Stockport
NHS Foundation Trust

Stockport NHS Foundation Trust
Annual Report and Accounts 2020-2021

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CONTENTS

	Page
Chair's introduction	6
Review of the year – Service improvements	8
Review of the year – Awards	11
Your support	14
Performance Report	17
Chief Executive's statement	17
The Trust	21
Key risks to delivering our objectives	24
Going Concern	25
Operational performance	26
Financial review	32
Sustainability	37
Accountability report	42
Directors' report	42
Remuneration report	63
Staff report	69
NHS Foundation Trust Code of Governance declarations	83
NHS Oversight Framework	95
Statement of Accountable Officer's Responsibilities	97
Annual Governance Statement	99
Independent Auditors report	112
Annual Accounts 2020-2021	119

Chair’s introduction

When the Trust published its annual report for 2019-20 few of us of could have anticipated that 12 months later we would still be providing hospital care for Covid-19 patients. By anyone’s standards, 2020-21 was an extraordinary year for the country, the NHS, and Stockport NHS Foundation Trust.

It was a year that impacted on all of our lives whether we or those closest to us contracted the virus, were furloughed, or suffered the isolation and loneliness of lockdown. For Stockport NHS Foundation Trust it was a year in which we saw the unwavering dedication and commitment of our staff in doing their very best for patients – whether they were providing hands on care or supporting clinical colleagues.

Theatre staff up skilled to work in intensive care, community nurses staffed our patient liaison team, ward staff found themselves working on different wards and in different teams, procurement colleagues ensured millions of items of personal protective equipment were always available, cleaners increased their efforts to help prevent cross infection, IT staff installed the technology to carry out remote outpatient appointments, and our HR and pharmacy teams organised a highly efficient vaccination programme. Every member of staff, in every part of the Trust played their part in helping us respond to the unprecedented challenges posed by the pandemic.

NHS staff are known for being great in a crisis, but few of us have experienced a crisis that has lasted over 12 months. The resilience of our staff to be there for our patients and just keep going is admirable, but it is not something we can take for granted.

The last year has taken a huge toll on colleagues and we know that for some people that impact will continue to affect them for some time to come. During 2020-21 we were committed to ensuring that the best possible range of health and wellbeing support for our staff was provided and available for all. That focus on supporting colleagues will continue as we start to work on recovering our services, and tackling the waiting list backlog that has built up as a result of the pandemic.

During the extraordinary year that was 2020-21 our organisation has also seen a number of leadership changes. It is testament to the individuals involved that the people changes and handovers of responsibilities, which can often destabilise an organisation, happened so smoothly.

The Board of Directors, which is leading our organisation into 2021-22, is now very different, and you can find more detail about the changes on page 46 of this report. Louise Robson stepped down from the Chief Executive role in November 2020 to lead work across the North of England on the development of integrated care systems in line with the Government’s White Paper *Integration and Innovation: working together to improve health and care for all*. The organisation was fortunate to secure the services of Karen James OBE, who maintained her Chief Officer responsibilities at Tameside & Glossop Integrated Care NHS Foundation Trust.

At the end of April 2021 Adrian Belton also stepped down from the role of Chair, which he had held for the previous four years, and I was delighted to be appointed by the Council of Governors as Chair of the Trust from 1 May 2021.

I would like to take this opportunity to thank both Louise and Adrian for leading our organisation through some truly challenging times. They laid the foundations of an excellent Board of Directors, as well as an organisation that is ready to embrace the changes that are facing the health and care system as a result of both recovery from the pandemic and the White Paper.

Good governance is at the heart of running a safe and effective organisation, and over the last year the Board of Directors made a number of improvements to the organisation's governance arrangements. With their experience and knowledge Karen, our new Chief Nurse, and Medical Director are enhancing those improvements, and the Board will continue to see this as a key area of focus on our journey towards being a "good" and eventually, an "outstanding" organisation.

We are fortunate at Stockport NHS Foundation Trust to have a Council of Governors that is so supportive of our organisation and our improvement journey. They want the very best for our patients, staff and the communities we serve, and they are not afraid to hold the Board, through the non-executive directors, to account for delivering what we say we will do. As we work through the changes to the health and care system planned for the next year our governors will be crucial in helping us to effectively engage with our members and local population.

As I take on the role of Chair I look forward to the opportunities that lie ahead for our organisation in 2021-22. During the pandemic we embraced the benefits of working in partnership with other organisations across Stockport and the wider Greater Manchester (GM) system. We will continue to build on that experience and further strengthen collaborative working for the benefit of patients and our staff.

This annual report is full of examples of the great work colleagues have delivered during 2020-21, and I look forward to working with the Board of Directors to enable even more improvements and service developments over the next 12 months.

Prof. Tony Warne

Chair

03.06.2021

Review of the Year – service improvements

Responding to the demands of the pandemic meant that many of our staff had to be innovative in the way they provided services. Here are just some of the innovations and improvements to services we introduced during 2020-21 – you will find more in the news and events section of our website www.stockport.nhs.uk

New video appointments system

A new system of videoconferencing for patients was introduced for our hospital and local community NHS services – with heart failure patients the first to benefit.

After a successful pre-pandemic pilot we rolled out videoconferencing to a number of services including children's services, rheumatology, gastroenterology, gynaecology, urology, community diabetes, nutrition and dietetics, paediatrics, COPD, health visiting, occupational health, and orthopaedic assessments.

This meant our clinical staff could continue to meet face-to-face with patients and carers, while protecting each other from the risk of infection.

Better telephone service

New software for the call centre appointments at Stepping Hill Hospital has meant a better service for patients.

The centre, which handles more than 16,000 calls a month, is the main contact point for patients with queries about appointments. Thanks to new software, callers are now more quickly and efficiently connected to the department they need.

The software was part of a project to improve our telecommunication system for patients and staff.

Children's lockdown lifeline

Our health visiting and school nursing teams were amongst the first in the country to set up a helpline for concerned parents during the lockdown.

Launched early in the pandemic the helpline was singled out for praise in a Department of Education review of services for children with special education needs and disabilities. Overall the review concluded that our services had performed extremely well in continuing to care for youngsters with special needs.

Staffed by health visitors the helpline provided help and advice to parents on a range of issues from immunisation to minor illnesses, and feeding problems to development needs. The pandemic

escalated existing plans to set up a support line, after the opportunities reduced for face-to-face meetings with parents and children, as a result of Covid-19.

Research success

As a key research site in Greater Manchester, working closely with the Greater Manchester Clinical Research Network, we are very proud of the research our teams, staff and patients take part in – and this year our efforts were even more important as the NHS tackled the challenge of Covid-19.

We were one of the top recruiting sites in the country in a new study testing the genetic make-up of patients in the fight against Covid19. We recruited 30 patients to put us in the top five of the 170 intensive care unit sites taking part in the study across the country.

Led by the University of Edinburgh in partnership with Genomics England, the study tested how patients' genetic makeup could influence their reaction to the virus in the hope of identifying those people most at risk, and so fast-track new therapies into clinical trials.

Our ward and ICU staff also recruited patients for studies involving the effective use of drugs, convalescent plasma, and other treatments for the coronavirus. The RECOVERY trial focused on evaluating drugs which have a positive impact on the chance of reducing mortality rates, and the REMAP CAP trial tested for effective treatment of patients critically ill with the virus. Both trials needed the donation of blood plasma (through NHS Blood and Transplant Services) from people who have previously tested positive for Covid19, and donors included our own staff.

We also took part in the SIREN study, led by Public Health England, aimed at understanding whether previous infection with SARS-CoV2 (the virus that causes COVID-19) protects against future infection, and over 100 staff volunteered to take part in this study.

During the year we were involved in 13 separate Covid19 related studies ranging from the virus in pregnancy, ICU and ward settings, to staff resilience during the pandemic. More than 860 patients took part in Covid19 studies at the hospital linked to the National Institute of Health Research.

£3.6m for winter

We were awarded a £3.6m share of a £18.437m package for Greater Manchester, to help hospitals upgrade their facilities and improve A&E capacity.

The extra funding supported the relocation of outpatient services at Stepping Hill Hospital to ensure separation of Covid and non-Covid patients. It also paid for the development of a new emergency assessment area for patients directly referred from GP surgeries, and the creation of extra cubicles in the emergency department to enable more patients to be seen.

Emergency care campus

Last year the Government pledged £30.6m to fund a new emergency care campus on the hospital site, and the major development took a big step forward when the outline business case was approved by our Board of Directors for submission to NHS England/NHS Improvement (NHSE/I)

It is hoped that, subject to approval by NHSE/I and local planners, building work should start on the campus in 2021 and be complete in 2023.

Baby lifeline bags

Our maternity department took delivery of ten innovative new Baby Lifeline bags to help midwives support home birthing mothers.

The bags contain standardised equipment in colour coded compartments to ensure midwives have everything they need quickly to hand for different stages of labour and birth, including emergencies.

A new CURE for smokers

Patients who smoke are benefitting from a new approach and a new hospital team dedicated to helping them kick the addiction.

CURE is a GM wide project aimed at identifying and helping all smokers admitted to hospital, and the Stepping Hill based team is working with patients to offer nicotine replacement therapy and specialist support to help patients kick the habit while in hospital, and stay smoke free once discharged.

New Year new scanner

Early in January 2021 we welcomed a new state-of-the-art CT scanner to Stepping Hill Hospital.

Housed in a new building, the scanner is being used by our radiology staff to identify signs of cancer, as well as other conditions such as blood clots, strokes, tumours, bone fractures, and surgical emergencies.

The radiology team carried out over 50,000 CT scans a year with two scanners, and the addition of a third machine with the potential of a fourth in the new building, means the service is well placed to tackle the backlog of diagnostic tests as a result of the pandemic.

Welcome to international recruits

Ten nurses from India and Nepal recently joined our organisation as part of our efforts to recruit and retain more staff.

They are among the 41 international nurses who have made Stockport their home since January 2020. Around nine per cent of our staff are from overseas, and after India the top countries for

recruitment include Ireland, Nigeria, Spain, Italy, and Poland.

Some of the latest recruits join relatives and friends who have previously become part of our nursing workforce and have been made welcome by their colleagues and local community.

First ultrasound clinic of its type in GM

Our rheumatology team set up the fast track ultrasound clinic to improve the diagnosis of Giant Cell Artertis (GCA), which can cause blindness.

GCA, which causes around 3,000 people a year in the UK to lose their sight, is usually diagnosed with a biopsy. But the first consultant-led clinic of its type in GM means patients no longer have to wait for an inpatient operation. Instead they can be diagnosed as an outpatient within one working day of referral by their GP, and so start sight saving treatment more quickly.

Our charity funded a specialist ultrasound probe for the new service thanks to donations from generous local people.

Review of the Year - awards

Our staff and services are often recognised in regional and national awards for their work – here is a snapshot of just some of the accolades they received during the last 12 months.

Decontamination top rating

Our hospital decontamination unit, which ensures surgical instruments are clean, sterile and safe, had an exceptional outcome following a re-certification audit.

The British Standards Institute (BSI) inspection found no compliance issues meaning standards were as high as possible, and ensuring the unit maintained its national certified standard of quality assurance for the next three years.

The unit ensures our operating theatres and endoscopy unit are provided with the correct sterile instruments for the thousands of procedures undertaken each year. Effective decontamination of instruments is a vital part of reducing the risks of cross infection - always important, but particularly during the pandemic.

Medical training award

Our clinical simulation team were shortlisted for a top national award for their outstanding work in supporting gastroenterology and other clinical teams.

The team was showcased in the medical education and training category of the Royal College of Physicians Excellence in Patient Care Awards for the way they use simulated clinical environments,

manikin patients, and the latest technology to provide important training for consultants, nurses, advanced clinical practitioners and healthcare assistants.

Queen's nursing award

Two Stockport nurses received some of the top nursing awards in the country for their outstanding work in caring for people in the community.

Specialist nurse practitioners Donna Davenport and Andrea Harris were presented with Queen's Nurse Awards, which recognise the best in community nursing across the UK. They were honoured for their achievements in lifelong learning, exemplary leadership, and high standards of practice and patient care.

Donna, a nurse for over 39 years, has worked in primary and community based nursing in Stockport since 1996 and is a district nurse facilitator, supporting training, education and continuing professional development for eight district nursing teams across the Stockport area.

Andrea has been a nurse for 35 years, including 18 years as a district nurse in the Stockport and Macclesfield areas. She is now matron / pathway lead for district nursing in the western areas of Stockport, organising and providing leadership for nurses caring for patients in the community.

Wound care excellence

Lisa Gough, a specialist tissue viability nurse at Stepping Hill Hospital was part of a team to receive national recognition for their efforts in increasing efficiency in wound care across GM.

The Greater Manchester Health & Social Care Partnership's Procurement Team was highly commended in the 'Project of the Year – under 20m' category of the UK National GO Excellence in Public Procurement Awards 2020.

The team was honoured for their project, which standardised the purchasing of wound care products, such as adhesive dressings and bandages across GM, to ensure the same high standards of care throughout the area, as well as making significant savings.

Recognition for bowel cancer nurse

Doreen Dooley, a colorectal clinical nurse specialist based at Stepping Hill Hospital, was shortlisted for a national award for the positive impact her leadership has had on bowel cancer patients and her colleagues.

Doreen, who has led the coloproctological nursing service at the hospital for the past 21 year, was shortlisted for the Bowel Cancer UK Gary Logue award, which recognises those who have gone above and beyond in their delivery of care.

She was honoured for the work she does training and supporting nurses into specialist roles, and

also introducing nurse-led clinics to support patients with colorectal cancers.

Two SAS awards

Dr M K Shashidhara, a senior specialty and associate specialist (SAS) doctor, and administrator Angela Berry, based at Stepping Hill Hospital, were both honoured at Health Education England North West's SAS Awards, which celebrate the best in educational support for SAS doctors in the region.

Dr Shashidhara was awarded the trophy for SAS Tutor / Lead of the Year. He has been an SAS tutor at Stepping Hill Hospital for 13 year, and has been a key part of making the hospital a leading centre for SAS doctors from across the region and beyond.

Angela Berry was named as SAS Administrator of the Year for her exceptional level of commitment to helping SAS doctors to develop their roles.

Top for safe abdominal surgery

Stepping Hill Hospital was named as the safest general hospital in the country for emergency abdominal surgery in the annual report from the National Emergency Laparotomy Audit.

We were one of four top trusts in the country for survival rates for emergency laparotomies, and also the best general hospital, with one quarter of the expected number of deaths according to national figures.

Cavell Star Award

Our lead nurse for infection prevention was presented with a national Cavell Star Award for her outstanding dedication and commitment.
Nesta Featherstone, Associate Nurse Director for infection prevention and control, was nominated for the award by colleagues for all her efforts during the pandemic in trying to minimise the risk of infection and protecting patients and colleagues.

The Cavell Nurses Trust is a charity which supports nurses, midwives, nursing associates and healthcare assistants, and its Star Awards are offered to outstanding members of these professions across the UK.

Radiographer's training award

Jack Butler, a chest reporting radiographer, received the In-Health Award for Academic Excellence in Clinical Reporting – Adult Chest Pathway for outstanding achievement on the post graduate certificate in clinical reporting course.

The course involves an intensive year of study, both within the university and clinical departments, with successful students having to balance their ongoing full-time practice with their study and home

lives, frequently studying in their own time.

Exemplary catering team

Our hospital catering service was chosen as one of just 14 exemplar sites for NHS catering across the country – and the only one in GM.

It followed recommendations by the national Independent review into NHS hospital food, which recognised the importance of good nutrition in both patient recovery and general support for healthier living in the wider community

Exemplar sites are test sites for national initiatives and support other services to raise the standards of NHS catering. Our catering team was singled out for its high standards of nutrition, and the diversity and choice it offers both patients and visitors.

Your support

We are always humbled by the support and good wishes we get from patients, their relatives and the local community for the care we provide. But during 2020-21 we were overwhelmed by the level of support we received as our staff worked hard to rise to the challenges of the pandemic.

The weekly clap for carers, Foodie Fridays; masses of donations, including hundreds of Easter eggs, hand cream and hampers, as well as wonderful hand drawn pictures from local children to adorn our "Corridor of Hope", were all hugely welcomed by our staff. The out pouring of thanks and good wishes was unexpected, but truly appreciated.

Here is a snap shot of just some of the support we received over the last year, but you can find out more about the donations we received, and how we spent the many financial contributions that came into the organisation in our charity's annual report for 2020-21, which is on our website.

Staff sanctuary

A room to provide a much-needed space of calm and reflection for staff was made all the more comfortable due to a generous gift from Macclesfield furniture store, Arighi Bianchi.

Within 24 hours of us appealing for help to furnish the room the store stepped forward with a generous offer of beautiful furniture. Our staff were invited to the store's warehouse to make their choice before Arighi staff drove it over to the hospital and helped to set it up.

The array of comfortable leather armchairs, sofas and other attractive furnishings made The Sanctuary in our education centre a warm and welcoming place for staff to relax and reflect.

Gifts to keep in touch

Thanks to mobile devices donated by solicitors firm Simpson Millar, and mergers and acquisitions company Benchmark International, many of our patients have been able to keep in touch with their families while in hospital during the pandemic.

With visiting to the hospital limited to the most exceptional circumstances, the kit has been crucial to enabling our patient liaison service to connect patients with their loved ones.

Communal garden

Staff are enjoying a new communal garden area in which to recharge and relax thanks to Real Housewives of Cheshire star Dawn Ward.

With the help of Manchester-based furniture company Desser & Co and Swinton Insurance, who donated furniture and funded the project, interior designer Dawn helped transform a previously under-used outside area near the hospital's emergency department (A&E) into a much more calming and relaxing place.

With its top quality furniture, the garden is open to all hospital and community staff to take time out. Other respite areas in the hospital and community have also been created with the generous support of a number of separate donors.

Stockport County Support

Stockport County Football Club was one of our first – and most generous supporters – during the pandemic.

They initially donated £75,000 for equipment but thanks to other fundraising initiatives and Stockport born actress Michelle Keegan donating her voice over fee for a club promotional video, the total donation from our football friends came to £95,000. The club also gifted us their sleeve sponsorship for the season with profits from the sale of every club shirt coming to our charity.

Some £12,000 of that funding has been used to buy a specialist medical treadmill to help our respiratory physiology team carry out key exercise lung function tests for patients with many conditions, including cancer and respiratory problems.

Club owner Mark Stott said: "We cannot thank our local NHS enough for their heroic work during these difficult times. As a community club we will do everything we can to support our local healthcare and key workers."

Pregnancy loss comfort bags

Thanks to charity CRADLE we took delivery of comfort bags to help support parents admitted to hospital who have lost a baby.

The bags include essential items, such as toiletries as well as notepads to write down questions or thoughts, and a “Dear friend” letter with details of how to access support from the charity.

Improving endoscopies

Endoscopy patients are benefiting from the generosity of local people who supported a two year fundraising appeal for a new state-of-the-art machine.

The scope guide enables lower bowel procedures to be carried out more easily and quickly, and so improving patients’ experiences. Costing £40,000 the new kit is being used on around 7,000 procedures a year, supporting patients with many different conditions, including bowel cancer, ulcers and growths.

The fundraising appeal was supported by many different donors including Hazel Grove ‘Knit ‘n’ Natter ’Group, Whaley Bridge Men’s Probus Group, Hazel Grove carnival committee, bucket collections from the local pubs in Hazel Grove including the Rising Sun; Dunelm and Flair Rugs stores offered donations, a father and son took part in a sponsored skydive, and two epic sponsored bike rides were completed by Derek Farndell and his grandson, Lewis.

Hampers fit for heroes

Thanks to funding from NHS Charities Together our hospital and community teams received seasonal treats in the form of luxury Christmas hampers to thank them for their efforts over the last year.

We have received £50,000 from the national charity, and as well as funding the hampers the donation is also supporting other staff health and well being initiatives.

PERFORMANCE REPORT

The purpose of the overview is to provide a summary of Stockport NHS Foundation Trust, its purpose, the key risks to achievement of its objectives, and how the organisation has performed during the year.

Chief Executive’s statement

Working in the GM system as Chief Executive of Tameside & Glossop Integrated Care NHS Foundation Trust I had an external view of the long standing issues that Stockport faces. But when I took up the role of Interim Chief Executive in November 2020 there were a number of things about the organisation that surprised me.

First and foremost were the commitment, dedication, and sense of family demonstrated by the many staff I have met. Despite being six months into a pandemic that had impacted on the way that everyone works in the organisation, staff were focused on working together to do their best for patients, and they were positive about the future. We cannot take that resilience and commitment for granted, and while the most recent NHS staff survey reflected some of the positive attitudes I have seen while at Stockport, there is still much for us to do to make the organisation a truly great place to work.

I found an organisation that knows where it needs to make improvements, and had started on that improvement journey. It had worked with staff and external stakeholders to determine a new set of values, and developed a five year strategy that clearly describes the organisation’s ambitions.

Work was well underway to revise governance arrangements, which are so important to the operation of an effective organisation, and the Trust was addressing the areas highlighted as requiring improvement in a review the Board had commissioned from NHS England/NHS Improvement (NHSE/I).

I was also welcomed by a relatively new team of executive directors, but with the skills and experience to effectively lead the organisation’s improvement journey. We recognise that we need time together to develop as an effective team, along with our new non-executive director colleagues on the Board of Directors, and that is an area of focus for us in 2021-22.

However, these positive attributes give me confidence that we have the foundations on which to build an organisation that will – with time, hard work and commitment – become an outstanding organisation.

And despite the massive impact of the pandemic we have already seen some green shoots of improvement that the Board is committed to maintaining. We welcomed the Care Quality Commission (CQC) back to the organisation in August 2020, where they found that we had rapidly addressed all the issues that had previously resulted in a section 29a notice and they commented very positively on the change of culture within the emergency department, with staff now proud to work there.

We spent more than £24m on capital investments to improve the ageing environment and equipment on the Stepping Hill Hospital site. We received £3.6m of winter funding for the emergency department, which has helped to improve the environment while we await Government approval of our outline business case for a £30.6m new emergency care campus that we hope to start building in late 2021.

We have seen the completion of a new CT building at Stepping Hill Hospital, and invested in a third state-of-the-art CT scanner along with extra staffing for the department. We have also invested in extra endoscopy capacity, as both CT and endoscopy services are crucial to our post-pandemic recovery plan.

We have also continued to invest in more staff, attracting over 40 new international nurses to our services and recruiting 100 health care assistants during 2020-21. That investment in our workforce is set to continue into 2021-22 with the Board of Directors recently agreeing a £5.4m business case for extra nursing and health care assistants following a review of our ward establishments, and we are also looking at further investment in our allied health professional workforce.

Under the leadership of our new Chief Nurse we have seen a re-focus on ensuring all our clinical teams deliver the same standards of care, and delivery against those standards is being measured by a new accreditation scheme, STARS.

We have addressed the key areas of improvement highlighted in the external governance review we commissioned from NHSE/I, and we will be making further refinements over the next 12 month building on the experience of our Chief Nurse and newly appointed Medical Director. We have also delivered against the comprehensive action plan we developed following the CQC's inspection in 2019, and delivery progress has been carefully tracked by our Quality Committee.

Despite significant changes to the NHS financial regime as a result of the pandemic, we fully delivered our financial plan for the second year running and we have detailed plans in place for 2021-22.

As the number of people seeking treatment via our emergency department has returned to pre-pandemic levels the operations team focused on ensuring an effective flow of patients through the hospital, which had previously negatively impacted on our performance against the four hour A&E standard. We are now seeing improvements in performance, and while nationally the standards in relation to A&E are set to change we will remain focused on ensuring the best possible patient experience in the department.

From my experience I know that an organisation such as ours cannot tackle its problems alone. I welcome the opportunity that Stockport System Improvement Board (SSIB) has given us to address some of the problems facing health and care services in the locality that were highlighted following the CQC's 2019 inspection of our services. The SSIB has not only helped to track successful delivery against our CQC action plan, but also strengthened existing partnerships between the trust, local authority, mental health providers, CQC, and NHSE/I.

In taking on the leadership of Stockport NHS Foundation Trust one of my key areas of focus was on

building and strengthening local and regional partnerships. The pandemic has demonstrated how strong we can be when the health and care system works well together. Over the last 12 months we have seen the benefit of collaboration, whether that was sourcing personal protective equipment from neighbouring trusts or working with our local authority colleagues to reduce delayed discharges from hospital by a staggering 50%.

We have worked incredibly closely with our partners in Stockport Metropolitan Borough Council (SMBC) and Stockport Clinical Commissioning Group (CCG) to address issues that had previously seemed almost impossible to resolve, and we need to continue to build on that collaboration to take advantage of the opportunities that will come from the Government's White Paper.

Collaboration is a key theme of those proposed changes and we already have a strong foundation on which to build even closer working relationships with statutory and voluntary sector partners developed over a number of years, whether that has been through the development of frailty services with the full involvement of primary care and charities such as Age Concern, or working with local care homes to enable the rapid discharge of patients who no longer need hospital care.

We have had a long association with East Cheshire NHS Trust that was further strengthened during the pandemic, and we are now working together on the development of a joint clinical strategy to ensure a consistent standard of services across the communities we serve, and to make the most effective use of all of our resources.

Retaining the Chief Officer responsibilities at Tameside and Glossop Integrated Care (T&G) NHS Foundation Trust, I have been able to share expertise and learning across both T&G and Stockport NHS Foundation Trust, particularly in relation to performance, estates and facilities, transformation, and IT – and I am sure we will see more of this type of collaboration between neighbouring organisations over the next year.

Collaboration is also the foundation on which we will recover and restore services following the pandemic. While some services continued to be delivered over the last 12 months many were negatively impacted by Covid-19 as NHS services focused on caring for the sickest patients, as well as minimising the risk of infection for patients and staff.

As a result the number of patients waiting for diagnosis and treatment has built up across the country, and no single organisation can address the waiting list alone. In line with the way we worked during the height of the pandemic, organisations across GM have come together to prioritise and treat those patients most in need, as well as those who have waited the longest for diagnosis and treatment.

We know that it will take some time for this collective effort to clear the backlog, but as well as focusing on our recovery plan we also want to continue the drive to deliver our five year strategy for the organisation. Looking ahead we have agreed our key objectives for 2021-22, and they are to:

- deliver safe, accessible and personalised service for those we care for,
- support the health and wellbeing of our communities and staff,
- work with partners to co-design and provide integrated service models within the locality and access acute providers within the sector,

- drive service improvement, innovation and transformation,
- develop our workforce to meet future service and user needs,
- use our resources effectively and efficiently,
- develop our estate & IM&T infrastructure to meet service user needs.

Having a workforce that has the capacity and capability to deliver our objectives, as well as meet the expectations of our patients and commissioners, will be crucial to our future success.

While we will continue to invest in more staff we equally have to concentrate on retaining the people who work for us. We have developed a detailed People Strategy, in line with the national People Plan, which is guiding our work in this area, including ensuring people have the training and development opportunities to meet their career aspirations, and that they feel the organisation is a great place to work.

No-one can doubt the superb efforts of all of our staff during the pandemic, and in February 2021 we took the time to publically thank a number of individuals and teams that had gone above and beyond what could be expected of them over the last year. It was a real pleasure for me to meet both hospital and community teams to present them with Thank You February awards, and we have developed those accolades into Making a Difference awards that will be rolled out during 2021-22.

Such recognition, along with the practical thank you gifts that our local communities have showered our staff with over the last year (*see more on pg 14*), have meant so much to colleagues. We will be looking for more opportunities in the coming months to recognise their great work, and to support their health and wellbeing.

The last 12 months have been tough for lots of people and I am in awe of the way the staff, partners and people of Stockport and surrounding areas have risen to the challenges of Covid-19. We undoubtedly still have lots to do to address the issues that this organisation – and the local health and care system – faces, but I believe that in 2020-21 we have laid the foundations for future success. I look forward to the challenges of 2021-22 with optimism and faith in my trust and system colleagues that we have the skills, experience and commitment to do our very best for the local communities we serve.

The Trust

Stockport NHS Foundation Trust was formed on 1 April 2004, pursuant to Section 6 of the Health and Social Care (Community Health and Standards) Act 2003. As one of the first NHS Foundation Trusts in England, the organisation provides:

- acute hospital services from Stepping Hill Hospital in Stockport predominately for the population of Stockport and the High Peak area of Derbyshire,
- community services for the people of Stockport.

From 2011-12 the Trust provided community services for the populations of Tameside and Glossop, but on 31 March 2016 those services transferred to Tameside & Glossop Integrated Care NHS Foundation Trust.

We employ around 5,200 staff, working in our hospital and community services to support people in their own homes. Our main sites are:

- Stepping Hill Hospital,
- The Meadows,
- Bluebell,
- Swanbourne Gardens,
- The Devonshire Centre.

We are licensed to provide the following mandatory services:

Anaesthetics	Neurosurgery
Community services	Obstetrics
Emergency and urgent care	Ophthalmology
Ear, nose and throat	Oral surgery
General medicine	Orthodontics
General surgery	Paediatrics
Genito-urinary medicine	Rehabilitation medicine
Gynaecology	Rheumatology
Haemotology	Trauma & orthopaedics
Medical oncology	Urology
Neurology	

Since 2017 we have delivered those services via four business groups, each led by a triumvirate made up of an Associate Medical Director (AMD), Business Group Director, and an Associate Director of Nursing (ADN).

The business groups are:

- Integrated Care,
- Women, Children & Diagnostics,
- Medicine & Clinical Support,
- Surgery, Gastrointestinal & Critical Care.

In February 2020, following the annual inspection of our services by the CQC, we decided to take emergency and urgent care services out of the Integrated Business Group and create a business group of its own, again led by an AMD, Business Group Director, and an ADN. So we currently have a total of five business groups, and to deliver their objectives they are supported by a number of corporate services, including:

- Corporate nursing,
- Communications,
- Estates and facilities,
- Finance,
- Information management & technology
- Procurement,
- Strategy & planning,
- Workforce & organisational development,
- Learning & development.

During 2019-20 we completed a major refresh of our strategy, which sets out our vision for our medium term future as well as our aims and aspiration as an organisation that punches above its weight in terms of influencing the development of the local and regional health and care system – delivering more than just an ordinary district general hospital trust.

Our strategic priorities and objectives were developed and informed through engagement and listening exercises with our staff and stakeholders, and they underpin the annual corporate objectives that were agreed by the Board of Directors in April 2021. We also carried out a major programme of engagement with our staff to re-define the values and behaviours, which underpin the successful delivery of our strategy.

Our high level strategy is to:

- continue to develop our position as an anchor institution for Stockport (second largest employer) to benefit local people and the economy,
- be the leading provider of integrated services locally,
- “punch above our weight” in Greater Manchester,
- become a clinically led and managerially enabled organisation,
- develop our capacity and capability for transformation so that we lead this across the local patch,
- forge strategic partnerships with neighbouring trusts and local partners to ensure sustainability and development of services.

Our values are – We Care, We Respect, We Listen.

Our strategic objectives are:

- to be a great place to work,
- always learning, continually improving;
- helping people to live their best lives,

- investing for the future by using our resources well,
- working with others for our patients and communities.

Karen James OBE

Chief Executive

03.06.2021

Key risks to delivering our objectives

The Board of Directors has identified its strategic objectives and associate risks in a Board Assurance Framework, which was the subject of a major review during 2020-21.

To strengthen our approach to risk identification and management we formed a new Risk Management Committee, chaired by the Chief Executive with representation from Executive Directors and Business Group management. It meets monthly to review the trust's corporate risk register and also take a deep dive into the individual risk registers of the business groups and corporate services.

The committee provides a regular report to the Board, which clearly articulates the risks to the delivery of our objectives, and over the last 12 months they were:

Staff

Ensuring there are sufficient staff with the right skills and experience is an ongoing challenge for many NHS organisations, and it is one that rightly concerned our Board of Directors during 2020-21.

We have taken positive steps forward in recruiting to some traditionally difficult to fill consultant roles, and we have continued to invest in the recruitment of international nurses, health care assistants, and nurse associate roles. That investment in our workforce will continue into 2021-22 as our Board has recently approved a £5.4m business case following a review of ward staffing.

Safe staffing levels are monitored closely and regularly reported to the Board of Directors. In preparation for the impact of Covid-19 we set up a staffing hub to best match the patient acuity levels in ward areas with the available staffing. This has proved extremely successful in managing the position and we have continued to maintain the hub.

Ageing estate

Following an external review of the management of the organisation's ageing estate and delivery of its estates and facilities services in 2019-20, we continued to closely monitor the delivery of a comprehensive action plan. We also agreed a plan to address the previous under investment in our estate and equipment.

During 2020-21 we spent over £24m on capital investments to make changes to some of our estate in response to the pandemic, as well as upgrade parts of Stepping Hill Hospital to standards expected of a modern hospital, such as the development of a new CT building.

We developed an outline business plan for the £30.6m emergency care campus and we hope to start work on this significant development later this year, subject to feedback from the Department of Health and Social Care and approval of a final business plan.

With support from the Director of Estates and Facilities at Tameside & Glossop Integrated Care NHS Foundation Trust we are now developing an estates strategy for the hospital, and looking at future options for providing modern health care facilities.

Major disruptive event/demand exceeding capacity

Many organisations identify in their risk registers the potential for a major disruptive event to impact on the provision of normal services, but few of us would have predicted a pandemic that impacted on services for more than 12 months and fully tested our emergency preparedness.

However, that was the position faced by NHS organisations across the country during 2020-21. Thanks to collaborative working across GM, partnership support across Stockport and surrounding areas, and the commitment of our staff, we were able to rapidly and repeatedly adjust our services in response to the demands of the pandemic.

Our A&E was divided to separate Covid-19 patients from non-Covid patients, wards were flexed to suit different patients' needs, our intensive care capacity was increased, theatre staff were up skilled to support intensive care colleagues, inpatient staff moved wards and teams, community staff adopted hospital based roles, and others supported clinical staff in many different ways.

A gold, silver and bronze command structure was adopted internally to mirror the structure happening at regional and national levels as the NHS operated in a level four command and control structure for much of the year.

Internally we set up new workforce, clinical, and financial advisory groups to support rapid decision making, and in line with national guidance we rationalised Board and assurance committee meetings to allow staff to focus on urgent operational demands.

Thanks to the efforts of the whole health and social care system we managed to cope with the demands of Covid-19, and while some services were able to continue almost as normal many others were impacted, resulting in a backlog of patients now waiting for diagnostic tests and treatment. We are working with trusts across GM to address that backlog, prioritising the patients most in need as well as those who have waited the longest to be seen.

Going concern

International Accounting Standard 1 (IAS 1) requires the trust to assess its ability to continue as a Going Concern as part of preparing the Annual Accounts. The process for considering Going Concern should be proportionate in nature and depth to the risk being faced by the entity.

