Stockport
NHS Foundation Trust

STOCKPORT NHS FOUNDATION TRUST

ANNUAL REPORT AND ACCOUNTS 2019-2020

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Chair's Introduction

In preparing this introduction to the Annual Report and Accounts for 2019-20 I looked back on what I had written for 2018-19. At that time I recognised the significant challenges that faced the health and social care system in Stockport, Greater Manchester, and nationally, but I was also optimistic about the many improvements we had made, both within the Trust and with partner organisations.

Those themes of challenge and improvement also typified the last 12 months, but when I wrote last year's introduction to the Annual Report and Accounts none of us could have predicted what was in store for us all in 2019-20.

During 2018-19 we had seen good progress in many areas, including our financial position and performance against some key quality standards. The winter is traditionally a time of intense pressure on health and social care services, but we had come through what the NHS regarded as a relatively good winter in terms of activity - so we went into 2019-20 hopeful that we could sustain and build on the progress we had made. For the first quarter we managed to do just that, but none of us could have predicted the spike in activity we saw over the summer and which continued unabated into the winter months.

Stockport has a significantly higher proportion of elderly residents compared to the rest of Greater Manchester, and as we age we are increasingly likely to be frail and living with a number of health conditions. Once elderly people come into hospital they can quickly lose their independence, and from the summer months onwards we saw increasing numbers of young people come through our doors, as well as elderly patients who no longer needed acute care but were unable to return home to live independently. So they stayed with us until they could move to an alternative care facility, or had a package of care wrapped around them to return home with support.

As these elderly patients filled our beds we struggled to accommodate patients with acute care needs coming through the doors of our emergency department, or those requiring surgery and elective care. The optimum level of bed occupancy to allow a safe flow of patients through a hospital is considered to be 80 - 85%, but at times during 2019-20 our bed occupancy rate was at 98%, and occasionally even 100%.

As a result patients requiring hospital care waited for longer in our emergency department, meaning that throughout the winter our A&E staff were frequently caring for the equivalent of a full ward of patients awaiting specialist inpatient care, as well as responding to the emergencies that continued to come through the doors. With this unrelenting pressure on the department it is perhaps unsurprising that we did not achieve our improvement trajectory of 80% against the four hour A&E standard, let alone the national standard of 95%.

With beds taken up by patients waiting to leave hospital it is also not surprising that we saw a rise in cancelled operations, as we were unable to guarantee those patients requiring surgery a bed in which they could recover. This in turn had a knock on effect on our waiting times, and you can read more about that in the operational performance section of this report (*see page 38).*

To an outsider the answer to this pressure may seem simple – open more beds - and we did. Each year we plan for winter based on our best analysis of the likely demand for services, but no-one locally or nationally could have predicted the numbers of people requiring care. The pressure was so unexpected that we instigated our winter plan two months early, opening extra hospital beds to try to cope with the increased demand.

However, it is not just a question of opening extra beds we also needed to have the staff available to ensure the patients in those beds were cared for safely. The staffing challenge facing the whole of the NHS is well documented, and we continue to work hard to not only recruit but also retain colleagues. We have been successful over the last 12 months in recruiting to a number of consultant vacancies that are often hard to fill but, in line with other NHS trusts, we do have a significant number of nurse vacancies and we often rely on our temporary nursing staff to fill those gaps. However, when the whole of the system is under pressure, as we were during 2019-20, it can be extremely difficult to find enough of our own temporary nursing staff, and we often had to turn to expensive agency staff to ensure we could care for our patients safely.

This in turn had a huge knock-on effect on our finances as we paid for agency nurses, invested in attracting a number of international nurses who joined us early in 2020, and started spending on our winter plan two months earlier than we anticipated. NHS England/NHS Improvement (NHSE/I) recognised this and gave us an extra £2.2m in winter funding, but it was just a fraction of what it actually cost us to meet the health needs of local people.

With such unrelenting pressure on colleagues it is perhaps unsurprising that when the Care Quality Commission (CQC) carried out its most recent regular inspection of our services that inspectors found we had been unable to consistently sustain the improvements we made during 2018-19. They visited us in January and February 2020, at the height of the winter and after our teams had worked through months of unprecedented demand for care, but still we and our colleagues were disappointed by some of the care they witnessed, particularly in our emergency department.

We took immediate action to address the issues they highlighted during the inspection, particularly those in relation to the care of people with mental health problems, and we are continuing to work on those areas. We will not be satisfied until the quality of care in all of our services is consistently of the standard we would want for our families.

You can read more about the CQC inspection on page 77, but as well as highlighting issues for us to address – and we are – the CQC also shone a light on issues that we cannot resolve on our own. Immediately after the initial feedback from the CQC we instigated a risk summit that brought together local health and social care partners and from that has developed Stockport System Improvement Board. It is meeting monthly to review the improvements we are making in response to the CQC inspection, but also to focus on the issues that all partners are working on to improve care for local people, including the flow of patients through the hospital and care of people with mental health problems.

The report also highlighted concerns about our governance processes in relation to quality, safety and staffing. In August 2019 we had recognised the need to improve our Trust-wide approach to governance and risk assurance, and we asked NHSE/I for its support to carry out an independent review of these processes. They were unable to start the work until the beginning of 2020, and at the time of writing this report we had just received their report. But in April 2020 we welcomed Paul Moore into the role of Interim Director of Quality Governance and Risk Assurance to take forward recommendations from the review that will re-shape how we manage governance and risk across the organisation, from ward to Board and back again.

He joined a number of new colleagues that we have welcomed to the Board of Directors and Executive Director Team over the last 12 months. These change were in completion of our intention to have the leadership skills, capabilities and experience to drive forward the organisation's transformation journey that we will need to deliver if we are to achieve our ambition to a be rated as a "good" and then, ultimately an "outstanding" trust.

Those changes began with the appointment of Louise Robson as Chief Executive, who joined us in January 2019, and it continued with the appointment of John Graham as Director of Finance, who joined us in May 2019; Greg Moores, who took up the role of Director of Workforce & Organisational Development in June 2019; Dr Marisa Logan-Ward and Mark Beaton, who joined us in Non-Executive roles in August 2019; and Caroline Parnell, who joined us as Director of Communications & Corporate Affairs in November 2019 after a period of supporting us on an interim basis.

Simon Bennett also took up the role of Director of Strategy, Partnerships and Transformation, prior to Hugh Mullen retiring as Director of Strategy, Partnership and Planning at the end of May 2020, and we are currently looking to recruit two new Non-Executive Directors with clinical and nursing backgrounds. We believe all these changes put us in a much stronger position to lead the organisation through what we expect will be a significant period of change, not only for the Trust but also the local, regional and national health and care system over the next 12 months.

Improving governance has been a theme of 2019-20 – not just us recognising that we need to re-shape our quality governance systems and process - but we have also been changing the way our Council of Governors operates so it is best equipped to deliver on its responsibilities to hold the Board of Directors to account. You can read more about that on page 70.

It seemed that no sooner had the CQC completed its inspection than we were thrown into preparing for the impact of the Covid-19 pandemic, and the impact on the Trust has been huge. Within a few short weeks our teams had transformed the function of wards, rapidly increased our intensive care capacity, and adapted new ways of working to hold virtual outpatient clinics. We suspended elective work and surgeons trained to support their colleagues in intensive care, school nurses joined hospital nursing teams, we welcomed retired nurses back to our wards, introduced seven day working across all areas, and throughout the organisation individuals joined new teams and took up new roles.

We rapidly transformed care and services in a way that would usually have taken months, if not years to achieve – and I am incredibly proud of the way our colleagues have approached what I hope is a once in a career situation. After months of pressure no one would have been surprised if our colleagues had crumbled under the pandemic. But that could not be further from the truth.

Throughout the organisation we have seen examples of individuals and teams facing the challenge head on, adapting the way they work, supporting each other and providing outstanding, life saving care on a daily basis. And it is was not only our frontline colleagues who delivered their best during these unprecedented times, back room staff from cleaners and porters to catering and administrative teams have all stepped up to provide the best possible support to their clinical colleagues and patients.

It has been truly humbling to see the way our colleagues have responded to the pandemic and I know that they have been immensely boosted by the huge groundswell of public support they have received, not just the weekly Clap for Carers but with the amazing donations that have flooded in to us week after week. These have been visible reminders of how much our services mean to local people.

And we have not just seen rapid changes inside the Trust as a result of the pandemic. We have also worked with partners in the local authorities and commissioners on successfully tackling long standing issues, for example, within two hours of a hospital patient being determined as no longer needing care our partners were arranging for them to return home or move to alternative care providers meaning that the number of medically optimised patients waiting in our beds is at the lowest levels we have ever seen.

Partners rapidly commissioned beds in Bramhall Manor, a newly built care home, to take patients needing further assessment, but with rehabilitation support from our community services the vast majority were able to return to living independently. Initiatives such as this mean that our bed occupancy rates are at safe levels and we have enough staff to safely care for those people who need acute hospital services.

None of us want to go back to the situation we found ourselves in during 2019-20, and the changes we and our partners have made as a result of the pandemic demonstrate that we can, by working together, successfully tackle these long standing issues.

We know that we will be living with Covid-19 for some time and may see further peaks, but after a hugely challenging year I am confident that with the amazing dedication of our staff, a strengthened Board of Directors and Executive Team, and a focus on improvement both within the Trust and with our partners, we can manage those peaks and build a “new normal” for our organisation and the local health and care system, which will be significantly better for those who need our care.

Adrian Belton

Chair

24 June 2020

Review of the Year – Service Improvements

Here are just some of the innovations and improvements to services we introduced during 2019-2020 – you will find more in the news and events section of our website www.stockport.nhs.uk

£30.6m for emergency care campus

The highlight of the year was the national announcement that the Trust was to receive £30.6m to build an ambitious emergency and urgent care campus at Stepping Hill Hospital.

The investment was one of 20 new NHS upgrades to support Sustainability and Transformation Partnership (STP) transformation across the country.

Louise Robson, Chief Executive, said: "This is very welcome news and a real cause for celebration, particularly for our emergency department staff, who provide such excellent care for patients' day in and day out despite the rising demand on the service, and the current limitation of the building and the local health and care system.

"The £30.6m will enable us to transform not only the environment from which we provide emergency care to the people of Stockport and the surrounding area, but it will also give local people a choice about how their health needs are met."

Last year we spent £1.2m provided by NHS England to expand the number of consulting and treatment rooms in the existing emergency department, but the new funding will enable the construction of a three storey purpose built emergency and urgent care campus. It will include an urgent care treatment centre, GP assessment unit, and planned investigation unit, as well as a new ambulance access road, and improved waiting areas.

We are currently working on the future model of care for emergency services, which will influence the design of the building that is expected to be constructed in the next two years.

Investment in new CT scanners

Diagnostic services at Stepping Hill Hospital are set to improve after a £2.6m investment in new CT scanners was agreed.

Work has begun on an extended building, which will house two new state of the art scanners and provide an improved environment for patients. The new scanners will be in addition to two existing machines on the hospital site, and the extra capacity should improve waiting times for diagnostic tests for both inpatients and outpatients.

The development is being funded by the Greater Manchester Health and Social Care Partnership as part of its Healthier Together programme to provide enhanced care for patients across Greater Manchester.

£1.8m investment in endoscopy services

We are investing £1.8 in improving our endoscopy services, with the Healthier Together programme funding around half the costs of the development.

The investment will improve our endoscopy suite with two new assessment rooms, a new procedure room and a redesigned recovery area, together with state-of-the-art equipment and improved training facilities.

The improvements will mean the endoscopy team will be able to carry out many more routine procedures, as well as being better equipped to handle emergencies, such as bleeding stomach ulcers.

Demand for our endoscopy services have increased year on year, from 10,000 procedures in 2015, to just over 11,200 in 2018, and the demand is expected to grow to over 13,000 a year by 2023. The complexity of procedures that can be done using endoscopy has also increased meaning that some patients can now avoid surgery. The enhanced services will enable us to meet this increased demand, and provide more rapid testing and treatment for both inpatients and outpatients.

We have also invested a further £300,000 in new state-of-the-art video processors and screens, and a more advanced colonoscope for use in endoscopy procedures. The screens give clinicians sharper more accurate pictures of organs and there is also an additional screen so that the patient can see what is happening during procedures, helping staff to more easily explain procedures.

Enhancing recovery after surgery

Surgical patients at Stepping Hill are now benefitting from a project to help improve their recovery and leave hospital earlier.

Enhanced Recovery After Surgery (ERAS) brings surgical medical, nursing and physiotherapy staff together to ensure that patients are in the best physical shape, before and after major abdominal surgery.

As well as encouraging more physical activity before and after operations, the programme promotes healthy lifestyle modifications together with more specialised care, such as muscle strengthening, oral hygiene and breathing exercises. Patients

are also referred for a pre and postoperative exercise programme provided by local sport and fitness service, Life Leisure.

The programme was initially developed by Manchester University NHS Foundation Trust, and a Health Foundation grant is funding the roll out of the improvement programme across Greater Manchester as part of the Healthier Together implementation work. The initial pilot at Manchester Royal Infirmary showed surgical patients had a 50% reduction in pulmonary complications following major surgery.

Faster fracture care thanks to virtual clinic

Fracture patients are now getting swifter and more efficient care thanks to a successful virtual fracture clinic.

The clinic uses the latest in scanning and communications technology so that orthopaedic consultants can examine fractures on screen, without the patient having to attend an outpatient appointment

Within 24 hours of attendance at A&E X-rays and notes are examined and reviewed virtually by an orthopaedic consultant. Patients are then contacted by telephone and provided with further advice and guidance on how to manage their fracture, without the need for a follow-up appointment.

Since the virtual clinic started it has reviewed over 2,300 patients. There has been a 16% reduction in patients having to attend fracture clinic appointments, and less than seven per cent of those discharged from the virtual clinic needed to return for a further appointment. For patients who do need to attend a clinic appointment, the time from A&E attendance to appointment has reduced by over 32%, and patients are now offered appointments within two to four days instead of four to seven days.

New heart scanning clinic

A new heart scanning clinic is ensuring patient get more speedy treatment by making scans quicker and easier.

The echocardiography clinic, which uses ultrasound to create images of the heart to scan for problems and defects, is the only one in the North West, and one of only three in the country. Run by an anaesthetist as part of the hospital's main pre-operative assessment unit, the clinic offers patients scan without having to move to a separate department, or booking another appointment.

Previously, any patient scheduled for an operation who had a history of heart problems would have been booked into a scan for an appointment at a separate echocardiography clinic, often on a different day. The patient is now seen much sooner before the operation, problems can be identified earlier, and cardiology plans,

including the right medication, can be started sooner. The clinic currently scans around 70 patients per year, with plans to double this activity.

Improved medical equipment support

Hospital and community staff have better support with medical equipment thanks to investment in new engineering staff and improved testing equipment.

Our Electrical and Biomedical Engineering (EBME) team has expanded and taken delivery of new state-of-the-art equipmenmt which can test the safety of medical equipment more quickly and accurately.

New testing devices, which carry out the role of a simulated patient, allow the team to be mobile, enabling them to visit teams to carry out tests on equipment, such as ECG devices, blood pressure testers and oxygen machines.

Previously, staff would have to take their equipment to the EBME department, but the new way of working ensures machines are quickly back up and running sooner, and that saves time for both clinical staff and the EBME team The new testing machines, which cost around £40,000, are also more accurate in detecting faults – meaning that care for patients is safer.

Our clinical research is on the up

Clinical research is crucial for the development of new NHS services and treatments, and the latest national research figures show that our clinical research activities are taking a major step forward..

The latest annual results from the National Institute of Health Research (NIHR) Clinical Research Network (CRN) showed 3,095 of our local population taking part in studies, up from 642 the previous year. This 382% increase is the fifth biggest increase for an NHS trust in the country.

Stepping Hill Hospital is now a key clinical research site, working closely with the Greater Manchester Clinical Research Network. Our research team covers areas such as heart disease, gastroenterology; ear, nose and throat; cancer, reproductive health, stroke, surgery and children. Many of the studies involve patients testing new drugs to see how effective they can be, or completing questionnaires to help improve hospital services.

The research team has also increased its profile in the Trust, with a successful open day for the public to raise awareness of our research studies. Some of the main areas of research were cancer, high intensity specialist acute care, and Meningitis B vaccination for teenagers, where the team was the top recruiter in the country.

Patients interested in taking part in any studies at Stepping Hill Hospital should email: research.development@stockport.nhs.uk or talk o their hospital doctor.

New Nursing Associates

Ensuring we have enough of the right staff with the right skills is key to our ability to provide safe quality care. So we were delighted to celebrate the graduation of our first cohort of 12 new nurse associates – and they were amongst the first in the country to qualify.

They were recruited from existing healthcare assistants as part of a scheme to provide a new caring role, bridging the gap between healthcare assistants and registered nurses. They work alongside these colleagues to deliver hands-on care, focusing on ensuring patients get the compassionate care they need, and freeing up registered nurses to focus on more complex clinical duties.

Nursing associates use their improved skills to help identify conditions among patients and plan care alongside registered nurses. They received their training on the job while also spending a day a week at university. They now work in medical and surgical wards at Stepping Hill Hospital, and also community settings such as health centres, helping to provide enhanced care and getting good feedback from both patients and other staff members.

The first cohort was such a success that we have invested in recruiting a further 30 trainee nursing associates.

School nurses lead the way on vaccines.

Our immunisation and school nursing teams have continued to lead the way in vaccinating teenage girls to help prevent cancer, and they are amongst the first in the country to offer the protection to boys too.

The teams fully immunised 90% of Year 8 girls (aged 12 and 13) with the HPV (human pipillomavirus) vaccination - a total of 1383 girls - and one of highest results in the country. They were also among the first to offer Year 8 boys the vaccine too, as the vaccination has been extended to them nationally for the first time to help prevent cancer.

Robotic surgery 1000th milestone

Our surgical teams reached a landmark in their pioneering surgery, when their 1000th patient had keyhole surgery using a surgical robot.

Since June 2015, the hospital surgical department has used the Da Vinci four armed surgical robot to carry out keyhole surgery. The robot is operated by surgeons to

carry out a wide range of surgery, including the removal or partial removal of kidneys, bladders and prostates.

The robot means surgeons can operate with more precision and less trauma to the body than normal surgery. This means less anaesthesia, reduced blood loss, reduced pain and discomfort, and a lower risk of infection.

The 1000th patient to receive the surgery was Maureen Craig, who had a tumour on her kidney and underwent a partial nephrectomy operation using the robot. She spent just two nights in hospital and was back at work as a podiatrist after just two weeks. Traditional surgery for this condition would typically result in a hospital stay of four to seven days, and a three month recovery period.

Joint success

Stepping Hill Hospital is one of the safest and best places in England and Wales for hip and knee replacement surgery according to national data.

We carry out around 800 hip and knee replacement operations every year, and the latest National Joint Registry (NJR) demonstrates that our services has a much better than average performance for knee replacement, with just 1.62% needing to be replaced within ten years, compared to 3.59% nationally.

Our hip replacements are also better than the England and Wales average, with just 3.84% needing replacement within ten years, compared to 5.16% nationally.

Figures also show that the hospital is amongst the best in England, Wales and Northern for mortality within 30 days of hip fracture surgery. The National Hip Fracture Database Annual Report, compiled by the Royal College of Physicians, highlights that Stepping Hill Hospital was one of 13 hospitals named as having low mortality rates across England, Wales and Northern Ireland, and the best in the North West.

First to back support charter

We were the first NHS Trust to back a new Greater Manchester-wide declaration of support for the LGBT+ community.

We signed up to the All Equals Charter, which was launched at the Manchester Pride Conference to help create a consistent approach to diversity and inclusion across the region. The charter promotes recognition of and respect for LGBT+ people and aims to ensure that LGBT+ safe spaces are created for all people in the community. As part of our staff network we have a very active LGBT+ group which promotes inclusiveness for both staff and patients.

New antenatal Rainbow Clinic

We have a new clinic to provide extra support for mums and dads-to-be who have previously experienced stillbirth, late miscarriage, or early neonatal death.

The Rainbow Clinic is part of a national project to help support parents who have previously suffered this type of trauma, providing individual care and additional scans to identify potential complications in subsequent pregnancies.

As well as specialist scans and diagnosis, the team that runs the clinic provides additional psychological care and support to a family who have already experienced loss, talking them through their worries and fears, and helping them to cope with the anxieties which can accompany a new pregnancy. The Rainbow Clinic at Stepping Hill Hospital is just the third to open in Greater Manchester.

Top rating for stroke service

Our stroke centre was rated the best in England, Wales and Northern Ireland for the third time in the last five years.

In the latest independent quarterly report from the Sentinel Stroke National Audit Programme (SSNAP), we came top in England, Wales and Northern Ireland out of a total of 224 organisations with routinely admitting acute stroke teams.

The report, produced by the Royal College of Physicians in collaboration with stroke clinicians, researchers and patient representatives, rates the quality and performance of services for every stroke patient, from treatment to recovery.

Our stroke centre assesses over 5000 a year patients with suspected stroke and treats over 1,200 inpatient strokes. It is one of only three specialist units in Greater Manchester, and it also treats patients from Eastern Cheshire, Trafford, Tameside and North Derbyshire.

FIT support for frail patients

Stockport has the highest ratio of elderly patients in Greater Manchester and with advanced age often comes frailty, so we set up a new team to provide extra person-centred support for frail patients, including people in the last 12 months of life and those diagnosed with dementia.

The Frailty Intervention Team (FIT) aims to improve outcomes and the quality of life for patients by ensuring they get the person-centred assessments they need to receive the right support, at the right time, in the right place.

The team is made up of GPs, consultants, pharmacists, occupational therapists, physiotherapists, social workers, and Age UK's Back Home team, all working together with community services to support patients when they are ready to be discharged. They also help them to leave hospital quicker, whether that is to go back their own home, or on to a care or nursing home.

One stop ultrasound clinic

The rheumatology team has introduced a pioneering new ultrasound clinic to improve the standard and quality of care for patients with symptoms of inflammatory arthritis.

The Early Inflammatory Arthritis (EIA) ultrasound clinic is a consultant led service and the only one of its kind in the Greater Manchester and Lancashire areas.

The clinic consultants are trained to provide an ultrasound examination of the musculoskeletal system in addition to their usual clinical assessment. This helps to provide an accurate and rapid diagnosis, and enables treatment to be started earlier as it avoids the need for multiple appointments.

The service, which started in November 2019, involves a review of patients suspected to have inflammatory arthritis within three weeks of referral by their GP. The patient receives a consultation and ultrasound assessment, as well as blood tests and X-rays if needed, all on the same day.

The service is expected to benefit over 480 patients a year, and the team aim to extend the 'one stop' ultrasound clinic model to other areas of rheumatology, including giant cell arthritis and large vessel vasculitis.

Audiology training for nursing home staff

Nursing and care home staff in Stockport are now able to give improved support for hearing impaired residents, thanks to our new specialist audiology training courses.

Our audiology specialists now offer a service visiting care homes to teach their staff in how to recognise and respond to hearing loss, and help with hearing aids. The course helps care home staff provide residents with more of the support they need, improving their quality of life, and reducing their need to use hospital and community health services.

This service is being provided by the trust's audiology team based at Stepping Hill Hospital, delivered by qualified and registered audiologists.

Dementia Friends training

More support for patients living with dementia is now available thanks to a new training programme.

A number of our hospital and community staff, as well as volunteers, have trained to become Dementia Friend as part of a national initiative to provide more awareness of the needs of people with dementia.

The training is provided by Mamoona Hood, our Matron for Dementia Care, and since the programme started in January 2020 we have over 40 Dementia Friends, with the number rising weekly. The Dementia Friends are not only able to provide better care for patients and visitors, but also help their colleagues to do so too.

Around 1,300 patients a year treated at Stepping Hill Hospital are living with dementia, and the training follows other new dementia friendly initiatives in recent months, including wards decorated in colours more soothing to patients with dementia, dementia friendly clocks and signage, and the creation of a Memory Café.

Review of the Year - Awards

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

Finance team the tops for working environment

Our finance and procurement department was named as the best healthcare finance team to work for in the North West.

The team won the Healthcare Financial Management Association awards North West 'Great Place to Work' award at its annual ceremony.

They were recognised for creating a positive and supportive working environment for all the team with initiatives including the spreadsheets to bed sheets pledge scheme to ensure financial measures are geared towards improving the patient experience, and a positivity tree, which celebrates staff achievements. Staff surveys show very high levels of satisfaction among the 68 people who work in the team.

A passport to successful support

Work to improve patient centred support for Armed Forces veterans who need our services was shortlisted for an award.

We were shortlisted in the Royal British's Legion's Public Sector Partner category thanks to a nomination by the Greater Manchester and Lancashire branch. The nomination recognised the work we have done to provide the right level of support for all patients who have served in the Armed Forces, including the development of an innovative Veterans Passport to Health and Care.

The passport is a handbook that the veteran owns and completes with information that is important to them, and which they can share with healthcare professionals, reducing the need to repeatedly relate information or experiences that may be distressing.

Created following feedback from a veteran, the handbook is part of an extensive training programme that we have rolled out to our hospital and community staff. We have also established a veterans' action group to take forward improvements.

The passport project is currently the only one of its kind in the North West, and it has generated a great deal of interest from other healthcare providers locally, nationally and as far afield as the Netherlands. The passport was also featured at the NHS Confederation conference in Manchester, attracting the attention of the Secretary of State for Health and Social Care.

Silver award for Armed Forces support

We were one of organisations from across the North West to receive a silver award from the Ministry of Defence Employer Recognition Scheme for our support to the broad armed forces community.

The scheme recognised employers who employ serving and former members of the armed forces, and demonstrate flexibility towards training and mobilisation commitments for reservists and cadet force adult volunteers.

We offer a pre-employment programme for veterans and their families, helping those looking for entry level employment within the NHS. It includes a four week block of Health and Social Care Level 1 accreditation pre-employment training then six weeks of work based training in our services. We also support national campaigns, including Reserves Day and Armed Forces Week, encouraging staff to wear their military uniforms to work.

We also won a top North West healthcare people management award for our outstanding support for staff who work in the armed forces.

We were honoured in the We Look After Our People category of the Healthcare People Management Association's Excellence Awards, which reward the best in NHS management across the North West.

Pain management award shared

Two of senior clinical nurse specialists in acute pain management shared the award for acute pain nurse of the year at the National Acute Pain Awards

Jill Hulme-Duvall and Colette Wharton shared the honour that celebrate the best in acute pain management across the country. They both started their nurse training in 1984 at Stockport School of Nursing. Jill has worked as a specialist nurse since the acute pain service started in 1993, and Colette joined the service in 2009.

They plan, prescribe and implement care and treatment options for both medical and surgical inpatients experiencing acute pain, and also educate patients, nurses and multidisciplinary teams in acute pain management.

They were recognised for going above and beyond in their roles to ensure that complex patients who need extra support are identified and appropriate pain management strategies implemented.

MBE recognition for doctor's work in the Manchester Arena terrorist attack

Sengottiyan Chandrasekaran, an anaesthetic consultant known as Dr Chandra, was in the foyer of Manchester Arena, waiting to pick up his teenage daughter from the Ariana Grande concert on the evening of 22 May 2017, when the deadly terrorist bomb struck.

Thankfully Dr Chandra was not injured, and he straight away went to help emergency services colleagues to treat badly injured people at the scene. After finding his daughter and her friend and dropping them off at home, he then went to work at Stepping Hill Hospital.

Working through the night in the intensive care unit and operating theatres treating people injured in the attack, and it was only in the morning that Dr Chandra mentioned to a colleague that he had been at the arena.

While the national media covered Dr Chandra's story at the time his natural modesty meant he did not give his name, but his efforts were publically recognised when he received an MBE for his contribution to the response to the terrorist attack. He received the honour from the Duke of Cambridge and he said he accepted it on behalf of all the colleagues he worked alongside that night.

Christie Quality Mark

Our outpatient cancer services received top marks for the care they offer patients when the Laurel Suite was presented with a Quality Mark accreditation by The Christie Hospital.

An independent team of inspectors, which included patient representatives and cancer nurses from other hospitals, assessed the services looking at safety, communication with patients, friendliness and openness of staff, standards of documentation, and overall quality of care.

Interviews and questionnaires were also carried out with patients, who said they were extremely pleased with the standards of care they received. The suite also received overwhelmingly positive results in the National Cancer Patient Experience Survey with patients frequently complimenting the caring and comforting nature of the service.

The hospital's Laurel Suite provides chemotherapy and supportive drug treatments to more than 3,800 patients a year.

1. PERFORMANCE REPORT

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

Chief Executive's Statement

This report reflects my first full year as Chief Executive of Stockport NHS Foundation Trust, and as I look back over 2019-20 I have thought about what initially drew me to the organisation.

The truth is that I wanted the opportunity to lead an organisation through a significant improvement journey, and in Stockport I could see an organisation with real potential, staffed by excellent people with a genuine will to improve.

And after the turbulent 12 months that typifies 2019-20 I am still convinced that despite all the challenges facing us, this organisation absolutely does have the potential to make major improvements in the way it operates and provides care to local people.

The organisation has been through a number of very difficult years that has stretched the resilience our staff and the senior leadership alike. As a result of the challenges it has faced it has also operated for a considerable period of time under external scrutiny. At the end of 2018-19 and the start of 2019-20 the situation had started to improve, and we no longer needed extra support from NHSE/I.

However, over the last 12 months we started to see not only the impact of intense and sustained pressures on our services - the worst I have seen in my NHS career - but we also began to uncover the hidden cost of decisions made many years ago when the Trust started to try to address its underlying financial position.

The organisation has suffered from variable levels of investment over the years, with some areas of Stepping Hill Hospital that do not seem to have had any improvements to the environment for many years, while others have had reasonable investment.

There had also been a lack of investment in equipment that would be viewed as basic in other NHS organisations, such as electric beds, and during 2019-20 we started to address some of that backlog of investment by spending £2m on equipment, and developing a plan for future years of spending on equipment and improvements to the estate, starting with the demolition of the ageing wards A12 and A15.

We worked hard to attract external funding, including £2.2m to help offset some of the extra spending to manage winter demand, and investment in our endoscopy and CT capacity (*see page 12).* Our drive for investment culminated in the national announcement that we are to receive £30.6m to develop an emergency and urgent care campus on the hospital site. This is a hugely important development for us that will transform the way we deliver emergency care. Despite some investment in 2018-19 to expand the current department, it only has the capacity to cope with 70,000 patients a year and it is on track to treat 100,000 patients.

Over the years, as the financial position worsened, there was also a lack of investment in staff development, and that has had an impact not only on our ability to retain staff but also to equip them with the skills to lead the innovation and service transformation we will need to be a successful organisation going forward. We are addressing that lack of focus on staff development as part of our People Strategy, and we have also joined the NHSE/I Culture programme that aims to create the sort of supportive culture our staff want to work and thrive in.

While some areas for improvement were obvious from the start, such as the maintenance of our estate, others started to surface during 2019-20.The CQC had highlighted some of the issues in their 2017 inspection report, but it became increasingly obvious that we still had lots to do around our governance arrangements, approach to risk management, and transparency around safety. This was one of the reasons why we decided to seek NHSE/I's support in carrying out an independent review of our governance, and this decision was endorsed by the CQC's most recent inspection of the Trust.

The time and effort that we have expended during 2019-20 to ensure the safety of our estate, is just one example where we have had to put back in the basics that had been stripped out over a number of years. We have reinstated key health and safety roles, as well as posts within our estates and facilities team; and set up new systems and processes to ensure we are abiding by national regulations and providing a safe environment for our patients, staff and visitors.

As part of our drive to improve our governance and risk assurance systems from ward to Board and back again, we are setting up a Risk Management Committee to ensure risks to services and how we operate are effectively identified, mitigated and managed. This is just one of a range of changes to our approach to governance and risk that we will make in 2020-21.

Over the last 12 months we have tackled a number of these emerging issues without drawing attention to ourselves – we have just got on and done what needed to be done. I am sure that there will be more issues that will surface in the coming year that we will have to address, but I am very conscious that we can only work on these concerns and make improvements at a pace the organisation can take.

