NHS
Tameside and Glossop
Integrated Care
NHS Foundation Trust

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Annual Report and Accounts 2019-2020

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

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Strategic Objectives, 2019-2020

Our Objectives for 2019/20

NHS
Tameside and Glossop Integrated Care
NHS Foundation Trust

Our Vision

To improve health outcomes for our population and influence wider determinants of health, through collaboration with our health and care partners

Working with partners, we will:

1. Deliver safe and caring services
2. Improve our patients' and carers' experience of our services
3. Support the health and wellbeing needs of our community and staff
4. Drive service improvement, innovation and transformation
5. Develop our workforce to meet future service and user needs
6. Use our resources wisely

Our Values and Behaviours

Safety	Respect	Caring	Communication	Learning
We challenge and respond to improve safety and quality for everyone	We recognise, value and respect everyone around us	We are caring and compassionate	We actively listen to our patients, their relatives, carers and colleagues	We promote and encourage learning

Introduction from Chair and Chief Executive

On behalf of the Board, we welcome you to the annual report on the Trust and its activities for the year ended 31st March, 2020.

The 2019-2020 year has been one of continued progress for the Trust. During the year, we have exceeded our financial plan and returned a small surplus in the year, for the first time in several years; continued to meet most of our targets under the NHS Constitution; and continued to improve the experience of those we care for. We pursued a strategic development programme, in conjunction with partners both in the locality and the Greater Manchester region.

Towards the end of the year, the nation and the NHS began to be significantly affected by the COVID-19 pandemic; and this continues to be a focus, to the exclusion of a range of usual activities, at the time of approval for this report. We are very pleased to be able to report that our staff have risen magnificently to the challenges this unprecedented period has given us; and that we have worked well in partnership with our local partners, and with the NHS across Greater Manchester. The Board anticipates that the need for this exceptional response will continue well into the 2020-2021 year, and has in mind the need to support our staff who are on the front line of helping patients in the most difficult of conditions.

As a result of the COVID-19 pandemic, there have been some changes to the requirements for this report. The detailed performance review section has been removed; and the Quality Accounts are not included within the document. It is currently anticipated that Quality Accounts will be required for the 2019-2020 year, but we understand that HM Government are considering an extension to the statutory time-frame for their production.

Patient care

At the start of the financial year, the Trust was being given an inspection by the Care Quality Commission (CQC) as part of their regular programme. That inspection rated the Trust 'Good' overall, with detailed findings of 'Good' for each of the five inspection domains from the CQC. The Board has warmly welcomed these outcomes, and is working hard to ensure that the care and experience we provide to patients continues to improve as we seek to move to an 'Outstanding' rating in the future.

Through the course of the year, the Trust has maintained compliance with most of the targets set out in the NHS Constitution- those related to 18-week maximum waits between referral and treatment, 6-week waits for the results of diagnostic tests, and the three waiting time standards for cancer referrals (14-day, 31-day and 62-day waits). For much of the year we also met the standard for 4-hour waits for admission or discharge in A&E services; in common with the wider NHS, this suffered during the 2019-202 winter period, and the Board closely monitored performance and the steps being taken to improve it. The increase in the number of patients attending A&E during this period was a key factor, as it rose significantly beyond what might reasonably have been forecast.

The primary care "walk-in" centre moved from Ashton to the Tameside General Hospital site during the year, as a further example of partnership working with our colleagues at the Clinical Commissioning Group and Tameside Council. The move has been a success and has supported giving better care to patients from our communities.

Finance

It is very pleasing to be able to say that, in line with the performance over a number of years, the Trust achieved the financial plan that had been agreed by the Board for the year. The plan included a very challenging requirement to make efficiency gains, and colleagues have managed to both achieve and exceed those targets in achieving a total of £11.58 million. It is particularly pleasing that, in making these gains, they were often accompanied by changes that provided positive improvements in patient care and experience as well; and that colleagues managed to exceed a very challenging efficiency target set by the Board, and locate over £7 million in recurrent (year-on-year) efficiency savings. Following the year-end, NHS Improvement confirmed that the Trust would receive a significant extra amount of central support through the Financial Recovery Fund; this, which is accrued into the 2019-2020 financial year accounts, means that the Trust has shown a small surplus for the year.

As part of the CQC process, the Trust is inspected for Use of Resources by NHS Improvement: and was rated 'Requires Improvement' in this area. The Board had previously recognised that, as a recipient of loan support from the Department of Health and Social Care, together with the Private Finance Initiative

arrangement, this was the highest rating available; and it was pleasing that the inspection noted the very high standard of work evidenced by the Finance team. Following the year-end, HM Government announced that loan support would be converted to Public Dividend Capital; the Board looks forward to the details of the arrangement, and to understanding the full impacts on the Trust.

The Board and governance

During the year, two Directors have retired from the Board; Cathy Elliott, who has been appointed as the Chair at Bradford and District NHS FT, and Anne Dray who retired having completed six years service to the Trust. We would like to record our thanks to both Cathy and Anne for their contributions and commitment to the Trust. Following an open recruitment process, Council appointed Andrew Light and David Curtis to be Non-Executive Directors for the Trust, and they both took office in January 2020.

During the year the Board has been undertaking a development programme, supported by Deloitte, to improve our way of working and the governance that we provide for the Trust. The programme has included a number of topics including how to move from Good to Outstanding as a Board; our role in system leadership; and ensuring that the Board's Committees are effective in supporting the work of the Board. Owing to the COVID-19 pandemic and the consequent changes to Board arrangements, the programme will now conclude in 2020-2021; remaining topics include developing culture and leadership, and ensuring that the Board has appropriate oversight of the Trust's risk management through the Board Assurance Framework.

Development work has also been undertaken by the Council of Governors, including undertaking a self-evaluation of their effectiveness, in line with the expectations in the *Code of Governance for Foundation Trusts*; and continuing work to improve their engagement with and representation of the various communities and groups that they represent on Council. This work will continue in 2020-2021.

Working in Partnership

It remains important for the Trust to work in partnership with others, both locally and regionally; and it remains pleasing that much of the work that we have been doing over the last several years is now being recommended nationally through the *NHS Forward View*. During the year, we have continued to work closely with local partners (Tameside and Glossop CCG, Tameside Council, High Peak Borough Council and Derbyshire County Council) to provide a more integrated service to our local communities based on providing the right care, at the right time, in the right place. We also continue to work closely with partners at the Greater Manchester level, which will become more important as the NHS moves more towards allocating resources and monitoring outcomes on the basis of Integrated Care Systems (which, for this Trust, would be Greater Manchester).

We have also engaged with the initiative, led by Tameside Council, on broader reform of the way public services operate in the Tameside area. This follows on naturally from our partnership work in the locality, and also has the potential to bring further services into the current integration framework, to provide further benefits for the local community.

Overall, the Trust has enjoyed a successful year, both operationally and financially. Whilst there will be challenges for the year ahead, particularly from COVID-19, the Board has confidence for the future based on our great staff and our successful record of system working.

Jane McCall
Trust Chair

Karen James
Chief Executive

Performance Report

Overview of performance

1. Introduction

1.1. This section of the Annual Report and Accounts gives an introduction to the Trust's performance over the year that ended 31st March, 2020.

1.2. This section also outlines the purpose of the Trust, our history, and the key issues and risks that the Board have identified as affecting our work and ability to meet the strategic objectives that we have set ourselves.

2. Statement of purpose and activities

2.1. The Trust exists, as part of the National Health Service, to provide health services to the population of England; and more specifically, mainly to the residents of the areas of Tameside Metropolitan Borough Council, and the Glossop, Tintwistle and St John's areas of Derbyshire. We provide a District General Hospital service, including an Accident and Emergency Department, together with community-based and intermediate care services. This range of services enables us, in combination with our partners, to provide care beyond the traditional acute setting.

2.2. With a significant part of our area in the Greater Manchester Region, we are closely involved with development of Greater Manchester's health and social care system; and as part of this wider approach, we are continuing to move towards greater integration of the health and social care systems in the Tameside area. These changes would not necessarily apply to the Derbyshire side of our area, but we are seeking to apply them in those areas in association with the relevant Clinical Commissioning Group. Across all of our area, we are seeking to be a leader in the development of digital and other services to divert patients from needing acute services, and providing them with care as close to home as possible; through such initiatives as Digital Care and closer working with our social care colleagues.

2.3. The Trust's business model is to move, over time, to being a provider of integrated care across both health and social care services. We have already moved forward in this work over the previous few years, with a consolidation of services being provided by the Trust and also other services which the Trust does not provide (such as Primary Care) being co-ordinated through the establishment of Neighbourhoods. The neighbourhood arrangements work to bring together health, social care and other local services in a single location, so that patients and service users have easier and co-ordinated access. With our key partners in the local health economy, we are also working in a linked fashion to better co-ordinate the interface between health provision (NHS) and social care provision (Local Authorities) so that the overall care and experience for patients and their carers is improved. However, it is important to recognise that there are limits to the work that can properly be undertaken by the Trust, given both the division of responsibilities reflected in legislation, and also the requirement that the objective of the Trust is the provision of services for the NHS. During the year, the Board has reviewed and reformulated its strategy, reflecting developing national and Greater Manchester objectives.

2.4. The Trust's organisational structure is as a Public Benefit Corporation, incorporated under the provisions of the *National Health Service Act 2006* (as amended, principally by the *Health and Social Care Act 2012*). The Board considers that this remains the most appropriate legal form for the provision of these services, given the legislative requirements.

3. History of the Trust

3.1. The Trust was authorised as a Foundation Trust in February 2008, the successor to various organisations that have been responsible for the provision of care on the Tameside General Hospital site for many years. The Trust now provides secondary and community healthcare services to the populations of the Tameside Metropolitan Borough area, and the Glossop, Tintwistle and St John's areas of Derbyshire. We are also working closely with our partners across the piece to deliver integrated care through the creation of co-ordinated provision in five neighbourhoods, which bring together primary and secondary health with social care and local voluntary and community services, for the benefit of patients.

3.2. The Trust is a Public Benefit Corporation, incorporated under the *National Health Service Act 2006*. As such, it is subject to regulation by Monitor (now part of NHS Improvement), who are responsible for regulating its organisational performance and governance. It is also regulated by the Care Quality Commission, who have primary responsibility for regulating the quality of care provision in the Trust (as with all registered providers of care). The Trust also has regulatory relationships with other statutory regulators including the Human Tissue Authority and the Human Fertilisation and Embryology Authority; and maintains relations with the statutory regulators for its individual members of staff, including the General Medical Council and the Nursing and Midwifery Council.

4. Key Issues and Risks

4.1. The Board recognises that the delivery of the objectives that it has set for the Trust can be affected by a range of issues. There is a policy and process in place to enable the Trust, through the Board, its Committees and management, to identify risk, set out and measure steps to mitigate and manage risk, and to identify the potential impacts if the risk eventuates.

4.2. Key external matters affecting the ability of the Trust to deliver its objectives include-

- National policy decisions, including those related to funding, national pay arrangements, and development priorities set out by NHS England through the Standard Contract;
- The expectations of clinical regulators, particularly the Care Quality Commission, and changes to those expectations from time to time;
- The position of the staffing market for key specialist staff, particularly clinical colleagues, who are a key factor in being able to provide high-quality and safe services.

4.3. The Board maintains a Board Assurance Framework (BAF) which sets out the strategic risks that the Board has identified as affecting the achievement of the strategic objectives. During the year, the BAF was considered, with suggestions for updates, at each formal meeting of the Board. The Board is considering a change in the way it oversees the BAF, given that the risks are strategic and might be expected to be longer-term in changing and responding to actions to mitigate or manage them.

4.4. For the 2020-2021 year, the Board considers the COVID-19 pandemic to be the key strategic risk facing the organisation. The business of the Trust has been heavily re-

focused to address this challenge, in line with the requirements of NHS England/ Improvement and the Department of Health and Social Care; and the financing of the Trust has been moved from the usual arrangements to ensure 'break-even' funding for the period that the pandemic continues to prevent business as usual. Based on the information made available by HM Government and NHS England/ Improvement, the Board expects that the significant change in business arrangements to continue for most or all of the 2020-2021 year; and that there will be continuing effects into the 2021-2022 year.

4.5. The Board has also given consideration to potential risks arising from the United Kingdom leaving the European Union, and the scheduled end of the 'transition period' on 31st December 2020. The Trust's response has been undertaken within the framework of national direction from NHS England/ Improvement, and from 1st April 2020 the Trust has been required, under the *NHS Standard Contract*, to comply with that guidance and direction. The Board has not identified any risks in this area that are not being managed through the national process.

5. Going Concern

5.1. IAS 1 requires management to assess, as part of the accounts preparation process, the NHS Foundation Trust's ability to continue as a going concern. The financial statements should be prepared on a going concern basis unless management either intends to apply to the Secretary of State for the dissolution of the NHS Foundation Trust without the transfer of the services to another entity, or has no realistic alternative but to do so.

5.2. Having given careful consideration to all information in their possession, the Board of Directors have concluded that there is a reasonable expectation that Tameside and Glossop Integrated Care NHS Foundation Trust has adequate resources to continue in operational existence for the 12 months following the approval of this statement. For this reason they continue to adopt the going concern basis in preparing the accounts.

5.3. The Directors recognise that there are uncertainties that affect whether the Trust should adopt this basis. The Directors have had particular regard to the following matters-

5.3.1. At the date of approval of this report, the Board had not completed the annual planning process for the 2020-2021 year, following the instruction from NHS England/ Improvement to cease planning activities during the COVID-19 emergency period. The incomplete planning undertaken to date indicates that the Trust could anticipate a full-year deficit of £ 20.441 million, net of central support from the Financial Recovery Fund and Marginal Rate Emergency Tariff support. The Board was continuing to review options to reduce or resolve that gap to secure the balance of the FRF allocation, being £16.1m.

5.3.2. For the period from April to the end of July 2020, the Trust has been funded under special and specific arrangements related to the COVID-19 emergency period, approved at national level and designed to ensure that all appropriate Trust expenditure in the period is refunded in full, with the intention to ensure that all Trusts 'break even' on their operations in the period. In the view of the Board, there is a reasonable likelihood that the COVID-19 emergency period, and the related specific funding regime, will continue beyond that date. The Board is also of the view that, given the significant disruption to other services, and the need to ensure in the public interest that the variety of other services are resumed in a safe and controlled manner, it is likely that there will be supportive funding arrangements for the remainder of 2020-2021, which may run into the following financial year, to ensure that services can be provided to the community.

5.3.3. On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS

England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. The affected interim loans, totalling £106,631m interim loan principal and £408k interest accrual, are classified as current liabilities within the financial statements. As the repayment of these loans will be funded through the issue of PDC, this does not present a going concern risk for the Trust.

5.3.4. The Department has announced that future funding support will be provided by way of PDC rather than further loan support, except for specific identifiable items. The Department has also indicated that it does not anticipate providing further day-to-day funding support for NHS providers except in exceptional circumstances.

5.4. The Trust has a continuing strong relationship with its main commissioner, and prior to the suspension of the process was progressing well with the negotiation of contractual arrangements for 2020-2021. If the Trust was unable to meet its debts as they fell due, it would need to enter discussions with Commissioners and regulators regarding the future of provision, particularly Commissioner-Requested Services under Condition CoS 7 of the Trust's Provider Licence which are required to be provided. At the Board meeting in May 2020, the Board agreed a declaration to NHS Improvement under the terms of its provider licence, confirming that it had a reasonable expectation that the Required Resources (to provide Commissioner-Requested Services) would be available for the 12 months following approval of the declaration.

5.5. The Directors have also considered the following factors in concluding that the Trust is a going concern;

5.5.1. Contractual agreement with its main commissioner (Tameside & Glossop Clinical Commissioning Group) to the Trust's overall service strategy;

5.5.2. Robust assessment of the impact of the block contract agreed with the main commissioner, and Payment by Results tariffs for secondary commissioner contracts, into the medium-term as part of the incomplete planning process;

5.5.3. Full identification of potential risks and opportunities incorporated into the partial financial plan for 2020-2021, including the potential impact of planned demand management initiatives;

5.5.4. The long-term financial settlement announced by HM Government for the NHS in 2019, and legislated for in the NHS Funding Act 2020;

5.5.5. The priorities set out in the 10-year plan published by NHS England, and in particular the expectations within that for the provider sector and individual providers to become financially self-sustainable in the medium-term;

5.5.6. The capital expenditure programme for 2020-2021, as agreed by the Board, has been risk assessed to reflect the requirements of the Trust to ensure delivery of Commissioner-Requested Services. It has also taken account of the national requirement that capital will be provided at the Integrated Care System level for further distribution amongst the individual organisations within that system.

5.6. Based on these indications, the Directors believe that it remains appropriate to prepare the accounts on a going concern basis. 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. At the date of approval of these financial statements, the Trust has no reason to believe that they cannot place reliance on the DHSC for financial support, should there be exceptional circumstances that require it. The financial statements do not include any adjustments

that would result from the basis of preparation being inappropriate.

6. Summary of Performance

6.1. During 2019-2020, the Trust has continued to perform well operationally, and to meet the financial plan agreed by the Board. We are pleased that, against most of the operational performance metrics regarded as key in the *Single Operating Framework*, we have met or exceeded the stated targets.

6.2. Throughout the year, we have met the requirements set out in the *NHS Constitution* for-

6.2.1. Cancer treatment waiting times, notably the 62-day, 31-day and 14-day pathways
6.2.2. The 18-week Referral to Treatment (RTT) pathway
6.2.3. Ensuring low cancelled operations and that those affected are treated with six weeks of the cancellation
6.2.4. Ensuring that no individual waits more than 52 weeks for treatment

6.3. For a significant proportion of the year, the Trust was also meeting the national target of ensuring that more than 95% of A&E patients were seen and either admitted or discharged within 4 hours of arrival. In common with the NHS both regionally and nationally, towards the end of the year performance against this indicator dropped substantially. The Board closely reviewed both performance and the underlying causes, which were identified as a significant increase in the number of patients choosing to attend A&E above that which could reasonably have been forecast; together with an increase in the acuity that patients were presenting with. The Board was satisfied that the response to these pressures was appropriate and focused on ensuring that each patient was seen, triaged and their condition responded to appropriately.

6.4. The financial performance of the Trust during the year was positive. The Board set a challenging financial plan for the year, which had been agreed with NHS Improvement as the regulator, and required the delivery of substantial savings on an on-going basis in order to receive additional central funding support. The Trust met its financial plan for the year, with the efficiency programme delivering more than had been planned for; of particular note is the £7.2 million of recurrent savings achieved through the efficiency programme in the year. The Board is particularly pleased to be able to report that the changes made through the efficiency programme have not just made financial savings, but have also identified improvements to patient care and experience which were also delivered. At the year-end, NHS Improvement awarded an additional £5.2 million in Financial Recovery Fund to the Trust, enabling us to report a small full-year surplus for the first time in several years.

6.5. During the year, the Trust received the outcome of the inspection by the Care Quality Commission (CQC) undertaken in March and April 2019. The Board is pleased that the overall rating was ‘Good’, supported by ‘Good’ ratings in each of the underlying inspection domains. A rating of ‘Requires Improvement’ was received in respect of the use of resources; the Board recognises that, given the position regarding support from Government loans, this was the best rating possible for the Trust.

6.6. The Trust has, during the year, adopted a Sustainable Development Management Plan, setting out how the Trust looks to reduce its environmental impact. This plan operates both in the context of the Greater Manchester strategy to reduce environmental impacts, and also the development of a national NHS approach led by NHS England. The Board has agreed that it will receive an annual report on progress against the strategy, in order to ensure that it is aware of progress and can address any areas of concern.

6.7. During the year, the Board has continued to focus on performance against the national ratios for mortality, known as the Summary Hospital-Level Mortality Indicator (SHMI) and the Hospital Standardised Mortality Ratio (HSMR), which have tended to be higher

than would be expected for the Trust. This work has been supported both internally and externally, and the Board has closely engaged with the regular *Learning from Deaths* reports presented. We have continued to review every death occurring in the care of the Trust for learning, both positive and negative; and colleagues have engaged in detailed analysis of the statistics that are submitted into the calculation of the ratios. The Board has particular assurance from the Trust's appropriate adoption of changes to the way that co-morbidities are recorded (coding), and from the several external reviews that have not identified any significant areas of concern. Greater detail in this area will be included in the Quality Accounts, to be published later in 2020.

6.8. At the end of the financial year, the United Kingdom started to move into the emergency response to the COVID-19 pandemic. This has had a significant impact on the Trust, with most 'normal' activities being suspended (such as non-urgent elective operations) and the Trust moving to activate its Emergency Planning, Preparedness and Response arrangements within the guidance being received from national and regional levels. The Board has remained involved, to ensure that appropriate governance is kept in place, whilst ensuring that the Trust is in a position to respond appropriately to this highly unusual situation. As part of the national response, the normal planning process has been suspended and the Trust is being funded on a 'break-even' basis for the period of the pandemic. The Board also has in mind the need, as the pandemic recedes, to carefully address how to return to providing its regular range of services whilst continuing to put in place lessons learned, for example in having remote appointments for out-patients.

6.9. Following the end of the financial year, HM Government announced that they would be converting all day-to-day loans to NHS provider bodies to be Public Dividend Capital. This change is expected to be formally implemented in September 2020, but to be treated as occurring on 2nd April 2020. In the case of this Trust, approximately £106 million in loans from the Department of Health and Social Care are expected to be converted to an equivalent amount of Public Dividend Capital in this process.

7. Emergency Preparedness, Resilience and Response (EPRR)

7.1. In accordance with the national guidance issued by NHS England, the Board has conducted a self-assessment during the year of its compliance with the national guidelines for EPRR. Based on detailed work undertaken, the Board declared that it was in substantial compliance, with a compliance rate against the Core Standards between 80% and 89%. For each Core Standard where compliance could not be declared, there was a clear plan to move towards compliance within the following 12 months.

7.2. Of the 64 Core Standards that apply to the Trust, the assessment approved by the Board was-

Fully compliant	Partially compliant	Not compliant
61	1	2

7.3. For the two Core Standards assessed as not compliant, the Board was satisfied that appropriate alternative arrangements were in place.

8. *Modern Slavery Act 2015*

8.1. The Trust is understood not to be formally subject to the reporting provisions set out in Part 6 of the *Modern Slavery Act 2015*, as it is not a 'commercial organisation' as defined in the Act. However, the Board has decided that it will give an overview as if these

responsibilities applied to the Trust.

8.2. As part of the National Health Service, the majority of the supplies used by the Trust are obtained through the NHS supply chain arrangements, which operate nationally and provide support to all NHS providers. The NHS supply chain arrangements include arrangements to ensure that supplies provided to the NHS can be reasonably assured not to have involved slavery or human trafficking; and the Trust relies of these arrangements as its assurance for supplies obtained through the NHS supply chain.

8.3. For supplies obtained outside of the NHS supply chain arrangements, the Trust's procurement arrangements include undertakings by suppliers that the goods have been obtained in a manner compliant with the *Modern Slavery Act*, and that the appropriate checks have been undertaken for the earlier parts of the supply chain. The Trust retains a right of inspection if a query is raised as to the provenance of any goods supplied.

8.4. The Trust is also aware of the potential for certain operations, such as building works undertaken on site, to involve offences under the Act. We require contractors to provide proof that the individuals working on site are lawfully able to be present in the UK and to work, are paid and taxed according to law, and otherwise meet the requirements in place to comply with the *Modern Slavery Act*. These requirements are also imposed on any sub-contractors down the chain for works being undertaken on site.

Karen James
Chief Executive

17th June, 2020

Accountability Report

Director's Report

9. Directors

9.1. During the year ended on 31st March, 2020, the following served as Directors of the Trust-

Sallie Bridgen
Patricia Cavanagh
David Curtis (appointed 6th January, 2020)
Anne Dray (retired 31st December, 2019)
Cathy Elliott (retired 31st July, 2019)
Karen James
Andrew Light (appointed 6th January, 2020)
Jane McCall
Peter Noble
Brendan Ryan
Sam Simpson
Martyn Taylor
Peter Weller

9.2. During the year, the following Directors held the offices indicated-

Trust Chair	Jane McCall
Trust Deputy Chair	Anne Dray (also Senior Independent Director) until 30th April 2019 Martyn Taylor (also Senior Independent Director) from 1st May 2019
Chief Executive	Karen James

10. Director's and Governors' Interests

10.1. In accordance with the requirements of the national guidance published by NHS England and applied through the NHS Standard Contract, the Trust maintains a Register of Interests (which includes information on gifts and hospitality). This includes details of the interests declared by Directors, and is published on-line at https://tgicft.mydeclarations.co.uk. The published register is updated on a live basis, as new entries are made by relevant staff and Directors. For those colleagues who have chosen to make declarations by alternative means, a spreadsheet is published on the Trust web-site.

10.2. A Register of Interests for Governors is maintained separately in line with the Standing Orders of the Council, and is laid before each scheduled meeting of the Council.

11. Cost allocation and charging

11.1. Throughout the year ended 31st March 2020, and at all subsequent times until the approval of this annual report by the Board, the Trust has been compliant with the guidance on cost allocation and charging that has been issued for the NHS by Her Majesty's Treasury.

12. Payment to suppliers

12.1. The Trust is subject to the provisions of the *Public Contracts Regulations 2015*, which set out a requirement that all public bodies will pay all valid, undisputed invoices in a timely manner and in any event within 30 days of confirmation that they are valid and undisputed. The Trust does not participate in the *Better Payment Practice Code*, as the provisions of the Regulations set out the required statutory standard for the Trust.

12.2. The Trust's performance for the year ended 31st March 2020, calculated in accordance with Regulation 113(7) of the Regulations and reported in line with the requirements set out by NHS Improvement, is-

	NHS Contracts		Other invoices		Total	
	Number	£000's	Number	£000's	Number	£000's
Invoices paid within 30 days	1,811	43,512	42,142	128,973	43,953	172,485
Invoices required to be paid within 30 days	217	33,051	11,062	76,414	11,279	109,465
Proportion of those paid to required (%)	12.0	76.0	26.2	59.2	25.6	63.5

13. Review of systems of internal control

13.1. Supported by the work of the Audit Committee and internal audit, the Board has reviewed the effectiveness of the systems of internal control in place during the course of the year. The review has been informed by the findings of the various internal audit reviews conducted during the year, together with relevant external reviews.

13.2. The outcomes of the Board's review are covered in the Annual Governance Statement, made by the Accounting Officer and bound into this report.

14. Governance and being Well-Led

14.1. The Board recognises that, as a Foundation Trust, it is important that the governance structures in place (both corporate and clinical) support and enable the Trust to be well-led. Key factors in delivering this include-

- Having the Board meeting regularly, with a clear view as to its strategic role and holding management to account;
- Operating as a single, unitary Board, with the Executive and Non-Executive Directors working together and recognising the contribution brought by colleagues;
- Support through a comprehensive system of Committees, which both support the development of strategy and engage in more detailed accountability work;
- Effective engagement with the Council of Governors, whose responsibility to appoint Non-Executive Directors is key to ensuring that the Board is effective.