When concluding whether or not the accounts for 2020-21 should be prepared on a going concern basis, IAS1 required that the Board of Directors will need to consider which of the following scenarios are most appropriate:

a. The trust is a going concern and it is appropriate for the accounts to be prepared on the going concern basis;
b. The trust is a going concern but there are material uncertainties regarding future issues which should be disclosed in the accounts to ensure a true and fair view;
c. The trust is not a going concern and the accounts will need to be prepared on an appropriate alternative basis.

On the 1st April 2021 NHSE/I issued a letter to NHS organisations with guidance on how management should assess going concern.

The letter references the financial reporting frameworks applicable to NHS bodies, the HM Treasury Financial Reporting Manual (FReM), upon which the DHSC Group Accounting Manual (GAM) and Foundation Trust Annual Reporting Manual are based. This framework provides that the anticipated continued provision of services is a sufficient basis for going concern. The GAM states specifically that DHSC group bodies must prepare their accounts on a going concern basis unless informed by the relevant national body or DHSC sponsor of the intention for dissolution without transfer of services or function to another entity.

After making enquiries, the Directors have a reasonable expectation that the services provided by the NHS Foundation Trust will continue to be provided by the public sector for the foreseeable future. For this reason, the Directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.

Operational performance

The Board of Directors has approved a set of key metrics to measure performance that cover:

- operational performance,
- quality performance,
- financial performance,
- work force performance,

These metrics include those set by us, as well as regional and national standards. Data detailing performance against the metrics are consolidated into a comprehensive Integrated Performance Report (IPR), which is reviewed on a monthly basis by the Board of Directors, and the metrics are grouped under the following domains:

The format and content of the IPR is regularly reviewed to ensure that the metrics accurately reflect our priorities. The table below summaries our performance against the NHSE/I Single Oversight Framework during 2020-21, with further commentary contained below for each standard.

Metric	Standard	Q1	Q2	Q3	Q4
Referral to Treatment: Incomplete Pathways	92%	58.2%	48.3%	58.2%	56.3%
Referral to Treatment: Waiting List Size	n/a	25,329	29,104	31,145	31,782
Cancer 62 day: Referral to Treatment	85%	56.9%	56.2%	66.4%	63.8%
Diagnostics: Maximum 6 Week Wait	1%	54.3%	55.6%	49.6%	50.4%
A&E 4hr standard: Arrival to treatment	95%	91.0%	74.7%	66.3%	74.3%

Covid-19 pandemic

Throughout 2020-21 the UK continued with its emergency response to the Covid-19 pandemic. This has had a significant impact on our organisation, with most ‘normal’ activities suspended, such as non-urgent elective operations, until the summer of 2021.

This has resulted in the backlog of patients waiting for diagnosis and treatment, and has severely impacted on our usual ability to meet nationally set performance standards.

As part of the national response, the normal planning process was suspended and we were funded on a break-even basis for the period of the pandemic.

We maintained emergency planning, preparedness and response arrangements throughout the pandemic in line with national and regional guidance, and part of this included the Board of Directors focusing on a core set of quality and operational standards.

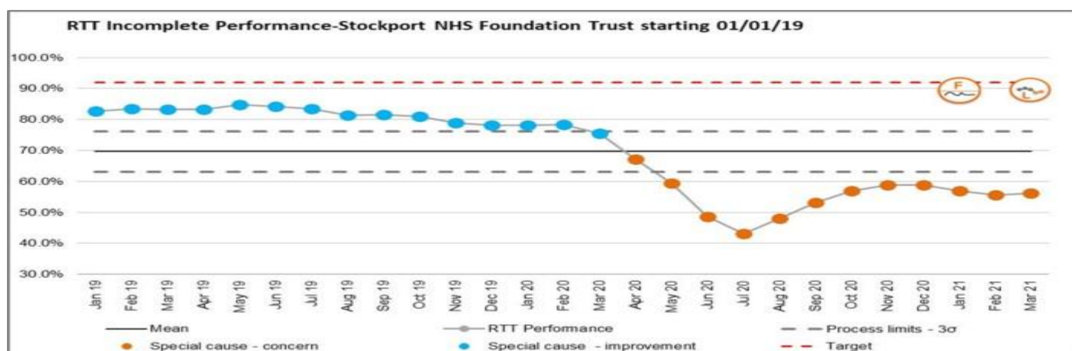
In line with national guidance, and as the first wave of the pandemic receded in the summer of 2020, operational planning and the focus of the Board shifted to addressing how to return to providing our usual range of services. This included the need to be mindful of increased infection prevention requirements, and continuing to maintain transformational initiatives, such as virtual appointments for out-patients clinics.

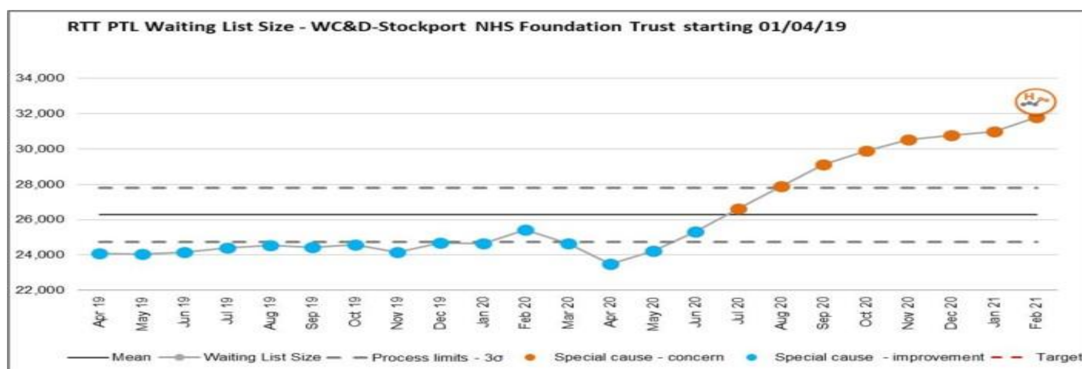
To ensure the safety of patients whose treatment had been delayed by the pandemic, we complied with national guidance on the regular review of patients waiting, and prioritised treatment in line with the Federation of Surgical Specialty Associations.

Referral to treatment

We last achieved the national referral to treatment incomplete standard in April 2019, and prior to the pandemic we had been working on an improvement trajectory that was developed and agreed with NHSE/I.

The pandemic and the curtailment of the vast majority of elective activity had a significant impact on our performance and the number of people waiting for treatment, defined by the waiting list size.



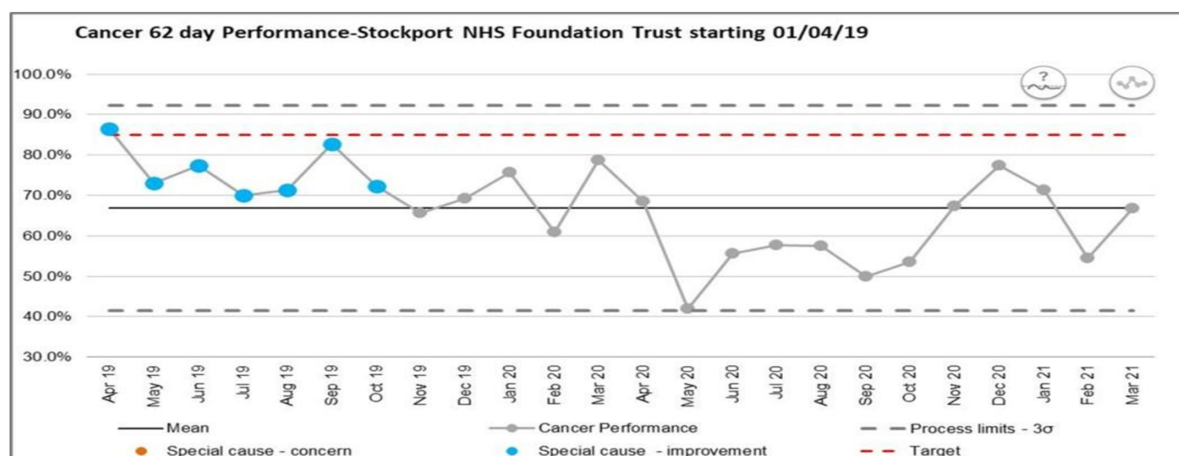


While the pandemic initially resulted in a significant reduction in GP referrals, which had a positive impact on the waiting list size, that was very short term and as expected the waiting list size grew significantly in 2020-21.

Cancer performance

Our performance against the 62 day cancer target was a challenge pre-Covid-19 and deteriorated further as a result of the pandemic. This was a similar position regionally and nationally.

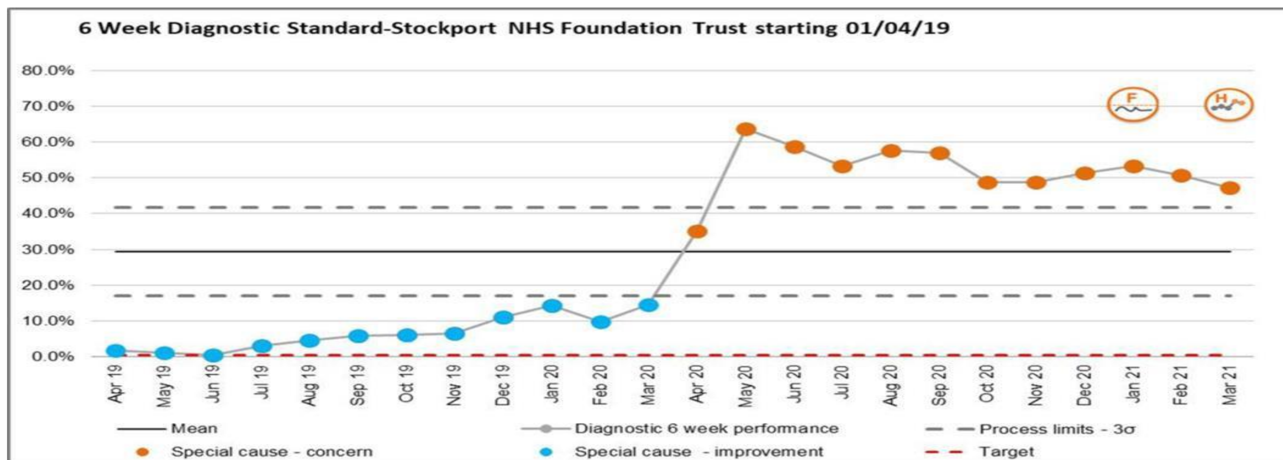
In responding to clinical urgency we have worked collaboratively across Greater Manchester (GM) to ensure patients received timely treatment and suffered no unintended consequences or incidents of harm due to delayed treatment. This has been monitored via Board sub-committees.



Given the size of the backlog locally and regionally, and ongoing limitations to services as a result of enhanced infection prevention and control measures, we expect performance against the 62 day cancer pathway to remain challenging in 2021-22.

Diagnostic performance

Our performance against the 62 day cancer target was a challenge pre-Covid-19 and also deteriorated further as a result of the pandemic. The impact of the pandemic on elective care will lead to much longer waits for diagnostic tests and treatment for patients with suspected cancer.



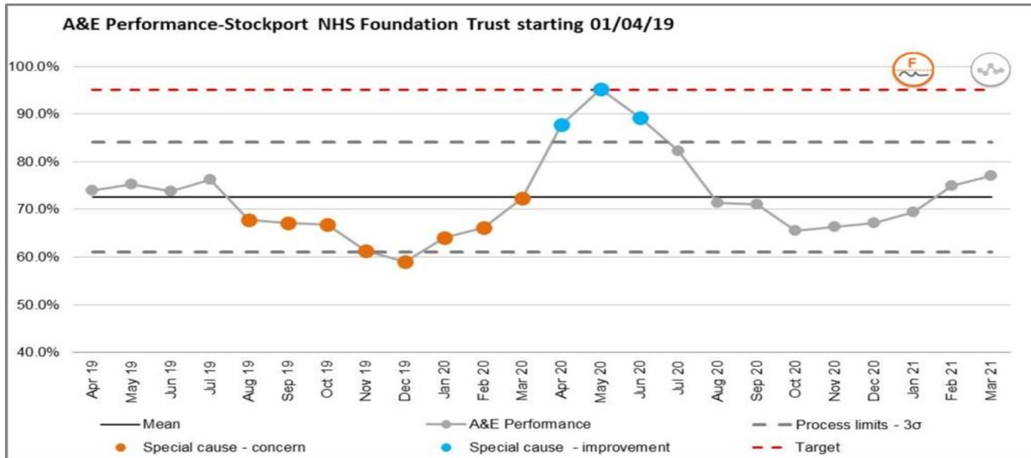
In recovering the diagnostic position we have invested in additional capacity for key diagnostics and accessed capacity across GM.

To address the capacity issues in endoscopy we have made significant investments in the service with the building of a new endoscopy suite and the recruitment of extra gastroenterology consultants. We have also taken advantage of external endoscopy capacity.

An increase in cancer referrals and emergency patients requiring CT scans put our existing CT capacity under pressure, coupled with the unexpected failure of our two existing scanners during 2019-20. We have invested in two further scanners to increase the capacity available and we are currently building a new scanning suite. We developed a recovery plan and as a result in February 2020 we were starting to see an improvement in the position. However, the pandemic has had a significant impact on endoscopy activity as national clinical guidance was to avoid this type of diagnostic procedure.

Four hour A&E standard

Our difficulties in achieving the four hour standard for emergency care have been well documented over a number of years, with the standard not previously being delivered since 2015.



As a result of the pandemic we saw significant improvements to the flow of patients through the hospital as we worked closely with commissioners, primary care, and local authority colleagues to ensure rapid hospital discharge, with the majority of patients returning home or moving to alternative care settings within two hours of being identified as no longer needing hospital care. Performance against this standard continues to be monitored - along with actions for our partners to improve the local health and care system - by Stockport System Improvement Board and our Board of Directors. We continue to seek to improve the performance, and this has supported an improvement in the standard in quarter 4.

Equality of service delivery

As a publicly funded organisation we are conscious of, and committed, to our duty to provide equality of access to all patients who need our services. Any proposed changes to modify any of our services are subject to thorough quality and equality assessments, overseen by our Chief Nurse and Medical Director

Equality of access and service delivery was something that we were particularly aware of during the pandemic. To safeguard our patients and staff by limiting the risk of infection, many of our out-patients appointments moved from face-to-face to virtual. This approach was rolled out across a number of our services and was welcomed by many of our patients. But we were aware that some patients would need to continue to be seen face-to-face due to the nature of their condition, or because they did not have the technology to enable virtual appointments. Therefore, we undertook face-to-face appointments on a risk assessed individual basis to meet the needs of our patients.

Following the success of our award winning Veteran's Passport to Health and Social Care designed to support former service people to smoothly navigate our services without having to repeatedly recall possible distressing past experiences, we also worked on the development of a passport for people with learning disabilities. We also completed a significant amount of work to meet the requirements of the Accessible Information Standard.

The CQC's inspection of our services in 2019 highlighted concerns about the care of patients with mental health issues in our A&E department. Over the last year we worked closely with colleagues at Pennine Care NHS Foundation Trust and with other partners as part of Stockport System

Improvement Board on improving services for people with mental health problems, as well as strengthening mental health training for our staff. We have set up a mental partnership board that meets monthly, developed a mental health board that meets every three months, and developed a memorandum of understanding for mental health support.

For more information about our approach to equality see page 82.

Consultation about service changes

We did not formally consult on any significant service change in 2020-21

Overseas operations

We did not conduct any overseas operations during 2020-21.

Financial review

The Group accounts include the consolidated financial results of Stockport NHS Foundation Trust, its associated Charity General Fund, and the trust's wholly owned subsidiary, Stepping Hill Healthcare Enterprises Ltd (trading as the Pharmacy Shop).

The Group accounts reflect the outturn of the trust of a £6.7m deficit in 2020-21 and subsidiaries' profit of £104k for Stepping Hill Enterprises Ltd. The trust's charity had net movement of £528k incoming funds in 2020-21. Further detail on both of these elements is provided in note 33 in the annual accounts. The figures quoted in the following section relate solely to the trust, as the other components are considered immaterial for the purposes of the Group accounts.

Due to Covid-19 the planning timetable for 2020-21 was suspended, and trusts have operated under an interim financial regime. For the first six months of the financial year all trusts were required to report a break even financial position. This was delivered by NHS England funding to cover all costs, including Covid-19, that were in excess of block income received. Payment by results was and remains suspended, replaced by block payments from commissioners.

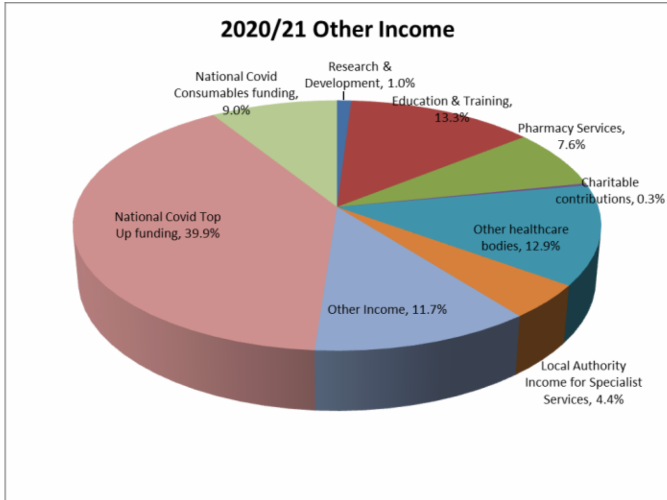
The revised financial regime from October 2020 retained most of the elements of the plan for the first half of the year. However, Integrated Care Systems (ICSs) were issued control total targets, which resulted in a reduced allocation of Covid-19 funding to the trust for the remainder of the year, and a planned deficit for Stockport NHS Foundation Trust.

With the backdrop of the Covid-19 pandemic, we have however continued to invest in improving services for patients, both in terms of the quality and safety of services and investing in buildings and equipment. Total investment through the capital programme in 2020-21 was £25.2m, which included £5.4m on equipment, £2.7m on estates, and £5.1m on IT investments, including upgrades of infrastructure and key clinical systems. This level of investment, included utilisation of slippage against capital plans across the GM ICS and the North Region, enabled us to invest an additional £5.4m in equipment and IT replacements.

Income and expenditure

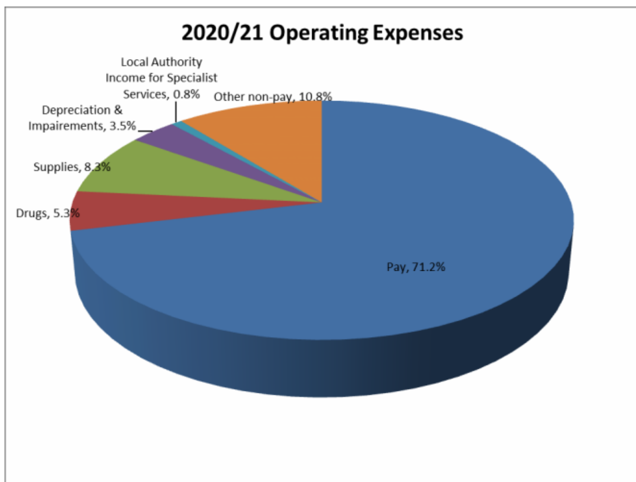
In 2020-21 our overall income was £383.4m (£339.9m in 2019-20). Income from provision of health services was greater than that from provision of goods and services for any other purpose. We did not receive or make any political donations in 2020-21. Our operating income in 2020-21 was £312.0m, an increase of £34.6m from 2019-20, reflecting the additional funding received under the interim financial regime.

We also earned income from a number of different sources and a breakdown of the £71.4m 'Other Income' is provided in the following chart:

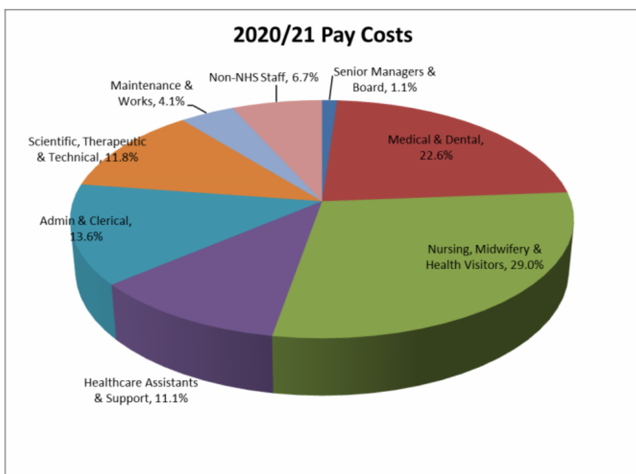


We had no fees and income (income generation) levied, which meet the disclosure criteria under the Managing Public Money definition.

Operating expenditure was £386.9m in 2020-21 (£333.9m in 2019-20). Our costs are divided into the following areas:



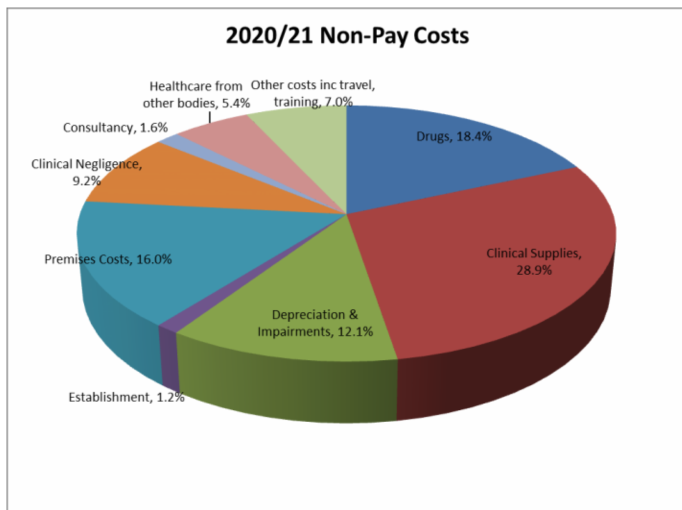
Pay costs account for 71% of our operating expenses, and our pay spend is split over the following categories:



Pay costs in 2020-21 were £275.6m (£243.5m in 2019-20) and the percentage split by staff group as shown in the above chart is in line with previous financial years.

We have continued with investment programmes to recruit to medical and nursing vacancies, including international recruitment and the recruitment of trainee nurse associates and associate physicians. However, we relied upon premium rate bank and agency staffing in our response to the Covid-19 pandemic. Agency costs increased from £10.4m in 2019-20 to £17.9m in 2020-21.

Non-pay expenditure of £111.3m in 2020-21 was incurred, and this is demonstrated by category in the following chart:



Non-pay costs increased by £20.9m during 2020-21, which includes clinical supplies relating to nationally funded Personal Protective Equipment (PPE) to support the response to the Covid-19 pandemic (£6.3m), impairment on our asset valuation compared with an impairment reversal 2019/20 (£5.2m), additional depreciation following increased capital investment in 2020-21 (£1.8m), and increased clinical negligence costs for the organisation (increasing by £1.3m to £10.3m).

Balance sheet

The trust has £135m of net assets at the year end, an increase of £3m from 2019-20. Material movements include increased capital spending as a result of additional investment secured for 2020-21, increased non-current assets, and additional cash compared to plan.

The regulations relating to the calculation of the Public Dividend Capital (PDC) and current commercial interest rates mean that it is more beneficial for us to keep bank balances in the Government bank account.

During September 2020 we repaid £46.1m of long term loans following the receipt of additional Public Dividend Capital from the Department of Health and Social Care. We will therefore no longer incur interest charges on these extinguished loans, but will instead pay Public Interest Capital interest on the replacement capital.

Our year-end cash balance was £32.5m compared to an opening cash position of £17.6m. In 2021-22 we are operating under the interim financial regime for cash, with block income payments being received, and it is not expected that we will require additional borrowing

Charitable funds

The Board of Directors acts as Corporate Trustee in respect of its charitable funds. The primary statements in our Accounts show the consolidated or group position, including the charitable funds and the unconsolidated trust position. Copies of the separate Annual Report and Accounts for these charitable funds (Registered Charity Number 1048661) are available on request from the Director of Finance, via the Trust's website, or The Charity Commission's website.

Our Charitable Funds Committee overseas the management of the charitable funds, and the policy remains one of annual spending in line with the continuing levels of bequests and donations received in year. This is consistent with the aims and objectives approved by The Charity Commission for NHS charities in general.

In 2020-21 charitable funds income was £545,000 and we are extremely grateful for donations of £94,000, grants (including NHS Charities Together) of £149,000, legacies of £158,000, and fundraising income of £96,000. The charity also received £47,000 investment income.

Expenditure in 2020-21 was £278,000, including £70,000 on purchases for patient welfare, £47,000 on supporting staff welfare and training activities, and £98,000 on equipment. Expenditure included:

- £31,000 for a minibus for Swanbourne Gardens Children's Respite Centre,
- £23,000 on hampers to support staff wellbeing during the pandemic,
- £22,000 for an outside restaurant space area for staff,
- £14,000 on a treadmill for the lung function service,
- £12,000 for physiotherapy equipment for intensive care patients.

Financial outlook

The interim financial regime for 2021-22 gives us guaranteed income for the first six months of the financial year. Without the enhanced funding arrangements brought about by the Covid-19 pandemic, our underlying deficit for 2021-22 was forecast to have been in excess of £88m.

As we consider how future services will be funded and delivered, embracing all the transformational work that has taken place during the pandemic and the clinical strategies across Greater Manchester, a refresh of the medium term financial strategy will take place in the context of a revised financial regime when this is announced. It remains our aim to safely return to financial balance.

In any future financial regime there will still be the requirement for efficiency savings to make the NHS affordable, and for us to maintain the highest standards of financial governance. We will continue to review our clinical services efficiency programme to ensure that all best practice and benchmarking data through mediums, such as the Model Hospital and Getting It Right First Time (GIRFT), are considered to identify opportunities for greater efficiency via different ways of working and adoption of best practice.

Capital planning 2021-22

We are planning capital expenditure of £24.5m in 2021-22, dependent on the release of external capital funding in relation to Healthier Together and our £30.6m Emergency Care Campus.

A summary of planned investments is as follows:

Capital Description	**2020-21**
Estates Backlog & High Risk Critical Infrastructure	4,132
Estates Capital Projects	5,893
Equipment	677
Information Management & Technology	1,171
Healthier Together	6,700
Emergency Care Campus	5,900
TOTAL	**24,473**

Our backlog maintenance priorities are:

- oxygen systems,
- main corridor pipework replacements,
- generator replacements,
- fire compliance,
- electrical board replacements,
- ward refurbishments.

There are a number of schemes in the information management and technology development programme, including key patient systems and IT infrastructure across the hospital and community services.

The equipment programme focuses on the on-going asset replacement programme across all business groups with the largest proportion of planned spend being in diagnostics and theatres.

We are committed to the development and delivery of our estates strategy, and delivery of our capital priorities.

Sustainability

Environmental matters

As an NHS organisation and a spender of public funds, we have an obligation to work in a way that has a positive effect on the communities we serve.

Sustainability means:

- spending public money well,
- the smart and efficient use of natural resources, and
- building healthy, resilient communities.

By making the most of social, environmental and economic assets we can improve health both in the immediate and long term, even in the context of the rising cost of natural resources. Demonstrating that we consider social and environmental impacts ensures we meet the legal requirements of the Public Services (Social Value) Act (2012).

To fulfill our responsibilities, we have agreed the following strategic vision statement in our sustainable development management plan (SDMP):

"*Stockport NHS Foundation Trust is committed to providing services in a way that is sustainable and supports our corporate and social responsibilities."*

As part of the NHS and the public health and social care system, we have a duty to contribute towards the ambition set out in 2014 of reducing the carbon footprint of the NHS by 28% (from a 2013 baseline) by 2020. We remain committed to supporting the NHS in achieving national targets, and we aim to reduce our carbon emissions by 28%, using 2013 as the baseline year.

Our Carbon Management Implementation Plan (CMIP), which has been in place since 2008, aims to reduce carbon emissions through:

- reducing energy use through rationalisation and efficient design,
- implementing a Green Travel plan through provision of low carbon travel, transport and access;
- increasing local procurement,
- reducing waste levels and increasing recycling of waste,
- reducing water use and associated waste,
- raising awareness of waste issues across the organisation.

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

- voltage optimisation electrical energy saving techniques to reduce supply voltage for site equipment. This improves power quality by balancing phase voltages and reducing our electricity demand and cost.
- installing cost effective duplex stainless steel plate heat exchangers to optimally improve energy efficiency and minimise waste water pollution,
- reducing energy costs by replacing old or inefficient boilers with new systems designed to use 30-40% less energy,
- increasing insulation of roof spaces and exposed pipe work and valves,
- reducing mechanical ventilation by improving airflow and natural ventilation through the installation of new windows,
- replacing inefficient engineering plant,
- continued use of green technologies such as LED lighting and heat recovery units and reviewing our supply chain management strategy,
- replacing our vehicles with low emission models which use efficient technology or alternative fuels rather than diesel, reducing both running costs and the environmental impact of our vehicle fleet;
- introducing an intelligent building management system to support more efficient management of heating systems,
- introducing a new waste compacting plant to improve efficiency and reporting via telemetry programmes.

We recognise that sustainability goes far beyond compliance with legislation, and we believe that development of sustainable practice is a fundamental corporate responsibility.

We have a Sustainable Development Management Plan (SDMP) in place in accordance with the NHS Carbon Reduction Strategy 2009. This plan sets out our commitments and actions to achieve NHS-wide carbon emission reduction targets. We achieved the target of a 10% reduction by 2015 and further carbon reduction strategies and projects are in place to achieve the target of a 28% reduction in energy use and carbon emissions. The main actions being taken to achieve this are summarised below:

Key Objectives

We have carried out a significant amount of work to reduce carbon emissions and achieve wider sustainability goals. Our key objectives for environmental and sustainability management includes:

- building on our carbon management programme and ensuring a long term vision for sustainable energy management for the organisation,
- ensuring that environmental protection and social issues, including prevention of pollution, are considered within our strategic planning, management and operations;
- reducing our environmental impacts in the areas of water and waste, including capital planning management schemes;

- plans continue to rationalise the site and make best use of the site footprint by working closely with business groups to consider various methods of service delivery for both clinical and non-clinical departments. In addition, our commitment to agile working continues with estate development being a key objective.
- increased recycling and waste reduction,
- fulfilling all compliance obligations relating to environmental management,
- environmental/sustainability key performance indicators reported and tracked at a local level and reported monthly as part of estates & facilities finance and performance meetings,
- reducing vehicle emissions by offering staff a capped choice of low emission or electric vehicles via the NHS Car Lease Scheme,
- increasing engagement with staff and the public at all levels through a range of communications channels,
- embedding sustainability principles in our current processes and policies whenever possible,
- capital planning processes to take into account sustainability options and to explore wider funding routes i.e. SALIX, Environmental Funders Network and CIBSE guidance,
- all capital schemes will be BREEAM certified to ensure sustainability feature in our master planning, infrastructure and building developments. BREEAM standards will also be considered as part of any refurbishment plans.

Carbon and Energy Management

Our approach to carbon and energy management is based on:

- reducing energy consumption,
- supplying energy as efficiently as possible,
- supplying required energy using low carbon and renewable sources where appropriate.

Efficient energy management necessitates close monitoring and analysis of energy consumption to enable consumption patterns and targets to be set for individual buildings across the estate. During 2020-21 a workforce review included the introduction of a dedicated energy and utilities manager, who brings additional focus to this area.

Energy Consumption

Our consumption of energy during 2020-21 is summarised in the table below, along with comparative performance in previous years. We recorded a slight increase in consumption throughout 2020-21, however we remain committed to reducing our overall energy usage during 2021-22. We have been able to sustain competitive priced utilities by negotiating competitive rates with its energy suppliers.

Resource		2016/17	2017/18	2018/19	2019/20	2020/21
Gas	Use (kWh)	31,040,831	30,185,153	31,229,742	32,358,588	32,667,002
Electricity	Use (kWh)	12,907,495	12,848,845	12,676,387	12,311,526	12,559,835

Water

Water consumption increased in 2020-21, with further investigative work required to identify reasons for this increase. Our estates team actively works to minimise water consumption through the use of water efficient technology across the estate.

Reducing consumption will continue to be an area of focus during 2021-22. However, we are conscious of the need to balance water efficiency initiatives with maintaining robust infection control regimes, and to guard against the risks of legionella contamination of water systems by regular flushing of water outlets.

Waste Management

Effective waste management is one of our core principles and we are committed to reducing our carbon footprint and improving understanding of the importance of effective waste management in the NHS.

Widely distributed specific waste containers encourage the collection of paper and cardboard, and we also recycle ink cartridges and batteries, with recycling set to increase during 2021-222.

We will continue our focus on sustainable waste management, and continue to work collaboratively with our contractors and partners to drive service and environmental improvements.

During 2020-21 our aim was to enhance the safe, compliant and sustainable management of waste and disposals across all of our sites, while maximising the volume of waste recycled. Recycling drop-off points and the segregation of cardboard, scrap metals, furniture and electrical waste, together with improvements made to waste compactors, collection bins and holding areas, contributed to improved recycling performance.

Our estates & facilities team offer advice and support for waste management to departments across the organisation, providing guidance, information, equipment and facilities to enable the safe handling, segregation, and storage of waste. Regular waste audits are also undertaken and outcomes during 2020- 21 informed the planned introduction of arrangements for management of an offensive waste stream, which is expected to further reduce the cost base for waste processing.

The table below provides a summary of the improvements we have made over the past four years in relation to the treatment of waste streams, and our recycling aspirations continue with plans to increase our level of recycling and ensure we capitalise on any recycling opportunities.

The table shows that in 2020-201 we increased our overall waste tonnage in line with our increased bed occupancy and high emergency throughput into the hospital:

Waste		2016/17	2017/18	2018/19	2019/20	2020/21
Recycling	(tonnes)	131.30	84.58	133.54	45. 2	44. 4
	tCO_2e	2.63	1.78	2.81	0.95	0.93
Other recovery	(tonnes)	692.00	650.46	533.75	517.09	504.16
	tCO_2e	13.84	13.66	11.21	108.69	105.97
High Temp disposal	(tonnes)	360.00	332.35	533.63	247.06	240.29
	tCO_2e	78.84	73.12	117.40	0	0
Landfill	(tonnes)	26.00	162.38	36.18	197.02	192.01
	tCO_2e	6.35	50.34	11.21	0	0
Total Waste (tonnes)		1209.30	1229.77	1237.11	1524.92	1486.78
% Recycled or Re-used		11%	7%	10.80%	13.5%	10.5%
Total Waste tCO_2e		101.66	138.89	142.63	109.64	.89

Smoke-free Hospitals

We want to look after the health of everyone who uses our hospital and we are committed to providing a clean and healthy environment for patients, visitors and staff.

