NHS
Tameside and Glossop
Integrated Care
NHS Foundation Trust

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Annual Report and Accounts 2020-2021

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

Contents


Our Objectives for 2021/22
NHS
Tameside and Glossop Integrated Care
NHS Foundation Trust
Our Vision
To improve health outcomes for our population and influence wider determinants of health, through collaboration with our health and care partners
Working with partners, we will:
1 Keep our patients safe and deliver personalised, caring services.
2 Keep our staff safe and support their health and wellbeing.
3 Develop our workforce to meet future service and user needs.
4 Use our resources wisely.
5 Work as effective partners across Greater Manchester and within the Tameside and Glossop locality.
Our Values and Behaviours
Safety
We challenge and respond to improve safety and quality for everyone
Respect
We recognise, value and respect everyone around us
Caring
We are caring and compassionate
Communication
We actively listen to our patients, their relatives, carers and colleagues
Learning
We promote and encourage learning

Table of Abbreviations

BAF	Board Assurance Framework
BAME	Black and Minority Ethnic
CCG	Clinical Commissioning Group
DAWN	Disability and Wellbeing Network
EDI	Equality, Diversity and Inclusion
EPRR	Emergency Planning, Resilience and Response
GM	Greater Manchester
ICS	Integrated Care System
ICFT	Integrated Care Foundation Trust
LCFS	Local Counter-Fraud Service
LGBT	Lesbian, Gay, Bisexual or Trans
MIAA	Mersey Internal Audit Service
NHS	National Health Service
PPE	Personal Protective Equipment
SIREN	Staff Inclusion Race Empowerment Network
WDES	Workforce Disability Equality Scheme
WRES	Workforce Race Equality Scheme

Chair and Chief Executive's Introduction

On behalf of the Board, we welcome you to the Annual Report and Accounts for the Trust, for the year ended on 31st March 2021.

This has been a year like no other for the NHS and the country. At the start of the year in April, we were just seeing the first wave of COVID-19, with the initial introduction of lock-down having been put in place a few weeks earlier. Throughout the year, our colleagues have given their all to care for people with COVID-19, through several waves and a number of lockdowns. Of course our colleagues have also been affected directly by COVID-19; with family members becoming ill and sadly dying, and also as staff directly contracting this disease. It is with particular sadness that we have to record the loss of colleagues and former colleagues to COVID-19, but we recall with gratitude their commitment to the safety and care of those we serve.

Overall performance

Inevitably, our performance focus has shifted this year, as we responded to COVID-19. The Trust was required, over the course of the year, to adjust our services to allow for social distancing, and support mass vaccination.

In common with the rest of the NHS provider sector, the pandemic has meant that much of our normal service had to be suspended during the course of the year. This was a national position, reflecting the priority need to care for the high number of COVID patients. As a Trust, a locality, and a region we have recognised that this has inevitably affected a large number of people as their treatment for a range of conditions has been delayed. Through the year we have maintained our cancer services, recognising the particular need to support people urgently when they are diagnosed with this condition. We also continued to provide our accident and emergency service, adjusted to meet the demands of COVID-19 and social distancing. The Board was pleased to receive additional capital funding, which supported the Trust's response to COVID.

Our community-based services have also been heavily impacted by COVID-19, but have continued to deliver excellent service and quality of care to the residents of Tameside and Glossop. Our community staff have continued to rise to the challenge, for example through ensuring that the childhood vaccination programme has continued to be delivered; and supporting care to be delivered in people's homes where this is possible.

Staff health and well-being

The Board recognises that it is only able to provide quality and safe health care for the population of Tameside and Glossop thanks to the dedication and commitment of our staff. During the unprecedented pressures of COVID-19, our colleagues have gone significantly above and beyond what might be expected of them to ensure that patients are treated safely, compassionately and with respect.

The impacts on staff of the pressures of the pandemic have been immense. They have had to adjust to providing services in difficult conditions, and all of our colleagues have also been dealing with COVID in their personal lives; with impacts on friends, relatives and loved ones who have contracted the disease.

Throughout the pandemic the Trust has sought to put in place support for all of its staff, both locally and as part of the Greater Manchester (GM) measures. A number of arrangements were made immediately at the start of the pandemic, including support from our occupational health department, local arrangements to escalate concerns, and access to mental health support if required. We have utilised the support in place of the Greater Manchester Resilience hub, which is

providing a range of mental health and other wellbeing support to staff when they need it. Our staff have also had access to the various support and wellbeing tools that were provided directly on a national basis by NHS England.

The 2020 national staff survey was undertaken between October and December, and the initial results were considered by the Board in March 2021. As you will see in the more detailed section later in the report, whilst the Trust had a solid performance being at or around the average in most measures, the Board is disappointed that it has not had a greater level of improvement moving towards its ambition to be in the upper quartile of the staff survey. It is important to recognise the survey timetabling meant that colleagues were being asked for their view whilst the second and third waves of COVID-19 were being dealt with in the acute sector; and this factor needs to be taken into account. As shown later in the report, the Board is agreeing an action plan to address how we can improve the satisfaction of our staff.

Equality, diversity and inclusion continue to be key considerations for the Board, the Trust and the NHS as a whole. We continue to work towards a better staff experience for all colleagues and potential colleagues who have a protected characteristic as defined in the Equality Act 2010: and towards the targets that have been set by NHS England to improve Black and Minority Ethnic (BAME) and disabled representation. With the approval of the Trust's Equality, Diversity and Inclusion Strategy, the Board set identified targets to improve its own diversity. During the year progress has been made to meet these with the appointment of a Non-Executive Director and an Associate Non-Executive Director from a BAME background; and the Board recognises the need to make further progress in the coming year to meet its agreed target overall. The Board has particularly welcomed the formation of the North-West Strategic Advisory Committee on these matters, and looks forward to their assistance in further improving diversity amongst the Trust's senior leadership.

Financial performance

The COVID-19 pandemic led to immediate and substantial changes in the NHS financial infrastructure. For the first half of the year, between April and September 2020, all providers were being financed on a 'break-even' basis: with all necessary expenditure being provided for by a direct grant through their Clinical Commissioning Group (CCG). As we have come to expect from our finance team, they responded to this substantial change in arrangements with exemplary thoroughness, shown by the fact that none of the Trust's claims for payments were subject to significant query. An internal audit review reported 'High Assurance' for the process.

For the second half of the year, changes were made in the financial arrangements, with the majority of funding being provided through a block grant from the CCG and additional funding for growth, COVID-related expenditure, and some other items being delegated to the Greater Manchester level and the allocation being determined locally. The Trust was heavily involved with the discussions at a Greater Manchester level, with the Finance Director playing a significant role; and agreement was reached on a consensus basis for allocations during the year.

It is very pleasing that, despite all the significant challenges during the year, the Trust has achieved a broadly break-even position, with a small surplus of £666,000 before revaluations and impairments at the year end. During the year, HM Government converted the loans provided to various trusts by the Department for Health and Social Care to public dividend capital; this means that the Trust no longer has an outstanding loan from HM Government, which has significantly improved our financial position. It remains the expectation that Trusts will be able to provide their services on at least a break-even basis; and the Board will remain focused on ensuring this is the case.

The Board

This has been a year of stability for the Board, as we work with recently-appointed colleagues to further develop our effectiveness and governance of the Trust. The Board had been expected to complete the agreed development programme with Deloitte, but the intervention of the pandemic meant that the last two sessions of the programme have had to be delayed.

The Board has continued to meet in its regular two monthly cycle, but has moved on to videoconferencing rather than physical meetings in accordance with government guidance during the pandemic. Board committees have also continued to function. The Board approved some limited changes to delegations to reflect the demands of the pandemic; however any decisions not directly related to the pandemic have remained subject to usual procedures and authorisation limits.

During the year, Peter Noble chose to retire from the Board at the end of his first term of three years; and we would like to thank him for his service and contribution. Following a full advertising and competitive process, the Council of Governors agreed that Dr Farath (Fara) Arshad should be appointed as a Director for three years from February 2021; and the Board appointed Abdul Hamied as an Associate Non-Executive Director to increase the diversity in the views available to the Board. In order to ensure stability in the Board during the period, the Council of Governors also agreed that, exceptionally, Martyn Taylor would be given a further year’s extension to his term, ending in April 2022, with a view to an appointment process being undertaken during the autumn of 2021.

In November, we agreed with Stockport Foundation Trust that we would share our Chief Executive in order to support them to improve, following the departure of their previous Chief Executive. Our Chief Executive remains responsible to the Board for the full range of the Trust's services; and is responsible to the Stockport Board for the day-to-day operations of their Trust. The Board is confident that this Trust retains sufficient capacity within the executive team and those supporting them to ensure that we can continue to provide the highest quality of care.

Looking forward

Following this unprecedented and exceptional year, it seems clear that they will be further significant work to be undertaken. For our patients and communities, the most pressing issue will be the restoration of a full range of services and addressing the significant backlog that was unavoidably created as a result of the COVID-19 pandemic. This will be undertaken in a coordinated way with our colleagues across Greater Manchester, but it is fair to say that in all likelihood it will take some time to return the levels of service to where they were before the pandemic struck.

As a Board we must also look to the significant changes likely to be legislated during the course of this year, following the publication of the recent white paper by HM Government. The proposed changes, whilst consistent with the direction of travel indicated by the NHS long-term plan and similar documents, will undoubtedly represent significant changes to the way that the NHS works; and we will be seeking to ensure that those changes approved by Parliament are implemented. There are a number of areas that will require further consideration, not least the impact of clinical commissioning groups being folded into the Integrated Care System: and the way that localities and the Integrated Care System (ICS) can integrate in practice to deliver the aims set out in the white paper. We look forward to working closely with all of our colleagues in Greater Manchester in order to take this forward.

Jane McCall
Trust Chair

Karen James, OBE
Chief Executive

Performance Overview

1. Summary and Overview

   1.1. This section of the Annual Report summarises the performance of the Trust over the year, and provides related information such as our history and the key risks that have been identified by the Board to the delivery of the agreed strategic objectives.

   1.2. Throughout the year, the key challenge that has faced the Trust has been the emergence and management of COVID-19, which moved to being a key public health emergency at the start of the year in April 2020. In common with the remainder of the NHS, the Trust has been focused during the course of the year in dealing with this pandemic; revising how we provide services as a result, ensuring the protection of our staff who have been providing exceptional care in the most trying of circumstances, and playing our part in protecting the public through participating in the delivery of the vaccination programme.

   1.3. As discussed in more detail in the performance appraisal section at 11 below, the impact of the pandemic was such that - in common with other NHS providers regionally and nationally - a number of our usual services had to be restricted in order to enable the Trust to meet the national priorities related to caring for patients with COVID-19. It was also necessary to engage in major restructuring of the physical provision of care, reflecting the need to prevent potential infection of others by those attending who were suffering from COVID-19. We have also been able to advance a number of major capital projects, together with making investments that have enabled us to improve the care and experience of patients. Looking forward, we are working on a significant capital investment to redevelop the Emergency Department, which we anticipate will have final approval in 2021.

   1.4. Throughout the unprecedented challenges of the year, we have seen again and again that our staff colleagues have delivered excellent patient care in the most pressurised circumstances. As a Board, we would want to record now, as we have during the course of the year, our admiration for all of our colleagues for their efforts and commitment to the care of our patients throughout this period.

2. Chief Executive's statement on performance

   2.1. The views of the Chief Executive on the Trust's performance during the course of the year are provided in the Chair and Chief Executive's introduction at page 4.

3. Our purpose and activities

   3.1. The Trust exists for the purpose of providing care for patients as part of the National Health Service.

   3.2. The Trust operates a secondary care hospital (Tameside General Hospital) and community services. It provides a range of services from the hospital site, including the provision of an Emergency Department service, a range of in-patient and surgical care, out-patient care, and a broad range of children's and adult services across the Tameside and Glossop area.

   3.3. We work closely with the Clinical Commissioning Group, the three local authorities in our area (Tameside Council, High Peak Borough Council and Derbyshire County Council) and the voluntary/ third sector to provide integrated services for patients. We recognise that health and social care interact with each other and the patient seeks a seamless service.

3.4. We operate within the Greater Manchester area, within which health and social care is partially-devolved under the Greater Manchester Mayor and Combined Authority. As such, we are an active participant in the devolved structures in place within Greater Manchester. These structures took on more importance during the second half of the year, as NHS England/ Improvement decided to move to funding systems rather than individual, and to devolve the allocation of funds for individual providers to systems. The Greater Manchester systems worked well and an allocation process was agreed through the relevant governance structures.

4. History of the Trust

4.1. Hospital and medical services have been provided by the Trust and its predecessor organisations since the mid-nineteenth century, as public provision moved on from the services required of the parish under the *Poor Law Acts*. Over the decades, we have provided key services to our local communities, including with the inception of the National Health Service in 1946, when the Tameside General Hospital became part of the NHS. We have then participated in the various structural changes made in the NHS, always focused on the delivery of the best possible services to our communities and patients.

4.2. The Trust achieved Foundation Trust status in 2013, giving greater autonomy and a more formalised link with our communities through the formation of the Council of Governors with the majority of Governors elected by and from our community. Since the achievement of Foundation Trust status, we have continued to develop our services; and have become an integrated care provider in 2016 to deepen our relationship with the other key partners in our locality, so that patients have a seamless service across health and social care provision.

5. Key Issues and Risks for the Trust

5.1. The Board, with the support of its committees, regularly reviews the key risks to the achievement of the corporate objectives that it has agreed for the year (for the corporate objectives for the 2021-2022 year, please see page 3).This is managed through the Board Assurance Framework, which sets out the key strategic risks that have been identified by the Board, together with a judgement on the current risk levels and the key controls and mitigations that are in place.

5.2. Exceptionally, during the year the Board reviewed and revised the Board Assurance Framework to reflect the significant environmental changes driven by the COVID-19 pandemic. The Board identified four key risks for the year in that environment-

5.2.1. Were our patients safe?
5.2.2. Were our staff safe?
5.2.3. Was the Trust using its resources effectively?
5.2.4. Was the Trust implementing the agreed recovery plan?

5.3. These risks, and the judgements on the likelihood and consequences of the risk eventuating, were regularly reviewed by the Board, with detailed input from its Committees themselves supported by the relevant Executive Director leads. The Board was confident that these risks were being effectively managed in the circumstances, and that all reasonable controls and mitigations were in place; however, the scores remained relatively high reflecting that many of the matters impacting on the risk were external to the Trust and beyond its control.

5.4. The allocation of oversight of these risks for the year was-

Are our patients safe?	Quality and Governance Committee
Are our staff safe?	Workforce Committee
Is the Trust using its resources effectively?	Finance Committee
Is the Trust implementing the agreed recovery plan?	Board of Directors

6. Performance Analysis

6.1. Overview

6.1.1. The Trust has a regular system of annually setting out objectives and performance targets, which are then monitored through the course of the year. Performance is reported to and monitored by the Board at its regular meetings, through the Integrated Performance Report and other key items of business. The Board's review is supported by the work undertaken in committee, where a greater level of detail can be reviewed and tested.

6.1.2. During 2019-2020, the Board had set out the strategic objectives shown at page 70. However, shortly after these had been approved by the Board, it became clear that the COVID-19 pandemic would become the defining feature of the year, and as a result it would be necessary to approach the agreed targets in a more flexible way to reflect this. In particular, it was necessary to recognise that, in line with the national arrangements put in place under the highest level of national emergency response (Level 4 in the Emergency Preparedness, Resilience and Response (EPRR) framework), and the need to change services to address patients with COVID-19, a range of our more usual services would need to be reduced to meet the exceptional demands being faced by the Trust.

6.1.3. The year also saw a very considerable change in the financing arrangements for the Trust, reflecting the considerable pressure placed on the NHS and individual organisations by the COVID-19 pandemic. Prior to the start of the year, the Trust had been engaged in the development of an annual plan in line with the national guidance issued by NHS England/ Improvement; this process remained incomplete, having been overtaken by events, although the work undertaken formed the basis of evaluation during the first part of the year.

6.1.4. For the first half of the year (April to September 2020), HM Government funded the NHS on the basis that all properly-incurred costs would be reimbursed; during that period, the Trust received a cash payment in-month that represented the majority of its expected costs, with any balance being paid after the month-end through a "true-up" process. The Trust had in place robust and substantial systems to monitor, record and control expenditure during this period, and the required "true-up" payments were made without deductions.

6.1.5. From October 2020 to the end of the financial year, the national funding system moved to central funding being provided from NHS England/ Improvement to the local ICS (with a single designated CCG acting as the 'banker' for the system). The Integrated Care System was then responsible for determining how those funds would be allocated to the individual organisations within its system; and was also given overall responsibility for ensuring that key targets set out by NHS England/ Improvement were met by the system overall. The Trust continued to perform well under these arrangements, and finished the year in a broadly 'break-even' position, with a small surplus of £666,000 before the impact of revaluations and impairments, having implemented continuing strong controls.

6.2. Key Performance Indicators

6.2.1. There are a range of indicators that the Board considers on a regular basis, through the Integrated Performance Report that is reported to the Board at each regular meeting. Given the exceptional circumstances of COVID-19, the Board's focus was changed to reflect the need to respond to the pandemic. The table below sets out the key performance indicators, as reviewed by the Board, and should be considered in the context of the year's focus on COVID-19.

	Target	Actual
Safe Service		
MRSA actual cases	0	6
C. Difficile actual cases	72	49
C. Difficile avoidable cases	0	2 [1]
Registered Nurse/ Midwife on shift (% of planned)	Over 86%	95.94%
Emergency re-admission within 30 days	Less than 12%	13.5%
Reported Serious Incidents	0	11
Breaches of 'Duty of Candour' requirements	0	0
Never Events	0	0
'Prevention of Future Deaths' notices from HM Coroner	0	2
Responsive Service		
4-hour wait in Accident & Emergency (Types 1 & 3)	Over 95%	85.27%
12-hour wait in Accident & Emergency	0	1
18-week referral to treatment time	Over 92%	75.8%
Waiting longer than 52 weeks referral to treatment	0	1,096
6-week wait for diagnostic tests	Less than 1%	40.25%
Caring Service		
Complaints responded to within the agreed timescale	Over 90%	97.3%
Staff sickness rates	Less than 4.8%	5.9%
Well-Led Service		
Staff meeting mandatory training requirements	Over 95%	N/A
Staff turnover	Less than 11%	N/A
A&E- Notify to Handover- over 60 minutes	Less than 10	53
Single Oversight Framework rating	1	3

6.2.2. In order to meet the new requirements for infection prevention led by COVID-19, the Emergency Department was substantially re-designed to provide areas for those with and without COVID-19 symptoms, and also to provide the additional space required for social distancing.

6.2.3. In line with national guidance, for most of the year the focus was on providing COVID-19 related services, and the wider range of services that would usually be available was, in a number of areas, suspended for all bar cancer and urgent

[1] These two cases as provisional at the end of the year, and are subject to review and validation.

cases. As a result, the Trust has recorded an unusually high level of patients having to wait for treatment, both against the 18-week usual target and the 52-week metric: this has been seen across providers both in Greater Manchester and across England. In partnership with providers across the Greater Manchester system, the Trust is engaged in planning to restore services and reduce waiting times.

6.2.4. National guidance during the year was to suspend some refresher training for staff, in order to remove pressures during the COVID-19 period. As a result, the Board has not been monitoring performance against the training metric during 2020-2021. Plans are in place to resume this training for colleagues as the national guidance changes.

6.3. Financial performance

6.3.1. During the year, there have been a number of changes to the financial arrangements that support the Trust's work. These can be summarised as follows-

6.3.2. Prior to the start of the year, a national planning process was underway, with NHS England/ Improvement having issued relevant guidance and an expectation that individual Trusts would submit annual plans, approved by their Boards, at the end of April 2020. This process was not completed, and final plans were not considered by the Board, as the national approach changed at short notice as a result of COVID-19 becoming a major national challenge.

6.3.3. When the size of the challenge from COVID-19 became clear, HM Government adopted a changed policy for funding the NHS for the first half of the 2020-2021 year (April to September 2020 inclusive). For that period, Ministers decided that the NHS would have a 'break-even' approach; all reasonably-incurred expenditure would be reimbursed. The Board is pleased to be able to report that all relevant expenditure by the Trust was robustly recorded and reported, with appropriate controls in place, and was duly reimbursed without any significant queries being raised. This outcome has been confirmed by a review undertaken by the Internal Audit service, which reported 'High Assurance' in this area.

6.3.4. For the second half of the year, a changed system of financing was introduced. The focus for funding streams moved from individual legal organisations to the ICS; NHS England/ Improvement provided a block of funding to one CCG within the system acting as 'banker', and it was then for the system to agree how that funding would be allocated to each individual organisation. Each ICS was expected to make significant progress towards being in balance (no deficit of expenditure over income), but it was recognised that the exceptional pressures from COVID-19, and the swift introduction of the new arrangements, might not make that possible for all systems. The Trust was fully involved in the processes for Greater Manchester, as the ICS for this Trust, to agree the allocation process and related matters; and consequently in discussions on any changes that were required in practice.

6.3.5. For a number of years, the Trust has been supported by loans received from the Department of Health and Social Care, reflecting that the normal funding arrangements in place had not enabled the Trust to meet its expenditure from the available income streams. At the start of the year (2nd April, 2020), HM Government announced its intention to convert the loans to Public Dividend Capital. This conversion was formally completed in September 2020, and the change is reflected in the Annual Accounts contained within this report.

