NHS
Countess of Chester Hospital
NHS Foundation Trust

Annual Report & Accounts

2020/2021

The Countess of Chester Hospital NHS Foundation Trust

Annual Report and Accounts 2020/21

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

Contents

The Performance Report

1. Performance Report

Performance Overview

Statement from the Chair and Chief Executive

Throughout 2020-2021, the Trust has faced incredible pressures as it has responded to the COVID-19 pandemic. It has had some of the highest proportions of bed occupancy in the North West and has been a fundamental part of the system-wide approach to the pandemic within the Cheshire and Merseyside region. The Countess of Chester Hospital has worked to address the immense healthcare pressures created by COVID-19, both in terms of treating those most ill with the virus and in maintaining as much elective capacity as possible throughout the pandemic. Over the course of this year, we have seen colleagues from across the Trust routinely going above and beyond what could be expected of them under such difficult conditions to provide life-saving care and treatment to those critically ill with the virus. We want to start this year's annual report by paying tribute to the staff at the Countess of Chester. It is only through their professionalism, perseverance and compassion under conditions of acute pressure that that we have been able to save a significant number of lives during the pandemic.

This year, the Trust enhanced its infection prevention and control measures to support the maintenance of essential healthcare services by reducing the risk of transmission of the virus among patients and healthcare workers. As part of our work to protect colleagues and patients, we successfully commenced a programme of asymptomatic testing at the Trust in December, open to staff working on site. This testing programme enabled us to monitor closely any local outbreaks within the Trust, allowing us to respond quickly to cut chains of virus transmission across the Trust.

Looking ahead, the successful roll-out of the national vaccination programme remains the best route out of the pandemic and for enabling the Trust to fully rebuild its pre-pandemic capacity for non-COVID treatment and care. The Countess of Chester is exceptionally proud to have been at the forefront of this vital programme, administering the first vaccine in Cheshire and being one of the first fifty hospital hubs to provide first and second dose COVID-19 vaccinations to over 15,000 people between December 2020 and the end of April 2021. With our Vaccination Centre closing on 28 April, we want to again thank all our colleagues for their work to support this programme, which had enabled us to provide vaccinations with speed and proficiency, helping to protect the local community and support the national effort to suppress the virus.

As part of both our response to COVID-19 and the future of healthcare beyond the pandemic, this year the Trust has made significant progress toward becoming more digitally mature and enabled. In January, the Board approved our Digital and Data Strategy 2021-2026, outlining plans to develop our digital infrastructure to the benefit

of both staff and patients. As part of this strategy, the Trust is now firmly on the road to introducing a new electronic patient record system (epr+) this year, which will replace our current Meditech system. Our Connecting Care, epr+ is due to go live this summer and will modernise and improve the way that we admit, care for and discharge our patients. The electronic patient record will be simpler to use and far more comprehensive, giving our clinical teams and community based health professionals all the information they need to care for our patients. All colleagues who need to use it will be trained prior to its launch and there will be a wealth of information available to colleagues, including videos and training sessions tailored to specific roles.

This year we have also been able to continue expanding our Continuous Improvement (CI) Programme, which supports colleagues by providing the tools and techniques to help embed positive change and improvements across the Trust. The CI programme is helping us to further improve our patient care and processes whilst cutting across different services and disciplines, ensuring a holistic approach to improving the quality of care throughout the Trust. In particular, our Health Records team benefitted from a bespoke improvement week which resulted in 13 significant improvements to make them more efficient. The CI team has also put in place a range of training for staff at all levels across the Trust.

In another important development, this year the NHS 111 First service was launched at the Trust. NHS 111 First is making it easier and safer for patients to get the right advice or treatment when they urgently need it including timed appointment slots in our Emergency Department or in a service that is right for them. We are continuing to scale up our capacity for providing appointment slots, which is helping the Trust manage demand at the Emergency Department, particularly as we continue to enforce strict social distancing measures to reduce the risk of COVID-19 transmission at the Trust.

The Countess also received £15 million worth of much-needed funding from the Government as part of its plan to upgrade Emergency Department facilities at NHS Trusts across the country. The funding will be awarded in two tranches, one in 2021 and another in 2022. Part of this funding will go towards helping to pay for the Same Day Emergency Care (SDEC) Centre due to begin construction in 2021. The new SDEC Centre will create a flexible space for same day emergency care and improve urgent care provision at the Trust, relieving pressure on the Trust's existing Emergency Department services.

On colleague engagement, we were pleased to see that this year's staff survey received a 42% response rate, compared to last year's 29.7%. This illustrates a greater willingness on the part of colleagues to engage with the Trust and feedback their experiences and concerns, helping us to shape an increasingly staff-focused strategy as we move forward. However, there is still much room for improvement, and maximising staff engagement will be an important priority for the Trust in 2021.

As part of the survey results, it was concerning to see that only 29% of colleagues responding said that they thought the Trust takes positive action on improving health and wellbeing services. The intense pressures of this year have highlighted how important it is that colleagues have reliable and consistent access to wellbeing

resources. We have already set up two designated wellness areas to facilitate wellbeing in various guises and where staff can get support if and when needed. We have bolstered our wellbeing provision with greater psychological support and better signposting to existing resources.

Developing the Trust's health and wellbeing offering to colleagues will also be particularly important as we continue to develop policy around our People Strategy 2021-2025. Incorporating lessons learnt from the pandemic, our People Strategy will aim to place the Trust's workforce at the heart of everything it does. Ultimately, it is only through fostering a culture of support and development for colleagues that we can continue to improve our ability to provide outstanding care for our patients and their families, as well as the working experience of all colleagues.

Susan Gilby

Susan Gilby
Chief Executive Officer

Chris Hannah

Chris Hannah
Chair

About the Countess of Chester Hospital NHS Foundation Trust

The Countess of Chester Hospital NHS Foundation Trust includes the Countess of Chester Hospital – a 550 bed hospital which provides the full range of acute and a number of specialist services, and Ellesmere Port Hospital – a rehabilitation, intermediate care and outpatient facility. Foundation Trust status was authorised by Monitor in 2004.

The Trust employs over 5,700 staff (including temporary bank staff) and provides acute emergency and elective services, primary care direct access services and obstetric services to a population of approximately 265,000 residents – mainly in Chester and its surrounding rural areas, Ellesmere Port and Neston and also to patients from the Deeside area of Flintshire which has a population of approximately 157,000. In 2020/21 there were more than 420,000 inpatient and outpatient attendances at the hospital, ranging from a simple outpatient appointment to major cancer surgery. Sadly, this represented a 149,000 reduction in inpatient and outpatient attendances compared with the previous year due to the impact of the COVID-19 pandemic.

We provide services to West Cheshire and Welsh patients covered by Betsi Cadwaladr University Health Board. Welsh patients represent approximately one fifth of our patients.

Foundation Trusts were established as public benefit corporations and operate as independent public institutions which are not subject to direction by the Secretary of State for Health or the performance management requirements of the Department of Health. As a Foundation Trust, we set our own strategy within the framework of contracts with our commissioners of health services and other regulatory bodies to continually improve the quality and safety of patient care. We work closely with our local health system partners in the Wirral and Cheshire area and our local communities.

The Countess of Chester Hospital is arranged into three clinical divisions: Urgent Care, Planned Care and Diagnostics and Pharmacy, with support services which include estates and facilities, human resources, corporate services, finance and information technology.

The Countess of Chester Hospital is the host of the Cheshire West Integrated Care Partnership (ICP) which focusses on developing integrated care in health and social care. For the local NHS, along with Cheshire West and Chester Council, it represents the evolution of our work over recent years. By joining up services which are currently provided separately, we can make better patient decisions by pooling experience, expertise and resources. By focussing on preventing ill-health and

unnecessary hospital admissions we can ensure local services are sustainable for the future.

The Countess of Chester works collaboratively within the wider Cheshire and Merseyside Health and Care Partnership.

Strategic Context

The COVID-19 pandemic, as for many, has been a significant challenge to the organisation in caring for our patients. It has changed our whole perspective and way of working. Traditional ways of working have had to change quickly, both clinically and non-clinically and we must continue to respond robustly to the ongoing implications and impact of the pandemic.

Most general acute Trusts have delivered a relatively traditional range of services in recent years. However, the *NHS Long Term Plan* (2019), the White Paper – Integration & Innovation (2021) and the pandemic have challenged us and asked the NHS for the reconfiguration of health and care provision at a place based level, many elements of which have been in a developmental stage within our locality for some time. New ways of working have been described in our emergent Integrated Care Partnership (ICP), and we have recognised and embraced the changes in our supply of workforce and the new roles afforded to us in how we deliver care. The full realisation of a mature ICP, and the primacy of its role, will have a significant impact on the type and scope of healthcare that is offered to the population of West Cheshire and beyond. We continue to be a key partner also in the wider Cheshire and Mersey Integrated Care System (ICS) which continues to evolve in the wider landscape of redesign and collaborative care.

Using the learning from the pandemic and the wider changes at a national and regional level, we will continue to improve the lives of our community and provide excellence in healthcare through partnership and innovation.

Corporate and supporting strategies

During this year we have engaged a wide range of stakeholders both internally and externally in development of our new Trust Five Year Strategy. This strategy, which will be submitted for Board approval in May 2021, will describe our key Trust vision, aims and objectives. It confirms The Countess of Chester Hospital's relationship with the Cheshire West Integrated Care Partnership, and with all the other parts of the health and social care economy, including that of North Wales. It defines our approach to a range of considerations including our people, digital and data, our approach to improvement, education, and research and innovation, corporate social responsibility, and our environmental impact.

The Trust Five Year Strategy will be supported by our newly-developed Clinical and Continuous Improvement Strategies. The Clinical Strategy describes the priority and direction of our clinical services over the next five years. We have begun to translate this strategy into operational planning, so that business plans and timelines are aligned over a five-year cycle. Our priorities include reducing outpatient activity on-site, and increasing the use of technology to provide digital alternatives where appropriate.

Our Continuous Improvement Strategy describes our ambition to be a leader in this regard, with all our staff trained and given the tools to improve how we provide care for our patients. Our aim is for the Countess of Chester Hospital to build and embed a culture of continuous improvement across the Trust. We will make improvement a daily routine activity and use improvement tools and techniques to solve the problems we face.

We have recently launched our Digital and Data strategy with our ambition to be an organisation that is data driven and supported by intelligent, integrated systems and solutions that are patient-focussed and able to support our staff in delivering safe and effective care. These will be closely aligned with our transformation ambitions. Our new electronic patient record will be a significant step forward in supporting our staff in delivering improved care.

Other enabling strategies will be developed over the coming 12 months that support the delivery of the Trust Five Year Strategy which will include our People, Environmental and Estates strategies.

Digital and Data Strategy

Digital Directions describes how our Trust will develop and deliver its digital and data services over the next five years to meet the challenges and opportunities posed in the Trust's Corporate Strategies[1] and NHS Long Term Plan[2] that describes a fundamentally changed health care offer.

The vision of this strategy is:

***To be a digitally mature health organisation that works with partners to support the wellbeing of the local community through intelligent decision making and clinical innovation*.**

The intention is to aim for a hospital that is digitally-facilitated with a focus on same-day care and a reconfiguration of discharge once inpatient care is clinically optimised as per the Trust's Clinical Strategy. This clinical ambition is set within a system

[1] The Trust Clinical Strategy was agreed in 2019, the corporate and People Strategies are being reviewed and are being shaped for approval in May 2021.
[2] NHS Long Term Plan (Jan 2019) – www.longtermplan.nhs.uk

approach to health outcomes which involves our local partners working within a context of place in West Cheshire.

The strategy sets out how the Trust will develop its plans for digitisation and innovation, working in the context of place in Cheshire West and the Cheshire and Merseyside region. Integrated care, flexible modes of working and supporting a population with a preference for home-based care guides the need for technology that will support this way of working. This will mean aligning investment in technology so that value for money is gained through Trust technical architecture as well as taking advantage of collaboration at scale at local, regional and national level.

The strategy highlights the strategic importance of developing data and information as a critical asset, the necessary technology to maintain this asset and how we will develop and support our people so that they can engage with the innovation and reap the benefit.

Digital Directions sets out a vision for digital and data services for the Trust, describing the objectives, proposed workstreams, governance, thematic and investment principles that will turn the vision into a reality over the next 5 years.

Electronic patient record replacement

We have been working on replacing our 20-year old electronic patient record (EPR) system during the past year with a hibernation period to allow for the response to the COVID-19 pandemic. An experienced team was contracted to work with a multi-disciplinary team of staff and clinicians to prepare for the transition over to the new EPR.

This is a complex programme of whole hospital clinical transformation and is the largest strategic change the organisation has ever undertaken. The epr+ system is branded as Connecting Care and will transform the way we provide care for patients in all areas and will make us a safer and smarter acute hospital, as we move towards becoming a more digitally mature organisation.

The first phase of the EPR implementation includes the following capabilities:

- Patient Administration
- Accident & Emergency
- Order Requesting & Result Reporting
- Electronic Prescribing & Medication Administration
- Clinical Documentation
- Clinical Decision Support
- Anaesthetics
- Women’s Health
- Bedside Management Devices

- Critical Care.