14.2. The governance provided at Board level is supported by a full structure of management-level groups, which are linked to the appropriate Executive Directors and support their accountability to the Board and the Board's Committee structure.

14.3. More detail about specific aspects of the governance structures can be found in the Annual Governance Statement, the section of this report on the work of the Board and Council starting at page 45, and the work of the Board's Committees starting at page 54.

14.4. In arriving at the overall evaluation of the Trust's performance that is set out at page 47, the Trust has had regard to the guidance in the *Well-Led Framework*. This has included reviewing the control systems in place, through the Quality & Governance Committee

and the Audit Committee, against the *Framework's* guidance in order to provide the Board with robust positive assurance that the Trust is meeting these expectations. The Board is also supported by the various Committees in managing risk through the Board Assurance Framework. The risks on the Framework are reviewed at least annually following the adoption of that year's corporate objectives, to ensure the relevant risks are identified; and regularly monitored through the course of the year.

14.5. The overall evaluation has also been informed by the outcomes of the CQC inspection process that was undertaken during the year. This process provided a 'Good' rating for the Trust in the 'Is [the Trust] Well-Led?' domain.

14.6. The regular reviews of internal control systems undertaken by the internal audit service include action plans to address deficiencies, many of which will fall within the broad scope of the *Well-Led Framework*. Action plans from reviews are scrutinised in the first instance by the Audit Committee, and a six-monthly update on progress is provided to the Committee to ensure that all actions are implemented appropriately. In terms of the Board Assurance Framework, the Board has reviewed and revised how the Framework is reported to the Board to ensure that the Board had clarity between strategic and operational risks, and also a greater line of sight to the key actions being taken to manage and mitigate the risks.

14.7. After careful review, the Board confirms that there are no material inconsistencies between the contents of this Annual Report and-

a. the Annual Governance Statement
b. The Corporate Governance Statement approved by the Board under Conditions G6 and FT4 of the NHS Improvement Licence;
c. The report from the Care Quality Commission on the Trust, dated 4th July 2019, and the action plans approved as a consequence.

Non-NHS Income

14.8. During the year, the Trust has received certain income beyond the provision of services for the purposes of the NHS in England, which we are required to report separately on under current legislation. The total income received in this year was £264,000, and the split between the various categories can be seen in the Annual Accounts at note 3.1. The funds raised were re-invested in the services provided by the Trust.

14.9. The law requires that the Trust ensures that its income from goods or services provided for the purposes of the health service in England exceeds its income from goods or services provided for other purposes. In the year, the Trust complied with this requirement.

15. Director's responsibility for the Annual Report and Accounts

15.1. The Directors acknowledge that they are responsible for the accuracy and reliability of the contents of the Annual Report and the Annual Accounts for the year ended 31st March 2020. The Board has been supported by its Committees in the preparation of these documents, and by the Internal Audit service and the external auditors; however, the responsibility for the contents of the documents remains with the Directors themselves.

15.2. Having carefully reviewed the contents of the documents, and taking into account the advice of the Audit Committee, the Directors consider that, taken as a whole, the Annual Report and Accounts are fair, balanced, and understandable; and provides the

information necessary for patients, regulators and other stakeholders to be able to assess the Trust's performance, business model and strategy.

Remuneration Report

16. Annual Statement on Remuneration

16.1. I am pleased to be able to present the report of the Nomination and Remuneration Committee, related to Director remuneration in the year.

16.2. During the year, the following major decisions have arisen for the Board Committee related to Executive Director pay-

- Reviewing the remuneration of the Executive team, following receipt of the letter dated 31st January 2020 from NHS England/ Improvement outlining the recommendation for the 2019/20 annual pay increase for those on the 'Very Senior Manager' scales;
- Considering a 'retire and return' arrangement in respect of the Medical Director, which was approved.

16.3. The context in which the Committee considered these matters was the need to ensure that the Trust is able to recruit and retain an Executive team that is able to provide the necessary leadership to the Trust and its staff: whilst giving due consideration to NHS England /Improvement guidance limiting Executive salaries to the upper quartile of the relevant pay range (as defined within NHS Improvement's published pay ranges). The Committee has had regard to the NHS Improvement guidance on pay for very senior managers in NHS Trusts and Foundation Trusts, to enable discussion to take place at the Remuneration Committee.

Non-Executive Directors

16.4. On behalf of the Council's Nomination and Remuneration Committee, I am also pleased to be able to present the report on remuneration and service decisions related to the Non-Executive Directors. Whereas the Board's Committee has decision-making authority, the Council Committee can only make recommendations to the Council, who have sole authority under the law for making decisions.

16.5. During the year, NHS England/ Improvement have published, with the approval of HM Treasury, standard expectations for the fees to be paid to Chairs and Non-Executive Directors in all NHS provider organisations, together with standardised arrangements for the appraisal of the Chairs of those organisations. Although not formally binding on it, Council has agreed to adopt the proposals; with the result that the level of NED fees have been slightly reduced for appointments in the year; this will continue as further appointments arise. The Council has not yet changed the arrangements in place for additional fees to be payable in respect of the Deputy Chair of the Trust, the Senior Independent Director, and the Chair of the Audit Committee.

Jane McCall
Chair of the Nomination and Remuneration Committee
Chair of the Council's Nomination and Remuneration Committee

17. Policy on remunerating Directors

17.1. The Trust recognises that, in order to ensure that the Trust is led by Executive Directors with the skills, capacity and leadership required to provide an outstanding service to the public of the Tameside and Glossop area, it must adopt a remuneration policy that will attract and retain individuals with the necessary skills and personality. Equally, as an organisation funded by the public purse, it recognises that it must not pay excess

amounts for the services of its Executive Directors, as this would not meet the requirement to be economic, efficient and effective.

17.2. The future policy on remuneration of Executive Directors, set by the Nomination and Remuneration Committee, is as set out in the table on page 25. The Executive Directors are employed on individual contracts, which, except for pay arrangements, largely reflect the terms and conditions in *Agenda for Change* arrangements. Other staff are generally employed on contracts following national terms and conditions: either the agreed national conditions for medical staff or the *Agenda for Change* arrangements. Those on national arrangements have pay set reflecting the national scales and progression requirements, rather than being subject to individual decision by the Nomination and Remuneration Committee. However, the general approach of the Nomination and Remuneration Committee is to be guided by the general policy set out in the national agreements, unless there is an identified need to take a different approach.

17.3. The future remuneration policy in respect of the Non-Executive Directors, including the Chair, is set by the Council of Governors with the advice of the Council's Nomination Committee. The general policy of the Council is to set fees that enable the Trust to attract and retain Non-Executive Directors with the skills, experience and knowledge to make an effective contribution to the work of the Board, and with specific regard to the skills needed by the Board to address identified future challenges. The Council also seeks to set remuneration levels at no greater a level than is required for that purpose.

17.4. During the year, NHS England and NHS Improvement jointly published guidance with the intention to standardise remuneration for Non-Executive Directors, including Chairs, in both Foundation Trusts and non-FT's. The Council intends to follow this guidance for future appointments and re-appointments, subject to reserving the position if specific matters are identified requiring a different approach.

17.5. The key points in the future remuneration policy in respect of Non-Executive Directors are-

- **Fees**; each Non-Executive Director receives fees for service (not a salary for employment). A single fee is in place for all Non-Executive Directors except the Chair, for whom a different fee arrangement has been approved. Additional fees are payable for designated positions, namely the Deputy Chair, Senior Independent Director, and the Chair of the Audit Committee.
- **Pensions**; Non-Executive Director positions are not pensionable, and do not participate in the NHS Pension Scheme arrangements.
- **Benefits in Kind**; Non-Executive Directors are not eligible for benefits in kind. They are eligible to have expenses properly incurred refunded by the Trust.

17.6. As can be seen from the table on page 25, during the year two Executive Directors received more than £150,000 in remuneration. The Committee has considered whether these figures remain reasonable, given the objectives set out above and in the table of future policy. The Committee has concluded that it has positive assurance that these figures are reasonable, by means of comparison with the data available on pay rates for the equivalent positions in Trusts of comparative size; and also in regard to the tables published by NHS Improvement for the four quartiles of salary payments, set out by size of acute provider. In respect of the Medical Director, the Committee has also had regard to the level of remuneration shown in national benchmarking for Medical Directors in similar-sized organisations.

17.7. The Trust's policy on setting notice periods for Executive Directors, as noted in the table

on page 18, is designed to ensure that the Trust can attract individuals of appropriate calibre to undertake Executive Director roles; and to provide some assurance that, when Executive Directors leave the organisation, there is sufficient time for the Trust to recruit a replacement and have them in post, in order to minimise disruption to the provision of services.

17.8. Each Executive Director is entitled, in the event that they are made redundant, to a redundancy payment. The calculation of any payment is based on a maximum salary of £80,000 and one month's payment for each year of service. Under the provisions of the *NHS Standard Contract* and Section 16.8 of the *Agenda for Change* national agreement, if a Director is made redundant and returns to work in the NHS within 12 months, they are required to pay back a proportion of the redundancy payment to the Trust. No discretion arises in respect of the payments by reference to performance in office.

17.9. In the event that an Executive Director lost office for disciplinary reasons, or for reason of a lack of competent performance in the office, no compensation would be payable.

18. How we took into account other employees

18.1. As noted above, employees in the Trust other than Directors are generally paid on two nationally-agreed schemes; the arrangements for medical and dental staff, and the *Agenda for Change* arrangements. The Nomination and Remuneration Committee has had regard to those arrangements, and in particular the national decisions on increases in rates of pay under those arrangements, in taking decisions regarding the Executive Directors during the course of the year. The Committee also had regard to guidance issued by NHS Improvement, on behalf of the Secretary of State, regarding pay and conditions for very senior staff. The Committee considered the anonymous comparator data produced by NHS Providers, in order to benchmark the remuneration being provided against Trusts of a similar size and operating within similar environments.

18.2. The Committee has not consulted with employees in setting the policy related to the remuneration of the Executive Directors, as it largely reflects the national arrangements in place for the NHS under the *Agenda for Change* scheme. This was negotiated nationally between NHS Employers for the employing Trusts, and the various recognised Trade Unions on behalf of employees; and can therefore be regarded as producing a balanced compromise of the interests of both parties.

19. Policy on Diversity and Inclusion

19.1. The Board's Nomination and Remuneration Committee (for Executive Directors) and the Council of Governors (for Non-Executive Directors) continue to be committed to promoting equality and diversity in appointments to the Board.

19.2. The policy objective, in line with the wider Equality Diversity and Inclusion strategy adopted by the Trust, is to ensure that there are full and appropriate opportunities for all to offer their skills and experience for appointment. As part of that strategy, the Board has set the following leadership targets that are relevant to Board appointments-

- Increasing Black and Minority Ethnic (BAME) diversity on the Board to at least 15% by March 2022;
- Increasing Disability diversity across non-clinical leadership positions (which includes the Board) to at least 5% by March 2022.

These imply that by March 2022 the Board will include in voting membership least 2 Directors from a BAME background, and at least one with a Disability background.

19.3. In common with other NHS provider organisations, we have been set a policy objective by NHS England, under their Workforce Race Equality Scheme, for representation of black and minority ethnic staff at Agenda for Change Band 8A and above, including representation at Board level. As set out in the Equality Diversity and Inclusion strategy, the Trust will seek to promote opportunities for under-represented groups to learn about available roles, be supported in applying for positions, and to be given adjustments to ensure that they have a fair opportunity to display their skills for appointment.

19.4. For Executive Directors, the Nomination and Remuneration Committee is committed to ensuring that, when a selection process is required, it is fair and equitable to everyone including those with protected characteristics. Whilst not within its area of responsibility, the Committee is aware of other work programmes being undertaken by the Trust to support and develop staff with protected characteristics, so that they can have the confidence and skills to apply for more senior roles including at Board level.

19.5. For Non-Executive Directors, the Council of Governors continues to seek to make appointments that would lead to a greater diversity at the Board. For the two appointments made during this year, Council agreed that the process would be undertaken in-house and put in place steps to encourage and support those with protected characteristics to come forward. Additional steps were taken to try and attract more candidates from a diverse background and from individuals who have a protected characteristic, including-

- amending the advertisement to make clear we welcome applications from such candidates;
- providing the advert and recruitment pack to external bodies who could forward the information on to a more diverse group of candidates.

19.6. It was pleasing that there was a greater diversity of candidates invited for interview, including a higher proportion of candidates from a BAME background, and some who had declared themselves as having other protected characteristics; and Council will continue to improve the process for the appointments it expects to be making later in the year. The Council is particularly aware that the Board has limited ethnic diversity at present; and, in order to ensure the Trust can attract the best individuals for the role, will be taking a range of measures to attract these candidates.

Future Remuneration Policy table (Executive Directors)

	How this component supports short and long-term objectives	How this component operates	Maximum payable	Recovery or withholding provisions
Salary	Appropriate salary enables the recruitment and retention of Executive Directors with the required skills, experience and talent.	Salary is paid *pro-rata* on a monthly basis, net of tax deductions, in accordance with the employment contract.	As per individual's contracts	There are no recovery or withholding provisions in respect of basic salary.
Bonus	The Committee considers that paying bonuses would not support the Trust's objectives.	N/A	N/A	N/A
Incentive schemes	The Committee considers that operating an incentives scheme would not support the Trust's objectives.	N/A	N/A	N/A
Notice periods	Having appropriate periods of notice enables the Trust to ensure smooth services during personnel changes	Each contract makes provision for the notice period to be served by the individual. The Committee's policy is that the notice period should usually be six months.	N/A	The period of notice may only be shortened if the Committee is satisfied that there are appropriate alternative arrangements in place.
Benefits in Kind	No benefits in kind are offered, as the Trust considers them not to be necessary to support objectives.	N/A Some Directors show taxable benefits in the table, owing to the operation of Inland Revenue rules. These are not benefits in kind but reflect expenses incurred.	N/A	Any improperly claimed benefits can be reclaimed (or their value) through contractual mechanisms.
Pension benefits	Provision of pension benefits encourages leaders to commit to the organisation. There is a national defined-benefit scheme that salaried leaders automatically enter.	Each Executive Director participates in the NHS Pension Scheme arrangements, under the relevant statutory Regulations.	Trust contribution of 14.3% of salary	There are no withholding provisions for the Trust. Recovery, or withholding of pension payments, is a matter for NHS Business Services and governed by the relevant statutory Regulations.

The policy statements above represent the current view of the Committee. The Committee is aware that the Department of Health and Social Care is considering issuing updated guidance to the NHS regarding the contractual arrangements for Executive Directors. Dependent on the contents of that guidance, which may be issued in a way to be compulsory on the Trust, the policy statements above may need to be updated.

20. Members of the Nomination and Remuneration Committee, and attendance

20.1. The Board has appointed all Non-Executive Directors to be members of the Nomination and Remuneration Committee, under the leadership of the Trust Chair.

20.2. During the year ended 31st March, 2020, the Committee met once. All members of the Committee, except Mr Light, were present at that meeting.

20.3. During the year, the Committee were supported in their considerations by-

- Karen James, Chief Executive
- Amanda Bromley, Director of Human Resources

21. The work of the Nomination and Remuneration Committee during the year

21.1. During the 2019-2020 year, we have continued to undertake our statutory role to determine the remuneration and related terms and conditions for the Executive team, as required under the *National Health Service Act 2006*. Our discussions and decisions have been informed by reviewing the appraisal outcomes for the Executive Directors; the changes in remuneration for the generality of Trust staff through the national contract and pay arrangements; and the guidance set out in the *Code of Governance for NHS Foundation Trusts*. We have also had regard to comparative information, particularly that produced by NHS Providers.

21.2. We also considered a request by the Medical Director to 'retire and return' under the relevant arrangements. The Committee considered that it would be in the best interests of the Trust for this to take place, and agreed with the request accordingly. It was submitted to NHS Improvement for their approval.

22. Service Contracts

	Date of contract	Unexpired term	Notice period
Patricia Cavanagh	August, 2014	Indeterminate	6 months
Karen James	October, 2014	Indeterminate	6 months
Brendan Ryan	October, 2014	Indeterminate	6 months
Sam Simpson	June, 2018	Indeterminate	6 months
Peter Weller	February, 2019	Indeterminate	6 months

23. Non-Executive Directors

23.1. In accordance with best practice, the Non-Executive Directors are appointed on Letters of Appointment, rather than employment contracts.

	Date of appointment	End of current term	Notice period
Sallie Bridgen	February, 2017	February, 2023	3 months
David Curtis	January, 2020	January, 2023	3 months
Anne Dray	January, 2014	Retired December, 2019	
Cathy Elliott	February, 2017	Retired July 2019	
Andrew Light	January, 2020	January, 2023	3 months
Jane McCall	January, 2018	January, 2021	3 months
Peter Noble	February, 2018	February, 2021	3 months
Martyn Taylor	May, 2015	April, 2021	3 months

24. Expenses for Directors and Governors

Directors

	2019-2020	2018-2019
Total number of Directors in office	13	14
Number of Directors receiving expenses for the year	4	5
Aggregate sum of expenses paid to Directors in the year	£2,741	£2,239

Governors

	2019-2020	2018-2019
Total number of Governors in office	32	29
Number of Governors receiving expenses for the year	Nil	1
Aggregate sum of expenses paid to Governors in the year	£Nil	£72

Remuneration Information

25. Single Total Remuneration Figure

Information for year ended 31st March, 2020

	Salary (bands of £5,000)	**Expense payments (taxable) to nearest £100**	**Performance pay and bonuses (bands of £5,000)**	**Long-Term performance pay and bonuses (bands of £5,000)**	**All pension related benefits (bands of £2,500)**	**Total (bands of £5,000)**
Sallie Bridgen	10-15	0	N/A	N/A	N/A	10-15
Amanda Bromley	100-105	0	N/A	N/A	27.5-30	130-135
Patricia Cavanagh	120-125	500	N/A	N/A	25-27.5	150-155
David Curtis [c]	0-5	0	N/A	N/A	N/.A	0-5
Anne Dray [a]	10-15	0	N/A	N/A	N/A	10-15
Cathy Elliott [b]	0-5	0	N/A	N/A	N/A	0-5
Karen James	175-180	0	N/A	N/A	95-97.5	275-280
Andrew Light [c]	0-5	0	N/A	N/A	N/A	0-5
Jane McCall	40-45	0	N/A	N/A	N/A	40-45
Peter Noble	10-15	0	N/A	N/A	N/A	10-15
Brendan Ryan	170-175	0	N/A	N/A	22.5-25	195-200
Sam Simpson	125-130	700	N/A	N/A	25-27.5	155-160
Martyn Taylor	15-20	0	N/A	N/A	N/A	15-20
Peter Weller	110-115	0	N/A	N/A	112.5-115	225-230

Notes are stated after the 2019 table

Information for year ended 31st March, 2019

	Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	Performance pay and bonuses (bands of £5,000)	Long-Term performance pay and bonuses (bands of £5,000)	All pension related benefits (bands of £2,500)	Total (bands of £5,000)
Sallie Bridgen	10-15	0	N/A	N/A	0	10-15
Amanda Bromley	95-100	0	N/A	N/A	62.5-65	160-165
Patricia Cavanagh	115-120	0	N/A	N/A	65-67.5	185-190
Anne Dray	15-20	0	N/A	N/A	0	15-20
Cathy Elliott	10-15	0	N/A	N/A	0	10-15
Karen James	160-165	0	N/A	N/A	10-12.5	170-175
Pauline Jones [d]	40-45	0	N/A	N/A	0	40-45
Jane McCall	40-45	0	N/A	N/A	0	40-45
Tracey McErlain-Burns [e]	65-70	0	N/A	N/A	167.5-170	235-240
Peter Noble	10-15	0	N/A	N/A	0	10-15
Brendan Ryan	165-170	0	N/A	N/A	10-12.5	175-180
Sam Simpson [f]	100-105	0	N/A	N/A	40-42.5	145-150
Martyn Taylor	10-15	0	N/A	N/A	0	10-15
Peter Weller [g]	15-20	0	N/A	N/A	15-17.5	30-35
Claire Yarwood [h]	20-25	0	N/A	N/A	5-7.5	25-30

Notes

a- Anne Dray retired from the Board on 31st December, 2019

b- Cathy Elliott retired from the Board on 31st July, 2019

c- Andrew Light and David Curtis joined the Board on 6th January, 2020

d- Pauline Jones retired from the Board on 30th September, 2018

e- Tracey McErlain-Burns retired from the Board on 30th November, 2018

f- Sam Simpson joined the Board on 1st June, 2018

g- Peter Weller joined the Board on 1st February, 2019

h- Claire Yarwood retired from the Board on 31st May, 2018

26. Total Pension Entitlement

Information for the year ending 31st March, 2020

	Real Increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 31 March 2020	Lump sum at pension age related to accrued pension at 31 March 2020	Cash equivalent transfer value at 1st April 2020	Real Increase/ (decrease) in cash equivalent transfer value	Cash equivalent transfer value at 31st March 2019
	Band of £2,500	Band of £,2500	Band of £5,000	Band of £5,000	£000's	£000's	£000's
Amanda Bromley	0-2.5	0-2.5	35-40	75-80	583	24	533
Patricia Cavanagh	0-2.5	0	55-60	145-150	1,192	33	1,114
Karen James	5-7.5	15-17.5	75-80	230-235	1,865	146	1,653
Brendan Ryan	0-2.5	2.5-5	75-80	225-230	N/A	N/A	N/A
Sam Simpson	0-2.5	0	40-45	95-100	823	27	760
Peter Weller	5-7.5	15-17.5	40-45	120-125	856	120	704

Notes

i. 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.

ii. The pension benefit table provides further information on the pension benefits accruing to the individual.

iii. The figures for the Cash-Equivalent Transfer Value (CETV) in the table above are calculated by the NHS Business Services Authority, who are responsible for the maintenance of the national NHS Pension arrangements. During the year, HM Government announced that the Guaranteed Minimum Pension sections of NHS Pension accruals will be required to be fully indexed for inflation, which was not the case previously. We are advised that the NHS Business Services Authority has not re-calculated the starting CETV value stated above (at 1st April 2019), so that figure and the figure at 31st March 2020 may not be directly comparable as they have been calculated in a different way. This may also impact on the figure stated for the real increase in CETV.

iv. The rules for the operation of the NHS Pension Scheme are set by HM Ministers under the relevant legislation. In 2015, Ministers amended the Pension Scheme Regulations to provide for a move from final salary provision to Career-Average provision, with transitional arrangements that enabled those in the final salary section to continue to accrue on that basis.
In the case of *The Lord Chancellor & Another v McCloud and others; The Home Secretary, the Welsh Ministers and others v Sargeant and others* [2018] EWCA Civ 2844, the Court of Appeal affirmed decisions of the Employment Appeals Tribunal that the relevant provisions in the pensions schemes for judicial officers and firefighters were unlawful as giving rise to age discrimination, contrary to the Equality Act 2010. It has been accepted that the relevant provisions in the NHS Pension Schemes suffer from the same defect. Since that judgement (and the subsequent refusal of leave to appeal to the UK Supreme Court), HM Government has been considering the appropriate response to these matters;

and have indicated that a consultation will be held later in 2020. It is not possible at this stage to give any view as to the possible impacts of changes that might be proposed. However, the policy of HM Government is that NHS employers and employees overall must meet the costs of the NHS Pension Scheme, without resort to Exchequer funds; and there is therefore a risk that the liabilities of the Trust for pensions, both in payment and accruing, could be increased as a result of this judgement.

27. Fair Pay multiple

27.1. The Trust is required to disclose the relationship between the remuneration of the highest-paid Director in the organisation, and the median remuneration of the Trust's workforce.

27.2. The mid-point of the banded remuneration of the highest-paid Director in the Trust (Karen James, Chief Executive) in the financial year 2019-2020 was £177,500 (financial year 2018-2019- £167,500 for Mr Brendan Ryan). This was 7.44 times the median remuneration of the workforce, which was £23,864 (financial year 2018-2019- 7.18 times the median remuneration of £23,338)

27.3. In 2019-2020, 2 employees received remuneration in excess of that paid to the highest-paid Director (2018-2019- two employees). Remuneration ranged from £206,792 to £226,899 (2017-2018- from £215,186 to £226,889).

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

28. Payments for loss of office

28.1. During the 2019-2020 financial year, no Director received compensation for loss of office (2018-2019- none).

29. Payments to past senior managers

29.1. During the 2019-2020 financial year, no payments have been made by the Trust to individuals who were previously Directors.

Karen James
Chief Executive

17th June, 2020

Staff Report

30. Introduction

30.1. Like most NHS providers, the Trust experiences workforce shortages within certain staff groups, due to national and international deficits within those professional groups. This is most notable in medical roles, nursing roles and some allied health professionals.

30.2. In the short term, there are clear recruitment and retention strategies to fill vacancies where possible. This includes robust advertising and recruitment processes, and holding regular recruitment open days for specific groups. There are also on-going actions plans to improve retention in these staff groups; and significant improvements have already been made in terms of retention.

30.3. In addition the Trust recognises the national drive set out in the Interim People Plan to utilise international recruitment to fill gaps in the national workforce. The Trust is working with agencies to pursue international recruit for both medical and nursing staff in 2020, enabling the Trust to supplement its existing workforce with experienced professionals from overseas.

30.4. In the medium to longer term, the Trust recognises that shortages are unlikely to be addressed through traditional means alone, and there is a need to consider different workforce models and ways of working. For example, the has recruited a third cohort of Trainee Nurse Associates, to supplement the registered nurse workforce, with consideration of extending this programme yet further. There is also a scoping exercise underway to understand the value of Physicians Associates and Advanced Clinical Practice to support in hard to recruit to medical posts.

30.5. A Place Based Pilot is in place to develop a new models of student placements, working collaboratively with Universities and the wider community, primary care and voluntary sector to develop 'placed based learning environments' In addition the ICFT is also working jointly with Primary Care to mitigate the recruitment gaps in Practice Nurse positions and a joint Practice Nurse two year rotational programme has been developed which will enable practice nurses to join practices 'practice nurse ready'.

30.6. Overall the Trust predicts that workforce numbers will stay similar over the next 3 – 5 years; but the skill mix and composition of the workforce is likely to look quite different.

