester General Hospital site. This followed the submission of a high-level business case in 2018/19. We were one of only 20 NHS organisations to receive funding, benefiting from the third largest share of the national allocation and the highest level of investment in the North West.

Park House has been a key improvement priority for us since we acquired Manchester Mental Health and Social Care NHS Trust (MMHSCT) in 2017. We will use this capital injection to replace the current dormitory-style accommodation with a modern, fit-for-purpose facility, which supports recovery and provides a much-improved working environment for our staff. Service users' privacy and dignity will be safeguarded through the

provision of single ensuite bedrooms. The new layout will also facilitate access to improved open spaces and gardens. Engagement, both internal and external, has been key both to the development of our bid and the achievement of a national funding commitment. Our scheme reflects our needs as well as supporting delivery of the wider ambitions for North Manchester. We are now planning a more comprehensive programme of further engagement with our key stakeholders - including Manchester City Council, commissioners, acute sector partners, housing providers and, most importantly, our service users and carers - for the next phase of this project in 2020/21.

Working Efficiently

Over the course of 2019/20, we have continued to face risks to the achievement of our strategic objectives from increasing demand on our services, challenges relating to workforce supply and our ability to deliver recurrent savings. Through effective management of our patient flow, the efforts of our staff in managing agency spend and setting ourselves challenging recovery plans, we ended the year reporting a net retained surplus of £3.625million and an operating surplus of £1.230 million (excluding impairments). We would like to take this opportunity to thank Ismail Hafeji, Director of Finance and IM&T for his skilled financial leadership and dedication to the Trust over the last nine years. Ismail retired at the end of March 2020 and his successor, Suzanne Robinson, will take on the role in summer 2020/21.

We recognise the need to sustain the improvements delivered this year, whilst also strengthening our productivity in other areas in 2020/21. We will apply our standardised quality improvement framework to deliver efficiencies in our acute care pathway, workforce, digital approaches, pharmacy and corporate services. This will include building on a successful project undertaken in our home-based treatment teams in 2019/20 to increase direct patient contact time across all of our community services.

Looking Forward

Future plans will be impacted by the continuing effect of the coronavirus pandemic. We will maintain sight of our achievements to date and re-evaluate our plans and priorities once the crisis has passed to determine how best to take forward our vision in 2020/21.

Thanks are extended to colleagues across the organisation for their efforts during 2019/20 to improve lives and support optimistic futures for our service users, their families and carers.

Neil Thwaite, Chief Executive
22 June 2020

Rupert Nichols, Chair
22 June 2020

For any further information on the information contained in this report, or to keep in touch with our developments please contact us on communications@gmmh.nhs.uk, follow us on Twitter @GMMH_NHS or like us on Facebook (www.facebook.com/Greater Manchester Mental Health).

Overview

The purpose of this overview is to introduce you to Greater Manchester Mental Health NHS Foundation Trust (GMMH) and provide a short summary of our history, purpose, the activities we undertake and how we organise ourselves. Information on our performance over the last twelve months and the key risks we face to the achievement of our strategic objectives is also provided. Further details on our quality performance can be found in our Quality Account.

About Us

GMMH is a statutory public body, which became an NHS Foundation Trust (public benefit corporation under Section 35 of the National Health Service Act) on 1 February 2008. We are part of the NHS, registered with the Care Quality Commission (CQC) and our performance has been rated by the CQC as ‘Good’ overall.

We are one of the largest specialist mental health providers in the country, supporting more than 53,000 service users across our local, specialist, substance misuse and prison populations. We employ over 5,700 whole time equivalent (WTE) staff and provide services from over 150 locations across the North West of England, as well as working with people in their homes and local communities.

We offer:

- Local mental health services to the people of Bolton, Manchester, Salford and Trafford, a combined population of around 1.3 million people
- Substance misuse services to people in Bolton, Salford, Trafford, Bury and Cumbria
- Services to over 8,000 people in prisons and secure accommodation in the North West of England
- Highly specialised mental health services for the region and wider NHS in England

Our Operating Model

Our clinical services are structured into three networks and eleven divisions:

- **Trafford, Manchester and City-Wide Network:**
  - North Manchester
  - Central and City-Wide
  - South Manchester and Trafford

- **Rehabilitation Services, IAPT (Improving Access to Psychological Therapies), Bolton and Salford Network:**
  - Primary Care Psychological Therapies (PCPT)
  - Rehabilitation
  - Bolton
  - Salford

- **Specialist Services Network:**
    - Adult Forensic and Mental Health and Deafness
    - Substance Misuse Services (SMS)
    - Health and Justice
    - Child and Adolescent Mental Health Services (CAMHS)

Our Strategic Framework

Our new five-year Strategy 2019 - 2024 *('Delivering Excellent Care and Supporting Wellbeing')* sets out our strategic vision - '*Working Together to Improve Lives and Support Optimistic Futures'* - and future direction of travel. It guides how we will lead and enhance services in collaboration with users, carers, staff and partners. Our Strategy is aligned with the NHS Long Term Plan (LTP), Greater Manchester Health and Wellbeing Strategy, commissioner strategies and locality plans and responds to the significant and often above average mental health needs of our local populations.

To deliver our vision we are focused on achieving five key strategic aims and objectives, as shown in the following strategy 'Plan on a Page'. Our aims are:

- Best Care, Every Day
- Compassionate, Supported, Motivated Staff
- Best Outcomes
- Individualised, Seamless Care
- Sustainable Services, Adding Value

Our Five Year **Trust** Strategy 2019 -2024

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This strategy describes our direction for GMMH over the next five years, guiding how we will lead and enhance services in collaboration with service users, carers, staff and partners: always with a shared purpose of improving health and wellbeing.

Our Vision	Working together to improve lives and support optimistic futures
Our Strategy	Delivering excellent care and supporting wellbeing

	Objective **One**	Objective **Two**	Objective **Three**	Objective **Four**	Objective **Five**
Strategic Objectives	Work with service users and carers to achieve their goals by delivering high quality care	Create an outstanding place to work, ensuring staff feel valued and are supported to reach their potential	Continuously improve services for users through Research, innovation and digital technology	Work in partnership with others to improve wellbeing and challenge stigma	Be a sustainable, well-led organisation that delivers social value
Programmes of Work	Quality Improvement • To improve outcomes • To deliver safest care • To integrate care around the person Best Care	Supply, recruitment and retention Outstanding place to work Transforming our workforce Outstanding leadership and management development	Research and Innovation Digital	Service users, Communities and Voluntary, Community and Social Enterprise sector (VCSE) Integrated care Public sector Trusted partnerships	Financially sustainable and well governed Safe, effective and supportive environments Productivity Delivering Social Value
Aims	Best care, every day	Compassionate, supported, motivated staff	Best outcomes	Individualised, seamless care	Sustainable services, adding value
Values	We inspire hope	We work together	We are caring and compassionate	We value and respect	We are open and honest

We have five core values that underpin how our staff and volunteers work together to care for our service users and deliver our vision. These are:

- We are caring and compassionate
- We inspire hope
- We are open and honest
- We work together
- We value and respect

At our 2019 Annual Members Meeting (AMM), we presented awards to individuals and teams from across the Trust who were felt to have best represented our values during the year. The winners and highly commended in each category were as follows:

- **We are Caring and Compassionate:**
  - Winner – Helen Craigie, Clinical Practice Lead, Park House
  - Highly Commended – Debbie Blore, Support, Time and Recovery Worker on Keats Ward at Meadowbrook and Nadia Coggin, Senior Mental Health Practitioner, Bolton Mental Health Liaison

- **We Inspire Hope:**
  - Winner – Dr Ruth Picucci, Clinical Psychologist, Bolton Early Intervention Team
  - Highly Commended – Joanne Hadfield, Positive and Safe Lead, Nursing and Governance

- **We are Open and Honest:**
  - Winner – Dr Emma Williams, Clinical Psychologist, Junction 17
  - Highly Commended – Andrew Haley, Psychological Therapist, Trafford Psychological Therapies

- **We Work Together:**
  - Winner – Akram Rahman, ICT Technician
  - Highly Commended – The Patient Flow Team

- **We Value and Respect:**
  - Winner – Dr Swanand Patwardhan, Consultant Psychiatrist, Park House
  - Highly Commended – Julian Dingle, Occupational Therapist, Woodlands Hospital

Our Key Risks and Uncertainties

Our Board of Directors has overall responsibility for ensuring that our risk management system is sufficiently robust to mitigate any significant risks that may threaten achievement of our strategic objectives. Assurance on the effectiveness of this system is gained primarily through the work of Board committees and the Executive Management Team, through the use of audit and other independent inspection or accreditation, and through the systematic collection and scrutiny of performance data.

Our Board Assurance Framework sets out the current key risks to achievement of the Trust's strategic objectives and identifies any gaps in controls and assurances on which the Board relies. We reviewed

and updated our strategic risk assessment following agreement of our new five-year strategy and new strategic objectives.

The Board of Directors is responsible for reviewing the Board Assurance Framework on a quarterly basis, to ensure that the main risks have been identified and appropriate action is being taken to address these.

As at March 2020, the most significant risks and uncertainties faced - based on their likelihood and impact - were related to:

- Coronavirus (COVID-19) pandemic
- Performance – with a specific focus on targets relating to Improving Access to Psychological Therapies (IAPT), Early Intervention in Psychosis (EIP) and Out of Area Placements (OAPs)
- Recruitment and retention
- Sustainable and resilient workforce model
- Future commissioning arrangements – in terms of the impact of any changes on the resources available to the Trust
- Financial sustainability
- Capital and estates – including the risks and challenges associated with our current inpatient provision in North Manchester (Park House)

Going Concern Disclosure

These accounts have been prepared on a going concern basis. After making enquiries, the Directors have a reasonable expectation that the NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

Performance Analysis

We are a well-performing organisation with a good track record of delivering financial, operational and quality targets set by our commissioners, regulators and the government. Performance was impacted as expected by the acquisition of Manchester Mental Health and Social Care NHS Trust (MMHSCT) on 1 January 2017. We have continued to focus on extending and embedding our robust approach to performance reporting, quality improvement and governance during 2019/20.

During 2019/20 this work has included the start of a comprehensive redesign of performance reporting to our Board of Directors to include key quality assurance measures and information from a wider range of services. The report will also provide more timely information to Board. Data will be presented in Statistical Process Control (SPC) charts, where appropriate, as visualising trends over time supports more accurate and easier analysis. New digital technologies are being used to support this development, which will be implemented for 2020/21 reporting. This approach will then be applied to further improve performance reporting at ward or team level.

Our Performance Management Framework defines our principles of performance management and sets out how these should be put into practice across the organisation.

Responsibility for delivering care to the standards required by regulators and commissioners is apportioned appropriately from Board-level through to individual members of staff. Our Performance Management Framework is operationalised through our governance structure with standing agenda items on performance at our monthly Board of Directors, Executive Management Team and Operational Leadership Committee meetings. This ensures a clear Trust-wide and divisional performance position for all key targets, which is owned at a senior level. Performance issues feed from these meetings into Network Hubs, divisional Senior Leadership Team meetings, monthly clinical improvement meetings, individual appraisals and supervision sessions and vice versa. This supports shared ownership across the organisation of key performance indicators (KPIs) and other mandatory targets. A monthly Trust-wide Performance Measures and Data Quality meeting scrutinises the detail around achievement of KPIs, agreeing actions to improve performance, sharing best practice across the Trust and escalating risk as appropriate. Delivery of CQUIN (Commissioning for Quality and Innovation) targets is also reviewed by exception on a monthly basis. Quarterly CQUIN meetings are held in specialist and district networks to monitor and support achievement against CQUIN targets. The Quality Improvement Committee (QIC) also plays a key role in the performance management framework by supporting triangulation of performance and quality information to improve delivery of care for our service users and carers.

Our Business Intelligence Team supports the organisation to reach and maintain required performance levels by operating processes and protocols for data collection and analysing and reporting performance against our key performance requirements and contractual commitments. Board scrutiny of performance follows a process of data validation and review at local service and divisional level, enabling robust explanation of the performance position and actions in place. Where necessary, remedial action is agreed to improve any areas of under-performance and this is monitored in subsequent meetings of the Board of Directors. This ensures that performance against KPIs is clearly visible at all levels with potential risks highlighted and appropriate actions put in place. This avoids any uncertainty around levels of performance either contractual or regulatory.

During 2019/20 the Trust has started to use Tableau to develop data visualisation in key service areas and support the more effective use of information both operationally and strategically. Examples of this include the development of dashboards for Patient Flow and IAPT services, enabling scrutiny of timely information at local and Trust level. This approach will be further developed during 2020/21 by our Business Intelligence team and operational services.

Achievement of our Key Performance Targets

The NHS Oversight Framework (updated in August 2019) sets out all key national performance requirements. Our key performance indicators and reports reflect these as appropriate.

The following table summarises our performance against our key performance indicators during 2019/20. KPIs have been mapped against the Care Quality Commission’s five domains to support assurance in each of these areas. A ‘Green’ rating indicates that performance has achieved the

required standard. Our Quality Account 2019/20 provides more detailed information on our CQUIN schemes and performance against the key mental health targets.

CQC Domain	Source	Indicator	GMMH	Latest Position
Effectiveness	Oversight Framework	Data Quality Maturity Index (DQMI) MHSDS Dataset Score – data completeness	A	Jan. 2020 – national published data
	Oversight Framework	Reduction in inappropriate out of area placements for adult mental health services	G	March 2020
	National CCG CQUIN	Recording of interventions - SNOMED	G	Jan. 2020 – national published data
	National CCG CQUIN	Use of anxiety disorder outcome score in IAPT services	A	Jan. 2020 – national published data
	National NHSE CQUIN	Addressing CAMHS Tier 4 staff training needs	G	Quarter 4 2019/20
Safety	Oversight Framework	Occurrence of never events	G	March 2020
	Oversight Framework	Admission to adult facilities of patients who are under 16	G	March 2020
	Oversight Framework	CPA (Care Programme Approach) 7 day Follow up	R	March 2020 – internal figures [1]
	Care Quality Commission (CQC)	Registration	G	July 2019 Inspection
	National CCG CQUIN	72 hour follow up post discharge	G	Jan. 2020 – national published data
	National CCG CQUIN	Flu Vaccinations - for frontline clinical staff	G	March 2020
Responsiveness	Oversight Framework	Early Intervention - treatment start within 2 weeks	G	March 2020

[1] Please note: Quarter 4 figures for 7-day follow up for those on CPA (Care Programme Approach) are our locally reported, internal figures. Publication of national Quarter 4 figures has been postponed by NHS Digital due to the COVID-19 response.

		IAPT - treated within 6 weeks	G	March 2020 – internal figures
		IAPT - treated within 18 weeks	G	March 2020 – internal figures
	National CCG CQUIN	Alcohol and Tobacco screening and brief advice - preventing ill health from risky behaviours	G	March 2020
	National NHSE CQUIN	Healthy Weight in Adult Secure MH services	G	Quarter 4 2019/20
Caring	Oversight Framework	IAPT Recovery – achievement of 50% recovery target	R	March 2020 – internal figures
	National NHSE CQUIN	Enabling better assessment of the communication needs of deaf people	G	Quarter 4 2019/20
Well-led	Locally-set	Sickness Rolling 12 Months	R	March 2020
	Locally-set	Sickness In-Month	R	March 2020
	Oversight Framework	Finance and Use of Resources	G	March 2020
		Strategic Change – including contribution to developing, agreeing and delivering Sustainability and Transformation Plans (STPs)	G	March 2020
		Leadership and improvement capability – demonstration of effective Board and governance, continuous improvement capability and an effective use of data	A	March 2020

We work hard to ensure our key performance metrics are achieved. Where there are areas rated as 'Amber' or 'Red' we put comprehensive action plans in place.

As at March 2020, our Trust-wide performance against the IAPT 6- and 18-week referral to treatment waiting time targets was rated as 'Green'. This rating reflects ongoing improvement in Salford and Manchester services during 2019/20 with the support of commissioners. Improvements have included

the agreement of trajectories to clear historical waiting lists and more effective and timely management of new referrals. Additional investment was also agreed with commissioners in Manchester and Salford to address capacity issues. The IAPT service has also made significant progress in delivering our digital ambitions, including by offering face to face clinic appointments for patients via video consultations. Our readiness and ability to deliver services in this way supported our early incident response to the COVID-19 crisis. Performance against the IAPT recovery target was rated as 'Red' at 2019/20 year-end. Our ability to achieve this target is limited by our delivery of Step 3 IAPT services only in Salford and Manchester. This impacts on our recovery rates in these areas as the recovery target is linked to the delivery of the whole stepped-care IAPT pathway. The Step 2 IAPT services in these areas contribute to the achievement of the target at a CCG pathway level.

In terms of out of area placements (OAPs), as at the end of March 2020, we achieved an 86% reduction on 2017/18 OAPs figures compared to a national reduction target of 66%. We are now focused on achieving the national target of zero reportable OAPs by the end of March 2021. Improvement work will include promoting and supporting timely discharges and developing alternatives to admissions in collaboration with the whole system, including third sector partners and voluntary agencies.

We narrowly missed achieving the national target for follow up of people on the Care Programme Approach (CPA) within 7 days of an inpatient discharge in March 2020 and Quarter 4 2019/20. We delivered 94.5% compliance against a target of 95% at year-end. We did, however, achieve this target during all other quarters in 2019/20. The position in Quarter 4 was impacted by the opening of additional beds that included patients from another CCG area and difficulties faced in following up patients with no fixed abode. Every effort is being made by services to follow up patients face to face or by telephone during the COVID-19 response.

The Data Quality Maturity Index (DQMI) reflects the completeness of MHSDS (Mental Health Services Data Set) recording against 36 data quality categories. Our latest national published figures are from January 2020 and show the Trust as performing below the national target of 95%. Performance has, however, improved throughout the year as a result of actions taken to strengthen reporting against new data categories introduced nationally. We expect the next national published figures to demonstrate this progress.

As at the end of 2019/20, we are reporting an overall rating of '1' for the finance and use of resources theme, against a planned rating of '3'. This is a result of our improving position against the agency spend metric during 2019/20, which stands as a '1' at year-end against a planned rating of '4'.

Staff sickness absence has continued to be a challenge during 2019/20, with rolling sickness levels consistently recorded above our locally set target. The actions we are taking to address this are summarised in the 'Our Staff' section of this report and include approaches to promote employee health and wellbeing and improve sickness absence management.

Our performance against the national CCG and NHS England CQUIN goals is good, both when compared to national targets and when compared to the England average positions. However, our performance against the IAPT CQUIN relating to consistent recording of Anxiety Disorder Specific Measures (ADSM) outcome measures for appropriate clients is rated as 'Amber' currently. Our latest

national published figures are from January 2020. Though we are not yet achieving the target, these figures demonstrate an improving position with performance now close to the England national average. This trajectory is expected to continue as improvements are embedded in practice and we await the next national published figures for March 2020.

Our Financial Performance

As demonstrated in our Annual Accounts, we delivered a positive financial position at the end of 2019/20. We maintained low levels of financial risk throughout the year, whilst also achieving the cost efficiencies required for future sustainability and making significant capital investment. Our year-end performance was enabled by steps taken during the year to strengthen reporting, monitoring and scrutiny of our financial position and increase local accountability. These included the establishment of a Finance Working Group of the Board of Directors, in addition to an operational Financial Oversight Group to oversee implementation of locally-determined financial recovery plans and agree a more pragmatic approach to future year budget setting.

Our year-end financial performance can be summarised as follows:

- Our overall income and expenditure position shows delivery of a net retained surplus of **£3.625 million**. Our operating surplus for the year is **£1.230 million**, excluding impairments**.** This difference in performance is due to the impact of the removal of Provider Sustainability Funding (PSF) relating to 2018/19 not notified or received until 2019/20 and also the receipt of additional non-recurrent mental health support from NHS England and NHS Improvement (NHSEI), which does not count towards control total achievement
- Our overall Finance and Use of Resources Rating as at 31 March 2020 is 1 (see 'NHS Oversight Framework' for further detail)
- Our total Comprehensive income, after movements direct to reserves, is £5.293 million
- The District Valuer undertook a desktop revaluation of our property, plant and equipment in February 2020. As the result of the desktop revaluation would not significantly change the values in the financial statements, the resultant revaluation has not been reflected in the financial outturn as reported at 31 March 2020

Income and Expenditure Position

The income the Trust receives from health services is greater than the income from any other sources. All income received by the Trust, including other income, is used to provide goods and services for the purposes of the health service in England. We received a total income of £337.4 million for 2019/20, which represented an increase on our planned income.

	For the Year to 31 March 2020		
	Plan	Actual	Variance
	£'000s	£'000s	£'000s
Clinical Income	279,599	299,829	20,230
Other Income	29,944	37,564	7,620
Total Income	**309,543**	**337,393**	**27,850**
Operating Expenditure	(294,584)	(320,325)	(25,741)
EBITDA	**14,959**	**17,068**	**2,109**
Depreciation	(7,558)	(7,324)	234
Interest Receivable	150	185	35
Interest Expense	(105)	(96)	9
Public Dividend Capital	(6,216)	(6,216)	0
Profit/(Loss) on disposal of assets		8	8
Surplus/(Deficit) before Other Non-Operating Expenses	**1,230**	**3,625**	**2,395**
Other Non-Operating Income/Expenses			
Impairment Losses (Reversals) net (on non PFI assets)			
Net Surplus/(Deficit)	**1,230**	**3,625**	**2,395**
Elements of Comprehensive Income	(15)	1668	1683
Comprehensive Income	**1,215**	**5,293**	**4,078**

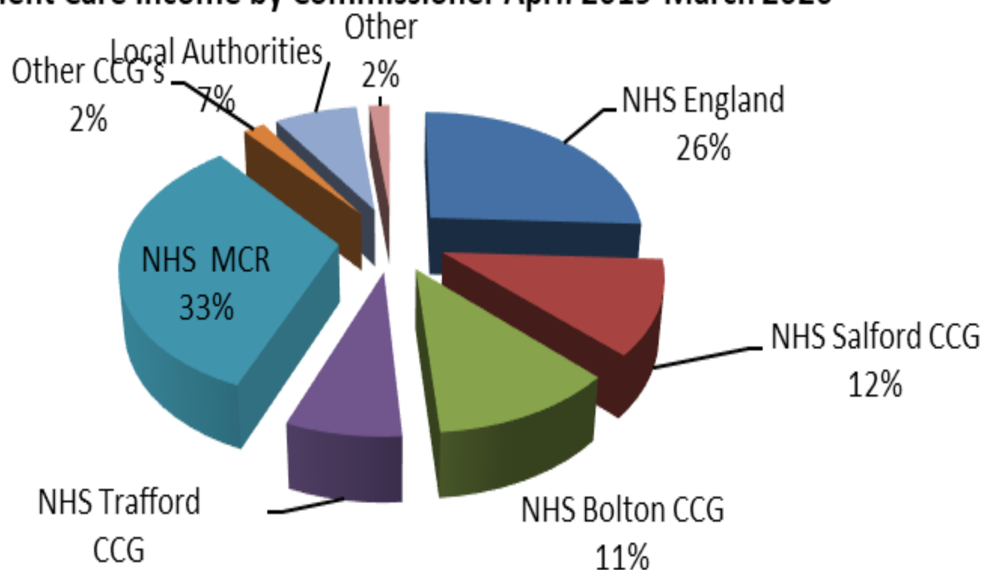
Within income, we have not levied any fees or charges where the full cost exceeds £1million or the service is otherwise material to the accounts.

The table below confirms our normalised operating performance:

Financial Performance for the year		**£'000s**
Surplus/(deficit) for the year from continuing operations		3,625
Remove impact of prior year PSF post accounts allocation		(855)
Remove Impact of Mental Health Support in year		(1,571)
Impairments following revaluation of PPE		0
Reversal of non-cash SOFP pension		43
Operating Surplus for the year		**1,242**

The majority of our £337.4 million income received related to patient care (£299.8 million). This can be broken down by commissioner as follows:

	NHS England	**NHS Salford CCG**	**NHS Bolton CCG**	**NHS Trafford CCG**	**NHS MCR**	**Other CCGs**	**Local Authorities**	**Other**	**Total**
Income (£'000s)	77,333	34,506	34,465	21,515	98,709	5,809	22,058	5,434	299,829



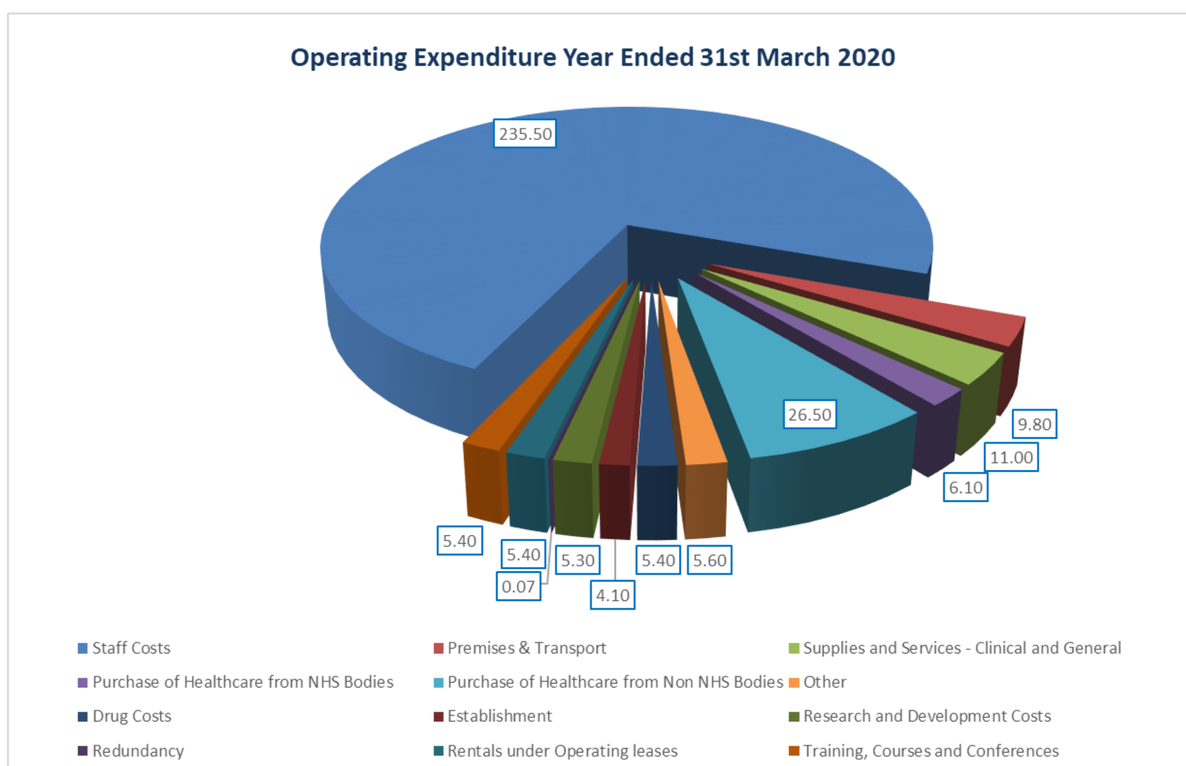
We received £37.6 million other income for non-patient care services, with the majority (£16.4 million) coming from Health Education England (HEE) to support education and training. In addition, we received income of £5.3 million to support research and development, £3.3 million Provider Sustainability Funding (PSF), £4.3 million transition and transformation funding to support the embedding of Manchester mental health services, £1.5m transformation funding from Bolton CCG to support local schemes and £6.8m other income.

Our Expenditure in 2019/20 totalled £327.6 million and can be analysed as follows:

Operating Expenses	Expenditure (£'000s)
Staff Costs	235,542
Premises & Transport	9,845
Supplies and Services - Clinical and General	11,033
Purchase of Healthcare from NHS Bodies	6,071
Purchase of Healthcare from Non NHS Bodies	26,508
Other	5,633
Drug Costs	5,363
Establishment	4,098
Research and Development Costs	5,297
Redundancy	74
Rentals under Operating leases	5,417
Training, Courses and Conferences	5,444
Total Operating Expenditure	**320,325**

Depreciation	7,324
Impairments of Property, Plant and Equipment	
Gain on disposal of land and buildings	(8)
Grand Total	**327,641**

The largest item of expenditure relates to staff costs at £235.5 million or 71.8% of operating expenses. The District Valuer undertook a desktop revaluation of our property, plant and equipment in February 2020. As the result of the desktop revaluation was not material, the resultant revaluation has not been reflected in the financial outturn as reported at 31 March 2020.



Capital Investment

We have continued to invest in the development and improvement of our estate (patient and non-patient facilities) in 2019/20. We invested a total of £10.688 million across the year. Key capital developments have included investment in the IM&T infrastructure, and the Trust's digital strategy, environmental improvements at the Park House site, refurbishment of community properties to enable the effective delivery of the Enhanced Community Model, the provision of 5 additional beds on our TEMSS (Therapeutically Enhanced Medium Secure Service) unit at Edenfield and the refurbishment of Borrowdale Ward, and the refurbishment of Harpurhey Wellbeing Centre to house IAPT services and other community activities and groups. We have also invested capital in backlog maintenance, statutory works, work to reduce ligature risks and energy performance improvements.

The following table provides an overview of our main areas of capital expenditure during the reporting period:

Capital Expenditure	Expenditure to 31 March 2020 (£'000s)
IM&T Expenditure (including Digital Strategy)	2,485
Park House environmental improvements	1,609
Enhanced Community Model – premises refurbishments	1,145
Adult Forensic Service Blended Women's Redesign Pathway	590
Harpurhey Wellbeing Centre (No.93)	579
Replacement of Vision Panels	544
Fire Alarm Replacement Program	467
Environment Improvement Works (First Impressions)	418
Salford Environmental Improvements	343
Moorside Environmental Improvements	330
Decentralisation of boilers	166
Other Specific Schemes less Than £200k	355
Ligature Audit Schemes	312
Backlog Maintenance Schemes	399
Statutory Schemes	188
Energy Improvement Scheme	98
Minor Schemes	160
Vehicle replacements	60
Corporate Overheads	440
Total	**10,688**

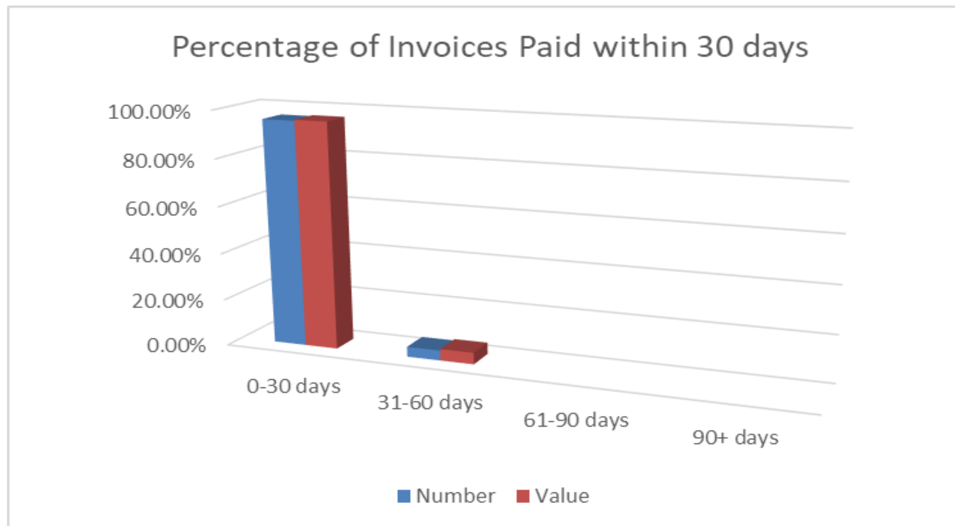
Liquidity and Short-Term Investments

As at 31 March 2020, our cash balance stood at £31.0 million, with interest receivable of £0.2 million being reinvested in the delivery of services.

Better Payment Practice Code – Measure of Compliance

The Better Payment Practice Code (BPPC) requires the Trust to pay all NHS and non-NHS trade creditors within 30 calendar days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed. Where this involves a non-public sector organisation, the Trust takes action to ensure that payments are made as quickly as possible.