Our performance against national standards during 2019-20 was disappointing to us all, and we did not always deliver the care that local people deserve. The Chair's Report (*see page 6)* addresses some of the challenges that have impacted on our services over the last 12 months - and we are not alone in having to face those issues.

An increasing population of elderly people living longer, often with complex needs, is an issue that the whole health and care sector has to tackle. A shortage of staff with the right skills and experience to meet the rising demand for care is a challenge faced by the NHS nationwide. The rising cost of providing care and increasing demand for services, including a year on year increase in referrals of people suspected of having cancer, places a financial burden on all NHS organisations. And we cannot address those challenges alone.

The Covid-19 pandemic has demonstrated the impressive skills of the health and care system when faced with a challenge, as referenced in the Chair's Report (*see page 6*). A positive factor of the last 12 months is how we've continued to build positive relationships with partners across Stockport, as well as Greater Manchester and East Cheshire, and these have come to the fore during the pandemic.

In Stockport we have worked incredibly closely with our partners in Stockport Metropolitan Borough Council (SMBC) and Stockport Clinical Commissioning Group (CCG) to address issues that had previously seemed almost impossible to resolve, and we need to continue to build on that progress to ensure the position does not slip back in a post-pandemic world.

Our community services have transformed the way they have worked with colleagues to aid rapid hospital discharge and rehabilitation. But we know that if we are to continue to work in this way post-pandemic then we must demonstrate to our partners the significant impact our community staff are having, and secure extra resources for their role in maintaining the health and independence of our local population.

As part of the regional Greater Manchester Hospital Cell we successfully worked with neighbouring trusts in GM and East Cheshire to maintain a consistent level of preparedness and services across the region during the pandemic. While the arrangements we have made in a national command and control situation are likely to remain for some time to come, we continue to work together on developing a recovery plan for the whole region. As co-chair of the GM Elective Care Reform Board I am keen to see the strength of that regional approach to addressing common issues continue, and be focused on tackling many of the challenges the NHS faces as a result of demand for care growing faster than capacity to deliver services.

We know that we cannot tackle all the challenges that Stockport NHS Foundation Trust faces alone, and that is why we continue to be committed to the principles of Stockport Together, as well as collaborative working across Greater Manchester, including East Cheshire, and the Healthier Together programme that will ultimately ensure that everyone living in the region has access to the best possible services. Each of these has a long way to go in delivering on its goals but the work we have done together, both before and during the pandemic, demonstrate that organisations can work together to make positive improvements at pace.

When I joined the organisation work had already begun to re-fresh the Trust's strategy. I was keen that our strategy reflected the rapidly changing regional and national context, so work on engaging our partners and staff in its development continued throughout 2019-20, and it was supported by an exciting programme of engagement with our staff around our values and behaviours. Every individual and team had the opportunity to get involved in that programme and it elicited over 3,500 comments, all of which were considered as we refreshed our values, behaviours and objectives (*see page 30)* that underpin the delivery of the Trust strategy, which was signed off by the Board in March 2020.

Now we are beginning the exciting next step of delivering our strategy with the development of our clinical services strategy. I am truly committed to the development of a clinically led, management enabled organisation, as they are generally the most successful. Having multi-disciplinary teams from across the organisation working together on developing the clinical strategies for each of our services is a major step forward in achieving that objective.

We already have good foundations in place to develop a clinically led organisation with lots of examples of how clinicians are taking the lead in making real improvements to our services, from the reduction in falls to our approach to days away from home and realistic medicine. We have seen clinical leadership result in impressive reductions in pressure ulcers in the community, which would be the envy of many trusts across the country. We have seen clinical leadership result in a stroke service that is second to none, and hip and knee surgery that puts our revision rates amongst the best in the country. These are real examples of how clinical leadership is the right way to go – driving improvements that directly benefit our patients and building a reputation for the organisation as a Trust that puts patients first and embraces improvement.

It will be strategies developed by our multi-disciplinary clinical teams that will determine the staffing and resources we will need to go forward, and key to achieving our vision for the future of the Trust and its services is a highly skilled and highly motivated workforce. We have seen what our staff can do when they are challenged – they have demonstrated incredibly resilience and commitment not only during the pandemic but throughout the 2019-20 winter, when pressure began to build on our services as early as the summer.

To have the workforce we need for a successful future then we have to make Stockport a place that attracts the best talent, both clinical and managerial, which is why the delivery of our People Strategy is so important, including the culture programme and the work we are doing to recruit, retain and support staff (*see the Staff Report).* We certainly have a more engaged workforce as the work around the development of our vision and behaviours demonstrates, along with the improved response rate for the annual NHS survey. While, the survey results show that we still have more to do to achieve our objective of making Stockport a great place to work, everyone who comes to the Trust talks about how friendly the organisation is, and that's certainly been my experience.

We need to build on that unique selling point, but also create a broader reputation for the organisation as a district general hospital and provider of community services that punches above its weight - an organisation that embrace a transformational approach, and genuinely unleashes the talents, aspirations and potential of all its staff.

In 2019-20 we began to lay the foundations for that by strengthening the Board of Directors and Executive Director Team, starting to address some of the under investment in the Trust, pushing on with delivery of our People Strategy, beginning to address the flaws in our governance and risk assurance processes, developing the Trust's strategy, and delivering our financial plan for the year.

We know that in the short term the challenges we face in relation to rising demand, workforce gaps, and a deteriorating underlying financial position - and their impact on our performance against national standards - will not go away. It is all too easy to focus on these operational demands, but while planning for further potential Covid-19 peaks we also need to look to the future.

We are currently working on recovery plans for ourselves, as well as for Stockport and Greater Manchester. We need to ensure that in delivering those plans and achieving the objectives set out in our strategy that the organisation is as effective as possible. During 2019-20 I visited a number of organisations that have transformed themselves, and that is what we will need to start to do over the next 12 months if we are to ensure Stockport is a safe and sustainable organisation able to achieve its ambitions and aspirations for the future.

We will review our current structures to ensure we have the right structures, people and development support in place to deliver on the clinical strategies. We will develop an accountability framework that gives our senior leadership the guidance, support and responsibility to identify what needs to be done and deliver on what we say we're going to do.

We will see our new values and behaviours embedded in every aspect of our organisation, from our job descriptions and annual appraisals to the everyday way we work together. We will maximise opportunities for staff to help shape the development of the organisation going forward, and proactively build our reputation as an organisation that actively "**cares, respects and listens"** to our staff, our patients and our partners.

When things are tough, as they undoubtedly have been during 2019-20, we quickly forget the positives, but the Review of the Year section of this report (*see page 11)* demonstrate that we have lots to be proud of.

We have also seen:

- the number of compliments received by our services rise,
- patients highly recommend us as a place to be cared for,
- new clinical staff join us,
- huge engagement from staff across the Trust in the development of our new values and behaviours,
- hundreds of Proud to Care certificates awarded to staff throughout the organisation,
- great developments driven by patient feedback such as the veteran's passport to health and care that has been hailed nationally as an example of good practice,
- national accreditation for a number of services, including Macmillan accreditation for our cancer care and Baby Friendly recognition for our integrated maternity services,
- a host of regional and national awards for everything from our services and staff, to our approach to equality and diversity (*see page 18)*.

All of these positives are down to the dedication, enthusiasm and commitment of our staff, who despite all the pressures continue to work every day to make a difference to our patients and their colleagues. They demonstrate the power of strong teams that care about and support each other.

It is because of the unique group of staff at Stockport NHS Foundation Trust that I am looking forward to 2020-21 with confidence that we can continue to make the improvements we need to make at a pace that will ensure we are able to rise to the challenges facing all health and care services, but also achieve our ambitions for the future.

The Trust

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

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

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

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

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

We are licensed to provide the following mandatory services:

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

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

The Business Groups are:

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

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

- Corporate nursing,
- Communications,
- Estates and facilities,
- Finance,
- Information Management & Technology,
- Procurement,
- Strategy & planning,
- Workforce & organisations development,
- Learning & development.

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

Our strategic priorities and objectives have been developed and informed through engagement and listening exercises with our staff and stakeholders. We have also carried out a major programme of engagement with our staff to re-define the values and behaviours that will underpin the successful delivery of our strategy.

Our high level strategy is to:

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

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

Our strategic objectives are:

- to be a great place to work,
- always learning, continually improving;
- helping people to live their best lives,
- investing for the future by using our resources well,
- working with others for our patients and communities.

Louise Robson

Chief Executive

24 June 2020

Key risks to delivering our objectives

The Board of Directors has identified its strategic objectives and associate risks in a Board Assurance Framework, which is subject to regular review by the Board.

The Corporate Risk Register, which is reviewed by the Board of Directors each month, also clearly articulated the risks to the delivery of our objectives over the last 12 months, and they are:

- availability of staff with the right skills and experience,
- an ageing estate,
- the financial position of the Trust and its commissioners.

Staff

Ensuring the organisation has sufficient staff with the right skills and experience is an ongoing challenge for many NHS organisations, and it is one that has rightly concerned the Board of Directors during 2019-20.

We have taken positive steps forward in recruiting to some traditionally difficult to fill consultant roles, and we have also invested in the recruitment of a number of overseas nurses, as well as the development of nurse associate roles. We have continued with efforts to recruit from the local population, but we acknowledge that there is keen competition for nurse recruits in Great Manchester.

In early 2020 the Board of Directors received a proposal to invest £8m in the short to medium term development of our nursing workforce. The Board supported the proposal in principle, but acknowledged that we did not have the available funds to meet the costs. We were in discussions with service commissioners, Greater Manchester Health and Social Care Partnership, and NHSE/I about the need for investment when the Covid-19 pandemic began.

At the time of writing this report the Trust had around 140 nurse vacancies and a staff sickness rate of 12%, with around eight per cent related to Covid-19. We rely heavily on bank and agency nurses to safely staff our services, and over the last year we have focused on increasing our bank staff and reducing our spending on agency staffing, managing to keep costs below the three per cent ceiling.

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

Moving into 2020-21 the Board of Directors will continue to monitor safe staffing levels and balance those against its stated risk appetite. As a result, this may mean consideration of the closure of some services, either in the short term or

permanently, if the Board cannot satisfy itself that it can continue to staff those services safely.

Ageing estate

At the start of 2019-20 a number of risks were identified in the management of the organisation's ageing estate and delivery of its estates and facilities services. Some of these risks were related to the unintended consequences of historic decisions to take considerable resources out of these services to meet cost improvement plans.

We commissioned an independent review of the services by a highly experienced director of NHS estates and facilities, and as a result of their feedback we developed a comprehensive action plan. This included recruiting new staff and investing £0.5m in ensuring that we have robust services in place to deliver our statutory responsibilities.

The action plan was monitored on a fortnightly basis by the Executive Directors and monthly by the Board of Directors. We recently asked the director to return to carry out an independent review of progress, and he concluded that our estates and facilities team was now delivering "standards you would expect to see in a well run service."

As well as the issues we identified in the estates and facilities services, it is clear that there has been an under-investment in some parts of our estate for a considerable period of time. That has resulted in areas in which it is difficult to provide the standard of care you would expect in a modern hospital.

We are currently developing a comprehensive estates strategy, but we have welcomed the commitment of significant capital investment in our endoscopy and CT services as part of the Healthier Together programme, and £30.6m of national funding for the development a new emergency care campus.

For 2020-21 we have agreed a capital programme of around £22m, including £7.8m to be spent on a number of estate projects that will address some of the ageing infrastructure, as well as fund new developments, including:

- site a modular building at Stepping Hill Hospital to help with decongestion of the emergency department prior to the building of the emergency care campus,
- upgrade the ground floor of our maternity block,
- re-provide the Outpatient B accommodation,
- Create extra car parking space.

Financial position

Since 2014, NHS funding has grown much more slowly than historic long-term trends. NHS providers are facing significant financial challenges, and very little central investment in transformation and capital is available. Local authority budgets are under significant pressure, affecting social care and public health provision. We continue to see a high proportion of patients in hospital beds medically fit for discharge and awaiting social care packages or placements, which results in a delay to their discharge.

In line with the publication of the NHS Long Term Plan the Government announced an increase in NHS funding to support the development of a new 10-year long-term plan for the NHS. While this funding is welcomed, it is widely acknowledged that this will not match the levels of increased demand the NHS is expecting to see. Providers will therefore be increasingly required to redouble efforts to ensure funding is used as efficiently and effectively as possible to increase productivity, reduce waste and face the challenges ahead. The ageing population and increasing demand for services places a significant financial strain upon our acute and community services.

The underlying financial deficit is currently in excess of £43m, and the Trust's Long Term Financial Plan (LTP) therefore indicates that the Trust will require continued support through the Financial Recovery Funding, and efficiency savings at levels in excess of the national requirement. Having delivered £47m in efficiency savings over the previous five years, we are finding the continued delivery of savings in excess of the national requirement extremely challenging.

The £30.6m emergency care and pathology campus development will help us to improve the emergency department estate and also introduce new services in line with increased provision of same day emergency care for patients as set out in the LTP. This forms part of a longer-term estate and site redevelopment plan which will require additional external capital funding. We also continue to plan for the release of external capital funding associated with being designated a specialist site for urgent and acute general surgery as part of the Healthier Together programme.

We are committed to the safe delivery of a financially sustainable future for Stockport NHS FT.

Going Concern

The Board of Directors is required to assess the ability of the organisation to continue as a going concern over the next 12 months and into the future, as part of preparing the Annual Accounts and as required by International Accounting Standards 1 (IAS 1).

This is assessment is undertaken by considering the information available about the future prospects of the organisation as at 31 March 2020, including an assessment of the future cost and productivity improvements required to enable us to manage through the difficult economic climate facing the organisation in the future. The financial and governance risks assessed by NHS Improvement are examined, as well as additional operational risks such as the potential loss of key personnel and activity changes.

At a Board of Directors meeting held on 27 February 2020, the Directors carefully considered a control total offer of a deficit of £28.9m which, if accepted, would earn Financial Recovery Funding of £21.8m and would require the delivery of a cost improvement and recovery programme of £27.3m, to deliver a break even position for 2020-21. In assessing the risk in the operational delivery of this and taking into account the requirement to invest in a number of quality and safety schemes, including clinical staff recruitment and the loss of income from commissioner contracts, the Board decided that it was not in a position to accept the control total. At the time of writing this report, and as a consequence of the revised financial regime in response to the pandemic, contracts for 2020-21 had not been signed with the organisation's main commissioners.

As a result of the Covid-19 pandemic the planning regime for health services in England was halted, and a temporary finance regime adopted for a minimum of the first four months of the financial year. This provided all NHS trusts with guaranteed income and cash resources, backed by a series of block contracts and top up mechanisms for operation in 2020-21. A process was also put in place for the reclaiming of Covid-19 costs for revenue and capital, with the focus on the principles of managing public money and maintaining good financial governance.

We received confirmation of the extinguishing of our revenue and capital loans of £46.1m from September 2020, which means that we will not be required to repay the principle capital debt. This was previously a risk in our long term financial strategy. Interest in the form of a dividend will be paid on the loan principles at a rate of 3.5% and this is higher than the interest previously of 1.5%, however it is under review for 2021-22.

The operational landscape of the NHS changed beyond recognition in the first two months of the Covid-19 pandemic with significant elements of elective activity postponed, revised clinical pathways transformed as technology was rapidly

adopted, and the way patients accessed services dramatically changed. It is unclear at this stage how the finance regime will operate for the rest of 2020-21, but early indications are that the block contracts and top up mechanisms are likely to be in place for the rest of the financial year.

We continue to work closely with Greater Manchester colleagues and East Cheshire on the future configuration of local services, and this will have greater focus as the plans for recovery for the NHS and the position going into winter 2020-21 are developed. There is no further risk to any of our services currently, and therefore this is evidence of the confirmation of the organisation's continuation as a going concern.

A detailed report assessing the financial risks facing the organisation was considered by the Board of Directors on 6 May 2020. The assessment focused on:

- the revised financial regime for the start of 2020-21,
- the continued level of staff vacancies, which are often covered by bank and agency staff;
- operational pressures in meeting the national patient standards,
- consequences of the investment required arising from the CQC's latest inspection,
- the challenging financial environment beyond the Covid-19 pandemic when the affordability of the NHS will remain challenged, and
- recurrent delivery of cost improvement programmes with minimal redundancy costs and the impact on commissioner requested services.

The Board concluded that while 2019-20 will be as challenging as the previous two financial years, particularly with regard to delivery of recurrent cost improvements, the offer of £24.5m to significantly reduce the deficit provides a more sustainable future for the organisation.

Stockport NHS Foundation Trust is therefore considered to be a going concern and the Board has reason to believe that this will remain the case for the next 12 months and beyond. The Board is committed to exercising the strong financial management required to achieve the control total and will continue to review the financial position and financial controls throughout 2020-21, together with future plans through a medium term financial strategy.

A key consideration of the going concern assessment was the overall availability of cash to enable us to meet our financial obligations. As the cash regime for the organisation is more secure than the previous financial year and with the change in regime which guarantees block income, the cash flow forecast starts the financial year with a balance of £17.6m and we are not forecasting to require additional cost support in the first three months of the year.

Our Cash Action Group has worked proactively throughout the year to maximise liquidity and this will continue to operate in the financial year 2020-21 to ensure that cash is maximised. The principle of cash flow between Greater Manchester trusts for provider to provider agreements has also been collectively agreed. However, the new regime does continue to allow for emergency cash provision should circumstances arise which provides working capital security for the organisation.

Consequently, after making enquiries, the Board of Directors has a reasonable expectation that Stockport NHS Foundation Trust has adequate resources (including external cash flow assistance) to continue its operations on an ongoing basis, whilst acknowledging material uncertainty relating to:

- the uncertainty of the sufficiency of the Trust's funding once the current block contract Covid-19 funding ceases,
- the lack of an agreed control total position to return to at that point,
- the uncertainty of whether additional one-off funding would be available to support the Trust.

The Board continues to adopt the going concern basis in preparing the accounts.

Operational performance

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

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

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

- safe,
- effective,
- caring,
- responsive,
- efficient.

The format and content of the IPR is regularly reviewed to ensure that the metrics accurately reflect our priorities.

The table below summaries our performance against the NHSE/I Single Oversight Framework during 2019-20:

Metric	Standard	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Referral to treatment: incomplete pathway	92%	84.2%	81.5%	78.2%	75.6%
Referral to treatment: waiting list size	22137	24154	24444	24673	24684
Cancer 62 day wait from referral to first treatment	85%	78.9%	75.2%	69.8%	72.5%
Maximum six week wait for diagnostics	1%	0.6%	5.8%	11.2%	14.5%
A&E four hour from arrival to treatment	95%	74.4%	70.6%	62.5%	67.3%

Referral to treatment standards

We last achieved the national referral to treatment incomplete standard in April 2019.

An improvement trajectory was developed and agreed with NHSI, which we achieved throughout quarter one and again in September 2019. However, since then performance has been significantly below trajectory due to a combination of factors, including:

- an increasing number of referrals in specialties such as cardiology and respiratory medicine,
- a growing numbers of urgent cancer referrals taking clinical priority over more routine non-urgent work,
- some specialist services having more patient referrals than the clinical capacity available could cope with rapidly,
- changes or closure of services provided by neighbouring hospitals, such as rheumatology and orthodontics, which meant patients came to us for care.

All these factors have resulted in increased waiting times for patients.

We also agreed an improvement trajectory with NHSI for the referral to treatment waiting list size, which we achieved throughout quarter one but the position deteriorated as the year continued.

The Covid-19 pandemic initially resulted in a significant reduction in GP referrals that had a positive impact on the waiting list size, but we expect that position to be only short term and for the waiting list size to grow in 2020-21.

Cancer standard

We were not alone in having struggled to achieve the cancer standard for our patients. Trusts across Greater Manchester faced similar challenges over the last 12 month.

Our performance was positive in the first quarter of 2019-20, however as the year went on overall performance deteriorated due to a number of factors, including:

- diagnostic capacity issues in pathology, endoscopy and CT,
- our breast services had historically performed well against the 62 day standard but they moved to other trusts during the year,
- a 12% increase in two week wait suspected cancer referrals, which followed the 21.8% increase seen in 2018/19;
- robotic surgical capacity for major urology cancer cases,
- delays in receiving funding to help implement straight to test pathways in colorectal, urology and lung,
- waiting times for diagnostic tests performed at other sites.

Most of these issues continue to cause problems, and as a result we expect the 62 day cancer pathway to remain challenging in 2020-21.

The Covid-19 pandemic has also affected the vast majority of elective activity, including cancer. While alternative models of care are being offered to those patients most in need there are a significant number of people waiting on the cancer pathway due to the risk of diagnostic tests and treatment during the pandemic.

Patients are being regularly reviewed in line with national guidance, but the impact of the pandemic on elective care will lead to much longer waits for diagnostic tests and treatment for patients with suspected cancer. We are also expecting a surge in demand post the pandemic as a result of people delaying seeking investigations, which will contribute further to extended waiting times.

Diagnostic standard

We failed to achieve the diagnostic standard due to a greater demand for diagnostic testing than the capacity available, particularly in endoscopy and CT scanning.

To address the capacity issues in endoscopy we have seen significant investment in the service (*see Review of the Year section)* with the building of a new endoscopy suite and the recruitment of extra gastroenterology consultants.

An increase in cancer referrals and emergency patients requiring CT scans put our existing CT capacity under pressure, coupled with the unexpected failure of our two existing scanners during 2019-20. We have invested in two further scanners to increase the capacity available and we are currently building a new scanning suite.

We developed a recovery plan and in February 2019 we were starting to see an improvement in the position as a result. However, the Covid-19 pandemic has had a significant impact on endoscopy activity as national clinical guidance is to avoid this type of diagnostic procedure.

A& E four hour standard

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

Acknowledging that our emergency department was not built to cope with the number of patients that we see on a daily basis, we welcomed the Government's commitment to a £30.6m emergency care campus development, which we have begun planning.

We agreed an improvement trajectory of 80% for this standard, but were unable to achieve it during 2019-20 due to increasing number of people attending the emergency department and the service being under unprecedented and unrelenting pressure from August 2019 and throughout the winter.

This was further compounded by difficulties in securing timely out of hospital care for many patients who longer need acute hospital service, which seriously impacted the flow of patients through the hospital and our ability to move patients from the emergency department to the most appropriate service to meet their needs.

These issues were highlighted by the CQC when it carried out its regular review of our services (*see page 79)*. We took immediate actions to address the concerns they raised during the inspection and we have developed a robust improvement plan for

our emergency department. This is being monitored - along with actions for our partners to improve the local health and care system - by Stockport System Improvement Board and our Board of Directors.

As a result of the Covid-19 pandemic we saw significant improvements to the flow of patients through the hospital as we worked closely with commissioners, primary care and local authorities to ensure rapid hospital discharge, with the majority of patients returning home or moving to alternative care settings within two hours of being identified as no longer needing acute hospital care. We also implemented a new hot and cold model of care in the emergency department, to separate Covid-19 patients from non Covid-19 patients.

These actions, along with those identified in our improvement plan and a reduction in patient numbers to around 200 per day, have resulted in a significant improvement in performance against the four hour standard in the first quarter of 2020-21. At the time of writing this report the department had consistently achieved the 95% standard, been rated as one of the top performing services in the North, and acknowledged for its level of improvement by Dr. Clifford Mann, National Clinical Advisor on A&E.

Service changes

The impact of demand for care rising more rapidly than capacity resulted in a number of service changes during 2019-20, including ones instigated by the Trust and other instigated by other organisations that had a knock-on impact on us.

East Cheshire

East Cheshire NHS Trust found itself unable to continue to provide rheumatology or orthodontic services during 2019-20 and as a result patients were directed elsewhere, including to Stockport, resulting in a significant increase in referrals for our services and associated rises in waiting times.

At the start of the pandemic East Cheshire NHS Trust raised concerns about its ability to continue to provide maternity services due to a number of its anaesthetists being required to support intensive care services. As a result pregnant women were directed to other trusts in the region for their care and East Cheshire's maternity team were also redeployed to work in partner organisations. We welcomed six mid-wives from East Cheshire and continue to provide care for a number of pregnant women from that area, with very positive patient feedback.

We are currently working closely with colleagues in East Cheshire on how we can together stablise a number of services for the benefit of both our populations, and also, as part of our recovery plans, look at how we can re-introduce services suspended as a result of the pandemic.

Breast services

There is a national shortage of radiologists, including those with specialist skills in breast radiology, and those staff are keen to work in large specialist centres that also provides breast screening.

Stockport does not provide the local breast screening service and for a couple of years we had struggled to maintain our breast services due to a combination of difficulties in recruiting breast radiologists and a year on year increase in referrals. In 2018, in partnership with commissioners, we decided to temporarily stop referrals to the service for patients outside of Stockport in an attempt to stabilise the service.

Between September 2018 and January 2019 we worked hard to recruit to key posts, and we were relatively successful in appointing interim staff to allow the service to re-open to High Peak and North Derbyshire patients. However, we were aware that this was only likely to be a temporary solution as it depended on interim and substantive clinicians remaining in Stockport.

These clinicians knew about a proposal to re-organise breast services across Greater Manchester to follow national guidance that recommends all services caring for breast patients would have to be both screening and symptomatic (diagnostic) centres. If this proposal was to go ahead then we would no longer be a provider of breast services.

While we continued to provide a safe and high quality service, in May 2019 we again faced staffing issues that meant all patients could not be seen within the national standard waiting time of two weeks. As a result the CCG agreed that we could no longer provide the service and instead it should be commissioned from neighbouring trusts. This was a sad decision for us and the breast service team, who transferred to neighbouring organisations, but it was the right decision for patients, who should be diagnosed and treated in a timely manner.

Bluebell

Bluebell had previously provided care for patients:

- needing end of life care,
- waiting for continuing health care assessments,
- without therapy needs,
- waiting for places in nursing and residential care home.

In September 2018, after discussions with commissioners, Bluebell became a transfer to assess unit to support patients who no longer need acute hospital care but are waiting for a package of support so they can return home, or to move to an

alternative care provider .Care at the facility is now led by a GP, and it has a focus on on-going therapy and rehabilitation to ideally help patients return home.

Consultation about service changes

We made no material changes to our services that required formal consultant during 2019-20, however we did join the CCG at SMBC's Overview and Scrutiny Committee to support their decision to de-commission our breast services.

Overseas operations

We did not conduct any overseas operations during 2019-20.

NHS England/NHS Improvement Single Oversight Framework

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

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

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

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

Finance and use of resources

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

Our performance against the metrics with regard to the use of resources is detailed in the following table:

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

The organisation therefore finished the year with an overall score of a 3, which is driven by 'excellent' performance in financial control, an improvement in achieving financial balance but 'poor' performance relating to liquidity as the Trust continues to access working capital support.

Financial Review

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

The Group accounts reflect the outturn of the Trust of a £2.6m surplus in 2019-20 and subsidiaries' profit of £81k for Stepping Hill Enterprises Ltd. The Trust Charity had net movement of £5k incoming funds in 2019-20. Further detail on both of these elements is provided in note 33 in the annual accounts. The figures quoted in the following section relate solely to the Trust as the other components are considered immaterial for the purposes of the Group accounts.

We accepted the control total for 2019-20 and delivered an improved financial deficit of £3.3m against a plan of £3.6m, as reflected in the financial controls section of the Single Oversight Framework. However, in achieving this position the organisation was then awarded additional Financial Recovery Fund to bring us to a balanced position; we therefore received £27.6m in Provider Sustainability Funds, Financial Recovery Funds and Marginal Rate Emergency Threshold Relief. The impairment reversal on the revaluation of assets of £2.7m delivered the organisation an overall surplus.

To achieve the plan we delivered a cost improvement programme of £13.5m against a target of £14.2m, however the recurrent savings achieved were £4.7m and therefore this presents an ongoing financial challenge in 2020-21. All efficiency schemes are subject to quality impact assessments to assess the potential impact on the quality and safety of services and ensure that any identified risks are effectively mitigated. Key delivery programmes in year focused on reductions in the use of agency staffing, operational productivity gains and the transformation of patient pathways.

Whilst achieving savings, we have continued to invest in improving services for patients, both in terms of the quality and safety of services and investing in buildings and equipment, such as a bed replacement programme. Total investment through

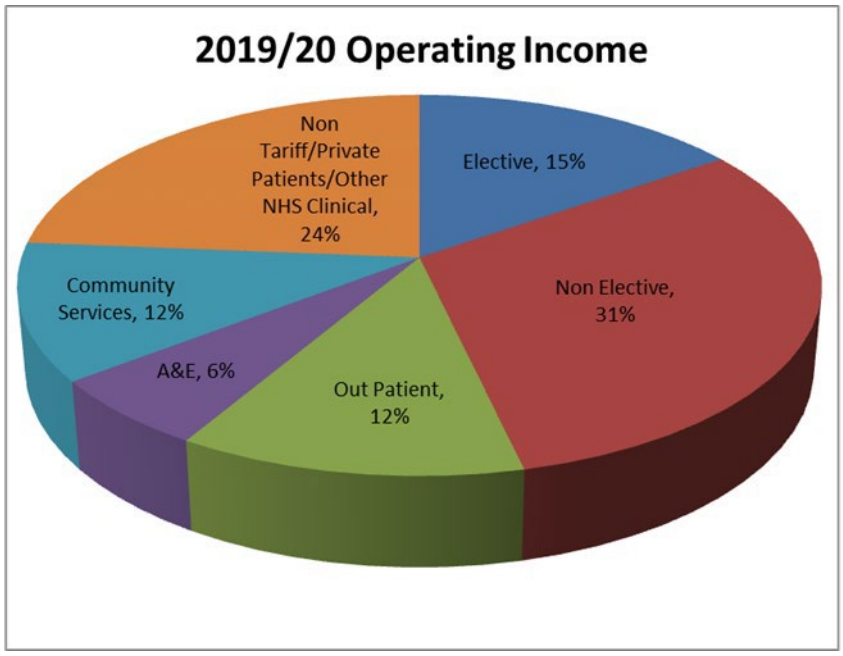
the capital programme in 2019-20 was £13.5m, which included £5.4m on equipment, £2.7m on estates, and £5.1m on IT investments, including upgrade of infrastructure and key clinical systems.

Income and Expenditure

In 2019-20 our overall income was £339.9m (£295.3m in 2018-19). Income from provision of health services was greater than that from provision of goods and services for any other purpose. We did not receive or make any political donations in 2019-20. Our operating income in 2019-20 was £277.4m, an increase of £11m from 2018-19, which predominantly related:

- to inflation in pay costs,
- a 6.3% increase to employer pension contributions,
- increased investments in winter,
- investment in community services.

The income is shown by activity in the chart below:



The introduction of blended contracts was made from April 2019 and we agreed a blended contract for urgent care (non-elective and emergency service) and outpatients for 2019-20 with Stockport CCG, our lead commissioner.

This meant that if activity was above the agreed contract level that income would be paid at 20% of the national tariff and if activity was below the agreed contract level then income would be received at a guaranteed 80% of national tariff.

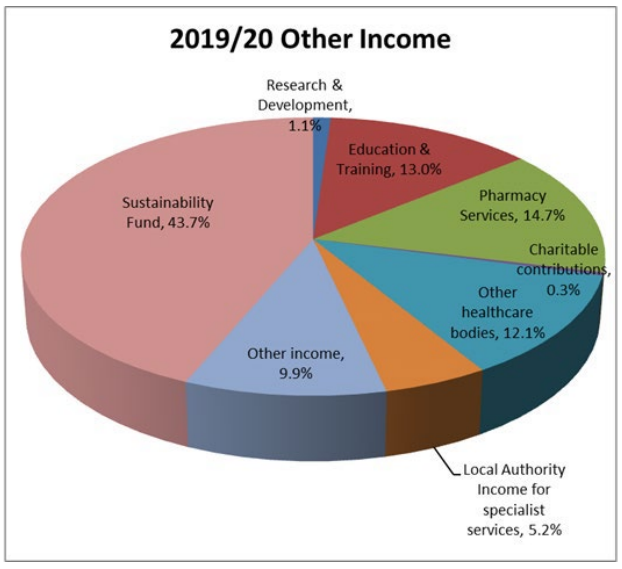
We continued to see growth in emergency attendances in-year, but saw a reduced number of urgent care admissions. In addition, we received income from Stockport CCG to provide system resilience during the 2019-20 winter as part of the overall Stockport system plan.