6.3.6. For the 2021-2022 year, NHS England/ Improvement continued the arrangements from the second half of the previous year into the first quarter (April to June 2021), reflecting the continuing pressure from COVID-19. The planning process was also delayed, with planning expected to be undertaken during the first quarter period.

6.3.7. For the 2020-2021 financial year, the key points from our financial performance were-

- The Trust balanced income and expenditure for the year, achieving a broad 'break-even' position despite the significant challenges of COVID-19 and the significant changes to national arrangements for financing NHS organisations during the year.
- We continued to operate robust systems of controls on financial matters, shown by the "High Assurance" internal audit assurance opinion on the controls in place regarding COVID-19 related expenditure and the related claims for reimbursement, as well as the annual key financial systems review.
- As a result of decisions by HM Government, in September 2020 the previous loans were converted into Public Dividend Capital, making the Trust loan-free.

6.4. Environmental Matters

6.4.1. The Trust is aware of its impact on the environment, and has set sustainability as one of its corporate objectives. As part of the NHS, we are also involved in delivering the ambition set out in *Delivering a Net Zero Health Service* published by NHS England in October 2020, which has set out the following requirements to be delivered by the NHS-

- For emissions directly controlled by the NHS (the NHS Carbon Footprint), reduction by 80% by 2032 (if not earlier), and net zero by 2040.

- For emissions we do not directly control but can influence (the NHS Carbon Footprint Plus), an 80% reduction by 2039 and net zero by 2045.

6.4.2. These are very challenging targets, both for the NHS generally and for this Trust. In January 2020, the Board approved a Sustainable Development Management Plan (now known as a Green Plan) which sets out our key objectives to reduce our impact on the environment.

6.4.3. During the year, we have continued to put our Green Plan into effect: and we have already moved to having 100% of the electricity used by the Trust from renewable sources. We have also taken some practical steps to influence other emissions outside of our direct control, through the introduction of better facilities for cycle usage in attending the Trust's sites. The Green Plan is intended to drive long-term change within the Trust, and the Board will continue to work to implement it across future years.

7. <u>Going Concern</u>

7.1. The Board is required, in preparing the Annual Accounts, to consider whether the Trust remains a 'going concern' for accounting purposes. Guidance received for the preparation of NHS accounts indicates that, if the services provided by the Trust will continue to be provided from public funds, a going concern basis would be appropriate to be adopted.

7.2. Taking that guidance into account, and after making enquiries, the Directors have a reasonable expectation that the Trust has adequate resources to continue in

operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

8. Equality of Service

8.1. The Public Sector Equality Duty (PSED), part of the Equality Act 2010, requires NHS organisations to eliminate unlawful discrimination, advance equality of opportunity, and foster good relations. The duty has a key role to play in making sure that fairness is at the heart of public bodies' work and that public services, including health and social care services, meet the needs of different groups. We know that the people who use our services are the true experts on how those services should be delivered and developed. By listening and acting on people's views and experiences we can improve our services for everyone who uses them.

8.2. We are committed to providing excellent care for everyone, and in doing so, making sure our services reach everyone. This includes closing any healthcare inequality gaps that people might face, improving the experience where health inequalities exist and for those with protected characteristics. This is a priority within our document: *Delivering Experience for the People Who Use Our Services*; and to achieve this goal we are committed to ensuring that we:

8.2.1. Work with individuals, local community groups and representative organisations when developing and reviewing services to ensure that our services can respond to people's individuals needs and experience
8.2.2. Understand the needs of patients and ensuring that there is support for available for people with additional needs, to help them access services
8.2.3. Work to reduce barriers that may prevent groups or individuals accessing our services or having a positive experience
8.2.4. Provide information in a range of accessible formats to meet individual needs and the requirements of the Accessible Information Standard (AIS)
8.2.5. Provide access to telephone and face to face interpreters for patients who require this service
8.2.6. Work alongside our Equality, Diversity and Inclusion Strategy to ensure our workforce, and voluntary services are representative of our local community and can respond to different people's needs
8.2.7. Understand experience by protected characteristics and identify areas for improvement
8.2.8. Provide digital translation and access to information in different languages alongside the building of new websites and digital platforms

8.3. We know that continuous engagement, monitoring and improvement is required to support our commitment to equality and we will continue to strive to ensure this is achieved. A number of programmes, work streams and actions are in place to reduce barriers that may prevent groups or individuals accessing our services or having a positive experience. This is a continuous process but over the past year we have taken a number of steps to achieve this. This includes:

- Working with individuals, local community groups and representative organisations to ensure that their voices of people with protected characteristics are heard and to triangulate feedback to ensure that we can respond to these. This has included Healthwatch, Action Together and the Bureau, Maternity Voice Partnership and Tameside Diversity Group.
- Endorsing a compassionate approach to visiting whilst visiting restrictions have been in place. Our approach is to ensure that people who are particularly

distressed, have mental health or learning disability needs, or are at the end of their life, are supported in receiving visits whilst in hospital.

- Continuing to collect Friends and Family Test (FFT) data to understand people's experience of care and including the optional capture of demographic data for patients and patient representatives to understand experience by different demographics.
- Launching the use of new technology to assist people in accessing information regarding their appointments, which can also assist in their information and communication needs
- Improving our capture of patient ethnicity demographics data within the Outpatients Department. At the end of the year the Trust's Outpatient data has achieved all targets and is above national average.
- Providing access to interpreter services for those who need them, utilising telephone interpretation for situations where face to face interpretation has not been possible due to national restrictions in place
- The community wellbeing service working alongside statutory partners to actively reach out to communities who may experience inequality, isolation or other challenges during the pandemic. This has been a partnership approach as the service is delivered by the voluntary sector which provides an extended network that can reach communities in a way that statutory providers cannot.
- The launch of a Tameside and Glossop volunteer reader panel to review patient information leaflets and provide advice and guidance regarding the creation of patient information so that it can be easily understood.

8.4. In the year ahead, we are committed to:

- Understanding feedback regarding people experience in more detail. For example, our Emergency Department FFT results show that people who said they have a non-white background have a less positive experience (positive response score of 79) compared to people who recorded being from a white background (positive response score of 83). As we have collected FFT responses over 2020-2021 we will review this data and work with partners to understand these differences further and how we can work with people to reduce barriers that exist
- Delivering training and development opportunities, working with community partners and people with lived experience to understand people's individual needs and work together to identify improvement actions
- Develop a co-design model to work alongside the people who receive support on service improvements in an authentically collaborative manner
- Continuing to work with a diverse range of partners to raise awareness of health inequalities and identify opportunities to work towards reducing these.

9. Modern Slavery Act

9.1. As part of the public service, the Trust is understood not to be subject to the reporting provisions that are set out in Part 6 of the *Modern Slavery Act 2015*. The Board has determined that it should give an overview as if these provisions applied to the Trust.

9.2. As part of the NHS, the majority of the supplies used by the Trust are obtained through NHS supply chain arrangements, which operate nationally and provide support to all NHS providers. These arrangements have appropriate controls to ensure that supplies provided to the NHS can be reasonably assured not to have involved slavery or human trafficking; and the Trust relies on these arrangements as its assurance for supplies that it obtains through the NHS Supply Chain.

9.3. For supplies that the Trust obtains from outside of the NHS supply chain, our procurement arrangements include undertakings from suppliers that they have obtained goods in a manner consistent with the Act's requirements: including that appropriate checking has taken place on suppliers earlier in the supply chain. If a question is raised regarding the provenance of goods supplied, the Trust retains appropriate rights of inspection.

9.4. There is also the potential for some operations on the Trust's sites, such as building works, to be undertaken in a way that would involve offences under the Act. The Trust requires contractors to provide proof that the individuals who are working on site are legally able to work in the UK, and that they are being paid and taxed in accordance with the statutory requirements: together with any other relevant provisions of the 2015 Act. The Trust ensures that those requirements are also imposed on any sub-contractors who are physically on-site.

Karen James
Chief Executive

9th June, 2021

Director's Report

10. Directors during the year

10.1. During the year ended on 31st March 2021, the following served as Directors of the Trust-

Fara Arshad (appointed 7th February, 2021)
Sallie Bridgen
Trish Cavanagh
David Curtis
Karen James
Andrew Light
Jane McCall
Peter Noble (retired 6th February, 2021)
Brendan Ryan
Sam Simpson
Martyn Taylor
Peter Weller

10.2. Jane McCall's first term of office ended in January 2021; the Council of Governors have agreed to appoint her to a second term of office, ending in January 2024. Council has also agreed to extend the term of Martyn Taylor as a Director for an additional 12 months to April 2022, to support the stability of the Board.

10.3. Peter Noble elected to retire from the Board at the end of his first term of office in February 2021. Following an open selection process, Council appointed Fara Arshad to succeed Mr Noble as a Non-Executive Director.

10.4. During the year, the Board has appointed Abdul Hamied as an Associate Non-Executive Director. This is a development position, with Mr Hamied attending the Board but without a vote; and participating in the activities of two committees, the Quality & Governance Committee and the Workforce Committee.

10.5. Jane McCall has been appointed as the Trust Chair by the Council, and chairs the Board of Directors. Martyn Taylor has been appointed by the Board to be the Deputy Chair, and also to be the Senior Independent Director.

11. Committee and Lead appointments

11.1. The Board is supported in its work by the committees which it has appointed to undertake more detailed scrutiny and oversight, and to engage with the detailed development of strategy prior to Board consideration. Subject to statutory exceptions,[2] each Committee is composed of Executive and Non-Executive Directors, with a Non-Executive Director appointed by the Board to chair each committee.

11.2. The appointment of Directors to the committees of the Board at 31st March 2021 are shown in the following table-

		Audit	Finance	N&R	Q&G	Workforce
Fara Arsad [3]	Non-Executive Director	x	x	x		
Sallie Bridgen	Non-Executive Director		x	x	x	x
Patricia Cavanagh	Deputy Chief Executive		x		x	x

2 The Audit Committee and the Nomination and Remuneration Committee can only consist of Non-Executive Directors.
3 From 7th February 2021

		Audit	Finance	N&R	Q&G	Workforce
David Curtis	Non-Executive Director			x	x	x
Karen James	Chief Executive		x	A		
Andrew Light	Non-Executive Director	x	x	x		x
Jane McCall	Trust Chair			x		
Brendan Ryan	Medical Director				x	x
Sam Simpson	Director of Finance	A	x			
Martyn Taylor	Non-Executive Director	x		x	x	
Peter Weller	Director of Nursing & Integrated Governance	A			x	x
Abdul Hamied	Associate Non-Executive Director				A	A

x- member
A- in attendance

11.3. In line with various items of national guidance, and also where the Board has identified a particular need than can be supported by an appointment, Non-Executive Directors have been appointed to lead roles. These support the Board through a greater focus on the area in question, and also provide both support and challenge to the Executive Director with responsibility for the area. At the 31st March 2021, the lead NED roles for the Trust were as follows-

Farath Arshad	NED Board Safety Champion Ockenden Maternity Safety Champion Safeguarding Lead Innovation and Technology Lead
Sallie Bridgen	End of Life Care Equality, Diversity and Inclusion Community and Patient Engagement
David Curtis	Infection Prevention and Control Mortality Review Maintaining High Professional Standards
Andrew Light	Local Counter-Fraud Emergency Preparedness, Resilience and Response Well-Being Guardian
Martyn Taylor	Procurement Freedom to Speak Up Organ Donation

12. Other interests held by Directors

12.1. Details of the other interests held by Directors can be seen on the Register of Interests, available on-line at https://tgicft.mydeclarations.co.uk/.

13. Cost allocation and charging guidance

13.1. The Directors confirm that, for the year ended 31st March 2021, the Trust has complied with the guidance on cost allocation and charging issued by HM Treasury.

14. Payments to suppliers

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

14.2. The Trust's performance for the year ended 31st March 2021, calculated in accordance with Regulation 113(7) of the Regulations and reported in line with the requirements set out by NHS Improvement, is-

	NHS Contracts		Other invoices		Total	
	Number	£000	Number	£000	Number	£000
Invoices paid within 30 days	703	48,663	24,836	115,938	25,539	159,127
Invoices required to be paid within 30 days	1,688	43,189	41,899	140,032	43,587	188,665
Proportion of those paid to required (%)	41.6%	88.8%	59.3%	82.8%	58.6%	84.3%

14.3. During the year, nominal liability to pay interest on invoices not paid within 30 days, incurred under the *Late Payment of Commercial Debts (Interest) Act 1988* totalled £Nil. No supplier sought payment and therefore payments in the year were £Nil.

15. Ensuring our services are well-led

15.1. The Board recognises that, in order to ensure that we can provide the best possible quality of care and patient experience, it is necessary to ensure that the Trust is well-led. Key elements of this include-

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

15.2. The Board has put into place a full set of committees, which support its work through more detailed review of operational performance, identification of possible mitigating or corrective actions, and initial consideration of strategic developments before they come for Board consideration. All committees are chaired by a Non-Executive Director, and have a balance of Executive and Non-Executive membership. Details of the work of the Board's committees can be found at page 66 onwards.

15.3. Board-level governance is supported by a full structure of management-level groups, which link to the appropriate Executive Directors and support their accountability to the Board and its committees. More details about specific aspects of these structures can be found in the report on the work of the Board and the Council starting at page 55, and the Annual Governance Statement starting at page **Error! Bookmark not defined.**.

15.4. In reviewing and considering the effectiveness of its Board-level governance, the Trust is required to have regard to the NHS Improvement *Well-Led Framework*, which reflects the regulatory expectations set out by the Care Quality Commission and against which the Trust's leadership will be assessed during inspections. The Trust

has taken this guidance into account in the reviews of control systems undertaken by the Audit Committee and the Quality and Governance Committee; these have provided the Board with robust assurance that the Trust is meeting the expectations set out in the Framework. The Board has also reviewed and refreshed its approach to the Board Assurance Framework (BAF) during the course of the year; the Board Committees continue to support the Board through detailed oversight of BAF risks, and providing assurance as to the level of control in place. All BAF risks are reviewed on an annual basis, to ensure that they remain relevant and reflect the updated corporate objectives agreed by the Board.

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

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

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

16. <u>Non-NHS Income</u>

16.1. During the year, the Trust has received certain income beyond the provision of services for the purposes of the NHS in England, which we are required to report separately on under current legislation. The total income received in this year was £522,000 and the split between the various categories can be seen in the Annual Accounts at note 3.1. The funds raised were re-invested in the services provided by the Trust.

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

Remuneration Report

17. Annual Statement on Remuneration

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

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

- Reviewing the remuneration of the Executive team, following receipt of the letter dated 31st January 2020 from NHS England/ Improvement outlining the recommendation for the 2019/20 annual pay increase for those on the 'Very Senior Manager' scales;
- Approving arrangements for the sharing of the Chief Executive with Stockport Foundation Trust, and the consequential flow of funds. The Committee approved an increase in the remuneration of the Chief Executive for the period she is shared with Stockport, reflecting the increased responsibilities, and appropriate re-charging from Stockport to this Trust of part of that increased salary. The Committee also approved an increase in the remuneration for the Deputy Chief Executive, reflecting that she would have increased day-to-day responsibilities in the Trust.

The context in which the committee considered these matters was the need to ensure that the Trust is able to recruit and retain an Executive team that is able to provide the necessary leadership to the Trust and its staff: whilst giving due consideration to NHS England /Improvement guidance limiting executive salaries to the upper quartile of the relevant pay range (as defined within NHS Improvement's published pay ranges). The Committee has had regard to the NHS Improvement guidance on pay for very senior managers in NHS Trusts and Foundation Trusts, to enable discussion to take place at the Remuneration Committee. During the year, the committee agreed that all Executive Directors should be placed at the median of the relevant grouping for a Trust of this size: this will lead to increases for the Finance Director, the Director of Nursing and Integrated Governance and the Director of Human Resources.

Non-Executive Directors

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

During the year, the Council continued to apply the standard NHS England/ Improvement guidance on remuneration for Non-Executive Directors (including Trust Chairs), together with the nationally-expected process for the appraisal of Trust Chairs. Council also approved an increase in the remuneration for the Trust Chair, in line with its agreed long-term process to raise those fees gradually into the median of the appropriate bracket in the NHS England/ Improvement guidance, subject to satisfactory performance being shown.

Jane McCall,
Chair, Board Nomination and Remuneration Committee
Chair, Council Nomination and Remuneration Committee

18. Policy on remunerating Directors

18.1. The Trust recognises that, in order to ensure that the Trust is led by Executive Directors with the skills, capacity and leadership required to provide an excellent service to the public of the Tameside and Glossop area, it must adopt a remuneration policy that will attract and retain individuals with the necessary skills and personality. Equally, as an organisation funded by the public purse, it recognises that it must not pay excess amounts for the services of its Executive Directors, as this would not meet the requirement to be economic, efficient and effective.

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

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

18.4. The Council continues to follow the guidance issued by NHS England/ Improvement in respect of the remuneration of Trust Chairs and other Non-Executive Directors, whilst reserving the right to depart from that guidance if specific matters requiring a different approach are identified. The Council is currently increasing the Chair's remuneration in stages, subject to satisfactory performance, to move the remuneration into the appropriate band under the guidance.

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

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

18.6. As can be seen from the table on page 26 during the year one Executive Director received more than £150,000 in remuneration. The Committee has considered whether these figures remain reasonable, given the objectives set out above and in the table of future policy. The Committee has concluded that it has positive assurance

that these figures are reasonable, by means of comparison with the data available on pay rates for the equivalent positions in Trusts of comparative size.

18.7. The Trust's policy on setting notice periods for Executive Directors, as noted in the table on page 27, is designed to ensure that the Trust can attract individuals of appropriate calibre to undertake Executive Director roles; and to provide some assurance that, when Executive Directors leave the organisation, there is sufficient time for the Trust to recruit a replacement and have them in post, in order to minimise disruption to the provision of services.

18.8. Each Executive Director is entitled, in the event that they are made redundant, to a redundancy payment. The calculation of any payment is based on a maximum salary of £80,000 and one month's payment for each year of service, up to a maximum of 24 months. Under the provisions of the NHS Standard Contract and Section 16.8 of the Agenda for Change national agreement, if a Director is made redundant and returns to work in the NHS within 12 months, they are required to pay back a proportion of the redundancy payment to the Trust. No discretion arises in respect of the payments by reference to performance in office.

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

19. How we took into account other employees

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

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

20. Policy on diversity and inclusion

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

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

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

These imply that by March 2022 the Board will include least 2 Directors from a BAME background, and at least one with a disability background. The Board has appointed an Associate Non-Executive Director from a BAME background, who whilst non-voting will add to the diversity of lived experience brought to the Board's discussions.

20.3. From the 2021-2022 year, through the NHS Standard Contract all provider organisations will be required to introduce a five-year action plan to improve BAME representation (a) amongst senior staff, at Agenda for Change Band 8A and above; and (b) on the Board of Directors; to be reflective of the higher of the BAME proportion of the local community or its overall staffing complement. The Trust will also be required to regularly publish reports on implementation and progress against the targets set in that action plan. There is also an obligation on the Trust to progress the actions set out in the NHS People Plan, which include actions to improve representation in senior positions for those with protected characteristics. The Trust has set itself targets in this area, which are set out on page 42.

20.4. The Trust has already adopted an Equality, Diversity and Inclusion Strategy that includes targets for Board-level recruitment against some protected characteristics, having regard to the policy direction for the NHS. As set out in the strategy, the Trust will seek to promote opportunities for under-represented groups to learn about available roles, be supported in applying for positions, and to be given adjustments to ensure that they have a fair opportunity to display their skills for appointment.

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

20.6. For Non-Executive Directors, the Council of Governors continues to seek to make appointments that would lead to a greater diversity at the Board. Council has agreed that recruitment processes will be undertaken in-house and put in place steps to encourage and support those with protected characteristics to come forward. Additional steps have been taken to try and attract more candidates from a diverse background and from individuals who have a protected characteristic, including-

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

20.7. Building on the work undertaken in the recruitment of Non-Executive Directors in 2019-2020, for the recruitment of one Non-Executive Director to the Board in the year the Trust continued to engage with local communities, and use different methods to ensure that the opportunity to join the Board. The diversity of both applications and the short-list was positive, although the appointed candidate has chosen not to formally confirm their ethnic background. The Board also appointed an Associate Non-Executive Director with a BAME background from the interviewed candidates, to enhance the diversity of lived experience available to the Board in its discussions.

20.8. In 2021-2022, Council anticipates undertaking a recruitment process for at least one Non-Executive appointment (although the individual appointed is not expected to take office until the 2022-2023 year). In undertaking the recruitment process, Council will continue to have in mind the targets that have been set to diversify the membership

of the Board of Directors, and particularly the target related to reflecting the BAME composition of the Trust's staff as required under the Standard Contract provisions.

Future Remuneration Policy table (Executive Directors)

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

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

21. Members of the Nomination and Remuneration Committee, and attendance at meetings

21.1. The Board has appointed all Non-Executive Directors to be members of the Nomination and Remuneration Committee. The committee is chaired by Jane McCall, Trust Chair.