Our performance against the BPPC as at 31 March 2020 is 95.7% in terms of number of invoices paid within 30 days and 96.1% by value of invoice. We have positive relationships with our suppliers and have not been required to pay any interest accrued by virtue of failing to pay invoices within the 30-day period.



Cost Allocation

We have complied with all cost allocation and charging requirements set out in the HM Treasury Guidelines in 2019/20.

Preparation of our Accounts

We have prepared our annual accounts for 2019/20 in accordance with paragraphs 24 and 25 to Schedule 7 to the National Health Service Act 2006, guidance issued by NHS Improvement, the independent regulator of NHS Foundation Trusts, and International Financial Reporting Standards (IFRS). Our accounting policies for use in preparing our accounts are reviewed annually to reflect any changing circumstances involving accounts regulation and guidance and are approved by our Board of Directors.

Accounting policies for pensions and other retirement benefits are set out in Note 8 to the accounts. Details of senior employees' remuneration can be found in the 'Remuneration Report' in this report.

Future Financial Strategy

The financial year 2019/20 has seen the continued consolidation and transformation of services. The next few years will prove to be a significant challenge as we continue to deliver improvements to mental health services across Greater Manchester, alongside the continued development of services for all service users.

The NHS continues to face an unprecedented financial dilemma where the supply of funding is struggling to match the growing demand for healthcare. The need to deliver year on year efficiency savings of circa 1.1% compounds this pressure. For the Trust, this equates to an estimated recurrent savings requirement of £4 million. We have an excellent track record of making all required efficiencies and have agreed plans to address this agenda without compromising service quality in 2020/21.
Our financial strategy for 2020/21 aligns with the national planning guidance and commissioners' strategic intentions. It is focused on achieving long-term financial sustainability for the organisation

whilst continuing to deliver key financial targets and effectively managing financial risks. Our financial objective is to deliver a financially stable organisation for the financial year 2020/21, whilst managing patient demand and acuity and ensuring the safety and quality of service provision within the resources we receive.

Our overall financial objectives for 2020/21 are to:

- Meet our Financial trajectory as set by NHS Improvement
- Report a Use of Resources (UoR) score of 2/3 for 2020/21
- Maintain our overall margin of average earnings before interest, tax, depreciation and amortisation (EBITDA). (EBITDA is used as a measure of operating efficiency and underlying financial sustainability)
- Maintain cash balances to support future working capital requirements
- Deliver cost improvement plans (CIPs) in line with national requirements
- Reduce our spending on agency and contract staff
- Reduce reliance on Out of Area Placements (OAPs) and the overall cost of OAPs to the Trust
- Be a financially stable and sustainable organisation

We will achieve this by:

- Using a combination of internal funds and external funding from Commissioners and the Department of Health to support the integration, service change and the transition process
- Undertaking regular reviews of the Trust's financial performance, including any variations against plan
- Holding a contingency to manage risk

Taking this approach will allow us to remain financially secure, to continue to invest in our services and to improve our buildings and ward environments.

Key challenges to be managed through this strategy over the coming years include the implementation of the Mental Health Investment Standard (MHIS), the ongoing transformation of services to meet the continued growth in both demand and acuity, the continuing impact of the devolution of health and social care in Greater Manchester and any tendering activity in substance misuse and other specialist services.

In addition, the response to the COVID-19 pandemic has meant that the NHS Long Term Plan and annual financial planning process has been suspended. In order that Trusts can react to the ongoing Pandemic all contracts with CCGs have been suspended for the first four months of 2020/21 and replaced with block contract cash payments, equivalent to 2019/20 income uplifted by 2.8% for inflation. This means that for the first 4 months of 2020/21 plans submitted to NHSEI will be replaced by a break-even plan. At the time of writing, guidance is still awaited regarding the ongoing monitoring and planning post 31 July 2020.

Delivering Social Value

We take our corporate social responsibilities seriously and are committed to contributing positively to the health and sustainability of all of the communities we work with and provide services to.

Social and Community Issues

We have continued to make a significant contribution to the social, economic, and environmental wellbeing of the communities we serve during 2019/20. It is a responsibility for all public authorities, under the Public Services (Social Value) Act 2012, to consider how they can develop and increase social value in this way.

Our five-year Strategy for 2019 to 2024 underlines our commitment to our communities, setting out a comprehensive vision of partnership working and collaborative approaches to support wellbeing. Delivery of this vision will be guided and organised through a Trust-wide Social Value Strategy which is currently in development.

During 2019/20, we have delivered a range of initiatives across all service areas which generate social value. Our Asset Fund programmes in Cumbria, Bolton Salford and Trafford, which are linked to our substance misuse services, have continued to provide financial support to service users and community groups looking to set up activities and support systems. Similarly, our Manchester Wellbeing Fund has been operational for over two years and in that time has invested over £750k in more than 300 community projects. These asset fund models have proven to be an effective way of building capacity in community groups and developing sustainable support for our service users. Our Manchester Wellbeing Fund is also based on a co-production model, enabling service users, carers and community representatives to make decisions on funding proposals alongside our clinical staff. Decisions are made in three monthly locality groups, which each oversee four of the 12 designated neighbourhoods in Manchester. This programme is also helping to address health inequalities across the city by allocating neighbourhood budgets in line with deprivation. Initial evaluations of these projects have demonstrated a significant social return on investment with tens of thousands of volunteer and activity hours being supported and created.

Apart from our asset funding schemes, we have also been actively supporting local Voluntary, Community and Social Enterprise (VCSE) groups through service sub-contracts and joint working arrangements. These include those in operation in our Achieve partnership where we are collaborating with the Big Life Group, THOMAS and Early Break to deliver services across several boroughs.

We also have extensive experience of neighbourhood health development through our 'buzz' service and Inclusion workers in Manchester, the Trafford Primary Care Mental Health service, and the Living Well pilot in Salford. In these teams, staff have been instrumental in developing neighbourhood asset maps and linking up service users and community groups with mainstream health provision. We also provide meeting space and other facilities for community groups at No.93, the community wellbeing hub in North Manchester. Across the Trust overall, we have established a multitude of connections

and relationships between services and local community groups and our staff interface on a daily basis with VCSE colleagues in support of our service users.

Our Recovery Academy plays a key role in supporting our service users and developing our links with local community groups. We also make a significant contribution to our local economy as a large employer, with our early adoption of Real Living Wage standards and our highly successful apprenticeship scheme creating many new opportunities that local residents can benefit from.

All of these current activities will be developed and co-ordinated through our emerging Trust-wide Social Value strategy to ensure that we continue to support wellbeing alongside delivering excellent clinical care.

Service User and Carer Engagement

During 2019/20 we have streamlined our processes for monitoring and supporting growth in service user and carer engagement. We have housed all national and local standards into a single framework to reduce bureaucracy for frontline services and enable support to be targeted where it is needed most. This framework - which includes standards from NICE, the NHS 10 Year Long Term Plan, The Care Act, Triangle of Care and our own Service User and Carer Engagement Strategies - is supported by a governance structure that establishes ownership at a local service level, is supported by our corporate Service User and Carer Engagement Team, and is monitored by our Quality Improvement Committee.

Our Service User and Carer Engagement Team (previously known as the CAREhub) holds responsibility for delivery of our Service User and Carer Engagement Strategies 2018 – 2021. We have made significant progress in our main priority areas during 2019/20 as follows:

Improving Collaborative Care - In October 2019 we piloted a training programme for staff known as EPIC (Enhancing Psychological Interventions in Care). EPIC is aimed at improving staff understanding of the impact of trauma on people's lives and developing skills in psychological interventions that support collaboration and empowerment. The pilot evaluated really well and we are planning a further roll out in 2020/21.

Between November 2019 and February 2020, we piloted new care planning folders designed by a young person from our Child and Adolescent Mental Health Services (CAMHS). The folders also contain self-help materials designed by our volunteer Peer Mentors. The development of these materials responded to research published in the Lancet in July 2019 evidencing the impact of self-help materials, combined with Peer Support, on reducing people's need to access crisis services. Evaluation of these resources is being completed during March 2020, with plans for a Trust-wide roll out to be drawn up if they are found to be effective.

We have also seen an improvement in 2019/20 in relation to our carer key performance indicators. These indicators require carers to be identified to support the triangulation of care between service users, their loved ones and clinical teams, and for the carers themselves to receive information, assessment and support. Across Bolton, Salford and Trafford our performance rose from 95.9% in

March 2019 to 96.5% in January 2020. Across Manchester services our performance rose from 4.3% to 75.9%.

Learning from Feedback – We continue to collect feedback from our service users and carers through our experience surveys which include the national Friends and Family Test. Feedback is collated quarterly, included in our internal Service User and Carer Experience report, and scrutinised via senior leaders. Feedback is a standard agenda item on all local management meetings. During 2019/20 our Governance Department, including our Customer Care Team, also developed an electronic platform to host Positive Learning at a local level via prepared 7-minute briefings. These have proved to be an excellent resource for individual reflection, team meetings, investigations and professional revalidation.

During 2019/20, we have also collected patient stories and video diaries through a project funded by our own Dragons' Den initiative. We employed an individual with lived experience of mental health and a background in creative arts to work with service users, carers and a local film maker to produce these materials for use as a reflective exercise in senior leadership meetings.

Co-Developing and Co-Delivering Services with Service Users and Carers – Our Service User and Carer Engagement Scheme goes from strength to strength and service users and carers across the Trust are engaged in a range of activities including service design and development; business planning and policy development; audit and inspections; recruitment and selection of frontline staff; and training and development.

We now have 200 volunteers working across the Trust, many of whom have their own lived experience of mental health and/or addiction difficulties. Our volunteers undertake many roles, but the most common include Peer Mentorship in our community services and Activity Assistant in our in-patient areas.

Our Recovery Academy has grown and now offers over 68 courses on mental health, addiction and recovery, to a student population of over 7,000. For the first time in 2019, our student population achieved an equal 50/50 split between those registered as professionals working in health, social care, welfare and criminal justice services and those registered as service users/carers/people with their own lived experience. Research into the effectiveness of our Recovery Academy has shown improved recovery rates for individuals with mental health difficulties as defined by themselves, and a reduction in social anxiety in particular. We are planning to measure the wider impact of our Recovery Academy in terms of delivering social value in 2020/21.

Equality

During 2019/20, we have continued to deliver a wide range of initiatives to support the vision set out in our Equality Diversity and Inclusion Strategy 2019-2021 and enable statutory requirements and local needs to be better met. Delivery of our Strategy is co-ordinated through a Trust-wide group, which brings together corporate colleagues and representatives from across our operational services. Our Strategy outlines a process of culture change focused on improving health outcomes and promoting more inclusive leadership and a more representative workforce.

Significant developments over the last year have included:

- The launch of our Spiritual Care Strategy, which identifies spiritual care as an integral component in helping us to understand, treat and promote recovery from mental ill health. We have increased the diversity of our Chaplaincy and Spiritual Care Team in 2019/20 through the appointment of our first rabbi (Rabbi Dr Chanan Tomlin MBE). Rabbi Tomlin will provide pastoral support to our Jewish service users and patients. Our involvement in a celebratory interfaith service at Manchester Cathedral on World Mental Health Day was also a highlight from the last twelve months
- The continued growth of our BAME staff network. Key achievements have included the facilitation of roadshows across the Trust during Black History Month and leading the establishment of our new reverse mentoring scheme. This scheme is enabling our Executive and Associate Directors to gain greater insight into the challenges faced by our BAME staff and take action to address these
- Launch of our LGBT+ and disabled staff networks to support staff and students in championing diversity and inclusion
- Partnership work with the LGBT (Lesbian, Gay, Bisexual and Transgender) Foundation, funded through our Dragons' Den and focused on piloting Pride into Practice in two of our sites
- Ongoing work with AccessAble to survey the accessibility of our locations and publish accessibility information on their website
- Development of trans advocacy in partnership with the LGBT Foundation to raise awareness and understanding
- Pro-active communications throughout the year to promote awareness of key dates and celebrations

Further information on our workforce-related equality, diversity and inclusion initiatives can be found in 'Our Staff' report.

We have continued to develop our systems and processes so that all service developments and new business opportunities are more fully informed by the Equality, Diversity and Inclusion agenda.

Pathways into Employment and Apprenticeships

2019/20 has seen us make steady progress with regard to pathways into employment and apprenticeships. We successfully registered as an Apprenticeship Training Provider with the Education and Skills Funding Agency (ESFA RoATP) for the second time in January 2020. This contract allows us to draw down funding directly from the Apprenticeship Levy. We have seen consistent numbers of our staff taking up apprenticeships this year, as well as an increase in services recruiting into roles specifically designed to support apprentice opportunities. As at the end of February 2020, 4.35% of our workforce were engaged in an apprenticeship programme, which is in excess of the Public Sector statutory target of 2.3%.

We currently have 224 colleagues on 38 different apprenticeship programme pathways and levels. We have continued to provide internally delivered apprenticeships in Health and Social Care, Business Administration, Customer Service, Leadership and Management (ILM) level 3 and 5. Our dedicated Functional Skills Tutor supports learners in the achievement of mathematics and English qualifications. Our internal apprenticeships are based entirely on the new apprenticeship standards and facilitate the stretch and challenge of learners via service improvement projects to support Cost Improvement Programmes (CIPs). We have achieved a 90% distinction rate for our internal apprenticeship programmes.

We were again delighted to have our Matrix Accreditation revalidated in 2020. The Matrix standard is a quality assurance framework that measures the career education, information, advice and guidance given to learners engaged in our apprenticeship programmes. We are awaiting our first full OFSTED inspection in 2020. We continue to demonstrate strong financial management of our Apprenticeship Levy and strengthen our partnerships with local training providers. This has enabled a number of our staff to access more specialist programmes such as the Trainee Nurse Associate Programme (TNA) with the Degree Nursing Apprenticeship coming into scope with the University of Bolton in September 2020.

We have continued to grow our work experience offer to the local community, which has provided a route of employment for some of those who have been on a placement with us. During 2018 we commenced a Cadet programme in partnership with Bolton College whereby Level 3 Healthcare Students have been able to undertake the practical elements of their qualification on some of our inpatient wards.

In February 2020 we celebrated National Apprenticeship Week for the fourth year running and, with the support of our Communications Team, embarked on a very successful social media campaign raising awareness of the vast array of apprenticeship opportunities available to our colleagues. A number of our Apprentices attended the Greater Manchester Combined Authority (GMCA) National Apprenticeship Week event where they networked with other Apprentices from across the region, sharing experiences, achievements and aspirations.

Sustainability

The sustainability agenda has risen in significance both for our organisation over the last twelve months, and also nationally and globally, as the opportunity to reduce the harmful effects of carbon emissions diminishes. All NHS organisations in Greater Manchester (making up the Greater Manchester Health and Social Care Partnership) declared a climate emergency in August 2019, in line with declarations made by the Greater Manchester Combined Authority and a number of local councils. In doing so, Greater Manchester became the first integrated care system in the country to declare a climate emergency. A joint Sustainable Development Management Plan (SDMP) was subsequently published in November 2019.

Key developments in 2019/20 include the appointment of a dedicated Sustainability Manager, the establishment of a Trust-wide Sustainability Steering Group and the launch of 'The Hive Collective' and our 'Clean Air Champions Network'. The latter is a 100+ member strong group of volunteers

committed to embedding sustainability across all of our services and supporting our Sustainability Manager to identify new projects and opportunities.
We have developed a draft GMMH Sustainability Strategy, which aligns with the regional SDMP and also the priorities set out in the 'For a Greener NHS' programme (launched in February 2020). Dedicated resources have been set aside to support delivery of the invest to save sustainability initiatives in 2020/21. This is with a view to limiting our environmental impacts and associated future costs and meeting rising energy, waste and environmental compliance expectations. For example, under the NHS Long Term Plan all energy purchased by NHS organisations must be 100% green by 2020/21.

Our sustainability performance in 2019/20 is described in further detail below.

Energy - Energy efficiency remains a key target for our Trust and the NHS as a whole. Our targeted energy efficiency programmes have continued to deliver positive results during the reporting period. Our total energy usage across our estate has, however, increased by 8% for gas and 3% for electricity due to the ongoing adoption of buildings following the Manchester acquisition and service developments (including new Teams and building moves).

Overall Trust Energy Performance	2018/19	2019/20
Tonnes of CO^2 (Tonne/$CO^{2)}$	5,416	7,315
Tonnes of Carbon	1,563	1,995

Note: Conversion factors based on fuel type (gas and electricity) have been applied to calculate overall energy consumption.

We will refresh our Energy Strategy and apply existing and new energy efficiency and reduction programmes across all of our estate going forward. This will include:

- Applying compliant temperature settings in all services and buildings
- Upgrading our Buildings Management System to install temperature sensors across multiple service to better manage local temperature
- Connecting individual utility meters to our Building Management System to increase efficiency in meter reading
- Renewing our electricity contract, choosing to procure 100% renewable energy in line with the NHS Long Term Plan

Waste – We have diverted over 5 tonnes of waste away from landfill this year via the 'Warp It' recycling and reuse programme. This equates to an almost 15 tonne reduction in our annual CO^2 emissions for waste. Efficiencies realised through 'Warp It' in 2019/20:

CO^2 Saved (Kg)	Cars off the Road	Waste Avoided (Kg)	Trees Planted Equivalent	Total Savings
14,803	3	5,345	20	£27,428

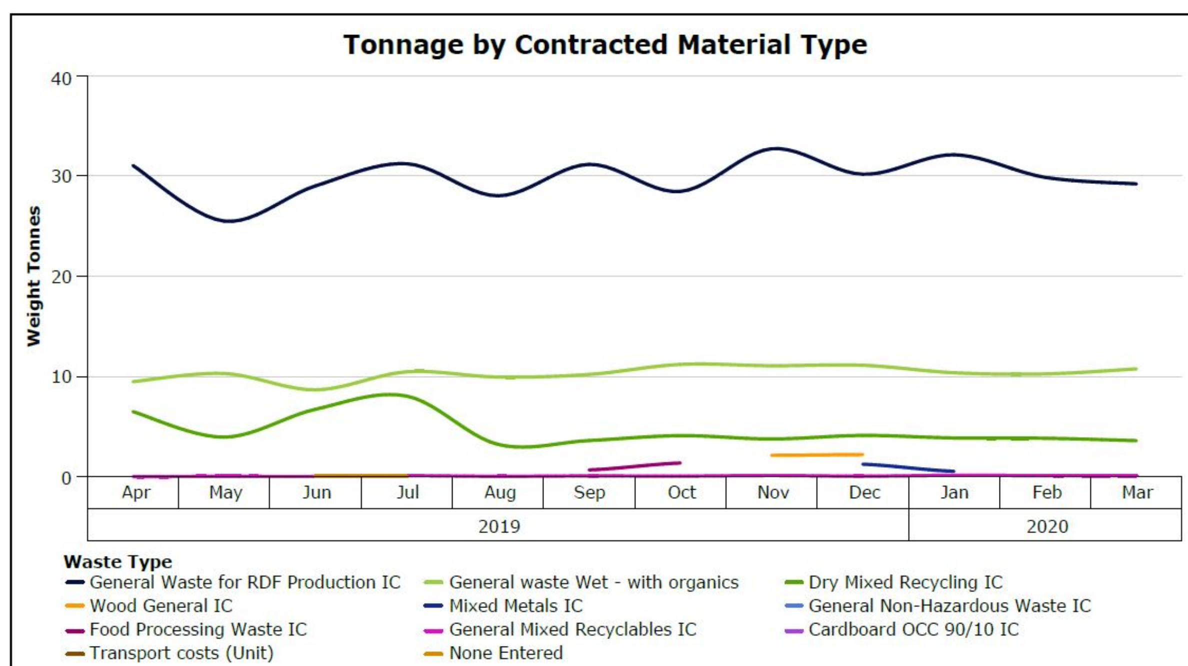
Activities include environmental charities shipping desks and cabinets from our own Warp It store to Sierra Leone to build a new school for the Kori Women's Project. (The Kori project works to educate, empower and improve the health of women and girls in the war-torn region.)

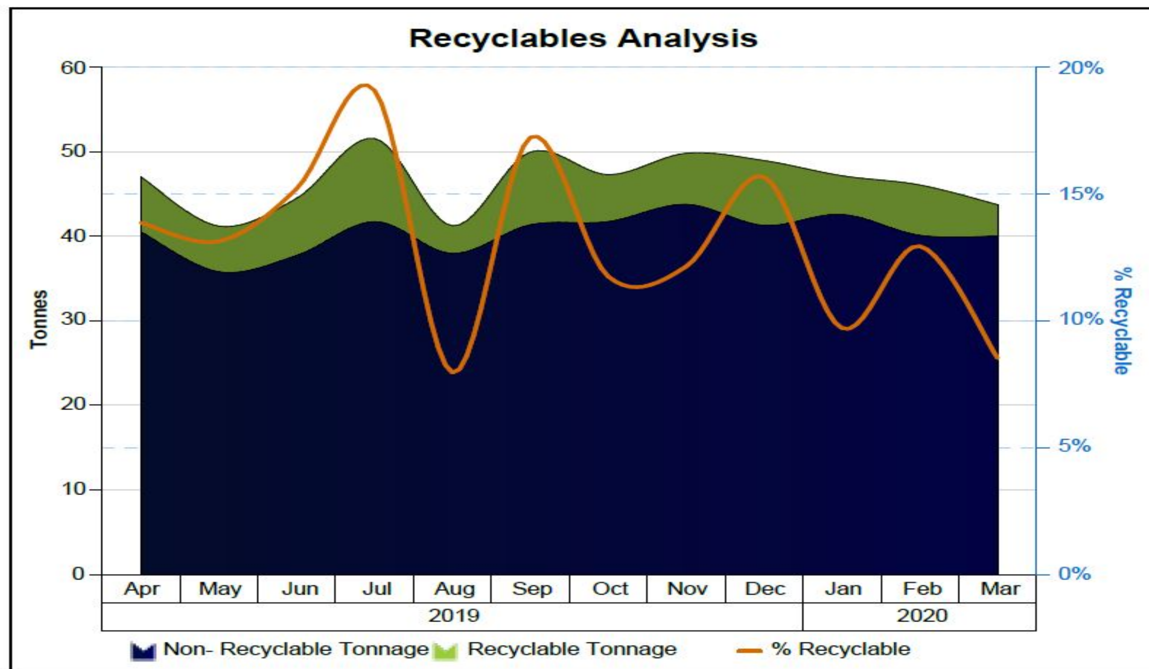
Since the introduction of 'Warp It' in 2015/2016 we have diverted over 31 tonnes of waste from landfill and avoided CO^2 emissions of nearly 100 tonnes:

CO^2 Saved (Kg)	Cars off the Road	Waste Avoided (Kg)	Trees Planted Equivalent	Total Savings
90,986	39	31,674	124	£202,358

During 2019/20 we have recycled approximately 13% of our waste. The total % recyclable has reduced following the acquisition of Manchester Mental Health and Social Care NHS Trust as Manchester services had limited or no recycling facilities in place. We are working hard to improve our performance in this area.

	Total 2019/2020
Total Tonnage Collected	558.503
Non- Recyclable Tonnage	448.509
Recyclable Tonnage	73.994
% Recyclable	13.25%





Innovations in waste management over the last year include:

- A mattress recycling programme diverting uncontaminated mattresses for recycling and reuse
- A programme to identify and receive cost rebates from Scrap Metal collection
- A Food Waste trial collecting food waste from wards and catering services for energy from waste incineration
- Development and delivery of an induction training programme for all Capital, Estates and Facilities staff who need to access our waste yard
- Waste yard environmental improvements, including to rooves and lighting, to comply with enhanced Environment Agency requirements for the provision of safe, legally complaint storage
- Completion of our baseline plastic purchasing data submission for the NHS Plastics Pledge (see below for further detail)

Our Waste Management Team have been nominated for the NHS Sustainability Awards 2020.

Transport – We have refreshed our Transport Policy during 2019/20. Our vehicle purchasing strategy now includes electric vehicles and we are developing further sustainable transport metrics as part of our refreshed Sustainable Development Management Plan.

Sustainable transport will be a key element of our ‘Single Point of Contact for Patient Transport’ project. This project is focused on using digital technologies to better understand the logistics and movements of our transport services in an effort to identify opportunities to drive down costs, develop a more sustainable service and reduce carbon emissions.

We commissioned the Energy Saving Trust to completed a Green Fleet Review of our vehicle fleets and management systems during 2019/20. This review assessed fossil fuel emissions and identified

opportunities for improvement. It has also helped us plan for the implementation of the Manchester Clean Air zone (current proposal 2022), by identifying which vehicles will require replacement.

Our Transport Team have also delivered cost and carbon savings by changing our vehicle fuel card provider. The new provider delivers via supermarket chains avoiding the costs and carbon emissions associated with the drive to fuel at designated points only. Our Transport Team have also been nominated for the NHS Sustainability Awards 2020.

Catering - Over the last year, our catering department have trialled a number of sustainability initiatives including food waste recovery and the use of non-plastic cups and takeaway containers. We have also released carbon savings (reduced Food Miles and transport emissions) by installing fridges at other premises. This enables providers to deliver food direct and avoids the need for redistribution by our Catering Department. Further sustainable catering metrics will be incorporated in our refreshed Sustainable Development Management Plan.

We were proud to commit to the NHS Plastics Pledge in 2019/20 and are focused on removing different plastics from our services, starting with catering, over a 5-year period. In 2019/20 plastic straws and stirrers have been removed from NHS Supply Chain catalogues and in subsequent years this will extend to include plastic and lined plastic cups, cutlery, sachets and plastic milk bottles. In each phase items essential to different patient groups will be assessed to ensure replacements are suitable.

Sustainability priorities and activities for 2020/21 include:

- Seeking Board of Directors' approval for our new Sustainability Strategy
- Commissioning a Sustainable Development Management Plan (SDMP) update
- Procuring 100% renewable energy in line with the NHS Long Term Plan
- Delivering further invest to save projects including LED roll-outs (high efficiency lighting) and Building Management System improvements
- Commissioning an in-depth analysis of our energy usage and spend, as a precursor to establishing a new carbon emissions baseline for all of our services and setting meaningful and challenging reduction targets
- Completing a lottery funding bid in partnership with Lancashire Wildlife Trust, focused on enhancing biodiversity and delivering opportunities for green health, social prescribing and improved patient outcomes

Modern Slavery

We are committed to ensuring that no modern slavery or human trafficking takes place in any part of our business or our supply chain. In early 2019/20, we completed our annual assessment of our risk exposure to modern slavery and reviewed our 'Slavery and Human Trafficking Policy Statement'. This statement is published on our website and sets out the actions we take to understand the potential risks and implement effective systems and controls. These include undertaking appropriate pre-employment checks on directly employed staff and requiring agencies to provide assurance that pre-

employment clearance has been obtained for any agency staff employed by the organisation. We also require all of our suppliers to comply with the provisions of the UK Modern Slavery Act (2015) through agreement of our 'Supplier Code of Conduct', purchase orders and tender specifications.

Anti-Fraud, Bribery and Corruption

We do not tolerate fraud, bribery and corruption and aim to eliminate such activity as far as possible to ensure that public resources are freed up for better patient care. We encourage anyone with reasonable suspicions of fraud, bribery and corruption to report them and have a policy in place to support this. Our commitment to anti-bribery is clearly set out in our Anti-Bribery Statement, which is available via our website.

Research and Innovation

The importance of our research and innovation activity has been highlighted this year through the agreement of our new strategic objective to *'continuously improve services for users through research, innovation and digital technology'.*

We have retained our focus on the six aims set out in our current Research and Innovation Strategy (agreed in December 2017) during the reporting period:

- Ensure our research and innovation activity is relevant to Trust, NHS and service user and carer priorities
- Maximise the opportunities for the community served by GMMH to participate in research and to benefit from developments in both research and innovation
- Ensure that clinical services are informed and improved by research involvement, dissemination and translation and innovation adoption
- Ensure the Trust maximises financial opportunities and income from research and innovation while ensuring value for money
- Ensure the Trust becomes a world-leading organisation for mental health research and innovation
- Ensure our research includes an emphasis on prevention in addition to treatment of established mental health problems

Our six funded Research Units - Psychosis Research Unit, Complex Trauma and Resilience Research Unit, Dementia Research Centre, Patient Safety Research Unit, Youth Mental Health Research Unit and CAMHS Digital Research Unit - have continued to thrive in 2019/20, achieving grant successes and maintaining their focus on co-production. Further investment has been confirmed for our Research Units for 2020/21, with the expectation set that the Units will align themselves more closely with clinical services, act on service user priorities and generate research income.

We were delighted to receive confirmation of funding for a further three Research Units in March 2020. Our new units will focus on mental health nursing, specialist perinatal mental health services and common mental health problems.

During 2019/20, our Research and Innovation Team has been supported by external research income including National Institute for Health Research (NIHR) grant successes leading to Research Capability Funding (RCF), a growing commercial research portfolio and income from the NIHR Greater Manchester Clinical Research Network (GM:CRN) and Health Innovation Manchester (HinM). Our external income has been supplemented by additional core funding from the Trust. Our total NIHR grant income for 2019/20 for all active grants and fellowships was £3,051,432. We also achieved a number of new NIHR grant successes over the last 12 months, which will run over the next three to five years. Areas of focus include looking at avoidable harm in prison settings and a peer-delivered disclosure course as an intervention to combat the stigma of psychosis.

During 2019/20, over 2000 patients, staff, relatives and carers participated in research projects approved by our Health Research Authority. As a Trust we have been involved in 87 clinical research studies, including 9 Clinical Trials of Investigational Medicinal Products (CTIMPs) and 8 of our own sponsored studies.

Customer Care

Our Customer Care Team have continued to support and facilitate the management of complaints, concerns and compliments received during the period. When we receive a complaint we aim to provide a timely, clear and transparent response, which evidences the action taken to deal with the concerns raised. All complaints received are recorded on our Datix system and reported to the Board of Directors on a quarterly basis as part of the Quality Report.

Learning from complaints is triangulated with other service user experience data and reviewed at our service user and carer experience meeting on a quarterly basis. We employ different methods to disseminate learning from complaints, including positive learning events and seven-minute briefings. Our most recent CQC Inspection Report noted that we "treated complaints seriously… learned from the outcome of investigations and complaints, sharing learning across the organisation to improve services".

We received 898 complaints during the reporting period. The following table breaks these complaints down by service area and provides a comparative position against 2018/19 data.

	2018/19	**2019/20**
Bolton	110	106
Manchester	343	355
Salford	124	122
Specialist Services	207	186
Trafford	68	65
City wide	-	64
Totals:	**852**	**898**

The increase of 46 complaints from 2018/19 to 2019/20 equates to an extra 4 complaints a month. Citywide complaints include complaints received about our IAPT and rehabilitation services, which were previously included in divisional totals.

409 improvement actions have been identified across the organisation as an outcome of complaints received in 2019/20. Of these, 259 actions had been completed by the end of March 2020 with the remaining 154 improvements still in progress.

Examples of service improvements during 2019/20 include:

- A ward manager ensuring their team treats carer involvement and communication with families as key considerations in discharge planning
- Verbal and written handover of concerns, regarding possible organic causes for a presentation, now occur between medics on different hospital sites or on different wards so that investigations can be completed without delay
- District services have recruited extra staff to improve the management of incoming calls to Community Mental Health Teams
- A senior manager and medic have developed awareness sessions for mental health liaison, home-based treatment and Community Mental Health Team (CMHT) staff on longitudinal risks, risk assessment in dual diagnosis patients and risk assessment and management of patients who disengage with services

Significant Events Post 1 April 2020

There have been no significant events since 1 April 2020, which have affected delivery of our strategy and key objectives.

Overseas Operations

We did not have any overseas operations during the year.

Neil Thwaite, Chief Executive
22 June 2020

Quality Report

Given the impact of coronavirus (COVID-19), arrangements for year-end accounts have been amended and there is no requirement to include a quality report in our 2019/20 Annual Report. We are however preparing a separate Quality Account, which incorporates all quality report requirements. Our plan is to finalise our Quality Account in June with a view to publishing on our website in July 2020. Our Quality Account will also be published on the NHS website in accordance with amended national timeframes, which are to be confirmed at the time of writing.