A complete smoking ban has been in place on our property since 2005 and during 2020-21 we continued to strengthen the effectiveness of this policy with a direct and honest poster campaign, supplemented by security officers politely reminding people of our non-smoking policy.

Sustainable Procurement

We are committed to the principles of sustainable development to support Government and Department of Health & Social Care's commitments in this area of policy, and the improvement of the nation's health and wellbeing.

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

Our procurement team has adopted a whole life cost approach by assessing the environmental impact of products from production to disposal costs. This approach will realise benefits for both our organisation and society in general, as well as minimise the impact on the environment. We also have in place a comprehensive Anti-Fraud, Bribery & Corruption Policy.

ACCOUNTABILITY REPORT

Directors' report

The Board of Directors is responsible for setting the strategic direction of the trust, taking into account the views of the Council of Governors. The Board is also responsible for ensuring that the day-to-day operation of the trust is as effective, economical and efficient as possible, and that all areas of identified risk are managed effectively.

The Board of Directors takes decisions with regards to:

- quality issues,
- strategic and development issues,
- finance and performance,
- governance.

Day-to-day management of the organisation is the responsibility of the Chief Executive and the Executive Directors, who take decisions subject to levels of delegated authority set out in the Scheme of Delegation and Standing Financial Instructions, which explicitly details those decisions reserved for the Board, and those that may be determined by standing committees or delegated to managers.

The balance, completeness and appropriateness of the membership of the Board are reviewed periodically, and when vacancies arise among Executive or Non-Executive Directors.

The Board of Directors is currently comprised of a Chairman, seven Non-Executive Directors, seven Executive Directors, an Associate Non-Executive Director, and two non-voting Corporate Directors. Executive Directors are appointed by the Non-Executive Directors, and their salaries, terms and conditions are determined by the Remuneration Committee (*see pg 68*).

The Chair and Non-Executive Directors are appointed by the Council of Governors and their salaries, terms and conditions are determined by the Nominations Committee (*see pg 72*). The Chair and Non-Executive Directors are appointed for an initial three years term and then, with the approval of the Council of Governors, they can be appointed for a further three year term. Any subsequent term of office, up to a maximum of nine years, is determined by the Council of Governors on an annual basis. We created a new Associate Non-Executive Director role this year to bring extra skills and capacity to the Board, and that is a two year appointment.

The Board considers each of the Non-Executive Directors to be independent, and they make annual declarations to this fact, a summary of which is presented to a public meeting of the Board of Directors.

Criteria for determining dependence, includes:

- being a trust employee within the last five years,
- a material business relationship with the trust within the last three years,
- receipt of remuneration from the trust in a addition to their Non-Executive Directors' fee,
- close family ties with any of the trust's directors, senior employees or advisers.

During the year the Board of Directors met 11 times in public, and those meetings were followed by private business sessions. Details of individual directors and their attendance at Board meetings are set out below:

	Attendance at Board Meetings
Catherine Anderson, Non-Executive Director Appointed 4 January 2016. Re-appointed 1 January 2019 to 31 December 2021. A consultant working with businesses to improve performance, with senior level experience in private business and universities.	11 of 11
Catherine Barber-Brown, Non-Executive Director Appointed 1 September 2016. Re-appointed 1 September 2019 to 31 August 2022. A consultant with senior level experience in the banking sector with a focus on strategy and change management.	10 of 11
Tony Bell, Non Executive Director Appointed 1 May 2021 to 30 April 2024. A senior qualified accountant with significant executive experience in the private and education sectors.	0 of 0
Adrian Belton, Chair Appointed 1 June 2017 to 31 May 2020. Re-appointed 1 June 2020 to 31 May 2023, stepped down in May 2021. Former Chief Executive of the Construction Industry Training Board and the Food and Environment Research Agency. In August 2019 he was also appointed as Non-Executive Chair of the Ministry of Defence's Science and Technology Laboratory.	10 of 11
Simon Bennett, Director of Strategy and Partnerships Appointed May 2020, left the organisation in December 2020. A career NHS manager.	6 of 7
Dr Mike Cheshire, Non-Executive Director (Senior Independent Director) Appointed 1 September 2013. Re-appointed 1 September 2016 to 31 August 2019. Re-appointed 1 September 2019 to 31 August 2020, when he left the organisation. Retired clinician and former Medical Director of NHS North West.	4 of 4
David Hopewell, Non-Executive Director (Chair of Audit Committee) Appointed 1 July 2018 to 30 June 2021. Re-appointed 1 July 2021 to 30 June 2024. A Fellow of the Institute of Chartered Accountants and experienced accountant having worked at a senior level in the private, public and charity sectors.	11 of 11
Nic Firth, Chief Nurse and Director of Quality Governance Appointed November 2020. A career NHS nurse.	4 of 4
John Graham, Director of Finance/Deputy Chief Executive Appointed May 2020. A career NHS manager.	11 of 11
Dr Marisa Logan-Ward, Non-Executive Director/Deputy Chair (*from April 2021)* Appointed 1 August 2019 to 31 July 2022. A biomedical scientist with senior level experience in the health sector.	10 of 11
Alison Lynch, Chief Nurse & Director of Quality Governance Appointed October 2017, left the organisation April 2021. A career NHS nurse.	2 of 2
Dr Andrew Loughney	3 of 4

Appointed January 2021. An obstetrician.	
Jackie McShane, Director of Operations Joined the Trust on secondment in December 2020. A career manager.	4 of 4
Paul Moore, Interim Director of Quality Governance & Risk Assurance (non-voting) Appointed May 2020, left the organisation in April 2021. A career NHS manager.	11 of 11
Mrs Mary Moore, Non-Executive Director Appointed October 2020. A career NHS nurse with experience of working at a senior level, both regionally and nationally.	6 of 6
Greg Moores, Director of Workforce & Organisation Development Appointed June 2019. A career NHS manager.	5 of 11
Hugh Mullen, Director of Strategy, Planning & Partnerships/Deputy Chief Executive Appointed January 2017, retired May 2020. A career NHS manager.	1 of 1
Joanne Newton, Associate Non-Executive Director Appointed 1 May 2021 to 30 April 2023. A qualified accountant with significant executive experience in the NHS.	0 of 0
Caroline Parnell, Director of Communications & Corporate Affairs (non-voting) Appointed November 2019. A former journalist, communications consultant, and NHS manager.	11 of 11
Louise Robson, Chief Executive Appointed January 2019, seconded to NHSE/I November 2020. A career NHS manager.	7 of 7
Dr Louise Sell, Non-Executive Director Appointed October 2020. A consultant liaison psychiatrist and a former executive medical director.	5 of 6
Malcolm Sugden, Non-Executive Director/ Deputy Chair Appointed 28 April 2010. Re-appointed 1 April 2018 to 31 March 2019. Re-appointed 1 April 2020 to 31 March 2021, when he left the organisation.	11 of 11
Bev Tabernacle-Pennington, Interim Chief Nurse Appointed July 2020, left the organisation November 2020. A career NHS nurse.	3 of 4
Sue Toal, Chief Operating Officer Appointed March 2017, seconded to Tameside & Glossop Integrated NHS Foundation Trust December 2020. A registered nurse and career NHS manager.	8 of 8
Prof. Tony Warne, Chair Appointed 1 May 2021 to 30 April 2024. A former nurse with extensive experience in clinical, nursing and management practice. The former Executive Dean of the University of Salford, where he continues to be Professor Emeritus.	0 of 0
Dr Colin Wasson Appointed April 2016, stepped down from the Board in December 2020. An intensive care consultant.	5 of 8

More details about the background, experience and capabilities of all members of the Board of Directors are available on our website, alongside information *on how to contact Board members.*

We keep a register of Directors' interests and a copy is available from the Director of Communications & Corporate Affairs by emailing caroline.parnell@stockport.nhs.uk or writing to Trust Headquarters, Stepping Hill Hospital, Oak House, Popular Grove, Stockport.

There have been significant changes to the make-up of the Board of Directors over the last 12 months in relation to both Executive and Non-Executive Directors:

Executive Directors

- Mrs Lynch, Chief Nurse, was seconded to Manchester NHS Foundation Trust as our contribution to the regional pandemic response. She subsequently joined that organisation on a permanent basis. Mrs Tabernacle-Pennington joined us as Interim Chief Nurse until the appointment of Mrs Firth to the role of Chief Nurse and Director of Quality Governance.
- Mrs Robson, Chief Executive, was asked to lead work on behalf of NHSE/I across the whole of the North of England around the development of Integrated Care Systems and Provider Collaboratives in response to the Government's White Paper. Mrs James joined the Trust as interim Chief Executive while maintaining her Chief Accountable Officer responsibilities at Tameside & Glossop Integrated Care NHS Foundation Trust.
- Mrs Toal and Mrs McShane swapped their respective roles at Stockport and Tameside & Glossop Integrated NHS Foundation Trusts to share learning and good practice between the two organisations.
- Mr Bennett, Director of Strategy and Partnerships, returned to NHSE/I and part of his responsibilities passed to his deputy, Mr Andy Bailey, who became Interim Director of Strategy.
- Mr Moore, Director of Risk Assurance and Quality Governance, left the organisation after making significant improvements to our governance systems and process.
- Dr Colin Wasson stepped down after five years as Medical Director to return to full-time clinical practice, and Dr Andrew Loughney was appointed to the role.

Non-Executive Directors

- Mr Belton stepped down as Chair after four years in the role and Prof. Warne was appointed to the role.
- Dr Sell and Mrs Moore were appointed as Non-Executive Directors to strengthen the clinical experience on the Board.
- Mr Sugden came to the end of his maximum nine years term of office as a Non-Executive Director and Mr Bell was appointed to the role.
- Mrs Newton was appointed to the newly created role of Associate Non-Executive Director to strengthen the skills and experience on the Board at a time of change in the health and care system.

To foster greater diversity in NHS boards we joined a regional scheme offering six monthly placements to people interested in becoming Non-Executive Directors, but who may be disadvantaged due to disability or their ethnic background. We welcomed Mr Stuart Lewis as our first placement, and during 2020-21 he had the opportunity to join all Board activities to gain greater insight into the role of a Non-Executive Director in an NHS Foundation Trust.

Despite the senior leadership changes during 2020-21, the Board considers that the skills and experiences of Non-Executive and Executive Directors provide a Board of Directors that is balanced, complete and appropriate.

The appointment of new Non-Executive and Executive Directors with strong clinical and nursing backgrounds is an acknowledgement of the significant transformation journey that we have begun, and the need to ensure a strong clinical leadership voice as the organisation changes.

Board development

The pandemic had a major impact on the way the Board conducted its business and its opportunities to undertake development activities. In line with national guidance the organisation rationalised a number of standard meetings within its governance structures and focused agendas on urgent and key decision making.

This approach impacted on the planned Board development programme for 2020-21, but it was able to meet for a facilitated full-day discussion to set out the principles of how it would like to work together in the future. It also took part in an NHSE/I led workshop to inform the development of the Board's integrated performance report, and spent time considering its risk appetite.

However we recognise that with the significant changes to its membership during 2020-21 that a strong Board and team development programme is needed, alongside individual development plans to address the needs of Board members identified during the annual appraisal process.

We have secured funding from NHSE/I for a development programme in 2021-22 that will include an evaluation exercise to understand the individual learning styles of each Board member, and facilitated sessions to underpin collective understanding of the responsibilities of a unitary body, as well as developing an agreed approach to effective team working.

The development programme will be supplemented with workshops throughout the year focusing on key elements of the Board's responsibilities, including refreshing its risk appetite, continuing to evolve effective governance systems and processes, equality and diversity, the organisation's strategy, and other areas that may be highlighted by the annual Board self-assessment process undertaken in June 2021.

We are also planning an external review of Board effectiveness during 2021, in line with best practice.

Appraisals

All directors have annual appraisals, with those for Non-Executive Directors led by the Chair and those for Executive and Corporate Directors led by the Chief Executive. Appraisal of the Chairman is led by the Senior Independent Director in line with arrangements agreed with the Council of Governors and national guidance.

Feedback from the Chair's appraisal and his appraisal of Non-Executive Director colleagues is presented to the Council of Governor's Nominations Committee, while a summary of the appraisals of Executive Directors is presented to the Remuneration Committee.

Well Led Framework

During 2020-21 the Board took a number of actions to ensure it addressed or improved some areas of its operations in line with NHSE/I's Well Led Framework.

This included:

- strengthening the capacity and capability of the Board,
- introducing STARs, a new assessment framework to consistently review the quality of care;
- strengthening its governance and risk management arrangements (*see Annual Governance Statement)*,
- refreshing its integrated performance report as part of improvements to its governance arrangements.

The Board of Directors usually carries out an annual reflective exercise to assess how it considers it has operated in line with Well-Led Framework. Due to the pandemic this exercise was stood down, but it will be undertaken in June 2021. During 2021-22 the Board will also commission an external review.

Audit Committee

We have an Audit Committee, which meets at least five times a year, comprised of Non-Executive Directors with regular attendance by Trust officers, internal and external auditors.

The key purpose of the Audit Committee is to provide the Board of Directors with:

- an independent and objective review of financial and organisational controls, and risk management systems and processes;
- assurance of value for money,
- compliance with relevant and applicable law,
- compliance with all applicable guidance, regulation, code of conduct and good practice, and
- advice as to the position of the trust as a going concern.

Details of the committee membership and attendance at meetings are below:

	Meeting attendance
David Hopewell, Chair	8 of 8
Malcolm Sugden	7 of 8
Marisa Logan- Ward	7 of 8
Catherine Barber-Brown	4 of 4

During 2020-21 the committee revised its membership to include the Chairs of the Board's assurance committees to enable the triangulation of relevant information from each of the key committees.

The Audit Committee received the outcomes of a number of internal audit reviews covering the following areas:

- Board assurance framework,
- Data security and protection toolkit,
- Key financial controls,
- ESR/payroll,
- Complaints,
- Estates and facilities support,
- Covid-19 costs,
- Business continuity – data review,
- Seven day services,
- IT back up architecture,
- IT critical applicants.

They also received the Head of Internal Audit Opinion, which was that there is substantial assurance that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.

To ensure that the independence of the external auditors is not compromised where work outside the scope of the Audit Code has been procured from external auditors, we have a policy which requires that no members of the team conducting the external audit may be a member of the team carrying out any additional work, and their lines of accountability must be separate.

Internal Audit

Internal Audit services, which include an anti-fraud service, have been provided by Mersey Internal Audit Agency (MIAA) since 1 April 2013. The contract for internal audit services was put to competitive tender and was re-awarded to MIAA from the start of 2019-20. The main purpose of the internal audit service is:

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

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

Manager. Additional investigation work was commissioned during the year and approved by the Audit Committee in quarter four. The internal audit plan was fully delivered during 2020-21 and the total cost of the service was £70,875.

Countering Fraud and Corruption

During 2020-21 the trust's anti-fraud specialist and the anti-fraud service was provided by Mersey Internal Audit Agency (MIAA) following re-tendering exercise the previous year.

Our Anti-Fraud and Corruption Policy supports our strong anti-fraud culture and the annual work plan, agreed by the Director of Finance and approved by the Audit Committee, covered areas such as enhancing the anti-fraud culture, deterring, preventing and investigating fraud.

The anti-fraud specialist regularly attends Audit Committee meetings to provide updates on the progress of the annual work plan and investigations. The total cost of the service, including investigation work in 2020-21, was £22,360.

We have in place a Raising Concerns at Work Policy, which outlines how staff can raise concerns, including those that may be related to fraud. Staff are reminded of their responsibility to report such matters as part of their induction, during mandatory training, through departmental training sessions, and fraud awareness events. The policy is supplemented by our Freedom to Speak Up Guardian, which was a post introduced in response to a recommendation arising from the Francis Report, and they provide quarterly reports on activities to the People Performance Committee and six monthly reports to the Board of Directors.

During 2020-21 the anti-fraud specialist focused on:

- raising awareness of potential fraud via training sessions and briefings,
- reviewing pre-employment checks arrangements,
- detection exercises.

We also participated in the national fraud initiative exercise at a cost of £1,150. This exercise matches a series of financial records from a number of sources to help identify and eliminate fraud across public sector bodies.

External Audit

Mazars LLP was appointed as our external audit provider by the Council of Governors with effect from 1 October 2019, following a competitive tender process. The cost of the external audit service totaled £58,440, comprised of £55,440 for the trust accounts, and £3,000 for charitable funds. All figures are inclusive of VAT.

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

Directors' responsibility for preparing accounts

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

The Audit Committee has delegated authority from the Board of Directors to review and approve the Annual Accounts. The Directors consider the Annual Report and Accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS Foundation Trust's performance, business model and strategy.

Accounting policies

The Annual Accounts have been prepared under a direction issued by Monitor under the National Health Service Act 2006. They have also been prepared in accordance with International Financial Reporting Standards (IFRS) and under the direction of Monitor's NHS Foundation Trust Annual Reporting Manual (ARM).

The accounting policies for pensions and other retirement benefits are set out in note 1.6 to the accounts, and details of senior managers' remuneration can be found in the Remuneration Report on pages 95 & 96. Note 8.2 to the Accounts provides further information about employees who have retired early on ill-health grounds during the year. We have complied with the cost allocation and charging mechanisms set out in HM Treasury and Office of Public Sector Information guidance.

Better Payment Practice Code

Under the current financial constraints, and as part of measures introduced as part of the Financial Improvement Programme, the organisation is no longer in a position to comply with the Better Payment Practice Code, which requires us to pay all valid non-NHS invoices by the due date, or within 30 days of receipt of goods or a valid invoice, whichever is later. This followed extensive dialogue with our supplier base that was broadly understanding of the change.

All suppliers' payment terms were reviewed and we continue to work with the small and medium enterprises to ensure they are not disproportionately affected by this change. We now have a policy of payment within 60 days and the performance against this for the last two financial years is as follows:

2020/2021	NHS	Non-NHS
Total number of invoices paid within year	3,401	43,533
Total number of invoices paid within 60 days	2,461	38,578
Percentage of invoices paid within 60 days	72.36%	88.62%
Total value of invoices paid within year (£000)	13,023	170,976
Total value of invoices paid within 60 days (£000)	8,857	159,951
Percentage of invoices paid within 60 days	68.01%	93.55%
Total number of invoices paid within year	3,401	43,533
Total number of invoices paid within 30 days	1,827	18,345
Percentage of invoices paid within 30 days	53.72%	42.14%
Total value of invoices paid within year (£000)	13,023	170,976
Total value of invoices paid within 30 days (£000)	7,198	131,104
Percentage of invoices paid within 30 days	55.27%	76.68%
2019/20	**NHS**	**Non-NHS**
Total number of invoices paid within year	3,875	50,155
Total number of invoices paid within 60 days	3,013	44,035
Percentage of invoices paid within 60 days	77.75%	87.80%
Total value of invoices paid within year (£000)	12,078	140,615
Total value of invoices paid within 60 days (£000)	6,034	130,209
Percentage of invoices paid within 60 days	49.96%	92.60%
Total number of invoices paid within year	3,875	50,155
Total number of invoices paid within 30 days	2,182	17,546
Percentage of invoices paid within 30 days	56.31%	34.98%
Total value of invoices paid within year (£000)	12,078	140,615
Total value of invoices paid within 30 days (£000)	3,988	98,524
Percentage of invoices paid within 30 days	33.02%	70.07%

No significant interest was incurred under the Late Payments of Commercial Debts (Interest) Act 1988 in respect of any liability to pay interest, which accrued by virtue of failing to pay invoices within the 30 day period where obligated to do so. No interest was paid in discharge of any such liability.

Income disclosures

The trust has complied with Section 43 (2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012), which requires that the income from the provision of goods and services for the purposes of the health services in England must be greater than its income from the provision of goods and services for other purposes.

The impact of income on the trust is significant. Our statutory accounts include a detailed breakdown of other income in note 4 of the Accounts.

Our Governors

The Council of Governors is ultimately responsible for holding the Board of Directors for account, via the Non-Executive Directors, for delivery of its responsibilities under the licence to operate as an NHS Foundation Trust.

Other responsibilities include:

- appointment/removal of the Chair and the other Non-Executive Directors,
- approval of the appointment of the Chief Executive,
- approval of the remuneration, allowances and other terms and conditions of Non-Executive Directors;
- appointment/removal of the trust's external auditor,
- receiving the annual accounts and any report of the external auditor on the annual accounts and annual report,
- contribute views to the Board of Directors on the trust's forward plan.

The pandemic impacted on the operation of the Council of Governors. In line with national guidance to rationalise governance structures we temporarily reduced the number of formal meetings, and to abide by social distancing rules we moved to virtual meetings.

To maintain effective communication with governors throughout the pandemic we introduced weekly written briefings instead of our previous monthly briefings, and set up virtual informal catch-up meetings between governors and Non-Executive Directors to share the key activities of the assurance committees that continued to meet during the pandemic.

Development programme

A review of the work of the Council of Governors during 2019-20 identified the need for a more robust development programme for new and existing governors to expand their knowledge of the role and the organisation.

A detailed development plan was created and endorsed by the Council of Governors with development opportunities incorporated into the Council meetings, as well as separate sessions planned on a range of issues including finance, performance standards, and quality.

The pandemic negatively impacted on our ability to deliver the separate sessions but where possible development opportunities were built into the formal Council meetings, such as a discussion about the potential impact of the Government's White Paper on the development of integrated care systems. Plans are in place to restart those sessions post-pandemic. The Director of Communications & Corporate Affairs continued to hold one to one induction sessions with all new governors.

Council agendas

A review of the Council's past agendas during 2019-20 identified that governors were not regularly receiving information about the performance of the organisation against national standards, as well as workforce, quality and finance indicators.

As a result the Council's annual work plan and meeting agendas were amended, with the support of the governors, to ensure that at each meeting they received a report detailing performance against key local and national standards, as well as presentations on key issues impacting on the trust.

During the pandemic governors continued to receive this information, either in formal meetings, in line with the annual work plan, or via the weekly briefings and monthly informal catch-up meetings with Non-Executive Directors.

During 2020-21 the Council of Governors approved the appointment of a new Chair, Non-Executive Director, and Associate Non-Executive Director. They also approved the re-appointment of Mr Hopewell as a Non-Executive Director for a further three year term of office, endorsed the appointment of Mrs James as Interim Chief Executive, and supported Mrs Anderson's appointment as Senior Independent Director and Dr Logan-Ward's appointment as Deputy Chair.

They discussed a range of issues including our:

- plans for a emergency care campus,
- veterans passport initiative,
- operational plan for 2021-22,
- CQC inspection of our services.

Prior to the pandemic governors had played an active role in the organisation, including:

- taking part in regular patient safety walkabouts,
- attending major internal events and conferences,
- helping to determine quality priorities,
- contributing their observations to clinical service reviews carried out in preparation for the CQC inspection,
- supporting activities related to the annual Patient Led Assessment of the Care Environment (PLACE)

As we see the national lockdown lift and the Covid-19 vaccination programme roll out, we are considering how we can re-start a number of previous governor involvement activities.

Throughout the pandemic a number of governors continued to regularly attend our virtual monthly public Board of Directors meetings, posing questions to the Board about the agenda at the end of each meeting. We also started to record these meetings, which was welcomed by governors unable to join the meetings in real time.

There is mechanism in place to resolve disagreements between the Board of Directors and Council of Governors. In the first instance it is the responsibility of the Chair, as leader of both forums, to attempt to reach a consensus. Failing that the next formal step would be for the Chairman to receive formal representation from the designated Lead Governor to seek to achieve a mutually acceptable position.

Engagement with governors

The Board of Directors is fully aware of the need to build and maintain effective relationships with governors. During 2019-20, as part of changes to strengthen governance arrangements in relation to the Council of Governors, the Chair considered how relationships could be further strengthened, and a number of improvements were made.

Despite the impact of the pandemic we managed to maintain and strengthen many of those engagement activities, including:

- increasing standard monthly briefings for governors to weekly to share the latest information about the trust,
- regular virtual drop-in sessions for governors to meet informally with the Chair to discuss any issues or concerns,
- monthly informal catch up meetings between Non-Executive Directors and governors to share information about activities, as well as discuss any issues or concerns;
- regular involvement of Non-Executive Directors in Council of Governors meetings, including leading discussions on key issues;
- Executive Directors attending Council of Governors meetings to present information and engage in discussion with governors.

Membership engagement

In 2018-19 we developed a membership strategy with the guiding principles of:

- regularly checking to determine that we are actively seeking representation from all aspects of our local society within our membership,
- membership activities should be of value to individuals and the organisation,
- all activities should be prioritised to ensure achievability within the time and resources available.

Our plans to continue to deliver that strategy during 2020-21 was severely impacted by the pandemic, largely as a result of the limitations of social distancing, shielding, and staff focused on urgent operational issues. This meant that our intentions to take part in face-to-face membership recruitment and engagement events had to be deferred.

However we were able to continue to:

- circulate a members newsletter three times a year that highlighted the latest news about the organisation’s activities as well as profiling the work of the governors and giving information on how members can contact their governor representatives,

- update our website to share information about governors and how members can contact them,
- hold a virtual annual member meeting, which attracted over 100 members and provide a vibrant opportunity to ask questions of the Board and governors;
- share social media messages,
- email updates about our activities.

During the pandemic we issued special briefings to all members to inform them about our preparations and the impact of the pandemic, and also shared health and wellbeing information.

Governors provide their time on a voluntary basis but we do reimburse travel expenses, and during 2020-201 a total of £170 in expenses was claimed.

We hold a register of governors interests, which is available on request from Soile Curtis, deputy company secretary, on 0161 419 5166 or email soile.curtis@stockport.nhs.uk

Details of how to contact our governors are available on our website.

Governors' elections

Despite the pandemic we decided to continue with our rolling programme of annual elections, but it did have an impact on the process as for the first time we had no contested seats that required an election using the single transferable vote system.

These were the constituencies were governors were appointed without election:

Heaton and Victoria (four seats for three year terms)

- Tad Kondratowicz
- Chris Summerton
- Two vacant seats

Staff (one vacancy for a one year term)

- Kaymo Jammeh

High Peak and Dales (one vacancy for a one year term)

- Catharine Grundy-Glew

We also sought candidates for two vacant seats in the Tame Valley and Werneth public constituency. Unfortunately no candidates came forward and these will be subject to a further election process in 2021.

During 2019-20 we introduced a maximum tenure of nine years for all governors and as a result we saw long standing governors leave the organisation, including Eve Brown, our former lead governor. Their contribution to the Council of Governors and the organisation as a whole is sincerely appreciated.

With Mrs Brown's departure the Council of Governors was asked to appoint a new lead governor and Roy Greenwood took on that role.

Membership of the Council of Governors

Full information about our public, staff and appointed governors are available on our website. Listed below are details of our current governors and their attendance at Council of Governors meetings during 2020-21:

Governor	Constituency	Attendance
S Alting	Appointed	4 of 4
R Cryer	Bramhall & Cheadle	1 of 4
C Dawson	Staff	0 of 4
L Dowson	High Peak & Dales	3 of 4
C Galasko	Outer Region	3 of 4
K Glass	Staff	2 of 4
R Greenwood	Tame Valley & Werneth	4 of 4
C Grundy-Glew	High Peak & Dales	2 of 2
Z Ikram	Marple & Stepping Hill	4 of 4
K Jamneh	Staff	2 of 4
J Keyes	Staff	1 of 4
M Kildare	Appointed	0 of 4
R King	Marple & Stepping Hill	3 of 4
D Kirk	Appointed	4 of 4
T Kondratowicz	Heatons & Victoria	4 of 4
T Leden	Bramhall & Cheadle	4 of 4
C Lyons	Tame Valley & Werneth	0 of 4
J Pantall	Bramhall & Cheadle	4 of 4
D Rowlands	Marple & Stepping Hill	4 of 4
M Slater	Bramhall & Cheadle	4 of 4
C Summerton	Heaton & Victoria	3 of 4
J Wells	Appointed	4 of 4
L Woodward	High Peak & Dales	3 of 4
J Wragg	Marple & Stepping Hill	1 of 4

Details of Board members attendance at Council of Governors meetings during 2020-21 are below:

Board member	Title	Attendance
Adrian Belton	Chair	4 of 4
Catherine Anderson	Non-Executive Director	4 of 4
Catherine Barber-Brown	Non-Executive Director	4 of 4
David Hopewell	Non-Executive Director	3 of 4
Marisa Logan-Ward	Non-Executive Director	4 of 4
Mary Moore	Non-Executive Director	2 of 2
Louise Sell	Non-Executive Director	2 of 2
Malcolm Sugden	Non-Executive Director	3 of 4
Nic Firth	Chief Nurse & Director of Quality Governance	2 of 2
John Graham	Director of Finance	2 of 4
Karen James	Interim Chief Executive	2 of 2
Greg Moores	Director of Workforce & OD	0 of 4
Andrew Loughney	Medical Director	1 or 2
Jackie McShane	Director of Operations	1 of 2
Caroline Parnell	Director of Communications & Corporate Affairs	3 of 4
Louise Robson	Chief Executive	1 of 2
Bev Tabernacle-Pennington	Interim Chief Nurse	1 o1
Colin Wasson	Medical Director (Executive)	0 of 4

Membership

Membership of the Trust is open on an opt-in basis to anyone over 11 years old and living in one of the following public constituencies:

- Bramhall and Cheadle,
- Tame Valley and Werneth,
- The Heatons and Victoria,
- Marple and Stepping Hill,
- High Peak and Dales,
- Outer region.

Information about how to become a public member is freely available on our website and displayed in various public areas across our services.

Staff are automatically members unless they choose to opt out, and staff membership is also open to anyone employed by another organisation but who exercises a function for the trust.

Details of the make-up of our members as of 31 March 2021 are below:

Constituency	No. of members
Bramhall and Cheadle	2,402
Tame Valley and Werneth	1,898
The Heatons and Victoria	1,989
Marple and Stepping Hill	2,487
High Peak and Dales	837
Outer region	1,298
Staff	5,161
Total	**16,072**

Nominations Committee

The Council of Governors has established a Nominations Committee, which takes the lead on:

- the appointment and re-appointment of Non-Executive Directors, including the Chair;
- reviewing benchmarking information on Non-Executive Directors remuneration,
- overseeing the appraisal process for Non-Executive Director, including the Chair.

The Committee makes recommendations on these key areas of business to the Council of Governors.

During 2020-21 the Committee met on six occasions to:

- oversee the recruitment and appointment process for a new Chair, Non-Executive Director, and Associate Non-Executive Director;
- review the outcome of the Chair's annual appraisal,
- receive a summary of the annual appraisals of Non-Executive Directors,

- consider the appointment of Dr Logan-Ward as Deputy Chair,
- consider the re-appointment of Mr Hopewell for a further three year term of office.

The Committee commissioned the services of The Finegreen Group to support the search and recruitment process for a new Chair, Non-Executive Director, and Associate Non-Executive Director. Mindful of our commitment to develop a diverse Board the company was instructed to conduct a search for candidates that encouraged interest from individuals who reflected the diversity of the population we serve.

Membership of the Committee and attendance during 2020-21 is detailed below:

Name	Position	Attendance
Adrian Belton	Chair	6 of 6
Catherine Anderson	Senior Independent Director (from August 2020)	3 of 3
Mike Cheshire	Senior Independent Director (until August 2020)	1 of 1
Malcolm Sugden	Deputy Chair	2 of 6
Richard King	Public governor	5 of 6
Robert Cryer	Public governor	4 of 6
Roy Greenwood	Lead governor	5 of 6
Tad Kondratowicz	Public governor	3 of 6
Michelle Slater	Public governor	2 of 3

Quality governance report

The organisation has in place a range of systems and processes established to ensure the effective governance of service quality, including performance against local and national standards related to quality as well as financial and workforce indicators.

These are reported and monitored at business group level, and the Executive Director team holds the business groups to account for achievement of the agreed standards via monthly performance reviews.

Sub-groups of the Board of Directors – Quality, Finance & Performance, and People Performance – receive key issues reports relevant to their terms of reference in relation to performance against these local and national standards. Where concerns are identified the committees seek further assurance that issues are being managed, and escalate concerns to the Board to ensure members are aware of the issues and have the opportunity to review mitigating actions.

The committees submit key issues reports to the Board of Directors, which also receives a monthly integrated performance report that provides detailed information about how the organisation is measured against local and national standards for quality, safety, staffing, finance and workforce.

During 2020-21 we revised our integrated performance report in line with recommendations from the governance review that we commissioned from NHSE/I, and following a Board workshop with NHSE/I's performance lead. The assurance committees also reviewed the standards and measures that they wished to track in their meetings.

The Board of Directors considers a patient story at its public meetings, which brings the practical impact of service quality to the heart of the board room. The Board also reviews the outcomes of a six-monthly strategic staffing review, in line with national guidance.

At the start of the pandemic, in line with national guidance, we stood down meetings of the Finance & Performance and People Performance Committees, and rationalised the agendas of our Board of Directors, Quality and Audit Committees meetings to focus on key strategic decision making and assurance. Although meetings of two of the Board's assurance committees were paused for a period during the pandemic a record was kept of the key items that would have been discussed, and the work plans revised accordingly to allow committee oversight once the meetings were re-established.

To manage the operational challenges facing the organisation during the pandemic we adopted a gold, silver and bronze command structure internally to mirror the structures happening at regional and national level as the NHS adopted a level four command and control structure for much of the year.

Internally we set up new workforce, clinical, and financial advisory groups to support rapid decision making. Their operation was regularly reviewed and they were formally stood-down at the end of March 2021.

Following the CQC's inspection in 2017 that highlighted concerns about the organisation's governance systems and processes, we developed a quality governance framework that has been in place in the organisation since 2018.

The framework is based on five management groups, each led by an Executive Director, which focuses on the following areas:

- infection prevention and control,
- medicines optimisation,
- patient experience,
- quality governance,
- safeguarding.

These groups consider the key risks to delivery of objectives in their specific area, and report risks and mitigating actions via a key issues report to the Quality Committee, a sub-committee of the Board of Directors.

Risks to performance and quality can be identified at any level of the organisation's governance structure and they are monitored by service, business group, or trust-level risk registers. Patient safety incidents are also monitored via weekly patient safety summits, chaired by the Chief Nurse, which aim to identify themes and lessons to learn for dissemination throughout the organisation.

In May 2020 we received the outcome of an independent review of our governance systems and processes that we asked Becky Southall, governance lead for NHSE/I, to carry out on our behalf.

The Board fully accepted the finding of that review and Paul Moore, Interim Director of Quality Governance and Risk Assurance, led on the development and implementation of an action plan to address the recommendations. He also suggested a number of revisions to our governance structure, which the Board fully accepted.

As a result of the review the group structure that fed into the Quality Committee was revised, training on risk identification and management was rolled out to all business groups, the structure and format of the Board Assurance Framework was re-developed, and a monthly Risk Committee set up and chaired by the Chief Executive and attended by all Executive Directors along with business group representatives.