21.2. During the year, the committee met three times. The attendance of members at the committee was as follows-

	July 2020	October 2020	November 2020
Fara Arshad			
Sallie Bridgen	✓	✓	✓
David Curtis	✓	✓	✓
Andrew Light	✓	✓	✓
Jane McCall	✓	✓	✓
Peter Noble	✓	✓	✓
Martyn Taylor	✓	✓	✓

21.3. During the year, the committee were supported in their considerations by-

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

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

22.1. During the 2020-2021 year, we have continued to undertake our statutory role to determine the remuneration and related terms and conditions for the Executive team, as required under the National Health Service Act 2006. Our discussions and decisions have been informed by reviewing the appraisal outcomes for the Executive Directors; the changes in remuneration for the generality of Trust staff through the national contract and pay arrangements; and the guidance set out in the Code of Governance for NHS Foundation Trusts. We have also had regard to comparative information, particularly that produced by NHS Providers.

22.2. After the end of the year, we agreed that all Executive Directors should be moved to the median remuneration for the Trust's band within the NHS Improvement guidance. As a result, there will be increases in remuneration for the Director of Finance, the Director of Nursing and Integrated Governance, and the Director of Human Resources in the 2021-2022 year.

22.3. We also gave consideration to the request to share our Chief Executive with Stockport Foundation Trust, to provide them with support when their Chief Executive left; and the related financial arrangements. The Committee was pleased to be able to agree to the request for support, being assured that the Executive team at the Trust had the capacity and capability to continue to ensure excellence of quality of care and patient experience within these changed circumstances; and that the Chief Executive would continue to be able to provide the organisational leadership required for the Trust. The arrangements were agreed for a 12-month period in the first instance, and will be reviewed before the end of that period to determine the most appropriate relationship in the longer-term. The committee also agreed an increase in remuneration for the Chief Executive, reflecting her expanded responsibilities during the sharing period; and arrangements for part of her remuneration to be re-charged

and paid by Stockport FT. An increase in remuneration for the Deputy Chief Executive was also agreed, reflecting her expanded day-to-day responsibilities at the Trust.

23. Service contracts for Executive Directors

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

24. Non-Executive Director appointment details

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

	Date of appointment	End of current term	Notice period
Fara Arshad	February, 2021	February, 2024	3 months
Sallie Bridgen	February, 2017	February, 2023	3 months
David Curtis	January, 2020	January, 2023	3 months
Andrew Light	January, 2020	January, 2023	3 months
Jane McCall	January, 2018	January, 2024	3 months
Martyn Taylor	May, 2015	April, 2022	3 months

24.2. During the year, the Board made the first appointment of an Associate Non-Executive Director for the Trust, in Abdul Hamied. Mr Hamied is not a Director and does not vote at Board or committee meetings; but is included in Board discussions and brings his experience to the Board's work. Mr Hamied was appointed in January 2021 for an initial 2-year term.

25. Expenses for Directors and Governors

25.1. During the year, the following expenses were paid to Directors and Governors respectively-

Directors

	2021-2022	2019-2020
Total number of Directors in office	12	13
Number of Directors receiving expenses for the year	3	4
Aggregate sum of expenses paid to Directors in the year	£378	£2,741

Governors

	2021-2022	2019-2020
Total number of Governors in office	29	32
Number of Governors receiving expenses for the year	Nil	Nil
Aggregate sum of expenses paid to Governors in the year	£Nil	£Nil

Remuneration Information

26. Single Total Remuneration Figure

Information for the year ended 31st March, 2021

	Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	Performance pay and bonuses (bands of £5,000)	Long-Term performance pay and bonuses (bands of £5,000)	All pension related benefits (bands of £2,500)	Total (Bands of £5,000)
Fara Arshad [a]	0-5	0	N/A	N/A	0	0-5
Sallie Bridgen	10-15	0	N/A	N/A	0	10-15
Amanda Bromley	100-105	0	N/A	N/A	30-32.5	130-135
Patricia Cavanagh	130-135	0	N/A	N/A	127.5-130	260-265
David Curtis	10-15	0	N/A	N/A	0	10-15
Karen James [d]	120-125	0	N/A	N/A	90-92.5	210-215
Andrew Light	10-15	0	N/A	N/A	0	10-15
Jane McCall	40-45	100	N/A	N/A	0	40-45
Peter Noble [b]	10-15	0	N/A	N/A	0	10-15
Brendan Ryan [e]	110-115	0	N/A	N/A	5-7.5	115-120
Sam Simpson	130-135	0	N/A	N/A	37.5-40	165-170
Martyn Taylor	15-20	0	N/A	N/A	0	15-20
Sue Toal [g]	35-40	0	N/A	N/A	0	35-40
Peter Weller	110-115	0	N/A	N/A	25-27.5	135-140

Notes are stated after the 2020 table

Information for the year ended 31st March 2020

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

Notes

a Fara Arshad joined the Board on 7th February, 2021

b Peter Noble retired from the Board on 6th February, 2021

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

d Karen James' remuneration disclosed in the table above represents the Trust's share of her remuneration, reflecting that she has been seconded to Stockport NHS Foundation Trust for 85% of her time since 9th November 2020. For 2020-21, the bandings for the Chief Executive Officer's total salary and pension related benefits were £275,000 - £280,000.

e Brendan Ryan's remuneration includes clinical-related payments of £6,408 up to 30th June 2020. On that date Mr Ryan retired, returning to the Trust with reduced duties and no clinical commitments.

f Patricia Cavanagh's remuneration increased in November 2020 to reflect increased responsibilities from that date.

g Sue Toal joined the Trust on a secondment agreement from Stockport NHS Foundation Trust on 14th December 2020. The remuneration stated above is the Trust's share of her remuneration for the period.

27. Total Pension Entitlement

Information for the year ended 31st March 2021

	Real Increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 31 March 2021	Lump sum at pension age related to accrued pension at 31 March 2021	Cash equivalent transfer value at 1st April 2021	Real Increase/ (decrease) in cash equivalent transfer value	Cash equivalent transfer value at 31st March 2020
	Band of £2,500	Band of £,2500	Band of £5,000	Band of £5,000	£000's	£000's	£000's
Amanda Bromley	0-2.5	0-2.5	35-40	75-80	633	26	583
Patricia Cavanagh	5-7.5	12.5-15	60-65	160-165	1,373	141	1,192
Karen James	5-7.5	15-17.5	80-85	250-255	2,062	138	1,865
Brendan Ryan	0-2.5	0-2.5	75-80	230-235	0	0	0
Sam Simpson	2.5-5	0-2.5	45-50	100-105	894	38	823
Peter Weller	0-2.5	2.5-5	40-45	125-130	925	38	856

Notes

i During the year, Brendan Ryan retired and started to take benefits from the pension scheme.

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

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

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

v The rules for the operation of the NHS Pension Scheme are set by HM Ministers under the relevant legislation. In 2015, Ministers amended the Pension Scheme Regulations to provide for a move from final salary provision to Career-Average provision, with transitional arrangements that enabled those in the final salary section to continue to accrue on that basis.
In the case of *The Lord Chancellor & Another v McCloud and others; The Home Secretary, the Welsh Ministers and others v Sargeant and others* [2018] EWCA Civ 2844, the Court of Appeal affirmed decisions of the Employment Appeals Tribunal that the relevant provisions in the pensions schemes for judicial officers and firefighters were unlawful as giving rise to age discrimination, contrary to the Equality Act 2010. It has been accepted that the relevant provisions in the NHS Pension Schemes suffer from the same defect. Since that judgement (and the subsequent refusal of leave to appeal to the UK Supreme Court), HM Government has been considering the appropriate response to these matters; and have indicated that a consultation will be held later in 2020. It is not possible at this stage to give any view as to the possible impacts of changes that might be proposed.

However, the policy of HM Government is that NHS employers and employees overall must meet the costs of the NHS Pension Scheme, without resort to Exchequer funds; and there is therefore a risk that the liabilities of the Trust for pensions, both in payment and accruing, could be increased as a result of this judgement. The figures in the above table are provided by NHS Pensions, who have not made any adjustments for the possible changes required as a result of the Court of Appeal's judgement.

28. Fair Pay multiple

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

    28.2. The mid-point of the banded remuneration of the highest-paid Director in the Trust (Trish Cavanagh, Deputy Chief Executive) in the financial year 2020-2021 was £132,500 (financial year 2019-2020- £177,500). This was 5.94 times the median remuneration of the workforce, which was £22,309 (financial year 2019-2020- 7.44 times the median remuneration of £23,864).

    28.3. In 2020-2021, no employees received remuneration in excess of that paid to the highest-paid Director (2019-2020- two employees, ranging between £206,792 to £226,899).

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

29. Payments for loss of office

    29.1. During the 2020-2021 financial year, no Director received compensation for loss of office (2019-2020- none).

30. Payments to past senior managers

    30.1. During the 2020-2021 financial year, no payments have been made by the Trust to individuals who were previously Directors.

Karen James
Chief Executive
9th June, 2021

Staff Report

31. Introduction

31.1. Unsurprisingly during this year the COVID-19 pandemic was the main driver of workforce demand and subsequent workforce supply solutions, identified training needs and training delivery, and increased staff support needs which were provided in a multitude of ways.

31.2. The early part of the year saw a rapidly increasing absence rate, which has continued at a higher level than in previous years, coupled with an increased workforce supply need due to additional roles being required as a response to the pandemic. This led to a significant, successful recruitment drive to bolster the workforce as well as sourcing additional workers through NHS Professionals and approved recruitment agencies.

31.3. The pandemic also led to rapid changes to the way day-to-day working practices were carried out, and where. Virtual meetings, increased homeworking and more flexibility became the new normal. These required new support mechanisms for staff, where social and work isolation can become a problem.

31.4. The Trust's staff responded magnificently to the pandemic and the necessarily changed work requirements. In some areas whole services were suspended and staff redeployed to undertake vastly different roles in support of the clinical response. This was done with the minimum of fuss and credit must be paid to the professionalism and flexibility of the workforce. This flexibility has continued throughout the year as demand for COVID-19 medical services has fluctuated, necessitating regularly changed clinical services and subsequent workforce needs.

31.5. In the second half of the year the Trust has been the lead employer for the Greater Manchester Mass Vaccination Centre, with around 650 additional employees recruited to provide support to the vaccination effort. This is a mix of existing NHS staff providing additional work and many new to the NHS employees joining the centre, with the programme being led overall by Salford NHS Foundation Trust. The Trust has established a specific "Bank" of staff and use of volunteers to staff the Vaccination Centre, which has separate financial and contractual arrangements from the Trust's other services. This has been a significant, but successful challenge in recruiting, training and deploying a large number of staff and volunteers within a tight timescale.

31.6. During the pandemic the Trust followed NHS Employers guidance in relation to mandatory and statutory training, this focussed provision for new starters and transferees predominantly. The organisation additionally prioritised training existing staff who needed to refresh their competency, if there were concerns that they had lapsed in the skill and used a risk-based rationale.

31.7. The advent of the COVID pandemic required the Trust to review the way in which it delivered the content of training courses and programmes which saw a move away from classroom delivery to e-Learning/virtual programmes which staff could access through work or personal IT devices at a time to suit them. The organisation also trialled blended-learning models such as the use of video-conferencing and the assessment and sign off of a specific skill in-situ. Where training could only be delivered in a classroom setting, this was undertaken in an environment where social distancing was maximised and where course trainers and participants wore

personal protective equipment (PPE) commensurate to the guidance at any given stage.

31.8. The organisation has continued to offer essential training to staff during the last 12 months utilising blended learning methods. Whilst apprenticeship learning was initially put on hold to release staff to focus on the pandemic, a few months later this was reinstated and continues to date. Undergraduate and postgraduate medical teaching has continued to be facilitated mainly via online teaching sessions, with some limited classroom simulation.

31.9. We launched a new provision of functional skills training (GCSE Maths and English) for staff and volunteers, with different options to access this content to ensure that staff could top-up their qualifications. These qualifications are essential for anyone wishing to pursue an apprenticeship.

31.10. We were proud to establish the ASPIRE Leadership Programme during this period, which is aimed at senior leaders. The content was designed to support those leaders during the pandemic and beyond providing insight tools about themselves, their teams and included coaching and action learning sets.

31.11. The organisation as Lead Employer for the GM Vaccination site was also involved in delivering education and training the staff employed to work at the GM Vaccination Centre, such training included immunisation & vaccination training as well as the provision of e-learning COVID modules and mandatory training such as Basic Life Support.

31.12. In July 2020 “We Are The NHS: People Plan for 2020/21” was published with a focus on ‘Looking After Our People’. In 2020-2021 we established and promoted a number of wellbeing interventions for staff including wellbeing apps, the Greater Manchester resilience hub, wobble rooms for staff, our Employee Assistance Programme and national assistance helplines.

31.13. Outside of the pandemic response, the Trust has been working to address underlying workforce shortages within certain staff groups, due to national and international deficits within those professional groups. In this year we have successfully recruited and deployed 35 international nurses from India and are currently in the process of recruiting a further 30 nurses who will hopefully join the workforce in the next financial year. This is expected to leave the Trust at or near zero nurse vacancies.

31.14. This year has also seen collaboration with NHS England in relation to our healthcare support workforce with a plan to recruit to all vacancies and also maintain no vacancies for this staff group.

32. Analysis of average staff costs and numbers

32.1. Total staff costs 2020-2021

	TOTAL £000’s	**Permanent** £000’s	**Other** £000’s
Medical and dental	**52,747**	39,466	13,281
Administration and estates	**29,767**	27,451	2,316
Healthcare assistants and other support staff	**26,755**	22,000	4,755

	TOTAL £000's	Permanent £000's	Other £000's
Nursing, midwifery and health visiting staff	**59,822**	50,436	9,386
Nursing, midwifery and health visiting learners	**0**	0	0
Scientific, therapeutic and technical staff	**17,708**	16,267	1,441
Healthcare science staff	**6,119**	5,933	186

32.2. Average Whole-Time Equivalents 2020-2021

	Total	Permanent	Other
Medical and dental	**409**	335	74
Administration and estates	**814**	773	41
Healthcare assistants and other support staff	**962**	811	151
Nursing, midwifery and health visiting staff	**1281**	1117	164
Nursing, midwifery and health visiting learners	**0**	0	0
Scientific, therapeutic and technical staff	**407**	397	10
Healthcare science staff	**144**	142	2

32.3. Gender Balance

	Female	Male
Directors	5	6
Other senior managers [4]	2	6
Employees as a whole	3,203	780

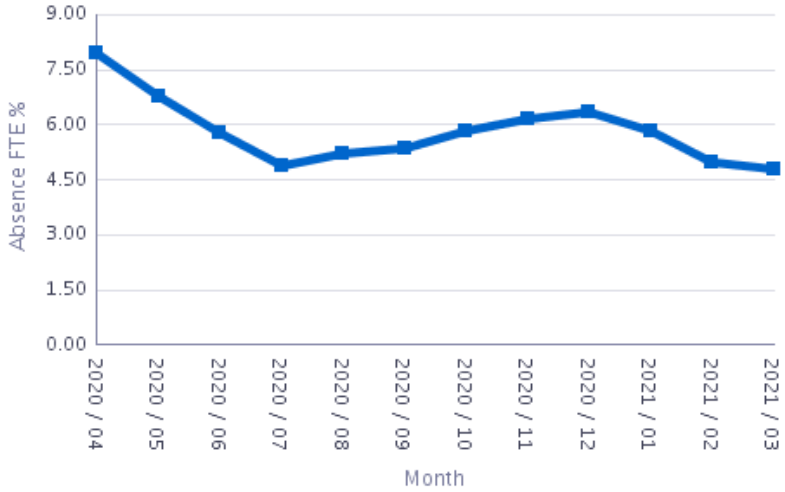
33. Gender Pay Gap

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

34. Sickness absence data

34.1. The Trust's sickness absence rates are shown below-

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



Month	Absence FTE %	Absence FTE	Available FTE
2020 / 04	7.94%	8,358.09	105,279.36
2020 / 05	6.78%	7,488.24	110,494.73
2020 / 06	5.79%	6,254.17	107,975.31
2020 / 07	4.89%	5,442.34	111,247.52
2020 / 08	5.22%	5,751.33	110,242.12
2020 / 09	5.34%	5,644.96	105,663.69
2020 / 10	5.84%	6,380.49	109,187.35
2020 / 11	6.16%	6,522.21	105,964.53
2020 / 12	6.34%	6,931.87	109,381.39
2021 / 01	5.83%	6,375.80	109,433.63
2021 / 02	4.96%	4,939.17	99,572.90
2021 / 03	4.79%	5,307.96	110,708.54

35. Staff policies, and actions to implement them

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

35.2. The Trust encourages dialogue from our employees and Trade Union members to improve our recruitment and employment processes. The Trust has in place a formal monthly Staff Partnership Forum with our Trade Union representatives, Staff Governors and senior managers. A Joint Local Negotiating Committee takes place every two months with representatives of the British Medical Association to facilitate similar discussions with our medical staff; both forums enable two-way

communication with our Trade Union colleagues. In addition we also have a monthly meeting with the Trade Unions within the health & social care economy to facilitate the exchange of information across three organisations (the Trust, the Clinical Commissioning Group and Tameside Council) given the level of integration taking place. There are also regular informal meetings with the representatives of the Trust's employees. During the COVID pandemic this dialogue was maintained via short weekly update meetings and frequent email and phone contact between HR and their local Trades Union colleagues.

35.3. The Trust has developed three staff networks, the Disability and Wellbeing Network (DAWN) for staff who have a long term condition/disability, Lesbian, Gay, Bisexual, Trans and Queer LBGTQ+ Network and the Staff Inclusion Race Empowerment Network (SIREN) for our BAME colleagues. The newly appointed network chairs are invited to the Staff Partnership Forum to share the work of the network with Trades Union colleagues, to receive Trust wide information and be a party to the negation and consultative framework within the Trust.

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

35.4.1. Temporary Staffing Policy
35.4.2. Rostering Policy
35.4.3. Locum Booking Policy
35.4.4. Sickness Management Policy
35.4.5. Social Media Policy

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

35.6. There are a number of informal methods that staff can use to obtain information about the development of the Trust, and raise any concerns or suggestions for improvement. Due to the COVID pandemic, Team Brief has been developed using a digital animation which can be posted via email and on social media. A range of additional communication methods are in place, including a Silver Command Briefing to keep employees up-to date with the COVID pandemic guidance, processes and required communication, in addition to the weekly digest to complement the *Catch Up with Karen* weekly e-mail circular; and use of social media, including Twitter, Instagram and a Staff Facebook group.

35.7. The Trust has a Freedom to Speak Up Guardian, who is vital to ensuring a culture where staff can speak up freely and openly without suffering any detriment. The Guardian reports to Board on a regular basis, participates in the Trust induction programme for staff and junior doctors, and provides training sessions. He has direct access to a designated Non-Executive lead, in line with the national guidance: and also direct access to both the Trust Chair and the Chief Executive. The previous Freedom to Speak Up Guardian left the Trust at the end of the year, and the Trust has jointly recruited a successor with Stockport NHS Foundation Trust.

35.8. As a Foundation Trust, staff have formal representation in the governance of the Trust, through the election of Staff Governors to Council. All staff are represented by

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

36. Occupational Health and Safety

36.1. The Trust has an in-house Occupational Health service, and an occupational health representative attends the meetings of the Health & Safety Committee and of the Infection Prevention and Control Committee. The Trust also has an employee assistance programme, which is a telephone support line available to staff at all times. The service is in addition to the current support functions but provides wider accessibility and support to our staff. Further mental health support during the COVID pandemic has been available via the Greater Manchester Resilience Hub, which has been promoted extensively within the Trust.

36.2. The Health and Safety Committee would ordinarily meet on a quarterly basis to provide a forum for Directors, senior managers & leads, Trade Union representatives, senior buyers, and a diverse range of clinical colleagues to discuss any health & safety concerns. Due to COVID-19 the meetings did not take place with the usual regularity. The committee works to help promote a positive health and safety culture across the Trust, and to ensure a safe place of work and system of work is provided to all staff. These meetings will now be re-established.

36.3. A programme of inspections was undertaken in relation to COVID health and safety across the Trust. Environmental inspections took place using a template risk assessment document which was devised to enable a COVID risk assessment to take place. The template enabled the assessment of social distancing to ensure workplace environments were COVID secure minimising the risk to our staff and patients. These inspections were discussed at Executive Gold Command meetings to ensure the recommendations were enacted. These inspections were undertaken by Trust managers and Trade Union health and safety representatives.

36.4. The table below illustrates the top staff (Health & Safety) incidents that were reported between April 2020 and March 2021-

Staff Incidents	
Physical Assaults on Staff	64
Accidental Injury - Staff To Self	62
Slips/Trips/Falls	53
Inoculation Injury	44
Non-physical assault on staff	29
Accidental Injury – Patient to staff	17

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

36.6. In December 2020 NHS England and NHS Improvement published the Violence Prevention and Reduction Standard, which provides a risk-based framework that

supports a safe and secure working environment for NHS staff. Work is currently ongoing in assessing the organisation practices against this standard, and identifying any areas where change may be required.

37. Expenditure on Consultancy

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

38. Diversity and Inclusion policies, initiatives and longer term ambitions

38.1. We recognise that Equality, Diversity and Inclusion (EDI) is the building block for compassionate care. With the Trust EDI strategy therefore, we have an aspiration to ensure that EDI is at the heart of everything we do. We believe that the EDI agenda is critical to building a future proof workforce that is truly reflective of the diverse communities we serve. We also believe that in building a diverse workforce, we will increase the talent pool from which we recruit and build services that are responsive to the needs of the local community.

