Stockport
NHS Foundation Trust

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Annual Report and Accounts 2025-26

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Chair’s Introduction

I am pleased to present this Annual Report as Chair of Stockport NHS Foundation Trust, a role I hold jointly with Tameside and Glossop Integrated Care NHS Foundation Trust.

This has been my first full year as Joint Chair, and it has reinforced what many in our communities already know; the care we provide is powered by compassionate and committed people. Every day, colleagues across our services go above and beyond to support patients, families and carers, often in the most difficult circumstances.

This year has also brought very real pressures: rising demand for our services, the needs of an ageing population, the continuing impact of the cost of living crisis, and the financial constraints faced across the NHS. These challenges are significant, and they make our shared focus on safe, high-quality, person-centred care more important than ever.

What has stood out throughout the year is the resilience and professionalism of our teams. From clinical teams delivering outstanding care, to corporate and support services colleagues keeping our hospitals and community services running, it is our people who make this Trust special. I want to record my sincere thanks to every member of staff and to our partners and volunteers who work alongside us.

This year we have also taken important steps to strengthen the partnership between Stockport NHS Foundation Trust and Tameside and Glossop Integrated Care NHS Foundation Trust. Over the past twelve months we have moved to formalise the relationship between our organisations, including establishing a Joint Board and governance structure. We are stronger together. Working more closely helps us to share expertise, reduce duplication and invest our resources where they will make the greatest difference. Most importantly, it gives us the opportunity to improve outcomes and experiences for the people who rely on our services, and to create a more supportive, sustainable environment for our staff. Achieving a Joint Board has not been easy and I am grateful for the contributions and support of everyone involved in helping us deliver it, including the support of the Council of Governors in implementing the changes.

This report reflects what we have achieved over the last year and the priorities shaping the year ahead. It captures the progress we are making, the lessons we have learned, and the ambition we hold for our communities. With the commitment of our people and the strength of our partnerships, I am confident we will continue to build on our legacy and deliver even better care for those we serve.

David Wakefield
Joint Chair

Performance Report

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

Chief Executive's Statement
This report reflects on our achievements over the past year, and the improvements made for patients and staff. Of course, there have been challenges during the year as well. Like NHS trusts across the country, we continue to see high demand for all services and factors such as the ongoing industrial dispute between resident doctors and the government have also placed us under additional pressures.

There have been a number of major improvements and changes on our hospital site this year, with an impressive three separate major building projects coming to their completion and opening for patients. The first was our emergency and urgent care campus; a major project with our partners which took nearly three years to complete. The new building has meant major changes to the front face of the hospital, becoming more welcoming and making for an improved experience for patients receiving emergency and urgent care. The design of the campus is centred on patient needs, with the best possible state-of-the-art facilities being made available for staff, including new assessment, treatment and consultation areas for several key emergency and urgent care services.

The second was our new outpatients building; a modern and efficient facility containing over 50 rooms, where patients, their families and carers now receive high quality care. Services available from the facility now include orthoptics, optometry, dentistry, cardiology, neurology, oncology, pain, podiatry, rheumatology and more, providing a much improved environment for each of them.

And in the final of the major three, our new magnetic resonance (MR) scanner suite, which includes two new state-of-the art MR scanners, now benefitting our stroke care, cancer care, and emergency and urgent care services, and helping to reduce waiting times, with patients no longer waiting more than six weeks for a scan.

In addition to these projects, we also opened a wonderful new acute frailty unit therapy garden to help patient recovery, with the support of both the Greener Communities Fund and our own Stockport NHS Charity.

While these projects were for building front line services, we also completed a major project behind the scenes too, when we introduced a new laboratory information management system (LIMS) for our hospital's pathology services, which is leading to faster diagnosis and treatment for patients. The new system, including microbiology, cellular pathology and blood sciences services, allows greater integration with other systems and ensures results can be shared with colleagues more swiftly and easily.

Long waits for emergency care have been a challenge for us for some time, and although we did not achieve the national access standards for emergency care, it was wonderful to see our trust in the top ten in the country for most improved A&E waiting times, in figures from NHS England comparing changes between March 2024 and March 2025. This was a real achievement and shows our improved emergency services estate is already having a positive impact.

There were other notable achievements too. Our surgical teams secured the highest level of accreditation from the Royal College of Anaesthetists and were ranked among the top trusts in the country for emergency abdominal surgery safety, according to the National Emergency Laparotomy Audit, demonstrating their consistently high standards in these areas. Our rheumatology department were recognised as an imaging training centre for ultrasound by the European Alliance of Associations of Rheumatology (EULAR) network, one of a handful of rheumatology departments in the UK to gain this status. Also, our gastroenterology team received level 1 accreditation with the Improving Quality in Liver Services (IQILS) accreditation programme.

Our performance has been strong in many areas. We reduced the number of patients waiting more than one year for elective treatment by over 85% and surpassed our plan for Referral to Treatment (RTT) 18-week performance, achieving a 7-point improvement over the year. With cancer services, we ensured circa 85% of patients on a suspected cancer pathway received a diagnosis, or confirmation they do not have cancer, within 28 days, exceeding the 80% national standard. We met our planned target for 62-day cancer pathway performance, and we also ranked in the top quartile nationally for both the 28-day and 62-day cancer access standards.

There is always a need to carefully manage our finances. The Trust's financial plan for 2025/26, agreed as part of the GM Integrated Care System (ICS), included a break even financial position after receipt of £43.2m deficit support funding (DSF) and a cost improvement programme (CIP) of £29.2m. Through robust financial management, the Trust delivered a final outturn break even position before revaluations and impairments, supported by revenue improvement, £43.2m of non-recurrent deficit funding and £3.9m of additional income.

We were recognised as a good place for our colleagues to work in too, with positive results from our annual NHS Staff Survey, and being awarded the Gold Standard by NHS England for our support for Apprenticeships.

Finally, our trust's relationship with Tameside and Glossop Integrated Care NHS Foundation Trust has gone from strength to strength, as we continue to work closely together to reduce duplication and align priorities to strengthen healthcare services. The two trusts remain separate entities, but to reflect the growing collaboration between the organisations a unifying name has been unveiled, South East Sector Healthcare Partnership, which you'll see more of in the months ahead.

Moving forward, we will build on all the positive developments described in this report and work hard to tackle the challenges highlighted to ensure Stockport NHS Foundation Trust continues to do its very best for the local population.

Karen James OBE
Chief Executive

The Trust

Established on 1 April 2004, Stockport NHS Foundation Trust was one of the first NHS foundation trusts in England. The Trust exists to provide high-quality care for patients as part of the NHS, offering a wide range of acute hospital and community services.

Around 6,300 staff work across our main sites and within local communities, delivering care in people's homes as well as clinical settings including:

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

We are licensed to provide the following 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
Haematology	Trauma and orthopaedics
Medical oncology	Urology
Neurology	

In 2020, the Trust Strategy 2020–2025 set out our plans for the years ahead and how we intended to play our part in improving health and care locally and across the region. Our current strategic priorities and objectives were shaped by listening to our staff and stakeholders, so that they reflect their views, experiences and ideas for the future. Our corporate objectives are reviewed annually and approved by the Board to operationalise our strategy. Corporate objectives for 2025/26 were:

- Deliver personalised safe and caring services,
- Support the health and wellbeing needs of our communities and colleagues,
- Develop effective partnerships to address health and wellbeing inequalities
- Develop a diverse, talented and motivated workforce to meet future service and user needs,
- Drive service improvement through research, innovation and transformation,
- Use our resources efficiently and effectively,
- Develop our estate and digital infrastructure to meet service and user needs.

As a key partner in the Greater Manchester Integrated Care System (GM ICS), and within place-based arrangements in Stockport, these objectives recognise the importance of working closely with others to deliver the best outcomes.

Over the past year, we have begun developing a new joint strategy with Tameside and Glossop Integrated Care NHS Foundation Trust (TG ICFT). This will bring together our shared ambitions, strengthen how we work together, and help us respond to the increasing challenges we face as NHS organisations, with the aim of improving the lives of the populations we serve. Throughout the development and delivery of this strategy, the Trust's values - Compassion, Accountability, Respect and Excellence (C.A.R.E) - will sit at its heart, shaping both what we do and how we work with patients, communities and colleagues.

Key risks to delivering our objectives

The Board uses the Board Assurance Framework (BAF) to identify and oversee the Trust's principal risks. The BAF helps the Board understand the key issues that could affect delivery of the Trust's corporate objectives and ensures appropriate controls and actions are in place.

For 2025/26, the Board approved the principal risks relating to delivery of the Trust's corporate objectives and assigned each risk to a relevant Board Committee for oversight. The Board of Directors reviewed the BAF on a quarterly basis to maintain a clear and comprehensive view of risk across the organisation.

During 2025/26, the Board identified its most significant principal risks as those relating to:

Urgent & Emergency Care: Capacity & Demand

Increased demand and high bed occupancy affected the availability of beds for patients needing admission from the Emergency Department (ED), making it more difficult to meet national urgent care access standards. Throughout the year, our teams focused on improving the parts of the patient journey within their control, including regular multidisciplinary reviews and actions to reduce long hospital stays. We also strengthened safe staffing arrangements and procedures to maintain quality and patient safety within the ED.

However, achieving sustained improvement requires further work with partners in the locality to address wider pressures on patient flow, including limited domiciliary and bed-based care for patients who no longer require hospital treatment. This risk was overseen by the Board's Finance & Performance Committee and remained outside the Trust's agreed risk appetite during the year.

Delivery of the agreed financial position 2025/26 and development of a multi-year financial recovery plan to secure financial sustainability

Delivering the Trust's financial plan remained a key risk during the year. This reflected continued growth in demand across hospital and community services, the impact of national pay awards, contractual pressures, and the ongoing costs of maintaining an ageing estate. A strong focus on the cost improvement programme and robust expenditure control helped to manage this risk. Oversight by the Finance & Performance Committee supported delivery of the financial plan for the year.

Looking ahead, the risk to longer term financial sustainability remains more challenging than ever, both for the Trust and across the GM ICS. The Trust was fully involved in developing a Medium Term Plan, but the Board recognises that maintaining financial sustainability over the next three years will require significant productivity improvements, enhanced use of

digital technologies, a continuation of our focus on cost improvement schemes, delivery of planned income assumptions from commissioners, and closer working with neighbouring NHS providers. This risk continued to be monitored by the Board's Finance & Performance Committee.

Ageing estate & insufficient funding mechanism for strategic regeneration of the hospital campus

As in previous years, parts of the Trust's estate continue to require significant investment and is increasingly difficult to maintain within limited capital resources. During the year, the Trust strengthened controls to manage the risks associated with an ageing estate, including enhanced monitoring, planned preventative maintenance, and targeted remedial works, with oversight provided through the Finance & Performance Committee.

Alongside this, several important capital projects were completed, including the delivery of the new Emergency and Urgent Care Campus, MR Scanner Suite and the new Outpatient Department, which have improved facilities for patients and staff. The Board has recognised the longer-term need to regenerate the hospital campus to support the delivery of modern, efficient care and has begun master planning work to shape future development. Work continues to explore potential options in partnership with Stockport Metropolitan Borough Council (SMBC).

Going Concern

Stockport NHS Foundation Trust has prepared its Annual Accounts on a going concern basis.

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

Performance Analysis

Each year, the Board of Directors agrees a set of key outcome measures to track progress and improvement against the Trust's corporate objectives, as well as delivery of the annual operational plan agreed through the Greater Manchester Integrated Care System (GM ICS). These measures bring together local priorities alongside relevant regional and national standards. Any significant risks that could affect achievement of the Trust's objectives are captured and monitored through the Board Assurance Framework (BAF).

The Performance Analysis provides further detail on how the Trust has performed in the following domains, in addition to how we work in partnership and collaborate with others:

- Operational performance
- Quality performance
- People performance
- Financial performance

Operational performance

In line with national guidance, during the year the Trust focused on delivering the objectives set out within the GM Urgent and Emergency Care Improvement Programme, the GM Elective Recovery Programme, and the 2025/26 Operational Planning Guidance.

Urgent and Emergency Care

Emergency Department (ED) attendances increased slightly in 2025/26 compared to 2024/25, with more than 300 patients seen each day on average. The Community Urgent Treatment Centre (UTC) saw just under 16,000 attendances, showing growing demand for urgent care.

Winter pressures were intensified by increased patient acuity and an exceptionally high incidence of norovirus - 45% higher than the usual winter average. Cases stayed high for longer than normal and there was a second spike in February and March. At the same time, space was limited because the UTC was being refurbished between January and March 2026.

Despite this, ED performance improved compared to the previous year and stayed above the planned levels each month. The March result was 70%, higher than March 2025 (69%), but still below the national target of 78%.

Work with partners continued to help manage demand, including guiding patients to services other than ED where appropriate. The Single Point of Access (SPOA) provides one phone number for urgent care across the locality and is helping direct people to urgent neighbourhood services.

Collaboration with North West Ambulance Service has also strengthened, resulting in improved pathways and greater use of alternatives to ED, including Same Day Emergency Care (SDEC).

Improving patient flow remains a priority. The Trust's Programme of Flow is embedded within daily operational processes, including regular multidisciplinary reviews of patients with long lengths of stay across acute adult wards. A new discharge trajectory programme is also being

introduced, with wards assigned daily discharge and stretch targets informed by historical demand and capacity data, though this remains at an early stage of implementation.

Planned Care

In line with national guidance, we continued to prioritise patients requiring urgent or cancer treatment, as well as those who had waited the longest. We prioritised reducing waits of over 52 weeks for elective care and put plans in place to sustainably increase elective capacity from 2025/26 onwards.

Referral to Treatment (RTT)

Metric	National standard	NHS 2025-26 Plan	SFT 2025-26 Plan	End Q1	End Q2	End Q3	End Q4
RTT: Incomplete pathways %	92.00%	65.00%	60.00%	57.10%	57.00%	58.40%	62.15%
RTT: Patients waiting 52+ weeks %	<1%	<1%	0.99%	2.90%	2.10%	1.70%	0.68%
RTT: Patients waiting 65+ weeks	0	0	0	21	1	0	2
Cancer: 62-day referral to treatment standard	85.00%	75.00%	75.00%	62.60%	72.10%	79.60%	75.98%
Cancer: 28-day faster diagnosis standard	80.00%	80.00%	80.00%	80.30%	83.70%	82.70%	84.23%
Cancer: 31-day referrlal to treatment standard	96.00%	93.00%	91.30%	86.605	88.10%	92.10%	90.90%
Diagnostics procedures waiting over 6 weeks	1.00%	5.00%	5.00%	22.05%	21.27%	16.07%	15.20%

**Provisional forecast March 2026 position for cancer standards. Final validated position not available at the time of writing*

Throughout the year, elective services faced challenges from industrial action and pressure on hospital buildings. Despite this, access to elective care improved significantly, and most year-end targets for referral to treatment and cancer waiting times were met. The opening of the new Outpatients B building in the summer was also a very positive milestone.

The national RTT standard is for 92% of patients to start non-urgent, consultant-led treatment within 18 weeks of referral. The Trust last met this standard in April 2019. The COVID-19 pandemic reduced elective activity and led to longer waiting lists. Since then, performance has gradually improved, while prioritising cancer, urgent cases and patients waiting the longest. Over the year, the total RTT waiting list reduced by over 1,400 patients (4.5%), and 18-week performance improved from circa 55% to 62%.

Long waits have fallen significantly. Almost all waits over 65 weeks have been eliminated, and the number of patients waiting over 52 weeks reduced by over 80% to circa 230 by the end of March 2026. Only 0.7% of patients are now waiting over a year, meeting the national target of less than 1%.

Cancer

Cancer waiting time performance improved steadily throughout the year, and the Trust is now among the top quartile nationally for both the 62-day standard and the 28-day Faster Diagnosis Standard (FDS). Performance against the 62-day standard reached the planned level of 75%, while the 28-day FDS remained above both the improvement plan and the national standard, with a forecast year-end position of 84%.

Challenges remain in meeting the 31-day diagnosis-to-treatment standard, mainly due to high demand for robotic urology cancer surgery. A second surgical robot has been introduced and is expected to help improve performance in 2026/27.

These improvements have been supported by ongoing service improvements, helping to streamline cancer pathways and improve patient care and experience.

Diagnostics

Although performance against the 6-week diagnostic standard improved during the year, the standard was not met and remains a challenge for the Trust. By the end of March 2026, 15.2% of patients on the diagnostic waiting list had been waiting longer than six weeks.

Paediatric Audiology is a key reason for this. Following a service review in 2024/25, much of the service was paused or limited during 2025/26 while further work was taken forward to improve how the service operates. Support from an independent provider, commissioned by NHS Greater Manchester, helped reduce the backlog later in the year. This work is continuing as part of a wider recovery plan, which also included appointing a new Head of Service for Audiology.

Endoscopy, MRI and echocardiography services have also faced access pressures, mainly due to increased demand as elective activity expanded to reduce RTT waiting lists. Improvement plans are in place, including increasing capacity and activity through the Community Diagnostic Centre.

Outpatient and Theatre Efficiency

The Trust continued to take part in the GIRFT (Getting It Right First Time) Further Faster programme throughout the year. Services focused on improving efficiency and redesigning patient pathways to help reduce elective waiting times. Teams have introduced new ways of working to better manage demand and increase productivity.

Use of patient-initiated follow-up (PIFU) has remained strong and continues to exceed the national 5% target. PIFU provides flexibility for patients, allowing them to book appointments only when needed, based on symptoms rather than fixed check-ups. This has reduced unnecessary follow-up appointments, freed up capacity and improved patient access. The Trust remains among the top quartile of trusts nationally for PIFU.

Progress has also been made in expanding specialist advice and guidance (A&G) services to help manage elective demand. The Trust remains in the top national quartile for all A&G requests and has continued to improve its use of pre-referral A&G, now ranking in the second-highest quartile nationally.

Improvements in outpatient DNA rates achieved during 2024/25 were maintained during 2025/26. The Trust continues to have the lowest DNA rate among Greater Manchester acute trusts, with performance broadly in line with the national average.

Theatre utilisation remained stable throughout the year. While overall utilisation is close to the national average, it remains below the 85% national target. Reducing cancelled operations remains a priority, with plans in place including improved digital pre-operative assessments.

Community Services
Most of the Stockport Community Services are now hosted under one division following the merger of the Divisions of Integrated Care and Women and Children in October 2025. The division, now named Division of Women, Children and Integrated Community Services has brought together the community offer for both Adults and Children and Young People.

Adult Community Services
The Trust delivers a wide range of adult community services from community clinics, care homes and in people's own homes for those who are housebound.

Demand for these services continued to increase during 2025/26, with referrals rising by 6.5% compared to 2024/25, representing an increase of almost 6,000 referrals.

During the year, there were over 465,600 patient contacts. Nearly 12% of appointments were delivered by telephone or video. Waiting times improved overall. In March 2026, patients waited an average of 5.8 weeks, compared to 6.9 weeks in March 2025.

The Discharge to Assess service continued to help people leave hospital as soon as they were medically fit, supporting them to return home safely. Two other important services within the Urgent Neighbourhood Model are the Urgent Community Response (UCR) service and the Hospital at Home service (previously known as the Virtual Ward). Both services help people avoid hospital admission where possible. Hospital at Home provides care in a person's own home, using remote monitoring technology alongside visits from a multidisciplinary healthcare team when needed. The UCR service provides a rapid assessment at home within two hours for people experiencing a short-term health crisis.

The Hospital at Home service was previously delivered by Tameside and Glossop Integrated Care NHS Foundation Trust. In January 2026, responsibility for the service transferred to Stockport Foundation Trust for Stockport residents. Recruitment to the full team has taken longer than expected, which has meant the service has not yet reached its target occupancy. Recruitment is ongoing, particularly for senior Advanced Clinical Practitioners and Digital Hub nurses, to support full delivery from mid 2026.

Children's Community Services
Demand for children's community services increased again in 2025/26, particularly within Children in Our Care, Children's Speech and Language Therapy, and the Children's Equipment and Adaptations service. Despite this rising demand, teams delivered notable service improvements during the year.

Children's therapy services introduced the Balanced System® (TBS) framework in partnership with Stockport Metropolitan Borough Council. The framework aims to improve and standardise access to therapy across the borough. Initially introduced in Speech and Language Therapy, it has since been extended to Physiotherapy and Occupational Therapy, resulting in improved access times. By the end of 2025/26, at least 92% of children across all therapy services were seen within referral-to-treatment standards.

The Children and Young People's ADHD service faced significant pressure during the year, with demand continuing to exceed capacity, particularly for diagnostic assessments. The Trust

is working closely with the GM Integrated Care Board to strengthen the pathway and improve timely access to assessment, diagnosis and treatment where appropriate.

The Trust continued to deliver an integrated health and early years model, bringing together public health nursing, health visiting, midwifery and early years services to improve outcomes for children aged 0-5 years and reduce health inequalities. Building on the success of the Family Nurse Partnership in Stockport, plans are in place to expand the service using the Public Health Nursing Grant. Expansion into Brinnington and Lancashire Hill would support some of the most disadvantaged young families and help improve health and developmental outcomes.

Maternity Services

The maternity service regularly reviews its performance against national maternity programmes and priorities. These include:

- Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS)
- Saving Babies Lives Care Bundle Version 3
- Actions from independent investigations into other maternity and neonatal services in England including Ockenden and East Kent
- Three-year delivery plan for maternity and neonatal services (2023)
- Health Inequalities - GMEC Equity and Equality
- Midwifery Continuity of Carer (MCoC)

During the year, the service achieved full compliance with CNST Year 7, demonstrating strong assurance against national safety standards.

Maternity services continue to work closely with the Local Maternity and Neonatal System (LMNS) and the GM Integrated Care Board (ICB). The 2025 annual assurance visit provided positive feedback. An action plan was developed to address the recommendations from this visit and to support ongoing improvement. In addition, a Trust Maternity Oversight Group was established in early 2025, following the feedback and outcomes of the LMNS and GM ICB assurance visit undertaken on 15 October 2024, as part of the Enhanced Surveillance process. Significant progress has been made during the year in addressing the recommended actions, providing assurance that the service is responding effectively and maintaining a strong focus on continuous improvement.

Quality performance

Providing safe, high-quality care is central to the Trust’s aims. Our goal is to improve health outcomes for our local population and work with partner organisations to tackle wider factors that affect health.

The Board regularly reviews information on quality, safety, performance and value for money across all services. This work is supported by the Trust’s Quality Committee.

The Trust publishes a separate Quality Account on its website, which sets out in more detail how we are improving the quality of care. Our priorities are shaped by national and local requirements, as well as commissioning and regulatory expectations. Key areas of focus include mortality, sepsis, falls, pressure ulcer prevention and infection prevention and control.

Mortality (Summary Hospital Level Mortality Indicator)
A continued focus on reducing avoidable deaths and learning from the care of patients who die while in our care underpins the Trust's approach to improving patient safety.

The Summary Hospital-level Mortality Indicator (SHMI) compares the number of deaths that occur with the number expected, including deaths within 30 days of discharge. In 2025/26, the Trust's SHMI remained within the expected range and was among the lowest (best) in Greater Manchester.

The Trust regularly reviews deaths through clinical audits, incident reporting and a strong, clinician-led Learning from Deaths process. Around 30% of deaths each year are reviewed to make sure care meets national standards. Learning from these reviews is shared with clinical teams every month. Oversight of mortality, including key themes and learning, is provided through a dedicated mortality review meeting. Key areas of focus during the year have included palliative and end-of-life care, falls management, patient flow and ward moves.

Sepsis
Prompt identification and treatment of sepsis is fundamental to reducing the risk of serious harm or death for patients. National guidance highlights the importance of spotting sepsis early using routine observations and providing timely, risk-based treatment.

Sepsis screening at the Trust remains very strong, with compliance consistently above 95%. This is supported by the routine use of NEWS2 screening tools and clear escalation pathways in line with national guidance. The Trust continues to focus on improving how quickly antibiotics are given. During 2025/26, between 70-75% of patients with suspected sepsis received antibiotics within agreed timeframes. While this is similar to performance across the NHS, it remains below the Trust's own ambition. All cases where delays occur are reviewed. Most delays are short, and learning is used to improve pathways, staff training and operational processes. The Trust worked with the Advancing Quality Alliance to benchmark performance and support improvement. This was strengthened in 2025 by appointing a senior sepsis practitioner to provide leadership, oversight and targeted education. Improving timeliness will remain a priority in 2026/27 to support safe care, with oversight provided to the Quality Committee and assurance to the Board.

Falls
During 2025/26, the Trust made strong progress in reducing inpatient falls and harm from falls, delivering almost 14% reduction in the overall falls rate per 1000 bed days, exceeding the quality improvement target. Significant improvements were also achieved in reducing falls associated with lapses in care or areas of concern, with a 47% year-on-year reduction, supported by enhanced governance, weekly multidisciplinary falls review panels, strengthened training compliance, and improved digital oversight through Patient Track and an enhanced falls dashboard. Although local Emergency Department (ED) targets for falls were not fully met, performance showed improvement across several months in the context of high demand and patient acuity and continues to be closely monitored. Overall, the Trust remains committed to sustained falls prevention through strong clinical leadership, system-wide collaboration, improved reporting and learning, and continued delivery of its Falls Action Plan.

Pressure Ulcers
Over the last year, the number of pressure ulcer incidents in the acute setting has reduced by 33% compared with the previous year. While we have achieved year-on-year reductions, this represents the most significant single year improvement in the last eight years. Our aim is to sustain and build on this progress to further reduce the harm associated with pressure ulcers. In the community, we have continued to improve the care provided, with fewer than 5% of pressure ulcers occurring due to a lapse in care. Looking ahead, to further reduce the number of pressure ulcer incidents in the community, we will strengthen partnerships with our community care providers so that we can work collaboratively to reduce the burden of pressure ulcers for our patients.

Infection Prevention & Control
2025/26 continued to be a challenging year with regards to infection prevention & control, as we work with Stockport's ageing population and the age and condition of the estate.

Standard infection prevention & control practice, processes and precautions are in place for all patients whether infection is known to be present or not and used by all staff, across all care settings. Despite this, several set trajectories were not achieved. The Trust achieved the trajectory for Clostridium difficile and exceeded the planned 10% reduction however it remains a significant challenge, both locally and nationally primarily linked to antibiotic usage for complex clinical presentations, long term conditions and relapses. This challenge has been replicated with other providers across GM, with work nationally being undertaken to review guidance and recommendations.

The Trust achieved the trajectory for pseudomonas but failed to achieve for MRSA, MSSA, E Coli and Klebsiella. Additional partnership working is being undertaken to support the planned reduction in E Coli numbers.

The Trust also saw an increase in the number of cases of norovirus between January and March 2026 requiring additional exploration and actions.

During 2025/26, the Infection Prevention & Control Team implemented the National Standard Infection Control (SICP's) Monitoring Tool. All inpatient areas were audited to provide a baseline for improvement in 2026/27.

Care Quality Commission
The Trust is registered with the Care Quality Commission (CQC) and fully compliant with the registration requirements of the CQC. The Trust engages in regular oversight meetings with the CQC, and the Trust seeks assurances through its governance framework that care is provided that is safe, effective, caring, responsive and well led. The Trust's overall rating remains as ''Requires Improvement'.

The CQC Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) inspectors carried out an inspection of the Trust's compliance with the IR(ME)R 17 Regulations in 2025/26. No enforcement action was taken against the Trust following this inspection. This inspection and other most recent inspections are illustrated below:

<table>
<tr><th>Year</th><th>Inspection Overview</th><th>Outcome</th></tr>
<tr><td>2025/26:

September 2025</td><td>IR(ME)R inspectors carried out an announced inspection of the Trust's compliance with the Ionising Radiation (Medical Exposure) Regulations 2017.</td><td>The IR(M)ER inspection did not identify any breaches under IR(M)ER17 which met the threshold for enforcement action. Areas for improvement were identified during the inspection. These related to actions required to ensure compliance with IR(ME)R17 and other published standards that support current best practice and enhance the quality of care provided to patients.

The Trust has developed an action plan in response to the recommendations. The action plan has been shared with the IR(ME)R inspection team and will be overseen to completion by divisional quality & safety meeting.</td></tr>
<tr><td>2023/24:

September 2023</td><td>Announced inspection of maternity services covering the domains of safe and well led, as part of the national maternity inspection programme.</td><td>The inspection report published in May 2024 reported both the safe and well led domains of care as: Requires Improvement.

<table><tr><td>Domain</td><td>Assessment</td></tr><tr><td>Safe</td><td>Requires Improvement</td></tr><tr><td>Effective</td><td>Requires Improvement</td></tr></table>
The Trust developed an action plan in response to 3 must do recommendations, and 4 should do recommendations included within the report. The action plan was overseen by the Trust's Quality Committee.</td></tr>
</table>

Research & Innovation

The Trust remains committed to research and innovation as a key way to improve patient care and outcomes. Research also benefits patients and staff by improving experience, supporting recruitment and retention, and strengthening our reputation.

2025/26 was another strong year, with continued delivery of our shared five-year research strategy with TG ICFT. The Trust supported 74 active studies across 19 specialities and recruited around 1,315 participants. This included a balanced mix of commercial and non-commercial studies, with 20 new studies opened.

Research has increasingly been built into everyday clinical care, leading to strong recruitment across several areas. In children's research, the PALOH-UK study recruited over 300 participants to assess a new genetic test for antibiotic-related hearing loss. In gastroenterology and cancer, over 400 patients participated in the COLO-COHORT study aligned to the two-week wait pathway. In trauma and orthopaedics, studies such as WHITE-15 INITIATE and PRESSURE-3 have supported assessing improvements in recovery and

prevention of complications following hip fracture. In surgery, the Trust was the top recruiting site nationally for the PARTIAL trial looking at the clinical and cost effectiveness of complex partial vs radical nephrectomy for clinically localised renal cell carcinoma.

Multidisciplinary research continues to work well, particularly in stroke and critical care, where teams have collaborated to offer a wide range of studies. This includes studies exploring genetic factors in critical illness and interventions for acute respiratory failure.

Engagement in research delivery continues to strengthen, with circa 200 staff from a wide range of professional groups actively contributing to study recruitment. The Trust has also prioritised patient and public engagement, using patient stories and outreach activity to raise awareness of research opportunities, alongside collaborative initiatives such as the joint Research Showcase event with TG ICFT. The Trust has also continued to strengthen engagement in communities, including partnership working with Stockport County Community Trust and the North-West Regional Research Delivery Network to improve access to research in underserved populations.

Feedback from patients taking part in research continues to be very positive. In 2026/27, the Trust will build on this progress by expanding access to research and supporting more inclusive participation across our population.

Tackling Health Inequalities

Health inequalities can arise when social determinants such as where you live and work create barriers to access to and outcomes from healthcare services that other groups do not face. NHS England's Statement on Information on Health Inequalities sets clear expectations for NHS organisations to collect, analyse and publish information on inequalities, and to take evidence-led action aligned to the Core20PLUS5 approach.

During 2025/26, the Trust's established Health Equity and Prevention Forum strengthened leadership and governance for this work. A baseline self-assessment and action plan have been developed, informed by analysis of activity and outcomes by deprivation, ethnicity, age and sex, in line with NHS England guidance. The areas of focus identified included improving access to maternity services for minority communities and increasing services for those at risk of alcohol-harm.

The Trust is working with system partners, communities and the voluntary, community and social enterprise (VCSE) sector to embed the delivery of services in communities through Neighbourhood Models of Healthcare. This includes focusing improvement activity on populations experiencing the greatest inequalities, consistent with the Core20PLUS5 framework. Further development is planned to strengthen the use of data to track impact and reduce unjustified variation.

By improving access and reducing waits, the Trust aims to help address health inequalities and ensure that everyone who needs care can access it in a timely way. The Health Equity and Prevention Forum uses performance reporting to understand how services impact the population of Stockport and to support equitable access to care. During 2026/27 the Trust will continue to strengthen its use of data and insight to understand variation by deprivation and

population group and will further embed health inequalities considerations into service planning, quality improvement and governance arrangements.

Through new joint governance arrangements, the Trust will also ensure that health inequalities data is built into Joint Board reporting and governance. This information will inform decision-making within the joint programme of work with TG ICFT.

Specific information on health inequalities for Stockport NHS Foundation Trust is published as follows:

- **Elective Care** – Inequalities in the percentage of people waiting over 18 weeks or 52 weeks for elective treatment. Elective waiting list and activity data is collected weekly in the Waiting List Minimum Dataset (WLMDS), submitted by the Trust and published nationally and by Greater Manchester ICB; information is broken down by demographics to allow greater visibility of potential health inequalities. Statistics » Waiting List Minimum Data Set (WLMDS) Information, https://curator.gmtableau.nhs.uk/dashboard/elective-equalities

- **Urgent and Emergency Care** – Inequalities in patients attending emergency services, including demand, demographics, acuity, mean waiting times. Data is submitted by the Trust in the Emergency Care Dataset (ECDS), published nationally Hospital Accident & Emergency Activity, 2025-26 - NHS England Digital and within Greater Manchester Strategic - Health Inequalities Statement - Urgent and Emergency Care | GM ADSP

- **Maternity and Neonatal** – Inequalities dashboard brings together key information to address health inequalities in maternity and neonatal care services from a range of data sources, with breakdowns by ethnicity and deprivation. Maternity and Neonatal Equalities dashboard - NHS England Digital

- **Smoking Cessation** – Inequalities in smoking prevalence in adults and pregnant women. The Trust collects and submits smoking cessation data, published nationally by NHSE Tobacco Dependence Services Dashboard LIVE: Health Inequalities - Tableau Server) and by Greater Manchester ICB (Strategic - Health Inequalities Statement - Smoking Cessation | GM ADSP)

- **Oral health** - Tooth extractions due to decay for children admitted as inpatients to hospital aged 10 years and under: Submitted by the Trust and published nationally by NHSE (SUS/HES Data Tooth Extractions - NHS Digital) and by GM ICB (https://curator.gmtableau.nhs.uk/dashboard/tooth-extractions)

The Trust does not provide mental health services.

Equality of Services

The Public Sector Equality Duty (PSED), set out in the Equality Act 2010, requires NHS organisations to eliminate discrimination, advance equality of opportunity, and foster good relations between different groups. The duty helps ensure that fairness and inclusion sit at the

heart of public services, so that health and care services meet the diverse needs of the communities they serve.