Accountability Report

Directors' Report

This is our annual overview of the arrangements put in place to ensure that our services were well-led during the period 1 April 2019 to 31 March 2020. This Directors' Report should be read alongside the Performance Report, Quality Account and Annual Governance Statement.

NHS Foundation Trust Code of Governance

In preparing this report, we have applied the principles of the NHS Foundation Trust Code of Governance on a 'comply or explain' basis. The NHS Foundation Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

We use the Code of Governance as a source of best practice guidance when reviewing and improving our governance structures and processes. All disclosures required by the Code are covered within this Accountability Report. We follow the Code guidance with exception to the composition of our Board of Directors (Code Reference B.1.2). Our Constitution provides for parity between executive and non-executive directors (including the Chair) rather than at least half the Board (excluding the Chair) comprising non-executive directors. Guidance relating to performance-related pay for executive directors (Code Reference D.1.1) is not applicable as our remuneration policy does not include any performance-related elements.

Our Governance Arrangements

We have continued to work hard during 2019/20 to ensure that our governance arrangements are sound and fit for purpose, both in the short-term and looking forward. We took temporary measures, from March 2020, to adapt our board assurance and governance arrangements to enable our response to COVID-19. These are described in more detail in our 'Annual Governance Statement', along with further information on our incident response and business continuity arrangements.

Our Board of Directors operate as a unitary Board, with decisions made collectively by executive and non-executive directors and responsibilities and liabilities shared. Our Board offers a wide range of skills and experience, with a number of directors having a medical or nursing professional background and other members offering skills and experience in finance, strategy, business development, the law and the third sector. We believe that our Board is balanced in its composition and appropriate to the requirements of the organisation.

Our Board of Directors sets the overall strategic direction for the Trust and is collectively responsible for monitoring all aspects of performance, providing financial stewardship and ensuring the provision of high quality, safe and effective services. Executive directors manage the day to day operational running of the organisation, whilst our non-executive directors are focused on challenging the Executive Team on management and strategy. Our non-executive directors do not hold any managerial responsibility, but are collectively accountable with the executive directors for the Trust's

performance. The contribution of non-executive directors and their relationships with executive directors and governors is facilitated by the Chair.

All of our non-executive directors are considered to be independent, as they have not been employed previously by the Trust, do not have any financial or other business interest in the organisation and do not have close family ties with any of the Trust's directors, senior employees or advisors. Other significant commitments held by the Chair during the reporting period, and other non-executive directors, are summarised in the Board of Directors' Register of Interests.

None of our current non-executive directors have currently served on the Board for more than six years. The Council of Governors agreed a seventh year of office (to commence on 1 August 2020) for one non-executive director (Anthony Bell) in July 2018 to maintain stability and organisational memory on the Board following the acquisition of Manchester Mental Health and Social Care NHS Trust. The views of governors will be sought in July 2020 on a seventh year of office for another Non-Executive Director (Julie Jarman) to maintain leadership of the quality improvement agenda.

Our Council of Governors provide local accountability by representing the interests of members and partner organisations. The Board of Directors retains overall responsibility for decision-making except where the Council of Governors has statutory responsibilities. Directors develop an understanding of the views of governors, and enable governors to fulfil their statutory duties, through attendance at Council of Governors' meetings and the Annual Members' Meeting. Governors' views have been sought on the Trust's forward plans and key strategic priorities during the period and Board members have also provided feedback on the Trust's undertakings and performance.

NHS Improvement's Well-led Framework

During our most recent Care Quality Commission (CQC) inspection (04 June to 10 July 2019), inspectors reviewed our leadership and governance arrangements against the well-led framework, which brings together the CQC's key lines of enquiry for well-led and NHS Improvement's framework for leadership and governance.

Our overall rating for well-led is 'Good'. This rating takes into account the CQC inspectors' views on leadership in individual services. The CQC rated our leadership as 'Good' because:

- We had an experienced and stable Board with a range of experiences that brought effective challenge and collective leadership. Leaders understood our challenges and recognised the positive progress that we had made. Leaders were able to identify where further improvement was required and worked together to ensure delivery of services
- Leadership, governance and culture supported the delivery of high-quality care. Leaders were visible and approachable
- Strategies and plans in place were aligned to the wider health and social care system. Plans were monitored and consistently implemented and there was evidence of improvement in the quality of services. We had completed a two-year programme to improve mental health services in the City of Manchester and were now developing our strategy and priorities for the next five years

- We identified, monitored and responded to current and future risks. There were effective audit process in place and actions were taken when issues were identified
- An open and transparent culture was promoted by the senior leadership team. Staff were encouraged to raise concerns and felt able to do so. When things went wrong, we adhered to the Duty of Candour, investigated what happened and acted to improve services
- We engaged constructively with staff and people who use services, working proactively to gather people's views and developed services with their full participation. We showed a commitment to act on feedback received regarding our services
- We continued to maintain strong financial management. Our financial position was closely monitored and understood by the board. Financial decisions were considered against their impact on the quality of service delivery and patient safety
- There were systems in place to support improvement and innovation. We played an active and lead role in supporting the development and delivery of mental health services across Greater Manchester. We worked collaboratively with others, including Greater Manchester Health and Social Care Partnership, to share learning and develop innovative services to meet the needs of the populations we serve
- We had a strong research strategy and a high level of research activity taking place throughout the organisation. We aim for our services to be academically informed and that research and innovation are embedded in our services and policies

Under the well-led domain, the CQC identified the need to improve our Trust-wide processes for monitoring supervision provision and compliance as a 'Must Do'. Since the inspection, we have launched our new Supervision Policy and introduced a new centralised electronic system for recording supervision to address the CQC's concerns.

No material inconsistencies have been identified between the outcomes of the CQC's most recent well-led assessment and our own current evaluation of the organisation's performance and system of internal control as set out in this Annual Report (specifically in the Annual Governance Statement and Performance Report) and our corporate governance statement.

Our Board of Directors

There have been two key changes to our Board of Directors during 2019/20. Alice Seabourne joined our Board as Medical Director on 1 October 2019, following the retirement of Chris Daly at the end of August 2019. (Chris Daly operated as Acting Medical Director during the interim period). Ismail Hafeji retired from his role as Director of Finance and IM&T at the end of March 2020, having worked in NHS finance since 1983 and as an Executive Director at GMMH since 2011. Suzanne Robinson, current Director of Finance and joint Deputy Chief Executive at Pennine Care NHS Foundation Trust, will be taking on the role later this year. Suzanne's appointment follows an extensive and thorough recruitment process involving service users, carers and governors.

The members of our Board of Directors at the end of 2019/20 were:

Non-Executive Directors

Rupert Nichols, Chair (current term ends July 2022)	
	Rupert is a solicitor and Chartered Secretary with 40 years' commercial board-level experience in a wide range of organisations in the legal and accountancy, logistics, manufacturing and services sectors. He has extensive experience in corporate governance, compliance, mergers and acquisitions and risk management. Previously Chair of Calderstones Partnership NHS Foundation Trust and board member of the NHS Confederation Mental Health Network, Rupert brings valuable experience of mental health and learning disabilities leadership to GMMH.

Anthony Bell, Non-Executive Director (current terms ends July 2021)	
	Anthony joined GMMH in 2014 and is a qualified accountant. Anthony has over 20 years of experience at board level in the education and social housing sectors, and has also held senior roles in the private sector. He is a non-executive director of two local housing associations and deputy chair of a managed workspace complex company that supports developing business. Anthony has also previously been a board member and treasurer of a training placement organisation for minority groups and an education trust which supported disadvantaged groups. Anthony is Chair of our Charitable Funds Committee and a member of the Audit Committee.

Helen Dabbs, Non-Executive Director (current term ends September 2021)

Helen most recently worked at executive level at NHS Improvement (NHSI) North (2015 to 2018) as Regional Nurse Director and Delivery and Improvement Director, where she had oversight of the safety, quality and financial sustainability of provider trusts and also supported trusts with their quality improvement agendas. Helen joined NHSI from Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH) where she held progressive roles including Director of Mental Health (2002 to 2005), Director of Operations (2005 to 2008), Acting Chief Executive Officer (2008 to 2009) and Deputy CEO/Director of Nursing and Partnerships (2009 to 2015). During her time at RDaSH, Helen also held number of additional roles including Specialist/Clinical Advisor to CHI/Healthcare Commission/Care Quality Commission (CQC) and National Taskforce Advisor to the Better Care Fund.

Stephen Dalton, Non-Executive Director and Vice Chair (current term ends December 2022)

Stephen has over forty years' experience in the NHS. He started his NHS career in 1976 as a general nurse on Merseyside, followed by a period working in mental health services in South Manchester and a series of clinical leadership roles including as a Director of Nursing. Stephen spent 17 years as a Trust Chief Executive, in Merseyside and Cumbria, responsible for delivering frontline clinical services and describes his career passion as mental health services.

Stephen is known nationally for his work as Chief Executive of the NHS Confederation and of the Mental Health Network, both roles demanded engagement at the highest level of government and the NHS. He is currently sponsored by NHS Employers to lead Chief Executive Development Groups at a national level.

Andrea Harrison, Non-Executive Director (current term ends December 2022)

Andrea is a chartered accountant with over 20 years business and financial experience in the private sector and is currently a Transformation Leader for a major pharmaceutical company (AstraZeneca). Andrea brings a wealth of experience in strategic and operational planning, performance management, merger & acquisition integration and change management.

Andrea is Chair of our Audit Committee.

Julie Jarman, Non-Executive Director (current term ends July 2020)

Julie joined GMMH in 2014. Julie has over 17 years' experience of senior management in the voluntary sector both in the UK and in international development. She also works as a management coach and mentor. Julie currently works as a Senior Principal Strategy lead for the Equality and Human Rights Commission. She is also a trustee of two charities (MIND in Salford and CLASS) and Chair of HomeWorkers Worldwide.

Julie is Chair of our Quality Improvement Committee and a member of the Charitable Funds Committee.

Pauleen Lane CBE, Non-Executive Director and Senior Independent Director (current term ends December 2022)

Pauleen is currently Group Manager for National Infrastructure at the Planning Inspectorate and also a visiting lecturer at Manchester University. She has a PhD in numerical modelling and geotechnical engineering. Her early career was in local governments - in officer and councillor positions at Trafford Council - and as a commissioner with the Audit Commission. She has experience in a range of public sector non-executive roles including at Liverpool Women's Hospital, the Sports Ground Safety Authority, the North West Development Agency, English Partnerships, Tenant Services Authority and the Coal Authority.

Pauleen is GMMH's Senior Independent Director and a member of the Audit Committee.

Executive Directors

Neil Thwaite, Chief Executive	
	Neil started his career in the NHS in 1993 and has worked across many NHS sectors including acute care, primary care, the Cancer Network and the Strategic Health Authority. Neil is formally qualified in business and project management, most recently successfully attaining a Master's in Business Administration at Manchester Business School. Neil joined GMMH in 2006 and was the Executive lead for the successful Foundation Trust application. He has a great deal of experience and a strong interest in service development, business planning, contracting, performance improvement and strategy.

Elizabeth Calder, Director of Performance and Strategic Development	
	Liz joined GMMH in 2019 from the Northern Care Alliance NHS Group, where she held the post of Deputy Director of Strategy and Planning and provided strategic leadership and support to key programmes of work. Since joining the NHS as a Graduate Management Trainee in 1994 Liz has worked in senior roles across the North West of England including commissioning, community, acute and tertiary organisations. As an Economics graduate with an MA from University of Manchester Liz has extensive experience in strategic change, significant transactions, service developments, contracting, tenders, planning and operational management. Recent roles have included working with partners to establish the first Integrated Care Organisation in the country and the national proton therapy service at The Christie.

Gill Green, Director of Nursing and Governance

Gill joined the Trust in August 2011. Gill has extensive experience in delivering nursing care in both acute and community settings and has worked for a number of different NHS organisations including Clatterbridge Hospital in Bebington, James Cook University Hospital in Middlesborough, Barnsley Care Services Direct and South West Yorkshire Partnership NHS Foundation Trust.

Gill also works closely with third sector providers and offers experience of trusteeships in this area. She is particularly involved in nursing workforce education and nursing leadership across the Greater Manchester area.

Ismail Hafeji, Director of Finance and IM&T (until 31 March 2020)

Ismail joined GMMH in 2011. Ismail offers a wealth of experience, having worked in NHS finance since 1983 at NHS Trusts, Health Authorities and PCTs around the North West. He has worked as a Finance Director for over ten years. His previous role was as Director of Finance, IT and Information with NHS Bolton. Ismail also worked as Acting Director of Finance for the former West Lancashire and Chorley and South Ribble PCTs.

Andrew Maloney, Director of Human Resources and Deputy Chief Executive

Andrew has worked in senior HR positions across a broad range of NHS sectors. From 2000 to 2004 he worked as the Assistant Director of HR for Sefton Health Authority and Sefton Primary Care Trust working on HR change management projects that supported the establishment of PCTs across Sefton. In 2004, Andrew joined The Walton Centre NHS Trust as Director of HR and was part of the executive team that led the organisation to Foundation Trust status. Andrew joined GMMH in 2009 as Director of HR and Governance and has more recently taken on wider responsibility for capital, estates and facilities (CEF) and corporate affairs. Andrew was also appointed as the Trust's Deputy Chief Executive in early 2019.

Deborah Partington, Director of Operations	
	Deborah began her NHS career over 30 years ago, when she started her nurse training in Salford. Since then she has held a variety of senior posts at the Trust including Clinical Leader, Head of Operations, Network Director and Associate Director of Operations. She was seconded to the NHS Confederation – Mental Health Network for a year working with them to represent health organisations across England within national strategic developments. As well as her nursing qualifications, Deborah also has a Masters in Health Services Management from the University of Manchester. A key focus of Deborah's current role is providing executive oversight of the operational management of all clinical services.

Dr Alice Seabourne, Medical Director from 1 October 2019	
	Alice's careers spans almost 30 years within the NHS. She has worked as a Consultant Psychiatrist in our Later Life Services since 1999 and continues to deliver this role, in our community services in Bolton, alongside her Medical Director commitments. Prior to taking on the role of Medical Director in 2019, Alice was also the Trust's Associate Medical Director for Rehabilitation, IAPT, Bolton and Salford from 2017. Alice is an active participant in the North West Leadership Academy's Aspirant Talent Management Programme and is a member of the North West Medical Directors Network. She has been actively involved in developing our Quality Improvement Strategy, particularly in the areas of rapid tranquilisation and the Mental Health Act.

Meetings of the Board of Directors

The first part of our Board meetings are held in public with the papers for each meeting published on our website. Governors are provided with a copy of the agenda prior to each Board meeting and access to a copy of the minutes following their approval at the subsequent meeting. The second part of our Board meetings are held in private and reserved for discussion of confidential items. During 2019/20, the Board of Directors met formally on 11 separate occasions, of which two meetings (in April and December 2019) were reserved solely for private discussion and Board development.

A quorum of seven directors, including not less than two executive directors, of which one must be the Chief Executive or Deputy Chief Executive, and not less than two non-executive directors, of which one must be the Chair or Vice-Chair, is required for a Board of Directors' meeting to take place.

The following table shows the attendance of individual directors at our 2019/20 Board meetings. As there were changes to the Board of Directors during the year, and a period of long-term sickness on the part of one Board member (Ismail Hafeji), not all Board members had the opportunity to attend all meetings. Janine Taylor, Associate Director of Finance attended Board meetings on Ismail Hafeji's behalf during his absence in Quarter 1 2019/20.

	Name	Meetings Attended
Non-Executive Directors	Rupert Nichols, Chair	11/11
	Anthony Bell, Non-Executive Director	11/11
	Helen Dabbs, Non-Executive Director	10/11
	Stephen Dalton, Non-Executive Director	10/11
	Andrea Harrison, Non-Executive Director	11/11
	Julie Jarman, Non-Executive Director	11/11
	Pauleen Lane, Non-Executive Director	10/11
Executive Directors	Neil Thwaite, Chief Executive	11/11
	Elizabeth Calder, Director of Performance and Strategic Development	11/11
	Chris Daly, Medical Director (to end Sept. 2019)	5/5
	Gill Green, Director of Nursing and Governance	11/11
	Ismail Hafeji, Director of Finance and IM&T	7/8
	Andrew Maloney, Director of HR and Deputy Chief Executive	11/11
	Deborah Partington, Director of Operations	9/11
	Alice Seabourne, Medical Director (from Oct. 2019)	6/6

Evaluating Board Performance and Effectiveness

Performance evaluation of both executive and non-executive members of the Board of Directors is by individual appraisal and collective evaluation. The Chair conducts all non-executive appraisals and also appraises the Chief Executive, whilst the Chair's performance is appraised by the Senior Independent Director. The Chief Executive appraises individual executive director performance. The appraisal

process is competency-based, targeted towards the specific requirements of individual roles and includes self- and peer-assessment. Objectives and personal development plans for the upcoming year are agreed through the appraisal process.

Appraisals of performance during 2018/19 were completed in Quarter 1 2019/20. The Nominations Committee of the Council of Governors received a report on the outcomes of the Chair and non-executive director appraisal process in June 2019, which provided assurance on the robustness of the process. 2018/19 appraisal outcomes were subsequently considered at a full meeting of the Council of Governors in July 2019. The Remuneration and Terms of Service Committee were briefed on the outcomes of the 2018/19 Chief Executive and executive director appraisal process.

For 2019/20 appraisals, we have updated the Chair's process to reflect the new national 'Framework for Conducting Annual Appraisals of NHS Provider Chairs'. Whilst national guidance is awaited on other Board-level appraisals, we have also updated the Chief Executive, non-executive director and executive director processes in line with the Chair's process to maintain consistency. Completion of 2019/20 appraisals was planned for Quarter 1 2020/21 but has been deferred until the COVID-19 crisis has passed.

Board development activity during the reporting period followed a formal schedule. Development activities have included focus on quality improvement, board effectiveness, the external commissioning landscape, systems thinking, Board assurance and financial performance and sustainability. A number of development sessions have been externally facilitated to bring new perspectives, independence and enable access to specific expertise, for example, in relation to quality improvement.

All individual Board members have completed an annual self-assessment against the requirements of the Fit and Proper Persons Regulations to determine that they are of good character, are physically and mentally fit, and offer the necessary skills, qualifications and experience. There were no issues identified in this regard.

Board members have also continued to evaluate the effectiveness of Board meetings at the end of each meeting with feedback reviewed at the subsequent meeting and informing future Board development activity.

Board Committee Structures

During the reporting period, the Board of Directors has been supported by four formal committees:

A. Audit Committee
B. Quality Improvement Committee
C. Charitable Funds Committee
D. Remuneration and Terms of Service Committee

The work of each of these Committees is described below. Reviews of the Terms of Reference and membership of individual Committees has been undertaken, as required, during the period to ensure

that they continue to be fit for purpose. The minutes of Committee meetings have been reported to the Board of Directors. Committee Chairs' reports have also been presented to the next meeting of the Board of Directors immediately following a Committee meeting to enable more timely feedback and assurance.

In October 2019, the Board of Directors took the decision to establish a time-limited Working Group (the Finance Working Group) to enable in-depth scrutiny and review of the Trust's financial position. In March 2020, the Board of Directors approved a recommendation from the Finance Working Group to establish a permanent strategic finance committee to support future monitoring of financial performance. Terms of reference for the new committee will be agreed in early 2020/21.

A. Audit Committee

The Audit Committee is responsible for reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the organisation's activities, on behalf of the Board of Directors. The Audit Committee ensures that an effective internal audit function is in operation, which meets all required standards, and reviews and monitors the work and findings of the Trust's external auditors. The Committee is also responsible for ensuring that the Trust has adequate anti-fraud arrangements in place.

The Audit Committee Terms of Reference were subject to an annual review in September 2019.

Committee Membership and Meetings

The Audit Committee has been chaired throughout the year by a non-executive director. The Committee's membership comprised two further non-executive directors selected on the basis of their individual skills and experience. Membership of the Audit Committee as at 31 March 2020 was as follows:

- Andrea Harrison, Committee Chair
- Anthony Bell, Committee Member and Vice-Chair
- Pauleen Lane, Committee Member

The Audit Committee has been assisted in its work through the routine attendance at meetings of our internal auditors, anti-fraud specialist and external auditors. The Director of Finance and IM&T, Director of HR and Deputy Chief Executive and Director of Nursing and Governance also attended meetings during the period as a result of their lead roles on matters considered by the Committee.

The Audit Committee met six times in 2019/20 and the table below shows each member's attendance.

Name	Meetings Attended
Anthony Bell, Committee Member and Vice-Chair	6/6
Andrea Harrison, Committee Chair	6/6

Pauleen Lane, Committee Member	5/6

Audit Committee members have had opportunity to meet privately with external and internal auditors during 2019/20. Right of access to the Committee Chair for internal audit, external audit and counter-fraud has also been maintained throughout the year.

Audit Committee Effectiveness

The Audit Committee completed a review of effectiveness in February 2020. The review was informed by an assessment, completed by the Committee Chair and Company Secretary, focused on committee administration, internal audit, external audit and anti-fraud. The outcomes of the review were positive overall, with two improvement actions - internal auditor compliance with Public Sector Internal Audit Standards (next review due in 2020/21) and internal audit key performance indicators - agreed and being progressed.

Assurance - Internal Audit

Our internal audit function has continued to be provided by Mersey Internal Audit Agency (MIAA) during 2019/20.

Our annual plan of internal audits is designed to support the Board of Directors and Audit Committee in discharging their governance responsibilities. The outcomes of internal audits give assurance to the Board, via the Audit Committee, that risks are understood and being addressed or reduced to an acceptable level. Internal audit plans fully comply with national standards and guidance.

The Internal Audit Plan for 2019/20 was agreed by the Audit Committee in April 2019 and reflected our risk assessment, assurance requirements and strategic objectives. The plan was reviewed during the year and amended as appropriate to reflect changing priorities. The plan was delivered in accordance with the schedule agreed by the Audit Committee at the start of the financial year, with the exception of a number of audits deferred at the Trust's request and a number of audits delayed due to the coronavirus pandemic.

Mersey Internal Audit Agency issued 12 internal assurance opinions during the reporting period, of which eight were a 'Substantial' assurance opinion and four were a 'Moderate' opinion. No critical recommendations and five high risk recommendations were raised in respect of the completed audits. The high risk recommendations were in relation to the reviews of Compliance with Targets, Statutory Compliance (Estates), ICT Asset Management and Quality Management. The Audit Committee has continued to secure assurance on progress with audit recommendations via twice-yearly follow-up reports.

A further two reviews were also completed by Mersey Internal Audit during 2019/20, one of our Assurance Framework and one of Travel Expenses. Assurance ratings were not applicable to these reviews due to the nature of the work. In terms of the Assurance Framework review, the Assurance Framework was found to be structured to meet NHS requirements, visibly used by the Board and

clearly reflective of the risks discussed by the Board. In terms of the travel expenses review, the report is being finalised at the time of writing.

The Committee received the Head of Internal Audit's opinion on the effectiveness of the Trust's system of internal control for the financial year 2019/20 in April 2020. The overall opinion was that 'Substantial Assurance' can be given that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.

In 2019/20, we spent £121,953k on the internal audit and anti-fraud services provided by Mersey Internal Audit Agency.

Assurance - External Audit

External audit services have continued to be provided by KPMG LLP during 2019/20. KPMG's current contract term as our external auditors commenced in December 2016. In April 2019, the Council of Governors agreed a two-year extension to KPMG's current contract (effective from 1 December 2019) on the recommendation of the Audit Committee. This followed a fully satisfactory review of the auditor's performance completed by the Audit Committee on the Council of Governors' behalf. The effectiveness of KPMG's services was judged on the basis of the quality of their audit provision, level of challenge, timeliness of reporting, engagement and communication, and value for money. In February 2020, KPMG confirmed their independence and policy on the provision of non-audit services.

KPMG have continued to present technical updates to the Audit Committee on accounting, business and regulatory matters that are relevant to our organisation and the wider healthcare sector during 2019/20.

In February 2020, the Audit Committee considered and approved the 'External Audit Plan for 2019/20', including the planned audit approach, materiality levels and financial statements and value for money risk assessments.

We incurred fees of £57,896k (excluding VAT) in 2019/20 for external audit services, comprising statutory audit fees of £54,842 and non-audit fees of £3,054 for audit-related assurance services.

Assurance - Anti-Fraud

Our anti-fraud services have continued to be provided by Mersey Internal Audit during the period and operated by a dedicated local Anti-Fraud Specialist. Our annual anti-fraud work plan was approved by the Audit Committee in February 2019 and informed by national and regional risk areas, GMMH-identified strategic risks, management requests, national standards and best practice. The Audit Committee received regular reports on the progress and outcomes of anti-fraud work during the period, in addition to briefings on 'live' anti-fraud investigations to enable more timely action We completed our annual self-assessment against the NHS Counter Fraud Authority's fraud, bribery and corruption standards for providers in late 2019/20 with performance rated as 'Green' in all areas. This is with the exception of one 'Inform and Involve' standard and one 'Hold to Account' standard, which

were both rated as 'Amber' due to the timing of the assessment. Action has already been taken in both of these areas.

All employees have been given an overview of our 'Anti-Fraud, Bribery and Corruption Policy' at induction with awareness sessions conducted on an ad hoc basis and the policy available to all staff thereafter.

On the basis of the information received by the Audit Committee, the Committee has been able to provide assurance to the Board, via the Committee Chair's Assurance Reports, on the overall adequacy of the arrangements in place to counter fraud, corruption and bribery. The Committee will continue to strengthen its oversight of anti-fraud work in 2020/21 with a view to improving the timeliness and appropriateness of our response.

Financial Statements, Operations and Compliance

On 27 April 2020, the Audit Committee reviewed a summary of the Trust's performance based on the annual accounts for the period 1 April 2019 to 31 March 2020. The Committee noted any variations from performance in 2018/19 including the explanations provided for this. Management brought to the Committee's attention significant movements in the accounts over the period.

The Committee reviewed the Trust's financial statements, with a particular focus on:

- Compliance with financial reporting standards
- Areas requiring significant judgements in applying accounting policies
- Any changes to accounting policies during the year – no changes were reported
- Whether the accounts offer a fair reflection of the Trust's performance

The Committee considered the significant audit risks identified in relation to the financial statements, including revenue recognition, valuation of land and building assets, valuation of Local Government Pension Scheme (LGPS) liability, fraudulent expenditure recognition and management override of controls. The Committee also considered the areas where the Trust has applied judgement in the treatment of revenue and costs to ensure that the annual accounts represented a true position of the Trust's finances.

In relation to the valuation of land and building assets, the Committee noted that the results of the valuation completed in year have not been transacted in the accounts. Though the valuation report identified a material uncertainty, the Committee received assurance from management's impairment review that the change in valuation did not have a material impact on the accounts.

Annual Governance Statement

At its meeting on 27 April 2020, the Audit Committee reviewed the draft Annual Governance Statement for 2019/20. The statement was judged consistent with the Audit Committee's view on the organisation's system of internal control.

B. Quality Improvement Committee

The Quality Improvement Committee provides leadership and oversight for the Trust's quality and integrated governance agenda, ensuring that the Board of Directors has a clear focus on quality, effectiveness and safety. During 2019/20, the Quality Improvement Committee has shifted the balance in our quality management system to incorporate improvement and innovation and enable delivery of our new Quality Improvement Strategy. The Committee has maintained a tight grip on assurance, control and planning to complement our improvement activities. The breadth of quality improvement activity undertaken in 2019/20 is celebrated in our Quality Account 2019/20.

The Board of Director members of the Quality Improvement Committee as at 31 March 2020 are listed below. The Committee has extended its membership during 2019/20 to ensure appropriate expert representation from the Trust's clinical services, professional leads and the governance team. The Committee completed an in-depth review of its function, format and shape in February 2020 to support future delivery of the Trust's ambitious quality improvement agenda.

The Quality Improvement Committee met on eight occasions times during the financial year. The Committee also held an extraordinary meeting in April 2019 to facilitate sharing of service-level quality improvement priorities. A meeting scheduled for March 2020 was stood down to enable focus on the Trust's COVID-19 response.

Board members' attendance at Quality Improvement Committee meetings was as follows:

	Name	Meetings Attended
Non-Executive Directors	**Helen Dabbs,** Committee Member	7/8
	Julie Jarman, Committee Chair	7/8
Executive Directors	**Elizabeth Calder,** Director of Performance and Strategic Development	5/8
	Chris Daly, Medical Director and Vice-Chair (to end Sept. 2019)	3/4
	Gill Green, Director of Nursing and Governance	8/8
	Andrew Maloney, Director of HR and Deputy Chief Executive	6/8
	Deborah Partington, Director of Operations *	1/8
	Alice Seabourne, Medical Director and Vice-Chair (from Oct. 2019)	4/4
	Neil Thwaite, Chief Executive	4/8

* An Associate Director of Operations attends each meeting of the Quality Improvement Committee where the Director of Operations is unable to attend. The Chief Executive is represented by the Deputy Chief Executive in his absence.

C. Charitable Funds Committee

Our Charitable Funds Committee aims to ensure that the Trust properly discharges its responsibilities as Corporate Trustee of the Trust's Charitable Funds.

During 2019/20, our focus has been on streamlining individual and dormant funds into three primary general funds (service user, staff and service user/staff) and prioritising spend of funds. We have used our charitable funds to deliver direct patient benefit by funding the following this year:

- Dementia friendly activity tables and resources for later life wards
- Redecoration and furnishings for inpatient wards
- Provision of Christmas gifts for all inpatients
- Course fees and training materials
- Reflexology and sensory items
- Arts and craft materials
- Items to enhance and improve outdoor spaces
- Pet therapy

The Committee has also considered the longer-term strategic direction of the charity, including its messaging and approach to fund-raising. The Trust will retain its charitable status going forward with the Charitable Funds Committee determining the focus of any fundraising activities as and when the need arises.

Committee membership during 2019/20 has been:

- Anthony Bell, Non-Executive Director and Committee Chair
- Gill Green, Director of Nursing and Governance
- Ismail Hafeji, Director of Finance and IM&T
- Julie Jarman, Non-Executive Director

The Charitable Funds Committee met three times in 2019/20 with attendance recorded as follows:

	Name	Meetings Attended
Non-Executive Directors	**Anthony Bell,** Committee Chair	3/3
	Julie Jarman, Committee Member	3/3
Executive Directors	**Gill Green,** Director of Nursing and Governance	3/3
	Ismail Hafeji, Director of Finance and IM&T	2/2

D. Remuneration and Terms of Service Committee

The Remuneration and Terms of Service Committee is responsible for reviewing the Trust's leadership requirements and identifying and appointing candidates to fill executive director vacancies on the Board. The Committee also monitors and evaluates the performance of executive directors and makes recommendations to the Board of Directors on remuneration and other conditions of service.

A key focus of the Remuneration and Terms of Service Committee in 2019/20 has been the appointment of the Trust's new Medical Director and new Director of Finance and IM&T. The Committee agreed the role requirements, remuneration and appointment criteria for both roles taking into account current and future needs.

Committee members led a thorough recruitment process, with the Chief Executive, to generate an appropriate candidate pool and select a preferred candidate for each role. Experienced recruitment specialists (Gatenby Sanderson) were also commissioned to support the Director of Finance and IM&T appointment.

The final stage of both selection processes required candidates to participate in structured discussions with a number of service users and carers, in addition to a meeting with Executive Directors (and, in the case of the Medical Director other Senior Leaders) and a formal interview with a selection panel. The selection panel comprised members of the Remuneration and Terms of Service Committee, plus the Chief Executive and an experienced NHS Executive Director operating in the capacity of independent external assessor. At the end of both processes, the selection panel's decision to appoint Alice Seabourne as Medical Director and Suzanne Robinson as Director of Finance and IM&T was unanimous.

Further information on the work of the Remuneration and Terms of Service Committee in 2019/20, including Committee membership and attendance at meetings, is provided in the Remuneration Report.