In March 2020 the Board of Directors received a presentation setting out the progress we had made in implementing the recommendations to come from the governance review and Mr Moore's revisions.

Mrs Firth, Chief Nurse, is now responsible for quality governance and risk assurance in the organisation, and the Board has agreed to make some further refinements to our governance structures and processes during 2021-22.

Care Quality Commission reviews

We are fully registered with the CQC for all of our services. In January 2020 the CQC carried out unannounced inspections of the following core services:

- urgent and emergency care,
- medical care(including older people's care),
- maternity,
- services for children and young people.

CQC inspectors carried out a further unannounced inspection in February 2020, and the Use of Resources review and Well Led inspection were also undertaken in February 2020.

During the inspections in early 2020 we received a section 31 letter and a subsequent 29a warning notice to inform us that the CQC had formed a view that the quality of health care provided by us required 'significant improvement' in relation to safe staffing in the emergency department, and the governance systems to monitor quality, safety and risk across the department.

We took immediate actions to address the concerns and we continue to work on those improvements every day. Changes include:

- environmental improvements, particularly to safeguard patients with mental health problems in our emergency department;
- putting a new leadership team into the emergency department,
- calling a system risk summit leading to the formation of Stockport System Improvement Board facilitated by NHSE/I with representation from all local health and care partners;

- commissioning an external review of staffing and governance in the emergency department,
- appointing an Interim Director of Quality Governance and Risk Assurance,
- developing and implementing an improvement plan for the emergency department that goes beyond the changes required by the CQC,
- placing a mental health specialist in the emergency department to work with us and Pennine NHS Foundation Trust on improvements,
- carrying out an external audit of staffing in the emergency department when the CQC visited,
- commissioning external support for work on improving the flow of patients through the hospital.

The inspection report, which was published in May 2020, reflected the concerns in both regulatory notices, and identified 25 breaches overall against regulations, the majority of which were in the following key areas;

- improving flow,
- effective governance,
- safe staffing.

Overall, the organisation’s rating remained as “requires improvement” however the ratings beneath this showed deterioration based on the 2018 inspection across 13 domains. This was comparable to the inspection ratings in 2017, which led to challenged provider status and regulatory action, including licence conditions. The key issues were the range of deteriorating ratings and the inadequate ratings for urgent and emergency care.

Ratings for Stepping Hill Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate ↓ 2020	Requires improvement →← 2020	Requires improvement ↓ 2020	Inadequate ↓ 2020	Inadequate ↓↓ 2020	Inadequate ↓ 2020
Medical care (including older people’s care)	Requires improvement →← 2020	Good ↑ 2020	Good →← 2020	Requires improvement ↓ 2020	Requires improvement ↓ 2020	Requires improvement →← 2020
Surgery	Good Oct 2016	Good Oct 2016	Good Oct 2016	Good Oct 2016	Good Oct 2016	Good Oct 2016
Critical care	Good Oct 2016	Good Oct 2016	Good Oct 2016	Requires improvement Oct 2016	Good Oct 2016	Good Oct 2016
Maternity	Requires improvement →← 2020	Good →← 2020	Good →← 2020	Requires improvement ↓ 2020	Requires improvement ↓ 2020	Requires improvement ↓ 2020
Services for children and young people	Requires improvement →← 2020	Requires improvement ↓ 2020	Good ↓ 2020	Good →← 2020	Requires improvement ↓ 2020	Requires improvement ↓ 2020
End of life care	Good Oct 2016	Good Oct 2016	Good Oct 2016	Good Oct 2016	Good Oct 2016	Good Oct 2016
Outpatients	Good Oct 2016	Not rated	Good Oct 2016	Good Oct 2016	Good Oct 2016	Good Oct 2016
Overall*	Requires improvement →← 2020	Requires improvement →← 2020	Good →← 2020	Requires improvement →← 2020	Requires improvement ↓ 2020	Requires improvement 2020

Some of the care the CQC inspectors saw when they visited us in early 2020 was not of the standard we want for our patients, and we publicly apologised for that.

We took immediate action to address the issues and in August 2020 CQC inspectors returned to Stepping Hill Hospital to see the improvements we had made to the emergency department. In their initial verbal feedback to us they commented positively about the significant changes they had seen, including rapid improvements to the culture of the department, and they subsequently wrote to us highlighting that they had found:

- the department were using a staffing tool to determine staffing levels in the department,
- recruitment of nursing staff was ongoing but all vacancies at band 6 and band 7 had been filled with substantive staff and band 5 vacancies had reduced,
- children's nurses had been recruited to meet the national workforce staffing standards and safeguarding training levels had significantly improved for medical and nursing staff,
- triage training rates and competency sign off had improved and further training was ongoing,
- the mental health assessment room had been refurbished and was compliant with national standards,
- a ligature assessment had been completed throughout the department,
- the department had introduced and were using a mental health assessment risk assessment tool. The team had also introduced a standard operating procedure for patients presenting in mental health crisis.
- Governance structures had improved so that quality, safety and risk were monitored in the department through a series of meetings and there were reports to the Board of Directors,
- the department had an awareness of its main risks at operational and strategic level,
- the risks were mitigated and reviewed,
- there was a memorandum of understanding to support partnership working between us and the local mental health NHS trust,
- effective mental health governance structures were in place with a monthly partnership board and a mental health board every three months,
- there was ongoing work to support improvements to mental health services,
- staff were involved in the change processes in the department so there was ownership of change,
- change management had organisational development and turnaround team support,
- staff were using the quality improvement methodology to develop and test the processes in the department.

The CQC confirmed that we had met all the requirements set out in the section 29a notice and noted that:

- the momentum of change needed to be maintained and embedded in the department so that change was sustainable in the medium and long term, particularly at times of additional pressure during winter;

- flow through the department to the rest of the hospital should be monitored so that patients are not in the department for longer than necessary.

To achieve and sustain these improvements we developed a robust improvement plan, which has been monitored through our Quality Committee on a monthly basis.

Stockport System Improvement Board also continues to meet monthly to review the progress being made by both ourselves and local partner organisations in addressing the concerns originally raised by the CQC.

Clinical audit

Clinical audit is well established in the organisation and recognised as important to quality improvement, as clinical audit findings can identify compliance levels that can be used for either assurance or identifying areas for improvement.

Projects registered during 2020-21include:

- 66 national audits,
- 161 local clinical audits,
- 76 service evaluations,
- 36 clinical quality Improvements,
- 204 quality monitoring projects.

Following publication of a national audit report, a review is undertaken by the relevant speciality as part of the governance framework. This provides assurance that there is understanding of the findings and that the appropriate actions are being taken. The reviews are considered for approval at the business groups' quality board meetings and then shared with the patient, safety & quality group for assurance or escalation.

Clinical audit and quality forums are held quarterly to share and discuss the results of clinical audits, and to agree the next steps. During 2020-21 some of these meetings were cancelled due to clinical priorities as a result of the pandemic, and the remainder were held virtually, which proved to be very successful.

We usually hold an annual event during national Clinical Audit Awareness Week to share and celebrate examples of the excellent activity that takes place, however due to social distancing guidance we undertook celebrations and recognition virtually.

Commissioning for Quality & Innovation (CQUIN)

In the past a proportion of our annual income has been conditional on us achieving quality improvement and innovation goals agreed with commissioners through the CQUIN payment framework. However, this requirement was not included in our contract for 2020-21.

Karen James OBE

Chief Executive

03.06.2021

Remuneration Report

Annual statement on remuneration from the Chair

The Board of Directors has established a Remuneration Committee, which is responsible for the review and consideration of remuneration and conditions of services of the Chief Executive and Executive Directors, and appointment of Executive Directors.

During 2020-21 the committee met on nine occasions to consider the number of changes that happened within the Executive Director team over the last year:

The committee, which is made up of all Non-Executive Directors, also:

- considered national guidance on Very Senior Manager (VSM) pay for 2020-21,
- reviewed the operation of the earn back arrangement in place for a small number of Executive Directors,
- received a summary of the appraisals of Executive Director performance in 2019-20,
- received a report on the appraisal of the Chief Executive's performance in 2019-20,
- agreed to appoint Mr Graham as Deputy Chief Executive in addition to his responsibilities as Director of Finance,
- considered the organisation's approach to senior leadership talent management.

Senior managers' remuneration policy

In determining and reviewing remuneration for Executive Directors, the committee takes into account:

- relevant benchmarking information from other NHS and public sector organisations,
- guidance from NHSE/I,
- national inflationary uplifts recommended for other NHS staff,
- variation or change to the responsibilities of Executive Directors.

In response to national guidance the committee agreed that staff in receipt of VSM should receive 1.03% pay increase for 2020-21.

A small number of Executive Directors are subject to an earn back arrangement, which is determined based on an annual appraisal process that considers their individual performance over the previous 12 months against a set of agreed individual objectives, as well as their contribution to the delivery of a set of agreed team objectives.

While not all objectives had been met in 2020-21 the committee considered that in light of the significant impact of the pandemic it would be inappropriate to implement the earn back arrangements on this occasion.

In considering the appointment of individuals to roles with a salary of more than £150,000 the committee's policy is to consider:

- benchmarking data with other similar sized organisations,
- market conditions ie national scarcity of required skills and experience,

- the trust's leadership capacity and capability requirements,
- the pay and conditions of other trust employees not subject to VSM,
- guidance from NHSE/I.

Details of Remuneration Committee membership and attendance at meetings are set out below:

	Meeting attendance
Adrian Belton, Chair	9 of 9
Malcolm Sugden, Deputy Chair	9 of 9
Catherine Anderson	9 of 9
Catherine Barber-Brown	9 of 9
Mike Cheshire	1 of 1
David Hopewell	9 of 9
Marisa Logan-Ward	7 of 9
Mary Moore	7 of 7
Louise Sell	7 of 7

To advise committee members meetings are attended by the Chief Executive and Director of Workforce and Organisational Development, other than when matters being discussed may result in a conflict of interest. Minutes of the meeting are recorded by the Director of Communications & Corporate Affairs as part of their Company Secretary responsibilities.

During 2020-21 the committee used the services of Gatenby Sanderson to recruit to the Medical Director role after a process was undertaken to identify the most appropriate external search and recruitment support. Mindful of our commitment to widen the diversity of the Board of Directors the recruitment company was instructed to undertake a search to attract candidates not only with the capability and experience required for the role, but also to reflect the diversity of the communities we serve.

The contracts of employment of all substantive Executive Directors, including the Chief Executive, are permanent and are subject to a six month notice period. For some directors appointed in 2019-20 an earn back arrangement was introduced and reviewed during 2020-21, however no other Executive Directors are subject to a performance related pay scheme and there are no special provisions regarding early termination of employment.

We have not released any Executive Director to serve as a Non-Executive Director elsewhere. Pension entitlements are detailed on page 72 and there are no special provisions regarding early termination of employment. No early termination payments were made during the year to any Executive Director or previous Executive Director.

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

The expenses paid to Directors during the year were:

	2020/21	2019/20
Total number of Directors in office	19	19
Number of Directors receiving expenses	4	9
Aggregate sum of expenses paid to Directors	£170	£4,780

Prof. Tony Warne

Chair

03.06.2021

Annual report on remuneration (which is subject to audit)

The salary and pension entitlement of Senior Managers is set out in the following tables:

Table 1 Single Table Figure – Non Executive Directors

Name	Start Date of Office	**Salary and allowances (bands of £5,000) 2020/2021**	Salary and allowances (bands of £5,000) 2019/2020	**All taxable benefits to nearest £100 2020/2021****	**Performance pay and bonuses (bands of £5,000) 2020/2021****	**Long term performance pay and bonuses (bands of £5,000) 2020/2021****
Non Executive Directors						
A Belton	01.06.17	45-50	45 - 50			
M Sugden	28.04.10	15-20	15 - 20			
D Hopewell	01.07.18	15-20	15 - 20			
Dr M Cheshire	01.09.13	5-10	15 - 20			
C Anderson	04.01.16	10-15	10 - 15			
C Barber-Brown	01.09.16	10-15	10 -15			
M Logan Ward	01.08.19	10-15	5 - 10			
M Beaton	01.08.19	-	5 - 10			
A Smith	01.04.16	-	0 - 5			
M Moore	1.10.20	5-10	-			
Dr L Sell	1.10.20	5-10	-			

Fair pay

We are required to disclose the relationship between the remuneration of the highest-paid director in the organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in Stockport NHS Foundation Trust in the financial year 2020-21 was £197.5k - £200k (2019-20 £205k - £210k). In 2020-21 this was 6.9 times the median remuneration of the workforce, which was £28,824. In 2019-20 the fair pay multiple was 7.5 times and the median remuneration was £27,690. The reduction in the ratio is due to the increase in median pay and the lower pay band of the highest paid director in 2020-21.

The Medical Director, Dr Wasson, was the highest paid director in the organisation in 2020-21 (2019-20 it was the Chief Executive). From the 1st January Dr Wasson stepped down from his Board role and continued to be employed as an Intensive Care Consultant. In 2020-21 two employees (2019-20 one employee) received remuneration in excess of the highest paid director. We paid two director posts in excess of the annual equivalent of £150,000, which is the threshold used by the Civil Service as a comparison to the Prime Minister's ministerial and parliamentary salary. The Remuneration Committee has satisfied itself that the salaries are reasonable and in line with other NHS Foundation Trusts of a similar size.

Table 1 - Single Table Figure – Executive Directors

Name	Start Date of Office	**Salary and allowances (bands of £5,000) 2020/2021**	Salary and allowances (bands of £5,000) 2019/2020	**All taxable benefits to nearest £100 2020/2021 (Note 2)**	**Performance pay and bonuses (bands of £5,000) 2020/2021 (Note 2)**	**Long term performance pay and bonuses (bands of £5,000) 2020/2021 (Note2)**	**All Pension Related Benefits (bands of £2,500) 2020/2021 (Note 1)**	**Total (bands of £5,000) 2020/2021**	All Pension Related Benefits (in bands of £2,500) 2019/2020	Total (in bands of £5,000) 2019/2020
Executive Directors		**£000**	£000				**£000**	**£000**	£000	£000
K James OBE (Note 3)	9.11.2020	60-65					30-32.5	90-95		
Chief Executive										
L Robson (Note 4)	07.01.2019	120-125	205 - 210				0	120-125	197.5 - 200	405 - 410
Chief Executive										
L Robson	09.11.2020	80-85					0	80-85	-	-
secondment										
Dr C Wasson (Note 5)	01.04.2016	155-160	205 - 210				0	155-160	90 - 92.5	300 - 305
Medical Director										
H Mullen	01.11.2017	20-25	120 -125				0	20-25	0 - 2.5	125 - 130
Director of Strategy, Planning & Partnerships/Deputy Chief Executive										
J.McShane (Note 9)	14.12.2020	30-35					127.5-130	162.5-165		
Director of Operations										
A Lynch (Note 7)	23.10.2017	70-75	115 -120				0-2.5	70-75	32.5 - 35.0	152.5 - 155.0
Chief Nurse & Director of Quality Governance										
J Graham	20.05.2019	140-145	115 -120				30-32.5	170-175	445 - 447.5	565 - 567.5
Director of Finance										
S Toal (Note 8)	01.12.2016	85-90	115 -120				0	85-90	97.5 - 100	215 -220
Chief Operating Officer										
G Moores	03.06.2019	120-125	95 - 100				0	120-125	385 - 387.5	485-490
Director of Workforce & Organisation Development										
C Parnell	01.11.2019	105-110	40 - 45				640-642.5	745-750	10 - 12.5	50-55
Director of Communications & Corporate Affairs										
P Moore	9.7.2020	75-80	-				0	75-80	-	-
Director of Quality Governance and Risk Assurance										
N J Firth	2.11.2020	55-60	-				60-62.5	115-120	-	-
Chief Nurse										
A D Loughney (Note 6)	01.01.2021	45-50	-					45-50		
Medical Director										
A Bailey (Note 10)	01.01.2021	20-25	-				90-92.5	115-120	-	-
Acting Director of Strategy & Planning										
H Brearley	27.03.2018		30 - 35				-	-	-	-
Interim Director of Workforce & Organisational Development										
M Patel	03.08.2015		15-20				-	-	27.5 - 30	45 - 50
Director of Finance										

Notes to the Remuneration Table (which is subject to audit)

1. 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. Where negative figures are calculated a zero figure is recorded.
2. There are no costs to include as prior year comparators in 2019/2020.
3. Mrs K James OBE was appointed as Chief Executive for 12 months from 9 November 2020. Total Remuneration as Chief Executive of Stockport NHS Foundation Trust and Tameside and Glossop Integrated Care NHS Foundation Trust was £180,000 - £185,000, of which the cost to Stockport NHS Foundation Trust is £60,000 - £65,000.
4. Mrs L Robson was seconded to NHSE/I from 9 November 2020. The above table discloses remuneration as Chief Executive. Total remuneration paid was £200,000 - £205,000 of which £40,000 - £45,000 was recharged to NHS Improvement.
5. Dr C Wasson's salary as Medical Director to 31 December 2020 reflects his full salary which is split 65% for his executive director role and 35% for his clinical role. From 1 January 2021 Dr Wasson continued his clinical role.
6. Mr A Loughney was appointed full time Medical Director from 1 January 2021.
7. Mrs A Lynch was seconded to Manchester Foundation Trust from 3 August 2020. The above table discloses remuneration as Chief Nurse. Total remuneration payable was £150,000 - £155,000 of which £30,000 - £35,000 was payment in lieu of notice.

8. Mrs S Toal was seconded to Tameside and Glossop Integrated Care Trust from 14 December 2020. The above table discloses remuneration as Chief Operating Officer. Total remuneration paid was £120,000 - £125,000.
9. Mrs J McShane was seconded to Stockport NHS Foundation Trust as Chief Operating Officer on 14 December 2020.
10. Mr A Bailey was appointed as Interim Director of Strategy from 1 January 2021.
11. Prior year comparatives are included for staff that left the trust in 2019/2020.
12. For those staff who are seconded the real increases in pensions figure reflect the full year increase.
13. Mr S Bennett (Director of Strategy and Partnerships from May 2020 to December 2020) and Mrs B Tabernacle-Pennington (Interim Chief Nurse from July 2020 to November 2020) were seconded into the Trust via NHSE/I. Remuneration information is not available as they were not directly employed by the Trust, however costs of the secondments were £115,000-£120,000 and £45,000-£50,000 respectively.

Table 2 – Pensions Benefits

Name	Start Date of Office	Real increase during the reporting year in the pension at pension age (bands of £2,500)	Real increase during the reporting year in related lump sum at pension age (bands of £2,500)	Total accrued pension at pension age (in bands of £5,000)	Lump sum at pension age related to the accrued pension at 31 March 2021 (bands of £5,000)	Cash Equivalent Transfer value at the 1 April 2020	Real Increase in Cash Equivalent Transfer Value during the reporting year	Cash Equivalent Transfer Value at the 31st March 2021
Executive Directors		**£000**	**£000**	**£000**	**£000**	£000	£000	£000
K James OBE	9.11.2020	**5-7.5**	**15-17.5**	**80-85**	**250-255**	**1,865**	138	**2,062**
Chief Executive								
L Robson	07.01.2019	**0-2.5**	**0**	**85-90**	**255-260**	**1,974**	38	**2,065**
Chief Executive								
Dr C Wasson	01.04.2016	**0-2.5**	**0**	**70-75**	**165-170**	**1,324**	18	**1,392**
Medical Director								
J McShane	14.12.20	**5-7.5**	**0**	**20-25**	**0**	**0**	68	**281**
Director of Operations								
A Lynch	23.10.2017	**0-2.5**	**0-2.5**	**40-45**	**130-135**	**941**	22	**996**
Chief Nurse & Director of Quality Governance								
J Graham	20.05.2019	**0-2.5**	**2.5-5**	**20-25**	**65-70**	**507**	45	**563**
Director of Finance								
S Toal	01.12.2016	**0-2.5**	**0-2.5**	**60-65**	**180-185**	**1,376**	29	**1,446**
Chief Operating Officer								
C Parnell	01.11.2019	**27.5-30**	**80-82.5**	**25-30**	**80-85**	**11**	628	**654**
Director of Communications & Corporate Affairs								
P Moore	9.7.2020	**0-2.5**	**0**	**40-45**	**95-100**	**734**	0	**760**
Director of Quality Governance & Risk Assurance								
N J Firth	2.11.2020	**0-2.5**	**0.2.5**	**55-60**	**130-135**	**945**	19	**1,029**
Chief Nurse								
A Bailey	1.1.21	**2.5-5**	**5-7.5**	**15-20**	**30**	**-**	55	**236**
Acting Director of Strategy								

Karen James OBE

Chief Executive

03.06.2021

Staff report

Our workforce

We recognise the exceptional work of all our staff and we have created a variety of initiatives and schemes to help engender the commitment and hard work of our dedicated workforce during what was an incredibly challenging year in 2020-21.

Staff costs and average whole time equivalent (WTE) for the year were as follows:

Staff costs – Group			2020/21	2019/20
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	182,785	1,235	**184,020**	170,317
Social security costs	15,752	-	**15,752**	14,644
Apprenticeship levy	826	-	**826**	833
Employer's contributions to NHS Pension scheme	30,344	-	**30,344**	28,531
Pension cost - other	100	-	**100**	94
Termination benefits	39	-	**39**	-
Temporary staff	-	45,250	**45,250**	29,753
Total staff costs	**229,846**	**46,485**	**276,331**	**244,172**

Average WTE

Average number of employees (WTE basis)			2020/21	2019/20
	Permanent	Other	Total	Total
	Number	Number	Number	Number
Medical and dental	512	74	**586**	558
Administration and estates	1,235	62	**1,297**	1,238
Healthcare assistants and other support staff	1,069	188	**1,257**	1,182
Nursing, midwifery and health visiting staff	1,395	276	**1,671**	1,540
Scientific, therapeutic and technical staff	615	17	**632**	592
Total average numbers	**4,826**	**617**	**5,443**	**5,110**

Our workforce of 4,926.15 whole time equivalent staff relates to a headcount of 5,933 staff as at 31 March 2020, and the profile of these staff can be shown by gender, which is 80% female and 20% male; of which:

Gender Headcount	Male	Female	Total
Directors	5	7	12
Other Senior Managers	16	24	40
Other Employees	1147	4734	5881

Health and wellbeing

Our commitment to the health and wellbeing of our staff continues to be an area of priority and focus for us. We believe that we must provide the best support to ensure that every member of our workforce is able to 'Make a Difference Every Day', and we understand that healthy staff mean better outcomes for patients.

We are continuing with the implementation of our approach to health and wellbeing initiatives as set out in a health and wellbeing wheel to support our staff with their:

- career,
- emotional life,
- finances,
- social, physical and psychological wellbeing;
- work-life balance,
- personal resilience.

Our comprehensive programme of health and wellbeing initiatives is complemented by other activities, including our approaches to coaching and leadership, which have a strong health and wellbeing focus.

We want to do as much as we can to:

- encourage and support staff to develop and maintain a healthy lifestyle,
- create a safe and healthy working environment,
- create an environment where staff feel valued and supported to stay in work.

Every employee will be supported to maintain and improve their health and wellbeing, and every employee is encouraged to take reasonable steps to improve their own health and wellbeing. Our approach to health and wellbeing supports the overarching aims of our People Strategy and acknowledges that the work our staff do is interlinked to their health and wellbeing. We are committed to promoting a culture where wellbeing is embraced by all of our staff.

Health and Wellbeing Framework

Everyone should feel able to thrive at work and for that reason the organisation has implemented the NHSE/I Health and Wellbeing Framework to offer increased support for our staff to improve their health and wellbeing. We have used the health and wellbeing diagnostic tool to understand where we are as an organisation in terms of our enablers and health interventions.

We have used the framework findings to inform our ongoing strategy and ensure we can deliver health and wellbeing interventions that suit our staff, as well as meet the requirements of our organisation.

Health and Wellbeing Guardian

Mrs Catherine Barber-Brown, a Non-Executive Director, is our health and wellbeing guardian and part of her role is to ensure that health and wellbeing is viewed as a priority for our organisation. We recognise that decisions made at Board level can often impact on staff and that it is important to have a Board member whose role is to ensure any significant changes improve the wellbeing of staff.

Our guardian attends the Health and Wellbeing Steering Group, People Performance Committee, and a number of staff networks to ensure that the health and wellbeing of our staff remains at the forefront of what we do.

Health and Wellbeing Wheel

We have taken a holistic approach to health and wellbeing and developed a health and wellbeing wheel that looks at six areas of staff wellbeing support (career, emotional, financial, physical, social, psychological). This approach has allowed us to tailor our health and wellbeing initiatives to meet all needs.

Health and Wellbeing Interventions

The pandemic has reduced the number of opportunities for face-to-face gatherings, but we have still offered a variety of health and wellbeing interventions, both online and face-to-face (with reduced numbers). We regularly hold Schwartz Rounds, virtual coffee breaks, tool-kit talks, and engagement events with the aim of sharing knowledge around the health and wellbeing interventions we offer, as well as some of the external support available, such as the Greater Manchester Resilience Hub and various apps.

Mental Health First Aiders

It is estimated that one in four people experience a mental health issue in any given year, and at least one in six employees is depressed, anxious, or suffering from stress-related issues at any one time (pre-COVID). So we have implemented mental health first aiders to signpost and support staff who may be struggling with their mental health.

We have trained 48 mental health first aiders via the programme run by Mental Health First Aid England, the only licensed and accredited provider in England. Two members of staff were already trained mental health first aiders, taking the total number in the organisation to 50.

Clinical psychologist resource

Since the pandemic began the organisation has secured a dedicated clinical psychologist resource that is offering tailored support to our staff. We are also using the resource to guide our health and wellbeing provision to ensure our approach to health and wellbeing supports the psychological wellbeing of our staff. The organisation is looking at options to extend this provision.

Covid-19 recovery

We significantly ramped up the support we have available to staff to meet the demands of the acute phases of the pandemic over the past 12 months. In the medium to long term many will cope and adjust to the extreme events they have experienced, but others will need additional support and we are preparing to support them with the lasting impacts.

We have developed a recovery strategy with the following six key themes:

- recognising effort and conveying appreciation at all levels,
- reviewing wellbeing response to the pandemic and preparing for the future increase,
- promoting emotional adjustment and mitigating harm,
- support to leaders,
- identifying individuals in psychological need,
- building psychological resilience and capacity for future challenges.

Sickness Absence Data

Our sickness absence data for 2020-21 is published by NHS Digital:

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

The pandemic has had a significant impact on our sickness absence figures and the way we have managed sickness absence. We have followed national guidance for staff with Covid-19 related absences in that they are supported and managed at no detriment to the staff member. An increased focus and enhanced offer for health and wellbeing support has been provided for staff.

Working in Partnership

We take a partnership approach to working with staff through our Joint Consultative and Negotiating Committee (JCNC) and Local Negotiation Committee (LNC). Both of these forums are attended by Executive Directors and include representatives from our staff side and trade union colleagues.

These meetings focus upon consulting with staff in a constructive manner in relation to key service changes across the organisation, as well as discussing and seeking approval of policies and procedures. Both forums share chairing arrangements between staff and management, and Executive Directors and senior managers are regularly in attendance.

Facility Time Trust Data for 2020-21

The tables below set out the relevant information for Stockport NHS Foundation Trust for the period 1 April 2020 to 31 March 2021.

Table 1: Relevant union officials

Number of employees who were relevant union officials during the relevant period

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
50	44.38fte

This was an increase of 1 (0.96fte) trade union colleagues since last year.

Table 2: Percentage of time spent on facility time by union officials employed by the Trust

Percentage of time	Number of employees
0%	0
1-50%	49
51%-99%	1
100%	0

Table 3: Percentage of pay bill spent on facility time

First Column	Figures
Provide the total cost of facility time	£201,453
Provide the total pay bill	£235.335mil
Provide the percentage of the total pay bill spent on facility time, calculated as: **(total cost of facility time ÷ total pay bill) x 100**	0.09%

Table 3 provides the total cost of facility time as a percentage of the Trust's overall total pay bill.

Table 4: Paid trade union activities

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	22.91%

During 2020-21 2,354 hours of facility time were spent on trade union activities and 10,280 hours were spent on trade union duties. This equates to 22.91% (which is equivalent to 2019-20) of total paid facility by relevant union officials was carried out on trade union activities.

Equality, diversity and inclusion

During 2020-21 equality, diversity and inclusion was globally emphasised, highlighting inequalities with the arrival of the pandemic, the Black Lives Matter movement, and the tragic case of Sarah Everard. We have continued on our journey and commitment with further determination and pace to ensure that our services and employment practices are fair, accessible and inclusive for the diverse communities we serve and the workforce we employ.

A culture of fairness and inclusion means that our patients, staff, and anyone who comes into contact with the organisation feels valued and respected. Our Equality, Diversity & Inclusion Annual Report published on our website reaffirms our commitment to the principles of equality and diversity. It sets out an ambitious agenda for action, ensuring that we meet our general and specific duties for equality, as required by legislation, and that we work effectively to meet the needs of our diverse workforce, patient population, and the communities we serve.

In relation to the emerging issues around the disproportionate impact of Covid-19 and vaccine hesitancy we have developed and implemented a number of interventions in recognition of colleagues' health and safety and ensuring colleagues feel safe in speaking up. This included risk assessments, confidential health and wellbeing questionnaires, safe space sessions, and reinforcing positive messages to disproportionately impacted groups.

Governance

To ensure that the appropriate assurance is provided we have an equality, diversity and inclusion (EDI) steering group with representation from all key business group areas. This group reports to the People Performance Committee and provides strategic direction for promoting and maintaining EDI across the organisation in both workforce and service delivery. This includes meeting legislative, contractual, and policy requirements, as well as adopting and embedding good practice across all of our functions.

During the pandemic our equality, diversity and inclusion lead was part of our command and control arrangements, and provided subject matter expertise as required.

All new or revised policies are subject to an equality impact assessment to ensure that they support the advancements of equality and do not have negative effects upon any particular groups. Completion of the assessments also serves to ensure that we comply with our duties under the Equality Act 2010. A number of tools have been developed to ensure equality impact assessments are completed in a robust manner - putting patients and the workforce at the heart of all we do.

Completion of an Equality and Quality Impact Assessments Workforce and Regulatory Response in relation to Covid-19 was also carried out.

Workforce Race Equality Standard (WRES)

NHS England introduced the Workforce Race Equality Standard (WRES) in 2015 to ensure employees from black and ethnic minority (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. Our performance against these standards in 2020–21 and an associated action plan, are published on our website.

Workforce Disability Equality Standard (WDES)

The WDES was introduced in April 2019 and is mandated for all NHS trusts and foundation trusts. The ten metrics explore the experiences of disabled staff in the NHS and how these compare to non-disabled employees. Our performance against these standards in 2020-21 and an associated action plan, are published on our website.

Equality Delivery System 2

EDS2 is a tool commissioned by the NHS Equality & Diversity Council to assess how well organisations have embedded equality into their work and identify any areas for improvement. There are four key goals against which organisations are assessed.

There was not a requirement to complete the EDS2 for 2020 due to the pandemic as long as the organisation continued to demonstrate due regard in accordance to the Equality Act 2010.

In 2021-22 we will be focusing on two EDS2 goals, which align to our EDI objectives for 2020-25. They are:

- Objective 2: Improved Patient Access and Experience
- Objective 4: Inclusive Leadership.

A detailed review and assessment process on the two objectives has been reinstated. Gender

Pay Gap

Legislation requires employers with 250 or more employees to publish statutory calculations each year that detail the pay gap between male and female employees. Our next gender pay gap report

will be published on our website in October 2021 in line with national pandemic guidance.

Remuneration

Information relating to exit packages, off-payroll arrangements and consultancy costs is included in the Remuneration Report on pages 95 to 96.

2020 National Staff Survey

The annual staff survey is a vital component for finding out the views of staff and helping to identify where improvements can be made at corporate, business group, and staff group levels to improve staff experience and further enhance engagement and staff satisfaction.

A change in our comparator group was made during the 2020 survey to include acute and acute and community combined organisations. In 2020 the NHS Staff Survey was delivered to 5,411 staff across the organisation and yielded a response rate of 51% - the highest rate of any trust in Greater Manchester. This represented an achievement of six percent above the national average response rate, although a four percent decrease on last year's result.

The table below provides an overview of our performance against the ten summary indicators compared to all acute and acute and community combined trusts over the last four years.

Summary Indicator	2020-21		2019 -20		2018-19		2017-18	
	Trust	Bench mark Group	Trust	Bench marking Group	Trust	Bench marking Group	Trust	Bench marking Group
Equality, Diversity & Inclusion	9.1	9.1	9.2	9.2	9.1	9.2	9.2	9.2
Health & Wellbeing	5.9	6.1	5.6	6.0	5.6	5.9	5.7	6.0
Immediate Managers	6.8	6.8	6.8	6.9	6.7	6.8	6.8	6.8
Morale	6.0	6.2	6.0	6.2	6.0	6.2	-	-
Quality of Appraisals	-	-	5.5	5.5	5.3	5.4	5.3	5.4
Quality of Care	7.2	7.5	7.2	7.5	7.2	7.4	7.3	7.5
Safe Environment Bullying & Harassment	8.1	8.1	8.1	8.2	8.2	8.1	8.3	8.1
Safe Environment Violence	9.4	9.5	9.4	9.5	9.5	9.5	9.5	9.5
Safety Culture	6.6	6.8	6.6	6.8	6.6	6.7	6.4	6.7
Staff Engagement	6.8	7.0	6.9	7.1	6.9	7.0	6.8	7.0

A summary of the findings are outlined below:

Equality, diversity and inclusion

This theme has reduced since 2019 to 9.1 in line with our comparator group. There was a continued rise in the number of staff reporting adequate adjustments to enable them to continue at work from 51.9% in 2018, 69.2% in 2019, and 71.5% in 2020. There was also recognition of the organisation acting fairly regardless of background, gender, disability to age, which now stands at 86.4%.

Incidents of discrimination from colleagues increased from 6.6% to 8.0%, although this remains below the national average. This trend mirrors discrimination from service users, their relatives, or members of the public, which rose 0.5% to 5.4%. This again remains below the national average.

We continue to make advances in implementing adequate adjustments to enable staff to carry out their work effectively, with a 1.4% increase from 2019. Monitoring of the EDI processes is undertaken by the EDI steering group and staff network groups.

Health and wellbeing

Although performance in this area remains below the national average our overall indicator has improved by 0.3%. We have continued to offer support for staff through a number of initiatives and now 24.6% of staff report that the organisation is taking positive action on health and wellbeing. During the pandemic our health and wellbeing provision was supported by a dedicated clinical psychology resource.

We have used data from the 2020 survey to inform a holistic health and wellbeing strategy, and we have implemented the Health and Wellbeing Framework alongside the introduction of a Health and Wellbeing Guardian. It is underpinned by the NHS People Plan.