31. Analysis of average staff costs and numbers

31.1. Total Staff Costs 2019- 2020

	TOTAL £000's	**Permanent** £000's	**Other** £000's
Medical and dental	**45,311**	41,802	3,509
Ambulance staff	**0**	0	0
Administration and estates	**26,812**	26,429	383
Healthcare assistants and other support staff	**24,904**	20,898	3,915
Nursing, midwifery and health visiting staff	**54,431**	48,019	6,411
Nursing, midwifery and health visiting learners	**0**	0	0

	TOTAL £000's	Permanent £000's	Other £000's
Scientific, therapeutic and technical staff	**15,241**	14,637	604
Healthcare science staff	**5,873**	5,758	116

Average Whole-Time Equivalents 2019-2020

	Total	Permanent	Other
Medical and dental	**355**	337	17
Ambulance staff	**0**	0	0
Administration and estates	**780**	774	6
Healthcare assistants and other support staff	**925**	801	124
Nursing, midwifery and health visiting staff	**1,199**	1,090	109
Nursing, midwifery and health visiting learners	**0**	0	0
Scientific, therapeutic and technical staff	**380**	373	7
Healthcare science staff	**146**	144	2

31.2. Gender Balance

	Female	Male
Directors	5	6
Other senior managers [1]	2	6
Employees as a whole	3,293	796

The Trust's official submission to the Cabinet Office related to Gender Pay Gap can be found at https://gender-pay-gap.service.gov.uk/.

32. Sickness absence data

32.1. Information on the Trust's sickness absence rates can be found at the following internet address-

https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

33. Staff policies, and actions to implement

33.1. The Trust recognises its responsibility, as one of the major employers in the locality, to provide equality of opportunity to all in our recruitment and employment process. Our Human Resources/ Recruitment service is responsible for looking at ways to ensure that all staff with 'protected characteristics' under the Equality Act 2010 are treated fairly, including disability. Where it is identified that, due to their disability, an individual requires a reasonable adjustment /adaptation in recruitment and/or employment this will be positively considered to retain them within our workforce. Disabled employees are given equality of access to training and development opportunities, which will be identified for

[1] Senior managers are those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS Foundation Trust.

their individual circumstances through the appraisal process, in the same way as other employees. The Trust's Recruitment System (Trac) provides monitoring data, which is extremely useful for enabling improvements in the recruitment process.

33.2. The Trust encourages dialogue from our employees and Trade Union members to improve our recruitment and employment processes. The Trust has in place a formal monthly Staff Partnership Forum with our Trade Union representatives, Staff Governors and senior managers. A Joint Local Negotiating Committee takes place every two months with representatives of the British Medical Association to facilitate similar discussions with our medical staff; both forums enable two-way communication with our Trade Union colleagues. In addition we also have a monthly meeting with the Trade Unions within the health & social care economy to facilitate the exchange of information across all three organisations (the Trust, the Clinical Commissioning Group and Tameside Council) given the level of integration taking place. There are also regular informal meetings with the representatives of the Trust's employees. An example of this is the feedback received from during the 'Good to Outstanding' engagement sessions in the Autumn of 2019.

33.3. The Trust continues to work in partnership with Trade Union colleagues to review our Human Resources policies. The following policies have been updated in line with changes in employment legislation, to ensure fair and consistent treatment, and to support the Trust's strategy for a healthier work life balance-

33.3.1. Special Leave Policy

33.3.2. Maternity, Paternity, Adoption and Shared Parental Leave Policy

33.4. The policies are reviewed through the regular formal meetings with Trade Union representatives, who are formally consulted on policy developments: the meetings also provide an opportunity for representatives to discuss with management issues of concern to the workforce. Trade Union representatives are also members of the Health and Safety Committee, in accordance with statutory requirements.

33.5. There are a number of informal methods that staff can use to obtain information about the development of the Trust, and raise any concerns or suggestions for improvement. The Chief Executive holds a monthly Team Brief on the Tameside General Hospital site, with digital versions produced to enable wider distribution to Community locations. A range of additional communication methods have been introduced, including "A Spotlight On" digital video, focused on a particular topic; a Weekly Digest to complement the *Catch Up with Karen* weekly e-mail circular; and use of social media, including Twitter, Instagram and a Staff Facebook group.

33.6. The Trust has a Freedom to Speak Up Guardian who is vital to ensuring a culture where staff can speak up freely and openly without suffering any detriment. The Guardian reports to Board on a quarterly basis, participates in the Trust induction programme for staff and junior doctors, and provides training sessions. He has direct access to a designated Non-Executive lead, in line with the national guidance: and also direct access to both the Trust Chair and the Chief Executive.

33.7. As a Foundation Trust, staff have formal representation in the governance of the Trust, through the election of Staff Governors to Council. All staff are represented by a Governor, and all staff are eligible to seek election and to vote in choosing who should be elected. Staff Governors have an equal voice and vote in Council meetings, and contribute to Council as a whole fulfilling its statutory duties to hold the Board to account through the Non-Executive Directors. The Trust continues to encourage staff to consider standing for election to Council, and to participate in the electoral process through the use of their votes.

34. Occupational Health and Health and Safety

34.1. The Trust has an in-house Occupational Health service, and an occupational health representative attends the meetings of the Health & Safety Committee and of the Infection Prevention and Control Committee. Reports on Occupational health activity are currently reported through to the Human Resources Divisional Team meeting.

34.2. The Health and Safety Committee meet on a quarterly basis to provide a forum for Directors, Senior Managers & Leads, Trade Union Representatives, Senior Buyers, and a diverse range of Clinical colleagues to discuss any Health & Safety concerns. The Committee works to help promote a positive health and safety culture across the Trust, and to ensure a safe place of work and system of work is provided to all staff.

34.3. A programme of inspections was undertaken in relation to health and safety issues across the Trust. These inspections were discussed at the Health & Safety Committee to review and make recommendations to the Departments, Wards and Services. The inspections are currently undertaken by the Health & Safety Advisor, Team Leader, Occupational Health and Estates and Facilities.

34.4. The table below illustrates the top staff (Health & Safety) incidents that were reported between April 2019 and March 2020-

Staff Incidents	
Physical Assaults on Staff	112
Inoculation Injuries	65
Accidental Injury - Staff To Self	58
Slips/Trips/Falls	37
Accidental Injury - Patient To Staff	21
Manual Handling Injuries	20

34.5. All security incidents which include 'Physical Assaults on Staff' are reviewed formally by the Estates and Facilities Compliance Risk Assurance Group (CRAG). In addition the work carried out by the security management group, is intended to highlight any risks or concerns.

34.6. Following the publication in the HSJ earlier in the year of significant breaches in compliance identified across the NHS by the Health and Safety Executive, the Trust formed a Task and Finish Group to investigate all physical and non-physical assaults that had taken place on staff with an objective of making significant improvements to the current systems/ practices to ensure our staff are kept as safe and secure as possible. The Group has plans to meet regularly to review the progress.

35. Expenditure on Consultancy

35.1. There may be occasions when we commission the services of independent consultancy firms to assist with matters such as employee relations. Where there is a requirement to do so, we follow our Standing Financial Instructions and procurement processes to ensure that it is cost effective and provides value for money.

36. Trade Union Facility Time

In accordance with the relevant statutory Regulations, we report the following questions and answers in the Annual Report.

What was the total number of your employees who were relevant union officials during the relevant period?

No of employees who were relevant union officials during the period	Full-time equivalent employee number
16	14.44

Table 2: Percentage of time spent on facility time

Percentage of time	Number of employees
0%	0
1-50%	14
51-99%	2
100%	0

Table 3: Percentage of pay bill spent on facility time

Total cost of facility time	£28,104.19
Total pay bill	£147,124,751.94
% of total pay bill spent on facility time	0.019%

Table 4: Paid trade union activities

Total paid facility and union time hours	2,056

Staff Survey

37. Overview

37.1. The Trust is committed to engagement with all of our staff, and has a number of formal and informal arrangements in place to support this aim. In addition, a range of communication mechanisms are in place to facilitate the provision of information; these include a weekly email out to all staff, monthly team brief, a “Focus on” short video on a particular topic or issue, a Trust closed Facebook page just for staff plus a range of social media usage.

37.2. The Trust also participates in the two main schemes for obtaining staff feedback- the national annual Staff Survey, and the staff 'Friends and Family' test which is undertaken quarterly. This section covers the results of the 2019 annual staff survey, reported in March 2020; with the staff 'Friends and Family' test being covered within the Quality Report. The Workforce Committee regularly receives the results of the Staff 'Friends and Family' test.

38. Summary of performance

38.1. The 2019 NHS Staff Survey was completed from September to December 2019. The results are presented as themes and questions from the questions asked within the survey, and in the context of the best, average and worst results for similar organisations where appropriate. The results for this Trust are benchmarked against 43 other organisations within the Combined Acute and Community Trust category.

38.2. During 2019, the Trust undertook a full census with the survey being sent to all staff to complete.

	2019		2018		2017	
	Trust	National average	Trust	National average	Trust	National average
Equality, diversity and inclusion	9.1	9.2	9.1	9.2	9.2	9.2
Health and wellbeing	5.9	6.0	5.9	5.9	6.4	6.0
Immediate managers	6.8	6.9	6.8	6.8	6.8	6.8
Morale	6.1	6.2	6.1	6.2		
Quality of appraisals	5.5	5.5	5.4	5.4	5.5	5.3
Quality of care	7.6	7.5	7.6	7.4	7.9	7.4
Safe environment-bullying and harassment	8.1	8.2	7.9	8.1	8.1	8.1
Safe environment-violence	9.5	9.5	9.5	9.5	9.4	9.5
Safety Culture	6.8	6.8	6.6	6.7	6.8	6.7
Staff Engagement	7.0	7.1	7.1	7.0	7.2	7.0
Team working	6.6	6.7				

39. Our plans to improve

39.1. Based on the outcomes of the Staff Survey for 2019, the Trust has committed to taking specific steps to deliver a positive trajectory for improvement in staff experience. To achieve this, the Trust has triangulated staff survey results with wider data sources drawn from-

39.1.1. The national Workforce Race Equality Scheme (WRES)
39.1.2. The national Workforce Disability Equality Scheme (WDES)
39.1.3. Feedback from our internal 'Good to Outstanding' engagement programme;
39.1.4. The feedback through the General Medical Council's survey of our Junior Doctor colleagues;

to inform the thinking and design work behind any action planning undertaken. These actions have already been mapped to the Trust's Workforce Strategy, the Equality, Diversity and Inclusion Strategy, the Health and Wellbeing Strategy, and the Sustainable Management Development Plan; and include:

39.1.5. Promoting equality of opportunity in career progression /promotion for minority groups of staff. To this end, "b-SEEN" (Staff Equality Engagement Network) has been launched, to enable staff to work together to develop equitable and fair talent management practice.
39.1.6. Making adequate adjustments for staff with disabilities, and staff managing long term conditions, by introducing a Disability and Wellbeing Network (DAWN). The Network is supporting the development to of a programme of work to meet the Level 3 Standard as a Disability-confident employer.
39.1.7. Addressing the increase in work-induced musculoskeletal injuries, as a part of our Sustainable Management Development Plan, to ensure our estate and equipment is reviewed against the needs of an ageing workforce.
39.1.8. Developing a plan to offer flexible working across the Trust where possible, working along experts from 'Timewise', a flexible working consultancy firm.
39.1.9. Developing compassionate and kind leadership, through the Trust's Introduction to line management programme, and the introduction of a bespoke leadership and management development programme for nursing leaders.
39.1.10. Tackling incivility in the workplace facilitated by the 'Civility saves lives' programme, commissioned for roll out in 2020
39.1.11. Creating clear, concise and tangible team objectives to supplement the revitalised appraisal process.

39.2. By focusing on these areas for improvement, the Trust hopes to improve staff experience; thereby moving towards becoming an employer of choice, and an outstanding provider of care for all.

High Off-Payroll arrangements

40. Policy towards 'off-payroll' arrangements

40.1. The Trust recognises that, on occasion, it is necessary to use the services of individuals who are only available as self-employed/ contractors ('off-payroll'). However, the Trust is cognisant of the requirements of Intermediaries Legislation and ensures that where an off-payroll arrangement is required that a HMRC assessment of the tax implications of the engagement is undertaken and appropriate tax arrangements are in place.

40.2. The Trust will only utilise individuals on an 'off-payroll' basis on an exceptional basis, usually where the structure of the market means that individuals with the necessary skills and experience are not available on an employed basis

41. Existing engagements at March 2020

This table reflects 'off-payroll' arrangements that are in place at the 31st March, 2020; pay more than £245 per day; and have been in place for six months or more

Number of existing engagements at the 31st March, 2020	4
The number of those engagements-	
• That have existed for less than a year	3
• That have existed for between one and two years	1
• That have existed for between two and three years	0
• That have existed for between three and four years	0
• That have existed for four years or longer	0

42. New engagements in the year

This table reflects new 'off-payroll' engagements made between 1st April 2019 and 31st March 2020, including those that exceeded 6 months in duration during the year; that paid more than £245 per day; and lasted longer than 6 months.

Number of new engagements (including those exceeding 6 months) between 1st April 2019 and 31st March 2020	4
Of which	
The number assessed as within the scope of IR35	4
The number assessed as not within the scope of IR35	0
Number engaged directly (via PSC contracted to trust) and are on the trust's payroll	0
Number of engagements reassessed for consistency/assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

43. Board members and those with significant financial responsibility

This table sets out information on Board members, and those senior staff with significant financial responsibility, who were 'off-payroll' during the course of the year. For this table, there is no minimum pay level or length of contract applied.

Number of Directors, or senior staff with significant financial responsibility, who were engaged on an 'off-payroll' basis during the year	0
Total number of individuals who were Directors, or senior staff with significant financial responsibility, during the course of the year[2]	0

[2] This includes both those paid directly through payroll, and those with 'off-payroll' arrangements.

Exit payments

44. Overview

44.1. In 2019-2020, the Trust has used exit packages in a total of 2 cases. Both related to agreements reached under Mutually-Agreed Redundancy Scheme (MARS) arrangements, which has been approved by NHS Improvement, to support the re-organisation of services. Careful consideration was given as to whether these were the appropriate way to proceed, and it was considered that the interests of the Trust and the service would be best supported by utilising this arrangement.

45. Staff Exit packages

	Number of compulsory redundancies		Number of other departures agreed		Total number of exit packages by cost band	
	2019-20	2018-19	2019-20	2018-19	2019-20	2018-19
Less than £10,000	0	0	1	0	1	0
£10,001 to £25,000	0	0	1	0	1	0
£25,001 to £50,000	0	0	0	0	0	0
£50,001 to £100,000	0	0	0	0	0	0
£100,001 to £150,000	0	0	0	0	0	0
£150,001 to £200,000	0	0	0	0	0	0
Total number of exit packages by type	0	0	2	0		
Total resource cost (£000's)	0	0			2	0

46. Non-compulsory departure payments

	Number of agreements		Total value of agreements (£'000's)	
	2019-20	2018-19	2019-20	2018-19
Voluntary redundancies, including early retirement- contract costs	0	0	0	0
Mutually-agreed resignations- contract costs	2	0	65	0
Early retirements in the interests of the efficiency of the service- contract costs	0	0	0	0
Contractual payments in lieu of notice period	0	0	0	0
Exit payments following Employment Tribunals or Court orders	0	0	0	6

	Number of agreements		Total value of agreements (£'000's)	
	2019-20	2018-19	2019-20	2018-19
Non-contractual payments, requiring approval of Her Majesty's Treasury [3]	0	0	0	0
Total	2	0	65	0
Of which: non-contractual payments requiring Treasury approval, made to individuals, where the payment value was more than 12 months' annual salary	0	0	0	0

46.1. As a single exist package can be made up of several components, each of which is counted separately in this note, the total number above will not necessarily match the total numbers given in the Notes to the Accounts, which will be the number of individuals.

46.2. The Remuneration Report on page 18 provides more detail on exit payments made to individuals named in that report (Directors, former Directors and other senior managers).

46.3. In respect of the amounts included in the table above as *Non-contractual payments, requiring approval of Her Majesty's Treasury*, the following were the maximum, minimum and median amounts-

	2019-2020 (£)	2018-2019 (£)
Maximum	Nil	Nil
Median	Nil	Nil
Minimum	Nil	Nil

[3] Includes any non-contractual severance payment made following a judicial mediation, and £Nil related to non-contractual payments made in lieu of notice.

Director's Biographies

Sallie Bridgen, Non-Executive Director

Sallie's career has been in housing and homelessness, working with Housing Associations, Local Authorities and charities. She has held senior positions at Shelter, the National Housing Federation, and was CEO of HDN, an organisation seeking to improve equality and diversity in housing. She now works to improve integration between housing and health, and with organisations on strategy and leadership. She is a Group Director for Progress Housing Group, and a Trustee of Together Dementia Support.

Sallie is Chair of the Finance Committee. She also serves on the Quality & Governance Committee, Workforce Committee and the Nomination & Remuneration Committee. She is the Lead NED for Equality & Diversity and End of Life care.

Trish Cavanagh, Chief Operating Officer

Trish joined the Board in July 2014 from University of South Manchester Foundation Trust, where she had been Associate Director of Operations. A registered nurse since 1986, and with an M.Sc. in Clinical Practice, Trish has long experience in operations and transformation in the NHS context.

Trish is responsible for the operational support provided to clinical functions in the Trust, including our community work and the contact-points with social care providers. She is also the lead for developing and implementing our transformational schemes, in partnership with local and regional partners. She is a member of the Workforce and Finance & Performance Committees, and is the Deputy Chief Executive.

David Curtis MBE, Non-Executive Director

David is a Mental Health and General Nurse, having had a 40 year full time career in the NHS. He has held senior clinical and managerial positions in Mental health, Acute and Community Services and in Nurse Education: his last NHS position was the Executive Director of Nursing and Integrated Governance in Pennine Care NHS Foundation Trust. In 2008 David was awarded an MBE for his services to Nursing and Health Care in Greater Manchester. David has also previously served as a Non-Executive Director in a health and Wellbeing NHS Foundation Trust.

David is the Chair of the Charitable Funds Committee, and is a member of the Finance Committee, the Nomination & Remuneration Committee, and Quality & Governance Committee. He is the lead NED for mortality.

Karen James OBE, Chief Executive and Accounting Officer

Karen James joined the Trust in 2014, following a successful career in the NHS. Having started her career as a Registered Nurse, she has over the last fourteen years held a number of executive leadership roles in large acute tertiary providers. Karen has significant experience in managing large scale change across complex economies, and has been successful in the delivery of improvements in organisational performance.

Karen leads the Executive team, and also services on the Quality & Governance and the Finance & Performance Committees as Chief Executive. She is the statutory Accounting Officer for the Trust.

	**Andrew Light, Non-Executive Director** Andrew is a Chartered Management Accountant with over 30 years' experience in the private sector. After graduate training and early roles gaining broad accounting experience Andrew enjoyed a 15 year career with Associated British Foods plc and progressed to his first Finance Director role with them. He joined Warburtons Limited in 2006 as Finance Director. The role has developed and broadened and became established for the first time on the Family Board of the business in 2014 with Andrew as CFO. Andrew has begun to relinquish some of his responsibilities at Warburtons in order to enable him to continue as a volunteer NED on the Board of England Squash and take on the role at the Trust. Andrew is the Chair of the Audit Committee, and sits on the Finance Committee and Workforce Committee. Andrew's role also includes being the lead NED for Business Continuity and Counter Fraud
	**Jane McCall, Chair** Appointed as Trust Chair in January 2018, Jane has significant experience as a Non-Executive Director in the NHS, including at Stockport Foundation Trust and University Hospitals of South Manchester Foundation Trust; the latter as Deputy Chair. Her background is in social housing. In addition to her role with the Trust, she holds Non-Executive positions with the Information Commissioner's Office, and is an external member of the House of Commons Commission. In May 2020, she became the Chair of Peaks and Plains Housing Trust, a social housing provider based in Macclesfield. Jane is the Chair of the Board and of the Council of Governors. She also Chairs the Nomination and Remuneration Committee of the Board, and serves on the Council's Nomination Committee.
	**Peter Noble, Non-Executive Director** Appointed to the Board in 2018, Peter has a long career in higher education and the NHS, most recent as Vice-President at the University of New South Wales, Chief Operating Officer at the UK Science Technology and Facilities Council, and a Board member of Sci-Tech Daresbury. He has previously led a number of academic health partnerships, both nationally and internationally. Peter is the Chair of the Workforce Committee. He also serves on the Audit Committee, the Quality and Governance Committee, the Charitable Funds Committee and the Nomination and Remuneration Committee. He is the Lead NED for Safeguarding Adults and Children.
	**Brendan Ryan, Medical Director** Brendan joined the Trust in 2014, having been Medical Director, and Consultant in Emergency Medicine, at the University Hospitals of South Manchester Trust for the previous 14 years. Brendan leads on professional medical issues, and serves on the Quality and Governance, and Workforce Committees. He is the Trust's Caldicott Guardian, Responsible Officer for Medical Revalidation, Director of R&D, and executive lead for patient safety. Brendan chairs a number of Trust committees, including Patient Safety, Executive Procurement Group, Digital Care Board, and the R&D Committee.

	**Sam Simpson, Finance Director** Sam joined the Trust in June 2018 and has worked in the NHS for over 25 years since joining the North West Financial Management Training Scheme. Sam has held senior finance roles in commissioner, provider and strategic health authority; and most recently, prior to joining the Trust, Sam was the Director of Finance for the Cheshire & Merseyside Sustainability Transformation Partnership. Sam spent two years at Greater Manchester Police and also has experience of working in local authorities and the education sector, and is a governor of Manchester Health Academy. Sam is a member of the Finance Committee and Charitable Funds Committee, and attends the Audit Committee.
	**Martyn Taylor, Deputy Chair and Senior Independent Director** Martyn is an Associate of the Chartered Institute of Bankers, and spent his career in banking. Prior to his retirement he led risk management related to troubled firms for a major bank, with a particular focus on the North of England. He also graduated from senior management development programmes at Harvard Business School and the Wharton University in Pennsylvania. Martyn joined the Board in May 2015, and his term will end in April 2021. He is the Chair of the Quality and Governance Committee, and serves on the Audit Committee and the Nomination & Remuneration Committee. He is the Lead NED for Freedom to Speak Up and for Organ Donation. From 1st May 2019, he has been Deputy Chair and Senior Independent Director
	**Peter Weller, Director of Nursing and Integrated Governance** Peter has a portfolio of over 30 years' nursing experience in provider, commissioner and regulatory organisations, having held a range of clinical and managerial leadership roles. Holding an MA in Professional Practice pertaining to Patient Safety and Quality Governance, Peter re-joined the Trust from NHS Improvement, where he was Senior Clinical Lead for Greater Manchester and Lancashire, overseeing a range of NHS providers and driving improvements in governance, workforce and clinical standards. He was previously the Director of Quality Governance at the Trust. Peter leads on Nursing, AHP and Quality/ Clinical governance matters, and is a member of the Quality and Governance Committee and the Workforce Committee. His role includes being the Director of Infection Prevention and Control for the Trust.

Corporate Governance

47. Introduction

47.1. The Board recognises the key importance, particularly in a public sector organisation, of ensuring that decisions are taken at an appropriate level, and with due consideration. It seeks to ensure this through ensuring that its arrangements for corporate governance represent best practice and are resourced and supported appropriately.

47.2. Corporate governance within the Trust takes place in the structure defined in the *National Health Service Act 2006*, and in particular Schedule 7 of that Act (as amended by the *Health and Social Care Act 2012*). It is also informed by the expectations of the Care Quality Commission, and the *Code of Governance for NHS Foundation Trusts* published by Monitor (now part of NHS Improvement).

47.3. The major corporate governance bodies within the Trust are the Council of Governors, largely elected by Trust members with responsibility for holding the Board to account and ensuring that the views of the public are represented to the Trust; and the Board of Directors, who are responsible for setting the direction and strategy of the Trust and for oversight of delivery. The Trust operates in a closely-regulated environment, with the main (but not only) statutory regulators being Monitor (now part of NHS Improvement) and the Care Quality Commission.

48. Statement of the application of the *Code of Governance*

48.1. Tameside and Glossop Integrated Care NHS Foundation Trust has applied the principles of the *NHS Foundation Trust Code of Governance*, published by Monitor, on a comply or explain basis. The *Code of Governance*, most recently revised in July 2014, is based on the principles of the *UK Corporate Governance Code* issued in 2012.

48.2. Where the Code has a requirement for disclosure, this has been addressed in the relevant section of this report, based on the table given in the *Annual Reporting Manual for NHS Foundation Trusts.*

48.3. The information in this report about our compliance, or explanations for non-compliance, with the *Code of Governance* is subject to review by the external Auditors.

49. Explanations for areas of non-compliance with the *Code*

49.1. After careful review, the Board has not identified any areas where the Trust failed to comply with the provisions of the *Code of Governance* during the year under review.

The Board of Directors and Council of Governors

50. High-level overview

50.1. There are two main governance bodies in the Trust; the Council of Governors and the Board of Directors. These are established by the Trust Constitution, in accordance with the requirements of Schedule 7 to the *National Health Service Act 2006*. The structure must follow that Schedule and the Trust has no authority to put in place different arrangements.

50.2. The Council of Governors is formed of volunteers, representing the public, staff and key stakeholders of the Trust. Governors are elected or appointed for a term of 3 years, and may be re-elected/ re-appointed for up to 9 years without a break in service. Council has a regular schedule of 4 meetings in the year, which are supplemented by development and briefing sessions. Council exercises certain limited powers, as defined by law; key powers include appointing the Chair and other Non-Executive Directors to the Board; determining the remuneration of the Non-Executive Directors; appointing the Trust's Auditor; and approving the appointment of the Non-Executive Director's choice as Chief Executive. The law does not permit Council to delegate its powers.

50.3. The Board of Directors is formed of Non-Executive Directors, who are not employed by the Trust; and Executive Directors, who form the senior management of the organisation. However, all Directors are equal and have the same statutory and legal responsibilities as Directors. The Non-Executive Directors must include the Trust Chair; and the Executive Directors are required by law to include a Chief Executive, a Director of Finance, and Directors registered with the General Medical Council or General Dental Council; and with the Nursing and Midwifery Council (as a nurse or midwife). Subject to the matters reserved to the Council of Governors by law, the Board of Directors exercises all of the powers available to the Trust as a legal entity.

50.4. The Board of Directors meets on a regular basis, having agreed that it will meet every two months (six times a year). The Board has both a defined schedule of future business, and a list of standing agenda items to be considered at every formal meeting, in order to ensure that it is exercising appropriate governance and oversight of the activities of the Trust. In the months between the formal Board meetings, the Directors have seminar sessions to receive briefings on forthcoming developments and policy changes, and to discuss policy proposals prior to formal consideration by the Board. The Board is also supported by a comprehensive Committee system, which reviews both performance and policy proposals in detail prior to Board consideration.