In line with this duty, providing high-quality, equitable care for all patients remains a core focus for the Trust. The Trust actively gathers, monitors and uses feedback from patients, carers, families and friends to inform service improvement and provide assurance on quality, safety and person-centred care, while recognising the need to understand and reflect the experiences and voices of all the communities served. During the year, good progress was made in delivering the Patient, Carers, Family and Friends Strategy, with the Patient Experience Team working closely with staff and partners to understand the experiences of different patient groups and embed sustainable improvements across services.

A wide range of initiatives were delivered to improve patient experience and promote equality. These included enhancements to policies and processes such as updated guidance on patient belongings, standardised visiting arrangements, improved interpreting services, and strengthened approaches to accessible information. Together, these changes support more equitable access to services and help ensure care is personalised, inclusive and responsive to individual needs.

The Patient Experience Team continues to play a key role in supporting compassionate and inclusive care through services such as Volunteer Services, Chaplaincy and Spiritual Care, and strengthened public health collaboration. Volunteers provided valued support across both clinical and non-clinical areas, while the Chaplaincy team offered emotional and spiritual care to patients, families and staff from all backgrounds. The Trust has also strengthened partnerships with community organisations to widen engagement and address health inequalities, including work with Walthew House to promote the Deaf First Responder role and deliver Deaf Awareness training.

People performance

Information regarding our people performance can be found in the Staff Report.

Financial performance

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 an outturn of £22.4 million deficit for 2025/26, which includes the Trust deficit of £22.1 million in 2025/26 and subsidiaries' profit of £29k for Stepping Hill Enterprises Ltd. The Trust's Charity had a net outflow of funds of £281k in 2025/26. Removing the impact of donated assets and technical impairments on valuation of land and buildings, the Trust's adjusted financial performance for 2025/26 was breakeven. 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.

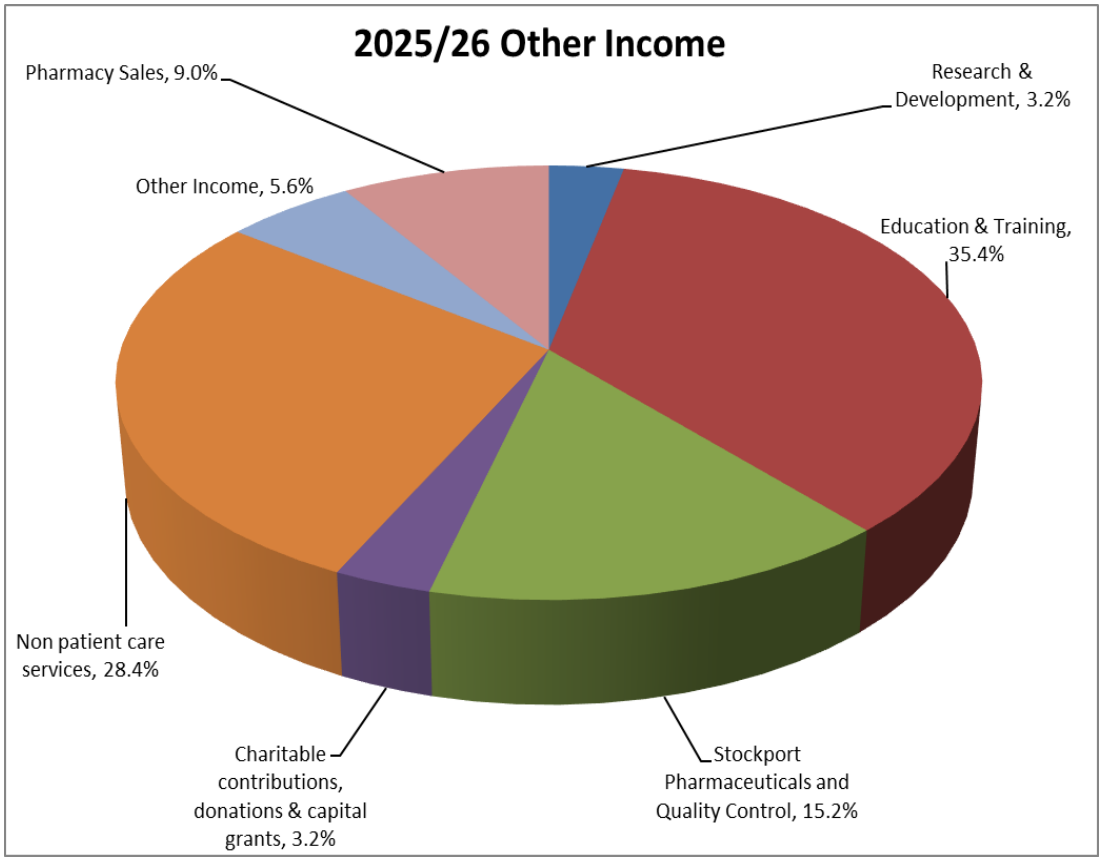
The Trust delivered its financial performance for revenue and capital in accordance with the agreed limits set.

In 2025/26 the Trust continued to invest in improving services for patients, both in terms of the quality and safety of services and investing in buildings and equipment. Total investment through the capital programme in 2025/26 was £30.3m, which included £13.4m on buildings and dwellings. Of this £3.7m was spent on the construction of a new Outpatients building, £1.7m on a newly refurbished Urgent Treatment Centre and £1.5m on final costs for the Emergency and Urgent Care Campus (EUCC). In 2025/26 the Trust also accounted for £0.8m in respect to recognition of leases under IFRS16 of which £0.4m was the lease of the Bluebell Ward at The Meadows after its transfer to Pennine Care NHS Foundation Trust.

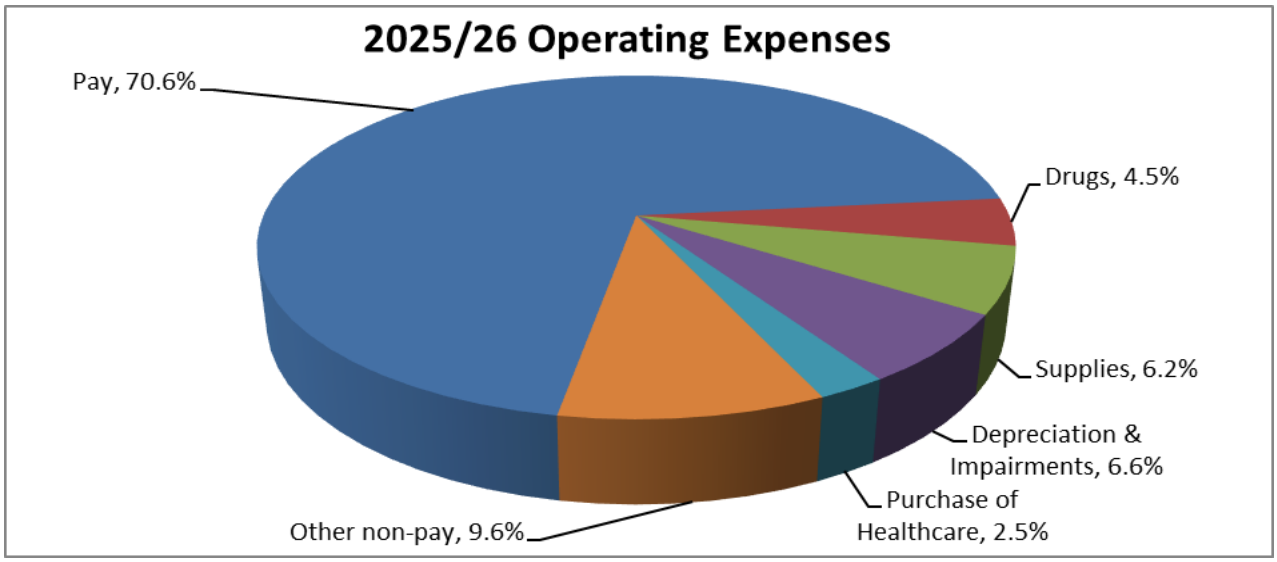
Investments in buildings and dwellings of £3.6m also included key infrastructure works schemes for critical and backlog maintenance such as major pipework replacements, roof replacements and fire safety including doors and fire compartmentation. The Trust spent £6.9m on IT investments including £2.7m on upgrades of network infrastructure, £1.8m on cyber security systems and £1.1m on sitewide device replacement. The Trust invested £9.1m on equipment including £3.7m on diagnostic equipment and £2.6m for a new surgical robot.

Income and expenditure

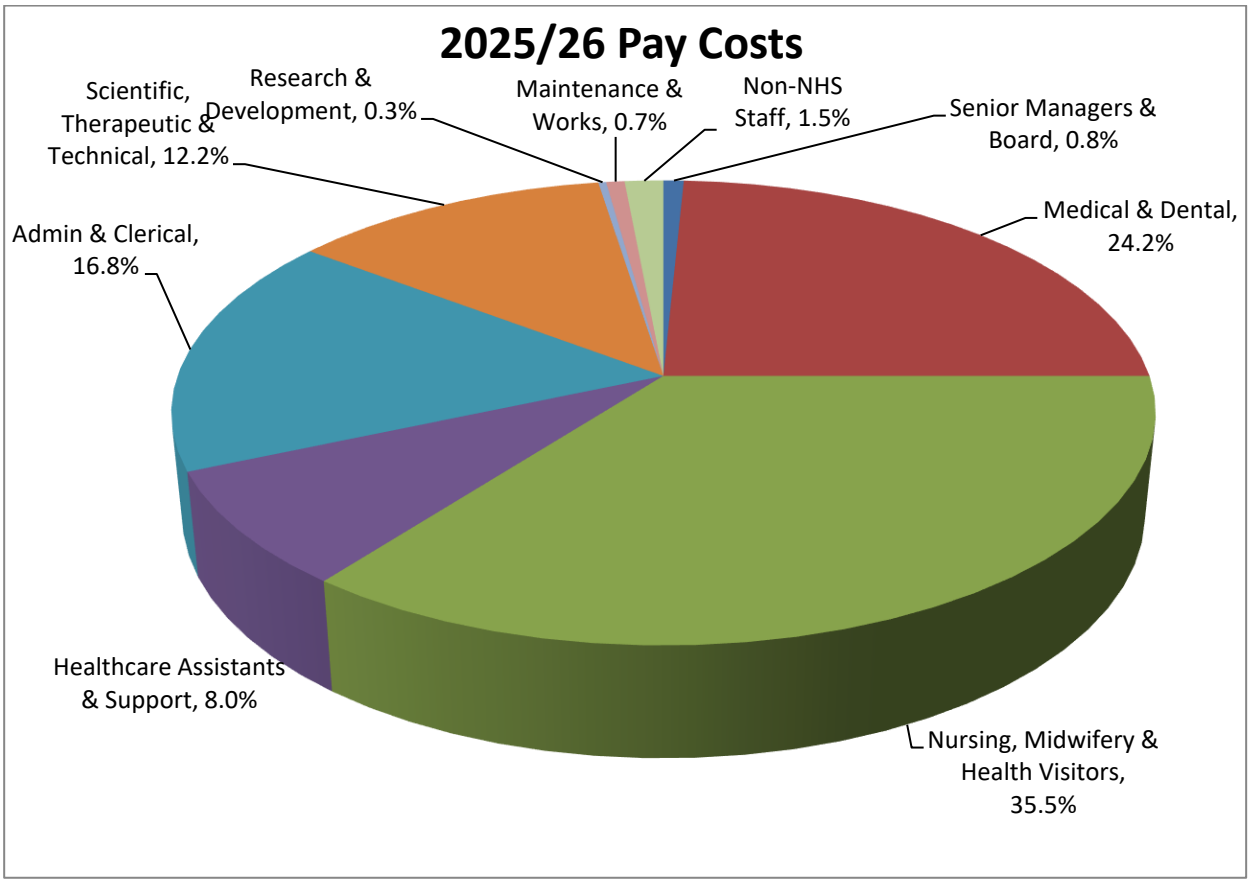
In 2025/26 Trust overall income was £539.9m (£515m in 2024/25). Income from the provision of health services was greater than that from provision of goods and services for any other purpose. The Trust did not receive or make any political donations in 2025/26. Income in 2025/26 is an increase of £24.8m from 2024/25; £23.5m an increase from commissioners, and £2m additional central funding for employer pension contributions. This is offset by a £0.7m decrease in Other Income. The Trust earned income from several different sources and a breakdown of the £42.8m 'Other Income' is provided in the following chart:



Operating expenditure was £551.1m in 2025/26 (£528.8m in 2024/25). Costs are divided into the following areas:



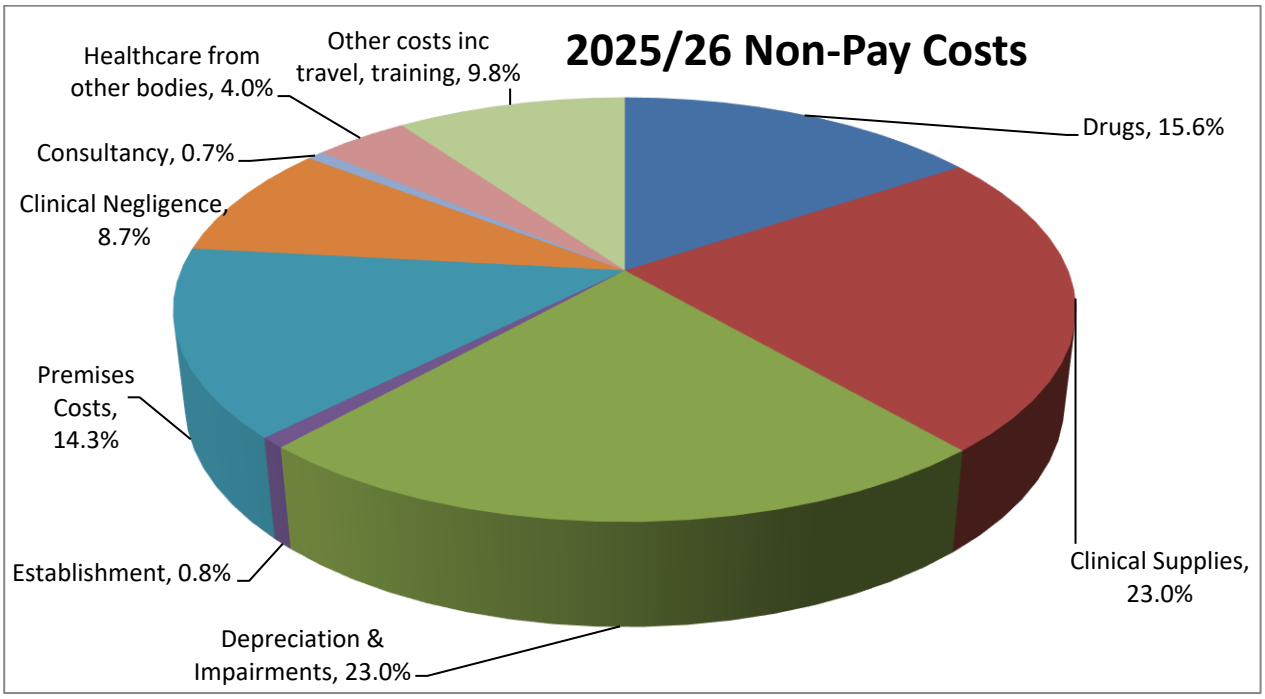
Pay costs account for 71% of operating expenses, and pay is split over the following categories:



Pay costs in 2025/26 were £392.2m (£371.6m in 2024/25). Between 2025/26 and 2024/25 there has been an increase in staff and executive director costs of £21m. This is due to an increase in substantive staff costs of £28m which is partly due to pay award and national

insurance (NI) rate increases (£13m) and partly due to increased substantive staff in post. Partially offsetting this is bank and agency costs which have reduced by £10m because of the increased substantive whole time equivalent (WTE) in post.

Non-pay expenditure of £158.8m in 2025/26 (£157.1m in 2024/25) was incurred, and this is demonstrated by category in the following chart:



Non-pay costs increased overall by £1.7m during 2025/26, which includes increased supplies and service costs (£3.7m) and additional computer hardware investment in 2025/26 (£1.4m). The Trust has also incurred additional spend of £2.3m on premises including electricity, water and gas charges. It also includes £1.1m on computer hardware devices and £1.4m on the Pathology Laboratory Information System (LIMS) in 2025/26. This is offset by a fall in impairments on the Trust's buildings by £2.6m.

Balance sheet

At the end of the year, the Trust had £206.1m in net assets, which is £3.1m less than in 2024/25. The main reasons for the change were:

- Charge to the income and expenditure account of £15.6m for impairments related to the revaluation of the Trust's land and buildings
- Charge to the income and expenditure account of £7m for the transfer of The Meadows land and buildings to Pennine Care NHS Foundation Trust
- £12.1m more in PDC capital funding, due to extra investment agreed for 2025/26
- £2.7m more receivables
- £9.1m more payables
- A £2.9m reduction in long-term liabilities

Because of the rules for the calculation of the Public Dividend Capital (PDC) and current commercial interest rates, it is financially better to keep our cash in the Government banking system. The Trust's year-end cash balance was £42.7m, up from £36.7m at the start of the

year.

Capital creditors increased by £6.8m in 2025/26. The Trust received much of its capital funding in March 2026, and these payments will be settled in April and May 2026.

Charitable funds

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

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

In 2025/26 charitable funds income was £613k and the Trust is extremely grateful for donations of £49k, legacies of £74k, grants from NHS Charities Together of £320k (see below) and fundraising income of £78k. The charity also received £92k investment income.

In 2023/24 Stockport NHS Charity was awarded nearly £1.25 million by NHS Charities Together (NHSCT), the national independent charity caring for the NHS, as the lead Charity for the Greater Manchester ICS Charities, for its Stage Two Community Partnerships programme. This programme will support projects to address health inequalities, mental health and hospital at home services for groups disproportionately affected during the Covid-19 pandemic. The Charity received its final instalment in 2025/26 and £313k was paid out to seven community organisations who were successful in bidding for funds.

In 2024/25 the Charity was also successful in a bid to the NHS Charities Together Greener Communities Fund for £68k and received its final instalment of £7k in 2025/26. The garden was opened in June 2025.

Expenditure in 2025/26 was £749k, including £422k on patient welfare, £188k for capital expenditure and £27k on supporting staff welfare and training activities. Expenditure included:

- £313k for the NHS Charities Together Community Partnerships initiative;
- £177k on furniture, equipment and staff facilities for the new Outpatients building;
- £60k on the Acute Frailty Unit Therapy Garden funded by NHSCT Greener Communities Grant;
- £26k for recognizing staff performance at the Trust Making a Difference Award Ceremony and other national achievement awards offset by £12k of sponsorship;
- £14k for Ultrasound equipment;
- £11k for breastfeeding chairs in the Neonatal Unit; and
- £4.6k for expansion of the Sound Ears noise at night devices in wards

Financial outlook

The Trust has submitted a compliant financial plan for 2026/27 in accordance with national guidance and as part of the Greater Manchester Integrated Care System. The plan has set:

- A breakeven revenue plan (for system reporting purposes) on the basis including an efficiency programme of £26.8m both in year and recurrently and non-recurrent deficit support funding (DSF) of £39.4m.
- An initial capital plan of £30.9m, £15.1m from internally generated funds (CDEL) and £16.7m from provider capital support (PDC) – noting that of the £16.7m PDC £9.8m is for Estates Safety for which we are awaiting final confirmation from NHSE.

The Trust will again receive a share of the nationally allocated CDEL (Capital Departmental Expenditure Limit) envelope, in addition to national PDC (Public Dividend Capital) funding for several schemes.

Set out in the NHS National Planning Guidance, NHS England's (NHSE) key planning assumptions for 2026/27 are outlined in the "Medium Term Planning Framework – delivering change together 2026/27 to 2028/29," which focuses on a three-year horizon rather than single-year plans. The framework aligns with the "10 Year Health Plan" and aims to shift care from hospital to community, analogue to digital, and sickness to prevention, alongside significant financial and operational reforms. NHS trusts are required to submit financial plans for 2026/27, 2027/28 and 2028/29 at organisation level only (previously at a system level). The overall priorities in 2026/27 continue to be improvements in elective and urgent care long waits and improved cancer and community performance. There is also a new focus on the implementation of neighborhood health teams for care closer to home.

The Trust continues to challenge and examine opportunities to manage and reduce costs to make the NHS affordable and is committed to delivering a challenging 5% efficiency programme for 2026/27.

Capital Planning 2026/27

The Trust is planning capital expenditure of £30.921m in 2026-27, dependent on the final Greater Manchester Integrated Care System (ICS) agreed capital allocation and release of external capital funding including Front Line Digitisation, Estates Safety and Elective Recovery.

A summary of planned investments is as follows:

Capital Description	CDEL Allocation £m	Public Dividend Capital £m	Total Capital Allocation £m
Estates	£9.714	£10.485	£20.199
Digital	£1.585	£5.583	£7.168
Equipment	£1.617	£0.675	£2.292
IFRS16 Lease Implications	£1.262	-	£1.262
2026/2027 Total	**£14.178**	**£16.743**	**£30.921**

Key priorities for 26/27 are;

- Development of an Electronic Patient Record (EPR)

- Development of a new Pathology lab
- Development of a Macmillan Information Centre
- Refurbishment of Lifts
- Site wide infrastructure improvements

There is a significant challenge to address growing estate critical infrastructure and backlog maintenance as well as replacement of ageing equipment and IT infrastructure to keep services safe and operational for patients, staff, and the public. The Trust is committed to the development and delivery of the estate strategy, and delivery of capital priorities.

Strategic Developments

Digital

The Trust's digital strategy includes the implementation of a comprehensive Electronic Patient Record (EPR) in collaboration with TG ICFT. The EPR contract was signed in March 2026 with all functionalities due to be live by October 2027. The implementation of an EPR is essential in enabling the Trust to improve efficiency and quality of care by replacing multiple clinical systems and bringing information into one comprehensive system, providing clinicians with real-time access to a complete patient record.

Implementation of a new LIMS (Laboratory Information Management System) for our hospital's pathology services, is leading to faster diagnosis and treatment for patients.

New digital and AI-enabled services are being introduced across the Trust to improve efficiency and patient care. Within radiology, artificial intelligence (AI) is being implemented, with the introduction of Lucida, which supports quicker and more accurate detection of prostate cancer. Several new projects have also commenced to digitise paper-heavy processes, including the rollout of electronic pre-operative assessments and the development of a test tracking system. The Trust continues to explore improvements in clinical documentation through advanced dictation tools. As part of this work ambient voice technology provided by Heidi will be piloted within Occupational Health Services, and Lyrebird will be piloted within Community Services. These initiatives aim to streamline workflows, improve turnaround times, and allow clinicians to spend more time focused on patient care.

Estates & Facilities

The Stepping Hill Hospital estate continues to present a significant challenge, due to the age, scale and condition of the site. In 2024, a comprehensive block-by-block condition survey was completed, to inform risk management, statutory compliance, and capital investment planning. This evidence base continues to guide operational priorities and longer-term strategic decision-making, with patient safety remaining the principal driver.

During late 2025, work commenced on the development of a Strategic Estate Vision (SEV) to establish a realistic, phased approach to the redevelopment of the Stepping Hill site. The SEV focuses on addressing known estate challenges through short, medium and long-term solutions and will support future site-wide development planning.

Significant capital investment has been delivered to support clinical services and improve safety. During the year, 29 capital schemes were completed, many of which focused on the replacement of high-risk critical infrastructure, including electrical, pipework and chiller upgrades.

The Emergency and Urgent Care Campus (EUCC) was fully completed in May 2025 and represents the Trust's largest and most complex capital project to date. The scheme has delivered a significant improvement in facilities for patients and staff and has received national recognition, including being shortlisted for Construction News Project of the Year and receiving a highly commended award for social value. A Changing Places facility was subsequently delivered on site, supported through contractor and Trust charity funding. Key clinical projects delivered or progressed also included continued development of the Macmillan Information Centre and the new outpatient building was completed and became operational in September 2025, enabling all outpatient services previously displaced by the loss of Outpatients B Department to return to Stepping Hill. The facility has received positive feedback from patients, staff and NHS England.

Maintaining an exemplary Catering Service remains a top priority, reflecting the diverse dietary needs and cultural preferences of our patients. With a strong reputation for excellence, the Catering Service continues to serve as a benchmark for high-quality healthcare food provision. The department currently retains its exemplar status and submitted its renewal application in early 2026. The team remains committed to delivering value for money, operating within budget, minimising waste, and providing fresh, tasty, nutritionally balanced meals for inpatients, staff, and visitors. Between October 2025 and April 2026, the Trust's Catering Team received significant national recognition. Joe Omolo, Apprentice Assistant Head Chef, was named joint winner of NHS Chef of the Year in October 2025. In April 2026, the Catering Team was awarded Public Sector Catering Team of the Year, and Catering Lead Erica Bell received the Hospital Caterers Association Caterer of the Year award.

The Portering Service continued to improve efficiency during 2025/26 through the effective use of an electronic task allocation system. This has enhanced rota management, improved staff deployment, and contributed positively to patient flow and overall patient experience.

The National Standards of Cleaning (2021 and 2025) remain embedded across the Trust, supported by strong collaboration between domestic and clinical teams and close partnership with the Infection Prevention and Control team. High cleaning standards were consistently maintained throughout the year despite significant winter pressures, with any short-term quality concerns addressed quickly. Cleaning performance scores continue to be displayed at ward and department entrances.

Waste segregation performance showed positive progress despite high winter infection rates impacting achievement of year-end targets. Compared with 2024/25, infectious incineration waste reduced, offensive waste increased by 8 tonnes, and overall waste was reduced by 13 tonnes compared with the previous winter. Domestic waste increased from 541 to 553 tonnes, reflecting improved segregation and removal of domestic waste from clinical streams. This progress supports readiness for future implementation of the 'Simpler Recycling' legislation across the Trust.

During the year, the Trust continued to strengthen service delivery through improvements to systems, policies, procedures and training, ensuring safe, efficient and compliant operations. The introduction of a new Computer Aided Facilities Management (CAFM) system in 2023/24 has now generated sufficient multi-year data to enable meaningful performance monitoring. This data is reviewed monthly to identify workflow pressures and process bottlenecks, supporting ongoing improvements to efficiency and user experience.

Enhanced governance arrangements have been implemented across operational engineering and compliance functions, including new and updated policies and procedures aligned to regulatory requirements. A standardised pre-commencement assurance process for external contractors has been embedded, providing confidence that all contractors operate to consistent health and safety standards in line with HSE guidance.

Progress against best-practice estate and infrastructure management remained strong during the year. Key achievements included full Trust coverage with in-date Electrical Installation Condition Reports (EICR), the appointment of a Ventilation Authorising Engineer to strengthen long-term ventilation assurance, and completion of a comprehensive review of boiler house steam-raising plant. This review included the development of a Technician Risk Assessment, representing an important step towards achieving BG01 compliance.

Building on a successful 2024/25, the Trust's Decontamination Services continued to deliver safe, reliable and high-quality care throughout 2025/26, with a clear focus on patient safety and quality outcomes. Both the Hospital Sterilisation and Decontamination Unit (HSDU) and the Endoscopy Decontamination Unit (EDU) achieved British Standards Institution (BSI) accreditation, providing strong assurance around quality and compliance. Both services passed with minimal non-conformances, an exceptional outcome for such a rigorous audit process. In addition, the EDU maintained green status following its Joint Advisory Group (JAG) annual accreditation.

Car parking has been a major challenge for both patients and staff over recent years. The Trust approved and began implementation of its revised Car Parking Strategy during the year, aiming to improve safety, efficiency and access for staff, patients and visitors while managing demand. Key progress included strengthened parking controls, revised policies and tariffs, and significant staff engagement. Approximately 250 temporary additional parking spaces were delivered to ease capacity pressures, alongside improved enforcement arrangements. Work continues on longer-term solutions, including development of a proposed multi-storey car park, which is central to future improvements in traffic flow and parking management.

Sustainability

According to the Met Office, 2025 was the hottest year on record in the UK, with increasingly extreme weather including periods of drought and flooding. These trends reflect the impacts of climate change and highlight the urgent need to reduce carbon emissions and address related health inequalities.

In August 2025, the Board approved a Joint Green Plan with TG ICFT, aligning priorities and building on previous commitments to accelerate progress towards net zero. The Plan focuses on embedding long-term transformation so that sustainable healthcare becomes standard practice, supported by ten key workstreams with actions over the next three years. Delivery

has been strengthened through the appointment of a Joint Sustainability Officer in June 2025, increasing capacity to drive progress and raise workforce awareness. Key updates for 2025/26 for each workstream in the plan are set out below.

Workforce and System Leadership
During development of the Joint Green Plan, it was agreed that the Trust's Net Zero lead and Chair of the Joint Green Plan Delivery Group would be a Board member. The Chief Finance Officer was appointed to this role and chaired the Delivery Group throughout 2025.

To support staff engagement, 'Building a Net Zero NHS and Carbon Literacy' training was made available in January 2026 and promoted across the organisation. In addition, the Trust's job description template is being revised to reflect staff responsibility for supporting the aims of the Joint Green Plan and the NHS net zero ambition.

Net Zero Clinical Transformation
The Trust continues to support delivery of the Greater Manchester Combined Authority (GMCA) ECO4 Flex programme, enabling energy-efficient home retrofits through health-based referrals. Since its launch in 2024, almost 500 installations have been completed in Stockport, including more than 150 in the current reporting year, delivering an estimated 3,375 tCO_2e saving. These measures improve warmth and energy efficiency in homes, support better health outcomes, particularly for residents with respiratory and cardiovascular conditions, and contribute to reduced demand on health services and Greater Manchester's net zero ambitions.

During 2025, a range of clinical transformation initiatives supported reduced patient travel, more efficient care pathways, and lower associated carbon emissions, while also improving patient experience and outcomes. Within the Division of Surgery, early assessment and treatment in Pain Management Services enabled earlier diagnosis and more sustainable long-term management, while a one-stop clinic for Lower Urinary Tract Symptoms reduced repeat attendances. The introduction of a surgical Same Day Emergency Care (SDEC) model has reduced emergency department waits, admissions, lengths of stay, and resource use. The Clinical Support Division expanded bowel cancer screening and introduced direct access to investigations, supporting earlier diagnosis and reducing unnecessary journeys. In the Medicine and Urgent Care Division, a supported discharge programme reduced stroke ward length of stay from 36 to 26 days, lowering resource use and emissions. Virtual cardiology clinics have also been introduced to reduce travel-related emissions, alongside wider transformation work to reduce waiting lists.

The Emergency Department at Stepping Hill Hospital is working towards Royal College of Emergency Medicine sustainability accreditation in line with GreenED goals. Key projects include switching intravenous medications to oral alternatives where clinically appropriate. Early audit results show a saving of 113 kg CO_2e per month from paracetamol alone, with further reductions expected due to repeated dosing during prolonged attendances. This initiative is now being rolled out across the wider Trust. Additional GreenED work includes reducing unnecessary blood tests and cannulation, exploring reusable suture kits and tourniquets, replacing plastic cups with paper alternatives, developing a green growing space, and introducing QR codes for patient information leaflets, significantly reducing paper usage.

Digital Transformation
All redundant IT equipment is collected for reuse or recycling, saving an estimated 2.93 tCO_2e in 2025. The Trust has migrated from legacy IT systems to more energy-efficient platforms, removing 40 on-site servers and moving to virtual servers with lower energy demand. A printer and desktop rationalisation programme has reduced the printer estate from 400 inefficient devices to 250 more efficient printers, with a projected 39% reduction in printing-related carbon emissions. The rollout of Virtual Desktop Infrastructure across the Trust has further reduced power consumption while extending the lifespan of desktop hardware and reducing electronic waste.

Medicines
Reducing the use of volatile anaesthetic gases remains a Trust priority. Desflurane has not been used since 2022, and sevoflurane is now the only volatile anaesthetic in use. From April to December 2025, sevoflurane usage reduced compared with the same period in 2024, delivering an estimated carbon saving of 15.7 tCO_2e.

Data Period	Sevoflurane Litres Used	Emissions (tCO_2e)
April – December 2024	210 litres	56.7 tCO_2e
April – December 2025	184.5 litres	41 tCO_2e

The Trust continues to reduce nitrous oxide usage following the capping of multiple manifolds in December 2024. Comparing April to December 2025 with the same period in the previous year, usage reduced by 23,400 litres, delivering an estimated saving of 10.61 tCO_2e. Discussions are now underway to explore the removal of the remaining maternity manifold in 2026, which would enable further reductions.

Data Period	Nitrous Oxide Litres Used	Emissions (tCO_2e)
April – December 2024	82,800 litres	39.71 tCO_2e
April – December 2025	59,400 litres	29.1 tCO_2e

The Trust continues to monitor the use of Entonox, with emissions for the period April to December 2025, 52.7 tCO_2e less than the same period last year.

Data Period	Entonox Litres Used	Emissions (tCO_2e)
April – December 2024	2,448,624	608.3 tCO_2e
April – December 2025	2,236,584	555.6 tCO_2e

The Trust continues to drive the move to low carbon respiratory care by promoting the use of dry powder inhalers over metered dose inhalers. The table below shows the number of each type of inhaler prescribed between April 2025 and January 2026 and compares it to the same period last year.

	Inhaler Type	April 24 to Jan 25 (Number)	April 25 to Jan 26 (Number)	Difference (Number)
Bronchodilators (0301)	Dry Powder Inhaler	860	800	-60
	Metered Dose Inhaler	4,029	3,523	-506
	Soft Mist Inhaler	187	187	0
Corticosteroids (respiratory) (0302)	Dry Powder Inhaler	718	861	143
	Metered Dose Inhaler	1,778	1,699	-79

This generates a reduction in emissions from inhalers for this period of 7tCO_2e when compared to the same period in 2024/25.

Data Period	Emissions (tCO_2e)
April 24 – January 25	80 tCO_2e
April 25 – January 26	87 tCO_2e

Pharmacy has supported the Greater Manchester *Only Order What You Need* campaign, encouraging the return of medicines for safe disposal. To further support this, four inhaler collection bins will be introduced in Q1 2026/27 and promoted through patient communications and prescribing information.

Pharmacy teams have also been working with the Royal Pharmaceutical Society Greener Pharmacy Toolkit, achieving Bronze status and commencing work towards Silver. To improve the use of patients' own medicines, elective surgical patients are provided with green bags at pre-operative appointments to bring their medicines into hospital. The Emergency Department is also promoting green bag use to ensure medicines are transferred with patients on admission to wards.