38.2. Our strategy was developed utilising robust data sets from the NHS Staff Survey results, the evidence contained within our Workforce Race Equality Scheme (WRES) and Workforce Disability Equality Scheme (WDES). The strategy was developed in consultation with stakeholders which included the Trust's senior leaders, staff from within the ICFT and wider health and care system, the voluntary and community sector, and our patients and public from across Tameside and Glossop who were also asked to contribute their views to what an EDI Strategy should consider and respond to over the 3 year lifespan of the Strategy.

38.3. The Trust has used a variety of measures to identify inequalities, and potential barriers to improving the diversity of our workforce, including the staff survey, the WRES, the WDES, The NHS Equality Delivery System and the publication of an annual equality monitoring report.

38.4. Our approach has set ambitious targets in terms of increasing representation across a variety of levels within the organisation:

38.5. For leadership diversity**:**

38.5.1. Increasing the proportion of BAME staff across leadership positions:

- non-clinical: from 4% to target 8%
- clinical: from 12% to target 20%

38.5.2. Increasing the proportion of disabled staff across leadership positions:

- non-clinical: from 0% to target 5%
- clinical: from 0% to target 5%
- Increased BAME representation on our Board by 15%

38.6. For workforce diversity:

38.6.1. Increasing the proportion of BAME staff in entry level positions:

- non-clinical: from 7% to target 10%
- clinical: from 11% to target 15%

38.6.2. Increasing the proportion of disabled staff in entry level positions:

- non-clinical: from 3% to target 7%
- clinical: from 4% to target 7%

38.7. During the last year, our activities in this area have included**:**

38.7.1. We have created staff equality networks for BAME staff, disabled staff and Lesbian, Gay, Bisexual and Transexual (LGBT) staff. The networks are an opportunity for staff from particular groups to share experiences, contribute to policy development and provide an environment for peer to peer support. Each of the staff networks is represented on the Trust Staff Partnership Forum.

38.7.2. We have developed relationships with local organisations including Step into Health, the Department for Work and Pensions, Pluss and the Job Centre: to support people into employment and ensuring our vacancies reach a diverse audience.

38.7.3. We have developed a training programme to enable inclusive recruitment practice that addresses unconscious bias; and revised the manager's job description and person specification template for Bands 5 and above, to reflect our commitment to recruiting for diversity and inclusion.

38.7.4. We have created a standard operating procedure for recruitment to Senior Nurse positions, with a focus on inclusion.

38.8. In the year ahead, the Trust is committed to**:**

38.8.1. Delivering positive action, through the establishment of internal diverse talent pools to support opportunities for under-represented staff to achieve positive promotion outcomes.

38.8.2. Continue to support those events which help to raise awareness of societal and structural inequality such as Pride, Black History Month, International Women's day and the International Day of Disabled People.

38.8.3. Review the effectiveness of our career development sessions for BAME staff in addressing levels of under-representation.

38.8.4. Roll out a reverse mentoring programme, matching suitable mentors and mentees across the organisation.

38.8.5. Continue to build an equality educational programme of Masterclasses to build staff and manager EDI competence.

39. Gender Pay Gap

39.1. In comparison to 2019, the overall gender pay gaps based on mean hourly rates of pay including medical and non-medical hourly rates of pay has remained largely unchanged. The 2020 mean pay gap is 28.2% compared to 28.6% in the previous year. This gap remains largely driven by the differential proportions of staff in the medical and dental workforce.

39.2. For the majority of the workforce (on Agenda for Change pay scales), the mean pay gap is small, and falling, at 2.9% for 2020 compared to 3.9% in 2019. This compares to a whole UK economy gender pay gap of 15.5%

39.3. The Trust is committed to continuing to reduce the gender pay gap for the workforce overall, as well as the gender pay gap within our medical workforce. Our actions to achieve this are set out in our annual gender pay gap report, and will be monitored by the Trust's Workforce Committee.

40. Trade Union Facility Time

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

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

No of employees who were relevant union officials during the period	Full-time equivalent employee number
12	10.5

40.3. Table 2: Percentage of time spent on facility time

Percentage of time	Number of employees
0%	0
1-50%	10
51-99%	2
100%	Nil

40.4. Table 3: Percentage of pay bill spent on facility time

Total cost of facility time	£27,773.34
Total pay bill	163,494,029.27
% of total pay bill spent on facility time	0.017%

40.5. Table 4: Paid trade union activities

Total paid facility and union time hours	1,972

Staff Survey 2020

41. Overview

41.1. Staff experience sits at the very heart of safe and quality focused patient care. Employee engagement has been identified by the NHS 10 year plan and its accompanying People Plan as a key driver to success.

41.2. The Trust is committed to engagement with all of our staff, and has a number of formal and informal arrangements in place to support this aim. In addition, a range of communication mechanisms are in place to facilitate the provision of information; these include a weekly email out to all staff, monthly team brief, a Trust closed Facebook page just for staff, a Trust-wide Health and Wellbeing newsletter and a range of social media channels.

41.3. 2020 has not been “business as usual” for the NHS workforce. The NHS has never before experienced a year like this one. However, it remains vital that we understand the unique impact on staff experience during the COVID-19 pandemic.

41.4. In addition to the annual NHS staff survey, throughout 2020, the Trust utilised the monthly NHS Pulse Survey to provide an ongoing ‘temperature check’ of how staff were coping during the pandemic. Throughout 2021, we will continue to utilise the pulse survey as a way to engage with the Trust workforce.

42. Summary of Performance

42.1. The 2020 NHS Staff Survey was completed from September to November 2020. The results are presented as themes from the questions asked within the survey, and in the context of the best, average and worst results for similar organisations where appropriate. The results for this Trust are benchmarked against 128 other organisations within the Combined Acute and Acute & Community Trust category.

42.2. During 2020, the Trust undertook a full census with the survey being sent to all staff to complete. The table below shows the scores across each of the survey themes, compared to the results for the previous 2 years, and benchmarked national averages.

	2020		**2019**		**2018**	
	Trust	**National average**	**Trust**	**National average**	**Trust**	**National average**
Equality, diversity and inclusion	9.0	9.1	9.1	9.2	9.1	9.2
Health and wellbeing	5.9	6.1	5.9	6.0	5.9	5.9
Immediate managers	6.7	6.8	6.8	6.9	6.8	6.8
Morale	5.9	6.2	6.1	6.2	6.1	6.2
Quality of appraisals			5.5	5.5	5.4	5.4
Quality of care	7.4	7.5	7.6	7.5	7.6	7.4
Safe environment-bullying and harassment	8.0	8.1	8.1	8.2	7.9	8.1
Safe environment-violence	9.5	9.5	9.5	9.5	9.5	9.5
Safety Culture	6.5	6.8	6.8	6.8	6.6	6.7

	2020		2019		2018	
	Trust	**National average**	**Trust**	**National average**	**Trust**	**National average**
Staff Engagement	6.8	7.0	7.0	7.0	7.1	7.0
Team working	6.2	6.5	6.6	6.6	6.6	6.6

43. Our Plans to Improve

43.1. Based on the outcomes of the Staff Survey for 2020, the Trust has committed to taking specific steps to deliver a positive trajectory for improvement in staff experience. To achieve this, the Trust has triangulated staff survey results with wider data sources drawn from -

43.1.1. The national Workforce Race Equality Scheme (WRES)
43.1.2. The national Workforce Disability Equality Scheme (WDES)
43.1.3. The feedback through the General Medical Council's survey of our junior doctor colleagues;

to inform the thinking and design work behind any action planning undertaken.

43.2. The Trust approved its Equality, Diversity and Inclusion Strategy and there is an ambitious work programme aimed at improving the experience our staff receive. The work programme includes:

43.2.1. Promoting equality of opportunity in career progression /promotion for minority groups of staff. To this end, the Trust has launched career development workshops for BAME staff, we have undertaken reviews of our recruitment and selection processes and developed appropriate training in relation to inclusive recruitment. Our annual equality monitoring report, and submissions to the WRES and WDES will be used to monitor progress in this area.
43.2.2. Working with our DAWN network to develop manager capability to provide reasonable adjustments for disabled colleagues. In addition, we are working with our network to realise our ambition of achieving Level 3 of the Government 'Disability-confident' standard.
43.2.3. Our three staff networks each have two co-chairs, and those individuals are invited to the Trust's Staff Partnership Forum to aid wider discussion and partnership working on Trust related issues
43.2.4. Roll out reverse mentoring.
43.2.5. The Trust's Health & Wellbeing Strategy was approved during 2020, and a key focus will be providing support to staff post COVID, addressing the increase in work-induced musculoskeletal injuries. As a part of our Sustainable Management Development Plan, we plan to ensure our estate and equipment is reviewed against the needs of an ageing workforce.
43.2.6. The workplace environment is vital in ensuring staff health & wellbeing, we have been developing a Trust-wide environment and wellbeing audit, to assess staff areas in order to recognise and share good practice, and to identify any areas that do not meet the required standards.
43.2.7. A Trust-wide health and wellbeing 'booklet' has been designed to signpost all staff, and in particular those staff without routine access to digital resources, to the health and wellbeing offers available to them.
43.2.8. Helping staff recover from the global COVID pandemic is vitally important. The development of support will be undertaken in partnership with staff,

through engagement surveys to establish which offers were most valued by colleagues.

43.2.9. Working with clinical teams on the development of flexible working pilots with the aim of increasing flexible working opportunities for staff across the Trust where possible.

43.2.10. We also plan to address incivility in the workplace by linking in with the 'Civility saves lives' programme, which is expected to be rolled out in 2021.

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

High Off-Payroll arrangements

44. Policy towards ‘off-payroll’ arrangements

44.1. The Trust recognises that, on occasion, it is necessary to use the services of individuals who are only available as self-employed/ contractors ('off-payroll'). This may reflect particular market sectors, or the choice of individuals on how to structure their careers. Equally, the Trust is fully supportive of the principle that the NHS that it is not used to support aggressive tax avoidance practices, or practices that are questionable in terms of the tax effects.

44.2. The Trust will only utilise individuals on an 'off-payroll' basis on an exceptional basis, usually where the structure of the market means that individuals with the necessary skills and experience are not available on an employed basis. We will require all individuals to confirm, and if appropriate to evidence, that they are eligible to be paid gross and account for their own tax to HMRC, rather than being within 'Pay-As-You-Earn' arrangements operated through payroll.

45. Existing arrangements at March 2021

45.1. This table reflects 'off-payroll' arrangements that are in place at the 31st March, 2021; and paid more than £245 per day.

Number of existing engagements at the 31st March, 2020	35
The number of those engagements-	
• That have existed for less than a year	33
• That have existed for between one and two years	0
• That have existed for between two and three years	2
• That have existed for between three and four years	0
• That have existed for four years or longer	0

46. New engagements in the year

46.1. This table reflects new 'off-payroll' engagements made between 1st April 2020 and 31st March 2021 that paid more than £245 per day.

Number of off payroll workers engaged during the year ended 31st March 2021	340
Of which	
The number assessed as within the scope of IR35	0
The number assessed as not within the scope of IR35	340
Number of engagements reassessed for consistency/assurance purposes during the year	0
Of which- number of engagements that saw a change to IR35 status following the consistency review	0
Number of engagements where the status was disputed under the provisions of the off-payroll legislation	0

Of which: number of engagement that saw a change to IR35 status following review	0

47. Board members and those with significant responsibility

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

Number of Directors, or senior staff with significant financial responsibility, who were engaged on an 'off-payroll' basis during the year	Nil
Total number of individuals who were Directors, or senior staff with significant financial responsibility, during the course of the year[5]	13

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

Exit Payments

48. Overview

48.1. In 2020-2021, the Trust used one exit payment package. This was a compulsory redundancy following a re-structure of a corporate service. Careful consideration was given as to whether this was the appropriate way to proceed, and it was considered that the interests of the Trust and the service would be best supported by utilising this arrangement.

49. Staff Exit Packages

	Number of compulsory redundancies		Number of other departures agreed		Total number of exit packages by cost band	
	2020-21	2019-20	2020-21	2019-20	2020-21	2019-20
Less than £10,000	0	0	0	1	0	1
£10,001 to £25,000	0	0	0	1	0	1
£25,001 to £50,000	0	0	0	0	0	0
£50,001 to £100,000	0	0	0	0	0	0
£100,001 to £150,000	1	0	0	0	1	0
£150,001 to £200,000	0	0	0	0	0	0
Total number of exit packages by type	1	0	0	2		

50. Non-Compulsory departure payments

	Number of agreements		Total value of agreements (£'000's)	
	2020-21	2019-20	2020-21	2019-20
Voluntary redundancies, including early retirement- contract costs	0	0	0	0
Mutually-agreed resignations- contract costs	0	2	0	65
Early retirements in the interests of the efficiency of the service- contract costs	0	0	0	0
Contractual payments in lieu of notice period	0	0	0	0
Exit payments following Employment Tribunals or Court orders	0	0	0	0
Non-contractual payments, requiring approval of Her Majesty's Treasury [6]	0	0	0	0
Total	0	2	0	65

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

	Number of agreements		Total value of agreements (£'000's)	
	2020-21	2019-20	2020-21	2019-20
Of which: non-contractual payments requiring Treasury approval, made to individuals, where the payment value was more than 12 months' annual salary	0	0	0	0

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

50.2. The Remuneration Report on page 17 provides more detail on exit payments made to individuals named in that report (Directors, former Directors and other senior managers).

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

	2020-21(£)	2019-20 (£)
Maximum	Nil	Nil
Median	Nil	Nil
Minimum	Nil	Nil

Director’s Biographies

Fara Arshad, Non-Executive Director

Fara's career has been spent as a Research Scientist in the private sector and academia in the UK and Europe. She has worked at several leading universities, heading research groups focused on Artificial Intelligence and its applications to education and healthcare. She has led research in applied computing R&D and evaluation including multidisciplinary work with industry, the NHS and its partners on strategic IT transformations leading to measurable benefits for users and organisations.

Recently retiring as the head of a university health informatics centre, Fara decided to retrain as a counsellor (supporting a school and a women’s charity as a volunteer and, provides communication support for Stroke survivors). She has served on Primary Care NHS Boards, gaining extensive experience of NHS governance.

Fara is Chair of the Charitable Funds Committee, and serves on the Audit, Finance and Nomination & Remuneration committees. She is the lead NED for Safeguarding, Women’s and Children’s Voice, and Innovation & Technology.

Sallie Bridgen, Non-Executive Director

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

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

Trish Cavanagh, Deputy Chief Executive

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

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

David Curtis MBE, Non-Executive Director

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

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

Karen James OBE, Chief Executive and Accounting Officer

Karen James joined the Trust in 2014, following a successful career in the NHS. Having started her career as a Registered Nurse, she has over the last fourteen years held a number of executive leadership roles in large acute tertiary providers. Karen has significant experience in managing large scale change across complex economies, and has been successful in the delivery of improvements in organisational performance. During the year, she took on the role of Chief Executive for Stockport Foundation Trust, whilst remaining the Chief Executive of this Trust.

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

Andrew Light, Non-Executive Director

Andrew is a Chartered Management Accountant with over 30 years' experience in the private sector.

After graduate training and early roles gaining broad accounting experience Andrew enjoyed a 15 year career with Associated British Foods plc and progressed to his first Finance Director role with them. He joined Warburtons Limited in 2006 as Finance Director. The role has developed and broadened and became established for the first time on the family Board of the business in 2014 with Andrew as CFO.

Andrew has begun to relinquish some of his responsibilities at Warburtons in order to enable him to continue as a volunteer NED on the Board of England Squash and take on the role at the Trust.

Andrew is the Chair of the Audit Committee, and sits on the Finance and committees. Andrew's role also includes being the lead NED for EPRR, Health and Wellbeing, and Counter Fraud.

Jane McCall, Chair

Appointed as Trust Chair in January 2018, Jane has significant experience as a Non-Executive Director in the NHS, including at Stockport Foundation Trust and University Hospitals of South Manchester Foundation Trust; the latter as Deputy Chair. Her background is in social housing.

In addition to her role with the Trust, she is the Chair of Peaks and Plains Housing Trust, a social housing provider based in Macclesfield, and a Non-Executive with the Information Commissioner's Office.

Jane is the Chair of the Board and of the Council of Governors. She also chairs the Nomination and Remuneration Committee of the Board, and serves on the Council's Nomination and Remuneration Committee.

Brendan Ryan, Medical Director

	Brendan joined the Trust in 2014, having been Medical Director, and Consultant in Emergency Medicine, at the University Hospitals of South Manchester Trust for the previous 14 years. Brendan leads on professional medical issues, and serves on the Quality & Governance and Workforce committees. He is the Trust's Caldicott Guardian, Responsible Officer for Medical Revalidation, Director of R&D, and Executive lead for patient safety. Brendan chairs a number of Trust groups, including Patient Safety, Executive Procurement Group, Digital Care Board, and the R&D Committee.
	**Sam Simpson, Finance Director** Sam joined the Trust in June 2018 and has worked in the NHS for over 25 years since joining the North West Financial Management Training Scheme. Sam has held senior finance roles in commissioner, provider and strategic health authority; and prior to joining the Trust, Sam was the Director of Finance for the Cheshire & Merseyside Sustainability Transformation Partnership. Sam spent two years at Greater Manchester Police and also has experience of working in local authorities and the education sector, and is a governor of Manchester Health Academy. Sam is a member of the Finance and Charitable Funds committees, and attends the Audit Committee.
	**Martyn Taylor, Deputy Chair and Senior Independent Director** Martyn is an Associate of the Chartered Institute of Bankers, and spent his career in banking. Prior to his retirement he led risk management related to troubled firms for a major bank, with a particular focus on the North of England. He also graduated from senior management development programmes at Harvard Business School and the Wharton University in Pennsylvania. Martyn joined the Board in May 2015, and his term has been extended to April 2022. He is the Chair of the Quality and Governance Committee, and serves on the Audit and Nomination & Remuneration committees. He is the Deputy Chair and Senior Independent Director, and the lead NED for Freedom to Speak Up and Organ Donation.
	**Peter Weller, Director of Nursing and Integrated Governance** Peter has a portfolio of over 30 years' nursing experience in provider, commissioner and regulatory organisations, having held a range of clinical and managerial leadership roles. Holding an MA in Professional Practice pertaining to Patient Safety and Quality Governance, Peter re-joined the Trust from NHS Improvement, where he was Senior Clinical Lead for Greater Manchester and Lancashire, overseeing a range of NHS providers and driving improvements in governance, workforce and clinical standards. He was previously the Director of Quality Governance at the Trust. Peter leads on Nursing, AHP and Quality/ Clinical governance matters, and is a member of the Quality & Governance and Workforce committees. His role includes being the Director of Infection Prevention and Control for the Trust.

Corporate Governance

51. Introduction

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

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

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

52. Statement of the application of the Code of Governance

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

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

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

53. Explanations for areas of non-compliance with the Code

53.1. During the year, the Council of Governors agreed to further extend the term on the Board of Martyn Taylor by one year, ending in April 2022. This will mean that Mr Taylor will have served seven consecutive years as a Director, when the Code recommends a normal limit of six years for Non-Executive Directors. Council took this decision having considered the view of the Board that giving a limited further extension to Mr Taylor would enable the Board to retain stability during a period of challenge and change, and support structured development of the Board.

The Board of Directors and Council of Governors

54. High-level overview

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

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

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

54.4. The Board of Directors meets on a regular basis, having agreed that it will meet every two months (six times a year). The Board has both a defined schedule of future business, and a list of standing agenda items to be considered at every formal meeting, in order to ensure that it is exercising appropriate governance and oversight of the activities of the Trust. In the months between the formal Board meetings, the Directors have seminar sessions to receive briefings on forthcoming developments and policy changes, and to discuss policy proposals prior to formal consideration by the Board. During the year, these were suspended in line with national guidance in responding to the COVID-19 pandemic. The Board is also supported by a comprehensive committee system, which reviews both performance and policy proposals in detail prior to Board consideration.

54.5. Under the Standing Orders of the Trust, the general powers of management of the Trust are delegated to the Chief Executive and through her to the staff operating the Trust's services, subject to the Board's decisions about reserving powers either to itself or to Board committees. Through the Standing Financial Instructions and the terms of reference for Board committees, the Board has reserved certain powers of final approval to itself or the relevant Board committees. During the year, limited changes were made to these arrangements to provide flexibility in responding to the COVID-19 pandemic.

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

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

Name	Office	Start date	Expected end of term
Fara Arshad	Non-Executive Director	February 2021	February 2024
Sallie Bridgen	Non-Executive Director	February 2017	January 2023
Trish Cavanagh	Chief Operating Officer	August 2014	N/A
David Curtis	Non-Executive Director	January 2020	January 2023
Karen James	Chief Executive	October 2014	N/A
Andrew Light	Non-Executive Director	January 2020	January 2023
Jane McCall	Trust Chair	January 2018	January 2024
Peter Noble	Non-Executive Director	February 2018	Retired February 2021
Brendan Ryan	Medical Director	October 2014	N/A
Sam Simpson	Director of Finance	June 2018	N/A
Martyn Taylor	Non-Executive Director	May 2015	April 2022
Peter Weller	Director of Nursing and Integrated Governance	February 2019	N/A

55.2. Attendance at meetings of the Board, and its Committees, was as follows. Information on the attendance of Directors at the Audit Committee can be found at page 73 and at the meetings of the Nomination and Remuneration Committee on page 21.