50.5. Under the Standing Orders of the Trust, the general powers of management of the Trust are delegated to the Chief Executive and through her to the staff operating the Trust's services, subject to the Board's decisions about reserving powers either to itself or to Board Committees. Through the Standing Financial Instructions and the Terms of Reference for Board Committees, the Board has reserved certain powers of final approval to itself or the relevant Board Committees.

51. Membership of the Board of Directors, and attendance at meetings

51.1. During the year, the following served as Directors of the Trust-

Name	Office	Start date	Expected end of term
Sallie Bridgen	Non-Executive Director	February 2017	January 2023
Trish Cavanagh	Chief Operating Officer	August 2014	N/A
David Curtis	Non-Executive Director	January 2020	January 2023
Anne Dray	Deputy Chair	January 2014	Retired December 2019
Cathy Elliott	Non-Executive Director	February 2017	Retired July 2019
Karen James	Chief Executive	October 2014	N/A
Andrew Light	Non-Executive Director	January 2020	January 2023
Jane McCall	Trust Chair	January 2018	January 2021
Peter Noble	Non-Executive Director	February 2018	February 2021
Brendan Ryan	Medical Director	October 2014	N/A
Sam Simpson	Director of Finance	June 2018	N/A
Martyn Taylor	Non-Executive Director	May 2015	April 2021
Peter Weller	Director of Nursing and Integrated Governance	February 2019	N/A

51.2. Attendance at meetings of the Board, and its Committees, was as follows. Information on the attendance of Directors at the Audit Committee can be found at page 56, and at the meetings of the Nomination and Remuneration Committee on page 18.

	Board of Directors		Finance Committee		Quality and Governance Committee		Workforce Committee	
	Attended	Possible	Attended	Possible	Attended	Possible	Attended	Possible
Sallie Bridgen	6	6	12	12	8	10	3	5
Trish Cavanagh	3	6	7	12	7	10	3	5
David Curtis	2	2	2	3	2	2		
Anne Dray	4	4	9	9				
Cathy Elliott	1	2	2	4	4	4	1	2
Karen James	6	6	7	12				
Andrew Light	2	2	3	3			0	1
Jane McCall	6	6						
Peter Noble	6	6			5	10	5	5
Brendan Ryan	4	6			9	10	5	5
Sam Simpson	6	6	11	12				
Martyn Taylor	6	6			9	10		
Peter Weller	5	6			8	10	4	5

52. Independent Non-Executive Directors

52.1. After careful review of their connections with Trust management, the Board considers all Non-Executive Directors to be independent of the management of the Trust.

52.2. The independence of the Non-Executive Directors has been reviewed during the year, having regard to the criteria in the *Code of Governance*, to identify any factors that might indicate that a Non-Executive Director was no longer independent.

52.3. Following the year-end, Jane McCall has been appointed to be the Chair of the Peaks and Plains Housing Association, based in Macclesfield. The Board is satisfied that no conflict of interest arises between the two positions, and that Jane will continue to have sufficient time to devote to her position at the Trust. In reaching that opinion, the Board noted that Jane will be retiring from her position on the House of Commons Commission in January 2021 .

53. Completeness, balance and appropriateness of the Board

53.1. Details of the skills, expertise and experience of the individual Directors can be found in the biography section, on page 41.

53.2. The Board has given consideration to the skills and experience represented in its own membership, in order to consider whether what is available through its membership provides balance, completeness and is appropriate to the environment and context in which the Trust operates. This has also been informed by discussions with the Council's Nomination and Remuneration Committee, who have responsibility for recommending to Council the skills and experience to be sought in making appointments of Non-Executive Directors to the Board.

53.3. The Board considers that the membership represents an appropriate balance, not just between Executive and Non-Executive Directors but also in the skills and experience that are available, in both the Executive and Non-Executive Directors and collectively, given the context and environment that the Trust is operating in. In particular, the Board considers that it has appropriate skills and experience to provide effective leadership to the Trust; develop effective strategy; provide financial management and direction as a whole; and relevant experience on key issues such as integration and organisational change. During the year the Board has commenced a succession planning exercise for both Directors and senior managers, in order to ensure that there is both a clear view of the skills to be sought in any replacement and also to inform the Board's view of the (different) skills to be sought in future appointments having regard to the challenges expected to face the Board and the Trust.

54. Performance evaluation

54.1. The Board recognises the importance of evaluating the performance of its key governance systems; starting with the Board, running through the Committees that support the Board, and including the performance of individual Directors. This reflects and builds on the expectations set out in the *Code of Governance for NHS Foundation Trusts*. The Trust also has obligations under Condition FT4 of the *NHS Improvement Provider Licence* to ensure effective governance systems, and similar obligations under the *Health and Social Care Act 2008 (Regulated Activities) Regulations 2014*.

54.2. During the year, the Board received the results of the Care Quality Commission inspection carried out in March and April 2019; which rated the Trust as 'Good' overall, and as 'Good' for the domain of "Is [the Trust] well-led?". The Board welcomed this

improved rating, which demonstrated the strength in the governance processes and systems in place within the Trust. The Board has set in place a programme which seeks to move the Trust from a rating of 'Good' to 'Outstanding', which will include further focus on the 'well-led' domain of inspection.

54.3. The Board has also collectively engaged in a programme of development facilitated by Deloitte LLP, with the intention of improving areas of weakness and further developing areas of strength. The programme has included an analysis of the Board's strengths and weaknesses, both as seen by the Directors and other senior colleagues; and a programme of seminars to enable the Board to discuss performance and possible improvement in key areas, learning from best practice in other Trusts and organisations through Deloitte's extensive experience. Owing to the impact of COVID-19 on Board arrangements, the programme will now conclude in the 2020-2021 year.

54.4. Each individual Director's performance is subject to a formal process of review and assessment, reflecting on their performance as a Director in the Board and Committee environment, as well as (for Executive Directors) their management performance and (for relevant Non-Executive Directors) their performance in specific responsibilities such as Chairs of Committees. Each Director, including the Chair and the Chief Executive, is set a range of objectives for the year, subject to review during the course of the year, and end of year achievement is assessed. The outcomes of the appraisals for the Executive Directors are reported to the Board's Nomination and Remuneration Committee; for the Non-Executive Directors, they are reported to the Council of Governors through the Council Nomination and Remuneration Committee.

55. Review of internal controls

55.1. The systems of internal control have been subject to continuing review by the Board during the course of the year, supported by the detailed work of the Audit Committee and the Internal Audit service. The Board has considered not only financial systems of control, but also the systems that provide control and assurance regarding the quality and safety of the care provided to patients, together with the systems to identify learning and ensure that changes are embedded into future practice. The Board has also taken into account the overall opinion of the Head of Internal Audit, who considered that the Trust's control systems provided Substantial Assurance that that there was a good system of internal control designed to meet the organisation's objectives, and that controls were generally being applied consistently.

55.2. Having considered the matters referred to above, and also the other matters considered by the Board during the course of the year, the Board is of the opinion that the control systems in place during the course of the year were satisfactory. Further details can be seen in the Annual Governance Statement.

56. Membership of and attendance at the Council of Governors

56.1. During the course of the year, the following have served as members of the Council of Governors-

Name	**Constituency**	**Elected/ Appointed**	**End of term of office**
Wendy Brelsford	Public Audenshaw	Elected	March 2022
Nicola Bullough	Staff Clinical Support	Elected	December 2022
Dorothy Cartwright	Public Stalybridge	Elected	March 2020

Name	Constituency	Elected/ Appointed	End of term of office
Kailish Chand	Action Together	Appointed	
Lesley Conroy	Public Ashton	Elected	March 2020
Anne Corrie	Public Longendale	Elected	March 2022
Lindsey Derbyshire	Staff Medical and Urgent Care	Elected	Retired January 2020
Alan Dow	Tameside & Glossop CCG	Appointed	Retired April 2019
Alec Hall	Public Mossley	Elected	December 2021
Mark Hindle	Public Hyde	Elected	May 2021
Mark Holden	Consort	Appointed	
Murtaza Husaini	Public England and Wales	Elected	March 2020
Sally Lewcock	Staff Women's and Children's Services	Elected	Retired January 2020
Vernon Marshall	Public Dukinfield	Elected	November 2022
Julie McCabe	High Peak Borough Council	Appointed	Retired May 2019
Mike McClusky	Staff Estates and Facility	Elected	June 2021
Anthony McKeown	High Peak Borough Council	Appointed	
Champak Mistry	Public Ashton	Elected	March 2022
John Phillips	Public Hyde	Elected	June 2020
Vikki Rutter	Public Dukinfield	Elected	Retired December 2019
Lucy Simm	Staff Women's and Children's Services	Elected	January 2023
Ken Simpson	Public Droyslden	Elected	Retired December 2019
Adrian Smith	Staff Clinical Support	Elected	Retired December 2019
Adrian Smith	Staff Medical and Urgent Care	Elected	February 2023
Gleeney Suarez	Staff Intermediate Tier and Neighbourhoods	Elected	October 2021
Lesley Surman	Public Glossop	Elected	December 2019
Raja Swamathan	Staff Surgery	Elected	June 2021
Emily Sykes	Young People	Appointed	Retired February 2020.
Mike Walker	Public Denton	Elected	March 2022
Brenda Warrington	Tameside Council	Appointed	
Chris Webster	Public Glossop	Elected	March 2020
Jean Wharmby	Derbyshire County Council	Appointed	
Richard Williams	Public Denton	Elected	October 2022

56.2. Following the year-end, the following were returned to serve on Council-
56.2.1. Frederick Keyser as the Governor for Stalybridge;
56.2.2. Andrew Morgan as the Governor for staff in the Corporate Services area.

56.3. During the year, John Phillips served as the Lead Governor. Council has elected Lesley Surman to be the Lead Governor following Mr Phillip's retirement from Council in June 2020.

56.4. Details of attendance at meetings of the Council of Governors can be seen in the table on page 52.

57. Membership areas

57.1. The Trust has two types of membership-

- Public membership, open to any member of the public who is resident in England
- Staff membership, provided automatically to all members of staff unless they choose to 'opt-out'

Public membership is divided into the following areas for the purpose of elections to the Council of Governors-

Public area	Local Government Wards covered
Ashton-under-Lyne	Ashton Hurst, Ashton St Michael's, Ashton St Peter's, Ashton Waterloo in Tameside MBC
Audenshaw	Audenshaw in Tameside MBC
Denton	Denton North East, Denton South and Denton West in Tameside MBC
Droyslden	Droylsden East and Droylsden West in Tameside MBC
Dukinfield	Dukinfield and Dukinfield Stalybridge in Tameside MBC
Glossop	Hadfield North, Hadfield South, Gamesley, Simmondley, Tintwistle, St John's, Dinting, Old Glossop, Howard Town, Whitfield, and Padfield in High Peak BC
Hyde	Hyde Godley, Hyde Newton, and Hyde Werneth in Tameside MBC
Longendale	Longendale in Tameside MBC
Mossley	Mossley in Tameside MBC
Stalybridge	Stalybridge North and Stalybridge South in Tameside MBC
Rest of England and Wales	All local government wards/ Divisions in England not covered above

57.2. At 4th May 2020, the number of Members in each of the Public Constituency areas were-

Public area	Number of members
Ashton-under-Lyne	475
Audenshaw	81
Denton	226
Droyslden	141
Dukinfield	197
Glossop	239
Hyde	274
Longendale	96
Mossley	85
Stalybridge	260
Rest of England	152
Total	2,231

58. Keeping the Directors aware of Governor and Member views

58.1. The Board recognises the importance of ensuring that the Board is aware of the views of both the Governors, as the elected representatives of the public using the Trust's services; and of members directly. Recognising the lines of accountability set out by Parliament, the Non-Executive Directors directly report to the Council on the activities of the Board; and will directly hear the concerns and feedback currently being fed through Governors. The Chair regularly provides a formal update to the Board on the matters discussed by the Council.

58.2. The Board also receives information on the views of the public particularly those who utilise its services. It regularly reviews the feedback across the Trust from patients through the national 'Friends and Family' test, and also the annual In-patient and out-patient surveys. The Board also receives feedback from the regular cross-system consultations that are undertaken through the Patient Experience Network, a cross-organisation engagement arrangement involving the Trust, the CCG and Tameside Council.

59. Development of and engagement with the Trust's membership

59.1. The Trust recognises the importance of engagement with its membership. During 2019-2020, the Council of Governors has given regular consideration to how it can improve the engagement of Governors with members, and has formed a working party to give more detailed consideration to options and report back to Council with recommendations. This work is now expected to continue into the 2020-2021 year.

59.2. During the year, the Trust has launched a new electronic newsletter for members, which is intended to be produced twice a year, with the aim of ensuring that they have key information about the Trust's activities. Members are also welcome to attend meetings of the Board and the Council, and can participate in the Annual Members' Meeting.

59.3. Members are encouraged to become involved with the engagement and consultation arrangements operated through the Patient Engagement Network with our local partners, which enables them to express their views and preferences as services are developed. Governors have been involved with the current process that is developing a Patient & Service User Engagement Strategy.

60. Contacting Governors and Directors

Members who wish to contact Directors or Governors should e-mail the Trust Secretary at Steve.Parsons@tgh.nhs.uk.

61. How Governors sought views from Members and the public on the Annual Plan

61.1. As noted earlier in the report, owing to the COVID-19 pandemic the Trust's planning process was suspended during the year. This occurred prior to Governors being invited to contribute to the plan.

62. Table of attendance at meetings of the Council of Governors

Governors

			Attended	Possible
Brelsford	Wendy	Public	5	5
Bullough	Nicola	Staff	1	1
Cartwright	Dorothy	Public	3	5
Chand	Kailish	Partnership	1	4
Conroy	Lesley	Public	4	5
Corrie	Anne	Public	5	5
Derbyshire	Lyndesy	Staff	0	4
Dow	Alan	Partnership	0	0
Hall	Alec	Public	5	5
Hindle	Mark	Public	2	5
Holden	Mark	Partnership	4	5
Hussaini	Mutarza	Public	2	5
Lewcock	Sally	Staff	1	4
Marshall	Vernon	Public	1	1
McCabe	Julie	Partnership	0	0
McClusky	Mike	Staff	3	5
McKeown	Anthony	Partnership	2	5
Mistry	Champak	Public	4	5
Phillips	John	Public	5	5
Rutter	Vikki	Public	0	4
Simm	Lucy	Staff	0	1
Simpson	Ken	Public	0	4
Smith	Adrian	Staff	4	5
Suarez	Gleeny	Staff	4	5
Surman	Lesley	Public	4	5
Swamarithian	Raja	Staff	3	5
Sykes	Emily	Partnership	0	4
Walker	Mike	Public	3	5
Warrington	Brenda	Partnership	3	5
Webster	Chris	Public	5	5
Wharmby	Jean	Partnership	0	5
Williams	Richard	Public	3	3

Directors

		Attended	Possible
Bridgen	Sallie	3	4
Cavanagh	Patricia	1	4
Curtis	David	1	1
Dray	Anne	2	3
Elliott	Cathy	0	1
James	Karen	2	4
Light	Andrew	0	1
McCall	Jane	5	5
Noble	Peter	3	4
Ryan	Brendan	3	4
Simpson	Sam	3	4
Taylor	Martyn	4	4
Weller	Peter	2	4

The work of the Board's Committees

63. Introduction

63.1. This section outlines the work undertaken by the various Committees of the Board, during the course of the year. Details of the work of the Nomination and Remuneration Committee can be found at page 23.

63.2. All Board Committees operate to agreed and written terms of reference, which are subject to regular review and can only be amended by the Board. Committees are composed of both Executive and Non-Executive Directors, except for the Audit Committee and the Nomination and Remuneration Committee, which only have Non-Executive Directors in membership. Each Committee is chaired by a Non-Executive Director appointed by the Board. The Committees meet on a prearranged cycle of meetings, agreed by the Board, and planned to ensure that they meet sufficiently often to discharge their strategic and oversight functions whilst not meeting unnecessarily. Each Committee has a plan of forward business, designed to ensure that all relevant matters are considered in a timely way to support the overall work of the Board.

63.3. As is common for NHS Provider organisations, under Section 51 of the *National Health Service Act 2006* the Foundation Trust also acts as the Trustee of a registered charity. For these purposes, the Directors constitute the Directors of the Charity's Trustee; and have delegated the day-to-day oversight of the Charity's operations to a Charitable Funds Committee. As required under the *Charities Act 2011*, a separate Annual Report and Accounts for the charity is produced and submitted to the Charity Commissioners, and published on their web-site; the work of the Charitable Funds Committee is discussed in that document.

64. Structure and membership

64.1. Board Committees are directly responsible and report to the Board, and where authorised, exercise Board powers as set out in the Terms of Reference. Each Committee reports in writing to the following Board meeting (in public session) on its activities at each meeting, and minutes of proceedings are provided to the Board in private session. The membership of Committees is determined by the Board having regard to the skills and experience required; and appointments are subject to regular rotation amongst the Non-Executive Directors, having regard to the guidance in the *Code of Governance for NHS Foundation Trusts*.

64.2. Each Committee is appointed by the Board of Directors, in line with the written terms of reference that the Board has approved to set out the Committee's role and responsibilities. The Board appoints both Executive and Non-Executive Directors to Committees, and (in line with the *Code of Governance*) each Committee has at least as many Non-Executive Directors as Executive Directors in membership. Details of attendance at Board Committees can be seen at page 45 of this Report.

64.3. For each Committee, there is a formal agenda of business, which is compiled based on a forward plan that is reviewed and updated at the end of each meeting to ensure all relevant items are addressed. Provision is also made for extra meetings to be called if required, but this has not been needed during the course of the year. The agenda and papers for the Committee are circulated in advance, with late papers only being allowed with the prior permission of the Committee Chair and where an appropriate explanation for the late provision can be given. Papers are expected to be succinct as is compatible with the Committee understanding the issues and options; and should be supported by both an executive summary and any more detailed information being

appended.

64.4. The performance and effectiveness of each Committee is reviewed on an annual basis, as recommended in the *Code of Governance*; and both Committees and the Board seek to make changes to develop contributions to effective governance. The Board has agreed that the Committee's Terms of Reference should be reviewed on a three-year cycle (earlier if needed), reflecting that, whilst important frameworks, the terms of reference should enable Committees, not act as unnecessary restrictions.

65. The work of the Board's Committees

65.1. Details of the work of the Board's Nomination and Remuneration Committee can be found in the Remuneration Report on page 18. The work of the Audit Committee is covered in detail in the section starting on page 56.

65.2. The Finance Committee has continued to focus on the delivery of the agreed financial plan, including undertaking 'deep dives' into the delivery of the proposed efficiency plans for key areas. These have provided assurance to the Board, through the course of the year, that there was a firm basis for the delivery of the plan. The Committee has also been closely involved in the forward planning process, and in the potential changes being driven by the strategic change in approach nationally, with the focus for both delivery of national resources and holding to account for performance being at the Integrated Care System (for us, Greater Manchester) level.

65.3. The Workforce Committee has continued to support the Board to better support the Trust's staff. During the year, key items of consideration have included the developing Workforce strategy; the Equality, Diversity and Inclusion strategy; and the results of the various surveys of staff opinion, including the national NHS Staff Survey and the Junior Doctor's survey of the General Medical Council. The Committee has also developed a dashboard to monitor key work-force related metrics, so that appropriate assurance can be provided to the Board.

65.4. The Quality and Governance Committee has been involved in the monitoring of all aspects of Trust operations that affect the quality of care provided, and the experience of those who use our services. It is regularly updated on matters such as complaints received, serious incidents and the reviews of mortality undertaken; together with key external findings, such as the GMC survey of Junior Doctors and findings by HM Coroner. It has a regular programme of visiting departments, wards and other areas of the Trust to engage with staff and patients, and follows up on identified actions to ensure that they are completed.

65.5. All of the Board's Committees have regularly reviewed the actions and controls in place for the Board Assurance Framework risks that the Board has allocated to their oversight; and have recommended to the Board changes to the BAF, or the addition of new risks, arising from their oversight work.

Audit Committee

66. Introduction to the work of the Committee

66.1. Every NHS organisation is required to have an Audit Committee, whose role is to support the Board by critically reviewing and reporting on the assurance arrangements and governance structures on which the Board places reliance. The Audit Committee scrutinises the Trust's overarching assurance framework, including risk management and performance management systems, challenging poor or unreliable sources of assurance, and managers themselves when controls are not working or data is unreliable.

66.2. The Audit Committee has a particular role in scrutinising financial controls, but its remit extends across all of the organisation's activities. It also reviews the end of year disclosure statements including the Annual Report and Accounts, and the Quality Report/ Accounts, prior to submission to the Board.

66.3. The Audit Committee is supported in its activities by the Internal Audit Service and a team of External Auditors who provide assurance and insight into the Trust's management arrangements. The Audit Committee is empowered to receive any information it requires or a report from any member of staff on any matter it determines, within its Terms of Reference.

67. Membership and attendance

67.1. The Board appoints members of the Audit Committee, who must be Non-Executive Directors.[4] During the year, the following have served on the Audit Committee-

- Anne Dray (Chair), until 31st December 2019
- Andrew Light (Chair), from 1st January 2020
- Peter Noble
- Martyn Taylor

67.2. The Committee is supported by Sam Simpson, the Director of Finance, colleagues from the Finance and Governance Departments, and the Trust Secretary. It is also supported by representatives of the external Auditors (KPMG), the Internal Audit service (MIAA), and the Local Counter-Fraud Service (MIAA).

67.3. During the year, attendance at the meetings of the Committee was as follows-

	April 2019	May 2019	July 2019	Sept 2019	Nov 2019	Feb 2020
Anne Dray	✓	✓	✓	✓	✓	
Andrew Light						✓
Peter Noble	Apologies	Apologies	✓	✓	✓	✓
Martyn Taylor	✓	✓	✓	Apologies	✓	✓

[4] See *National Health Service Act 2006*, Schedule 7, para 23(6)

68. Our work during the year

68.1. During the last year, the Committee has continued to provide support and assurance to the Board related to the various control systems in place for the Trust. This has been undertaken mainly through the assurance work undertaken by the Internal Audit service, and which is outlined below. The Committee has particularly focused on those areas where the Internal Audit service has found less than adequate controls; our approach has been to seek assurance that Trust management recognises the issues identified, and has put in place a series of responsive actions which can reasonably be expected to resolve the issues within a reasonable time-frame.

68.2. The Committee has also been engaged with the work of the Local Counter-Fraud service, as detailed below, to ensure that there is appropriate focus and assurance that we are protecting public funds provided to the Trust for the public service, and taking action where fraudulent activity is suspected or proved.

69. The structure and work of Internal Audit

69.1. The Trust maintains an Internal Audit service, which is provided on a contracted basis by Merseyside Internal Audit Agency (MIAA). MIAA provides a professional internal audit service which maintains the appropriate professional registrations, and is subject to national regulation as such. The MIAA engagement is led by a Managing Director, with the day-to-day engagement led by the audit manager and supported by various specialist staff.

69.2. The Internal Audit service works to an annual plan which is agreed with the Committee prior to the start of the year. The annual plan is constructed in consultation with the Executive team, and within a rolling overall three-year framework which is designed to ensure that all relevant areas are reviewed within that timescale. Compliance with the plan is monitored at each meeting of the Committee, and Committee approval is required for all changes to the plan. The Committee's workplan also indicates where the Committee expects to receive the various reports from reviews by the Internal Audit service, and (where appropriate) dates where the Committee has requested updates on actions/ further review reports from MIAA.

69.3. Internal Audit also provide a Head of Internal Audit Opinion, which contributes to the assurances available to the Accounting Officer and the Board, and which underpins the Board's own assessment of the effectiveness of the organisation's system of Internal Control. This Opinion assists the Board in the completion of its Annual Governance Statement, along with considerations of organisational performance, regulatory compliance, the wider operating environment and health and social care transformation.

69.4. During the year, the Trust conducted an open competition for the provision of internal audit services (together with Local Counter-Fraud services), in line with the requirements of the *Public Contract Regulations 2015*. The competition was conducted on the basis of inviting expressions of interest from those who were on the 'pre-cleared' list maintained nationally for the provision of internal audit services to the NHS. Two firms applied and were assessed; following that process, the Audit Committee agreed to re-appoint MIAA to provide the services for a five-year contract period.

70. Our assessment of the external audit process

70.1. The Committee will be assessing the effectiveness of the external audit process following the completion of the audit with the issue of the Auditor's report and opinion.

This will then be the subject of a report to the Council of Governors in September, for consideration in association with this Annual Report and Accounts. The Committee anticipates seeking assurance that the external audit process was conducted in accordance with relevant regulations, and was appropriately planned and conducted.

70.2. The fees paid for the external audit for the year ended 31st March 2020 were £63,000.

70.3. The appointment of the external auditor is a matter for the Council of Governors, although it is advised by the Audit Committee. The external auditor is appointed through a tender process, as required by the *Public Contracts Regulations 2015*; to date, Council has agreed the period of appointment should be for a period of 5 years. The current appointment of the external auditor (KPMG LLP) was extended by Council by one year to October 2020.

70.4. It has been intended to operate the tender process for external audit services through the first half of the 2020 calendar year, with a view to inviting Council to make a formal decision on appointment in June 2020. Owing to the impact of the COVID-19 pandemic, and in particular the consequent challenges in operating a tender process satisfactorily with reduced capacity in the Trust, the Audit Committee is recommending to Council that the current appointment of KPMG be extended for a further year to October 2021, so that the tender process can be run in the first half of the 2021 calendar year. The Committee has been advised that, in the exceptional circumstances prevailing, this course of action is compliant with the Trust's obligations under the *Public Contracts Regulations.*

71. Other services provided by the Auditors

71.1. During 2018-2019, KPMG LLP provided no non-audit services to the Trust.

71.2. If there were to be a proposal for KPMG LLP to provide non-audit services, appropriate controls are in place to ensure that it does not affect the independence of the provision of the external audit service; and would be subject to the prior approval of the Audit Committee.

72. Key issues of focus during the course of the year

72.1. The key issues that the Committee reviewed during the year, based on the reviews undertaken by MIAA, were-

72.1.1. Incident reporting, where 2 'High' recommendations were made in a review reporting "Limited" assurance overall;

72.1.2. Controls related to leave for Medical staff, where 4 'High' recommendations were made in a review reporting "Limited" assurance overall;

72.1.3. Complaints Management and Waste Management, both of which reported 'Moderate' assurance and had one 'High' recommendation.