All of these areas are regularly monitored via the health and wellbeing steering group and People Performance Committee.

Immediate managers

We are now in line with the national average for support from immediate managers with an overall score of 6.8. We have delivered a comprehensive leadership development programme combined with various tailored interventions, and team effectiveness measures aimed at increasing leadership capabilities.

We have worked, and continue to work, with NHSE/I to deliver the NHS Improvement Culture and Leadership Programme aimed at creating an environment in which our workforce has more influence over decision making in line with our aspirations for a collective leadership style. These measures will be monitored via our workforce and organisation development integrated plan and development dashboards used to inform the People Performance Committee and people engagement and leadership group.

Morale

Staff morale remains just below the national average at 6.0. Measures are in place to support and encourage staff morale via the health and wellbeing and leadership programmes, which we are currently implementing. We are holding a number of listening events, focus groups, and engagement seminars to work collaboratively with our staff on producing morale boosting interventions.

Business groups are offered personalised support to address the main themes raised in the staff survey results for their wards and departments. This co-design approach aims to rectify the identified issues, ensuring that the interventions that are in place add value to both individuals and the wider organisation. This will also be monitored via the health and wellbeing steering group and People Performance Committee.

Quality of care

Our rating of 7.2 for quality of care has remained stable for the past three years, although below the national average. This will be monitored at business group quality meetings.

Bullying and harassment

There has been a decrease of 0.9% in staff experiencing harassment or bullying from other colleagues, which means that our overall score for bullying and harassment has remained at 8.1 in line with the national average. Reports of bullying and harassment received from line managers have remained the same at 8.1.

Bullying and harassment from patients/service users, their relatives, or other members of the public remains under the national average at 24.6%, and has fallen since our 2019 staff survey.

Monitoring of bullying and harassment falls under the remit of various projects and will be monitored by Datix reporting, EDI steering group, staff network group; and People Performance Committee.

Violence

Instances of violence from patients/service users, their relatives, or other members of the public have risen by 0.8% since our 2019 staff survey. This measures 1.3% above the national average. Instances of violence from colleagues are also above the national average by 0.2% although a decline from last year's survey (1.6%).

The number of employees who have experienced violence from managers continues to fall and currently sits at 0.4%. Monitoring of these processes will be undertaken by the EDI steering group, staff network group, and People Performance Committee.

Safety culture

This theme has been stable at 6.6 for the previous three years, although this remains below the national average. Staff reporting being treated fairly when involved in an error or near miss has fallen by 0.7% to 56.6%. There has been a year-on-year increase in staff involved in an error or

near miss feeling that the organisation takes action (70.7%), although feedback on changes has fallen by 0.3% to 62.0%.

There has been an increase in numbers of staff who feel secure about raising concerns about unsafe clinical practice (71.3%). Work remains to be done regarding concerns raised by patients/service users, as this continues to decline against the national average. This will be monitored by business group quality meetings.

Staff engagement

Staff recommending the organisation as a place to work has increased to 55.1%, with the national average being 66.9%. Staff recommending the organisation as a place to receive treatment has fallen to 60.3% from our position in 2019 of 61.7%, against the national average of 74.3% for 2020.

The findings of our 2020 NHS Staff Survey have been shared with all staff. The results, our response, and action plans will be reported through our established governance structures, via the People Performance Committee, people engagement and leadership group, and our Board of Directors.

Off payroll arrangements

The following tables detail the numbers of staff employed through other means than payroll. Off payroll staff are paid the equivalent of more than £245 per day and have an engagement lasting longer than six months. It is our policy that employees are paid via our payroll and so these arrangements apply to staff contracted through an agency, which then pays the individual via their own personal service company or via the agency payroll. The arrangements apply to some interim managers but not to medical agency staff.

Table 1

	2020/21	2019/20
No of existing arrangements as of 31 March Of which:	Nil	Nil
Less than one year at time of reporting	-	-
Between one and two years at time of reporting	-	-
Between two and three years at time of reporting	-	-
Between three and four years at time of reporting	-	-
Four or more years at time of reporting	-	-

Table 2

	2020/21	2019/20
No of new engagements, or those that reached 6 months duration, between 1 April and 31 March	Nil	Nil
Of which:		
- Number assessed as within the scope of IR35	-	-
- Number assessed as not within the scope of IR35	-	-
Number engaged directly (via PSC contracted to trust) and are on trust's payroll	-	-
Number of engagements reassessed for consistency / assurance purposes during	-	-
Number of engagements that saw a change to IR35 status following the consistency review	-	-

Table 3

	2020/21	2019/20
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	Nil	Nil
Number of individuals that have been deemed "board members and/or senior officials with significant financial responsibility". This figure should include both off-payroll and on-payroll engagements.	19	18

Exit packages (subject to audit)

Redundancy and other departure costs are paid in accordance with the provisions of the NHS Scheme and trust policies. Any exit packages exceeding contractual amounts, and outside of the terms of the normal pension provisions, require Treasury approval before they are offered.

The trust did not offer a Mutually Agreed Resignation Scheme or Voluntary Redundancy Scheme during 2020-21.

The following tables show the exit packages for 2020-21 compared to 2019-20:

Exit package cost band (including any special payment element)	**Number of compulsory redundancies 20/21**	**Number of other departures agreed 20/21**	**Total number of exit packages 20/21**
<£10,000	1	-	1
£10,001 - £25,000	-	-	-
£25,001 - £50,000	-	1	1
£50,001 - £100,000	-	-	-
£100,001 - £150,000	-	-	-
£150,001 - £200,000	-	-	-
>£200,000	-	-	-
Total number of exit packages by type	**1**	**1**	**2**
Total resource cost	**£8.302.33**	**£30,309**	**£38,611.33**

Comparator 2019-20

Exit package cost band (including any special payment element)	Number of compulsory redundancies 2019/20	Number of other departures agreed 2019/20	Total number of exit packages 2019/20
<£10,000	2	-	**2**
£10,001 - £25,000	1	-	**1**
£25,001 - £50,000	2	2	**4**
£50,001 - £100,000	1	-	**1**
£100,001 - £150,000	-	-	**-**
£150,001 - £200,000	-	-	**-**
>£200,000	-	-	**-**
Total number of exit packages by type	**6**	**2**	**8**
Total resource cost	**£159,000**	**£75,000**	**£234,000**

Exit Packages – Non Compulsory Departures

Exit packages: other (non-compulsory) departure payments	2020/21		2019/20	
	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
	Number	£000	Number	£000
Voluntary redundancies including early retirement contractual costs	-	-	2	75
Contractual payments in lieu of notice	1	30	-	-
Total	**1**	**30**	**2**	**75**

Consultancy costs

We procure expert advice to deliver key project where we do not have internal expertise or, in some circumstances, we may not have the required capacity. Consultancy costs in 2020-21 are summarised below:

Consultancy area	£000	Note
Strategy: The provision of objective advice and assistance relating to corporate strategies, appraising business structures, value for money reviews, business performance measurement, management services, product design and process and production management.	1,414	(a)
IT/IS: The provision of objective advice and assistance relating to IT/IS systems and concepts, including strategic studies and development of specific projects. Defining information needs, computer feasibility studies and making	122	(b)

computer hardware evaluations. Including consultancy related to e-business.		
Human Resource, training and education: The provision of objective advice and assistance in the formulation of recruitment, retention, manpower planning and HR strategies and advice and assistance relating to the development of training and education strategies.	182	
Programme and Project Management: The provision of advice relating to ongoing programmes and one-off projects. Support in assessing, managing and or mitigating the potential risks involved in a specific initiative; work to ensure expected benefits of a project are realised.	0	
Property and Construction: The provision of specialist advice relating to the design, planning and construction, tenure, holding and disposal strategies. This can also include the advice and services provided by surveyors and architects.	19	(c)
Finance: The provision of objective finance advice including advice relating to corporate financing structures, accountancy, control mechanisms an systems. This includes both strategic and operational finance.	0	
Technical: The provision of applied technical knowledge. To aid understanding, this can be sub-divided into: - Technical Studies: Research based activity including studies, prototyping and technical demonstrators.	73	(d)
Procurement: The provision of objective procurement advice including advice in establishing procurement strategies.	0	
Total cost 2020-21	**1,810**	

(a) We commissioned external support to help in the review of our values and behaviours which follows on from the review of the overall trust strategy. We also commissioned work from experts in reviewing business processes with regards to cost improvement programmes and delivery of organisational efficiencies.

(b) As we are no longer pursing an EPR programme consultancy costs have been incurred in updating a number of key patient systems.

(c) We are expanding our emergency and urgent care footprint and consultancy costs have been incurred on the site reconfiguration and future building projects.

(d) We have used specialist VAT advisors for general advice and specific projects relating to contracts.

As a comparator we incurred £568k on consultancy expenditure in 2019/20.

NHS Foundation Trust Code of Governance Disclosures

The organisation applies the main and supporting principles of NHS Improvement's Code of Governance for NHS Foundation Trusts on a comply or explain basis. The Code, more recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

NHS Foundation Trusts are required to provide a specific set off disclosures in their annual report to meet the requirements of the Code of Governance, and these are detailed in the following table:

Reference	Statutory Requirement
A.2.2	The role of Chairperson and Chief Executive must not be undertaken by the same person **The Trust complies with this requirement.**
A.5.10	The Council of Governors has a statutory duty to hold the Non- Executive Directors, individually and collectively, to account for the performance of the Board of Directors. **The Board of Directors and Council of Governors comply with this requirement.**
A.5.11	The 2006 Act, as amended, gives the Council of Governors a statutory requirement to receive the following documents. These documented should be provided in the annual report as per the NHS Foundation Trust Annual Reporting Manual: a) The annual accounts, b) Any report of the auditor on them, and c) The annual report. **The Trust complies with this requirement.**
A.5.12	The directors must provide governors with an agenda prior to any meeting of the board, and a copy of the approved minutes as soon as practicable afterwards. There is no legal basis on which the minutes of private sessions of board meetings should be exempted from being shared with the governors. In practice, it may be necessary to redact some information, for example, for data protection or commercial reasons. Governors should respect the confidentiality of these documents. **The Trust complies with this requirement.**
A.5.13	The Council of Governors may require one of more of the directors to attend a meeting to obtain information about performance of the trust's functions or the directors' performance of their duties, and to help the Council of Governors to decide whether to propose a vote on the trust's or directors' performance. **The Trust is aware of this requirement. This situation did not arise during 2020-21.**
A.5.14	Governors have the right to refer a question to the independent panel for advising governors. More than 50% of governors who vote must approve this referral. The council should ensure dialogue with the Board of Directors takes place before considering such a referral, as it may be possible to resolve questions in this way. **The Trust is aware of this requirement. This situation did not arise during 2020-21**
A.5.15	Governors should use their new rights and voting powers from the 2012 Act to represent the interests of members and the public on

	major decisions taken by the Board of Directors. These are outlined in full at A.5.15 **The Trust complies with this requirement.**
B.2.11	It is a requirement of the 2006 Act that the Chairperson, the other Non-Executive Directors and, except in the case of the appointment of a Chief Executive, the Chief Executive, are responsible for deciding the appointment of Executive Directors. The nominations committee with responsibility for Executive Director nominations should identify suitable candidates to fill Executive Director vacancies as the arise and make recommendations to the Chairperson, the other Non- Executive Directors and, except in the case of the appointment of the Chief Executive, the Chief Executive. **The Trust complies with this requirement.**
B.2.12	It is for the Non-Executive Directors to appoint and remove the Chief Executive. The appointment of a Chief Executive requires the approval of the Council of Governors. **The Trust complies with this requirement.**
B.2.13	The governors are responsible at a general meeting for the appointment, re-appointment and removal of the Chairperson and the other Non-Executive Directors. **The Trust complies with this requirement.**
B.4.3	The Board has a duty to take steps to ensure that governors are equipped with the skills and knowledge they need to discharge their duties appropriately. **The Trust complies with this requirement.**
B.5.8	The Board of Directors must have regard to the views of the Council of Governors on the NHS Foundation Trust's forward plan. **The Trust complies with this requirement.**
B.7.3	Approval by the Council of Governors of the appointment of a Chief Executive should be a subject of the first general meeting after the appointment by a committee of the Chairperson and Non-Executive Directors. All other Executive Directors should be appointed by a committee of the Chief Executive, the Chairperson and Non-Executive Directors. **The Trust complies with this requirement.**
B.7.4	Non-Executive Directors, including the Chairperson, should be appointed by the Council of Governors for the specified terms subject to re-appointment thereafter at intervals of no more than three years and subject to the 2006 Act provision relating to the removal of a director. **The Trust complies with this requirement.**
B.7.5	Elected governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. **The Trust complies with this requirement.**
D.2.4	The Council of Governors is responsible for setting the remuneration of Non-Executive Directors and the Chairperson. **The Trust complies with this requirement.**
E.1.7	The Board of Directors must make Board meetings and the annual meeting open to the public. The Trust's constitution may provide for members of the public to be excluded from a meeting for special reasons. **The Trust complies with this requirement.**
E.1.8	The Trust most hold annual members' meetings. At least one of the directors must present the Trust's annual report and accounts, and any report of the auditor on the accounts, to members at this meeting. **The Trust complies with this requirement.**

The provisions below require a supporting explanation. Where the information is already in the annual report a reference to its location is sufficient to avoid unnecessary duplication.

Reference	Statutory requirement
A.1.1	The schedule of matters reserved for the Board of Directors should include a clear statement detailing the roles and responsibilities of the Council of Governors. This statement should describe how any disagreements between the Council of Governors and the Board of Directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the Board of Directors and Council of Governors operate, including a summary of the types of decisions to be taken by each of the boards and which are delegated to the executive management of the Board of Directors **See page 40, 50, 56.**
A.1.2	The annual report should identify the Chairperson, the Deputy Chairperson (where there is one), the Chief Executive, the Senior Independent Director (see A.4.1) and the Chairperson and members of the Nominations, Audit and Remuneration Committees. It should also set out the number of meetings of the Board and those Committees, and individual attendance by directors. **See pages 41, 45, 56, 64**
A.5.3	The annual report should identify the members of the Council of Governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor. **See page 53, 54.**
FT ARM	The annual report should include a statement of the number of meetings of the Council of Governors and individual attendance by governors and directors. **See page 54.**
B.1.1	The Board of Directors should identify in the annual report each Non- Executive Director it considers to be independent, with the reasons where necessary. **See page 40, 41.**
B.1.4	The Board of Directors should include in its annual report a description of each director's skills, expertise and experience. Alongside this, in the annual report, the Board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS foundation Trust. **See page 41, 42.**
FT ARM	The annual report should include a brief description of the length of appointments of the Non-Executive Directors and how they may be terminated. **See page 41, 42.**
B.2.10	A separate section of the annual report should describe the work of the nominations committee (s), including the process it has use in relation to Board appointments. **See page 55.**
FT ARM	The disclosure in the annual report on the work of the Nominations Committee should include an explanation if neither an external search consultancy nor open advertising has been use in the appointment of a Chair or Non-Executive Director **See page 56.**

B. 3.1	A chairperson's other significant commitments should be disclosed to the Council of Governors before appointment and include in the annual report. Changes to such commitments should be reported to the Council of Governors as they arise, and included in the next annual report **See page 42.**
B. 5.6	Governors should canvass the opinion of the Trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the Board of Directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied. **See page 50, 51.**
FT ARM	If, during the financial year, the governors have exercised their power under paragraph 10C of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report. **Executive Directors attend the Council of Governors meetings as a matter of course and governors have not had to exercise their power during 2020-21**
B.6.1	The Board of Directors should state in the annual report how performance of the Board, its committees and its directors, including the Chairperson, has been conducted. **See page 44.**
B. 6.2	Where there has been external evaluation of the Board and/or governance of the trust the external facilitator should be identified in the annual report and a statement made as to whether they have any other connection to the trust. **See page 58.**
C.1.1	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, a fair, balanced and understandable and provide the information necessary for patients, regulators, and other stakeholders to assess the NHS foundation trust's performance, business model and strategy. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report). **See pages 56, 98.**
C. 2.1	The annual report should contain a statement that the Board has conducted a review of the effectiveness of its system of internal controls. **See page 98.**
C.2.2	A trust should disclose in the annual report: a) If it has an internal audit function, how the function is structured and what role it performs; or b) If it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes. **See page 46.**
C.3.5	If the council of governors does not accept the audit committee's recommendation on the appointment, reappointment or removal of an external auditor, the board of directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the council of governors has taken a different position. **This situation did not occur in 2020-21.**

C.3.9	A separate section of the annual report should describe the work of the Audit Committee in discharging its responsibilities. The report should include: • The significant issues that the committee considered in relation to financial statements, operations and compliance and how these issues were addressed; • An explanation of how it assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of current audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and • If the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded. **See page 45.**
D.1.3	Where an NHS foundation trust releases an Executive Director, for example, to service as a Non-Executive Director elsewhere, the remuneration disclosure of the annual report should include a statement of whether or not the director will retain such earnings. **This situation did not occur in 2020-21**
E.1.4	Contact procedures for members who wish to communicate with governors and/or directors should be made clearly available to members on the NHS foundation trust's website and in the annual report. **See page 42, 53.**
E.1.5	The Board of Directors should state in the annual report the steps they have taken to ensure that the members of the board, and in particular the Non-Executive Directors, develop an understanding of the views of governors and members about the NHS foundation trust, for example, through attendance at meetings of the Council of Governors, director face-to-face contact, surveys of members' opinions and consultants. **See page 52.**
E.1.6	The Board of Directors should monitor how representative the NHS foundation trust's membership is, and the level and effectiveness of member engagement and report on this in the annual report. **See page 55.**
FT ARM	The annual report should include: • A brief description of the eligibility requirements for joining different membership constituencies, including the boundaries of public membership; • Information on the number of members in each constituency, and • A summary of the membership strategy, an assessment of the membership and a description of any steps taken during the year to ensure a representative membership, including progress towards any recruitment targets for members. **See page 55.**

The FT Annual Reporting Manual (ARM) indicates that the disclosure is required by the ARM rather than the Code of Governance.

The information detailed below is available on request from the Director of Communications & Corporate Affairs by emailing caroline.parnell@stockport.nhs.uk or writing to the Trust headquarters at Oak House, Stepping Hill Hospital, Poplar Grove, Stockport.

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

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

Reference	Statutory requirement
B.7.1	In the case of the re-appointment of Non-Executive Directors, the Chairperson should confirm to the governors that following formal performance evaluation, the performance of the individual proposed for re-appointment continues to be effective and to demonstrate commitment to the role.

There was one instance of a Non-Executive Director seeking re-appointment during 2020-21. Relevant information was provided to the Council of Governors in relation to the re-appointment of Mr David Hopewell for a further three years with effect from June 2021.

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

Reference	Statutory requirement
B.7.2	The names of governors submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to take an informed decision on their election. This should include performance information. **Relevant information is included within the election material circulated to members by Electoral Reform Services, however there was no requirement for an election in 2020-21.**

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

A disclosure is only required for departure from the Code for provisions listed in this section. NHS foundation trusts are welcome but not required to provide a simple statement of compliance with each individual provision.

Reference	Summary
A.1.4	The Board should ensure that adequate systems and processes are maintained to measure and monitor the NHS foundation trust's effectiveness, efficiency and economy, as well as the quality of its health care delivery. **The Trust complies with this requirement.**
A.1.5	The Board should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and delivery of performance. **The Trust complies with this requirement.**
A.1.6	The Board should report on its approach to clinical governance. **The Trust complies with this requirement.**
A.1.7	The Chief Executive as the accounting officer should follow the procedure set out by Monitor for advising the Board and Council and for recording and submitting objections to decision. **The Trust complies with this requirement.**
A.1.8	The Board should establish the constitution and standards of conduct for the NHS foundation trust and its staff in accordance with NHS values and accepted standards of behaviour in public life. **The Trust complies with this requirement.**
A.1.9	The Board should operate a code of conduct that builds on the values of the NHS foundation trust and reflect high standard of probity and responsibility. **The Trust complies with this requirement.**
A.1.10	The NHS foundation trust should arrange appropriate insurance to cover the risk of legal action against its directors. **The Trust complies with this requirement.**

A.3.1	The Chairperson should, on appointment by the Council, meet the independence criteria set out in B.1.1. A Chief Executive should not go on to be the Chairperson of the same NHS Foundation Trust. **The Trust complies with this requirement.**
A.4.1	In consultation with the Council, the Board should appoint one of the independent Non-Executive Directors to be the Senior Independent Director. **The Trust complies with this requirement.**
A.4.2	The Chairperson should hold meetings with the Non-Executive Directors without the Executive present. **The Trust complies with this requirement.**
A.4.3	Where directors have concerns that cannot be resolved about the running of the NHS foundation trust, or a proposed action, they should ensure their concerns are recorded in the Board minutes. **The Trust complies with this requirement.**
A.5.1	The Council of Governors should meet sufficiently regularly to discharge its duties. **The Trust complies with this requirement.**
A.5.2	The Council of Governors should not be so large as to be unwieldly. **The Trust complies with this requirement.**
A.5.4	The roles and responsibilities of the Council of Governors should be set out in a written document. **The Trust complies with this requirement.**
A.5.5	The Chairperson is responsible for leadership of both the Board and the Council but the governors also have a responsibility to make the arrangements work and should take the lead in inviting the Chief Executive to their meetings and inviting attendance by other Executives and Non-Executives, as appropriate. **The Trust complies with this requirement.**
A.5.6	The Council should establish a policy for engagement with the Board of Directors for those circumstances when they have concerns. **The Trust complies with this requirement.**
A.5.7	The Council should ensure its interaction and relationship with the Board of Directors is appropriate and effective. **The Trust complies with this requirement.**
A.5.8	The Council should only exercise its power to remove the Chairperson or any Non-Executive Directors after exhausting all means of engagement with the Board. **The Trust complies with this requirement.**
A.5.9	The Council should receive and consider other appropriate information required to enable it to discharge its duties. **The Trust complies with this requirement.**
B.1.2	At least half the Board, excluding the Chairperson, should comprise Non-Executive Directors determined by the Board to be independent. **The Trust complies with this requirement.**
B.1.3	No individual should hold, at the same time, positions of director and governor of any NHS foundation trust. **The Trust complies with this requirement.**
B.2.1	The Nominations Committee or committees, with external advice as appropriate, are responsible for the identification and nomination of Executive and Non-Executive Directors. **The Trust complies with this requirement.**

B.2.2	Directors on the Board of Directors and governors on the Council should meet the “fit and proper” persons test described in the provider licence. **The Trust complies with this requirement.**
B.2.3	The Nominations Committee(s) should regularly review the structure, size and composition of the Board and make recommendations for changes were appropriate. **The Trust complies with this requirement.**
B.2.4	The Chairperson or an independent Non-Executive Director should chair the Nominations Committee(s). **The Trust complies with this requirement.**
B.2.5	The governors should agree with the Nominations Committee a clear process for the nomination of a new Chairperson and Non-Executive Directors. **The Trust complies with this requirement.**
B.2.6	Where an NHS foundation trust has two Nominations Committees, the Nominations Committee responsible for the appointment of Non- Executive Directors should consist of a majority of governors. **The Trust complies with this requirement.**
B.2.7	When considering the appointment of Non-Executive Directors, the Council should take into account the views of the Board and the Nominations Committee on the qualifications, skills and experience required for each position. **The Trust complies with this requirement.**
B. 2.8	The annual report should describe the processes following by the Council in relation to appointments of the Chairperson and Non- Executive Directors. **The Trust complies with this requirement.**
B.2.9	An independent external advisor should not be a member of, or have a vote on the Nominations Committee(s). **The Trust complies with this requirement.**
B.3.3	The Board should not agreed to a full-time Executive Director taking on more than one Non-Executive directorship of an NHS Foundation Trust or another organisation of comparable size and complexity. **The Trust complies with this requirement.**
B.5.1	The Board and the Council of Governors should be provided with high quality information appropriate to their respective functions and relevant to the decisions they have to make. **The Trust complies with this requirement.**
B.5.2	The Board, and in particular Non-Executive Directors, may reasonably wish to challenge assurances received from the executive management. They need not seek to appoint a relevant advisor for each and every subject area that comes before the Board, although they should, wherever possible, ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis. **The Trust complies with this requirement.**
B.5.3	The Board should ensure that directors, especially Non-Executive Directors, have access to independent advice, at the NHS foundation trust’s expense, where they judge it necessary to discharge their responsibilities as directors. **The Trust complies with this requirement.**
B.5.4	Committees should be provided with sufficient resources to undertaken their duties. **The Trust complies with this requirement.**

B.6.3	The Senior Independent Director should lead the performance evaluation of the Chairperson. **The Trust complies with this requirement.**
B.6.4	The Chairperson, with the assistant of the Board Secretary, if applicable, should use the performance evaluations as the basis for determining individual and collective professional development programmes for non-executive directors relevant to their duties as Board members. **The Trust complies with this requirement.**
B.6.5	Led by the Chairperson, the Council should periodically assess their collective performance and they should regularly communicate to members and the public details on how they have discharged their responsibilities. **The Trust complies with this requirement.**
B.6.6	There should be a clear policy and a fair process, agreed and adopted by the Council, for the removal from the Council of any governor who consistently and unjustifiably fails to attend the meetings of the Council, or has an actual or potential conflict of interest, which prevents the proper exercise of their duties. **The Trust complies with this requirement.**
B.8.1	The Remuneration Committee should not agree to an executive member of the Board leaving the employment of an NHS foundation trust, except in accordance with the terms of their contract of employment, including but not limited to service of their full notice period and/or material reductions in their time commitments to the role, without the Board first having completed and approved a full risk assessment. **The Trust complies with this requirement.**
C.1.2	The directors should report that the NHS foundation trust is a going concern with supporting assumptions or qualifications as necessary. **The Trust complies with this requirement.**
C.1.3	A least annually and in a timely manner, the Board should set out clearly its financial, quality and operating objectives for the NHS foundation trust and disclose sufficient information, both quantitative and qualitative, of the NHS foundation trust's business and operation, including clinical outcome data to allow members and governors to evaluate its performance. **The Trust complies with this requirement.**
C.1.4	a) The Board of Directors must notify Monitor and the Council of Governors without delay and should consider whether it is in the public's interest to bring to the public attention, any major new developments in the NHS foundation trust's sphere of activity which are not public knowledge, which it is able to disclose and which may lead by virtue of their effect on its assets and liabilities, or financial position or on the general course of its business, to a substantial change to the financial wellbeing, health care delivery performance or reputation and standing of the NHS foundation trust. b) The Board of Directors must notify Monitor and the Council of Governors without delay and should consider whether it is in the public interest to bring to the public attention all relevant information which is not public knowledge concerning a material change in:

	• The NHS foundation trust's financial condition, • The performance of its business; and/or • The NHS foundation trust's expectation as to its performance, which if made public, would be likely to lead to a substantial change to the financial wellbeing, health care delivery, performance or reputation and standing of the NHS foundation trust. **The Trust complies with this requirement.**
C.3.1	The Board should establish an Audit Committee composed of at least three members who are all independent Non-Executive Directors. **The Trust complies with this requirement.**
C.3.3	The Council should take the lead in agreeing with the Audit Committee the criteria for appointing, re-appointing and removing external auditors. **The Trust complies with this requirement.**
C.3.6	The NHS foundation trust should appoint an external auditor for a period of time which allows the auditor to develop a strong understanding of the finances, operations and forward plans for the NHS foundation trust. **The Trust complies with this requirement.**
C.3.7	When the council ends an external auditor's appointment in disputed circumstances, the chairperson should write to Monitor informing it of the reasons behind the decision. **The Trust complies with this requirement.**
C.3.8	The Audit Committee should review arrangements that allow staff of the NHS foundation trust and other individuals where relevant, to raise, in confidence, concerns about possible improprieties in matters of financial report and control, clinical quality, patient safety or other matters. **The Trust complies with this requirement.**
D.1.1	Any performance related elements of remuneration of Executive Directors should be designed to align their interest with those of patients, service users and taxpayers, and to give these directors keen incentives to perform at the highest levels. **The Trust did not have a performance related element of remuneration for all Executive Directors in 2019-20 but it did introduce an earn-back element to the remuneration for some Executive Directors appointed in year. This arrangement was reviewed in 2020-21.**
D.1.2	Levels of remuneration for the Chairperson and other Non-Executive Directors should reflect the time commitment and responsibilities of their roles. **The Trust complies with this requirement.**
D.1.4	The Remuneration Committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' term of appointments would give rise to in the event of early termination. **The Trust complies with this requirement.**
D.2.2	The Remuneration Committee should have delegated responsibility for setting remuneration for all Executive Directors, including pension rights and any compensation payments. **The Trust complies with this requirement.**

D.2.3	The Council should consult external professional advisers to market test the remuneration levels of the Chairperson and other Non- Executives at least one every three years and when they intend to make a material change to the remuneration of a Non-Executive. **The Trust complies with this requirement.**
E.1.2	The Board should clarify in writing how the public interests of patients and the local community will be represented, including its approach for addressing the overlap and interface between governors and any local consultative forums. **The Trust complies with this requirement.**
E.1.3	The Chairperson should ensure that the views of governors and members are communicated to the Board as a whole. **The Trust complies with this requirement.**
E.2.1	The Board should be clear as to the specific third party bodies in relation to which the NHS foundation trust has a duty to co-operate. **The Trust complies with this requirement.**
E.2.2	The Board should ensure that effective mechanisms are in place to co-operate with relevant third party bodies and that collaborative and productive relationships are maintained with relevant stakeholders at appropriate levels of seniority in each. **The Trust complies with this requirement.**

NHS Oversight Framework

NHS England/NHS Improvement's Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs, and it looks at the following areas:

- quality of care,
- finance and use of resources,
- operational performance,
- strategic change,
- leadership and capability (Well-Led).

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

Stockport NHS Foundation Trust was placed in segment 3 throughout 2020-21, 2019-20 and 2018-19.This segmentation information is the trust's position as at 31 March 2021. Current segmentation information for NHS trusts and foundation trusts is published on the NHSE/I website.

Regulatory action

In April 2013 the trust signed enforcement undertakings with Monitor in relation to breaches of the four hour A&E standard and potential weaknesses in the governance processes.

In August 2014 this was superseded by the imposition of an additional licence condition under section 111 of the Health and Social Care Act 2012. In July 2015 the additional licence condition relating to governance was formally removed by Monitor in recognition of actions the organisation had taken in response to recommendations made following an independent governance review.

However, inconsistent delivery of the four hour A&E standard continued to be a major challenge for us, and in December 2017 NHS Improvement modified the additional licence condition that required us to address the following issues:

- failure to take action necessary to ensure compliance with the A&E four hour maximum waiting standard on a sustainable basis;
- lack of a clear vision and strategy around which the licensee's Board can determine is focus and priorities;
- lack of a long term financial recovery plan demonstrating how the licensee aims to return to a financial break-even position and of a credible plan to deliver the required cost improvement programme;
- failure to ensure that the licensee's Board and its committees have effective oversight of quality, safety, finances and A&E performance;

- failure to respond sufficiently and in a timely manner to concerns identified by the CQC in its inspection of January 2016; and
- any other issues relating to the operation of the licensee's Board and its other governance arrangements, including those identified in any independent assessment of its governance arrangements, that have caused or contributed to, or will cause or contribute to, the breach, or the risk of breach, of the conditions of the licensee's licence.

Our progress in addressing these issues was subject to formal monitoring via enhanced financial oversight meetings and quarterly review meetings with NHS Improvement. A Quality Improvement Board, jointly chaired by NHS Improvement and Greater Manchester Health and Social Care Partnership, was also established to focus on quality issues and urgent and emergency care.
At the start of 2019-20 we were considered to have made sufficient progress against the issues identified in December 2017 to no longer require intensive support from NHSE/I although the licence conditions were not lifted. We remain grateful for the ongoing support we receive from NHSE/I in helping to sustain progress and address issues that we have identified.

For example, in May 2020 we received the outcome of an independent review of our governance systems and processes that we asked NHSE/I to carry out on our behalf. The Board fully accepted the findings of that review and we made a number of improvements to our governance systems and processes, which was reviewed by the Board in March 2021.

Thanks to the support of NHSE/I we were able to work with Attain on a review of our implementation of the staff e.rostering system, we have taken part in the infection prevention and control improvement programme and are now sharing our learning and best practice with other organisations, and we have been actively involved in the maternity improvement programme.

Statement of Accounting Officer’s Responsibilities

Statement of the Chief Executive’s responsibilities as the accounting officer of Stockport NHS Foundation Trust

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

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

The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Stockport NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual, and in particular to:

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis,
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements;
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance,
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust’s performance, business model and strategy, and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of Stockport NHS Foundation Trust, and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned Act.

The Accounting Officer is also responsible for safeguarding the assets of Stockport 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 OBE

Chief Executive

03.06.2021

Annual Governance Statement

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Stockport NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control has been in place in Stockport NHS Foundation Trust for the year ended 31 March 2021 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

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

- The Board of Directors, which is responsible for overseeing all aspect of risk management as well as defining its risk appetite;
- The Audit Committee, which is responsible for receiving and reviewing assurance on systems in place in the organisation to manage risk;
- The Chief Executive and designated Executive Directors with responsibility for specific areas of risk management;
- The Risk Management Committee, which reports to the Board, has responsibility for organisation-wide co-ordination and prioritisation of risk management issues,
- an assessment of the level of risk management training that is required for staff and its delivery;
- in-depth risk management master classes delivered by the Interim Director of Governance and Risk Assurance for all senior staff involved in assessing risks. This has been supplemented by focused training for individuals, team and groups as required;
- staff with specific responsibility for co-ordinating and advising on aspects of risk management having adequate training and development to fulfil their role;

- training sessions that equip staff to manage aspects of risk, such as incident reporting, investigation and lessons learned;
- the organisation's Risk Management Policy that clearly defines levels of authority to manage and mitigate risks, according to risk scored ratings.

The risk and control framework

The organisation has a Risk Management Policy, approved by the Board of Directors, which sets out our approach to the management of risk and the systems to assist in the identification, assessment, control and monitoring of risk.

Risk management is recognised within the organisation as being fundamental to our ability to effectively deliver safe, high quality services, with systems and processes in place throughout the organisation to identify, assess and mitigate risk, as well as provide the necessary training and development opportunities for staff with specific responsibilities for co-ordinating and advising on risk management.

Our principal sources of risk identification are:

- our risk assessment process,
- incident reports and investigations,
- issues arising from complaints,
- claims information
- identification of emerging risks through business intelligence,
- correlation of principle risks in the Board Assurance Framework and the significant risk register.

We work hard to foster an open and accountable reporting culture, and this is reflected in the feedback in the annual NHS Staff Survey. Staff are encouraged to identify and report incidents by an online reporting tool, and we have high levels of incident reports.