	Board of Directors		Finance Committee		Quality and Governance Committee		Workforce Committee	
	Attended	Possible	Attended	Possible	Attended	Possible	Attended	Possible
Fara Arshad	1	1	2	2				
Sallie Bridgen	9	9	12	13	8	10	4	5
Trish Cavanagh	7	9	5	13	2	10		
David Curtis	9	9	13	13	10	10	1	1
Karen James	9	9	2	13				
Andrew Light	9	9	12	13			5	5
Jane McCall	9	9						
Peter Noble	8	8			7	8	4	4
Brendan Ryan	8	9			8	10	4	5
Sam Simpson	9	9	12	13				
Martyn Taylor	9	9			10	10		
Peter Weller	9	9			10	10	3	5

56. Independent Non-Executive Directors

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

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

56.3. During the year, the Council of Governors decided to extend further the term of Mr Martyn Taylor as a Non-Executive Director until April 2022, at which point he will have served seven years consecutively as a Non-Executive Director. Under the guidance set out in the Code of Governance for NHS Foundation Trusts, a Non-Executive Director serving more than 6 years may be relevant to considerations of independence, having regard to the risk that independence may be eroded by a long period of service on the Board. Having considered the particular situation of Mr Taylor, including his contributions to the Board and Board committees, the Board is satisfied that he remains independent of the management of the Trust.

57. Completeness, balance and appropriateness of the Board

57.1. Details of the skills, expertise and experience of the individual Directors can be found in the biography section, on page 52.

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

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

58. Performance evaluation

58.1. The Board recognises the importance of evaluating the performance of its key governance systems; starting with the Board, running through the committees that support the Board, and including the performance of individual Directors. This reflects and builds on the expectations set out in the Code of Governance for NHS Foundation

Trusts. The Trust also has obligations under Condition FT4 of the NHS Improvement Provider Licence to ensure effective governance systems, and similar obligations under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

58.2. The latest Care Quality Commission report, received in the 2019-2020 year, gave the Trust a rating of 'Good' for the inspection strand "Is [the Trust] Well-Led?" The Board had developed plans to further improve leadership with a view to achieving an "Outstanding" rating in future inspections; these were inevitably disrupted as the Trust and the NHS responded to the COVID-19 pandemic and its exceptional demands on services. During 2021-2022, the Board intends to re-start these programmes, appropriately for the continued impacts of COVID-19, with a view to obtaining the advantages that they offer to the Trust, staff and patients.

58.3. The Board has also collectively engaged in a programme of development facilitated by Deloitte LLP, with the intention of improving areas of weakness and further developing areas of strength. The programme has included an analysis of the Board's strengths and weaknesses, both as seen by the Directors and other senior colleagues; and a programme of seminars to enable the Board to discuss performance and possible improvement in key areas, learning from best practice in other Trusts and organisations through Deloitte's extensive experience. This programme was interrupted during the 2020-2021 year, with national and regional guidance for the Board to focus on key matters only and to release time for Executive Directors where possible; the Board is now reviewing how the remaining sessions can best be taken forward.

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

59. Membership of and attendance at the Council of Governors

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

Name	**Constituency**	**Elected/ Appointed**	**End of term of office**
Wendy Brelsford	Public Audenshaw	Elected	March 2022
Nicola Bullough	Staff Clinical Support	Elected	Retired May 2021
Dorothy Cartwright	Public Stalybridge	Elected	Retired March 2020
Kailish Chand	Action Together	Appointed	
Lesley Conroy	Public Ashton	Elected	Resigned March 2021
Anne Corrie	Public Longendale	Elected	March 2022
Alec Hall	Public Mossley	Elected	December 2021
Mark Hindle	Public Hyde	Elected	May 2021

Name	Constituency	Elected/ Appointed	End of term of office
Mark Holden	Consort	Appointed	
Murtaza Husaini	Public England and Wales	Elected	March 2020
Fredrick Keizer	Public Stalybridge	Elected	Retired August 2020
Joan Kniveton	Public Droyslden	Elected	October 2023
Vernon Marshall	Public Dukinfield	Elected	November 2022
Mike McCluskey	Staff Estates and Facility	Elected	Retired April 2021
Anthony McKeown	High Peak Borough Council	Appointed	
Champak Mistry	Public Ashton	Elected	March 2022
Andrew Morgan	Staff Corporate Services	Elected	April 2024
William Moss	Public Hyde	Elected	October 2023
John Phillips	Public Hyde	Elected	Retired June 2020
Adrian Smith	Staff Medical and Urgent Care	Elected	February 2023
Gleeney Suarez	Staff Intermediate Tier and Neighbourhoods	Elected	October 2021
Lesley Surman	Public Glossop	Elected	December 2022
Raja Swaminathan	Staff Surgery	Elected	June 2021
Richard Umpleby	Public Stalybridge	Elected	October 2023
Mike Walker	Public Denton	Elected	March 2022
Brenda Warrington	Tameside Council	Appointed	
Chris Webster	Public Glossop	Elected	March 2023
Jean Wharmby	Derbyshire County Council	Appointed	
Richard Williams	Public Denton	Elected	October 2022

59.2. Following the year-end, the following new Governors were returned to serve on Council-
59.2.1. Representing Staff in Women's and Children's Services- Tina Ollerenshaw

59.3. During the year, John Phillips served as the Lead Governor until his retirement from Council in June 2020. Lesley Surman has succeeded him as the Lead Governor. Council has elected Mark Hindle as the Deputy Lead Governor.

59.4. Details of attendance at meetings of the Council of Governors can be seen in the table on page 63.

60. Membership areas

60.1. The Trust has two types of membership-
60.1.1. Public membership, open to any member of the public who is resident in England
60.1.2. Staff membership, provided automatically to all members of staff unless they choose to 'opt-out'

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

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

61.1. At 19th April 2021, the number of Members in each of the Public Constituency areas were-

Public area	Number of members
Ashton-under-Lyne	461
Audenshaw	81
Denton	219
Droylsden	136
Dukinfield	189
Glossop	229
Hyde	269
Longendale	93
Mossley	82
Stalybridge	258
Rest of England	144
Total	2,165

62. .Keeping the Directors aware of Governor and Member views

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

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

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

63.1. The Trust recognises the importance of engagement with its membership. During 2020-2021, the Council of Governors has given regular consideration to how it can improve the engagement of Governors with members, and has formed a working party to give more detailed consideration to options and report back to Council with recommendations. This work is now expected to continue into the 2021-2022 year.

63.2. During the year, the Trust has continued to provide an electronic newsletter for members, produced twice a year, with the aim of ensuring that they have key information about the Trust's activities. Members are also welcome to attend meetings of the Board and the Council, and can participate in the Annual Members' Meeting.

63.3. Members are encouraged to become involved with the engagement and consultation arrangements operated through the Patient Engagement Network with our local partners, which enables them to express their views and preferences as services are developed.

64. Contacting Governors and Directors

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

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

67. As noted earlier in the report, owing to the COVID-19 pandemic the Trust's planning process was suspended during the year. This occurred prior to Governors seeking any public views on the plan.

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

Governors

			Attended	Possible
Brelsford	Wendy	Public	3	4
Bullough	Nicola	Staff	3	4
Chand	Kailish	Partnership	2	4
Conroy	Lesley	Public	3	4
Corrie	Anne	Public	4	4
Hall	Alec	Public	4	4
Hindle	Mark	Public	3	4
Holden	Mark	Partnership	3	4
Hussaini	Mutarza	Public	0	4
Keizer	Fredrick	Public	1	1
Kniveton	Joan	Public	1	2
Marshall	Vernon	Public	3	4
McCluskey	Mike	Staff	1	4
McKeown	Anthony	Partnership	3	4
Mistry	Champak	Public	3	4
Morgan	Andrew	Staff	2	4
Moss	William	Public	0	2
Phillips	John	Public	1	1
Smith	Adrian	Staff	1	4
Suarez	Gleeny	Staff	1	4
Surman	Lesley	Public	4	4
Swaminathan	Raja	Staff	2	4
Umpleby	Richard	Public	2	2
Walker	Mike	Public	0	4
Warrington	Brenda	Partnership	4	4
Webster	Chris	Public	3	4
Wharmby	Jean	Partnership	1	4
Williams	Richard	Public	4	4

Directors

		Attended	Possible
Arshad	Fara	1	1
Bridgen	Sallie	4	4
Cavanagh	Patricia	2	4
Curtis	David	3	4
James	Karen	4	4
Light	Andrew	4	4
McCall	Jane	4	4
Noble	Peter	3	3
Ryan	Brendan	3	4
Simpson	Sam	4	4
Taylor	Martyn	4	4
Weller	Peter	1	4

The work of the Board's Committees

69. Introduction

69.1. This section outlines the work undertaken by the various committees of the Board, during the course of the year. Details of the work of the Nomination and Remuneration Committee can be found at page 22.

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

69.3. During the course of the year, with the implementation of EPRR arrangements to support the NHS during COVID-19, a command structure was introduced supporting the work of the Board and its committees. This operated at Gold (Executive), Silver (operational leadership) and Bronze (departmental) levels, in line with the EPRR guidance issued by NHS England. The Board, supported by its committees, continued to function and discharge its responsibilities throughout the period.

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

70. Structure and membership

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

70.2. Each committee is appointed by the Board of Directors, in line with the written terms of reference that the Board has approved to set out the committee's role and responsibilities. The Board appoints both Executive and Non-Executive Directors to Committees, and (in line with the Code of Governance) each committee has at least as many Non-Executive Directors as Executive Directors in membership. Details of attendance at Board committees can be seen at page 55 of this Report.

70.3. For each committee, there is a formal agenda of business, which is compiled based on a forward plan that is reviewed and updated at the end of each meeting to ensure all

relevant items are addressed. Provision is also made for extra meetings to be called if required. The agenda and papers for the committee are circulated in advance, with late papers only being allowed with the prior permission of the committee chair and where an appropriate explanation for the late provision can be given. Papers are expected to be succinct as is compatible with the committee understanding the issues and options; and should be supported by both an executive summary and any more detailed information being appended.

70.4. The performance and effectiveness of each Committee is reviewed on an annual basis, as recommended in the Code of Governance; and both committees and the Board seek to make changes to develop contributions to effective governance. Owing to the impact of COVID-19, it was not possible to complete a review in the 2020-2021 year. The Board has agreed that the committee's terms of reference should be reviewed on a three-year cycle (earlier if needed), reflecting that, whilst important frameworks, the terms of reference should enable committees, not act as unnecessary restrictions.

71. <u>The work of the Board's Committees</u>

71.1. Details of the work of the Board's Nomination and Remuneration Committee can be found in the Remuneration Report on page 17. The work of the Audit Committee is covered in detail in the section starting on page 72.

71.2. The Finance Committee has continued to meet throughout the pandemic remotely. It has focussed on maintaining grip and control of finances, while adapting to the different funding regimes put in place to manage COVID expenditure. The Committee has provided assurance to the Board, through the course of the year, on delivery of the financial plan. The committee has also been closely involved in the forward planning process, and in the potential changes being driven by the strategic change in approach nationally, with the focus for both delivery of national resources and holding to account for performance being at the ICS level.

71.3. The Workforce Committee has continued to focus on supporting the health and wellbeing of the Trust's staff. During the year, key items of consideration have included the developing Workforce Strategy; the Equality, Diversity and Inclusion Strategy; the Health & Wellbeing Strategy, and the results of the various surveys of staff opinion, including the national NHS Staff Survey and the General Medical Council (GMC) survey of junior doctors. The committee has reviewed the impact of COVID-19 on staff health and wellbeing, including absence levels, colleagues needing to shield, and support being provided to staff. The committee also reviews a dashboard to monitor key work-force related metrics, so that appropriate assurance can be provided to the Board.

71.4. The Quality and Governance Committee has been involved in the monitoring of all aspects of Trust operations that affect the quality of care provided by the Trust, and the experience of those who use our services. It is regularly updated on matters such as complaints received, serious incidents and the reviews of mortality undertaken; together with key external findings including patient survey and experience information, and findings by HM Coroner. During the year, given the restrictions imposed by COVID-19, the traditional programme of visiting areas of the hospital has been replaced by a series of 'video walkabouts', in areas selected by committee members, to provide assurance regarding the quality of care and the well-being of staff.

71.5. All of the Board's committees have regularly reviewed the actions and controls in place for the Board Assurance Framework risks that the Board has allocated to their

oversight; and have recommended to the Board changes to the BAF, or the addition of new risks, arising from their oversight work.

Audit Committee

72. Introduction to the work of the Committee

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

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

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

73. Membership and attendance

73.1. The Board appoints members of the Audit Committee, who must be Non-Executive Directors.[7] During the year, the following have served on the Audit Committee-

73.2. Andrew Light (Chair)
73.3. Peter Noble (until February 2021)
73.4. Fara Arshad (from February 2021)
73.5. Martyn Taylor

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

73.7. During the year, attendance at the meetings of the committee was as follows-

	May 2020	June 2020	July 2020	Sept 2020	Nov 2020	Feb 2021
Fara Arshad						✓
Andrew Light	✓	✓	✓	✓	✓	✓
Peter Noble	✓	✓	✓	✓	✓	
Martyn Taylor	✓	✓	✓	Apologies	✓	✓

7 See National Health Service Act 2006, Schedule 7, para 23(6)

74. Our work during the year

74.1. During the last year, the committee has continued to provide support and assurance to the Board related to the various control systems in place for the Trust. This has been undertaken mainly through the assurance work undertaken by the Internal Audit service, and which is outlined below. The committee has particularly focused on those areas identified as having the most risk as a result of the COVID-19 pandemic, leading to flexibility with the plan for the Internal Audit service during the year; our approach has been to seek assurance that Trust management recognises the issues identified, and has put in place a series of responsive actions which can reasonably be expected to resolve the issues within a reasonable time-frame.

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

75. The structure and work of Internal Audit

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

75.2. The Internal Audit service works to an annual plan which is agreed with the committee prior to the start of the year. The annual plan is constructed in consultation with the Executive team, and within a rolling overall three-year framework which is designed to ensure that all relevant areas are reviewed within that timescale. Compliance with the plan is monitored at each meeting of the committee, and committee approval is required for all changes to the plan. During the year, COVID-19 impacted on the delivery of the agreed internal audit plan, and the committee agreed changes to the plan accordingly. Sufficient reviews were undertaken to ensure that the service could issue the Head of Internal Audit opinion, which reported that there was Substantial Assurance available.

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

76. Our assessment of the external audit process

76.1. The committee will be assessing the effectiveness of the external audit process, following the completion of the audit with the issue of the auditor's report and opinion. This will then be the subject of a report to the Council of Governors in September, for consideration in association with this Annual Report and Accounts. The committee anticipates seeking assurance that the external audit process was conducted in accordance with relevant regulations, and was appropriately planned and conducted.

76.2. The fees paid for the external audit for the year ended 31st March 2021 were £65,000 exclusive of VAT.

76.3. The appointment of the external auditor is a matter for the Council of Governors, although it is advised by the committee. The external auditor is appointed through a tender process, as required by the Public Contracts Regulations 2015; to date, Council has agreed the period of appointment should be for a period of 5 years. The current appointment of the external auditor (KPMG LLP) was extended by Council by one year to October 2021, in light of the COVID-19 pandemic, with a competitive process for appointment being planned for the 2021-2022 year.

77. Other services provided by the auditors

77.1. During 2020-2021, KPMG LLP provided no non-audit services to the Trust.

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

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

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

78.1.1. Key Financial Controls (High Assurance)
78.1.2. ESR HR/ Payroll (Substantial Assurance)
78.1.3. Data Protection and Security Toolkit (no formal risk opinion)
78.1.4. Medicines Management (Substantial Assurance)
78.1.5. COVID-19 Claims (High Assurance)

78.2. As part of the planning for the external audit, the external auditor identified one significant risk, related to value for money within the financial sustainability domain. Additionally, the following standard risks were identified-

78.2.1. Valuation of land and buildings
78.2.2. Fraud from expenditure recognition
78.2.3. Fraud from revenue recognition
78.2.4. Management override of controls

78.3. The risk related to fraud from revenue recognition was considered rebutted on initial review, in line with professional auditing standards. The committee were assured that these issues were being appropriately addressed through management, and shown appropriately in the financial statements.

79. The work of the Local Counter-Fraud Service

79.1. A key part of the control systems in place at the Trust is the Local Counter-Fraud Service (LCFS), which is provided on an arms-length basis by MIAA. The service is accredited by the NHS Counter-Fraud Authority, and provides a professional support service in this area. The service is maintained in accordance with the requirements of the NHS Standard Contract.

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

79.3. During the course of the year, LCFS have reviewed 9 cases of potential fraud. A number of these have resulted in action, either to improve controls or take action against an individual. The Trust has also welcomed those referrals where no fraud was shown, as this demonstrates understanding of the importance of potential cases being reported for investigation.

NHS Oversight Framework

80. Introduction

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

80.1.1. quality of care
80.1.2. finance and use of resources
80.1.3. operational performance
80.1.4. strategic change
80.1.5. leadership and improvement capability (well-led)

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

80.3. Through the course of the year, the Trust has been in Segment 3, reflecting that the Trust was historically found to be in breach of certain licence requirements, as reflected in the Annual Governance Statement. At the date of this report, there are no outstanding actions for the Trust to take in respect of these matters; and the Trust is starting discussions with NHS Improvement as to whether it remains in breach of the licence, given its improved financial position. Current segmentation information for NHS Trusts and Foundation Trusts is published on the NHS England/ Improvement web-site.

Karen James
Chief Executive

9th June, 2021

Our Objectives for 2019/20

NHS
Tameside and Glossop Integrated Care
NHS Foundation Trust

Our Vision

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

Working with partners, we will:

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

Our Values and Behaviours

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

Accounting Officer’s responsibility statement

Statement of the Chief Executive's responsibilities as the Accounting Officer of Tameside and Glossop Integrated Care 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 Tameside and Glossop Integrated Care NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Tameside and Glossop Integrated Care NHS Foundation Trust and of its income and expenditure, 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’s Group Accounting Manual and in particular to:

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

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

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

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

Karen James
Chief Executive

9th June, 2021

Annual Governance Statement

1. Scope of responsibility

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

2. The purpose of the system of internal control

2.1. The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Tameside and Glossop Integrated Care NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Tameside and Glossop Integrated Care NHS Foundation Trust for the year ended 31st March 2021, and up to the date of approval of the Annual Report and Accounts.

3. Capacity to handle risk

3.1. The effective management of risk, and its reduction where possible, is a key priority at all levels of the Foundation Trust. It is a key component of all governance discussions, with the Board Assurance Framework being reviewed and challenged regularly at meetings of the Board of Directors and of Board committees. The Audit Committee regularly reviews and challenges the control systems underlying the management of risk in the Foundation Trust.

3.2 Operationally, risk management is led by myself and the Executive Directors, who have responsibility for the overall management and mitigation of risks within their areas of responsibility. There is a Risk Management group for the Foundation Trust, which has an operational overview of risk across the Trust to support the Board and its Committees. During the course of COVID-19 pandemic in 2020-2021, this was replaced by work undertaken through our Gold Command structure. All staff have both the opportunity and expectation of reporting all perceived risks within their area of operation, which are then subject to a process of review, validation and (if appropriate) scoring and management. Management of risk is undertaken at a level appropriate to the potential impact of the risk, including departments, divisions and on a cross-Trust basis. The Board maintains a Board Assurance Framework, reflecting the risks identified to the achievement of the Trust's strategic objectives and how they are managed. During the course of 2020-2021, this was amended to reflect the Board's assurance requirements within the architecture for managing COVID-19.

3.3 Risk management is a key part of the Trust's training for all staff, to ensure that all staff can identify and address risk within their area. Managers receive training appropriate to their grade, in order to have an appropriate oversight of risks and their management within their area, and to support more junior colleagues. Overall responsibility for ensuring that appropriate training and guidance is available sits

within the Integrated Governance Unit, who are also responsible for ensuring that reporting to the Board and Board committees is appropriate and complies with the conditions of the NHS Improvement licence related to risk management.

4. **The risk and control framework**

4.1. The Trust has adopted a formal risk management strategy, which sets out how the Trust will seek to identify, control and manage risk; this was superseded by the COVID-19 management arrangements during the pandemic. This strategy recognises that the Trust provides services that carry, in some cases, an inherently high level of risk; and seeks to manage and mitigate that risk as far as possible. At a corporate level, the strategy seeks to identify and manage the risks faced by the Trust in the local, regional and national environment, recognising that the Trust operates within a national service and within an environment which has significant political interest at all levels.

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

4.3 All staff colleagues have a responsibility to identify potential risk within their area of responsibility, and to ensure that it is evaluated and controlled. There are comprehensive policies and systems in place for the identification and management of risks at all levels, within a single framework to ensure that the evaluation of risk is consistent and reliable. Risks are managed at the level appropriate to the identified impact and likelihood of the risk eventuating, including departmental, divisional and cross-Trust structures. Due to the COVID-19 pandemic, and the consequent shift in methods of operation, the overall management of operational risks has been undertaken through the Silver and Gold Command structures within the Trust.

4.4 The Board maintains a Board Assurance Framework, which identifies the risks to achieving the strategic objectives that have been set by the Board for the Trust. Each identified risk is allocated to the oversight of a Board committee (or occasionally the Board itself), and that Committee is responsible for regular challenge to the assessment and management of the allocated risks. Details of the Board Assurance Framework are reported regularly to the Board of Directors for consideration, challenge and assessment of available assurance. During the year, the Trust has continued reviewing and revising the way that the Board Assurance Framework is presented to the Board and committees, to enable better understanding of the information presented.