72.2. As part of the planning for the external audit, the key risks raised by the auditors and the Committee's consideration were as follows-

Key risk	Committee response
Fraudulent revenue recognition [a]	The Committee reviewed and endorsed the assurance work proposed to be undertaken by the auditors. The Committee also noted that the assessment of low risk by the auditors (prior to audit)

Key risk	Committee response
Management over-ride of controls [a]	The Committee noted that this was, in theory, a heightened risk given the Trust's financial position and NHS Improvement's interest in the position. The Committee endorsed the proposed work of the auditors to provide assurance in this area.
Valuation of Land and Buildings	The Committee noted that the external valuer had noted that, given the economic consequences of COVID-19, there was a material uncertainty around the valuation of land and buildings. The Committee endorsed the view of the auditors that this would not require qualification of the audit opinion.
Introduction of IFRS 16 (Leases)	The Committee noted that, owing to the impact of COVID-19, a national decision had been taken to delay introduction of this standard for the public sector would be delayed to the 2021-2022 year.
Financial resilience	The Committee noted the work undertaken on the Going Concern statement, taking into account the national decision to discontinue planning processes in light of COVID-19. Given the likelihood of 'break-even' funding arrangements continuing for the following 12 months, the Committee were supportive of using the going concern basis for preparation of the accounts.

a- These are standard risks assessed for all organisations.

72.3. The Committee were assured that these issues were being appropriately addressed through management, and shown appropriately in the financial statements.

73. <u>The work of the Local Counter-Fraud Service</u>

73.1. A key part of the control systems in place at the Trust is the Local Counter-Fraud service (LCFS), which is provided on an arms-length basis by MIAA. The service is accredited by the NHS Counter-Fraud Authority, and provides a professional support service in this area. The service is maintained in accordance with the requirements of the *NHS Standard Contract.* As noted above, during the year MIAA were appointed to provide the service for a further five-year period.

73.2. The pro-active work of the LCFS is undertaken in accordance with a plan that is agreed by the Committee prior to the start of the year, and progress is monitored by the Committee at each meeting through the LCFS progress report. A significant part of the LCFS's work is reactive, responding to reports of potential illegitimate activities, investigating them, and where appropriate recommending next steps to the Trust or the prosecuting authorities.

73.3. During the course of the year, LCFS have reviewed five suggestions of the illegitimate use of funds or resources. A number of these have resulted in action, either to improve controls or take action against an individual.

73.4. A full review of the Trust's compliance with the requirements of the NHS Counter-Fraud Agency (CFA) was held during the year, with a compliance visit by a CFA reviewer. Whilst the Trust was largely compliant, this identified some areas where more work was needed. An action plan has been put into place, to be fully compliant by the end of the 2019-2020 year, and is monitored at each meeting of the Audit Committee.

Single Oversight Framework

74. Overview

74.1. The *Single Oversight Framework* issued by NHS Improvement is the framework for overseeing NHS providers, and identifying their support needs. The *Framework* considers five key themes-

- The quality of care
- Finance and the use of resources
- Operational performance
- Strategic change by the organisation
- The organisation's leadership and capability to improve ('well-led')

74.2. Based on the evaluation of the providers position against these themes, organisations are assessed in segments from 1 (providers with maximum autonomy and little support needed) to 4 (providers receiving the most support). A Foundation Trust is placed in segments 3 or 4 only where NHS Improvement (Monitor) has formally found that it is, or there is reason to believe that it is, in breach of the requirements of its Provider Licence.

75. Current segment for this Trust

75.1. As of 7th June 2020, being the last practical date before this report was approved by the Board, the Trust was listed by NHS Improvement as in Segment 3. The latest segmentation information, updated as required by NHS Improvement, is available through the NHS Improvement web-site.

75.2. The Trust remains formally subject to Enforcement conditions imposed by NHS Improvement (as Monitor), originally in 2015 and revised in 2018. The Trust has complied with all the relevant conditions that have been outlined by NHS Improvement, and there are no outstanding actions which the Trust is required to perform. However, until such time as NHS Improvement determines to formally remove the Enforcement conditions, the Trust will be regarded as subject to that level of regulatory action.

76. Finance and the use of resources

76.1. Analysis under the finance and use of resources theme of the *Framework* is based on scoring five measures from 1 (best) to 4 (worst). The scores are then weighted and combined to provide an overall score for this theme. However, as one of five themes, the overall segmentation may not directly reflect the score on finance and the use of resource. In respect of the two segments where the Trust can exercise direct influence, we have maintained the best possible rating.

76.2. Scores for this theme are calculated quarterly. For the 2019-2020 year, and for comparison the 2018-2019 year, the scores for each quarter were-

		2019-2020				2018-2019			
		Q4	Q3	Q2	Q1	Q4	Q3	Q2	Q1
Financial Sustainability	Capital service capacity	4	4	4	4	4	4	4	4
	Liquidity	4	4	4	4	4	4	4	4
Financial Efficiency	I&E Margin	4	4	4	4	4	4	4	4
Financial Controls	Distance from financial plan	1	1	1	1	1	1	1	1
	Agency spend	1	1	1	1	1	1	1	1
Overall score for quarter		3	3	3	3	3	3	3	3

Karen James
Chief Executive

17th June, 2020

Statement of Accounting Officer's Responsibilities

Statement of the Chief Executive's responsibilities as the Accounting Officer of Tameside and Glossop Integrated Care NHS Foundation Trust

The *National Health Service 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 Directions which require Tameside and Glossop Integrated Care 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 Tameside and Glossop Integrated Care NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care's 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.

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 him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of 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.

Karen James
Chief Executive

17th June, 2020

Annual Governance Statement

1. Scope of responsibility

1.1. 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.

2. The purpose of the system of internal control

2.1. 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 Tameside and Glossop Integrated Care 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 Tameside and Glossop Integrated Care NHS Foundation Trust for the year ended 31 March 2020, and up to the date of approval of this Annual Report and Accounts.

3. Capacity to handle risk

3.1. The effective management of risk, and its reduction where possible, is a key priority at all levels of the Foundation Trust. It is a key component of all governance discussions, with the Board Assurance Framework and high-level entries on the Corporate Risk Register being reviewed and challenged at every meeting of the Board of Directors and of Board Committees. The Audit Committee regularly reviews and challenges the control systems underlying the management of risk in the Foundation Trust.

3.2. Operationally, risk management is led by myself and the Executive Directors, who have responsibility for the overall management and mitigation of risks within their areas of responsibility. I lead the overall Risk Management group for the Foundation Trust, which has an operational overview of risk across the Trust to support the Board and its Committees. All staff have both the opportunity and expectation of reporting all perceived risks within their area of operation, which are then subject to a process of review, validation and (if appropriate) scoring and management. Management of risk is undertaken at a level appropriate to the potential impact of the risk, including departments, divisions and on a cross-Trust basis. Additionally, the Board maintains a Board Assurance Framework, reflecting the risks identified to the achievement of the Trust's strategic objectives and how they are managed.

3.3. Risk management is a key part of the Trust's training for all staff, to ensure that all staff can identify and address risk within their area. Managers receive training appropriate to their grade, in order to have an appropriate oversight of risks and their management within their area, and to support more junior colleagues. Overall responsibility for ensuring that appropriate training and guidance is available sits within the Integrated Governance Unit, who are also responsible for ensuring that reporting to the Board and Board Committees is appropriate and complies with the conditions of the NHS Improvement Licence related to risk management.

4. The risk and control framework

4.1. The Trust has adopted a formal risk management strategy, which sets out how the Trust will seek to identify, control and manage risk. This strategy recognises that the Trust provides services that carry, in some cases, an inherently high level of risk; and seeks to manage and mitigate that risk as far as possible. At a corporate level, the strategy seeks to identify and manage the risks faced by the Trust in the local, regional and national environment, recognising that the Trust operates within a national service and within an environment which has significant political interest and controversy at all levels.

4.2. The aim of the risk management strategy is to support the Board, Board Committees and operational management to identify risk, evaluate its potential effect, and then manage that down to a level that is either acceptable or irreducible. The strategy recognises that, for some risks, it may not be possible to reduce the risk to a level that the Board would regard as acceptable, and therefore recognises that some irreducible risk levels must be taken, given the services provided by the Trust.

4.3. All staff colleagues have a responsibility to identify potential risk within their area of responsibility, and to ensure that it is evaluated and controlled. There are comprehensive policies and systems in place for the identification and management of risks at all levels, within a single framework to ensure that the evaluation of risk is consistent and reliable. Risks are managed at the level appropriate to the identified impact and likelihood of the risk eventuating, including departmental, divisional and cross-Trust structures. Overall responsibility for management of operational risks is undertaken by the Risk Management Group, led by myself, to ensure that there is appropriate leadership and accountability for the management of risk. The Board and Board Committees are regularly updated on high-rated risks on the operational risk register, enabling them to challenge and assess the level of assurance available.

4.4. The Board also maintains a Board Assurance Framework, which identifies the risks to achieving the strategic objectives that have been set by the Board for the Trust. Each identified risk is allocated to the oversight of a Board Committee (or occasionally the Board itself), and that Committee is responsible for regular challenge to the assessment and management of the allocated risks. Details of both the Board Assurance Framework, and the higher-rated risks on the operational risk register, are reported to each meeting of the Board of Directors for consideration, challenge and assessment of available assurance. During the year, the Trust has started reviewing and revising the way that the Board Assurance Framework is presented to the Board and Committees, to enable better understanding of the information presented.

4.5. The Board recognises that, working in a healthcare environment, many of its day-to-day activities will carry relatively high risks that are not susceptible to effective reduction. This arises from the specialist nature of many medical procedures, and also the need to provide care and treatment for individuals who are undergoing acute health challenges.

4.6. Within that context, the Board has adopted an approach to desirable risk (the ‘risk appetite’). The assessment of each risk includes an assessment of the risk appetite in relation to that risk, which seeks to identify the Trust’s willingness to accept risk in that area; and a target score is set, which seeks to express the irreducible minimum risk associated with the activity (the point where the decision becomes to accept the risk or cease the activity). Each assessment of risk appetite and target risk score is reviewed regularly at the appropriate level of governance, with the Board reviewing the assessments for risks on the Board Assurance Framework on a regular basis.

The Board annually reviews the overall approach to risk appetite, as part of assessing the strategic risks following approval of the year's corporate objectives and key success criteria.

4.7. Ensuring that quality is at the heart of everything that the Trust does for patients is a key activity for the Board. This is undertaken in a number of ways;

4.7.1. At each scheduled meeting, the Board receives a detailed Integrated Performance Report, which includes performance data for all significant areas of activity. Areas that have failed to achieve the agreed or nationally-set targets are subject to exception reporting, which outlines the details of the failures, any identified underlying causes, and the steps being taken by management to bring performance back to target. The Board has the opportunity to challenge the steps proposed, and to require further or different actions to be taken in order to address these challenges.

4.7.2. The Board has appointed a Quality and Governance Committee, which is responsible to the Board for detailed oversight of management actions to ensure the quality of services; and for recommending to the Board strategic actions to improve service quality. The Committee meets on a monthly basis, and exercises detailed oversight of the quality of services provided by the Trust; including reviewing deaths and serious untoward incidents, quality performance data, and feedback from patients. The Committee also regularly triangulates its findings through scheduled 'walk-about' visits to operational areas such as wards, in order to ensure that the 'lived experience' of providing and receiving care is reflected in the information received. The Committee reports both findings and recommendations to the Board at each Board meeting following a Committee meeting, for consideration and approval. At each scheduled meeting, the Board receives an update on serious incidents that are under investigation, together with confirmation that the Duty of Candour is being implemented for relevant incidents; and a 'patient story' to understand the journey and experience of care at the Trust.

4.7.3. The Board has also appointed a Workforce Committee to ensure that there is a key focus on ensuring the workforce is sufficient in numbers and skills to provide safe and quality care. The Committee regularly reviews performance and future strategy on workforce matters, and during the year has updated the strategy taking into account the national guidance in *Developing Workforce Safeguards.* The Board regularly reviews information of nursing staffing on a ward basis, together with details of new and continuing investigations where staff suspensions have been judged necessary

4.7.4. As part of its responsibility to have oversight of relevant control systems, the Audit Committee reviews both the governance systems in place and the various data reporting systems: in order to give assurance that they are reliable and provide the necessary information, in a timely way, to comply with the Trust's obligations under the NHS Improvement Licence. The Committee is supported in this by the Internal Audit service, who undertake arms-length reviews to a programme agreed by the Committee: and which indicate both available levels of assurance, and actions to increase assurance. Management are required to formally respond to the recommendations, and the Audit Committee regularly reviews progress to ensure that actions are delivered by management to the agreed timetable.

4.8. Performance information is subject to regular review, to ensure that it is reliable and continues to meet the requirements of the Trust. Performance information produced

through data systems is regularly triangulated against the 'lived experience' of care, using qualitative information from sources such as complaints and complements, national and local surveys of patients experience (including the 'Friends and Family' test), and triangulation visits from Directors and senior managers. Mismatches are challenged in a variety of forums, and it is a responsibility of the Director of Performance to ensure that mismatches are explored to ensure that the data reporting systems remain reliable. Performance reporting systems are also subject to regular review by both the Internal and External Audit services.

4.9. Compliance with the Care Quality Commission's requirements, within the limits set by the *Health and Social Care Act 2008 (Regulated Activities) Regulations 2014*, is a statutory requirement on the Trust as a provider of healthcare services. The Quality and Governance Committee regularly reviews the Trust's compliance with these requirements, including reviewing progress against the action plan agreed by the Board following the CQC full inspection in 2019. The three year review plan for Internal Audit also includes regular reviews of the controls in place to ensure compliance with those requirements, which advise the Board about the levels of assurance available.

4.10. Management of risk to the security of the data held by the Trust, both on patients and staff colleagues, is a key activity. Data risks are included within the overall risk management process, and regularly reviewed. A comprehensive suite of policies and procedures are in place to ensure that data is handled appropriately and with care, and these are supported by a comprehensive programme of training for staff. The Trust participates in the annual assessment of our compliance through the national Data Security and Protection Toolkit (which has replaced the Information Governance Toolkit), and our compliance has been reviewed by the Internal Audit service, which reported Substantial Assurance in April 2020.

4.11. Where a data security incident is identified, it will be treated as a serious incident and investigated accordingly. All incidents meeting the requirements of the Information Commissioner are reported to their office as a matter of course, and that office may also choose to investigate independently. During the year, no incidents have required reporting to the Information Commissioner, and no concerns have been raised by their office.

4.12. Unusually, at present the Trust faces only one major risk- the impact of the COVID-19 pandemic on the provision of services. The key risk factors are-

4.12.1. Workforce and Staffing
4.12.2. Clinical Equipment, Personal Protective Equipment, Environmental and Procurement
4.12.3. Financial
4.12.4. Effectiveness, Safety Capacity and Demand
4.12.5. Leadership, Structure and Command
4.12.6. Recovery and Post-Pandemic impacts.

4.13. The response to this risk is being undertaken through the Emergency Preparedness, Resilience and Response (EPRR) route, with national leadership and co-ordination provided by NHS England/ Improvement and the Department of Health and Social Care. Internally, the Trust has adopted a Bronze/ Silver/ Gold Command structure, with clear levels of responsibility. The Board has approved temporary changes to the Scheme of Delegation and related documents, to reflect the temporary command structure and to ensure that necessary expenditure for COVID-19 work can be approved, whilst retaining appropriate levels of control.

4.14. In the Tameside area, we are joining with our partners (the CCG and Tameside MBC) to undertake the 'Care Together' programme with the aim of both improving the services provided and delivering them in a more efficient way, to the benefit of all three public services. Care Together also has local delivery of the Greater Manchester regional efficiency plans, under the GM Health and Social Care arrangements.

4.15. The Trust Efficiency Programme (TEP) has been developed to ensure that the Trust continues to improve its efficiency, whilst maintaining high standards of patient care and experience. It is informed by the Model Hospital research, which has identified areas where the Trust can seek to improve processes and thereby reduce expenditure. During 2019-2020, the TEP programme delivered £11.682 million in efficiencies, of which £7.028million were recurrent. The Trust has developed a further challenging TEP programme for 2020-2021, which has been delayed under national guidance as a result of the COVID-19 situation. Final approval for 2020-2021 planning, in line with that guidance, is expected later in 2020 but a deadline has not yet been confirmed.

4.16. During the course of the year, the Trust has received the outcomes of its latest inspection by the Care Quality Commission (CQC). Overall, the CQC rated the Trust as 'Good', with some areas rated as 'Outstanding'; and also gave a 'Good' rating for the strand "Is [the Trust] well-led?". The Board has considered the detailed feedback in the report, and plans are in place for further improvement. The Board also commissioned a development programme undertaken by external experts from Deloitte, which has been running through the year. Owing to the need to cease non-essential business for the COVID-19 period, this programme will now be concluded in the 2020-2021 year.

4.17. Under the NHS Improvement (Monitor) Licence granted to the Trust, the Trust has obligations (set out in Licence Condition FT4) to ensure that it has appropriate and effective systems of governance in place. The Trust is obliged, at least annually, to review the systems of governance in place, identify the key risks to their effectiveness and the mitigations of those risks, and make a declaration to NHS Improvement regarding whether or not the Trust is compliant with the requirements.

4.18. The Board has considered the provisions of Condition FT4, the risks to ensuring compliance, and the available mitigations. This review took into account that the Trust is subject to Enforcement Undertakings, based on identified failings to comply with the requirements of the Licence. The Board identified the following as the principal risks to compliance with these requirements;

Key risk	Mitigation
Ensuring that the Trust is a going concern (FT4.4(d))	Careful and detailed financial planning Working in partnership arrangements within the locality (Care Together) and regionally (Greater Manchester) Continuing open dialogue with Commissioners on future direction Challenging efficiency schemes based on Model Hospital learning Close management and Board monitoring of performance against plans

Delivery of agreed business plans (FT4.4(g))	Detailed management structures to review progress and hold to account Detailed monthly reporting to governance through the Finance and Performance Committee Reserve plans for Financial Recovery Board arrangements if performance does not match agreed plans Regular performance updates to regulators
Delivery of high-quality care within a challenging financial environment (FT4.5)	Quality Assurance mechanisms for efficiency schemes Involvement of Medical Director and Chief Nurse in financial management discussions and setting of financial plans Involvement of clinical colleagues in the development and delivery of individual efficiency schemes

4.19. As noted above, the key risk currently faced by the Trust is COVID-19. As a result, the Trust's planning processes for 2020-2021 have been suspended, in accordance with the directions given by NHS England/ Improvement. The Trust is being funded on a 'break-even' basis, under the exceptional national arrangements, for the period of the COVID-19 pandemic.

4.20. The Board continues to exercise clear oversight of the activities of the Trust, receiving detailed reporting on performance, risk and finance at each scheduled meeting. In accordance with the need to promote transparency in the public service, all matters are considered by the Board in public, unless to do so would be prejudicial to the public interest. The Board is supported by a comprehensive Committee system, which undertakes detailed review of performance and challenges within their areas of responsibility; and by the work of the Executive team and senior management reporting to them.

4.21. The Board has approved a Risk Management Strategy and Policy. This sets out the high-level approach to the recognition, management and mitigation of risk in the Trust, and the relevant reporting arrangements. The Board Assurance Framework, recognising the key strategic risks faced by the Trust, is reviewed at every scheduled meeting by the Board, supported by detailed review of risks within their area by Board Committees. Operational risks are actively managed by the Executive Directors, through the Risk Management Committee that reports directly to the Quality and Governance Committee.

4.22. During the year, the internal audit service have undertaken a review of the risk management culture within the Trust, together with the regular review of the operation of the Board Assurance Framework. The review of the Board Assurance Framework reported that Significant Assurance was available. Owing to the intervention of COVID-19, the review of risk management culture was paused part-way through the process and will report in 2020-2021.

4.23. During the year, the Board received a 'Good' rating from the Care Quality Commission for the 'Is [the Trust] Well-Led?' strand of inspection. This has provided further assurance to the Board that there are appropriate systems and controls in place to ensure compliance with the requirements of Condition FT4 in the provider licence.

4.24. The Corporate Governance statement, and the judgements made by the Board in agreeing it, have been supported through a number of channels-

4.24.1. The Directors are intimately involved in the governance of the Trust through their work at the Board, and also as members of the Board's Committees. In

reaching a conclusion on the judgements in the statement, they brought these experiences to bear, particularly those of the Non-Executive Directors who have a particular responsibility for providing challenge to proposals brought forward.

4.24.2. As part of their regular programme of work, the Internal Audit service has reviewed the effectiveness of the governance systems in place, and has reported to myself and the Audit Committee. These findings have formed part of the evidence base that informed the judgements reached by the Board.

4.24.3. During the course of the year, the Board has undertaken a programme of development, led by external consultants from Deloitte and focused on addressing key areas of Board responsibility. The skills available to the Board have been reviewed and considered as part of the process of appointing new Non-Executive Directors, and also in connection with recommendations to Council regarding the re-appointment of retiring Directors.

4.24.4. The Board is responsible to the Council of Governors, and has benefited from frank feedback and sometimes challenge from Governors about the way that it has sought to discharge its duties. Governors have regularly attended the public sessions of the Board's meetings, and also meetings of the Boards Committees.

4.25. Through these mechanisms, the Board has gained reasonable assurance that the Corporate Governance Statement is a fair representation of the governance position of the Trust at the date it was agreed. The Board has recognised that those factors identified by NHS Improvement, in the Enforcement Undertakings, as breaches of the Licence represent the key risks to compliance until those undertakings are discharged, as reflected in the risks described at 4.18 above.

4.26. The Trust recognises that it is vital to ensure that risk management is embedded throughout the Trust. There are a range of systems and procedures in place that support this embedding, including-

4.26.1. The Trust continues to encourage all staff, at all levels, to identify and report incidents, including 'near misses'. There is a comprehensive system in place to enable colleagues to report incidents, supported by dedicated resource that reviews all reports and identifies the appropriate level for response. Learning from incidents is a key part of the process, and each colleague who reports an incident is entitled to a response that identifies both the response of the Trust and how learning will be taken to prevent recurrence of that type of incident. During the course of the year, the Trust has identified the need to improve the feedback to individuals and has worked to make this more effective.

4.26.2. Similarly, there are systems in place to enable risk at all levels to be identified, from the 'shop floor' to the Board of Directors. Risks are regularly reviewed at the appropriate level: with the management-level Risk Management Committee, led by myself, meeting quarterly to provide oversight. Each Board Committee has responsibility for review and assessing available levels of assurance for risks within its area of responsibility, and the Board regularly reviews both the Board Assurance Framework and the high-rated risks on the Corporate Risk Register.

4.26.3. Each death of a patient under the care of the Trust is subject to review, with the aim of identifying and sharing learning; this may be either good practice, or areas for development. There are established systems to ensure that this learning is shared and embedded across the care that the Trust provides.

4.27. The development of all projects are subject to an analysis of the risks that will be involved, which may include clinical, financial, reputational or other types of risk. Part of the process of developing an acceptable business care for a project includes both

the identification of these risks, and also the ways in which they can be mitigated or managed; clear identification of the irreducible level of risk; and identification of the risk appetite to measure that irreducible risk against, in terms of determining whether to proceed with the project. All significant projects, and all projects which will have impacts on clinical staffing, are subject to the Medical Director and the Chief Nurse confirming in writing that they are satisfied that there are not unacceptable risks to patient care as a result.

4.28. The Trust involves its public stakeholders in the management of risks in a number of ways. Many of the risks are being managed in association with the partners in the local health economy, which includes the elected members of Tameside Council, High Peak Borough Council and Derbyshire County Council. With those partners, we participate in the Tameside engagement forum; designed to enable all of the partners to engage the public on all developments in a joined-up way, and enabling that public consideration to be holistic. This does not replace the statutory requirements on consultation that apply for some areas, but is intended to complement and assist the development of policy, particularly taking into account the Trust's obligations under Section 242 of the *National Health Service Act 2006*. Recognising that the Tameside arrangements do not directly apply to all services in the Glossop area, we also seek opportunities to engage with the public in that area, together with engagement with the two Local Authorities with responsibility for the area.

4.29. The Trust is proud of the care and services it delivers. At the centre of this important work are our staff, who support patients and service users in their place of residence, neighbourhoods and hospital wards. The continuing challenges facing the supply and retention of the NHS's workforce are well documented, with demand for healthcare staff continuing to exceed supply, despite increases. The Trust have risen to this challenge, through progressing and developing flexible approaches to roles, which improving efficiencies. Innovative ways of working have been introduced to achieve this, alongside introducing new roles and developing existing ones. This is a challenging time, but one that brings significant opportunities for workforce development.

4.30. However, we recognise that these ongoing challenges require the Trust to ensure services achieve best outcomes against the premises of achieving financial balance; no impact on the quality of care; and maintaining the quality of patient, service user and staff experience. The Trust has adopted a number of controls to ensure that it is able to do so:

4.30.1. We have workforce governance systems in place. Reflecting national guidance and expectations, the Trust has utilised the NHS Improvement Workforce Safeguards to ensure we use best practice in effective staff deployment and workforce planning. During this year, the Trust volunteered to support NHS Improvement with a pilot framework to support Trusts with meeting the requirements of the Workforce Safeguards. In February 2020, The NHS Improvement team successfully visited the Trust to pilot the framework and assess our compliance with the standards. As a result of this review, the Trust's workforce plan is being developed in accordance with the feedback received.

4.30.2. The Trust is using the advice in the safeguards to continuously review governance issues related to redesigning roles and responding to unplanned changes in workforce; and in the annual assessment of the effectiveness of workforce safeguards.

4.30.3. Rosters are developed in advance by the operational teams, based on agreed establishments. Staffing meetings are regularly held to look ahead, identify, and

act on any changes in capacity and demand since the rosters were developed. The staffing position across the organisation is reviewed and discussed at operational meetings four times each day, so staff can be re-deployed if required, or additional temporary staff requested, to ensure safe staffing levels are maintained across all area: and key workforce assurance markers are considered and discussed by the Executive Management Team each week. There are appropriate procedures and controls in place to ensure that, where required, additional staff can be sourced in the short-term, whilst ensuring that there is appropriate senior management or Director authorisation. Staffing levels for each area in the Trust are set as part of the annual planning process, in accordance with results from the use of any relevant evidence-based tools, triangulated with professional judgement and outcomes. These are subject to regular review through the Trust's management and governance processes, and if required establishment adjustments and proposals are considered and quality impact assessed to ensure the quality and safety of provision.

4.30.4. The Board has established a Workforce Committee, chaired by a Non-Executive Director. The Board receives a regular 'safe staffing' report at each scheduled public Board meeting, in line with the national guidance; and this is subject of more detailed reviews through the Board's Committees. The Quality and Governance Committee triangulate quality data, and ensure that workforce considerations are included in lines of enquiry and assurance processes. Recruitment of staff, particularly in the nursing and midwifery area, is undertaken in partnership across Greater Manchester utilising an overarching framework.