Register of Interests

As set out in our constitution, all members of the Board of Directors have a responsibility to declare any relevant and material interests which may be at conflict with, or preferentially enhanced by, their relationship with the Trust. Declarations are entered into a Register of Interests and are available to the public on request via Kim Saville, Company Secretary (kim.saville@gmmh.nhs.uk). The Register is kept up to date by means of an annual review at the end of each financial year and updated within the year recording any changes to interests. Board members are also required to declare any conflicts of interest that arise in the course of conducting Trust business, specifically at the beginning of each Board of Directors' meeting. The declared interests of members of the Board of Directors at the end of March 2020 are shown in the table overleaf.

Register of Interests Declared by the Board of Directors – March 2020

Name	Position/Role	Term of Office	Interests Declared	Type of Interest	Date of Entry onto Register / Amendment
Anthony Bell	Non-Executive Director	31.07.21	• Non-Executive Director – Cariocca Enterprises	• Non-financial personal	30.10.17
			• Non-Executive Director – Inclusion Housing, York	• Financial	30.10.17
			• Chair – Equity Enterprises Ltd. Subsidiary Board, Equity Housing Group Ltd., Cheadle Hulme, Cheshire	• Financial	30.10.17
			• Non-Executive Director – Equity Housing Group Ltd., Cheadle Hulme, Cheshire	• Financial	11.12.18
Elizabeth Calder	Director of Performance and Strategic Development	N/A	• Husband is employed as a Director of Manchester University NHS Foundation Trust	• Indirect	11.02.19
Helen Dabbs	Non-Executive Director	09.09.21	• Specialist Advisor for the Care Quality Commission (CQC) since 2003	• Non-financial professional	24.09.18
			• Member of Leeds and York Partnership NHS Foundation Trust since 2015	• Non-financial professional	24.09.18
Stephen Dalton	Non-Executive Director	31.12.22	• Lead for Chief Executive Development Groups – sponsored by NHS Employers	• Financial	26.03.18
			• Director – SJ Dalton Ltd.	• Financial	26.03.18
			• Member of East London NHS Foundation Trust	• Non-financial professional	05.03.20
Gill Green	Director of Nursing and Governance	N/A	• Nominal Director (Council Member) of the Mental Health and Learning Disability Network	• Non-financial professional	22.01.19
Ismail Hafeji	Director of Finance and IM&T	N/A	• Assessor for the Healthcare Financial Management Association (HFMA) – role involves marking examinations arranged by the HFMA. Work is outside of NHS time.	• Financial	25.07.18

Name	Position/Role	Term of Office	Interests Declared	Type of Interest	Date of Entry onto Register / Amendment
			• Trustee of Home-Start Blackburn (Charity)	• Non-financial personal	30.01.19
Andrea Harrison	Non-Executive Director	31.12.22	• Transformation Leader, AstraZeneca PLC	• Financial	26.03.18
Julie Jarman	Non-Executive Director	31.07.20	• Trustee of MIND in Salford	• Non-financial personal	26.03.20
			• Chair – HomeWorkers Worldwide	• Non-financial personal	26.03.20
			• Company Director of small mineral rights holding company (Blenkie Ltd)	• Financial	14.02.18
			• Senior Principal Strategy – Equality and Human Rights Commission	• Financial	26.03.20
			• Trustee – CLASS	• Non-financial personal	26.03.20
Pauleen Lane	Non-Executive Director	31.12.22	• Group Manager National Infrastructure, The Planning Inspectorate	• Financial	30.01.17
			• Visiting Lecturer, The University of Manchester	• Financial	30.01.17
			• Governor, St. Hilda's Primary School, Firswood	• Non-financial personal	30.01.17
			• Member of Central Manchester University Hospitals NHS Foundation Trust, University Hospital of South Manchester NHS Foundation Trust and Liverpool Women's NHS Foundation Trust	• Non-financial professional	30.01.17
			• Partner (Martin Rathfelder) is a member of the Manchester Provider Programme Selection Board	• Indirect	25.03.19
Andrew Maloney	Deputy CEO/Director of HR	N/A	• Nil	-	26.02.19
Rupert Nichols	Chair	08.07.22	• Director – NeedleSmart Limited	• Financial	26.03.18
			• Chair – Rainford Academies Trust	• Non-financial personal	26.03.18
			• Director, Greenwhitestar Acquisitions Limited	• Financial	12.03.20

Name	Position/Role	Term of Office	Interests Declared	Type of Interest	Date of Entry onto Register / Amendment
			• Trustee, The Chartered Institute of Logistics and Transport	• Non-financial personal	12.03.20
			• Member of Mersey Care NHS Foundation Trust	• Non-financial professional	12.03.20
Deborah Partington	Director of Operations	N/A	• Sister (Susan Gambles) is a local Councillor in Wigan – from May 2018	• Indirect	24.07.18
			• Sister (Susan Gambles) has been a Non-Executive Director on Equity Housing Board since 2016	• Indirect	24.07.18
Alice Seabourne	Medical Director	N/A	• Husband works for Codethink (a Manchester-based IT firm). Unlikely that this firm would have any links with GMMH directly or indirectly as they work with opensource software.	• Indirect	20.10.19
Neil Thwaite	Chief Executive	N/A	• Member of Mersey Care NHS Foundation Trust	• Non-financial professional	26.02.19

Appointment and Removal of Non-Executive Directors

The Council of Governors is responsible for the appointment and, where required, removal of non-executive directors including the Chair. The Council of Governors is supported in this consideration by recommendations from its Nominations Committee. There were no removals of Non-Executive Directors during 2019/20.

In July 2019, the Council of Governors approved the re-appointment of Rupert Nichols, Chair, for a second three-year term effective from 9 July 2019 and the re-appointment of three non-executive directors (Stephen Dalton, Andrea Harrison and Pauleen Lane) for second three-year terms effective from 1 January 2020. The re-appointments were made on the basis of recommendations received from the Nominations Committee following a review of performance.

Our Council of Governors

Our Council of Governors comprises elected and appointed governors who represent the interests of our members, the wider public and our partner organisations. Governors hold the Board of Directors to account for the performance of the Trust through non-executive directors and also exercise their statutory duties as set out in legislation.

The Chair of the Board of Directors also chairs the meetings of our Council of Governors with the Chief Executive and other executive and non-executive directors regularly in attendance. Attendance at meetings enables Board members to understand the views of governors and members. Should any conflicts or disagreements arise between our Council of Governors and the Board of Directors, we would resolve these in accordance with the procedures laid down in our Constitution. The Lead Governor and Senior Independent Director would also play a key role in dispute resolution as and when required.

Minutes and papers for our Council of Governors meetings are publicly available via our website.

Governor Activities

During 2019/20, key duties exercised by the Council of Governors have included:

- Re-appointing the Trust's Chair and three non-executive directors for second terms of office;
- Receiving the outcomes of the Chair and Non-Executive Director annual appraisal process and approving an associated pay uplift;
- Receiving a report from the Trust's external auditors on their annual audit findings and opinion;
- Approving a two-year extension to the external auditor's term of officer, effective from December 2019, on the basis of performance and advice received from the Audit Committee;
- Advising on quality improvement priorities and selecting a local indicator for external assurance; and
- Giving views on the Trust's forward plans and key strategic developments and challenges – this includes advising on the Trust's new five-year strategy and key enabling strategies

Committees and Working Groups

The Council of Governors has one formal committee (the Nominations Committee) and one Working Group focused on implementation of our Membership Engagement Strategy. Both groups operate within clear Terms of Reference and report progress to the full Council of Governors.

Elections

The following individuals stepped down from their seats on the Council of Governors during the reporting period:

- Lynn Howe, Public Governor (City of Manchester) – in October 2019
- Diane Hughes, Service User and Carer Governor – in December 2019

We held elections during January to March 2020 to fill both these vacant seats plus twelve other seats held by public, service user and carer and staff governors coming to the end of their terms of office. The results of these elections were announced on 13 March 2020 with the following candidates elected for three-year terms effective from 1 April 2020:

- Les Allen – Public (Bolton)
- Paul Connelly – Public (Salford)
- Iris Nickson – Public (Trafford) (re-elected)
- Terry Corbett – Public (City of Manchester)
- Sharon Mason – Public (Other England and Wales)
- Dan Stears – Service User and Carer
- Avril Clarke – Service User and Carer
- Stuart Edmondson – Staff (Nursing) (re-elected)
- Lesley O'Neill – Staff (Nursing) (re-elected)
- Judy Harrison – Staff (Medical)
- Jane Lee – Staff (Allied Health Professionals) (re-elected)
- Diomidis Psomas – Staff (Psychological Therapies)
- Arif Patel – Staff (Non-Clinical)
- Rick Wright – Staff (Social Care) (re-elected)

We welcomed one new Appointed Governor to the Council of Governors during the reporting period:

- Detective Chief Inspection (DCI) Amanda Whittaker-Murray, Greater Manchester Police (GMP) - Amanda replaced DCI Sara Wallwork on our Council of Governors following her retirement from GMP after 30 years of service.

Attendance at Meetings

The full Council of Governors met on five occasions in 2019/20. The following table shows governor attendance at meetings during the period.

Constituency	Governor	Term of Office	Number of Meetings Attended
Elected Governors			
Public: Bolton	Albert Phipps	31.03.2020	4/5
	Emma Wood	31.03.2022	3/5
Public: Salford	Maureen Burke	31.03.2022	5/5
	David Sutton	31.03.2020	5/5
Public: Trafford	Gary Cooke	31.03.2022	3/5
	Iris Nickson	31.03.2020	5/5
Public: City of Manchester	Jermaine Chappell	31.03.2022	1/5
	Nayla Cookson	31.03.2022	4/5
	Lynn Howe	31.03.2020	2/3
Public: Other England and Wales	Rob Beresford	31.03.2020	4/5
	Angela Beadsworth	31.03.2022	3/5
Service User and Carer	Diane Hughes	31.03.2022	3/5
	Nathan Prescott	31.03.2022	5/5
	Dan Stears	31.03.2020	4/5
	Margaret Willis	31.03.2022	4/5
Staff: Medical	Victoria Sullivan	31.03.2020	1/5
Staff: Nursing	Stuart Edmondson	31.03.2023	4/5
	Lesley O'Neill	31.03.2023	2/5
Staff: Psychological Therapies	Nasur Iqbal	31.03.2020	5/5
Staff: Allied Health Professionals	Jane Lee	31.03.2023	4/5
Staff: Non-Clinical Staff	Anita Arrigonie	31.03.2020	3/5
Staff: Social Care	Rick Wright	31.03.2023	2/5
Appointed Governors			
University of Salford	Margaret Rowe, Executive Dean of the School of Health and Society	March 2023	2/5
Greater Manchester Police (GMP)	DCI Sara Wallwork	October 2019	0/3
	DCI Amanda Whittaker-Murray	October 2022	1/2
University of Manchester	Dr Tim Bradshaw, Reader in Mental Health, Division of Nursing Midwifery and Social Work	July 2021	3/5

Greater Manchester Combined Authority (GMCA)	Mat Ainsworth, Assistant Director for Employment (Strategy, Policy and Delivery)	September 2021	4/5
Greater Manchester Voluntary Sector	Stewart Lucas, Strategic Lead at Mind in Greater Manchester	October 2021	3/5

The table below shows attendance by Directors at meetings of the Council of Governors in 2019/20. Attendance at Council of Governors meetings by Board members is optional but encouraged, particularly to support discussions on key strategic issues. However, where individual directors are unable to attend Council of Governors meetings the views of the Board are represented by those directors in attendance. Governors are also encouraged to observe Board of Directors meetings to support them in enacting their statutory duties.

	Name	**Number of Meetings Attended**
Non-Executive Directors	**Rupert Nichols,** Chair	5/5
	Anthony Bell, Non-Executive Director	5/5
	Helen Dabbs, Non-Executive Director	4/5
	Stephen Dalton, Non-Executive Director	2/5
	Andrea Harrison, Non-Executive Director	1/5
	Julie Jarman, Non-Executive Director	4/5
	Pauleen Lane, Non-Executive Director	3/5
Executive Directors	**Neil Thwaite,** Chief Executive	5/5
	Elizabeth Calder, Director of Performance and Strategic Development	2/5
	Chris Daly, Medical Director (to end Sept. 2019)	1/3
	Gill Green, Director of Nursing and Governance	5/5
	Ismail Hafeji, Director of Finance and IM&T	1/3
	Andrew Maloney, Director of HR and Deputy Chief Executive	4/5
	Deborah Partington, Director of Operations	1/5
	Alice Seabourne, Medical Director (from Oct. 2019)	2/2

Council of Governors Effectiveness Review

In October 2019, all governors were invited to share their views on the performance of the Council of Governors by completing a short survey. Members of the Board of Directors were also invited to comment on the difference made by the Council of Governors over the last 12 months and the opportunities for the future.

Governors reviewed the outcomes of the survey at their meeting in December 2019 and agreed areas for improvement to be taken forward by the Membership Engagement Working Group via, for example, the Membership Engagement Strategy action plan.

Register of Interests – Council of Governors

All governors have a responsibility to declare any material or relevant interests. Declarations are reported publicly and recorded in a Register of Interests, which is maintained by the Company Secretary. The Register is available to the public on request via Kim Saville, Company Secretary (kim.saville@gmmh.nhs.uk).

Our Members

Our membership community is made up of public, service user and carer, and staff members. From these members, governors are elected to sit on our Council of Governors to represent members' interests in how our services are delivered and developed and how the organisation is run. Our constitution, which is publicly available, sets out the eligibility criteria for joining our different membership constituencies and the boundaries for public constituency areas. Eligible staff are automatically 'opted in' as members, but have the option to 'opt out' if they prefer.

In line with the terms of our Constitution, members of the Trust have the following rights and benefits to:

- be able to elect Governors
- be able to stand as a Governor
- receive regular information about our activities, such as newsletters
- provide opinions and be kept informed of plans for future developments
- be involved and consulted on issues such as changes and improvements to services
- act as an ambassador for their community or interest group
- attend member events

Our Current Membership

The following table provides a breakdown of our membership as at the end of March 2020.

Constituency		No. as at End 2019/20
Public	Bolton	693
	Salford	581
	Trafford	540
	City of Manchester	2,114
	Other England and Wales	884
Sub-Total Public		**4,812**
Service Users and Carers		1,271
Total Public, Service User and Carer Membership		**6,083**

All members of staff who are eligible to be a member of the Staff Constituency are automatically 'opted in' to our membership unless they notify the Trust that they do not wish to be a member.

We routinely monitor and validate the numbers and profile of our membership. Through the work of the Membership Engagement Working Group, we aim to take targeted action to engage a more representative membership community.

Membership Engagement Strategy

The Council of Governors approved a refreshed Membership Strategy in early 2018/19. The Strategy aims to guide governors in their role of engaging with local communities and helping to improve our services through governors' understanding and sharing of the needs of the communities they represent. The strategy is focused on three key priorities - membership community, membership engagement and governor development. Progress made in each area during 2019/20 is as follows:

Membership Community – Our membership database is refreshed regularly to ensure membership information is accurate. A key priority in 2020/21 will be analysing our membership profile to ensure it is representative and to inform effective engagement activities with harder to reach groups, for example, young people. In our most recent elections, communications were targeted to encourage nominations from across the breadth of the Trust's diverse population. Governor networks have also been mapped to identify opportunities to strengthen our membership community.

Membership Engagement – We launched our new Members' Magazine ('Improving Lives') in December 2019. 'Improving Lives' is focused on keeping members, and other interested stakeholders, up to date on key strategic developments and opportunities for involvement, and also raising the profile of the Trust and mental health in general. Governors receive training in the use of social media to enable increased and effective engagement with their membership and are also briefed on upcoming events in their local communities, which may provide opportunity for member recruitment and engagement.

Governor Development – Our approach to governor development is informed by the views and experience of our governors. Key development activities undertaken in 2019/20 have included:

- Development sessions focused on key strategic issues and our forward plans - led by Board members and other senior leaders
- Broad meeting agendas, with contribution from Board members (executive and non-executive), other senior leaders and elected and appointed governors – to keep governors informed, up to date and enabled to deliver the requirements of their role
- Briefings from the Chair and Chief Executive on changes in the national, regional and local operating environment, our performance and key developments
- Opportunity for involvement in PLACE inspections and local quality improvement and service transformation projects
- Governor service visits, which are combined with non-executive director service visits and provide opportunity for governors to learn more about individual services (achievements, challenges and opportunities) and influence change

- Access to external training and networking opportunities

Implementation of our Membership Engagement Strategy is driven by a dedicated Governor Working Group with updates reported to each Council of Governors meeting. A review of the current Strategy is planned for early 2020/21.

Interested in Becoming a Member?

Membership is free and you can choose your level of engagement as a member from very active to as little as receiving newsletters and updates. If you are interested in becoming a member of Greater Manchester Mental Health NHS Foundation Trust, and are eligible to do so, please contact Steph Neville, Head of Corporate Affairs via steph.neville@gmmh.nhs.uk or on 0161 358 1607.

If you are an existing member and would like to contact your governor representative, or a director of the Trust, please also contact Steph Neville or visit our website at www.gmmh.nhs.uk/contact-us.

Signed

Neil Thwaite, Chief Executive
Date: 22 June 2020

Remuneration Report

I am pleased to present our Remuneration Report for 2019/20. This report outlines our approach to setting the remuneration of our senior managers and the decisions and payments made during the reporting period. For the purposes of this report, senior managers are defined as the executive and non-executive members of our Board of Directors.

The remuneration, allowances and other terms of service of our Chief Executive, other executive directors and other senior managers on locally-determined pay are determined by the Remuneration and Terms of Service Committee of our Board of Directors. The remuneration of the Chair and other non-executive directors is agreed by our Council of Governors following recommendations from the Nominations Committee.

Annual Statement on Remuneration

Remuneration and Terms of Service Committee

The Remuneration and Terms of Service Committee of the Board of Directors was chaired by Rupert Nichols, Chair during the reporting period. All non-executive directors are members of the Committee.

During 2019/20, the Remuneration and Terms of Service Committee met on three occasions (twice in September 2019 and again in February 2020). The first meeting in September 2019 was convened to approve the appointment of our new Medical Director. Similarly, the meeting in February 2020 approved the appointment of our new Director of Finance and IM&T. Attendance at each meeting was as follows:

Name	Number of Meetings Attended
Rupert Nichols, Chair	3/3
Anthony Bell, Non-Executive Director	3/3
Helen Dabbs, Non-Executive Director	1/3
Stephen Dalton, Non-Executive Director	2/3
Andrea Harrison, Non-Executive Director	2/3
Julie Jarman, Non-Executive Director	3/3
Pauleen Lane, Non-Executive Director	2/3

On the occasions where non-executive directors were unable to attend meetings of the Remuneration and Terms of Service Committee, the Chair sought their opinion/views in advance of the meeting.

Both Neil Thwaite, Chief Executive and Andrew Maloney, Director of HR and Deputy Chief Executive attended two out of the three meetings in an advisory capacity.

On 30 September 2019, the Committee undertook its annual review of executive director (including the Chief Executive) and associate director pay. The Committee agreed a 2.5% consolidated uplift to Chief Executive and executive director remuneration (effective from 1 April 2019) in line with the

national pay deal for consultant medical staff and following a review of the outcomes of the annual appraisal process. The Committee also approved a proposal for associate director pay to be uplifted in line with the 2019/20 Agenda for Change pay points.

Nominations Committee

The Nominations Committee of the Council of Governors was convened on two occasions during the reporting period in July 2019 and October 2019. The Committee was chaired by the Chair of the Trust and attendance of Committee members at the meeting was as follows:

Name	Number of Meetings Attended
Rupert Nichols, Chair	2/2
Angela Beadsworth, Public Governor (Other England and Wales)	2/2
Stuart Edmondson, Staff Governor (Nursing)	1/2
Iris Nickson, Public Governor (Trafford)	2/2
Albert Phipps, Lead Governor	1/2
Nathan Prescott, Service User and Carer Governor	0/2
Dan Stears, Service User and Carer Governor	2/2
Margaret Willis, Service User and Carer Governor	2/2

In October 2019, the Nominations Committee reviewed Chair and non-executive director pay rates in the context of the annual appraisal outcomes and national benchmarking data. The Committee agreed to recommend the award of a 2.5% consolidated uplift for the Chair and all other non-executive directors, in line with the national pay deal for consultant medical staff in 2019/20 and the uplift awarded to the Trust's Chief Executive and executive directors. This recommendation was approved by the Council of Governors in December 2019 and backdated to 1 April 2019.

Rupert Nichols

Chair

22 June 2020

Senior Managers' Remuneration Policy

Our senior managers' remuneration policy helps attract and retain high-performing and talented individuals. We take account of the financial challenges facing the wider-NHS when implementing this policy.

Our remuneration policy for directors is based on a spot rate informed by external benchmarking data. Remuneration is subject to periodic review, as indicated in our 'Annual Statement on Remuneration'. Increases in pay are informed by recommendations from the National Pay Review bodies for Very Senior Managers. It is our policy to not pay any annual or long-term performance-related bonuses. Performance against agreed strategic objectives is monitored via the annual appraisal process.

The only non-cash elements of executive director remuneration are pension-related benefits, accrued under the NHS pension scheme, and car leases. Pension contributions are made by both the employer and employee in accordance with the rules of the national scheme.

All contracts for executive directors are substantive NHS contracts and are subject to the giving of three months' notice by either party. This is with the exception of the Chief Executive who has a six month notice period. Our normal disciplinary and performance management policies apply to senior managers. Our redundancy policy is consistent with the NHS redundancy terms for all staff.

Our senior managers' remuneration policy reflects our Trust-wide commitment to strengthening equality, diversity and inclusion. Both the Remuneration and Terms of Service Committee and Nominations Committee recognise diversity when preparing role descriptions and person specifications and when agreeing the search and selection process. We use external recruitment consultants that are specialists in ensuring access to diverse talent pools and supporting candidates through the recruitment process. All selection panels include independent external advisors and, where possible, reflect the diversity of the Trust and a broad range of protected characteristics. Remuneration levels are benchmarked against national data to ensure consistency, equity and fairness.

Annual Report on Remuneration

Remuneration of Board Members

The following table details the salary paid to each member of our Board of Directors during 2019/20 in comparison to 2018/19, including taxable 'benefits in kind'. As per our Remuneration Policy, benefits in kind relate to the provision of lease cars. The dates of directors' service contracts, including the unexpired terms of non-executive director contracts, are provided in the 'Our Board of Directors' section of this report. Details of off-payroll engagements and exit packages in 2019/20 are provided in our staff report ('Our Staff'). As was the case in 2018/19, there were no annual or long-term performance-related bonuses paid to Board members during 2019/20.

Only one senior manager (the Chief Executive) received a salary in excess of the £150,000 threshold for disclosure used in the Civil Service for their Board-level role during 2019/20. When originally agreeing this salary, the Remuneration and Terms of Services Committee took into account benchmarking data and advice received from NHS Improvement. Committee members continue to view the agreed baseline salary and subsequent uplifts as appropriate to the role.

Name	Title	2019/20 Salary and Fees	Taxable Benefits	2019/20 All Pension Related Benefits *	2019/20 Total Remuneration	2018/19 Salary and Fees	Taxable Benefits	2018/19 All Pension Related Benefits *	2018/19 Total Salary
		(Bands of £5,000) £'000	(To nearest £100)	(Bands of £2,500) £'000s	(Bands of £5,000) £'000s	(Bands of £5,000) £'000s	(To nearest £100)	(Bands of £2,500) £'000s	(Bands of £5,000) £'000s
R Nichols	Chair	45 - 50			45 - 50	45 - 50			45 - 50
A Harrison	Non-Executive Director	15 - 20			15 - 20	15 - 20			15 - 20
P Lane	Non-Executive Director	10 - 15			10 - 15	10 - 15			10 - 15
S Dalton	Non-Executive Director	10 - 15			10 - 15	10 - 15			10 - 15
H Dabbs	Non-Executive Director	5 - 10			5 – 10	5 - 10			5 – 10
A Bell	Non-Executive Director	10 - 15			10 - 15	10 - 15			10 - 15
J Jarman	Non-Executive Director	15 - 20			15 - 20	10 - 15			10 - 15
K Doran	Non-Executive Director 2018/2019	N / a	N / a	N / a	N / a	5 - 10			5 - 10
N Thwaite	Chief Executive	175 - 180	5,900	147.5 - 150	335 - 340	175 - 180	5,900	55 – 57.5	235 - 240
G Green	Director of Nursing and Governance	135 - 140			135 - 140	130 - 135			130 - 135
I Hafeji	Director of Finance and IM&T	135 - 140	5,500	30 – 32.5	170 - 175	130 - 135	5,500		140 - 145

A Maloney	Director of HR and Deputy Chief Executive	135 - 140	5,900		140 - 145	130 - 135	5,900		140 - 145
D Partington	Director of Operations	135 – 140	5,000		140 – 145	130 – 135	5,000	42.5 - 45	180 – 185
C Daly **	Medical Director	85 - 90		1,765 – 1,767.5	1,850 – 1,855	190 - 195			190 - 195
A Seabourne **	Medical Director	50 -55		955 – 957.5	1,005 – 1,010	n / a	n / a	n / a	n / a
M Lee	Acting Director of Development and Performance 2018/2019	N / a	N / a	N / a	N / a	80 - 85	4,000	145 – 147.5	230 – 235
E Calder	Director of Performance and Strategic Development	120 – 123		172.5 -175	295 -300	15 - 20		65 – 67.5	80 - 85

* Pension Related Benefits - The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the benefit being a member of the pension scheme could provide. The pension benefit disclosures table provides further information on the pension benefits accruing to the individual.

** In line with the NHS Foundation Trust Annual Reporting Manual (ARM), the Medical Director remuneration includes remuneration for duties that are not part of the Medical Director management role. Both Chris Daly and Alice Seabourne were 0.6 WTE Medical Director (remuneration band 115 – 120) and 0.4 WTE clinical during 2019/20.

Pension Benefit Disclosures

The pension benefit disclosures of executive directors are detailed in the table below. Non-executive director remuneration is non-pensionable.

Notes to the pension benefits disclosures:

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

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

Name	Title	Real Increase in Pension at at Pension Age	Real Increase in Lump Sum at Pension Age	Total Accrued Pension at Pension Age at 31 March 2020	Total Accrued Lump Sum at Pension Age at 31 March 2020	Cash Equivalent Transfer Value at 31 March 2020	Cash Equivalent Transfer Value at 31 March 2019	Real increase in Cash Equivalent Transfer Value	Employer's Contribution to Stakeholder Pension
		(Bands of £2,500) £'000s	(Bands of £2,500) £'000s	(Bands of £5,000) £'000s	(Bands of £5,000) £'000s	£'000s	£'000s	£'000s	£'000s
N Thwaite	Chief Executive	5 – 7.5	15- 17.5	55 – 60	135 -140	1,003	837	133	13
I Hafeji	Director of Finance and IM&T	0 -2.5	7.5 – 10	60 – 65	185 - 190	1,547	1,411	82	20
A Maloney	Director of HR and Deputy Chief Executive	0	0	35 – 40	80 – 85	633	662	0	8
E Calder	Director of Performance and Strategic Development	7.5 – 10	17.5 – 20	30 – 35	80 – 85	603	434	141	18

To note:

- Gill Green (Director of Nursing and Governance), Deborah Partington (Director of Operations), Chris Daly (Medical Director) and Alice Seabourne (Medical Director) were not members of the NHS Pension Scheme during 2019/20 and are therefore excluded from the above table.

Reporting bodies are required to disclose the relationship between the remuneration of their highest paid senior manager and the median remuneration of the organisation’s workforce. The banded remuneration of our highest-paid director (the Chief Executive) in 2019/20 was £175,000 - £180,000 (excluding taxable and pension-related benefits). As shown in the following table this was 6.76 times the median remuneration of the entire workforce, calculated on the basis of full-time staff as at 31 March 2020 with amounts annualised according to whole time equivalents and hours paid. The 2019/20 ratio is lower than the ratio reported for 2018/19 due to a change in the highest paid director from the Medical Director in 2018/19 to the Chief Executive in 2019/20.

	2019/20	2018/19
Band of Highest Paid Director Total	175 – 180 (£000s)	190 – 195 (£000s)
Mid-point of Highest Paid Director	177.5	192.5
Staff Median Total Remuneration	£26,568	£24,321
Ratio	6.76 times	7.94 times

Governor and Director Expenses

We reimburse expenses necessarily incurred by our directors and governors in the course of their business for the Trust. Expenses paid include mileage re-imbursement, parking expenses and other transport costs such as rail fares. We paid expenses to the value of the following to governors and members of the Board of Directors during the financial year.

	2019/20		2018/19	
	Governors	Directors	Governors	Directors
Total Number in Office during the year	27	15	27	16
Number Receiving Expenses	6	11	4	11
Aggregate Expenses Sum Paid (to the nearest £'00)	400	13,091	679	9,521

Neil Thwaite
Chief Executive
Date: 22 June 2020

Our Staff

Our goal is to provide an outstanding place to work, where all of our staff can thrive and reach their full potential.

We have developed an ambitious Workforce and Organisational Development Strategy 2018 to 2021 to help us deliver this goal through focus on four High Impact Areas:

- Supply, Recruitment and Retention
- Creating an Outstanding Place to Work
- Transforming our Workforce
- Outstanding Leadership and Management

Our Workforce Strategy articulates the values, leadership behaviours and organisational culture that we consider essential to providing an outstanding place to work and supporting individuals to achieve their potential. We want our leaders to engage, motivate and inspire others and lead positive performance. We want to promote an open and transparent culture and provide an inclusive and healthy environment where everyone is treated with respect and dignity.

Progress in delivery of our Workforce Strategy is overseen by our Workforce Strategy Programme Board, with six-monthly updates reported to our Board of Directors.

Staff Costs

Our total staff costs incurred in 2019/20 equated to £240.2million.

	Staff Group		2019/20	2018/19
	Permanent (£'000s)	Other (£'000s)	Total Costs (£'000s)	Total Costs (£'000s)
Salaries and wages	165,187	1,654	166,841	168,871
Social security costs	14,745		14,745	14,613
Apprenticeship levy	750		750	804
Employer's contributions to NHS pensions	20,417		20,417	19,844
Pension cost – other	8,936		8,936	
Other post-employment benefits	107		107	220
Other employment benefits				-
Termination benefits	74		74	264
Temporary staff		29,816	29,816	19,980
Total Gross Staff Costs	**210,216**	**31,470**	**241,686**	**224,596**
Recoveries in respect of seconded staff	(1,532)		(1,532)	(1,427)
Total Staff Costs	**208,684**	**34,470**	**240,154**	**223,169**
Of which:				
Costs capitalised as part of assets	351		351	797

Workforce Demographics

We employ a diverse workforce including doctors, nurses, therapists, specialist practitioners and administrators who work in a variety of settings within local communities and hospitals.

During 2019/20, we employed 5,743 whole time equivalent (WTE) staff. This number includes bank and agency staff and is broken down as follows:

	Permanently Employed (No.)	Other Employment Arrangement (No.)	Total Number 2019/20 (WTE)	Total Number 2018/19 (WTE)
Medical and dental	278	49	327	375
Ambulance staff	0	0	0	0
Administration and estates	233	12	245	598
Healthcare assistants and other support staff	1,880	380	2,260	1,941
Nursing, midwifery and health visiting staff	1,254	540	1,794	1,383
Nursing, midwifery and health visiting learners	35	0	35	30
Scientific, therapeutic and technical staff	798	44	842	874
Healthcare science staff	0	0	0	0
Social care staff	105	0	105	90
Other	135	0	135	167
Total	4,718	1,025	5,743	5,458
Of which: Number of employees engaged on capital projects	6	1	7	12

'Other' employment includes employees that do not have a permanent (UK) employment contract with the Trust.

Our number of male and female staff (calculated on a headcount basis and including bank staff) as at the end of March 2020 was:

	Male	Female	Total
Directors	6	8	14
Workforce (excluding Directors)	1,426	3,913	5,339
Total	**1,432**	**3,921**	**5,353**

Gender Pay Gap

Our Workforce and Organisational Development Strategy sets out our ambition to create an inclusive environment which embraces diversity. Our annual Gender Pay Gap Report provides valuable intelligence to enable us to move towards achieving this ambition. Due to coronavirus, the national end March 2020 deadline for completing and publishing our gender pay gap report for 2019/20 (snapshot date of 31 March 2019) has been deferred. We will finalise and publish our gender pay gap report as soon as any updated guidance and timescales are released. Previous years' data can be found at https://www.gmmh.nhs.uk/gender-pay-gap-reporting.