The epr+ system will be integrated with 23 other clinical and operational systems and seven types of medical devices. Around 820,000 patient records will be migrated into the new system. The epr+ will be live at the end of July 2021.

Cheshire West Integrated Care Partnership

The Countess of Chester Hospital is the host organisation for Cheshire West Integrated Care Partnership (CWICP). CWICP is an alliance of provider organisations, including – Countess of Chester NHS Foundation Trust, Cheshire and Wirral Partnership NHS Foundation Trust, Central Cheshire Integrated Care Partnership, Primary Care Cheshire, South Cheshire and Vale Royal GP federation and Cheshire West and Chester Council, collaborating to meet the health and care needs of the population.

CWICP model of care is through nine Care Communities, geographical areas of around 30,000-50,000 people which build on the strengths of our local communities, aligning with our Primary Care Networks and local Council Ward boundaries. Care Communities' priorities will be developed through steering groups, made up of local people and organisations who will support residents to stay healthy and well and access the care and support they want closer to home.

CWICP's Mission is:

- Five more healthy years for the people of Cheshire West
- Support where and when you want it.

2020/21 focused on a number of areas across service delivery and transformation, including:

Service Delivery:

- Therapy services and dietetics in hospital and intermediate care beds, in community care, primary care and outpatients
- Intermediate care and rehabilitation at Ellesmere Port Hospital, in care homes and patients' own homes through rapid response and Hospital at Home
- Complex discharge planning and support for patient flow, delivered through the ICP's integrated discharge team and discharge hub.

Transformation:

Enhancing Community Based Services

1. Delivering a consistent care community team approach to ensure seamless care
2. Delivering a comprehensive offer of support for the most frequent users of the Emergency Department and hospital services (sometimes referred to as High Intensity Users)
3. Digitally enhancing our services to support and provide the most effective care.

Care Homes

1. Improving the quality of care for the people who live in care homes
2. Developing an improved engagement model between our care homes and the wider health and care system
3. Providing an improved offer of support to care homes, use of digital technology and ensuring the staff and residents in our care homes are seen as an active part in their care community and the wider health and care system.

Cheshire and Merseyside Health and Care Partnership

Cheshire and Merseyside Health and Care Partnership is a collection of NHS, local authority, voluntary, community, faith and social enterprise organisations from across the nine local authority areas that make up Cheshire and Merseyside.

Partners come together to work collaboratively, developing strategies that improve public Health, reduce health inequalities and ensure that the health and care system across Cheshire and Merseyside is sustainable.

We have a responsibility to improve the health and well-being of our population and the Health Care Partnership do this by:

- Coordinating plans to make sure our services continue to meet everyone's needs
- Joining up services to provide better care, closer to home
- Ensuring all partners across Cheshire and Merseyside focus on addressing the causes of poor health, as well as improving diagnosis and treatment.

Patient experience and stakeholder relations

Seeking patient and family feedback is vital in ensuring that the services provided are meeting the needs of the population. The Patient Experience Operational Group (PEOG) continues to monitor patient feedback from compliments, comments, concerns, complaints, Friends and Family Test and correspondence received. A rich picture of patient insight is gathered by understanding lived experience stories and shaping and implementing change with patient involvement.

Condition-specific user groups such as cancer, diabetes and respiratory involve patients in consultative groups to understand how services can be improved to meet their needs.

The elected governors play an essential part in providing feedback about how services can improve on behalf of patients and the public. Governors undertake independent reviews of departments and clinical areas every six weeks in GovRounds which are welcomed by staff as an opportunity to give their own experiential feedback to an independent body of representatives. During the pandemic these GovRounds have been paused due to the pandemic but the plan is to resume this activity as soon as it is deemed safe to do so.

In addition to previous Enter and View visits, which are reported to PEOG, Healthwatch conducted a pan-Cheshire survey into Wellbeing During Coronavirus between May and October 2020, which we welcomed the learning from patient feedback. The learning will be used to inform the refreshed Patient Experience and Involvement Strategy.

Work is currently being undertaken to review and refresh the Trusts Patient Experience and Involvement Strategy, which will outline our intentions as to how the Trust will proactively seek feedback from its patients and staff to use this information to make improvements and changes to the way we work and inform future planning.

Weekly whole hospital meetings are chaired on a rotational basis by the Executive Team and offer staff the opportunity to ask questions and share feedback as well as receiving regular updates on the Trusts current position.

Principal risks faced by the Trust

The Board considers and agrees its principle risks quarterly via the Board Assurance Framework. During 2020-21 the Board undertook a review of the Board Assurance Framework and agreed refreshed and revised strategic risks and risk scores. Detail with regards to the top risks the organisation faces are provided in more detail within the *Annual Governance Statement* section of this annual report.

The following table shows The Countess of Chester Hospital's 2020/21 strategic risks from our assurance framework, along with the total residual risk score following mitigating actions, during the last quarter of the year (quarter 4, January to March 2021):

Table 1 - Strategic risks 2020/21

Strategic risks 2020/21		Overseeing Board committee	Total residual risk score at quarter 4*	
People (P)				
P1	Recruitment	Finance and Performance	4 x 2	= 8
P2	Retention	Finance and Performance	3 x 3	= 9
P3	Staff engagement	Finance and Performance	3 x 4	= 12
P4	Education and training	Finance and Performance	4 x 3	= 12
P5	Workforce capacity	Finance and Performance	4 x 4	= 16
Quality & Safety (Q)				
Q1	Quality & Safety	Quality & Safety	4 x 3	= 12
Q2	Safety - 'Think Family' - Safeguarding Adults & Children	Quality & Safety	4 x 3	= 12
Q3	Safety - Infection Prevention & Control	Quality & Safety	4 x 4	= 16
Q4	Safety - Nursing & Midwifery Workforce	Quality & Safety	4 x 4	= 16
Q5	Patient safety - failure to identify preventable clinical harm and preventable avoidable death	Quality & Safety	4 x 2	= 8
Q6	Failure to provide an adequately trained and skilled medical workforce to support the services we provide	Quality & Safety	4 x 3	= 12

Effectiveness (E)				
E1	Underlying Long Term Trust Financial Sustainability	Finance and Performance	4 x 2	= 8
E2	Uncertainty of financial funding and consequences of breaching control total under current COVID-19 financial regime	Finance and Performance	3 x 2	= 6
E3	Financial Ledger System stability	Finance and Performance	3 x 3	= 9
E4	Access, Waiting Times, Care Pathways and Constitutional Standards	Finance and Performance	4 x 4	= 16
E5	Business Continuity - Pandemic Flu / Virus	Finance and Performance	4 x 4	= 16
E6	EU Exit transition	Finance and Performance	3 x 3	= 9
E7	Cyber security (Digital Strategy)	Finance and Performance	5 x 3	= 15
E8	EPR+ Programme	Finance and Performance	4 x 3	= 12
Collaboration and Transformation (C)				
C1	Failure to progress implementation plan of the clinical services strategy	Finance and Performance	3 x 2	= 6
Good Governance (G)				
G1	Failure to progress implementation of the governance improvement plan	Finance and Performance	3 x 3	= 9
G2	Failure to ensure appropriate Information Governance	Finance and Performance	3 x 5	= 15

**The risk score is formed based on 'likelihood' and 'consequence rating' as follows:*

Consequence: 5 Catastrophic, 4 Major, 3 Moderate, 2 Minor, 1 Negligible.

Likelihood: 5 Almost certain, 4 Likely, 3 Possible, 2 Unlikely, 1 Rare.

The grading bands of risks are: 1-5 Very low, 6-8 Low, 9-14 Moderate, 15-25 High.

Performance analysis

The Board and its committees receive the Integrated Performance Report each month, which includes detailed exception reports, and performance against key quality indicators. This includes actions being undertaken to address any issues and risks. The Board receives quarterly updates on cancer performance, a Winter Resilience Plan during quarter three and ad-hoc reports pertaining to specific areas of operational risk.

Like many Trusts the performance of the Trust, as shown in Table 2 below, has been significantly impacted in 2020/21 due to the pandemic. Our focus in 2021/22 will be on improving this with partners across our local and regional system.

Table 2 - Key performance indicators, by quarter ('Q'), 2020/21

Infection control targets	**Target**	**Q1**	**Q2**	**Q3**	**Q4**
Clostridium difficile	36	5	9	14	15
Methicillin-resistant Staphylococcus aureus (MRSA)	0	0	0	0	0
Waiting times targets	**Target**	**Q1**	**Q2**	**Q3**	**Q4**
Total time in A&E/ ED	95%	95.60%	91.80%	80.40%	87.50%
% 18 weeks referral to treatment incomplete pathway	92%	57.27%	41.73%	48.43%	48.70%
Diagnostic six-week target	1%	60.83%	36.30%	25.57%	26.10%
Cancer targets	**Target**	**Q1**	**Q2**	**Q3**	**Q4***
14 days – all cancers	93%	92.98%	81.79%	79.8%	74.05%
14 days – breast symptomatic	93%	93.73%	39.95%	57.93%	25.75%
31 day – decision to treat to treatment	96%	88.19%	75.52%	88.15%	89.22%
31 days – subsequent surgical treatment	94%	53.13%	44.44%	68.52%	59.09%
31 days – subsequent non-surgical treatment	98%	100%	100%	100%	100%
62 days – first treatment from urgent GP referral	85%	64.13%	64.55%	69.64%	64.34%
62 days – first treatment from screening referral	90%	76.47%	60.00%	80.65%	50.00%

*Quarter 4 figures are processed one month in arrears.

Infection control

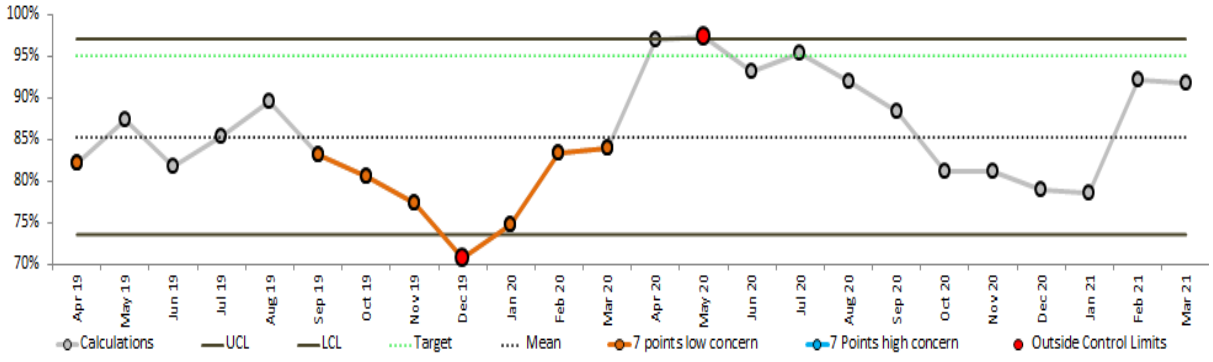
In 2020/2021, 43 cases of Clostridium difficile infection have been reported. There were 0 cases of avoidable MRSA bacteraemia infections during 2020/21 – compared to 3 in the previous year.

Emergency Department (ED) / A&E access measure

This access measure is to achieve a maximum wait of four hours in A&E from patient arrival to admission, transfer or discharge. Performance has improved compared to the previous year. Despite pressures of the pandemic, improvements have been seen due to a number of changes made that include:

- Continued redesign and expansion of our A&E department to improve dignity and care for patients but also improve flow through the department;
- Providing enhanced assessment areas for patient cohorts such as the frail and elderly;
- Improving our workforce models to deliver seven-day services;
- Continued improvement in the number of patients receiving same-day emergency care and avoiding unnecessary patient stays overnight;
- The increase and remodelling of our bed capacity to provide improved access for patients requiring overnight stay.

Figure 1 - A&E four-hour wait standard
% of A&E attendances that were seen within four hours of arrival



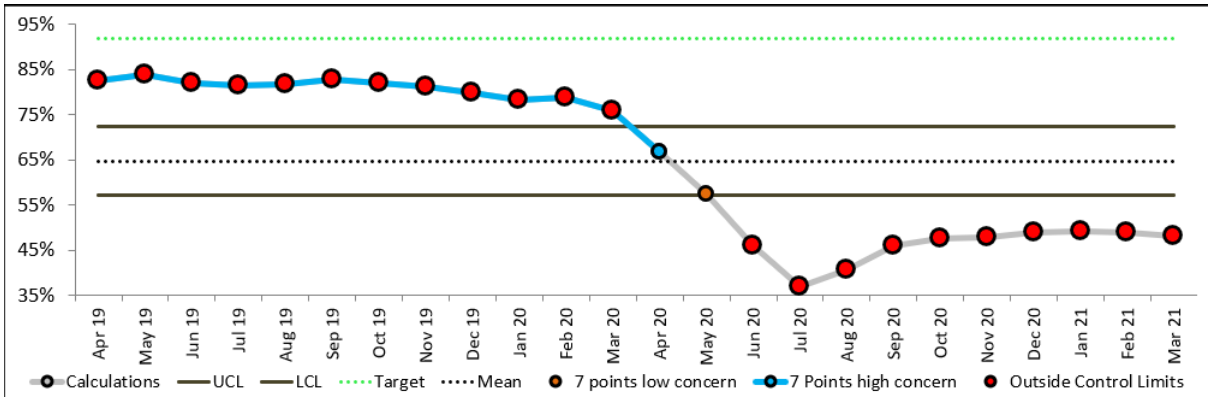
18 weeks referral to treatment (RTT)

The threshold for this target is 92% and monitors the percentage of incomplete pathways for English patients within 18 weeks of referral to treatment. Performance saw a significant reduction due to the pressures of the pandemic and the need to restrict elective activity in order to meet the increase demand of urgent and acute

patients, especially those requiring respiratory support in both our wards and our Intensive Care Unit. A full commissioned review was also undertaken in 2020 that identified areas of waiting list management that has yet to be fully realised due to the urgent care pressures. In line with other Trusts across the region, the Trust is now working with partners to agree a plan to improve the amount of elective activity being undertaken and therefore improve performance and reduce waiting times.