Our Serious Incident Policy aims to ensure that when a serious event or incident happens there are systematic measures for safeguarding patients, property, resources, and our reputation. Abiding by the policy ensures that a thorough investigation is undertaken, lessons learned and disseminated throughout the organisation, as well as to partner organisations as appropriate, to try to reduce the likelihood of similar incidents happening in the future.

Equality and quality impact assessments are used extensively and can inform risk mitigation actions, where appropriate.

We use a 5 x 5 matrix to assess and rate risks on both the likelihood and consequence, to generate a risk score of between one and 25. The risk score then determines the level of escalation, management, and scrutiny required.

This risk assessment process applies to all types of risk, including clinical, financial and operational. Risk registers are maintained by each business group and they are regularly reviewed at the business groups' quality board meetings. Any risk with a residual score of 15 or above is placed on the trust's Significant Risk Register, which is monitored on a monthly basis by the Risk Management Committee, which is chaired by the Chief Executive.

During 2019-20 a number of issues arose that prompted the Board of Directors and Executive Director team to question the effectiveness of some of our governance systems and processes and risk management approach. As a result we sought the support of NHSE/I to carry out an independent governance review of our systems and processes, from ward to Board.

Unfortunately NHSE/I were unable to start this work until the beginning of 2020 and the Board of Directors received the report in May 2020. It concluded that our Board and committee structures were largely in line with other NHS organisations, but it made a number of recommendations in relation to the sub-structure of groups that feed into the committees, the quality of data and information that feeds into the governance structure, and our approach to risk management.

The Board reflected on the feedback and fully accepted all the recommendations, a number of which we had already started to address under the leadership of an Interim Director of Quality Governance and Risk Assurance. These included:

- revising the approach to risk management with increased training for business group leaders on the identification, scoring and management of emerging risks,
- creation of a monthly Risk Management Committee, chaired by the Chief Executive and attended by all Executive Directors and business group representatives;
- changes to the sub-group structure that feeds into the Quality Committee,
- revising the integrated performance report and making greater use of SPI charts to track performance and trends following a Board workshop led by NHSE/I.

In March 2021 the Board received an update on delivery of the action plan created following the NHSE/I governance review, and received assurance that the priority actions had been completed and the remainder were in progress.

Any data security risks are subject to our risk assessment process, with escalation through to the trust's risk register as appropriate. Data security is incorporated into annual information governance training that is mandatory for all staff and compliance levels are monitored by the information governance and security group, and where appropriate it reports its activities to the Audit Committee.

Management capability in terms of leadership, the available of knowledgeable and skilled staff, and adequate financial and physical resources to ensure that processes and internal controls work effectively, are routinely monitored by the Executive Directors team.

The Board of Directors has continued to monitor and review the system of internal control and, where necessary, to identify improvements to accountability arrangements, processes, or capability in order to deliver better outcomes.

The Board of Directors has a number of committees to provide assurance, and each is chaired by a Non-Executive Director. These include:

- Audit Committee,
- Finance and Performance Committee,
- Quality Committee,
- People Performance Committee.

Reports from these committees, which are structured with sections relating to alert, assure and advise, detail the key issues considered by the committees and associated risks. They are presented by the chairs of the committees at each Board of Directors meeting.

Impact of the Covid-19 pandemic

As a result of the Covid-19 pandemic, and in line with best practice guidance from NHSE/I, we took the decision to temporarily rationalise our established Board and committee meeting structure to allow Executive Directors and other senior managers to focus on the operational pressures caused by the virus.

We maintained meetings of the Quality and Audit Committees, but suspended meetings of the other committees at the height of the pandemic. However, any key issues that would have gone to Finance and Performance or People Performance Committees were temporarily escalated to the Board of Directors

Board agendas were minimised to focus on key strategic and operational risks, with detailed notes of usual Board business kept in order to pick up these areas post pandemic. The meetings continued to be held on a monthly basis, but to abide by social distancing guidance they were held virtually. Papers continued to be posted on our website and members of the public were invited to send in questions about those papers, which would be answered in the subsequent minutes.

The Board of Directors also approved the creation of three new time limited operational groups:

- Clinical Advisory Group,
- Workforce Advisory Group,
- Financial Advisory Group.

These groups were established to help co-ordinate and manage the impact of the pandemic on our usual models of operations. The agreed terms of reference for the groups set out the scope of their responsibilities, as well as reporting lines for any decisions with financial consequences or which would set a precedent for the trust or partner organisations.

The groups provided weekly key issues reports to the Executive Director team, which escalated any significant operational or strategic risks to the Board of Directors. The groups were stood down at the end of March 2021.

Board Assurance Framework

Our Board Assurance Framework (BAF) details the principal risks associated with delivery of our strategic objectives, along with control measures and sources of assurance including any gaps in mitigating actions. During 2019-20 the Board of Directors held a development session to determine its risk appetite against a range of themes from finance to transformation, and this was reviewed by the Board in 2020-21. Each of the principle risks are assessed against that agreed risk appetite.

For 2020-21 – and in light of the pandemic - our strategic objectives were rolled over from the previous year. They were:

- SO1: A great place to work,
- SO2: Always learning, continually improving,
- SO3: Helping others live their best lives,
- SO4: Using resources well to invest in the future,
- SO5: Working with others for our patients and communities.

These objectives were underpinned by the following Key Lines of Enquires (KLOEs):

- Are our patients safe?
- Are our staff safe?
- Are we using our resources effectively?
- Are we implementing the recovery plan?

As part of our commitment to continuous improvement, significant improvements were made to the BAF's format, structure and content in the final quarter of the year to ensure it is in line with current best practice.

The main changes to the BAF included:

- a more granular presentation of the organisation's key strategic risks to enable debate and a shared understanding of the organisation's top risks;
- the identification of initial, tolerable, and target risk scores;
- the identification of actions where there are gaps in control; and
- improved alignment to lead Board committees.

The refreshed BAF mapped eight strategic (principal) risks against our strategic objectives. These represent a combination of internal and external strategic risks to achieving the objectives identified for 2020-21.

The BAF identified the top six risks (score of 15 or above) to achieving the strategic objectives as:

- deterioration in standards of safety and care,
- demand overwhelms capacity to deliver care effectively,
- critical shortage of workforce capacity and capability,
- failure to implement recovery plan to achieve and maintain financial sustainability,
- major disruptive event leading to rapid operational instability,
- condition of the trust's estate fails to meet current standards, national specifications and to provide a sustainable patient environment.

All were identified as risks that would have a significant impact on the delivery of patient care, patient and staff experience, financial sustainability, and reputation of the trust, or a combination of these. As such they required the most focus from the Board in terms of scrutiny and assurance, and these key issues were reflected in the agendas of the monthly Board meetings, even taking into account the need to rationalise meetings during the pandemic in line with national guidance. Particular attention was also given to those risks that are not wholly within our control to mitigate.

The process undertaken to develop the 2020-21 BAF had the oversight of our internal auditor as part of year end reporting, and the BAF will remain subject to ongoing review and development over the coming months.

In March 2021 the Board approved a new set of objectives for 2021-22:

- deliver safe accessible and personalised services for those we care for,
- support the health and wellbeing needs of our communities and staff,
- co-design and provide integrated service models within our locality and across our acute providers,

- drive service improvement through high quality research, innovation and transformation,
- develop a diverse, capable and motivated workforce to meet future serviced and user needs,
- use our resources in an efficient and effective manner
- develop our estates and IM&T infrastructure to meet service and user needs.

A lead Executive Director has been assigned to each objective, which have also been aligned to a Board committee. During 2021-22 the Executive Directors will report to the relevant committees on a monthly basis the key risks to delivery of those objectives, along with mitigating actions. Those committee reviews will feed into the BAF along with any significant risks escalated from the business groups to the Risk Management Committee on a monthly basis. The BAF will be reported to the Audit Committee and Board of Directors on a quarterly basis.

Our governance framework ensures that risks are identified and, where necessary, escalated for action from the business groups to Executive Directors team, committees and the Board of Directors.

Risks or developments that may have an impact on the quality of care are identified through the completion of quality and equality risk assessments for business cases and cost improvement schemes. These assessments are subject to validation by the Medical Director and Chief Nurse, and we seek to engage proactively with the public and external stakeholders about the management of any risks that may impact on them.

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

Quality Governance Framework

We have arrangements in place to monitor and continually improve the quality of care for patients. The Board of Directors monitors performance against a suite of indicators relating to quality, safety, staffing operational, financial and workforce metrics via an integrated performance report that is presented at each Board meeting. Sub-sets of the report are also presented to the Board's assurance committees.

The report triangulates a range of metrics relating to locally agreed priority areas, as well as those nationally mandated via the NHSE/I Single Oversight Framework. As part of the report the Board receives monthly safe staffing information, as well as a six monthly safe staffing report.

Staffing was one of the key risks identified during 2020-21 (*see pg 23)* and the Board of Directors has invested in a number of additional posts including international nurses and nursing associates, as well as approving a £5.3m workforce business case. During the pandemic we established a staffing hub to safely manage our staffing resource and we have continued to operate the hub as we moved into restoration and recovery.

Following the review of governance that we asked NHSE/I to undertake, our Interim Director of Quality Governance and Risk Assurance introduced a new governance structure with the support of the Board. Under the new structure the quality governance group was replaced by a patient safety and quality group, which reports into the Quality Committee. This new group has a broader terms of reference that includes:

- quality governance,
- patient experience,
- infection prevention and control,
- safeguarding,
- medicines optimisation.

During the pandemic, in line with national guidance, meetings of some Board committees and the groups which report into them were stood down. However the Quality Committee and patient safety and quality group continued to meet, and the committee continued to report key quality issues into the Board of Directors on a monthly basis.

To support and strengthen rapid decision making and oversight during the pandemic, three advisory groups (*see page 62)* were formed, including the clinical advisory group, chaired by the Medical Director. The groups, which were stood down at the end of March 2021, reported to the weekly Executive Directors meeting with escalation to the Board as appropriate.

During 2020-21 we identified two never events that we reported to the CQC, NHSE/I, and commissioners. Both were subject to a thorough investigation to learn lessons and to try to prevent the same issues happening in the future, although one has yet to be completed. One event related to the wrong procedure being undertaken and the other related to a wrong side block being administered.

Compliance

We are fully compliant with the registration requirements of the CQC. Some of our services were subject to a CQC inspection in January and February 2020 (*see page 63)*. The inspection report was published in May 2020 and the Board of Directors fully accepted the findings. We have developed a comprehensive improvement plan that is monitored on a monthly basis by the Board of Directors and Stockport Improvement Board

CQC inspectors returned to Stepping Hill Hospital in August 2020 to see the improvements we had made to the emergency department. They highlighted a number of positive changes that we had made and confirmed that we had met all the requirements of the section 29a notice.

With regards to the Developing Workforce Safeguards we are fully compliant and we have followed the national guidance in relation to safe staffing governance. As previously highlighted, the Board of Directors receives safe staffing information via the monthly integrated performance report, which also includes information for all staff groups on appraisals, temporary staffing usage, sickness absence, and training.

The Board also receives a six monthly strategic staffing report, which evidences that our approach to safe staffing is in line with NQB guidance. The report describes how assessments are undertaken against three components of evidence based tools and professional judgement, and outcomes are used to inform our staffing governance processes. Through these reports the Chief Nurse provides assurance to the Board that staffing is safe in wards and departments.

We have staffing in extremis guidelines in place to respond to unplanned workforce challenges. This guidance aims to help manage daily staffing levels to ensure safe, effective patient care. Reviews take place three times a day and the outcomes are shared with ward managers, night sisters, matrons, associate nurse directors, the deputy chief nurse and chief nurse, as well as on-call teams. During the Covid-19 pandemic we enhanced this approach to safe staffing with the development of a staffing hub that ensured staffing resources were spread appropriately across the organisation, and we plan to continue the hub post pandemic.

The foundation trust has published on its website an up-to-date register of interest, including fits and hospitality, for decision making staff (as defined by the trust with reference to the guidance) within the past 12 months as required by the Managing Conflicts of Interest guidance. During 2019-20 we implemented an electronic system for registering interests, gifts and hospitality, and also updated our policy. An internal audit report, which offered limited assurance, suggested refining the policy to focus on embedding the practice of all decisions makers registering annual declarations of interests, as well as gifts and hospitality as they arise. The pandemic delayed the implementation of some of the audit recommendations as staff were diverted to support front line colleagues, but these improvements will be made in 2021-22.

As an employer with staff entitled to membership of the NHS Pension Scheme, we have control measures 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

We have control measures in place to ensure that all of our obligations under equality, diversity and human rights legislation are complied with *(see page 80).*

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

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

The Board of Directors draws on a range of assurance sources and material in its ongoing review of the economy, efficiency and effectiveness of the use of resources. The annual internal audit programme, together with the reports from individual audits, provides assurance to the Audit Committee about the operational arrangements to secure economy, efficiency and effectiveness in the use of resources.

Assurance is also provided through scrutiny of performance against objectives and standards, which are achieved through a number of channels including:

- approval of annual budgets by the Board of Directors,
- monthly reporting to the Board on key performance indicators covering access, finance, quality and workforce standards;
- scrutiny of performance against the financial plan and monitoring delivery of strategic change projects by the Finance and Performance Committee,
- Board of Directors consideration of key issues reports from its assurance committees,
- Executive Directors monthly performance review meetings with business groups.

Compliance with the NHS Foundation Trust Code of Governance is reviewed by the Audit Committee on a six monthly basis and is a core element of the committee's work plan. Outcomes from these reviews inform the compliance declarations detailed on page 91 of the report. Work of the Audit, Nominations and Remuneration Committees are detailed on pages 50, 60 and 68 of the report.

Data quality and governance

Specific risks relating to information governance, data protection and data quality are reviewed by the information governance and security group, which reports into the Board's Finance and Performance Committee.

As well as adopting proactive measures to prevent the loss of data and improve data quality and cyber security, the group ensures that specific procedures for detecting, reports and dealing with any issues of data loss and breaches are in place. These actions include:

- controls for the encryption of mobile devices, including email encryption software;
- email and web security controls to protect against malicious software and websites,
- regular security updates and patching applied to hardware and systems in line with NHS Digital threat advice and alerts,
- independent security assessments and penetration testing,
- ongoing review of information flows of personal identification data, internally and externally, and ensuring appropriate measures to maintain secure transfer of date;
- ongoing review of information assets to ensure they are appropriately risk assessed and that security measures are in place to maintain confidentiality, integrity and availability of data;
- review of information security policies, procedures and guidance issued around handling and sharing of personal data in compliance with the General Data Protection Regulations (GDPR) and Data Protection Act 2018;
- all staff are required to complete data security e.learning as part of our mandatory training programme,
- ISO 27001 accreditation, which is an international best practice standard in information security management;

- accreditation to the NHS secure email standard (DCB 1596) for our email service from NHS Digital to enable secure information sharing from other NHS organisations and local authorities,
- compliance with the annual NHS Data Security and Protection Toolkit (DSPT) assessment.

We have a Board-level senior information risk owner with lead responsibility for ensuring that information risk is properly identified, managed and appropriate assurance mechanisms exist. This role is undertaken by the Deputy Chief Executive/Director of Finance.

The Medical Director is our Caldicott Guardian with responsibility for patient confidentially. We have a data protection office, which is a mandatory requirement for public authorities, to ensure our compliance with the Data Protection Act.

The annual assessment against the DSPT submission deadline has been extended to 30 June 2021 due to the pandemic. The toolkit is a mandatory requirement to provide assurance of good information governance and data security practices. An internal audit progress review of our DSPT was carried out in March 2021 and identified good progress in meeting the requirements and a final audit will take place towards the end of May 2021.

We proactively report information governance incidents on our internal incident management system, as well as via the NHS DSPT reporting tool. During 2020-21 we reported 37 information governance incidents via the DSPT reporting tool to the Information Commissioners Office (ICO). Some 21 of those incidents resulted in no further action by the ICO and 16 are still awaiting a response from the ICO. Most of the incidents related to breaches of confidentiality where personal data had been disclosed in error. Other incidents related to loss, misplacement, unauthorised access, or technical system failure.

Each incident was fully investigated and appropriate action taken to prevent learn lessons and prevent similar incidents in the future. Individuals are formally notified by letter of any breach of their confidentiality.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the Head of Internal Audit Opinion, the work of the internal auditors, clinical audit, and the executive managers and clinical leads within Stockport NHS Foundation Trust, who have responsibility for the development and maintenance of the internal control framework.

I have drawn on 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, the other committees that form part of the organisation's assurance, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The process for maintaining and reviewing the effectiveness of the system of internal control is based on governance architecture with subject specific management groups at its foundation. Management groups, such as the quality governance group, report assurance – positive or negative – and escalate emergent issues to a Board assurance committee. The Board's committees review reports from management groups, initiate further management action where necessary and report outcomes at each meeting to the Board of Directors via key issue reports based on an alert, assure, and advise approach.

The Audit Committee has a specific remit to assess the effectiveness of internal controls and systems, and it considers the outcomes of work undertaken by internal audit to test system effectiveness at each meeting. It also reviews assurance reports from management on system effectiveness and actions taken to address audit recommendations. The Audit Committee also present a key issues report to the Board.

In May 2021 the Audit Committee received the Head of Internal Audit Opinion that concluded that the organisation has "a good system of internal controls designed to meet the organisation's objectives, which are generally being applied consistently."

The Board of Directors considers matters reported through the committees' key issues reports at each meeting and either acknowledges the assurances provided or determines where remedial action is required.

In describing the process that has been applied in maintaining and reviewing the effectiveness of internal control I have considered:

- The Board Assurance Framework, which has been the subject of significant revision 2020-21 in line with current best practice to provide the Board with evidence of the effectiveness of the system of internal controls that manage the principle risk to the organisation's strategic objectives.
- The Head of Internal Audit Opinion, which provided substantial assurance that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.
- The organisation and its services continue to be registered with the Care Quality Commission.
- The process for the follow-up of audit recommendations, which is monitored by the Audit Committee.
- Committees within the Board's committee structure have a clear timetable of meetings, annual work plans, and a clear reporting structure that enables matters to be reported and/or escalated in a timely manner.

The organisation has a comprehensive risk-based internal audit programme in place and the programme was delivered in full during 2020-21, despite the impact of the pandemic that meant changes had to be made to how the programme was carried out. Outcomes of the internal audit programme are reported to the Audit Committee and appropriately led plans are in place to address any audits that result in a limited assurance assessment.

The monitoring of governance processes is informed by an integrated performance report, which includes a comprehensive set of indicators that are reviewed by the Board of Directors at each meeting. During 2020-21 the organisation made further refinements to the report to improve the triangulation of data and support enhanced oversight of performance against key standards and objectives. Data validation and availability is tested as part of the internal audit assessments, where appropriate.

Following the CQC's visit in early 2020, the NHSE/I governance review and other service reviews that we commissioned, the organisation has made a number of improvements to its emergency and urgent care services, patient flow, and care of patients with mental health problems, as well as strengthening its governance and risk assurance systems and processes. These will continue to be areas of focus for our organisation during 2021-22, along with our performance against agreed corporate objectives for the year.

Conclusion

My review confirms that Stockport NHS Foundation Trust has generally sound systems of internal control that support the achievement of its policies, aims and objectives. However, the organisation acknowledges that it needs to continue improve its emergency and urgent care services, as well as maintain its strengthened governance and risk assurance systems and processes. I am assured that arrangements are in place to address these areas during 2020-21.

Karen James OBE

Chief Executive

03.06.2021

Independent auditor’s report to the Council of Governors of Stockport NHS Foundation Trust

Report on the audit of the financial statements

Opinion on the financial statements

We have audited the financial statements of Stockport NHS Foundation Trust (‘the Trust’) and its subsidiaries (‘the Group’) for the year ended 31 March 2021 which comprise the Consolidated Statement of Comprehensive Income, the Trust and Group Statements of Financial Position, the Group Consolidated Statement of Changes in Equity, the Trust Statement of Changes in Equity, the Trust and Group Statements of Cash Flows, and notes to the financial statements, including the summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards as interpreted and adapted by HM Treasury’s Financial Reporting Manual 2020/21 as contained in the Department of Health and Social Care Group Accounting Manual 2020/21, and the Accounts Direction issued under the National Health Service Act 2006.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the Trust and Group as at 31 March 2021 and of the Trust’s and the Group’s income and expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2020/21; and
- have been properly prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor’s responsibilities section of our report. We are independent of the Trust and Group in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC’s Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the Accounting Officer’s use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Trust's or the Group’s ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Accounting Officer with respect to going concern are described in the relevant sections of this report.

Other information

The Directors are responsible for the other information. The other information comprises the information included in the Annual Report, other than the financial statements and our auditor’s report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We are also required to consider whether we have identified any inconsistencies between our knowledge acquired during the audit and the Directors' statement that they consider the Annual Report is fair, balanced and understandable and whether the Annual Report appropriately discloses those matters that we communicated to the Audit Committee which we consider should have been disclosed.

We have nothing to report in these regards.

Responsibilities of the Accounting Officer for the financial statements

As explained more fully in the Statement of Accounting Officer's Responsibilities, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

The Accounting Officer is required to comply with the Department of Health and Social Care Group Accounting Manual 2020/21 and prepare the financial statements on a going concern basis, unless the Trust is informed of the intention for dissolution without transfer of services or function to another entity. The Accounting Officer is responsible for assessing each year whether or not it is appropriate for the Trust and Group to prepare financial statements on the going concern basis and disclosing, as applicable, matters related to going concern.

Auditor's responsibilities for the audit of the financial statements

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 an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a 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 the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. Based on our understanding of the Trust and Group, we identified that the principal risks of non-compliance with laws and regulations related to the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012), and we considered the extent to which non-compliance might have a material effect on the financial statements.

We evaluated the Accounting Officer's incentives and opportunities for fraudulent manipulation of the financial statements (including the risk of override of controls) and determined that the principal risks were related to posting manual journal entries to manipulate financial performance, management bias through judgements and assumptions in significant accounting estimates, and significant one-off or unusual transactions.

Our audit procedures were designed to respond to those identified risks, including non-compliance with laws and regulations (irregularities) and fraud that are material to the financial statements. Our audit procedures included but were not limited to:

- discussing with management and the Audit Committee the policies and procedures regarding compliance with laws and regulations;
- communicating identified laws and regulations throughout our engagement team and remaining alert to any indications of non-compliance throughout our audit; and
- considering the risk of acts by the Trust and Group which were contrary to applicable laws and regulations, including fraud.

Our audit procedures in relation to fraud included but were not limited to:

- making enquiries of management and the Audit Committee on whether they had knowledge of any actual, suspected or alleged fraud;
- gaining an understanding of the internal controls established to mitigate risks related to fraud;
- discussing amongst the engagement team the risks of fraud; and
- addressing the risks of fraud through management override of controls by performing journal entry testing; reviewing management judgements and assumptions in significant accounting estimates, and reviewing any significant one-off or unusual transactions.

There are inherent limitations in the audit procedures described above and the primary responsibility for the prevention and detection of irregularities including fraud rests with management and the Audit Committee. As with any audit, there remained a risk of non-detection of irregularities, as these may involve collusion, forgery, intentional omissions, misrepresentations or the override of internal controls.

We are also required to conclude on whether the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate. We performed our work in accordance with Practice Note 10: Audit of financial statement and regularity of public sector bodies in the United Kingdom, and Supplementary Guidance Note 01, issued by the NAO in April 2021.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

Matter on which we are required to report by exception

We are required to report to you if, in our opinion, we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2021.

We have not completed our work on the Trust's arrangements. On the basis of our work to date, having regard to the guidance issued by the Comptroller and Auditor General in April 2021, we have not identified any significant weaknesses in arrangements for the year ended 31 March 2021.

We will report the outcome of our work on the Trust's arrangements in our commentary on those arrangements within the Auditor's Annual Report. Our audit completion certificate will set out any matters which we are required to report by exception.

Responsibilities of the Accounting Officer

The Chief Executive as Accounting Officer is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in the Trust's use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

Auditor's responsibilities for the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required by Schedule 10(1) of the National Health Service Act 2006 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its 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 its use of resources are operating effectively.

We have undertaken our work in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in April 2021.

Report on other legal and regulatory requirements

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2020/21; and
- the other information published together with the audited financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception under the Code of Audit Practice

We are required to report to you if:

- in our opinion the Annual Governance Statement does not comply with the NHS Foundation Trust Annual Reporting Manual 2020/21; or
- the Annual Governance Statement is misleading or is not consistent with our knowledge of the Trust and Group and other information of which we are aware from our audit of the financial statements; or
- we refer a matter to the regulator under Schedule 10(6) of the National Health Service Act 2006; or
- we issue a report in the public interest under Schedule 10(3) of the National Health Service Act 2006.

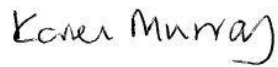
We have nothing to report in respect of these matters.

Use of the audit report

This report is made solely to the Council of Governors of Stockport NHS Foundation Trust as a body in accordance with Schedule 10(4) of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust as a body for our audit work, for this report, or for the opinions we have formed.

Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate until we have completed the work necessary to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness is its use of resources.



Karen Murray, Key Audit Partner
For and on behalf of Mazars LLP

One St Peter's Square
Manchester
M2 3DE

4th June 2021

Audit Completion Certificate issued to the Council of Governors of Stockport NHS Foundation Trust for the year ended 31 March 2021

In our auditor's report dated 4 June 2021 we explained that the audit could not be formally concluded until we had completed the work necessary to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness is its use of resources.

This work has now been completed.

No matters have come to our attention since 4 June 2021 that would have a material impact on the financial statements on which we gave our qualified opinion.

The Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

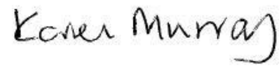
We are required to report to you if, in our opinion, we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2021.

On the basis of our work, having regard to the guidance issued by the Comptroller and Auditor General in April 2021, we have identified the following significant weakness in the Trust's arrangements for the year ended 31 March 2021:

Significant weakness in arrangements	Recommendation
NHS England / Improvement licence condition modifications and CQC inspection report The Trust has continued to operate under modifications to its conditions of licence. These modifications were issued by NHS Improvement in December 2017. In addition in May 2020 CQC issued a report into their inspection of the Trust and rated the Trust as 'requires improvement', also issuing a section 29a warning notice to the Trust. The Trust has evidenced significant progress through the year in improving performance across a number of these areas of weakness. This improvement has continued in 2021/22. Despite these significant improvements in performance through the year, the Trust does continue to operate under the licence modifications and some of the actions to address the CQC inspection report recommendations are still to be embedded. In our view, the continuation of the licence modifications represent a significant weakness in arrangements in relation to: • Improving economy, efficiency and effectiveness: how the body uses information about its costs and performance to improve the way it manages and delivers its services	The Trust should ensure that it continues to deliver and embed the remaining actions in the action plans, and sustains the direction of travel of improvements that it has demonstrated through the year. In particular, it should ensure that robust monitoring and reporting processes are maintained, and that challenge, scrutiny and escalation arrangements drive the required improvements and sustain the progress made to-date in implementing the actions to address the issues raised by the CQC.

Certificate

We certify that we have completed the audit of Stockport NHS Foundation Trust in accordance with the requirements of chapter 5 of part 2 of the National Health Service Act 2006 and the Code of Audit Practice.



Karen Murray, Key Audit Partner
For and on behalf of Mazars LLP

One St Peter's Square
Manchester
M2 3DE

4 October 2021

Stockport NHS Foundation Trust

Annual accounts for the year ended 31 March 2021

Foreword to the accounts

Stockport NHS Foundation Trust

These accounts, for the year ended 31 March 2021, have been prepared by Stockport NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed ……………………………………………….

Name	**K James OBE**
Job title	**Chief Executive**
Date	**3rd June 2021**

Consolidated Statement of Comprehensive Income

	Note	Group 2020/21 £000	Group 2019/20 £000	Trust 2020/21	Trust 2019/20
Operating income from patient care activities	3	311,990	277,373	311,990	277,373
Other operating income	4	72,320	63,300	71,408	62,570
Operating expenses	6, 8	(387,464)	(334,481)	(386,891)	(333,867)
Operating (deficit)/surplus from continuing operations		**(3,154)**	**6,192**	**(3,493)**	**6,076**
Finance income	11	47	194	-	145
Finance expenses	12	(675)	(1,727)	(675)	(1,727)
PDC dividends payable		(2,710)	(2,021)	(2,710)	(2,021)
Net finance costs		**(3,338)**	**(3,554)**	**(3,385)**	**(3,603)**
Other gains / (losses)	13	310	(8)	40	37
Gains / (losses) arising from transfers by absorption	35	105	-	105	-
Corporation tax expense		(24)	(34)	-	-
Surplus / (deficit) for the year from continuing operations		**(6,101)**	**2,596**	**(6,733)**	**2,510**
Other comprehensive income					
Will not be reclassified to income and expenditure:					
Impairments	7	(2,900)	(4,709)	(2,900)	(4,709)
Revaluations	17	48	7,070	48	7,070
Total comprehensive income / (expense) for the period		**(8,953)**	**4,957**	**(9,585)**	**4,871**

The Group Accounts include the consolidated financial results of Stockport NHS Foundation Trust, its' associated Charity, Stockport NHS Foundation Trust General Fund (Charity Commission Number 1048661), and Stepping Hill Healthcare Enterprises Limited (trading as the Pharmacy Shop).

The Group Accounts reflect the outturn of the Trust of £6.7 million deficit in 2020/2021 (£2.51 million surplus in 2019/2020) and subsidiaries' profit of £104k for Stepping Hill Healthcare Enterprises Limited (£81k profit in 2019/2020). The Trust Charity has net movement in funds of £528k incoming in 2020/2021 compared to net movement in funds of £5k incoming resources in 2019/2020.

Adjusted financial performance (control total basis):	**2020-21**	**2019-20**
Surplus / (deficit) for the period	(6,101)	2,596
Remove impact of consolidating NHS charitable fund	(528)	(5)
Remove net impairments not scoring to the Departmental expenditure limit	2,543	(2,658)
Remove (gains) / losses on transfers by absorption	(105)	-
Remove I&E impact of capital grants and donations	(1,141)	116
Adjusted financial performance surplus / (deficit)	**(5,332)**	**50**

Statements of Financial Position

	Note	Group 31 March 2021 £000	Group 31 March 2020 £000	Trust 31 March 2021 £000	Trust 31 March 2020 £000
Non-current assets					
Intangible assets	14	2,980	1,343	2,980	1,343
Property, plant and equipment	15	164,924	156,286	164,924	156,286
Other investments / financial assets	18	1,557	1,287	-	-
Receivables	21	248	302	248	302
Total non-current assets		**169,709**	**159,218**	**168,152**	**157,931**
Current assets					
Inventories	20	1,552	1,837	1,356	1,571
Receivables	21	16,499	20,744	17,997	23,182
Cash and cash equivalents	22	34,991	19,785	32,534	17,631
Total current assets		**53,042**	**42,366**	**51,887**	**42,384**
Current liabilities					
Trade and other payables	23	(52,532)	(37,270)	(52,750)	(38,299)
Borrowings	25	(1,810)	(48,140)	(1,810)	(48,140)
Provisions	26	(3,362)	(2,866)	(3,362)	(2,866)
Other liabilities	24	(4,578)	(1,320)	(4,578)	(1,320)
Total current liabilities		**(62,282)**	**(89,596)**	**(62,500)**	**(90,625)**
Total assets less current liabilities		**160,469**	**111,988**	**157,539**	**109,690**
Non-current liabilities					
Borrowings	25	(18,662)	(20,304)	(18,662)	(20,304)
Provisions	26	(2,935)	(2,891)	(2,935)	(2,891)
Other liabilities	24	(343)	(375)	(343)	(375)
Total non-current liabilities		**(21,940)**	**(23,570)**	**(21,940)**	**(23,570)**
Total assets employed		**138,529**	**88,418**	**135,599**	**86,120**
Financed by					
Public dividend capital		145,881	86,817	145,881	86,817
Revaluation reserve		46,788	49,640	46,788	49,640
Income and expenditure reserve		(56,798)	(50,169)	(57,070)	(50,337)
Charitable fund reserves	19	2,658	2,130	-	-
Total taxpayers' equity		**138,529**	**88,418**	**135,599**	**86,120**

The notes on pages 125 to 166 form part of these accounts.

Name	**K James OBE**
Position	**Chief Executive**
Date	**3rd June 2021**

Consolidated Statement of Changes in Equity for the year ended 31 March 2021

Group	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Charitable fund reserves £000	Total £000
Taxpayers' and others' equity at 1 April 2020 - brought forward	**86,817**	**49,640**	**(50,169)**	**2,130**	**88,418**
Surplus/(deficit) for the year	-	-	(6,907)	806	**(6,101)**
Impairments	-	(2,900)	-	-	**(2,900)**
Revaluations	-	48	-	-	**48**
Public dividend capital received	59,064	-	-	-	**59,064**
Other reserve movements	-	-	278	(278)	**-**
Taxpayers' and others' equity at 31 March 2021	**145,881**	**46,788**	**(56,798)**	**2,658**	**138,529**

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

Group	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Charitable fund reserves £000	Total £000
Taxpayers' and others' equity at 1 April 2019 - brought forward	**85,452**	**47,279**	**(52,761)**	**2,125**	**82,095**
Surplus/(deficit) for the year	-	-	2,374	222	**2,596**
Impairments	-	(4,709)	-	-	**(4,709)**
Revaluations	-	7,070	-	-	**7,070**
Public dividend capital received	1,365	-	-	-	**1,365**
Other reserve movements	-	-	217	(217)	**-**
Taxpayers' and others' equity at 31 March 2020	**86,817**	**49,640**	**(50,169)**	**2,130**	**88,418**

Information on reserves

Public Dividend Capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to the Trust by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and Expenditure Reserve - Group

The balance of this reserve is the accumulated surpluses and deficits of Stockport NHS Foundation Trust and its subsidiary, Stepping Hill Healthcare Enterprises Ltd, which are consolidated into these Accounts with the Trust.

Income and Expenditure Reserve - Trust

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

Charitable funds reserve

This reserve comprises the ring-fenced funds held by the NHS charitable funds consolidated within these financial statements. These reserves are classified as restricted or unrestricted; a breakdown is provided in note 19.