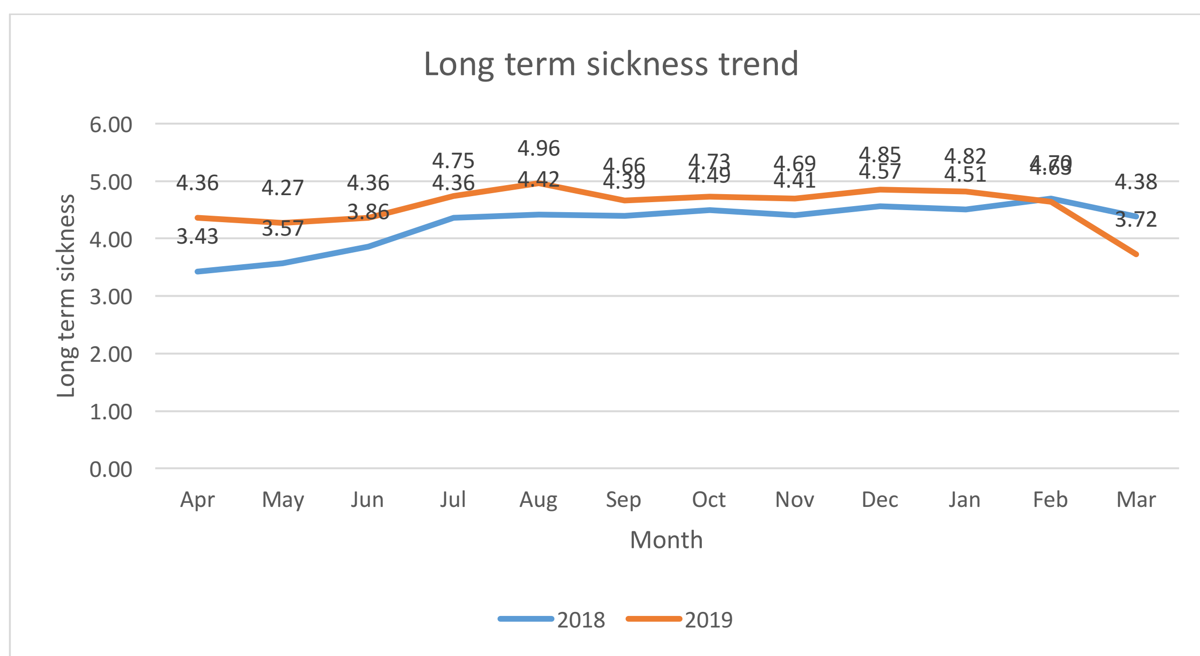
Sickness Absence

At the end of March 2020, our sickness absence rate for the rolling 12-month period was 6.54% and 7.23% in month. Our average number of sick days per full time equivalent (FTE) for the period January 2019 to December 2019 was 14.37, this compares to 13.0 in the previous twelve months.

Staff Sickness Absence	2019	2018
Average FTE	4,690	4,513
Adjusted FTE Days Lost – As Per Cabinet Office Definitions	67,386	59,364
Average Sick Days per FTE	14.37	13.0

Our sickness absence rates are publicly available here – https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates.

Overall absence levels continue to be driven by long term sickness, however, this position has improved since August 2019 (see graph below). This is the result of proactive and early intervention from both the HR team and line managers which has helped to reduce the length of absence.



Absence due to mental health-related illnesses continues to be our highest reason for absence (31.2%) followed by unknown (20.2%) and musculoskeletal problems/back problems (13.2%). This mirrors the national position.

We have seen absence due to mental health-related illnesses increasing over the reporting period. During 2019/20, we launched our new Mental Health First Aiders (MHFA) programme and trained our first cohort of First Aiders. A role profile is under development and our MHFAs are due to be launched across the organisation by summer 2020. Our Sickness Absence Policy is under review. Following extensive discussions with our trade union colleagues, and a workshop with line managers, our new approach will focus on employee wellbeing. Our new policy, which is due to launch in early 2020/21, will provide line managers with a framework that encourages staff to remain well in work.

Policies and Actions

All policies, which affect staff, are developed in partnership with our staff-side representatives. During 2019/20, we have been working jointly to develop HR policies that support best practice management of staff and create an outstanding workplace.

We have developed and launched a new Disciplinary Policy, which seeks to improve the experience of staff who are exposed to disciplinary processes. The new policy has been supplemented with appropriate training.

Our Trust values are incorporated in all policies that affect staff to ensure our values are firmly embedded in management practice. Equality Impact Assessments are completed for each policy to consider the impact the policy may have on different groups of staff and ensure that our policies and practices do not discriminate or disadvantage people on the basis of any protected characteristics. We use the Equality Delivery System 2 (EDS2) as an assessment tool to measure equality performance with the aim of delivering better outcomes for people using and working in the NHS. We applied this tool to the goal of 'A Representative and Supported Workforce' in a recent grading exercise, with a number of improvement actions agreed as an outcome.

Equality, Diversity and Inclusion (EDI)

We recognise the key role equality, diversity and inclusion plays in building a successful organisation. Over the last year, we have taken significant steps to develop and improve our approach to EDI. This work has been led by our Director of Nursing and Governance, supported by a Strategic Lead for Equality and Diversity who has a focus on service users and carers.

Development work is planned and delivered via multi-professional groups, whose membership includes Staff Side representatives. Groups include our Equality, Diversity and Human Rights Steering Group, our Workforce Race Equality Standards (WRES) Group and our Workforce Disability Equality Standard (WDES) group. As previously noted, we have also introduced a number of new and growing

Staff Networks to support the development of our BAME, LGBT+ and disabled workforce. We have made significant progress against a number of other staffing-related EDI projects during 2019/20:

- The launch of **Opening Opportunities -** a modular career development programme ring-fenced for our disabled and BAME staff. The National WRES Team have recently issued targets to increase the profile of BAME staff in higher-banded posts. We will be implementing positive action to prepare staff for progression to higher-banded roles as part of the Opening Opportunities course and will apply a structured talent management approach where we know there are vacancies

- The launch of our innovative **Reverse Mentoring** scheme, supporting executive and associate directors to gain insight into the challenges faced by our staff from BAME backgrounds. Our 27 volunteer BAME mentors from across the organisation and mentees all attended development sessions to enable understanding of their roles prior to commencing the scheme

- Working in partnership with the LGBT Foundation to implement **Pride in Practice** – we will be the first Mental Health Trust to follow this programme, which has traditionally supported primary care services to develop relationships with their LGBT patients. Two of our service areas have been funded to receive enhanced support from the LGBT Foundation to achieve the Pride in Practice award. Whilst this award is primarily aimed at strengthening support for LGBT service users, we hope it will also facilitate a more inclusive and welcoming work environment for our LGBT staff.

- Appointment of a dedicated **Disability Advisor** - in addition to the establishment of our Disability Staff Network, an experienced member of staff side has been seconded to the role of Disability Advisor. This invaluable role ensures new recruits, and members of staff already working in the Trust, can access advice and support regarding reasonable adjustments. In addition, as part of the recruitment process, candidates are encouraged to make contact with the Disability Advisor to ensure reasonable adjustments are in place ready for when they commence employment. The Disability Advisor also attends every induction to ensure all staff are aware of how she can support them.

- Learning from the experiences of our **Disabled Workforce** - in 2019, we held a listening event with members of our disabled workforce to understand more about their experiences and the actions that would make a difference for them. This led to the creation of a centralised process and budget for ensuring reasonable adjustments are made for our disabled staff in an efficient and timely way. Further guidance on supporting staff with reasonable adjustments was also subsequently developed for managers and our Disability Passport has been updated to help guide conversations between managers and staff about adjustments and other required support. The passport follows an employee throughout their employment journey with the Trust, supporting their transition to new roles and services. Feedback gained from the listening event also led to places on our Opening Opportunities programme being ring-fenced for disabled staff.

- **Disability Confident Scheme** - we continue to be at Level 2 of the Disability Confident Scheme and are working towards achieving Level 3 and being a Disability Confident Leader. This scheme helps the Trust to demonstrate our commitment to, and progress in, 'getting the right people' and 'keeping and developing' our disabled workforce.

Our over-arching Workforce Equality Plan is available to view at https://www.gmmh.nhs.uk/equality-and-diversity. This plan sets out how we will continue to improve our performance against both the Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES). Our current position against the WRES and WDES is as follows:

WRES Indicator	All MH Trusts 2018	GMMH 2018	GMMH 2019
Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BAME applicants	1.19	1.85	1.57
Relative likelihood of BAME staff entering formal disciplinary process compared to white staff	1.69	3.35	2.64
Relative likelihood of BAME staff accessing non-mandatory training and CPD compared to white staff	1.10	1.16	1.02
Percentage of BAME staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	33%*	40%	40%
Percentage of BAME staff experiencing harassment, bullying or abuse from staff in the last 12 months	25%*	20%	24%
Percentage of BAME staff believing that trust provides equal opportunities for career progression or promotion	73%*	77%	71%
Percentage of BAME staff personally experiencing discrimination at work from a manager/team leader or other colleagues	14%*	13%	14%
BAME Board Membership	7%	14%	14%

*2017 national staff survey data – 2018 unavailable at time of publishing

WDES Indicator	GMMH 2019	
Relative likelihood of disabled staff compared to non-disabled staff being appointed from shortlisting across all posts	1.28	
Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process	25.65 (NB – only 3 formal capability cases occurred in reporting period)	
% of staff experiencing harassment, bullying or abuse from patients / service users, their relatives or other members of the public in the last 12 months	37.9% (30%)	
% of staff experiencing harassment, bullying or abuse from managers in the last 12 months	18.7% (10.8%)	
% of staff experiencing harassment, bullying or abuse from colleagues in the last 12 months	20.6% (12.8%)	
% of staff experiencing harassment, bullying or abuse at work in the last 12 months, they or a colleague reported it	62.7% (64.7%)	
% of staff believing that the Trust provides equal opportunities or career progression for promotion	75.1% (86.3%)	
% of staff saying they felt pressure to come to work despite not feeling well enough to perform their duties	28.9% (18.3%)	
% of staff saying that they are satisfied with the extent to which the organisation values their work	38.7% (53.4%)	
% of staff saying their employer has made adequate adjustments to enable them to carry out their work	73.2%	
The staff engagement score for disabled staff compared to overall staff engagement score (in brackets)	6.4 (7)	
Has your Trust taken action to facilitate the voices of disabled staff in the organisation to be heard	Yes	
% difference between the organisations Board voting membership and the organisations overall workforce	Board Dis 7% Non 64% Unk 29%	% diff 2% -4% 2%

Health and Wellbeing

We have progressed our commitment to improving staff health and wellbeing during 2019/20. Examples of this include:

- Launch of our Mental Health First Aiders scheme, as referenced above
- Regular delivery of Schwartz Rounds across many of our clinical service areas and corporately. Schwartz Rounds are an evidence-based forum enabling staff from all backgrounds to come together to talk about the emotional and social challenges of working in a care environment
- Senior Leaders' development session focussed on resilience and wellbeing - ensuring our most senior leaders role model positive wellbeing behaviours
- Providing ring-fenced time for a Disability Employment Advisor – this is an experienced union representative, with high levels of knowledge around supporting disabled staff and links into national networks, who is helping us to develop our model and approach to supporting disabled staff
- Establishing a Disabled Staff Network

People Asset Management (PAM) have continued to provide our Occupational Health and Employee Assistance Programme services over the last twelve months. Our data shows that 5,205 appointments took place over 2019/20 for health surveillance appointments, management and well-being referrals. The Employee Assistance data shows that there were 1,735 recorded contact to the helpline and website. This information is used to help develop and guide health and well-being activity and there are plans to further promote the Employee Assistance Programme to staff. We have also been able to 'flex' the offering provided as part of our Occupational Health and Employee Assistance Programme during the COVID-19 pandemic, with the introduction of specific COVID-19 referrals and follow up advice and guidance from Occupational Health for staff who have been tested for COVID-19.

NHS Staff Survey

Staff Engagement

We take the views of our staff into account when making decisions that are likely to affect their interests. Members of our Board of Directors meet with staff-side (Trade Union) representatives on a monthly basis through our Joint Consultation and Negotiating Committee JCNC). This Committee discusses all policies, organisation change programmes and service developments. This approach is replicated for medical staff via the Local Negotiating Committee (LNC), which meets every two months.

Our managers also run regular Staff Forums in partnership with staff-side. These forums enable staff to raise concerns, including about issues that impact on wellbeing, and facilitate early resolution.

NHS Staff Survey

This section summarises the findings of our 2019 National Staff Survey. This is the second year that the survey has been broken down into themes covering the following eleven areas of staff experience:

- Equality, diversity and inclusion
- Health and wellbeing
- Immediate managers
- Morale
- Quality of appraisals
- Quality of care
- Safe environment – bullying and harassment
- Safe environment – violence
- Safety culture
- Staff engagement
- Team working

We received a response rate of 49.9% against a national average of 54% in the 2019 Survey. Whilst still below the national response rate, our response rate did improve by 2% compared to the previous year, whereas the national rate remained the same.

Key Changes in our 2019 Staff Survey

Our 2019 Survey results did not demonstrate any statistically significant changes in any of the themes. Our performance did, however, improve or stay the same in all areas. This is with the exception of Health and Wellbeing, where performance also declined nationally. Positively, our overall Trust score for Safe Environments – Violence increased from 9.1 to 9.2. Whilst this is still below the national average, improvements have not been reported overall amongst other mental health providers over the period.

Breaking down our results demonstrates improvements made in many of our divisions and service areas, most notably North Manchester and Forensic Mental Health services. The lack of consistent improvement across all areas has, however, resulted in limited movement in our overall Trust performance.

Key Results – Themes

Our indicator scores for each theme surveyed as part of the 2019/20 Staff Survey are shown below. The indicators scores are based on a score out of 10 for certain questions grouped together under each theme, with the indicator score being the average of those.

	2019/20		2018/2019		2017/18	
Theme	Trust Indicator Score	Benchmarking Group	Trust Indicator Score	Benchmarking Group	Trust Indicator Score	Benchmarking Group
Equality, diversity and inclusion	8.9	9.0	8.8	8.8	9.0	9.0
Health and wellbeing	5.7	6.0	5.8	6.1	6.0	6.1
Immediate managers	7.1	7.3	7.1	7.2	7.1	7.2
Morale	6.1	6.3	6.0	6.2	New category	
Quality of appraisals	5.4	5.8	5.4	5.7	5.3	5.5
Quality of care	7.1	7.4	7.1	7.3	7.2	7.3
Safe environment – bullying and harassment	7.9	8.0	7.9	7.9	7.9	8.0
Safe environment – violence	9.2	9.3	9.1	9.3	9.1	9.2
Safety culture	6.7	6.8	6.7	6.7	6.7	6.7

Staff engagement	6.9	7.0	6.9	7.0	7.0	7.0
Team Work	6.7	7.0	6.6	6.9	6.8	6.9

Areas for Improvement

We will continue to work hard to deliver improvements across all Staff Survey themes. Through triangulation of survey data with other key performance indicators, such as reasons for sickness absence, we have identified the following essential actions for progression in 2020/21. These include initiatives already in progress as part of Workforce Strategy that will have a positive impact on staff experience:

Health & Wellbeing - Whilst we are aiming to deliver improvements across all areas, special attention will be given to health and wellbeing. Together with Staff Side, our Human Resources Team have commenced a quality improvement programme focused on our management of staff when they become unwell in work. The output of this will be a new Workplace Wellbeing Policy, which will include toolkits and resources for managers to ensure early intervention and a speedy and supportive response to those requiring workplace adjustments. We will also review and update our other employment policies to reflect the vision articulated in the interim NHS People Plan, and reinforced through our Workforce and Organisational Development Strategy, to create a positive and inclusive culture.

Morale and Immediate Managers – We will work hard to ensure our new approach to supervision and appraisal is viewed as an opportunity to make improvements for staff. Empowered managers who know, understand and develop their staff, and treat them compassionately, will have a direct impact on an individual's day to day experience at work. Training in both of these areas is in development, with a view to making appraisal and supervision discussions more meaningful and enabling managers to use them as a key tool to support their staff. These developments will be accompanied by a new Leadership Strategy, which is due to launch in early 2020/21.

Staff Engagement – We are working in partnership with our Communications and Marketing Team to develop a comprehensive and sustainable staff engagement plan.

Equality, Diversity & Inclusion – Our equality, diversity and inclusion commitments for 2020/21 have been described elsewhere in this 'Our Staff' report.

Reporting Facilities Time

Under the Trade Union (Facility Time Publication Requirements) Regulations 2017, which came into force on 1 April 2018, public sector employers are now required to publish information on employees who are trade union officials and the facility time taken by them during the preceding 12-month period.

The following tables confirm:

- the total number of our employees who were union officials during the period 1 April 2019 to 31 March 2020
- the percentage of each of the above employee's working time spent on trade union duties (facility time);
- the percentage of our total pay bill spent on facility time; and
- the hours spent by employees who were union officials on paid trade union activities, as a percentage of total paid facility time hours

Relevant Union Officials:

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
9	4.9

Percentage of Time Spent on Facility Time:

Percentage of time	Number of employees
0%	0
1-50%	3
51-99%	4
100%	2

Percentage of Pay Bill Spent on Facility Time:

Total cost of facility time	£140,139.40
=Total pay bill	£240,154,000
Percentage of the total pay bill spent on facility time, calculated as:	0.06%

Paid Trade Union Activities:

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated	100%

Expenditure on Consultancy

We have not incurred any expenditure on external consultancy services during 2019/20.

Off-Payroll Engagements

It is our policy that all executive directors and other senior managers and clinicians are paid via our payroll. We only appoint individuals off-payroll in exceptional circumstances, for example, contractors undertaking temporary project work. Where off-payroll engagements are used, we undertake risk-based assessments as to whether assurance is required that the individual is paying the right amount of tax.

The following tables detail our use of existing and new off-payroll engagements in 2019/20, including lengths of engagement at the time of reporting. We can confirm that we had no off-payroll engagements, costing more than £245 per day and lasting longer than six months, as of year-end.

Table 1 – For all off-payroll engagements as of 31 March 2020, costing more than £245 per day and lasting longer than six months	**2019/20**
No. of existing engagements as of 31 March 2020	0
Of which:	
No. that have existed for less than one year at time of reporting	0
No. that have existed for between one and two years at time of reporting	0
No. that have existed for between two and three years at time of reporting	0
No. that have existed for between three and four years at time of reporting	0
No. that have existed for four or more years at time of reporting	0

We had no new off-payroll engagements, or any that reached six months in duration, that cost more than £245 per day and lasted longer than six months during 2019/20.

Table 2 – For all new off-payroll engagements, or those that reached six months in duration, between 01 April 2019 and 31 March 2020, costing more than £245 per day and lasting longer than six months	**2019/20**
No. of new engagements, or those that reached six months in duration, between 1 April 2019 and 31 March 2020	0
Of which:	
No. assessed as within the scope of IR35 (the 'off-payroll rules')	0
No. assessed as not within the scope of IR35	0
No. engaged directly (via PSC (personal service company) contracted to trust) and are on the Trust's payroll	0

No. of engagements reassessed for consistency/assurance purposes during the year	0
No. of engagements that saw a change to IR35 status following the consistency review	0

We have not appointed any Board members or senior officials with significant financial responsibility, or individuals deemed as such, via off-payroll engagements in 2019/20.

Table 3 - For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 01 April 2019 and 31 March 2020	**2019/20**
No. of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year	0
No. of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. This figure must include both off-payroll and on-payroll engagements	0

Exit Packages

The following tables disclose the number of compulsory and other (non-compulsory) departures which attracted an exit package during 2019/20. The value and type of associated payment is also detailed. The total cost of exit packages in 2019/20 was £74k, compared to £264k in 2018/19. We funded no exit packages in excess of £100k in 2019/20.

Exit Packages Cost Band (incl. any special payment element)	**Number of Compulsory Redundancies**		**Number of Other Departures**		**Total Number of Exit Packages**	
	2019/20	**2018/19**	**2019/20**	**2018/19**	**2019/20**	**2018/19**
<£10,000	-	-	-	2	-	2
£10,001 - £25,000	-	-	-	5	-	5
£25,001 - £50,000	2	-	-	-	2	-
£50,001 - £100,000	-	-	-	-	-	-
£100,001 - £150,000	-	-	-	-	-	-
£150,001 - £200,000	-	-	-	1	-	1
>£200,000	-	-	-	-	-	-
Total Number of Exit Packages by Type	**2**	**0**	**0**	**8**	**0**	**8**
Total Resource Cost (£)	**£74,000**	**£0**	**£0**	**£264,000**	**£74,000**	**£264,000**

As demonstrated in the following table, the non-compulsory departure payments incurred in 2019/20 related to voluntary redundancies. No payments required Treasury approval.

	2019/20		2018/19	
	Payments Agreed (No.)	Total Value of Agreements (£'000)	Payments Agreed (No.)	Total Value of Agreements (£'000)
Voluntary redundancies including early retirement contractual costs	-	-	8	264
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	-	-	-	-
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring Treasury approval	-	-	-	-
Of which:				
Non-contractual payments requiring Treasury approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-

NHS Oversight Framework

NHS England and NHS Improvement's NHS Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led)

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach or suspects breach of its licence.

Segmentation

We have been placed in Segment 2. Providers in segment 2 are described as being offered targeted support from NHS Improvement and have potential support needs in one or more of the five themes, but are not in breach of their provider licence and formal action is not needed. This segmentation information is the Trust's position as at March 2020. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

Finance and Use of Resources

The finance and use of resources theme is based on the scoring of five measures from '1' to '4', where '1' reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the NHS Oversight Framework, the segmentation of the trust disclosed above might not be the same as the overall finance score here.

Area	Metric	2019/20 Scores				2018/19 Scores			
		Q4	Q3	Q2	Q1	Q4	Q3	Q2	Q1
Financial sustainability	Capital service capacity	1	1	1	1	2	4	1	4
	Liquidity	1	1	1	1	1	1	1	1
Financial efficiency	I&E Margin	2	2	2	2	1	1	2	2
Financial controls	Distance from financial plan	1	2	1	1	1	1	2	1
	Agency spend	1	2	2	3	4	4	4	4
Overall Scoring		1	2	1	2	3	3	3	3

As at the end of March 2020, we are reporting a rating of ‘1’ for the finance and use of resources theme, against a planned rating of ‘3’. This is a result of our improving position against the agency spend metric during 2019/20, which stands as a ‘1’ at year-end against a planned rating of ‘4’. Our performance against this metric has improved as a result of the action taken to tighten controls and reduce spend on agency staffing. These include the commissioning of NHS Professionals to provide temporary engagement and direct resourcing services.

Statement of Accounting Officer's Responsibilities

Statement of the Chief Executive's Responsibilities as the Accounting Officer of Greater Manchester Mental Health NHS Foundation Trust

The National Health Service Act 2006 (NHS Act 2006) states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the 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 Direction which require Greater Manchester Mental Health 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 Greater Manchester Mental Health NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care 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 and Social Care 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
- confirm that 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 and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable them 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 the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information of which the foundation trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

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

Signed

Neil Thwaite, Chief Executive
Date: 22 June 2020

Annual Governance Statement

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 ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Greater Manchester Mental Health 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 Greater Manchester Mental Health NHS Foundation Trust for the year ended 31 March 2020 and up to the date of approval of the annual report and accounts.

Capacity to Handle Risk

As Accounting Officer, I have overall responsibility for ensuring that an effective system of risk management is in operation within the Trust. I have delegated responsibility for this, including responsibility for the development and implementation of our 'Risk Management Framework' and for the identification, assessment, treatment and management of risk, to the Director of Nursing and Governance during the reporting period.

Our Risk Management Framework is consistent with best practice and Department of Health guidance. It provides a clear, structured, systematic approach to the management of risks to ensure that risk assessment is an integral part of clinical, managerial and financial processes across the organisation.

The following senior managers are identified as accountable to me, and responsible for providing assurance on specific risk areas, in the Risk Management Framework:

Risk Area	Responsible Director
Safeguarding, clinical governance, infection prevention and control, health and safety, security (as the nominated Security Management Director) and emergency	Director of Nursing and Governance

preparedness (as the Accountable Emergency Officer)	
Human Resources, Estates and Facilities (including fire and food safety)	Director of HR and Deputy Chief Executive
Finance and information (as the Senior Information Risk Owner (SIRO))	Director of Finance and IM&T
Clinical and operational services	Director of Operations
Business development and compliance with Care Quality Commission standards	Director of Performance and Strategic Development
Clinical, medicines management and standards of medical practice	Medical Director

A supporting system for managing risk has been devolved to the Associate Director of Nursing and Governance with support from the Head of Risk Management. The Risk Management Framework also clearly defines risk and clinical governance structures within divisions and the responsibilities of senior managers, managers and all other staff in relation to risk.

The Audit Committee of the Board of Directors has delegated responsibility for the establishment and maintenance of an effective system of governance, risk management and internal control, which operates across the Trust and supports the achievement of our key strategic objectives. The Audit Committee is concerned with evidencing the probity and efficiency of the risk management system in relation to the Trust's financial, governance and clinical operations. The Board's Quality Improvement Committee oversees the system of quality governance and the overall assurance process associated with managing clinical service delivery effectively. The Board of Directors routinely receive minutes and briefings from all committees.

The Risk Management Committee serves as a sub-group of the Audit Committee and is responsible for ensuring the effective application of risk management across the Trust. The Committee has been chaired by the Director of Nursing and Governance during 2019/20, with membership including the Associate Directors of Nursing and Governance, Finance and HR; the Director of Pharmacy; Heads of Service/Deputy Directors or their Risk Management Leads from each division/department; and senior Trust managers with responsibility for patient safety, governance and risk management.

The Risk Management Committee is able to constitute advisory sub-groups to deal with specialist and specific risk issues. Sub-groups monitor risks relevant to their specialist area and escalate risks scoring 12 and above to the Risk Management Committee.

Risk management training is provided for all new starters through our Trust induction programme. Our Trust-wide Training Needs Analysis identifies risk management training requirements for specific staff groups, which are appropriate to the grade, role and location of staff. Examples include safeguarding training (adults and children), prevention and management of violence and aggression (PMVA) and basic and intermediate life support. Tailored training for specific roles is also identified by managers and agreed with individual members of staff via the annual appraisal and personal development planning process. Root-cause analysis training is provided to staff members with direct

responsibility for risk management within their area of work. Training uptake is monitored centrally and at a divisional/service level.

We aim to ensure learning from both good practice and experience. Actions and recommendations from incidents, events, complaints and inquests are recorded on our incident reporting and risk management system (Datix), with local services held responsible for monitoring progress against these. We use our internal audit programme and clinical audit programme to test and evidence that changes in practice have been implemented.

We communicate our lessons learnt across the Trust in a number of different ways. These include briefings, newsletters and learning events, and with external stakeholders. The Board of Directors receives reports on the numbers and levels of serious untoward incidents and any emerging trends and action taken. Reflective practice is encouraged both collectively, including through Schwarz Rounds, and individually through clinical supervision. We have introduced a new, centralised system for monitoring supervision compliance through our electronic Learning Hub during 2019/20.

We have effective mechanisms in place to act upon alerts and recommendations made by all relevant central bodies including the National Patient Safety Agency (NPSA), NHS Resolution and the Health and Safety Executive (HSE).

The Risk and Control Framework

Our governance structures during 2019/20 – including scopes of work and accountabilities – are detailed elsewhere in this report (in the 'Directors' Report of the Accountability Report).

We activated our Major Incident Plan in response to the emergence of COVID-19 in January 2020. Planning and control over decision-making was subsequently escalated to Gold Command in March 2020. Gold Command comprises the Chief Executive, Director of Nursing and Governance, Medical Director, Director of Human Resources / Deputy Chief Executive and Director of Operations, supported by planning and implementation leads and sub-groups focused on digital; Mental Health Act; physical healthcare and infection, prevention and control; clinical guidance; clinical ethics; and workforce planning. All local business continuity plans were refreshed as part of our early response with a clear service escalation plan also agreed. We also established a Clinical Ethics Forum, accountable to Gold Command, in early April 2020 in partnership with Pennine Care NHS Foundation Trust and North West Boroughs Healthcare NHS Foundation. The Ethics Forum is advising the member Trusts on complex ethical issues and decisions arising from the crisis.

As part of our incident response we took temporary measures, from March 2020, to adapt our board assurance and governance arrangements. These included holding all Board, Board committee and Council of Governors meeting remotely (via audio or video conference; reviewing quorum; suspending meetings where assessed as safe and appropriate; refocusing agendas to prioritise COVID-19 and business critical items only; and establishing clear mechanisms for either deferring non-critical information and assurance items or decisions or managing those items outside of meetings. The right to use Emergency Powers to make decisions, as enabled through our Standing Orders, was also retained. Effective from May 2020, we introduced a new, interim Board assurance committee focused

on COVID-19. The aim of this committee is to provide the Board of Directors with assurance on the monitoring of safety, quality, risk, financial and contracting arrangements during our planning and response to COVID-19. Meetings of our Quality Improvement Committee and our planned new committee focused on strategic finance have been suspended during the operation of the COVID-19 Committee.

Records of decisions taken and changes made as part of our COVID-19 response are being maintained to inform our recovery planning. All changes reflect the rapidly changing environment and the significant and sustained pressure placed on our Senior Leaders and other staff. By introducing a more streamlined governance and assurance framework, we have been able to maintain business continuity whilst also reducing the burden on our staff.

Risk Management

Risk management is embedded throughout the organisation and all staff are encouraged to report incidents and raise concerns. All services are required to identify core risks to the delivery of their business plans as part of the annual planning process.

Our Risk Management Framework, which has continued to be applied during COVID-19, establishes a formal structured approach to the identification, assessment, treatment and management of risks. The process starts with a systematic identification of risks throughout the organisation which are documented within risk registers. These risks are then analysed in order to determine their relative importance using a risk scoring matrix. Low scoring risks are managed by the area in which they are found. Higher scoring risks are managed at progressively higher levels within the organisation and escalated to the Risk Management Committee every two months for monitoring and consideration for escalation to the Board Assurance Framework. Achieving control of the higher scoring risks is given priority over lower scoring risks. Risk control measures are identified and taken to reduce the potential for harm.

The Board reviews and approves the Board Assurance Framework on a quarterly basis. The Board receives updates on assurances, controls and actions being taken to mitigate risk from the designated lead Committees/groups and agrees any further actions required or changes to the Board Assurance Framework. Changes may include the addition of new strategic risks, which have arisen through Board papers or Board discussion and may reflect current or likely future challenge within the health economy, or de-escalation of risks from the Board Assurance for local management and monitoring. When approving the Board Assurance Framework, the Board considers risk appetite.

As documented elsewhere in this report, the most critical strategic risks facing the organisation at the end of the reporting period, which are being managed and mitigated at Board-level relate to:

- Coronavirus (COVID-19) pandemic – we have also maintained a separate register of the operational risks associated with COVID-19 via our Gold Command structure
- Performance - with a specific focus on targets relating to Improving Access to Psychological Therapies (IAPT), Early Intervention in Psychosis (EIP) and Out of Area Placements (OAPs)
- Recruitment and retention

- Sustainable workforce model
- Future commissioning arrangements - in terms of the impact of any changes on the resources available to the Trust
- Financial sustainability
- Capital and estates - including the risks and challenges associated with our current inpatient provision in North Manchester (Park House)

Our Board Assurance Framework sets out the controls and assurances we are relying on to manage and mitigate these risks and identifies actions to address any gaps. We reviewed and updated our strategic risk assessment in Quarter three 2019/20 following agreement of our new five-year strategy and associated strategic objectives.