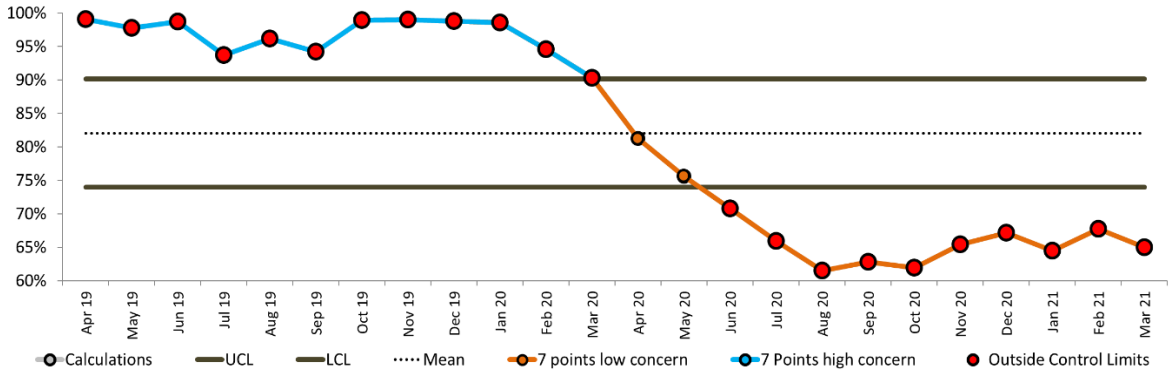
The following graph shows the English referral to treatment performance by month.

Figure 2 - English 18 weeks referral to treatment – incomplete pathways
% of incomplete pathways for English patients within 18 weeks



The RTT target in Wales of 26 weeks is different to the English target and Welsh patients are normally seen within the contractual target. The following graph shows the Welsh target performance for admitted and non-admitted patients, by month.

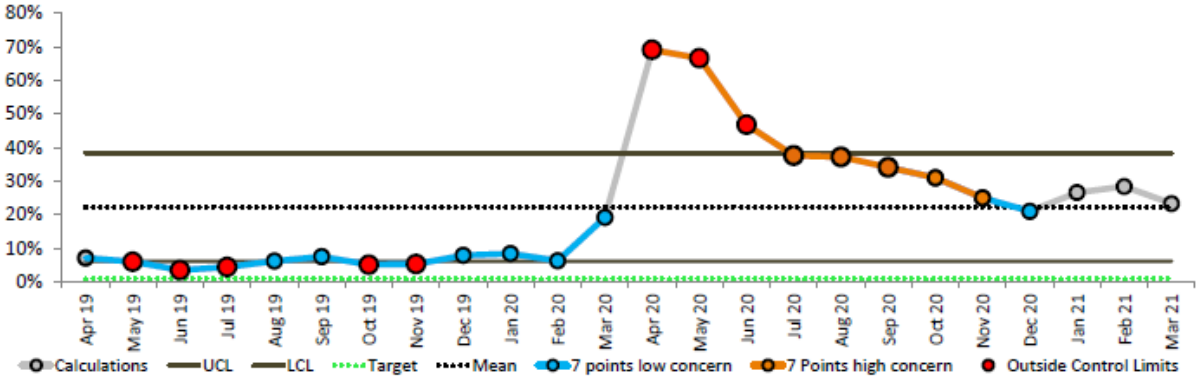
Figure 3 - Welsh 26 weeks referral to treatment – incomplete pathways
Non-admitted patients starting treatment within 26 weeks of referral



Diagnostics six-week standard

This standard is for diagnostic tests to be carried out within six weeks of the request being received. We did not achieve the 1% target during 2019/20 however this deteriorated further at the start of the pandemic. Actions have been put in place to improve performance which has been seen throughout the year; however, high demand on our diagnostic services continues to place a pressure on these services. We will continue to ensure proactive management of capacity and demand within endoscopy and imaging services and work with partners to identify opportunities for further improvement.

Figure 4 - Diagnostic tests exceeding six weeks
% of diagnostic tests that were carried out after six weeks of the request being received



Cancer 62 day standard

Performance for our Cancer standards has reduced due to the impact of the pandemic. We continue to work collaboratively with primary care and partners to improve our patient pathways and increase our capacity. It is expected performance will improve over the coming months more sustainably as specialities deliver against agreed actions supported by the Cancer Alliance.

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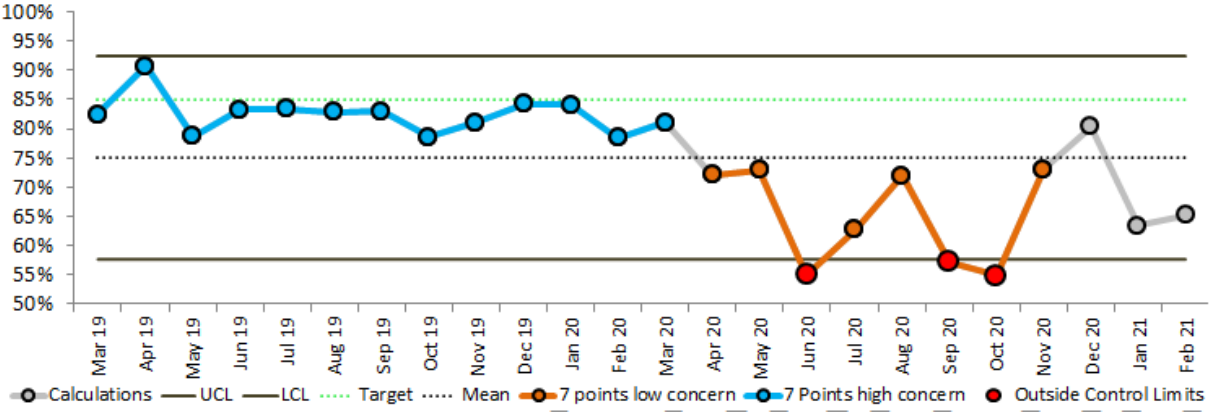
Figure 5 - Cancer treatments – 62-day standard
% of patients having their first treatment for cancer within 62 days of an urgent referral through GP two-week referral route



Activity

The Trust saw a significant reduction in activity in 2020/21 across all areas as it responded to provide care for those in most need throughout the waves of the pandemic. A significant amount of work has been undertaken in relation to infection prevention to ensure patients remained safe within the Trust, which resulted in the Trust being able to see fewer patients. These changes in provision as well as the increased acuity of our patients led to significant reductions in our activity.

Table 3 - Activity 2018/19 to 2020/21

	2018/19	2019/20	2020/2021	% change
Elective inpatients	4,690	4,200	2848	-32.19%
Elective day case patients (same day)	37,395	35,444	24,647	-30.46%
Non-elective (urgent) inpatients	32,682	33,422	21,674	-35.15%
Outpatients – first attendance	65,142	75,195	72,021	-4.22%
A&E	75,645	77,891	66,627	-14.46%

Summary Hospital Mortality Indicator (SHMI)

Table 4 - SHMI quarterly values 2019/20*

	Countess of Chester Hospital SHMI	Best trust	Worst trust	Outlier alert level
July 2018 – June 2019	1.08	0.70	1.20	Band 2 – As expected
October 2018 – September 2019	1.09	0.70	1.19	Band 2 – As expected
November 2018 – October 2019	1.10	0.68	1.20	Band 2 – As expected
November 2019 – October 2020	1.05	0.68	1.18	Band 2 – As expected

*Latest period available

Both SHMI and the Hospital Standardised Mortality Ratios (HSMR) indicators continue to be analysed and reviewed within the Trust on a monthly basis, via the Learning from Deaths group.

The improvements in the governance structures and infrastructure have seen greater scrutiny and transparency for clinical teams and the Board. The Countess of Chester Hospital will continue to work hard to identify areas to improve over the coming year.

Equality, diversity and human rights

We have a well-developed and award-winning equality governance framework, which includes patients and third sector organisations from across the full range of protected characteristics. We undertake a significant number of inclusion and engagement activities with protected groups who sit as members of our equality groups for Gender and Sexuality, Equality Disability Age and Safeguarding, and Faith and Culture. Equality groups are chaired by external stakeholders from local charities and organisations.

Staff engagement is essential to ensuring effective equality and diversity practice in the Trust, and new staff networks have been formed as well as the growth of existing staff networks in 2020/21. The Trust now has staff networks for LGBTQ+, BAME, Women's, Disability, Neurodiversity and Carers.

The following achievements in 2020/21 are a consequence of our transparent, inclusive and engaging equality, diversity and human rights agenda. The COVID-19

pandemic brought about new challenges with regards to equality and diversity and the Trust sought to both respond to concerns and bring about proactive initiatives in a timely way.

The restrictions brought about by COVID-19, meant that many meetings and events could not take place face to face, therefore in 2020 there were several initiatives to help ensure communication via the internet, Microsoft teams, Eventbrite and web portals.

We are proud to have achieved the following:

Public Sector Equality Duty

- NHS Equality Delivery System 2 (EDS2) rating in 2020/21 scored The Countess of Chester Hospital at *'Achieving'* status across one of the 18 EDS2 outcomes. Following assessment by stakeholder groups from the protected characteristics and Healthwatch, the remaining two outcomes were rated as *'Excelling'*.
- Published our fifth annual NHS Workforce Race Equality Standard (WRES), submission in July 2019.
- Published our sixth annual NHS Workforce Disability Equality Standard (WDES), submission in August 2020.
- Published our second annual NHS Workforce Disability Equality Standard (WDES), submission in August 2020.
- Submitted our Gender Pay Gap (GPG) 2020.
- Introduced our first online and face to face workshop discussions on the results of the WRES.
- Introduced our first online and face to face workshop discussions on the results of the GPG resulting in its content influencing future action plans for all these areas.

Networking and establishing best practice

- The Countess of Chester Hospital is a member of the following regional multi-stakeholder groups: North West Equality Group, Cheshire Equality Leads Forum, Cheshire and Merseyside Health and Care Partnership Equality Diversity and Inclusion (EDI) Steering Group, and Cheshire and Wirral EDI Leads.
- In 2020, The Countess of Chester Hospital joined with Cheshire Police, Cheshire and West Cheshire Council, Cheshire East Council, Cheshire and Wirral Partnership and Cheshire Fire to provide online events for staff for Black History Month and Day of Invisible Disabilities that included a range of influential speakers.

- Continued to facilitate stakeholders from across the protected characteristics to be involved in – and in some cases chair – The Countess of Chester Hospital's equality groups, the equality governance framework and joint working initiatives.

Events, staff and community engagement

- With the cancellation of Chester Pride 2020 due to the pandemic, the Trust ensured that the online alternative was promoted to staff via the Trust Communications Team. Countess of Chester Hospital continued to ensure staff representation to Chester's 'City of Sanctuary' group monthly meeting.
- In partnership with Chester City of Sanctuary, the hospital produced content for a booklet to welcome new refugee families to the area advising the services of Countess of Chester Hospital.
- Celebrated Awareness events via a range of Trust communications mechanisms to support Black History Month, Disability Awareness Day, Day of Invisible Disabilities, South Asian Heritage Month, Neurodiversity Week, Carers Week, Ramadan, Diwali, Easter, Christmas, Trans Awareness Day, Trans Day of Remembrance, LGBTQ+ History Month, International Women's Day, St Patricks Day.
- Continued to increase the membership of The Countess of Chester Hospital's equality groups with increased staff membership.
- Joined the NHS Rainbow Badge Scheme to demonstrate being allies to LGBTQ+ Staff and Patients.
- Early in the COVID-19 pandemic, the Trust facilitated an Executive Panel Q&A for BAME staff members to discuss concerns raised regarding risk to BAME staff. This was chaired by the Trusts Director of HR, Director of Nursing and Medical Director
- Appointed BAME Staff Network Lead to Staff Side Partnership.
- Appointed BAME Representative to LNC Group to represent BAME doctors and Dentists.
- Utilised an online tool for working carers, and facilitated a face to face workshop to introduce new 'Working Carers Online Toolkit' in Partnership with Carers UK.
- Promoted online support groups facilitated by Cheshire and Warrington Carers for working the hospitals Carers.
- Introduced a range of initiatives to encourage participation in the staff survey amongst staff from minority groups.