Travel and Transport

Travel and transport are a significant source of air pollution and emissions, and the Trust remains committed to reducing their impact to support population health. To monitor progress, the Trust repeated its staff travel survey in September 2025, with almost 400 responses received.

Compared with 2024, the results show positive shifts in travel behaviour. While overall use of motorised vehicles remained stable, active travel increased by 4%. There was a 4% reduction in petrol and diesel vehicle use alongside a corresponding increase in electric vehicles. Home working increased by 4%, with a 3% reduction in staff regularly travelling to other sites. Among those who cycle to work, electric bike use increased by 2%, and use of changing facilities increased by 12%.

In January 2026, the Trust secured £28,000 from the NHS Electric Vehicle Charger Scheme to support fleet decarbonisation. This funding enabled the installation of nine 7kW electric vehicle charge points, completed in March, providing essential infrastructure to support the transition to electric vehicles in line with the NHS Net Zero Travel and Transport Roadmap.

Supply Chain and Procurement
In 2025/26, almost 1,800 walking aids were returned through the walking aid reuse scheme, with 74% cleaned, refurbished and reissued. This delivered a carbon saving of 23.15 tCO_2e over the year.

Sustainability and social value continue to account for 10% of the scoring in all Trust tenders, and this is now delivering measurable carbon savings. One example is the Blood Sciences department, which achieved My Green Lab Gold Certification in October 2025. This internationally recognised standard reflects the department's commitment to reducing energy use, cutting waste and using resources more efficiently across Biochemistry and Haematology. The project was funded and supported by Siemens as part of their social value commitment and delivered tangible environmental benefits. For example, redundant reagents were reused by another Trust rather than disposed of, saving 0.42 tCO_2e.

During the year, several other tenders included a 10% social value and sustainability weighting, including enteral feeds, taxi services, disposable products and IT end-user devices. Performance against sustainability commitments will now be monitored throughout these contracts.

The Trust has also introduced reusable theatre hats to replace single-use versions. In 2024/25, 69,720 disposable hats were purchased. While the exact carbon saving has not yet been calculated, studies show reusable theatre hats have a significantly lower carbon footprint, typically 56% to 79% lower, due to reduced manufacturing and disposal impacts compared with disposables.

Food and Nutrition
In May 2025, the Trust introduced a new digital system to record food waste, replacing a manual process and improving data accuracy. The system has been used to track untouched meals and identified that 6.6% of food waste in October came from meals that were not consumed, indicating over-ordering by wards and departments. High levels of untouched meals were identified in A&E. In response, plated evening meals have been removed and replaced with hot soup flasks, which is already reducing evening food waste.

Work has also been undertaken to reduce the carbon impact and cost of meat dishes while improving nutrition. Five dishes have been redesigned: two are now fully plant-based, and three use a 60% meat and 40% pea protein blend. Carbon and nutritional benefits are currently being quantified.

Estates and Facilities
The main heating system at Stepping Hill Hospital is an ageing, gas-fired steam system and is the Trust's largest directly controlled source of carbon emissions, accounting for around 55% of total emissions. To meet the NHS net zero target by 2040 and the Trust's Green Plan commitment by 2038, decarbonising heat is a priority. In 2025, the Trust worked with the Carbon and Energy Fund to look at ways to reduce carbon emissions at the Stepping Hill site. This included exploring whether the hospital could connect to the new heat network being developed by Stockport Council.

Alongside strategic planning, a number of energy efficiency improvements have been delivered. Since April 2025, five 25-year-old mortuary fridges have been replaced with modern, energy-efficient models. The new fridges are significantly more efficient, with up to 46% better performance than comparable units, delivering substantial energy savings. Two ageing laboratory chillers at Quality Control North West have also been replaced due to inefficiency and reliability issues.

A rolling lift replacement programme has started following a £650,000 investment. Two lifts have been replaced this year with smart lifts featuring eco-modes to minimise energy use while maintaining performance. In addition, 42 single-glazed windows on wards have been replaced with double-glazed units to reduce heat loss.

Working with the Trust's laundry provider, Elis, linen returns have improved from 92% to 98%. This has been achieved through better staff awareness of linen handling and bagging, reducing items lost to waste streams and allowing more textiles to be upcycled or repurposed.

Climate Change Adaptation
The Trust continues to work closely with the GM ICB to plan for the impacts of climate change, including higher temperatures, storms and heavy rainfall and a Greater Manchester Climate Change Adaptation Plan has been drafted, alongside this, a Trust-specific risk assessment template is being developed to identify and manage local climate risks.

Climate adaptation is considered in all major redevelopments and new builds. All capital projects procured in 2025 included building management systems, allowing heating and cooling to be monitored and controlled more effectively to respond to changing climate conditions.

Nature For Health
The Trust secured funding in 2024/25 to appoint a Nature Recovery Ranger for two years from April 2026. A programme of work has been developed with support from the Centre for Sustainable Healthcare. The Ranger will assess opportunities to improve biodiversity across Trust sites and lead activities that encourage staff, patients and visitors to engage with green spaces and benefit from their positive health impacts.

In September 2025, Contract Managers took part in a corporate social responsibility day with the charity Signpost for Carers, supporting gardening work to improve outdoor spaces for carers. This activity contributed to community wellbeing and delivery of the Trust's Green Plan nature recovery objectives.

Performance Update
Whilst it is not a mandated requirement to publish performance data in this annual report, it is considered good practice. The data for 2025/26 includes estimated figures for the later months and is therefore subject to minor change.

The data is reported by emissions source and includes scope 3 emissions associated with each source. This is in line with Greener NHS guidelines, as it allows the Trust to understand the total emissions from each source that can be controlled.

Emissions Source	Total tCO_2e							Trend from 2019/20 to 2024/25
	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	
Electricity	3,874	3,488	3,815	3,368	3,722	3,911	3615	↓
Gas	6,877	6,525	7,033	6,638	6,034	6,596	6526	↓
Other Energy	0	383	383	237	2	171	171	↔
Refrigerant Gases	No Data	No Data	No Data	22	6	15	59	unknown
Waste	322	335	361	336	298	265	191	↓
Water	190	197	97	107	126	106	114	↓
Medical Gases	1,280	1,296	1,148	1,179	1,105	859	779	↓
Inhalers	No Data	61	No Data	151	114	103	96	unknown
Business Travel	No Data	197	No Data	No Data	361	340	286	unknown
Fleet	62	81	60	46	36	24	40	↓
Total	**12,605**	**12,564**	**12,896**	**12,085**	**11,803**	**12,391**	**11878**	↓

The data shows a downward trend in the total emissions measured when compared to the baseline year of 2019/20 and shows further progress has been made in 2025/26 compared to 2024/25. Gas and electricity usage is responsible for a large proportion of the Trust emissions and the work outlined to decarbonise the hospital will enable the Trust to make progress at scale in this area.

Priorities for 2026/27

The following high-level priorities have been identified for 2026/27:

- Procure a strategic decarbonisation partner through the Carbon and Energy Fund to reduce gas and electricity emissions at Stepping Hill Hospital
- Explore removal of the nitrous oxide manifold from Maternity Theatres and further reduce Entonox use across the Trust
- Embed Green Plan requirements into core strategic processes, including Quality Improvement projects and business case templates
- Refresh the Trust Travel Plan in line with the NHS Net Zero Travel and Transport Roadmap
- Introduce monitoring and reporting of supply chain emissions
- Implement recycling collections in line with Simpler Recycling guidance
- Improve on-site biodiversity and deliver nature-based activities through the Nature Recovery Ranger role
- Introduce monitoring of carbon emissions from patient and restaurant menus
- Secure approval of the Greater Manchester Climate Adaptation Plan and complete a Trust-specific risk assessment
- Build on net zero clinical transformation by strengthening prevention, patient self-care, lean service delivery and low-carbon alternatives

Task Force on Climate-related Financial Disclosures (TCFD)

NHS England's NHS foundation trust annual reporting manual adopted a phased approach to incorporate the TCFD recommended disclosures as part of sustainability annual reporting requirements for NHS bodies, stemming from HM Treasury's TCFD aligned disclosure guidance for public sector annual reports. TCFD recommended disclosures are as interpreted and adapted for the public sector by HM Treasury. Local NHS bodies are not required to disclose scope 1, 2 and 3 greenhouse gas emissions under TCFD requirements as these are computed nationally by NHS England.

The Trust recognises climate change as a principal risk for the organisation when viewed through the TCFD framework. Aligned to the national Net Zero NHS requirements and Greater Manchester's ambition to reach carbon neutrality by 2038, the Trust is taking coordinated action with TG ICFT to reduce emissions, improve climate resilience, and embed sustainability across all services. This approach is outlined in the Joint Green Plan published in August 2025.

Governance

The Board maintains oversight of climate related issues through Annual Green Plan Progress Reports and biannual scrutiny by the Finance & Performance Committee. Delivery of the Green Plan is led by the Joint Green Plan Delivery Group, chaired by the Net Zero Board Lead (Chief Finance Officer). Operational delivery is driven by the Director of Estates and Facilities, supported by the Sustainability Manager and Sustainability Officer. Governance arrangements are detailed within the Trust's Green Plan. The Green Plan also highlights Workforce and System Leadership actions that are currently in progress, that will strengthen future sustainability governance arrangements in the organisation.

Strategy

In order to manage climate related risk the Trust has a number of strategies in place that support the journey to net zero and set out the strategic direction for the trust in relation to sustainability:

- Joint Green Plan 2025–2028: This document contains a clear action plan that details how the Trust will reduce emissions from its operations and progress toward the net zero target.
- Heat Decarbonisation Plan: Provides a roadmap to decarbonising the estate.
- Green Travel Plan: Details how the Trust will promote the shift to more sustainable travel options.
- Greater Manchester Climate Adaptation Plan (draft) – Sets out high level climate risks to the health sector across GM, based on the UK Government's Climate Change Risk Assessment and informed by extensive GMCA led stakeholder engagement. Following publication of the Plan, the Trust will produce a local action plan to mitigate the risks identified.

The Trust works closely with other key organisations across GM to join up thinking and support progress around climate related matters. Key stakeholders include the GMCA, NHS GM, the Council and other Trusts.

Risk Management

Failure to deliver the Green Plan, meet Net Zero targets and prepare for the impacts of climate change is recognised as a Board Assurance Framework (BAF) risk due to the potential impact on population health. Progress against this risk is reported quarterly to the Finance & Performance Committee to provide assurance and oversight of mitigating actions. The Joint Green Plan Delivery Group oversees programme-level risks and ensures these are reflected in BAF updates where required.

During 2025, the Trust has worked with NHS GM and partner Trusts to develop a system-wide Climate Adaptation Plan. The draft plan identifies climate-related risks at system level, aligned with the UK Climate Change Risk Assessment and GMCA regional risks. The plan is nearing

completion and will be supported by a Trust-specific action plan to address local climate risks and develop metrics to monitor the impact of extreme weather.

From an Emergency Preparedness, Resilience and Response (EPRR) perspective, the Trust recognises that climate change increases the risk of heatwaves, flooding and severe weather. These risks are considered through the Trust's risk assessment processes, informed by the Greater Manchester Community Risk Register. The Trust contributes to multi-agency resilience planning through the GM Resilience Forum, ensuring climate risks are reflected in emergency preparedness and business continuity planning. The Green Plan sets out the actions the Trust is taking to adapt its estates and services to manage the risks associated with climate change.

Metrics and Targets
The Green Plan sets out the data collected to monitor progress and how often this data is reviewed. Performance measures and targets are also detailed and progress against the Plan is reported annually through an annual report, which is presented to the Board.

Conclusion
The Trust is committed to embedding sustainability in all aspects of healthcare delivery, strengthening climate resilience and reducing emissions across estates, clinical services, supply chains and workforce practices.

Partnerships & Collaboration

Collaboration with Tameside & Glossop Integrated Care NHS Foundation Trust (TG ICFT)

As referenced throughout this report, we have continued to expand on the strategic and operational collaboration with colleagues at TG ICFT by progressing the development of a new joint strategic framework that includes a new joint organisational strategy, joint quality strategy and joint clinical strategy; established our new joint corporate governance arrangements; and taken forward the integration of our corporate services.

Tameside and Stockport Clinical Collaboration (TASCC)

Over the past year clinical colleagues at SFT and TG ICFT have worked together to develop a new joint clinical strategy, setting out how our clinical teams will collaborate over the coming years to:

- deliver better outcomes for patients
- offer staff greater flexibility to develop their skills and experience
- improve recruitment and retention
- ensure high-quality and sustainable services for the communities we serve
- and make the best use of available resources.

Four clinical areas have been chosen to establish a basis for our initial collaboration:

- Gastroenterology teams are looking to reduce waiting times through joint management of resources, create sustainable services that meet the growing number of referrals seen in the area and optimise joint rotas for some services.
- Radiology teams have already made significant savings through joint procurement of reporting services, implemented a new Community Diagnostics Centre to meet growing demand for imaging and reduced waiting times at the Trusts.
- Pharmacy teams have been working together to share learning and resources, including creation of a joint posts across the two Trusts.
- Pathology teams have focussed initially on joint working in medical microbiology services, which has resulted in jointly recruited consultant posts and a joint operational lead as part of a single managerial and leadership structure.

A review has commenced of all the clinical services delivered by both Trusts to inform new models of care for each service that builds on the shared knowledge and learning and moves to delivering single services across both sites or services on just one of the two sites.

Joint Operational Planning

The Trust has put in place a joint operational planning approach with TG ICFT, based on a shared commitment to improving outcomes for our populations by working more closely across organisations.

In response to the new NHS 10-Year Plan, the Trusts have aligned strategic, operational and financial planning , resulting in a shared understanding of need, capacity and priorities. The Trusts use the same data and information to inform decisions about where to focus effort and investment. Early involvement of clinical, operational and corporate teams has helped ensure plans focus on reducing unwarranted variation, making best use of shared resources and delivering services at scale where this adds most value. This joint approach

has enabled a consistent response to national and system priorities while still meeting local needs and provides a strong foundation for more sustainable services and deeper integration over time.

System Partnerships
The Trust has continued to play an active role in the ongoing development of the GM ICS, as major reform has taken place. Our Chief Executive is chair of the Trust Provider Collaborative (TPC), which represents all GM providers. TPC has responsibility for the oversight of several work programmes to help reduce unwarranted variation and inequality in health outcomes by improving access to services and experience and improving resilience.

The Trust continues to operate in partnerships across GM through the network of professional groups (e.g. Directors of Strategy, Chief Operating Officers, Medical Directors, Chief Nurses & Directors of People).

The Trust has taken an active role in the continued development of the work programmes that contribute to improved outcomes for patients within the locality in particular the development of the Live Well programme and the approach to neighbourhood health as described in the 10 Year NHS Health Plan with Stockport locality being one of the few areas included in the national neighbourhood health programme.

Children's Therapy Service
The Trust was successfully awarded a contract to deliver Children's Therapy services within the Stockport Locality, enabling implementation of a fully integrated model to complement our existing provision. This has enabled all children's therapy provision to be provided by the Trust with targeted support in early years resulting in children starting school meeting their potential and reducing the specialist need at school age.

Accountability Report

Directors' Report

The Board of Directors brings together a broad range of skills, experience and expertise to support the effective governance of the Trust. The Board is responsible for setting the Trust's vision, culture and strategic direction, ensuring the organisation is well led, financially sustainable, and effectively manages risk in the delivery of its objectives.

Day-to-day management of the Trust is delegated to the Chief Executive and Executive Directors. Decisions are taken in accordance with the Scheme of Reservation and Delegation and the Standing Financial Instructions, which clearly set out matters reserved for the Board and those delegated to Board committees or management.

In line with its succession planning arrangements, the Board regularly reviews its size, balance and composition, including when vacancies or reappointments arise. This ensures that the Board maintains an appropriate mix of skills, experience and perspectives to address both current priorities and future challenges.

During the year, SFT and TG ICFT developed plans to adopt joint corporate governance arrangements from 1 April 2026, including the establishment of a Joint Board (a Joint Committee). Legal advice confirmed that, to exercise the full range of permissible functions, the Joint Board should comprise all Executive and Non-Executive Directors from both statutory Boards.

A comprehensive review of Board composition was undertaken by the Trusts' Remuneration Committee, supported by the Councils of Governors' Nominations Committee. The review considered the skills, experience and independence required to support joint working, developing governance arrangements and forthcoming strategic challenges. The outcomes of this review, alongside planned retirements and standing downs, informed changes to Board membership effective from 1 April 2026. The Board considers that its composition provides a balanced and effective combination of skills and expertise, including partnership working, strategic change, financial oversight, commercial and digital capability, while maintaining a manageable Board size.

Throughout 2025/26, the Board maintained an appropriate balance between Executive and Non-Executive Directors and collectively provided effective leadership, strategic direction and oversight of performance.

Executive Directors are appointed by the Non-Executive Directors, with their remuneration, terms and conditions determined by the Remuneration Committee. The Chair and Non-Executive Directors are appointed by the Council of Governors, with their remuneration, terms and conditions determined by the Nominations Committee.

All Non-Executive Directors are considered to be independent. Independence is reviewed annually through a formal declaration process, supported by reviews of interests and performance, with a summary reported at a public meeting of the Board.

The criterion for determining independent includes:

- has been an employee of the trust within the last two years
- has, or has had within the last two years, a material business relationship with the trust either directly or as a partner, shareholder, director or senior employee of a body that has such a relationship with the trust
- has received or receives remuneration from the trust apart from a director's fee, participates in the trust's performance-related pay scheme or is a member of the trust's pension scheme
- has close family ties with any of the trust's advisers, directors or senior employees
- holds cross-directorships or has significant links with other directors through involvement with other companies or bodies
- has served on the trust board for more than six years from the date of their first appointment
- is an appointed representative of the trust's university medical or dental school.

Board Attendance

During the year the Board of Directors met 10 times, including 7 in public session.

High-level biography of individual directors during 2025/26 and their attendance at Board meetings is set out below:

Director	Attendance at Board Meetings
Chair & Non-Executive Directors	
David Wakefield, Joint Chair Appointed 1 April 2025 to 31 March 2028. A qualified accountant and has held several senior executive posts, including Commercial Finance Director for Royal Mail, previous chair roles at NHS Trusts, and a number of non-executive directorships.	10 of 10
Dr Marisa Logan-Ward, Non-Executive Director Appointed 1 August 2019 to 31 July 2022. Re-appointed 1 August 2022 to 31 July 2025 A biomedical scientist with senior level experience in the health sector. Marisa was also Deputy Chair and the Interim Chair from 1 January 2024 to 31 March 2025. Marisa stood down as a Non-Executive Director on 31 July 2025.	4 of 4
Dr Samira Anane, Non-Executive Director Appointed 1 September 2022 to 31 August 2025. Re-appointed 1 September 2025 to 31 July 2026. A practicing GP, with nearly two decades' experience of working within the NHS. Samira stood down as a Non-Executive Director on 31 March 2026.	8 of 10
Anthony Bell, Non-Executive Director Appointed 1 May 2021 to 30 April 2024. Re-appointed 1 May 2024 to 30 April 2027. A senior qualified accountant, with significant executive experience in the	8 of 10

private and education sectors.	
David Curtis MBE, Non-Executive Director Appointed 1 August 2025 to 31 July 2028. A mental health and general nurse, with significant experience in senior clinical and managerial positions in mental health, acute and community services and in nurse education.	6 of 6
Beatrice Fraenkel, Non-Executive Director Appointed 4 January 2023 to 3 January 2026. A qualified industrial design engineer and ergonomist with over 30 years' experience in regeneration, housing, health and regulation. Beatrice stood down as Non-Executive Director on 31 December 2025.	6 of 8
David Hopewell, Non-Executive Director Appointed 1 July 2018 to 30 June 2021. Re-appointed 1 July 2021 to 30 June 2024. Re-appointed 1 July 2024 to 30 June 2025. Re-appointed 1 July 2025 to 30 June 2026. A Fellow of the Institute of Chartered Accountants and experienced accountant having worked at a senior level in the private, public and charity sectors. David was also Chair of Audit Committee. David stood down as a Non-Executive Director on 31 March 2026.	8 of 10
David Jago, Non-Executive Director Appointed 1 February 2026 to 30 January 2029. A qualified Chartered Institute of Public Finance and Accountancy (CIPFA) accountant with extensive experience working in finance roles across a number of trusts within Cheshire and Merseyside and Greater Manchester.	2 of 2
Dr Louise Sell, Non-Executive Director Appointed 1 October 2020 to 30 September 2023. Re-appointed 1 October 2023 to 30 September 2026. Re-appointed 1 October 2026 to 30 September 2027. A consultant psychiatrist and a former executive medical director. Louise was also the Senior independent Director during 2025/26 and Deputy Chair following Dr Marisa Logan-Ward's term of office ending.	9 of 10
Executive Directors	
Karen James OBE, Chief Executive Appointed as interim Chief Executive, November 2020. Appointed as substantive Chief Executive, November 2021. Karen started her career as a registered nurse, going on to hold several executive leadership roles in large acute tertiary providers before becoming Chief Executive.	8 of 10
Amanda Bromley, Chief People Officer Appointed November 2021. Amanda has extensive operational and strategic experience, obtained from holding senior HR positions in a number of organisations in acute, community and mental health services across the North West.	8 of 10
Paul Buckley, Director of Strategy & Partnerships (non-voting) Appointed April 2024. Paul has extensive senior management experience gained from previous operational and strategic roles within a number of hospital Trusts in London, the North West and South Yorkshire.	9 of 10
Nic Firth, Chief Nurse Appointed November 2020.	10 of 10

Nic trained as a nurse at Stockport NHS Foundation Trust. Over her career she held a number of senior nursing leadership roles including Executive Director of Nursing at Aintree University Hospital and Director of Nursing within the Northern Care Alliance, before rejoining Stockport NHS Foundation Trust as Chief Nurse. Nic stood down as an Executive Director on 31 March 2026.	
John Graham, Chief Finance Officer / Deputy Chief Executive Appointed May 2019. John is an experienced Director of Finance who has worked for a range of organisations including a Health Authority, the Northwest Regional Office, the Directorate of Health and Social Care North, a Mental Health Foundation Trust and a leading University Teaching Hospital.	9 of 10
Dr Andrew Loughney, Medical Director Appointed January 2021. Andrew is a Consultant Obstetrician. He has held a number of medical leadership roles, including Medical Director at Liverpool Women's Hospital, before joining Stockport NHS Foundation Trust. Andrew stood down as an Executive Director on 30 September 2025.	5 of 5
Jackie McShane, Chief Operating Officer Appointed on secondment December 2020. Appointed as substantive Director of Operations November 2021. Employment transferred to Stockport NHS Foundation Trust, April 2022. Jackie has significant senior management experience in acute sector NHS roles across a number of North West trusts, including previously holding the same post at Tameside & Glossop Integrated Care NHS Foundation Trust. Prior to joining the NHS Jackie worked within the private sector in the logistics sector.	8 of 10
Dilraj Sandher, Chief Medical Officer Appointed October 2025. Alongside his executive role, Dilraj is a Trauma and Orthopedic Consultant. He started his consultant career at Manchester Royal Infirmary. He was previously the Deputy Medical Director at Stockport NHS Foundation Trust.	5 of 5

More details about the background and experience of all members of current 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 Company Secretary by emailing corporateoffice@stockport.nhs.uk or writing to Trust Headquarters, Stepping Hill Hospital, Oak House, Poplar Grove, Stockport.

Key changes in the year (and effective from 2026/27) are set out below:

Executive Directors

Andrew Loughney, Medical Director, left the Trust in September 2025. From October 2025, Dilraj Sandher was appointed as Chief Medical Officer, a joint role with TG ICFT.

Nic Firth, Chief Nurse, retired at the end of March 2026. Jacqui Burrow, Chief Nurse at TG ICFT, commenced as the joint Chief Nurse for both SFT and TG ICFT from April 2026, having held the Chief Nurse role at TG ICFT from the start of the year.

As a result of the Board composition review, it was agreed that from 2026/27 only Executive Directors holding voting rights would be Board members. Consequently, Paul Buckley, Director of Strategy and Partnerships (a joint role with TG ICFT), will cease to be a Board member from April 2026.

Non-Executive Directors

Marisa Logan-Ward and Beatrice Fraenkel stood down at the end of their respective terms of office in July 2025 and December 2025. Samira Anane and David Hopewell both stood down in March 2026.

David Jago was appointed as a Non-Executive Director in February 2026 and Peter Blythin, David Coorey, and Farooq Hakim commenced their new appointments as Non-Executive Directors from 1 April 2026. These were all joint roles with TG ICFT. In addition, an existing Non-Executive Director from TG ICFT, Michael Forrest, was also appointed to SFT from 1 April 2026.

To support continuity and ongoing Board stability, the Council of Governors reappointed Louise Sell for a further 12 months, extending her term of office to September 2027.

A high-level biography of directors joining the Board from 2026/27 is included below:

Non-Executive Directors
Peter Blythin, Non-Executive Director Appointed 1 April 2026 to 31 March 2029. A qualified nurse with significant NHS experience across a variety of leadership roles including Trust, regional and national board director positions.
David Coorey, Non-Executive Director Appointed 1 April 2026 to 31 March 2029. A highly experienced commercial leader, he has served in senior roles up to most recently Global Senior Vice President in discovery research.
Farooq Hakim, Non-Executive Director Appointed 1 April 2026 to 31 March 2029. A seasoned executive with over 30 years of experience leading large-scale business and technology transformations. He has also held a range of civic and non-executive roles.
Michael Forrest, Non-Executive Director/Deputy Chair Appointed 1 April 2026 to 31 March 2028. Michael's experience includes working for nine years at North West Ambulance Service (NWAS) undertaking roles including Deputy Chief Executive, Director of Workforce and Interim Chief Executive. In addition to his role at the Trust, Michael is also a Non-Executive Director at Bury and Rochdale Doctors On Call (BARDOC) which provide GP and dentistry out-of-hours services across Greater Manchester.
Executive Directors
Jacqui Burrow, Chief Nurse Appointed April 2026. Joint position with Tameside & Glossop Integrated Care NHS Foundation Trust. Jacqui began her nursing career a registered general nurse before training as a health visitor and subsequently moving into strategic nursing and quality roles. Jacqui was deputy chief nurse at the Northern Care Alliance NHS Foundation Trust before joining the Trust in 2026.

Board Effectiveness
The Board recognises the importance of regularly evaluating the effectiveness of its governance arrangements. This includes the performance of the Board as a whole, its supporting committees, and the contribution of individual Directors, in line with the expectations set out in the Code of Governance for NHS Provider Trusts.

As previously referenced, the development of joint corporate governance arrangements provided an opportunity to review existing governance structures. Drawing on the NHS England (NHSE) Insightful Provider Board guidance and the NHS Oversight Framework self-assessment, the Board established bespoke arrangements to support effective and proportionate governance within the new joint working arrangements.

All Directors are subject to a formal annual appraisal process. This considers their effectiveness as members of the Board and its committees and, for Executive Directors, their performance in fulfilling their management responsibilities. Each Director, including the Chair and Chief Executive, agrees a set of objectives at the start of the year, which are reviewed during the year and assessed at year end.

The outcomes of Executive Directors' appraisals are reported to the Board's Remuneration Committee. The appraisal outcomes for the Chair and Non-Executive Directors are reported to the Council of Governors through the Nominations Committee.

The Care Quality Commission and NHS England Well Led Framework
The Board recognises that being a well-led organisation is essential to delivering high-quality care and a positive experience for patients and staff.

Key elements of effective Board leadership include:
- Meeting regularly and maintaining a focus on strategy, while holding managers to account.
- Operating as a single, unitary Board, with Executive and Non-Executive Directors working collaboratively and valuing the contribution of all members.
- Using a clear and effective committee structure to support strategy development and undertake detailed scrutiny.
- Maintaining effective engagement with the Council of Governors, which appoints the Non-Executive Directors and holds the Board to account for its performance.

The effectiveness of Board-level governance is reviewed with reference to national frameworks, including the Care Quality Commission (CQC) and NHS England (NHSE) Well-Led guidance. From April 2024, trusts have been assessed against the CQC Single Assessment Framework, supported by new well-led guidance jointly developed by CQC and NHSE. In addition, the NHSE Well-Led Framework (2017) continues to provide guidance for developmental reviews of leadership and governance. While the two frameworks are separate, there is significant overlap between them.

During 2024/25, the Trust mapped the NHSE Well-Led Framework Key Lines of Enquiry (KLOEs) to the new CQC Well-Led Quality Statements. A self-assessment was completed, including a position statement, supporting evidence, indicative ratings and agreed development actions. In October 2025, the Board completed a self-assessment against the

NHS Oversight Framework Provider Capability Assessment, structured around the domains of The Insightful Provider Board guidance. NHSE confirmed agreement with the Trust's overall assessment. MIAA also carried out desk-based reviews of both the Well-Led and NHS Oversight Framework self-assessments, concluding that they were robust, comprehensive and supported by appropriate evidence.

Assurance over governance is further supported through regular internal audit reviews of systems of internal control. Action plans arising from audit work are reviewed by the Audit Committee, with progress monitored to ensure actions are completed effectively and on time.

The Trust will keep its governance arrangements under continuous review. As the new joint governance arrangements are embedded, the Board will continue to assess and tailor development activity to reflect organisational priorities, emerging risks and opportunities for improvement.

In relation to the Board Assurance Framework (BAF), principal risks are allocated to the relevant Board committees and reviewed regularly alongside related risks from the corporate risk register. This provides clear oversight of strategic risks, distinguishes them from operational risks, and ensures visibility of the actions in place to manage and mitigate risk.

The outcomes of significant internal or external investigations and reviews are also considered by the appropriate Board committees and, where necessary, by the Board itself.

Board Committees

Throughout 2025/26 the Board of Directors established the following statutory committees:

- Audit Committee
- Remuneration Committee – More information about this committee can be found in the Remuneration Report.
- Charitable Funds Committee – More information about this committee can be found in the Trust's charity annual report and accounts available on the website.

Audit Committee

Every NHS organisation is required to have an Audit Committee to support the Board by reviewing and reporting on the effectiveness of the Trust's governance arrangements, risk management and systems of internal control across all areas of the Trust's activity. It also reviews the end-of-year disclosure statements, including the Annual Report and Accounts, before these are submitted to the Board for approval.

The Committee is supported by the internal audit service and the external auditors, both of whom provide independent assurance and insight into the Trust's governance, risk management and financial control arrangements.

The Trust's Audit Committee meets at least five times a year and comprises only Non-Executive Directors. Trust officers attend meetings as required, alongside representatives from internal and external audit.

The Committee is chaired by a Non-Executive Director with recent and relevant financial experience and includes at least three Non-Executive Directors. Throughout 2025/26,

membership included the Chairs of the Board's assurance committees, enabling triangulation of assurance and oversight across the Board's committee structure.

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

Membership	Attendance at Audit Committee Meetings
David Hopewell, Non-Executive Director / Chair of Audit Committee	6 of 6
Anthony Bell, Non-Executive Director / Chair of Finance & Performance Committee	6 of 6
Beatrice Fraenkel, Non-Executive Director / Chair of People Performance Committee	3 of 5
Louise Sell, Non-Executive Director / Senior Independent Director	6 of 6
David Curtis, Non-Executive Director / Chair of People Performance Committee	1 of 1
David Jago, Non-Executive Director	1 of 1

Internal Audit

The Trust's internal audit service is provided by Mersey Internal Audit Agency (MIAA) under contractual arrangement. MIAA is compliant with complies with the Global Internal Audit Standards (GIAS), and its auditors hold appropriate professional registrations.

The purpose of internal audit is to provide independent and objective assurance to the Accountable Officer, the Board and the Audit Committee on the effectiveness of the Trust's risk management, governance and internal control arrangements. Internal audit operates to a risk-based annual plan, approved by the Audit Committee at the start of each year and developed within a rolling three-year framework to ensure appropriate coverage of all key risk areas. Progress against the plan is monitored at each Audit Committee meeting, and any changes require Audit Committee approval.

The key issues that the Audit Committee reviewed during the year, based on the reviews undertaken by MIAA, were:

- Recruitment and Onboarding – Substantial Assurance
- Key Financial Processing Controls – Substantial Assurance
- Fit & Proper Persons Review – Substantial Assurance
- Assurance Framework Opinion – Standards Met
- Estates & Facilities Procurement – Moderate Assurance
- Quality Spot Check: Consent – Limited Assurance
- Risk Management Core Controls – Substantial Assurance
- Data Protection & Security Toolkit – Medium Confidence (Assessment of Self-Assessment), High Risk (Assurance rating across the National Data Guardian Standards)

Underpinned by the work conducted through the risk-based internal audit plan, Audit Committee also received 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 applied consistently.

Countering Fraud and Corruption

A key element of the Trust's internal control framework is the Local Counter-Fraud Service (LCFS), which is provided on an arm's-length basis by MIAA. The service is accredited by the NHS Counter Fraud Authority and operates in accordance with the requirements of the NHS Standard Contract.

The Trust's Anti-Fraud and Corruption Policy is supported by an annual counter-fraud work plan. The plan, agreed by the Chief Finance Officer and approved by the Audit Committee, focuses on promoting awareness, deterring and preventing fraud, and investigating suspected cases. The LCFS undertakes both proactive and reactive work, including responding to reports of suspected fraud, carrying out investigations, and, where appropriate, recommending further action to the Trust or relevant prosecuting authorities.

The LCFS attends Audit Committee meetings on a regular basis to provide updates on delivery of the work plan and the progress of any investigations.

The Trust also has a Freedom to Speak Up: Raising Concerns at Work Policy, aligned with national guidance, which sets out how staff can raise concerns, including those related to fraud. Staff are reminded of their responsibility to do so through induction and ongoing awareness activity, including training sessions, fraud alerts, newsletters and internal briefings. The policy is supported by the Freedom to Speak Up Guardian, with activity reported to the People Performance Committee and six-monthly updates provided to the Board of Directors.

Significant issues in relation to the preparation of the Trust's financial statements

In 2025/26, the Audit Committee considered the following significant issues in relation to the preparation of the Trust's financial statements (for 2024/25), reflecting areas of judgement, complexity or higher risk. In each case, the Committee reviewed management's approach, considered the findings and any challenge from external audit, and satisfied itself that the matters had been appropriately addressed and disclosed.