4.31. The Trust is expected to comply with the recommendations in *Developing Workforce Safeguards*, published by NHS Improvement. The Trust's actions to comply with these recommendations are detailed in the table below:

Effective workforce planning	The Trust has set an establishment as part of the annual planning process, taking into account the factors mentioned in *Developing Workforce Safeguards*.
	The Trust seeks to minimise the use of agency staff, and has appropriate control systems in place to ensure that agency use is subject to appropriate scrutiny. The Trust has spent less during the 2019-2020 year than the agency 'cap' set by NHS Improvement.
	The Board continues to maintain a strategic focus on ensuring that the Trust has a workforce that can deliver quality of care, together with oversight of delivery.
Deploying Staff Effectively	A Workforce Dashboard has been implemented, that enables the Workforce Committee to review performance and plans in detail.
	The reporting and planning arrangements in place seek to triangulate staffing against a number of other factors, including the quality of care and financial impacts.

	There is a clear allocation of time to ensure that the Board reviews, discusses and agrees actions as a result of any identified changes.
	There are standard procedures and controls in place to enable immediate challenges to be addressed appropriately.
Responding to challenges	The Executive team reviews agency use and areas of challenge on a weekly basis.
	The Board, and its Committees, regularly review the 'safe staffing' report and the underlying data, in a holistic way against other available data.

4.32. The Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission.

4.33. The Foundation Trust has published on its web-site an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) within the past twelve months, as required by the '*Managing Conflicts of Interest in the NHS'* guidance.

4.34. 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.

4.35. Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

4.36. The Foundation Trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

5. Review of economy, efficiency and effectiveness of the use of resources

5.1. I and the Trust recognise that Parliament has set out a requirement for the Trust to ensure that the services that are provided have due regard to the economy, efficiency and effectiveness of the use of public resources. The Trust undertakes a number of activities to seek to ensure the Trust's activities deliver all three of these requirements, each of which Parliament has given an equal weighting.

5.2. Ultimate responsibility for ensuring that the Trust complies with this legal duty rests with the Board of Directors, through setting the strategic direction of the Trust, together with monitoring and oversight of performance. This work is supported by the Board's Committees, which look more closely at both performance and strategic direction and provide advice and recommendation to the Board. In particular, the Finance Committee has a close oversight of the Trust's efficiency plans which closely support the delivery of these responsibilities. The Quality and Governance Committee oversees the quality impacts, which impacts on the efficiency and effectiveness of delivery of services: both preventive of illness and treating illness when it arises.

5.3. The Trust's executive leadership is also aware of the need to ensure that the

provision of services meet these requirements. When considering service developments, consideration is given to how the proposals will impact on these requirements, both when proposals are being developed and considered through governance for approval. In line with regulatory requirements, efficiency is recognised through the need for quality impact approval from the Medical Director and the Chief Nurse for all significant projects. When reviewing implementation, consideration is given to how well the project or development has advanced these requirements, and where further improvements might give better achievement of them.

5.4. The Trust maintains an internal audit service, part of whose remit is to review the delivery of economy, efficiency and effectiveness in the various reviews they undertake during the year. The Internal Audit service is formally accountable to me as the Accounting Officer, but operationally reports to the Audit Committee; and has direct access to both myself and the Audit Committee (through its Chair) whenever opportunity requires. Details of the work of the Internal Audit service are provided in the Annual Report.

5.5. As part of their annual work, and in accordance with the requirements set out by HM Treasury and NHS Improvement (Monitor), the external auditors review and express an opinion on compliance with the duty to provide services that are economic, efficient and effective. This opinion is made available to the Audit Committee in draft, and is formally given to NHS Improvement. For 2019-2020, the external auditors are reporting that the Trust had adequate arrangements to secure economy, efficiency and effectiveness, except in relation to achieving a break-even position in the foreseeable future

6. Information governance

6.1. During the year, there were no serious incidents related to information governance identified.

7. Ensuring Data Quality

7.1. The Trust recognises the importance of having effective data collection and analysis, in order to understand the operation of the services and enable the Board to effectively judge what actions are needed to improve performance. The Trust has in place a number of systems for the collection of data regarding the operation of services, and these are automated where possible in order to reduce the possibility of human error. The Executive team receives every week a full suite of performance data from across the Trust, which is reviewed to identify any areas which are starting to be a concern and take immediate action to address them. The Board and its Committees review a more selective set of data, which enables them to focus on the key areas of strategic performance, together with exception reporting to identify the underlying cause of underperformance and the steps being taken to bring performance back to the required standard.

7.2. The Trust has a clear policy process in place, to ensure that the care provided to patients is safe and to the highest standards. It is important, in this context, to keep in mind that the general approach is that policies should normally be followed; but that it is recognised that, in some circumstances, the professional judgement of clinical colleagues will justify a departure from policy in the individual case and for the best interests of the patient. Policies are subject to a formal process of development, approval and regular review, to ensure that they continue to reflect best practice. In respect of each patient, the policy is to provide a care plan that responds to the individual needs of the patient, with a view to ensuring that they are cared for in a way that minimises the period and impact of their condition. In

appropriate cases, plans will be prepared on a multi-disciplinary basis, including colleagues from other agencies, in order to ensure that all relevant conditions are taken into account and that care is planned across agencies.

7.3. Having access to colleagues with the necessary skills and experience is also crucial in order to ensure that patient care is provided in a safe and appropriate manner. The Board, supported by the Workforce Committee, regularly reviews the level of staffing available in the various areas of the Trust: in respect of nursing and midwifery staff, this is prepared in accordance with the guidance of the National Quality Board and NHS Improvement, and against local standards for medical and other staff. The Trust has also put into place workforce plans, taking into account anticipated acuity and demand levels, with the aim of ensuring that staff with the appropriate skills and experience are available when required. The Board has also sought to minimise the usage of agency staff, taking into account the national policy: and this is reviewed by the full Board at each scheduled meeting.

7.4. The Trust has developed its capability for Referral-to-treatment (RTT) time monitoring and reporting, using its data warehouse and bespoke reporting tool and based on national RTT guidance, to ensure that it is able to maintain compliance with the requirements. The data used to generate these reports is subject to rigorous, and routine, validation.

8. Review of effectiveness

8.1. 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 other Board Committees; and a plan to address weaknesses and ensure continuous improvement of the system is in place.

8.2. The Board continues to recognise the importance of having effective internal control systems, for both financial and clinical systems. Our aim is to ensure that we have the necessary systems and controls in place to give reasonable assurance regarding the quality, efficiency and effectiveness of the Trust's services.

8.3. The systems of internal control are under continuous review, in order to ensure that they continue to meet the requirements of the Trust and appropriate standards for the management of public funds. During the year, the Board approved further changes to the Standing Financial Instructions, with the intent of increasing the seniority of authorisation required for spend at a given level, reflecting a current need to increase the overall level of control applied in the Trust. Since the year-end, the Board has approved temporary changes in the control structure, specifically limited to spending for and the period of the COVID-19 incident, to ensure that the Trust can respond with appropriate speed whilst maintaining robust controls.

8.4. The Board has overall responsibility for the operation of the Trust, the effectiveness of the systems of internal control, and for ensuring that public funds are used responsibility in the provision of services. Supported by the Board Committees, the Board regularly reviews performance, both financial and operational, to ensure that the agreed plans are progressing as envisaged and that there is reasonable assurance that the targets set by the Board will be met. It also reviews issues such

as patient experience, recognising that part of the control environment for an NHS provider is to ensure that patients receive the best available care and service whilst with the Trust.

8.5. The Audit Committee has primary responsibility for oversight of the controls systems for the Trust, including financial and governance, and for advising the Board as to the available levels of assurance. It is supported in this work by the internal and external audit providers, the Local Counter-Fraud Service (LCFS), and work undertaken by other Committees (as discussed below). Key functions that it undertakes which enable it to judge the amount of available assurance include-

8.5.1. The regular reports of the Internal Audit service, which provide specific advice on the level of assurance available in relation to the area reviewed. These also enable the Audit Committee to review management's response and proposed actions to the review's findings, and to form a view about the level of assurance those responses provide

8.5.2. Advice from both the internal and external audit providers on the environment in which the Trust is operating

8.5.3. The work of the LCFS which provides evidence for the Committee to judge the available assurance for systems to detect and prevent fraud and misappropriation on the public funds made available to the Trust

8.5.4. Regular review of the main documentation related to the Trust's control systems- this will usually cover the Standing Financial Instructions, the Schedule of Delegations, and the Schedule of Matters Reserved to the Board of Directors (for decision).

8.6. As indicated in the detailed section of the Annual Report, the Committee has met regularly through the year and has provided positive assurance to the Board from its work.

8.7. The Quality and Governance Committee operates to provide assurance to the Board about, *inter alia*, the systems of control in place to ensure that the quality of patient care and experience is as high as possible. The Quality and Governance Committee regularly reviews information related to the effectiveness of the control systems, including reports about serious incidents, patient experience, and complaints related to services. It also reviews a range of external reporting, including from HM Coroner, professional bodies, and professional regulators such as the General Medical Council and the Nursing & Midwifery Council. In its work through the course of the year, and in particular when reviewing the draft Quality Report for the Trust, the Committee is able to assess and report to the Board on the levels of assurance available, and areas for further consideration or development.

8.8. The Quality and Governance Committee also has oversight on behalf of the Board of clinical audit activities, which form an important part of the Trust's work. A plan for clinical audits is agreed at the start of every year, and progress is monitored through the course of the year to ensure that the work plan is being appropriately prosecuted. The majority of the programme reflects national audit programmes and similar, which the Trust is expected to participate in, and details of which are provided in the Quality Report. The Trust does seek to ensure that it obtains learning and implements change as a result of the work of clinical audit, and the Quality and Governance Committee is responsible for assessing the assurance available and reporting to the Board.

8.9. The Trust retains an internal audit service provided by an external provider, Mersey Internal Audit Agency (MIAA). MIAA is an internal NHS service, provided by a partnership of Trusts. The service is provided in accordance with the relevant

national standards, and the Head of Internal Audit has direct access to both the Audit Committee and myself as the Accounting Officer. MIAA undertakes a planned programme of reviews across various areas of the Trust, within the context of a three-year framework. That framework is regularly reviewed in ensure that areas for review are selected based on perceived risk and that all relevant areas are covered in the review period. The detailed annual plan is reviewed and approved by the Audit Committee.

8.10. MIAA's individual reviews are undertaken on an arm's-length basis from the Trust's management, and are reported to the Audit Committee with an assessment of the overall assurance available, actions that are recommended to improve the control environment, and an assessment of the risk levels related to those actions. The reports are accompanied by a statement by Trust management, setting out how they intend to address the report and detailed actions to be taken to improve the control environment. The Audit Committee is authorised to review the reports, and where concerned regarding the response of management may require further action or report to the Board. Agreed actions are monitored in a co-operative process between MIAA and the Governance Department; and progress reported to the Committee at least every six months. For the 2019-2020 year, the Head of Internal Audit reported to the Audit Committee that there was Substantial Assurance available that that there was a good system of internal control designed to meet the organisation's objectives, and that controls were generally being applied consistently.

9. Conclusion

9.1. No significant internal control issues arose during the year ended 31st March, 2020; or in the period from then to the date of the making of this statement.

Karen James
Chief Executive

17th June, 2020

Independent auditor's report

to the Council of Governors of Tameside and Glossop Integrated Care NHS Foundation Trust

. REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

1. Our opinion is unmodified

We have audited the financial statements of Tameside and Glossop Integrated Care 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	£4m (2018/19:£4m) 1.66% (2018/19: 1.69%) of total operating income

Risks of material misstatement		vs 2018/19
Recurring risks	Valuation of land and buildings	◀▶
	Fraudulent revenue recognition	◀▶
	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.

We no longer consider there to be a material uncertainty related to going concern due to 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.

	The risk	Our response
Valuation of land and building assets Land and buildings (£126.3 million; 2018/19: £122.3 million) *Refer to paragraph 72.2 (Audit Committee Report), note 1.7 (accounting policy) and note 12 (financial disclosures)*	**Subjective Valuation:** Land and buildings are initially recognised at cost. Non-specialised property assets in operational use are subsequently recognised at current value in existing use (EUV). Specialised assets (such as hospitals) where a market value is not readily ascertainable, are subsequently recognised at the depreciated replacement cost of a modern equivalent asset that has the same service potential as the existing property (DRC). A review is carried out each year to test assets for potential impairment or revaluation. There is significant judgement involved in determining the appropriate valuation basis (EUV or DRC) for each asset according to the degree of specialisation, as well as over the assumptions made in arriving at the valuation. In 2019/20, the Trust commissioned a desktop valuation from an external valuer as at 31 March 2020. As a result, the value of land and building assets was increased by £5 million. Given the materiality and the judgement involved in determining the carrying amounts of land and buildings, this has been identified as a key audit risk. 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. **Disclosure Quality:** There is a risk that uncertainties expressed by the Trust's valuers around the impact of the Covid-19 pandemic on the market-based values of land and buildings will be inappropriately disclosed.	Our procedures included: — **Assessing valuer's credentials:** We assessed the competence, capability, objectivity and independence of the Trust's external valuer and considered the terms of engagement of, and the instructions issued to, the valuer to confirm consistency with the requirements of the Department of Health and Social Care Group Accounting Manual 2019/20; — **Methodology choice:** We tested a sample of additions to land and buildings during the year to confirm that the additions were appropriately valued in the financial statements; — **Test of details:** We critically assessed the Trust's formal consideration of indications of impairment within its estate, including the process undertaken and the adequacy of the judgements made by management in determining whether assets are impaired or surplus to requirements; — **Test of details:** We agreed movements in asset valuation per the Trust's Fixes Asset Register to the reports provided by the valuer; — **Test of details:** We undertook work to understand the basis upon which movements in the valuation of land and buildings as per the Fixed Asset Register have been identified and treated in the financial statements and determined whether they have complied with the requirements of the Department of Health and Social Care Group Accounting Manual 2019/20; and — **Benchmarking assumptions:** We corroborated significant assumptions and key data elements, used by the external valuer, to supporting evidence. — **Assessing Transparency:** We considered the adequacy of the disclosures made around the uncertainty caused by 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 valuation figures. — We ensured that the disclosures made were in line with the requirements of the Department of Health and Social Care Group Accounting Manual 2019/20, supplemented by additional guidance issued by NHS Improvement in April 2020.

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

	The risk	Our response
Fraudulent expenditure recognition Operating expenses (£73.6 million; 2018/19: £72.7 million) Trade and other payables (£23.0 million; 2018/19: £23.0 million) *Refer to paragraph 72.2 (Audit Committee Report), note 1.6 (accounting policy) and note 4 (financial disclosures).*	**Effects of irregularities:** As most public bodies are net spending bodies, the risk of material misstatement due to fraud related to expenditure recognition may be greater than the risk of fraud related to revenue recognition. There is a risk that the Trust may manipulate expenditure to meet externally set targets and we had regard to this when planning and performing our audit procedures. The key risk of material misstatements is around the completeness of expenditure, due to fraudulent financial reporting, which may arise from the manipulation of expenditure recognition (for instance by deferring expenditure to a later period).	Our procedures included: — **Control design and operation:** We assessed the design and implementation, and the operating effectiveness of the application of appropriate segregation of duties between those responsible for monitoring budgets (e.g. General Managers) and those preparing the financial statements (members of the Finance Team) to confirm that appropriate anti-fraud controls, such as segregation of duties were designed, implemented and operating effectively; — **Control design and operation:** We assessed the design and implementation, and the operating effectiveness of the application of the three way match control, which matches the purchase order to the goods received note and valid invoice, prior to making a payment to the supplier; — **Test of detail:** We tested all material items of expenditure in April 2020 cashbooks and confirmed that these items had been accounted for in the correct period, with reference to when the service was delivered, through inspection of relevant source documentation such as invoices; — **Test of detail:** We tested all invoices received in April 2020 and confirmed that these items had been accounted for in the correct period, with reference to when the service was delivered, through inspection of relevant source documentation such as invoices; — **Test of detail:** We inspected confirmations of balances provided by the Department of Health and Social Care as part of the AoB exercise and compared the relevant expenditure and payables recorded in the Trust's financial statements to the income receivables balances recorded within the accounts of other providers and other bodies within the AoB boundaries. Where applicable we investigated variances and reviewed relevant correspondence to assess the reasonableness of the Trust's approach to recognising expenditure and payables with other providers and other bodies within the AoB boundaries; — **Test of detail:** We critically assessed the allocation of asset lives with reference to the classification of the asset, consistency of the life with prior year and relevant accounting standards, to assess the impact of these asset lives on the depreciation charged against the assets in the year; and — **Test of detail:** We vouched a sample of journals posted before and after the year and to supporting documentation to confirm inclusion in the correct period and to critically assess whether any manual adjustments to expenditure were appropriate.

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

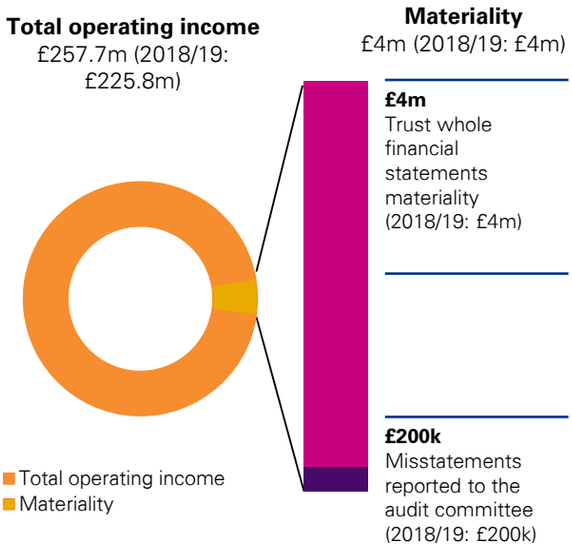
	The risk	Our response
Fraudulent income recognition Income from patient care activities (£220.1 million; 2018/19: £205.1 million) *Refer to paragraph 72.2 (Audit Committee Report), note 1.3 accounting policy) and note 3.1 (financial disclosures).*	**Effect of irregularities:** The main source of income for the Trust is the provision of healthcare services to the public under contracts with NHS Commissioners. There is a significant risk of material misstatements in respect of this income recognition, since this includes a number of significant estimates. The Trust participates in the national Agreement of Balances (AoB) exercise for the purpose of ensuring that intra-NHS balances are eliminated on the consolidation of the Department of Health and Social Care's resource accounts. The AoB exercise identifies mismatches between income and expenditure and receivable and payable balances recognised by the Trust and its commissioners, which will be resolved after the date of approval o these financial statements. Mis-matches can occur for a number of reasons, but the most significant arise where: - the Trust and Commissioners record different accruals for completed periods of healthcare which have not yet been invoices; or - income relating to partially completed period of healthcare is apportioned across the financial year and the Commissioners and the Trust make different apportionment assumptions. Where there is a lack of agreement, mis-matches can also be classified as formal disputes as set out in the relevant contract. Whilst the risk of error is low, due to the nature of the income, there is a risk of fraudulent income recognition due to the pressure on management to deliver the agreed control total.	Our procedures included: — **Test of details:** 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 the agreement to appropriate third party confirmations; and — **Test of details:** We inspected confirmations of balances provided by the Department of Health and Social Care as part of the AoB exercise and compared the relevant income recorded in the Trust's financial statements to the expenditure balances recorded within the accounts of the Commissioners. Where applicable we investigated variances and reviewed relevant correspondence to assess the reasonableness of the Trust's approach to recognising income from Commissioners. We confirmed that none of the variances had been escalated to formal disputes.

3. Our application of materiality

Materiality for the Trust financial statements as a whole was set at £4 million (2018/19: £4 million), determined with reference to a benchmark of total operating income (of which it represents approximately 1.66%) (2018/19: 1.69%). We consider operating 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 £200k (2018/19:£200k), 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 at the Trust's headquarters in Tameside and then 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, 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 and capital 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 in Note 1.2 to 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.

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6. Respective responsibilities

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 62, 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
Sustainable resource deployment	**Financial resilience (including delivery of the Trust Efficiency Programme and management of the Trust's cash position)** The Trust reported a surplus of £50k for 2019/20 which includes the receipt of £25m of provider sustainability and financial recovery funding. There is a risk that the Trust is not currently able to articulate and deliver a financially sustainable long term financial strategy.	Our work included: - Performing an analysis of the Trust's forecast position against the plan; - Considering the core assumptions in the Trust's 2020/21 Annual plan submission; - Considering the extent to which recurrent cost improvement schemes were achieved in 2019/20 and identified for 2020/21, including identifying saving plans, monitoring in-year performance and addressing any slippage; - Considering the Trust's arrangements to manage working capital, including the processes for forecasting and monitoring cash flows and delivering cash savings; - Understanding the level of cash and loan support required by the Trust from DHSC and whether the Trust has access to this funding; and - Considering the Trust's position of identifying a long term financially sustainable plan for the Trust. **Our findings on this risk area:** We were satisfied that the Trust has appropriate arrangements in place to: - Manage their financial position to meet their control total and forecast position; - Produce a realistic annual plan for 2020/21 based on appropriate assumptions; - Manage cost improvement schemes effectively to meet the planned Trust Efficiency Programme; - Manage working capital including forecasting cash flow requirements on a rolling 13 week basis; and - Monitor cash flow against forecasts to identify any unexpected variances. Existing DHSC support loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) as part of the national reforms to the NHS cash regime for the 2020/21 financial year announced by DHSC and NHS England and Improvement on 2 April 2020. The Trust has modelled the impact of the PDC dividends on their cashflow and has not identified any issues. Management have forecast a breakeven position through to 2023/24 based on the funding arrangements in place during 2020/21 due to the Covid-19 pandemic and their financial improvement trajectory and indicative financial recovery fund allocations provided by NHS England and NHS Improvement for the purposes of strategic planning. The matters outlined provide evidence that the Trust has appropriate arrangements in place in relation to the sustainable resource deployment criterion.

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 Tameside and Glossop Integrated Care 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
1 St Peter's Square
Manchester
M2 3AE
23 June 2020

KPMG

Foreword to the accounts

These accounts, for the year ended 31 March 2020, have been prepared by Tameside and Glossop Integrated Care NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed 

Name **Karen James**

Position **Chief Executive**

Date **17.6.2020**

Statement of Comprehensive Income

	Note	31 March 2020 £000	31 March 2019 £000
Operating income from patient care activities	3.1/3.2	220,050	205,136
Other operating income	3.4	37,607	20,659
Total operating income from continuing operations		**257,657**	**225,795**
Operating expenses	4	(252,210)	(236,824)
Operating surplus (deficit) from continuing operations		**5,447**	**(11,029)**
Finance income	9	74	60
Finance expenses	10	(5,285)	(4,964)
Finance expenses - unwinding of discount	19	(36)	(2)
PDC dividends payable		0	0
Net finance costs		**(5,247)**	**(4,906)**
Gains/(losses) on disposal of assets		0	0
Surplus (deficit) for the year		**200**	**(15,935)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	12	(435)	(7,202)
Revaluations	12	5,472	2,298
Other recognised gains and losses		0	0
Other reserve movements		0	0
Total comprehensive expense for the period		**5,237**	**(20,839)**

Financial performance for the year - memorandum only, does not form part of the accounts	**31 March 2020 £000**	**31 March 2019 £000**
Surplus (deficit) for the year	**200**	**(15,935)**
Net impairments	**(108)**	**(74)**
Loss on asset disposals	**0**	**0**
Donations received for PPE & intangible assets	**0**	**0**
Depreciation - donated assets	**165**	**169**
Remove impact of prior year PSF post accounts reallocation	**(207)**	**0**
Operating surplus (deficit) for the year	**50**	**(15,840)**
Adjusted financial performance excluding PSF & FRF	**(25,235)**	**(23,348)**

Statement of Financial Position

	Note	31 March 2020 £000	31 March 2019 £000
Intangible assets	11	1,446	521
Property, plant and equipment	12	132,190	129,232
Trade and other receivables	14	7,426	6,653
Total non-current assets		**141,062**	**136,406**
Current assets			
Inventories	13	1,976	1,568
Trade and other receivables	14	21,352	12,728
Cash and cash equivalents	15	3,376	2,300
Total current assets		**26,704**	**16,596**
Current liabilities			
Trade and other payables	16	(22,976)	(22,996)
Other liabilities	17	(1,549)	(1,474)
Borrowings	18	(108,551)	(56,626)
Provisions	19	(320)	(178)
Total current liabilities		**(133,396)**	**(81,274)**
Total assets less current liabilities		**34,370**	**71,728**
Non-current liabilities			
Other liabilities	17	0	0
Borrowings	18	(49,242)	(93,082)
Provisions	19	(872)	(569)
Total non-current liabilities		(50,114)	(93,651)
Total assets employed		**(15,744)**	**(21,923)**
Financed by			
Public dividend capital	SoCIE	55,827	54,885
Revaluation reserve	SoCIE	45,539	41,822
Income and expenditure reserve	SoCIE	(117,110)	(118,630)
Total taxpayers' equity		**(15,744)**	**(21,923)**

The notes on pages 5 to 37 form part of these accounts.

Signed

Name **Karen James**

Position **Chief Executive**

Date **17.6.2020**

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

	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2019 - brought forward	**54,885**	**41,822**	**(118,630)**	**(21,923)**
Surplus/(deficit) for the year	0	0	200	**200**
Impact of implementing IFRS 9	0	0	0	**0**
Public dividend capital received	942	0	0	**942**
Impairments	0	(435)	0	**(435)**
Revaluations	0	5,472	0	**5,472**
Other reserve movements	0	(1,320)	1,320	**0**
Taxpayers' and others' equity at 31 March 2020	**55,827**	**45,539**	**(117,110)**	**(15,744)**

Statement of Changes in Equity for the year ended 31 March 2019	Public Dividend Capital £000	Revaluation Reserve £000	Income and Expenditure Reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2018 - restated	**53,446**	**48,011**	**(103,908)**	**(2,451)**
Surplus/(deficit) for the year	0	0	(15,935)	**(15,935)**
Impact of implementing IFRS 9	0	0	(72)	**(72)**
Public dividend capital received	1,439	0	0	**1,439**
Impairments	0	(7,202)	0	**(7,202)**
Revaluations	0	2,298	0	**2,298**
Other reserve movements	0	(1,285)	1,285	**0**
Taxpayers' and others' equity at 31 March 2019	**54,885**	**41,822**	**(118,630)**	**(21,923)**

Statement of Cash Flows

	Note	31 March 2020 £000	31 March 2019 £000
Cash flows from operating activities			
Operating surplus/(deficit)	SOCI	5,447	(11,029)
Non-cash income and expense:			
Depreciation and amortisation	4	5,527	5,671
Impairments and reversals of impairments	4	(108)	(74)
(Increase)/decrease in receivables and other assets	14	(9,397)	(6,671)
(Increase)/decrease in inventories	13	(408)	103
Increase/(decrease) in payables and other liabilities	16	(133)	1,061
Increase/(decrease) in other liabilities	17	75	(110)
Increase/(decrease) in provisions	19	409	(107)
Net cash generated from/(used in) operating activities		**1,412**	**(11,156)**
Cash flows from investing activities			
Interest received	9	74	60
Purchase of intangible assets	11	(1,046)	(191)
Purchase of property, plant, equipment and investment property	12	(3,106)	(4,704)
Receipt of cash donations to purchase capital assets		0	0
Sales of property, plant, equipment and investment property		0	0
Net cash generated from/(used in) investing activities		**(4,078)**	**(4,835)**
Cash flows from financing activities			
Public dividend capital received		942	1,439
Public dividend capital repaid		0	0
Movement on loans from the Department of Health		9,503	21,728
Capital element of PFI, LIFT and other service concession payments		(1,448)	(1,391)
Interest paid on PFI, LIFT and other service concession obligations		(3,411)	(3,352)
Interest paid on Loans from Department of Health		(1,844)	(1,548)
PDC dividend (paid)/received		0	0
		3,742	**16,876**
Increase/(decrease) in cash and cash equivalents		**1,076**	**885**
Cash and cash equivalents at 1 April		**2,300**	**1,415**
Cash and cash equivalents transferred under absorption accounting		0	0
Cash and cash equivalents at 31 March	15	**3,376**	**2,300**

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 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
IAS 1 requires management to assess, as part of the accounts preparation process, the NHS Foundation Trust's ability to continue as a going concern. The financial statements should be prepared on a going concern basis unless management either intends to apply to the Secretary of State for the dissolution of the NHS Foundation Trust without the transfer of the services to another entity, or has no realistic alternative but to do so.