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

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

the assessments for risks on the Board Assurance Framework on a regular basis. The Board annually reviews the overall approach to risk appetite, as part of assessing the strategic risks following approval of the year's corporate objectives and key success criteria.

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

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

4.7.2 The Board has appointed a Quality and Governance Committee, which is responsible to the Board for detailed oversight of management actions to ensure the quality of services; and for recommending to the Board strategic actions to improve service quality. The committee exercises detailed oversight of the quality of services provided by the Trust; including reviewing serious untoward incidents, prioritised quality performance data, and feedback from patients. The committee also regularly triangulates its findings, traditionally through scheduled 'walk-about' visits to operational areas such as wards, in order to ensure that the 'lived experience' of providing and receiving care is reflected in the information received. Owing to the necessary restrictions imposed by the COVID-19 pandemic, these have been in a video format during the course of this year. The committee reports both findings and recommendations to the Board at each Board meeting following a committee meeting, for consideration and approval. At each scheduled meeting, the Board receives an update on serious incidents that are under investigation, together with confirmation that the 'duty of candour' is being implemented for relevant incidents.

4.7.3 The Board has appointed a Workforce Committee to ensure that there is a key focus on ensuring the safety of our staff, and consideration of key workforce issues to provide safe and quality care. The committee regularly reviews performance and future strategy on workforce matters, and during the year has updated the strategy taking into account the national NHS People Plan. The Board regularly reviews information on nursing staffing on a detailed basis, together with details of new and continuing investigations where staff suspensions have been judged necessary.

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

4.8 Performance information is subject to regular review, to ensure that it is reliable and continues to meet the requirements of the Trust. Performance information produced through data systems is regularly triangulated against the 'lived experience' of care, using qualitative information from sources such as complaints and complements, national and local surveys of patients experience (including the 'Friends and Family' test), and triangulation visits from Directors and senior managers. Mismatches are challenged in a variety of forums, and it is a responsibility of the Director of Performance and IM&T to ensure that mismatches are explored to ensure that the data reporting systems remain reliable. Performance reporting systems are also subject to regular review by both the internal and external audit services.

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

4.10 Management of risk to the security of the data held by the Trust, both on patients and staff colleagues, is a key activity. Data risks are included within the overall risk management process, and regularly reviewed. A comprehensive suite of policies and procedures are in place to ensure that data is handled appropriately and with care, and these are supported by a comprehensive programme of training for staff. The Trust participates in the annual assessment of our compliance through the national Data Security and Protection Toolkit.

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

4.12 During the year, NHS England/ Improvement changed its funding arrangements so that some of the funding streams for the Trust were allocated at a Greater Manchester level; the Trust was fully involved in the discussions on allocation and the Board is satisfied that there was no significant impact on the Trust from that change. This change will be continued into the 2021-2022 year, and the Board has positive assurance about the Trust's continuing involvement in the allocation discussions.

4.13. As part of the response to the COVID-19 pandemic, the NHS nationally moved to a Level 4 incident under the Emergency Preparedness, Resilience and Response (EPRR) arrangements; with national leadership and co-ordination provided by NHS England/ Improvement and the Department of Health and Social Care. Internally, the Trust adopted a Bronze/ Silver/ Gold Command structure, with clear levels of responsibility. The Board has approved temporary changes to the Scheme of Delegation and related documents, to reflect the temporary command structure and to ensure that necessary expenditure for COVID-19 work can be approved, whilst retaining appropriate levels of control. These are regularly reviewed to ensure that they remain appropriate.

4.14. In response to the COVID-19 pandemic, the Board reviewed and revised the key strategic risks facing the Trust, identifying four key risks for inclusion on the Board Assurance Framework-

4.14.1. Are our patients safe?
4.14.2. Are our staff safe?
4.14.3. Are we using our resources effectively?
4.14.4. Are we implementing the COVID-19 and services recovery plan?

4.15. These risks have been carefully assessed, and have been regularly reviewed by the Board and its Committees to ensure that the Trust is taking all reasonable steps to mitigate and manage the risks.

4.16. In 2019, the Trust has received the outcomes of its latest inspection by the Care Quality Commission (CQC). Overall, the CQC rated the Trust as 'Good', with some areas rated as 'Outstanding'; and also gave a 'Good' rating for the strand "Is [the Trust] well-led?" The Board considered the detailed feedback in the report, and plans are in place and being delivered for further improvement.

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

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

Key risk	Mitigation
Ensuring that the Trust is a going concern (FT4.4(d))	Careful and detailed financial planning Working in partnership arrangements within the locality and regionally Continuing open dialogue with Commissioners on future direction Challenging efficiency schemes based on Model Hospital learning Close management and Board monitoring of performance against plans
Delivery of agreed business plans (FT4.4(g))	Detailed management structures to review progress and hold to account Detailed monthly reporting to governance through the Finance Committee Regular performance updates to regulators
Delivery of high-quality care within a challenging financial environment (FT4.5)	Quality Assurance mechanisms for efficiency schemes Involvement of Medical Director and Director of Nursing & Integrated Governance in financial management discussions and setting of financial plans Involvement of clinical colleagues in the development and delivery of individual efficiency schemes and business cases

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

4.20. The Board has approved a Risk Management Strategy and Policy. This sets out the high-level approach to the recognition, management and mitigation of risk in the Trust, and the relevant reporting arrangements. The Board Assurance Framework, recognising the key strategic risks faced by the Trust, is reviewed regularly by the Board, supported by detailed review of risks within their area by Board committees and oversight of control systems by the Audit Committee through engagement with other committees. Operational risks are actively managed by the Executive Directors, through the Risk Management Committee that reports directly to the Quality and Governance Committee.

4.21. During the year, the internal audit service has undertaken a review of the Board Assurance Framework, which reported that Significant Assurance was available.

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

4.22.1. The Directors are intimately involved in the governance of the Trust through their work at the Board, and also as members of the Board's committees. In reaching a conclusion on the judgements in the statement, they brought these experiences to bear, particularly those of the Non-Executive Directors who have a particular responsibility for providing challenge to proposals brought forward.

4.22.2. The skills available to the Board have been reviewed and considered as part of the process of appointing a new Non-Executive Director, and also in connection with recommendations to Council regarding the re-appointment of Non-Executive Directors reaching the end of their terms.

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

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

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

4.24.1. The Trust continues to encourage all staff, at all levels, to identify and report incidents, including 'near misses'. There is a comprehensive system in place to enable colleagues to report incidents, supported by dedicated resource that reviews all reports and identifies the appropriate level for response. Learning

from incidents is a key part of the process, and each colleague who reports an incident is entitled to a response that identifies both the response of the Trust and how learning will be taken to prevent recurrence of that type of incident. During the course of the year, the Trust has worked to make feedback to individuals from incidents more effective.

4.24.2. Similarly, there are systems in place to enable risk at all levels to be identified, from the 'shop floor' to the Board of Directors: and risks are regularly reviewed at the appropriate level. Each Board committee has responsibility for review and assessing available levels of assurance for risks within its area of responsibility, and the Board regularly reviews the Board Assurance Framework.

4.24.3. Currently each death of a patient under the care of the Trust is subject to review, under the Medical Examiner system, with the aim of identifying and sharing learning; this may be either good practice, or areas for development. There are established systems to ensure that this learning is shared and embedded across the care that the Trust provides. During the COVID-19 pandemic, the Trust temporarily reviewed only a sample of deaths, in line with guidance issued by NHS England/ Improvement; this recognised that review of all deaths during this period was unlikely to be practicable.

4.25. The development of all projects are subject to an analysis of the risks that will be involved, which may include clinical, financial, reputational or other types of risk. Part of the process of developing an acceptable business case for a project includes both the identification of these risks, and also the ways in which they can be mitigated or managed; clear identification of the irreducible level of risk; and identification of the risk appetite to measure that irreducible risk against, in terms of determining whether to proceed with the project. All significant projects, and all projects which will have impacts on clinical staffing, are subject to the Medical Director and the Director of Nursing & Integrated Governance confirming in writing that they are satisfied that there are not unacceptable risks to patient care as a result.

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

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

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

4.28.1. We have workforce governance systems in place. Reflecting national guidance and expectations, the Trust has utilised the Developing Workforce Standards to ensure we use best practice in effective staff deployment and workforce planning. We are also working to implement the recommendations in the NHS People Plan, including the appointment of a Non-Executive Director as a Well-being Guardian. The Trust is using the advice in the guidance to continuously review governance issues related to redesigning roles and responding to unplanned changes in workforce; and in the annual assessment of the effectiveness of workforce safeguards.

4.28.2. Rosters are developed in advance by the operational teams, based on agreed establishments. Staffing meetings are regularly held to look ahead, identify, and act on any changes in capacity and demand since the rosters were developed. The staffing position across the organisation is reviewed and discussed at operational meetings four times each day, so staff can be re-deployed if required, or additional temporary staff requested, to ensure safe staffing levels are maintained across all areas: and key workforce assurance markers are considered and discussed by the Executive Management Team each week. There are appropriate procedures and controls in place to ensure that, where required, additional staff can be sourced in the short-term, whilst ensuring that there is appropriate senior management or Director authorisation. Staffing levels for each area in the Trust are set as part of the annual planning process, in accordance with results from the use of any relevant evidence-based tools, triangulated with professional judgement and outcomes. These are subject to regular review through the Trust's management and governance processes, and if required establishment adjustments and proposals are considered and quality impact assessed to ensure the quality and safety of provision. During the course of the COVID-19 pandemic, the Gold, Silver and Bronze Command structure ensured continued oversight, insight and foresight into staffing and workforce issues.

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

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

Effective workforce planning	The Trust has set an establishment as part of the annual planning process, taking into account the factors mentioned in Developing Workforce Safeguards.
	The Trust seeks to minimise the use of agency staff, and has appropriate control systems in place to ensure that agency use is subject to appropriate scrutiny.
	The Board continues to maintain a strategic focus on ensuring that the Trust has a workforce that can deliver quality of care, together with oversight of delivery.
Deploying Staff Effectively	A Workforce Dashboard has been implemented, that enables the Workforce Committee to review performance and plans in detail.
	The reporting and planning arrangements in place seek to triangulate staffing against a number of other factors, including the quality of care and financial impacts.
	There is a clear allocation of time to ensure that the Board reviews, discusses and agrees actions as a result of any identified changes.
	There are standard procedures and controls in place to enable immediate challenges to be addressed appropriately.
Responding to challenges	The Executive team reviews agency use and areas of challenge on a weekly basis.
	The Board, and its Committees, regularly review the 'safe staffing' report and the underlying data, in a holistic way against other available data.

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

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

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

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

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

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

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

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

5.3. The Trust's executive leadership is also aware of the need to ensure that the provision of services meet these requirements. When considering service developments, consideration is given to how the proposals will impact on these requirements, both when proposals are being developed and considered through governance for approval. In line with regulatory requirements, efficiency is recognised through the need for quality impact approval from the Medical Director and the Director of Nursing & Integrated Governance for all significant projects. When reviewing implementation, consideration is given to how well the project or development has advanced these requirements, and where further improvements might give better achievement of them.

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

5.5. As part of their annual work, and in accordance with the requirements set out by HM Treasury and NHS England/ Improvement, the external auditors review and express an opinion on compliance with the duty to provide services that are economic, efficient and effective. This opinion is made available to the Audit Committee in draft, and is formally given to NHS Improvement. For 2020-2021, the external auditors are reporting that the Trust had adequate arrangements to secure economy, efficiency and effectiveness.

5.6. During the year, no serious incidents related to information governance were identified. No incidents were required to be notified to the Information Commissioner or the Department of Health and Social Care in accordance with the Data Security Incident Reporting Tool.

6. Data quality and governance

6.1. The Trust recognises the importance of having effective data collection and analysis, in order to understand the operation of the services and enable the Board to effectively judge what actions are needed to improve performance. The Trust has in place a number of systems for the collection of data regarding the operation of services, and these are automated where possible in order to reduce the possibility of human error. The executive team receives every week a full suite of performance

data from across the Trust, which is reviewed to identify any areas which are starting to be a concern and take immediate action to address them. The Board and its committees review a more selective set of data, which enables them to focus on the key areas of strategic performance, together with exception reporting to identify the underlying cause of underperformance and the steps being taken to bring performance back to the required standard.

6.2. The Trust has a clear policy process in place, to ensure that the care provided to patients is safe and to the highest standards. It is important, in this context, to keep in mind that the general approach is that policies should normally be followed; but that it is recognised that, in some circumstances, the professional judgement of clinical colleagues will justify a departure from policy in the individual case and for the best interests of the patient. Policies are subject to a formal process of development, approval and regular review, to ensure that they continue to reflect best practice. In respect of each patient, the policy is to provide a care plan that responds to the individual needs of the patient, with a view to ensuring that they are cared for in a way that minimises the period and impact of their condition. In appropriate cases, plans will be prepared on a multi-disciplinary basis, including colleagues from other agencies, in order to ensure that all relevant conditions are taken into account and that care is planned across agencies.

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

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

7. Review of effectiveness

7.1. As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on 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 and the Audit Committee; and a plan to address weaknesses and ensure continuous improvement of the system is in place.

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

7.3. The systems of internal control are under continuous review, in order to ensure that they continue to meet the requirements of the Trust and appropriate standards for the management of public funds. During the year, the Board approved further changes to the Standing Financial Instructions, with the intent of increasing the seniority of authorisation required for spend at a given level, reflecting a current need to increase the overall level of control applied in the Trust. The Board has also approved temporary changes in the control structure, specifically limited to spending for and the period of the COVID-19 incident, to ensure that the Trust can respond with appropriate speed whilst maintaining robust controls; and with a specified time limit to ensure that they do not continue longer than necessary for dealing with the pandemic.

7.4. The Board has overall responsibility for the operation of the Trust, the effectiveness of the systems of internal control, and for ensuring that public funds are used responsibly in the provision of services. Supported by the Board committees, the Board regularly reviews performance, both financial and operational, to ensure that the agreed plans are progressing as envisaged and that there is reasonable assurance that the targets set by the Board will be met. It also reviews issues such as patient experience, recognising that part of the control environment for an NHS provider is to ensure that patients receive the best available care and service whilst with the Trust.

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

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

7.5.2. In line with best practice, the committee regularly meets privately with the internal and external audit providers, without management attending, to obtain assurance as to the control environment in place.

7.5.3. Advice from both the internal and external audit providers on the environment in which the Trust is operating is provided to the committee on a regular basis.

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

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

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

7.7. The Quality and Governance Committee operates to provide assurance to the Board about, inter alia, the systems of control in place to ensure that the quality of patient care and experience is as high as possible. The Quality and Governance Committee regularly reviews information related to the effectiveness of the control systems, including reports about serious incidents, patient experience, and complaints related

to services. It also reviews a range of external reporting, including from HM Coroner, professional bodies, and professional regulators such as the General Medical Council and the Nursing & Midwifery Council. In its work through the course of the year, and in particular when reviewing the draft Quality Accounts for the Trust, the committee is able to assess and report to the Board on the levels of assurance available, and areas for further consideration or development.

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

7.9. The Trust retains an internal audit service provided by an external provider, Mersey Internal Audit Agency (MIAA). MIAA is an internal NHS service, provided by a partnership of Trusts. The service is provided in accordance with the relevant national standards, and the Head of Internal Audit has direct access to both the Audit Committee and myself as the Accounting Officer. MIAA undertakes a planned programme of reviews across various areas of the Trust, within the context of a three-year framework. That framework is regularly reviewed in ensure that areas for review are selected based on perceived risk and that all relevant areas are covered in the review period. The detailed annual plan is reviewed and approved by the Audit Committee.

7.10. MIAA's individual reviews are undertaken on an arm's-length basis from the Trust's management, and are reported to the Audit Committee with an assessment of the overall assurance available, actions that are recommended to improve the control environment, and an assessment of the risk levels related to those actions. The reports are accompanied by a statement by Trust management, setting out how they intend to address the report and detailed actions to be taken to improve the control environment. The Audit Committee is authorised to review the reports, and where concerned regarding the response of management may require further action or report to the Board. Agreed actions are monitored in a co-operative process between MIAA and the Governance Department; and progress reported to the committee at least every six months. For the 2020-2021 year, the Head of Internal Audit reported to the Audit Committee that there was Substantial Assurance available that that there was a good system of internal control designed to meet the organisation's objectives, and that controls were generally being applied consistently.

8. Conclusion

8.1. No significant internal control issues arose in the year ended 31st March 2021: or in the period from then to the making of this statement.

Karen James
Chief Executive

9th June, 2021

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of Tameside and Glossop Integrated Care NHS Foundation Trust ("the Trust") for the year ended 31 March 2021 which comprise the Trust Statement of Comprehensive Income, Trust Statement of Financial Position, Trust Statement of Changes in Taxpayers Equity and Trust Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2021 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the Accounts Direction issued under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006 and the Department of Health and Social Care Group Accounting Manual 2020/21.

Basis for opinion

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

Going concern

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

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

Our conclusions based on this work:

- we consider that the Directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate;
- we have not identified, and concur with the Directors' assessment that there is not a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for the going concern period.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the absence of reference to a material uncertainty in this auditor's report is not a guarantee that the Trust will continue in operation.

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

To identify risks of material misstatement due to fraud ("fraud risks") we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Audit Committee and internal audit and inspection of policy documentation as to the Trust's high-level policies and procedures to prevent and detect fraud, including the internal audit function, the counter fraud function and the Trust's channel for "whistleblowing", as well as whether they have knowledge of any actual, suspected or alleged fraud.
- Assessing the incentives for management to manipulate reported financial performance as a result of the need to achieve control totals delegated to the Trust by NHS Improvement.
- Reading Board and Audit Committee minutes.
- Using analytical procedures to identify any usual or unexpected relationships.
- Reviewing the Trust's accounting policies.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards, and taking into account possible pressures to meet delegated targets, we performed procedures to address the risk of management override of controls and the risk that Trust management may be in a position to make inappropriate accounting entries and the risk of bias in accounting estimates and judgements such as asset valuations and impairments.

On this audit we did not identify a fraud risk related to revenue recognition due to the temporary NHS funding arrangements that have been in place throughout the financial year and we don't believe there to be an incentive to manipulate other operating income streams that are material. However, in line with the guidance set out in Practice Note 10 Audit of Financial Statements of Public Sector Bodies in the United Kingdom we also recognised a fraud risk related to expenditure recognition, particularly in relation to non-NHS expenditure and non-NHS accruals between 1 October 2020 and 31 March 2021.

We did not identify any additional fraud risks.

We performed procedures including:

- Identifying journal entries to test based on risk criteria and comparing the identified entries to supporting documentation. These included journal entries posted at the end of the financial year or as post-closing entries which reduced expenditure and/or accruals that were considered outside of the normal course of business and other unusual journal characteristics.
- Assessing significant estimates for bias.
- Assessing the completeness of disclosed related party transactions and verifying they had been accurately recorded within the financial statements.
- Assessing the completeness and accuracy of recorded expenditure through specific testing of non-NHS expenditure and non-NHS accruals between periods 6 and 13.

Identifying and responding to risks of material misstatement due to non-compliance with laws and regulations

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the directors and other management (as required by auditing standards), and

discussed with the directors and other management the policies and procedures regarding compliance with laws and regulations.

As the Trust is regulated, our assessment of risks involved gaining an understanding of the control environment including the entity's procedures for complying with regulatory requirements.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

The Trust is subject to laws and regulations that directly affect the financial statements including financial reporting legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

Whilst the Trust is subject to many other laws and regulations, we did not identify any others where the consequences of non-compliance alone could have a material effect on amounts or disclosures in the financial statements.

Context of the ability of the audit to detect fraud or breaches of law or regulation

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as these may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

Other information in the Annual Report

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

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information; and
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Annual Governance Statement

We are required to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2020/21. We have nothing to report in this respect.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2020/21.

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 74, the Accounting Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity.

Auditor's responsibilities

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

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

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

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

Under the Code of Audit Practice, we are required to report if we identify any significant weaknesses in the arrangements that have been made by the Trust to secure economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

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

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

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

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

We have undertaken our review in accordance with the Code of Audit Practice and related statutory guidance having regard to whether the Trust had proper arrangements in place to ensure financial sustainability, proper governance and the use of information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice to report to you if:

- any reports to the Regulator have been made under paragraph 6 of Schedule 10 of the National Health Service Act 2006.
- any matters have been reported in the public interest under paragraph 3 of Schedule 10 of the National Health Service Act 2006 in the course of, or at the end of the audit.

We have nothing to report in these respects.

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

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

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of Tameside and Glossop Integrated Care NHS Foundation Trust for the year ended 31 March 2021 in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice.