During the year, the Board of Directors accepted and de-escalated a number of strategic risks from the Board Assurance Framework on the basis of the work undertaken to reduce and mitigate the risk. The de-escalated risks were focused on:

- IM&T - specifically the delivery of our patient information system (Paris) in Manchester
- Cyber security
- General Data Protection Regulation (GDPR)
- Cultural alignment

Actual and potential risks, which may impact on external stakeholders and key partner agencies, including local authorities, commissioners, other NHS providers, the judicial system, voluntary organisation and service users, are handled through structured mechanisms and forums such as Overview and Scrutiny Committees, contract monitoring meetings, Council of Governor meetings and service user forums.

Well-led

Our compliance with the Care Quality Commission's well-led framework was tested as part of our most recent inspection. We maintained an overall rating of 'Good' across all of our core services as an outcome of this inspection.

Quality Governance

Our Quality Governance Framework defines our approach to quality improvement and innovation. The framework describes the structures and processes in place at and below Board level for delivering effective quality assurance. It ensures that the Trust's intentions and systems for delivering robust quality governance are clear and accessible to all staff involved in the planning, delivery and monitoring of services. It also reinforces the importance of embedding the principles of quality within our clinical approaches to support the delivery of high quality, safe and effective care. By defining explicit roles and responsibilities, the framework ensures that we make effective use of Board executives, clinical leaders and service directors in driving the quality agenda. The framework also contributes to developing the Board's capability to understand and promote continuous quality improvement. Quality governance activities are routinely reported to the Board of Directors through

the Quality Improvement Committee, which leads on setting the quality agenda and measuring performance against agreed quality priorities.

We are fully compliant with the registration requirements of the Care Quality Commission (CQC). Assurance has been obtained on compliance with the CQC registration requirements and the fundamental need to ensure the provision of services that are safe, effective, caring, responsive and well-led through the work of the Quality Improvement Committee and via the following mechanisms:

Internal Controls	External Controls	Quality Assurance Reports
Service User and Carer Feedback	Royal College of Psychiatrists (RCPsych) Service Accreditation	Deep Dive Audit Reports
Mental Health Safety Thermometer	NICE guidance	Intelligent Monitoring
Positive and Safe Forum	NICE Quality Standards	Quality Board Performance Report
Local QI collaboratives	PLACE Activity	Quality Key Performance Indicators
Local and Trust-wide Clinical Audit	National Staff & Patient Surveys	Single Oversight Framework
Clinical Governance Systems	District Healthwatch Feedback	Board Assurance Framework
Complaints & Incidents	CQC Mental Health Act visits	Board Performance Reporting
CQUIN Programme	CQC regulatory inspections	Quality Improvement Single Page Plan updates
Council of Governors	Mersey Internal Audit Agency	Care Hub / Service User and Carer Experience Meeting Activity Reports
The Dragons' Den	Quality Accounts and Quality Improvement Priorities (QIPs)	Quality Improvement Quarterly Update Progress Reports
Non-Executive Director and Governor service visits	External Benchmarking	Positive and Safe Dashboards
Task and Finish Groups	POMH (Prescribing Observatory for Mental Health) Improvement Programmes	Safewards reports

Work to deliver our Quality Improvement Strategy, as detailed elsewhere in this report and in our Quality Account 2019/20, complements our approach to quality governance.

Compliance with NHS Foundation Trust Condition 4 (FT Governance)

I can report no principle risks to compliance with the NHS foundation trust licence condition 4 (FT governance) other than the risks described elsewhere in this report. We have complied with this condition throughout this financial year and are planning continued compliance in 2020/21.

We have effective systems in place for the collection, analysis and reporting of information, which provides assurance on our compliance with the licence.

The Board of Directors maintains oversight of the Trust's performance through review of monthly Performance Reports focused on regulatory and workforce standards and finance and a separate quarterly Performance Report focused on quality. The Board's quarterly Quality Report has been strengthened during 2019/20 in line with our increased focus on using improvement-oriented data to drive, monitor and inform our quality improvement activity. Work is also underway to strengthen the content, presentation and timeliness of the monthly Performance Report to Board for April 2020 data onwards.

Our governance structures, including the Terms of Reference for key committees of the Board of Directors, are subject to continuous review to ensure that they are sound and fit for purpose. Reporting lines and lines of accountability are clear and communicated across the organisation. The responsibilities of individual directors are set out in job descriptions and monitored through the annual appraisal process.

We are able to assure ourselves of the validity of our Corporate Governance Statement through the systems of oversight and scrutiny described in this Annual Governance Statement and the wider report.

Workforce Safeguards

We are committed to ensuring that all of our clinical areas are staffed to a safe and effective level. We comply with 'Developing Workforce Safeguards' and the associated 'Safe, Sustainable and Productive Staffing' guidance produced by NHS Improvement on behalf of the National Quality Board. The guidance recommends a triangulated approach to governing and managing safe staffing levels, combining the need to use professional judgements with evidenced-based tools and data.

All of our wards have an agreed safe staffing establishment and skill mix, which is displayed in ward areas. Each ward has a standing staffing profile that can be adjusted according to acuity, demand and professional judgement.

Safe and sustainable staffing is dependent on many variables beyond numbers of staff. Staffing level and skill mix are also influenced by ward-specific guidance, including Accreditation for Inpatient Mental Health Services (AIMS) and other quality standards. We also monitor a range of quality metrics - including staff-related indictors (e.g. job satisfaction), service user indicators (e.g. use of restrictive interventions) and process-related indicators (e.g. complaints) - and triangulate these through our reporting mechanisms.
We use an e-rostering system to plan and monitor staffing levels and report monthly staffing levels to NHS Digital using the Strategic Data Collection Service (SDCS). We received a 'Substantial' assurance opinion from our internal auditors on the adequacy and effectiveness of our e-rostering system during 2019/20.

We apply a standard operating procedure for reporting and monitoring safe staffing, which is complemented by a Resourcing Policy. Our Associate Directors of Nursing and Governance and Operations are jointly responsible for reporting and monitoring staffing levels. Staffing levels are monitored locally through our operational Network Hubs, with updates provided to the Operational Leadership Committee. A number of our services also run daily 'Safety Huddles'. These serve as a real-time, useful sense-check of staffing levels within inpatient services, taking into account the complexity of service users at that time.

We are one of a small number of Trusts in England to have piloted the Mental Health Optimal Staffing Tool (MHOST) during 2019/20. (MHOST is an evidence-based, multi-disciplinary safer staffing support tool). Following a successful pilot on our adult forensic wards, work is now underway to roll MHOST out across our inpatient wards.

Information on safe staffing (fill rates and skill mix) is reported to the Board of Directors on a quarterly basis, following review by the Quality Improvement Committee. During 2019/20, we have introduced the use of Statistical Process Control (SPC) in our safe staffing reports to enable more effective tracking of staffing levels over time and identification of trends and hotspots. Staff are encouraged to report any concerns they may have about the safety of care on their wards, including staffing levels, using Datix.

Staffing levels and skill mix are aligned with strategic and operational plans to sustain high quality care. We operate an annual workforce planning process, led by our services, which reviews our workforce (establishment, skills and roles) in the context of planned and anticipated local, regional and national changes. A key aim is ensuring we have the right workforce profile to deliver our future strategic objectives.

Safe staffing and a sustainable workforce model are identified as key strategic risks on our Board Assurance Framework. Controls to mitigate these risks include our safe staffing governance arrangements, as described here, and the continued implementation of our Workforce and Organisational Development Strategy 2018 to 2021, which sets out targeted and proactive action to address supply, recruitment and retention challenges.

Conflicts of Interest

We have published on our website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined in our Conflicts of Interest Policy) within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance.

Compliance with NHS Pension Scheme

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.

Equality, Diversity and Human Rights

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. Our arrangements for ensuring that equality, diversity and human rights are incorporated into core trust business, including through the use of s, are described elsewhere in this report.

Sustainable Development

We have undertaken risk assessments and have a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). We ensure that our obligations under the Climate Change Act and Adaptation Reporting requirements are complied with.

Review of Economy, Efficiency and Effectiveness of the Use of Resources

Network and divisional performance is monitored through local Senior Leadership Teams (SLTs), Network Hubs and the Operational Leadership Committee. During 2019/20, we also introduced a new Financial Oversight Group to strengthen financial oversight and reinforce local ownership and accountability. As previously reported, the Board of Directors maintains oversight of the Trust's performance through review of Performance Reports focused on regulatory and workforce standards finance and quality.

We operate a robust, annual business planning process, which helps strengthen our clinical, financial and operational sustainability and supports delivery of our strategic objectives. Our 'Business Planning Framework' sets out basic principles and a clear process for business planning, including time-frames and responsibilities of key stakeholders. Individual services identify future priorities, cost improvement programmes and capital plans in their business plan, and also report progress against previous years' plans. Cost improvement programmes are subject to a comprehensive quality impact assessment, which considers any potential impacts on service delivery and quality, before being approved by the Executive Management Team.

Planning commenced during 2019/20, in line with the NHS Operational Planning and Contracting Guidance 2020/21, was suspended in March 2020 as part of the national response to COVID-19. Prior to the suspension of the planning round we had completed our contribution to the development of a system-level (Greater Manchester) Operational Plan. We had also prepared a first draft of our own over-arching Operational Plan for 2020/21, incorporating the key headlines from our local business plans and reflecting the views of our Council of Governors and other key stakeholders. Our draft Operational Plan, which has been shared with our Board of Directors, describes how we will progress our longer-term strategic agendas, whilst also ensuring short-term resilience and affordability. has been shared with the Board of Directors

During 2019/20, performance against our strategic objectives has been monitored via a number of channels, including:

- Monthly reporting to the Board of Directors on performance against key performance indicators and quality standards, including NHS Improvement targets, CQC requirements, contractual performance targets, workforce and activity measures
- Regular reporting to the Board of Directors on progress in the delivery of key strategic priorities/work programmes
- Routine briefings to the Executive Management Team on changes to, influences on, the Trust's financial position and operational performance
- Routine reporting to the Council of Governors
- Periodic reporting to NHS Improvement
- Compliance with the requirements of our provider licence
- Performance management of individual divisions and services
- Compliance with our Standing Financial Instructions and Scheme of Reservation and Delegation
- Decision-making on all key strategic issues reserved for the Executive Management Team or Board of Directors

A programme of internal audits has also been undertaken over the year by our internal auditors (Mersey Internal Audit Agency (MIAA)) with oversight provided by the Audit Committee. Our approach to internal audit is risk-based, aligned to our strategic objectives and focused on core systems and other areas that present the greatest opportunities for improvement. In 2019/20, keys areas covered by our internal audit plan were as follows:

- *Governance and Leadership* – statutory compliance (estates) and assurance framework opinion
- *Financial Performance and Sustainability* – procurement and key financial systems
- *Information and Technology* – Paris implementation, ICT asset management, critical applications (Paris) and Data Security and Protection Toolkit
- *Quality improvement* – safeguarding and Quality Matters
- *Workforce* – travel expenses

A number of further audits - focused on compliance with targets, out of area placements and e-rostering - were completed and reported on in 2019/20 as a carry forward from our 2018/19 plan.

The Audit Committee has reviewed all completed internal audit reports and secured assurance on recommendations made. The Internal Audit review of our Board Assurance Framework found that our Assurance Framework is structured to meet NHS requirements, is visibly used by Board and clearly reflects the risks discussed by the Board.

Information Governance

We aim to deliver a high standard of excellence in information governance by ensuring that information is collated, stored, used and disposed of securely, efficiently and effectively and that all of our processes adhere to legal requirements. In line with the General Data Protection Regulation (GDPR) and the Data Protection Act 2018, we review all of our information governance policies annually ensuring that service user, staff and organisational information is treated in the strictest of confidence at all times.

We are fully compliant with the national Data Security and Protection Toolkit, which sets standards for maintaining high levels of security and confidentiality of information at all times. We also received 'High' assurance from the Information Commissioner's Office (ICO) – the highest level of assurance – following an audit in 2019. This demonstrates the robustness of our information governance processes and procedures and our data protection compliance.

All information governance incidents are investigated to understand the cause and consequences of the breach and any actions taken or required. Incidents are also assessed in terms of risk and impact and classified in line with the Toolkit. We classified 48 of the 190 incidents reported to us in 2019/20 as Level 2. Of those incidents, the vast majority (31) related to breaches of confidentiality and seven related to information security. The remainder were either not classified or related to data loss and theft, information quality and insecure disposal.

We continue to work closely with the ICO and report, as a minimum, any incidents categorised as Level 4 or above. During 2019/20 we reported 47 incidents to the ICO, with 12 of the reported incidents

assessed as fair warning[2] incidents. We have not received any punitive or restrictive notifications from the ICO during the reporting period.

Data Quality and Governance

We have taken the following steps to assure the Board of Directors that appropriate controls are in place to ensure the accuracy of data:

- **Governance and Leadership** - as set out in our Quality Governance Framework, I am ultimately responsible for achieving robust clinical quality across the organisation, whilst the Director of Nursing and Governance is responsible for ensuring compliance with our Quality Account. The Director of Nursing and Governance and Medical Director share responsibility for ensuring that quality governance principles are embedded throughout the organisation, monitoring trends in key clinical quality and clinical outcome measures and accounting for quality governance.

  The Quality Improvement Committee develops and defines our quality strategy on behalf of the Board of Directors and identifies our key quality priorities, goals and standards. This Committee also regularly tracks progress against our agreed Quality Account priorities, ensuring that the required standards are achieved and action is taken on sub-standard performance.

- **Policies and Protocols –** recognising the importance of high-quality information to the effective functioning of the organisation, we operate a range of policies covering all aspects of information governance. Ensuring high quality data is the responsibility of all staff. Our 'Clinical System Data Quality Policy' provides guidance for all staff involved in the capture, processing or us of patient-related data and information. Our 'Information Governance Policy' provides guidance in relation to openness and information sharing, information security, information quality assurance and compliance with legal requirements. Considered alongside our other information governance policies, these provide an integrated framework of requirements, standards and best practice.

- **Systems and Processes, Data Use and Reporting –** we have robust systems in place for checking the quality and reliability of all performance information (including waiting time data) reported to the Board of Directors. Information is recorded in the relevant electronic system and data quality and validation checks completed by relevant personnel, both in local services and our central corporate teams, prior to reporting to Board.

  We operate a regular audit cycle to check the accuracy of data and support services to make improvements. The remit of our 'Performance Measures and Data Quality Group' includes raising awareness of the importance of data quality, ensuring all staff are aware of their data quality responsibilities and supporting the development of policies and procedures to improve

[2] A fair warning incident is an incident involving unauthorised access to a patient's clinical record by a staff member who is also a relative of the patient and has no involvement in the patient's care

data quality. Training is also provided to ensure staff have the necessary skills to deliver our data quality commitments.

- **People and Skills –** Roles and responsibilities in relation to quality are clearly defined in job descriptions and policies and procedures. Where new ways of collecting, monitoring or reporting data are agreed, these are shared with all affected staff. Training is provided, where required, to ensure staff have the necessary skills to implement new ways of working and improve service quality.

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 performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and the Quality Improvement Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The process applied in maintaining and reviewing the effectiveness of the system of internal control throughout this financial year has included:

- Regular review of economy, efficiency and effectiveness by the Board of Directors, its committees and the time-bound Finance Working Group
- Completion of the annual risk-based internal audit plan with scrutiny by the Audit Committee of all completed internal audit reports and associated controls
- Quarterly review of the Board Assurance Framework by the Board of Directors
- Risk Management Committee review of high scoring operational risks and regular review of local operational risk registers at a service-level
- Assessment and monitoring of care quality by the Quality Improvement Committee and its sub-groups
- Quality Improvement Committee oversight of the clinical audit programme through an annual report from our 'Quality Improvement in Clinical Care Group'
- Review of serious incidents and learning by the Quality Improvement Committee, including those related to risk management and clinical effectiveness
- Weekly meetings of the Executive Management Team, providing opportunity for consideration of any performance concerns or emerging or changing risks
- Review and monitoring by sub-groups of the Executive Management Team of the implementation of our Workforce and Organisational Development Strategy, Digital Strategy and annual capital investment programme
- Clear Terms of Reference and reporting lines for all committees of the Board of Directors, and any sub-groups, allowing any issues to be raised

The Board Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its strategic objectives have been reviewed. My review is also informed by the work of external audit, the Care Quality Commission, NHS Resolution and other external inspections, accreditations and reviews.

Head of Internal Audit Opinion

Mersey Internal Audit Agency, the Trust's internal auditors, have provided an overall opinion of 'Substantial Assurance' as to the effectiveness of the Trust's system of internal control. This opinion demonstrates that our system of internal control is designed to meet our objectives and that controls are generally being applied consistently.

The Head of Internal Audit Opinion is underpinned by the work conducted through the risk-based internal audit plan and is provided in the context that the Trust, like other NHS organisations, is facing a number of challenging issues and wider organisational factors. The Head of Internal Audit Opinion has not been affected by the emergence of COVID-19.

Conclusion

No significant internal control issues or gaps in control have been identified in this Annual Governance Statement. The Trust has continued to strengthen its system of internal control during the period to ensure that it remains fit for purpose and has adapted this system towards year-end to enable an appropriate response to the COVID-19 pandemic.

Signed

Neil Thwaite, Chief Executive
Date: 22 June 2020

Independent auditor's report

to the Council of Governors of Greater Manchester Mental Health NHS Foundation Trust

. REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

1. Our opinion is unmodified

We have audited the financial statements of Greater Manchester Mental Health NHS Foundation Trust ("the Trust") for the year ended 31 March 2020 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1,

In our opinion:

— the financial statements give a true and fair view of the state of the Trust's affairs as at 31 March 2020 and of its income and expenditure for the year then ended; and

— the Trust's financial statements have been properly prepared in accordance with the Accounts Direction issued under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006, the NHS Foundation Trust Annual Reporting Manual 2019/20 and the Department of Health and Social Care Group Accounting Manual 2019/20.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Trust in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Overview

Materiality: financial statements as a whole	£5.5m (2019:£5.25m) 1.72% (2019: 1.71%) of total income

Risks of material misstatement		**vs 2019**
Recurring risks	Valuation of land and buildings	◄►
	Recognition of NHS Income and deferred income	◄►
	Valuation of LGPS net pension liability	◄►
	Fraudulent Expenditure Recognition	◄►

2. Key audit matters: our assessment of risks of material misstatement

Key audit matters are those matters that, in our professional judgment, were of most significance in the audit of the financial statements and include the most significant assessed risks of material misstatement (whether or not due to fraud) identified by us, including those which had the greatest effect on:the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. 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. In arriving at our audit opinion above, the key audit matters, in decreasing order of audit significance, were as follows (unchanged from 2019:

	The risk	Our response
Valuation of land and buildings (£185.9 million; 2019: £182.3 million) *Refer to page 56 (Audit Committee Report), page 131-134 (accounting policy) and page 163-166 (financial disclosures)*	**Subjective Valuations** Land and buildings are required to be maintained at up to date estimates of year-end market value in existing use (EUV) for non-specialised property assets in operational use, and, for specialised assets where no market value is readily ascertainable, the depreciated replacement cost (DRC) of a modern equivalent asset that has the same service potential as the existing property (MEAV). It is also necessary to consider whether there is any indication of impairment. Impairment could occur as a result of loss of market value due to conditions in the market or due to deterioration in the value in use of the asset, either because of its condition or because of obsolescence Valuation is completed by the District Valuer, an external expert engaged by the Trust, using construction indices and so accurate records of the current estate are required. Full valuations are completed every five years, with desktop valuations completed in interim periods. Valuations are inherently judgmental, therefore our work focused on whether the valuer's methodology, assumptions and underlying data, were appropriate and correctly applied. The Trust had a desktop valuation performed in March 2020. Calculation of potential movements in values up to 31 March 2020 was carried out using Royal Institution of Chartered Surveyors (RICs) indices data provided by the District Valuer but this amount was not transacted in the 2019/20 financial statements. The Trust complete a formal review of impairment indicators across the Trust's estate covering the period up to year-end. There is a risk that uncertainties expressed by the Trust's valuer around the impact of the Covid-19 pandemic on the values of the land and buildings will be appropriately disclosed. The effect of these matters is that, as part of our risk assessment, we determined that the valuation of land and buildings has a high degree of estimation uncertainty, with a potential range of reasonable outcomes greater than our materiality for the financial statements as a whole.	Our procedures included: — **Assessing valuer's credentials:** We critically assessed the competence, capability, objectivity and independence of the Trust's external valuer. This included a review of the National Audit Office's Gerald Eve assurance report regarding their assessment of the Valuation Office Agency. — **Assessing valuation assumptions:** We reviewed the valuation reports, terms of engagement of, assumptions used by, and the instructions issued to, the Valuer and compared these with the requirements of the GAM. — **Assessing valuation assumptions:** We critically assessed the assumptions underpinning the Trust's calculation of market value movements to the Royal Institute Chartered Surveyors data obtained by the Valuer and corresponding with audit teams at other Trusts in the region, to assure ourselves that indices are comparable. — **Test of detail:** We tested the estate covered by the desktop valuation by comparing he Trust's underlying records of the estate held in the fixed asset register to the assets in the prior year valuation report. — **Test of detail:** We tested the Trust's formal consideration of indications of impairment and surplus assets within its estate. This included an assessment of the adequacy of the written instructions communicated to the Valuer to inform the impairment process and a review of the evidence to support the conclusions formed, as well as a testing of the Trust's impairment review for completeness. — **Assessing transparency**: we considered the adequacy of the disclosures around the key judgements and degree of estimation involved in concluding whether there has been any material movement in the value of land and buildings since 31 March 2019/ specifically we considered the adequacy of disclosures made around the uncertainty caused by the Covid-19 pandemic on market data used to underpin the valuer's assumptions and management's consideration of these factors when arriving at the year end figure. We also assessed how the Trust have disclosed using this information to drive their impairment review for the 2019/20 year.

2. Key audit matters: our assessment of risks of material misstatement (cont.)

	The risk	Our response
Recognition of NHS Income and deferred income Income from patient care activities (£299.8 million; 2019: £280.2m) Deferred Income (£10.6 million; 2019: £12.9m) *Refer to page 56 (Audit Committee Report), page 130 (accounting policy) and page 176-179 (financial disclosures)*	**Subjective Estimate** The main source of income for the Trust is the provision of healthcare services to the public under contracts with NHS commissioners. The Trust also receives funding for Education & Training and Research from other bodies in the DH boundary. These activities will frequently span years and as such a significant proportion of the income each year is deferred. We recognise that incentives in the NHS differ significantly to those in the private sector which have driven the requirement to make a rebuttable presumption that this is a significant risk. These incentives in the NHS include the requirement to meet regulatory and financial covenants, for example pressure on management to deliver the control total each year, rather than broader share based management concerns. We have therefore classified NHS income and deferred income as a significant risk to respond to this.	Our procedures included: — **Test of Operating Effectiveness:** We tested a sample of contracts to ensure these were signed by both parties and that contract variations are agreed by both the Trust and the other party. — **Test of detail:** We compared the actual income for the Trust's most significant commissioners against the block contracts agreed at the start of the year and checked the validity of any significant variations between the actual income and the contract via agreement to appropriate third party confirmations. — **Test of detail:** We compared the income balances reported by the Trust as part of the 2019/20 Agreement of Balances (AoB) exercise to the balances reported in the accounts. — **Test of detail:** For any variances or mismatches identified as part of the AoB exercise, we sought explanations and supporting evidence for the Trust's position from the client. This included mismatches arising from the deferral of income by the trust where the commissioner had recognised the full amount in expenditure in the year. — **Test of detail:** We analysed the deferred income balances, and compared a sample of the balances carried forward to documentation to determine whether the income was being deferred appropriately, in line with conditions of the funding. We also tested a sample of income released in year to determine whether income was being recognised appropriately. — **Test of detail:** Cut off procedures were performed in order to gain assurance that income has been correctly recognised in the period.

2. Key audit matters: our assessment of risks of material misstatement (cont.)

	The risk	Our response
Valuation of LGPS net pension liability LGPS Plan Assets £17.9m (2019: £16.7m) LGPS defined benefit obligation £16.6m (2012: £20.1m) *Refer to page 56 (Audit Committee Report), page 130 (accounting policy) and page 176 - 179 (financial disclosures)*	**Subjective Valuation:** The Trust is an admitted body of the Greater Manchester Pension Fund (GMPF), part of the Local Government Pension Scheme (LGPS), which is a defined benefit scheme. This follows the Trust's absorption of services as part of the MMHSC transfer in 2017. The Trust's share of the pension scheme assets is based on the last triennial valuation, which was completed as at 31 March 2019. Thereafter the actuary uses an estimated rate of return in the asset roll forward calculations (included in the IAS 19 Actuarial Valuation as at 31 March 2020 for accounting purposes) so there is risk the difference between that and the actual return over the same period, materially impacts the fair value of plan assets during the year. The gross pension liability is a significant estimate, based on the number of staff in the scheme and the characteristics of those staff, such as their age and their length of service. The liability is calculated using a range of assumptions, including estimates on inflation and lifespan. Due to the level of judgement and expertise required to prepare the IAS19 valuation for the purposes of preparing the financial statements, the Trust relies on the LGPS scheme actuary, who is appointed by GMPF. The actuary relies on the information provided by the GMPF on the employees, deferred members and pensioners of the Trust. There is a risk that the information, assumptions and methodology used in the valuation of the Trust's pension assets and liabilities are inappropriate. This could have a material impact on the gross pension liability or the gross pension asset reported in the financial statements.	Our procedures included: — **Assessing actuary's credentials:** We critically assessed the competency, objectivity and independence of the Scheme's actuary. — **Assessing valuation assumptions:** We reviewed the appropriateness of the key assumptions included within the valuation of the assets and the liabilities, with the use of a KPMG Actuary. Our actuary also reviewed the methodology applied in the valuation by Scheme's actuary. — **Assessing the administrating body and pension fund:** We performed risk assessment procedures over the pension administering body and fund. Such as review of minutes and risk registers from the Local Authority, — **Test of detail:** We used the IAS 19 valuation provided by the Scheme Actuary for accounting purposes to ensure that this reconciled to the pension balances in the Trust's financial statements. — **Test of detail:** We reviewed the controls in place at Trust that ensures the data provided to the pension fund for the purposes of the IAS19 valuation was complete and accurate. — **Test of detail:** We agreed the estimated movement in the fair value of plan assets during the year, included in the IAS 19 Actuarial Valuation as at 31 March 2020, to the Trust's financial statements. — **Test of detail:** We tested a sample of active members and obtained the number of deferred members and pensioners from the pension fund to there have been no material changes that could impact the actuarial valuation. — **Test of detail:** We performed substantive analytical procedures to create an expectation of the estimated cashflows (interest income, employee and employer contributions, benefits paid) used to determine the movements in plan assets during the year.

2. **Key audit matters: our assessment of risks of material misstatement (cont.)**

	The risk	Our response
Fraudulent Expenditure Recognition Other Operating Expenditure (excl. Staff Costs, impairment and depreciation) (£85.6 million; 2019: £80.6 million) Trade and other payables (£31.6 million; 2018/19: £30.9 million) *Refer to page 56 (Audit Committee Report), page 131 (accounting policy) and page 151 – 162 and 171 (financial disclosures)*	**Subjective Estimate:** In the public sector, auditors also consider the risk that material misstatements due to fraudulent financial reporting may arise from the manipulation of expenditure recognition (for instance by deferring expenditure to a later period). This may arise due to the audited body manipulating expenditure to meet externally set targets. As most public bodies are net spending bodies, then the risk of material misstatement due to fraud related to expenditure recognition may in some cases be greater than the risk of material misstatements due to fraud related to revenue recognition and so the auditor has regard to this when planning and performing audit procedures We do not consider this risk to apply to all expenditure in the period. The incentives for fraudulent expenditure recognition lie within accrued expenditure at year-end, as well as completeness of recognition of new provisions or release of existing provisions. Our response to this risk focused on non-pay spend, including agency payments. Salary costs are considered lower risk in terms of the scope for fraudulent recognition and misrepresentation by management.	Our procedures included: — **Test of Operating Effectiveness:** We tested a sample of invoices to verify these had followed the Trust's 3 way match approval control. — **Test of detail:** We inspected all material items of expenditure in the March and April 2020 cashbooks and to agree these have been accounted for correctly by evaluating when the service had been delivered; — **Test of detail:** We inspected all material items of expenditure in the April 2020 bank statements to identify if there were any unrecorded liabilities that should have been accounted for in the 2019/20 financial statements; — **Test of detail:** We tested a sample of accruals to supporting evidence to agree that the expenditure has been accounted for in the correct period. — **Test of detail:** We inspected confirmations of balances provided by the Department of Health as part of the AoB exercise and compared the relevant payables recorded in the Trust's financial statements to the receivables balances recorded within the accounts of other providers and other bodies within the AoB boundary. Where applicable we investigated variances and reviewed relevant correspondence to assess the reasonableness of the Trust's approach to recognising expenditure to other providers and other bodies within the AoB boundary.

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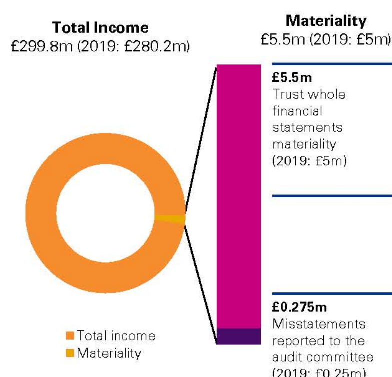
3. Our application of materiality

Materiality for the Trust financial statements as a whole was set at £5.5 million (2019: £5 million), determined with reference to a benchmark of total income (of which it represents approximately 1.72%) (2019: £1.71%). We consider total income to be more stable than a surplus- or deficit-related benchmark.

We agreed to report to the Audit Committee any corrected and uncorrected identified misstatements exceeding £0.275 million (2019:£0.25 million), in addition to other identified misstatements that warranted reporting on qualitative grounds.

Our audit of the Trust was undertaken to the materiality level specified above and was performed both at the Trust's Prestwich site for the interim visit and remotely.



4. We have nothing to report on going concern

The Accounting Officer has prepared the financial statements on the going concern basis as they have not been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over their ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

Our responsibility is to conclude on the appropriateness of the Accounting Officer's conclusions and, had there been a material uncertainty related to going concern, to make reference to that in this audit report. However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the absence of reference to a material uncertainty in this auditor's report is not a guarantee that the Trust will continue in operation.

In our evaluation of the Accounting Officer's conclusions, we considered the inherent risks to the Trust's business model, including the impact of Brexit, and analysed how those risks might affect the Trust's financial resources or ability to continue operations over the going concern period.

The risk that we considered most likely to adversely affect the Trust's available financial resources over this period was the availability and extent of temporary revenue support from DHSC to enable it to meet liabilities. This is in the context of changes to the cash and capital regime published by DHSC in April 2020 alongside revised arrangements for NHS contracting and payment applicable for part of the 2020/21 year and published in March and May 2020.

As this was the risk that could potentially cast significant doubt on the Trust's ability to continue as a going concern, we considered sensitivities over the level of available financial resources indicated by the Trust's financial forecasts taking account of reasonably possible (but not unrealistic) adverse effects that could arise from these changes individually and collectively and evaluated the achievability of the actions the Accounting Officer consider they would take to improve the position should the risk materialise.

Based on this work, we are required to report to you if we have anything material to add or draw attention to in relation to the Accounting Officers statement on page 90 of the financial statements on the use of the going concern basis of accounting with no material uncertainties that may cast significant doubt over the Trust's use of that basis for a period of at least twelve months from the date of approval of the financial statements.

We have nothing to report in these respects, and we did not identify going concern as a key audit matter.

5. We have nothing to report on the other information in the Annual Report

The directors are responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work we have not identified material misstatements in the other information.

In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements

Remuneration report

In our opinion the part of the remuneration report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2019/20.

Corporate governance disclosures

We are required to report to you if:

— we have identified material inconsistencies between the knowledge we acquired during our financial statements audit and the directors' statement that they consider that the annual report and financial statements taken as a whole is fair, balanced and understandable and provides the information necessary for stakeholders to assess the Trust's position and performance, business model and strategy; or

— the section of the annual report describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee; or

— the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2019/20 is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements.

We have nothing to report in these respects.

6. Respective responsibilities

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 94, the Accounting Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

We have nothing to report on the statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if:

— any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006.

— 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.

We have nothing to report in these respects.