Elective income continued to be received on a case by case basis under the rules within the health payment system, Payment by Results (PBR). Elective income was behind plan at the end of the year, with fewer referrals to some of the sub-specialties within orthopaedics for in patient cases. We performed in line with plan for day case surgery, continuing to see patients across a range of specialties, and saw an increased number of patients for diagnostic testing.

Private patient and overseas visitors' income represented a modest proportion of total operating income with £0.3m earned in 2019-20 compared with £0.4m in 2018-19. The highest areas of income relates to urology services with patients treated using a specialist robot. We therefore confirm that income from the provision of goods and services for the purposes of the health service in England was greater than our income from the provision of goods and services for any other purpose.

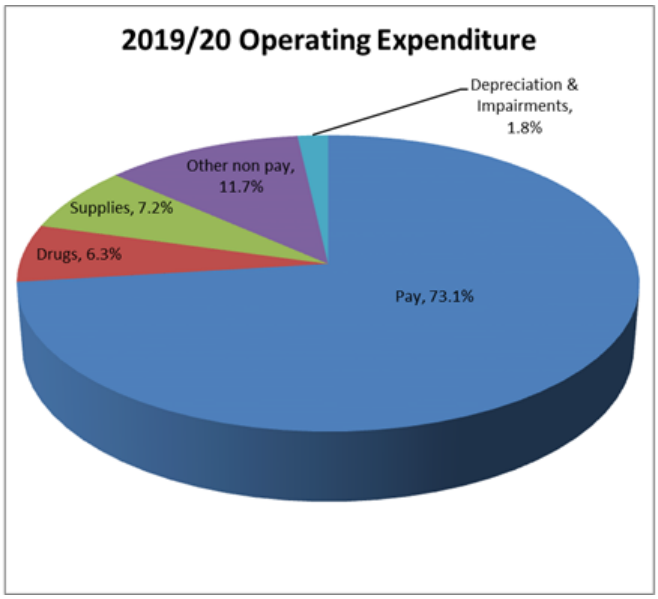
Our Board of Directors accepted the control total for 2019-20 and we delivered our financial plan against this value. Therefore, income of £27.6m was earned from the Provider Sustainability Fund, Financial Recovery Fund and reimbursement of the Marginal Rate Emergency Tariff funding.

We also earned income from a number of different sources and a breakdown of the £63.3m 'Other Income' is provided in the chart below:

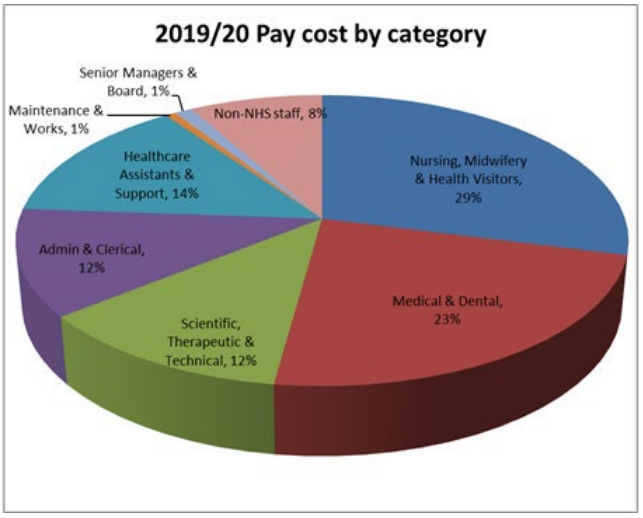


We had no fees and income (income generation) levied, which meet the disclosure criteria under the Managing Public Money definition. We had trading activities within Stockport Pharmaceuticals, whereby it secured contracts via published procurement processes and had recovered full cost within an operating margin, and therefore this is outside the scope of disclosure.

Operating expenditure was £333.9m in 2019-20 (£323.1m in 2018-19). Our costs are divided into the following areas:



Pay costs account for 73% of our operating expenses, and our pay spend is split over the following categories:



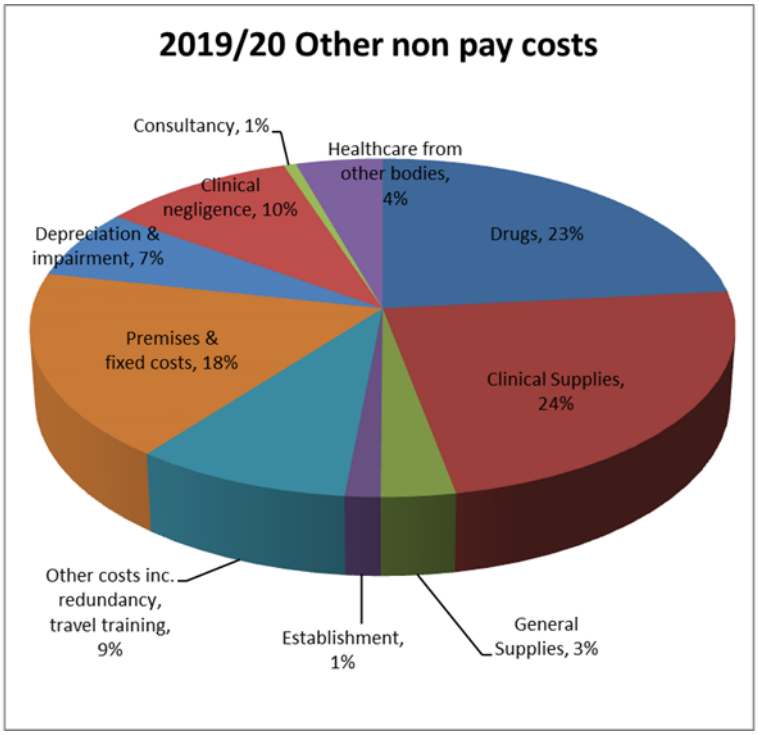
Pay costs in 2019-20 were £243.5m (£223.7m in 2018-19) and the percentage split by staff group as shown in the above chart is in line with previous financial years.

In 2019-20 we increased the employer's pension contribution rate in line with national guidance and this increased pay costs by £8.7m. The Agenda for Change pay deal for NHS staff, excluding medical staff, was agreed in 2018-19 and this resulted in increased costs of £9.3m in year. The medical and dental pay award was also agreed in year and the additional cost of this was £0.9m.

We have continued with investment programmes to recruit to medical and nursing vacancies, including international recruitment and the recruitment of trainee nurse associates and associate physicians. However, we continue to use agency staff

where there are particular specialties with high national vacancy rates for specialist services. Agency costs reduced from £11.8m in 2018-19 to £10.4m in 2019-20.

Non-pay expenditure of £89.8m in 2019-20 was incurred, and this can be demonstrated by category in the chart below:



Overall non pay costs reduced from £99.2m in 2018-19; therefore a reduction year on year of £10m. We had a reversal of impairments on our asset valuation, which accounted for £4.4m of the reduction comparison. The Clinical Negligence costs for the organisation reduced by £1.5m to a total cost of £8.9m.

We continued to contribute towards the Stockport Together programme in year but the accounting treatment for this transaction has changed in year and therefore the purchase of healthcare from NHS bodies has reduced by £2.5m.

Premises costs for community property which are managed by NHS Property Services increased significantly in year due to rebasing of charges and additional work to improve properties. We have reduced our clinical supplies costs, which predominantly related to a reduction in the case mix of patients needing high cost prosthetics.

Balance Sheet

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

We have drawn down revenue support of £41.7m since 2018-19 and paid £1m in interest on this and other long term loans drawn down for capital builds in previous years. Our modest retained cash balances earned interest of £0.1m in 2019-20.

It was announced in March 2020 that there will be a process put in place where interim revenue loans are to be extinguished in 2020-21. We will continue to pay a dividend of 3.5% of the loan value and this rate will be reviewed in 2020-21 for possible implementation in 2021-22.

Our year-end cash balance was £17.6m compared to an opening cash position of £4.9m. In 2020-21 we are operating under a revised financial regime for cash during the Covid-19 pandemic, with block income payments being received and it is not expected that we will require additional borrowing

Charitable Funds

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

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

In 2019-20, charitable funds income was £267,000 and we are extremely grateful for donations of £157,000, legacies of £9,000 and fundraising income of £52,000. The charity also received £50,000 investment income.

Expenditure in 2019-20 was £217,000 including £115,000 on purchases for patient welfare, £27,000 on supporting staff welfare and training activities, £54,000 on equipment, and £3,000 to support research. Expenditure included:

- £34,000 for an Endoscopy Scope Guide,
- £10,000 for a magic sensory carpet for the Swanbourne Gardens Children's Respite Centre,
- £17,000 for the first stage of a programme to introduce noise sound meters on wards,

- £10,000 for smaller items of equipment in the neonatal unit,
- £7,000 to provide new ultrasound couches for the sonography unit.

Financial Outlook

Due to the Covid-19 pandemic the planning process for 2020-21 was suspended and an alternative financial regime was introduced. The Board of Directors had therefore not concluded a full submission of an annual plan for 2020-21. A draft plan was submitted in December 2019 with a series of conditions for acceptance of the control total offered for 2020-21. Without additional national support we continue to have an underlying recurrent deficit of around £43m.

The interim financial regime for 2020-21 gives us guaranteed block income for a minimum of the first four months of the financial year, a process for capturing Covid-19 costs, and where cash will also be matched.

As the Covid-19 situation develops and we consider how future services will be delivered, embracing all the transformational work that has taken place during the pandemic and the clinical strategies across Greater Manchester, a refresh of the medium term financial strategy will take place in the context of a revised financial regime. It remains our aim to continue with financial balance and potentially move into a permanent surplus position.

Our long term debt balance from loans received as revenue support, are to be repaid in September 2020 from awarded Public Dividend Capital. We will therefore no longer incur interest on these as loans, but we will pay Public Dividend Capital interest on them instead. The total loan principle, which will be treated in this way, is £46.1m. We do not expect to require further borrowing in the first half of the financial year under the new finance regime as the block arrangements cover the management of cash balances.

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

Capital Planning 2020/21

We are planning capital expenditure of £22.1m in 2020-21, dependent on the release of capital funding in relation to Healthier Together and the emergency campus and pathology development.

A summary of planned investments is as follows:

Capital description	**Plan 2019/20 £k**
Equipment	2,789
Property Schemes	477
Estates - backlog maintenance	2,555
Information Management & Technology	3,867
Healthier Together	10,825
Emergency Campus & Pathology	1,567
Total Capital Plan	**22,080**

Our backlog maintenance priorities are:

- generator replacements,
- fire compliance,
- electrical board replacements,
- ward refurbishments.

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

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

Sustainability

Environmental Matters

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

Sustainability means:

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

By making the most of social, environmental and economic assets we can improve health, both in the immediate and long term, even in the context of the rising cost of natural resources.

Demonstrating that we consider social and environmental impacts ensures that we meet our legal requirements set out in the Public Services (Social Value) Act (2012).

To fulfill our responsibilities, we have made the following strategic vision statement in our sustainable development management plan:

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

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

Our carbon management implementation plan, which has been in place since 2008, aims to reduce carbon emissions by:

- reducing energy use through rationalisation and efficient design,
- implementing a green travel plan through provision of low carbon travel, transport and access,
- increasing local procurement,
- reducing waste levels and increasing waste recycling,
- reducing water use and associated waste
- increasing organisation-wide awareness of environment issues.

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

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

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

We have a sustainable development management plan in place in accordance with the NHS Carbon Reduction Strategy 2009. This plan sets out our commitments and actions to achieve NHS-wide carbon emission reduction targets.

We achieved the target of a 10% reduction by 2015, and further carbon reduction strategies and projects are in place to achieve the target of a 28% reduction in energy use and carbon emissions by 2020. The main actions being taken to achieve this are summarised below.

Key Objectives

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

- building on our carbon management programme and ensuring a long term vision for sustainable energy management,
- ensuring that environmental protection and social issues, including prevention of pollution, are considered within our strategic planning, management and operations;
- reducing our environmental impacts on water and waste, including capital planning management schemes;
- planning to continue to rationalise the hospital site and make best use of its footprint by working closely with business groups to consider various methods of service delivery for both clinical and non-clinical departments, as well as continuing with our commitment to agile working;
- increasing recycling and waste reduction,
- fulfilling all compliance obligations relating to environmental management,
- reporting and tracking environmental and sustainability key performance indicators locally, and reporting monthly as part of Estates & Facilities' finance and performance meetings.
- reducing vehicle emissions by offering staff a capped choice of low emission or electric vehicles via the NHS car lease scheme,
- increasing engagement with staff and the public at all levels through a range of communications channels,
- embedding sustainability principles our current processes and policies whenever possible,
- ensuring our capital planning processes take into account sustainability options and exploring wider funding routes i.e. SALIX, Environmental Funders Network and CIBSE guidance.
- ensuring all capital schemes are BREEAM certified to ensure sustainability features in the our master planning, infrastructure and building developments. BREEAM standards will also be considered as part of any refurbishment plans.

<u>Carbon and Energy Management</u>

Our approach to carbon and energy management is based on:

- reduction in energy consumption,
- the supply of energy as efficiently as possible, and
- the supply of required energy using low carbon and renewable sources where appropriate.

Efficient energy management necessitates close monitoring and analysis of energy consumption to enable consumption patterns and targets to be set for individual buildings across the estate. Automatic utility metering continue to be rolled out across the estate, which provides half hourly gas, electricity and water consumption data for our buildings. Automatic meter reading helps us to scrutinise consumption

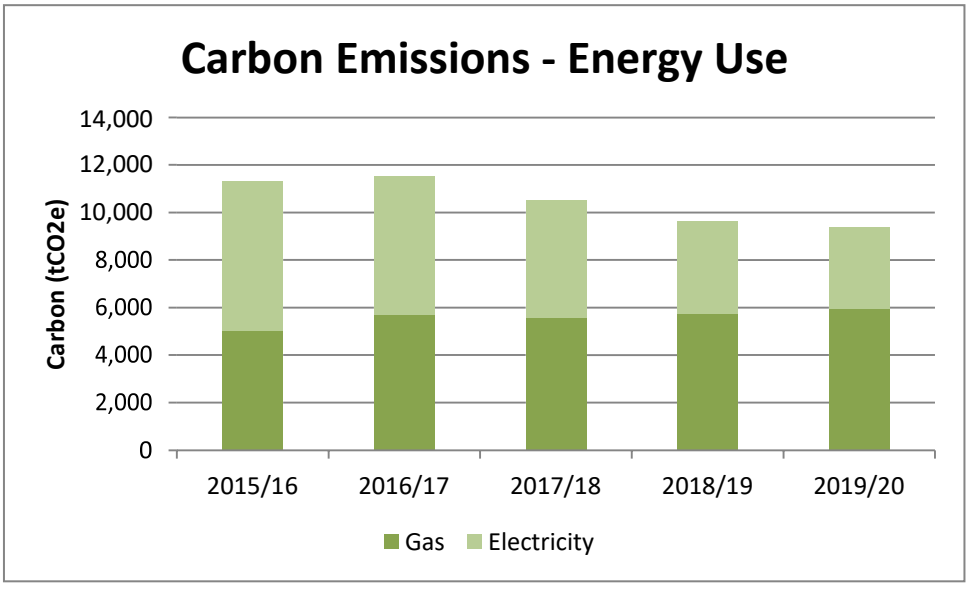
patterns to identify and address inefficiencies, while also enabling greater financial control of energy budgets by eliminating estimated readings.

Energy and Water Consumption

Our consumption of energy during 2019-20 is summarised in the table below along with comparative performance in previous years. We continue to achieve a year on year reduction in energy, and we have been able to sustain competitive priced utilities through a combination of:

- negotiating competitive rates with our energy suppliers,
- introduction of a number of energy efficiency projects,
- raising staff awareness of the need to manage consumption.

Resource		2015/16	2016/17	2017/18	2018/19	2019/20
Gas	Use (kWh)	27,282,955	31,040,831	30,185,153	31,229,742	32,358,588
	tCO_2e	5,032	5,712	5,559	5,745	5,949
Electricity	Use (kWh)	12,572,918	12,907,495	12,848,845	12,676,387	12,311,526
	tCO_2e	6,291	5,800	4,939	3,894	3,414
Total Energy Co2e		11,323	11,511	10,498	9,639	9,363



Water

Water consumption increased in 2019 - 20, with further investigative work required to identify reasons for the increase.

Our estates team actively works to minimise water consumption through the use of water efficient technology across our buildings, and reducing consumption will continue to be an area of focus during 2020-21.

However, we are conscious of the need to balance water efficiency initiatives with maintaining robust infection control regimes and to guard against the risks of legionella contamination of water systems by regular flushing of water outlets.

At the beginning of 2020 a significant steam and hot water leak was located in an obscure corner of our duct network. Although difficult to manage the engineering team implemented a solution which we expect to result in a reduction in consumption.

Waste Management

Effective waste management is a core principle for the organisation, and we are committed to reducing our carbon footprint and improving understanding of the importance of effective waste management in the health service.

Widely distributed recycling bins encourage the collection of paper, cardboard, plastics, tins and glass for recycling, and the waste management team also recycles ink cartridges and batteries. During 2020-21 we will continue to focus on sustainable waste management and work collaboratively with our contractors and partners to drive service and environmental improvements.

During 2019- 20 our aim was to enhance the safe, compliant and sustainable management of waste and disposal across all of our sites, while maximising the volume of waste recycled.

Recycling drop-off points and the segregation of cardboard, scrap metals, furniture and electrical waste, together with improvements made to waste compactors, collection bins and holding areas, have contributed to improved recycling performance. We appointed a new clinical waste contractor in January 2019, which has continued to deliver efficiencies in 2019 -20.

The estates & facilities team provides advice and support for waste management to departments across the organisation, providing guidance, information, equipment and facilities to enable the safe handling, segregation and storage of waste.

Regular waste audits are undertaken and outcomes during 2019-20 informed the planned introduction of arrangements for management of an offensive waste stream, which is expected to further reduce the cost base for waste processing.

The table below provides a summary of improvements over the past four years in relation to treatment of waste streams. Our recycling aspirations continue with plans to increase our level of recycling and ensure we capitalise on any recycling opportunities. The following table illustrates that in 2019 - 20 we have increased our

overall waste tonnage, which is consistent with our increased bed occupancy and high emergency throughput into the hospital.

Waste		2016/17	2017/18	2018/19	2019/20
Recycling	(tonnes)	131.30	84.58	133.54	45.92
	tCO_2e	2.63	1.78	2.81	0.95
Other recovery	(tonnes)	692.00	650.46	533.75	517.09
	tCO_2e	13.84	13.66	11.21	108.69
High Temp disposal	(tonnes)	360.00	332.35	533.63	247.06
	tCO_2e	78.84	73.12	117.40	0
Landfill	(tonnes)	26.00	162.38	36.18	197.02
	tCO_2e	6.35	50.34	11.21	0
Total Waste (tonnes)		1209.30	1229.77	1237.11	1524.92
% Recycled or Re-used		11%	7%	10.80%	13.5%
Total Waste tCO_2e		101.66	138.89	142.63	109.64

Smoke-free Hospitals

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

A complete smoking ban has been in place on our property since 2005, and during 2019 - 20 we took steps to strengthen the effectiveness of this policy with a direct and honest poster campaign supplemented by security officers politely reminding people of our non-smoking policy.

Green Travel Plan

We continue to operate a travel plan, which contains specific mode share targets relating to an action plan of travel plan measures. Additionally, the travel plan continues to reference the supporting work undertaken, including TRICS surveys, traffic surveys and a parking study, to inform the plan targets and measures.

The purpose of the travel plan is to:

- encourage the use of modes of transport to and from the site other than the car,
- discourage the use of single occupancy car travel to the site,
- make provision for staff, patients and visitors to travel to the site by alternative

modes of transport other than the car;
- ensure that on-site car parking is effectively managed,
- ensure that parking demand does not exceed on-site provision or place a demand on nearby streets and car parks, and
- ensure that the transport needs of hospital departments within the site are met in a sustainable way.

Our revised travel plan is a long-term strategy for the Stepping Hill Hospital site that seeks to deliver sustainable transport objectives through positive action, and is subject to regular review (DfT Good Practice Guidelines: Delivering Travel Plans through the Planning Process, 2009).

The travel plan aims to make the site more accessible to all users, whether or not they have access to a car, and helps to promote social equality within the local community. It covers both the hospital and community sites and will improve accessibility for patients and visitors alike. There are plans to further increase changing and shower facilities on site during 2020-21 to encourage and support colleagues who choose to cycle, walk or run to work.

Sustainable Procurement

We are committed to the principles of sustainable development to support Government and Department of Health & Social Care commitments in this area of policy, and the improvement of the nation's health and wellbeing. We recognise that it has an influential role in furthering sustainable development through the procurement of buildings, goods and services.

Sustainability, environmental and social principles are embedded in our procurement processes to ensure that a balanced consideration of social, ethical, environmental and economic factors is undertaken as part of the procurement evaluation process.

Our procurement team has adopted a 'whole life cost' approach by assessing the environmental impact of products from production to disposal costs. This approach will realise benefits for both the organisation and society in general, as well as minimizing the impact on the environment. We also have in place a comprehensive anti-fraud, bribery & corruption policy.

2. ACCOUNTABILITY REPORT

Board of Directors

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

The Board of Directors takes decisions with regards to:

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

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

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

The Board of Directors is comprised of a Chairman, seven Non-Executive Directors, seven Executive Directors, and two non-voting Corporate Directors. Executive Directors are appointed by the Non-Executive Directors, and their salaries, terms and conditions are determined by the Remuneration Committee (*see* page *65)*. The Chair and Non-Executive Directors are appointed by the Council of Governors and their salaries, terms and conditions are determined by the Nominations Committee (*see page 77)*. The Chair and Non-Executive Directors are appointed for an initial three years term and then, with the approval of the Council of Governors, they can be appointed for a further three year term. Any subsequent term of office, up to a maximum of nine years, is determined by the Council of Governors on an annual basis.

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

Criteria for determining dependence, includes:

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

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

	Attendance at Board meetings
Catherine Anderson, Non-Executive Director Appointed 4 January 2016 Re-appointed 1 January 2019 to 31 December 2021 A consultant working with businesses to improve performance, with senior level experience in private business and universities.	9 of 11
Catherine Barber-Brown, Non-Executive Director Appointed 1 September 2016 Re-appointed 1 September 2019 to 31 August 2022 A consultant with senior level experience in the banking sector with a focus on strategy and change management.	10 of 11
Mark Beaton, Non-Executive Director Appointed 1 August 2019, stepped down March 2020 Senior level private sector experience in the fields of technology, consultancy and outsourcing.	7 of 7
Adrian Belton, Chair Appointed 1 June 2017 to 31 May 2020 Former Chief Executive of the Construction Industry Training Board and the Food and Environment Research Agency. In August 2019 he was also appointed as Non-Executive Chair of the Ministry of Defence's Defence Science and Technology Laboratory.	10 of 11
Simon Bennett, Director of Strategy, Partnerships and Transformation Appointed May 2020 Career NHS manager	0 of 0
Hilary Brearley, Interim Director of Workforce & Organisational Development (non-voting) Appointed March 2018 to May 2019 HR professional with senior level experience in the public and private sectors.	2 of 2
Dr Mike Cheshire, Non-Executive Director (Senior Independent Director) Appointed 1 September 2013 Re-appointed 1 September 2016 to 31 August 2019 Re-appointed 1 September 2019 to 31 August 2020 Retired clinician and former Medical Director of NHS North West.	11 of 11
David Hopewell, Non-Executive Director (Chair of Audit Committee) Appointed 1 July 2018 to 30 June 2021 A Fellow of the Institute of Chartered Accountants and experienced accountant having worked at a senior level in the private, public and charity sectors.	7 of 11
John Graham, Director of Finance Appointed May 2020 Career NHS manager	10 of 10

Dr Marisa Logan-Ward, Non-Executive Director Appointed 1 August 2019 to 31 July 2022 Biomedical scientist with senior level experience in the health sector.	7 of 7
Alison Lynch, Chief Nurse & Director of Quality Governance Appointed October 2017 A career NHS nurse	11 of 11
Paul Moore, Interim Director of Quality Governance & Risk Assurance (non-voting) Appointed May 2020 Career NHS Manager	0 of 0
Greg Moores, Director of Workforce & Organisation Development Appointed June 2019 Career NHS manager	7 of 10
Hugh Mullen, Director of Strategy, Planning & Partnerships/Deputy Chief Executive Appointed January 2017 – retired May 2020 Career NHS manager	10 of 11
Feroz Patel, Director of Finance Appointed August 2015 to April 2019 Career NHS manager	2 of 2
Caroline Parnell, Director of Communications & Corporate Affairs (non-voting) Appointed November 2019, interim from March 2019 Former journalist and consultant, NHS manager	10 of 11
Louise Robson, Chief Executive Appointed January 2019 Career NHS manager	11of 11
Malcolm Sugden, Non-Executive Director and Deputy Chair Appointed 28 April 2010 Re-appointed 1 April 2018 to 31 March 2019 Re-appointed 1 April 2020 to 31 March 2021	11 of 11
Sue Toal, Chief Operating Officer Appointed March 2017 Registered nurse and career NHS manager	10 of 11
Dr Colin Wasson Appointed April 2016 Intensive care consultant	8 of 11

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

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

There have been significant changes to the make-up of the Board of Directors with the appointment of two new Non-Executive Directors (Dr Logan-Ward and Mr Beaton), the appointment of three new Executive Directors (Mr Graham, Mr Moores and Mr Bennett), and the appointment of two new non-voting Corporate Directors (Mrs Parnell and Mr Moore).

The Council of Governor's is currently in the process of appointing two new Non-Executive Directors to replace Mr Beaton and Dr Cheshire, and the search is focusing on finding individuals with strong clinical and nursing backgrounds.

While there have been a number of changes to Board member during 2019-20, the Board considers that the skills and experiences of Non-Executive and Executive Directors provides a Board of Directors that is balanced, complete and appropriate. The appointment of new Non-Executive Directors with clinical and nursing backgrounds is an acknowledgement of the significant transformation journey that we have begun, and the need to ensure a strong clinical leadership voice as the organisation changes.

The Board recognises that with such a significant change in its membership during 2019-20 a strong team development programme is required. During 2019 it carried out a 360 degree evaluation exercise that sought views about the Board from senior staff in the organisation and external stakeholders, and it will also undertake a Board effectiveness review during 2020-21.

The Board has used the outcome of 360 degree evaluation exercise and the development of a refreshed Trust strategy to shape a programme of team development with monthly activities and a full day development session each quarter. Issues covered in these sessions include determining the Board's risk appetite, governance and assurance; and preparation for the CQC inspection, including Well-Led.

The Trust has secured funding from NHSE/I for the further development of this programme in 2020-21, with a range of external facilitators lined up to lead sessions on a range of issues including:

- transformation,
- quality improvement,
- people factors including equality, diversity and inclusion,
- quality of care and patient safety,
- use of data and information.

All directors have annual appraisals, with those for Non-Executive Directors led by the Chair and those for Executive and Corporate Directors led by the Chief Executive. Appraisal of the Chairman is led by the Senior Independent Director in line with arrangements agreed with the Council of Governors, and in March 2020 the Council of Governor's Nominations Committee reviewed local arrangements for the Chair's appraisal to ensure they were in line with new national guidance.

Audit Committee

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

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

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

Details of the Committee membership and attendance at meetings are detailed below:

	Meeting attendance
David Hopewell, Chair	6 of 6
Catherine Anderson	5 of 5
Malcolm Sugden	5 of 6
Mark Beaton	1 of 1
Marisa Logan- Ward	2 of 2

During 2019-20 the Committee received the outcomes of a number of internal audit reviews covering the following areas:

- Fit and Proper Persons,
- Conflicts of interest,
- Financial systems,
- Financial integrity,
- Financial ledger upgrade assurance,
- Cyber essential systems,
- Data security and toolkit,
- DBS application and retention processes,
- Clinical coding.

They also received the Head of Internal Audit Opinion which was that the organisation had “good systems of internal control designed to meet organisational objectives, and controls are generally being applied consistently.”

A key function of the Committee during 2019-20 was oversight of the future provision of external audit services. Although the Council of Governors takes the lead on this process, Committee members provided advice and support to the robust procurement process that resulted in the Council of Governors agreeing to a recommendation to award a five year contract to Mazars LLP.

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

Internal Audit

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

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

MIAA deliver a risk-assessed audit plan, which is approved each year by the Audit Committee. This is delivered by appropriately qualified and trained Internal Auditors, led by a nominated Audit Manager. Additional investigation work was commissioned during the year and approved by the Audit Committee in quarter four. The internal audit plan was fully delivered during 2019-20 and the total cost of the service was £89,416.

Countering Fraud and Corruption

During 2019-20 the Trust's anti-fraud specialist and the anti-fraud service was provided by Mersey Internal Audit Agency (MIAA) and was also subject to a re-tendering exercise.

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

The anti-fraud specialist regularly attends Audit Committee meetings to provide updates on the progress of the annual work plan and investigations. The total cost of the service including investigation work in 2019-20 was £22,050.

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

During 2019-20 the anti-fraud specialist focused on:

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

We also participated in the national fraud initiative exercise at a cost of £2,000. This exercise matches a series of financial records from a number of sources to help identify and eliminate fraud across public sector bodies.

External Audit

Mazars LLP was appointed as our external audit provider by the Council of Governors with effect from 1 October 2019, following a competitive tender process. The cost of the external audit service totaled £60,720, comprised of £55,440 for the Trust accounts, and £5,280 for Charitable Funds. All figures are inclusive of VAT.

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

Directors' responsibility for preparing accounts

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

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

Accounting Policies

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

The accounting policies for pensions and other retirement benefits are set out in note 1.6 to the accounts, and details of senior managers' remuneration can be found in the Remuneration Report on pages 97 & 98. Note 8.2 to the Accounts provides further information about employees who have retired early on ill-health grounds during the year. We have complied with the cost allocation and charging mechanisms set out in HM Treasury and Office of Public Sector Information guidance.

Better Payment Practice Code

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

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

NHS	**2019/20**	**2018/19**
Total number of invoices paid within year	3,875	3,815
Total number of invoices paid within 60 days	3,013	2,443
Total number of invoices within 60 days as %	**77.80%**	**64.00%**
Total number of invoices within 30 days	2,182	1,613
Total number of invoices within 30 days as %	**56.31%**	**42.28%**
Total value of invoices within year	12,078	19,397
Total value of invoices within 60 days	6,034	11,501

Total value of invoices within 60 days as %	**50.0%**	**59.29%**
Total Value of invoices paid within 30 days	3,988	8,334
Total value of invoices within 30 days as %	**33.02%**	**42.97%**

Non NHS	**2019/20**	**2018/19**
Total number of invoices paid within year	50,155	53,488
Total number of invoices paid within 60 days	44,035	43,806
Total number of invoices within 60 days as %	**87.80%**	**81.90%**
Total number of invoices within 30 days	17,546	18,107
Total number of invoices within 30 days as %	**35.0%**	**33.85%**
Total value of invoices within year	140,615	137,809
Total value of invoices within 60 days	130,209	121,803
Total value of invoices within 60 days as %	**92.60%**	**88.39%**
Total Value of invoices paid within 30 days	98,524	91,048
Total value of invoices within 30 days as %	**70.07%**	**66.07%**

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

Income disclosures

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

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

Annual statement on remuneration from the Chair

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

During 2019-20 the Committee met on five occasions to consider the recruitment and appointment of a number of Executive Team posts, including:

- Director of Finance,
- Director of Workforce and OD,
- Director of Communications and Corporate Affairs,
- Director of Strategy and Partnerships

- Interim Director of Quality Governance and Risk Assurance.

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

- reviewed executive salaries,
- agreed the Committee's revised terms of reference, and
- reviewed the organisation's arrangements for Fit and Proper Persons.

Senior managers' remuneration policy

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

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

With regards to remuneration during 2019-20 the Committee considered benchmarking information and agreed to increase the salaries of the Chief Nurse, and Chief Operating Officer to ensure they were on a par with colleagues in other equivalent NHS organisations, as well as other members of the Executive Team.