James Boyle
for and on behalf of KPMG LLP
Chartered Accountants
1, St Peter's Square
Manchester
M2 3AE

11 June 2021

Foreword to the accounts

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

Signed 

Name **Karen James**

Position **Chief Executive**

Date **09.06.21**

Statement of Comprehensive Income

	Note	31 March 2021 £000	31 March 2020 £000
Operating income from patient care activities	3.1/3.2	241,777	220,050
Other operating income	3.4	45,129	37,607
Total operating income from continuing operations		**286,906**	**257,657**
Operating expenses	4	(281,150)	(252,210)
Operating surplus from continuing operations		**5,756**	**5,447**
Finance income	9	0	74
Finance expenses	10	(3,470)	(5,285)
Finance expenses - unwinding of discount	19	(11)	(36)
PDC dividends payable		(1,676)	0
Net finance costs		**(5,157)**	**(5,247)**
Gains from transfers by absorption		67	0
Surplus for the year		**666**	**200**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	12	(3,530)	(435)
Revaluations	12	264	5,472
Other recognised gains and losses		0	0
Other reserve movements		0	0
Total comprehensive expense for the period		**(2,600)**	**5,237**

Statement of Financial Position

	Note	31 March 2021 £000	31 March 2020 £000
Non-current assets			
Intangible assets	11	1,681	1,446
Property, plant and equipment	12	131,772	132,190
Trade and other receivables	14	8,226	7,426
Total non-current assets		**141,679**	**141,062**
Current assets			
Inventories	13	2,139	1,976
Trade and other receivables	14	6,915	21,352
Cash and cash equivalents	15	22,834	3,376
Total current assets		**31,888**	**26,704**
Current liabilities			
Trade and other payables	16	(26,093)	(22,976)
Other liabilities	17	(1,219)	(1,549)
Borrowings	18	(1,576)	(108,551)
Provisions	19	(1,747)	(320)
Total current liabilities		**(30,635)**	**(133,396)**
Total assets less current liabilities		**142,932**	**34,370**
Non-current liabilities			
Other liabilities	17	0	0
Borrowings	18	(47,666)	(49,242)
Provisions	19	(850)	(872)
Total non-current liabilities		**(48,516)**	**(50,114)**
Total assets employed		**94,416**	**(15,744)**
Financed by			
Public dividend capital	SoCIE	168,587	55,827
Revaluation reserve	SoCIE	41,128	45,539
Income and expenditure reserve	SoCIE	(115,299)	(117,110)
Total taxpayers' equity		**94,416**	**(15,744)**

The notes on pages 5 to 35 form part of these accounts.

Signed 

Name **Karen James**

Position **Chief Executive**

Date **09.06.21**

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

	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2020 - brought forward	**55,827**	**45,539**	**(117,110)**	**(15,744)**
Surplus/(deficit) for the year	0	0	666	**666**
Impact of implementing IFRS 9	0	0	0	**0**
Public dividend capital received	112,760	0	0	**112,760**
Impairments	0	(3,530)	0	**(3,530)**
Revaluations	0	264	0	**264**
Other reserve movements	0	(1,145)	1,145	**0**
Taxpayers' and others' equity at 31 March 2021	**168,587**	**41,128**	**(115,299)**	**94,416**

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

Statement of Cash Flows

	Note	31 March 2021 £000	31 March 2020 £000
Cash flows from operating activities			
Operating surplus/(deficit)	SOCI	5,756	5,447
Non-cash income and expense:			
Depreciation and amortisation	4	5,853	5,527
Impairments and reversals of impairments	4	572	(108)
Income recognised in respect of capital donations (cash and non-cash)		(907)	0
(Increase)/decrease in receivables and other assets	14	14,375	(9,397)
(Increase)/decrease in inventories	13	(163)	(408)
Increase/(decrease) in payables and other liabilities	16	2,952	(133)
Increase/(decrease) in other liabilities	17	(330)	75
Increase/(decrease) in provisions	19	1,394	409
Net cash generated from operating activities		**29,502**	**1,412**
Cash flows from investing activities			
Interest received	9	0	74
Purchase of intangible assets	11	(595)	(1,046)
Purchase of property, plant, equipment and investment property	12	(7,774)	(3,106)
Receipt of cash donations to purchase capital assets		0	0
Sales of property, plant, equipment and investment property		0	0
Net cash used in investing activities		**(8,369)**	**(4,078)**
Cash flows from financing activities			
Public dividend capital received		112,760	942
Public dividend capital repaid		0	0
Movement on loans from the Department of Health		(106,631)	9,503
Capital element of PFI, LIFT and other service concession payments		(1,512)	(1,448)
Interest paid on PFI, LIFT and other service concession obligations		(3,470)	(3,411)
Interest paid on Loans from Department of Health		(408)	(1,844)
PDC dividend paid		(2,414)	0
Net cash used in financing activities		**(1,675)**	**3,742**
Increase in cash and cash equivalents		**19,458**	**1,076**
Cash and cash equivalents at 1 April		**3,376**	**2,300**
Cash and cash equivalents transferred under absorption accounting		0	0
Cash and cash equivalents at 31 March	15	**22,834**	**3,376**

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

Note 1.1 Accounting convention
These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.2 Going concern
Accounting standard IAS 1, Presentation of Financial Statements, requires management to make an assessment of the Trust's ability to continue as a going concern. The Treasury's Financial Reporting Manual (FReM) interprets IAS 1 in such a way that the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents is normally sufficient evidence of going concern.
In respect of adopting the 'going concern' basis of accounting, Management have had regard to;

The guidance in the Annual Reporting Manual that the 'going concern' basis should be adopted if the services in question will continue to be provided, even if not by the same legal entity;

The commissioning intentions of the Tameside and Glossop CCG, and the related intentions of Tameside MBC and Derbyshire CC;
The planning discussions held at a Greater Manchester level, in the context of the national change of approach to having planning driven and activity funded and accountable at an Integrated Care System level;
The discussions being held at an NHS North-West Regional level, and nationally, regarding planning direction for the period to 31st March 2022 and beyond;
The legislative proposals announced in the Gracious Speech (11th May 2021) for NHS reform, including the statutory creation and setting of responsibilities for Integrated Care Systems; and for a statutory requirement for provider organisations to co-operate in the provision of services.

Based on these factors, and their knowledge of the performance of the Trust, Management has concluded that the services provided by the Trust can be expected to be continued for at least twelve months from the expected date of the approval of the Annual Report and Accounts. On that basis, having regard to the guidance in the Annual Reporting Manual, the adoption of the 'going concern' basis by the Board for the Annual Accounts for the year ended 31st March, 2021. Management are not aware of material uncertainties in respect of events or conditions that cast significant doubt upon the going concern ability of the Trust.

Note 1.3 Revenue from Contracts with Customers
Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

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

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 have a similar pattern of transfer. At the year end, the Trust accrued income relating to activity delivered in that year, where a patient care spell was incomplete. This accrual was disclosed as a contract receivable as entitlement to payment for work completed was usually only dependent on the passage of time.

In 2019/20, the PSF 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 was 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 1.3.1 Grants and donations

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.3.2 Other income

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

Note 1.4 Expenditure on employee benefits

Short-term employee benefits

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

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employer, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as they become due.

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

Note 1.5 Discontinued Operations

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

Note 1.6 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.7 Property, plant and equipment

Note 1.7.1 Recognition

Property, plant and equipment is capitalised where:

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

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

Note 1.7.2 Valuation

The valuation exercise was carried out in March 2021 with a valuation date of 31 March 2021. In applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2020 'Red Book'.

Market activity is being impacted in many sectors. As at the valuation date, we consider that we can attach less weight to previous market evidence for comparison purposes, to inform opinions of value.

The values in the report have been used to inform the measurement of property assets at valuation in these financial statements.

Of the £122.4m net book value of land and buildings, £107.5m relates to specialised assets valued on a depreciated replacement cost basis. Here the valuer bases their assessment on the cost to the Trust of replacing the service potential of the assets.

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

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

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

Land and non-specialised buildings – market value for existing use

Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

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

Property, plant and equipment (continued)

Note 1.7.3 Subsequent expenditure

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

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

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

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset, when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Note 1.7.4 Depreciation

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

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

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

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

Note 1.7.5 Revaluation gains and losses

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

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

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

Note 1.7.6 Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.
Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Note 1.7.7 De-recognition

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

Following reclassification, the assets are measured at the lower of their existing carrying amount and their fair value less costs to sell. Depreciation ceases to be charged 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.

Note 1.8 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.

Note 1.9 Private Initiative (PFI) transactions

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

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

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

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

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

Note 1.10 Intangible assets

Note 1.10.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

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

Note 1.10.2 Software

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

Note 1.10.3 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

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

Note 1.10.4 Amortisation

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

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

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

Note 1.10.5 Valuation

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

Note 1.11 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method. Pharmacy stock is measured at a weighted average cost.

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

Note 1.13 Financial instruments and financial liabilities

Note 1.13.1 Recognition

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

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, i.e., when receipt or delivery of the goods or services is made.

Note 1.13.2 De-recognition

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

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

Note 1.13.3 Classification and measurement

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

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are classified as subsequently measured at amortised cost.

Financial liabilities classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

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

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

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

Financial assets measured at fair value through other comprehensive income

A financial asset is measured at fair value through other comprehensive income where business model objectives are met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On derecognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the Trust elected to measure an equity instrument in this category on initial recognition.

The Trust has not got any equity instruments at fair value.

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

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

Impairment of financial assets

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

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses.

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

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

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

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

Note 1.13.4 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.

Note 1.14.1 Finance leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property, plant and equipment.

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to finance costs in the Statement of Comprehensive Income.

Note 1.14.2 Operating leases
Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially in other liabilities on the statement of financial position and subsequently as a reduction of rentals on a straight-line basis over the lease term.

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

Note 1.14.3 Leases for land and buildings
Where a lease is for land and buildings, the land and building components are separated. Leased land is treated as an operating lease. Leased buildings are assessed as to whether they are operating or finance leases.

Note 1.14.4 The Trust as lessor
Finance leases

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

Operating leases

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

Note 1.15 Provisions
The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation.

Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective for 31 March 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%

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.

Note 1.18 Contingencies

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

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets. Contingent liabilities are not recognised, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

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

Note 1.19 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

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

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined in the PDC dividend policy issued 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.

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 1.20 Value Added Tax

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

Note 1.21 Foreign exchange

The functional and presentational currencies of the trust are sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

• monetary items (other than financial instruments measured at "fair value through income and expenditure") are translated at the spot exchange rate on 31 March

• non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and

• non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

Note 1.22 Third party assets

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

Note 1.23 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.
The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.24 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2020/21.

Note 1.25 IFRS 16 Leases

IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 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 a rate 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 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. Where PFI liabilities are material with payments linked to a price index will now be included.

From 1 April 2022, the principles of IFRS 16 will also be applied to the Trust's PFI liabilities where future payments are linked to a price index representing the rate of inflation. The PFI imputed lease liability will be remeasured when a change in the index causes a change in future imputed lease payments and that change has taken effect in the cash flow. Under existing accounting practices, amounts relating to changes in the price index are expensed as incurred. This is expected to increase the PFI liability on the statement of financial position upon transition to IFRS 16. The effect of this has not yet been quantified.

Note 1.26 Critical accounting estimates and judgements

Note 1.26.1 Critical accounting judgments and key sources of estimation uncertainty

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

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

Valuation of Land and Buildings

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

Note 2 Operating segments

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

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

Note 3 Operating income from patient care activities

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

Note 3.1 Income from patient care activities

	31 March 2021	31 March 2020
Acute services	**£000**	**£000**
Block contract / system envelope income	171,274	120,580
High cost drugs income from commissioners	4,790	5,349
Other NHS clinical income*	22,964	51,715
Community Services	31,223	32,108
All other services		
Overseas Visitors	104	125
Injury cost recovery scheme	765	783
Prescription Income	143	125
AfC pay award central funding	0	733
Additional pension contribution central funding **	6,755	6,351
Other clinical income	3,761	2,180
Total income from activities	**241,777**	**220,050**

*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. Comparatives in this note are presented to be comparable with the current year activity. This does not reflect the contracting and payment mechanisms in place during the prior year.

**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

Income from patient care activities received from:	31 March 2021	31 March 2020
	£000	**£000**
NHS England	14,692	15,481
CCGs	193,459	168,986
Local Authorities	32,189	34,392
NHS Foundation Trusts	10	86
NHS Trusts	3	37
Department of Health and Social Care	35	22
NHS other (including Public Health England)	0	33
Overseas visitors	104	125
Injury cost recovery scheme	765	783
Non NHS: other	522	105
Total income from activities	**241,777**	**220,050**
Of which:		
Related to continuing operations	241,777	220,050
Related to discontinued operations	0	0

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

	2020/21	2019/20
	£000	£000
Income recognised this year	104	125
Cash payments received in-year	59	31
Amounts added to provision for impairment of receivables	145	124
Amounts written off in-year	57	48

Note 3.4 Other operating income

	31 March 2021	31 March 2020
	£000	£000
Other operating income recognised in accordance with IFRS 15:		
Research and development	358	394
Education and training	4,927	4,963
Non-patient care services to other bodies	4,645	3,822
Provider sustainability fund (PSF)	0	4,934
Financial recovery fund (FRF)	0	20,558
Reimbursement and top up funding	27,707	0
Other (recognised in accordance with IFRS 15)*	1,010	2,223
Other operating income recognised in accordance with other standards:		
Education and training (excluding notional apprenticeship levy income)	287	240
Cash grants for the purchase of capital assets - received from other bodies	0	0
Charitable and other contributions to expenditure	36	64
Donated equipment from DHSC for COVID response (non-cash)	907	0
Contributions to expenditure - receipt of equipment donated from DHSC for COVID response below capitalisation threshold	194	0
Contributions to expenditure - consumables (inventory) donated from DHSC group bodies for COVID response	4,687	0
Rental revenue from operating leases	66	60
Income in respect of staff costs where accounted on gross basis	305	349
Other income	0	0
Total other operating income	**45,129**	**37,607**
Of which:		
Related to continuing operations	45,129	37,607
Related to discontinued operations	0	0

	31 March 2021	31 March 2020
Other income *	**£000**	**£000**
Car parking	167	1,230
Staff accommodation rentals	75	66
Catering	273	377
Clinical Excellence Awards	54	46
Other	441	504
	1,010	**2,223**

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

	31 March 2021
	£000
Revenue recognised in the reporting period that was included within contract liabilities at the previous period end	0
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	0

Note 3.6 Transaction price allocated to remaining performance obligations

	31 March 2021
Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	**£000**
within one year	0
after one year, not later than five years	0
after five years	0
Total revenue allocated to remaining performance obligations	**0**

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

Note 3.7 Income from activities arising from commissioner requested services

Under the terms of its provider licence, the Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider license and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2020/21	2019/20
	£000	£000
Income from services designated as commissioner requested services	240,387	219,037
Income from services not designated as commissioner requested services	1,390	1,013
Total	**241,777**	**220,050**

Note 4 Operating expenses

	31 March 2021	31 March 2020
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	3,658	4,790
Purchase of healthcare from non-NHS and non-DHSC bodies	3,293	2,838
Staff and executive directors costs	199,110	178,504
Remuneration of non-executive directors	126	117
Supplies and services - clinical (excluding drugs costs)	15,151	14,818
Supplies and services – clinical: utilisation of consumables donated from DHSC group bodies for COVID response	4,254	0
Supplies and services - general	3,191	2,724
Supplies and services - general: notional cost of equipment donated from DHSC for COVID response below capitalisation threshold	194	0
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	9,145	10,258
Consultancy costs	96	54
Establishment	1,816	1,621
Premises	11,802	11,044
Transport (including patient travel)	504	700
Depreciation on property, plant and equipment	5,493	5,406
Amortisation on intangible assets	360	121
Net impairments	572	(108)
Movement in credit loss allowance: contract receivables/contract assets	74	(29)
Movement in credit loss allowance: all other receivables and investments	(18)	(21)
Increase in provisions	1,486	260
Change in provisions discount rate	(22)	(11)
Audit fees payable to the external auditor		
audit services- statutory audit	78	63
other auditor remuneration (external auditor only)	0	44
Internal audit costs	87	84
Clinical negligence	8,500	8,002
Legal fees	499	505
Insurance	309	257
Research and development - staff costs	319	307
Education and training - staff costs	904	726
Education and training - non-staff costs	633	505
Education and training - notional expenditure funded from apprenticeship fund	287	240
Rentals under operating leases	4,659	4,353
Redundancy	140	65
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI)	3,669	3,586
Hospitality	0	20
Losses, ex gratia & special payments	209	190
Other	572	177
Total	**281,150**	**252,210**
Of which:		
Related to continuing operations	281,150	252,210
Related to discontinued operations	0	0

Note 4.1 Other auditor remuneration

	31 March 2021 £000	31 March 2020 £000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	0	0
2. Audit-related assurance services	0	2
3. Taxation compliance services	0	0
4. All taxation advisory services not falling within item 3 above	0	0
5. Internal audit services	0	0
6. All assurance services not falling within items 1 to 5	0	0
7. Corporate finance transaction services not falling within items 1 to 6 above	0	0
8. Other non-audit services not falling within items 2 to 7 above	0	42
Total	**0**	**44**

Note 4.2 Limitation on auditor's liability

The External Auditors Liability is limited to £1m. The scope of work for the External Auditors is to provide a Statutory Audit to the NHS Foundation Trust. This will be conducted in accordance with the Audit Code for NHS Foundation Trusts (the Audit Code) issued by Monitor in accordance with paragraph 24 of schedule 7 of the Act. The scope of the work is for the External Auditors to be satisfied that the NHS Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The External Auditors are to provide their opinion on the financial statements.

Note 5 Impairment of assets

	31 March 2021 £000	31 March 2020 £000
Net impairments charged to operating surplus resulting from:		
Changes in market price	572	(108)
Other	0	0
Total net impairments charged to operating surplus	**572**	**(108)**
Impairments charged to the revaluation reserve	3,530	435
Total net impairments	**4,102**	**327**

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

Note 6 Employee benefits

	31 March 2021 Total £000	31 March 2020 Total £000
Salaries and wages *	144,588	130,741
Social security costs	13,484	12,457
Apprenticeship levy	660	614
Employer's contributions to NHS pensions	15,458	14,501
Pension cost - employer contributions paid by NHSE on provider's behalf (6.3%)	6,755	6,351
Temporary staff - external bank	9,923	9,332
Temporary staff - agency/contract staff	9,605	5,606
	200,473	**179,602**
Recoveries in respect of seconded staff	0	0
Total staff costs	**200,473**	**179,602**
Of which		
Costs capitalised as part of assets	**62**	**58**

* Increase is due to covid pay cost, pay award and incremental drift.

Average number of employees (WTE basis) is on page 38 of the Annual Report

Note 6.1 Retirements due to ill-health

During 2020/21 there were 2 early retirement from the NHS Foundation Trust agreed on the grounds of ill-health (5 in the year ended 31 March 2020). The estimated additional pension liability of this ill-health retirements is £42k (£269k in 2020).

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

Note 6.2 Directors' remuneration

The aggregate amounts payable to directors were:	31 March 2021 £000	31 March 2020 £000
Salary	749	822
Taxable benefits	0	0
Performance related bonuses	0	0
Employees' pension related benefit	294	316
Total	**1,043**	**1,138**

The remuneration disclosed in the table above represents the Trust's share of the remuneration of the Chief Executive Officer, who has been working for Stockport NHS Foundation Trust.

Further details of directors' remuneration can be found in the remuneration report on page 31 of the Annual Report.

Note 7 Pension costs

The NHS Foundation Trust offers retirement benefits to its employees from the NHS Pension Scheme.

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2021, is based on valuation data as 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.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

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

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.

Note 8 Operating leases

Lessor

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

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

	31 March 2021	31 March 2020
Operating lease revenue	**£000**	**£000**
Minimum lease receipts	66	60
Total	**66**	**60**

	31 March 2021	31 March 2020
	£000	**£000**
Future minimum building leases receipts due:		
not later than one year;	42	32
later than one year and not later than five years;	109	106
later than five years.	420	399
Total	**571**	**537**

Lessee

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

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

	31 March 2021	31 March 2020
	£000	**£000**
Operating lease expense		
Minimum lease payments	4,659	4,353
Total	**4,659**	**4,353**

	31 March 2021	31 March 2020
	£000	**£000**
Future minimum building leases payments due:		
not later than one year;	3,536	3,300
later than one year and not later than five years;	6,844	7,874
later than five years.	3,422	4,446
Total	**13,802**	**15,620**

	2021	2020
	£000	**£000**
Future minimum other leases payments due:		
not later than one year;	795	866
later than one year and not later than five years;	1,799	2,660
later than five years.	0	0
Total	**2,594**	**3,526**

	2021	2020
	£000	**£000**
Future minimum on all lease payments due:		
not later than one year;	4,331	4,166
later than one year and not later than five years;	8,643	10,534
later than five years.	3,422	4,446
Total	**16,396**	**19,146**

Note 9 Finance income

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

	31 March 2021 £000	31 March 2020 £000
Interest on bank accounts	0	74
Total	**0**	**74**

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

Note 10 Finance expenditure

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

	31 March 2021 £000	31 March 2020 £000
Interest expense:		
Loans from the Department of Health	0	1,875
Main finance costs on PFI scheme obligations	2,098	2,159
Contingent finance costs on PFI scheme obligations	1,372	1,251
Total	**3,470**	**5,285**

Future revenue support will be available in the form of PDC that carries a dividend payable at 3.5%.