Statement of Changes in Equity for the year ended 31 March 2021

Trust	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2020 - brought forward	**86,817**	**49,640**	**(50,337)**	**86,120**
Surplus/(deficit) for the year	-	-	(6,733)	**(6,733)**
Impairments	-	(2,900)	-	**(2,900)**
Revaluations	-	48	-	**48**
Public dividend capital received	59,064	-	-	**59,064**
Taxpayers' and others' equity at 31 March 2021	**145,881**	**46,788**	**(57,070)**	**135,599**

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

Trust	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2019 - brought forward	**85,452**	**47,279**	**(52,847)**	**79,884**
Surplus/(deficit) for the year	-	-	2,510	**2,510**
Impairments	-	(4,709)	-	**(4,709)**
Revaluations	-	7,070	-	**7,070**
Public dividend capital received	1,365	-	-	**1,365**
Taxpayers' and others' equity at 31 March 2020	**86,817**	**49,640**	**(50,337)**	**86,120**

Statements of Cash Flows

	Note	Group 2020/21 £000	Group 2019/20 £000	Trust 2020/21 £000	Trust 2019/20 £000
Cash flows from operating activities					
Operating (deficit) / surplus		(3,154)	6,192	(3,493)	6,076
Non-cash income and expense:					
Depreciation and amortisation	6.1	10,887	9,054	10,887	9,054
Net impairments	7	2,543	(2,658)	2,543	(2,658)
Income recognised in respect of capital donations	4	(1,296)	-	(1,296)	-
(Increase) / decrease in receivables and other assets		4,788	(9,227)	5,690	(10,194)
(Increase) / decrease in inventories		285	(145)	215	(158)
Increase / (decrease) in payables and other liabilities		8,461	6,059	7,649	7,210
Increase / (decrease) in provisions		556	(1,907)	556	(1,907)
Movements in charitable fund working capital		(27)	-	-	-
Tax (paid) / received		(35)	-	-	-
Net cash flows from / (used in) operating activities		**23,007**	**7,368**	**22,751**	**7,423**
Cash flows from investing activities					
Interest received		7	139	7	139
Purchase of intangible assets		(2,156)	(649)	(2,156)	(649)
Purchase of PPE and investment property		(13,024)	(11,700)	(13,024)	(11,700)
Sales of PPE and investment property		63	57	63	57
Receipt of cash donations to purchase assets		43	-	43	-
Net cash flows from charitable fund investing activities		47	49	-	-
Net cash flows from / (used in) investing activities		**(15,020)**	**(12,104)**	**(15,067)**	**(12,153)**
Cash flows from financing activities					
Public dividend capital received		59,064	1,365	59,064	1,365
Movement on loans from DHSC		(47,606)	20,059	(47,606)	20,059
Capital element of finance lease rental payments		(84)	(85)	(84)	(85)
Capital element of PFI, LIFT and other service concession payments		(31)	(29)	(31)	(29)
Interest on loans		(931)	(1,678)	(931)	(1,679)
Interest paid on PFI, LIFT and other service concession obligations		(9)	(10)	(9)	(10)
PDC dividend (paid) / refunded		(3,192)	(2,128)	(3,192)	(2,128)
Net cash flows from / (used in) financing activities		**7,211**	**17,495**	**7,211**	**17,493**
Increase / (decrease) in cash and cash equivalents		**15,198**	**12,759**	**14,895**	**12,763**
Cash and cash equivalents at 1 April - brought forward		**19,785**	**7,027**	**17,631**	**4,868**
Cash and cash equivalents transferred under absorption accounting	35	8	-	8	-
Cash and cash equivalents at 31 March	22.1	**34,991**	**19,785**	**32,534**	**17,631**

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 2020/21 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

Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.2 Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

Note 1.3 Consolidation

NHS Charitable Funds

The Trust is the corporate trustee to Stockport NHS Foundation Trust General Fund. The Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

The charitable fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

- recognise and measure them in accordance with the Trust's accounting policies and
- eliminate intra-group transactions, balances, gains and losses.

Other Subsidiaries

Stepping Hill Healthcare Enterprises Limited

Stepping Hill Healthcare Enterprises Limited is a limited company, incorporated on the 16th September 2014, and operational from the 1st November 2014. Its principal activities are to dispense drugs to the outpatients of Stockport NHS Foundation Trust. The Company is wholly owned by Stockport NHS Foundation Trust.

The company's latest Accounts to the 31st March 2020 have been submitted to Companies House in line with the filing deadline. It has taken advantage of the small company exemption from audit under section 479A of the Companies Act 2006 which does not require an audit if included in the parent's consolidated accounts.

Note 1.4 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).

Note 1.4 Revenue from contracts with customers continued

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.

The Trust agrees a schedule of payments with clinical commissioning groups based on the agreed contract/block income allocations at the start of the financial year. Payment is made in equal instalments (in 2019/2020 with a quarterly reconciliation for additional income earned or credit note issued for underperformance). In 2020/2021 the Trust was in receipt of one month block contract income in advance as a recogniton of the demands of the Covid-19 pandemic. Payments for goods and services from other NHS and non-NHS bodies is upon receipt of invoices with payment terms set at 30 days unless otherwise agreed. In Greater Manchester, in 2020/2021 Trust providers agreed a system for the invoicing and payment of income for services specifically in response to the Covid-19 circumstances.

Revenue from NHS contracts

The accounting policies for revenue recognition and the application of IFRS 15 are consistently applied. The contracting arrangements in the NHS changed between 2019/20 and 2020/21 affecting the application of the accounting policy under IFRS 15. This difference in application is explained below.

2020/21

The main source of income for the Trust is contracts with commissioners for health care services. In 2020/21, the majority of the Trust's income from NHS commissioners was in the form of block contract arrangements. During the first half of the year the Trust received block funding from its commissioners as defined by the interim finance regime for NHS Trusts. For the second half of the year, block contract arrangements were agreed at a System/Sustainability and Transformation Partnership level. The related performance obligation is the delivery of healthcare and related services during the period, with the Trust's entitlement to consideration not varying based on the levels of activity performed.

The Trust has received additional income outside of the block and system envelopes to reimburse specific costs incurred and other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

Comparative period (2019/20)

In the comparative period (2019/20), the Trust's contracts with NHS commissioners included those where the Trust's entitlement to income varied according to services delivered. A performance obligation relating to delivery of a spell of health care was generally satisfied over time as healthcare was received and consumed simultaneously by the customer as the Trust performed it. The customer in such a contract was the commissioner, but the customer benefited as services were provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligned with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that were substantially the same and had a similar pattern of transfer.

In 2019/20, the Provider Sustainability Fund and Financial Recovery Fund enabled 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.

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.

Note 1.5 Other forms of income

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.

Additional Employer Pension Contributions

The increase in employer pension contributions due in 2020/21 has been paid over centrally by NHS England for provider organisations. The Trust expenditure in staff costs is recorded as being with the NHS Pension Scheme, with a corresponding notional income amount from NHS England recorded.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Trading Activities

The Trust has assessed other sources of operating income for inclusion under IFRS 15. For example the Trust generates income under commercial contracts for its Pharmaceuticals Manufacturing Service, Aseptics Unit and Quality Control. Income under these contracts is recognised for the development, manufacture and ongoing supply of products. Income is generated through invoices under which payment terms are agreed at 30 days unless otherwise negotiated.

Other income recognised under IFRS 15 includes catering and car parking income where cash revenue streams are recognised at the point of sale where an oral contract is implied and ticket issued.

Note 1.6 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 employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales.

NHS Pension Scheme continued

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 and when they become due.

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

The Group offers an additional defined contribution workplace pension scheme, the National Employment Savings Scheme (NEST), to employees of the Foundation Trust. It also offers a similar scheme to its subsidiary, Stepping Hill Healthcare Enterprises Limited.

Note 1.7 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 1.8 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 1.9 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably
• the item has cost of at least £5,000, or
• collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

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.

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie 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. The Trust ensures that asset values are kept up to date, as a minimum, with a full valuation every five years and an interim valuation at three years. Where assets are subject to significant volatility, then annual revaluations may be required. 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 meeting the 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.

Measurement

The Trust requested a valuation of its land and building at the 31st March 2021. Valuations are carried out by the District Valuer, who is external to the Trust, and in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. The valuation has recorded a downward movement in valuation in BCIS indices, market values and existing use values and the valuation is transacted in full in the financial statements.

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. Assets are valued by professional valuers on the next occasion when all assets of that class are revalued unless there is an indication that initial cost is less than fair value.

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.

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’.

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.

De-recognition

Assets intended for disposal are reclassified as ‘held for sale’ once the criteria in IFRS 5 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 and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. 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.

Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

In 2020/21 this includes assets donated to the Trust by the Department of Health and Social Care as part of the response to the coronavirus pandemic. As defined in the GAM, the Trust applies the principle of donated asset accounting to assets that the trust controls and is obtaining economic benefits from at the year end.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as ‘held for sale’ cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Plant and Equipment are depreciated evenly over the estimated life of the asset, as follows:

	Min life Years	**Max life Years**
Medical equipment, engineering plant and equipment : 5 to 10 years	5	10
Transport equipment: 7 years	5	7
Office and Information technology equipment: 5 years	5	5
Furniture & fittings: 10 years	5	10
Soft Furnishings: 7 years	5	7
Set up costs in new buildings: 10 years	10	10

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

PFI 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.

Useful lives of property, plant and equipment

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

	Min life Years	Max life Years
Buildings, excluding dwellings	24	29
Dwellings	30	40
Plant & machinery	5	15
Transport equipment	7	7
Information technology	5	8
Furniture & fittings	7	10

Finance-leased assets (including land) are depreciated over the shorter of the useful life or the lease term, unless the Trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.10 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised. Expenditure on development is capitalised where it meets the requirements set out in IAS 38.

Software

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

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value 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.

Amortisation

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

Useful lives of intangible assets

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

	Min life Years	Max life Years
Software licences	3	10

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.

In 2020/21, the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

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 the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.13 Financial assets and financial liabilities

Recognition

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

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

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, fair value through profit and loss or fair value through other comprehensive income.

Financial liabilities classified as subsequently measured at amortised cost or fair value through profit and loss.

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.

Financial assets and financial liabilities at fair value through profit and loss

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.

The Group measures the pooled Charity Common Investment Fund with CCLA as a financial asset at fair value through profit and loss.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

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

The Trust has assessed its receivables on an individual basis for expected credit losses and impaired these where judged to be necessary. The Trust Injury Cost Recovery Scheme income is reduced by a nationally agreed expected credit loss percentage. The Trust does not normally recognise expected credit losses for other NHS bodies except for circumstances of genuine dispute.

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

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

Derecognition

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.

The Trust as a lessee

Finance Leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded.

Note 1.14 Leases continued

Finance leases

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.

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.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

The Trust as a 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 2021:

		Nominal rate
Short-term	Up to 5 years	Minus 0.02%
Medium-term	After 5 years up to 10 years	0.18%
Long-term	Exceeding 10 years	1.99%

Note 1.15 Provisions continued

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	1.20%
Year 2	1.60%
Into perpetuity	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 0.95% in real terms.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at note 26.3 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.16 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 27 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 27 unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.17 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

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, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

Note 1.17 Public dividend capital continued

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.

Note 1.18 Value added tax

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

Note 1.19 Corporation tax

Health Service bodies, including Foundation Trusts, are exempt from taxation on their principal healthcare income under section 519A ICTA 1988. The Trust may incur corporation tax through its wholly owned subsidiary Stepping Hill Healthcare Enterprises Limited.

Note 1.20 Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

Note 1.21 Foreign exchange

The functional and presentational currency of the Trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items are translated at the spot exchange rate on 31 March
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

Note 1.22 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 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.25 Transfers of functions to / from other NHS bodies / local government bodies

For functions that have been transferred to the Trust from another NHS or local government body, the transaction is accounted for as a transfer by absorption. The assets and liabilities transferred are recognised in the accounts using the book value as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net gain / loss corresponding to the net assets/ liabilities transferred is recognised within income / expenses but not within operating activities.

For property, plant and equipment assets and intangible assets, the cost and accumulated depreciation / amortisation balances from the transferring entity's accounts are preserved on recognition in the Trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the Trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

For functions that the Trust has transferred to another NHS or local government body, the assets and liabilities transferred are de-recognised from the accounts as at the date of transfer. The net loss / gain corresponding to the net assets/ liabilities transferred is recognised within expenses / income, but not within operating activities. Any revaluation reserve balances attributable to assets de-recognised are transferred to the income and expenditure reserve.

Note 1.26 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2020/21.

Note 1.27 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Leases

IFRS 16 Leases will replace *IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. 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 2022, the Trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The trust's incremental borrowing rate will be defined by HM Treasury. Currently this rate is 0.91% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, 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.

The implementation date for IFRS 16 in the NHS was revised to 1 April 2022 in November 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity in from April 2022 and beyond, a quantification of the expected impact of applying the standard in 2022/23 is currently impracticable. However, the Trust does expect this standard to have a material impact on non-current assets, liabilities and depreciation.

Other standards, amendments and interpretations

As required by IAS 8, Trusts should disclose any other standards, amendments and interpretations that have been issued but are not yet effective or adopted for the public sector and an assessment subsequent application will have on the financial statements.

IFRS 17 - Insurance Contracts - application required for accounting periods beginning on or after 1 January 2021.

IFRIC 23 Uncertainty over Income Tax treatments - application required for accounting periods beginning on or after 1 January 2019.
IFRS 16 Leases is being applied by HM Treasury in the Government Financial Reporting Manual (FReM) from 1 April 2022.

Note 1.28 Critical judgements in applying accounting policies

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

The Trust uses the District Valuer service to provide revalued amounts for its land, buildings and dwellings. These valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. In 2020/2021 the Trust has undertaken a review exercise of its alternative site valuation of land and builldings. The valuation at the 31st March 2021 has been judged as material to update and the subsequent increase to assets has been enacted through the revaluation reserve.

Note 1.29 Sources of estimation uncertainty

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

Since the start of the pandemic, DHSC has provided centrally procured personal protective equipment to Trusts free of charge. It is not the Trust's accounting policy to include such items as inventories on the Statement of Financial Position and they are not considered material to do so.

Other provisions includes estimated costs associated with banding claims by specific sections of the workforce and also include estimates of costs for employment legal cases.

Under IAS 19 Employee Benefits the Trust has calculated the expected cost of annual leave earned but unable to be taken in the financial year 2020/2021 because of the demands on the workforce due to Covid-19. The Trust has assessed the need to accrue for five days annual leave carry forward. A corresponding income benefit has been accrued for funding from DHSC to meet this cost.

Note 2 Operating Segments

In line with IFRS 8 on Operating Segments, the Board of Directors, as Chief Operating Decision Maker (CODM), have assessed that the Trust continues to report its Annual Accounts on the basis that it operates as a single entity in the healthcare segment only. The accompanying financial statements have consequently been prepared under one single operating segment.

All of the Foundation Trust's activities are in the provision of healthcare, which is an aggregate of all the individual specialty components included therein, and the very large majority of the healthcare services provided occur at the one geographical main site. Similarly, the large majority of the Foundation Trust's revenue originates with the UK Government; namely through contracts with NHS Commissioners. The majority of expenses incurred are payroll expenditure on staff involved in the production or support of healthcare activities generally across the Trust together with the related supplies and overheads needed to establish this production. The business activities which earn revenue and incur expenses are therefore of one broad combined nature and therefore on this basis one segment of 'Healthcare' is deemed appropriate. In applying the aggregation criteria the CODM also recognises that the Trust's business groups operate under one common regulatory framework.

In consolidating the charitable funds the Trust has considered the level of its charitable funds and has considered them immaterial to report as a separate operating segment as the charitable funds revenue are not 10% or more of the combined assets of all operating segments.

In consolidating the financial results of the Stepping Hill Healthcare Enterprises Limited Company, the Trust considers that the provision of an outpatient dispensing service to patients still falls under the healthcare operating segment. In addition its revenue streams are also not 10% or more than all the combined assets of all operating segments.

Note 2 Operating Segments continued

The Trust's view on segmental reporting remains unchanged from its financial statements in 2019/2020. The Board, as Chief Operating Decision Maker, does not receive separate information routinely to evaluate how to allocate resources and assess performance as described within IFRS 8 Operating Segments for any of its internal business groups and continues with its integrated business group structures with services aligned across all the business groups.

Note 3 Operating income from patient care activities (Group and Trust)

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4

Note 3.1 Income from patient care activities (by nature)

	Foundation Trust and Group	
	2020/21	**2019/20**
	£000	**£000**
Acute services		
Block contract / system envelope income*	254,073	-
Elective Income (2019/20 only)	-	42,496
Non Elective Income (2019/20 only)	-	86,136
Outpatients Income (2019/20 only)	-	33,795
A&E Income (2019/20 only)	-	16,801
High cost drugs income from commissioners (excluding pass-through costs)	11,329	10,389
Other NHS clinical income	340	44,943
Community services		
Block contract / system envelope income*	27,498	26,847
Income from other sources (e.g. local authorities)	5,455	5,511
All services		
Private patient income	186	341
Additional pension contribution central funding**	9,313	8,737
Other clinical income	3,796	1,377
Total income from activities	**311,990**	**277,373**

*As part of the coronavirus pandemic response, transaction flows were simplified in the NHS and providers and their commissioners moved onto block contract payments at the start of 2020/21. In the second half of the year, a revised financial framework built on these arrangements but with a greater focus on system partnership and providers derived most of their income from these system envelopes.

**The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

Note 3.2 Income from patient care activities (by source)

	Foundation Trust and Group	
	2020/21	**2019/20**
Income from patient care activities received from:	**£000**	**£000**
NHS England	29,919	24,124
Clinical commissioning groups	275,769	245,916
Other NHS providers	214	527
NHS other	23	46
Local authorities	5,455	5,511
Non-NHS: private patients	186	341
Non-NHS: overseas patients (chargeable to patient)	2	94
Injury cost recovery scheme	422	814
Total income from activities	**311,990**	**277,373**
Of which:		
Related to continuing operations	311,990	277,373

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

	2020/21	2019/20
	£000	£000
Income recognised this year	2	94
Cash payments received in-year	19	37
Amounts added to provision for impairment of receivables	1	57
Amounts written off in-year	1	36

Note 4 Other operating income (Group)

	2020/21			2019/20		
	Contract income £000	Non-contract income £000	Total £000	Contract income £000	Non-contract income £000	Total £000
Research and development	711	-	**711**	698	-	**698**
Education and training	8,847	631	**9,478**	7,869	352	**8,221**
Provider sustainability fund (2019/20 only)	-	-	**-**	6,060	-	**6,060**
Financial recovery fund (2019/20 only)	-	-	**-**	17,974	-	**17,974**
Marginal rate emergency tariff funding (2019/20 only)	-	-	**-**	3,599	-	**3,599**
Reimbursement and top up funding*	28,469		**28,469**	-	-	**-**
Receipt of capital grants and donations**	-	1,296	**1,296**	-	-	**-**
Contributions to expenditure - consumables (inventory)and equipment less than £5,000 donated from DHSC group bodies for COVID response***	-	6,404	**6,404**	-	-	**-**
Charitable fund incoming resources	-	497	**497**		218	**218**
Stockport Pharmaceuticals and Quality Control	5,398	-	**5,398**	5,085	-	**5,085**
Stockport Healthcare Enterprises Ltd income	4,026	-	**4,026**	-	-	**-**
Local Authorities	3,172	-	**3,172**	3,267	-	**3,267**
NHS and WGA Bodies	9,195	-	**9,195**	7,678	-	**7,678**
Non-NHS Bodies	2,549	-	**2,549**	2,716	-	**2,716**
Rents and car parking income	192	-	**192**	1,968	-	**1,968**
Catering sales	307	-	**307**	538	-	**538**
Other income	626	-	**626**	5,278	-	**5,278**
Total other operating income	**63,492**	**8,828**	**72,320**	**62,730**	**570**	**63,300**
Of which:						
Related to continuing operations			**72,320**			**63,300**

*Between October 2020 to March 2021 the financial framework for NHS providers allocated a fixed funding stream for Greater Manchester. In addition to the CCG Contract allocations recorded in Income from Patient Care Activities the Trust received additional funding to allow the GM system to meet a break even position through Reimburesment and Top Up Funding. This also included monies to meet Covid-19 expenditure costs, specialist directly commissioned services and some elements of Non NHS income not recovered due to Covid (such as car parking where charges to staff have been suspended).

** Within the receipt of capital grants and donations are funds from Stockport NHS Charity for £79,000 for donated assets, £43,000 from the Mail Force Charity for testing equipment and £1,253,000 from DHSC for Imaging and Medical Equipment assets received free of charge to assist the Covid-19 pandemic in 2020-202 and for which ownership will be transferred in 2021/2022. This is notional income to meet the capital cost of these items.

*** During 2020-2021 the Trust was in receipt of centrally procured personal protective equipment. The notional income and expenditiure of items provided are accounted for at the costs per month provided by the DHSC for inclusion in the financial statements. This value has been assessed as £6,304,000. In addition the cost of donated equipment below the capitalisation value is included at notional income of £100,000. Notional expenditure is recorded within operating expenses.

For Group Accounts elimination, adjustments have been made to remove Trust income received from its Pharmacy Shop subsidiary for purchases of drugs and services charged by the Trust for use of its facilities. Group Other operating income includes income earned by the Pharmacy Shop on its outpatient dispensing service, prescription charges and retail income from the Pharmacy Shop itself.

Note 4.1 Other operating income (Trust)

	2020/21			2019/20		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	711		**711**	698		**698**
Education and training	8,847	631	**9,478**	7,869	352	**8,221**
Provider sustainability fund (2019/20 only)	-	-	**-**	6,060	-	**6,060**
Financial recovery fund (2019/20 only)	-	-	**-**	17,974	-	**17,974**
Marginal rate emergency tariff funding (2019/20 only)	-	-	**-**	3,599	-	**3,599**
Reimbursement and top up funding	28,469	-	**28,469**	-	-	**-**
Receipt of capital grants and donations	-	1,375	**1,375**	-	-	**-**
Charitable and other contributions to expenditure	-	199	**199**	-	217	**217**
Contributions to expenditure - consumables (inventory)and equipment less than £5,000 donated from DHSC group bodies for COVID response	-	6,404	**6,404**	-	-	**-**
Stockport Pharmaceuticals and Quality Control	5,398	-	**5,398**	5,085	-	**5,085**
Pharmacy Sales	3,900	-	**3,900**	4,070	-	**4,070**
Local Authorities	3,172	-	**3,172**	3,267	-	**3,267**
NHS and WGA Bodies	9,195	-	**9,195**	7,608	-	**7,608**
Non-NHS Bodies	2,487	-	**2,487**	2,716	-	**2,716**
Rents and car parking income	313	-	**313**	1,968	-	**1,968**
Catering sales	307	-	**307**	538	-	**538**
Other Income	-	-	**-**	549	-	**549**
Total other operating income	**62,799**	**8,609**	**71,408**	**62,001**	**569**	**62,570**
Of which:						
Related to continuing operations			**71,408**			**62,570**

Note 5 Additional information on contract revenue (IFRS 15) recognised in the period

	Foundation Trust and Group	
	2020/21	2019/20
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	1,575	989

Note 5.1 Transaction price allocated to remaining performance obligations

	Foundation Trust and Group	
	31 March 2021	31 March 2020
Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:		
within one year	4,578	1,319
after one year, not later than five years	343	375
Total revenue allocated to remaining performance obligations	**4,921**	**1,694**

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 5.2 Income from activities arising from commissioner requested services

Under the terms of its provider licence, the Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	Foundation Trust and Group	
	2020/21	**2019/20**
	£000	**£000**
Income from services designated as commissioner requested services	311,380	276,124
Income from services not designated as commissioner requested services	610	1,249
Total	**311,990**	**277,373**

Note 5.3 Profits and losses on disposal of property, plant and equipment

In 2020/2021 the Trust has disposed of property, plant, equipment and transport with a gain on the disposal of equipment of £40,000.

Note 5.4 Fees and charges (Group)

HM Treasury requires disclosure of fees and charges income. The following disclosure is of income from charges to service users where income from that service exceeds £1 million and is presented as the aggregate of such income. The cost associated with the service that generated the income is also disclosed.

	Foundation Trust and Group	
	2020/21	**2019/20**
	£000	**£000**
Income	5,427	5,086
Full cost	(5,266)	(4,897)
Surplus / (deficit)	**161**	**189**

Note 6.1 Operating expenses (Group)

	2020/21	2019/20
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	3,768	3,983
Purchase of healthcare from non-NHS and non-DHSC bodies	2,283	2,723
Staff and executive directors costs	275,687	243,560
Remuneration of non-executive directors	154	155
Supplies and services - clinical (excluding drugs costs)	22,989	21,245
Supplies and services – clinical: utilisation of consumables donated from DHSC group bodies for COVID response	6,304	-
Supplies and services - general	2,811	2,746
Supplies and services - general: notional cost of equipment donated from DHSC for COVID response below capitalisation threshold	100	-
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	20,791	21,258
Consultancy costs	1,810	568
Establishment	1,373	1,309
Premises	13,945	12,689
Transport (including patient travel)	1,005	1,199
Depreciation on property, plant and equipment	10,371	8,562
Amortisation on intangible assets	516	492
Net impairments	2,543	(2,658)
Movement in credit loss allowance: contract receivables / contract assets	185	215
Movement in credit loss allowance: all other receivables and investments	-	(126)
Increase/(decrease) in other provisions	635	(1,583)
Change in provisions discount rate(s)	179	154
Audit fees payable to the external auditor		
audit services- statutory audit	55	61
other auditor remuneration (external auditor only)	-	9
Internal audit costs	130	113
Clinical negligence	10,285	8,945
Legal fees	346	422
Insurance	285	243
Research and development - staff	636	612
Research and development - non staff	60	23
Education and training	1,476	1,807
Rentals under operating leases	3,851	3,418
Redundancy	8	-
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI)	1,189	1,369
Car parking & security	353	348
Losses, ex gratia & special payments	36	68
Other services, eg external payroll	373	-
Other NHS charitable fund resources expended	8	-
Other	924	552
Total	**387,464**	**334,481**
Of which:		
Related to continuing operations	387,464	334,481

Note 6.2 Operating expenses (Trust)

	2020/21	2019/20
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	3,768	3,983
Purchase of healthcare from non-NHS and non-DHSC bodies	2,283	2,723
Staff and executive directors costs	275,447	243,305
Remuneration of non-executive directors	154	155
Supplies and services - clinical (excluding drugs costs)	22,989	21,245
Supplies and services – clinical: utilisation of consumables donated from DHSC group bodies for COVID response	6,304	-
Supplies and services - general	2,811	3,090
Supplies and services - general: notional cost of equipment donated from DHSC for COVID response below capitalisation threshold	100	-
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	20,528	20,972
Consultancy costs	1,810	568
Establishment	1,373	1,309
Premises	13,945	12,689
Transport (including patient travel)	1,005	1,199
Depreciation on property, plant and equipment	10,371	8,562
Amortisation on intangible assets	516	492
Net impairments	2,543	(2,658)
Movement in credit loss allowance: contract receivables / contract assets	185	215
Movement in credit loss allowance: all other receivables and investments	-	(126)
Increase/(decrease) in other provisions	635	(1,583)
Change in provisions discount rate(s)	179	154
Audit fees payable to the external auditor		
audit services- statutory audit	55	61
other auditor remuneration (external auditor only)	-	9
Internal audit costs	130	113
Clinical negligence	10,285	8,945
Legal fees	346	422
Insurance	285	243
Research and development - staff	636	612
Research and development - non staff	60	23
Education and training	1,476	1,455
Rentals under operating leases	3,851	3,418
Redundancy	8	-
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI)	1,189	1,369
Car parking & security	353	348
Losses, ex gratia & special payments	36	68
Other services, eg external payroll	373	-
Other	862	487
Total	**386,891**	**333,867**
Of which:		
Related to continuing operations	386,891	333,867

Note 6.3 Other auditor remuneration (Group)

	2020/21	2019/20
	£000	£000
Other auditor remuneration paid to the external auditor:		
1. Audit-related assurance services	-	9
Total	**-**	**9**

Note 6.4 Limitation on auditor's liability (Group)

There is no limitation on auditor's liability for external audit work carried out for the financial years 2020/21 or 2019/20.

Note 7 Impairment of assets (Group)

	2020/21	2019/20
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	2,543	(2,658)
Total net impairments charged to operating surplus / deficit	**2,543**	**(2,658)**
Impairments charged to the revaluation reserve	2,900	4,709
Total net impairments	**5,443**	**2,051**

In 2020/2021 the Trust undertook a revaluation exercise of its land, buildings and dwellings on an alternate site basis which resulted in an impairment charge of £2.5 million to the Statement of Comprehensive Income (SoCi). Impairments reflect the fall in value of property as reflected in the District Valuer report as at the 31st March 2021. Where revaluation reserve balances exist impairment charges of £2.9 million have been charged in 2020-21.

Note 8 Employee benefits (Group)

	2020/21	2019/20
	Total	Total
	£000	£000
Salaries and wages	184,020	170,317
Social security costs	15,752	14,644
Apprenticeship levy	826	833
Employer's contributions to NHS pensions	30,344	28,531
Pension cost - other	100	94
Termination benefits	39	-
Temporary staff (including agency)	45,250	29,753
Total staff costs	**276,331**	**244,172**

Staff costs for the Group include staff employed by the Trust subsidiary, Stepping Hill Healthcare Enterprises Limited.

Note 8.1 Employee benefits (Trust)

	2020/21 Total £000	2019/20 Total £000
Salaries and wages	183,707	170,066
Social security costs	15,752	14,644
Apprenticeship levy	826	833
Employer's contributions to NHS pensions	30,344	28,531
Pension cost - other	100	90
Termination benefits	39	-
Temporary staff (including agency)	45,250	29,753
Total staff costs	**276,018**	**243,917**

Note 8.2 Retirements due to ill-health (Foundation Trust and Group)

During 2020/21 there was 1 early retirement from the Trust agreed on the grounds of ill-health (4 in the year ended 31 March 2020). The estimated additional pension liabilities of these ill-health retirements is £1k (£283k in 2019/20).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 9 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”. An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2021, is based on valuation data as at 31 March 2020, updated to 31 March 2021 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.

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 at 20.6% of pensionable pay. The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

Note 9 Pension costs

b) Full actuarial (funding) valuation

The Government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The Government has set out that the costs of remedy of the discrimination will be included in this process. HMT valuation directions will set out the technical detail of how the costs of remedy will be included in the valuation process. The Government has also confirmed that the Government Actuary is reviewing the cost control mechanism (as was originally announced in 2018). The review will assess whether the cost control mechanism is working in line with original government objectives and reported to Government in April 2021. The findings of this review will not impact the 2016 valuations, with the aim for any changes to the cost cap mechanism to be made in time for the completion of the 2020 actuarial valuations.

The Group offers an additional defined contribution workplace pension scheme, the National Employment Savings Scheme (NEST), to employees of the Foundation Trust. It also offers a similar scheme to its subsidiary, Stepping Hill Healthcare Enterprises Limited. The Trust has paid £100k (£90k in 2019/2020) to NEST in employer contributions and £5k (£4k in 2019/2020) for the subsidiary.

Note 10 Operating leases (Group)

Note 10.1 Stockport NHS Foundation Trust as a lessor

The Group and Trust do not have any operating lease agreements where they are the lessor.

Note 10.2 Stockport NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Stockport NHS Foundation Trust is the lessee.

In 2020/2021 the Trust has leasing arrangements for its community buildings. This includes five year leases with NHS Property Services Ltd for community services provided in the Stockport area. These leases are held in line with current commissioning contracts. It also has a lease arrangement for the Swanbourne Gardens Childrens Respite building. This is due to expire in January 2023.

	Foundation Trust and Group	
	2020/21	**2019/20**
	£000	**£000**
Operating lease expense		
Minimum lease payments	3,851	3,418
Total	**3,851**	**3,418**

	31 March 2021	31 March 2020
	£000	**£000**
Future minimum lease payments due:		
- not later than one year;	3,849	3,414
- later than one year and not later than five years;	14,001	13,129
Total	**17,850**	**16,543**

Note 11 Finance income (Group)

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

	2020/21	2019/20
	£000	**£000**
Interest on bank accounts	-	145
NHS charitable fund investment income	47	49
Total finance income	**47**	**194**

Interest on bank accounts in 2019/2020 was earned on balances held in the Government Banking Service bank account. Interest rates were reduced to zero in 2020/2021.

Note 11.1 Finance income (Trust)

	2020/21	2019/20
	£000	£000
Interest on bank accounts	-	145
	47	**339**

Note 12 Finance expenditure (Group and Trust)

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

	Foundation Trust and Group	
	2020/21	2019/20
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	680	1,712
Main finance costs on PFI and LIFT schemes obligations	10	9
Total interest expense	**690**	**1,721**
Unwinding of discount on provisions	(15)	6
Total finance costs	**675**	**1,727**

Note 12.1 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015 (Group)

	2020/21	2019/20
	£000	£000
Total liability accruing in year under this legislation as a result of late payments	-	-
Amounts included within interest payable arising from claims made under this legislation	-	-

Note 13 Other gains / (losses) (Group)	Foundation Trust and Group	
	2020/21	2019/20
	£000	£000
Gains on disposal of assets	40	37
Total gains / (losses) on disposal of assets	**40**	**37**
Fair value gains / (losses) on charitable fund investments & investment properties	270	(45)
Total other gains / (losses)	**310**	**(8)**

In 2020/2021 the Charity continues to invest in the CCLA Equity Common Investment Fund and this has made an unrealised gain of £270,000 (£45,000 loss in 2019/2020).There were no disposals in 2020/2021.

In 2020/2021 the Trust had a gain on disposal of assets of £40k (loss of £37k in 2019/2020); all comprising of cash proceeds relating to the sale of items of medical equipment no longer in use and fully depreciated.

Note 14.1 Intangible assets - 2020/21

Foundation Trust and Group	Software licences £000	Total £000
Valuation / gross cost at 1 April 2020 - brought forward	**8,847**	**8,847**
Additions	2,156	**2,156**
Reclassifications	(3)	**(3)**
Disposals / derecognition	(544)	**(544)**
Valuation / gross cost at 31 March 2021	**10,456**	**10,456**

Within the above note the gross cost of fully depreciated assets of £0.5 million have been removed from the Trust Statement of Financial Position and asset register with £6.9 million fully depreciated assets remaining.