Accessibility

- Enhanced the governance and accessibility of the Health Passport and Reasonable Adjustments for disabled people and carers, and promoted these at the front of the hospital.
- Introduced an emergency one page reasonable adjustment passport for individuals.
- Undertook extensive discussions with Stakeholders on the Accessibility Information Standard (AIS) and created a new AIS Policy to promote alongside the new Cerner system (in process).
- Plans to promote AIS as part of the Cerner launch (in process).
- Installed hearing loops in A+E treatment rooms of the new building. These were signed off as fit for purpose in partnership with Chester Deaf Society.
- Identified a location for a Changing Places accessible toilet and made an application for grant funding (decision postponed during COVID-19).
- Launch of a new Carers Strategy.
- Launch of a new Translation and Interpretation Strategy.
- Undertook full Equality Impact Assessment (EIA) for the implementation of 111 to ensure accessibility needs of attendees were met.
- In partnership with Equality, Disability Age and Safeguarding group, created a one page document to support the use of lollipop signs with consideration given to people with disabilities.
- Promoted Trust-wide information on the challenges and consideration regarding guide dogs and social distancing in COVID-19 pandemic.
- Participated in and promoted national discussion groups aimed at increasing vaccination rates of the COVID-19 vaccination across BAME groups.
- Formed a new Palliative Care Carers ‘task and finish group’ to look at how to better support Carers with inclusion from representatives from minority groups.

Training and staff development

- Introduced online bespoke Trust Rainbow Badge Training across the year to all staff rainbow badge wears to cover a history of being LGBTQ+ in Chester and North Wales and highlight local services.
- Facilitated online Eventbrite events for Black History Month in October 2020 and Day of Invisible Disabilities in December 2020 with key speakers.
- Continued to promote information as part of the awareness days noted previously.
- Ran online training sessions regarding the use of pronouns for A+E.

- Ran bespoke Rainbow Badge training for different departments to become 'Rainbow Badge'.
- Ran online training sessions about transgender awareness.
- Introduced fully-funded NCFE level 2 training for colleagues about equality and diversity, dementia, mental health awareness, safeguarding vulnerable adults and autism.
- Invited all local trusts to attend any equality and diversity training.
- Facilitated bespoke Equality and Diversity sessions to newly appointed international nurses from Africa, India and Japan with a specific focus on cultural differences and differences in supporting minority groups in the UK.
- Facilitated bespoke sessions with Ward Managers who would be receiving new International Nurses to discuss possible cultural differences and considerations.
- New International Nurses have a welcome session with the Trust BAME Network lead as part of their induction.
- Ran training sessions Managers as part of Attendance Management Training with regards to providing reasonable adjustments.
- The Trust is a member of Cheshire and Merseyside Patient Equality Focused Forum Military Veterans and Armed Forces Community Task and Finish Group.
- Delivered a Board of Directors development session on equality and diversity, and unconscious bias.

Modern Slavery Statement

We are committed to ensuring there is no modern slavery or human trafficking in any part of our business activity. Our commitment to social and environmental responsibility is covered by our approach to modern slavery and human trafficking, which is part of our Safeguarding Strategy and arrangements.

Modern Slavery – safeguarding, training and promotion

Our commitment to 'no modern slavery or human trafficking' is reflected in a number of our policies and procedures. These include our *Safeguarding and Promoting the Welfare of Children, Safeguarding Adults Policy* and *Safeguarding Strategy*, which have been developed and maintained within the national and local safeguarding children governance and accountabilities frameworks. It includes guidance on initial contact with a suspected human trafficking victims and the National Referral Mechanism.

Our safeguarding training includes role relevant modern slavery awareness and resources to promote understanding of the Department of Health's Provider Responses, Treatment and Care for Trafficked People (PROTECT) project.

Sustainable Development Progress

We are mandated by NHS England to reduce our carbon emissions by 51% by 2025 as part of the NHS Long Term Plan. This is a fundamental part of our corporate and social responsibility. The national Sustainable Development Plan identifies the key targets and milestones to help us achieve this mandate, and by incorporating the principles of 'sustainability' at the heart of our whole business, will assist us to maintain the Carbon Reduction Strategy and conduct all future business in a sustainable way.

Our results so far

Despite the global pandemic, we have implemented a number of improvements to significantly improve our environmental sustainability, including:

The Countess of Chester Hospital Sustainability Development Plan (draft) was produced in the 2020. This document gathered some momentum as the Trust started to move beyond the pandemic and more towards business as usual. In gathering momentum and traction, a sustainability survey has been produced ready for launch to all staff to formally invite our colleagues on our sustainability journey and ask what matters to them in our first step toward our sustainable future.

The survey results will help us form the Sustainability Development Committee and supporting sub groups which in turn will measure our progress in our collective approach toward our agreed goals.

New Build Health Care Units

The design & build of our Same Day Emergency Care unit (SDEC) will see an approach that is completely aligned to our Sustainability Development work stream.

SDEC Sustainability Overview:

The design of the SDEC building is taking into consideration the viable options for the most appropriate low zero carbon technologies based on site constraints and the operations and functionality of the site. The new building is required to comply with Part L of the UK Building Regulations which in essence, deals with the conservation of fuel and power in new buildings. With respect to the SDEC this ensures compliance to carbon dioxide emission rates and building fabric and services efficiency standards. The SDEC will also comply with Local Planning requirements and BREEAM *(Building Research Establishment Environmental Assessment Method)*. BREEAM is an assessment undertaken by independent licensed assessors using scientifically-based sustainability metrics and indices which cover a range of

environmental issues. Its categories evaluate energy and water use, health and wellbeing, pollution, transport, materials, waste, ecology and management processes.

To achieve this rating, the SDEC will need to achieve a minimum of 15% predicted energy use to be provided by on-site decentralised, renewable and low or zero carbon energy sources. This can be done by linking with or contributing to available local off-site renewable energy sources. A minimum 34% carbon reduction is also required through the same sources. The low carbon feasibility review evaluated the suitable technologies required to reduce the energy consumed and associated carbon emitted for the SDEC. The review made recommendations and concluded that the available options for the project are air source heat pumps, air to water heat pumps for domestic water, roof mounted photovoltaic (PV) and solar thermal array. These options are being considered for viability as part of the ongoing design phase of the project. Life cycle cost is also an important factor when choosing an LZC technology, and a number of factors need to be considered: Energy saving costs, Capital cost, Available grants and tariffs, and maintenance costs. The Life Cycle Costing is being undertaken during this stage of the project.

Transport and travel

We continue to actively promote alternative travel and have plans to install new staff secure bike parking facilities during 2021 as well as installing ‘dock less’ parking bays for electric scooter rental on our site. We are working closely with the City of Chester’s in their participation in the Department for Transport’s micro-mobility trial, as part of their planned expansion of the e-scooter rental scheme, in line with the approved Department for Transport, Vehicle Special Order.

This collaborative working with Chester City and with the commercial electric scooter rental provider Ginger Teleporter Limited, launched the trial in the City of Chester on the 21st December 2020. The trial supports the Council’s Climate Emergency response plans for a ‘green’ restart of local travel and will help mitigate the impact of reduced public transport capacity, providing a sustainable mode of transport around the city and to our hospital

We have improved on our electric fleet within the Trust Transport Service, with vehicles being made ready for our in-house Security Service and our Portering Service.

As technology advances in e-vehicle design and range, all future vehicle procurement exercises will see a full transition toward a complete e-vehicle fleet. We are currently assessing a suitable e-vehicle for our Waste & Environment team in the collection of health care waste from across our site.

Whilst currently, four fixed e-vehicle charge points with dedicated vehicle parking bays support these vehicles and colleagues wishing to charge their own vehicles, we

are assessing costs in the installation of many additional e-vehicle charge points, both for an increased Transport service fleet and staff & colleagues who have elected to purchase their own e-vehicles.

We will revisit how active promotion in the use of alternative modes of transport to and from the site, by re-energising the cycle to work scheme and using Cheshire West and Chester Council's Park and Ride service.

We are currently assessing what improvements/changes we can make to our existing secure cycle facilities as well as additional staff secure cycling store facilities as well as the potential for shower/changing facilities that positively contribute to colleagues using pedal power to and from work.

Environmental & Waste Management

We have successfully maintained our 'no waste to landfill' status and despite much increased volumes of health care associated waste during the pandemic, we have successfully maintained correct segregation of all waste prior to leaving our site. As a standard at COCH, any waste that cannot be recycled is converted to Refuse Derived Fuel (RDF) – with the exception of a small volume of clinical waste that is incinerated.

Our current healthcare associate waste contract expires on May 31st of 2021 and as we go to the wider market place to secure a new contract, it is our intention to capitalise on innovation, technological advancement in waste management to secure a new waste contract that assists our Trust in its continued Sustainability Development journey.

The return to 'business as usual' will see us introduce additional waste streams as part of the wider Waste Management Responsibilities Strategy and new waste management contract – including the collection of plastic bottles, aluminium cans and wastepaper. We also propose to investigate to better segregate and manage used silicone tubing as part of O_2 (oxygen) administration, giving sets (spent liquid bags and tubes) as part of IV (intravenous) equipment, and glass bottles and receptacles.

Energy

Effective April 2021, we have secured a contract through 'Inspire Energy' who have committed to guaranteeing all our electrical supply will be from renewable energy sources or sustainable sources. This approach & commercial contract formally sets out our stall and intent in how we at COCH will work and operate in the future in a continued sustainable way.

The LED lighting replacement project is now completed and fully operational throughout the Trust, which in turn will see a reduction in energy usage as well as a substantial saving in energy costs of £300,000.

Procurement

We recognise the impact of our procurement activities on our overall carbon footprint. The Countess of Chester Hospital's future 'Procurement Strategy' will incorporate sustainable development principles with greater prominence given to procuring goods and services in a sustainable manner. Areas we have already started to explore involve the procurement of cleaning consumables in bulk containers, where the product is dispensed locally and by our own staff. This approach will largely irradiate the need for independent solutions and products being delivered in small plastic containers, which in turn should much reduce the unit cost to the Trust.

Pharmaceuticals

Anaesthesia and the associated gases are high on the NHS England and NHS Improvement list of contributors that increase CO_2 (carbon dioxide) emissions. We will work with colleagues in this specialism to identify less-polluting alternatives, as well as looking at lower emissions prescribed inhalers.

The Countess of Chester Country Park

The Country Park is now a thriving, 29-hectare public space – having been transformed from a derelict brownfield site. The Countess of Chester Hospital continues to work with partners, led by the Land Trust, to sustain and enhance the Country Park though appropriate maintenance whilst maximising opportunities for community engagement through a range of health and wellbeing, educational and environmental initiatives.

Our plans for the future

Our objectives toward sustainability will see us focus on the following areas over the next five years:

As we move out of the pandemic, and in a 'reduced risk' working environment, we will go into a formal arrangement to measure and quantify our carbon emissions across our site. This will include provision for the production of a thermal map of our existing real estate and how we can mitigate energy loss. We will ensure we include all outlying buildings, new and old, in order to understand where and how we insulate effectively to save energy and reduce carbon emissions.

This approach has to be our starting point in being able to provide evidence & assurance in our reduction in carbon emissions by 51% by 2025.

The combined disciplines of Estates, Capital Development & Facilities Services are assessing the viability and practicality of ‘passive house standards’ energy conservation as well as ground source heat pumps for warming water and providing supplemental heating in all new builds as well as some of our existing real estate.

We will include provision in our wider assessment of all energy saving technology to look at solar heat reflection (such as films) to reduce reliance on comfort cooling and ‘fans’ for temperature control during the warmer summer months.

Self-cleaning glass, triple glazing and rain water harvesting are other areas we will investigate in our energy saving & carbon reduction strategy going forward for new build projects and where possible, retro fit solutions for the existing real estate.

In addition, we will conduct a thorough study in to how we can move away from steam as a historic energy source in the heating of our water to more efficient, local heating strategies.

Technological advancement in waste management will see us look at different strategies for dealing with health care associated waste with efforts focused on a solution on our own site as opposed to very large heavy goods vehicles visiting our site every day to remove waste.

Financial Review – 2020/21

The Countess of Chester Hospital NHS Foundation Trust reported a deficit of £1.1m (before impairment) at the end of the 2020/21 financial year.

Due to the COVID-19 outbreak, the NHS operated under a national financial framework throughout 2020/21. This meant for the first six months of the year, the Trust was supported to break even via a national 'top-up' process. For the second six months of the year, funding was delegated to Cheshire & Merseyside Health and Care Partnership, requiring commissioners and providers to operate within a fixed financial envelope.

The Trust was set a target by NHSI/E not to exceed a deficit of £5.2m in year, which it successfully achieved.

Going Concern Overview

After making enquiries, the directors have a reasonable expectation that the services provided by The Countess of Chester Hospital 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.

Income and expenditure

The table below summarises the financial position pre-impairment. The Countess of Chester Hospital's total income for 2020/21 was £313.0 million. The majority of income comes from our main commissioner NHS Cheshire Clinical Commissioning Group (CCG) at £181.5 million, with £24.9 million received from Betsi Cadwaladr University Health Board, and £38.3 million from NHS England. A further £31.3m was received from other Clinical Commissioning Groups for patient care services, and £8.2m was received to fund Training and Education.