Review of Accounting Policies: The Committee reviewed and approved update to the accounting policies for inclusion in the notes to the financial statements of the annual accounts of the Trust and its subsidiaries and received assurance that the changes were prepared in accordance with the latest statutory guidance.

Going Concern: The Committee reviewed management's assessment of the Trust's ability to continue as a going concern. This included consideration of the Trust's financial position, cash flow forecasts, system support arrangements, and assumptions underpinning the approved financial plan. The Committee was satisfied that it was appropriate to prepare the financial statements on a going concern basis and that any material uncertainties were appropriately disclosed.

Continuity of Services 7 - Availability of Resources: The Committee reviewed the Continuity of Services declaration, sought assurance on the availability of resources, and recommended the declaration to the Board for approval. In doing so, it noted key financial,

activity, and capital risks that could impact resource availability, while recognising that the plan remains challenging but achievable if underlying assumptions and funding arrangements are delivered as expected.

Annual Accounts including Property Valuation: The Committee reviewed the year-end valuation of land and buildings, which represents a significant balance in the financial statements, notably transactions relating to The Meadows land and building, valuation of the Emergency & Urgent Care Campus upon completion and accounting treatment for the newly formed Southeast Manchester Community Diagnostic Centre. The Committee was satisfied with the methodology, assumptions applied, and the results of external audit's work in this area.

External Audit Findings and Adjustment: The Committee considered the external audit findings, including the unqualified opinion and that there were no matters reported that would require modification of the audit opinion or material changes to the financial statements. The Committee was satisfied that the final financial statements presented a true and fair view of the Trust's financial position and results.

Overall Conclusion: Having considered the significant issues above, the Audit Committee was satisfied that appropriate assurance had been received and recommended the Annual Report and Accounts to the Board of Directors for approval.

External Audit Appointment

The Council of Governors has a statutory responsibility for appointing and, where necessary, removing the NHS foundation trust's external auditor. The Audit Committee is responsible for overseeing the appointment process in liaison with the Council of Governors and, following completion of that process, for making a recommendation to the Council regarding the award of the external audit contract.

As previously reported, following a procurement exercise conducted in line with NHS procurement regulations and relevant governance requirements, Forvis Mazars was appointed as the Trust's external auditor by the Council of Governors in June 2024, following a recommendation from the Audit Committee. The appointment was made for an initial term of three years, covering the 2024/25, 2025/26 and 2026/27 financial years, with an option to extend the contract by a further two years subject to mutual agreement. At the time of appointment, the total cost of the external audit service was £372,941, excluding VAT.

Throughout 2025/26, representatives from Forvis Mazars attended meetings of the Audit Committee on a regular basis, enabling the Committee to monitor and assess the effectiveness of the external audit service.

Forvis Mazars did not provide any non-audit services to the Trust during 2025/26. If non-audit services were proposed in the future, appropriate safeguards are in place to protect auditor independence, including a policy governing non-audit services, which was most recently refreshed and approved by the Audit Committee in February 2026.

Board Assurance Committees

In addition to the statutory committees, the Board of Directors established the following committees throughout 2025/26:

- Quality Committee
- Finance & Performance Committee
- People Performance Committee

Each committee operates under Board-approved terms of reference and workplans that support the Board in discharging its wide-ranging governance and regulatory responsibilities, including oversight of the delivery of the corporate objectives. Where issues or concerns are identified, committees seek appropriate assurance that these are being effectively managed and, where necessary, escalate matters to the Board to ensure visibility for all members and to enable review of mitigating actions.

Attendance was as follows:

Quality Committee: Membership	Attendance at Meetings
Louise Sell, Non-Executive Director / Chair of Quality Committee	9 of 10
Samira Anane, Non-Executive Director	8 of 10
David Curtis, Non-Executive Director / Chair of People Performance Committee	3 of 6
Marisa Logan-Ward, Non-Executive Director / Deputy Chair	3 of 4
Nic Firth, Chief Nurse	8 of 10
Andrew Loughney, Medical Director	5 of 5
Jackie McShane, Chief Operating Officer	8 of 10
Dilraj Sandher, Chief Medical Officer	5 of 5

Finance & Performance Committee: Membership	Attendance at Meetings
Anthony Bell, Non-Executive Director / Chair of Finance & Performance Committee	9 of 10
Samira Anane, Non-Executive Director	8 of 10
David Hopewell, Non-Executive Director / Chair of Audit Committee	8 of 10
Paul Buckley, Director of Strategy & Partnerships	10 of 10
Nic Firth, Chief Nurse	8 of 10
John Graham, Chief Finance Officer	6 of 10
Jackie McShane, Chief Operating Officer	10 of 10

People Performance Committee: Membership	Attendance at Meetings
David Curtis, Non-Executive Director / Chair of People Performance Committee	4 of 4

Beatrice Fraenkel, Non-Executive Director / Chair of People Performance Committee	3 of 4
David Hopewell, Non-Executive Director / Chair of Audit Committee	5 of 6
David Jago, Non-Executive Director	1 of 1
Marisa Logan-Ward, Non-Executive Director	2 of 2
Amanda Bromley, Chief People Officer	4 of 6
Nic Firth, Chief Nurse	3 of 6
Andrew Loughney, Medical Director	3 of 3
Dilraj Sandher, Chief Medical Officer	3 of 3

Directors' responsibility for preparing accounts

The Accounting Officer (Chief Executive) delegates responsibility for preparing the annual accounts to the Chief Finance Officer, with the finance team producing professionally prepared financial statements. The Audit Committee, under delegated authority from the Board, reviews the Annual Report and Accounts and recommends them for approval.

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 and strategy.

So far as the Directors are aware, there is no relevant audit information of which the auditors are unaware. The Directors have taken appropriate steps to make sure they were aware of any relevant audit information and that this information was shared with the auditors.

Cost Allocation & Charging Guidance

Stockport NHS Foundation Trust has complied with the cost allocation and charging mechanisms set out in HM Treasury and Office of Public Sector information guidance.

Better Payment Practice Code

As part of measures introduced as part of the financial improvement programme, the Trust is no longer in a position to comply with the Better Payment Practice Code, which requires payment of 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 the Trust's supplier base that was broadly understanding of the change.

All suppliers' payment terms were reviewed, and the Trust continues to work with the small and medium enterprises to ensure they are not disproportionately affected by this change. The Trust now has a policy of payment within 60 days and the performance against this for the last two financial years is set out in the tables below.

No significant interest was incurred under the Late Payments of Commercial Debts (Interest) Act 1988 in respect of any liability to pay interest, which was 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.

2025/26	NHS	Non-NHS
Total number of invoices paid within the year	7,028	56,692
Total number of invoices paid within 60 days	6,882	55,551
Percentage of invoices paid within 60 days	97.92%	97.52%
Total value of invoices paid within year (£000)	19,923,096	232,327,984
Total value of invoices paid within 60 days (£000)	18,247,541	225,414,632
Percentage of invoices paid within 60 days	91.59%	97.02%
Total number of invoices paid within year	7,028	56,692
Total number of invoices paid within 30 days	6,435	40,238
Percentage of invoices paid within 30 days	91.56%	70.64%
Total value of invoices paid within year (£000)	19,923,096	232,327,984
Total value of invoices paid within 30 days (£000)	15,269,034	202,718,798
Percentage of invoices paid within 30 days	76.64%	87.26%
2024/25	**NHS**	**Non-NHS**
Total number of invoices paid within the year	6,104	55,410
Total number of invoices paid within 60 days	5,915	53,999
Percentage of invoices paid within 60 days	96.90%	97.45%
Total value of invoices paid within year (£000)	14,881,806	229,437,392
Total value of invoices paid within 60 days (£000)	12,167,331	220,511,469
Percentage of invoices paid within 60 days	81.76%	96.11%
Total number of invoices paid within year	6,104	55,410
Total number of invoices paid within 30 days	5,472	36,500
Percentage of invoices paid within 30 days	89.65%	65.87%
Total value of invoices paid within year (£000)	14,881,806	229,437,392
Total value of invoices paid within 30 days (£000)	8,822,133	194,272,620
Percentage of invoices paid within 30 days	59.28%	84.67%

Income disclosures

Income generation disclosures as required by Section 43 2(A) of the NHS Act 2006 are included in note 5.3 of the Annual Accounts.

The Trust has complied with Section 43 (2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012), which requires that the income from the provision of goods and services for the purposes of the health services in England must be greater than its income from the provision of goods and services for other purposes. The impact of income on the Trust is significant. The Trust's statutory accounts include a detailed breakdown of other income in note 4 of the Annual Accounts.

Karen James OBE
Chief Executive
25th June 2026

Remuneration Report

Annual statement on remuneration from the Chair
In accordance with the requirements of the HM Treasury Financial Reporting Manual (FReM) and NHS England, this Remuneration Report includes the following sections:

- An annual statement on remuneration from the chairman of the remuneration committees
- Senior managers' remuneration policy
- Annual report on remuneration

The Board of Directors has established a Remuneration Committee, responsible for reviewing and determining the remuneration and terms and conditions of service of the Chief Executive and Executive Directors, as well as overseeing the appointment of Executive Directors. The Nominations Committee, established by the Council of Governors, is responsible for matters relating to the appointment, remuneration and terms of service of the Non-Executive Directors, including the Chair. Each committee discharges its responsibilities and reports to the Board of Directors or the Council of Governors, as appropriate.

2025/26 Major Decisions on Remuneration
During 2025/26, the Remuneration Committee made the following major decisions on remuneration:

- Considered national guidance on Very Senior Manager (VSM) pay for 2025/26 and approved the implementation of the annual salary increase of 3.25% for VSM staff.
- Confirmed no earn back arrangements implemented.
- Approved the Very Senior Manager (VSM) Remuneration Policy & Future Policy Table.

The Committee's discussions took place following the publication of the NHS England (NHSE) VSM Pay Framework in May 2025. In doing so, it balanced the need to attract and retain strong Executive Directors within the requirements of NHS England guidance, comparator data and wider market conditions.

During 2025/26, the Nominations Committee of the Council of Governors reviewed the pay levels for Non-Executive Directors, taking into account the move to a joint Non-Executive Director role, alongside the remuneration structure set out by NHS England. The Committee then recommended to the Council of Governors that joint Non-Executive Directors should be paid £15,000, with additional responsibility payments of up to £2,000 for the Chair of the Audit Committee, the Vice-Chair and the Senior Independent Director.

David Wakefield
Joint Chair

Senior managers' remuneration policy

Future Policy Table

	How this component supports short and long-term objectives	How this component operates	Maximum payable	Recovery or Withholding Provisions
Salary	Establish levels of remuneration that are sufficient to attract, retain and motivate Executive Directors and senior managers with the skills and experience required to lead the Trust, without paying more than is necessary for this purpose.	Executive Director salary agreed on appointment by the Remuneration Committee. The Remuneration Committee considers: - relevant benchmarking information - guidance from NHS England including the Very Senior Managers (VSM) Pay Framework - national inflationary uplifts. recommended for other NHS staff. Salary is paid pro-rata monthly, net of tax deductions, in accordance with the employment contract.	No prescribed maximum annual increase. When reviewing salaries, the Remuneration Committee take account of individual and organisational performance, and any national award offered to the wider employee population.	For one Executive Director appointed in 2019/20 an earn-back arrangement is in place.
Bonus	The current remuneration policy of the Trust does not make provision for performance related bonuses as the Trust considers them not to be necessary to support objectives.	N/A	N/A	N/A
Taxable benefits	The current remuneration policy of the Trust does not make provision for taxable benefits as the Trust considers them not to be necessary to support objectives.	N/A	N/A	N/A

Pension related benefits	Provision of pension benefits encourages commitment to the Trust.	The Trust operates the standard NHS pension scheme.	Maximum in line with standard NHS pension scheme.	There are no withholding provisions for the Trust. Recovery, or withholding of pension payments, is a matter for NHS Business Services and governed by the relevant statutory regulations.
Notice periods	Having appropriate periods of notice enables the Trust to maintain service continuity during personnel changes.	Each contract makes provision for the notice period to be served by the individual. The notice period for Executive Directors should usually be six months.	N/A	The period of notice may only be shortened if the Remuneration Committee is satisfied that there are appropriate alternative arrangements in place.
Non-Executive Directors	To establish levels of remuneration which are sufficient to attract, retain and motivate Non-Executive Directors (including the Chair) of the quality and with the skills and experience required to lead the Trust successfully, without paying more than is necessary for this purpose, and at a level which is affordable for the Trust.	The remuneration of the Non-Executive Directors, including the Chair, is set by the Council of Governors on the recommendation of the Nominations Committee having regard to the responsibilities of the role. The remuneration of the Non-Executive Directors and Chair is reviewed annually taking into account national guidance and benchmarking information. The Non-Executive Directors do not receive any pension or taxable benefits. The award of supplementary payments are paid to the Deputy Chair, Chair of Audit Committee, and the Senior Independent Director.	N/A	No change.

All Executive Directors are employed on permanent contracts with a six-month notice period. Those who are joint directors hold honorary contracts with the non-host employing organisation. An earn-back arrangement applies to one Director appointed in 2019/20; no other Executive Directors are subject to this scheme and there are no special arrangements for early termination of employment. For joint Executive Directors employed by TG ICFT, remuneration is reviewed through the Remuneration Committees meeting in common. No Executive Director has been released to undertake external roles, such as serving as a Non-Executive Director elsewhere. Pension entitlements are set out in the Remuneration Report.

The Remuneration Committee reviewed all Executive Director salaries against agreed performance objectives, the NHS England Very Senior Manager (VSM) Pay Framework and benchmarking data from trusts of a similar size. The Committee concluded that remuneration levels are reasonable and fully compliant with the VSM Pay Framework.

The Trust follows nationally agreed NHS pay arrangements for staff, including Agenda for Change and Medical and Dental terms and conditions. Senior managers are employed on Trust-wide terms and conditions designed to attract and retain high-quality leaders.

The Board's Remuneration Committee (for Executive Directors) and the Council of Governors (for Non-Executive Directors) are committed to promoting equality and diversity in appointments to the Board in line with the Trust's Equality, Diversity & Inclusion Strategy. The Committee maintains awareness of Trust-wide programmes that support the development and progression of staff from under-represented groups, to strengthen the pipeline to senior and Board-level roles. Further information can be found within the Staff Report.

Annual Report on Remuneration

Remuneration Committee

The Remuneration Committee, whose membership includes all non-executive directors, met on four occasions during 2025/26 considering the following matters:

- Chief Executive & Executive Director annual performance
- Joint Chief Medical Officer Proposal
- Very Senior Manager (VSM) Pay Framework
- Senior Managers' Remuneration Policy
- Very Senior Manager (VSM) pay award for 2025/26
- Mutually Agreed Resignation Scheme (MARS)
- Board Composition Review
- Board Succession Planning & Talent Management
- Annual Review of Committee Effectiveness

Membership and attendance at meetings during 2025/26 is set out below:

Members	Meeting attendance
David Wakefield, Joint Chair	4 of 4
Marisa Logan-Ward, Interim Chair	1 of 1
Samira Anane, Non-Executive Director	3 of 4
Anthony Bell, Non-Executive Director	4 of 4
David Curtis, Non-Executive Director	3 of 4
Beatrice Fraenkel, Non-Executive Director	3 of 4
David Hopewell, Non-Executive Director	2 of 4
David Jago, Non-Executive Director	N/A*
Louise Sell, Non-Executive Director	4 of 4

*Commenced in post on 1 February 2026; no meetings were held during the remainder of the year.

To advise committee members, meetings are attended by the Chief Executive and Chief People Officer, other than when matters being discussed may result in a conflict of interest. Minutes of the meetings are recorded by the Company Secretary.

Nominations Committee

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

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

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

During 2025/26 the Nominations Committee met on eight occasions, five of which were held in common with TG ICFT Nominations Committee, due to the nature of the matters being discussed. The Nominations Committee considered the following matters:

- Chair and Non-Executive Director annual performance
- Reappointment of a Non-Executive Director
- Non-Executive Director Appointment & Selection Process: Clinician (Nursing / Midwifery / Allied Health Professional or Healthcare Scientist)
- Board Composition Review Recommendation
- Joint Non-Executive Director Proposal
- Remuneration of Joint Non-Executive Directors
- Joint Non-Executive Director Appointment & Selection Process: Finance, Digital Innovation & Transformation, Strategic Partnerships & Change Management, Commercial & Business Acumen

Membership and attendance at meetings during 2025/26 is set out below:

Name	Position	Attendance
David Wakefield	Joint Chair	8 of 8
Sue Alting	Lead governor	8 of 8
Howard Austin	Public governor	3 of 3
Richard King	Public governor	2 of 2
Michelle Slater	Public governor	5 of 6
Chris Summerton	Public governor	3 of 4
Sarah Thompson	Public governor	7 of 8

To advise Committee members, meetings are attended by the Chief Executive and Chief People Officer as appropriate. Minutes are recorded via the Company Secretariat.

As part of the Trust's transition to a joint Non-Executive Director model and the recruitment of several specialist joint Non-Executive Directors, the Nominations Committee supported the appointment of executive search agencies to assist with the selection and recruitment processes. The Chief People Officer invited proposals from agencies through an established procurement framework. Seymour John was appointed to support the development of the candidate pool for the joint Non-Executive Director role with financial expertise/Chair of Audit Committee. The fee was shared equally between the two trusts, with the total amount £7,500 (excluding VAT). Gatenby Sanderson was appointed to support the recruitment and selection of three joint Non-Executive Directors with expertise in Digital Innovation & Transformation, Strategic Partnerships & Change Management, Commercial & Business Acumen. As with the previous appointment, fees were shared equally between the two trusts, with the total amount £22,745 (excluding VAT). The process included approval of the job description and person specification, agreement of the advertising approach, shortlisting, and an interview panel, leading to a recommendation and final approval by the Council of Governors.

Directors & Governors Expenses

During the year, the following expenses were paid to Directors and Governors respectively:

	2025/26	2024/25
Total number of Directors in office	17	15
Number of Directors receiving expenses for the year	0	0
Aggregate sum of expenses paid to Directors in the year	£0	£0

	2025/26	2024/25
Total number of Governors in office	27	31
Number of Governors receiving expenses for the year	3	2
Aggregate sum of expenses paid to Governors in the year	£105.25	£20.80

Annual report on remuneration (subject to audit)

For the purpose of the accounts and Remuneration Report, the Chief Executive has agreed the definition of a "senior manager" to be board member directors only.

The salary and pension entitlement of senior managers is set out in the following tables:

Table 1: Single Total Figure – Non-Executive Directors (subject to audit)

Name	Title	Start Date of Office	Salary and allowances (bands of £5,000) 2025/26	Salary and allowances (bands of £5,000) 2024/25
			£000	£000
David Wakefield (Note 1)	Joint Chair	01/04/2025	30-35	-
Marisa Logan Ward (Note 2)	Non-Executive Director	01/08/2019	5-10	40-45
Samira Anane (Note 3)	Non-Executive Director	01/09/2022	10-15	10-15
Anthony Bell	Non-Executive Director	01/05/2021	10-15	10-15
David Curtis	Non-Executive Director	01/08/2025	5-10	-
Beatrice Fraenkel (Note 4)	Non-Executive Director	04/01/2023	5-10	10-15
David Hopewell (Note 5)	Non-Executive Director	01/07/2018	15-20	15-20
David Jago (Note 6)	Non-Executive Director	01/02/2026	0-5	-
Louise Sell	Non-Executive Director	01/10/2020	15-20	15-20
Mary Moore (Note 7)	Non-Executive Director	1/10/2020	-	10-15

Notes to Remuneration Table 1 (subject to audit)

1.	David Wakefield was appointed as Chair on 1 April 2025 in a shared post with Tameside and Glossop Integrated Care NHS Foundation Trust. The above table discloses the Trusts 50% share of renumeration. Total renumeration across both Trusts was £60,000-£65,000
2.	Marisa Logan-Ward left the Trust on 31 July 2025.
3.	Samira Anane left the Trust on 31 March 2026
4.	Beatrice Fraenkel left the Trust on 31 December 2025
5.	David Hopewell left the Trust on 31 March 2026
6.	David Jago was appointed as Non-Executive Director on 2/2/2026 in a shared post with Tameside and Glossop Integrated Care NHS Foundation Trust. The above table discloses the Trusts 50% share of renumeration. Total renumeration across both Trusts was £0-£5,000
7.	Mary Moore left the Trust on 31 March 2025

Table 2: Single Total Figure – Executive Directors (subject to audit)

Name	Start Date of Office	Salary and allowances (bands of £5,000) 2025/26	Salary and allowances (bands of £5,000) 2024/25	All Pension Related Benefits (bands of £2,500) 2025/2026 (Note 1)	Total (bands of £5,000) 2025/26	All Pension Related Benefits (bands of £2,500) 2024/2025 (Note 1)	Total (bands of £5,000) 2024/2005
		£000	£000	£000	£000	£000	£000
Karen James (Note 4) Chief Executive	9/11/2020	115-120	110-115	0	115-120	17.5-20	130-135
Jackie McShane Chief Operating Officer	14/12/2020	140-145	140-145	47.5-50	190-195	25-27.5	165-170
John Graham (Note 5) Chief Finance Officer and Deputy Chief Executive	20/05/2019	85-90	90-95	80-82.5	165-170	37.5-40	125-130
Nicola Firth (Note 6) Chief Nurse	02/11/2020	150-155	90-95	62.5-65	215-220	27.5-30	115-120
Andrew Loughney (Note 7) Medical Director	01/01/2021	110-115	210-215	-	110-115	-	210-215
Amanda Bromley (Note 8) Chief People Officer	01/11/2021	70-75	70-75	52.5-55	125-130	32.5-35	100-105
Paul Buckley (Note 9) Director of Strategy and Partnerships	01/04/2024	60-65	60-65	50-52.5	110-115	62.5-65	125-130
Dilraj Sandher (Note 10) Chief Medical Officer	01/10/2025	50-55	-	37.5-40	85-90	-	-
Caroline Parnell (Note 11) Director of Communications & Corporate Affairs	01/11/2019	-	0-5	-	-	-	0-5

Notes to Remuneration Table 2 (subject to audit)

1.	For Executive Directors shared with Tameside and Glossop Integrated Care NHS Foundation Trust, salary is apportioned between organisations; however, the pension-related benefits disclosed represent the full value of benefits accrued by the individual and are not split. The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. Where negative figures are calculated a zero figure is recorded. The

	pension benefits values does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide.
2.	All members of the Executive Team covered by pension arrangements are affected by the Public Service Pensions Remedy and their membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023. Negative values are not disclosed in this table but are substituted for a zero.
3.	There were no taxable benefits, performance pay and bonuses and long term performance pay and bonuses in 2025/26 and 2024/25.
4.	The above table reflects the Trusts 50% share of remuneration for Karen James reflecting the dual role with Tameside and Glossop Integrated Care NHS Foundation Trust. Total remuneration in 2025/26 across both Trusts was £230,000-£235,000 (2024/25 £225,000-£230,000). Total remuneration and pension related benefits across both Trusts was £230,000-£235,000 (2024/25 £240,000-£245,000). Karen James started to take benefits from the 1995 pension scheme from 1st April 2025 but remains a member of the 2015 pension scheme.
5.	From 1/7/2022 John Graham was shared 50% with Tameside and Glossop Integrated Care NHS Foundation Trust and the above table discloses the share for the Trust from this date. Total remuneration in 2025/26 across both Trusts was £175,000-£180,000 (2024/25 £180,000-£185,000). Total remuneration and pension related benefits in 2025/26 across both Trusts was £255,000- £260,000 (2024/25 £220,000-£225,000). The total salary disclosed excludes £5,000-£10,000 relating to three weeks' annual leave purchased under the Trust's salary sacrifice arrangements during the year. (£10,000-£15,000 across both Trusts).
6.	From 1/1/2026 Nicola Firth reduced her contracted working hours from full-time to 0.72 whole-time equivalent. From 1/12/2022 to 2/3/2025 Nicola Firth was shared 50% with Tameside and Glossop Integrated Care NHS Foundation Trust and the above table discloses the share for the Trust up to 2/3/2025 with 100% thereafter. Total remuneration across both Trusts in 2024/25 was £165,000-£170,000. Total remuneration and pension related benefits in 2024/25 across both Trusts was £195,000-£200,000.
7.	Andrew Loughney left the Trust on 30/09/2025. He chose not to be covered by the pension arrangements during the reporting year.
8.	Amanda Bromley was appointed to Chief People Officer (former title Director of People & Organisational Development) from 1/11/21 in a shared post with Tameside and Glossop Integrated Care NHS Foundation Trust. The above table discloses 50% Trust share of total remuneration. Total remuneration in 2025/26 across both Trusts was £140,000-£145,000 (2024-25 £140,000-£145,000). Total remuneration and pension related benefits were £195,000-£200,000 (2024-25 £170,000-£175,000).
9.	Paul Buckley was appointed to Director of Strategy and Partnerships from 1/4/24 in a shared post with Tameside and Glossop Integrated Care NHS Foundation Trust. The above table discloses 50% Trust share of total remuneration. Total remuneration in 2025/26 in the role of Director of Strategy and Partnerships across both Trusts was £120,000-£125,000 (2024-25 £120,000-£125,000). Total remuneration and pension related benefits in 2025/26 across both Trusts was £170,000- £175,000 (2024-25 £185,000-£190,000).
10.	Dilraj Sandher was appointed to the Chief Medical Officer post from 1/10/25 in a shared post with Tameside and Glossop Integrated Care NHS Foundation Trust. The above table discloses 50% Trust share of total remuneration. The real increase in cash equivalent transfer value during the reporting year has been adjusted to reflect 50% of the year. Total remuneration in 2025/26 in the role of Chief Medical Officer across both Trusts from 1/10/25 was £100,000-£105,000. Total remuneration and pension related benefits in 2025/26 from 1/10/25 across both Trusts was £135,000- £140,000.
11.	In March 2024, it was agreed that Caroline Parnell would take redundancy from 7/4/24. The Trust accounted for the redundancy costs in accordance with Section 16 of the NHS Terms and Conditions of Service Handbook within the 2023/24 financial statements. The figure in the table for 2024/25 reflects the salary paid from 1/4/24 to 7/4/24.

Table 3: Pensions Benefits (subject to audit)

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 2025 (bands of £5,000)	Cash Equivalent Transfer value at the 1 April 2025	Real Increase in Cash Equivalent Transfer Value during the reporting year	Cash Equivalent Transfer Value at the 31st March 2026
Executive Directors		**£000**	**£000**	**£000**	**£000**	£000	£000	£000
Karen James Chief Executive	09/11/2020	**0**	**0**	**15-20**	**0**	227	57	**317**
Jackie McShane Chief Operating Officer	14/12/2020	**2.5-5.0**	**0**	**35-40**	**0**	522	41	**587**
John Graham Chief Finance Officer and Deputy Chief Executive	20/05/2019	**5.0-7.5**	**2.5-5.0**	**45-50**	**100-105**	174	45	**245**
Nicola Firth Chief Nurse	02/11/2020	**2.5-5.0**	**2.5-5.0**	**80-85**	**205-210**	1,710	78	**1,838**
Amanda Bromley Chief People Officer	01/11/2021	**2.5-5.0**	**0-2.5**	**55-60**	**150-155**	1,217	59	**1,314**
Paul Buckley Director of Strategy and Partnerships	01/04/2024	**2.5-5.0**	**2.5-5.0**	**55-60**	**140-145**	1,180	58	**1,277**
Dilraj Sandher Chief Medical Officer	01/10/2025	**0-2.5**	**0-2.5**	**85-90**	**80-85**	1,378	36	1,500

Fair Pay Disclosures

NHS foundation trusts are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the lower quartile, median and upper quartile remuneration of the organisation's workforce.

The banded annualised remuneration of the highest-paid director in the organisation in the financial year 2025/26 was £150-155k (2024/25, £210-215k).

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

For employees of the Trust as a whole, the range of remuneration in 2025/26 was from £20-25k to £215k-220k (2024/25 £20-25k to £210-215k). The percentage change in average employee remuneration (based on the total for all Trust based employees on an annualised basis divided by full time equivalent number of employees) between years is 4.5% (2024/25 2.9%). The percentage change in remuneration for the highest paid director is a reduction 28.2% (2024/25 - 4.9%). 114 employees received remuneration in excess of the highest-paid director in 2025/26 (2024/25 5 employees). The Trust paid four director posts more than the annual equivalent of £150,000 (2024/25 4 directors).

The remuneration of the employee at the 25th percentile, median and 75th percentile is set out below. The pay ratio shows the relationship between the total pay and benefits of the highest paid director (excluding pension benefits) and each point in the remuneration range for the organisation's workforce. The ratios of total remuneration and salary component of remuneration to the highest paid director have reduced in 2025/26 from the levels in the previous financial year. The highest paid director reduced by 28%, alongside a pay award for the year of 3.3%. In 2024/25, the Medical Director role was a full-time post at the Trust, however, during 2025/26 the Medical Director left part way through the year and the role was subsequently filled as a shared post with TG ICFT. As a result, the Chief Nurse became the highest paid director in 2025/26.

Pay Ratios 2025/26	25th percentile	Median	75th percentile
Total Remuneration	£33,063	£46,528	£59,544
Salary Component of total remuneration	£30,162	£42,896	£57,209
Mid Point of Banded Remuneration of highest paid director	£152,500	£152,500	£152,500
Total Remuneration: pay ratio for highest paid director	4.6:1	3.3:1	2.6:1
Salary Component of total remuneration: pay ratio for highest paid director	5.1:1	3.6:1	2.7:1

Pay Ratios 2024/25	25th percentile	Median	75th percentile
Total Remuneration	£31,386	£44,962	£61,171
Salary Component of total remuneration	£28,879	£41,678	£58,560
Mid Point of Banded Remuneration of highest paid director	£212,500	£212,500	£212,500
Total Remuneration: pay ratio for highest paid director	6.8:1	4.7:1	3.5:1
Salary Component of total remuneration: pay ratio for highest paid director	7.4:1	5.1:1	3.6:1

Note – In line with guidance, Non-Executive Directors are excluded from the 2025/26 calculation. Non-Executive Directors were included in the 2024/25 calculation; however, restatement is not required, therefore the prior year has not been restated.

Karen James OBE
Chief Executive
25th June 2026

Staff Report

Throughout the year, we have taken steps to support and recognise our workforce, introducing initiatives designed to reflect the commitment and resilience shown by colleagues in a challenging operating environment.

Staff costs and average whole time equivalent for the year were as follows. The tables below have been subject to audit:

Staff Costs - Group					2025/26		2024/25
	Permanent		Other		Total		Total
	£000		£000		£000		£000
Salaries and wages	255,445		14,639		**270,084**		**253,326**
Social security costs	33,244		-		**33,244**		**24,741**
Apprenticeship levy	1,370		-		**1,370**		**1,286**
Employer's contributions to NHS pension scheme	53,115		-		**53,115**		**48,303**
Pension cost - other	54		-		**54**		**67**
Temporary staff	-		35,101		**35,101**		**44,371**
Total staff costs	**343,228**		**49,740**		**392,968**		**372,094**

Average Whole Time Equivalents (WTE)

Average number of employees (WTE basis)					2025/26		2024/25
	Permanent		Other		Total		Total
	Number		Number		Number		Number
Medical and dental	637		65		**702**		**702**
Administration and estates	1,410		55		**1,465**		**1,465**
Healthcare assistants and other support staff	1,124		165		**1,289**		**1,276**
Nursing, midwifery and health visiting staff	1,819		175		**1,994**		**1,957**
Scientific, therapeutic and technical staff*	633		6		**639**		**618**
Healthcare science staff	81		-		**81**		**75**
Total average numbers	**5,704**		**466**		**6,170**		**6,093**

The Trust's workforce of average whole time equivalent staff relates to a headcount of 6,669 staff as of 31st March 2026, and the profile of these staff can be shown by gender, which is 76% female and 24% male, of which:

Gender Headcount	Male	Female	Total
Directors	5	4	9
Other Senior Managers	17	33	50
Other Employees	1552	5058	6610
Total	**1574**	**5095**	**6669**

Sickness absence

The annual sickness figure from April 2025 to March 2026 is 5.62%, which has seen a reduction of 0.21% compared to the previous year.

Turnover
Our turnover data for 2025/26 is published by NHS Digital: NHS workforce statistics - NHS England Digital. The position for 2025/26 was 12.02%.

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

In comparison to 2023/24, the overall gender pay gap for 2024/25 (latest data) has increased marginally from 17.81% to 17.97%. It is higher than the whole UK economy figure of 12.8%. There is a significant difference in the gender pay gap between medical staff and non-medical staff (AfC) group. By considering those staff groups separately, we can see that the gender pay gap has decreased since 2024 in the medical workforce, and decreased in the AfC grades, where the overall AfC pay gap now favours women.

The median average rates of pay show that the gender pay gap has increased since last year and still favours women across the organisation as a whole.

The only bonus scheme therefore, applied in the Trust relates to Clinical Excellence Awards (CEA). There is a 53% gap between male and female CEA payments. The median difference in bonus pay between men and women is 50% representing a median difference of payment of £3,016 between men and women. The awards were closed to new entrants in 2025.

Staff policies and actions applied during the financial year
The Trust has an established policy review group that ensures employment policies stay up to date, legally compliant and aligned with organisational priorities. The group works with managers and Trade Union colleagues to update policies, improve processes, reflect changes in employment law, promote fairness and consistency, and support a healthy work–life balance.

In addition, the Trust is working jointly with colleagues at TG ICFT to standardise HR policies wherever possible. Review cycles are being aligned so that, when policies are due for review, they are jointly developed or reviewed across both organisations to support consistency and efficiency.

During 2025/26, the policy review group considered and supported the review or development of the following policies:
- Over and Underpayments
- Acting Up and Secondment
- Armed Forces
- E-Rostering
- Rapid Access to Trust Services
- Work Experience
- Pay Progression for Consultants and SAS Doctors
- Job Planning for Consultants and SAS Doctors

- Recruitment and Retention Premia

All approved policies are supported by an Equality Impact Assessment to promote equality and inclusion and are communicated across the organisation, with training provided where required. The policy review group meets regularly and formally consults with Trade Union representatives, who play an active role in shaping policy and raising workforce issues. Trade Union representatives are also members of the Health and Safety Joint Consultative Committee, in line with statutory requirements. This collaborative approach ensures employment policies are compliant, inclusive and responsive to the needs of the workforce.