Amortisation at 1 April 2020 - brought forward	**7,504**	**7,504**
Provided during the year	516	**516**
Disposals / derecognition	(544)	**(544)**
Amortisation at 31 March 2021	**7,476**	**7,476**
Net book value at 31 March 2021	**2,980**	**2,980**
Net book value at 1 April 2020	**1,343**	**1,343**

Note 14.2 Intangible assets - 2019/20

Foundation Trust and Group	Software licences £000	Total £000
Valuation / gross cost at 1 April 2019 - as previously stated	**8,198**	**8,198**
Additions	649	**649**
Valuation / gross cost at 31 March 2020	**8,847**	**8,847**
Amortisation at 1 April 2019 - as previously stated	**7,012**	**7,012**
Provided during the year	492	**492**
Amortisation at 31 March 2020	**7,504**	**7,504**
Net book value at 31 March 2020	**1,343**	**1,343**
Net book value at 1 April 2019	**1,186**	**1,186**

Note 15.1 Property, plant and equipment - 2020/21

Foundation Trust and Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2020 - brought forward	**8,113**	**121,674**	**1,832**	**1,601**	**51,187**	**354**	**20,250**	**646**	**205,657**
Transfers by absorption	-	-	-	-	97	-	-	-	**97**
Additions	-	2,113	24	7,376	10,167	74	4,418	132	**24,304**
Impairments	-	(5,443)	-	-	-	-	-	-	**(5,443)**
Revaluations	-	(4,738)	(4)	-	-	-	-	-	**(4,742)**
Reclassifications	-	2,651	-	(5,019)	209	(206)	2,368	-	**3**
Disposals / derecognition	-	-	-	-	(13,508)	(10)	(5,614)	-	**(19,132)**
Valuation/gross cost at 31 March 2021	**8,113**	**116,257**	**1,852**	**3,958**	**48,152**	**212**	**21,422**	**778**	**200,744**
Accumulated depreciation at 1 April 2020 - brought forward	**-**	**-**	**-**	**-**	**34,983**	**89**	**13,843**	**456**	**49,371**
Provided during the year	-	4,738	52	-	3,388	24	2,140	29	**10,371**
Revaluations	-	(4,738)	(52)	-	-	-	-	-	**(4,790)**
Disposals / derecognition	-	-	-	-	(13,508)	(10)	(5,614)	-	**(19,132)**
Accumulated depreciation at 31 March 2021	**-**	**-**	**-**	**-**	**24,863**	**103**	**10,369**	**485**	**35,820**
Net book value at 31 March 2021	**8,113**	**116,257**	**1,852**	**3,958**	**23,289**	**109**	**11,053**	**293**	**164,924**
Net book value at 1 April 2020	**8,113**	**121,674**	**1,832**	**1,601**	**16,204**	**265**	**6,407**	**190**	**156,286**

Within the above note the gross cost of fully depeciated assets of £19.1 million have been removed from the Trust's Statement of Financial Position and asset register with £21.3 million of fully depreciated assets remaining.

Note 15.2 Property, plant and equipment - 2019/20

Foundation Trust and Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2019 - as previously stated	**8,113**	**119,217**	**1,517**	**2,798**	**46,301**	**147**	**16,550**	**639**	**195,282**
Additions	-	607	-	1,984	6,317	207	3,682	7	**12,804**
Impairments	-	(5,311)	-	-	-	-	-	-	**(5,311)**
Reversals of impairments	-	3,260	-	-	-	-	-	-	**3,260**
Revaluations	-	2,046	315	-	-	-	-	-	**2,361**
Reclassifications	-	1,855	-	(3,181)	1,308	-	18	-	**-**
Disposals / derecognition	-	-	-	-	(2,739)	-	-	-	**(2,739)**
Valuation/gross cost at 31 March 2020	**8,113**	**121,674**	**1,832**	**1,601**	**51,187**	**354**	**20,250**	**646**	**205,657**
Accumulated depreciation at 1 April 2019 - as previously stated	**-**	**-**	**-**	**-**	**35,116**	**70**	**12,628**	**422**	**48,236**
Provided during the year	-	4,651	58	-	2,585	19	1,215	34	**8,562**
Revaluations	-	(4,651)	(58)	-	-	-	-	-	**(4,709)**
Disposals / derecognition	-	-	-	-	(2,718)	-	-	-	**(2,718)**
Accumulated depreciation at 31 March 2020	**-**	**-**	**-**	**-**	**34,983**	**89**	**13,843**	**456**	**49,371**
Net book value at 31 March 2020	**8,113**	**121,674**	**1,832**	**1,601**	**16,204**	**265**	**6,407**	**190**	**156,286**
Net book value at 1 April 2019	**8,113**	**119,217**	**1,517**	**2,798**	**11,185**	**77**	**3,922**	**217**	**147,046**

Note 15.3 Property, plant and equipment financing - 2020/21

Foundation Trust and Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2021									
Owned - purchased	8,113	115,042	1,805	3,958	21,492	78	11,053	271	**161,812**
Finance leased	-	-	-	-	61	-	-	-	**61**
On-SoFP PFI contracts and other service concession arrangements	-	830	-	-	-	-	-	-	**830**
Owned - donated/granted	-	385	47	-	1,736	31	-	22	**2,221**
NBV total at 31 March 2021	**8,113**	**116,257**	**1,852**	**3,958**	**23,289**	**109**	**11,053**	**293**	**164,924**

Note 15.4 Property, plant and equipment financing - 2019/20

Foundation Trust and Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2020									
Owned - purchased	8,113	120,390	1,785	1,601	15,449	265	6,407	190	**154,200**
Finance leased	-	-	-	-	78	-	-	-	**78**
On-SoFP PFI contracts and other service concession arrangements	-	866	-	-	-	-	-	-	**866**
Owned - donated/granted	-	418	47	-	677	-	-	-	**1,142**
NBV total at 31 March 2020	**8,113**	**121,674**	**1,832**	**1,601**	**16,204**	**265**	**6,407**	**190**	**156,286**

Note 16 Donations of property, plant and equipment

In 2020/2021 NHS England and NHS Improvement's Imaging Services Transformation team managed the deployment of CT scanners, relocatable boxes to house CT scanners, injector pumps and mobile x-ray units to Trusts as part of the pandemic response. This equipment was made available to Trusts free of charge and ownership of these assets will formally transfer in 2021/2022. Stockport NHS Foundation Trust received one CT Scanner with relocatable box and four ultrasound machines under this arrangement with a value of £1.07 million. These assets have been capitalised in 2020/2021 and notional income recorded to the equivalent value.

In 2020/2021 the Department of Health and Social Care (DHSC) established a national pandemic equipment pool (termed the 'national loan stock') of ventilators and other medical equipment also to support the pandemic response in England. This equipment was also made available to trusts free of charge with ownership to transfer to the Trust or assets returned. In total the Trust received £0.1 million of assets below the capitalisation value of £5,000 including syringe drivers, volumetric pumps, oxygen concentrators, NIV Bpap machines and enteral feeding pumps. These items have been expensed in the Trust's income and expenditure account in 2020/2021 with equivalent non cash income recorded from DHSC.

The Trust also received £0.2 million of items over the capitalisation value including patient monitors and mechanical ventilators. These items were capitalised on the Statement of Financial Position at the 31st March 2021 and notional income recorded.

The Mail Force Charity donated £43,000 to purchase laboratory testing equipment to assist the Trust during the pandemic.

In 2020/2021 the Group Property, Plant and Equipment note discloses the net book value of assets previously provided by donations on the receipt of cash income. In addition to purchasing smaller revenue items for patient and staff welfare charitable funding has provided a minibus for the Swanbourne Garden Children's Respite Centre, physiotherapy equipment for intensive care patients, an upgrade to the outdoor space outside the Hospital Staff Restaurant and a treadmill for the Lung Function Service. This charitable funding has come via the Trust's Charity with significant contributions from NHS Charities Together and Stockport County Football Club. Further details on this funding and expenditure by the Charity will be available in the financial statements of Stockport NHS Foundation Trust General Fund, a registered Charity.

Note 17 Revaluations of property, plant and equipment

In 2020/2021 the Trust undertook a valuation of land and buildings by the District Valuer in compliance with International Accounting Standards, the Royal Institute of Chartered Surveyors, the Treasury Financial Reporting Manual and the Department of Health Group Accounts Manual. The valuation was undertaken at the the 31st March 2021 prepared on an alternative site basis. The valuation was based on land on its existing site but on a much smaller footprint and buildings based on a Modern Equivalent Basis. Further disclosures on this revaluation can be found at note 1.9 Property, Plant and Equipment: Measurement. The movements on the revaluation reserve are shown below.

Revaluation Reserve Movements	**Foundation Trust and Group**	
	£000	**£000**
	Property, Plant and Equipment	**Total Revaluation Reserve**
Revaluation reserve at 1 April 2020 - brought forward	**49,640**	**49,640**
Net impairments	(2,900)	**(2,900)**
Revaluations	48	**48**
Revaluation reserve at 31 March 2021	**46,788**	**46,788**
At 1 April 2019	**47,279**	**47,279**
Impairment	(4,709)	**(4,709)**
Revaluations	7,070	**7,070**
Revaluation Reserve at 31 March 2020	**49,640**	**49,640**

Note 18 Other investments / financial assets (non-current)

	2020/21	2019/20
Carrying value at 1 April - brought forward	**1,287**	**1,332**
Movement in fair value through income and expenditure	270	(45)
Carrying value at 31 March	**1,557**	**1,287**

The above note details the investments held by the Trust Charity consolidated in Group numbers only.

For the Consolidated Group the Charity held investments in equity common investment funds. In 2020/2021 the Group reported £47,000 (£49,000 in 2019/2020) in interest receivable on these investments and a gain on valuation of £270,000 at the 31st March 2021 (£45,000 loss in 2019/2020).

Note 19 Analysis of charitable fund reserves

The Trust has consolidated its charitable fund, Stockport NHS Foundation Trust General Fund (known as Stockport NHS Charity) - Charity Commission Number Registration Number 1048661, within the Group Accounts.

	31 March 2021 £000	31 March 2020 £000
Unrestricted funds:		
Unrestricted income funds	296	286
Restricted funds:		
Endowment funds	10	10
Other restricted income funds	2,352	1,834
	2,658	**2,130**

Unrestricted income funds are accumulated income funds that are expendable at the discretion of the trustees in furtherance of the Charity's objects. Unrestricted funds may be earmarked or designated for specific future purposes which reduces the amount that is readily available to the Charity.

Restricted funds may be accumulated income funds which are expendable at the Trustee's discretion only in furtherance of the specified conditions of the donor and the objects of the Charity. They may also be capital funds (e.g. endowments) where the assets are required to be invested, or retained for use rather than expended. For Stockport NHS Foundation General Fund these funds relate to specified business groups and departments at the Trust. There is one permanent endowment fund where the monies are retained for use rather than expended.

Note 20 Inventories

	Group		Trust	
	31 March 2021	31 March 2020	31 March 2021	31 March 2020
	£000	£000	£000	£000
Drugs	1,052	994	856	729
Consumables	433	765	433	765
Energy	67	77	67	77
Total inventories	**1,552**	**1,836**	**1,356**	**1,571**
of which:				

Inventories recognised in expenses for the year were £6,716k (2019/20: £176k). Write-down of inventories recognised as expenses for the year were £0k (2019/20: £0k).

Note 20 Inventories continued

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2020/21 the Trust received £6,304k of items purchased by DHSC.

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

The Trust only records material consumables in Inventories and has taken the option to exclude donated PPE from the inventories note in the Accounts. The deemed cost of these inventories was charged directly to expenditure on receipt with the corresponding benefit recognised in income.

Note 21.1 Receivables

	Group		Trust	
	31 March 2021	**31 March 2020**	**31 March 2021**	**31 March 2020**
	£000	**£000**	**£000**	**£000**
Current				
Contract receivables	14,365	20,332	15,724	23,053
Allowance for impaired contract receivables / assets	(1,244)	(1,064)	(1,244)	(1,064)
Prepayments (non-PFI)	1,559	472	1,559	472
Interest receivable	-	20	-	20
PDC dividend receivable	575	93	575	93
VAT receivable	1,217	876	1,105	608
Other receivables	-	15	278	-
NHS charitable funds receivables	27	-	-	-
Total current receivables	**16,499**	**20,744**	**17,997**	**23,182**
Non-current				
Contract receivables	320	377	320	377
Allowance for impaired contract receivables / assets	(72)	(82)	(72)	(82)
Prepayments (non-PFI)	-	7	-	7
Total non-current receivables	**248**	**302**	**248**	**302**
Of which receivable from NHS and DHSC group bodies:				
Current	7,665	15,945	7,665	15,945

Within the Group note adjustments have been made for transactions with the Trust's Charity and subsidiary Outpatient Drug Dispensing Service - Stepping Hill Healthcare Enterprise Limited.

Note 21.2 Allowances for credit losses - 2020/21

	Foundation Trust and Group		Foundation Trust and Group	
	Contract receivables and contract assets 2020/21	**All other receivables 2020/21**	**Contract receivables and contract assets 2019/20**	**All other receivables 2019/20**
	£000	**£000**	**£000**	**£000**
Allowances as at 1 Apr - brought forward	**1,146**	-	**1,038**	**126**
New allowances arising	494	-	276	-
Changes in existing allowances	-	-	126	(126)
Reversals of allowances	(309)	-	(187)	-
Utilisation of allowances (write offs)	(15)	-	(107)	-
Allowances as at 31 Mar - carried forward	**1,316**	**-**	**1,146**	**-**

Note 21.3 Exposure to credit risk

In assessing its exposure to credit risk the Trust reviews its aged receivables report on an individual invoice and debtor basis. It has assessed its lifetime expected losses as detailed in the provisions matrix. The percentage applied for the NHS Injury Recovery Scheme on its current balance is a nationally agreed percentage provided annually by the DHSC. All other receivables are recognised at their gross carrying amount.

Provision for Expected Credit Losses

	Foundation Trust and Group		
	Current	More than 360 days past due date	£000
Lifetime expected credit loss			
NHS Injury Recovery Scheme	22.43%	-	690
Foundation Trusts	-	100%	100
Non NHS Customers	-	100%	388
Salary Overpayments	-	100%	67
Private Patients	-	100%	11
Overseas Visitors	100%	-	60
			1,316

Note 22.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	Group		Trust	
	2020/21	2019/20	2020/21	2019/20
	£000	£000	£000	£000
At 1 April	**19,785**	**7,027**	**17,631**	**4,868**
Transfers by absorption	8	-	8	-
Net change in year	15,198	12,758	14,895	12,763
At 31 March	**34,991**	**19,785**	**32,534**	**17,631**
Broken down into:				
Cash at commercial banks and in hand	2,137	1,581	402	103
Cash with the Government Banking Service	32,132	17,528	32,132	17,528
Other current investments	722	676	-	-
Total cash and cash equivalents as in SoFP	**34,991**	**19,785**	**32,534**	**17,631**
Total cash and cash equivalents as in SoCF	**34,991**	**19,785**	**32,534**	**17,631**

Note 23.1 Trade and other payables

	Group		Trust	
	31 March 2021	31 March 2020	31 March 2021	31 March 2020
	£000	£000	£000	£000
Current				
Trade payables	6,264	13,450	6,130	13,450
Capital payables	12,074	2,047	12,074	2,047
Accruals	26,163	14,343	26,515	15,485
Social security costs	2,399	2,215	2,399	2,215
Other taxes payable	2,112	1,856	2,112	1,822
Other payables	3,520	3,359	3,520	3,280
Total current trade and other payables	**52,532**	**37,270**	**52,750**	**38,299**
Of which payables from NHS and DHSC group bodies:				
Current	4,601	8,194	4,601	8,194

Consolidation adjustments by the Group have removed payables between the Trust, Charity and the Stepping Hill Healthcare Enterprises Limited subsidiaries.

Note 23.2 Early retirements in NHS payables above

There are no early retirement payables in the note above. The payables note above does include amounts in relation to outstanding pension contributions.

Foundation Trust and Group	31st March 2021	31st March 2020
	£000	£000
- outstanding pension contributions	2,927	2,724

Note 24 Other liabilities

Foundation Trust and Group	31st March 2021	31st March 2020
	£000	£000
Current		
Deferred income: contract liabilities	4,578	1,320
Total other current liabilities	**4,578**	**1,320**
Non-current		
Deferred income: contract liabilities	343	375
Total other non-current liabilities	**343**	**375**

Note 25 Borrowings

Foundation Trust and Group	31st March 2021	31st March 2020
	£000	£000
Current		
Loans from DHSC	1,719	48,025
Obligations under finance leases	60	84
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	31	31
Total current borrowings	**1,810**	**48,140**
Non-current		
Loans from DHSC	18,429	19,980
Obligations under finance leases	-	60
Obligations under PFI, LIFT or other service concession contracts	233	264
Total non-current borrowings	**18,662**	**20,304**

Note 25.1 Reconciliation of liabilities arising from financing activities (Group)

Foundation Trust and Group - 2020/21	Loans from DHSC	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000
Carrying value at 1 April 2020	**68,005**	**144**	**295**	**68,444**
Cash movements:				
Financing cash flows - payments and receipts of principal	(47,606)	(84)	(31)	**(47,721)**
Financing cash flows - payments of interest	(931)	-	(10)	**(941)**
Non-cash movements:				
Interest Charge arising in year	680	-	10	**690**
Carrying value at 31 March 2021	**20,148**	**60**	**264**	**20,472**

Foundation Trust and Group - 2019/20	Loans from DHSC	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000
Carrying value at 1 April 2019	**47,913**	**229**	**325**	**48,467**
Cash movements:				
Financing cash flows - payments and receipts of principal	20,059	(85)	(29)	**19,946**
Financing cash flows - payments of interest	(1,678)	-	(10)	**(1,689)**
Non-cash movements:				
Interest Charge arising in year	1,711	-	9	**1,720**
Carrying value at 31 March 2020	**68,005**	**144**	**295**	**68,444**

Note 26.1 Provisions for liabilities and charges analysis (Group and Trust)

Group	Pensions: injury benefits	Legal claims	Re-structuring	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2020	**3,223**	**93**	**23**	**2,418**	**5,757**
Change in the discount rate	179	-	-	-	**179**
Arising during the year	72	106	47	2,725	**2,950**
Utilised during the year	(170)	(51)	(23)	(15)	**(259)**
Reversed unused	-	(32)	-	(2,283)	**(2,315)**
Unwinding of discount	(15)	-	-	-	**(15)**
At 31 March 2021	**3,289**	**116**	**47**	**2,845**	**6,297**
Expected timing of cash flows:					
- not later than one year;	354	116	47	2,845	**3,362**
- later than one year and not later than five years;	703	-	-	-	**703**
- later than five years.	2,232	-	-	-	**2,232**
Total	**3,289**	**116**	**47**	**2,845**	**6,297**

The provision for 'Legal Claims' provides for the Liability to Third Parties Schemes (LTPS) and Public & Employers Liability Scheme (PES). This provision covers the excess amount payable by the Trust and not the full liability of claims which are covered by the NHS Resolution under the non-clinical risk pooling scheme.The contingent liability at note 27 also relates to this scheme. Both figures are supplied by NHS Resolution and revised annually by NHS Resolution based on up to date information at the 31st March.

The provision for 'Pensions - injuy benefits' is for the reimbursement of injury benefit allowances to the NHS Pensions Agency for ten members of former staff over their estimated life expectancy.

Within other provisions the Trust has provided for costs for banding claims and possible future charges to the Trust on NHS Pension final pay controls for staff approaching retirement age.

Note 26.2 Provisions for liabilities and charges analysis (Group and Trust)

Foundation Trust and Group	Current	Current	Non-Current	Non-Current
	2020/21	2019/20	2020/21	2019/20
Pensions: injury benefits	354	332	2,935	2,891
Other legal claims	116	93	-	-
Restructurings	47	23	-	-
Other	2,845	2,418	-	-
Total	**3,362**	**2,866**	**2,935**	**2,891**

Note 26.3 Clinical negligence liabilities

At 31 March 2021, £194,419k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Stockport NHS Foundation Trust (31 March 2020: £170,497k).

Note 27 Contingent assets and liabilities (Group and Trust)

	31 March 2021	31 March 2020
	£000	£000
Value of contingent liabilities		
NHS Resolution legal claims	(73)	(57)
Gross value of contingent liabilities	**(73)**	**(57)**

Further detail on the provision and contingent liability for NHS Resolution claims is disclosed at note 26.

Note 28 Stockport NHS Foundation Trust as a lessee

Obligations under finance leases where the Trust is the lessee.

Foundation Trust and Group	**31st March 2021**	**31st March 2020**
Gross lease liabilities	**£000**	**£000**
of which liabilities are due:		
- not later than one year;	17	84
- later than one year and not later than five years;	43	60
Net lease liabilities	**60**	**144**
of which payable:		
- not later than one year;	60	84
- later than one year and not later than five years;	-	60

This note gives details of two finance leases for the community EPR EMIS patient record system and an agreement for Point of Care testing. The EPR EMIS system was fully paid in 2019/2020 leaving the 2020/2021 outstanding liability for the Point of Care Testing equipment.

Note 29 On-SoFP PFI, LIFT or other service concession arrangements

Under IFRIC 12 the Trust recognises a service concession arrangement with Alliance Medical for the provision of a building to perform MRI scanning services.

Note 29.1 On-SoFP PFI, LIFT or other service concession arrangement obligations

The following obligations in respect of the PFI, LIFT or other service concession arrangements are recognised in the statement of financial position:

Foundation Trust and Group	**31 March 2021**	**31 March 2020**
	£000	**£000**
Gross PFI, LIFT or other service concession liabilities	**301**	**342**
Of which liabilities are due		
- not later than one year;	40	40
- later than one year and not later than five years;	161	161
- later than five years.	100	141
Finance charges allocated to future periods	(37)	(47)
Net PFI, LIFT or other service concession arrangement obligation	**264**	**295**
- not later than one year;	31	31
- later than one year and not later than five years;	138	133
- later than five years.	95	131

Note 29.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

Total future commitments under these on-SoFP schemes are as follows:

Foundation Trust and Group	31 March 2021	31 March 2020
	£000	£000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**8,303**	**8,540**
Of which payments are due:		
- not later than one year;	1,444	1,220
- later than one year and not later than five years;	5,776	4,880
- later than five years.	1,083	2,440

Note 29.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

Foundation Trust and Group	2020/21	2019/20
	£000	£000
Unitary payment payable to service concession operator	**1,230**	**1,409**
Consisting of:		
- Interest charge	10	9
- Repayment of balance sheet obligation	31	31
- Service element and other charges to operating expenditure	1,189	1,369
Total amount paid to service concession operator	**1,230**	**1,409**

Foundation Trust and Group	31 March 2021	31 March 2020
Property, plant and equipment	1,319	3,405
Intangible assets	195	-
Total	**1,514**	**3,405**

Capital commitments reflect those capital projects started or contractually committed to in 2020/2021 and due within one year. These commitments includes Information Technology projects to establish a Data Warehouse at the Trust and the rollout of the Greater Manchester PACS Radiology system. Other commitments are for equipment in the Critical Care unit and upgrade of one of the Trust's X Ray Rooms. Contractual commitments of £1.5 million are outstanding with £0.5 million incurred to date at the 31st March 2021.

Note 31 Financial instruments

Note 31.1 Financial risk management

IFRS 7 Financial Instruments Disclosure requires declaration of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. Financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies to which IFRS 7 mainly applies. Stockport NHS Foundation Trust has powers to borrow or invest surplus funds, and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Foundation Trust in undertaking its activities. For the Group the Charity does hold investments and is, therefore, exposed to a degree of financial risk. This risk is carefully managed by pursuing a low risk investment strategy. The Charity holds its investments within common investment funds with a market leader provider of Charity Investments, CCLA Management Ltd.

Note 31 Financial instruments

Liquidity Risk

In response to the Covid-19 pandemic a decision was made by NHS England and NHS Improvement to fund NHS Trusts to cover all costs for the first six months of the year to a break even position. Block payments were introduced and throughout the financial year were paid one month in advance until March 2021. Revenue and capital costs were funded that specifically related to Covid-19 such as increased cost of temporary staffing, additional equipment for staff and patients as well as loss of income. Personal protective equipment was provided free of charge in 2020/2021 and continues into 2021/2022. The Trust was also provided with capital equipment to treat Covid-19 patients and was reimbursed for the costs of running a vaccination hub.

Between October 2020 to March 2021 the Trust was provided with a fixed funding stream via the Greater Manchester system that continued to fund block contract income. Trusts were funded to enable the GM system to meet a break even position through Reimburesment and Top Up Funding. This covered the loss in cash revenues for such services as car parking where charges to staff have been suspended. Nationally the financial positions of Trusts are being further supported by early payments in March of forecast loss of income and the commitment to fund carry forward untaken annual leave to a maximum of five days and the settlement of the Flowers provision legal claim for backdated overtime payments.

In 2021/2022 NHSEI have issued financial planning guidance for the first six months of the year with the ongoing commitment to fund Trusts with system funding through block payments. Guidance is awaited for the regime from October 2021 onwards.

The Trust's treasury management operations are carried out by the Finance department, within parameters defined formally within the Trust's Standing Financial Instructions and policies agreed by the Board of Directors. Similarly treasury management for the Trust Charity and subsidiary, Stepping Hill Healthcare Enterprises Ltd, are also carried out by the Finance department. All treasury activity is subject to review by Internal and External Audit.

The Trust finances its capital expenditure from internally generated funds or funds made available from the Department of Health as Public Dividend Capital. The Trust has also borrowed commercially from the Department of Health NHS Financing Facility within approved borrowing limits to finance strategic capital schemes in previous years. In 2020/2021 the Trust has been in receipt of £13 million of PDC to deliver capital projects over and above depreciation funded schemes.

At the 31 March 2021 the Trust's cash balances were held solely in its Government Banking Services bank accounts and Barclays current accounts as per note 22.1. Stockport NHS Foundation Trust is, therefore, not exposed to significant liquidity risk.

Market and Interest Rate Risk

At the 31 March 2021 the Trust's financial liabilities carried either nil or fixed rates of interest. The Trust's financial assets relate to loans and receivables and its cash balances held within its Government Banking Service bank accounts and commercial current account. Interest on cash balances are set by HM Treasury through the Royal Bank of Scotland. The conversion of loans to PDC in 2020/2021 does bring additional costs to the Trust as loans with lower rates of interest will be converted to the higher 3.5% PDC Dividend rate. However, an adjustment to the Trust's initial control total offer was made to compensate for this. Stockport NHS Foundation Trust is not, therefore, exposed to significant interest rate risk.

Foreign Currency Risk

The Trust has negligible foreign currency income or expenditure.

Credit Risk

The Trust receives most of its income from its commissioners currently based on block payments and system top ups. It operates a robust debt management policy and, where necessary, provides for the risk of particular debts not being discharged by the applicable party. Non NHS customers do not make up a large proportion of income with the majority of income coming from other public sector bodies which are considered low risk. This position means that Stockport NHS Foundation Trust is, therefore, not exposed to significant credit risk. Where it has significant commitments (for example large capital contract awards and payments) it uses a credit rating agency before payments are made or contracts awarded.

Financial Instruments continued.

Charitable Funds

The Group accounts include the financial statements of the Stockport NHS Charitable Fund. The charitable fund places its short term cash in bank accounts with the Trust's commercial bank, Barclays PLC. The Charity also invests monies of £2.3 million for longer term investment with CCLA Investment Management Ltd. It holds one common investment fund in equity funds of £1.6 million and one cash deposit account holding £0.7 million. The Charity receives quarterly updates on the performance of its investments and allocates gains and losses when realised to its charitable funds. This policy is reviewed on an annual basis to mitigate for any possible market losses on the valuation of its equity common investment fund.

Stepping Hill Healthcare Enterprises Limited

The Group accounts include the financial statements of its trading subsidary, Stepping Hill Healthcare Enterprises Limited. The subsidary holds its cash with the Trust commercial banker, Barclays PLC, in a separate bank account. Its income is predominantly with the parent and it currently purchases drugs for its dispensing services using the Trust Pharmacy as its wholesale supplier. It is not considered, therefore, to have market or liquidity risks.

Note 31.2 Carrying values of financial assets (Group)

The Group holds financial assets that qualify as basic financial instruments that includes cash and receivables held at amortised cost and Charity investments held at fair value. The latter are recognised initially at transaction value and subsequently measured at fair value. through the Statement of Comprehensive Income.

Carrying values of financial assets as at 31 March 2021	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Trade and other receivables excluding non financial assets	13,016	-	**13,016**
Other investments / financial assets	-	-	**-**
Cash and cash equivalents	33,639	-	**33,639**
Consolidated NHS Charitable fund financial assets	1,379	1,557	**2,936**
Total at 31 March 2021	**48,034**	**1,557**	**49,591**

Carrying values of financial assets as at 31 March 2020	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Trade and other receivables excluding non financial assets	19,598	-	**19,598**
Cash and cash equivalents	18,578	-	**18,578**
Consolidated NHS Charitable fund financial assets	1,207	1,287	**2,494**
Total at 31 March 2020	**39,383**	**1,287**	**40,670**

Note 31.3 Carrying values of financial assets (Trust)

Carrying values of financial assets as at 31 March 2021	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Trade and other receivables excluding non financial assets	15,006	-	**15,006**
Cash and cash equivalents	32,534	-	**32,534**
Total at 31 March 2021	**47,540**	**-**	**47,540**

Carrying values of financial assets as at 31 March 2020	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Trade and other receivables excluding non financial assets	22,284	-	**22,284**
Cash and cash equivalents	17,631	-	**17,631**
Total at 31 March 2020	**39,915**	**-**	**39,915**

Note 31.4 Carrying values of financial liabilities (Group)

Carrying values of financial liabilities as at 31 March 2021	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	20,148	**20,148**
Obligations under finance leases	60	**60**
Obligations under PFI, LIFT and other service concessions	264	**264**
Trade and other payables excluding non financial liabilities	45,094	**45,094**
Provisions under contract	3,452	**3,452**
Total at 31 March 2021	**69,018**	**69,018**

Carrying values of financial liabilities as at 31 March 2020	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	68,005	**68,005**
Obligations under finance leases	144	**144**
Obligations under PFI, LIFT and other service concessions	295	**295**
Trade and other payables excluding non financial liabilities	33,199	**33,199**
Provisions under contract	3,339	**3,339**
Total at 31 March 2020	**104,982**	**104,982**

Note 31.5 Carrying values of financial liabilities (Trust)

Carrying values of financial liabilities as at 31 March 2021	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	20,148	**20,148**
Obligations under finance leases	60	**60**
Obligations under PFI, LIFT and other service concessions	264	**264**
Trade and other payables excluding non financial liabilities	45,312	**45,312**
Provisions under contract	3,452	**3,452**
Total at 31 March 2021	**69,236**	**69,236**

Carrying values of financial liabilities as at 31 March 2020	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	68,005	**68,005**
Obligations under finance leases	144	**144**
Obligations under PFI, LIFT and other service concessions	295	**295**
Trade and other payables excluding non financial liabilities	34,262	**34,262**
Provisions under contract	3,339	**3,339**
Total at 31 March 2020	**106,045**	**106,045**

Note 31.6 Fair values of financial assets and liabilities

Other than the investments held by the Group Charity all financial assets and liabilities are held at carrying value at the 31st March 2020 as book value is considered to be a reasonable approximation of fair value.

Note 31.7 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	Group		Trust	
	31 March 2021 £000	31 March 2020 restated* £000	31 March 2021 £000	31 March 2020 restated* £000
In one year or less	47,692	82,376	47,910	83,439
In more than one year but not more than five years	9,057	9,388	9,057	9,388
In more than five years	15,873	17,921	15,873	17,921
Total	**72,622**	**109,685**	**72,840**	**110,748**

* This disclosure has previously been prepared using discounted cash flows. The comparatives have therefore been restated on an undiscounted basis.

Note 32 Losses and special payments

	2020/21		2019/20	
Group and trust	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	3	-	16	4
Bad debts and claims abandoned	43	21	69	36
Stores losses and damage to property	-	-	1	22
Total losses	**46**	**21**	**86**	**62**
Special payments				
Ex-gratia payments	33	15	31	5
Total special payments	**33**	**15**	**31**	**5**
Total losses and special payments	**79**	**36**	**117**	**67**

These amounts are reported on an accruals basis and exclude provisions for future losses.

Note 33 Gifts

Neither the Trust or Group made gifts of any value in 2020/2021 or 2019/2020.

Note 34 Related parties

Stockport NHS Foundation Trust is a body corporate authorised by NHS Improvement (legal entity Monitor), the Independent Regulator of NHS Foundation Trusts, in exercise of the powers conferred by the National Health Service Act 2006. The Department of Health and Social Care is the parent body of all Foundation Trusts.

The Trust has 22 members of the Council of Governors; 20 representing public and staff and a further 3 appointed by partner organisations. None of the Council of Governors or parties related to them has undertaken any material transactions with Stockport NHS Foundation Trust.

During the 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 Stockport NHS Foundation Trust.

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 Receivable and Payable balances.

Note 34 Related parties continued

The Trust and Group's related parties include all Whole of Government bodies as defined by the Treasury. The key transactions are with the following bodies:

	Income		Expenditure	
	31st March 2021 £000	31st March 2020 £000	31st March 2021 £000	31st March 2020 £000
NHS Stockport CCG	193,258	191,742	(4)	(49)
NHS Derby and Derbyshire CCG	25,222	24,387	-	-
NHS Manchester CCG	33,627	-	(40)	-
NHS Cheshire CCG	15,067	13,578	(101)	(282)
NHS Tameside & Glossop CCG	9,802	9,307	(1)	-
Stockport MBC	8,627	8,765	(72)	(202)
NHS England	49,705	43,520	(5)	(15)
Public Health England	89	111	(388)	(381)
NHS Resolution	-	-	(10,505)	(9,136)
Health Education England	8,631	7,633	-	-
Manchester Foundation NHS Trust	2,840	1,969	(2,514)	(2,355)
Derbyshire Community Health Services NHS FT	-	-	(528)	(514)
Tameside & Glossop Integrated Care NHS FT	391	383	(9)	(42)
Age UK	-	3	(135)	(113)
	347,259	**301,398**	**(14,302)**	**(13,089)**

	Receivables		Payables	
	31st March 2021 £000	31st March 2020 £000	31st March 2021 £000	31st March 2020 £000
NHS Stockport CCG	84	750	(6)	(2,549)
NHS Derby and Derbyshire CCG	-	-	-	(2)
NHS Cheshire CCG	-	282	(101)	-
NHS Tameside & Glossop CCG	-	-	-	(314)
Stockport MBC	1,119	283	(164)	(445)
NHS England	3,160	11,391	(140)	(38)
Public Health England	-	-	(118)	(61)
NHS Resolution	-	-	-	(4)
Health Education England	461	212	(826)	(271)
Manchester Foundation Trust	1,158	997	(1,342)	(753)
Derbyshire Community Health Services NHS FT	-	-	(45)	-
Tameside & Glossop Integrated Care NHS FT	22	85	(57)	(126)
	6,004	**14,000**	**(2,799)**	**(4,563)**

Note 35 Transfers by absorption

In 2020/2021 Manchester Foundation Trust received funding to purchase Radiology Home Workstations on its behalf and other Trusts in the Greater Manchester system. These assets have been transferred to the Trust under a transfer of absorption to remove the asset from the Statement of Financial Position of Manchester Foundation Trust and onto Stockport's. The Public Dividend Capital funding related to the fifteen workstations for Stockport FT was £105,000. The workstations cost £97,000. Therefore, the transfer of absorption is transacted as £97,000 equipment transfer and £8,000 cash transfer.

Note 36 Events after the reporting date

The accounts were authorised for issue by the Accountable Officer on the 3rd June 2021.

The Trust has no events to report after the 31st March 2021.