In 2020/21, NHS provider contracts with English commissioners operated on a block contract basis, meaning the majority of income was fixed. Welsh contract income mirrored this arrangement for the first six months of the year, with a national risk sharing arrangement, linked to historic activity levels, being in place for the second part of the financial year.

The Countess of Chester Hospital experienced a number of expenditure pressures on its budget during the year, with both medical and nursing pay spend exceeding planned levels. This was driven by the need to maintain sufficient clinical capacity whilst managing the impact of COVID-19 on the workforce. The consequent expenditure on medical agency was £2.1 million for the year. Consumable costs were generally in-line with activity and budget.

Figure 6 - Income and expenditure 2018/19 to 2020/21

	2020/21 £000	2019/20 £000	2018/19 £000
Income	313.0	271.9	238.2
Expenses	(306.5)	(264.7)	(240.5)
EBITDA	6.5	7.2	(2.3)
Interest, Depreciation and Dividend	(7.6)	(6.9)	(5.9)
(Deficit)/Surplus before impairment	(1.1)	0.3	(8.1)
Impairments	(6.8)		(5.1)
(Deficit)/Surplus for the year	(7.9)	0.3	(13.2)

The impairment in year arises from the revaluation of the Trust properties at 31 March 2021 and reflects the movement in price indices since the previous valuation in 2018/19. Impairments are excluded from the measured financial performance of the organisations on the basis it doesn't reflect the underlying performance.

The majority of The Countess of Chester Hospital's expenditure is spent on clinical care, with staff representing the largest proportion of spend at £218 million.

The following charts summarise income and expenditure by category:

Figure 7 - Pay expenditure (£218 million) 2020/21

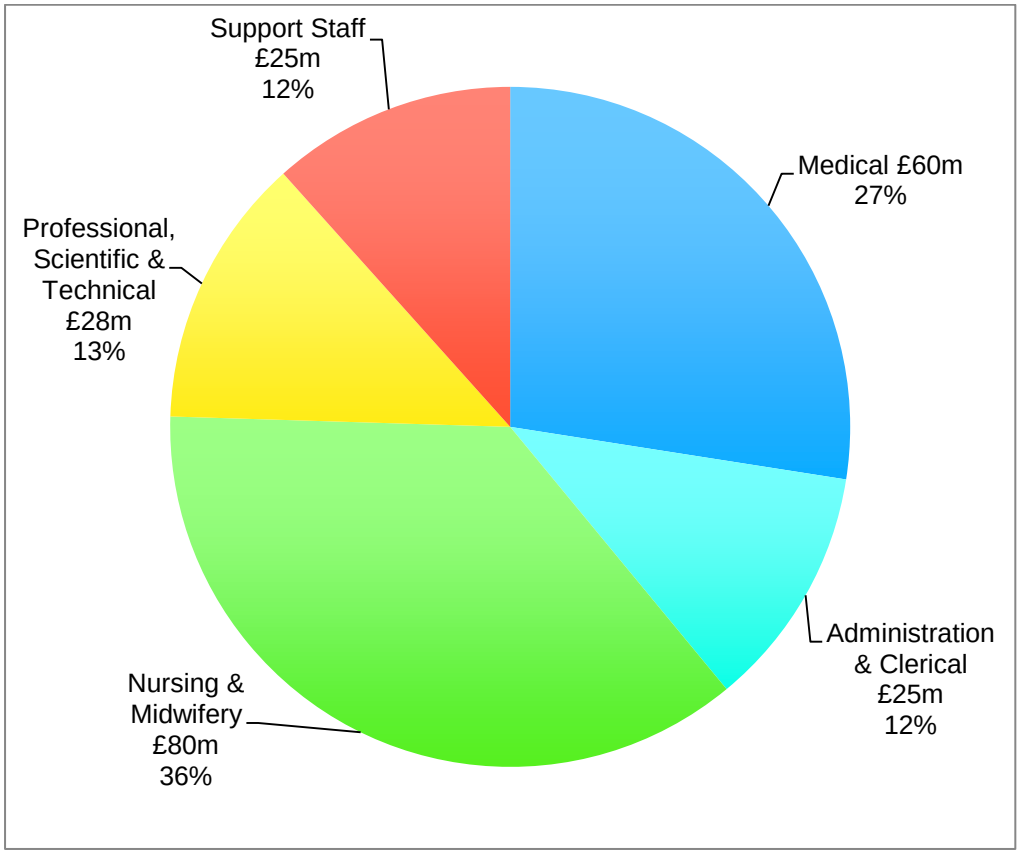
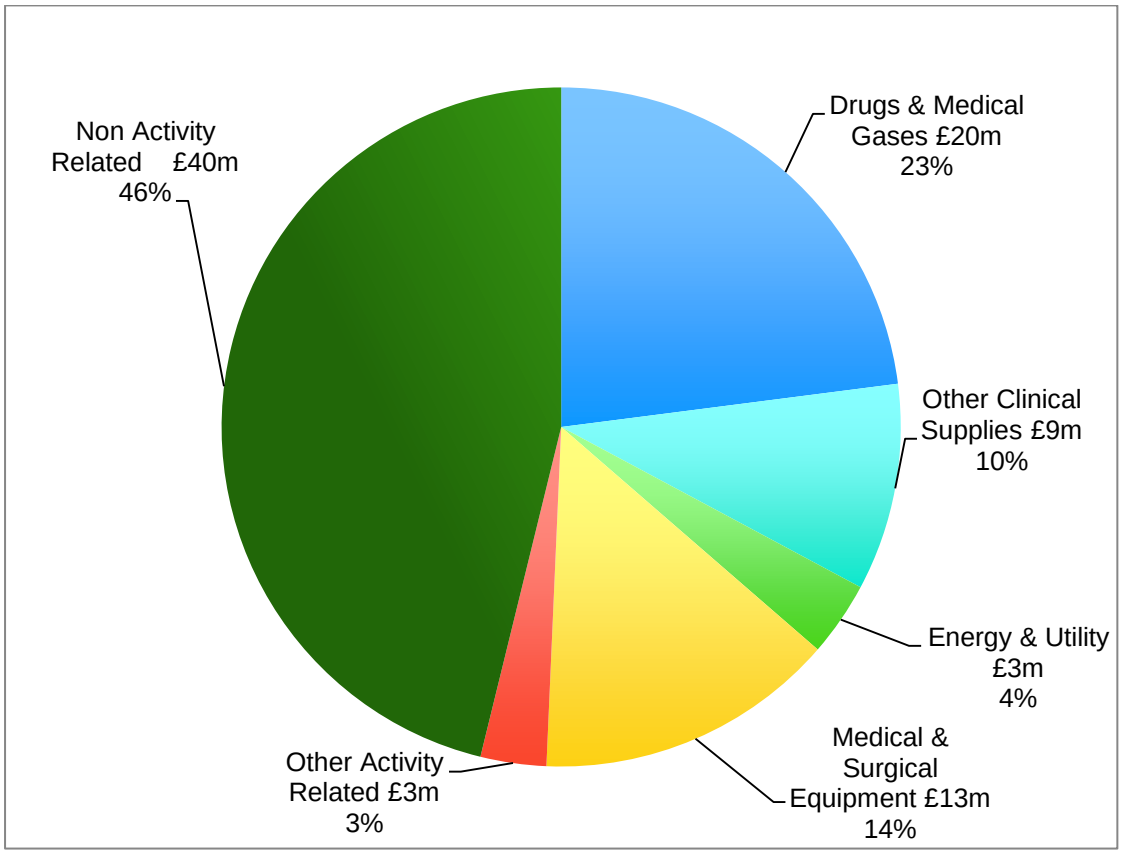


Figure 8 - Non-pay expenditure (£88 million) 2020/21



Cost Reduction and Efficiency (CRS)

Under the national framework operated during 2020/21, the annual planning and contracting process, together with the requirement to deliver efficiency savings was suspended to enable providers and commissioners to focus efforts on the pandemic response.

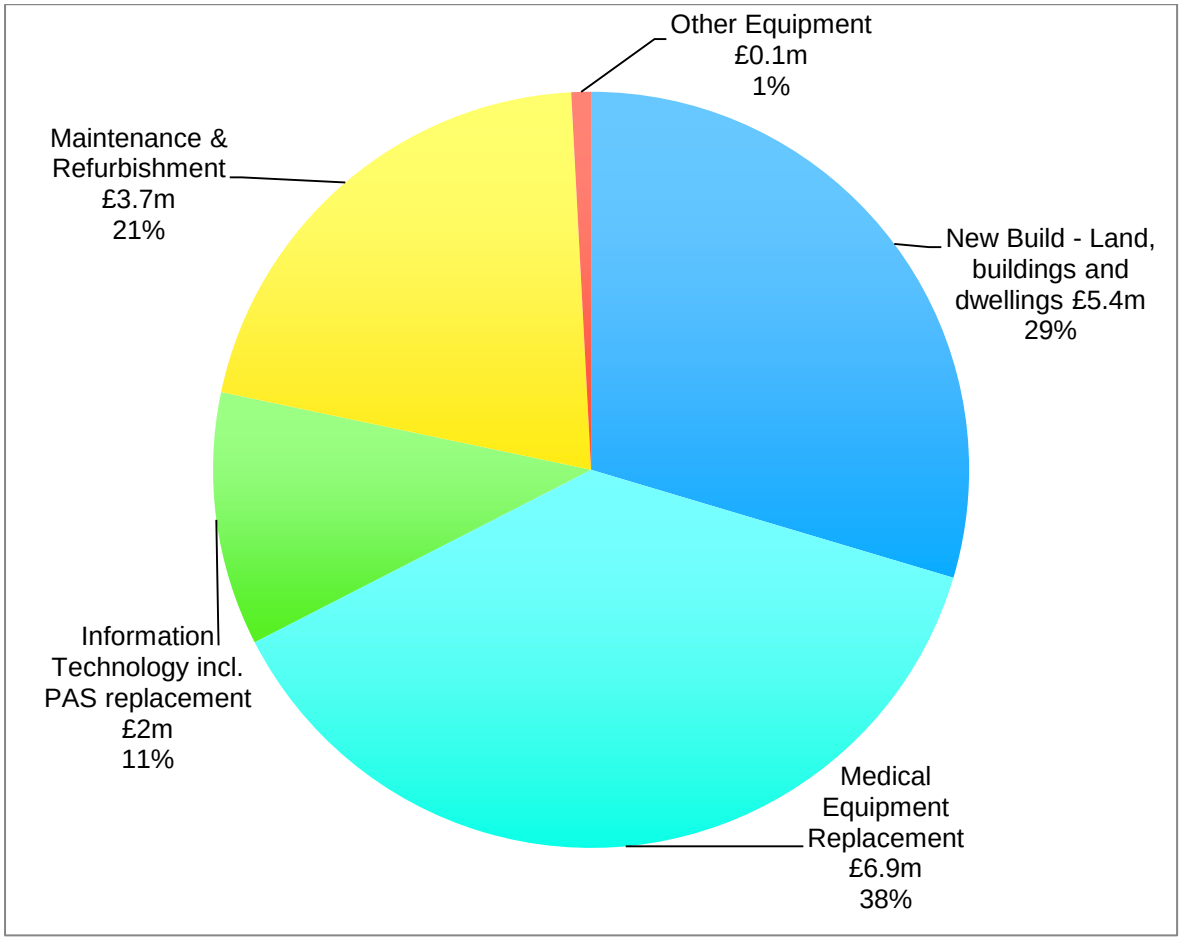
The Countess of Chester Hospital will be required to continue to deliver significant savings annually for the foreseeable future as the NHS seeks to recover from the pandemic and transform services. Financial Plans under development for 2021/22 will incorporate the national requirement to deliver 0.28% efficiency improvements plus a further efficiency requirement of 2.92% to achieve an in year break-even position.

A challenging efficiency target of £9m (3.2%) has been set for 2021/22. This can no longer be achieved in isolation, and The Countess of Chester Hospital will need to continue to work collaboratively with partners within the local health system to achieve this.

Capital investment

Being a Foundation Trust allows us to manage our finances so that we can invest in the infrastructure and estate of the hospital. Capital resources amounting to £22.8 million were spent during 2020/21 in the areas shown in the chart below:

Figure 9 - Capital expenditure (£18.1 million) 2020/21



Capital expenditure for 2021/22 will be capped at a system level and the Trust will be required to seek agreement to its plans from Cheshire & Merseyside Health and Care Partnership.

Susan Gilby

Susan Gilby
Chief Executive Officer
8 June 2021

The Accountability Report

2. Accountability Report

Directors' Report 2020/21

Board of Directors

The Board of Directors is responsible for setting and driving forward the strategic direction of The Countess of Chester Hospital NHS Foundation Trust. The Board is made up of Executive Directors and Non-Executive Directors who develop and monitor the Trust's strategic aims and performance against key objectives and other indicators. Together, their role is to receive, accept and challenge reports to fulfil all of their responsibilities and to be able to assure the Council of Governors.

The Board composition helps to ensure that the skills and strengths provided by the Non-Executive and Executive Directors throughout the year provide a good, well-balanced Board. The balance is reviewed throughout the year as well as whenever Director level vacancies, Executive or Non-Executive, arise. The Board members provide a breadth of public and private sector expertise. Board composition has been refreshed during 2020/21.