The salary of the Medical Director was also increased to ensure it they were on a par with colleagues in equivalent NHS organisations, and to take into account that they would have had cost of living pay rises if they had remained on medical terms and conditions when they took on the Executive Director role.

In response to national guidance to consider increasing senior managers' remuneration in line with the national pay award for other NHS staff, the Committee decided not to award the national increase to Executive Directors as salaries had already been increased as part of the benchmarking exercise.

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

	Meeting attendance
Adrian Belton, Chair	5 of 5
Malcolm Sugden, Deputy Chair	3 of 5
Catherine Anderson	4 of 5
Catherine Barber-Brown	3 of 5
Mark Beaton	3 of 4
Mike Cheshire	5 of 5
David Hopewell	4 of 5
Marisa Logan-Ward	2 of 4

To advise Committee members meetings are attended by the Chief Executive and Director of Workforce and Organisational Development, other than when matters

being discussed may result in a conflict of interest. Minutes of the meeting are recorded by the Director of Communications & Corporate Affairs as part of their Company Secretary responsibilities.

During 2019-20 the Committee used the services of The Finegreen Group to recruit to the roles of Director of Finance and Director of Workforce and Organisational Development.

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

We have not released an Executive Director to serve as a Non-Executive Director elsewhere. Pension entitlements are detailed on page 96 and there are no special provisions regarding early termination of employment. No early termination payments were made during the year to any Executive Director or previous Executive Director.

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

The expenses paid to Directors during the year were:

	2019/20	2018/19
Total number of Directors in office	19	18
Number of Directors receiving expenses	9	8
Aggregate sum of expenses paid to Directors	£4,780	£3,488

Adrian Belton

Chair

24 June 2020

Louise Robson

Chief Executive

24 June 2020

Our Governors

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

Other responsibilities include:

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

At the start of 2019-20 our Council of Governors had 26 seats – 20 elected by the public, four elected by our staff, and two appointed by Stockport Metropolitan Borough Council and Stockport College.

During the year we undertook a review of our Constitution, and we increased the number of appointed governors to reflect the importance of key partnership, offering positions to Stockport CCG, Healthwatch, Age Concern Stockport, and local universities.

We also reviewed how the Council of Governors was operating to ensure that it could effectively deliver its responsibilities to hold the Board of Directors to account, and with the support of governors and directors we:

- introduced a maximum nine year tenure for all governors,
- gave the Board more flexibility around voting members to allow the appointment of between six to eight Non-Executive Directors,
- removed Tameside and Glossop from the membership constituencies to reflect the move of those community services out of the organisation,
- changed the boundaries of our Outer Area constituency to welcome members from the rest of England,
- increased the minimum number of members in each constituency from four to 50 for public constituencies and from 16 to 100 for the staff constituency,
- separated the annual elections from the annual members meeting, allowing the meeting to be held within six months of the end of the financial year.

We also reviewed:

- the workings of the Council's sub-groups,
- governors induction and development programme,
- the content of agendas for Council meetings to ensure all governors received the information they needed to discharge their responsibilities.

Sub-groups

During 2018-19 the Council of Governors had developed a small number of sub-groups focusing on quality of care, membership engagement, and governance. However, attendance at the latter two groups was consistently below quorum and more than half of the Council of Governors wanted to attend the quality sub-group.

A review of these groups and its attendance prompted a decision during 2019-20 to disband the groups, and instead incorporate their agendas into the Council of Governor meetings to ensure that all governors were sighted on, and involved in quality, membership, and governance issues. As a result of this expansion of the Council of Governors agenda it was agreed to increase the number of meetings a year from four to five.

Development programme

The review of the work of the Council of Governors also identified the need for a more robust development programme for new and existing governors to expand their knowledge of the role and the organisation. As a result a detailed development plan was created and endorsed by the Council of Governors, with development opportunities incorporated into the Council meetings, as well as separate sessions planned on a range of issues including finance, performance standards, and quality.

Council agendas

A review of the Council's past agendas identified that they were not regularly receiving information about the performance of the organisation against national standards, as well as workforce, quality and finance indicators. This information was shared in some of the sub-groups but was not regularly presented to all governors.

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

As part of these changes during 2019-20 the Council of Governors was actively involved in the refresh of our strategy, as well as the development of new values and behaviours. They also approved the appointment of two new Non-Executive Directors and new external auditors, and they discussed a range of issues including:

- end of life care,
- emergency care and winter planning,
- outpatient improvement programme,
- patient experience,
- quality improvement plan,
- People Strategy.

The shielding and social distancing guidance introduced as part of the response to the Covid-19 pandemic meant that two meetings of the Council of Governors had to be cancelled, and there was also an impact on planned development sessions. To ensure that governors remained up to date with activities within the organisation we introduced a weekly Covid-19 briefing and the opportunity for telephone discussions with the Chair. We also held a virtual briefing session on the outcome of the CQC's regular inspection of our services.

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

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

A number of governors regularly attended our monthly public Board of Directors meetings, posing questions to the Board about the agenda at the end of each meeting.

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

Engagement with governors

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

- monthly briefings for governors to share the latest information about the Trust,
- regular drop in sessions for governors to meet informally with the Chair to discuss any issues or concerns,
- informal pre-meetings between Non-Executive Directors and governors prior to each Council of Governors meeting to share information about activities, as well as discuss any issues or concerns;
- regular involvement of Non-Executive Directors in Council of Governors meetings, including leading discussions on key issues,

- Executive Directors attending Council of Governors meetings to present information and engage in discussion with governors.

Membership engagement

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

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

In line with the strategy governors and Board members have sought to encourage a broad membership and engage members in a number of ways over the last 12 months, including:

- attendance at internal events, such as conferences and award ceremonies, where they met staff members;
- circulation of a members newsletter three times a year that highlights the latest news about the Trust's activities as well as profiling the work of the governors and giving information on how members can contact their governor representatives,
- our website carries information about governors and how members can contact them,
- the annual member meeting, which regularly attracts over 100 members and where governors and staff can showcase initiatives and activities;
- membership recruitment activities,
- sharing social media messages,
- email updates about our activities.

During the Covid-19 pandemic we issued a special briefing to all members to inform them about our preparations to manage the impact of the pandemic, and also share health and wellbeing information.

Governors provide their time on a voluntary basis but we do reimburse travel expenses and during 2019-20 a total of £124.16 in expenses was claimed.

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

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

Governors' elections

Elections to the Council of Governors are held on a rolling annual basis and in 2019-20 we held elections for the following seats using the single transferable vote system. The results of the elections were announced at the annual members meeting in October:

Bramhall & Cheadle (four seats)

Total number of eligible voters		2,485
Number of postal votes	268	
Number of online votes	136	
Total number of votes cast		404
Turnout		16.3%
Number of invalid votes		7
Total votes counted		397

The following individuals were elected to represent the Bramhall and Cheadle constituency for three years:

- Robert Cryer,
- Michelle Slater,
- Toni Leden,
- John Pantall.

Marple and Stepping Hill

Total number of eligible voters		2,568
Number of postal votes	260	
Number of online votes	125	
Total number of votes cast		385
Turnout		15%
Number of invalid votes		4
Total votes counted		381

The following individuals were elected to represent the Marple and Stepping Hill constituency for three years:

- Julie Wragg,
- David Rowlands,
- Ron Catlow,
- Richard King

However, Mr Catlow had also been elected as a governor for another Trust in the region, and as individuals cannot be governors in two NHS Foundation Trusts, he

stepped aside and the position was filled by Zahida Ikram, who was the candidate with the next highest number of votes.

We also sought candidates for a vacant seat in the Tame Valley and Werneth public constituency and one in the staff constituency. Unfortunately no candidates came forward and these will be subject to a further election process in 2020.

As part of the review of the Trust's constitution the requirement to announce election results at the annual members' meeting was removed to allow the meeting to be held within six months of the annual report and accounts being completed. Elections will continue to be held on an annual basis and results announced at the completion of the election process in October.

As a result of the election and changes to the governor tenure we saw a number of long standing governors leave the organisation, including Les Jenkins, our former lead governor. Their contribution to the Council of Governors and organisation as a whole is sincerely appreciated.

Membership of the Council of Governors

Details of our governors and their attendance at Council of Governors meetings during 2019-20 are below:

Governor	Constituency	Attendance
L Appleton	Tame Valley & Werneth	1 of 1
S Alting	Appointed	0 of 0
C Barton	Heatons & Victoria	0 of 4
E Brown, lead governor	Heatons & Victoria	4 of 4
R Catlow	Marple & Stepping Hill	2 of 2
R Cryer	Bramhall & Cheadle	2 of 4
C Dawson	Staff	1 of 4
L Dowson	High Peak & Dales	3 of 4
C Galasko	Outer Region	4 of 4
K Glass	Staff	3 of 4
R Greenwood	Tame Valley & Werneth	4 of 4
L Jenkins	Marple & Stepping Hill	2 of 2
T Johnson	Bramhall & Cheadle	2 of 2
Z Ikram	Marple & Stepping Hill	1 of 1
J Keyes	Staff	4 of 4
R King	Marple & Stepping Hill	4 of 4
T Kondratowicz	Heatons & Victoria	4 of 4
T Leden	Bramhall & Cheadle	1 of 1
C Lyons	Tame Valley & Werneth	4 of 4
T McGee	Appointed	2 of 3
C Mitchell	Staff	1 of 1
T Morley	Tame Valley & Werneth	2 of 2
J Pantall	Bramhall & Cheadle	0 of 1
D Rowlands	Marple & Stepping Hill	1 of 1
M Slater	Bramhall & Cheadle	1 of 1
J Wells	Appointed	3 of 3
L Woodward	High Peak & Dales	4 of 4
J Wragg	Marple & Stepping Hill	1 of 4
G Wright	Heatons & Victoria	4 of 4

Details of Board members attendance at Council of Governors meetings during 2019-20 are below:

Board member	Title	Attendance
Adrian Belton	Chair	4 of 4
Catherine Anderson	Non-Executive Director	4 of 4
Catherine Barber-Brown	Non-Executive Director	3 of 4
Mark Beaton	Non-Executive Director	1 of 2
Dr Mike Cheshire	Non-Executive Director	4 of 4
David Hopewell	Non-Executive Director	2 of 4
Dr Logan-Ward	Non-Executive Director	2 of 2
Malcolm Sugden	Non-Executive Director	3 of 4
Dr Gill Burrows	Medical Director	1 of 1
John Graham	Director of Finance	2 of 3
Alison Lynch	Chief Nurse	4 of 4
Greg Moores	Director of Workforce & OD	3 of 3
Hugh Mullen	Director of Strategy, Planning & Partnerships	1 of 4
Caroline Parnell	Director of Communications & Corporate Affairs	4 of 4
Feroz Patel	Director of Finance	0 of 1
Louise Robson	Chief Executive	4 of 4
Sue toal	Chief Operating Officer	2 of 4
Dr Colin Wasson	Medical Director (Executive)	0 of 4

Membership

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

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

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

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

Details of the make-up of our members as of 31 March 2020 are below:

Constituency	No. of members
Bramhall and Cheadle	2,458
Tame Valley and Werneth	1,932
The Heatons and Victoria	2,030
Marple and Stepping Hill	2,543
High Peak and Dales	1,381
Outer region	782
Staff	5,180
Total	**16,306**

Nominations Committee

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

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

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

During 2019-20 the Committee met on three occasions to:

- oversee the recruitment and appointment process for two new Non-Executive Directors,
- consider the re-appointment of the Chair and two existing Non-Executive Directors,
- review the Trust's process for appraising the Chair to ensure it was in line with new national guidance,
- review new national guidance on the remuneration of Non-Executive Directors.

The Committee commissioned the services of The Finegreen Group to support the search and recruitment process for two new Non-Executive Directors.

Membership of the Committee and attendance during 2019-20 is detailed below:

Name	Position	Attendance
Adrian Belton	Chair	3 of 3
Malcolm Sugden	Deputy Chair	1 of 3
Evelyn Brown	Lead governor	3 of 3
Gerry Wright	Public governor (committee member until December 2019)	2 of 3
Richard King	Public governor (committee member	1 of 1

	since December 2019)	
Robert Cryer	Public governor	2 of 3
Roy Greenwood	Public governor	1 of 3
Tad Kondratowicz	Public governor (committee member from December 2019)	1 of 1
Les Jenkins	Former lead governor (committee member until October 2019)	0 of 0

Governance Report

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

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

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

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

The integrated performance report was reviewed in 2018 in line with views from Board members and operational managers, and we plan to make further changes in 2020-21 to reflect the recommendations from the governance review that we asked NHSE/I to undertake and which was conducted by Ms Rebecca Southall.

During 2019-20 we developed a safety heat map to provide ward level information about a host of indicators, and we have used the heat map to identify areas where further reviews are required of identified risks and mitigating actions.

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

Quality governance reporting

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

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

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

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

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

In August 2019 we asked NHSE/I to undertake an independent review of our governance systems and processes. That review was unable to be undertaken until early 2020, and at the time of writing this report we had just received the outcome of the review and appointed Paul Moore as Interim Director of Quality Governance and Risk Assurance to take forward the review's recommendation. We plan to revise our quality governance framework and risk management processes during 2020-21.

Care Quality Commission Reviews

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

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

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

During the inspection we received a section 31 letter and a subsequent 29a warning notice to inform us that the CQC had formed a view that the quality of health care provided by the us required 'significant improvement' in relation to safe staffing in the emergency department, and the governance systems to monitor quality, safety and risk across the department. We took immediate actions to address the concerns and we continue to work on those improvements every day.

Changes include:

- environmental improvements, particularly to safeguard patients with mental health problems in our emergency department;
- putting a new leadership team into the emergency department,
- calling a system risk summit leading to the formation of Stockport System Improvement Board facilitated by NHSE/I with representation from all health and care partners;
- commissioning an external review of staffing and governance in the emergency department,
- appointing an Interim Director of Quality Governance and Risk Assurance,
- developing and implemented an improvement plan for the emergency department that goes beyond the changes required by the CQC,
- placing a mental health specialist in the emergency department to work with us and Pennine NHS Foundation Trust on improvements,
- carrying out an external audit of staffing in the emergency department when the CQC visited,
- commissioning external support for work on improving the flow of patients through the hospital

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

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

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

Ratings for Stepping Hill Hospital

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

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

We have taken, and will continue to take, actions to ensure sustained improvement in the quality and safety of care we provide across all of our services. We will not be satisfied until the care we provide to every patient every day is of the high standard we would want for our own families.

The report listed a number of actions we "must do" and "should do" to make improvements. Most of these were about governance and internal controls, as well as some relating to specific quality, safety and care issues. They have been incorporated into a comprehensive action plan that is being monitored by the Board of Directors on a monthly basis.

The inspectors did highlight some positives including:

- improvements, particularly in medical care, in staff knowing how to support patients who lack capacity to make decisions for themselves, or have mental health problems;
- good ratings for medical care, maternity and services for children and young people,
- improved compliance with Fit and Proper Person requirements.

The inspectors put the spotlight on a number of areas for us to improve – and we are. There were also issues that need all health and care partners across Stockport to address, and immediately after the inspection we welcomed the creation of Stockport System Improvement Board. It brought together partners from the local authority, mental health services, commissioners, regulators and ourselves to jointly improve care for the local communities we all serve.

Clinical Audit

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

During 2019-20 we took part in 56 national projects, 221 local clinical audit projects, and 204 quality monitoring projects were registered.

Following publication of a national audit report a review is undertaken by the relevant speciality, as part of the governance framework. This provides assurance that there is understanding of the findings and that the appropriate actions are being taken.

The reviews are considered at both the Business Groups' Quality Board meetings and by the organisation's Quality Governance Group. Clinical audit and quality forums are also held quarterly for sharing and discussing the results of clinical audits, and to agree the next steps.

A clinical audit group meets quarterly to support the delivery of the clinical audit strategy, and we hold an annual event during national Clinical Audit Awareness Week to share and celebrate some examples of the excellent activity that takes place.

Commissioning for Quality & Innovation (CQUIN)

A proportion of our income in 2019-20 was conditional on achieving quality improvement and innovation goals agreed with commissioners through the Commissioning for Quality and Innovation payment framework (CQUIN).

The level of income associated with Stockport commissioners in 2019-20 was £2.9m, which represented one per cent of income in line with national guidance. Achievement of the CQUIN indicators during 2019- 20 were more challenging than previous years, but as the result of changes to the NHS financial regime caused by the Covid-19 pandemic we received funding in line with full delivery of CQUIN indicators.

Staff Report

Our Workforce

We recognise the exceptional work of all our staff and we have created a variety of initiatives and schemes to help engender the commitment and hard work of our dedicated workforce during what was a challenging year in 2019-20.

These initiatives have included the creation of a leadership management development framework, supporting a compassionate and inclusive leadership culture to engage staff at all levels & values led culture.

Staff costs and average WTE for the year were as follows:

Staff Costs	**Permanent £000**	**Other £000**	**2019/20 £000**
Salaries & wages	169,293	1,024	170,317
Social security costs	14,744	-	14,644
Apprenticeship levy	833	-	833
Employer's contributions to NHS pensions	28,531	-	28,531
Pension cost – other	94	-	94
Other post-employment benefits	-	-	-
Other employment benefits	-	-	-
Termination benefits	-	-	-
Temporary staff – external bank	-	19,333	19,333
Temporary staff – agency/contract	-	10,420	10,420
Total gross staff costs	**214,519**	**29,753**	**244,172**
Of which: Costs capitalised as part of assets	-	-	-

Average WTE	**Permanent WTE**	**Other WTE**	**2019/20 WTE**
Medical & dental	494	64	558
Ambulance staff	-	-	-
Administration and estates	1,214	24	1,238
Healthcare assistants & other support staff	1,024	158	1,182
Nursing, midwifery and health visiting staff	1,363	177	1,540
Nursing, midwifery & health visiting learners	-	-	-
Scientific, therapeutic and technical staff	577	15	592
Healthcare science staff	-	-	-
Social care staff	-	-	-
Other	-	-	-
Total average numbers	**4,672**	**438**	**5,110**
Of which: Number of employees (WTE) engaged on capital projects	1	-	1

Our workforce of 4,644.22 whole time equivalent staff relates to a headcount of 5,454 staff as at 31st March 2020 and the profile of these staff can be shown by gender which is 80% Female and 20% Male; of which:

Gender Headcount	Male	Female	Total
Directors	5	4	9
Other Senior Managers	10	19	29
Other Employees	1,085	4,331	5,416

Health and Wellbeing

Our commitment to the health and wellbeing of our staff continues to be an area of priority and focus and a key enabler of our People Strategy. We believe that the way to provide the best experience for our patients is to provide the best experience for our staff. We want to do as much as we can to support our staff to enable them to be:

- at their best,
- motivated,
- committed to their work, and
- to reach their full potential.

Our workforce health and wellbeing approach brings together multiple strands with the aim of improving the health and wellbeing of staff and is a crucial part of delivering our commitment to improving the health and wellbeing of the workforce.

Our occupational health service is designed to organise the physical, psychological and social health of all staff and to support managers by undertaking health interventions and providing advice on medical issues. In addition to the core services of new employee health assessments, management referrals and immunisation and vaccination programmes, other services offered to staff include fast track physiotherapy and lifestyle health advice.

A range of health promotion support services are provided for staff including smoking cessation and raising awareness to prevent workplace incidents, such as sharps injuries.

Vaccinating health care staff against potential workplace infections will protect staff from infection and mitigate the risk of transfer to patients. The occupational health service leads on the delivery of the staff flu vaccination each autumn with the assistance of many link nurses and achieved a good uptake of 80% of clinical staff during 2019-20.

Our service continues to be successful in retaining accreditation of the national quality assurance scheme called Safe, Effective, Quality Occupational Health Service (SEQOHS), which provides assurance on quality and effectiveness and allows the service to continue to bid for new occupational health work in the region.

Sickness Absence Data

Our Sickness absence data, for 2019/20 is published by NHS Digital: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

We have reviewed and refined our sickness absence policy and supporting procedures, in partnership with our trade union colleagues, to enable staff and managers to better address the challenges presented by staff ill health.

Working in Partnership

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

These meetings focus upon consulting with staff in a constructive manner in relation to key service changes across the organisation, as well as discussing and seeking approval of policies and procedures. Both forums share chairing arrangements between staff and management, and Executive Directors and senior managers are regularly in attendance. Major project developments include a local staff representative, as part of steering groups to ensure positive levels of union engagement.

Facility Time Trust Data for 2019-20

The tables below set out the relevant information for Stockport NHS Foundation Trust for the period 1st April 2018 to 31st March 2019.

Table 1: Relevant union officials

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
49	43.42fte

This was an overall increase of 14 (12.06fte) trade union colleagues since last year.

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

Percentage of time	Number of employees
0%	0
1-50%	48
51%-99%	1
100%	0

This was an overall increase of 14 trade union colleagues spending between one to 50% of their working time on facility time.

Table 3: Percentage of pay bill spent on facility time

Provide the total cost of facility time	£172,961
Provide the total pay bill	£223.900mil
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.10%

Table 3 provides the total cost of facility time as a percentage of the Trust's overall total pay bill. During 2019-20 the percentage of pay bill spent on facility time increased from 0.08%.

Table 4: Paid trade union activities

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	20.86%

During 2019-20 2,354 hours of facility time were spent on trade union activities and 8,932 hours were spent on trade union duties. This equates to 20.86% (an increase of 0.86%) of total paid facility by relevant union officials was carried out on trade union activities.

Equality, Diversity and Inclusion

During 2019-20 we continued on our journey and commitment to ensuring that our services and employment practices are fair, accessible and inclusive for the diverse communities which we serve and the workforce we employ.

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

Employees who become disabled during their employment are supported via a number of mechanisms, including a reasonable adjustment policy. This policy sets out what managers and staff need to know to support them in making decisions about applying for and considering requests for reasonable adjustments in the workplace, and discussing requests from patients about how they could receive more accessible services across a range of different settings.

Governance

To ensure that the appropriate assurance is provided we have developed an Equality, Diversity & Inclusion Steering Group, which has representation from all key business group areas. This group reports to the People Performance Committee and provides strategic direction for promoting and maintaining EDI across the organisation in both workforce and service delivery. This includes meeting legislative, contractual and policy requirements, as well as adopting and embedding good practice across all of our functions.

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

Workforce Race Equality Standard (WRES)

NHS England introduced the Workforce Race Equality Standard (WRES) in 2015 to ensure employees from black and ethnic minority (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. Our performance against these standards in 2019 – 20 and an associated action plan are published on our website.

Workforce Disability Equality Standard (WDES)

During 2019-20 we worked on publishing data and information for the WDES, which looks at the experiences of disabled staff in the NHS and how these compare to non-disabled employees. Data was published against 10 metrics in August 2019, as well as an associated action plan.

Gender Pay Gap

The Trust complied with the requirement to publish a Gender Pay Gap Report by 30 March 2019, as required by gender pay reporting legislation. The legislation requires employers with 250 or more employees to publish statutory calculations each year that detail the pay gap between male and female employees.

The Gender Pay Gap Report is available on our website and an action plan has been developed to progress initiatives to address any identified gaps. The deadline for 2019-20 was 30 March 2020, however to the Covid-19 pandemic enforcement of reporting deadlines does not apply to organisations in the 2019-20 reporting year. The link to the 2018-19 report is https://gender-pay-gap.service.gov.uk/Employer/Mzg7JnSK/2018

Remuneration

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

2019 National Staff Survey

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

In 2019 the NHS Staff Survey was delivered to 5101 staff across the organization and yielded a response rate of 55%. The median response rate of other organisations within the group (combined acute and community trusts) was 46%. This represented an achievement of nine percent above the national average response rate, and 25% increase on last year's result.

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

Summary Indicator	2019-20		2018-19		2017-18	
	Trust	Bench marking Group	Trust	Bench marking Group	Trust	Bench marking Group
Equality, Diversity & Inclusion	9.2	9.2	9.1	9.2	9.2	9.2
Health & Wellbeing	5.6	6.0	5.6	5.9	5.7	6.0
Immediate Managers	6.8	6.9	6.7	6.8	6.8	6.8
Morale	6.0	6.2	6.0	6.2	-	-
Quality of Appraisals	5.5	5.5	5.3	5.4	5.3	5.4
Quality of Care	7.2	7.5	7.2	7.4	7.3	7.5

Safe Environment – Bullying & Harassment	8.1	8.2	8.2	8.1	8.3	8.1
Safe Environment – Violence	9.4	9.5	9.5	9.5	9.5	9.5
Safety Culture	6.6	6.8	6.6	6.7	6.4	6.7
Staff Engagement	6.9	7.1	6.9	7.0	6.8	7.0

A summary of the findings are outlined below:

Equality, Diversity and Inclusion

This theme has improved since 2018 at 9.2; there was a significant rise in the number of staff reporting adequate adjustments to enable them to continue at work, from 51.9% in 2018 to 69.2% in 2019. There was also recognition of the organisation acting fairly regardless of background, gender, disability to age, which increased by 2.1% from the previous year.

Incidents of discrimination from colleagues increased from 5.3% to 6.6%, although this remains below the national average. This is in contrast to discrimination from service users, their relatives or members of the public, which has fallen to 4.8%. This again remains below the national average.

We have made huge advances in implementing adequate adjustments to enable staff to carry out their work effectively, with a 17.3% increase from 2018. Monitoring of the EDI processes is undertaken by the EDI Steering Group and staff network groups.

Health and Wellbeing

Although performance in this area remains below the national average we have continued to offer support for staff through a number of initiatives, and from January 2020 a dedicated workforce wellbeing resource has been in place supported by specific mental health and mindfulness initiatives.

Information gathered from our staff survey results has informed our Health & Wellbeing Strategy and helped to identify key themes to address to further support our workforce, including staff morale, bullying and harassment, EDI, and staff engagement. All of these areas are regularly monitored via the Health & Wellbeing Steering Group and People Performance Committee.

Immediate Managers

We remain 0.1% (6.8%) below the national average of 6.9%, but have increased by 0.1% on last year's score of 6.7%. We are exploring various options to increase our management and leadership capabilities, including a comprehensive leadership

development programme combined with various tailored interventions and team effectiveness measures.

We are working with NHSE/I on a culture change programme aimed at creating an environment in which our workforce has more influence over decision making. These measures will be monitored via our Getting it Right First Time (GIRFT) data and development dashboards used to inform the People Performance Committee and Workforce Advisory Group, which was established in response to the Covid-19 pandemic.

Morale

Staff morale remains just below the national average at 6.0%. Measures are in place to support and encourage staff morale via the health and wellbeing and leadership programmes, which we are currently implementing.

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

Quality of Appraisals

This remains in line with the national average of 5.5%, but has increased by 0.2% since the 2018 survey. All questions were answered positively, including values being discussed, helping to set clear objectives, and staff feeling valued following their appraisal.

An annual audit of appraisal quality was undertaken in February 2020 to ensure that the quality of appraisals continues to improve. The audit looked at circa 2% of all appraisals which were chosen at random. Appraisals will be monitored via the People Performance Committee and Workforce Advisory Group.

Quality of Care

We have seen a reduction in the level of care staff feeling that they can deliver or aspire to deliver quality care, dropping marginally by 0.4%. However, this has been a trend over the last five years, and there was an overall reduction of 4% for these three questions. It should be noted that staff responded positively to the questions related to satisfaction with the level of care their patients received, with an increase of 0.6% on last year's results. This will be monitored at Business Group Quality Meetings.

Bullying and Harassment

There has been an increase of 2.2% to 18.8% of staff experiencing harassment or bullying from other colleagues. This is compared to the national average of 18%. However there has been a 1.5% decrease in the number of staff reporting harassment and bullying from their managers.

Bullying and harassment from patients/service users, their relatives or other members of the public remains under the national average at 25.3%, although this has risen by 2.4% from our 2018 staff survey.

Monitoring of bullying and harassment falls under the remit of various projects and will be monitored by Datix Reporting, EDI Steering and Staff Network Groups; and People Performance Committee.

Violence

Instances of violence from patients/service users, their relatives or other members of the public have risen by 2% since our 2018 staff survey and to 1.5% above the national average. Instances of violence from colleagues are also above the national average by 0.3%.

The number of employees who have experienced violence from managers fell sharply from 2018 and currently sits at 0.7%. Monitoring of these processes will be undertaken by the EDI Steering and Staff Network Groups; and People Performance Committee.

Safety Culture

This theme has improved since the last survey with staff reporting improvements in being treated fairly when involved in an error or near miss (57.5%). There has been a year on year increase in staff who are involved in an error or near miss feeling that the organisation takes action (69.8%) and that they receive feedback about changes (62.2%).

There has been a slight decline in numbers of staff who feel secure raising concerns about unsafe clinical practice (69.5%). Work remains to be done regarding concerns raised by patients/service users, as this currently sits 4.3% below the national average. This will be monitored by Business Group Quality Meetings.

Staff Engagement

Staff recommending the organisation as a place to work has increased from 54.5% to 54.9%, with the national average being 64%. However, recommending the organisation as a place to receive treatment has fallen by 2.4% from our position in 2018 to 61.8%, against the national average of 71%.

The findings of our 2019 NHS Staff Survey have been shared with all staff. The results, our response, and action plans will be reported through our established governance structure, via the People Performance Committee and our Board of Directors.

Off payroll arrangements

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

Table 1

	2019/20	**2018/19**
No of existing arrangements as of 31 March 2020 Of which:	Nil	Nil
Less than one year at time of reporting	-	-
Between one and two years at time of reporting	-	-
Between two and three years at time of reporting	-	-
Between three and four years at time of reporting	-	-
Four or more years at time of reporting	-	-

Table 2

	2019/20	**2018/19**
No of new engagements, or those that reached 6 months duration, between 1 April 2019 and 31 March 2020	Nil	Nil
Of which:		
- Number assessed as within the scope of IR35	-	-
- Number assessed as not within the scope of IR35	-	-
Number engaged directly (via PSC contracted to trust) and are on trust's payroll	-	-
Number of engagements reassessed for consistency / assurance purposes during the year	-	-
Number of engagements that saw a change to IR35 status following the consistency review	-	-

Table 3

	2019/20	2018/19
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	Nil	Nil
Number of individuals that have been deemed "board members and/or senior officials with significant financial responsibility". This figure should include both off-payroll and on-payroll engagements.	19	18

Exit packages

Redundancy and other departure costs are paid in accordance with the provisions of the NHS Scheme and Trust policies. Any exit packages exceeding contractual amounts, and outside of the terms of the normal pension provisions, require Treasury approval before they are offered. The Trust did not offer a Mutually Agreed Resignation Scheme or Voluntary Redundancy Scheme during 2019-20. The following tables show the exit packages for 2019-20 compared to 2018-19:

The following tables show the exit packages for 2019/20 and comparator to 2018/19:

2019 -20

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

Comparator 2018/19

Exit package cost band (including any special payment element)	**Number of compulsory redundancies** **2018/19**	**Number of other departures agreed** **2018/19**	**Total number of exit packages** **2018/19**
<£10,000	3	-	**3**
£10,001 - £25,000	-	-	
£25,001 - £50,000	-	-	**-**
£50,001 - £100,000		-	
£100,001 - £150,000	-		
£150,001 - £200,000	1	-	**1**
>£200,000	-	-	**-**
Total number of exit packages by type	**4**	**-**	**4**
Total resource cost	£176,041	0	**£176,041**

For the non-compulsory elements this can be further broken down in the following table:

	2019/20		**2018/19**	
Exit packages: other non-compulsory departure payments	Payments agreed number	Total value of agreements £000	Payments agreed number	Total value of agreements £000
Voluntary redundancies including early retirement contractual costs	2	75	-	-
Mutually agreed resignations (MARS contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	-	-	-	-
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval	-	-	-	-
Total	**2**	**75**	**-**	**-**

Consultancy Costs

We procure expert advice to deliver key project where we do not have internal expertise or, in some circumstances, we may not have the required capacity. Consultancy costs in 2019-20 are summarised below:

Consultancy area	£000	Note
Strategy: The provision of objective advice and assistance relating to corporate strategies, appraising business structures, value for money reviews, business performance measurement, management services, product design and process and production management	470*	(a)
IT/IS: The provision of objective advice and assistance relating to IT/IS systems and concepts, including strategic studies and development of specific projects. Defining information needs, computer feasibility studies and making computer hardware evaluations. Including consultancy related to e-business	11	(b)
Human Resource, training and education: The provision of objective advice and assistance in the formulation of recruitment, retention, manpower planning and HR strategies and advice and assistance relating to the development of training and education strategies	0	
Programme and Project Management: The provision of advice relating to ongoing programmes and one-off projects. Support in assessing, managing and or mitigating the potential risks involved in a specific initiative; work to ensure expected benefits of a project are realised	0	
Property and Construction: The provision of specialist advice relating to the design, planning and construction, tenure, holding and disposal strategies. This can also include the advice and services provided by surveyors and architects	64	(c)
Finance: The provision of objective finance advice including advice relating to corporate financing structures, accountancy, control mechanisms an systems. This includes both strategic and operational finance.		
Technical: The provision of applied technical knowledge. To aid understanding, this can be sub-divided into: - Technical Studies: Research based activity including studies, prototyping and technical demonstrators	23	(d)

Procurement: The provision of objective procurement advice including advice in establishing procurement strategies	0	
Total cost 2019/20	**568**	

(a) We commissioned external support to help in the review of our values and behaviours which follows on from the review of the overall Trust strategy. We also commissioned work from experts in reviewing business processes with regards to cost improvement programmes and delivery of organisational efficiencies. *We also hosted modelling expertise on behalf of Greater Manchester of £74k which was reimbursed.