Having given careful consideration to all information in their possession, the Board of Directors have concluded that there is a reasonable expectation that Tameside and Glossop Integrated Care NHS Foundation Trust has adequate resources to continue in operational existence for the 12 months following the approval of this statement. For this reason they continue to adopt the going concern basis in preparing the accounts.

The Directors recognise that there are uncertainties that affect whether the Trust should adopt this basis. The Directors have had particular regard to the following matters .

At the date of approval of this report, the Board had not completed the annual planning process for the 2020-2021 year, following the instruction from NHS England/ Improvement to cease planning activities during the COVID-19 emergency period. The incomplete planning undertaken to date indicates that the Trust could anticipate a full-year deficit of £ 20.441 million, net of central support from the Financial Recovery Fund and Marginal Rate Emergency Tariff support. The Board was continuing to review options to reduce or resolve that gap to secure the balance of the FRF allocation, being £16.1m.

For the period from April to the end of July 2020, the Trust has been funded under special and specific arrangements related to the COVID-19 emergency period, approved at national level and designed to ensure that all appropriate Trust expenditure in the period is refunded in full, with the intention to ensure that all Trusts 'break even' on their operations in the period. In the view of the Board, there is a reasonable likelihood that the COVID-19 emergency period, and the related specific funding regime, will continue beyond that date. The Board is also of the view that, given the significant disruption to other services, and the need to ensure in the public interest that the variety of other services are resumed in a safe and controlled manner, it is likely that there will be supportive funding arrangements for the remainder of 2020-2021, which may run into the following financial year, to ensure that services can be provided to the community.

On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. The affected interim loans, totalling £106,631m interim loan principal and £408k interest accrual, are classified as current liabilities within the financial statements. As the repayment of these loans will be funded through the issue of PDC, this does not present a going concern risk for the Trust.

The Department has announced that future funding support will be provided by way of PDC rather than further loan support, except for specific identifiable items. The Department has also indicated that it does not anticipate providing further day-to-day funding support for NHS providers except in exceptional circumstances.

The Trust has a continuing strong relationship with its main commissioner, and prior to the suspension of the process was progressing well with the negotiation of contractual arrangements for 2020-2021. If the Trust was unable to meet its debts as they fell due, it would need to enter discussions with Commissioners and regulators regarding the future of provision, particularly Commissioner-Requested Services under Condition CoS 7 of the Trust's Provider Licence which are required to be provided. At the Board meeting in May 2020, the Board agreed a declaration to NHS Improvement under the terms of its provider licence, confirming that it had a reasonable expectation that the Required Resources (to provide Commissioner-Requested Services) would be available for the 12 months following approval of the declaration.

The Directors have also considered the following factors in concluding that the Trust is a going concern;

- Contractual agreement with its main commissioner (Tameside & Glossop Clinical Commissioning Group) to the Trust's overall service strategy;
- Robust assessment of the impact of the block contract agreed with the main commissioner, and Payment by Results tariffs for secondary commissioner contracts, into the medium-term as part of the incomplete planning process;
- Full identification of potential risks and opportunities incorporated into the partial financial plan for 2020-2021, including the potential impact of planned demand management initiatives;
- The long-term financial settlement announced by HM Government for the NHS in 2019, and legislated for in the NHS Funding Act 2020;
- The priorities set out in the 10-year plan published by NHS England, and in particular the expectations within that for the provider sector and individual providers to become financially self-sustainable in the medium-term;

The capital expenditure programme for 2020-2021, as agreed by the Board, has been risk assessed to reflect the requirements of the Trust to ensure delivery of Commissioner-Requested Services. It has also taken account of the national requirement that capital will be provided at the Integrated Care System level for further distribution amongst the individual organisations within that system.

Based on these indications, the Directors believe that it remains appropriate to prepare the accounts on a going concern basis. 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. At the date of approval of these financial statements, the Trust has no reason to believe that they cannot place reliance on the DHSC for financial support, should there be exceptional circumstances that require it. The financial statements do not include any adjustments that would result from the basis of preparation being inappropriate.

Note 1.3 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. This accrual is disclosed as a contract receivable as entitlement to payment for work completed is usually only dependent on the passage of time.

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 does not receive income where a patient is readmitted within 30 days of discharge from a previous planned stay. This is considered an additional performance obligation to be satisfied under the original transaction price. An estimate of readmissions is made at the year end this portion of revenue is deferred as a contract liability.

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.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Provider sustainability fund (PSF) and Financial recovery fund (FRF)

The PSF and FRF enable providers to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds is accounted for as variable consideration.

Note 1.3.1 Grants and donations

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. Where the grant is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income

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 from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.3.2 Other income

Other income includes income from Car parking and catering and this is recognised at a point in time.

Note 1.4 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 two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employer, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care 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: the cost to the trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as 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.

Note 1.5 Discontinued operations

Discontinued operations occur where activities either cease without transfer to another entity, or transfer to an entity outside of the boundary of Whole of Government Accounts, such as private or voluntary sectors. Such activities are accounted for in accordance with IFRS 5. Activities that are transferred to other bodies within the boundary of Whole of Government Accounts are 'machinery of government changes' and treated as continuing operations.

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 economic lives.

Note 1.7.2 Valuation

The valuation exercise was carried out in March 2020 with a valuation date of 31 March 2020. In applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2020 'Red Book', the valuer has declared a 'material valuation uncertainty' in the valuation report. This is based on uncertainties in markets caused by COVID-19.

Market activity is being impacted in many sectors. As at the valuation date, we consider that we can attach less weight to previous market evidence for comparison purposes, to inform opinions of value. Indeed, the current response to COVID-19 means that we are faced with an unprecedented set of circumstances on which to base a judgement.

The District Valuer has reported on the basis of 'material valuation uncertainty' as per VPS 3 and VPGA 10 of the RICS Red Book Global. Consequently, less certainty – and a higher degree of caution – should be attached to our valuation than would normally be the case. Given the unknown future impact that COVID-19 might have on the real estate market, we recommend that you keep the valuation of this property / these properties under frequent review.

The values in the report have been used to inform the measurement of property assets at valuation in these financial statements. With the valuer having declared this material valuation uncertainty, the valuer has continued to exercise professional judgement in providing the valuation and this remains the best information available to the Trust.

Of the £125.7m net book value of land and buildings, £111.3m relates to specialised assets valued on a depreciated replacement cost basis. Here the valuer bases their assessment on the cost to the Trust of replacing the service potential of the assets. The uncertainty explained above relates to the estimated cost of replacing the service potential, rather than the extent of the service potential to be replaced.

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.

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.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity. This basis has been applied to the Trust's Private Finance Initiative (PFI) scheme where the construction is completed by a special purpose vehicle and the costs have recoverable VAT for the Trust.

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

Property, plant and equipment (continued)

Note 1.7.3 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.

Note 1.7.4 Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic lives on a straight line basis. Freehold land is considered to have an infinite life and is not depreciated.
Property, plant and equipment which has been reclassified as 'held for sale' ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Assets in the course of construction are not depreciated until the asset is brought into operational use.

Useful Economic lives of property, plant and equipment
Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min Life Years	Max Life Years
Buildings	5	60
Dwellings	5	60
Plant & machinery	5	15
Transport equipment	7	7
Information technology	5	10
Furniture & fittings	5	10

Note 1.7.5 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 expenditure.

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'.

Note 1.7.6 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 1.7.7 De-recognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

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 1.8 Donated and grant funded assets

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 1.9 Private Initiative (PFI) transactions

PFI and LIFT transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the Trust. In accordance with HM Treasury's FReM, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost, the charges for services and lifecycle replacement of components of the asset. The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the NHS Foundation Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operators' planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Note 1.10 Intangible assets

Note 1.10.1Recognition

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.

- it is probable that future economic benefit will flow to the NHS Foundation Trust;
- the cost of the asset can be measured reliably;
- the cost is at least £5,000; and
- the NHS Foundation Trust can measure reliably the expenses attributable to the asset during development.

Note 1.10.2 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 1.10.3 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 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.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

Note 1.10.4 Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

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

	Min Life Years	Max Life Years
Intangible assets - purchased		
Software	5	10
Licences	3	10
Patents		
Other (purchased)		
Goodwill		

Note 1.10.5 Valuation

All Intangible Assets are stated at their valuation amount, which is reviewed by management on an annual basis.

Note 1.11 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. Pharmacy stock is measured at a weighted average cost.

Note 1.12 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 Tameside & Glossop Integrated Care NHS Foundation Trusts cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.13 Financial instruments 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, i.e., when receipt or delivery of the goods or services is made.

Note 1.13.2 De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the trust has transferred substantially all of the risks and rewards of ownership.
Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.13.3 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.

Financial assets measured at fair value through other comprehensive income

A financial asset is measured at fair value through other comprehensive income where business model objectives are met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On derecognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the Trust elected to measure an equity instrument in this category on initial recognition.
The Trust has not got any equity instruments at fair value.

Financial assets and financial liabilities at fair value trough income and expenditure

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

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.

The Trust has three categories of receivable, oversea visitors (OSV), salary overpayment (SOP) and general. The Trust adopts a average debt collection percentage over the last twelve months to determine the percentage to be used to recognise the credit loss. The OSV and SOP is at 54 days, at this point it is referred for external debt collection.

Matrix	O/S 30 days	O/S 60 days	O/S 90 days	O/S over 90 days
General	38.40%	50.50%	73.90%	88.80%
OSV	Provide at 54 Days			
SOP	Provide at 54 Days			

For financial assets that have become credit impaired since initial recognition, expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount.

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 1.13.4 Deregonition

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.

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 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 implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

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.

Note 1.14.2 Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially in other liabilities on the statement of financial position 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.

Note 1.14.3 Leases for land and buildings

Where a lease is for land and buildings, the land and building components are separated. Leased land is treated as an operating lease. Leased buildings are assessed as to whether they are operating or finance leases.

Note 1.14.4 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 HM Treasury's discount rates effective for 31 March 2020:

		Nominal rate
Short-term	Up to 5 years	0.51%
Medium-term	After 5 years up to 10 years	0.55%
Long-term	Exceeding 10 years	1.99%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective 31 March 2020:

	Inflation rate
Year 1	1.90%
Year 2	2.00%
Into perpetuity	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 0.5% in real terms.

Note 1.16 Clinical Negligence Costs

The NHS Resolution (NHSR) operates a risk pooling scheme under which the NHS Foundation Trust pays an annual contribution to the NHSR, which, in return, settles all clinical negligence claims. Although the NHSR is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS Foundation Trust. The total value of clinical negligence provisions carried by the NHSR on behalf of the NHS Foundation Trust is disclosed at note 18.1 but is not recognised in the NHS Foundation Trust's accounts.

Note 1.17 Non-clinical risk pooling

The NHS Foundation 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 1.18 Contingencies
A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the control of the NHS Foundation Trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably.

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. Contingent liabilities are not recognised, 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.

Contingent Liabilities are not recognised unless the probability of a transfer of economic benefits is remote.

Note 1.19 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.

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 and grant funded assets,
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health 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 calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

The Trust does not pay PDC due to having negative liabilities.

Note 1.20 Value Added Tax
Most of the activities of the NHS Foundation Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.21 Foreign exchange
The functional and presentational currencies of the trust are sterling.
A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.
Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:
• monetary items (other than financial instruments measured at "fair value through income and expenditure") are translated at the spot exchange rate on 31 March
• non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
• non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.
Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.
Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

Note 1.22 Third party assets

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts.. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

Note 1.23 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.

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 1.24 Early adoption of standards, amendments and interpretations
No new accounting standards or revisions to existing standards have been early adopted in 2019/20.

Note 1.25 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 a rate 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 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 1.26 Critical accounting estimates and judgements

Note 1.26.1 Critical accounting judgments and key sources of estimation uncertainty

In the application of the NHS Foundation Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates, and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised, if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

Note 1.26.2 Critical judgments and key sources of estimation uncertainty in applying accounting policies

The following are the key estimations that management has made in the process of applying the Trust's accounting policies that have the most significant effect on the amounts recognised in the financial statements.

Partially Completed Spells

The calculation is to establish a value, and therefore recognise the value of "work in progress" in line with accounting standards. The calculation is based on the total number of inpatients as at 31st March 2020, taking into account our current average length of stay and average income per patient based on the current years tariff package calculating the income due for their care in the current financial year.

Maternity Pathway

Under the current national tariff system Antenatal Care is paid for by Commissioners at the time of booking, a single payment covers all aspects of the care, outpatient inpatient and community care up until the point the pregnancy ends. Given that this care is delivered over a number of months it is necessary to only recognise in the Trusts Accounts the actual value of income reflective of the care the patient has received up to 31st March 2020. The calculation is based on the number of patients booked per month and their expected delivery month in the following financial year.

Valuation of Land and Buildings

See 1.7.2 -Valuations are carried out by professionally qualified valuers, District Valuers Services, in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisals and Valuation Manual and this includes external factors including indices.

Note 2 Operating segments

All activity for Tameside and Glossop Integrated Care NHS Foundation Trust is healthcare related. As the operating segments have similar characteristics there is no requirement to report segmentally.

Whilst The Trust has a divisional structure in place, the services that are provided are essentially all the same (patient care) and the majority of risks faced by each division are fundamentally the same.

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.3

Note 3.1 Income from patient care activities

	31 March 2020	31 March 2019
Acute services	**£000**	**£000**
Elective income	22,507	21,081
Non elective income	58,461	54,864
First outpatient income	12,554	12,676
Follow up outpatient income	11,677	11,276
A & E income	15,381	12,034
High cost drugs income from commissioners	5,349	5,338
Other NHS clinical income	51,715	52,376
Community Services	32,108	29,495
All other services		
Overseas Visitors	125	105
Injury cost recovery scheme	783	1,073
Prescription Income	125	155
AfC pay award central funding	733	2,905
Additional pension contribution central funding	6,351	0
Other clinical income	2,181	1,758
Total income from activities	**220,050**	**205,136**

The recent revaluation of public sector pension schemes resulted in a 6.3% increase (14.38% to 20.68% incl. admin levy) in the employer contribution rate for the NHS Pension Scheme. A transitional approach was agreed whereby an employer rate of 20.68% will apply from 1st April 2019, however in 2019/20 the NHS Business Service Authority (BSA) will only collect 14.38% from employers.

Central payments have been made by NHS England and the Department of Health and Social Care ('DHSC') for their respective proportions of the outstanding 6.3% on local employers' behalf. NHS providers will record expenditure in their accounts relating to the full 20.68%, therefore including the 6.3% paid by NHS England and will record notional income from NHS England in their accounts, with the 6.3% having no impact on the bottom line.

Note 3.2 Income from patient care activities

Income from patient care activities received from:	31 March 2020	31 March 2019
	£000	**£000**
NHS England	15,481	6,751
CCGs	168,986	167,317
Local Authorities	34,392	26,656
NHS Foundation Trusts	86	158
NHS trusts	37	8
Department of Health and Social Care	22	2,905
NHS other (including Public Health England)	33	0
Overseas visitors	125	105
Injury cost recovery scheme	783	1,073
Non NHS: other	105	163
Total income from activities	**220,050**	**205,136**
Of which:		
Related to continuing operations	220,050	205,136
Related to discontinued operations	0	0

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

	2019/20	2018/19
	£000	£000
Income recognised this year	125	105
Cash payments received in-year	31	85
Amounts added to provision for impairment of receivables	124	108
Amounts written off in-year	48	52

Note 3.4 Other operating income

	31 March 2020	31 March 2019
	£000	£000
Other operating income recognised in accordance with IFRS 15:		
Research and development	394	394
Education and training	4,963	4,876
Non-patient care services to other bodies	3,822	5,012
Provider sustainability fund (PSF)	4,934	7,508
Financial recovery fund (FRF)	20,558	0
Other (recognised in accordance with IFRS 15)*	2,223	2,187
Other operating income recognised in accordance with other standards:		
Education and training (excluding notional apprenticeship levy income)	240	231
Cash grants for the purchase of capital assets - received from other bodies	0	0
Charitable and other contributions to expenditure	64	72
Profit on disposal of non-current assets	0	0
Reversal of impairments	0	0
Rental revenue from operating leases	60	65
Income in respect of staff costs where accounted on gross basis	349	314
Other income	0	0
Total other operating income	**37,607**	**20,659**
Of which:		
Related to continuing operations	37,607	20,659
Related to discontinued operations	0	0

	31 March 2020	31 March 2019
Other income *	**£000**	**£000**
Car parking	1,230	1,178
Staff accommodation rentals	66	53
Catering	377	359
Clinical Excellence Awards	46	46
Other	504	551
	2,223	**2,187**

Note 3.5 Additional information on revenue from contracts with customers recognised in the period

	31 March 2020
	£000
Revenue recognised in the reporting period that was included within contract liabilities at the previous period end	1,474
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	0

Note 3.6 Transaction price allocated to remaining performance obligations

	31 March 2020
Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	**£000**
within one year	1,380
after one year, not later than five years	169
after five years	0
Total revenue allocated to remaining performance obligations	**1,549**

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 3.7 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	2018/19
	£000	£000
Income from services designated as commissioner requested services	219,037	203,795
Income from services not designated as commissioner requested services	1,013	1,341
Total	**220,050**	**205,136**

Note 4 Operating expenses

	31 March 2020	31 March 2019
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	4,790	5,163
Purchase of healthcare from non-NHS and non-DHSC bodies	2,838	2,678
Staff and executive directors costs	178,504	164,009
Remuneration of non-executive directors	117	119
Supplies and services - clinical (excluding drugs costs)	14,818	14,683
Supplies and services - general	2,724	2,825
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	10,258	10,794
Consultancy costs	54	37
Establishment	1,621	1,838
Premises	11,044	9,235
Transport (including patient travel)	700	708
Depreciation on property, plant and equipment	5,406	5,588
Amortisation on intangible assets	121	83
Net impairments	(108)	(74)
Movement in credit loss allowance: contract receivables/contract assets	(29)	(28)
Movement in credit loss allowance: all other receivables and investments	(21)	(18)
Increase/(decrease) in provisions	260	1
Change in provisions discount rate(s)	(11)	(12)
Audit fees payable to the external auditor		
audit services- statutory audit	63	62
other auditor remuneration (external auditor only)	44	12
Internal audit costs	84	84
Clinical negligence	8,002	8,305
Legal fees	505	335
Insurance	257	230
Research and development - staff costs	307	274
Education and training - staff costs	726	652
Education and training - non-staff costs	505	612
Education and training - notional expenditure funded from apprenticeship fund	240	231
Rentals under operating leases	4,353	4,333
Redundancy	65	0
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI)	3,586	3,495
Hospitality	20	22
Losses, ex gratia & special payments	190	220
Other	177	328
Total	**252,210**	**236,824**
Of which:		
Related to continuing operations	252,210	236,824
Related to discontinued operations	0	0

Note 4.1 Other auditor remuneration

	31 March 2020 £000	31 March 2019 £000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	0	0
2. Audit-related assurance services	2	12
3. Taxation compliance services	0	0
4. All taxation advisory services not falling within item 3 above	0	0
5. Internal audit services	0	0
6. All assurance services not falling within items 1 to 5	0	0
7. Corporate finance transaction services not falling within items 1 to 6 above	0	0
8. Other non-audit services not falling within items 2 to 7 above	0	0
Total	**2**	**12**

Note 4.2 Limitation on auditor's liability

The External Auditors Liability is limited to £2m. The scope of work for the External Auditors is to provide a Statutory Audit to the NHS Foundation Trust. This will be conducted in accordance with the Audit Code for NHS Foundation Trusts (the Audit Code) issued by Monitor in accordance with paragraph 24 of schedule 7 of the Act. The scope of the work is for the External Auditors to be satisfied that the NHS Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The External Auditors are to provide their opinion on the financial statements.

Note 5 Impairment of assets

	31 March 2020 £000	31 March 2019 £000
Net impairments charged to operating surplus resulting from:		
Changes in market price	(108)	(74)
Other	0	0
Total net impairments charged to operating surplus	**(108)**	**(74)**
Impairments charged to the revaluation reserve	435	7,202
Total net impairments	**327**	**7,128**

Impairments have resulted from a annual valuation exercise carried out by the District valuer.

Note 6 Employee benefits

	31 March 2020 Total £000	31 March 2019 Total £000
Salaries and wages *	130,741	123,080
Social security costs	12,457	11,705
Apprenticeship levy	614	576
Employer's contributions to NHS pensions	14,501	13,864
Pension cost - employer contributions paid by NHSE on provider's behalf (6.3%)	6,351	0
Temporary staff - external bank	9,332	9,246
Temporary staff - agency/contract staff	5,606	6,437
	179,602	**164,908**
Recoveries in respect of seconded staff	0	0
Total staff costs	**179,602**	**164,908**
Of which		
Costs capitalised as part of assets	**58**	**39**

* Increase is due to pay award and incremental drift.

Average number of employees (WTE basis) is on page 28 of the Annual Report

Note 6.1 Retirements due to ill-health

During 2019/20 there were 5 early retirement from the NHS Foundation Trust agreed on the grounds of ill-health (1 in the year ended 31 March 2019). The estimated additional pension liability of this ill-health retirements is £269k (£12k in 2019).

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

Note 6.2 Directors' remuneration

The aggregate amounts payable to directors were:	31 March 2020 £000	31 March 2019 £000
Salary	822	807
Taxable benefits	0	0
Performance related bonuses	0	0
Employer's pension contributions	316	372
Total	**1,138**	**1,179**

Further details of directors' remuneration can be found in the remuneration report on page 23 of the Annual Report.

Note 7 Pension costs

The NHS Foundation Trust offers retirement benefits to its employees from the 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 for Health and Social Care 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 to 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 Operating leases

Lessor

This note discloses income generated in operating lease agreements where Tameside and Glossop Integrated Care NHS Foundation Trust is the lessor.

The Trust has two lessors, relating to the PFI building and the renting of two shops for the length of the contract.

	31 March 2020	31 March 2019
Operating lease revenue	**£000**	**£000**
Minimum lease receipts	60	65
Total	**60**	**65**

	31 March 2020	31 March 2019
	£000	**£000**
Future minimum building leases receipts due:		
not later than one year;	32	41
later than one year and not later than five years;	106	104
later than five years.	399	425
Total	**537**	**570**

Lessee

This note discloses costs and commitments incurred in operating lease arrangements where Tameside and Glossop Integrated Care NHS Foundation Trust is the lessee.

The Trust has four significant leases, one with London and Manchester Healthcare Ltd (L&M Ltd) for the Stamford Unit, Ashton & Glossop Primary Care Centres and Olympus Keymed Ltd for a managed clinical equipment service.

	31 March 2020	31 March 2019
	£000	**£000**
Operating lease expense		
Minimum lease payments	4,353	4,333
Total	**4,353**	**4,333**

	31 March 2020	31 March 2019
	£000	**£000**
Future minimum building leases payments due:		
not later than one year;	3,300	3,364
later than one year and not later than five years;	7,874	10,425
later than five years.	4,446	6,687
Total	**15,620**	**20,476**

	2020	2019
	£000	**£000**
Future minimum other leases payments due:		
not later than one year;	866	849
later than one year and not later than five years;	2,660	2,519
later than five years.	0	0
Total	**3,526**	**3,368**

	2020	2019
	£000	**£000**
Future minimum on all lease payments due:		
not later than one year;	4,166	4,213
later than one year and not later than five years;	10,534	12,944
later than five years.	4,446	6,687
Total	**19,146**	**23,844**

Note 9 Finance income

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

	31 March 2020 £000	31 March 2019 £000
Interest on bank accounts	74	60
Total	**74**	**60**

The Trust received interest from cash deposited with HM Treasury, and the Government Banking Service provided by Citi Bank.

Note 10 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money.

	31 March 2020 £000	31 March 2019 £000
Interest expense:		
Loans from the Department of Health	1,875	1,612
Main finance costs on PFI scheme obligations	2,159	2,217
Contingent finance costs on PFI scheme obligations	1,251	1,135
Total	**5,285**	**4,964**

The interest charge on the Interim Revenue Support loans was £1.875k in 2019/20 at a rate of 1.5%. Future revenue support will be available in the form of PDC that carries a dividend payable at 3.5%.