The Trust has ensured a constitutional option to vary the numbers slightly as and when the need arises, provided always that the Board retains a majority of Non-Executive Directors.

The Board of Directors may delegate any of its powers to a Committee of Directors or to an executive director. The Board has reserved the issues set out in its Scheme of Reservation and Delegation and further guidance about the operation is set out in the Standing Orders and Standing Financial Instructions.

The Directors of the Board undergo an annual performance assessment, reviewing performance against agreed objectives, personal skills and competencies and progress with personal development plans.

Board Effectiveness Evaluation

A strong unitary Board is fundamental to the success of the Trust. The effectiveness of the Board is aligned to the delivery and performance of our services year-on-year and is closely monitored by the Governors throughout the year, as part of their role of holding the Non-Executive Directors to account and, through them, the Board to account. The Board continues to evaluate its performance throughout the year through appraisals (individually and collectively) and is ultimately held to account by the Council of Governors on behalf of the Trust's members. In support of improving

the performance of the unitary Board, in year external training and facilitation has been provided to the Board collectively and individually.

Membership of the Board of Directors

The composition of the Board of Directors during 2020/21 was as follows:

Non-Executive Directors (Independent)

- Ms Chris Hannah – Interim Trust Chair
  Appointed as Non-Executive Director for a three year term, 1 April 2018 – 31 March 2020 and as Interim Trust Chair 1 April 2020 – 31 March 2021, extended to 30 September 2021.
- Mr Andrew Higgins – Vice Chair
  Re-appointed September 2019 for one further year to 31 October 2020, and subsequently to 30 September 2021.
- Mrs Ros Fallon – Senior Independent Director
  Appointed March 2019 for a one-year term of office to 30 April 2020 and re-appointed in December 2019 for a further two-year term of office to 30 April 2022.
- Mr David Williamson
  Appointed for a three-year term of office, 1 November 2019 – 31 October 2022.
- Mr Mark Adams
  Appointed for a three-year term of office, 1 January 2020 – 31 December 2022.
- Ms Bridget Fletcher
  Appointed for a three-year term of office, 1 February 2020 – 31 January 2023.
- Mr Paul Jones
  Appointed for a three-year term of office, 1 March 2020 – 28 February 2023.
- Ken Gill
  Appointed for a three year term of office, 11 January 2021 – 10th January 2024.
- Ms Andrea Campbell – Associate Non-Executive Director and Chair of Cheshire West Integrated Care Partnership (hosted by the Trust) - appointed for a 12 month term of office from 1 April 2020 and reappointed for a further 12 month term from 1 April 2021 (non-voting member).

Executive Directors

- Dr Susan Gilby – Chief Executive Officer
- Mrs Alison Kelly – Director of Nursing and Quality and Deputy Chief Executive
- Mr Simon Holden – Director of Finance

- Mrs Alyson Hall – Director of Human Resources and Organisation Development
- Mr David Coyle – Chief Operating Officer (from 20 July 2020)
- Mr Darren Kilroy – Executive Medical Director
- Ms Cara Williams – Chief Digital Information Officer (from 1 May 2020).

In addition, Alison Lee holds the position of Managing Director of the Cheshire West Integrated Care Partnership and Dr Chris Ritchieson the position of Medical Director.

Attendance at Board of Directors and Board committee meetings

Attendance at the Board meetings held during 2020/21 and Board committees, along with Directors expenses, were as follows:

Table 5 - Attendance at Board of Directors and Board committee meetings, including Directors expenses

	Board of Directors	Audit Committee	Finance and Performance Committee	Quality and Safety Committee*	Remuneration Committee	Directors expenses 2020/21
No of meetings held in 2020/21	7	6	4	7	3	
Chris Hannah	7	1/1	-	1/1	2	Nil
Susan Gilby	6	1/1	4	5	2	£127.32
Darren Kilroy	7	-	4	6	-	Nil
Alison Kelly	6	1/1	2	5	-	£18.90
Alyson Hall	7	1/1	1	3	1	Nil
Simon Holden	7	6	4	7		Nil
Cara Williams	5/5	1/1	4	3/6	-	Nil
David Coyle	4/5	-	2/3	4/5	-	Nil
Andrew Higgins	7	6	4	2/3	3	Nil
Ros Fallon	7	1/1	-	7	3	Nil
David Williamson	7	6	4	2/3	3	Nil
Mark Adams	7	6	4	2/3	3	Nil
Bridget Fletcher	7	-	3	7	3	Nil
Paul Jones	7	-	-	7	3	Nil
Ken Gill	2/2	1/1	-	-		Nil

*Note: Three meetings of the Quality & Safety Committee had an extended remit in relation to critical finance/workforce/performance matters during the COVID-19 pandemic. Two meetings of the Finance & Performance Committee were cancelled to enable a focus on the pandemic, and in response to NHS Reducing the Burden guidance.

Board of Directors' Profiles

Chris Hannah, Chair
Chris Hannah was appointed as Chair of the Trust in April 2020. She leads the Trust Board of Directors and Council of Governors in setting the strategic direction of the Trust, and ensuring the Trust provides the best possible care to the communities it serves.

Chris has almost four decades of experience in NHS management, including a number of chief executive positions including Cheshire and Merseyside Strategic Health Authority. She has more recently worked both as chair of the Cheshire West Integrated Care Partnership and as a non-executive director at the Countess since 2018.

Dr Susan Gilby, Chief Executive Officer
Dr Susan Gilby joined The Countess in August 2018 as medical director, before becoming acting chief executive in October 2018 and then the substantive chief executive in April 2019.

Susan, who first worked at The Countess during her specialist training, has previously worked as medical director at Wirral University Teaching Hospital NHS Foundation Trust and Wye Valley NHS Trust and as associate medical director at Mid Cheshire Hospitals NHS Foundation Trust.

Dr Darren Kilroy, Executive Medical Director
Dr Darren Kilroy joined the Countess full-time in April 2018 after working between The Countess and East Cheshire NHS Trust, where he was deputy medical director.

Darren trained in emergency medicine in the North West as well as Australia and, following an initial subspecialty interest in medical education, worked in several leadership roles in Greater Manchester alongside his consultant post. He sits on NHS Employers' Medical Workforce Forum and advises NHS Improvement in relation to bank and agency pay in healthcare.

Simon Holden, Director of Finance
Simon Holden joined the Trust in January 2016, and is an experienced senior NHS leader, having held both chief executive and director of finance posts in a number of different NHS organisations.

Simon is a fellow member of the Association of Chartered Certified Accountants (FCCA), and also a fellow of the Royal Institution of Chartered Surveyors (FRICS) and has held a number of senior roles during his 38 years within the NHS.

Alison Kelly, Director of Nursing and Quality / Deputy Chief Executive
Alison Kelly joined the Countess in March 2013, having previously been the deputy chief nurse at the University Hospital of South Manchester since 2008.

Alison has a wide range of experience as a senior nurse, such as work on practice development in a number of trusts in the North West, including Blackpool and East Cheshire. She is particularly interested in driving the patient experience agenda and identifying how patient feedback can enhance service development and improvement.

Alyson Hall, Director of Human Resources and Organisation Development
Alyson Hall joined the Trust in 2019 and has over 30 years' experience gained in both the public and private sector. Prior to joining the NHS in 2015 she worked with various blue light services including Greater Manchester Fire and Rescue Service.

Alyson is a fellow member of the Chartered Institute of Personnel and Development and holds a postgraduate qualification in organisational development and employment law. She has extensive employee relations and transformational change experience, gained within the public sector working at a local, regional and national level.

David Coyle, Chief Operating Officer
David Coyle joined the Board of Directors on 20 July 2020.

David is a registered nurse and has worked in a variety of clinical and operational settings throughout the NHS as both a senior nurse and manager. He has worked mainly in the NHS but also brings experience from NHS commissioning, community settings and local authorities where he worked in senior integrated health roles.

Cara Williams, Chief Digital Information Officer
Cara Williams joined the Trust in May 2020. Cara has over 25 years' experience working within information and communication technology, customer services and digital transformation in local government, fire and rescue services as well as public sector partnerships, in England, Scotland and Wales.

Cara is a fellow of the British Computer Society, has an MBA in Public Administration, and is a qualified programme, project and change manager with experience in delivering public service reform.

Andrew Higgins, Non-Executive Director
Andrew Higgins is a chartered accountant with a background in audit and advisory services. Formerly a partner in a major accounting and advisory firm with a career spanning 33 years in the UK and overseas, Andrew has experience of working with a variety of commercial and not-for-profit organisations. For the past ten years, he has held non-executive director roles in a range of organisations and currently chairs a West Midlands Building Society.

Ros Fallon, Non-Executive Director
Ros Fallon has experience of whole system strategic planning, operational delivery and performance improvement. Ros has led transformational change programmes both locally and nationally and has held executive director positions in the NHS in Cumbria and Liverpool. She has also worked within the NHS as a registered nurse, and practiced as a clinical midwife for 17 years in Manchester, Cheshire and Warrington before undertaking an MSc in Health Informatics and moving into strategic leadership roles.

David Williamson, Non-Executive Director
David Williamson joined the Board in November 2019. He brings a valuable blend of business consulting skills, acquired during 10 years with a multi-national company and over 20 years in senior business change and IT leadership roles across a range of consumer facing industries. David has over 15 years of Board-level experience in a variety of roles all of which had particular emphasis on joined-up strategic planning and effective governance of both operational and transformational delivery.

Mark Adams, Non-Executive Director
Mark Adams has worked in healthcare management for over 30 years. A former chief executive of multinational companies, he has worked in the UK as well as abroad and also held positions as a trustee and non-executive director. Mark now manages one of the UK's largest health and social care organisations supporting 3500 individuals with Learning Disabilities or those living with Dementia.

Bridget Fletcher, Non-Executive Director
Bridget Fletcher has over 40 years' clinical and board experience in the NHS, most latterly as chief executive of an acute and community Foundation Trust in Yorkshire. She initially trained as a nurse and worked within acute and specialist hospitals, moving into a variety of leadership and management roles including that of chief nurse. Bridget has extensive experience of leading integration within health and care settings, and is well versed in the challenges of delivering care on a day to day basis whilst transforming care for the future.

Paul Jones, Non-Executive Director
Paul Jones brings over 15 years of Board-level experience to the Trust. A chartered engineer by profession, he was primarily based in Cheshire, but has also worked in the USA, Germany and the Netherlands.

Having graduated in mechanical engineering from Manchester Metropolitan University, Paul has worked in the automotive industry for over 30 years. Paul is a fellow of the Institution of Mechanical Engineers and is also the current chair of its Automobile Division Board.

Ken Gill, Non-Executive Director
Ken Gill is an experienced executive and non-executive director. He is a chartered accountant and former chief executive with a strong track record of strategy development and delivery, as well as considerable strategic and operational financial management experience. Ken has significant experience of regulation, standards and system level operation in three professional sectors: medicine/health, education and accountancy and has also worked in a government agency of the Department for Education.

Register of Interests

There are no company Directorships held by the Directors or Governors where companies are likely to do business or are seeking to do business with the Trust, other than those highlighted in the related party note in the financial statements.

Where there are Directorships with companies the Trust may do business with, we have mechanisms to ensure that there is no direct conflict of interest and those Directors would not be involved. Based on the Register of Directors' Interests and known circumstances, there is nothing to preclude any of the current Non-Executive Directors from being declared as independent.

The Register of Interests is held by the Company Secretary and Board members declarations have been made available on The Countess of Chester Hospital's website during 2020/21. Anyone requiring a copy of the register should visit the website at:

https://www.coch.nhs.uk/corporate-information/board-of-directors/register-of-interests.aspx

or, email coi.declarations@nhs.net.

The Board of Directors have individually signed to confirm that they meet the *Fit and Proper Persons Test*.

Statement as to Disclosure to Auditors

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

The accounts have been prepared under a direction issued by NHS Improvement (NHSI) and recorded in the accounting officer's statement later in this report. The Directors are responsible for ensuring that the accounts are prepared in accordance with regulatory and statutory requirements. A Director is regarded as having taken all the steps that they ought to have taken as a Director in order to do the things mentioned above, and:

- made such enquiries of his/her fellow Directors and of the company's auditors for that purpose; and
- taken such other steps (if any) for that purpose, as are required by his/her duty as a Director of the company to exercise reasonable care, skill and diligence.

Relevant audit information means information needed by the NHS foundation trust's auditor in connection with preparing their report.

Better Payment Practice Code

The Better Payment of Practice Code has a target that 95% of suppliers are paid within 30 days. The Trust's performance in relation to this target is shown in the tables below:

Table 6 - Better payment practice code
% payment within 30 days of receipt of undisputed invoices – target 95%

	2016/17	2017/18	2018/19	2019/20	2020/21
Volume	94.78%	97.74%	98.20%	98.20%	94.91%
Value	93.71%	96.33%	98.80%	99.40%	97.70%

Table 7 - Revised better payment practice code
% payment within 30 days of receipt of undisputed invoices – target 95%

	2019/20 NHS	2019/20 Non NHS	2020/21 NHS	2020/21 Non NHS
Volume	94.00%	98.40%	91.81%	95.05%
Value	99.50%	99.40%	98.33%	97.55%

No interest was paid to suppliers under the Late Payment of Commercial Debts (Interest) Act 1998.