Staff Experience and Engagement

Staff experience remains central to delivering safe, high-quality care. National NHS priorities continue to highlight the importance of employee engagement, and the Trust uses a range of formal and informal mechanisms to understand and respond to staff experience.

Over the past year, the Trust has continued to gather staff feedback through listening sessions, surveys, staff networks and established routes for raising concerns. These insights help us understand what colleagues value about working at the Trust and where further improvement is needed. The Big Conversation programme has continued, providing opportunities for teams to share their experiences directly with Executive Directors. Feedback from these sessions is used alongside annual NHS Staff Survey results and wider workforce metrics to identify strengths, themes and improvement actions.

The Trust continues to promote the quarterly NHS People Pulse Survey to provide more regular insight into staff experience. While response rates remain lower than desired, participation continues to be encouraged in a way that avoids survey fatigue and protects engagement with the annual NHS Staff Survey.

A strong culture of openness is supported through the Freedom to Speak Up arrangements. The Freedom to Speak Up Guardian reports regularly to the People Committee and the Board, and has direct access to the Chair, Chief Executive and a designated Non-Executive Director. Thirteen Freedom to Speak Up Champions also support the Guardian across the organisation.

As a Foundation Trust, staff play a formal role in governance through elected staff governors on the Council of Governors. Staff governors help hold the Board to account and contribute to key decision-making, and colleagues continue to be encouraged to stand for election and participate in the voting process.

Staff are kept informed and able to share views through regular communications, including monthly Team Brief, weekly all-staff emails and increased use of digital and social media channels to support two-way engagement.

The Trust continues to deliver its Organisational Development programme, focused on leadership and relationships, talent management, innovation and consultancy support. Improvement activity is shaped by staff feedback and ongoing reflection, with an emphasis on building capability, strengthening culture and embedding sustainable change.

Staff Survey

The NHS Staff Survey provides a consistent and reliable way to understand staff experience across organisations. It allows trends to be tracked over time, comparisons to be made between staff groups, and areas for improvement to be identified. Listening to staff feedback and responding to their views is essential to improving services across the NHS.

The survey questionnaire is developed by the NHS Staff Survey Coordination Centre in partnership with the NHS Advisory Board, and NHS England sets clear guidance on which staff groups are included.

The 2025 survey was open from 1 October to 28 November 2025. The Trust achieved a 47.4% overall response rate, with 3,046 employees completing the survey. This is an increase of 2.1% on responses received in the 2024 survey (45.3%). The median response rate in the 2025 survey for the Trust's benchmarking group was 47%.

For the fifth consecutive year, the survey questions were linked to the elements and themes within the NHS People Promise:

- We are compassionate and inclusive
- We are recognised and rewarded
- We each have a voice that counts
- We are safe and healthy
- We are always learning
- We work flexibly
- We are a team

A direct comparison since the 2022 survey results can now be achieved. Each element and sub-theme of the People Promise is scored out of a possible 10. The table below shows the Trust's People Promise element/theme scores since 2022 and scores compared to the benchmarking group for the same period.

People Promise Elements	Trust				Benchmarking Group			
	2022	2023	2024	2025	2022	2023	2024	2025
We are compassionate and inclusive	7.30	7.48	7.41	7.46	7.25	7.31	7.29	7.28
We are recognised and rewarded	5.78	6.08	6.06	6.11	5.73	5.94	5.92	5.87
We each have a voice that counts	6.66	6.81	6.75	6.75	6.65	6.70	6.67	6.60
We are safe and healthy	5.86	6.18	6.13	6.17	5.92	6.11	6.13	6.07
We are always learning	5.39	5.72	5.71	5.73	5.35	5.61	5.64	5.57
We work flexibly	6.07	6.33	6.37	6.33	6.00	6.20	6.24	6.22
We are a team	6.72	6.93	6.90	6.92	6.64	6.75	6.75	6.75
Themes								
Staff Engagement	6.74	6.94	6.87	6.85	6.80	6.91	6.84	6.74
Morale	5.65	5.96	5.95	5.96	5.68	5.90	5.93	5.84

The 2025 survey results show that there has been no significant improvement in any of the People Promise themes. The 2025 staff engagement score decreased to 6.85 from 6.87 last year and the 2025 staff morale score increased to 5.96 compared to 5.95 last year.

The 2025 staff survey results show there were 6 questions (6%) where the scores showed significant improvement from the previous year, compared to 2 in the previous year. There was 1 question where the score has significantly declined since the previous survey, compared to 10 in the previous year. 92 questions have shown no significant movements since 2024, or the score is suppressed.

The table below shows the questions where the Trust's 2025 scores have significantly improved since last year.

Question	2024	2025	Difference
13a In the last 12 months, I have personally experienced physical violence at work from patients/service users, their relatives or other members of the public.	11.7%	9.7%	-2.0%
14a In the last 12 months, I have personally experienced harassment, bullying or abuse at work from patients/service users, their relatives or other members of the public.	23.0%	20.5%	-2.5%
14c In the last 12 months, I have personally experienced harassment, bullying or abuse at work from other work colleagues.	16.8%	14.0%	-2.8%
16a In the last 12 months, I have personally experienced discrimination at work from patients/service users, their relatives or other members of the public.	7.5%	5.4%	-2.1%
16b In the last 12 months, I have personally experienced discrimination at work from a manager/team leader or other colleagues.	7.9%	6.4%	-1.5%
23a In the last 12 months, I have had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review.	87.9%	90.3%	+2.4%

The table below shows the question where the Trust's 2025 scores have significantly declined since last year

Question	2024	2025	Difference
24b There are opportunities for me to develop my career in this organisation.	51.4%	48.8%	-2.6%

The Trust's 2025 staff survey results reflect the ongoing commitment of colleagues during a period of sustained operational challenge. Continuing to listen carefully to staff feedback helps us understand what is making a positive difference and where further action is needed to support our workforce.

Mandatory and Role Specific Training

During 2025/26, statutory and mandatory training compliance remained consistently high, with an average completion rate of 95% across the year. This reflects sustained organisational focus on improving access to training, supporting staff to complete required modules, and strengthening accountability.

The introduction of the Mandatory Training Accountability Framework in October 2025 represented an important development. The framework clearly defined expectations for timely completion and reinforced shared responsibility between individuals and managers.

Since implementation, there has been a notable reduction in the number of staff with training overdue by more than 18 months, supporting a stronger culture of compliance.

Additional capacity was provided through mandatory training days delivered by the Learning and Education Team, increasing flexibility and access for staff. These sessions were well attended and contributed to maintaining high levels of compliance throughout the year.

Compliance with role-specific training also remained strong, with an average completion rate of 94.4%. This reflects effective local oversight and continued engagement from services to ensure staff maintain the skills and competencies required for safe and effective practice. Overall, the year saw sustained high performance, improved accountability and continued assurance that statutory, mandatory and role-specific training requirements are being met.

Clinical Training

During 2025/26, the Trust continued to deliver a comprehensive clinical induction programme for registered and non-registered staff. In total, 358 colleagues completed clinical induction, with a further 165 attending Healthcare Support Worker (HCSW) induction. HCSWs received structured workplace support from the Clinical Skills Team to support safe practice and early consolidation of learning.

Conflict resolution and de-escalation training remained a priority, with just over 1,000 colleagues completing face-to-face sessions. Urgent Care services were also supported to deliver the Restraint Reduction Network-accredited Safe Holding programme, promoting safe, lawful and least-restrictive practice.

Investment in acute illness management training continued, with more than 280 colleagues completing the Greater Manchester Acute Illness Recognition and Management Course and a further 211 attending the community-focused programme. Together, these programmes support earlier recognition and effective management of clinical deterioration across acute and community settings.

Career development for support staff remained a focus, with over 70 Band 2 HCSWs participating in clinical skills sessions to support progression to Band 3 roles. More than 830 colleagues also accessed refresher and update sessions across a range of core clinical skills.

Resuscitation training remained a strong area of delivery. 94 colleagues completed Immediate Life Support and 74 achieved Advanced Life Support accreditation. The Advanced Life Support faculty expanded to over 50 instructors, with a further 10 identified for development. Across the year, 832 resuscitation update sessions supported 4,659 colleagues across adult and paediatric pathways.

Apprenticeships

During the year, almost 100 colleagues began apprenticeship programmes, demonstrating the Trust’s continued commitment to developing talent and widening career pathways. A new Executive-endorsed model of targeted apprenticeship drop-in sessions increased engagement, particularly across non-clinical roles, and improved access to development opportunities.

In response to upcoming national funding changes, the Trust took proactive action to support colleagues to secure apprenticeship places, helping to protect workforce development and future leadership capacity. At year end, the Trust supported 213 apprentices across 36 programmes, spanning key clinical professions and a wide range of non-clinical and leadership pathways.

Vocational Learning
During 2025/26, 204 learners completed work experience placements across the Trust. In recognition of the quality of this offer, the Trust received the NHS England Gold Award for excellence in work experience. A new joint Work Experience Policy, developed with TG ICFT, has strengthened governance and improved consistency across the region.

Working with system partners, the Trust delivered a Stockport-wide Safari Day for under-14s, engaging 150 young people and promoting early interest in NHS careers, particularly among under-represented groups. Plans are in place to repeat the event in 2026. Three pre-employment programmes supported 18 candidates, with seven progressing into substantive roles. The Trust's partnership with The King's Trust continued to gain national recognition, highlighting the impact of joint work in supporting young people into healthcare careers.

Pre-Registration Programme – Cadet and T Levels
The Cadet and T Level programme continued to grow in 2025/26 and can now support up to 200 learners across a wide range of clinical and non-clinical settings, including Nursing, Midwifery, Therapies, Community and Social Care.

Following a successful regional bid, the Trust was appointed as host for a Department for Education-funded T Level Industry Placement Co-ordinator post. Working with partners across Greater Manchester, the role is increasing placement capacity, particularly within social care, and strengthening education-to-employment pathways.

Recruitment and progression remained a key focus. Around 40% of the current cadet cohort have expressed a preference to move directly into employment with the Trust on completion of the programme, demonstrating its value as a pipeline into substantive roles. For those progressing to university, ongoing placement opportunities at the Trust support future recruitment and long-term workforce sustainability.

Preceptorship
During the year, the Preceptorship Programme was fully reviewed and enhanced through the introduction of a new electronic portfolio aligned to the National Preceptorship Framework for Nursing, Midwifery and Allied Health Professionals (AHP). The new approach improves consistency, oversight and assurance, while maintaining a high-quality experience for newly qualified staff. There are currently 197 preceptees using the system, with early feedback highly positive.

Protected learning time was also redesigned, reducing formal study from five full days to two structured half-day sessions. This enables more learning to take place in the clinical environment, supporting confidence, application in practice and patient safety.

In 2026/27, a new joint Preceptorship Policy will be developed with TG ICFT to maintain alignment with national standards and support a consistent, sustainable approach across the system.

Leadership Development
Significant progress was made during the year in strengthening leadership development across both Trusts. A redesigned, joint-trust leadership development offer was introduced, providing a more cohesive, values-based approach aligned to organisational priorities. A central element of this was the launch of the C.A.R.E. Leadership Way Resource Hub in December 2025, which now acts as a single access point for leadership development opportunities, including workshops, diagnostics, tools and resources. By March 2026, the hub had been accessed more than 500 times by over 110 users, demonstrating strong early engagement.

The leadership offer was further enhanced through the introduction of new internally-led development focused on emerging priorities, including AI in Everyday Leadership and Bringing People With You: Managing Human Reactions to Change. Leaders were also encouraged to build system-wide thinking and networks through the promotion of relevant regional webinars covering themes such as psychological safety, allyship and NHS productivity. In addition, a joint Learning Owners Network was established across both SFT and TG ICFT to ensure consistent communication, alignment to the C.A.R.E. Leadership Way and a more integrated leadership development offer.

Health & Wellbeing
Over the past year, the Trust has continued to strengthen its joint Health and Wellbeing offer with TG ICFT. The programme aligns with the NHS People Promise and national wellbeing priorities, focusing on creating a culture where staff feel safe, healthy and supported at work. In the context of continued pressures highlighted in the 2025 NHS Staff Survey, the joint programme has improved visibility of support, increased access to wellbeing resources, and strengthened collaboration across both Trusts.

Key achievements in 2025/26:

- Face-to-face wellbeing roadshows and the Wellbeing on Wheels programme provided accessible support across clinical and non-clinical areas, with a focus on engaging harder-to-reach teams and those experiencing higher levels of stress or musculoskeletal absence.
- Support was strengthened through new financial wellbeing provision, with the introduction of HSBC as a partner offering one-to-one guidance, webinars and practical tools.
- Mental health and psychological wellbeing were promoted through Stress Awareness Month activities, continued delivery of Schwartz Rounds, and partnership working with the Staff Psychological and Wellbeing Service to provide webinars, trauma-informed training and individual support.
- Targeted support continued for women’s health and menopause, alongside physical wellbeing campaigns such as Move This May and enhanced musculoskeletal support, including back care initiatives and dedicated MSK practitioners.

- A Winter Wellbeing campaign raised awareness of available support, while governance and communication were strengthened through the establishment of a Joint HWB Steering Group, a new cross-Trust newsletter, and the expansion of Health and Wellbeing Champion networks to support peer-to-peer engagement.

Priorities for 2026/27 include expanding the Health and Wellbeing Champion network, embedding financial wellbeing as a core offer, strengthening support for menopause and other gender-specific health needs, rolling out the back care campaign across both Trusts, improving evaluation to better evidence impact, and exploring opportunities for shared psychological wellbeing services.

Equality, Diversity, and Inclusion

The Trust's ambition is to embed equality, diversity and inclusion (EDI) into everything we do, creating an environment where all colleagues can thrive and patients consistently receive compassionate, high-quality care. By making EDI part of everyday practice and decision-making, we strengthen our workforce, culture and patient experience.

Inclusive recruitment

Through collaborative working, the Trust has strengthened engagement with local communities to widen access to employment and volunteering opportunities. Activity has included attendance at Jobcentre Plus events and recruitment fairs, delivery of a Trust-wide recruitment day attended by over 2,000 local residents, and continued partnership with Pure Innovations to support candidates with applications and interviews.

Social media recruitment reach has expanded through joint working with TG ICFT, increasing the Trust's Facebook following from 75 to 260 and enabling engagement with over 20 local community groups. The Trust has also worked with Disability Stockport and the Department for Work and Pensions to promote vacancies directly to under-represented groups.

Inclusive recruitment practices have been strengthened by offering alternative application methods and sharing interview information in advance. Feedback from candidates and recruiting managers is being collected to evaluate impact and inform further improvements.

Becoming an anti-racist organisation

Building on the success of our Bronze award last year, the Trust has ensured that anti-racism is a central theme in the development of our joint EDI strategy, including commitments around anti-racism training, and incorporating actions into the new strategy, to progress our ambitions for Silver.

Understanding the lived experience of our colleagues

Recognising that staff survey data is primarily quantitative, the Trust uses additional approaches to better understand colleagues' lived experience. This includes continued delivery of the Big Conversation Programme, with feedback triangulated alongside staff survey results, Freedom to Speak Up reports and wider workforce metrics.

Extensive engagement also informed the development of the joint EDI strategy, ensuring views from colleagues across both organisations were reflected. In addition, several staff

networks have been brought together across SFT and TG ICFT, recognising shared experiences and challenges and enabling a more consistent and coordinated approach.

Career progression

Recognising that career progression remains an area of inequality, the Trust has taken targeted action to accelerate improvement. The Career Progression Task Group has been reinvigorated and expanded to include divisional representation, strengthening ownership and pace of delivery.

Data on career progression has been analysed to identify where focused action will have the greatest impact. In response, a mentoring scheme pilot has been developed, supported by trained internal coaches to provide career coaching. In addition, a leadership development programme for ethnic minority colleagues has been designed and is scheduled to launch in the spring.

Applications for the new, joint-trust Elevate with C.A.R.E. – Developing Future Black & Minority Ethnic (BAME) Leadership Programme opened in January 2026. The programme has been created to address the progression ceiling experienced by BAME colleagues at Band 6 across all professional groups (excluding medical staff). Twenty colleagues from both Trusts, working in Bands 5–6, successfully secured places and are now engaged in a blended learning journey designed to build confidence, visibility, and career readiness.

Bullying and harassment

Recognising the harm caused by unacceptable behaviour, we have taken clear action to strengthen culture, confidence and support. This has included the launch of the Trust's refreshed values and behaviours - Compassion, Accountability, Respect and Excellence - and embedding these across the organisation.

The Trust delivered pilot training focused on Responding to a First Disclosure and sexual harassment in the workplace, helping colleagues respond appropriately and supportively. Internal conduct processes have also been reviewed and strengthened, drawing on internal learning, peer review and legal advice, and developed collaboratively with TG ICFT.

In addition, Freedom to Speak Up Champions have been appointed to further support the work of the FTSU Guardian and promote a culture where staff feel safe to raise concerns.

Violence and aggression

A communication plan addressing unwanted behaviour, including violence and aggression, has been implemented. This reinforces the importance of reporting concerns, highlights the support available to staff, and encourages completion of the relevant checklists.

In support of the Trust's values and behaviours, phase two of the Civility Saves Lives programme - *Having the Conversation* - is currently underway. These sessions equip staff with the skills and confidence to challenge and manage inappropriate behaviour.

The Trust also launched its Sexual Misconduct Policy in May 2025, supported by an anonymous reporting tool for all forms of unwanted behaviour. The communications

approach reinforces the Trust's zero-tolerance stance and promotes reporting, including through anonymous channels, to ensure staff feel safe and supported.

Developing our new strategy

Throughout the 2025, a consultation exercise was run across both SFT and TG ICFT to inform our new joint EDI strategy. Bringing together the consultation responses, and the requirements of EDI local and national standards, a joint strategy was approved by both Boards in November & December 2025, with a subsequent approval of divisional objectives to support implementation of the strategy.

Future priorities and targets

The Trust will continue to deliver the People Plan, Workforce EDI Strategy and Organisational Development Plan that addresses the areas staff have identified as requiring improvement. Based on the findings of the 2025 NHS national staff survey, and broader staff engagement, key priorities over the next 12 months include:

We are compassionate and inclusive
• We will design and implement a refreshed EDI training offer in a phased way. Including the pilot and evaluation of neurodiversity training. • We will Take proactive steps to address the disproportionate levels of bullying and harassment experienced by disabled staff. • Enhance the organisations' Reverse Mentoring Scheme to help increase participation of Board Members as mentees. • Implement a structured "Return to Work" support package for those returning from parental leave to ensure career momentum is maintained.
We are recognised and rewarded
• We will hold our annual staff awards ceremony. • We will implement a reviewed quarterly staff award scheme.
We each have a voice that counts
• We will continue to promote and enhance our employee voice channels and the Trust's Freedom to Speak Up approach. • We will continually work to improve the response rate to the annual NHS staff survey.
We are safe and healthy
• We will continue to enhance our employee health & wellbeing through the delivery of our new health and wellbeing plan. • We will continue our work in relation to the sexual safety charter, including the promotion of appropriate training. • Ongoing planned communication plan to encourage staff and managers to report incidents and to remain them of the support available for staff who have experienced or witnessed violent, aggressive or unwanted behaviour. • Ongoing planned communication plan to encourage staff and managers to report incidents and to remain them of the support available for staff who have experienced or witnessed violent, aggressive or unwanted behaviour.

We are always learning
• We are continuing to deliver 2-hour 'Appraisals with Impact' training sessions for all line managers to help improve the process of cascading and setting team & individual performance objectives. • We are continuing to deliver the 1-day coaching skills training course.
We work flexibly
• We will continue to promote flexible working opportunities, and the national flexible working guidance and toolkit
We are a team
• We will continue to develop and promote our care leadership way offer, specifically the "Engaging your team" session, in order to help managers understand and utilise their staff survey results.
Staff Engagement
• We will work with divisions and teams to maximise staff feedback, incident reports and complaints to inform the design of interventions and actions that will help improve colleague experience and patient care.
Morale
• We will design and deliver tailored staff morale boosting initiatives/interventions with divisions and teams.

Consultancy costs

The Trust procures expert advice to deliver key project where there is no internal expertise or, in some circumstances, not the required capacity. Consultancy costs in 2025/26 are summarised below:

Consultancy area	£000	Note
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.	417	(a)
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.	6	(b)
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.	588	(c)
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.	49	(d)

Legal: The provision of external legal advice and opinion including advice in connection with the policy formulation and strategy development particularly on commercial and contractual matters.	69	(e)
Total Cost 2025/26	**1,129**	

(a) Includes services to support Business Intelligence (BI)
(b) Includes HR investigation support.
(c) Includes costs for survey and structural engineering services
(d) VAT advisors for general advice and projects
(e) Legal Advice for commercial and contractual matters

As a cost comparator 2024/25 = £441k.

High Off-Payroll arrangements

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

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

Table 1: Length of all highly paid off-payroll engagements
For all off-payroll engagements as of 31 March 2026, for more than £245(1) per day:

	Number
No. of existing engagements as of 31 March 2026	-
Of which:	-
Number that have existed for less than one year at the time of reporting	-
Number that have existed for between one and two years at the time of reporting	-
Number that have existed for between two and three years at the time of reporting	-
Number that have existed for between three and four years at the time of reporting	-
Number that have existed for four or more years at the time of reporting	-

[1] The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

Table 2: Off-payroll workers engaged at any point during the financial year
For all off-payroll engagements as of 31 March 2026, for more than £245(1) per day:

	Number
No. of temporary off-payroll workers engaged between 1 April 2025 and 31 March 2026	-
Of which:	-
No. not subject to off-payroll legislation [(2)]	-
No. subject to off-payroll legislation and determined as in-scope of IR35[(2)]	-
No. subject to off-payroll legislation and determined as out of scope of IR35[(2)]	-
The number of engagements reassessed for compliance or assurance purposes during the year	-
Of which: no. of engagements that saw a change to IR35 status following review	-

1 The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

2 A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Trust must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes.

Table 3: Off-payroll board member/senior official engagements
For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2025 and 31 March 2026:

	Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	0
Total no. of individuals on payroll and off-payroll that have been deemed "board members, and/or senior officials with significant financial responsibility", during the financial year. This figure must include both on payroll and off-payroll engagements	17

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 offered a Mutually Agreed Resignation Scheme Voluntary Redundancy Scheme during 2025/26 with the following tables, which have been subject to audit, showing the exit packages for 2025/26, compared to 2024/25.

Exit package cost band (including any special payment element)	Number of compulsory redundancies 2025/26	Number of other departures agreed 2025/26	Total number of exit packages 2025/26
<£10,000	-	-	-
£10,001 - £25,000	-	1	1

£25,001 - £50,000	-	1	1
£50,001 - £100,000	-	-	-
£100,001 - £150,000	-	-	-
£150,001 - £200,000	-	-	-
>£200,000	-	-	-
Total number of exit packages by type	**-**	**2**	**2**
Total resource cost	**-**	**£41,000**	**£41,000**

Comparator 2024/25

Exit package cost band (including any special payment element)	Number of compulsory redundancies 2024/25	Number of other departures agreed 2024/25	Total number of exit packages 2024/25
<£10,000	-	-	-
£10,001 - £25,000	1	-	1
£25,001 - £50,000	-	-	-
£50,001 - £100,000	-	-	-
£100,001 - £150,000	-	-	-
£150,001 - £200,000	-	-	-
>£200,000	-	-	-
Total number of exit packages by type	**1**	**-**	**1**
Total resource cost	**£23,000**	**-**	**£23,000**

Exit Packages: Other (non-compulsory) departure payments				
	2024/25		2025/26	
	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
	Number	£000	Number	£000
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	**2**	**41**
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/DHSC approval	-	-	-	-
Total	**-**	**-**	**2**	**41**
Of which:				
Non-contractual payments requiring	-	-	-	-

HMT/DHSC approval made to individuals where the payment value was more than 12 months of their annual salary				

Code of Governance for NHS Provider Trusts disclosures

The Code of Governance for NHS provider trusts (the Code) was published in October 2022 and has been applicable since 1st April 2023. NHS Foundation Trusts are required to provide specific disclosures in their annual report to meet the requirements of the Code, and these are detailed in the following table:

Code Section	Summary of Requirement
A 2.1	The board of directors should assess the basis on which the trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB, and place-based partnerships. The board of directors should ensure the trust actively addresses opportunities to work with other providers to tackle shared challenges through entering into partnership arrangements such as provider collaboratives. The trust should describe in its annual report how opportunities and risks to future sustainability have been considered and addressed, and how its governance is contributing to the delivery of its strategy. **Comply – See Performance Report**
A 2.3	The board of directors should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the trust's vision, values and strategy, it should seek assurance that management has taken corrective action. The annual report should explain the board's activities and any action taken, and the trust's approach to investing in, rewarding and promoting the wellbeing of its workforce. **Comply – See Staff Report**
A 2.8	The board of directors should describe in the annual report how the interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision-making, and set out the key partnerships for collaboration with other providers into which the trust has entered. The board of directors should keep engagement mechanisms under review so that they remain effective. The board should set out how the organisation's governance processes oversee its collaboration with other organisations and any associated risk management arrangements. **Comply – See Performance Report**
B 2.6	The board of directors should identify in the annual report each non-executive director it considers to be independent. **Comply – See Directors Report**
B 2.13	The annual report should give the number of times the board and its committees met, and individual director attendance. **Comply – See Directors Report & Remuneration Report**
B 2.17	For foundation trusts, this schedule should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also 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 the council of governors operate, including a summary of the types of decisions to be taken by the board, the council of governors, board committees and the types of decisions which are delegated to the executive management of the board of directors. **Comply – See Directors' Report & Accountability Report (Council of Governors & Membership)**
C 2.5	Open advertising and advice from NHS England's Non-Executive Talent and

	Appointments team is available for use by nominations committees to support the council of governors in the appointment of the chair and non-executive directors. If an external consultancy is engaged, it should be identified in the annual report alongside a statement about any other connection it has with the trust or individual directors. **Comply – See Remuneration Report**
C 2.8	The annual report should describe the process followed by the council of governors to appoint the chair and non-executive directors. The main role and responsibilities of the nominations committee should be set out in publicly available written terms of reference. **Comply – See Remuneration Report. Nominations Committee Terms of Reference available via Company Secretary**
C 4.2	The board of directors should include in the annual report a description of each director's skills, expertise and experience. **Comply – See Directors Report**
C 4.7	All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years, according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the trust or individual directors. **Explain – See below**
C 4.13	The annual report should describe the work of the nominations committee(s), including: • the process used in relation to appointments, its approach to succession planning and how both support the development of a diverse pipeline • how the board has been evaluated, the nature and extent of an external evaluator's contact with the board of directors and individual directors, the outcomes and actions taken, and how these have or will influence board composition • the policy on diversity and inclusion including in relation to disability, its objectives and linkage to trust vision, how it has been implemented and progress on achieving the objectives • the ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and how far the board reflects the ethnic diversity of the trust's workforce and communities served • the gender balance of senior management and their direct reports. **Comply – See Directors Report, Remuneration Report & Staff Report**
C 5.15	Foundation trust 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. **Comply – See Accountability Report (Council of Governors & Membership)**
D 2.4	The annual report should include: • the significant issues relating to the financial statements that the audit committee considered, and how these issues were addressed • an explanation of how the audit committee (and/or auditor panel for an NHS trust) has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor; length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans • where there is no internal audit function, an explanation for the absence, how internal assurance is achieved and how this affects the external audit • an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services.

	Comply – See Directors' Report
D 2.6	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, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy. **Comply – See Directors' Report**
D 2.7	The board of directors should carry out a robust assessment of the trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the annual report. **Comply – See Performance Report & Annual Governance Statement**
D 2.8	The board of directors should monitor the trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The board should report on internal control through the annual governance statement in the annual report. **Comply – See Annual Governance Statement**
D 2.9	In the annual accounts, the board of directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern. Trusts should refer to the DHSC group accounting manual and NHS foundation trust annual reporting manual which explain that this assessment should be based on whether a trust anticipates it will continue to provide its services in the public sector. As a result, material uncertainties over going concern are expected to be rare. **Comply – See Performance Report**
E 2.3	Where a trust releases an executive director, e.g. to serve as a non-executive director elsewhere, the remuneration disclosures in the annual report should include a statement as to whether or not the director will retain such earnings. **Comply – See Remuneration Report**
Appendix B, Para 2.3 (not in Schedule A)	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. **Comply – See Accountability Report (Council of Governors & Membership)**
Appendix B, Para 2.14 (not in Schedule A)	The board of directors should ensure that the NHS foundation trust provides effective mechanisms for communication between governors and members from its constituencies. Contact procedures for members who wish to communicate with governors and/or directors should be clear and made available to members on the NHS foundation trust's website and in the annual report. **Comply – See Accountability Report (Council of Governors & Membership)**
Appendix B, Para 2.15 (not in Schedule A)	The board of directors should state in the annual report the steps it has 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, e.g. through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations. **Comply – See Accountability Report (Council of Governors & Membership)**

Additional requirement of FT ARM resulting from legislation	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. This is required by paragraph 26(2)(aa) of schedule 7 to the NHS Act 2006, as amended by section 151 (8) of the Health and Social Care Act 2012. *Power to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the foundation trust's or directors' performance). ** As inserted by section 151 (6) of the Health and Social Care Act 2012) **N/A – Governors have not exercised this power during 2025/26.**

Where information is required to be made publicly available, or available to governors or members, the relevant information is published on the Trust's website and/or can be obtained on request from the Company Secretary by emailing: corporateoffice@stockport.nhs.uk or by writing to the Trust Headquarters at Oak House, Stepping Hill Hospital, Poplar Grove, Stockport.

For all other provisions where no specific requirements apply, the Trust adopts the required "comply or explain" approach. The Board has reviewed compliance with the Code and except where set out below, the Trust complies with the Code; any departures are explained in line with the "comply or explain" principle.

Provision C 4.7 – Boards strongly encouraged to carry out an externally facilitated developmental review using the well-led framework at least every three years.

Explanation: The Trust has not undertaken a formal externally facilitated Well Led developmental review within the three to five year timeframe set out in the 2017 NHS England Well Led Framework. However, alternative assurance has been obtained through a combination of internal audit coverage, independently facilitated reviews, structured self-assessments aligned to the Well Led Framework, the CQC Single Assessment Framework and the NHS Oversight Framework, with independent validation by MIAA, and for the latter, by NHS England.

Provision E.2.2 – Levels of remuneration for the chair and other non-executive directors should reflect the Chair and non-executive director remuneration structure.

Explanation: The Council of Governors approved a transition to a joint non-executive director model for 2025/26. They also agreed remuneration above the standard NHS England framework, reflecting the broader scope and added responsibilities of joint roles, alignment with regional benchmarks, and cost sharing between the two Trusts. These arrangements were formally approved by both Councils of Governors.

Council of Governors and Membership

The basic governance structure of all NHS foundation trusts include:
- a public and staff membership
- a Council of Governors
- a Board of Directors.

Membership
Membership of the Trust is open on an opt-in basis to anyone over 16 years old and living in one of the following public constituencies:
- Bramhall and Cheadle
- Heatons and Stockport West
- Marple and Hazel Grove
- High Peak and Dales
- Tame Valley and Werneth
- Rest of England & Wales

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

Staff are automatically members unless they choose to opt out.

Details of the make-up of our members as of 31 March 2026 are below:

Constituency	Number of members
Bramhall and Cheadle	2,107
Heatons and Stockport West	1,802
High Peak and Dales	728
Marple and Hazel Grove	2,258
Tame Valley and Werneth	1,642
Outer Region	1,394
Staff	6,669
Total	16,600

Public Constituency	Number of members	Eligible membership
Age		
0 - 16	0	75,232
17- 21	139	18,389
22+	8,070	297,492
Ethnicity		
White	7,534	342,655
Mixed	93	8,848
Asian or Asian British	447	22,160
Black or Black British	138	3,652
Other	11	4,907
Socio-economic grouping		
AB	3,103	40,525
C1	2,926	53,185
C2	1,927	34,904
DE	1,975	39,922
Gender		
Male	3,656	190,979
Female	5,940	200,132

* Where figures do not equal the total number of members, information has not been provided.

Council of Governors

Governors are the direct representatives of members, staff, stakeholders, and public interests and play a central role in the governance arrangements of NHS foundation trusts.

The primary role of the Council of Governors is to hold the Non-Executive Directors, both individually and collectively, to account for the performance of the Board of Directors, while representing the interests of the Trust's members and the public. In addition, the Council of Governors has the following statutory responsibilities:

- Approving the appointment of the Chief Executive
- Appointing and removing the Chairman and other Non-Executive Directors
- Deciding the remuneration of the Chairman and Non-Executive Directors
- Appointing and removing the NHS Foundation Trusts Auditors
- Contributing to the forward plans of the organisation
- Receiving the NHS Foundation Trust's Annual Accounts, Auditor's Report and Annual Report
- When appropriate, making recommendations and/or approving revisions of the Foundation Trust Constitution.

The composition of the Council of Governors during 2025/26 was:

Constituency	Number
Public	
Bramhall & Cheadle	**4**

Heatons & Stockport West	**4**
High Peak & Dales	**3**
Marple & Hazel Grove	**4**
Tame Valley & Werneth	**4**
Outer Region	**1**
Staff	
Staff	**4**
Appointed	
Stockport Metropolitan Borough Council	**1**
Age UK Stockport (Charity)	**1**
Stockport Healthwatch	**1**
Greater Manchester University	**1**
Total	**28**

Governors' elections

Elections were held during 2025/26 as follows:

Constituency	Number of Positions Available	Number of Nominations Received
Public		
Bramhall & Cheadle	4	6
High Peak & Dales	1	1
Marple & Hazel Grove	4	2
Tame Valley & Werneth	2	0

At the end of 2025/26, the Trust had vacancies for governors in the following constituencies:

- Heatons & Stockport West – 1 vacancy
- Marple & Hazel Grove – 2 vacancies
- Tame Valley & Werneth – 1 vacancy
- Staff – 2 vacancies
- Greater Manchester University – 1 vacancy

During 2025/26 several long-standing governors left the organisation. Their contribution to the Council of Governors and the Trust is sincerely appreciated.

Mrs Sue Alting, Appointed Governor, Age UK Stockport, has continued in the role of Lead Governor.