Note 11 Intangible assets - 2019/20

	Software Licences	Licenses & Trademarks	Other	Total
	£000	£000	£000	£000
Valuation/gross cost at 1 April 2019 - brought forward	**604**	**0**	**0**	**604**
Additions	1,046	0	0	**1,046**
Impairments	0	0	0	**0**
Disposals / derecognition	0	0	0	**0**
Gross cost at 31 March 2020	**1,650**	**0**	**0**	**1,650**
Amortisation at 1 April 2019 - brought forward	**83**	**0**	**0**	**83**
Provided during the year	121	0	0	**121**
Impairments	0	0	0	**0**
Disposals / derecognition	0	0	0	**0**
Amortisation at 31 March 2020	**204**	**0**	**0**	**204**
Net book value at 31 March 2020	**1,446**	**0**	**0**	**1,446**
Net book value at 1 April 2019	**521**	**0**	**0**	**521**

Note 11.1 Intangible assets - 2018/19

	Software licences	Licenses & Trademarks	Other	Total
	£000	£000	£000	£000
Valuation/gross cost at 1 April 2018 - as previously stated	**413**	**0**	**0**	**413**
Additions	191	0	0	**191**
Impairments	0	0	0	**0**
Disposals / derecognition	0	0	0	**0**
Valuation/gross cost at 31 March 2019	**604**	**0**	**0**	**604**
Amortisation at 1 April 2018 - as previously stated	**0**	**0**	**0**	**0**
Provided during the year	83	0	0	**83**
Impairments	0	0	0	**0**
Disposals / derecognition	0	0	0	**0**
Amortisation at 31 March 2019	**83**	**0**	**0**	**83**
Net book value at 31 March 2019	**521**	**0**	**0**	**521**
Net book value at 1 April 2018	**413**	**0**	**0**	**413**

Note 12 Property, plant and equipment - 2019/20

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2019 - brought forward	**13,581**	**108,178**	**526**	**701**	**15,903**	**72**	**7,680**	**166**	**146,807**
Additions	0	0	0	2,005	591	94	522	7	3,219
Impairments	0	(435)	0	0	0	0	0	0	(435)
Reclassifications	0	2,549	0	(2,549)	0	0	0	0	0
Revaluations	850	994	40	0	0	0	0	0	1,884
Disposals / derecognition	0	0	0	0	(826)	0	0	0	(826)
Valuation/gross cost at 31 March 2020	**14,431**	**111,286**	**566**	**157**	**15,668**	**166**	**8,202**	**173**	**150,649**
Accumulated depreciation at 1 April 2019 - brought forward	**0**	**0**	**0**	**0**	**11,360**	**72**	**6,032**	**111**	**17,575**
Provided during the year	0	3,662	34	0	1,142	0	556	12	**5,406**
Impairments	0	0	0	0	0	0	0	0	**0**
Revaluations	0	(3,554)	(34)	0	0	0	0	0	**(3,588)**
Reversals of impairments	0	(108)	0	0	0	0	0	0	**(108)**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Disposals/ derecognition	0	0	0	0	(826)	0	-	0	**(826)**
Accumulated depreciation at 31 March 2020	**0**	**0**	**0**	**0**	**11,676**	**72**	**6,588**	**123**	**18,459**
Net book value at 31 March 2020	**14,431**	**111,286**	**566**	**157**	**3,992**	**94**	**1,614**	**50**	**132,190**
Net book value at 1 April 2019	**13,581**	**108,178**	**526**	**701**	**4,543**	**0**	**1,648**	**55**	**129,232**
Total revaluation	850	4,548	74	0	0	0	0	0	5,472
Total impairment	0	(435)	0	0	0	0	0	0	(435)
	850	**4,113**	**74**	**0**	**0**	**0**	**0**	**0**	**5,037**

Note 12.1 Property, plant and equipment - 2018/19

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2018 - as previously stated	**14,481**	**112,706**	**480**	**738**	**16,463**	**91**	**7,304**	**120**	**152,383**
Additions	0	0	0	3,471	736	0	231	0	**4,438**
Reversals of impairments	(900)	(6,159)	(143)	0	0	0	0	0	**(7,202)**
Reclassifications	0	3,304	0	(3,508)	13	0	145	46	**0**
Revaluations	0	(1,673)	189	0	0	0	0	0	**(1,484)**
Disposals / derecognition	0	0	0	0	(1,309)	(19)	0	0	**(1,328)**
Valuation/gross cost at 31 March 2019	**13,581**	**108,178**	**526**	**701**	**15,903**	**72**	**7,680**	**166**	**146,807**
Accumulated depreciation at 1 April 2018 - as previously stated	**0**	**0**	**11**	**0**	**11,531**	**91**	**5,431**	**107**	**17,171**
Provided during the year	0	3,834	11	0	1,138	0	601	4	**5,588**
Impairments	0	71	0	0	0	0	0	0	**71**
Reversals of impairments	0	(3,760)	(22)	0	0	0	0	0	**(3,782)**
Reclassifications	0	(145)	0	0	0	0	0	0	**(145)**
Revaluations	0	0	0	0	0	0	0	0	**0**
Disposals / derecognition	0	0	0	0	(1,309)	(19)	0	0	**(1,328)**
Accumulated depreciation at 31 March 2019	**0**	**0**	**0**	**0**	**11,360**	**72**	**6,032**	**111**	**17,575**
Net book value at 31 March 2019	**13,581**	**108,178**	**526**	**701**	**4,543**	**0**	**1,648**	**55**	**129,232**
Net book value at 1 April 2018	**14,481**	**112,706**	**469**	**738**	**4,932**	**0**	**1,873**	**13**	**135,212**
Total revaluation	0	2,087	211	0	0	0	0	0	2,298
Total impairment	(900)	(6,085)	(143)	0	0	0	0	0	(7,128)
	(900)	**(3,998)**	**68**	**0**	**0**	**0**	**0**	**0**	**(4,830)**

Note 12.2 Property, plant and equipment financing - 2019/20

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2020									
Owned	14,431	68,893	566	157	3,939	92	1,614	50	**89,742**
On-SoFP PFI contracts and other service concession arrangements		39,885	0	0	0	0	0	0	**39,885**
Donated	0	2,508	0	0	55	0	0	0	**2,563**
NBV total at 31 March 2020	**14,431**	**111,286**	**566**	**157**	**3,994**	**92**	**1,614**	**50**	**132,190**

Note 12.3 Property, plant and equipment financing - 2018/19

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2019									
Owned	13,581	66,758	526	701	4,398	0	1,648	55	**87,667**
On-SoFP PFI contracts and other service concession arrangements	0	38,965	0	0	0	0	0	0	**38,965**
Donated	0	2,455	0	0	145	0	0	0	**2,600**
NBV total at 31 March 2019	**13,581**	**108,178**	**526**	**701**	**4,543**	**-**	**1,648**	**55**	**129,232**

Note 13 Inventories

	31 March 2020 £000	31 March 2019 £000
Drugs	672	401
Consumables	1,279	1,139
Energy	25	28
Total inventories	**1,976**	**1,568**

Note 14 Trade receivables and other receivables

	31 March 2020 £000	31 March 2019 £000
Current		
Contract receivables (IFRS 15): invoiced	3,165	5,002
Contract receivables (IFRS 15): not yet invoiced / non-invoiced	15,356	6,037
Contract assets (IFRS 15)	1,122	784
Allowance for impaired contract receivables / assets	(567)	(596)
Allowance for impaired other receivables	(100)	(121)
Prepayments (non-PFI)	1,842	882
VAT receivable	515	712
Other receivables	19	28
Total current trade and other receivables	**21,352**	**12,728**
Non-current		
PFI prepayments:		
Lifecycle replacements	6,441	5,703
Contract assets (IFRS 15)	741	950
Clinician pension tax provision reimbursement funding from NHSE	244	0
Total non-current trade and other receivables	**7,426**	**6,653**
Total Receivables	**28,778**	**19,381**

The Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit (CRU) that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

The increase in contract receivable relates to receiving financial recovery fund (FRF).

Note 14.1 Allowances for credit losses - 2019/20

	receivables £000	receivables £000
Allowances as at 1 Apr 2019 - brought forward	**596**	**121**
New allowances arising	183	53
Reversals of allowances	(123)	(52)
Utilisation of allowances (write offs)	(89)	(22)
Allowances as at 31 Mar 2020	**567**	**100**

Note 15 Cash and cash equivalents movements

Cash and cash equivalents comprise of 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.

	31 March 2020 £000	31 March 2019 £000
At 1 April	**2,300**	**1,415**
Net change in year	1,076	885
At 31 March	**3,376**	**2,300**
Broken down into:		
Cash at commercial banks and in hand	116	67
Cash with the Government Banking Service	3,260	2,233
Deposits with the National Loan Fund	0	0
Other current investments	0	0
Total cash and cash equivalents as in SoFP	**3,376**	**2,300**
Bank overdrafts (GBS and commercial banks)	0	0
Drawdown in committed facility	0	0
Total cash and cash equivalents as in SoCF	**3,376**	**2,300**

Note 15.1 Third party assets held by the NHS Foundation Trust

Tameside and Glossop Integrated Care NHS Foundation Trust hold cash and cash equivalents which relate to monies held by The Trust on behalf of patients. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2020 £000	31 March 2019 £000
Bank balances	4	2
Monies on deposit	0	0
Total third party assets	**4**	**2**

Note 16 Trade and other payables	31 March 2020 £000	31 March 2019 £000
Current		
Trade payables	8,886	8,141
Capital payables	410	297
Accruals	5,706	7,030
Social security costs	1,928	1,842
Other taxes payable	1,536	1,452
PDC dividend payable	0	0
Other payables	4,510	4,234
Total current trade and other payables	**22,976**	**22,996**
Non-current		
Total non-current trade and other payables	**0**	**0**
Of which payables from NHS and DHSC group bodies:		
Current	22,976	22,996
Non-current	0	0

Note 17 Other liabilities	31 March 2020 £000	31 March 2019 £000
Current		
Other deferred income	1,549	1,474
Total other current liabilities	**1,549**	**1,474**
Non-current		
Other deferred income	0	0
Total other non-current liabilities	**0**	**0**

Note 18 Borrowings	31 March 2020 £000	31 March 2019 £000
Current		
Loans from the Department of Health	107,039	55,177
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	1,512	1,449
Total current borrowings	**108,551**	**56,626**
Non-current		
Loans from the Department of Health	0	42,328
Obligations under PFI, LIFT or other service concession contracts	49,242	50,754
Total non-current borrowings	**49,242**	**93,082**
Total borrowings	**157,793**	**149,708**

Note 18.1 Reconciliation of liabilities arising from financing activities

	Loans from DHSC £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2019	**97,505**	**52,203**	**149,708**
Cash movements:			
Financing cash flows - payments and receipts of principal	9,503	(1,448)	**8,055**
Financing cash flows - payments of interest	(1,844)	(2,160)	(4,004)
Non-cash movements:			
Application of effective interest rate	1,875	2,159	4,034
Carrying value at 31 March 2020	**107,039**	**50,754**	**157,793**

Note 19 Provisions for liabilities and charges analysis

	Pensions - former directors	Pensions - injury benefits	Other legal claims	Clinician pension tax reimbursement	Other
	£000	£000	£000	£000	£000
At 1 April 2019	0	544	203	0	0
Change in the discount rate	0	(11)	0	0	0
Arising during the year	0	0	158	244	151
Utilised during the year	0	(32)	(52)	0	0
Reclassified to liabilities held in disposal groups	0	0	0	0	0
Reversed unused	0	0	(49)	0	0
Unwinding of discount	0	36	0	0	0
At 31 March 2020	**0**	**537**	**260**	**244**	**151**
Expected timing of cash flows:					
- not later than one year;	0	32	137	0	151
- later than one year and not later than five years;	0	127	123	0	0
- later than five years.	0	378	0	244	0
Total	**0**	**537**	**260**	**244**	**151**

The above provisions are subject to uncertainties relating to the estimated costs and expected timings of the settlement. The cost and timing of the provision for employer's and occupier's liability has been calculated using the information provided by the NHS Resolution Authority. The injury benefits provision is an amount that is payable for the remaining life of three individuals. The provision has been calculated based on the historic annual payment and the expected remaining life of the individual.

Below is a table detailing a breakdown of the above provisions:

	31 March 2020	31 March 2019
	£000	£000
Employer's liabilities - NHS Resolution	**248**	188
Public liabilities - NHS Resolution	**12**	15
Total legal claims	**260**	**203**
Injury benefits - NHS Business Services Authority - Pensions Division	**537**	544
Total pensions	**537**	**544**
Clinician pension tax reimbursement	**244**	0
Total clinical pension tax provisions	**244**	**0**
Other provisions - industrial tribunal claims	**68**	0
Other provisions - Dilapidations	**83**	0
Total other provisions	**151**	**0**
Total provisions	**1,192**	**747**

Note 19.1 Clinical negligence liabilities

At 31 March 2020, £216,444k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Tameside and Glossop Integrated Care NHS Foundation Trust (31 March 2019: £202,252k).

The Trust has no contingent liabilities in 2019/20, which relate to the Employer's and Occupier's Liability. This is the difference between the provision which the Trust as made for the claim and the actual excess which the Trust could be liable to pay against the claim.

Note 20 Contractual capital commitments

	31 March 2020	31 March 2019
	£000	£000
Property, plant and equipment	737	95
Intangible assets	0	0
Total	**737**	**95**

Note 20.1 Other financial commitments

The Trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangement), analysed by the period during which the payment is made:

	31 March 2020	31 March 2019
	£000	£000
Not later than 1 year	5,735	4,876
after 1 year and not later than 5 years	9,582	8,101
paid thereafter	0	0
Total	**15,317**	**12,977**

Note 21 Private Finance Initiative contracts

Note 21.1 PFI scheme off-Statement of Financial Position
The Trust does not have any PFI scheme off-Statement of Financial Position.

Note 21.2 PFI scheme on-Statement of Financial Position
In 2011 extensive new acute facilities were built through PFI investment by Consort Healthcare.

The contract with Consort Healthcare expires at the end of the contract term (28th August 2041) and there is no provision within the contract to re-price or re-negotiate the prices and dates. There is however the facility for variations to the contract and the Trust has procedures to manage those variations in line with Standing Financial Instructions. The Annual Service Payment will be inflated each April based on the preceding February RPI.
The Trust has the right to use the buildings, however Consort Healthcare has the responsibility for maintaining the buildings to an agreed standard. All lifecycle replacement is also the responsibility of Consort Healthcare.

A key feature of the PFI scheme is that the operator is responsible for ensuring that the property is maintained to an agreed standard for the entire life of the contract. These are known as lifecycle costs. The cost which the operator expects to incur in doing this is reflected in the unitary payment and reflects two elements:
• maintenance (planned and reactive); and
• replacement of components as they wear out during the contract – this is known as capital lifecycle.

After the expiry of the contract, the license with Consort Healthcare to operate out of these buildings will expire and the Trust will become responsible for the maintenance and lifecycle costs of those buildings.

The building is valued within the cycle of the Trusts land & building valuation exercise. The building is valued exclusive of VAT. This is allowable as the VAT is recovered on all payments relating to a fully managed and serviced building under a PFI.

Note 21.3 On-Statement of Financial Position PFI, LIFT or other service

The Trust has the following obligations in respect of the finance lease element of on-Statement of Financial Position PFI and LIFT schemes:

	31 March 2020 £000	31 March 2019 £000
Gross PFI, LIFT or other service concession liabilities	**77,139**	**80,747**
not later than one year;	3,610	3,607
later than one year and not later than five years;	14,437	14,437
later than five years.	59,093	62,703
Finance charges allocated to future periods	(26,386)	(28,544)
Net PFI, LIFT or other service concession arrangement obligation	**50,754**	**52,203**
not later than one year;	1,512	1,449
later than one year and not later than five years;	6,709	6,438
later than five years.	42,533	44,316
	50,754	**52,203**

Note 21.4 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

The Trust's total future obligations under these on-SoFP schemes are as follows:

	31 March 2020 £000	31 March 2019 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**262,361**	**271,656**
Of which liabilities are due:		
not later than one year;	9,407	9,182
later than one year and not later than five years;	40,044	39,083
later than five years.	212,910	223,391
	262,361	**271,656**

Note 21.5 Analysis of amounts payable to service concession operator

This note provides an analysis of the Trust's expenditure in 2019/20:

	31 March 2020 £000	31 March 2019 £000
Unitary payment payable to service concession operator	9,182	8,960
Consisting of:		
Interest charge	2,159	2,217
Repayment of finance lease liability	1,448	1,393
Service element	3,586	3,495
Contingent rent	1,251	1,135
Addition to lifecycle prepayment	738	720
Total amount paid to service concession operator	**9,182**	**8,960**

Note 22 Financial instruments

Note 22.1 Liquidity risk

The Trust's net operating costs are incurred under annual service contracts with local Clinical Commissioning Groups (CCG's), which are financed from resources voted annually by Parliament. The Trust has agreed a block contract with Tameside and Glossop CCG, the main commissioner for the Trust. The Trust receives cash each month based on the profiling of the contract value. The Trust financial plan and budgets are based on this contract value. This means that in periods of significant over-spend on budgets, there can be a significant cash flow impact. Wherever possible this is mitigated by rephrasing income payments with Commissioners. As the Trust has a deficit financial plan, there is also a reliance on a revenue support loan the DH to provide the cash to support financial obligations.

The Trust presently finances its capital expenditure from internally generated funds or funds made available from Government, in the form of additional Public Dividend Capital, under an agreed limit. In addition, the Trust can borrow, both from the Department of Health Financing Facility and commercially, to finance capital schemes. Although given current Department of Health loan conditions, this is only possible with NHSI approval. Financing would be drawn down to match the capital spend profile of the scheme concerned and the Trust would not therefore be exposed to significant liquidity risks in this area; the Trust did not borrow under this arrangement in the year 2019/20.

Future revenue support will be available, this support will be provided as PDC which does not require principal repayment but carries a dividend payable at 3.5%.

During the COVID-19 outbreak, temporary arrangements are in place to ensure all providers have sufficient funding to respond to the crisis, including meeting reasonable additional costs. DHSC revenue support should not be needed during this period but will be available as a safety net, should it be required. NHS organisations are also required to pay suppliers promptly, especially during COVID-19.

Note 22.2 Interest-rate risk

All of the Trust's financial assets and liabilities carry nil or fixed rates of interest. The Trust is not, therefore, exposed to significant interest-rate risk. The only risk is therefore regarding the level of interest generated on the Trust's investment which may be higher or lower than planned at the start of the year, due to fluctuating interest rates on National Loan Fund (NLF) investments. The value of interest generated in 2019/20 was £74k (2018/19 was £60k).

Note 22.3 Credit risk

The main source of income for the Trust is from NHS Commissioners in respect of healthcare services provided under local agreements and NHS Contracts. Non NHS customers do not represent a large proportion of income, the majority of this relates to other public sector bodies which are considered low risk. The Trust is therefore, not exposed to significant credit risk.

Note 22.4 Treasury management arrangements

The Trust operates within an agreed Treasury Management policy that governs the nature of the cash investments. The credit risk to the Trust is minimal for the investments. Investments are limited to a maximum amount of £3m with each commercial bank and a maximum period of 95 days. Investments can only be placed with commercial banks who have a Fitch credit rating of AA+. The Trust is also able to place investments with HM Treasury in the NLF. The Treasury Management policy states an unlimited value can be placed with the NLF.

Interim revenue loan debt at 31 March 2020 are to be extinguished during 2020/21. Providers will be issued Public Dividend Capital (PDC) to effect the repayment of outstanding balances at 31 March 2020.
Future revenue support will be available, this support will be provided as PDC which does not require principal repayment but carries a dividend payable at 3.5%

Note 22.5 Currency risk

The Trust does not have any overseas foreign transactions or balances. There is no currency or translation risk to the Trust.

Note 23 Carrying values of financial assets

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
Carrying values of financial assets as at 31 March 2020 under IFRS 9	**£000**	**£000**	**£000**	**£000**
Receivables (excluding non financial assets) - with DHSC group bodies	17,330	0	0	**17,330**
Receivables (excluding non financial assets) - with other bodies	2,650	0	0	**2,650**
Cash and cash equivalents at bank and in hand	3,376	0	0	**3,376**
Total at 31 March 2020	**23,356**	**0**	**0**	**23,356**

	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total book value
Carrying values of financial assets as at 31 March 2019 under IAS 39	**£000**	**£000**	**£000**	**£000**
Trade and other receivables excluding non financial assets	12,084	0	0	**12,084**
Cash and cash equivalents at bank and in hand	2,300	0	0	**2,300**
Total at 31 March 2019	**14,384**	**0**	**0**	**14,384**

Note 23.1 Carrying value of financial liabilities

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

Carrying values of financial liabilities as at 31 March 2020 under IFRS 9	Held at amortised cost	Held at fair value through the I&E	Total book value
	£000	**£000**	**£000**
Loans from the Department of Health and Social Care	107,039	0	**107,039**
Obligations under PFI, LIFT and other service concession contracts	50,754	0	**50,754**
Trade and other payables (excluding non financial liabilities) - with DHSC group bodies	2,948	0	**2,948**
Trade and other payables (excluding non financial liabilities) - with other bodies	14,567	0	**14,567**
Total at 31 March 2020	**175,308**	**0**	**175,308**

	Other financial liabilities	Held at fair value through the I&E	Total book value
	£000	**£000**	**£000**
Carrying values of financial liabilities as at 31 March 2019 under IAS 39			
Loans from the Department of Health and Social Care	97,505	0	**97,505**
Obligations under PFI, LIFT and other service concession contracts	52,203	0	**52,203**
Trade and other payables excluding non financial liabilities	17,788	0	**17,788**
Total at 31 March 2019	**167,496**	**0**	**167,496**

Note 23.2 Maturity of financial liabilities

	31 March 2020	31 March 2019
	£000	**£000**
In one year or less	126,066	74,414
In more than one year but not more than two years	1,576	43,840
In more than two years but not more than five years	5,133	4,926
In more than five years	42,533	44,316
Total	**175,308**	**167,496**

Note 24 Losses and special payments

	31 March 2020		31 March 2019	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Bad debts and claims abandoned	45	109	60	82
Stores losses and damage to property	12	29	12	59
Total losses	**57**	**138**	**72**	**141**
Special payments				
Ex gratia payments in respect of:				
Loss of personal effects	12	6	15	4
Personal injury with advice	2	7	6	18
Employers negligence and injury	13	38	9	55
Other	0	0	7	1
Total special payments	**27**	**51**	**37**	**78**
Total losses and special payments	**84**	**189**	**109**	**219**
Compensation payments received		0		0

There were no cases exceeding £250,000 in either the current or prior year.

Note: the amounts are reported on an accruals basis but exclude provisions for future

Note 25 Events after the reporting date

On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. Given this relates to liabilities that existed at 31 March 2020, DHSC has updated its Group Accounting Manual to advise this is considered an adjusting event after the reporting period for providers. Outstanding interim loans totalling £106,631m interim loan principal and £408k interest accrual as at 31 March 2020 in these financial statements have been classified as current as they will be repayable within 12 months.

Note 26 Related parties

The Trust is a public benefit body authorised by NHS Improvement, the independent Regulator of NHS Foundation Trusts.

During the period there has been no material transactions with any member of the Board or members of key management staff or parties related to them, with Tameside Integrated Care NHS Foundation Trust.

The Department of Health and Social Care is regarded as a related party. During the year Tameside and Glossop Integrated Care Hospital NHS Foundation Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are listed below, along with details of Income and Expenditure and the Debtor and Creditor balances.

The Trust is a corporate trustee of the Tameside & Glossop Integrated Care NHS Foundation Trust Charitable Fund. The Trust has received monies from the charity in respect of its management of the charity to the value of £64k (£72k to 31 March 2019). The charity is registered with the Charity Commission for England and Wales (1055818) and produces its own annual report and accounts. Under IFRS 10, NHS bodies are required to consolidate their charitable funds with their own statements where they are considered to be

	Receivables		Payables	
	31 March 2020 £000	31 March 2019 £000	31 March 2020 £000	31 March 2019 £000
NHS England - Core	13,539	4,764	0	314
NHS Tameside and Glossop CCG	1,781	1,396	1,414	1,383
HM Revenue & Customs	515	712	3,464	3,294
Pennine Care NHS Foundation Trust	304	329	67	70
Manchester University NHS Foundation Trust	263	377	1,580	1,231
NHS England - North West Regional Office	260	46	0	0
Stockport Metropolitan Borough Council	208	374	0	0
NHS Stockport CCG	201	176	4	4
Other NHS Bodies (including Welsh Health Bodies)	199	60	119	146
Other CCGS	165	359	51	42
Stockport NHS Foundation Trust	126	522	69	122
Salford Royal NHS Foundation Trust	92	157	185	225
Pennine Acute Hospitals NHS Trust	85	38	57	140
The Christie NHS Foundation Trust	60	75	188	117
Tameside Metropolitan Borough Council	50	264	1	2
NHS England - North West Specialised Commissioning Hub	48	0	0	552
NHS England - Central Specialised Commissioning Hub	2	23	0	0
NHS Pension Scheme	0	0	1,997	1,914
NHS Professionals	0	0	658	1,010
NHS Manchester CCG	0	395	207	22
NHS Oldham CCG	0	40	137	74
NHS Heywood, Middleton and Rochdale CCG	0	18	107	2
Community Health Partnerships	0	0	6	6
Health Education England	0	139	0	2
NHS Property Services	0	127	0	0
Total	**17,898**	**10,391**	**10,311**	**10,672**

	Income		Expenditure	
	31 March 2020 £000	31 March 2019 £000	31 March 2020 £000	31 March 2019 £000
NHS Tameside and Glossop CCG	153,102	152,193	1,651	1,836
Tameside Metropolitan Borough Council	33,874	26,214	851	891
NHS England - Core	27,139	7,552	8	0
NHS Oldham CCG	6,254	6,384	0	34
NHS Manchester CCG	6,048	6,326	0	0
NHS England - North West Specialised Commissioning Hub	5,784	5,345	0	0
Health Education England	5,043	4,967	0	6
NHS Stockport CCG	1,930	1,636	0	0
Pennine Care NHS Foundation Trust	1,424	1,414	355	468
NHS England - North West Regional Office	1,372	1,528	0	0
Other CCGS	1,031	970	0	0
Manchester University NHS Foundation Trust	902	762	3,327	3,701
NHS Heywood, Middleton and Rochdale CCG	655	724	0	0
Stockport Metropolitan Borough Council	628	456	0	0
Salford Royal NHS Foundation Trust	338	343	273	242
Pennine Acute Hospitals NHS Trust	239	252	27	35
NHS Bury CCG	144	168	0	0
NHS Trafford CCG	134	162	0	0
NHS Salford CCG	130	144	0	0
The Christie NHS Foundation Trust	126	99	437	474
Other NHS Bodies (including Welsh Health Bodies)	118	108	479	477
NHS Derby and Derbyshire CCG	116	106	0	0
NHS England - North East Specialised Commissioning Hub	81	68	0	0
Stockport NHS Foundation Trust	66	137	391	370
Department of Health and Social Care	22	2,905	0	2
NHS England - Central Specialised Commissioning Hub	18	20	0	0
Public Health England (PHE)	1	0	1	1
NHS Pension Scheme	0	0	20,852	13,864
HM Revenue & Customs	0	0	13,071	12,281
NHS Professionals	0	0	10,553	10,165
NHS Resolution	0	0	8,162	8,468
Community Health Partnerships	0	0	1,669	1,641
NHS Blood and Transplant	0	0	829	621
Care Quality Commission	0	0	152	149
Bolton NHS Foundation Trust	0	1	70	125
Royal Liverpool and Broadgreen University Hospitals NHS Trust	0	0	58	105
Northumbria Healthcare NHS Foundation Trust	0	0	8	34
Other Local Authorities	0	3	4	4
NHS Property Services	0	97	0	0
Total	**246,719**	**221,084**	**63,228**	**55,994**