Income Disclosures Required by Section 43(2A) of the NHS Act 2006

The income from the provision of health services is far greater than the income from the provision of goods and services for other purposes.

Cost Allocation and Charging Requirements

The NHS Foundation Trust has complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information guidance.

Quality Governance and Well Led Disclosures

The information on the arrangements in place to govern quality, together with the arrangements in place to ensure that services are Well Led, are within the Annual Governance Statement of this annual report.

Financial Risk

In assessing the financial position of the Trust, the Board does not consider there is exposure to any significant risk with regard to financial instruments. This is expanded in our financial statements.

Political or Charitable Donations

There have been no political or charitable donations in the year.

Stakeholder Relations

Information about our work with patients, stakeholders and partnerships can be found within the Performance Report section of this annual report..

Patient Care

Information of patient care activities and our performance against key patient care targets can be found within the Performance Report section of this annual report.

Susan Gilby

Dr Susan Gilby
Chief Executive Officer

8 June 2021

Governance Report

Our Approach to Governance

The Trust is managed by the Board of Directors, which is accountable to the Council of Governors. The Governors have a responsibility to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors.

The Governors also have a duty to represent the interests of Trust members and the public. They act as the voice of local people and are responsible for helping to set the direction and shape the future of the hospital.

The Board of Directors and Council of Governors enjoy a strong and continually growing working relationship. The Chair of the Board is also the Chair of the Council of Governors and is responsible for ensuring that the Board and the Council work together effectively. The link between the two is enabled in a number of ways, including informal updates, attendance at each other's meetings, verbal and written reports and the exchange of minutes.

In addition, we welcome our Governors among the public attendees at every meeting of the Board of Directors held in public. Business is conducted in private session only where necessary.

Some Governors also sit on Trust-wide committees and forums, providing feedback to the wider Council of Governors in support of their principal "holding to account" responsibility.

The Board of Directors is assured by four formal committees, which report into the Board and are monitored through the Trust's audit processes. These committees are:

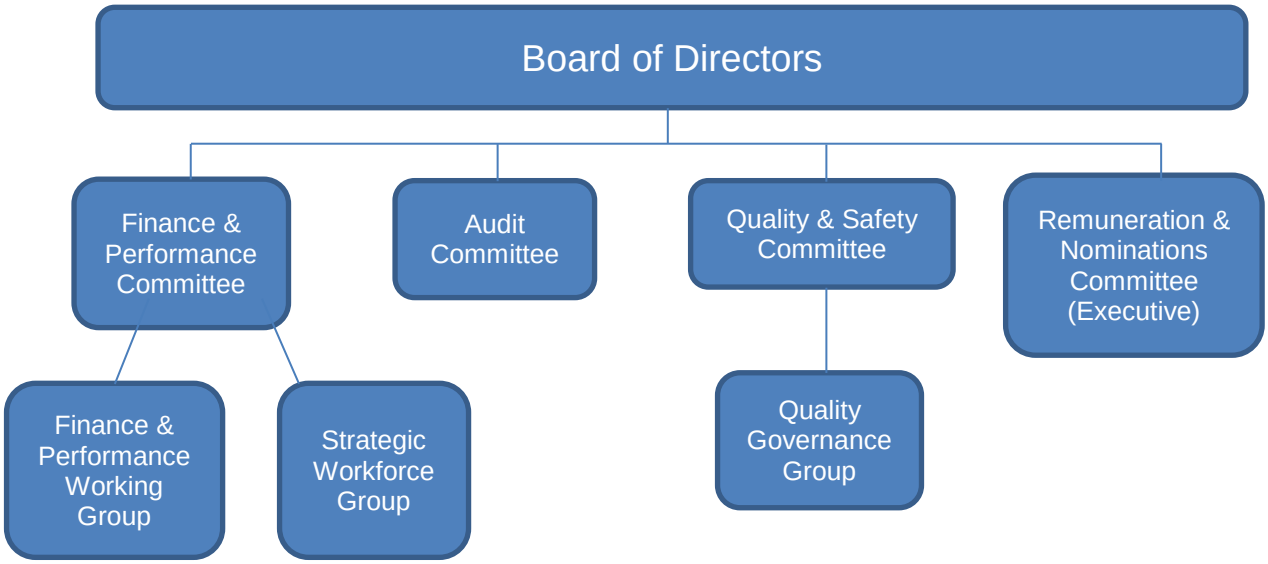
- Audit Committee
- Finance & Performance Committee
- Quality & Safety Committee
- Remuneration Committee

The Board considers each of the Non-Executive Directors to be independent.

Our Governance Structure

The Trust's governance agenda is managed through the Board's governance committees each chaired by a Non-Executive Director, reporting directly to the Board.

Figure 10 - Trust Board Governance Structure



Audit Committee

With support from all of the Board's governance committees, the Audit Committee has a particular role in the review and providing assurance to the Board on the Trust's overall governance, risk management and internal control procedures. This includes arrangements for preparation of Annual Accounts and Annual Report, the Board Assurance Framework and the Annual Governance Statement.

The Audit Committee consists of three independent Non-Executive Directors, at least one of whom (the Committee Chair) is a qualified accountant in the period up to 31 March 2021. During the year a Non-Executive Director was appointed and who will be Chair of the Audit Committee from 1 April 2021.

In addition to committee members, executive directors and senior staff are regularly invited to attend the Committee to answer questions and inform agenda content, and internal and external auditors are also present at meetings. Private meetings with both internal or external auditors are held as and when required. During the year, there have been no changes in either internal or external audit providers, who are Mersey Internal Audit Agency (MIAA) and KPMG respectively.

The current contract for external audit services finishes in June 2021 following the completion of the audit of the accounts for the current year ended 31 March 2021. The contract was originally tendered for in 2016 and was for a period of 3 years, with an extension for a further 2 years. In accordance with the responsibility of the Council of Governors to appoint the Trust's external auditors, the Council of Governors at its meeting in December 2020 following consideration of the market

conditions, approved a recommendation to extend the existing external audit contract for an additional one year with an option to extend for a further one year if required.

During the year, the Audit Committee undertook the full range of its responsibilities, including:

- Reviewing the Annual Governance Statement and supporting assurance processes in conjunction with the Head of Internal Audit opinion
- Approving a risk-based internal audit plan and actively reviewed the findings of all audits and monitored progress
- Approving the plan and reviewed the work of the local anti-fraud specialist
- Reviewing Accounting Policies and significant judgements
- Reviewing and approved the updated corporate governance manual covering standing orders, standing financial instructions and scheme of delegation
- Agreeing the nature and scope of the external audit plan and reviewed the reports, recommendations and management responses
- Reviewing the annual financial statements and recommended their adoption to the Board of Directors
- Reviewing the effectiveness of the Committee
- Agreeing updated Terms of Reference for the Committee and recommended these to Board for ratification
- Reviewing procurement waivers
- Reviewing bad debt write-off
- Reviewing the Annual Report and data quality of the Quality Account
- Approving the policy for engagement of the auditors for non-audit work
- Reviewing the effectiveness of internal audit process
- Reviewing the NHS Provider Licence self-assessment
- Reviewing any proposals for work outside the audit plan, which is subject to approval by the Audit Committee in accordance with the non-audit services policy. All additional work provided in-year was undertaken in accordance with this policy.

Quality & Safety Committee

The Quality & Safety Committee is responsible for providing the Trust Board with assurance on all aspects of the quality of clinical care, on the quality governance systems supporting the Trust, and on standards of quality and safety. It works closely with the Audit Committee and a number of sub-committees report into the Committee to inform its work, especially the Quality Governance Group. Its work is guided by a detailed annual cycle of business which routinely reviews the Trust's

Integrated Performance Report which includes a full range of live performance metrics relevant to the oversight of the Committee.

As reported in the Annual Governance Statement during the phases of the COVID-19 pandemic the work of the Committee continued albeit in a truncated form but allowing for business critical quality issues to be dealt with. For example, it provided particular focus on the Trust's management of infection prevention and control measures during the pandemic and as part of this reviewed a detailed risk register and action plan.

Nevertheless, despite the curtailment for a period during the year of some aspects of its routine work it has continued to ensure oversight of many of the critical items of its agenda which have included:

- Reviewing serious incidents, complaints, claims and coronial cases
- Reviewing the mortality indicators report and learning from deaths report
- Reviewing the Board Assurance Framework/Strategic Risk Register for the risks associated with the work of the Committee
- Considering the output and actions required from a number of "deep dive" reviews, including falls, pressure ulcers, sepsis management
- Approving a number of annual reports relevant to its work, including the Think Safeguarding and Guardian of Safe Working Hours Report.

Following publication of the national reports – First Do No Harm and the Ockenden Report – the Committee has reviewed the findings and recommendations, and continues to review the Trust's action plans in response to the required actions.

Finance & Performance Committee

The Finance & Performance Committee is responsible for supporting the Board to ensure that all appropriate action is taken to achieve the financial and operational performance objectives of the Trust through regular review of financial and operational strategies and performance, investments, and capital plans. Other responsibilities include all efficiency programmes, procurement strategy, and the people and workforce development strategy.

As reported in the Annual Governance Statement during the first phase of the COVID-19 pandemic the business critical work of the Committee was transacted through the Quality & Safety Committee. The Committee's usual business cycle was restored and the Committee is playing a critical role in the recovery and restoration of services following the second phase of the pandemic.

The Council of Governors

The Council of Governors and relationship with the Board

The Council of Governors has a duty to hold the non-executive directors individually and collectively to account for the performance of the Board of Directors and are also responsible for representing the interests of the members, public and colleagues in the governance of the Trust. Governors are responsible for regularly feeding back information about the Trust, its vision and its performance to members and the public and the stakeholder organisations that either elected or appointed them.

View from our Lead Governor

Lead Governor, Peter Folwell looks back at the year of COVID-19

The Council of Governors has remained active throughout the pandemic, albeit working in very different ways, to continue representing members and the population served by the Trust.

When the difficulties posed by coronavirus became clear, it had significant implications for the governors, given that many public governors are retired and therefore in the more vulnerable age groups. We were desperate to continue our work as much as possible, but we also recognised that one of the best ways we could support the hospital and our amazing healthcare teams was to step back and avoid adding to their burden at such a crucial time.

With this in mind, as the hospital shifted to a pandemic response footing, regular group meetings and discussions were streamlined considerably, but we remained part of all those deemed crucial enough to continue.

With visiting no longer permitted, it was no longer possible for the governors to have a physical presence in the hospital. This meant that, unfortunately, our GovRounds had to be suspended. Of all the things we do, nothing is better than us actually getting out into different areas and speaking to people to provide feedback. However, it would have been inappropriate for that to continue while patients couldn't see their loved ones and also to keep everyone as safe as possible.

Despite those changes, the governors have still had a very full calendar. We have been adjusting to the world of virtual meetings like everyone else, but we have been actively involved in the recruitment of new non-executive directors

and the drafting of the Trust's new constitution. Our first-ever virtual Annual Members' Meeting was a huge success in October 2020 with many staff members attending. A total of eight new governors joined the Council of Governors, while three existing governors were re-elected for another three years.

One surprising benefit of the past year has been that we have held more informal sessions online than we ever would normally. These getting-to-know-you sessions with the non-executive directors have been both fun and informative. I am convinced that they will make us a stronger unit as we work with the hospital's management in 2021-22 and beyond. In relation to our plans and priorities for the forthcoming year, we have already begun to consider how we can improve communication with our members, both staff and public, and have agreed to establish a group dedicated to supporting this.

I do hope we can get back out into the wards and departments soon. I can't wait to see familiar faces again and we have something very important to say: "Thank you."

The Council of Governors holds the non-executive directors and Board of Directors to account in a variety of ways including by observing and appraising the performance of the Chair and Non-Executive Directors, by analysis of the integrated performance reports and chair's reports that they receive, by challenging and raising questions as appropriate.

In addition to the formal quarterly meetings of the Council of Governors, the governors hold a Governor Forum meeting at least eight times a year. Non-Executive Directors and Executive Directors regularly attend these meetings. At these meetings, the governors receive an update about Trust matters in relation to quality and operational information and have the opportunity to raise any issues on behalf of the members.

Governors Forum topics during 2020/21 have included:

- Operational Updates on the position of the Trust during the COVID-19 pandemic
- The Family Support service
- Ward Accreditation Programme
- Governor role briefing
- The role of external audit
- Review and approval of the revised Constitution

- Digital strategy update.

At the Council of Governors' meetings there are interactive sessions where governors hold the Board to account and provide feedback from the membership about the quality of the Trust's services received by members. During 2020/21, updates have been received at the Council of Governors meetings about the development of the Cheshire West Integrated Care Partnership. Questions from governors in regard to Chair's Reports from Board committees have continued this year, in order to strengthen the role of the governors in holding the Non-Executive Directors to account.