Membership of the Council of Governors

Information about our public, staff and appointed governors is available on our website. Listed below are details of all our governors throughout 2025/26 and their attendance at Council of Governors meetings:

Governor	Constituency	Attendance
Public		
Dominic Hardwick	**Bramhall & Cheadle**	**2 of 3**
Keith Holloway	**Bramhall & Cheadle**	**3 of 3**
Adrian Nottingham	Bramhall & Cheadle	0 of 2
Michelle Slater	**Bramhall & Cheadle**	**5 of 5**
Sarah Thompson	**Bramhall & Cheadle**	**5 of 5**
Tad Kondratowicz	**Heatons & Stockport West**	**4 of 5**
Victoria MacMillan	**Heatons & Stockport West**	**2 of 5**
Chris Summerton	Heatons & Stockport West	3 of 3
Steve Williams	**Heatons & Stockport West**	**5 of 5**
Michael Chantler	**High Peak & Dales**	**2 of 5**
Tony Gosling	**High Peak & Dales**	**5 of 5**
Lesley Surman	**High Peak & Dales**	**2 of 3**
Peter Chadbourne	**Marple & Hazel Grove**	**3 of 3**
Val Cottam	**Marple & Hazel Grove**	**5 of 5**
Richard King	Marple & Hazel Grove	2 of 2
Tony Moore	Marple & Hazel Grove	1 of 2
John Morris	Marple & Hazel Grove	0 of 2
Callum Kidd	**Outer Region**	**1 of 5**
Howard Austin	**Tame Valley & Werneth**	**5 of 5**
Alexander Wood	**Tame Valley & Werneth**	**4 of 5**
Staff		
Yogalingam Ganeshwaran	Staff	1 of 2
Paula Hancock	**Staff**	**4 of 5**
David McAllister	**Staff**	**2 of 5**
Ruth Perez-Merino	Staff	2 of 3
Appointed		
Sue Alting	**Age UK Stockport**	**4 of 5**
David Kirk	**Healthwatch Stockport**	**3 of 5**
Helen Foster-Grime	**Stockport Metropolitan Borough Council**	**0 of 3**
Vacant	**Greater Manchester University**	**0 of 5**

Current governors in bold black type. Governors that stepped down during 2025/26 in blue type.

Formal meetings of the Council of Governors are held quarterly, with occasional extraordinary meetings as required. Informal catch-up meetings also take place between governors and Non-Executive Directors, providing an opportunity to share the key activities of the assurance committees and ensure feedback from governors can be shared with colleagues.

All governors are required to comply with the Council of Governors Code of Conduct and declare any interests that may result in a potential conflict of interest in their role as governor of Stockport NHS Foundation Trust. We hold a register of governors' interests, which is available on request from the Company Secretary on 0161 419 5164 or email corporateoffice@stockport.nhs.uk

Details of how to contact governors are available on the Trust website.

Governor Training & Development

Training and development for governors during 2025/26 included an induction programme for new governors. In addition, three joint development sessions were held with governors from TG ICFT. These sessions focused on the development of a joint organisational strategy and forward plans, seeking governors' views on strengths, challenges and future opportunities. They also explored the evolving joint corporate governance arrangements, including future Board composition and how the two Councils of Governors can work together to provide effective oversight and representation as the partnership develops.

External training opportunities were also made available to governors, with a number of governors attending events delivered by NHS Providers, including sessions focused on the future role of governors.

Council of Governor Meetings

During 2025/26 the Council of Governors considered, and approved as required, the following matters in formal meetings:

- The re-appointment of Samira Anane, Non-Executive Director, for a one-year term of office from 1 September 2025.
- Appointment of David Curtis, Non-Executive Director, commencing in post from 1 August 2025.
- Appointment of David Jago, Joint Non-Executive Director and Audit Committee Chair, commencing in post from 1 February 2026.
- Appointment of Michael Forrest, David Coorey, Peter Blythin and Farooq Hakim, joint Non-Executive Directors, commencing in post from 1 April 2026.
- Remuneration and terms of service of joint Non-Executive Directors.
- Appraisal process and outcome for Chair and Non-Executive Directors.
- Appointment of Sue Alting as Lead Governor.
- Appointment of Louise Sell as Deputy Chair, and subsequent appointment of Michael Forrest as Deputy Chair following board composition review, effective from 1 April 2026.
- Appointment of David Curtis as the Senior Independent Director prior to recommendation to the Board of Directors.
- Revision and approval of the Trust Constitution, including the revised composition of the Council of Governors.
- Receipt of the Annual Report & Accounts 2024/25, and the External Auditors Report.
- The Trust Plans for 2025/26, alongside development of forward plans and the Joint Organisational Strategy and Joint Quality Strategy with TG ICFT.

In addition to receiving information about the operational, financial, people and quality performance of the organisation, the Council of Governors considered and provided views on a range of issues in line with their duties including:

- Development of the Membership Action Plan, with regular progress report against the Membership Strategy and Action Plan via the Membership Development Group.
- National staff survey results.
- Patient communication with a focus on reducing 'Do Not Attends'.
- Health inequalities, including work taking place at Trust & Stockport locality.
- Confirmation of Governors' Standards of Business Conduct.

- Confirmation of Nominations Committee membership.
- SFT and TG ICFT Joint Corporate Governance Model.

The Council of Governors was kept informed of ICS developments at both GM and Locality level through reports presented to the Council, including updates provided by the Joint Chair.

Governors have continued to represent the views of members and the public through Council of Governors meetings and informal discussions with the Chair and Non-Executive Directors.

Board of Director engagement with governors

The Board of Directors and the Council of Governors work together constructively within their respective statutory roles. A formal process is in place, as set out in within the Trust Constitution, to resolve any disputes should they arise. Governors regularly observe Board meetings held in public to gain insight into Board-level discussions, decision-making and the challenge provided by Non-Executive Directors. In turn, Executive and Non-Executive Directors regularly attend meetings of the Council of Governors, contributing to discussions and providing additional information where required.

In addition to formal meetings, informal meetings are held between governors and the Chair and Non-Executive Directors, providing opportunities to share key updates and ensure governors' feedback is communicated effectively.

Details of Board members' attendance at Council of Governors' meetings during 2025/26 are set out below. This includes one extraordinary meeting held in private, where attendance was limited to specific Executive and Non-Executive Directors due to the nature of the business considered.

Board Member	Title	Attendance
Non-Executive Directors		
David Wakefield	Joint Chair	5 of 5
Marisa Logan-Ward	Non-Executive Director / Deputy Chair	0 of 1
Samira Anane	Non-Executive Director	3 of 4
Anthony Bell	Non-Executive Director	2 of 4
David Curtis	Non-Executive Director	3 of 3
Beatrice Fraenkel	Non-Executive Director	0 of 3
David Hopewell	Non-Executive Director	1 of 4
David Jago	Non-Executive Director	1 of 1
Louise Sell	Non-Executive Director / Deputy Chair	4 of 4
Executive Directors		
Karen James	Chief Executive	4 of 5
Amanda Bromley	Chief People Officer	2 of 4
Paul Buckley	Director of Strategy & Partnerships	1 of 4
Nic Firth	Chief Nurse	0 of 4
John Graham	Chief Finance Officer / Deputy Chief Executive	3 of 4
Andrew Loughney	Medical Director	2 of 2
Jackie McShane	Chief Operating Officer	1 of 4

Dilraj Sandher	Chief Medical Officer	0 of 2

Membership development and engagement

The Council of Governors have an approved Membership Strategy and annual action plan. The aims of the strategy are:

- To maintain a sizeable membership that is representative of the communities the Trust serves.
- To develop an active and engaged membership.

The Council of Governors' Membership Development Group oversees delivery of the Membership Strategy and action plan, supports the development of membership initiatives, and keeps key membership issues under review. Governors are encouraged to use their own networks to gather feedback and help identify themes from members and the wider community.

Working with the Organisational Development Team, further opportunities to recruit and engage young people were progressed during the year. These included incorporating membership information into the Volunteers' Induction programme and regular attendance by the Corporate Affairs Team and governors at the Trust's fortnightly student inductions to promote membership.

The Membership Development Group reported good overall progress against the Membership Action Plan in 2025/26, particularly in improving representation of young people within the membership.

Members Event

A well-attended health talk, "You, I and MRI!", was held in June 2025, with around 50 members and governors attending. The event provided an opportunity for members to engage with governors and share feedback on Trust services.

Communication with members

A range of methods were utilised to communicate with members, including:

- issuing a regular members' newsletter, sharing updates on the Trust's activities and highlighting the work of governors
- holding an Annual Members' Meeting, attended by more than 40 members, which provided an open and engaging opportunity to ask questions of the Board
- using social media to share Trust updates, promote the role of governors and encourage new members to join.

Members can also contact governors and provide feedback at any time, with contact details available via the website.

NHS Oversight Framework

NHS England's NHS Oversight Framework 2025/26 is the framework for assessing health systems including providers. It promotes transparency, improvement, and helps identify potential support or intervention needs. NHS organisations are allocated to 1 of 5 'segments'.

Segmentation indicates performance and whether improvement is required, from high performing across all domains (segment 1) to low performance across a range of domains (segment 4). An organisation assessed as segment 4 combined with a low capability to improve is allocated to segment 5.

NHS England's oversight response to an organisation is based on:

- Its segment derived from scored metrics under 5 performance domains (being access to services, effectiveness and experience of care, patient safety, people and workforce, and finance and productivity)
- considering financial override which may limit a segment to be no better than 3
- contextual metrics which are not scored (for example those under sixth domain of improving health and reducing inequality)
- capability assessments which consider the organisation's leadership and governance.

Segmentation

Stockport NHS Foundation Trust was in segment 3 at 31 March 2026. Current segmentation information for NHS trusts and foundation trusts is published on the NHS England website: https://www.england.nhs.uk/publication/nhs-system-oversight-framework-segmentation/.

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 England.

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

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

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

myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

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

Karen James OBE
Chief Executive
25th June 2026

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 2026 and up to the date of approval of the annual report and accounts.

Capacity to handle risk
Leadership of the Trust's risk management process is provided through a clear governance and accountability framework. The Board of Directors (the Board) sets the Trust's risk appetite and oversees the management of principal risks to the achievement of the Trust's objectives through the Board Assurance Framework. Executive leadership is provided by the Chief Executive and Executive Directors, who are accountable for managing risks within their respective portfolios.

The Audit Committee provides independent oversight of the effectiveness of risk management and internal control. It is supported by the Risk Management Group, which coordinates and reviews organisational and divisional risk profiles and reports to the Audit Committee.

Risk is also reviewed through divisional performance arrangements, ensuring effective escalation from ward to Board and identification of emerging or cross-Trust issues.

Staff are supported to manage risk appropriate to their roles through mandatory and role-specific training, including risk management awareness and training, clear policies and guidance on risk management processes. The Trust promotes learning from good practice and experience through incident reporting, audit findings, and regulatory and internal reviews, with learning shared across the organisation through governance structures and targeted communications.

The Trust received a high assurance rating for the 'risk management core controls' internal audit completed in 2024/25, providing independent assurance that the Trust has a strong

system of core risk management controls in place.

The risk and control framework

Risk management is fundamental to the Trust's ability to deliver high-quality services, make effective decisions and achieve its principal objectives. The Trust's Risk Management Strategy and Policy, approved by the Board, sets out the approach to identifying, assessing, managing and monitoring risk across the organisation.

Risks are identified through a range of sources, including risk assessments, incident reporting and investigation, complaints and claims, and the identification of emerging issues through business intelligence and performance information.

All risks are assessed using a 5 x 5 risk matrix, which considers the likelihood and impact of risks to generate a risk score between 1 and 25. The risk score determines the level of escalation, management and oversight required. This approach applies consistently to all risks, including clinical, financial and operational risks.

Risk registers are maintained and regularly reviewed within each division and corporate functions. Risks with a residual score of 15 or above are recorded on the Trust's significant risk register and are monitored by the Risk Management Group.

Board Assurance Framework

The Board uses the Board Assurance Framework (BAF) as its primary tool for managing and assuring delivery of the agreed strategic objectives. The BAF sets out the principal risks to delivery of the objectives, the key controls in place to manage them, and the assurances relied upon by the Board. The Board is supported by a committee structure chaired by Non-Executive Directors which, during 2025/26, comprised the Finance & Performance Committee, Quality Committee and People Performance Committee. Principal risks were allocated to the appropriate Board Committee for detailed oversight, except for two cross-cutting strategic partnership risks, which were retained at Board level due to their organisation-wide nature. These risks were considered alongside related risks on the Trust's significant risk register and informed discussion and decision-making regarding actions to reduce risk. Following each meeting, Committee Chairs reported key issues to the Board. The Committee Chairs were also members of the Audit Committee, providing regular update with a specific focus on how significant risks were being managed, the effectiveness of the controls in place, and whether there were any significant internal control issues of which the Audit Committee needed to be made aware.

Where the Trust was unable to fully mitigate risks within its direct control, these were also escalated to locality and/or Greater Manchester (GM) system forums. These major principal risks during the year included the delivery of national access standards, particularly in urgent care; delivery of both the annual financial plan and ongoing financial sustainability; and the condition of the Trust's estate and critical infrastructure, including rising maintenance requirements, limited capital, and the challenge of securing funding for long-term site regeneration.

In 2025/26, the Trust's internal auditors, Mersey Internal Audit Agency (MIAA), confirmed that the assurance framework met NHS requirements, was clearly used by the Board, and accurately reflected the significant risks under discussion.

Corporate Governance

The Board gains assurance on the effectiveness of governance and internal controls through a range of structured reviews and independent assessments. These include evidence-based self-assessments against national governance and oversight frameworks, alongside internal and external challenge.

At the end of 2024/25, the Trust completed a self-assessment against the NHS England Well-Led framework, aligned to the CQC Well-Led quality statements, identifying areas of strength and targeted development actions. During the year, the Board undertook a self-assessment against the NHS Oversight Framework Provider Capability Assessment, providing an opportunity for the Board to reflect on overall effectiveness. These assessments were subject to independent review by the Trust's internal auditors, MIAA, who concluded that the assessments were comprehensive and supported by appropriate evidence. NHS England also confirmed agreement with the Trust's overall assessment. This provided additional assurance to the Board on the effectiveness of leadership, governance and oversight arrangements.

During 2025/26, no material risks were identified in relation to compliance with the NHS Provider Licence (Condition 4 – Governance). The Trust's governance framework and information flows support effective Board oversight and provide assurance that statutory duties and strategic objectives are being delivered. Key sources of assurance include the Integrated Performance Report, the Board Assurance Framework, escalation reports from Board Committees, and a comprehensive suite of operational, quality, people and financial reports.

The Board oversees delivery of the Trust's objectives through an annual planning process, including approval of the operational plan and confirmation of compliance with national and GM system requirements. Corporate objectives and outcome measures are agreed to support delivery of the plan and are monitored throughout the year by the Board and its Committees. This is complemented by the operational divisional performance review process, providing assurance on delivery from ward to Board.

During 2025/26, significant work was undertaken to design and prepare for the implementation of joint corporate governance arrangements between SFT and TG ICFT. In March 2026, both Boards agreed to proceed following detailed assessment of readiness across statutory, legal and operational considerations. The agreed model establishes a Joint Board Committee, known as the Joint Board, with maximum delegated authority from both statutory Boards. Supporting the Joint Board, are several joint Board Committees, including Quality, People, and Finance & Performance, alongside aligned Remuneration and Charitable Funds Committees operating in common. Audit Committees will remain separate during 2026/27. This model will support the achievement of shared strategic objectives, strengthened oversight, and consistent decision-making, while maintaining statutory accountability.

Terms of reference and workplans for the Joint Board and joint Board Committees have been aligned with NHS England's Insightful Provider Board guidance, the NHS Oversight Framework and operational planning requirements. The Scheme of Reservation of Powers and Delegation was updated to clearly define matters reserved to the statutory Boards and those delegated to the Joint Board, Board Committees or individual directors. Targeted development, including training in effective report writing for senior leaders, was undertaken to support high-quality governance and assurance reporting.

The Board keeps governance and internal control arrangements under continuous review. As joint arrangements continue to embed, assurance from audits, reviews and self-assessments will inform further refinement to ensure governance remains effective, proportionate and responsive to emerging risks and priorities.

Quality Governance

The Board recognises that the Trust operates in an environment where many day-to-day activities carry inherent risk. This reflects the nature of healthcare services, the treatment of patients who may be acutely unwell, and increasing demand for care. The Trust therefore has established quality governance arrangements to manage these risks and support continuous improvement in quality and safety of care.

The Trust has fully transitioned to the NHS Patient Safety Incident Response Framework (PSIRF), which provides a consistent and systems-focused approach to responding to patient safety incidents. Oversight arrangements are embedded within the Trust's governance structure through the Patient Safety Incident Response Group, Patient Safety and Quality Group, and the Quality Committee, which provide assurance to the Board on the effectiveness of patient safety systems, learning and improvement.

The Trust has published its Patient Safety Incident Response Plan and Policy and continues to work collaboratively with staff, patients, families, carers and partner organisations to embed PSIRF. The framework promotes compassionate, proportionate responses that focus on system learning and improvement rather than blame.

The Board promotes an open, transparent and fair culture, in which staff are encouraged to raise concerns and report incidents without fear of reprisal. This commitment is reflected in the findings of the annual NHS Staff Survey. The Trust maintains high levels of incident reporting through its online reporting system and uses this information to support continuous learning and improvement. Patient safety incidents are routinely submitted to the national Learn from Patient Safety Events (LfPSE) system, enabling local and national analysis and shared learning.

During 2025/26, the Trust identified two never events, both of which were declared on StEIS and reported to the Care Quality Commission (CQC), NHS England, and commissioners in line with the NHS Never Events Policy and Framework. Neither incident met the threshold for a Patient Safety Incident Investigation (PSII) under PSIRF. The never events were:

- A retained laparoscopic retrieval bag, with learning identified and shared with relevant stakeholders to support system-wide improvement.
- A wrong-side fascia iliaca block in the Emergency Department, with findings and learning shared with stakeholders to inform improvement actions.

The Board receives assurance that learning from these events has been captured, shared and embedded through the Trust's quality governance arrangements, and that actions are monitored to completion.

The Quality Committee provides robust oversight of the Trust's quality governance arrangements through a programme of assurance reporting. This includes ward assessment and accreditation, aligned to the CQC fundamental standards and recognition of themes of good practice and areas for improvement. The Committee receives regular assurance on learning from deaths, including compliance with national policy and key learning themes; patient experience, drawing on national survey results, complaints and feedback, with agreed actions taken in response. Oversight is also provided on infection prevention and control, safeguarding and health and safety, including performance against key performance indicators and compliance with statutory requirements and national guidance.

Assurance on clinical effectiveness is received through clinical audit and related quality improvement activity. Maternity services are subject to specific scrutiny, including reporting in line with the Perinatal Quality Surveillance Model (PQSM).

In addition, the Quality Committee oversees the Trust's compliance with CQC requirements, including consideration of CQC enquiries, preparation for inspection, and delivery of action plans arising from previous inspections.

Risks or developments that may affect the quality of care are identified and assessed through formal quality and equality impact assessments for business cases and cost improvement schemes. The Quality Impact Assessment (QIA) process is led by a multidisciplinary group of Executive Directors, including the Chief Nurse, Medical Director, Chief Finance Officer, Chief People Officer and Chief Operating Officer, to ensure robust scrutiny from both clinical and corporate perspectives.

The QIA process is underpinned by the Trust's risk management framework and seeks to engage with relevant stakeholders to identify and manage potential impacts. Any scheme assessed as high risk is overseen by the Quality Committee. This provides assurance on the rationale for decisions taken, the adequacy of mitigating actions, and confidence that proposed schemes do not adversely impact patient safety and quality or contribute to health inequalities.

Developing Workforce Safeguards

The Trust remains compliant with the Developing Workforce Safeguards and follows national guidance on safe staffing governance. The Board receives regular assurance on workforce matters through the integrated performance report, which includes information on staffing levels across all staff groups, use of temporary staffing, sickness absence, and training and development.

In addition, the People Committee receives regular safer care reports, providing assurance on safe staffing arrangements for nursing, allied health professional and medical staff. Through these reports, the Chief Nurse and Medical Director provide updates on current and emerging workforce risks, challenges in maintaining safe staffing levels, and the actions in place to mitigate those risks, including measures to support staff health and wellbeing and

enable employees to remain safely and effectively at work. The Committee, and Board, also consider the biannual nursing and midwifery staffing establishment review, undertaken in line with national guidance and professional standards. This review draws on patient acuity and dependency data, quality standards, benchmarking information and professional judgement to provide assurance on the adequacy of nursing and midwifery staffing levels and to inform any required decision-making or adjustments to establishments.

The Trust is fully compliant with the registration requirements of the CQC.

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

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

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

The foundation trust has undertaken risk assessments on the effects of climate change and severe weather and has developed a Green Plan following the guidance of the Greener NHS programme. The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Review of economy, efficiency and effectiveness of the use of resources
The Trust's financial plan for 2025/26, agreed as part of the GM Integrated Care System (ICS), included a break even financial position after receipt of £43.2m Deficit Support Funding (DSF) and a cost improvement programme (CIP) of £29.2m. Delivery of the financial plan and development of a sustainable recovery plan remained significant risks during the year. Through robust financial management, the Trust delivered a final outturn break even position before revaluations and impairments, supported by revenue improvement, £43.2m of non-recurrent deficit funding and £3.9m of additional income.

The Trust has operated in financial deficit for a several years, with delivery of its medium-term financial plan dependent on recurrent cost improvement of 5% of operating expenditure, full recovery of contract income for activity delivered, and changes to block income arrangements. Financial performance and productivity are overseen through a Financial Improvement Group, alongside formal monthly scrutiny by the Finance & Performance Committee. Planning for 2026/27 has built on the approach taken in 2025/26, with continued development of cost improvement schemes, all of which are subject to Quality Impact Assessment prior to approval. To accelerate delivery and strengthen accountability, Executive Directors have been assigned specific areas of responsibility across the productivity and efficiency portfolio.

Both the internal audit programme and the external audit is developed in consideration of national and local system risks, place based developments and local strategic risk assessment. The outcome of the audits supports in providing assurance to the Audit Committee about the operational arrangements to secure economy, efficiency and effectiveness in the use of resources.

Information governance

The Trust adopts proactive technical and organisational measures to ensure the confidentiality, integrity, and availability of data. The Trust has a secure IT infrastructure to ensure all staff have access to key information systems and data to support the delivery of patient care. Effective policies and procedures, including annual data security awareness training for all staff, are in place to prevent the loss of data and improve information and cyber security. The Trust proactively reports and investigates all information governance and IT security incidents on the Trust's incident management system.

The Trust has 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. This role is undertaken by the Deputy Chief Executive/Chief Finance Officer. The Trust's Medical Director is the Trust's Caldicott Guardian, with responsibility for ensuring patient confidentiality and that appropriate information sharing arrangements are in place. The SIRO and Caldicott Guardian are supported by the Trust's Data Protection Officer to ensure compliance with the Data Protection Act and UK General Data Protection Regulations.

The Trust completes an annual NHS Data Security and Protection Toolkit (DSPT) self-assessment, which significantly changed for 2024/25 to adopt the National Cyber Security Centre's Cyber Assessment Framework (CAF) as its basis for cyber security and information governance assurance, and is subject to an independent audit by the Trust's internal auditor, MIAA. The Trust's annual DSPT submission for 2024/25 was published as 'Approaching Standards', as not all mandatory requirements were met, but was supported by an improvement plan to address the remaining requirements. At the time of writing, the Trust is currently working on the 2025/26 DSPT assessment, due to be submitted on the 30 June 2026.

During 2025/26, the Trust reported one information governance related incident to the Information Commissioner's Office (ICO) via the DSPT reporting tool. The incident concerned a data breach arising from a cyber-attack on one of the Trust's third-party service providers, Synnovis, which occurred in June 2024. However, it was in November 2025, following the completion of Synnovis' investigation, that the Trust was informed that Trust data held by Synnovis may have been impacted. The breach involved limited personal data relating to 69 patients and did not include any clinical or health information. Synnovis advised that there was no evidence of misuse of the compromised data, nor any indication of ongoing malicious activity following the incident. The Trust is currently awaiting a response from the ICO regarding any further investigation or actions that may be required.

Data quality and governance
The Trust recognises that high-quality, accurate information is essential to delivering and improving services for patients and colleagues. Processes are in place to ensure that information provided to the Board and its Committees is accurate, timely, consistent, valid and complete. All staff are responsible for the timely and accurate recording of data, in line with the Trust's Data Quality Policy.

The established Information Governance and Security Group, the Data Quality Assurance Group, and the Digital & Informatics Group, have oversight of the review of external and internal data quality scorecards to ensure data that is critical to key processes, pathways, and performance indicators, is reliable and accurate. The Trust has a Data Quality Team which reviews errors and inconsistencies in data and a team of data validators who are responsible for the quality and integrity of our elective waiting lists, working closely with divisional staff to review and improve data accuracy. Digital validation of the waiting list and divisional performance review processes ensure that elective access waiting times are managed and monitored.

Data is collected through a range of systems to support the operation of services, with automation used where possible to reduce the risk of human error. The implementation of a new AI-driven document reading solution is helping improve the accuracy of the waiting list, and reducing the manual effort required for Referral to Treatment (RTT) validation.

The Business Intelligence Team provides the Executive Team each week with a full suite of performance data from across the Trust, allowing review and immediate action regarding any areas which are starting to be a concern. The monthly Integrated Performance Report incorporates key quality, operational, workforce, and financial metrics, and includes a qualitative narrative highlighting variation. Statistical Process Control (SPC) charts are included, where possible, to show any special cause variation and performance against forecasts, with benchmarking information included to provide context. This enables focus on the key areas of strategic performance, together with exception reporting to identify the underlying cause of underperformance and the necessary steps required to bring performance back to the required standard.

Data sources reported to the Board and its committees are kept under regular review to ensure they remain relevant, proportionate and aligned to the Trust's corporate objectives.

Review of effectiveness
As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the Head of Internal Audit Opinion, the work of the internal auditors, clinical audit, and the executive managers and clinical leads within Stockport NHS Foundation Trust, who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee, the other committees that form part of the organisation's assurance, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Trust's governance arrangements support the delivery of its aims and objectives and provides clear routes for identifying, managing and escalating issues to the appropriate Board committee and, where necessary, to the Board. In reviewing the effectiveness of the Trust's system of internal control, I have drawn assurance from the following sources:

- The Board Assurance Framework, which provides the Board with a structured and comprehensive view of the principal risks to the Trust's strategic objectives and the effectiveness of the controls and assurances in place to manage those risks.
- The corporate governance structure, supported by clear terms of reference, annual work plans and established reporting arrangements, which enabled timely review, challenge and escalation of matters requiring Board oversight.
- The Head of Internal Audit Opinion, which provided substantial assurance that the Trust has a sound system of internal control, appropriately designed to support the delivery of organisational objectives and applied consistently in practice.
- The Trust's continued registration with the Care Quality Commission, alongside consideration of the outcomes of external inspections, accreditations and regulatory reviews, as reported elsewhere in the Annual Report.
- The independent view of the Board self-assessment against the Provider Capability Assessment as part of the NHS Oversight Framework, which focused on the capability and leadership of the organisation. NHS England confirmed agreement with the Trust's overall position. MIAA concluded that the assessment was robust, comprehensive and supported by appropriate evidence.
- The Trust's active engagement in system-level governance arrangements within Greater Manchester and Stockport. These arrangements enable Executive Directors and senior leaders to work with system partners to identify and address shared risks and challenges that require a coordinated response.

Taken together, these arrangements provide me with reasonable assurance that the Trust has maintained an effective system of governance and internal control during the year.

Conclusion

Throughout the year, the Board of Directors has continued to exercise effective leadership and oversight of the Trust's governance and internal control arrangements. The Board has maintained clear sight of the key risks facing the organisation and has received appropriate assurance through established governance, reporting and scrutiny mechanisms.

Based on the systems, processes and sources of assurance described in this Annual Governance Statement, including internal governance arrangements and independent audit, review and inspection activity, there is sufficient evidence to confirm that no significant internal control issues were identified during the year. The Trust has continued to operate sound systems of internal control that support the delivery of its strategic objectives. Where opportunities for improvement have been identified through internal or independent review, actions have been agreed and are monitored through the relevant Board committees, with escalation to the Board as required.

Looking ahead, the Board remains mindful of the significant challenges facing the Trust, particularly in relation to financial sustainability in the context of sustained demand and system pressures. The Trust will continue to work closely with system partners, including

through the developing joint arrangements with TG ICFT and wider place-based and Greater Manchester collaborations, to strengthen resilience, address shared risks and support sustainable improvement during 2026/27 and beyond.

Karen James OBE
Chief Executive
25th June 2026

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

Report on the audit of the financial statements

Opinion on the financial statements

We have audited the financial statements of Stockport NHS Foundation Trust ('the Trust') and its subsidiaries ('the Group') for the year ended 31 March 2026 which comprise the Trust and Group Statement(s) of Comprehensive Income, the Trust and Group Statement(s) of Financial Position, the Trust and Group Statement(s) of Changes in Taxpayers' Equity , the Trust and Group Statement(s) of Cash Flows, and notes to the financial statements, including material accounting policy information.

The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards as interpreted and adapted by HM Treasury's Financial Reporting Manual 2025/26 as contained in the Department of Health and Social Care Group Accounting Manual 2025/26, 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 2026 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 2025/26; 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 for the audit of the financial statements" section of our report. We are independent of the Trust and Group in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

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

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

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

Other information

The other information comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. The Directors are responsible for the other information. 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.

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 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 2025/26 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 public sector 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.

The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud.

Based on our understanding of the Trust, we did not identify any laws and regulations that have an indirect effect on the preparation of the financial statements where non-compliance might have a material effect on the financial statements.

To help us identify instances of non-compliance with these laws and regulations, and in identifying and assessing the risks of material misstatement in respect to non-compliance, our procedures included, but were not limited to:

- gaining an understanding of the legal and regulatory framework applicable to the Trust and Group, the environment in which it operates, and the structure of the Trust and Group, and considering the risk of acts by the Trust and Group which were contrary to the applicable laws and regulations, including fraud;
- inquiring with management and the Audit Committee, as to whether the Trust and Group is in compliance with laws and regulations, and discussing their policies and procedures regarding compliance with laws and regulations;
- inspecting correspondence, if any, with relevant licensing or regulatory authorities;
- reviewing minutes of relevant meetings in the year;
- communicating identified laws and regulations throughout our engagement team and remaining alert to any indications of non-compliance throughout our audit; and

- considering the risk of acts by the Trust and Group which were contrary to applicable laws and regulations, including fraud.

We also considered those laws and regulations that have a direct effect on the preparation of the financial statements, such as the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012).

In addition, we evaluated management's incentives and opportunities for fraudulent manipulation of the financial statements (including the risk of override of controls) and determined that the principal risks were related to: posting manual journal entries to manipulate financial performance, management bias through judgements and assumptions in significant accounting estimates, revenue and expenditure recognition (which we pinpointed to the cut off assertion), and significant one-off or unusual transactions.

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

- making enquiries of management, Head of Internal Audit and the Audit Committee on whether they had knowledge of any actual, suspected or alleged fraud;
- gaining an understanding of the internal controls established to mitigate risks related to fraud;
- discussing amongst the engagement team the risks of fraud; and
- addressing the risks of fraud through management override of controls by performing journal entry testing.

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

We are also required to conclude on whether the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate. We performed our work in accordance with Practice Note 10: Audit of financial statements and regularity of public sector bodies in the United Kingdom, (Revised 2024) and Supplementary Guidance Note 01, issued by the Comptroller and Auditor General in November 2024.

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

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

Matter on which we are required to report by exception

We are required to report to you if, in our opinion, we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2026.

On the basis of our work, having regard to the guidance issued by the Comptroller and Auditor General in March 2026, we have identified the following significant weakness in the Trust's arrangements for the year ended 31 March 2026.

In June 2022 we identified a significant weakness in relation to financial sustainability for the 2021/2022 year. In our view this significant weakness remains for the year ended 31 March 2026:

Significant weakness in arrangements – issued in a previous year	Recommendation
In 2021/2022 we reported a significant weakness in the Trust's arrangements to secure financial sustainability as a result of its cumulative deficit and a lack of clear plans to address this position without significant additional funding. These circumstances continue to exist and as such, the previously reported significant weakness in arrangements to secure financial sustainability remains in place.	The Trust needs to address the underlying deficit by tackling its cost base and identifying recurrent savings. It should produce and deliver a breakeven plan that delivers the efficiencies set out in transformation programmes that require digital, workforce and operational redesign.

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 under 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, and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our work in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in March 2026.

Report on other legal and regulatory requirements

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2025/26; and
- the other information published together with the audited financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

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

We are required to report to you if:

- in our opinion the Annual Governance Statement does not comply with the NHS Foundation Trust Annual Reporting Manual 2025/26; or
- we refer a matter to the regulator under Schedule 10(6) of the National Health Service Act 2006; or
- we issue a report in the public interest under Schedule 10(3) of the National Health Service Act 2006.

We have nothing to report in respect of these matters.

Use of the audit report

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

Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate until we have received confirmation from the NAO that the group audit of the Department of Health and Social Care has been completed and that no further work is required to be completed by us.