We have nothing to report in respect of our work on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

Under the Code of Audit Practice we are required to report to you if the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in the use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

The Trust is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources

Under Section 62(1) and Schedule 10 paragraph 1(d), of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in the use of resources .

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in November 2017, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

Report on our review of the adequacy of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required by guidance issued by the C&AG under Paragraph 9 of Schedule 6 to the Local Audit and Accountability Act 2014 to report on how our work addressed any identified significant risks to our conclusion on the adequacy of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources. The 'risk' in this case is the risk that we could come to an incorrect conclusion in respect of the Trust's arrangements, rather than the risk of the arrangements themselves being inadequate.

We carry out a risk assessment to determine the nature and extent of further work that may be required. Our risk assessment includes consideration of the significance of business and operational risks facing the Trust, insofar as they relate to 'proper arrangements'. This includes sector and organisation level risks and draws on relevant cost and performance information as appropriate, as well as the results of reviews by inspectorates, review agencies and other relevant bodies.

The significant risks identified during our risk assessment are set out overleaf together with the findings from the work we carried out on each area.

Significant Risk	Description	Work carried out and judgements
Financial Sustainability	NHS Trusts and Foundation Trusts submitted financial plans for 2019/20, that in aggregate forecast a system deficit. So maintaining financial balance, whilst maintaining the quality of healthcare provision, is therefore a key objective for all organisations. The Trust achieved a surplus £2.1m and received additional one off Provider Sustainability Funding (PSF) relating to 19/20 which does not form part of the assessment of performance for control total purposes. The Trust received £3.35m of PSF for 2019-20 with £0.855m of PSF reallocated from 2018/19. The sustained financial pressure on the sector means that the Trust must continue to identify and achieve challenging savings goals to continue to meet these targets. At each year end, the risk therefore increases that the Trust will not be able to identify the required level of savings to meet further savings targets. The Trust planned to deliver Cost Improvement Programme (CIP) savings of £4.879m in year. The actual CIP achievement was £4.45m. The Trust also continues to face pressures from Out of Areas Placements (OAPs) costs, a long-term funding solution to remove this pressure has not yet been identified. Furthermore, the Trust continues to receive transitional support from Commissioners and is looking at negotiating contracts to secure more recurrent funding in the 2020-21 financial year.	Our work included: — Reviewing the arrangements in place to deliver recurrent cost improvements. We also reviewed how the shortfall in the planned Cost Improvement Programme is managed by the Trust — Seeking evidence that the Trust has in a place a process to identify further Cost Improvement Programme schemes to meet future savings targets; — For the current year, we reviewed the arrangements in place to deliver and report on the forecast outturn, and especially the arrangements in place to deliver the Cost Improvement Programme, reduce the agency spend and manage the Out of Area Placements position; and — We also considered the extent to which the Trust will be able to deliver its control total in the future, and maintain a surplus position across the medium term. This included a review of forecasts including cash flows, and the arrangements in place to deliver forecast positions. This included delivery of targets required to secure additional Provider Sustainability Fund (PSF) income. — Following the COVID-19 outbreak, the planning for 2020/21 was suspended. Additionally, normal NHS Business Rules have been suspended and commissioners have been deterred from progressing contract negotiations with providers and Trusts have been unable to implement significant operational savings. **Our findings on this risk area:** – The financial performance at the end of March 2020 was a surplus of £2.1m, £855k above the planned control total due to receipt of additional Provider Sustainability Funding relating to 2018/19. This outturn includes £3,3m of Provider Sustainability Funding for achieving the Trust's control total. The Trust have a forecast deficit of £5.2m for 2020/21. As noted above, NHS planning has been suspended and as such this is yet to be agreed by NHSI. – The Budget setting process for 2020/21 has identified a deficit before mitigations of £9.5m which is offset by an estimated vacancy rate equalling £4.3m, resulting in a financial gap/risk of £5.2m. The main increases relate to incremental drift and pay award above the 2.9% funded in the uplift. – The £5.2m risk has been put forward to be included in the Greater Manchester System Risk total on a non-recurrent basis for 2020/21, whilst the Trust continues to reduce its cost base, via Cost Improvement Programmes, Quality Improvement and productivity programmes. – Achievement of the Cost Improvement Programme for 2020/21 will be challenging without major service transformation, however the Trust is planning a breakeven position going forward within the Long Term Financial Plan submitted to NHSI. The current funding arrangements in relation to the Covid-19 pandemic are not expected to impact negatively on this position.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

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

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of Greater Manchester Mental Health NHS Foundation Trust for the year ended 31 March 2020 in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice issued by the National Audit Office.

Debra Chamberlain
for and on behalf of KPMG LLP

Chartered Accountants
One St. Peter's Square,
Manchester,
M2 3AE

24 June 2020

Financial Review

Foreword to the Accounts

These accounts for the year ended 31 March 2020 have been prepared by Greater Manchester Mental Health NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 within the NHS Act 2006.

Signed

Neil Thwaite, Chief Executive

Date: 22 June 2020

Statement of Comprehensive Income

	Note	2019/20 £'000s	2018/19 £'000s
Operating income from patient care activities	3	299,829	280,211
Other operating income	4	37,564	39,075
Operating expenses	5	(327,649)	(308,340)
Operating surplus/(deficit) from continuing operations		**9,744**	**10,946**
Finance income	10	185	163
Finance expenses	11	(96)	(109)
PDC dividends payable		(6,216)	(5,886)
Net finance costs		**(6,127)**	**(5,832)**
Other gains / (losses)	12.1	8	(12)
Surplus / (deficit) for the year from continuing operations		**3,625**	**5,102**
Surplus / (deficit) for the year		**3,625**	**5,102**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	6	-	(3,723)
Revaluations		-	4,378
Other recognised gains and losses:		-	-
Remeasurements of the net defined benefit pension scheme liability / asset	28	2,003	(906)
Other reserve movements		(15)	(15)
Total comprehensive income / (expense) for the period		**5,613**	**4,836**

Adjusted financial performance (control total basis):	2019/20	2018/19
Surplus / (deficit) for the period	3,625	5,102
Remove net impairments not scoring to the Departmental expenditure limit	-	2,190
Remove impact of prior year PSF post accounts reallocation	(855)	-
Remove Impact of NHSEI Mental Health Non Recurrent Support	(1,571)	-
Remove non-cash element of on-SoFP pension costs	43	136
Remove income from disposal of PPE	(12)	0
Adjusted financial performance surplus / (deficit)	**1,230**	**7,428**
Adjusted financial performance surplus / (deficit) excluding PSF, FRF + MRET	**333**	**730**

Statement of Financial Position

	Note	31 March 2020 £'000s	31 March 2019 £'000s
Non-current assets			
Intangible assets	13	2,297	2,344
Property, plant and equipment	14	194,660	191,512
Receivables	16	10,933	10,393
Total non-current assets		**207,890**	**204,249**
Current assets			
Inventories		-	-
Receivables	16	21,339	23,233
Assets Held For Sale	17	260	-
Cash and cash equivalents	19	31,012	29,578
Total current assets		**52,611**	**52,811**
Current liabilities			
Trade and other payables	20	(31,648)	(30,955)
Borrowings	22	(326)	(326)
Other financial liabilities		-	-
Provisions	24	(454)	(563)
Other liabilities	21	(10,662)	(12,902)
Liabilities in disposal groups	18	-	-
Total current liabilities		**(43,090)**	**(44,746)**
Total assets less current liabilities		**217,411**	**212,314**
Non-current liabilities			
Trade and other payables	20	-	-
Borrowings	22	(1,801)	(2,125)
Other financial liabilities		-	-
Provisions	24	(3,474)	(3,160)
Other liabilities	21	(214)	(2,174)
Total non-current liabilities		**(5,489)**	**(7,459)**
Total assets employed		**211,922**	**204,855**
Financed by			
Public dividend capital		110,445	108,991
Revaluation reserve		30,659	30,659
Pension reserve		2,021	18
Other reserves		395	410
Income and expenditure reserve		68,402	64,777
Total taxpayers' equity		**211,922**	**204,855**

The notes on pages 127 to 184 form part of these accounts.

The financial statements were approved by the Audit Committee, operating with the delegated authority of the Board of Directors, on 22 June 2020 and signed on its behalf by:

Signed:

Name: Neil Thwaite
Position: Chief Executive
Date: 22 June 2020

Statement of Changes in Equity for the year ended 31 March 2020

	Public dividend capital £'000s	Revaluation reserve £'000s	Pension Reserve £'000s	Other reserves £'000s	Income and expenditure reserve £'000s	Total £'000s
Taxpayers' equity at 1 April 2019 - brought forward	**108,991**	**30,659**	**18**	**410**	**64,777**	**204,855**
Surplus/(deficit) for the year	-	-	-	-	3,625	**3,625**
Transfers by absorption: transfers between reserves	-	-	-	-	-	**-**
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	-	-	-	-	**-**
Other transfers between reserves	-	-	-	-	-	**-**
Impairments	-	-	-	-	-	**-**
Revaluations	-	-	-	-	-	**-**
Transfer to retained earnings on disposal of assets	-	-	-	-	-	**-**
Share of comprehensive income from associates and joint ventures	-	-	-	-	-	**-**
Fair value gains/(losses) on financial assets mandated at fair value through OCI	-	-	-	-	-	**-**
Fair value gains/(losses) on equity instruments designated at fair value through OCI	-	-	-	-	-	**-**
Recycling gains/(losses) on disposal of financial assets mandated at fair value through OCI	-	-	-	-	-	**-**
Foreign exchange gains/(losses) recognised directly in OCI	-	-	-	-	-	**-**
Other recognised gains and losses	-	-	-	-	-	**-**
Remeasurements of the defined net benefit pension scheme liability/asset	-	-	2,003	-	-	**2,003**
Public dividend capital received	1,454	-	-	-	-	**1,454**
Public dividend capital repaid	-	-	-	-	-	**-**
Public dividend capital written off	-	-	-	-	-	**-**
Other movements in public dividend capital in year	-	-	-	-	-	**-**
Other reserve movements	-	-	-	(15)	-	**(15)**
Taxpayers' equity at 31 March 2020	**110,445**	**30,659**	**2,021**	**395**	**68,402**	**211,922**

Statement of Changes in Equity for the year ended 31 March 2019

	Public dividend capital	Revaluation reserve	Pension Reserve	Other reserves	Income and expenditure reserve	Total
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Taxpayers' equity at 1 April 2018 - brought forward	105,406	30,552	924	425	59,127	**196,434**
Prior period adjustment						
Taxpayers' equity at 1 April 2018 - restated	**105,406**	**30,552**	**924**	**425**	**59,127**	**196,434**
Surplus/(deficit) for the year	-	-	-	-	-	**-**
Transfers by absorption: transfers between reserves	-	-	-	-	-	**-**
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	-	-	-	5,102	**5,102**
Other transfers between reserves	-	-	-	-	-	**-**
Impairments	-	-	-	-	-	**-**
Revaluations	-	-	-	-	-	**-**
Transfer to retained earnings on disposal of assets	-	(548)	-	-	548	**-**
Share of comprehensive income from associates and joint ventures	-	-	-	-	-	**-**
Fair value gains/(losses) on available-for-sale financial investments	-	(3,723)	-	-	-	**(3,723)**
Recycling gains/(losses) on available-for-sale financial investments	-	4,378	-	-	-	**4,378**
Foreign exchange gains/(losses) recognised directly in OCI	-	-	-	-	-	**-**
Other recognised gains and losses	-	-	-	-	-	**-**
Remeasurements of the defined net benefit pension scheme liability/asset	-	-	(906)		-	**(906)**
Public dividend capital received	3,585	-	-	-	-	**3,585**
Public dividend capital repaid	-	-	-	-	-	**-**
Public dividend capital written off	-	-	-	-	-	**-**
Other movements in public dividend capital in year	-	-	-	-	-	**-**
Other reserve movements	-	-	-	(15)	-	**(15)**
Taxpayers' equity at 31 March 2019	**108,991**	**30,659**	**18**	**410**	**64,777**	**204,855**

Information on Reserves

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 organisation. Additional PDC may also be issued to Trusts by the Department of Health and Social Care on the acquisition of/or merger with another NHS Trust or for DHSC funded capital expenditure. A charge, reflecting the cost of capital utilised by the 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.

Pension reserve

This relates to the Trust's membership as an admitted body of the Greater Manchester Pension Fund. Actuarial gains and losses arising from changes in the actuarial assumption used in the annual IAS 19 valuation of the fund are recorded in the pension reserve.

Other Reserves

The balance of this reserve is from the transfer of a property to the Trust in 2000/01.

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the Trust.

Statement of Cash Flows

	Note	2019/20 £'000s	2018/19 £'000s
Cash flows from operating activities			
Operating surplus / (deficit)		9,744	10,946
Non-cash income and expense:			
Depreciation and amortisation	5.1	7,324	7,558
Net impairments	6	-	2,190
Non-cash movements in on-SoFP pension liability		43	136
(Increase) / decrease in receivables and other assets		1,354	(7,393)
(Increase) / decrease in inventories		-	-
Increase / (decrease) in payables and other liabilties		(2,385)	(3,547)
Increase / (decrease) in provisions		204	(260)
Other movements in operating cash flows		(16)	(15)
Net cash generated from / (used in) operating activities		**16,268**	**9,615**
Cash flows from investing activities			
Interest received		185	163
Purchase and sale of financial assets / investments		-	-
Purchase of intangible assets		(936)	(1,399)
Sales of intangible assets		-	-
Purchase of property, plant, equipment and investment property		(8,741)	(9,411)
Sales of property, plant, equipment and investment property		12	10
Receipt of cash donations to purchase capital assets		-	-
Net cash generated from / (used in) investing activities		**(9,480)**	**(10,637)**
Cash flows from financing activities			
Public dividend capital received		1,454	3,585
Public dividend capital repaid		-	-
Movement on loans from the Department of Health and Social Care		(324)	(5,762)
Interest on loans		(44)	(73)
Other interest		-	-
PDC dividend (paid) / refunded		(6,389)	(5,858)
Cash flows from (used in) other financing activities		(51)	(40)
Net cash generated from / (used in) financing activities		**(5,354)**	**(8,148)**
Increase / (decrease) in cash and cash equivalents		**1,434**	**(9,170)**
Cash and cash equivalents at 1 April - brought forward		**29,578**	**38,748**
		-	-
Cash and cash equivalents at 31 March	19.1	**31,012**	**29,578**

Notes to the Accounts

Note 1 Accounting Policies and Other Information

Note 1.1 Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2019/20 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Note 1.1.1 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.

Note 1.2 Going concern

These accounts have been prepared on a going concern basis.

International Accounting Standard (IAS) 1 requires management to make an assessment of the NHS Foundation Trust's ability to continue operating as a going concern. At the Trust Board meeting held on 24 February 2020, the Trust Board considered the IAS 1 requirement and confirmed that a going concern basis for accounts preparation was appropriate.

In 2020/21, in response to the Covid-19 pandemic, all detailed financial planning was suspended. In addition, the requirement for Trusts to agree contracts with its commissioners was removed. Instead, Trusts are receiving regular monthly 'block' payments together with top-up payments designed to ensure that there are sufficient funds available to adequately deal with the crisis. Currently the Trust is unclear what form of contracting and payment mechanism will replace this approach, which is currently confirmed only until the end of October 2020.

Providers have been told by DHSC to continue to expect NHS funding to flow at similar levels to that previously provided where services are reasonably still expected to be commissioned. While mechanisms for contracting and payment are not definitively in place, it is clear that NHS services will continue to be funded, and government funding is in place for this. As with any Trust placing reliance on the DHSC for financial support, the directors acknowledge that there can be no certainty that this support will continue although, at the date of approval of these financial statements, they have no reason to believe that it will not do so.

Note 1.3 Interests in other entities

The Trust does not have any interests in other entities and consequently is not required to produce consolidated accounts under IAS27.

Note 1.4 Revenue

Note 1.4.1 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

The main source of income for the Trust is contracts with Commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the Commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Revenue is recognised to the extent that collection of consideration is probable. Where contract challenges from Commissioners are expected to be upheld, the Trust reflects this in the transaction price and derecognises the relevant portion of income.

Where the Trust is aware of a penalty based on contractual performance, the Trust reflects this in the transaction price for its recognition of revenue. Revenue is reduced by the value of the penalty.

The Trust receives income from Commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its Commissioner but they affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance

obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

Provider Sustainability Fund (PSF)

The PSF enables providers to earn income liked to the achievement of financial controls and performance targets. Income earned from the fund is accounted for as variable consideration.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. At contract inception, the Trust assesses the outputs promised in the research contract to identify as a performance obligation each promise to transfer either a good or service that is distinct or a series of distinct goods or services that are substantially the same and that have the same pattern of transfer. The Trust recognises revenue as these performance obligations are met, which may be at a point in time or over time depending upon the terms of the contract.

Note 1.4.2 Revenue grants and other contributions to expenditure

Government grants are grants from government bodies other than income from Commissioners or 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.
The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.4.3 Other income

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 such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme - Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and

Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

Local Government Pension Scheme

Staff who transferred from Manchester City Council on 1 September 2010 can remain members of the GMPF, which in turn is a member of the Local Government Pension Scheme (LGPS). Details of this scheme can be obtained from the GMPF, Council Offices, Wellington Road, Ashton under Lyne, OL6 6DL.

Details of the Trust assets and liabilities as a member of the scheme have been calculated by an independent actuary, Hyman Robertson LLP. A full actuarial report for the full GMPF was produced in March 2019. This report set out member contribution rates up to and including 2022/23.

The Trust has a number of employees who are members of the above fund. The funds within the LGPS are multi-employer schemes and each employer's share of the underlying assets and liabilities can be identified. Hence a defined benefit accounting approach is followed. The scheme has full actuarial valuation at intervals not exceeding three years. In between the full actuarial valuations, the assets and liabilities are updated at the year end, using the principal actuarial assumptions at that date. The full disclosure requirements of IAS19 Employee Benefits are given in note 28.

The pension scheme assets are measured using market value. Pension scheme liabilities are measured using the projected unit actuarial method and are discounted at the current rate of return on a high quality corporate bond of equivalent terms and currency to the liability. The increase in the present value of the liabilities of the defined benefit pension scheme expected to arise from employee service in the period is charged to operating expenses.

The expected return on the scheme assets and the increase during the year in the present value of the schemes' liabilities arising from the passage of time are included in other finance costs.

Actuarial gains and losses are recognised within retained earnings in the Statement of Changes in Taxpayers' Equity and in Other Comprehensive Income.
National Employment Savings Pension Scheme (NEST)

Under the Pensions Act 2008 employers must offer a pension scheme to all its employees. As from the 1st July 2013, when the scheme came into operation in the Trust, staff who are not eligible to join the NHS Pensions Scheme or LGPS are automatically enrolled into NEST. This scheme is a defined contribution pension scheme created as part of the government's workplace pensions reforms.

Accounting for defined contribution plans requires the Trust to report on the amounts contributed for that period. Consequently, no actuarial assumptions are required to measure the obligation for the expense and there is no possibility of any actuarial gain or loss. The Trust settles its obligations within the annual reporting period in which the employees render the related service.

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Under the Pensions Act 2008 employers must offer a pension scheme to all its employees. As from the 1st July 2013, when the scheme came into operation in the Trust, staff who are not eligible to join the NHS Pensions Scheme or LGPS are automatically enrolled into NEST. This scheme is a defined contribution pension scheme created as part of the government's workplace pensions reforms.

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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

Note 1.7.1 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
- the cost of the item can be measured reliably
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

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 lives.

Note 1.7.2 Measurement

Valuation

All property, plant and equipment assets 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 valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

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 lives in a manner consistent with the consumption of economic or service delivery benefits. 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' cease 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.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of 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 of 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 expenditure 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.

Note 1.7.3 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 abandoned 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 useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.7.4

Donated and 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.

Note 1.7.5

Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions

The Trust does not have any PFI or LIFT assets.

Note 1.7.6

Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Buildings, excluding dwellings	1	72
Plant & machinery	5	15
Transport equipment	7	7
Information technology	3	7
Furniture & fittings	3	3

Finance-leased assets (including land) are depreciated over the shorter of the useful 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

Note 1.8.1 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, e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset and
- the Trust can measure reliably the expenses attributable to the asset during development

Software

Software which is integral to the operation of hardware, e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, e.g application software, is capitalised as an intangible asset.

Note 1.8.2 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 of 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 lives in a manner consistent with the consumption of economic or service delivery benefits.

Note 1.8.3 Useful economic life of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Development expenditure	3	7
Software licences	3	7
Other (purchased)	3	7

Note 1.9 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.

The Trust does not hold any inventories.

Note 1.10 Investment properties

Investment properties are measured at fair value. Changes in fair value are recognised as gains or losses in income/expenditure.

Only those assets which are held solely to generate a commercial return are considered to be investment properties. Where an asset is held, in part, for support service delivery objectives, then it is considered to be an item of property, plant and equipment. Properties occupied by employees, whether or not they pay rent at market rates, are not classified as investment properties.

The Trust does not hold any investment properties.

Note 1.11 Cash and cash equivalents

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 3 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.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.12 Carbon Reduction Commitment scheme (CRC)

The CRC scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The Trust is not registered with the CRC scheme.

Note 1.13 Financial assets and financial liabilities

Note 1.13.1 Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes 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 and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Note 1.13.2 Classification and measurement

Note 1.13.2 Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

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.

Financial assets are classified as subsequently measured at amortised cost.

Financial liabilities classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Note 1.13.3 De-recognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market.

The Trust's loans and receivables comprise: 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.

The Trust does not hold any Available-for-sale Financial Assets.

Note 1.14 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Note 1.14.1 The Trust as lessee

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the 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 an item of property plant and equipment.

The annual rental charge 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

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

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 1.14.2 The Trust as lessor

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.15 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.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 25 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 NHS Resolution 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 1.16 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 entity's control) are not recognised as assets, but are disclosed in note 26 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 26, 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 1.17 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 organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the 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. (iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.18 Value added tax

Most of the activities of the 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 1.19 Corporation tax

The Trust does not pay any corporation tax.

Note 1.20 Foreign exchange

The functional and presentational currency of the Trust is 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 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 1.21 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 1.22 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 the Trust 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 1.23 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 1.24 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

Leases

The Trust as lessee, has classified a lease between the Trust and Manchester University NHS Foundation Trust (formerly University Hospital of South Manchester NHS Foundation Trust) relating to Laureate House as an operating lease. This lease has been classified as an operating lease following an assessment of the lease agreement against the International Financial Reporting Standards (IFRS) criteria which identified that the asset does not transfer to the Trust at the end of the lease nor does the Trust have any option to purchase the asset. The lease is not for the major part of the economic life of the asset and the asset is not specialised in nature. Although the present value of the minimum lease payments at inception is substantially all of the fair value of Laureate House, the Trust has judged that this in itself is not sufficient to classify the lease as a finance lease and in substance therefore, the lease is an operating lease.

Impairment

In line with the Trusts revaluation policy, an impairment review was undertaken during 2019/20. To inform this review the trust engaged the District valuer to undertake a desktop revaluation of the Trust's land and buildings. The Trust deems that the impact of this desktop valuation is not material to the financial statements and consequently has not transacted it.

Note 1.24.1 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

Modern Equivalent Asset Valuation

Independent valuers have provided valuations of the Trust's land and building assets (estimated financial value and estimated remaining useful life), applying a Modern Equivalent Asset method of valuation. For 2019/20 the Trust has engaged the District Valuer to undertake a desktop revaluation and has revalued its land and building assets accordingly. Future revaluations of the Trust's property may result in further material change to the carrying value of land and buildings assets. For 2019/20 the District Valuer has applied Royal Institute of Chartered Surveyors (RICS) forecast rebuild indices, the BCIS Tender Price Indices, for assets valued at depreciated replacement cost, resulting in a total decrease in carrying values of £964k. In applying the RICS Valuation Global Standards (Red Book), the valuer has declared a "material valuation uncertainty" in the valuation report. This is on the basis of uncertainties in markets caused by COVID-19.

It is impracticable to disclose the extent of the possible effects of an assumption or another source of estimation uncertainty at the end of the reporting period. On the basis of existing knowledge, outcomes within the next financial year that are different from the assumption around the valuation of our land, property, plant and equipment could require a material adjustment to the carrying amount of the asset recorded in note 14.

Financial Value of Provisions for Liabilities and Charges

The Trust make financial provisions for obligations of uncertain timing or amount at the date of the Statement of Financial Position. These are based on estimates, using as much relevant information as is available at the time the accounts are prepared. They are reviewed to confirm that the values included in the financial statements best reflect the current relevant information, and where necessary the values of the provisions are amended.

Greater Manchester Pension Fund (GMPF)

To facilitate the TUPE transfer of social care staff from Manchester City Council to the former Manchester Mental Health and Social Care Trust on 1 September 2010, the Care Trust became an admitted body to the GMPF. With effect from 1 January 2017, this admitted body status transferred to Greater Manchester Mental Health Foundation Trust. Full actuarial valuations of the fund are undertaken every 3 years, the latest being March 2016. In between full actuarial valuations, the assets and liabilities are updated at each year end using principal actuarial assumptions as at that date.

An actuarial report is produced detailing the opening and closing assets and liabilities of the Trust share of the GMPF.

The principal actuarial assumptions used at 31 March 2019 and 31 March 2018 in measuring the present value of the defined benefit scheme liabilities are:

Financial Assumptions	**31 March 2020**	31 March 2019
	% pa	% pa
Pension Increase Rate (CPI)	**1.9%**	2.5%
Salary Increase Rate	**2.7%**	3.3%
Discount Rate	**2.3%**	2.4%

The expected return on assets is based on the long-term future expected investment return for each asset class.

	31 March 2020	31 March 2019
Demographic Assumptions (life expectancies)	**Years**	Years
Current Pensioners – Male	**20.5**	21.5
Current Pensioners – Female	**23.1**	24.1
Future Pensioners – Male	**22.0**	23.7
Future Pensioners – Female	**25.0**	26.2

Sensitivity Analysis

The sensitivities regarding the principal assumptions used to measure the scheme liabilities are as follows:

	31 March 2020	
	%	**£000**
0.5% decrease in real discount rate	**10%**	**1,734**
0.5% increase in salary increase rate	**0%**	**45**

0.5% increase in pension increase rate	**10%**	**1,684**

	31 March 2019	
	%	£000
0.5% decrease in real discount rate	12%	2,354
0.5% increase in salary increase rate	1%	300
0.5% increase in pension increase rate	10%	2,015

Note 1.25 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2019/20.

Note 1.26 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Leases

IFRS 16 Leases will replace *IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations and is applicable in the public sector for periods beginning 1 April 2021. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The Trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.
On transition to IFRS 16 on 1 April 2021, the Trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the Trust's incremental borrowing rate. The Trust's incremental borrowing rate will be defined by HM Treasury. Currently this rate is 1.27% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2021 for existing finance leases.

For leases commencing in 2021/22, the Trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000).

Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

HM Treasury revised the implementation date for IFRS 16 in the UK public sector to 1 April 2021 on 19 March 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity in from April 2021 and beyond, a quantification of the expected impact of applying the standard in 2021/22 is currently impracticable. However, the Trust does expect this standard to have a material impact on non-current assets, liabilities and depreciation.

Note 2 Operating Segments

All of GMMH's activities are in the provision of healthcare, which is an aggregate of all the individual specialty components included therein. Similarly, the large majority of the Foundation Trust's income originates with the UK Whole of Government Accounting (WGA) bodies. The majority of expenses incurred are payroll expenditure on staff involved in the production or support of healthcare activities generally across the Trust together with the related supplies and overheads needed to establish this production. The business activities which earn revenue and incur expenses are therefore of one broad combined nature and therefore on this basis one segment of Healthcare is deemed appropriate.

The operating results of the Foundation Trust are reviewed monthly or more frequently by the Trust's chief operating decision maker which is the overall Foundation Trust Board and which includes senior professional non-executive directors. The Trust Board review the financial position of the Foundation Trust as a whole in their decision making process, rather than individual components included in the totals, in terms of allocating resources. This process again implies a single operating segment under IFRS 8.

The finance report considered monthly by the Trust Board contains summary figures for the whole Trust together with graphical line and bar charts relating to different total income activity levels, and directorate expense budgets with their cost improvement positions. Similarly only total balance sheet positions and cash flow forecasts are considered for the whole Foundation Trust. The Board as chief operating decision maker therefore only considers one segment of healthcare in its decision making process.

The single segment of 'Healthcare' has therefore been identified consistent with the core principle of IFRS8 which is to enable users of the financial statements to evaluate the nature and financial effects of business activities and economic environments."

Note 3 Operating Income from Patient Care Activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4.1

Note 3.1 Income from patient care activities (by nature)

	2019/20 £000	2018/19 £000
Mental health services		
Cost and volume contract income	7,339	5,892
Block contract income	246,450	208,136
Clinical partnerships providing mandatory services (including S75 agreements)	-	29,008
Clinical income for the secondary commissioning of mandatory services	-	-
Other clinical income from mandatory services	37,104	34,561
All services		
Agenda for Change pay award central funding	-	2,614
Other clinical income***	8,936	-
Total income from activities	**299,829**	**280,211**

*** Other clinical income in 2019/20 relates to the 6.3% central employer pension contributions made by NHS England on behalf of the Trust as per National guidance

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2019/20 £000	2018/19 £000
NHS England	77,333	63,309
Clinical commissioning groups	195,004	154,911
Department of Health and Social Care *	-	2,614
Other NHS providers	2,786	32,297
NHS other	-	-
Local authorities	22,058	24,790
Non NHS: other	2,648	2,290
Total income from activities	**299,829**	**280,211**
Of which:		
Related to continuing operations	-	-
Related to discontinued operations	299,829	280,211

*In 2018/19 the Agenda for Change pay award was centrally funded by the Department of Health and Social Care.

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

The Trust's only overseas visitor activities are in respect of reciprocal EU treatments which do not generate income.

Note 4 Other Operating Income

	2019/20 £000	2018/19 £000
Other operating income from contracts with customers:		
Research and development (contract)	5,342	4,906
Education and training (excluding notional apprenticeship levy income)	16,460	15,814
Non-patient care services to other bodies	-	-
Provider sustainability / sustainability and transformation fund income (PSF / STF)	3,335	6,698
Other contract income ***	12,044	11,283
Other non-contract operating income		
Charitable and other contributions to expenditure	15	15
Rental revenue from operating leases	368	359
Total other operating income	**37,564**	**39,075**
Of which:		
Related to continuing operations	37,564	39,075
Related to discontinued operations	-	-

*** Other Income comprises:	2019/120 £000	2018/19 £000
Car parking	269	254
Clinical excellence awards	154	191
Catering	172	205
Property Rentals - Psychological Therapies	428	310
Apprentice levy reclaim	274	363
VAT reclaims	-	1,455
Salary Recharges	2,120	1,291
Transition and transformation income**	5,763	3,587
Release of deferred income *	2,240	3,246
Other	624	381
	12,044	**11,283**

* Relates to the release of deferred income to match expenditure within operating expenses.
** Relates to income received from commissioners as part of the acquisition business case to fund the transition and transformation of Manchester services, and additional income for Bolton CCG local transformation schemes

Note 4.1 Additional information on revenue from contracts with customers recognised in the period

	2019/20 £000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	6,516
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	-

Note 4.2 Transaction price allocated to remaining performance obligations

	31 March 2020 £000
Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	
within one year	
after one year, not later than five years	-
after five years	-
Total revenue allocated to remaining performance obligations	**-**

The Trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the Trust recognises revenue directly corresponding to work done to date is not disclosed.