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

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

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

As a comparator we incurred £478k on consultancy expenditure in 2018/19.

Fair pay

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

The banded remuneration of the highest paid director in Stockport NHS Foundation Trust in the financial year 2019-20 was £205k - £210k (2018-19 £200k - £205k). In 2019-20 this was 7.5 times the median remuneration of the workforce which was £27,690, in 2018-19 the fair pay multiple was 7.7 times and the median remuneration was £26,177.

The Medical Director was the highest paid director in the organisation in 2019-20 (2018-19 it was the Chief Executive). In 2019-20 one employee (2018-19 two employees) received remuneration in excess of the highest paid director. We paid two director posts in excess of the annual equivalent of £150,000, which is the threshold used by the Civil Service as a comparison to the Prime Minister's ministerial and parliamentary salary. The Remuneration Committee has satisfied itself that the salaries are reasonable and in line with other NHS Foundation Trusts of a similar size.

Annual report on remuneration

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

Salary and Pension Entitlements of Senior Managers

Table 1 - Single Total Figure

Name	Start Date of Office	Salary and allowances (bands of £5,000) 2019/2020	Salary and allowances (bands of £5,000) 2018/2019	Expense payments (taxable) to nearest £100 2019/2020**	Performance pay and bonuses (bands of £5,000) 2019/2020**	Long term performance pay and bonuses (bands of £5,000) 2019/2020**	All Pension Related Benefits (bands of £2,500)* 2019/2020	Total (bands of £5,000) 2019/2020	All Pension Related Benefits (in bands of £2,500) 2018/2019	Total (in bands of £5,000) 2018/2019
		£000	£000	£000	£000	£000	£000	£000	£000	£000
Executive Directors										
Mrs L Robson	07.01.2019	**205 - 210**	45 -50	-	-	-	**197.5 - 200**	**405 - 410**	177.5 - 180.0	225 -230
Chief Executive										
Dr C Wasson	01.04.2016	**205 - 210**	195 - 200	-	-	-	**90 - 92.5**	**300 - 305**	42.5 - 45.0	240 - 245
Medical Director										
Mr H Mullen	01.11.2017	**120 -125**	120 - 125	-	-	-	**0 - 2.5**	**125 - 130**	-	120 -125
Director of Strategy, Planning & Partnerships/Deputy Chief Executive										
Ms A Lynch	23.10.2017	**115 -120**	115 -120	-	-	-	**32.5 - 35.0**	**152.5 - 155.0**	117.5 - 120.0	235 - 240
Chief Nurse & Director of Quality Governance										
Mr J Graham	20.05.2019	**115 -120**		-	-	-	**445 - 447.5**	**565 - 567.5**	-	-
Director of Finance										
Mrs S Toal	01.12.2016	**115 -120**	110 - 115	-	-	-	**97.5 - 100**	**215 -220**	25.0 - 27.5	135 -140
Chief Operating Officer										
Mr G Moores	03.06.2019	**95 - 100**	-	-	-	-	**385 - 387.5**	**485-490**	-	-
Director of W orkforce & Organisation Development										
Mrs C Parnell	01.11.2019	**40 - 45**	-	-	-	-	**10 - 12.5**	**50-55**	-	-
Director of Communications & Corporate Affairs										
Mrs H Brearley	27.03.2018	**30 - 35**	125 -130	-	-	-	-	-	125 -130	-
Interim Director of Workforce & Organisational Development										
Mr M Patel	03.08.2015	**15-20**	115 -120	-	-	-	**27.5 - 30**	**45 - 50**	0.0 - 2.5	115 -120
Director of Finance										
Mrs C Drysdale	01.01.2018	-	195 - 200	-	-	-	-	-	-	195 -200
Managing Direcor Stockport Neighbourhood Care										
Mrs H Thomson	06.01.2019	-	155 - 160	-	-	-	-	-	-	155 - 160
Interim Chief Executive										
Mr P Buckingham	01.01.2017	-	85 -90	-	-	-	-	-	-	85 -90
Director of Corporate Affairs										
Mrs M Wood	01.05.2018	-	70 - 75	-	-	-	-	-	-	-
Improvement Director										
Non Executive Directors										
Mr A Belton	01.06.17	**45 - 50**	45 - 50							
Mr M Sugden	28.04.10	**15 - 20**	15 - 20							
Mr D Hopewell	01.07.18	**15 - 20**	10 - 15							
Dr M Cheshire	01.09.13	**15 - 20**	15 - 20							
Mrs C Anderson	04.01.16	**10 - 15**	10 - 15							
Mrs C Barber-Brown	01.09.16	**10 -15**	10 - 15							
Mrs M Logan Ward	01.08.19	**5 - 10**	-							
Mr M Beaton	01.08.19	**5 - 10**	-							
Mrs A Smith	01.04.16	**0 - 5**	10 - 15							
Mr J Sandford	01.07.11	-	0 - 5							

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

1. *The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights.
2. ** There are no costs to include as prior year comparators for 2018/2019
3. Mrs L Robson was appointed as Chief Executive from the 7th January 2019.
4. Mrs H Thomson acted as Interim Chief Executive from the 1st January 2018 to the 6th January 2019.
5. Mrs H Brearley acted as Interim Director of HR and Workforce from the 27th March 2018 until the permanent appointment of Mr G Moores on the 3rd June 2019.

6. Dr C Wasson's salary as Medical Director reflects his full salary which is split 65% for his executive director role and 35% for his clinical role.
7. Mr J Graham was appointed as Director Finance on the 20th May 2019, replacing Mr M Patel.
8. Mr P Buckingham retired from his post as Director of Corporate Affairs on 28th February 2019.
9. Mrs C Parnell was appointed to the post of Director of Communications & Corporate Affairs on the 1st November 2019.
10. Prior year comparatives are included for staff who left the Trust in 2018/2019 also including Mrs M Wood, who was seconded onto the Board of Directors as Improvement Director between May 2018 and December 2018, and Mrs C Drysdale, Managing Director of Stockport Neighbourhood Care.

Salary and Pension Entitlements of Senior Managers

Table 2 - Pension Benefits

Name	Start Date of Office	Real increase during the reporting year in the pension at pension age (bands of £2,500)	Real increase during the reporting year in related lump sum at pension age (bands of £2,500)	Total accrued pension at pension age (in bands of £5,000)	Lump sum at pension age related to the accrued pension at 31 March 2020 (bands of £5,000)	Cash Equivalent Transfer value at the 1 April 2019	Real Increase in Cash Equivalent Transfer Value during the reporting year	Cash Equivalent Transfer Value at the 31st March 2020
		£000	£000	£000	£000	£000	£000	£000
Executive Directors								
Mrs L Robson	07.01.2019	**7.5 - 10**	**27.5 - 30.0**	**80-85**	**250-255**	**1,658**	247	**1,974**
Chief Executive								
Dr C Wasson	01.04.2016	**5 - 7.5**	**2.5-5**	**70-75**	**165-170**	**1,198**	87	**1,324**
Medical Director								
Mr H Mullen	01.11.2017	**0 - 2.5**	**0 - 2.5**	**50 - 55**	**165 - 170**	**1,287**	37	**1,363**
Director of Strategy, Planning & Partnerships/Deputy Chief Executive								
Ms A Lynch	23.10.2017	**0 - 2.5**	**5 - 7.5**	**40-45**	**125 - 130**	**851**	53	**941**
Chief Nurse & Director of Quality Governance								
Mr J Graham	20.05.2019			**0 - 5**	**10 - 15**	**549**	-454	**112**
Director of Finance								
Mrs S Toal	01.12.2016	**5 - 7.5**	**15 - 17.5**	**55 - 60**	**175 - 180**	**1,201**	129	**1,376**
Chief Operating Officer								
Mr G Moores	03.06.2019	**2.5 - 5**	**-**	**15 - 20**	**0**	**0**	33	**221**
Director of W orkforce & Organisation Development								
Mrs C Parnell	01.11.2019	**0 - 2.5**	**-**	**0 - 5**	**0**	**0**	0	**11**
Director of Communications & Corporate Affairs								
Mr M Patel	03.08.2015	**0 - 2.5**		**30 - 35**	**65 - 70**	**467**	2	**504**
Director of Finance								

Benefits and related Cash Equivalent Transfer Values (CETVs) do not allow for any potential future adjustment arising from the McCloud judgment. The method used to calculate CETVs has changed to remove the adjustment for Guaranteed Minimum Pension (GMP) on 8 August 2019. If an individual was entitled to a GMP, this will affect the calculation of the real increase in CETV which has been reported. This is more likely to affect individuals who are members of the 1995 Section and 2008 Section of the NHS Pension Scheme.

Louise Robson

Chief Executive

24 June 2020

Code of Governance

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

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

Reference	Statutory Requirement
A.2.2	The role of Chairperson and Chief Executive must not be undertaken by the same person **The Trust complies with this requirement.**
A.5.10	The Council of Governors has a statutory duty to hold the Non-Executive Directors, individually and collectively, to account for the performance of the Board of Directors. **The Board of Directors and Council of Governors comply with this requirement.**
A.5.11	The 2006 Act, as amended, gives the Council of Governors a statutory requirement to receive the following documents. These documented should be provided in the annual report as per the *NHS Foundation Trust Annual Reporting Manual*: a) The annual accounts, b) Any report of the auditor on them, and c) The annual report. **The Trust complies with this requirement.**
A.5.12	The directors must provide governors with an agenda prior to any meeting of the board, and a copy of the approved minutes as soon as practicable afterwards. There is no legal basis on which the minutes of private sessions of board meetings should be exempted from being shared with the governors. In practice, it may be necessary to redact some information, for example, for data protection or commercial reasons. Governors should respect the confidentiality of these documents. **The Trust complies with this requirement.**

A.5.13	The Council of Governors may require one of more of the directors to attend a meeting to obtain information about performance of the trust's functions or the directors' performance of their duties, and to help the Council of Governors to decide whether to propose a vote on the trust's or directors' performance. **The Trust is aware of this requirement. This situation did not arise during 2019-20.**
A.5.14	Governors have the right to refer a question to the independent panel for advising governors. More than 50% of governors who vote must approve this referral. The council should ensure dialogue with the Board of Directors takes place before considering such a referral, as it may be possible to resolve questions in this way. **The Trust is aware of this requirement. This situation did not arise during 2019-20.**
A.5.15	Governors should use their new rights and voting powers from the 2012 Act to represent the interests of members and the public on major decisions taken by the Board of Directors. These are outlined in full at A.5.15 **The Trust complies with this requirement.**
B.2.11	It is a requirement of the 2006 Act that the Chairperson, the other Non-Executive Directors and, except in the case of the appointment of a Chief Executive, the Chief Executive, are responsible for deciding the appointment of Executive Directors. The nominations committee with responsibility for Executive Director nominations should identify suitable candidates to fill Executive Director vacancies as the arise and make recommendations to the Chairperson, the other Non-Executive Directors and, except in the case of the appointment of the Chief Executive, the Chief Executive. **The Trust complies with this requirement.**
B.2.12	It is for the Non-Executive Directors to appoint and remove the Chief Executive. The appointment of a Chief Executive requires the approval of the Council of Governors. **The Trust complies with this requirement.**
B.2.13	The governors are responsible at a general meeting for the appointment, re-appointment and removal of the Chairperson and the other Non-Executive Directors. **The Trust complies with this requirement.**
B.4.3	The Board has a duty to take steps to ensure that governors are equipped with the skills and knowledge they need to discharge their duties appropriately. **The Trust complies with this requirement.**
B.5.8	The Board of Directors must have regard to the views of the Council of Governors on the NHS Foundation Trust's forward plan. **The Trust complies with this requirement.**
B.7.3	Approval by the Council of Governors of the appointment of a Chief Executive should be a subject of the first general meeting after the appointment by a committee of the Chairperson and Non-Executive Directors. All other Executive Directors should be appointed by a committee of the Chief Executive, the Chairperson and Non-Executive Directors.

	The Trust complies with this requirement.
B.7.4	Non-Executive Directors, including the Chairperson, should be appointed by the Council of Governors for the specified terms subject to re-appointment thereafter at intervals of no more than three years and subject to the 2006 Act provision relating to the removal of a director. **The Trust complies with this requirement.**
B.7.5	Elected governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. **The Trust complies with this requirement.**
D.2.4	The Council of Governors is responsible for setting the remuneration of Non-Executive Directors and the Chairperson. **The Trust complies with this requirement.**
E.1.7	The Board of Directors must make Board meetings and the annual meeting open to the public. The Trust's constitution may provide for members of the public to be excluded from a meeting for special reasons. **The Trust complies with this requirement.**
E.1.8	The Trust most hold annual members' meetings. At least one of the directors must present the Trust's annual report and accounts, and any report of the auditor on the accounts, to members at this meeting. **The Trust complies with this requirement.**

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

Reference	Statutory requirement
A.1.1	The schedule of matters reserved for the Board of Directors should include a clear statement detailing the roles and responsibilities of the Council of Governors. This statement should describe how any disagreements between the Council of Governors and the Board of Directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the Board of Directors and Council of Governors operate, including a summary of the types of decisions to be taken by each of the boards and which are delegated to the executive management of the Board of Directors **See page 70 and page 59**
A.1.2	The annual report should identify the Chairperson, the Deputy Chairperson (where there is one), the Chief Executive, the Senior Independent Director (see A.4.1) and the Chairperson and members of the Nominations, Audit and Remuneration Committees. It should also set out the number of meetings of the Board and those Committees, and individual attendance by directors. **See pages 59, 77, 63, and 67**
A.5.3	The annual report should identify the members of the Council of Governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the

	duration of their appointments. The annual report should also identify the nominated lead governor. **See page 75**
FT ARM	The annual report should include a statement of the number of meetings of the Council of Governors and individual attendance by governors and directors. **See page 75**
B.1.1	The Board of Directors should identify in the annual report each Non-Executive Director it considers to be independent, with the reasons where necessary. **See page 59**
B.1.4	The Board of Directors should include in its annual report a description of each director's skills, expertise and experience. Alongside this, in the annual report, the Board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS foundation Trust. **See page 60**
FT ARM	The annual report should include a brief description of the length of appointments of the Non-Executive Directors and how they may be terminated. **See page 59**
B.2.10	A separate section of the annual report should describe the work of the nominations committee (s), including the process it has use in relation to Board appointments. **See page 77**
FT ARM	The disclosure in the annual report on the work of the Nominations Committee should include an explanation if neither an external search consultancy nor open advertising has been use in the appointment of a Chair or Non-Executive Director **See page 77**
B. 3.1	A chairperson's other significant commitments should be disclosed to the Council of Governors before appointment and include in the annual report. Changes to such commitments should be reported to the Council of Governors as they arise, and included in the next annual report **See page 60**
B. 5.6	Governors should canvass the opinion of the Trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the Board of Directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied. **See page 73**
FT ARM	If, during the financial year, the governors have exercised their power under paragraph 10C of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report. **Executive Directors attend the Council of Governors meetings as a matter of course and governors have not had to exercise their power during 2019-20.**
B.6.1	The Board of Directors should state in the annual report how

	performance of the Board, its committees and its directors, including the Chairperson, has been conducted. **See page 62**
B. 6.2	Where there has been external evaluation of the Board and/or governance of the trust the external facilitator should be identified in the annual report and a statement made as to whether they have any other connection to the trust. **See page 112**
C.1.1	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, a fair, balanced and understandable and provide the information necessary for patients, regulators, and other stakeholders to assess the NHS foundation trust's performance, business model and strategy. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report). **See page 65, 114 and 116**
C. 2.1	The annual report should contain a statement that the Board has conducted a review of the effectiveness of its system of internal controls. **See page 115**
C.2.2	A trust should disclose in the annual report: a) If it has an internal audit function, how the function is structured and what role it performs; or b) If it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes. **See page 64**
C.3.5	If the council of governors does not accept the audit committee's recommendation on the appointment, reappointment or removal of an external auditor, the board of directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the council of governors has taken a different position. **This situation did not occur in 2019-20.**
C.3.9	A separate section of the annual report should describe the work of the Audit Committee in discharging its responsibilities. The report should include: • The significant issues that the committee considered in relation to financial statements, operations and compliance and how these issues were addressed; • An explanation of how it assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of current audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and • If the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how

	auditor objectivity and independence are safeguarded. **See page 63**
D.1.3	Where an NHS foundation trust releases an Executive Director, for example, to service as a Non-Executive Director elsewhere, the remuneration disclosure of the annual report should include a statement of whether or not the director will retain such earnings. **This situation did not occur in 2019-20**
E.1.4	Contact procedures for members who wish to communicate with governors and/or directors should be made clearly available to members on the NHS foundation trust's website and in the annual report. **See page 59 and 73**
E.1.5	The Board of Directors should state in the annual report the steps they have taken to ensure that the members of the board, and in particular the Non-Executive Directors, develop an understanding of the views of governors and members about the NHS foundation trust, for example, through attendance at meetings of the Council of Governors, director face-to-face contact, surveys of members' opinions and consultants. **See page 72**
E.1.6	The Board of Directors should monitor how representative the NHS foundation trust's membership is, and the level and effectiveness of member engagement and report on this in the annual report. **See page 73**
FT ARM	The annual report should include: • A brief description of the eligibility requirements for joining different membership constituencies, including the boundaries of public membership; • Information on the number of members in each constituency, and • A summary of the membership strategy, an assessment of the membership and a description of any steps taken during the year to ensure a representative membership, including progress towards any recruitment targets for members. **See page 73 and 76**

FTM ARM indicates that the disclosure with required by the NHS Foundation Trust Reporting Manual rather than the Code of Governance.

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

Reference	Statutory responsibility
A.1.3	The Board of Directors should make available a statement of the objectives of the NHS foundation trust showing how it intends to balance the interests of patients, the local community and other stakeholders, and use this as the basis for its decision making and

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

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

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

There were three instances of Non-Executive Directors seeking re-appointment during 2019-20. Relevant information was provided to the Council of Governors in relation to the re-appointment of Mr Adrian Belton with effect from May 2020, Mr Malcolm Sugden from 31 March 2020, and Dr Mike Cheshire from August 2020. The Committee agreed to recommend to the Council of Governors to re-appoint Mr Belton for a further three years and Mr Sugden for a further one year, but it decided not to recommend that Dr Cheshire was re-appointed. The Council of Governors accepted the recommendations.

The provisions listed below require supporting information to be made available to members, even in the case that the NHS foundation trust is compliant with the

provision. This information should be set out in papers accompanying a resolution to elect or re-elect a governor.

Reference	Statutory requirement
B.7.2	The names of governors submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to take an informed decision on their election. This should include performance information. **Relevant information is included within the election material circulated to members by Electoral Reform Services, which managed governor elections on behalf of the Trust in 2019-20.**

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

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

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

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

	The Trust complies with this requirement.
B.2.1	The Nominations Committee or committees, with external advice as appropriate, are responsible for the identification and nomination of Executive and Non-Executive Directors. **The Trust complies with this requirement.**
B.2.2	Directors on the Board of Directors and governors on the Council should meet the "fit and proper" persons test described in the provider licence. **The Trust complies with this requirement.**
B.2.3	The Nominations Committee(s) should regularly review the structure, size and composition of the Board and make recommendations for changes were appropriate. **The Trust complies with this requirement.**
B.2.4	The Chairperson or an independent Non-Executive Director should chair the Nominations Committee(s). **The Trust complies with this requirement.**
B.2.5	The governors should agree with the Nominations Committee a clear process for the nomination of a new Chairperson and Non-Executive Directors. **The Trust complies with this requirement.**
B.2.6	Where an NHS foundation trust has two Nominations Committee, the Nominations Committee responsible for the appointment of Non-Executive Directors should consist of a majority of governors. **The Trust complies with this requirement.**
B.2.7	When considering the appointment of Non-Executive Directors, the Council should take into account the views of the Board and the Nominations Committee on the qualifications, skills and experience required for each position. **The Trust complies with this requirement.**
B. 2.8	The annual report should describe the processes following by the Council in relation to appointments of the Chairperson and Non-Executive Directors. **The Trust complies with this requirement.**
B.2.9	An independent external advisor should not be a member of, or have a vote on the Nominations Committee(s). **The Trust complies with this requirement.**
B.3.3	The Board should not agreed to a full-time Executive Director taking on more than one Non-Executive directorship of an NHS Foundation Trust or another organisation of comparable size and complexity. **The Trust complies with this requirement.**
B.5.1	The Board and the Council of Governors should be provided with high quality information appropriate to their respective functions and relevant to the decisions they have to make. **The Trust complies with this requirement.**
B.5.2	The Board, and in particular Non-Executive Directors, may reasonably wish to challenge assurances received from the executive management. They need not seek to appoint a relevant advisor for each and every subject area that comes before the Board, although they should, wherever possible, ensure that they have sufficient

	information and understanding to enable challenge and to take decisions on an informed basis. **The Trust complies with this requirement.**
B.5.3	The Board should ensure that directors, especially Non-Executive Directors, have access to independent advice, at the NHS foundation trust's expense, where they judge it necessary to discharge their responsibilities as directors. **The Trust complies with this requirement.**
B.5.4	Committees should be provided with sufficient resources to undertaken their duties. **The Trust complies with this requirement.**
B.6.3	The Senior Independent Director should lead the performance evaluation of the Chairperson. **The Trust complies with this requirement.**
B.6.4	The Chairperson, with the assistant of the Board Secretary, if applicable, should use the performance evaluations as the basis for determining individual and collective professional development programmes for non-executive directors relevant to their duties as Board members. **The Trust complies with this requirement.**
B.6.5	Led by the Chairperson, the Council should periodically assess their collective performance and they should regularly communicate to members and the public details on how they have discharged their responsibilities. **The Trust complies with this requirement.**
B.6.6	There should be a clear policy and a fair process, agreed and adopted by the Council, for the removal from the Council of any governor who consistently and unjustifiably fails to attend the meetings of the Council, or has an actual or potential conflict of interest, which prevents the proper exercise of their duties. **The Trust complies with this requirement.**
B.8.1	The Remuneration Committee should not agree to an executive member of the Board leaving the employment of an NHS foundation trust, except in accordance with the terms of their contract of employment, including but not limited to service of their full notice period and/or material reductions in their time commitments to the role, without the Board first having completed and approved a full risk assessment. **The Trust complies with this requirement.**
C.1.2	The directors should report that the NHS foundation trust is a going concern with supporting assumptions or qualifications as necessary. **The Trust complies with this requirement.**
C.1.3	A least annually and in a timely manner, the Board should set out clearly its financial, quality and operating objectives for the NHS foundation trust and disclose sufficient information, both quantitative and qualitative, of the NHS foundation trust's business and operation, including clinical outcome data to allow members and governors to evaluate its performance. **The Trust complies with this requirement.**
C.1.4	a) The Board of Directors must notify Monitor and the Council of

	Governors without delay and should consider whether it is in the public's interest to bring to the public attention, any major new developments in the NHS foundation trust's sphere of activity which are not public knowledge, which it is able to disclose and which may lead by virtue of their effect on its assets and liabilities, or financial position or on the general course of its business, to a substantial change to the financial wellbeing, health care delivery performance or reputation and standing of the NHS foundation trust. b) The Board of Directors must notify Monitor and the Council of Governors without delay and should consider whether it is in the public interest to bring to the public attention all relevant information which is not public knowledge concerning a material change in: • The NHS foundation trust's financial condition, • The performance of its business; and/or • The NHS foundation trust's expectation as to its performance, which if made public, would be likely to lead to a substantial change to the financial wellbeing, health care delivery, performance or reputation and standing of the NHS foundation trust. **The Trust complies with this requirement.**
C.3.1	The Board should establish an Audit Committee composed of at least three members who are all independent Non-Executive Directors. **The Trust complies with this requirement.**
C.3.3	The Council should take the lead in agreeing with the Audit Committee the criteria for appointing, re-appointing and removing external auditors. **The Trust complies with this requirement.**
C.3.6	The NHS foundation trust should appoint an external auditor for a period of time which allows the auditor to develop a strong understanding of the finances, operations and forward plans for the NHS foundation trust. **The Trust complies with this requirement.**
C.3.7	When the council ends an external auditor's appointment in disputed circumstances, the chairperson should write to Monitor informing it of the reasons behind the decision. **The Trust complies with this requirement.**
C.3.8	The Audit Committee should review arrangements that allow staff of the NHS foundation trust and other individuals where relevant, to raise, in confidence, concerns about possible improprieties in matters of financial report and control, clinical quality, patient safety or other matters. **The Trust complies with this requirement.**
D.1.1	Any performance related elements of remuneration of Executive Directors should be designed to align their interest with those of patients, service users and taxpayers, and to give these directors keen incentives to perform at the highest levels. **The Trust did not have a performance related element of remuneration for all Executive Directors in 2019-20 but it did introduce an earn-back element to the remuneration for some Executive Directors appointed in year. This arrangement will be**

	evaluated in 2020-21.
D.1.2	Levels of remuneration for the Chairperson and other Non-Executive Directors should reflect the time commitment and responsibilities of their roles. **The Trust complies with this requirement.**
D.1.4	The Remuneration Committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' term of appointments would give rise to in the event of early termination. **The Trust complies with this requirement.**
D.2.2	The Remuneration Committee should have delegated responsibility for setting remuneration for all Executive Directors, including pension rights and any compensation payments. **The Trust complies with this requirement.**
D.2.3	The Council should consult external professional advisers to market test the remuneration levels of the Chairperson and other Non-Executives at least one every three years and when they intend to make a material change to the remuneration of a Non-Executive. **The Trust complies with this requirement.**
E.1.2	The Board should clarify in writing how the public interests of patients and the local community will be represented, including its approach for addressing the overlap and interface between governors and any local consultative forums. **The Trust complies with this requirement.**
E.1.3	The Chairperson should ensure that the views of governors and members are communicated to the Board as a whole. **The Trust complies with this requirement.**
E.2.1	The Board should be clear as to the specific third party bodies in relation to which the NHS foundation trust has a duty to co-operate. **The Trust complies with this requirement.**
E.2.2	The Board should ensure that effective mechanisms are in place to co-operate with relevant third party bodies and that collaborative and productive relationships are maintained with relevant stakeholders at appropriate levels of seniority in each. **The Trust complies with this requirement.**

Regulatory Ratings

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

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

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

- failure to take action necessary to ensure compliance with the A&E four hour maximum waiting standard on a sustainable basis;
- lack of a clear vision and strategy around which the Licensee's Board can determine is focus and priorities;
- lack of a long term financial recovery plan demonstrating how the Licensee aims to return to a financial break-even position and of a credible plan to deliver the required cost improvement programme;
- failure to ensure that the Licensee's Board and its committees have effective oversight of quality, safety, finances and A&E performance;
- failure to respond sufficiently and in a timely manner to concerns identified by the CQC in its inspection of January 2016; and
- any other issues relating to the operation of the Licensee's Board and its other governance arrangements, including those identified in any independent assessment of its governance arrangements, that have caused or contributed to, or will cause or contribute to, the breach, or the risk of breach, of the conditions of the Licensee's licence.

Our progress in addressing these issues was subject to formal monitoring via enhanced financial oversight meetings and quarterly review meetings with NHS Improvement. A Quality Improvement Board, jointly chaired by NHS Improvement and Greater Manchester Health and Social Care Partnership, was also established to focus on quality issues and urgent and emergency care.

At the start of 2019-20 we were considered to have made sufficient progress against the issues identified in December 2017 to no longer require intensive support from NHSE/I although the licence conditions were not lifted. We remain grateful for the ongoing support we receive from NHSE/I in helping to sustain progress and address issues that we have identified.

For example, in August 2019 we recognised the need to strengthen our current governance and risk assurance system and processes and asked NHSE/I to undertake an independent governance review. This was carried out by Ms Rebecca Southall, an experienced governance expert employed by NHSI.

Due to other commitments that piece of work was unable to start until early in 2020, and at the time of writing this report the Board of Directors had just received the completed report, but we had already appointed an interim Director of Quality Governance and Risk Assurance to take forward the review's recommendations and improvements we had identified.

We have also welcomed ongoing support from the Emergency Care Intensive Support Team (ECIST), which is continuing to work with our urgent and emergency

care staff to improve systems and processes, as well as the care of patients, particularly those with mental health needs.

With funding from NHSI and Greater Manchester Health and Social Care Partnership we commissioned PriceWaterhouseCooper (PWC) to build on our ongoing work to improve the flow of patients through the hospital. This has been a long standing challenge for the local health and care system, but we are hopeful that into 2020-21 we can sustain the major improvements that have taken place in response to the pandemic.

A key part of the work by PWC was to be a coaching approach to help teams address any barriers to the effective flow of patients out of hospital, but the pandemic has impacted on the timescales for delivery of that element of their support. We are currently working with them on devising a way to continue with coaching while also abiding by social distancing guidance.

Statement of Accounting Officer's Responsibilities

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

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

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

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

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

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;

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

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

The Accounting Officer is also responsible for safeguarding the assets of Stockport NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

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

Louise Robson

Chief Executive

24 June 2020

Annual Governance Statement

Scope of responsibility

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

The purpose of the system of internal control

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

The system of internal control has been in place in Stockport NHS Foundation Trust for the year ended 31 March 2020 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

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

- The Board of Directors, which is responsible for overseeing all aspect of risk management as well as defining its risk appetite;
- The Audit Committee, which is responsible for receiving and reviewing assurance on systems in place in the organisation to manage risk;
- The Chief Executive and designated Executive Directors with responsibility for specific areas of risk management;
- The Safety and Risk Group, which reports to a sub-group of the Quality Committee and has responsibility for organisation-wide co-ordination and prioritisation of risk management issues. The group uses a peer review approach to provide guidance and encourage learning from best practice.
- an assessment of the level of risk management training that is required for staff and its delivery;

- general risk management training sessions delivered on a six monthly basis, supplemented by focused training for individuals, team and groups as required;
- staff with specific responsibility for co-ordinating and advising on aspects of risk management having adequate training and development to fulfil their role;
- training sessions that equip staff to manage aspects of risk, such as incident reporting, investigation and lessons learned;
- the organisation's Risk Management Strategy that clearly defines levels of authority to manage and mitigate risks, according to risk scored ratings.

The risk and control framework

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

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

Our principal sources of risk identification are:

- our risk assessment process,
- incident reports and investigations,
- issues arising from complaints,
- claims information.

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

Our Incident Reporting and Management Policy aims to ensure that when a serious event or incident happens there are systematic measures for safeguarding patients, property, resources and our reputation. Abiding by the policy ensures that a thorough investigation is undertaken, lessons learned and disseminated throughout the organisation, as well as to partner organisations as appropriate, to try to reduce the likelihood of similar incidents happening in the future. Equality and quality impact assessments are used extensively and can inform risk mitigation actions, where appropriate.