Karen Murray, Key Audit Partner
For and on behalf of Forvis Mazars LLP (Local Auditor)

One St Peter's Square
Manchester
M2 3DE

25 June 2026

Stockport NHS Foundation Trust

Annual accounts for the year ended 31 March 2026

Foreword to the accounts

Stockport NHS Foundation Trust

These accounts, for the year ended 31 March 2026, 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 **Karen James OBE**
Job title **Chief Executive**
Date **25 June 2026**

Consolidated Statement of Comprehensive Income

		Group		Trust	
		2025/26	2024/25	2025/26	2024/25
	Note	£000	£000	£000	£000
Operating income from patient care activities	3	497,069	471,579	497,069	471,579
Other operating income	4	43,122	43,461	42,801	43,444
Operating expenses	7,9.1	(551,564)	(529,199)	(551,051)	(528,813)
Operating surplus/(deficit) from continuing operations		**(11,374)**	**(14,159)**	**(11,181)**	**(13,790)**
Finance income	11	2,318	1,990	2,226	1,896
Finance expenses	12	(780)	(833)	(780)	(833)
PDC dividends payable		(5,264)	(6,006)	(5,264)	(6,006)
Net finance costs		**(3,726)**	**(4,849)**	**(3,819)**	**(4,943)**
Other gains / (losses)	13	(7,268)	(33)	(7,124)	49
Corporation tax expense		(7)	(6)	-	-
Surplus / (deficit) for the year		**(22,375)**	**(19,047)**	**(22,124)**	**(18,684)**
Other comprehensive income					
Will not be reclassified to income and expenditure:					
Impairments	8	(784)	(11,026)	(784)	(11,026)
Revaluations	17	7,677	2,558	7,677	2,558
Total other comprehensive income for the period		**6,893**	**(8,468)**	**6,893**	**(8,468)**
Total comprehensive income / (expense) for the period		**(15,482)**	**(27,515)**	**(15,231)**	**(27,152)**
Surplus/ (deficit) for the period attributable to:					
Stockport NHS Foundation Trust		(22,375)	(19,047)	(22,124)	(18,684)
Total		**(22,375)**	**(19,047)**	**(22,124)**	**(18,684)**
Total comprehensive income/ (expense) for the period attributable to:					
Stockport NHS Foundation Trust		(15,482)	(27,515)	(15,231)	(27,152)
Total		**(15,482)**	**(27,515)**	**(15,231)**	**(27,152)**

Statements of Financial Position

		Group		Trust	
		31 March 2026	31 March 2025	31 March 2026	31 March 2025
	Note	£000	£000	£000	£000
Non-current assets					
Intangible assets	14	7,983	6,256	7,983	6,256
Property, plant and equipment	15	226,850	227,020	226,850	227,020
Right of use assets	18	8,215	9,381	8,215	9,381
Other investments / financial assets	19	1,548	1,692	-	-
Receivables	22	678	668	678	668
Total non-current assets		**245,275**	**245,017**	**243,727**	**243,325**
Current assets					
Inventories	21	1,026	1,139	863	951
Receivables	22	16,695	14,424	17,517	15,183
Non-current assets held for sale	23	-	7,050	-	7,050
Cash and cash equivalents	24	44,159	38,038	42,653	36,725
Total current assets		**61,880**	**60,651**	**61,033**	**59,909**
Current liabilities					
Trade and other payables	25	(66,495)	(60,806)	(66,751)	(61,272)
Borrowings	27	(3,332)	(3,280)	(3,332)	(3,280)
Provisions	28	(2,109)	(1,442)	(2,109)	(1,442)
Other liabilities	26	(6,342)	(4,927)	(6,342)	(4,927)
Total current liabilities		**(78,278)**	**(70,455)**	**(78,534)**	**(70,921)**
Total assets less current liabilities		**228,876**	**235,214**	**226,226**	**232,313**
Non-current liabilities					
Borrowings	27	(17,570)	(20,263)	(17,570)	(20,263)
Provisions	28	(2,514)	(2,789)	(2,514)	(2,789)
Total non-current liabilities		**(20,084)**	**(23,052)**	**(20,084)**	**(23,052)**
Total assets employed		**208,792**	**212,162**	**206,142**	**209,261**
Financed by					
Public dividend capital		274,804	262,692	274,804	262,692
Revaluation reserve		66,212	59,614	66,212	59,614
Income and expenditure reserve		(134,160)	(112,362)	(134,873)	(113,045)
Charitable fund reserves	20	1,937	2,218	-	-
Total taxpayers' equity		**208,792**	**212,162**	**206,142**	**209,261**

The notes on pages 119 to 158 form part of these accounts.

Name **Karen James OBE**
Position **Chief Executive**
Date **25 June 2026**

Consolidated Statement of Changes in Taxpayers' Equity for the year ended 31 March 2026

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 2025 - brought forward	**262,692**	**59,614**	**(112,362)**	**2,218**	**212,162**
Surplus/(deficit) for the year	-	-	(22,843)	468	**(22,375)**
Impairments	-	(784)	-	-	**(784)**
Revaluations	-	7,677	-	-	**7,677**
Public dividend capital received	12,112	-	-	-	**12,112**
Other reserve movements	-	(296)	**1,045**	(749)	**-**
Taxpayers' and others' equity at 31 March 2026	**274,804**	**66,212**	**(134,160)**	**1,937**	**208,792**

Consolidated Statement of Changes in Taxpayers' Equity for the year ended 31 March 2025

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 2024 - brought forward	**225,443**	**68,266**	**(93,887)**	**2,607**	**202,428**
Surplus/(deficit) for the year	-	-	(19,894)	847	**(19,047)**
Impairments	-	(11,026)	-	-	**(11,026)**
Revaluations	-	2,558	-	-	**2,558**
Public dividend capital received	37,249	-	-	-	**37,249**
Other reserve movements	-	(183)	1,419	(1,236)	**-**
Taxpayers' and others' equity at 31 March 2025	**262,692**	**59,614**	**(112,362)**	**2,218**	**212,162**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. 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 the Group comprising the Trust, Charity and Stepping Hill Healthcare Enterprises Limited (trading as the Pharmacy Shop).

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 Taxpayers' Equity for the year ended 31 March 2026

Trust	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2025 - brought forward	**262,692**	**59,614**	**(113,045)**	**209,261**
Surplus/(deficit) for the year	-	-	(22,124)	**(22,124)**
Impairments	-	(784)	-	**(784)**
Revaluations	-	7,677	-	**7,677**
Public dividend capital received	12,112	-	-	**12,112**
Other reserve movements	-	(296)	296	**-**
Taxpayers' and others' equity at 31 March 2026	**274,804**	**66,212**	**(134,873)**	**206,142**

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2025

Trust	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2024 - brought forward	**225,443**	**68,266**	**(94,545)**	**199,164**
Surplus/(deficit) for the year	-	-	(18,684)	**(18,684)**
Impairments	-	(11,026)	-	**(11,026)**
Revaluations	-	2,558	-	**2,558**
Public dividend capital received	37,249	-	-	**37,249**
Other reserve movements	-	(183)	183	**-**
Taxpayers' and others' equity at 31 March 2025	**262,692**	**59,614**	**(113,045)**	**209,261**

Statements of Cash Flows

	Note	Group 2025/26 £000	Group 2024/25 £000	Trust 2025/26 £000	Trust 2024/25 £000
Cash flows from operating activities					
Operating surplus / (deficit)		(11,374)	(14,159)	(11,181)	(13,790)
Non-cash income and expense:					
Depreciation and amortisation	7.1	20,848	21,008	20,848	21,008
Net impairments	8	15,623	18,265	15,623	18,265
Income recognised in respect of capital donations	4	(615)	(1,000)	(803)	(1,000)
(Increase) / decrease in receivables and other assets		(793)	(984)	(856)	(1,356)
(Increase) / decrease in inventories		113	58	88	49
Increase / (decrease) in payables and other liabilities		325	9,550	114	9,933
Increase / (decrease) in provisions		335	468	335	467
Tax (paid) / received		(6)	(27)	-	-
Net cash flows from / (used in) operating activities		**24,456**	**33,179**	**24,168**	**33,576**
Cash flows from investing activities					
Interest received		2,219	1,862	2,219	1,862
Purchase of intangible assets		(3,527)	(154)	(3,527)	(154)
Purchase of PPE and investment property		(19,185)	(40,459)	(19,229)	(40,459)
Sales of PPE and investment property		99	49	99	49
Receipt of cash donations to purchase assets		570	-	803	-
Net cash flows from charitable fund investing activities		92	94	-	-
Net cash flows from / (used in) investing activities		**(19,732)**	**(38,608)**	**(19,636)**	**(38,702)**
Cash flows from financing activities					
Public dividend capital received		12,112	37,249	12,112	37,249
Movement on loans from DHSC		(1,551)	(1,551)	(1,551)	(1,551)
Capital element of lease liability repayments		(1,682)	(1,892)	(1,682)	(1,892)
Capital element of PFI, LIFT and other service concession payments		-	(195)	-	(195)
Interest on loans		(402)	(462)	(402)	(462)
Interest paid on lease liability repayments		(336)	(326)	(336)	(326)
PDC dividend (paid) / refunded		(6,745)	(6,497)	(6,745)	(6,497)
Net cash flows from / (used in) financing activities		**1,396**	**26,326**	**1,396**	**26,326**
Increase / (decrease) in cash and cash equivalents		**6,120**	**20,898**	**5,928**	**21,200**
Cash and cash equivalents at 1 April - brought forward		**38,039**	**17,141**	**36,725**	**15,525**
Cash and cash equivalents at 31 March	24	**44,159**	**38,038**	**42,653**	**36,725**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS England 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 2025/26 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

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

Note 1.2 Going concern

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

Note 1.3 Consolidation

NHS Charitable Funds

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

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

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

Other subsidiaries

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.

The amounts consolidated are drawn from the published financial statements of the subsidiaries for the year.

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.

Subsidiaries which are classified as held for sale are measured at the lower of their carrying amount and 'fair value less costs to sell'.

Note 1.3 Consolidation continued

Stepping Hill Healthcare Enterprises Limited

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

The company's latest accounting period to the 31st March 2025 have been prepared and submitted to Companies House. It has taken advantage of the small company exemption from audit under section 479A of the Companies Act 2006 which does not require an audit if included in the parent's consolidated accounts.

Note 1.4 Revenue from contracts with customers

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

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

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS). The NHSPS sets out rules to establish the amount payable to trusts for NHS-funded secondary healthcare.

Aligned payment and incentive contracts (API) form the main payment mechanism under the NHSPS. API contracts contain both a fixed and variable element. Under the variable element, providers earn income for elective activity (both ordinary and day case), out-patient procedures, out-patient first attendances, diagnostic imaging including nuclear medicine, and chemotherapy delivery activity. The precise definition of these activities is set in the NHSPS detailed guidance. Income is earned at NHSPS prices based on actual activity. The fixed element includes income for all other services covered by the NHSPS assuming an agreed level of activity with 'fixed' in this context meaning not varying based on units of activity. Elements within this are accounted for as variable consideration under IFRS 15 as explained below.

High costs drugs and devices excluded from the calculation of national prices are reimbursed by commissioners based on actual usage or at a fixed baseline in addition to the price of the related service.

The Trust also receives income from commissioners under the Best Practice Tariff (BPT) scheme. Delivery under the scheme is part of how care is provided to patients. As such BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner and are accounted for as variable consideration under IFRS 15. Payment for BPT on non-elective services is included in the fixed element of API contracts. BPT earned on elective activity is included in the variable element of API contracts and paid in line with actual activity performed.

Additional payments for specialised services reflecting patient complexity are included within the fixed element of API contracts. This is accounted for as variable consideration under IFRS 15.

Where the relationship with a particular integrated care board is expected to be a low volume of activity (annual value below £1.5m), an annual fixed payment is received by the provider as determined in the NHSPS documentation. Such income is classified as 'other clinical income' in these accounts.

Note 1.4 Revenue from contracts with customers continued

Revenue from research contracts

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

NHS injury cost recovery scheme

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

Note 1.5 Other forms of income

Grants and donations

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grants is used to fund capital expenditure, it is credited to the 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 apprenticeship service account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Additional Employer Pension Contributions

The increase in employer pension contributions due in 2025/26 has been paid over centrally by NHS England for provider organisations. The Trust expenditure in staff costs is recorded as being with the NHS Pension Scheme, with a corresponding notional income amount from NHS England recorded.

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.

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

Note 1.6 Expenditure on employee benefits

Short-term employee benefits

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

Pension costs

NHS Pension Scheme

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

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

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 the 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 the Whole of Government Accounts are ‘machinery of government changes’ and treated as continuing operations.

Note 1.9 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

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

Note 1.9 Property, plant and equipment continued

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 value in existing use is defined as market value except where a building is so specialised in nature no active market exists from which to draw satisfactory transactional evidence. In this case a valuer will adopt a depreciated replacement cost (DRC) model on a modern equivalent asset (MEA) basis.
A DRC model estimates current value in existing use 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. 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.

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 are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Revaluation gains and losses

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

Note 1.9 Property, plant and equipment continued

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

De-recognition

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated and grant funded assets

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

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

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. Annual contract payments to the operator (the unitary charge) are apportioned between the repayment of the liability including the finance cost, the charges for services and lifecycle replacement of components of the asset.

Initial recognition

In accordance with HM Treasury's FReM, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability. Initial measurement of the asset and liability are in accordance with the initial measurement principles of IFRS 16 (see leases accounting policy).

Assets are subsequently accounted for as property, plant and equipment and/or intangible assets as appropriate.

The liability is subsequently reduced by the portion of the unitary charge allocated as payment for the asset and increased by the annual finance cost. The finance cost is calculated by applying the implicit interest rate to the opening liability and is charged to finance costs in the Statement of Comprehensive Income. The element of the unitary charge allocated as payment for the asset is split between payment of the finance cost and repayment of the net liability.

Where there are changes in future payments for the asset resulting from indexation of the unitary charge, the Trust remeasures the PFI liability by determining the revised payments for the remainder of the contract once the change in cash flows takes effect. The remeasurement adjustment is charged to finance costs in the Statement of Comprehensive Income.

The service charge is recognised in operating expenses 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	31
Dwellings	13	47
Plant & machinery	5	15
Transport equipment	5	7
Information technology	5	10
Furniture & fittings	5	10

Note 1.10 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance controlled by the Trust. They are capable of being sold separately from the rest of the trust's business or arise from contractual or other legal rights. Intangible assets 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 where it meets recognition criteria.

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. From 1 April 2025, subsequent measurement of intangible assets is at cost less amortisation.

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

Impairments

Where indicators of impairment exist, the recoverable amount is assessed as the higher of its fair value and the cost to replace the service capacity. Where this is lower than the carrying value an impairment is recognised in expenditure. The recoverable amount of intangible assets under construction is assessed annually, irrespective of indicators of impairment.

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	2	10

Note 1.11 Inventories

The Trust's Inventory balance consists of Pharmacy inventory which is measured at average cost. The cost of general ward-level consumable items, fuel oil and theatre inventories are excluded from the Statement of Financial Position as they are considered immaterial to hold as an asset because these items are low value and/or frequently moved and consumed. Instead, they are treated as expenditure in the year of purchase.

Note 1.12 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

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

Note 1.13 Financial assets and financial liabilities

Recognition

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

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

Classification and measurement

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

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

Financial assets are classified as subsequently measured at amortised cost, fair value through profit and loss or fair value through other comprehensive income.

Financial liabilities classified as subsequently measured at amortised cost or fair value through profit and loss.

Financial assets and financial liabilities at amortised cost

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

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

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

Financial assets measured at fair value through other comprehensive income

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

Financial assets and financial liabilities at fair value through profit and loss

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

The Group measures the pooled Charity Common Investment Fund with CCLA as a financial asset at fair value through profit and loss.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

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

The Trust has assessed its receivables on an individual basis for expected credit losses and impaired these where judged to be necessary. The Trust Injury Cost Recovery Scheme income is reduced by a nationally agreed expected credit loss percentage. The Trust does not normally recognise expected credit losses for other NHS bodies except for circumstances of genuine dispute.

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

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

Derecognition

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

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

Note 1.14 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

The Trust as a lessee

Recognition

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

Note 1.14 Leases continued

Initial measurement

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.81% applied to new leases commencing in 2025 and 5.32% to new leases commencing in 2026.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term or other systematic basis. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

The Trust as a lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. 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.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

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

Income from operating leases is recognised on a straight-line basis or another systematic 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 from 31 March 2026:

Note 1.15 Provisions continued

		Nominal rate	Prior year rate
Short-term	Up to 5 years	3.64%	4.03%
Medium-term	After 5 years up to 10 years	4.22%	4.07%
Long-term	After 10 years up to 40 years	5.32%	4.81%
Very long-term	Exceeding 40 years	5.07%	4.55%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2026:

	Inflation rate	Prior year rate
Year 1	2.5%	2.60%
Year 2	2.0%	2.30%
Into perpetuity	2.0%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.95% in real terms (prior year: 2.40%).

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 28.2 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.

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.

Note 1.17 Public dividend capital continued

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

This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

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

Note 1.18 Value added tax

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

Note 1.19 Corporation tax

Health Service bodies, including Foundation Trusts, are exempt from taxation on their principal healthcare income under section 519A ICTA 1988. The Trust may incur corporation tax through its wholly owned subsidiary 'Stepping Hill Healthcare Enterprises Limited'.

Note 1.20 Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

Note 1.21 Third party assets

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

Note 1.22 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 Transfers of functions to / from other NHS bodies / local government bodies

Functions transferring between NHS bodies are accounted for as a transfer by absorption where assets and liabilities are de-recognised. In 2025/26 the Trust has transferred the Neuro-Rehab service to Northern Care Alliance NHS Foundation Trust. The Trust has assessed the transaction between the Trusts and have not de-recognised the Devonshire Centre but are treating the arrangement as an operating lease.

Note 1.25 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2025/26.

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

The DHSC GAM does not require the following IFRS Standards to be applied in 2025/26:

IFRS 18 Presentation and Disclosure in Financial Statements - The Standard has been adopted by the UK Endorsement Board to be effective for accounting periods beginning on or after 1 January 2027. The Standard has not yet been adopted by the FReM and early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

IFRS 19 Subsidiaries without Public Accountability: Disclosures - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

Note 1.27 Prospective changes to non-investment asset valuations

Changes to valuation of property, plant and equipment (PPE) assets – The DHSC GAM for 2026/27 and associated consultation response document confirms future changes which will impact on the financial statements.

From 2026/27 NHS bodies' valuation methodology will be a mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years. The requirement in IAS 16 to revalue an asset when its fair value differs materially from its carrying value is being withdrawn for the public sector. Given the variation in PPE valuations in any given year, and future changes in indices, it is not possible to quantify the impact of applying these changes in future periods. PPE and right of use assets currently subject to revaluation have a total book value of £184.9m as at 31 March 2026.

Note 1.28 Critical judgements in applying accounting policies

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

The Trust uses the District Valuer service to provide revalued amounts for its Trust, building and dwellings. These valuations are in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. In 2025/26 the Trust has undertaken a review of its MEA valuation and commissioned a valuation of its land and buildings.

In 2025/26 the Trust's new Outpatients Building capital scheme was included within the valuation by the District Valuer. The Outpatients capital scheme is a new build replacement of the demolished Outpatients B facility. The Trust has applied the valuation of the District Valuer to its MEA re-valuation to calculate the impairment of the newly constructed asset upon go-live.

In 2024/25 the contract for The Meadows PFI facility expired and the Trust and Pennine Care NHS Foundation Trust jointly agreed to buy the facility from Walker Healthcare for £6.05 million with a PDC re-allocation of funds from PCFT to SFT. As the named partner on the original contract (but the minority occupier of the facility) the SFT Board agreed to the onwards transfer of the building for £6.05 million and land at nil consideration with a £1m valuation . This transaction concluded in 2025/26 with the sale of the The Meadows Land and Building. This was accounted for as a capital grant in kind loss on disposal of £7.05m. Having provided the initial funding for the purchase, a capital grant in kind expense transaction is used as the Trust is de-recognising a non current asset gifted to another organisation. The land and buildings have been de-recognised as assets held for sale from the Statement of Financial Position. A formal lease is in place for SFT's continued occupancy of the Bluebell ward and is now reported as a Right of Use Asset.

The Trust has estimated the fair value or the current value in existing use of the right of use assets as being that represented by the rent reviews provided for in the lease agreements. This is on the basis that these rent reviews reflect changes in the market prices and conditions and there are no significant periods between the rent reviews provided in the lease arrangements. The carrying value of Right of Use Assets at the 31st March 2026 is £8.2 million.

Where there is no evidence of a contract for a property lease required for the provision of long term health care, the Trust has assumed the lease terms to be 10 years based on known commissioning intentions, unless there are specific circumstances which would require a different contract term to be more appropriate.

Note 1.28 Critical judgements in applying accounting policies continued

In 2025/26 the Trust agreed a transfer of the existing Neuro-rehabilitation service to Northern Care Alliance NHS Foundation Trust. The Trust will retain ownership of the Devonshire Centre site where the service is based and a lease arrangement will be entered into with NCA for the Centre. The service transferred on the 1st March 2026 and a tenancy at will agreement is in place while the final lease agreement is concluded. The Trust have assessed this to be an operating lease on the basis that ownership will not transfer to NCA, the lease is not for the major economic life of the building and there is a break clause in the lease that, if the funding for Neurorehab services is withdrawn by the commissioners to NCA, then they will have the right to exit/terminate the lease early. There is no right for NCA to purchase the site at any stage.

Note 1.29 Sources of estimation uncertainty

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

As at 31st March 2026, the Valuation Office Agency provided a valuation of the Trust's land and building assets (estimated financial value and estimated remaining useful life) applying a modern equivalent asset method of valuation (i.e. a valuation based on a modern equivalent asset built to accommodate existing services). Furthermore, the valuation is based on a theoretical design configuration of the Trust's clinical and non-clinical services on the Stepping Hill site where an assumption has been made that the asset's service delivery potential can be reproduced by an MEA with a stated lower GIA. These gross internal areas (GIAs) of this design have been adopted by the valuer. This valuation, based on estimates provided by a qualified professional, led to an decrease in the reported value of the Trust's land and building asset values of to £184.9 million which has resulted in a £6.9m increase in the Revaluation Reserve. Future revaluations of the Foundation Trust's asset base may result in further material changes to the carrying value of non-current assets. An additional increase of 1% in the land and building net book value of would result in a revised net book value of £186.7m and an increase of 5% would result in a revised net book value of £194.1m.

Note 2 Operating Segments

In line with IFRS 8 on Operating Segments, the Trust and the Group are required to disclose financial information across significant Operating Segments, which reflect the way the management runs the organisation. The Board of Directors, as Chief Operating Decision Maker (CODM), have assessed that the Trust reports 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 divisions operate under one common regulatory framework.

In consolidating the charitable funds the Trust has considered the level of its charitable funds and has considered them immaterial to report as a separate operating segment as the charitable funds revenue are not 10% or more of the combined assets of all operating segments.

In consolidating the financial results of the Stepping Hill Healthcare Enterprises Limited Company, the Trust considers that the provision of an outpatient dispensing service to patients still falls under the healthcare operating segment. In addition its revenue streams are also not 10% or more than all the combined assets of all operating segments.

Note 3 Operating income from patient care activities (Group and Trust)

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4

Note 3.1 Income from patient care activities (by nature)	2025/26	2024/25
	£000	£000
Income from commissioners under API contracts - variable element*	94,645	80,268
Income from commissioners under API contracts - fixed element*	317,828	311,768
High cost drugs income from commissioners	14,247	14,178
Other NHS clinical income	237	231
Community services		
Income from commissioners under API contracts*	39,264	38,094
Income from other sources (e.g. local authorities)	6,833	6,105
All services		
National pay award central funding***	-	1,055
Additional pension contribution central funding**	21,197	19,198
Other clinical income	2,817	682
Total income from activities	**497,069**	**471,579**

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2025/26 NHS Payment Scheme documentation.
https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/

**Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.38% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.78%) and related NHS England funding (9.4%) have been recognised in these accounts.

***Additional funding was made available directly to providers by NHS England in 2024/25 for implementing the backdated element of pay awards where government offers were finalised after the end of the 2023/24 financial year. NHS Payment Scheme prices and API contracts are updated for the weighted uplift in in-year pay costs when awards are finalised.

Note 3.2 Income from patient care activities (by source)

	2025/26	2024/25
Income from patient care activities received from:	£000	£000
NHS England	25,443	35,833
Integrated care boards	463,569	428,629
Other NHS providers	237	231
NHS other	82	100
Local authorities	6,833	6,105
Non-NHS: overseas patients (chargeable to patient)	7	-
Injury cost recovery scheme	898	682
Total income from activities	**497,069**	**471,579**
Of which:		
Related to continuing operations	497,069	471,579

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

	2025/26	2024/25
	£000	£000
Income recognised this year	7	-
Cash payments received in-year	7	-

Note 4 Other operating income (Group)

	2025/26			2024/25		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	1,383	-	**1,383**	1,021	-	**1,021**
Education and training	14,509	625	**15,134**	13,183	1,084	**14,267**
Non-patient care services to other bodies	12,122		**12,122**	13,628		**13,628**
Receipt of capital grants and donations and peppercorn leases		615	**615**		1,000	**1,000**
Revenue from operating leases		16	**16**		-	**-**
Charitable fund incoming resources		520	**520**		835	**835**
Stockport Pharmaceuticals and Quality Control	6,521		**6,521**	6,678		**6,678**
Stockport Healthcare Enterprises Limited	3,816		**3,816**	3,791		**3,791**
Rents and car parking income	1,672		**1,672**	1,224		**1,224**
Catering Sales	735		**735**	657		**657**
Other income	588	-	**588**	360	-	**360**
Total other operating income	**41,346**	**1,775**	**43,122**	**40,542**	**2,918**	**43,461**
Of which:						
Related to continuing operations		-	43,122			43,461

Note 4.1 Other operating income (Trust)

	2025/26			2024/25		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	1,383	-	**1,383**	1,021	-	**1,021**
Education and training	14,509	625	**15,134**	13,183	1,084	**14,267**
Non-patient care services to other bodies	12,138		**12,138**	13,628	-	**13,628**
Receipt of capital grants and donations and peppercorn leases		803	**803**		1,000	**1,000**
Charitable and other contributions to expenditure		561	**561**		1,236	**1,236**
Revenue from operating leases		16	**16**		-	**-**
Stockport Pharmaceuticals and Quality Control	6,521		**6,521**	6,678		**6,678**
Pharmacy Sales	3,855		**3,855**	3,733		**3,733**
Rents and car parking income	1,656		**1,656**	1,224		**1,224**
Catering Sales	735		**735**	657		**657**
Other income		-	**-**		-	**-**
Total other operating income	**40,796**	**2,005**	**42,801**	**40,124**	**3,320**	**43,444**
Of which:						
Related to continuing operations			42,801			43,444

Note 5.1 Income from activities arising from commissioner requested services (Group and Trust)

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

	2025/26	2024/25
	£000	£000
Income from services designated as commissioner requested services	496,164	470,897
Income from services not designated as commissioner requested services	905	682
Total	**497,069**	**471,579**

Note 5.2 Profits and losses on disposal of property, plant and equipment (Group and Trust)

In 2025/2026 the Trust has disposed of property, plant, equipment and transport with a loss on the disposal of £7.2m. Of this, £7.05m relates to the capital grant in kind loss on disposal of The Meadows land and building that was transferred to Pennine Care NHS Foundation Trust. This transaction is agreed with the Department of Health upon the transfer of non current assets to another NHS body. Pennine Care NHS Foundation Trust have recognised a gain of an equal sum.

The Trust has also disposed of plant and equipment with a net book value of £179k. This includes the value of a GE CT scanner of £120k; received as Covid donated equipment but no longer required. Cash proceeds from the sale of these disposed assets (and other nil book value assets) following auction are £105k leaving a net loss on disposal of £74k for plant and equipment. Disposals included the trade in value of the CT Scanner at £40k, mobile X Ray machines at £37k, and other equipment for £28k at nil net book value on the Trust's asset register.

Note 5.3 Fees and charges (Group and Trust)

The following disclosure is of income from charges to service users where the full cost of providing 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. The following table discloses the income and expenditure related to the Trust's Stockport Pharmaceuticals and Quality Control trading activities.

	2025/26	2024/25
	£000	£000
Income	6,681	7,205
Full cost	(6,371)	(6,587)
Surplus / (deficit)	**310**	**618**

Note 6 Operating leases - Stockport NHS Foundation Trust as lessor

Note 6.1 Operating leases income (Group and Trust)

	2025/26	2024/25
	£000	£000
Lease receipts recognised as income in year:		
Minimum lease receipts	16	-
Total in-year operating lease income	**16**	**-**

Note 6.2 Future lease receipts (Group and Trust)

	2026	2025
	£000	£000
Future minimum lease receipts due in:		
- not later than one year	191	-
- later than one year and not later than two years	191	-
- later than two years and not later than three years	191	-
- later than three years and not later than four years	191	-
- later than four years and not later than five years	191	-
- later than five years	1,894	-
Total	**2,849**	**-**

Note 7.1 Operating expenses (Group)

	2025/26	2024/25
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	4,097	3,772
Purchase of healthcare from non-NHS and non-DHSC bodies	9,699	10,431
Staff and executive directors costs	388,973	368,263
Remuneration of non-executive directors	126	139
Supplies and services - clinical (excluding drugs costs)	31,275	27,562
Supplies and services - general	3,106	3,473
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	24,913	24,364
Consultancy costs	1,129	441
Establishment	1,771	1,883
Premises	25,092	22,749
Transport (including patient travel)	1,322	1,432
Depreciation on property, plant and equipment	19,048	19,006
Amortisation on intangible assets	1,800	2,002
Net impairments	15,623	18,265
Movement in credit loss allowance: contract receivables / contract assets	103	8
Increase/(decrease) in other provisions	466	662
Change in provisions discount rate(s)	(102)	10
Fees payable to the external auditor		
audit services- statutory audit	148	142
Internal audit costs	104	106
Clinical negligence	13,776	13,984
Legal fees	220	1,031
Insurance (as a policy holder)	482	531
Research and development	1,189	1,076
Education and training	4,621	5,175
Car parking & security	462	340
Hospitality	1	0
Losses, ex gratia & special payments	77	21
Other services, eg external payroll	355	568
Other	1,688	1,763
Total	**551,564**	**529,199**
Of which:		
Related to continuing operations	551,564	529,199

Note 7.2 Operating expenses (Trust)

	2025/26	2024/25
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	6,329	3,772
Purchase of healthcare from non-NHS and non-DHSC bodies	7,467	10,431
Staff and executive directors costs	388,652	368,012
Remuneration of non-executive directors	126	139
Supplies and services - clinical (excluding drugs costs)	31,275	27,562
Supplies and services - general	3,106	3,473
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	24,806	24,314
Consultancy costs	1,129	441
Establishment	1,771	1,883
Premises	25,082	22,744
Transport (including patient travel)	1,322	1,432
Depreciation on property, plant and equipment	19,048	19,006
Amortisation on intangible assets	1,800	2,002
Net impairments	15,623	18,265
Movement in credit loss allowance: contract receivables / contract assets	103	8
Increase/(decrease) in other provisions	466	662
Change in provisions discount rate(s)	(102)	10
Fees payable to the external auditor		
audit services- statutory audit	144	142
Internal audit costs	104	106
Clinical negligence	13,776	13,984
Legal fees	220	1,031
Insurance (as a policy holder)	482	531
Research and development	1,189	1,076
Education and training	4,621	5,175
Car parking & security	462	340
Hospitality	1	-
Losses, ex gratia & special payments	77	21
Other services, eg external payroll	355	568
Other	1,617	1,683
Total	**551,051**	**528,813**
Of which:		
Related to continuing operations	551,051	528,813

Note 7.3 Other auditor remuneration (Group)

The Trust did not have any other auditor remuneration.

Note 7.4 Limitation on auditor's liability (Group)

There is no limitation on auditor's liability for external audit work carried out for the financial years 2025/26 or 2024/25.

Note 8 Impairment of assets (Group and Trust)

	2025/26	2024/25
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Over specification of assets	-	371
Abandonment of assets in course of construction	30	268
Changes in market price	1,370	7,776
Other	14,222	9,850
Total net impairments charged to operating surplus / deficit	**15,623**	**18,265**
Impairments charged to the revaluation reserve	784	11,026
Total net impairments	**16,407**	**29,291**

In 2025/2026 the Trust undertook a revaluation exercise of its land, buildings and dwellings on a modern equivalent basis which resulted in a net impairment charge of £15.623 million to the Statement of Comprehensive Income (SoCi). Impairments reflect the fall in value of property as reflected in the District Valuer report as at the 31st March 2026 or a reversal of impairment where a previous fall in value had been recorded. Where revaluation reserve balances exist impairment charges of £784k have been charged in 2025/26.

In 2025/26 the Trust capitalised the new Outpatients Facility as a cost of £23.794 million. The District Valuer has valued the building at £9.157 million. The impairment at the 31st March 2026 is calculated at £14.222 million. The Trust has also impaired design fees of £30k for two capital projects.

Note 9.1 Employee benefits (Group)

	2025/26	2024/25
	Total	Total
	£000	£000
Salaries and wages	270,084	253,326
Social security costs	33,244	24,741
Apprenticeship levy	1,370	1,286
Employer's contributions to NHS pensions	53,115	48,303
Pension cost - other	54	67
Temporary staff (including agency)	35,101	44,371
Total staff costs	**392,968**	**372,094**
Of which		
Costs capitalised as part of assets	373	222

Note 9.2 Employee benefits (Trust)

	2025/26 Total £000	2024/25 Total £000
Salaries and wages	269,763	253,119
Social security costs	33,198	24,705
Apprenticeship levy	1,370	1,286
Employer's contributions to NHS pensions	53,115	48,303
Pension cost - other	47	59
Temporary staff (including agency)	35,101	44,371
Total gross staff costs	**392,594**	**371,843**
Recoveries in respect of seconded staff		-
Total staff costs	**392,594**	**371,843**
Of which		
Costs capitalised as part of assets	373	222

Note 9.3 Retirements due to ill-health (Group)

During 2025/26 there were 7 early retirements from the Trust agreed on the grounds of ill-health (4 in the year ended 31 March 2025). The estimated additional pension liabilities of these ill-health retirements is £359k (£63k in 2024/25).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 10 Pension costs

Past and present employees are covered by the provisions of the 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 the 1995, 2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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

In 2025/26 Trust employer pension contributions were £53.1m and £47k for NEST. The Pharmacy Shop paid £7.3k employers pensions contributions to the Creative Solutions workplace pension scheme. In 2025/26 estimated employer contributions to the NHS Pension scheme are £61.3m and for NEST £115k.

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 2026, is based on valuation data as at 31 March 2024, updated to 31 March 2026 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 Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and 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 (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 at 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027

The Trust offers employees both at the Trust and its subsidiary, Stepping Hill Enterprises Limited, an additional defined contribution workplace pension scheme offered by the National Employment Savings Scheme (NEST) and Creative Solutions.