Note 4.3 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 license 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:

	2019/20 £000	2018/19 £000
Income from services designated as commissioner requested services	299,829	280,211
Income from services not designated as commissioner requested services	37,564	39,075
Total	**337,393**	**319,286**

Note 5 Operating Expenses

Note 5.1 Operating expenses

	2019/20 £000	2018/19 £000
Purchase of healthcare from NHS and DHSC bodies	11,563	9,396
Purchase of healthcare from non-NHS and non-DHSC bodies	18,109	17,571
Purchase of social care	586	586
Staff and executive directors costs	235,542	218,554
Remuneration of non-executive directors	146	140
Supplies and services - clinical (excluding drugs costs)	4,294	5,112
Supplies and services - general	7,341	5,757
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	5,363	5,002
Consultancy costs	-	-
Establishment	4,228	3,300
Premises	9,407	9,144
Transport (including patient travel)	2,580	2,854
Depreciation on property, plant and equipment	6,341	6,812
Amortisation on intangible assets	983	746
Net impairments	-	2,190
Movement in credit loss allowance: contract receivables / contract assets	190	15
Movement in credit loss allowance: all other receivables and investments	-	-
Increase/(decrease) in other provisions	360	253
Change in provisions discount rate(s)	297	(148)
Audit fees payable to the external auditor		
audit services- statutory audit	66	65
other auditor remuneration (external auditor only)	4	14
Internal audit costs	122	152
Clinical negligence	970	1,051
Legal fees	831	750
Insurance	51	42
Research and development	5,297	4,902
Education and training	5,301	4,980
Rentals under operating leases	5,417	6,017
Early retirements	-	-
Redundancy	74	264
Car parking & security	328	345
Hospitality	32	52
Losses, ex gratia & special payments	78	132
Other services, e.g. external payroll	257	287
Other	1,491	2,003
Total	**327,649**	**308,340**
Of which:		
Related to continuing operations	327,649	308,340
Related to discontinued operations	-	-

Note 5.2 Other auditor remuneration

	2019/20 £000	2018/19 £000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	-	-
2. Audit-related assurance services	4	14
3. Taxation compliance services	-	-
4. All taxation advisory services not falling within item 3 above	-	-
5. Internal audit services	-	-
6. All assurance services not falling within items 1 to 5	-	-
7. Corporate finance transaction services not falling within items 1 to 6 above	-	-
8. Other non-audit services not falling within items 2 to 7 above	-	-
Total	**4**	**14**

Note 5.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2m (2018/19: £2m).

Note 6 Impairment of Assets

	2019/20 £000	2018/19 £000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	-	2,190
Other	-	-
Total net impairments charged to operating surplus / deficit	**-**	**2,190**
Impairments charged to the revaluation reserve	-	3,723
Total net impairments	**-**	**5,913**

A desktop revaluation of land and buildings was undertaken as at 31 March 2020 by the District Valuer, followed by an impairment review by the Trust, which resulted in no change to the valuation of the Trust's assets (2018/19 net impairment of £5,913,000).

Note 7 Employee Benefits

	2019/20 Total £000	2018/19 Total £000
Salaries and wages	166,841	168,871
Social security costs	14,745	14,613
Apprenticeship levy	750	804
Employer's contributions to NHS pensions	20,417	19,844
Pension cost - other*	8,936	-
Other post-employment benefits	107	220
Other employment benefits	-	-
Termination benefits	74	264
Temporary staff (including agency)	29,816	19,980
Total gross staff costs	**241,686**	**224,596**
Recoveries in respect of seconded staff	(1,532)	(1,427)
Total staff costs	**240,154**	**223,169**
Of which		
Costs capitalised as part of assets	351	797

* This relates to employer contributions of 6.3% paid by NHSE on behalf of the Trust.

Note 7.1 Retirements due to ill-health

During 2019/20 there was 1 early retirement from the Trust agreed on the grounds of ill-health (none in the year ended 31 March 2019). The estimated additional pension liabilities of these ill-health retirements is £69k (0£k in 2018/19).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 7.2 Directors Remuneration

The aggregate amounts payable to directors were:

	2019/20 £	2018/19 £
Salary	1,184,826	1,152,495
Taxable benefits	22,289	26,370
Employer's pension contributions	73,291	55,249
Total	**1,280,406**	**1,234,114**

Further details of directors' remuneration can be found in the remuneration report.

There have been no payments to directors for long term incentive schemes, other pension benefits, guarantees and advances.

Note 8 Pension Costs

Note 8.1 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 the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are 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 if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the 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 scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) 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 is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2020, is based on valuation data as at 31 March 2019, updated to 31 March 2020 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 report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. 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 schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 at 20.6%, and the Scheme Regulations were amended accordingly.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

Note 8.2 National Employment Savings Pension Scheme (NEST)

Under the Pensions Act 2008 employers must offer a pension scheme to all its employees. As from the 1st July 2013 when the scheme came into operation in the Trust (its staging date), staff who are not eligible to join the NHS Pension Scheme are automatically enrolled into NEST. The scheme is a defined contribution pension scheme. Under a defined contribution plan, an entity pays fixed contributions to a separate entity (a fund) and has no obligation to pay further contributions if the fund does not hold sufficient assets to pay employee benefits.

Contributions payable to a defined contribution plan are recognised as an expense as the employee provides services in exchange for the contribution. The Trust contributes 1% of their pensionable pay. The total contribution by the Trust for 2019/20 has been fully charged to expenses in the period. Details of the scheme can be found on the NEST Pensions website at:

http://www.nestpensions.org.uk/schemeweb/NestWeb/includes/public/docs/understanding-NEST.PDF.pdf

Note 9 Operating Leases

Note 9.1 Greater Manchester Mental Health NHS Foundation Trust as a lessor

This note discloses income generated in operating lease agreements where Greater Manchester Mental Health NHS Foundation Trust is the lessor.

	2019/20 £000	2018/19 £000
Operating lease revenue		
Minimum lease receipts	368	274
Contingent rent	-	-
Other	-	85
Total	**368**	**359**

	31 March 2020 £000	31 March 2019 £000
Future minimum lease receipts due:		
- not later than one year;	368	213
- later than one year and not later than five years;	1,472	851
- later than five years.	1,840	1,950
Total	**3,680**	**3,014**

The Trust is a lessor in a small number of operating leases for various premises, the longest of which expires in 2033.

Note 9.2 Greater Manchester Mental Health NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Greater Manchester Mental Health NHS Foundation Trust is the lessee.

Each lease has standard terms and conditions without the option to purchase upon the expiry of the lease.

Under existing arrangements there are no operating restrictions imposed by the leases. Proposals to change the use would require consultation with the relevant landlord.

In classifying its leases as operating leases, The Trust has assessed all leases against the IFRS criteria, and assessed that for all leases other than for Laureate House:

I. ownership of the asset does not transfer to the lessee at the end of the lease
II. the Trust as lessee does not have the option to buy the asset at a price below the fair value of the asset
III. the lease is not for the major part of the economic life of the asset

IV. at inception, the present value of the minimum lease payments is not at least substantially all of the fair value of the asset

V. the assets are not specialised in nature

The most significant of these in annual value are for the lease of Laureate House which ends in 2033.

In the case of the Laureate House lease, although the present value of the minimum lease payments at inception is substantially all of the fair value of Laureate House, the Trust has judged that this in itself is not sufficient to classify the lease as a finance lease and in substance, the lease is an operating lease as all the other indicators set out above are met.

	2019/20	2018/19
	£000	£000
Operating lease expense		
Minimum lease payments	5,417	6,017
Total	**5,417**	**6,017**

	31 March 2020	31 March 2019
	£000	£000
Future minimum lease payments due:		
- not later than one year;	5,610	5,665
- later than one year and not later than five years;	16,052	15,937
- later than five years.	36,337	39,634
Total	**57,999**	**61,236**
Future minimum sublease payments to be received	-	-

Note 10 Finance Income

Finance income represents interest received on assets and investments in the period.

	2019/20	2018/19
	£000	£000
Interest on bank accounts	185	163
Total finance income	**185**	**163**

Note 11.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money, the unwinding of discount and finance costs associated with GMPF.

	2019/20 £000	2018/19 £000
Interest expense:		
Loans from the Department of Health and Social Care	44	73
Total interest expense	**44**	**73**
Unwinding of discount on provisions	1	4
Other finance costs	51	32
Total finance costs	**96**	**109**

Note 11.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

The Trust did not incur any late payment of commercial debt interest.

Note 12 Other Gains / (Losses)

Note 12.1 Other gains / (losses)

	2019/20	2018/19
	£000	£000
Gains on disposal of assets	12	-
Losses on disposal of assets	(4)	(12)
Total gains / (losses) on disposal of assets	**8**	**(12)**
Total other gains / (losses)	**8**	**(12)**

Note 12.2 Discontinued Operations

The Trust has no discontinued operations.

Note 13 Intangible Assets

Note 13.1 Intangible assets - 2019/20

	Software licences	Development expenditure	Intangible assets under construction	Other (purchased)	Total
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2019 - brought forward	**3,328**	**983**	**-**	**96**	**4,407**
Transfers by absorption	-	-	-	-	**-**
Additions	-	859	77	-	**936**
Impairments	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	**-**
Revaluations	-	-	-	-	**-**
Reclassifications	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	**-**
Valuation / gross cost at 31 March 2020	**3,328**	**1,842**	**77**	**96**	**5,343**
Amortisation at 1 April 2019 - brought forward	**1,982**	**-**	**-**	**81**	**2,063**
Transfers by absorption	-	-	-	-	**-**
Provided during the year	739	237	-	7	**983**
Impairments	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	**-**
Revaluations	-	-	-	-	**-**
Reclassifications	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	**-**
Amortisation at 31 March 2020	**2,721**	**237**	**-**	**88**	**3,046**
Net book value at 31 March 2020	**607**	**1,605**	**77**	**8**	**2,297**
Net book value at 1 April 2019	**1,346**	**983**	**-**	**15**	**2,344**

Note 13.2 Intangible assets - 2018/19

	Software licences £000	Development expenditure £000	Intangible assets under construction £000	Other (purchased) £000	Total £000
Valuation / gross cost at 1 April 2018 - as previously stated	**2,912**	**-**	**-**	**96**	**3,008**
Prior period adjustments	-	-	-	-	**-**
Valuation / gross cost at 1 April 2018 - restated	**2,912**	**-**	**-**	**96**	**3,008**
Transfers by absorption	-	-	-	-	**-**
Additions	416	983	-	-	**1,399**
Impairments	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	**-**
Revaluations	-	-	-	-	**-**
Reclassifications	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	**-**
Valuation / gross cost at 31 March 2019	**3,328**	**983**	**-**	**96**	**4,407**
Amortisation at 1 April 2018 - as previously stated	**1,243**	**-**	**-**	**74**	**1,317**
Prior period adjustments	-	-	-	-	**-**
Amortisation at 1 April 2018 - restated	**1,243**	**-**	**-**	**74**	**1,317**
Transfers by absorption	-	-	-	-	**-**
Provided during the year	739	-	-	7	**746**
Impairments	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	**-**
Revaluations	-	-	-	-	**-**
Reclassifications	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	**-**
Amortisation at 31 March 2019	**1,982**	**-**	**-**	**81**	**2,063**
Net book value at 31 March 2019	**1,346**	**983**	**-**	**15**	**2,344**
Net book value at 1 April 2018	**1,669**	**-**	**-**	**22**	**1,691**

Note 14 Property, Plant and Equipment

Note 14.1 Property, plant and equipment - 2019/20

	Land £000	Buildings excluding 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 2019 - brought forward	**21,838**	**190,809**	**2,184**	**1,051**	**701**	**7,968**	**2,743**	**227,294**
Transfers by absorption	-	-	-	-	-	-	-	**-**
Additions	-	3,304	4,452	332	60	1,573	31	**9,752**
Impairments	-	-	-	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	-	-	-	**-**
Revaluations	-	-	-	-	-	-	-	**-**
Reclassifications	-	1,348	(1,348)	-	-	-	-	**-**
Transfers to / from assets held for sale	(260)	(59)	-	-	-	-	-	**(319)**
Disposals / derecognition	-	-	-	-	-	(71)	-	**(71)**
Valuation/gross cost at 31 March 2020	**21,578**	**195,402**	**5,288**	**1,383**	**761**	**9,470**	**2,774**	**236,656**
Accumulated depreciation at 1 April 2019 - brought forward	**-**	**26,721**	**-**	**766**	**465**	**5,499**	**2,331**	**35,782**
Transfers by absorption	-	-	-	-	-	-	-	**-**
Provided during the year	-	5,013	-	76	65	983	204	**6,341**
Impairments	-	-	-	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	-	-	-	**-**
Revaluations	-	-	-	-	-	-	-	**-**
Reclassifications	-	-	-	-	-	-	-	**-**
Transfers to / from assets held for sale	-	(59)	-	-	-	-	-	**(59)**
Disposals / derecognition	-	-	-	-	-	(68)	-	**(68)**
Accumulated depreciation at 31 March 2020	**-**	**31,675**	**-**	**842**	**530**	**6,414**	**2,535**	**41,996**

Net book value at 31 March 2020	**21,578**	**163,727**	**5,288**	**541**	**231**	**3,056**	**239**	**194,660**
Net book value at 1 April 2019	**21,838**	**164,088**	**2,184**	**285**	**236**	**2,469**	**412**	**191,512**

Note 14.2 Property, plant and equipment - 2018/19

	Land £000	Buildings excluding 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 2018 - as previously stated	**19,053**	**186,237**	**4,289**	**1,006**	**696**	**7,046**	**2,403**	**220,730**
Prior period adjustments	-	-	-	-	-	-	-	**-**
Valuation / gross cost at 1 April 2018 – restated	**19,053**	**186,237**	**4,289**	**1,006**	**696**	**7,046**	**2,403**	**220,730**
Transfers by absorption	-	-	-	-	-	-	-	**-**
Additions	-	-	7,161	46	67	963	340	**8,577**
Impairments	-	(4,669)	-	-	-	-	-	**(4,669)**
Reversals of impairments	890	-	-	-	-	-	-	**890**
Revaluations	1,895	-	-	-	-	-	-	**1,895**
Reclassifications	-	9,266	(9,266)	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	(25)	-	(1)	(62)	(41)	-	**(129)**
Valuation/gross cost at 31 March 2019	**21,838**	**190,809**	**2,184**	**1,051**	**701**	**7,968**	**2,743**	**227,294**
Accumulated depreciation at 1 April 2018 - as previously stated	**-**	**21,908**	**-**	**710**	**460**	**4,303**	**2,045**	**29,426**
Prior period adjustments	-	-	-	-	-	-	-	**-**

Accumulated depreciation at 1 April 2018 – restated	**-**	**21,908**	**-**	**710**	**460**	**4,303**	**2,045**	**29,426**
Transfers by absorption	-	-	-	-	-	-	-	**-**
Provided during the year	-	5,183	-	57	67	1,219	286	**6,812**
Impairments	-	3,126	-	-	-	-	-	**3,126**
Reversals of impairments	-	(992)	-	-	-	-	-	**(992)**
Revaluations	-	(2,483)	-	-	-	-	-	**(2,483)**
Reclassifications	-	-	-	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	(21)	-	(1)	(62)	(23)	-	**(107)**
Accumulated depreciation at 31 March 2019	**-**	**26,721**	**-**	**766**	**465**	**5,499**	**2,331**	**35,782**
Net book value at 31 March 2019	**21,838**	**164,088**	**2,184**	**285**	**236**	**2,469**	**412**	**191,512**
Net book value at 1 April 2018	**19,053**	**164,329**	**4,289**	**296**	**236**	**2,743**	**358**	**191,304**

Note 14.3 Property, plant and equipment financing - 2019/20

	Land £000	Buildings excluding 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 2020								
Owned – purchased	21,578	163,727	5,288	541	231	3,056	239	**194,660**
NBV total at 31 March 2020	**21,578**	**163,727**	**5,288**	**541**	**231**	**3,056**	**239**	**194,660**

Note 14.4 Property, plant and equipment financing - 2018/19

	Land £000	Buildings excluding 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 2019								
Owned – purchased	21,838	164,088	2,184	285	236	2,469	412	**191,512**
NBV total at 31 March 2019	**21,838**	**164,088**	**2,184**	**285**	**236**	**2,469**	**412**	**191,512**

Note 14.5 Gross carrying amount of any fully depreciated assets still in use

There are 421 (2018/19 345) equipment assets which are fully depreciated. The gross carrying cost of these totals £7,538,359 (2018/19 £5,921,382).

Note 15 Investment Property

The Trust does not hold any Investment Property.

Note 16 Trade Receivables and Other Receivables

	31 March 2020 £000	31 March 2019 £000
Current		
Contract receivables*	18,374	21,194
Allowance for impaired contract receivables / assets*	(599)	(458)
Prepayments (non-PFI)	2,539	2,091
VAT receivable	1,018	396
Other receivables	7	10
Total current trade and other receivables	**21,339**	**23,233**
Non-current		
Prepayments (non-PFI)**	10,933	10,393
Total non-current trade and other receivables	**10,933**	**10,393**
Of which receivables from NHS and DHSC group bodies:		
Current	13,927	17,925
Non-current	10,933	10,393

*Following the application of IFRS 15 from 1 April 2018, the Trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

**The Non-current prepayment relates to the lease of Laureate House from Manchester University NHS Foundation Trust

The majority of trade is with Clinical Commissioning Groups and NHS England, as commissioners for NHS patient care services. As CCGs' and NHS England are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary

Note 16.1 Allowances for credit losses

	2019/20		2018/19	
	Contract receivables and contract assets	**All other receivables**	**Contract receivables and contract assets**	**All other receivables**
	£000	**£000**	**£000**	**£000**
Allowances as at 1 Apr 2019 - brought forward	**458**	**-**	-	515
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	-	-	515	(515)
New allowances arising	461	-	258	-
Reversals of allowances	(271)	-	(243)	-
Utilisation of allowances (write offs)	(49)	-	(72)	-
Allowances as at 31 March 2020	**599**	**-**	458	-

With the exclusion of NHS debtors, receivables 90 days past their due date are fully impaired. Additionally, where specific circumstances are known individual invoices are impaired in full. Other debts are partially provided for.

Note 17 Non-Current Assets Held for Sale

	2019/20 £000	2018/19 £000
NBV of non-current assets held for sale at 1 April 2019	**-**	-
Assets classified as held for sale in the year	**260**	-
NBV of non-current assets held for sale at 31 March 2020	**260**	-

At 31 March 2020 the Renal Dialysis Unit on the Prestwich site was re-classified as an asset held for resale.

Note 18 Liabilities in Disposal Groups

The Trust has no liabilities in disposal groups in 2019/20 (2018/19 Nil).

Note 19 Cash and Cash Equivalent Movements

Note 19.1 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.

	2019/20	2018/19
	£000	£000
At 1 April	**29,578**	**38,748**
Prior period adjustments	-	-
At 1 April (restated)	**29,578**	**38,748**
Transfers by absorption	-	-
Net change in year	1,434	(9,170)
At 31 March	**31,012**	**29,578**
Broken down into:		
Cash at commercial banks and in hand	531	592
Cash with the Government Banking Service	30,481	28,986
Deposits with the National Loan Fund	-	-
Other current investments	-	-
Total cash and cash equivalents as in SoFP	**31,012**	**29,578**
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	**31,012**	**29,578**

Note 19.2 Third party assets held by the Trust

The Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2020	31 March 2019
	£000	£000
Bank balances	212	306
Monies on deposit	602	470
Total third-party assets	**814**	**776**

Note 20 Trade and Other Payables

	31 March 2020 £000	31 March 2019 £000
Current		
Trade payables	8,531	10,684
Capital payables	2,809	1,798
Accruals	13,068	11,345
Social security costs	4,235	4,056
VAT payables	-	-
Other taxes payable	-	195
PDC dividend payable	-	173
Other payables**	3,005	2,704
Total current trade and other payables	**31,648**	**30,955**
Non-current		
Trade payables	-	-
Total non-current trade and other payables	**-**	**-**
Of which payables from NHS and DHSC group bodies:		
Current	5,450	6,355
Non-current	-	-

** Other payables includes outstanding NHS Pensions contributions of £2,841k (2018/19 £2,704k).

Note 20.1 Early retirements in NHS payables above

There is Nil (2018/19 Nil) included in payables above related to the cost of early retirements.

Note 21 Other Liabilities

	31 March 2020 £000	31 March 2019 £000
Current		
Deferred income: contract liabilities	10,662	12,902
Total other current liabilities	**10,662**	**12,902**
Non-current		
Deferred income: contract liabilities	-	-
Net pension scheme liability	214	2,174
Total other non-current liabilities	**214**	**2,174**

Note 22 Borrowings

	31 March 2020 £000	31 March 2019 £000
Current		
Loans from the Department of Health and Social Care	326	326
Total current borrowings	**326**	**326**
Non-current		
Loans from the Department of Health and Social Care	1,801	2,125
Total non-current borrowings	**1,801**	**2,125**

Borrowings relate to a Capital Investment Loan taken out by the former Manchester Mental Health and Social Care Trust (MMHSCT) which transferred to Greater Manchester Mental Health NHS Foundation Trust as part of the acquisition of MMHSCT on 1 January 2017.

Note 22.1 Reconciliation of liabilities arising from financing activities

	Loans from DHSC	**Total**
	£000	**£000**
Carrying value at 1 April 2019	**2,451**	**2,451**
At start of period for new FTs	**-**	**-**
Cash movements:		**-**
Financing cash flows - payments and receipts of principal	-	**-**
Financing cash flows - payments of interest	-	-
Non-cash movements:		**-**
Impact of implementing IFRS 9 on 1 April 2018	(324)	(324)
Transfers by absorption	-	**-**
Additions	44	**44**
Application of effective interest rate	-	**-**
Change in effective interest rate	-	**-**
Changes in fair value	-	**-**
Carrying value at 31 March 2020	**2,171**	**2,171**

Note 23 Finance Leases

The Trust has no finance leases.

Note 24 Provisions for Liabilities and Charges Analysis

	Pensions: injury benefits	Legal claims	Re-structuring	Total
	£000	£000	£000	£000
	2019/20	2019/20	2019/20	
At 1 April 2019	3,319	296	108	**3,723**
At start of period for new FTs	**-**	**-**	**-**	**-**
Change in the discount rate	297	-	-	**297**
Arising during the year	184	219	-	**403**
Utilised during the year	(163)	(225)	(65)	**(453)**
Reversed unused			(43)	**(43)**
Unwinding of discount	1	-	-	**1**
At 31 March 2020	**3,638**	**290**	**-**	**3,928**
Expected timing of cash flows:				
- not later than one year;	164	290	-	**454**
- later than one year and not later than five years;	652	-	-	**652**
- later than five years.	2,822	-	-	**2,822**
Total	**3,638**	**290**	**-**	**3,928**

Provisions relate to:

Pensions - Injury Benefit	The pension rights of former employees who retired as a result of industrial injury
Legal claims	The amounts due from the Trust in respect of non-clinical claims lodged with the NHSLA's Liability for Third Party claims scheme (LTPS). The LTPS is a risk-pooling scheme under which the Trust pays an annual contribution to the NHSLA and in return, receives assistance with the costs of claims arising.

Note 24.1 Clinical negligence liabilities

At 31 March 2020, £1,658k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Greater Manchester Mental Health NHS Foundation Trust (31 March 2019: £2,214k).

Note 25 Contingent Assets and Liabilities

	31 March 2020	31 March 2019
	£000	£000
Value of contingent liabilities		
NHS Resolution legal claims	(163)	(223)
Gross value of contingent liabilities	**(163)**	**(223)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(163)**	**(223)**

Net value of contingent assets	**-**	**-**

Note 26 Contractual Capital Commitments

	31 March 2020 £000	31 March 2019 £000
Property, plant and equipment	1,018	2,832
Intangible assets	-	-
Total	**1,018**	**2,832**

Note 27 Other Financial Commitments

The Trust does not have any other financial commitments.

Note 28 Defined Benefit Pension Schemes

Note 28.1 Changes in the defined benefit obligation and fair value of plan assets during the year

	2019/20	2018/19
	£000	£000
Present value of the defined benefit obligation at 1 April	**(20,066)**	**(17,860)**
Prior period adjustment		-
Present value of the defined benefit obligation at 1 April - restated	**(20,066)**	**(17,860)**
Transfers by absorption	-	-
Current service cost	(132)	(241)
Interest cost	(480)	(482)
Contribution by plan participants	(23)	(50)
Remeasurement of the net defined benefit (liability) / asset:		
- Actuarial (gains) / losses	3,785	(1,696)
Benefits paid	339	263
Past service costs	(45)	-
Present value of the defined benefit obligation at 31 March	**(16,622)**	**(20,066)**
Plan assets at fair value at 1 April	**17,892**	**16,728**
Prior period adjustment		-
Plan assets at fair value at 1 April -restated	**17,892**	**16,728**
Transfers by normal absorption	-	-
Interest income	429	450
Remeasurement of the net defined benefit (liability) / asset		
- Return on plan assets	-	-
- Actuarial gain / (losses)	(1,782)	790
- Changes in the effect of limiting a net defined benefit asset to the asset ceiling	-	-
Contributions by the employer	185	137
Contributions by the plan participants	23	50
Benefits paid	(339)	(263)
Plan assets at fair value at 31 March	**16,408**	**17,892**
Plan surplus/(deficit) at 31 March	**(214)**	**(2,174)**

Note 28.2 Reconciliation of the present value of the defined benefit obligation and the present value of the plan assets to the assets and liabilities recognised in the balance sheet

	31 March 2020	31 March 2019
	£000	£000
Present value of the defined benefit obligation	(16,622)	(20,066)
Plan assets at fair value	16,408	17,892
Net defined benefit (obligation) / asset recognised in the SoFP	**(214)**	**(2,174)**
Fair value of any reimbursement right	-	-
Net (liability) / asset recognised in the SoFP	**(214)**	**(2,174)**

Note 28.3 Amounts recognised in the SoCI

	2019/20	2018/19
	£000	£000
Current service cost	(132)	(241)
Interest expense / income	(51)	(32)
Past service cost	(45)	-
Total net (charge) / gain recognised in SOCI	**(228)**	**(273)**

Note 28.4 Changes in the defined benefit obligation and fair value of plan assets during the year

The fair value of the scheme's assets and liabilities recognised on the statement of financial position were as follows:

	Period ended 31 March 2020				Period ended 31 March 2019			
	Quoted prices in active markets £000s	**Quoted prices not in active markets £000s**	**Total £000s**	**Percentage of total assets**	Quoted prices in active markets £000s	Quoted prices not in active markets £000s	Total £000s	Percentage of total assets
Equity Securities:								
Consumer	**1,490**		**1,490**	**9%**	988		988	6%
Manufacturing	**1,261**		**1,261**	**8%**	1,034		1,034	6%
Energy and Utilities	**943**		**943**	**6%**	1,005		1,005	6%
Financial Institutions	**1,824**		**1,824**	**11%**	1,416		1,416	8%
Health and Care	**740**		**740**	**5%**	528		528	3%
Information Technology	**658**		**658**	**2%**	319		319	2%
Other	**342**		**342**	**2%**	196		196	1%
Debt Securities:								
Corporate Bonds (investment grade)	**621**		**621**	**4%**	669		669	4%
Corporate Bonds (non-investment grade)								
UK Government				**0%**	118		118	1%
Other	**529**		**529**	**3%**	454		454	3%
Private Equity:								
All		**847**	**847**	**5%**		838	838	5%
Real Estate:								
UK Property		**691**	**691**	**4%**		850	850	5%
Overseas Property								
Investment Funds and Unit Trusts:								
Equities	**1,646**		**1,646**	**10%**	4,045		4,045	23%
Bonds	**1,894**		**1,894**	**12%**	2,226		2,226	12%

Hedge Funds								
Commodities								
Infrastructure		**796**	**796**	**5%**		858	858	5%
Other	**412**	**1,454**	**1,866**	**11%**	349	1,543	1,892	11%
Derivatives:								
Inflation								
Interest Rate								
Foreign Exchange								
Other			**0**	**0%**	9		9	0%
Cash and Cash Equivalents:								
All	**260**		**260**	**2%**	447		447	2%
Totals			**16,408**	**100%**			17,892	100%
Present value of defined benefit obligation			**(16,622)**				(20,066)	
Net benefit deficit			**(214)**				(2,174)	

Note 29 Financial Instruments

Note 29.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Due to the service provider relationship the Trust has with Clinical Commissioning Groups (CCG): and the way those CCG are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in undertaking its activities. creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has restricted 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 Trust in undertaking its activities.

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. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency Risk

The Trust is principally a domestic organisation with the great majority or transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust borrows from Government for capital expenditure subject to affordability as confirmed by NHS Improvement. The borrowings are for 1-25 years, in line with the associated assets and interest is charged at the national loans fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

The Trust may also borrow from Government for revenue financing, subject to approval by NHS Improvement. Interest rates are confirmed by the Department of Health (the lender) at the point borrowing is undertaken. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The Maximum exposures as at 31 March 2020 are in receivables from customers as disclosed in the Trade and Other Receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not therefore exposed to significant liquidity risk.

Note 29.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2020	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total book value £000
Trade and other receivables excluding non-financial assets	17,782	-	-	**17,782**
Cash and cash equivalents at bank and in hand	31,012	-	-	**31,012**
Total at 31 March 2020	**48,794**	**-**	**-**	**48,794**

Carrying values of financial assets as at 31 March 2019	Loans and receivables £000	Assets at fair value through the I&E £000	Held to maturity £000	Available-for-sale £000	Total book value £000
Trade and other receivables excluding non-financial assets	20,746	-	-	-	**20,746**
Cash and cash equivalents at bank and in hand	29,578	-	-	-	**29,578**
Total at 31 March 2019	**50,324**	**-**	**-**	**-**	**50,324**

Note 29.3 Carrying value of financial liabilities

	Held at amortised cost £000	Held at fair value through the I&E £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2020			
Loans from the Department of Health and Social Care	2,127	-	**2,127**
Trade and other payables excluding non-financial liabilities	27,413	-	**27,413**
Provisions under contract	3,638	-	**3,638**
Total at 31 March 2020	**33,178**	**-**	**33,178**

	Other financial liabilities £000	Held at fair value through the I&E £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2019			
Loans from the Department of Health and Social Care	2,451	-	**2,451**
Trade and other payables excluding non-financial liabilities	26,531	-	**26,531**
Provisions under contract	3,319	-	**3,319**
Total at 31 March 2019	**32,301**	**-**	**32,301**

Note 29.4 Fair values of financial assets and liabilities

The Trust deems that the book value (carrying value) of financial assets and liabilities is a reasonable approximation of fair value.

Note 29.5 Maturity of financial liabilities

	31 March 2020 £000	31 March 2019 £000
In one year or less	27,896	27,016
In more than one year but not more than two years	966	966
In more than two years but not more than five years	1,449	1,926
In more than five years	2,867	2,393
Total	**33,178**	**32,301**

Note 30 Losses and Special Payments

	2019/20		2018/19	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	1	1	7	-
Fruitless payments	-	-	-	-
Bad debts and claims abandoned	53	20	45	96
Stores losses and damage to property	1,111	62	1,452	83
Total losses	**1,165**	**83**	**1,504**	**179**
Special payments				
Compensation under court order or legally binding arbitration award	-	-	-	-
Extra-contractual payments	-	-	-	-
Ex-gratia payments	64	57	48	17
Special severance payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	**64**	**57**	**48**	**17**
Total losses and special payments	**1,229**	**140**	**1,552**	**196**
Compensation payments received		-		-

Note 31 Gifts

There were no gifts made.

Note 32 Related Parties

The Department of Health and Social Care is regarded as a related party. During the year the Trust has had a number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department.

	Receivables		Payables	
	31 March 2020 £000	31 March 2019 £000	31 March 2020 £000	31 March 2019 £000
Value of balances with Related parties at 31 March 2020				
Department of Health and Social Care	**359**	325	**-**	-
Other NHS Bodies (DH Group)	**24,502**	27,993	**5,450**	6,182
Other (WGA + LA's)	**3,637**	1,785	**10,893**	10,802
Total	**28,498**	**30,103**	**16,343**	**16,984**

	Income		Expenditure	
	2019/20 £000	2018/19 £000	2019/20 £000	2018/19 £000
Value of balances with Related parties at 31 March 2020				
Department of Health and Social Care	**3,973**	5,977	**0**	-
Other NHS Bodies (DH Group)	**291,331**	278,049	**21,568**	21,000
Other (WGA + LA's)	**23,988**	26,033	**46,325**	36,765
Total	**319,292**	**310,059**	**67,893**	**57,765**

Note 33 Events after the Reporting Date

There were no events after the reporting date having a material effect on the financial statements.