Note 11 Intangible assets - 2020/21

	Software Licences	Licenses & Trademarks	Other	Total
	£000	£000	£000	£000
Valuation/gross cost at 1 April 2020 - brought forward	**1,650**	**0**	**0**	**1,650**
Additions	595	0	0	**595**
Impairments	0	0	0	**0**
Disposals / derecognition	0	0	0	**0**
Gross cost at 31 March 2021	**2,245**	**0**	**0**	**2,245**
Amortisation at 1 April 2020 - brought forward	**204**	**0**	**0**	**204**
Provided during the year	360	0	0	**360**
Impairments	0	0	0	**0**
Disposals / derecognition	0	0	0	**0**
Amortisation at 31 March 2021	**564**	**0**	**0**	**564**
Net book value at 31 March 2021	**1,681**	**0**	**0**	**1,681**
Net book value at 1 April 2020	**1,446**	**0**	**0**	**1,446**

Note 11.1 Intangible assets - 2019/20

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

Note 12 Property, plant and equipment - 2020/21

	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	**14,431**	**111,286**	**566**	**157**	**15,668**	**166**	**8,202**	**173**	**150,649**
Additions	0	0	0	4,060	3,227	0	638	14	7,939
Transfers by absorption							67		67
Additions - equipment donated from DHSC for COVID response (non-cash)					907				907
Impairments	0	(3,530)	0	0	0	0	0	0	(3,530)
Reclassifications	0	3,811	0	(3,930)	119	0	0	0	0
Revaluations	0	(4,119)	(5)	0	0	0	0	0	(4,124)
Disposals / derecognition	0	0	0	0	(541)	0	0	(76)	(617)
Valuation/gross cost at 31 March 2021	**14,431**	**107,448**	**561**	**287**	**19,380**	**166**	**8,907**	**111**	**151,291**
Accumulated depreciation at 1 April 2020 - brought forward	**0**	**0**	**0**	**0**	**11,676**	**72**	**6,588**	**123**	**18,459**
Provided during the year	0	3,782	34	0	1,117	16	532	12	**5,493**
Impairments	0	586	0	0	0	0	0	0	**586**
Revaluations	0	(4,354)	(34)	0	0	0	0	0	**(4,388)**
Reversals of impairments	0	(14)	0	0	0	0	0	0	**(14)**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Disposals/ derecognition	0	0	0	0	(541)	0	-	(76)	**(617)**
Accumulated depreciation at 31 March 2021	**0**	**0**	**0**	**0**	**12,252**	**88**	**7,120**	**59**	**19,519**
Net book value at 31 March 2021	**14,431**	**107,448**	**561**	**287**	**7,128**	**78**	**1,787**	**52**	**131,772**
Net book value at 1 April 2020	**14,431**	**111,286**	**566**	**157**	**3,992**	**94**	**1,614**	**50**	**132,190**
Total revaluation	0	249	29	0	0	0	0	0	278
Total impairment	0	(4,116)	0	0	0	0	0	0	(4,116)
	0	**(3,867)**	**29**	**0**	**0**	**0**	**0**	**0**	**(3,838)**

Note 12.1 Property, plant and equipment - 2019/20

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

Note 12.2 Property, plant and equipment financing - 2020/21

	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	14,431	66,966	561	287	6,213	78	1,787	52	**90,375**
On-SoFP PFI contracts		38,038	0	0	0	0	0	0	**38,038**
Donated	0	2,444	0	0	8	0	0	0	**2,452**
Owned - equipment donated from DHSC for COVID response	0	0	0	0	907	0	0	0	**907**
NBV total at 31 March 2021	**14,431**	**107,448**	**561**	**287**	**7,128**	**78**	**1,787**	**52**	**131,772**

Note 12.3 Property, plant and equipment financing - 2019/20

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2020									
Owned	14,431	68,893	566	157	3,937	94	1,614	50	**89,742**
On-SoFP PFI contracts	0	39,885	0	0	0	0	0	0	**39,885**
Donated	0	2,508	0	0	55	0	0	0	**2,563**
NBV total at 31 March 2020	**14,431**	**111,286**	**566**	**157**	**3,992**	**94**	**1,614**	**50**	**132,190**

Note 13 Inventories

	31 March 2021	31 March 2020
	£000	£000
Drugs	543	672
Consumables	1,140	1,279
Consumables donated from DHSC group bodies	433	0
Energy	23	25
Total inventories	**2,139**	**1,976**

Note 14 Trade receivables and other receivables

	31 March 2021	31 March 2020
	£000	£000
Current		
Contract receivables (IFRS 15): invoiced	2,987	3,165
Contract receivables (IFRS 15): not yet invoiced / non-invoiced	873	15,356
Contract assets (IFRS 15)	1,220	1,122
Allowance for impaired contract receivables / assets	(641)	(567)
Allowance for impaired other receivables	(82)	(100)
Prepayments (non-PFI)	1,309	1,842
PDC dividend receivable	738	0
VAT receivable	421	515
Other receivables	90	19
Total current trade and other receivables	**6,915**	**21,352**
Non-current		
PFI prepayments:		
Lifecycle replacements	7,197	6,441
Contract assets (IFRS 15)	743	741
Clinician pension tax provision reimbursement funding from NHSE	286	244
Total non-current trade and other receivables	**8,226**	**7,426**
Total receivables	**15,141**	**28,778**

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

Note 14.1 Allowances for credit losses - 2020/21

	Contract receivables and contract assets	All other receivables
	31 March 2021	31 March 2020
	£000	£000
Allowances as at 1 Apr 2020 - brought forward	**567**	**100**
New allowances arising	438	67
Reversals of allowances	(284)	(72)
Utilisation of allowances (write offs)	(80)	(13)
Allowances as at 31 Mar 2021	**641**	**82**

Note 15 Cash and cash equivalents movements

Cash and cash equivalents comprise of cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	31 March 2021 £000	31 March 2020 £000
At 1 April	**3,376**	**2,300**
Net change in year	19,458	1,076
At 31 March	**22,834**	**3,376**
Broken down into:		
Cash at commercial banks and in hand	109	116
Cash with the Government Banking Service	22,725	3,260
Deposits with the National Loan Fund	0	0
Other current investments	0	0
Total cash and cash equivalents as in SoFP	**22,834**	**3,376**
Bank overdrafts (GBS and commercial banks)	0	0
Drawdown in committed facility	0	0
Total cash and cash equivalents as in SoCF	**22,834**	**3,376**

Note 15.1 Third party assets held by the NHS Foundation Trust

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

	31 March 2021 £000	31 March 2020 £000
Bank balances	4	4
Monies on deposit	0	0
Total third party assets	**4**	**4**

Note 16 Trade and other payables	31 March 2021 £000	31 March 2020 £000
Current		
Trade payables	6,118	8,886
Capital payables	575	410
Accruals	7,199	5,706
Social security costs	1,931	1,928
Other taxes payable	1,661	1,536
PDC dividend payable	0	0
Other payables	8,609	4,510
Total current trade and other payables	**26,093**	**22,976**
Non-current		
Total non-current trade and other payables	**0**	**0**
Of which payables from NHS and DHSC group bodies:		
Current	26,093	22,976
Non-current	0	0

Note 17 Other liabilities	31 March 2021 £000	31 March 2020 £000
Current		
Other deferred income	1,219	1,549
Total other current liabilities	**1,219**	**1,549**
Non-current		
Other deferred income	0	0
Total other non-current liabilities	**0**	**0**

Note 18 Borrowings	31 March 2021 £000	31 March 2020 £000
Current		
Loans from the Department of Health	0	107,039
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	1,576	1,512
Total current borrowings	**1,576**	**108,551**
Non-current		
Loans from the Department of Health	0	0
Obligations under PFI, LIFT or other service concession contracts	47,666	49,242
Total non-current borrowings	**47,666**	**49,242**
Total borrowings	**49,242**	**157,793**

Note 18.1 Reconciliation of liabilities arising from financing activities

	Loans from DHSC £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2020	**107,039**	**50,754**	**157,793**
Cash movements:			
Financing cash flows - payments and receipts of principal	(106,631)	(1,512)	**(108,143)**
Financing cash flows - payments of interest	(408)	(2,098)	**(2,506)**
Non-cash movements:			
Application of effective interest rate	0	2,098	**2,098**
Carrying value at 31 March 2021	**0**	**49,242**	**49,242**

Note 19 Provisions for liabilities and charges analysis

	Pensions - former directors	Pensions - injury benefits	Other legal claims	Clinician pension tax reimbursement	Other	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2020	0	537	260	244	151	**1,192**
Change in the discount rate	0	(22)	0	0	0	**(22)**
Arising during the year	0	0	123	42	1,405	**1,570**
Utilised during the year	0	(32)	(80)	0	0	**(112)**
Reclassified to liabilities held in disposal groups	0	0	0	0	0	**0**
Reversed unused	0	0	(42)	0	0	**(42)**
Unwinding of discount	0	11	0	0	0	**11**
At 31 March 2021	**0**	**494**	**261**	**286**	**1,556**	**2,597**
Expected timing of cash flows:						
- not later than one year;	0	33	158	0	1,556	**1,747**
- later than one year and not later than five years;	0	461	103	0	0	**564**
- later than five years.	0	0	0	286	0	**286**
Total	**0**	**494**	**261**	**286**	**1,556**	**2,597**

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

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

	31 March 2021	31 March 2020
	£000	£000
Injury benefits - NHS Business Services Authority - Pensions Division	**494**	537
Total pensions	**494**	**537**
Employer's liabilities - NHS Resolution	**249**	248
Public liabilities - NHS Resolution	**12**	12
Total legal claims	**261**	**260**
Clinician pension tax reimbursement	**286**	244
Total clinical pension tax provisions	**286**	**244**
Other provisions - industrial tribunal claims	**15**	68
Other provisions - dilapidations	**138**	83
Other provisions - final salary pension	**169**	0
Other provisions - PFI defects	**1,234**	0
Total other provisions	**1,556**	**151**
Total provisions	**2,597**	**1,192**

Note 19.1 Clinical negligence liabilities

At 31 March 2021, £220,165k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Tameside and Glossop Integrated Care NHS Foundation Trust (31 March 2020: £216,444k).

The Trust has no contingent liabilities in 2020/21, which relate to the Employer's and Occupier's Liability. This is the difference between the provision which the Trust has made for the claim and the actual excess which the Trust could be liable to pay against the claim.

Note 20 Contractual capital commitments

	31 March 2021	31 March 2020
	£000	£000
Property, plant and equipment	1,109	737
Intangible assets	0	0
Total	**1,109**	**737**

Note 20.1 Other financial commitments

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

	31 March 2021	31 March 2020
	£000	£000
Not later than 1 year	5,726	5,735
after 1 year and not later than 5 years	6,253	9,582
paid thereafter	0	0
Total	**11,979**	**15,317**

Note 21 Private Finance Initiative contracts

Note 21.1 PFI scheme off-Statement of Financial Position

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

Note 21.2 PFI scheme on-Statement of Financial Position

In 2011 extensive new acute facilities were built through PFI investment by Consort Healthcare.

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

The Trust has the right to use the buildings, however Consort Healthcare has the responsibility for maintaining the buildings to an agreed standard. All lifecycle replacement is also the responsibility of Consort Healthcare.

A key feature of the PFI scheme is that the operator is responsible for ensuring that the property is maintained to an agreed standard for the entire life of the contract. These are known as lifecycle costs. The cost which the operator expects to incur in doing this is reflected in the unitary payment and reflects two elements:

- maintenance (planned and reactive); and
- replacement of components as they wear out during the contract – this is known as capital lifecycle.

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

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

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

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

	31 March 2021 £000	31 March 2020 £000
Gross PFI, LIFT or other service concession liabilities	**73,529**	**77,139**
not later than one year;	3,610	3,610
later than one year and not later than five years;	14,437	14,437
later than five years.	55,482	59,093
Finance charges allocated to future periods	(24,288)	(26,386)
Net PFI, LIFT or other service concession arrangement obligation	**49,242**	**50,754**
not later than one year;	1,576	1,512
later than one year and not later than five years;	6,991	6,709
later than five years.	40,675	42,533
	49,242	**50,754**

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

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

	31 March 2021 £000	31 March 2020 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**250,163**	**262,361**
Of which liabilities are due:		
not later than one year;	9,536	9,407
later than one year and not later than five years;	40,593	40,044
later than five years.	200,034	212,910
	250,163	**262,361**

Note 21.5 Analysis of amounts payable to service concession operator

This note provides an analysis of the Trust's expenditure in 2020/21:

	31 March 2021 £000	31 March 2020 £000
Unitary payment payable to service concession operator	9,407	9,182
Consisting of:		
Interest charge	2,098	2,159
Repayment of finance lease liability	1,512	1,448
Service element	3,669	3,586
Contingent rent	1,372	1,251
Addition to lifecycle prepayment	756	738
Total amount paid to service concession operator	**9,407**	**9,182**

Note 22 Financial instruments

Note 22.1 Liquidity risk

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

The Trust presently finances its capital expenditure from internally generated funds or funds made available from Government, in the form of additional Public Dividend Capital, under an agreed limit. In addition, the Trust can borrow, both from the Department of Health Financing Facility and commercially, to finance capital schemes. Although given current Department of Health loan conditions, this is only possible with NHSI approval. Financing would be drawn down to match the capital spend profile of the scheme concerned and the Trust would not therefore be exposed to significant liquidity risks in this area; the Trust did not borrow under this arrangement in the year 2020/21.

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

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

Note 22.2 Interest-rate risk

All of the Trust's financial assets and liabilities carry nil or fixed rates of interest. The Trust is not, therefore, exposed to significant interest-rate risk. The only risk is therefore regarding the level of interest generated on the Trust's investment which may be higher or lower than planned at the start of the year, due to fluctuating interest rates on National Loan Fund (NLF) investments. The value of interest generated in 2020/21 was £0k (2019/20 was £74k).

Note 22.3 Credit risk

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

Note 22.4 Treasury management arrangements

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

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

Note 22.5 Currency risk

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

Note 23 Carrying values of financial assets

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

	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
Carrying values of financial assets as at 31 March 2021 under IFRS 9	**£000**	**£000**	**£000**	**£000**
Receivables (excluding non financial assets) - with DHSC group bodies	2,788	0	0	**2,788**
Receivables (excluding non financial assets) - with other bodies	2,542	0	0	**2,542**
Cash and cash equivalents at bank and in hand	22,834	0	0	**22,834**
Total at 31 March 2021	**28,164**	**0**	**0**	**28,164**

	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total book value
Carrying values of financial assets as at 31 March 2020 under IAS 39	**£000**	**£000**	**£000**	**£000**
Receivables (excluding non financial assets) - with DHSC group bodies	17,330	0	0	**17,330**
Receivables (excluding non financial assets) - with other bodies	2,650	0	0	**2,650**
Cash and cash equivalents at bank and in hand	3,376	0	0	**3,376**
Total at 31 March 2020	**23,356**	**0**	**0**	**23,356**

Note 23.1 Carrying value of financial liabilities

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

Carrying values of financial liabilities as at 31 March 2021 under IFRS 9	Held at amortised cost **£000**	Held at fair value through the I&E **£000**	Total book value **£000**
Loans from the Department of Health and Social Care	0	0	**-**
Obligations under PFI	49,242	0	**49,242**
Trade and other payables (excluding non financial liabilities) - with DHSC group bodies	832	0	832
Trade and other payables (excluding non financial liabilities) - with other bodies	19,402	0	19,402
Total at 31 March 2021	**69,476**	**0**	**69,476**

	Other financial liabilities	Held at fair value through the I&E	Total book value
Carrying values of financial liabilities as at 31 March 2020 under IAS 39	**£000**	**£000**	**£000**
Loans from the Department of Health and Social Care	107,039	0	**107,039**
Obligations under PFI, LIFT and other service concession contracts	50,754	0	**50,754**
Trade and other payables (excluding non financial liabilities) - with DHSC group bodies	2,948	0	2,948
Trade and other payables (excluding non financial liabilities) - with other bodies	14,567		14,567
Total at 31 March 2020	**175,308**	**0**	**175,308**

Note 23.2 Maturity of financial liabilities

	31 March 2021	31 March 2020
	£000	**£000**
In one year or less	23,844	128,164
In more than one years but not more than five years	14,437	14,437
In more than five years	55,482	59,093
Total	**93,763**	**201,693**

The prior year comparator figures in this note were previously prepared on a discounted cash flow basis. In line with the recommendations of the Group Accounting Manual this has been updated to be shown on an undiscounted basis. This has no impact on the value of the liabilities within the Statement of Financial Position.

Note 24 Losses and special payments

	31 March 2021		31 March 2020	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Bad debts and claims abandoned	61	93	45	109
Stores losses and damage to property	2	48	12	29
Total losses	**63**	**141**	**57**	**138**
Special payments				
Ex gratia payments in respect of:				
Loss of personal effects	1	1	12	6
Personal injury with advice	0	0	2	7
Employers negligence and injury	8	66	13	38
Other	0	0	0	0
Total special payments	**9**	**67**	**27**	**51**
Total losses and special payments	**72**	**208**	**84**	**189**
Compensation payments received		0		0

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

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

Note 25 Events after the reporting date

The Trust has no events after the reporting date to report.

Note 26 Related parties

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

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

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

The Trust is a corporate trustee of the Tameside & Glossop Integrated Care NHS Foundation Trust Charitable Fund. The Trust has received monies from the charity in respect of its management of the charity to the value of £36k (£64k to 31 March 2020). The charity is registered with the Charity Commission for England and Wales (1055818) and produces its own annual report and accounts. Under IFRS 10, NHS bodies are required to consolidate their charitable funds with their own statements where they are considered to be under common control; however, consideration is given to the materiality of the funds held. As with prior year, the Trust's charitable funds are not considered material and so their results have not been consolidated. The statements of the Trust's charitable fund are available upon request.

	Receivables		Payables	
	31 March 2021 £000	31 March 2020 £000	31 March 2021 £000	31 March 2020 £000
The Christie NHS Foundation Trust	559	60	0	188
HM Revenue & Customs	421	515	3,592	3,464
NHS England - Core	572	13,539	0	0
North West Regional Office (including commissioning hub 13Y)	172	308	0	0
NHS Manchester CCG	338	0	0	207
Lancashire Teaching Hospitals NHS Foundation Trust	216	0	0	0
Manchester University NHS Foundation Trust	165	263	324	1,580
NHS Tameside and Glossop CCG	137	1,781	2	1,414
Other NHS Bodies (including Welsh Health Bodies)	115	199	69	119
Salford Royal NHS Foundation Trust	83	92	86	185
Health Education England	78	0	0	0
Stockport NHS Foundation Trust	56	126	22	69
Other CCGS	11	165	2	51
Pennine Care NHS Foundation Trust	146	304	389	67
Stockport Metropolitan Borough Council	0	208	0	0
NHS Stockport CCG	0	201	2	4
Pennine Acute Hospitals NHS Trust	0	85	58	57
Tameside Metropolitan Borough Council	0	50	1	1
NHS England - Central Specialised Commissioning Hub	0	2	0	0
NHS Pension Scheme	0	0	2,120	1,997
NHS Professionals	0	0	804	658
NHS Oldham CCG	0	0	29	137
NHS Heywood, Middleton and Rochdale CCG	0	0	2	107
Community Health Partnerships	0	0	0	6
Total	**3,069**	**17,898**	**7,502**	**10,311**

	Income		Expenditure	
	31 March 2021 £000	31 March 2020 £000	31 March 2021 £000	31 March 2020 £000
NHS Tameside and Glossop CCG	154,885	153,102	0	1,651
Tameside Metropolitan Borough Council	31,557	33,874	860	851
NHS Manchester CCG	30,505	6,048	0	0
NHS England - Core	27,233	27,139	5	8
North West Regional Office (including commissioning hub 13Y)	9,234	7,156	0	0
NHS Oldham CCG	6,445	6,254	0	0
Health Education England	5,342	5,043	0	0
NHS Stockport CCG	1,898	1,930	0	0
Pennine Care NHS Foundation Trust	1,457	1,424	401	355
Manchester University NHS Foundation Trust	788	902	3,501	3,327
NHS Heywood, Middleton and Rochdale CCG	780	655	0	0
Stockport Metropolitan Borough Council	737	628	0	0
The Christie NHS Foundation Trust	362	126	512	437
Salford Royal NHS Foundation Trust	341	338	267	273
Lancashire Teaching Hospitals NHS Foundation Trust	288	0	0	1
Pennine Acute Hospitals NHS Trust	247	239	215	27
Other NHS Bodies (including Welsh Health Bodies)	100	118	283	478
Stockport NHS Foundation Trust	46	66	377	391
Department of Health and Social Care	35	22	0	0
Other CCGS	9	1,031	0	0
NHS Pension Scheme	0	0	22,213	20,852
HM Revenue & Customs	0	0	14,144	13,071
NHS Professionals	0	0	12,316	10,553
NHS Resolution	0	0	8,697	8,162
Community Health Partnerships	0	0	1,706	1,669
NHS Blood and Transplant	0	0	1,088	829
Care Quality Commission	0	0	158	152
Royal Liverpool and Broadgreen University Hospitals NHS Trust	0	0	113	58
Bolton NHS Foundation Trust	0	0	37	70
NHS Property Services	0	0	2	0
Public Health England (PHE)	0	1	1	1
NHS Bury CCG	0	144	0	0
NHS Trafford CCG	0	134	0	0
NHS Salford CCG	0	130	0	0
NHS Derby and Derbyshire CCG	0	116	0	0
NHS England - North East Specialised Commissioning Hub	0	81	0	0
Northumbria Healthcare NHS Foundation Trust	0	0	0	8
Other Local Authorities	0	0	0	4
NHS England - Central Specialised Commissioning Hub	(561)	18	0	0
Total	**271,728**	**246,719**	**66,896**	**63,228**