Note 11 Finance income (Group)

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

	2025/26	2024/25
	£000	£000
Interest on bank accounts	2,226	1,896
NHS charitable fund investment income	92	94
Total finance income	**2,318**	**1,990**

Note 11.1 Finance income (Trust)

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

	2025/26	2024/25
	£000	£000
Interest on bank accounts	2,226	1,896
Total finance income	**2,226**	**1,896**

Note 12.1 Finance expenditure (Group and Trust)

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

	2025/26	2024/25
	£000	£000
Interest expense:		
Interest on loans from the Department of Health and Social Care	387	446
Interest on lease obligations	336	326
Total interest expense	**723**	**772**
Unwinding of discount on provisions	57	62
Total finance costs	**780**	**833**

Note 12.2 The late payment of commercial debts (interest) Act 1998

The Trust has no late payment of commercial debt interest to report in 2025/26 or 2024/2025

Note 13 Other gains / (losses) (Group)

	2025/26	2024/25
	£000	£000
Gains on disposal of assets	105	49
Losses on disposal of assets	(7,229)	-
Total gains / (losses) on disposal of assets	**(7,124)**	**49**
Fair value gains / (losses) on charitable fund investments & investment properties	(144)	(82)
Total other gains / (losses)	**(7,268)**	**(33)**

Note 14.1 Intangible assets - 2025/26

Group and Trust	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Cost at 1 April 2025 - brought forward *	**11,427**	**2,354**	**13,781**
Additions	2,971	556	**3,527**
Reclassifications	955	(955)	**-**
Disposals / derecognition	(214)	-	**(214)**
Cost at 31 March 2026	**15,139**	**1,955**	**17,094**
Amortisation at 1 April 2025 - brought forward	**7,525**	**-**	**7,525**
Provided during the year	1,800	-	**1,800**
Disposals / derecognition	(214)	-	**(214)**
Amortisation at 31 March 2026	**9,111**	**-**	**9,111**
Net book value at 31 March 2026	**6,028**	**1,955**	**7,983**
Net book value at 1 April 2025	**3,902**	**2,354**	**6,256**

Note 14.2 Intangible assets - 2024/25

Group and Trust	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2024 - as previously stated	**17,161**	**2,598**	**19,759**
Additions	100	54	**154**
Impairments	-	(298)	**(298)**
Disposals / derecognition	(5,834)	-	**(5,834)**
Valuation / gross cost at 31 March 2025	**11,427**	**2,354**	**13,781**
Amortisation at 1 April 2024 - as previously stated	**11,357**	**-**	**11,357**
Provided during the year	2,002	-	**2,002**
Disposals / derecognition	(5,834)	-	**(5,834)**
Amortisation at 31 March 2025	**7,525**	**-**	**7,525**
Net book value at 31 March 2025	**3,902**	**2,354**	**6,256**
Net book value at 1 April 2024	**5,804**	**2,598**	**8,402**

Note 15.1 Property, plant and equipment - 2025/26

Group and Trust	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 2025 - brought forward	**8,245**	**157,404**	**2,280**	**20,424**	**53,906**	**344**	**32,336**	**1,020**	**275,958**
Additions	-	7,222	143	4,737	9,933	-	3,723	252	**26,009**
Impairments	-	(16,670)	(115)	(31)	-	-	-	-	**(16,816)**
Reversals of impairments	-	409	-	-	-	-	-	-	**409**
Revaluations	-	1,581	60	-	-	-	-	-	**1,641**
Reclassifications	-	24,362	-	(24,362)	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(3,468)	(70)	(2,763)	(426)	**(6,728)**
Valuation/gross cost at 31 March 2026	**8,245**	**174,308**	**2,368**	**768**	**60,370**	**274**	**33,296**	**846**	**280,473**
Accumulated depreciation at 1 April 2025 - brought forward	**-**	**-**	**-**	**-**	**28,986**	**238**	**18,968**	**746**	**48,938**
Provided during the year	-	5,963	73	-	5,812	36	5,261	125	**17,270**
Revaluations	-	(5,963)	(73)	-	-	-	-	-	**(6,036)**
Disposals / derecognition	-	-	-	-	(3,289)	(70)	(2,763)	(426)	**(6,549)**
Accumulated depreciation at 31 March 2026	**-**	**-**	**-**	**-**	**31,509**	**204**	**21,466**	**445**	**53,624**
Net book value at 31 March 2026	**8,245**	**174,308**	**2,368**	**768**	**28,861**	**70**	**11,830**	**401**	**226,850**
Net book value at 1 April 2025	**8,245**	**157,404**	**2,280**	**20,424**	**24,919**	**106**	**13,368**	**274**	**227,020**

During the current year, the Trust identified fully depreciated assets within plant and machinery which had been disposed of in prior years and whose values remained within the cost and accumulated depreciation balances disclosed in the note above. These have been disposed in 2025/26 at a gross cost and accumulated depreciation balances of £1.6 m. In addition assets of £5 m, that fully depreciated in 2025/26, have been disposed of from gross cost and accumulated depreciation. Assets with a net book value of £179k were disposed at a loss (see note 5.2).

Note 15.2 Property, plant and equipment - 2024/25

Group and Trust	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 2024 - as previously stated	**8,245**	**144,804**	**2,135**	**38,667**	**53,524**	**344**	**37,855**	**892**	**286,466**
Prior period adjustments	-	-	-	-	-	-	-	-	-
Valuation / gross cost at 1 April 2024 - restated	**8,245**	**144,804**	**2,135**	**38,667**	**53,524**	**344**	**37,855**	**892**	**286,466**
Additions	1,000	14,122	-	12,037	1,612	-	1,494	128	**30,391**
Impairments	-	(28,831)	-	(268)	(73)	-	-	-	**(29,172)**
Reversals of impairments	-	179	-	-	-	-	-	-	**179**
Revaluations	-	(2,907)	171	-	-	-	-	-	**(2,736)**
Reclassifications	-	30,038	(26)	(30,012)	-	-	-	-	-
Transfers to / from assets held for sale	(1,000)	-	-	-	-	-	-	-	**(1,000)**
Disposals / derecognition	-	-	-	-	(1,157)	-	(7,013)	-	**(8,170)**
Valuation/gross cost at 31 March 2025	**8,245**	**157,404**	**2,280**	**20,424**	**53,906**	**344**	**32,336**	**1,020**	**275,958**
Accumulated depreciation at 1 April 2024 - as previously stated	**-**	**-**	**-**	**-**	**24,235**	**192**	**20,312**	**664**	**45,403**
Prior period adjustments	-	-	-	-	-	-	-	-	-
Accumulated depreciation at 1 April 2024 - restated	**-**	**-**	**-**	**-**	**24,235**	**192**	**20,312**	**664**	**45,403**
Provided during the year	-	5,228	66	-	5,909	46	5,669	82	**17,000**
Revaluations	-	(5,228)	(66)	-	-	-	-	-	**(5,294)**
Disposals / derecognition	-	-	-	-	(1,157)	-	(7,013)	-	**(8,170)**
Accumulated depreciation at 31 March 2025	**-**	**-**	**-**	**-**	**28,986**	**238**	**18,968**	**746**	**48,938**
Net book value at 31 March 2025	**8,245**	**157,404**	**2,280**	**20,424**	**24,919**	**106**	**13,368**	**274**	**227,020**
Net book value at 1 April 2024	**8,245**	**144,804**	**2,135**	**38,667**	**29,290**	**152**	**17,543**	**228**	**241,063**

Note 15.3 Property, plant and equipment financing - 31 March 2026

Group and Trust	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
Owned - purchased	8,245	173,669	2,309	398	28,387	61	11,830	380	**225,278**
Owned - donated/granted	-	639	59	370	474	9	-	21	**1,572**
NBV total at 31 March 2026	**8,245**	**174,308**	**2,368**	**768**	**28,861**	**70**	**11,830**	**401**	**226,850**

Note 15.4 Property, plant and equipment financing - 31 March 2025

Group and Trust	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
Owned - purchased	8,245	156,795	2,222	20,424	24,277	93	13,368	270	**225,694**
Owned - donated/granted	-	609	58	-	642	13	-	4	**1,326**
NBV total at 31 March 2025	**8,245**	**157,404**	**2,280**	**20,424**	**24,919**	**106**	**13,368**	**274**	**227,020**

Note 15.5 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2026

The Trust transferred the Neuro-Rehabilitation service to Northern Care Alliance NHS Foundation Trust on the 1st March 2026. The Neuro- Rehabilitation service operates from the Devonshire Centre building. A tenancy at will arrangement is in place pending completion of the formal lease contract. There were no assets subject to an operating lease in 2024/25.

Group and Trust	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
Subject to an operating lease	293	2,652	-	-	-	-	-	-	**2,945**
Not subject to an operating lease	7,952	171,656	2,368	768	28,861	70	11,830	401	**223,905**
NBV total at 31 March 2026	**8,245**	**174,308**	**2,368**	**768**	**28,861**	**70**	**11,830**	**401**	**226,850**

Note 16 Donations of property, plant and equipment

In 2025/26 Stockport NHS Charity has donated assets to the Trust of £188k (£287k in 2024/25). The Charity has contributed £175k for the staff facilities within the new Outpatients building and £13k for a Point of Care Ultrasound machine. In addition the Trust has signed an agreement with Macmillan Charity Support to fund a Cancer Information Centre. The Trust has accrued for £570k grant income in 2025/26. The Trust has also received contributions of time and building materials from its suppliers in 2025/26 to the value of £44k for schemes including the Changing Places facility, external Outpatients facility area and Treehouse childrens garden.

Note 17 Revaluations of property, plant and equipment

In 2025/2026 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 31st March 2026. The valuation was based on land on its existing site but on a much smaller footprint and buildings based on a Modern Equivalent Basis. Further disclosures on this revaluation can be found at note 1.9 Property, Plant and Equipment: Measurement. The movements on the revaluation reserve are shown below. .

Revaluation Reserve Movements	**Group and Trust**	
	£000	**£000**
	Property, Plant and Equipment	**Revaluation Reserve**
Revaluation reserve at 1 April 2025 - brought forward	**59,614**	**59,614**
Net impairments	**(784)**	**(784)**
Revaluations	**7,677**	**7,677**
Other reserve movements	**(296)**	**(296)**
Revaluation reserve at 31 March 2026	**66,212**	**66,212**

Where the balance on the revaluation reserve exceeded the net book value of the related assets, the excess was transferred to the income and expenditure reserve. The value transferred in the year was £296k

	Group and Trust	
	£000	**£000**
	Property, Plant and Equipment	**Revaluation Reserve**
Revaluation reserve at 1 April 2024 - brought forward	**68,266**	**68,266**
Net impairments	**(11,026)**	**(11,026)**
Revaluations	**2,558**	**2,558**
Other reserve movements	**(183)**	**(183)**
Revaluation reserve at 31 March 2025	**59,614**	**59,614**

Note 18 Leases - Stockport NHS Foundation Trust as a lessee

This note details information about leases for which the Trust is a lessee.

In 2025/2026 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. These leases are held in line with current commissioning contracts for the provision of long term healthcare. Where no signed contract exists an assumption of ten years has been assigned to the life of the lease unless other specific terms or circumstances are identified. The community property buildings were re-measured at a cost of £217k in 2025/26 (£651k in 2024/25). The Trust also has a small number of leased vehicles, portacabins and medical equipment.

In 2025/26 the Trust has entered into four new leases over one year at a value of £554k. This includes the five year lease for the Bluebell ward at The Meadows for £487k, two Pathology leases for £47k and a £20k lease for vehicles for the Quality Control trading unit.

Note 18.1 Right of use assets - 2025/26

Group and Trust	Property (land and buildings)	Plant & machinery	Transport equipment	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2025 - brought forward	**12,385**	**1,698**	**31**	**14,113**	**12,385**
Additions	487	47	20	**554**	487
Remeasurements of the lease liability	217	-	-	**217**	217
Disposals / derecognition	(353)	(204)	-	**(557)**	(353)
Valuation/gross cost at 31 March 2026	**12,736**	**1,541**	**51**	**14,327**	**12,736**
Accumulated depreciation at 1 April 2025 - brought forward	**4,414**	**295**	**24**	**4,733**	**4,414**
Provided during the year	1,527	242	9	**1,778**	1,527
Disposals / derecognition	(194)	(204)	-	**(398)**	(194)
Accumulated depreciation at 31 March 2026	**5,747**	**333**	**33**	**6,112**	**5,747**
Net book value at 31 March 2026	**6,989**	**1,208**	**18**	**8,215**	**6,989**
Net book value at 1 April 2025	**7,971**	**1,403**	**7**	**9,381**	**7,971**

Net book value of right of use assets leased from other NHS providers	438
Net book value of right of use assets leased from other DHSC group bodies	6,551

Note 18.2 Right of use assets - 2024/25

Group and Trust	Property (land and buildings)	Plant & machinery	Transport equipment	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	**13,529**	**291**	**31**	**13,850**	**11,734**
Additions	-	1,407	-	**1,407**	-
Remeasurements of the lease liability	651	-	-	**651**	651
Disposals / derecognition	(1,795)	-	-	**(1,795)**	-
Valuation/gross cost at 31 March 2025	**12,385**	**1,698**	**31**	**14,113**	**12,385**
Accumulated depreciation at 1 April 2024 - brought forward	**4,343**	**164**	**14**	**4,521**	**2,923**
Provided during the year	1,866	131	10	**2,007**	1,491
Disposals / derecognition	(1,795)	-	-	**(1,795)**	-
Accumulated depreciation at 31 March 2025	**4,414**	**295**	**24**	**4,733**	**4,414**
Net book value at 31 March 2025	**7,971**	**1,403**	**7**	**9,381**	**7,971**
Net book value at 1 April 2024	**9,186**	**127**	**17**	**9,329**	**8,811**

Net book value of right of use assets leased from other DHSC group bodies	7,971

Note 18.3 Revaluations of right of use assets

In 2025/26 remeasurement of lease liabilities of other properties are in line with market uplifts to leases as per invoicing arrangements with NHS Property Services and other landlords.

Note 18.4 Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the statement of financial position. A breakdown of borrowings is disclosed in note 27.

	Group and Trust	
	2025/26	2024/25
	£000	£000
Carrying value at 1 April	**9,661**	**9,495**
Lease additions	554	1,407
Lease liability remeasurements	217	651
Interest charge arising in year	336	326
Early terminations	(165)	-
Lease payments (cash outflows)	(2,018)	(2,218)
Carrying value at 31 March	**8,585**	**9,661**

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure.

These payments are disclosed in Note 7.1. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

Note 18.5 Maturity analysis of future lease payments at 31 March 2026

	Group and Trust	
	Total	Of which leased from DHSC group bodies:
	31 March 2026	31 March 2026
	£000	£000
Undiscounted future lease payments payable in:		
- not later than one year;	1,687	1,458
- later than one year and not later than five years;	4,936	4,043
- later than five years.	1,962	1,821
Total gross future lease payments	**8,585**	**7,322**
Finance charges allocated to future periods	-	-
Net lease liabilities at 31 March 2026	**8,585**	**7,322**
Of which:		
Leased from other NHS providers		443
Leased from other DHSC group bodies		6,879

Note 18.6 Maturity analysis of future lease payments at 31 March 2025

	Group and Trust	
	Total	Of which leased from DHSC group bodies:
	31 March 2025 £000	31 March 2025 £000
Undiscounted future lease payments payable in:		
- not later than one year;	1,620	1,405
- later than one year and not later than five years;	6,123	5,055
- later than five years.	1,917	1,776
Total gross future lease payments	**9,660**	**8,236**
Finance charges allocated to future periods	-	-
Net finance lease liabilities at 31 March 2025	**9,660**	**8,236**
Of which:		
Leased from other DHSC group bodies		8,236

Note 19 Other investments / financial assets (non-current)

	Group and Trust	
	2025/26 £000	2024/25 £000
Carrying value at 1 April - brought forward	**1,692**	**1,774**
At start of period for new FTs	-	-
Movement in fair value through income and expenditure	(144)	(82)
Carrying value at 31 March	**1,548**	**1,692**

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 2024/2025 the Group reported £92k (£94k in 2024/2025) in interest receivable on these investments and a loss on valuation of £144k at the 31st March 2026 (£82k loss at the 31st March 2025).

Note 20 Analysis of charitable fund reserves

The Trust has consolidated its charitable fund, Stockport NHS Charity - Charity Commission Number Registration Number 1048661, within the Group Accounts.

	31 March 2026 £000	31 March 2025 £000
Unrestricted funds:		
Unrestricted income funds	532	532
Restricted funds:		
Other restricted income funds	1,405	1,686
	1,937	**2,218**

Unrestricted income funds are accumulated income funds that are expendable at the discretion of the trustees in furtherance of the charity's objects. Unrestricted funds may be earmarked or designated for specific future purposes which reduces the amount that is readily available to the charity.

Restricted funds may be accumulated income funds which are expendable at the trustee's discretion only in furtherance of the specified conditions of the donor and the objects of the charity. They may also be capital funds (e.g. endowments) where the assets are required to be invested, or retained for use rather than expended.

Note 21 Inventories

	Group		Trust	
	2026	2025	2026	2025
	£000	£000	£000	£000
Drugs	1,026	1,139	863	951
Total inventories	**1,026**	**1,139**	**863**	**951**
of which:				

Inventories recognised in expenses for the year were £23,891k (2024/25: £22,741k). Write-down of inventories recognised as expenses for the year were £0k (2024/25: £0k).

Note 22.1 Receivables

	Group		Trust	
	31 March 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
Current				
Contract receivables	9,556	10,538	9,610	10,859
Allowance for impaired contract receivables / assets	(914)	(873)	(914)	(873)
Prepayments (non-PFI)	3,443	2,135	3,441	2,135
Interest receivable	215	208	215	208
Operating lease receivables	16	-	16	-
PDC dividend receivable	1,875	394	1,875	394
VAT receivable	2,174	1,596	2,060	1,490
Other receivables	330	426	1,215	970
Total current receivables	**16,695**	**14,424**	**17,517**	**15,183**
Non-current				
Contract receivables	351	299	351	299
Allowance for impaired contract receivables / assets	(86)	(73)	(86)	(73)
Other receivables	414	442	414	442
Total non-current receivables	**678**	**668**	**679**	**668**
Of which receivable from NHS and DHSC group bodies:				
Current	7,166	7,376	8,689	7,376
Non-current	414	442	414	442

Within the Group note adjustments have been made for transactions with the Trust's Charity and subsidiary Outpatient Drug Dispensing Service - Stepping Hill Healthcare Enterprises Limited.

Note 22.2 Allowances for credit losses - 2025/26

Group and Trust	Contract receivables and contract assets	Contract receivables and contract assets
	£000	£000
	2025/26	2024/25
Allowances as at 1 Apr 2025 - brought forward	946	948
New allowances arising	287	302
Reversals of allowances	(184)	(294)
Utilisation of allowances (write offs)	(49)	(10)
Allowances as at 31 Mar 2026	**1,000**	**946**

Note 23 Non-current assets held for sale and assets in disposal groups

Group and Trust	2025/26	2024/25
	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 1 April	**7,050**	**-**
Assets classified as available for sale in the year	-	1,000
Assets purchased for subsequent disposal	-	6,050
Assets sold in year	(7,050)	-
NBV of non-current assets for sale and assets in disposal groups at 31 March	**-**	**7,050**

In 2024/25 the Trust de-recognised the land and buildings related to the Meadows after purchasing the PFI Facility on expiry of the agreement. Funds were provided by Pennine Care NHS Foundation Trust (PCFT), the majority occupier of the facility with an agreement to transfer back to PCFT as agreed by NHS regional and national teams. This transaction was concluded in 2025/26.

Note 24 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	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
At 1 April	**38,038**	**17,141**	**36,725**	**15,525**
Net change in year	6,121	20,898	5,928	21,200
At 31 March	**44,159**	**38,038**	**42,653**	**36,725**
Broken down into:				
Cash at commercial banks and in hand	1,781	1,599	275	286
Cash with the Government Banking Service	42,378	36,439	42,378	36,439
Total cash and cash equivalents as in SoFP	**44,159**	**38,038**	**42,653**	**36,725**
Total cash and cash equivalents as in SoCF	**44,159**	**38,038**	**42,653**	**36,725**

Note 24.1 Third party assets held by the trust

Stockport NHS Foundation Trust held no cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties.

Note 25 Trade and other payables

	Group		Trust	
	31 March 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
Current				
Trade payables	6,718	8,188	6,718	8,188
Capital payables	14,639	7,860	14,639	7,860
Accruals	32,579	33,666	32,852	33,666
Social security costs	3,629	2,843	3,624	2,835
Other taxes payable	3,498	3,138	3,487	3,132
Pension contributions payable	4,405	4,070	4,404	4,069
Other payables	1,026	1,040	1,026	1,522
Total current trade and other payables	**66,495**	**60,806**	**66,751**	**61,272**
Of which payables from NHS and DHSC group bodies:				
Current	5,965	5,652	5,965	5,652

Note 26 Other liabilities

Group and Trust	31 March 2026	31 March 2025
	£000	£000
Current		
Deferred income: contract liabilities	6,342	4,927
Total other current liabilities	**6,342**	**4,927**

Note 27 Borrowings

Group and Trust	31 March 2026	31 March 2025
	£000	£000
Current		
Loans from DHSC	1,645	1,660
Lease liabilities	1,687	1,620
Total current borrowings	**3,332**	**3,280**
Non-current		
Loans from DHSC	10,672	12,223
Lease liabilities	6,898	8,040
Total non-current borrowings	**17,570**	**20,263**

Note 27.1 Reconciliation of liabilities arising from financing activities (Group)

Group and Trust - 2025/26	Loans from DHSC	Lease liabilities	PFI and LIFT schemes	Total
	£000	£000	£000	£000
Carrying value at 1 April 2025	**13,883**	**9,661**	**-**	**23,544**
Cash movements:				
Financing cash flows - payments and receipts of principal	(1,551)	(1,682)	-	**(3,233)**
Financing cash flows - payments of interest	(402)	(336)	-	**(738)**
Non-cash movements:				
Additions	-	554	-	**554**
Lease liability remeasurements	-	217	-	**217**
Application of effective interest rate	387	336	-	**723**
Early terminations	-	(165)	-	**(165)**
Carrying value at 31 March 2026	**12,317**	**8,585**	**-**	**20,902**

Group and Trust - 2024/25	Loans from DHSC	Lease liabilities	PFI and LIFT schemes	Total
	£000	£000	£000	£000
Carrying value at 1 April 2024	**15,451**	**9,495**	**194**	**25,140**
Cash movements:				
Financing cash flows - payments and receipts of principal	(1,551)	(1,892)	(195)	**(3,638)**
Financing cash flows - payments of interest	(462)	(326)	-	**(788)**
Non-cash movements:				
Additions	-	1,407	-	**1,407**
Lease liability remeasurements	-	651	-	**651**
Application of effective interest rate	446	326	-	**771**
Carrying value at 31 March 2025	**13,883**	**9,661**	**-**	**23,543**

Note 28.1 Provisions for liabilities and charges analysis

Group and Trust	Pensions: injury benefits	Legal claims	Pay-related claims (including Agenda for Change)	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2025	**2,827**	**130**	**283**	**991**	**4,231**
Change in the discount rate	(102)	-	-	(34)	**(136)**
Arising during the year	43	46	183	511	**783**
Utilised during the year	(218)	(46)	-	(30)	**(294)**
Reversed unused	-	-	-	(46)	**(46)**
Unwinding of discount	57	-	-	28	**85**
At 31 March 2026	**2,607**	**130**	**466**	**1,420**	**4,623**
Expected timing of cash flows:					
- not later than one year;	507	130	466	1,006	**2,109**
- later than one year and not later than five years;	898	-	-	62	**961**
- later than five years.	1,201	-	-	351	**1,553**
Total	**2,607**	**130**	**466**	**1,420**	**4,623**

The provision for 'Pensions - injury benefits' is for the reimbursement of injury benefit allowances to the NHS Pensions Agency for ten members of former staff over their estimated life expectancy.

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 29.2 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.

For the pay related provisions the Trust has provided for costs for outstanding job banding claims. Within other provisions there are VAT reclaim provisions based on the Midland Partnership ruling and review of contracted out service IT reclaims. Legal claims relate to notified employment tribunals. There is also a provision for Clinicians Pension Tax Reimbursement. This is a nationally provided figure for the tax charge of clinicians incurred in 2019/20 where additional work has led to a breach of the annual pension allowance. The charge is offset by a matching receivable as the future cost will be met by the NHS Pension Scheme.

Note 28.2 Clinical negligence liabilities

At 31 March 2026, £154,121k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Stockport NHS Foundation Trust (31 March 2025: £157,948k).

Note 29 Contingent assets and liabilities

	31 March 2026	31 March 2025
	£000	£000
Value of contingent liabilities		
NHS Resolution legal claims	(57)	(62)
Net value of contingent liabilities	**(57)**	**(62)**
Net value of contingent assets	**-**	**738**

In 2024/25 the Trust included a contingent asset based on its claim for Vat Recovery on car parking charges (Brockenhurst Claim). The claim was not successful and the contingent asset has been removed.

Note 30 Contractual capital commitments

	Group	
Group and Trust	31 March 2026 £000	31 March 2025 £000
Property, plant and equipment	701	7,362
Intangible assets	13,943	-
Total	**14,644**	**7,362**

Capital commitments reflect those capital projects started or contractually committed to in 2025/2026. These commitments includes the signed contract for the Electronic Patient Record business case for implementation milestones of the scheme with the main supplier. An initial payment of £468k was payable on contract signature in February 2026 with a remaining capital contract commitment of £13.9 million over the next two financial years. The Trust has a capital commitment for the completion of the Macmillan Cancer Information Centre for £652k with expenditure to date £448k. The scheme is due for completion by June 2026. The remaining order commitment is for the Aseptics Annex 1 capital scheme for £49k with works to date paid of £711k due for completion in April 2026.

Note 31 Financial instruments

Note 31.1 Financial risk management

IFRS 7 Financial Instruments Disclosure requires declaration of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. Financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies to which IFRS 7 mainly applies. Stockport NHS Foundation Trust has financial assets and liabilities that 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

Operating costs for the Trust are funded under annual contracts and service agreements with NHS Commissioners. In 2025/2026 NHS England funded NHS Trusts under the NHS Payment Scheme (NHSPS) and managed through the GM Integrated Care System. The majority of the Trust's income is earned from the GM ICS and other local NHS commissioners in the form of aligned payment and incentive contracts to fund an agreed level of activity as detailed at note 1.4. In 2025/26 Greater Manchester ICS continues to pay providers on the 1st working day of the month to assist Trusts with cashflow management. In addition it received non recurrent revenue support of £43.2 million, cash backed to assist the Trust achieve its plan and meet its cash needs . Although reduced for 2026/27, the Trust ICS Contract offer includes deficit support funding of £39.4 million as part of the planning process.

The Trust has in place four loans with the NHS Independent Trust Financing Facility that were put in place to finance major capital developments (including the Cardiac and Surgical Unit and theatre extensions). The Trust is exposed to liquidity risk for these financial liabilities. The Trust engaged in a rigorous approval process with NHSI prior to the facilities put in place and have met all principal and interest obligations since inception.

In 2025/2026 capital costs were funded from internal depreciation and £12.1m in PDC cash funding for specific programmes including Estates Safety Schemes for £3.8m, Urgent Treatment Centre £1.7m, Electronic Patient Record £2.1m and £4.5m for Digital Diagnostic/Cyber schemes. In 2026/27 capital schemes are approved subject to accurate cash spend profiles to assist in managing the Trust's cash outflows.

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. There is a monthly Cashflow Monitoring Group responsible for monitoring the cash levels of the organisation in the short, medium and longer term to deliver actions to improve the forecast liquidity and to preserve cash.

At the 31 March 2026 the Trust's cash balances were held solely in its Government Banking Services bank accounts and Barclays current accounts as per note 25.1.

It is expected that the above arrangements with robust financial planning and monitoring in year means that Stockport NHS Foundation Trust is not exposed to significant liquidity risk, will preserve cash balances and minimize the need for further revenue support requests.

Market and Interest Rate Risk

At the 31 March 2026 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.

Foreign Currency Risk

The Trust has negligible foreign currency income or expenditure and no overseas operations. There is, therefore, a very low exposure to currency rate fluctuations.

Credit Risk

The Trust receives most of its income from its commissioners based on agreed contract payments. It operates a robust debt management policy and, where necessary, provides for the risk of particular debts not being discharged by the applicable party. Non NHS customers do not make up a large proportion of income with the majority of income coming from other public sector bodies which are considered low risk. This position means that Stockport NHS Foundation Trust is, therefore, not exposed to significant credit risk. Where it has significant commitments (for example large capital contract awards and payments) it uses a credit rating agency before payments are made or contracts awarded.

Charitable Funds

The Group accounts include the financial statements of the Stockport NHS Charitable Fund. The charitable fund places its short term cash in bank accounts with the Trust's commercial bank, Barclays PLC. The Charity also invests monies of £2.8 million for longer term investment with CCLA Investment Management Ltd. It holds one common investment fund in equity funds of £1.5 million and one cash deposit account holding £1.3 million. The Charity receives quarterly updates on the performance of its investments and allocates gains and losses when realised to its charitable funds. This policy is reviewed on an annual basis to mitigate for any possible market losses on the valuation of its equity common investment fund.

Stepping Hill Healthcare Enterprises Limited

The Group accounts include the financial statements of its trading subsidiary, Stepping Hill Healthcare Enterprises Limited. The subsidiary holds its cash with the Trust commercial banker, Barclays PLC, in a separate bank account. Its income is predominantly with the parent and it currently purchases drugs for its dispensing services using the Trust Pharmacy as its wholesale supplier. It is not considered, therefore, to have market or liquidity risks.

Note 31.2 Carrying values of financial assets (Group)

The Group holds financial assets that qualify as basic financial instruments that includes cash and receivables held at amortised cost and Charity investments held at fair value. The latter are recognised initially at transaction value and subsequently measured at fair value. through the Statement of Comprehensive Income.

Carrying values of financial assets as at 31 March 2026	Held at amortised cost	Held at fair value through P&L	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	8,923	-	-	**8,923**
Cash and cash equivalents	42,886	-	-	**42,886**
Consolidated NHS Charitable fund financial assets	1,548	1,273	-	**2,821**
Total at 31 March 2026	**53,357**	**1,273**	**-**	**54,630**

Carrying values of financial assets as at 31 March 2025	Held at amortised cost	Held at fair value through P&L	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	9,891	-	-	**9,891**
Cash and cash equivalents	36,968	-	-	**36,968**
Consolidated NHS Charitable fund financial assets	1,692	1,070	-	**2,762**
Total at 31 March 2025	**48,551**	**1,070**	**-**	**49,621**

Note 31.3 Carrying values of financial assets (Trust)

Carrying values of financial assets as at 31 March 2026	Held at amortised cost	Held at fair value through P&L	Total book value
	£000	£000	£000
Trade and other receivables excluding non financial assets	8,977		**8,977**
Cash and cash equivalents	42,653		**42,653**
Total at 31 March 2026	**51,630**	**-**	**51,630**

Carrying values of financial assets as at 31 March 2025	Held at amortised cost	Held at fair value through P&L	Total book value
	£000	£000	£000
Trade and other receivables excluding non financial assets	10,212		**10,212**
Cash and cash equivalents	36,725		**36,725**
Total at 31 March 2025	**46,937**	**-**	**46,937**

Note 31.4 Carrying values of financial liabilities (Group)

Carrying values of financial liabilities as at 31 March 2026	Held at amortised cost	Held at fair value through P&L	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	12,317	-	**12,317**
Obligations under leases	8,585	-	**8,585**
Trade and other payables excluding non financial liabilities	50,984	-	**50,984**
Provisions under contract	130	-	**130**
Total at 31 March 2026	**72,016**	**-**	**72,016**

Carrying values of financial liabilities as at 31 March 2025	Held at amortised cost	Held at fair value through P&L	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	13,883	-	**13,883**
Obligations under leases	9,660	-	**9,660**
Trade and other payables excluding non financial liabilities	47,054	-	**47,054**
Provisions under contract	130	-	**130**
Total at 31 March 2025	**70,727**	**-**	**70,727**

Note 31.5 Carrying values of financial liabilities (Trust)

Carrying values of financial liabilities as at 31 March 2026

	Held at amortised cost	Held at fair value through P&L	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	12,317	-	**12,317**
Obligations under leases	8,585	-	**8,585**
Trade and other payables excluding non financial liabilities	51,256	-	**51,256**
Provisions under contract	130	-	**130**
Total at 31 March 2026	**72,288**	**-**	**72,288**

Note 31.6 Carrying values of financial liabilities (Trust)

Carrying values of financial liabilities as at 31 March 2025

	Held at amortised cost	Held at fair value through P&L	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	13,883	-	**13,883**
Obligations under leases	9,660	-	**9,660**
Trade and other payables excluding non financial liabilities	47,054	-	**47,054**
Provisions under contract	130	-	**130**
Total at 31 March 2025	**70,727**	**-**	**70,727**

Note 31.7 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 2025 as book value is considered to be a reasonable approximation of fair value.

Note 31.8 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	Group		Trust	
	31 March 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
In one year or less	54,696	50,757	54,968	50,757
In more than one year but not more than five years	11,069	13,393	11,069	13,393
In more than five years	7,818	8,532	7,818	8,532
Total	**73,583**	**72,682**	**73,855**	**72,682**

Note 32 Losses and special payments

	2025/26		2024/25	
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	41	26	15	4
Bad debts and claims abandoned	11	23	-	-
Stores losses and damage to property	19	20	2	107
Total losses	**71**	**69**	**17**	**111**
Special payments				
Ex-gratia payments	16	8	29	17
Total special payments	**16**	**8**	**29**	**17**
Total losses and special payments	**87**	**77**	**46**	**128**

Note 33 Related parties

Stockport NHS Foundation Trust is a body corporate authorised by NHS England, 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 28 members of the Council of Governors; 20 public governors, 4 staff governors 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.

The Department of Health and Social Care is regarded as a related party. During the year Stockport NHS Foundation Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are listed in the following table. The Trust and Group's related parties include all Whole of Government bodies as defined by the Treasury.

In addition, the Trust has material transactions with other government departments and other central and local government bodies; significantly Stockport MBC, HM Revenue and Customs within HM Treasury and the NHS Business Services Authority (Pensions).

NHS Greater Manchester ICB

NHS Derby and Derbyshire ICB

NHS Cheshire and Merseyside ICB

NHS England

NHS Resolution

Health Education England

UK Health Security Agency (replaced Public Health England)

Manchester University Foundation NHS Trust

Derbyshire Community Health Services NHS FT

Tameside & Glossop Integrated Care NHS FT

Pennine Care NHS Foundation Trust

East Cheshire NHS Trust

Northern Care Alliance NHS Foundation Trust

Mersey and West Lancashire NHS Teaching Hospitals Trust

The Christie NHS Foundation Trust

Macmillan Cancer Support