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

assessment process applies to all type of risk, including clinical, financial and operational. Risk registers are maintained by each Business Group and they are regularly reviewed at the Business Groups' Quality Board meetings. Any risk with a residual score of 15 or above is placed on the Trust's risk register, which is monitored on a monthly basis by the Safety and Risk Group, relevant Board Committees and the Board of Directors.

During 2019-20 a number of issues arose that prompted the Board of Directors and Executive Director Team to question the effectiveness of some of our governance systems and processes and risk management approach. These concerns included issues in relation to previous decisions made about the management of our estates and facilities, as well as quality issues that were highlighted in external reviews of our services. As a result we sought the support of NHSE/I to carry out an independent governance review of our systems and processes, from ward to Board and back again.

Unfortunately, NHSE/I were unable to start this work until the beginning of 2020 and at the time of writing this report we had just received the outcomes of that review. However, the delay did not stop us from making improvements to the way we currently operate with a view to overhauling our governance and risk management processes in 2020-21.

These changes included:

- major improvements and investment in our estates and facilities,
- the appointment of an interim Director of Quality Governance and Risk Assurance to take forward the review recommendations,
- commissioning a series of independent reviews of systems and processes in services where concerns were raised via existing governance processes,
- identifying systems and processes for internal audit to review.

During 2019-20 our corporate governance team also worked closely with our Business Groups to review their risk registers to ensure individuals and teams fully understood how to accurately score and mitigate emerging risks, and when it is appropriate to escalate those risks. This fed into further improvements we have made to the Trust's risk register to clearly articulate those organisational risk scored 15 or above, as well as provide the Board of Directors with greater assurance around the effectiveness of mitigating actions

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

Management capability in terms of leadership, the available of knowledgeable and skilled staff, and adequate financial and physical resources to ensure that processes and internal controls work effectively is routinely monitored by the Executive Directors team. In 2020-21 we expect that as a result of the NHSE/I governance review we will be investing further in staff to support the revised governance and risk assurance process, and in line with the outcomes of the CQC's Well-Led review we will be further developing and refining practice and processes.

The Board of Directors has continued to monitor and review the system and internal control and, where necessary, to identify improvements to accountability arrangements, processes or capability in order to deliver better outcomes. In 2019-20 this included a review of the Board and Committee meeting cycle, which resulted in changes to the scheduling of meetings to ensure members' received the most up to date information to inform assurance and decision making.

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

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

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

Impact of the Covid-19 pandemic

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

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

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

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

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

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

The groups provided weekly key issues reports to the Executive Director Team, which escalated any significant operational or strategic risks to the Board of Directors.

At the time of writing this report this the temporary Board, Committee and Advisory Group structure had been in place for three months, and was being reviewed by the Board on a monthly basis with the intention of moving back to established structures as soon as practicably possible.

Board Assurance Framework

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

The BAF is reviewed by the Board of Directors on a quarterly basis, taking into account any development in the external environment that may impact on the organisation's ability to achieve its objectives. With the refresh of our Trust strategy for 2020-21 we will also be reviewing the content of the BAF in line with our new objectives.

The BAF identified the risks to our principal objectives as:

- Risk 1 – if the Trust strategy is not implemented it will result in missed opportunities to improve the quality of care we provide, leading to poor patient and staff experience, inability to modernise services, delays in delivering integration and failure to engage effectively and lead developments with partners.
- Risk 2 – the Trust will fail to achieve the 2019-20 developments set out in the Quality Improvement Plan, resulting in not consistently providing the safest, highest quality care to patients, their families and carers.

- Risk 3 – failure to maintain financial stability, which will impact on the Trust's compliance with the NHS Improvement Provider Licence.
- Risk 4 – not continuing to develop effective external partnerships and alliances leading to failure to improve the health of the local population and reduce health inequalities, failure to develop new care pathways and failure to achieve long term clinical and financial stability and viability.
- Risk 5 – not delivering the NHS Improvement Single Oversight Framework operational performance metrics impacting on the quality of care we provide, patient and staff experience and the Trust's Provider Licence.
- Risk 6 – the Trust fails to recruit, develop and retain a suitably skilled and motivated workforce.
- Risk 7 – not delivering the Trust's capital programme in a planned and efficient manner.

The Board of Directors considered that these risks, originally agreed in 2018-1, continued to be relevant in 2019-20. In line with its refreshed Trust strategy the Board will agree new objectives for the 2020-21 BAF and associated risks to delivery of the strategy. It is expected that those will reflect the challenges posed to the organisation by its financial position, workforce, and ageing estate, as well as continuing to respond to the demands of the on-going pandemic and the need to develop robust recovery plans for the Trust and region.

The current governance framework, and revised approach we will implement in 2020-21, ensure that risks are identified and, where necessary, escalated for action from the Business Groups to Executive Directors Team, Committees and the Board of Directors.

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

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

At the time of writing this report the Board of Directors was considering its Corporate Governance Statement and risks associated with:

- issues raised in the CQC's inspection report,
- required improvements to our governance and risk systems and processes, as highlighted in the governance review;
- issues arising from other external reviews we had commissioned.

Quality Governance Framework

We have arrangements in place to monitor and continually improve the quality of care for patients. The Board of Directors monitors performance against a suite of indicators relating to quality, safety, staffing operational, financial and workforce metrics via an integrated performance report that is presented at each Board meeting. The report triangulates a range of metrics relating to locally agreed priority areas, as well as those nationally mandated via the NHSE/I Single Oversight Framework. As part of the report the Board receives monthly safe staffing information, as well as a six monthly safe staffing report and quarterly updates on delivery of our People Strategy.

Staffing was one of the key risks identified during 2019-20 *(see page 32)* and the Board of Directors funded the further recruitment of overseas nurses and also a cohort of 30 nursing associates as part of investing in our future workforce. During the pandemic we established a staffing hub to safely manage our staffing resource and we intend to maintain the hub post-pandemic.

We have continued to implement our quality governance framework that was developed in 2018, this included maintaining groups that address the following issues within a process of escalation of issues and assurance reporting:

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

Through this framework of issue specific groups and reporting to the Quality Committee and Board of Directors, we have continued to work on delivering our quality improvement plan focusing on the following areas:

- high quality safe care plan,
- urgent care delivery,
- quality improvement initiatives,
- safe staffing,
- safety collaborative,
- reducing unwarranted variation in clinical practice,
- Quality Improvement Faculty.

Progress in delivering the plan was monitored during 2019-20 by the Quality Committee and Board of Directors.

During 2019-20 we identified two never events that we reported to the CQC, NHSE/I and commissioners, and they were thoroughly investigated to learn lessons and try to prevent the same issues happening in the future. One event related to insulin being administered using an incorrect syringe, and the other related to the retention of a guide wire post a procedure.

Compliance

Our services are registered with the CQC and some of those services were subject to a CQC inspection in January and February 2020. The inspection report was published in May 2020 and the Board of Directors fully accepted the findings. We have developed a comprehensive improvement plan that is monitored on a monthly basis by the Board of Directors and Stockport System Improvement Board (*see page 79).*

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

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

We have staffing in extremis guidelines in place to respond to unplanned workforce challenges, such as those we experienced during the 2019-20 winter and the pandemic. This guidance aims to help manage daily staffing levels to ensure safe, effective patient care. Reviews take place three times a day and the outcomes are shared with ward managers, night sisters, matrons, asocial nursing directors, deputy chief nurse and chief nurse, as well as on-call teams. During the Covid-19 pandemic we enhanced this approach to safe staffing with the development of a staffing hub that ensured staffing resources were spread appropriately across the organisation, and we plan to continue the hub post pandemic.

In line with Managing Conflicts of Interest guidance we publish a register of interests, including gifts and hospitality, for those staff we define in our policy as decision makers. During 2019-20 we implemented an electronic system for registering interests, gifts and hospitality, and also updated our policy. Following an internal audit report, which offered limited assurance, we plan to further refine the policy in 2020-21 to focus on embedding the practice of all decisions makers registering annual declarations of interests, as well as gifts and hospitality as they arise.

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

We have control measures in place to ensure that all of our obligations under equality, diversity and human rights legislation are complied with (*see page 86)*.

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

Information risks

Specific risks relating to information governance, data protection and data quality are reviewed by our Information Governance and Security Group with oversight by the Finance and Performance Committee.

As well as adopting proactive measures to prevent loss of data and ensure improvements in data quality and cyber security, the group ensures that specific procedures are in place to detect, report and manage any issues of data loss and breaches. Other actions to guard against risks to information and cyber threats include:

- IT security controls for the encryption of all laptops and mobile devices, including email encryption software and restrictions on the use of removable media on all Trust computers;
- email and web security controls and filters to protect against malicious software and websites,
- regular security updates and patches applied to computers and systems in accordance with NHS Digital's thread advisories and alerts,
- independent security assessments and penetration testing of IT infrastructure and systems,
- ongoing review of information assets to ensure they are appropriately risk assessed and security measures are in place to maintain confidentiality, integrity and availability of data,
- review of information security policies, procedures and guidance issued around the handling and sharing of personal data in compliance with the General Data Protection Regulations (GDPR) and the Data Protection Act 2018,

- all staff must complete data security awareness e-learning annually as part of our mandatory training programme,
- we continue to maintain our ISO 27001 accreditation, which is an international best practice standard in information security management;
- we achieved accreditation for our secure email service from NHS Digital to enable secure information sharing with other NHS organisations and local authorities.

We have a Board-level senior information risk owner (SIRO) with lead responsibility for ensuring that information risk is properly identified and managed, and that appropriate assurance mechanisms exist. The SIRO role was undertaken by the Director of Strategy, Planning and Partnership and on his retirement at the end of May 2020 the responsibility passed to the Director of Finance.

Usually we complete our annual self assessment against the Data Security & Protection Toolkit in March each year. However, due to the pandemic the deadline was moved to 30 September 2020. The toolkit is a mandatory requirement to provide assurance of good information governance and data security practices. We plan to meet all the requirements of the toolkit and an internal audit review of our self-assessment was carried out in February 2020 and identified substantial assurance.

During 2019-20 there was one data breach incident that met the threshold to report to the Information Commissioner's Office (ICO) in relation to records stolen from a doctor's car, although no action was taken by the ICO and the records were found and recovered a few days later.

All incidents are reported within our internal incident management system and are subject to investigation, with appropriate action taken to mitigate risk of reoccurrence.

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

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

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

- approval of annual budgets by the Board of Directors,

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

Compliance with the NHS Foundation Trust Code of Governance is reviewed by the Audit Committee on a six monthly basis and is a core element of the committee's work plan. Outcomes from these reviews inform the compliance declarations detailed on page 99 of the report. Work of the Audit, Nominations and Remuneration Committee are detailed on pages 63, 77 and 67 of the report.

Annual Quality Report

NHSE/I issued guidance that due to the Covid-19 pandemic the usual timescales for production of an annual quality report have been amended and it is not required to be the subject of an external audit. Our quality report for 2019-20 will be published before the end of 2020.

Review of effectiveness

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

My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee, the other committees that form part of the organisation's assurance, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

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

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

In May 2020 the Audit Committee received the Head of Internal Audit Opinion that concluded that the organisation has "a good system of internal controls designed to meeting the organisations objectives, which are generally being applied consistently."

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

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

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

The organisation has a comprehensive risk-based internal audit programme in place and the programme was delivered in full during 2019-20, despite the impact of the pandemic that meant changes had to be made to how the programme was carried out. Outcomes of the internal audit programme are reported to the Audit Committee and appropriately led plans are in place to address any audits that result in a limited assurance assessment.

The monitoring of governance processes is informed by an integrated performance report, which includes a comprehensive set of indicators that are reviewed by the Board of Directors at each meeting. During 2020-21 the organisation plans to make further refinements to the report to improve the triangulation of data and support enhanced oversight of performance against key standards and objectives. Data

validation and availability is tested as part of the internal audit assessments, where appropriate.

As a result of issues raised in the CQC's latest inspection report and themes arising from the independent governance review, as well as other service reviews commissioned by the Trust, the organisation has identified the need to make significant improvements to its emergency and urgent care services, patient flow and care of patients with mental health problems, as well strengthen its governance and risk assurance systems and processes. These will be areas of particular focus for the organisation during 2020-21.

Conclusion

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

Louise Robson

Chief Executive

24 June 2020

3. ANNUAL ACCOUNTS 2019 – 2020

Foreword to the accounts.

These accounts are prepared in accordance with paragraphs 24 and 25 of Schedule 7 of the NHS Act 2006 and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.

Louise Robson Chief Executive 24 June 2020

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

Report on the financial statements

Opinion on the financial statements

We have audited the financial statements of Stockport NHS Foundation Trust ('the Trust') and its subsidiaries ('the Group') for the year ended 31 March 2020 which comprise the Consolidated Statement of Comprehensive Income, the Trust and Group Statements of Financial Position, the Group's Consolidated Statement of Changes in Equity, the Trust's Statement of Changes in Equity, the Trust and Group Statements of Cash Flows, and notes to the financial statements, including the summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by HM Treasury's Financial Reporting Manual 2019/20 as contained in the Department of Health and Social Care Group Accounting Manual 2019/20 (GAM), and the Accounts Direction issued under the National Health Service Act 2006.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the Trust and Group as at 31 March 2020 and of the Trust's and the Group's income and expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2019/20; and
- have been properly prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

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

Material uncertainty related to going concern

We draw attention to Note 1.2 in the financial statements, which sets out the Directors' view concerning the Trust's and the Group's ability to continue as a going concern. As stated in Note 1.2, these events or conditions, along with the other matters as set forth in Note 1.2, indicate that a material uncertainty exists that may cast significant doubt on the Trust's and the Group's ability to continue as a going concern. Our opinion is not modified in respect of this matter.

Explanation of material uncertainty

The material uncertainty disclosed in Note 1.2 relates to:

- the uncertainty of the sufficiency of the Trust's funding once the current block contract Covid-19 funding ceases;
- the lack of an agreed control total position to return to at that point; and
- the uncertainty of whether additional one-off funding would be available to support the Trust.

As a result of this assessment, the Directors' have concluded that there is a material uncertainty related to going concern. The financial statements do not include the adjustments that would result if the Trust or the Group were unable to continue as a going concern.

What audit procedures we performed

In forming our conclusion that there is a material uncertainty related to going concern, we:

- Assessed the Trust's judgements relating to its consideration of going concern.

- Reviewed the Trust's financial plan for the period to June 2021, including cash flow forecasts and underlying assumptions.
- Reviewed the potential impact of the longer-term uncertainties at the point at which the current Covid-19 funding regime ends.
- Assessed the appropriateness of the going concern disclosure in Note 1.2 in the financialstatements.

Key audit matters

In addition to the matter described in the "Material uncertainty related to going concern" section of our report, key audit matters are those matters that, in our professional judgement, were of most significance in our audit of the financial statements of the current period and include the most significant assessed risks of material misstatement (whether or not due to fraud) that we identified. These matters included those which had the greatest effect on the overall audit strategy, the allocation of resources in the audit, and directing the efforts of the engagement team. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

Key audit matter	Our response and key observations
Valuation of land & buildings within property, plant and equipment (Trust) *Note 15.1 to the financial statements discloses information on the Trust's holding of property, plant and equipment (PP&E) which includes £131.6m of land and buildings held at current value at 31 March 2020. These assets are subject to periodic revaluation in line with the requirements of the GAM. Note 1.9 to the financial statements describes the Trust's accounting policy with respect to the valuation of land and buildings and includes disclosure of a material valuation uncertainty as a result of the Covid-19 pandemic.* The Trust's holding of PP&E includes a portfolio of land and building assets that are held at current value. Management engage a valuation expert ('the valuer') to provide the Trust with valuations in accordance with Royal Institution of Chartered Surveyors (RICS) requirements. We consider there to be a significant risk of material misstatement in relation to the valuation of the Trust's land and buildings as a result of the: • High degree of estimation uncertainty associated with the valuations; • Level of judgement applied by management and the valuer in estimating current values; and • Extent to which the valuations are reliant on complete and accurate source data on individual assets being provided to the valuer. The significant risk of material misstatement is further increased due to the additional estimation uncertainty arising from the Covid-19 pandemic.	Our audit procedures included, but were not limited to: • Obtaining an understanding of the skills, experience and qualifications of the valuer, and considering the appropriateness of the instructions to the valuer from the Trust. • Obtaining an understanding of the basis of valuation applied by the valuer in the year. This included understanding and evaluating the methodology applied to estimate the gross replacement cost of the Trust's operational land and buildings on a modern equivalent asset basis. • Sample testing the completeness and accuracy of underlying data provided by the Trust and used by the valuer as part of their valuations. • Testing the accuracy of how valuation movements were presented and disclosed in the financial statements. • Making direct enquiries with the valuer to understand the nature of the material valuation uncertainty disclosed in their valuation report. • Using relevant market and cost data to assess the reasonableness of the valuation as at 31 March 2020. In doing so, we also considered relevant valuation indices prepared by an independent third party, to assess the effect of the material valuation uncertainty disclosed by the valuer and the Trust in the financial statements. ***Key observations*** We obtained sufficient appropriate evidence to conclude that the valuation of land and buildings included in the financial statements is reasonable.

Revenue recognition (Trust) *The Trust recognised £339.9m of revenue from activities in the Statement of Comprehensive Income. The Trust's primary source of revenue is through contracts with commissioning bodies in respect of the provision of acute and community healthcare services. Notes 3.1, 4 and 4.1 provide further information on the nature of the Trust's revenue and Note 3.2 provides further information on the source of the Trust's revenue.* ISA (UK) 240 incudes a rebuttable presumption that there is a risk of fraud in relation to revenue recognition. We have not rebutted the presumed risk on the basis that the Trust has continued financial pressures in 2019/20 and there is a perceived incentive to recognise revenue before it has been earned. We consider that the risk relating to revenue recognition impacts on revenue from patient care and other income as well as the trade and other receivables recognised as current assets in the Statement of Financial Position. The risk related solely to the cut-off assertion, being the recognition of income around the financial year end.	Our audit procedures included, but were not limited to: • Evaluating the Trust's accounting policy in respect of revenue recognition to ensure that it is in line with the requirements of the GAM. • Reconciling revenue recognised through contracts with commissioners, to the underlying contractual agreement and any agreed variations in the year to appropriate evidence. • Testing a sample of other revenue by agreeing the transactions to appropriate source documentation and obtaining assurance that each item was recorded in the correct financial year and at the correct value. • Considering information provided by the Department of Health and Social Care in respect of year-end intra-NHS transactions. ***Key observations*** We obtained sufficient appropriate evidence to conclude that revenue recognised in the financial statements is reasonable.

Our application of materiality

The scope of our audit was influenced by our application of materiality. We set certain quantitative thresholds for materiality. These, together with qualitative considerations, helped us to determine the scope of our audit and the nature, timing and extent of our audit procedures on the individual financial statement line items and disclosures, and in evaluating the effect of misstatements, both individually and on the financial statements as a whole. Based on our professional judgement, we determined materiality for the financial statements as follows:

	Trust	Group
Overall materiality	£6.6m	£6.65m
Basis for determining materiality	2% of gross operating expenses	
Rationale for benchmark applied	Gross operating expenses is a key measure of financial performance for the users of the financial statements.	
Performance materiality	£4.62m	£4.655m
Reporting threshold	£0.198m	£0.2m

An overview of the scope of our audit

As part of designing our audit, we determined materiality and assessed the risk of material misstatement in the financial statements. In particular, we looked at where the Accounting Officer made subjective judgements such as making assumptions on significant accounting estimates.

We gained an understanding of the legal and regulatory framework applicable to the Trust and the Group and the sector in which they operate. We considered the risk of acts by the Trust and Group which were contrary to the applicable laws and regulations including fraud. We designed our audit procedures to respond to those identified risks, including non-compliance with laws and regulations (irregularities) that are material to the financial statements.

We focused on laws and regulations that could give rise to a material misstatement in the financial statements, including, but not limited to, the National Health Service Act 2006.

We tailored the scope of our audit to ensure that we performed sufficient work to be able to give an opinion on the financial statements as a whole. We used the outputs of our risk assessment, our understanding of the Trust's and the Group's accounting processes, controls and their environments, and considered qualitative factors in order to ensure that we obtained sufficient coverage across all financial statement line items. There were no changes to the scope of the current year audit from the scope in the prior year.

Our tests included, but were not limited to:

- obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by irregularities including fraud or error;
- review of minutes of board meetings in the year;
- discussions with the Trust's internal auditor; and
- enquiries of management.

As a result of our procedures, we did not identify any key audit matters relating to irregularities, including fraud (other than the key audit matter on revenue recognition outlined above). The risks of material misstatement, including due to fraud, that had the greatest effect on our audit, including the allocation of resources and effort, are discussed under 'Key audit matters' within this report.

Our group audit scope included an audit of the Trust and Group financial statements. Our approach to auditing the group was based on our understanding of the group structure and an assessment of the significance of individual components to the group financial statements. In summary:

- Full scope audit procedures were carried out on the Trust which represents 97.6% of the Group's total assets, 97.8% of the Group's total liabilities, 99.7% of the Group's income and 99.8% of the Group's expenditure.
- Analytical procedures were performed on Stockport NHS Foundation Trust General Fund and Stepping Hill Healthcare Enterprises Limited which were non-significant components included in the Group financial statements.

At the Group level we also tested the consolidation process and carried out analytical procedures to confirm our conclusion that there were no significant risks of material misstatement of the aggregated financial information.

Other information

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

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

We are also required to consider whether we have identified any inconsistencies between our knowledge acquired during the audit and the Directors' statement that they consider the Annual Report is fair, balanced and

understandable and whether the Annual Report appropriately discloses those matters that we communicated to the Audit Committee which we consider should have been disclosed.

We have nothing to report in these regards.

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

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

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

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

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2019/20; and
- the other information published together with the audited financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Annual Governance Statement	
We are required to report to you if, in our opinion: • the Annual Governance Statement does not comply with the NHS Foundation Trust Annual Reporting Manual 2019/20; or • the Annual Governance Statement is misleading or is not consistent with our knowledge of the Trust and Group and other information of which we are aware from our audit of the financial statements.	We have nothing to report in respect of these matters.
Reports to the regulator and in the public interest	
We are required to report to you if: • we refer a matter to the regulator under Schedule 10(6) of the National Health Service Act 2006 because we have a reason to believe that the Trust, or a Director or officer of the Trust, is about to make, or has made, a decision	We have nothing to report in respect of these matters.

involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency; or
- we issue a report in the public interest under Schedule 10(3) of the National Health Service Act 2006.

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

Matter on which we are required to report by exception
We are required to report to you if, in our opinion, we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2020.

Qualified conclusion
On the basis of our work, having regard to the guidance issued by the Comptroller and Auditor General in April 2020, with the exception of the matters described in the 'Basis for qualified conclusion' paragraph below, we are satisfied that, in all significant respects, Stockport NHS Foundation Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2020.

Basis for qualified conclusion
In considering the Trust's arrangements for properly informed decision making and for securing sustainable resource deployment, we identified the following matters:
- The Trust's license condition modified and issued by NHS Improvement on 15 December 2017 has remained in place throughout 2019/20. This modification relates to the Trust's non-compliance with the A&E 4 hour waiting time and the Trust failed to achieve the A&E 4 hour waiting time national target throughout 2019/20.
- While the Trust exceeded its 2019/20 financial control total agreed with NHS Improvement by £0.3 million, delivering a deficit of £3.3 million, the financial position achieved for the year was reliant on £24.5 million of one-off funding and significant non-recurrent savings. The Trust does not yet have an agreed financial control total for 2020/21, and when the Trust reverts back to its agreed contracts with commissioners from the current Covid-19 pandemic funding, it has significant challenges and risks to deliver a sustainable financial position.

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

Auditor's responsibilities for the review of arrangements for securing economy, efficiency and effectiveness in the use of resources
We are required by Schedule 10(1) of the National Health Service Act 2006 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in April 2020, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2020.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary.

Use of the audit report

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

Certificate

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

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

One St Peter's Square
Manchester
M2 3DE

24 June 2020

Stockport NHS Foundation Trust

Annual accounts for the year ended 31 March 2020

Foreword to the accounts

Stockport NHS Foundation Trust

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

Signed 

Name **Louise Robson**
Job title **Chief Executive**
Date **24 June 2020**

Consolidated Statement of Comprehensive Income

		Group		Trust	
		2019/20	2018/19	2019/20	2018/19
	Note	£000	£000		
Operating income from patient care activities	3	277,373	260,352	277,373	260,352
Other operating income	4	63,300	35,525	62,570	34,956
Operating expenses	6	(334,481)	(323,455)	(333,867)	(323,063)
Operating surplus/(deficit) from continuing operations		**6,192**	**(27,578)**	**6,076**	**(27,755)**
Finance income	11	194	166	145	119
Finance expenses	12	(1,727)	(1,038)	(1,727)	(1,038)
PDC dividends payable		(2,021)	(2,434)	(2,021)	(2,434)
Net finance costs		**(3,554)**	**(3,306)**	**(3,603)**	**(3,353)**
Other gains / (losses)	13	(8)	101	37	4
Corporation tax expense		(34)	(31)	-	-
Surplus / (deficit) for the year		**2,596**	**(30,814)**	**2,510**	**(31,104)**
Other comprehensive income					
Will not be reclassified to income and expenditure:					
Impairments	7	(4,709)	-	(4,709)	-
Revaluations	17	7,070	3,668	7,070	3,668
Total comprehensive income / (expense) for the period		**4,957**	**(27,146)**	**4,871**	**(27,436)**

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

The Group Accounts reflect the outturn of the Trust of £2.51 million surplus in 2019/2020 (£31.1 million deficit in 2018/2019) and subsidiaries' profit of £81k for Stepping Hill Healthcare Enterprises Limited (£127k profit in 2018/2019). The Trust Charity has net movement in funds of £5k incoming in 2019/2020 compared to net movement in funds of £163k outgoing resources in 2018/2019.

Statements of Financial Position

	Note	Group 31 March 2020 £000	Group 31 March 2019 £000	Trust 31 March 2020 £000	Trust 31 March 2019 £000
Non-current assets					
Intangible assets	14	1,343	1,186	1,343	1,186
Property, plant and equipment	15	156,286	147,046	156,286	147,046
Other investments / financial assets	18	1,287	1,332	-	-
Receivables	22	302	471	302	471
Total non-current assets		**159,218**	**150,035**	**157,931**	**148,703**
Current assets					
Inventories	20	1,837	1,692	1,571	1,413
Receivables	22	20,744	11,249	23,182	12,721
Cash and cash equivalents	23	19,785	7,027	17,631	4,868
Total current assets		**42,366**	**19,968**	**42,384**	**19,002**
Current liabilities					
Trade and other payables	24	(37,270)	(30,174)	(38,299)	(30,087)
Borrowings	26	(48,140)	(2,050)	(48,140)	(2,050)
Provisions	28	(2,866)	(5,646)	(2,866)	(5,646)
Other liabilities	25	(1,320)	(1,279)	(1,320)	(1,279)
Total current liabilities		**(89,596)**	**(39,149)**	**(90,625)**	**(39,062)**
Total assets less current liabilities		**111,988**	**130,854**	**109,690**	**128,643**
Non-current liabilities					
Borrowings	26	(20,304)	(46,417)	(20,304)	(46,417)
Provisions	28	(2,891)	(2,012)	(2,891)	(2,012)
Other liabilities	25	(375)	(330)	(375)	(330)
Total non-current liabilities		**(23,570)**	**(48,759)**	**(23,570)**	**(48,759)**
Total assets employed		**88,418**	**82,095**	**86,120**	**79,884**
Financed by					
Public dividend capital		86,817	85,452	86,817	85,452
Revaluation reserve		49,640	47,279	49,640	47,279
Income and expenditure reserve		(50,169)	(52,761)	(50,337)	(52,847)
Charitable fund reserves	19	2,130	2,125	-	-
Total taxpayers' equity		**88,418**	**82,095**	**86,120**	**79,884**

The notes on pages 8 to 50 form part of these accounts.

Name Louise Robson
Position : Chief Executive

Date **24 June 2020**

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

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

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

Group	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Charitable fund reserves	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2018 - brought forward	**84,390**	**43,778**	**(21,951)**	**1,962**	**108,179**
Surplus/(deficit) for the year	**-**	**-**	**(31,119)**	**305**	**(30,814)**
Other transfers between reserves	-	(167)	167	-	**-**
Revaluations	-	3,668	-	-	**3,668**
Public dividend capital received	1,062	-	-	-	**1,062**
Other reserve movements	-	-	142	(142)	**-**
Taxpayers' and others' equity at 31 March 2019	**85,452**	**47,279**	**(52,761)**	**2,125**	**82,095**

Information on reserves

Public Dividend Capital

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

Revaluation reserve

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

Income and Expenditure Reserve - Group

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

Income and Expenditure Reserve - Trust

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

Charitable funds reserve

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

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

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

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

Trust	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
Taxpayers' and others' equity at 1 April 2018 - brought forward	**84,390**	**43,778**	**(21,909)**	**106,258**
Surplus/(deficit) for the year	-	-	(31,104)	**(31,104)**
Revaluations	-	3,668	-	**3,668**
Public dividend capital received	1,062	-	-	**1,062**
Other reserve movements	-	(167)	167	**-**
Taxpayers' and others' equity at 31 March 2019	**85,452**	**47,279**	**(52,847)**	**79,884**

Statements of Cash Flows

	Note	Group 2019/20 £000	Group 2018/19 £000	Trust 2019/20 £000	Trust 2018/19 £000
Cash flows from operating activities					
Operating surplus / (deficit)		6,192	(27,578)	6,076	(27,755)
Non-cash income and expense:					
Depreciation and amortisation	6	9,054	9,274	9,054	9,274
Net impairments	7	(2,658)	1,823	(2,658)	1,823
(Increase) / decrease in receivables and other assets		(9,227)	(3,275)	(10,194)	(3,409)
(Increase) / decrease in inventories		(145)	(118)	(158)	(25)
Increase / (decrease) in payables and other liabilities		6,059	(1,238)	7,210	(1,584)
Increase / (decrease) in provisions		(1,907)	(552)	(1,907)	(550)
Movements in charitable fund working capital		-	5	-	-
Tax (paid) / received		-	(31)	-	-
Net cash flows from / (used in) operating activities		**7,368**	**(21,690)**	**7,421**	**(22,226)**
Cash flows from investing activities					
Interest received		139	114	139	114
Purchase of intangible assets		(649)	(459)	(649)	(459)
Purchase of PPE and investment property		(11,700)	(8,850)	(11,700)	(8,850)
Sales of PPE and investment property		57	188	57	188
Net cash flows from charitable fund investing activities		49	47	-	-
Net cash flows from / (used in) investing activities		**(12,104)**	**(8,960)**	**(12,153)**	**(9,007)**
Cash flows from financing activities					
Public dividend capital received		1,365	1,062	1,365	1,062
Movement on loans from DHSC		20,059	22,894	20,059	22,894
Capital element of finance lease rental payments		(85)	(84)	(85)	(84)
Capital element of PFI, LIFT and other service concession payments		(29)	(29)	(29)	(29)
Interest on loans		(1,678)	(852)	(1,679)	(852)
Interest paid on PFI, LIFT and other service concession obligations		(10)	(11)	(10)	(11)
PDC dividend (paid) / refunded		(2,128)	(2,402)	(2,128)	(2,402)
Net cash flows from / (used in) financing activities		**17,495**	**20,578**	**17,494**	**20,578**
Increase / (decrease) in cash and cash equivalents		**12,759**	**(10,072)**	**12,763**	**(10,655)**
Cash and cash equivalents at 1 April - brought forward		**7,027**	**17,098**	**4,868**	**15,523**
Cash and cash equivalents at 31 March	23	**19,785**	**7,027**	**17,631**	**4,868**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

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

Accounting convention

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

Note 1.2 Going concern

These accounts have been prepared on a going concern basis.

IAS1 requires the Board of Directors to assess, as part of the accounts preparation process, the Trust's ability to continue as a going concern. As a non-trading entity in the public sector the anticipated continuation of the provision of a service in the future is normally sufficient evidence of going concern. The financial statements should be prepared on a going concern basis unless there are plans for, or no realistic alternative other than, the dissolution of the Trust without the transfer of its services to another entity.

There is a material uncertainty which may cast significant doubt as to the entity's ability to continue as a going concern and therefore it may be unable to realise its assets and discharge its liabilities in the normal course of business. The material uncertainty relates to:

- the uncertainty of the sufficiency of the Trust's funding once the current block contract Covid-19 funding ceases,
- the lack of an agreed control total position to return to at that point,
- the uncertainty of whether additional one-off funding would be available to support the Trust.

This is addressed further in the Annual Report. The Directors consider the future provision of service evidenced by the signed contracts, agreements with commissioning bodies and arrangements put in place to ensure funding to meet expenditure during the Covid-19 pandemic is sufficient evidence that the Trust will continue as a going concern for the forseeable future.

On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. The affected loans totalling £46.05 million interim loan principal and £0.235 million interest accrual are classified as current liabilities within these financial statements. As the repayment of these loans will be funded through the issue of PDC, this does not present a going concern risk for the Trust.

Note 1.3 Consolidation

Subsidiary Undertakings

Subsidiary entities are those over which the Trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to minority interests are included as a separate item in the Statement of Financial Position.

Subsidiary Undertakings

The amounts consolidated are drawn from the estimated financial statements of the subsidiaries for the year. Where a subsidiary's published financial statements differ from the estimated position this is adjusted in Group Accounts at the following financial year end. Where subsidiaries' accounting policies are not aligned with those of the Trust (including where they report under UK FRS 102) then amounts are adjusted during consolidation where the differences are material. Inter-entity balances, transactions and gains/losses are eliminated in full on consolidation.

NHS Charitable Funds

Stockport NHS Foundation Trust is the Corporate Trustee to Stockport NHS Foundation Trust General Fund, registered in England with the Charity Commission: Registration Number 1048661. The Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

The charitable fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:
• recognise and measure them in accordance with the trust's accounting policies and
• eliminate intra-group transactions, balances, gains and losses.

Stepping Hill Healthcare Enterprises Limited

Stepping Hill Healthcare Enterprises Limited is a limited company, incorporated on the 16th September 2014. Its principal activities are to dispense drugs to the outpatients of Stockport NHS Foundation Trust. It also operates as a pharmacy shop to staff and visitors to the Trust. The Company is wholly owned by Stockport NHS Foundation Trust. The company's latest accounting period to the 31st March 2019 have been prepared, audited and submitted to Companies House with estimated financial results for 2019/2020 consolidated into the Group Accounts.

Note 1.4 Revenue from contracts with customers

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

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

The Trust agrees a schedule of payments with clinical commissioning groups based on the agreed contract at the start of the financial year. Payment is made in equal instalments with a quarterly reconciliation for additional income earned or credit note issued for underperformance. Payments for goods and services from other NHS and non-NHS bodies is upon receipt of invoices with payment terms set at 30 days unless otherwise agreed

The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient.

Note 1.4 Revenue from contracts with customers continued

Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of IFRS 15 entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, if applicable and material, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

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

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

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioners but they affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

Revenue from research contracts

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

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 have been satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

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

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

Note 1.5 Other forms of income

Grants and donations

Government grants are grants from government bodies other than income from commissioners or NHS Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grants 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.

Trading Activities

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

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

Note 1.6 Expenditure on employee benefits

Short-term employee benefits

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

Pension costs

NHS Pension Scheme

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

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

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

Note 1.7 Expenditure on other goods and services

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

Note 1.8 Discontinued operations

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

Note 1.9 Property, plant and equipment

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 or
- forms part of the initial equipping and setting-up cost of a new building or refurbishment of a ward or unit irrespective of their individual or collective cost.

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

Subsequent expenditure

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

Measurement

Valuation

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

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

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

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

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

The Trust's latest full valuation exercise was carried out in February 2020 with a valuation date of 31 March 2020. In applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2020, the valuer has declared a 'material valuation uncertainty' in the valuation report. This is on the basis of uncertainties in markets caused by COVID 19 that mean that the valuer can attach less weight to previous market evidence for comparison purposes, to inform opinions of value. The current response to Covid-19 means that the valuer has been faced with an unprecedented set of circumstances on which to base a judgement.

RICS have issued further guidance on the 15th April 2020 on the likely impact of Covid-19 on valuations. As this is a fast moving and evolving situation it is considered that there will be likely downward movements in valuation in BCIS indices, market values and exiting use values. However it considers that it is too early to quantify the impact of the Coronavirus pandemic in value terms with any accuracy or consistency.

The values in the report have been used to inform the measurement of property assets at valuation in these financial statements. With the valuer having declared this material valuation uncertainty, the valuer has continued to exercise professional judgement in providing the valuation and this remains the best information available to the Trust. As further market evidence comes available then the full extent of the Covid-19 impact will become clearer and the Trust will undertake an assessment of its valuation of land and buildings to assess if an early impairment review is necessary.

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.

Depreciation

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

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

Plant and Equipment are depreciated evenly over the estimated life of the asset, as follows:
Medical equipment, engineering plant and equipment : 5 to 10 years
Transport equipment: 7 years
Office and Information technology equipment: 5 years
Furniture & fittings: 10 years
Soft Furnishings: 7 years
Set up costs in new buildings: 10 years

Revaluation gains and losses

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

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

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

Impairments

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

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

Derecognition

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

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

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.

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

Useful lives of property, plant and equipment

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

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

Finance-leased assets (including land) are depreciated over the shorter of the useful life or the lease term, unless the trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.10 Intangible assets

Recognition

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

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised. Expenditure on development is capitalised where it meets the requirements set out in IAS 38.

Software

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

Measurement

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

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

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

Amortisation

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

Useful lives of intangible assets

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

	Min life Years	Max life Years
Software licences	4	10

Note 1.11 Inventories

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

Note 1.12 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

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

Note 1.13 Financial assets and financial liabilities

Recognition

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

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

Classification and measurement

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

Note 1.13 Financial assets and financial liabilities continued

Classification and measurement

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

Financial assets are classified as subsequently measured at amortised cost, fair value through profit and loss or fair value through other comprehensive income.

Financial liabilities are classified as subsequently measured at amortised cost or fair value through profit and loss.

Financial assets and financial liabilities at amortised cost

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

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

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

Financial assets measured at fair value through other comprehensive income

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

Financial assets and financial liabilities at fair value through profit and loss

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

The Group measures the pooled Charity Common Investment Fund with CCLA as a financial asset at fair value through profit and loss.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

Impairment of financial assets continued

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

The Trust has assessed its receivables on an individual basis for expected credit losses and impaired these where judged to be necessary. The Trust Injury Cost Recovery Scheme income is reduced by a nationally agreed expected credit loss percentage. The Trust does not normally recognise expected credit losses for other NHS bodies except for circumstances of genuine dispute.

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

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

Derecognition

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

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

Note 1.14 Leases

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

The Trust as a lessee

Finance leases

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

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

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases

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

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

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Note 1.14 Leases continued

The Trust as a lessor

Finance leases

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

Operating leases

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

Note 1.15 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective for 31 March 2020:

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 0.5% in real terms (0.29% in 2018/2019).

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 28.3 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.16 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 29 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 29, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

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

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

Note 1.17 Public dividend capital

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

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

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for

(i) donated and grant funded assets and assets purchased in response to COVID 19,
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.

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

In response to the Covid-19 pandemic the Trust, as with other NHS bodies in the NHS, has incurred capital expenditure to support the treatment of patients and assist in agile working to comply with social distancing. The Trust was issued with an initial PDC allocation of £27k for Covid-19 capital assets and this sum has been directed to be excluded from the calculation of PDC Dividend.

Note 1.18 Value added tax

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

Note 1.19 Corporation tax

Health Service bodies, including Foundation Trusts, are exempt from taxation on their principal healthcare income under section 519A ICTA 1988. The Trust incurs corporation tax through its wholly owned subsidiary Stepping Hill Healthcare Enterprises Limited.

Note 1.20 Foreign exchange

The functional and presentational currency of the Trust is sterling.

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

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

• monetary items are translated at the spot exchange rate on 31 March
• non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
• non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

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

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

Note 1.21 Third party assets

Assets belonging to third parties 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 the DH GAM.

Note 1.22 Losses and special payments

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

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.23 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.24 Early adoption of standards, amendments and interpretations

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

Note 1.25 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Leases

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

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The Trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2021, the Trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the Trust's incremental borrowing rate The Trust's incremental borrowing rate will be a rate defined by HM Treasury. Currently this rate is 1.27% but this may change between now and adoption of the standard.

The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2021 for existing finance leases.

For leases commencing in 2021/22, the Trust will not recognise a right of use asset or lease liability for short term

The implementation of IFRS 16 has been deferred by a year to the 1st April 2021 by HM Treasury and DHSC in response to Covid-19. Prior to this the Trust had begun an assessment of existing operating leases and potential new leases and engaged in a national Agreement of Leases exercise with other NHS and WGA bodies. In its draft planning returns the Trust has estimated an initial impact of applying IFRS 16 in 2020/21 on the opening statement of financial position and the in-year impact on the statement of comprehensive income and capital additions. This work is ongoing as numbers are finalised with bodies such as NHS Property Services to use as the basis of calculating the right of use assets and lease liability and with the suspension of the 2020/21 operational planning process. This work will now be completed in 2020/21 for the 1st April 2021 opening statement of financial position.

Other standards, amendments and interpretations

As required by IAS 8 the Trust can disclose that the following standards have been issued or amended but have not yet been adopted by the HM Treasury FReM and are therefore not applicable to DH group accounts in 2019/20. The impact of IFRS 16 is discussed at note 1.26 and is still under assessment. IFRS 17 Insurance Contracts will replace IFRS 4 and has an effective date of the 1st January 2021. IFRS 17 and IFRIC 23 is considered to be immaterial.

IFRS 16 Leases – application required for accounting periods beginning on or after 1st January 2019, but not yet

IFRS 17 - Insurance Contracts - application required for accounting periods beginning on or after 1 January 2021.

IFRIC 23 Uncertainty over Income Tax treatments - application required for accounting periods beginning on or after 1 January 2019.

Note 1.26 Critical judgements in applying accounting policies

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

The Trust uses the District Valuer service to provide revalued amounts for its land, buildings and dwellings. These valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. In 2019/2020 the Trust has undertaken a full revaluation of its alternative site valuation of land and builldings. As disclosed above at note 1.9 the valuer has disclosed a material uncertainty within its report because of the ongoing Covid-19 pandemic. The Trust has assessed the valuation and report and judged to transact the valuation in its entirety and perform an early impairment review in 2020/2021 if necessary.

In applying IRFS 15 the Trust has reviewed its policy around the recognition of partially completed spells and maternity pathway income. The Trust is entitled to recognise income for partially completed spells of activity at the 31st March 2020. As the individual National Tariff price and procedure code is not known for partially completed spells the Trust has based its calculation of such income based on the average length of stay and the cumulative activity. In 2019/20 the Trust has agreed full and final settlements with all its main CCG commissioners and has agreed not to include partially completed spell activity accruals.

Note 1.27 Sources of estimation uncertainty

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

The Provision for Restructurings and Redundancy includes estimated costs associated with the workforce elements of the Trust's future plans. The provision has been updated from the previous financial year to take account of current circumstances with the previous year's provision reveresd into the Statement of Comprehensive Income. Other provisions also include estimates of costs for employment legal cases.

IFRS 15 paragraphs 124 to 126 also requires disclosure of estimations in determining transaction price or satisfaction of performance obligations where they are satisfied over time.The timing of year end processes precludes determining the final figure for non-contracted activity in February and March of the financial year. The year-end figures are based on estimates which may be different to the final year end outturn for the year. Stockport NHS Foundation Trust includes a general non-provider specific 'provision' for non-contracted activity.

Note 2 Operating Segments

In line with IFRS 8 on Operating Segments, the Board of Directors, as Chief Operating Decision Maker (CODM), have assessed that the Trust continues to report its Annual Accounts on the basis that it operates as a single entity in the healthcare segment only. The accompanying financial statements have consequently been prepared under one single operating segment.

All of the Foundation Trust's activities are in the provision of healthcare, which is an aggregate of all the individual specialty components included therein, and the very large majority of the healthcare services provided occur at the one geographical main site. Similarly, the large majority of the Foundation Trust's revenue originates with the UK Government; namely through contracts with NHS Commissioners. The majority of expenses incurred are payroll expenditure on staff involved in the production or support of healthcare activities generally across the Trust together with the related supplies and overheads needed to establish this production. The business activities which earn revenue and incur expenses are therefore of one broad combined nature and therefore on this basis one segment of 'Healthcare' is deemed appropriate. In applying the aggregation criteria the CODM also recognises that the Trust's business groups operate under one common regulatory framework.

In consolidating the charitable funds the Trust has considered the level of its charitable funds and has considered them immaterial to report as a separate operating segment as the charitable funds revenue are not 10% or more of the combined assets of all operating segments.

In consolidating the financial results of the Stepping Hill Healthcare Enterprises Limited Company, the Trust considers that the provision of an outpatient dispensing service to patients still falls under the healthcare operating segment. In addition its revenue streams are also not 10% or more than all the combined assets of all operating segments.

The Trust's view on segmental reporting remains unchanged from its financial statements in 2018/2019. The Board, as Chief Operating Decision Maker, does not receive separate information routinely to evaluate how to allocate resources and assess performance as described within IFRS 8 Operating Segments for any of its internal business groups and continues with its integrated business group structures with services aligned across all the business groups.

Note 3 Operating income from patient care activities (Group and Trust)

Note 3.1 Income from patient care activities (by nature)	**2019/20 £000**	**2018/19 £000**
Acute services		
Elective income	42,496	41,136
Non elective income	86,136	81,724
First outpatient income	16,773	16,891
Follow up outpatient income	17,022	15,787
A & E income	16,801	14,287
High cost drugs income from commissioners (excluding pass-through costs)	10,389	10,227
Other NHS clinical income	44,943	46,998
Community services		
Community services income from CCGs and NHS England	26,847	22,633
Income from other sources (e.g. local authorities)	5,511	5,755
All services		
Private patient income	341	381
Agenda for Change pay award central funding*	-	3,622
Additional pension contribution central funding**	8,737	-
Other clinical income	1,377	911
Total income from activities	**277,373**	**260,352**

*Additional costs of the Agenda for Change pay reform in 2018/19 received central funding. From 2019/20 this funding is incorporated into tariff for individual services.

**The Trust is required to account for the increase in employer pension contributions of 6.3%. This has been paid by NHS England and the related income and expenditure accounted for on a gross basis in the Trust accounts in 2019/2020.

Note 3.2 Income from patient care activities (by source)

	Foundation Trust and Group	
	2019/20	2018/19
Income from patient care activities received from:	£000	£000
NHS England	24,124	14,488
Clinical commissioning groups	245,916	234,539
Department of Health and Social Care	-	3,622
Other NHS providers	527	582
NHS other	46	74
Local authorities	5,511	5,755
Non-NHS: private patients	341	370
Non-NHS: overseas patients (chargeable to patient)	94	11
Injury cost recovery scheme	814	911
Total income from activities	**277,373**	**260,352**
Of which:		
Related to continuing operations	277,373	260,352

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

	Foundation Trust and Group	
	2019/20	2018/19
	£000	£000
Income recognised this year	94	11
Cash payments received in-year	37	-
Amounts added to provision for impairment of receivables	57	7
Amounts written off in-year	36	-

Note 3.4 Income from activities arising from commissioner requested services

	Foundation Trust and Group	
	2019/20	2018/19
	£000	£000
Income from services designated as commissioner requested services	276,124	259,060
Income from services not designated as commissioner requested services	1,249	1,292
Total	**277,373**	**260,352**

Note 4 Other operating income (Group)

	2019/20			2018/19		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	698	-	**698**	638	-	**638**
Education and training	7,869	352	**8,221**	7,685	272	**7,957**
Provider sustainability fund (PSF)	6,060	-	**6,060**	616	-	**616**
Financial recovery fund (FRF)	17,974	-	**17,974**	-	-	**-**
Marginal rate emergency tariff funding (MRET)	3,599	-	**3,599**	-	-	**-**
Stockport Pharmaceuticals and Quality Control	5,085	-	**5,085**	5,510	-	**5,510**
Stockport Healthcare Enterprises Ltd income	4,220	-	**4,220**	3,848	-	**3,848**
Local Authorities	3,267	-	**3,267**	2,878	-	**2,878**
NHS and WGA Bodies	7,678	-	**7,678**	8,945	-	**8,945**
Non-NHS Bodies	2,716	-	**2,716**	2,267	-	**2,267**
Rents and car parking income	1,968	-	**1,968**	1,853	-	**1,853**
Catering sales	538	-	**538**	356	-	**356**
Charitable fund incoming resources	-	218	**218**	-	161	**161**
Other income	1,058	-	**1,058**	496	-	**496**
Total other operating income	**62,730**	**570**	**63,300**	**35,092**	**433**	**35,525**
Of which:						
Related to continuing operations			**63,300**			**35,525**

For Group Accounts elimination, adjustments have been made to remove Trust income received from its Pharmacy Shop subsidiary for purchases of drugs and services charged by the Trust for use of its facilities. Group Other operating income includes income earned by the Pharmacy Shop on its outpatient dispensing service, prescription charges and retail income from the Pharmacy Shop itself.

Note 4.1 Other operating income (Trust)

	2019/20			2018/19		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	698	-	**698**	638	-	**638**
Education and training	7,869	352	**8,221**	7,685	272	**7,957**
Non-patient care services to other bodies	-	-	**-**	-	-	**-**
Provider sustainability fund (PSF)	6,060	-	**6,060**	616	-	**616**
Financial recovery fund (FRF)	17,974	-	**17,974**	-	-	**-**
Marginal rate emergency tariff funding (MRET)	3,599	-	**3,599**	-	-	**-**
Stockport Pharmaceuticals and Quality Control	5,085	-	**5,085**	5,510	-	**5,510**
Pharmacy Sales	4,070	-	**4,070**	3,779	-	**3,779**
Local Authorities	3,267	-	**3,267**	2,878	-	**2,878**
NHS and WGA Bodies	7,608	-	**7,608**	8,945	-	**8,945**
Non-NHS Bodies	2,716	-	**2,716**	2,267	-	**2,267**
Rents and car parking income	1,968	-	**1,968**	1,853	-	**1,853**
Catering sales	538	-	**538**	356	-	**356**
Charitable fund incoming resources	-	217	**217**	129	-	**129**
Other income	549	-	**549**	28	-	**28**
Total other operating income	**62,001**	**569**	**62,570**	**34,684**	**272**	**34,956**
Of which:						
Related to continuing operations			**62,570**			**34,956**

Note 5 Additional information on contract revenue (IFRS 15) recognised in the period

	Foundation Trust and Group	
	2019/20	2018/19
	£000	£000
Revenue recognised in the reporting period that was included within contract liabilities at the previous period end	989	526

Note 5.1 Transaction price allocated to remaining performance obligations

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

Note 5.2 Profits and losses on disposal of property, plant and equipment

In 2019/2020 the Trust has disposed of property, plant, equipment and transport with a loss on the disposal of equipment of £21,000 offset by proceeds of £58,000 less costs, therefore giving a total profit on disposal of £37,000.

Note 5.3 Fees and charges (Group and Trust)

HM Treasury requires disclosure of fees and charges income. The following disclosure is of income from charges to service users where income from that service exceeds £1 million and is presented as the aggregate of such income. The cost associated with the service that generated the income is also disclosed.

	Foundation Trust and Group	
	2019/20	2018/19
	£000	£000
Income	5,086	5,512
Full cost	(4,897)	(5,231)
Surplus / (deficit)	**189**	**281**

The above note identifies the costs associated with significant trading and income generating activities. This notes discloses the income and costs associated with the trading activitie of Stockport Pharmaceuticals. Stockport Pharmaceuticals is an NHS Pharmaceutical Manufacturing Organisation specialising in the manufacture and development of Sterile Liquid, Non-sterile Products and Aseptically Prepared Injectables for use in NHS patients.
Income includes amounts assigned to education and training and other categories within note 4.

Note 6.1 Operating expenses (Group)

	2019/20 £000	2018/19 £000
Purchase of healthcare from NHS and DHSC bodies	3,983	6,233
Purchase of healthcare from non-NHS and non-DHSC bodies	2,723	2,402
Staff and executive directors costs	243,560	223,459
Remuneration of non-executive directors	155	149
Supplies and services - clinical (excluding drugs costs)	21,245	23,974
Supplies and services - general	2,746	2,572
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	21,258	20,874
Consultancy costs	568	478
Establishment	1,309	1,705
Premises	12,689	10,157
Transport (including patient travel)	1,199	1,162
Depreciation on property, plant and equipment	8,562	8,663
Amortisation on intangible assets	492	611
Net impairments	(2,658)	1,823
Movement in credit loss allowance: contract receivables / contract assets	215	(226)
Movement in credit loss allowance: all other receivables and investments	(126)	(6)
Increase/(decrease) in other provisions	(1,583)	(250)
Change in provisions discount rate(s)	154	(38)
Audit fees payable to the external auditor		
audit services- statutory audit	61	48
other auditor remuneration (external auditor only)	9	22
Internal audit costs	113	95
Clinical negligence	8,945	10,433
Legal fees	422	238
Insurance	243	266
Research and development	635	539
Education and training	1,807	1,012
Rentals under operating leases	3,418	3,222
Charges to operating expenditure for off-SoFP PFI / LIFT schemes	1,369	1,325
Car parking and security	348	309
Other losses and special payments - non-staff	68	106
Other	552	2,098
Total	**334,481**	**323,455**
Of which:		
Related to continuing operations	334,481	323,455

Note 6.2 Operating expenses (Trust)

	2019/20 £000	2018/19 £000
Purchase of healthcare from NHS and DHSC bodies	3,983	6,233
Purchase of healthcare from non-NHS and non-DHSC bodies	2,723	2,402
Staff and executive directors costs	243,305	223,206
Remuneration of non-executive directors	155	149
Supplies and services - clinical (excluding drugs costs)	21,245	23,974
Supplies and services - general	3,090	2,572
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	20,972	20,735
Consultancy costs	568	478
Establishment	1,309	1,705
Premises	12,689	10,157
Transport (including patient travel)	1,199	1,162
Depreciation on property, plant and equipment	8,562	8,663
Amortisation on intangible assets	492	611
Net impairments	(2,658)	1,823
Movement in credit loss allowance: contract receivables / contract assets	215	(226)
Movement in credit loss allowance: all other receivables and investments	(126)	(6)
Increase/(decrease) in other provisions	(1,583)	(250)
Change in provisions discount rate(s)	154	(38)
Audit fees payable to the external auditor		
audit services- statutory audit	55	48
other auditor remuneration (external auditor only)	15	22
Internal audit costs	113	95
Clinical negligence	8,945	10,433
Legal fees	422	238
Insurance	243	266
Research and development	635	539
Education and training	1,455	1,012
Rentals under operating leases	3,418	3,222
Charges to operating expenditure for off-SoFP PFI / LIFT schemes	1,369	1,325
Car parking and security	348	309
Other losses and special payments - non-staff	68	106
Other	487	2,098
Total	**333,867**	**323,063**
Of which:		
Related to continuing operations	333,867	323,455

Note 6.3 Other auditor remuneration (Group)

	2019/20 £000	2018/19 £000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the Trust		22
2. Audit Related Assurance Services	9	-
Total	**9**	**22**

Note 6.4 Limitation on auditor's liability (Group)

There is no limitation on auditor's liability for external audit work carried out for the financial years 2019/20 or 2018/19.

Note 7 Impairment of assets (Group)

	2019/20 £000	2018/19 £000
Net impairments charged to operating surplus / deficit resulting from:		
Abandonment of assets in course of construction	-	1,823
Changes in market price	(2,658)	-
Total net impairments charged to operating surplus / deficit	**(2,658)**	**1,823**
Impairments charged to the revaluation reserve	4,709	-
Total net impairments/reversal of impairments	**2,051**	**1,823**

In 2019/2020 the Trust undertook a revaluation exercise of its land, buildings and dwellings on an alternate site basis which resulted in reversal of impairment of £2.7 million to the Statement of Comprehensive Income (SoCi). Reversals of impairments reflect the increase in value of property where previous charges have been made to income and expenditure.

Note 8 Employee benefits (Group)

	2019/20 Total £000	2018/19 Total £000
Salaries and wages	170,317	169,646
Social security costs	14,644	13,945
Apprenticeship levy	833	751
Employer's contributions to NHS pensions	28,531	18,931
Pension cost - other	94	54
Temporary staff (including agency)	29,753	20,671
Total staff costs	**244,172**	**223,998**
Of which		
Costs capitalised as part of assets	-	43

Staff costs for the Group include staff employed by the Trust subsidary, Stepping Hill Healthcare Enterprises Limited.

Note 8.1 Employee benefits (Trust)

	2019/20 Total £000	2018/19 Total £000
Salaries and wages	170,066	169,393
Social security costs	14,644	13,945
Apprenticeship levy	833	751
Employer's contributions to NHS pensions	28,531	18,931
Pension cost - other	90	54
Temporary staff (including agency)	29,753	20,671
Total staff costs	**243,917**	**223,745**
Of which		
Costs capitalised as part of assets	-	43

Note 8.2 Retirements due to ill-health (Group and Trust)

During 2019/20 there were 4 early retirements from the trust agreed on the grounds of ill-health (5 in the year ended 31 March 2019). The estimated additional pension liabilities of these ill-health retirements is £283k (£196k in 2018/19).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 9 Pension costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2020, is based on valuation data as 31 March 2019, updated to 31 March 2020 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

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

Note 9 Pension costs continued

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 to19/20 is 20.6% and the Schemes Regulations were amended accordingly.

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

The Group offers an additional defined contribution workplace pension scheme, the National Employment Savings Scheme (NEST), to employees of the Foundation Trust. It also offers a similar scheme to its subsidiary, Stepping Hill Healthcare Enterprises Limited. The Trust has paid £90k (£51k in 2018/2019) to NEST in employer contributions and £4k (£3k in 2018/2019) for the subsidiary.

Note 10 Operating leases (Group and Trust)

Note 10.1 Stockport NHS Foundation Trust as a lessor

The Group and Trust do not have any operating lease agreements where they are the lessor.

Note 10.2 Stockport NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Stockport NHS Foundation Trust is the lessee.

In 2019/2020 the Trust has leasing arrangements for its community buildings. This includes leases with NHS Property Services Ltd for community services provided in the Stockport area. The estimation of future minimum lease payments due to NHS Property Services has been updated to the prior year comparator in 2018/2019 and 2019/2020 to show a longer expected lease term of these properties. These leases are held in line with current commissioning contracts. It also has a lease arrangement for the Swanbourne Gardens Childrens Respite building. This is due to expire in January 2023.

	Foundation Trust and Group	
	2019/20	2018/19
	£000	£000
Operating lease expense		
Minimum lease payments	3,418	3,222
Total	**3,418**	**3,222**

	31 March 2020	31 March 2019
	£000	£000
Future minimum lease payments due:		
- not later than one year;	3,414	3,218
- later than one year and not later than five years;	13,129	13,164
Total	**16,543**	**16,382**

Note 11 Finance income (Group)

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

	Group	
	2019/20	2018/19
	£000	£000
Interest on bank accounts	145	119
NHS charitable fund investment income	49	47
Total finance income	**194**	**166**

Note 11 Finance income (Trust)

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

	Trust	
	2019/20	2018/19
	£000	£000
Interest on bank accounts	145	119
Total finance income	**145**	**119**

Note 12.1 Finance expenditure (Group and Trust)

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

	Foundation Trust and Group	
	2019/20	2018/19
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	1,712	1,025
Main finance costs on PFI and LIFT schemes obligations	9	11
Total interest expense	**1,721**	**1,036**
Unwinding of discount on provisions	6	2
Total finance costs	**1,727**	**1,038**

Note 12.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015 (Group)

The Trust and Group has no late payment of commercial debts to report in 2019/2020.

Note 13 Other gains / (losses) (Group)

	Group	
	2019/20	2018/19
	£000	£000
Gains on disposal of assets	58	30
Losses on disposal of assets	(21)	(26)
Total gains / (losses) on disposal of assets	**37**	**4**
Fair value gains / (losses) on charitable fund investments & investment properties	(45)	97
Total other gains / (losses)	**(8)**	**101**

In 2019/2020 the Charity continues to invest in the CCLA Equity Common Investment Fund and this has made an unrealised loss of £45,000 (£97,000 gain in 2018/2019).There were no disposals in 2019/2020.

In 2019/2020 the Trust had a gain on disposal of assets of £37k (loss of £4k in 2018/2019) comprising of cash proceeds of £58k offset by the write off of net book value of £21k. The cash proceeds relate to the trade-in prices achieved for items of medical equipment, vehicles and fittings as they were replaced and the loss on disposal to a mammography unit no longer in use.

Note 14.1 Intangible assets - 2019/20

Foundation Trust and Group	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2019 - brought forward	**8,198**	-	**8,198**
Additions	649	-	**649**
Valuation / gross cost at 31 March 2020	**8,847**	**-**	**8,847**
Amortisation at 1 April 2019 - brought forward	**7,012**	**-**	**7,012**
Provided during the year	492	-	**492**
Amortisation at 31 March 2020	**7,504**	**-**	**7,504**
Net book value at 31 March 2020	**1,343**	**-**	**1,343**
Net book value at 1 April 2019	**1,186**	**-**	**1,186**

Within the above note the gross cost of fully depreciated assets is £6.5 million.

Note 14.2 Intangible assets - 2018/19

Foundation Trust and Group	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2018 - brought forward	**7,691**	**1,879**	**9,570**
	413	46	**459**
Impairments	-	(1,823)	**(1,823)**
Reclassifications	102	(102)	**-**
Disposals / derecognition	(8)	-	**(8)**
Valuation / gross cost at 31 March 2019	**8,198**	**-**	**8,198**
	6,409	**-**	**6,409**
Amortisation at 1 April 2018 - as previously stated			
Transfers by absorption	-	-	**-**
Provided during the year	611	-	**611**
Disposals / derecognition	(8)	-	**(8)**
Amortisation at 31 March 2019	**7,012**	**-**	**7,012**
Net book value at 31 March 2019	**1,186**	**-**	**1,186**
Net book value at 1 April 2018	**1,282**	**1,879**	**3,161**

Note 15.1 Property, plant and equipment - 2019/20

Foundation Trust and Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2019 - brought forward	**8,113**	**119,217**	**1,517**	**2,798**	**46,301**	**147**	**16,550**	**639**	**195,282**
Additions	-	607	-	1,984	6,317	207	3,682	7	**12,804**
Impairments	-	(5,311)	-	-	-	-	-	-	**(5,311)**
Reversals of impairments	-	3,260	-	-	-	-	-	-	**3,260**
Revaluations	-	2,046	315	-	-	-	-	-	**2,361**
Reclassifications	-	1,855	-	(3,181)	1,308	-	18	-	**-**
Disposals / derecognition	-	-	-	-	(2,739)	-	-	-	**(2,739)**
Valuation/gross cost at 31 March 2020	**8,113**	**121,674**	**1,832**	**1,601**	**51,187**	**354**	**20,250**	**646**	**205,657**
Accumulated depreciation at 1 April 2019 - brought forward	**-**	**-**	**-**	**-**	**35,116**	**70**	**12,628**	**422**	**48,236**
Provided during the year	-	4,651	58	-	2,585	19	1,215	34	**8,562**
Revaluations	-	(4,651)	(58)	-	-	-	-	-	**(4,709)**
Disposals / derecognition	-	-	-	-	(2,718)	-	-	-	**(2,718)**
Accumulated depreciation at 31 March 2020	**-**	**-**	**-**	**-**	**34,983**	**89**	**13,843**	**456**	**49,371**
Net book value at 31 March 2020	**8,113**	**121,674**	**1,832**	**1,601**	**16,204**	**265**	**6,407**	**190**	**156,286**
Net book value at 1 April 2019	**8,113**	**119,217**	**1,517**	**2,798**	**11,185**	**77**	**3,922**	**217**	**147,046**

Within the above note the gross cost of fully depeciated assets is £37.5 million.

Note 15.2 Property, plant and equipment - 2018/19

Foundation Trust and Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2018 - brought forward	**8,180**	**118,595**	**1,595**	**1,544**	**44,309**	**211**	**14,647**	**588**	**189,669**
Additions	-	1,253	48	2,552	1,974	18	1,558	51	**7,454**
Revaluations	(95)	(742)	(263)	-	-	-	-	-	**(1,100)**
Reclassifications	-	111	-	(1,298)	842	-	345	-	**-**
Transfers to / from assets held for sale	28	-	137	-	-	-	-	-	**165**
Disposals / derecognition	-	-	-	-	(824)	(82)	-	-	**(906)**
Valuation/gross cost at 31 March 2019	**8,113**	**119,217**	**1,517**	**2,798**	**46,301**	**147**	**16,550**	**639**	**195,282**
Accumulated depreciation at 1 April 2018 - as previously stated	**-**	**-**	**-**	**-**	**33,140**	**127**	**11,572**	**374**	**45,213**
Provided during the year	-	4,716	49	-	2,774	20	1,056	48	**8,663**
Revaluations	-	(4,716)	(52)	-	-	-	-	-	**(4,768)**
Transfers to / from assets held for sale	-	-	3	-	-	-	-	-	**3**
Disposals / derecognition	-	-	-	-	(798)	(77)	-	-	**(875)**
Accumulated depreciation at 31 March 2019	**-**	**-**	**-**	**-**	**35,116**	**70**	**12,628**	**422**	**48,236**
Net book value at 31 March 2019	**8,113**	**119,217**	**1,517**	**2,798**	**11,185**	**77**	**3,922**	**217**	**147,046**
Net book value at 1 April 2018	**8,180**	**118,595**	**1,595**	**1,544**	**11,169**	**84**	**3,075**	**214**	**144,456**

Note 15.3 Property, plant and equipment financing - 2019/20

Foundation Trust and Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Charitable fund PPE assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2020										
Owned - purchased	8,113	120,390	1,785	1,601	15,449	265	6,407	190	-	**154,200**
Finance leased	-	-	-	-	78	-	-	-	-	**78**
On-SoFP PFI contracts and other service concession arrangements	-	866	-	-	-	-	-	-	-	**866**
Owned - donated	-	418	47	-	677	-	-	-	-	**1,142**
NBV total at 31 March 2020	**8,113**	**121,674**	**1,832**	**1,601**	**16,204**	**265**	**6,407**	**190**	**-**	**156,286**

Note 15.4 Property, plant and equipment financing - 2018/19

Foundation Trust and Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Charitable fund PPE assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2019										
Owned - purchased	8,113	118,022	1,469	2,798	10,315	77	3,922	217	-	**144,933**
Finance leased	-	-	-	-	95	-	-	-	-	**95**
On-SoFP PFI contracts and other service concession arrangements	-	794	-	-	-	-	-	-	-	**794**
Owned - donated	-	401	48	-	775	-	-	-	-	**1,224**
NBV total at 31 March 2019	**8,113**	**119,217**	**1,517**	**2,798**	**11,185**	**77**	**3,922**	**217**	**-**	**147,046**

Note 16 Donations of property, plant and equipment

In 2019/2020 the Group Property, Plant and Equipment note discloses the net book value of assets previously provided by donations on cash income. In addition to purchasing smaller revenue items for patient and staff welfare (see note 37) charitable funding has provided two pieces of equipment: a sensory magical carpet for £10k and an Endoscopy Scope Guide for £34k .

Note 17 Revaluations of property, plant and equipment

In 2019/2020 the Trust undertook a valuation of land and buildings by the District Valuer in compliance with International Accounting Standards, the Royal Institute of Chartered Surveyors, the Treasury Financial Reporting Manual and the Department of Health Group Accounts Manual. The valuation was undertaken at the the 31st March 2020 prepared on an alternative site basis. The valuation was based on land on its existing site but on a much smaller footprint and buildings based on a Modern Equivalent Basis. Further disclosures on this revaluation and the impact of Covid-19 can be found at note 1.9 Property, Plant and Equipment: Measurement. The movements on the revaluation reserve are shown below.

Revaluation Reserve Movements	**Foundation Trust and Group**		
	2019/20 £000	**2019/20 £000**	**2019/20 £000**
	Property, Plant and Equipment	**Assets Held for Sale**	**Total Revaluation Reserve**
Revaluation reserve at 1 April 2019 - brought forward	**47,279**	**-**	**47,279**
Net impairments	(4,709)		**(4,709)**
Revaluations	7,070		**7,070**
Revaluation reserve at 31 March 2020	**49,640**	**-**	**49,640**
At 1 April 2018	**43,434**	**344**	**43,778**
Impairment			**-**
Revaluations	3,668		**3,668**
Transfer to other reserves	-	(167)	**(167)**
Other reserve movements	177	(177)	**-**
Revaluation Reserve at 31 March 2019	**47,279**	**-**	**47,279**

Note 18 Other investments / financial assets (non-current)

	Group	
	2019/20 £000	**2018/19 £000**
Carrying value at 1 April - brought forward	**1,332**	**1,235**
Movement in fair value through income and expenditure	(45)	97
Carrying value at 31 March	**1,287**	**1,332**

The above note details the investments held by the Trust Charity consolidated in Group numbers only.

For the Consolidated Group the Charity held investments in equity common investment funds. In 2019/2020 the Group reported £49,000 (£47,000 in 2018/2019) in interest receivable on these investments and a loss on valuation of £45,000 at the 31st March 2020 (£97,000 gain in 2018/2019).

Note 19 Analysis of charitable fund reserves

The Trust has consolidated its charitable fund, Stockport NHS Foundation Trust General Fund - Charity Commission Number Registration Number 1048661, within the Group Accounts.

	31 March 2020 £000	31 March 2019 £000
Unrestricted funds:		
Unrestricted income funds	286	284
Restricted funds:		
Endowment funds	10	10
Other restricted income funds	1,834	1,831
	2,130	**2,125**

Unrestricted income funds are accumulated income funds that are expendable at the discretion of the trustees in furtherance of the charity's objects. Unrestricted funds may be earmarked or designated for specific future purposes which reduces the amount that is readily available to the charity.

Restricted funds are accumulated income funds which are expendable at the Trustee's discretion only in furtherance of the specified conditions of the donor and the objects of the Charity. For Stockport NHS Foundation General Fund these funds relate to specified business groups and departments at the Trust. There is one permanent endowment fund where the monies are retained for use rather than expended.

Note 20 Inventories

	Group		Trust	
	31 March 2020 £000	31 March 2019 £000	31 March 2020 £000	31 March 2019 £000
Drugs	994	686	729	408
Consumables	765	928	765	928
Energy	77	77	77	77
Total inventories	**1,837**	**1,692**	**1,571**	**1,413**

Included in Group inventories is £266,000 drugs for Stepping Hill Healthcare Enterprises Limited.

Note 21 Non-current assets held for sale and assets in disposal groups

	Group	
	2019/20	2018/19
	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 1 April	**-**	**315**
Assets sold in year	-	(153)
Assets no longer classified as held for sale, for reasons other than disposal by sale	-	(162)
NBV of non-current assets for sale and assets in disposal groups at 31 March	**-**	**-**

Note 22.1 Receivables

	Group		Trust	
	31 March 2020 £000	31 March 2019 £000	31 March 2020 £000	31 March 2019 £000
Current				
Contract receivables	20,332	8,650	23,053	10,301
Allowance for impaired contract receivables / assets	(1,064)	(1,038)	(1,064)	(1,038)
Prepayments (non-PFI)	472	2,354	472	2,349
Interest receivable	20	14	20	14
PDC dividend receivable	93	-	93	-
VAT receivable	876	1,269	608	956
Other receivables	15	-	-	139
NHS charitable funds receivables	-	-		
Total current receivables	**20,744**	**11,249**	**23,182**	**12,721**
Non-current				
Contract receivables	377	395	377	395
Allowance for impaired contract receivables / assets	(82)	-	(82)	(126)
Prepayments (non-PFI)	7	202	7	202
Total non-current receivables	**302**	**471**	**302**	**471**
Of which receivable from NHS and DHSC group bodies:				
Current	15,945	4,670	15,945	4,679

In 2019/2020 the Trust has accrued £10.5 million of Provider Sustainability Fund (PSF) and Financial Recovery Fund (FRF) earned with receipt due in 2020/2021. The Trust was not in receipt of PSF and FRF in 2018/2019.

Note 22.2 Allowances for credit losses

	Foundation Trust and Group		Foundation Trust and Group	
	Contract receivables and contract assets £000	All other receivables £000	Contract receivables and contract assets	All other receivables
	31 March 2020	31 March 2020	31 March 2019	31 March 2019
	1,038	126		1,435
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018			1,303	(1,303)
New allowances arising	276		243	
Changes in existing allowances	126	(126)		(6)
Reversals of allowances	(187)		(469)	
Utilisation of allowances (write offs)	(107)		(39)	
	1,146	-	1,038	126

Note 22.3 Exposure to credit risk

In assessing its exposure to credit risk the Trust reviews its aged receivables report on an individual invoice and debtor basis. It has assessed its lifetime expected losses as detailed in the provisions matrix. The percentage applied for the NHS Injury Recovery Scheme on its current balance is a nationally agreed percentage provided annually by the DHSC. All other receivables are recognised at their gross carrying amount.

Provision for Expected Credit Losses

	Foundation Trust and Group		
Lifetime expected credit loss	**Current**	**More than 360 days past due date**	**£000**
NHS Injury Recovery Scheme	21.89%	-	**719**
CCGs & Other WGA bodies (excluding specifc assessments below)	-	100%	**170**
Foundation Trusts	-	100%	**7**
Non NHS Customers	-	100%	**19**
Salary Overpayments	-	100%	**51**
Trust - Maternity Pathways	55%	-	**23**
CCGs - Non Contract Activity	10%	-	**25**
Private Patients and Overseas Visitors	100%	100%	**132**
			1146

Note 23.1 Cash and cash equivalents movements

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

	Group		Trust	
	2019/20	**2018/19**	**2019/20**	**2018/19**
	£000	**£000**	**£000**	**£000**
At 1 April	**7,027**	**17,098**	**4,868**	**15,523**
Net change in year	12,758	(10,071)	12,763	(10,655)
At 31 March	**19,785**	**7,027**	**17,631**	**4,868**
Broken down into:				
Cash at commercial banks and in hand	1,581	1,688	103	156
Cash with the Government Banking Service	17,528	4,712	17,528	4,712
Other current investments	676	627		
Total cash and cash equivalents	**19,785**	**7,027**	**17,631**	**4,868**

Note 23.2 Third party assets held by the trust

Stockport NHS Foundation Trust held no cash or cash equivalents which relate to monies held by patients or other parties. It does, if requested, retain patient monies and belongings in sealed pouches for the duration of the individual's stay.

Note 24.1 Trade and other payables

	Group		Trust	
	31 March 2020 £000	31 March 2019 £000	31 March 2020 £000	31 March 2019 £000
Current				
Trade payables	13,450	7,546	13,450	7,489
Capital payables	2,047	943	2,047	943
Accruals	14,343	18,652	15,485	18,652
Social security costs	2,215	22	2,215	22
Other taxes payable	1,856	36	1,822	6
PDC dividend payable	-	14	-	14
Other payables	3,359	2,961	3,280	2,961
Total current trade and other payables	**37,270**	**30,174**	**38,299**	**30,087**
Of which payables from NHS and DHSC group bodies:				
Current	7,403	8,681	7,403	8,681

Consolidation adjustments by the Group have removed payables between the Trust, Charitable Fund and the Stepping Hill Healthcare Enterprises Limited subsidiaries.

Note 24.2 Early retirements in NHS payables above

There are no early retirement payables in the note above. The payables note above does include amounts in relation to outstanding pension contributions.

Foundation Trust and Group	31 March 2020 £000	31 March 2019 £000
- outstanding pension contributions	2,724	2,583

Note 25 Other liabilities

	Group		Trust	
	2020 £000	2019 £000	2020 £000	2019 £000
Current				
Deferred income: contract liabilities	1,320	1,279	1,320	1,279
Total other current liabilities	**1,320**	**1,279**	**1,320**	**1,279**
Non-current				
Deferred income: contract liabilities	375	330	375	330
Total other non-current liabilities	**375**	**330**	**375**	**330**

Note 26 Borrowings

	Group and Trust	
	31 March 2020	31 March 2019
	£000	£000
Current		
Revenue Support Loans from DHSC	41,724	1,746
Capital Loans from DHSC	6,301	190
Other loans	-	-
Obligations under finance leases	84	84
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	31	30
Total current borrowings	**48,140**	**2,050**
Non-Current		
Revenue Support Loans from DHSC		
Capital Loans from DHSC	19,980	24,445
Revenue Support Loans from DHSC	-	21,532
Obligations under finance leases	60	145
Obligations under PFI, LIFT or other service concession contracts	264	295
NHS charitable funds: other current borrowings	-	-
Total non-current borrowings	**20,304**	**46,417**

DHSC has announced that PDC will be issued in 2020/21 to repay interim loans. Stockport NHS FT have been notified that this sum will be £46.055 million comprising of £41.490 million in revenue support loans and £4.565 million interim capital loan. Therefore, non current revenue support loans issued in 2018/2019 have been moved to current liabilities at the 31st March 2020.

Note 26.1 Reconciliation of liabilities arising from financing activities (Group and Trust)

Group - 2019/20	Loans from DHSC	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000
Carrying value at 1 April 2019	**47,913**	**229**	**325**	**48,467**
Cash movements:				
Financing cash flows - payments and receipts of principal	20,059	(85)	(29)	**19,946**
Financing cash flows - payments of interest	(1,678)	-	(10)	**(1,689)**
Non-cash movements:				
Interest charge arising in year (application of effective interest rate)	1,712		9	**1,721**
Carrying value at 31 March 2020	**68,005**	**144**	**295**	**68,444**

Note 26.1 Reconciliation of liabilities arising from financing activities continued (Group and Trust)

Group - 2018/19	Loans from DHSC	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000
Carrying value at 1 April 2018	**24,634**	**313**	**354**	**25,301**
Cash movements:				
Financing cash flows - payments and receipts of principal	22,894	(84)	(29)	**22,781**
Financing cash flows - payments of interest	(852)	-	(11)	**(863)**
Non-cash movements:				
Impact of implementing IFRS 9 on 1 April 2018	212	-	-	**212**
Application of effective interest rate	1,025	-	11	**1,036**
Carrying value at 31 March 2019	**47,913**	**229**	**325**	**48,467**

Note 27 Finance leases

Note 27.1 Stockport NHS Foundation Trust as a lessor

The Group and Trust do not have any finance lease agreements where they are the lessor.

Note 27.2 Stockport NHS Foundation Trust as a lessee

Obligations under finance leases where the Trust is the lessee.

	31 March 2020	31 March 2019
	£000	£000
Gross lease liabilities	**144**	**229**
of which liabilities are due:	84	84
- not later than one year;	60	135
- later than one year and not later than five years;		10
- later than five years.		
Net lease liabilities	**144**	**229**
of which payable:		
- not later than one year;	84	84
- later than one year and not later than five years;	60	135
- later than five years.		10

This note gives details of two finance leases for the community EPR EMIS patient record system and an agreement for Point of Care testing.

Note 28.1 Provisions for liabilities and charges analysis (Group)

Foundation Trust and Group	Current	Current	Non - Current	Non - Current
	2019/20	2018/19	2019/20	2018/19
	£000	£000	£000	£000
Pensions: injury benefits	**332**	169	**2,891**	2,012
Other legal claims	**93**	138	-	-
Restructurings	**23**	121	-	-
Redundancy	**-**	4,377	-	-
Other	**2,418**	841	-	-
Total	**2,866**	5,646	**2,891**	2,012

Note 28.2 Movement in Provisions for liabilities and charges analysis (Group and Trust)

Foundation Trust and Group	Pensions: injury benefits	Legal claims	Re-structuring	Redundancy	Other	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2019	**2,181**	**138**	**121**	**4,377**	**841**	**7,658**
Change in the discount rate	154	-	-	-	-	**154**
Arising during the year	1,055	59	23	-	2,541	**3,678**
Utilised during the year	(157)	(48)	(25)	-	(248)	**(478)**
Reversed unused	(16)	(56)	(96)	(4,377)	(716)	**(5,261)**
Unwinding of discount	6	-	-	-	-	**6**
At 31 March 2020	**3,223**	**93**	**23**	**0**	**2,418**	**5,757**
Expected timing of cash flows:						
- not later than one year;	332	93	23	-	**2,418**	**2,866**
- later than one year and not later than five years;	777	-	-	-	-	**777**
- later than five years.	2,114	-	-	-	-	**2,114**
Total	**3,223**	**93**	**23**	**-**	**2,418**	**5,757**

In 2019/2020 the Trust has been notified of an additional injury benefit award increasing the provision by the award discounted over the life expectancy of the claimant.

The provision for 'Legal Claims' provides for the Liability to Third Parties Schemes (LTPS) and Public & Employers Liability Scheme (PES). This provision covers the excess amount payable by the Trust and not the full liability of claims which are covered by the NHS Resolution under the non-clinical risk pooling scheme.The contingent liability at note 29 also relates to this scheme. Both figures are supplied by NHS Resolution and revised annually by NHS Resolution based on up to date information at the 31st March.

Within other provisions the Trust has provided for costs for legal cases including employment legal provision on the calculation of holiday pay.

Note 28.3 Clinical negligence liabilities

At 31 March 2020, £170,497k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Stockport NHS Foundation Trust (31 March 2019: £170,205k).

Note 29 Contingent liabilities

	Foundation Trust and Group	
Value of contingent liabilities	**31 March 2020**	**31 March 2019**
	£000	**£000**
NHS Resolution legal claims	(57)	(103)
Gross value of contingent liabilities	**(57)**	**(103)**

Note 30 Contractual capital commitments

	Foundation Trust and Group	
	31 March 2020	31 March 2019
	£000	£000
Property, plant and equipment	3,405	440
Intangible assets	-	22
Total	**3,405**	**462**

Capital commitments reflect those capital projects started or contractually committed to in 2019/2020 and due within one year. This includes an upgrade to the Trust telephony system and the restaurant refurbishment commitments to the purchase of medical equipment.

Note 31 Defined benefit pension schemes

Neither the Trust nor the Group held any on-Statement of Financial Position Defined Benefit Pension Schemes during 2019/2020 or 2018/2019.

Note 32 On-SoFP PFI, LIFT or other service concession arrangements

Under IFRIC 12 the Trust recognises a service concession arrangement with Alliance Medical for the provision of a building to perform MRI scanning services.

Note 32.1 On-SoFP PFI, LIFT or other service concession arrangement obligations

The following obligations in respect of the PFI, LIFT or other service concession arrangements are recognised in the statement of financial position:

	Group and Trust	
	31 March 2020	31 March 2019
	£000	£000
Gross PFI, LIFT or other service concession liabilities	**342**	**382**
Of which liabilities are due		
- not later than one year;	40	40
- later than one year and not later than five years;	161	161
- later than five years.	141	181
Finance charges allocated to future periods	(47)	(57)
Net PFI, LIFT or other service concession arrangement obligation	**295**	**325**
- not later than one year;	31	30
- later than one year and not later than five years;	133	129
- later than five years.	131	166

Note 32.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

Total future commitments under these on-SoFP schemes are as follows:

	Group		Trust	
	31 March 2020 £000	31 March 2019 £000	31 March 2020 £000	31 March 2019 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**8,540**	**12,200**	**8,540**	**12,200**
Of which payments are due:				
- not later than one year;	1,220	1,220	1,220	1,220
- later than one year and not later than five years;	4,880	4,880	4,880	4,880
- later than five years.	2,440	6,100	2,440	2,440

Note 32.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	Group		Trust	
	2019/20 £000	2018/19 £000	2019/20 £000	2018/19 £000
Unitary payment payable to service concession operator	**1,409**	**1,365**	**1,409**	**1,365**
Consisting of:				
- Interest charge	9	11	9	11
- Repayment of balance sheet obligation	31	29	31	29
- Service element and other charges to operating expenditure	1,369	1,325	1,369	1,325
Total amount paid to service concession operator	**1,409**	**1,365**	**1,409**	**1,365**

Note 33 Financial instruments

IFRS 7 Financial Instruments Disclosure requires declaration of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. Financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies to which IFRS 7 mainly applies. Stockport NHS Foundation Trust has powers to borrow or invest surplus funds, and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Foundation Trust in undertaking its activities. For the Group the Charity does hold investments and is, therefore, exposed to a degree of financial risk. This risk is carefully managed by pursuing a low risk investment strategy. The Charity holds its investments within common investment funds with a market leader provider of Charity Investments, CCLA Management Ltd.

Liquidity Risk

In 2019/20 the Trust's income was largely received under annual service contracts with local Clinical Commissioning Groups. The Trust agrees an annual contract value with cash payments paid each month based on the profiling of the contract value. The Trust's financial plan and budgets are based on these contract values. If there are periods of expenditure overspend to income or under-achievement of planned activity levels these can produce a significant cash flow impact.

In response to the Covid-19 pandemic a decision been made by NHS England and NHS Improvement to fund NHS Trusts to cover all costs for the first four months of the year. Block payments have been introduced with April and May paid in the first month of the financial year. It has also been agreed to fund revenue and capital costs specifically related to Covid-19 such as loss of income and equipment.

Note 33 Financial instrument continued

Note 33.1 Financial risk management

Liquidity Risk

The temporary arrangements described above will ensure that the Trust has sufficient liquidity until the end of Juy 2020. Top up payments are also being made to fund Trusts for other areas of lost income such as the suspension of car park fees.

The Trust awaits guidance on funding arrangments beyond July 2020. Changes to the allocation of the Financial Recovery Fund are expected to result in a reduced level of support from DHSC in the form of revenue support loans.

From the 30th September 2020 revenue support loans will be converted to PDC. Where Trusts still require revenue support for liquidity purposes this will be issued as PDC and not loans from 2020/2021 onwards.

The Trust's treasury management operations are carried out by the Finance department, within parameters defined formally within the Trust's Standing Financial Instructions and policies agreed by the Board of Directors. Similarly treasury management for the Trust Charity and subsidiary, Stepping Hill Healthcare Enterprises Ltd, are also carried out by the Finance department. All treasury activity is subject to review by Internal and External Audit.

The Trust finances its capital expenditure from internally generated funds or funds made available from the Department of Health as Public Dividend Capital. The Trust has also borrowed commercially from the Department of Health NHS Financing Facility within approved borrowing limits to finance strategic capital schemes in previous years. There has been an additional interim capital loans drawn in 2019/2020 to meet emergency capitl requirments. This loan is included in the loans to be converted to PDC in 2020/2021. The Trust has also had initial approval to build a £30.6 million Emergency Care ansd Pathology Campus. £1.6 million funding has been granted in 2020/21 for the design and development of the outline and full business case.

At the 31 March 2020 the Trust's cash balances were held solely in its Government Banking Services bank accounts and Barclays current accounts as per note 23.1. Further consideration of the Trust's liquidity has been looked at as part of the going concern declaration. Stockport NHS Foundation Trust is, therefore, not exposed to significant liquidity risk.

Market and Interest Rate Risk

At the 31 March 2020 the Trust's financial liabilities carried either nil or fixed rates of interest. The Trust's financial assets relate to loans and receivables and its cash balances held within its Government Banking Service bank accounts and commercial current account. Interest on cash balances are set by HM Treasury through the Royal Bank of Scotland. The conversion of loans to PDC in 2020/2021 does bring additional costs to the Trust as loans with lower rates of interest will be converted to the higher 3.5% PDC Dividend rate.However, an adjustment to the Trust's initial control total offer was made to compensate for this. The Department of Health and Social Care have also confirmed that at review of the PDC Dividend rate will be completed for the 2021/2022 financial year so that Trusts will not be disadvantaged longer term in the change to the NHS debt regime. Stockport NHS Foundation Trust is not, therefore, exposed to significant interest rate risk.

Credit Risk

The Trust receives most of its income from its commissioners based on annual contracts adjusted quarterly. It operates a robust debt management policy and, where necessary, provides for the risk of particular debts not being discharged by the applicable party. Non NHS customers do not make up a large proportion of income with the majority of income coming from other public sector bodies which are considered low risk. This position, and the temporary introduction of block contracts and top up payments to meet costs to July 2020, mean that Stockport NHS Foundation Trust is, therefore, not exposed to significant credit risk.

Foreign Currency Risk

The Trust has negligible foreign currency income or expenditure.

Charitable Funds

The Group accounts include the financial statements of the Stockport NHS Charitable Fund. The charitable fund places its short term cash in bank accounts with the Trust’s commercial bank, Barclays PLC. The Charity also invests monies of £1.9 million for longer term investment with CCLA Investment Management Ltd. It holds one common investment fund in equity funds of £1.3 million and one cash deposit account holding £0.7 million. The Charity receives quarterly updates on the performance of its investments and allocates gains and losses when realised to its charitable funds. This policy is reviewed on an annual basis to mitigate for any possible market losses on the valuation of its equity common investment fund.

Note 33.1 Financial risk management continued

Stepping Hill Healthcare Enterprises Limited

The Group accounts include the financial statements of its trading subsidary, Stepping Hill Healthcare Enterprises Limited. The subsidary holds its cash with the Trust commercial banker, Barclays PLC, in a separate bank account. Its income is predominantly with the parent and it currently purchases drugs for its dispensing services using the Trust Pharmacy as its wholesale supplier. It is not considered, therefore, to have market or liquidity risks.

Note 33.2 Carrying values of financial assets (Group)

Carrying values of financial assets as at 31 March 2020	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Trade and other receivables excluding non financial assets	19,598	-	**19,598**
Cash and cash equivalents	18,578	-	**18,578**
Consolidated NHS Charitable fund financial assets	1,207	1,287	**2,494**
Total at 31 March 2020	**39,383**	**1,287**	**40,670**

The Group Charity only holds financial assets that qualify as basic financial instruments. These are recognised initially at transaction value and subsequently measured at fair value through the Statement of Financial Activities

Carrying values of financial assets as at 31 March 2019	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Trade and other receivables excluding non financial assets	7,895	-	**7,895**
Cash and cash equivalents	6,095	-	**6,095**
Consolidated NHS Charitable fund financial assets	932	1,332	**2,264**
Total at 31 March 2019	**14,922**	**1,332**	**16,254**

Note 33.3 Carrying values of financial assets (Trust)

Carrying values of financial assets as at 31 March 2020	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Trade and other receivables excluding non financial assets	22,284	-	**22,284**
Cash and cash equivalents	17,631	-	**17,631**
Total at 31 March 2020	**39,915**	**-**	**39,915**

Carrying values of financial assets as at 31 March 2019	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Trade and other receivables excluding non financial assets	9,685	-	**9,685**
Cash and cash equivalents	4,868	-	**4,868**
Total at 31 March 2019	**14,553**	**-**	**14,553**

Note 33.4 Carrying values of financial liabilities (Group)

Carrying values of financial liabilities as at 31 March 2020	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	68,005	**68,005**
Obligations under finance leases	144	**144**
Obligations under PFI, LIFT and other service concessions	295	**295**
Trade and other payables excluding non financial liabilities	33,199	**33,199**
Provisions under contract	3,339	**3,339**
Total at 31 March 2020	**104,982**	**104,982**

Carrying values of financial liabilities as at 31 March 2019	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	47,913	**47,913**
Obligations under finance leases	229	**229**
Obligations under PFI, LIFT and other service concessions	325	**325**
Other borrowings	-	**-**
Trade and other payables excluding non financial liabilities	30,102	**30,102**
Other financial liabilities	-	**-**
Provisions under contract	2,439	**2,439**
Consolidated NHS charitable fund financial liabilities	-	**-**
Total at 31 March 2019	**81,008**	**81,008**

Note 33.5 Carrying values of financial liabilities (Trust)

Carrying values of financial liabilities as at 31 March 2020	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	68,005	**68,005**
Obligations under finance leases	144	**144**
Obligations under PFI, LIFT and other service concessions	295	**295**
Other borrowings		**-**
Trade and other payables excluding non financial liabilities	34,262	**34,262**
Provisions under contract	3,339	**3,339**
Total at 31 March 2020	**106,045**	**106,045**

Carrying values of financial liabilities as at 31 March 2019	Held at amortised cost	Total book value
	£000	£000
Loans from the Department of Health and Social Care	47,913	**47,913**
Obligations under finance leases	229	**229**
Obligations under PFI, LIFT and other service concessions	325	**325**
Other borrowings		**-**
Trade and other payables excluding non financial liabilities	30,048	**30,048**
Other financial liabilities		**-**
Provisions under contract	2,439	**2,439**
Total at 31 March 2019	**80,954**	**80,954**

Note 33.6 Fair values of financial assets and liabilities

Other than the investments held by the Group Charity all financial assets and liabilities are held at carrying value at the 31st March 2020 as book value is considered to be a reasonable approximation of fair value.

Note 33.7 Maturity of financial liabilities

	Group		Trust	
	31 March 2020	31 March 2019	31 March 2020	31 March 2019
	£000	£000	£000	£000
In one year or less	81,787	34,591	82,850	34,537
In more than one year but not more than two years	1,987	1,666	1,987	1,666
In more than two years but not more than five years	5,188	29,249	5,188	29,249
In more than five years	16,019	15,502	16,019	15,502
Total	**104,982**	**81,008**	**106,045**	**80,954**

Note 34 Losses and special payments

	2019/20		2018/19	
Group and trust	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	16	4	18	2
Bad debts and claims abandoned	69	36	31	91
Stores losses and damage to property	1	22	-	-
Total losses	**86**	**62**	**49**	**93**
Special payments				
Ex-gratia payments	31	5	38	14
Total special payments	**31**	**5**	**38**	**14**
Total losses and special payments	**117**	**67**	**87**	**107**

These amounts are reported on an accruals basis and exclude provisions for future losses.

Note 35 Gifts

Neither the Trust or Group made gifts of any value in 2019/2020 or 2018/2019.

Note 36 Related parties

Stockport NHS Foundation Trust is a body corporate authorised by Monitor, the Independent Regulator of NHS Foundation Trusts, in exercise of the powers conferred by the National Health Service Act 2006. The Department of Health and Social Care is the parent body of all Foundation Trusts.

The Trust has 26 members of the Council of Governors; 24 representing public and staff and a further 2 appointed by partner organisations. None of the Council of Governors or parties related to them has undertaken any material transactions with Stockport NHS Foundation Trust.

Note 36 Related parties continued

The Trust and Group's related parties include all Whole of Government bodies as defined by the Treasury. The key transactions are with the following bodies:

	Income		Expenditure	
	31 March 2020	31 March 2019	31 March 2020	31 March 2019
	£000	£000	£000	£000
Stockport CCG	191,742	184,123	(49)	(2,118)
North Derbyshire CCG	24,387	22,376		-
Eastern Cheshire CCG	13,578	12,720	(282)	-
Tameside & Glossop CCG	9,307	9,543	-	-
Stockport MBC	8,765	8,633	(202)	(348)
NHS England	43,520	15,626	(15)	(68)
NHS Resolution	-	5	(9,136)	(10,648)
Health Education England	7,633	7,684		(5)
	298,932	**260,710**	**(9,684)**	**(13,187)**

	Receivables		Paybles	
	31 March 2020	31 March 2019	31 March 2020	31 March 2019
	£000	£000	£000	£000
Stockport CCG	750	147	(2,549)	(2,735)
North Derbyshire CCG	-	91	(2)	(1,046)
Eastern Cheshire CCG	282	-	-	(828)
Tameside & Glossop CCG	-	-	(314)	(286)
Stockport MBC	283	1,339	(445)	(368)
NHS England	11,391	970	(38)	(7)
NHS Resolution	-	-	(4)	(25)
Health Education England	212	686	(271)	(14)
	12,918	**3,233**	**(3,623)**	**(5,309)**

Note 37 Events after the reporting date

The accounts were authorised for issue by the Accountable Officer on 24 June 2020.

On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow the repayment. Given this relates to liabilities that existed at 31 March 2020, DHSC has updated its Group Accounting Manual to advise this is considered an adjusting event after the reporting period for providers. Outstanding interim loans totalling ££46.055 millon interim loan principal and £0.235 million interest accrual as at 31 March 2020 in these financial statements have been classified as current as they will be repayable within 12 months.