The types of decisions taken by the Council of Governors include:

- Appoint and, if appropriate, remove the Chair
- Appoint and, if appropriate, remove the other non-executive directors
- Decide the remuneration and allowances, and the other terms and conditions of office, of the Chair and the other non-executive directors
- Approve the appointment of the Chief Executive
- Appoint and, if appropriate, remove the NHS Foundation Trust's External Auditor
- Decide on a quality of care issue to be reviewed for the Quality Account
- Determine a local quality measure for auditing internally and externally for the Quality Account
- To agree the Membership Strategy and the policy for the composition of the Council of Governors.

Any disagreements between the Council of Governors and the Board of Directors will be dealt with in accordance with the Trust's Constitution.

Composition of Council of Governors

The total number of governor positions established within the Constitution is 27, as follows:

Table 8 - Composition of Council of Governors

Constituency area	Number of governor positions established
Chester and Rural Cheshire	8
Ellesmere Port and Neston	4
Flintshire	3
Rest of England & Wales	1
Staff	5
Partnership organisations	6
Total	27

In December 2020 the Board of Directors and Council of Governors agreed a refreshed Constitution which saw the former *Wider Area* Constituency renamed and revised to The r*est of England and Wales*.

It was pleasing that a number of governor vacancies were filled during the summer 2020 election process. As at 31 March 2021, there were four governor vacancies, which include two public governors and two partnership governors.

The membership of the Council of Governors during 2020/21, for both elected and appointed governors, and their length of tenure, is as follows:

Table 9 - Membership of Council of Governors

Governor/Constituency	Term of office
Public – Chester and Rural Cheshire	
Ms Caroline Stein	Re-elected in October 2020 for a third term of office until October 2023
Ms Jennifer Gill	Elected October 2017 for three years until October 2020
Mr Hugh Hoather	Elected October 2020 for three years until October 2023
Ms Ella Foreman	Elected October 2020 for three years until October 2023
Ms Karen Newbury	Re-elected in September 2019 for a second term of office for three years until September 2022
Mr John Jones	Re-elected in October 2020 for a second term of office for three years until October 2023
Mr Hems de Winter	Elected October 2018 for three years until October 2021
Ms Brenda Southward	Elected October 2018 for three years until October 2021
Mr Andrew Firman	Elected October 2020 for a three years until

	October 2023
Public – Ellesmere Port and Neston	
Cllr Brian Jones	Re-elected 2018 for a second term of office for three years until October 2021
Mr Peter Folwell (Lead Governor from October 2018)	Re-elected September 2019 for a second term of office until September 2022
Dr Mike Morris	Elected September 2019 for three years until September 2022
	One Vacant position
Public – Flintshire	
Mr Stuart Hatton	Appointed 18 February 2020 until October 2020 (following a Flintshire Governor standing down) and then elected in October 2020 for a three year term of office until October 2023.
Mr Russell Jackson (Deputy Lead Governor from October 2018)	Re-elected September 2019 for a third term of office for three years until September 2022
Ms Ruth Overington	Re-elected in September 2019 for a second term of office for three years until September 2022
Public – The Rest of England & Wales (formerly Wider Area)	
	This position remains vacant
Partnership organisations appointed governors	
Ms Carol Berry Voluntary Services	Appointed 14 January 2020 and stood down 5 August 2020
Mr David Foulds Voluntary Services	Appointed 9 November 2020
Prof Angela Simpson University of Chester	Appointed 18 January 2020
NHS Cheshire CCG	*Position un-appointed/vacant since 23 January 2020*
Cllr Steve Collings Cheshire West and Chester Council	Appointed 12 June 2019
Mr Michael Boyle Flintshire Community Health Council	Appointed September 2016
Betsi Cadwaladr Health Board	*Position remains un-appointed/vacant*
Staff	
Dr Ian Benton Doctors	Re-elected for second term of office October 2017 for three years until October 2020
Dr Santokh Singh Doctors	Elected October 2020 for three years until October 2023

Ms Katy Cottrell Allied Health Professionals	Elected October 2020 for three years until October 2023
Ms Paula Edwards Nurses/Midwives	Elected October 2020 for three years until October 2023
Ms Hayley Cooper Nurses/Midwives	Elected October 2020 for three years until October 2023
Mr Steve Bridge Other staff groups	Re-elected October 2017 for three years until October 2020
Ms Deborah Brown Other staff groups	Elected October 2020 for three years until October 2023

Election of Council of Governors

Notice of election was published in July 2020 in the following public constituencies:

- Chester and Rural Cheshire
- Ellesmere Port and Neston
- Flintshire
- Wider Area (subsequently renamed as *the rest of England & Wales*).

Notice of election was published in July 2020 in the following staff constituencies:

- Allied Healthcare Professionals and Technical/Scientific
- Nursing and Midwifery
- Doctors
- Other staff group.

An election was held in the summer of 2020 with the results announced at the Annual Members Meeting held on 14 October 2020. The election turnout was as follows:

- Chester City and Rural Cheshire – position contested, three governors appointed and two governors re-elected following a ballot.
- Ellesmere Port and Neston – no valid nomination received, position remains vacant.
- Flintshire – position uncontested; one governor elected.
- Wider area (subsequently re-named as *the rest of England & Wales*) – no valid nomination received, position remains vacant.
- Staff – Allied Health Professionals – position uncontested, one governor appointed.
- Doctors – position contested, one governor appointed following a ballot.
- Staff – Nursing and Midwifery – position contested; two governors were elected following a ballot.

- Other staff group – uncontested, one governor appointed.

The Board confirm that elections are held in accordance with the model election rules and were undertaken independently by Civica Election Services (CES). The Report of Voting and Uncontested Report for election to the Council of Governors were received by the Council of Governors at its meeting of 11th December 2020.

Attendance at Council of Governors' meetings

There have been four public meetings of the Council of Governors' and five private meetings held during 2020/21.

The attendance by governors is shown below, along with expenses of governors:

Table 10 - Attendance at public Council of Governors' Meetings

No. meetings 2020/21	4	Governors' expenses 2020/21
Council of Governors		
Mr Peter Folwell (Lead Governor)	4	Nil
Mr Russell Jackson (Deputy Lead Governor)	4	Nil
Ms Karen Newbury	3	Nil
Mr John Jones	4	Nil
Ms Jennifer Gill	1/2	Nil
Cllr Brian Jones	2	Nil
Ms Carol Berry	0/1	Nil
Prof Angela Simpson	3	Nil
Ms Ruth Overington	4	£52.80
Mr David Foulds	1/2	Nil
Mr Stuart Hatton	3	Nil
Dr Mike Morris	4	Nil
Hugh Hoather	2/2	Nil
Ella Foreman	2/2	Nil
Andrew Firman	2/2	Nil
Cllr Steve Collings	3	Nil
Mr Michael Boyle	2	Nil
Brenda Southward	1	Nil
Dr Caroline Stein	4	Nil

Hems de Winter	4	Nil
Dr Ian Benton	1/2	Nil
Dr Santokh Singh	0/2	Nil
Mr Steve Bridge	2/2	Nil
Ms Deborah Brown	2/2	Nil
Katy Cottrell	2/2	Nil
Hayley Cooper	1/2	Nil
Paula Edwards	1/2	Nil

Governors' Nominations Committee

Non-Executive Directors, including the Trust Chair, are appointed by the Council of Governors for the specified terms – subject to re-appointment thereafter at intervals of no more than three years, and are subject to the 2006 Act provisions relating to the removal of a director. In order to support the Council of Governors in this role, a Governors' Nominations Committee has been established. Its membership comprises public, partner and staff governors, and the Trust Chair. It is chaired by a Governor and is sometimes assisted, as appropriate, by the Senior Independent Director. The terms of reference of the Committee were also revised and approved in year.

During 2020/21, the Governor's Nominations Committee met on three occasions to consider a number of matters including the appointment of the substantive Trust Chair, a Non-Executive Director and Chair of Audit Committee, proposed extensions of terms of office for some Non-Executive Directors and the Interim Trust Chair. The Committee also considered the Trust Chair's and Non-Executive Directors' objectives for the year, together with accompanying appraisal arrangements. In accordance with its role, the Committee continued to make recommendations for the decision of the Council of Governors.

There were also changes to membership in the year with Steve Bridge (Staff Governor) leaving the Committee on completion of his term of office as Staff Governor, and Deborah Brown and Professor Angela Simpson joining the Committee as Staff and Partner Governors respectively.

The attendance at the Governors' Nominations Committee meeting by its members was as follows in 2020/21:

Table 11 - Attendance at Governors' Nominations Committee Meetings 2020/21

Date	03.06.20	23.09.20	03.03.21
Russell Jackson (Chair)	☑	☑	☑
Chris Hannah	☑	☑	☑
Peter Folwell	☑	☑	☑
Karen Newbury	☑	☑	☑
Steve Bridge (2/2)	☑	☑	
Deborah Brown (1/1)			☑
Professor Angela Simpson (1/1)			☑

Membership

The members of the Foundation Trust are those individuals whose names are entered in the register of members. Members are either a member of one of the public constituencies or a member of one of the classes of staff constituency. Membership is open to any individual who is at least 16 years of age. The Trust's Constitution, which was updated in December 2020, also makes provision for Youth Associates to become involved with the Trust who are at least 11 years of age, but less than 16 years of age.

An individual may not become, or continue to be, a member of the Foundation Trust if they are under 16 years of age; or within the last five years they have been involved as a perpetrator in a serious incident of physical or verbal aggression at any of the Trust's sites or facilities or against any of the Trust's employees or other persons who exercise functions for the purposes of the Trust, or against registered volunteers.

Public membership

There are four public constituencies:

- Chester and Rural Cheshire
- Ellesmere Port and Neston
- Flintshire
- The rest of England & Wales (formerly *Wider Area*).

Staff membership

The staff constituency is divided into four classes as follows:

- Doctors
- Nursing and midwifery

- Allied healthcare professionals and technical/scientific
- Other staff groups.

Membership size and movements

Membership changes in 2020/21 and those estimated for 2021/22 are shown in the following table:

Table 12 - Changes in membership during 2020/21 and estimated changes for 2021/22

Public constituency	Last year (2020/21)	Next year (estimated 2021/22)
At year start	6,144	6,041
New members	11	84
Members leaving*	214	96
At year end	5,941	6,029

Note that in July 2020 the Trust undertook a validation of its membership which resulted in a higher number of members leaving during the year. The members leaving figure also includes deceased members.

Table 13 - Changes in staff constituency during 2020/21 and estimated changes for 2021/22*

Staff constituency	Last year (2020/21)	Next year (estimated 2021/22)
At year start	5,093	5,730
New members	1,372	1,015
Members leaving	735	601
At year end	5,730	6,144

*figures include bank staff.

Membership Strategy

The 2020/21 target to maintain current levels of public membership was not achieved due to a small drop in membership, however this, in part, relates to a positive exercise undertaken to validate the membership, as part of the governor election communication in July 2020, along with a monthly validation of deceased members.

The governors have recently agreed to establish a group to consider membership engagement further and this group will meet regularly in 2021/22 to consider methods of communication with current members, seek new members, and review diversity of the membership. It is The Countess of Chester Hospital's intention to maintain public membership to at least its current levels.

Current and future engagement with members

The Trust engages with its members via the following:

- *Countess Matters* magazine (paused during the COVID-19 pandemic)
- Local newspaper articles
- Facebook and social media
- Updates on the Trust's Website
- Participating in governor elections and notice of elections
- Annual Members Meeting held on 14 October 2020, via videoconference, due to the COVID-19 pandemic.

Members can communicate with governors via the following email address:

Coch.membershipenquiriescoch@nhs.net and further information on Trust membership can be found on The Countess of Chester Hospital's website: www.coch.nhs.uk .

Remuneration report 2020/21

Annual Statement of Remuneration

The Remuneration Committee is responsible for the appointment of the Chief Executive and, together with the Chief Executive, other executive directors of the Board of Directors. It reviews and recommends the terms and conditions of service for the Executive Directors and Very Senior Managers (VSMs) who are not subject to "Agenda for Change" terms and conditions, and reviews the performance of these staff annually. The Committee also has oversight of the Trust's senior management pay framework

The Committee is chaired by the Trust Chair and includes, as members, all Non-Executive Directors. The Chief Executive, Director of HR and Organisation Development, and Head of Corporate Affairs/Company Secretary attend by invitation to ensure the Committee is appraised of relevant internal or external advice, data or information. It is important to note that the Chief Executive or relevant executive would not be present where discussions related to their appraisal, terms and conditions or appointment.

The Remuneration Committee is required to ensure levels of remuneration are sufficient to attract, retain and motivate directors of the quality required to run the organisation successfully, but to avoid paying more than is necessary.

The Committee meets as required and met on three occasions during 2020/21. In the course of these meetings the Committee considered the appointments and remuneration of the Chief Operating Officer and Chief Digital Information Officer, the outcome of appraisals of Executive Directors, and agreed in line with national guidance that the earn back element of the VSM (Very Senior Managers) contracts in excess of £150,000 p.a. would not be reviewed for 2019/20. In March 2021 the Committee, in line with national guidance, also approved a 1.03% consolidated VSM pay award for 2020/21. The Committee also reviewed and updated its terms of reference and adopted an agreed cycle of business for the year.

In considering the executive directors' remuneration, the Committee takes into account the national inflationary uplifts recommended for other NHS colleagues, any variation in or change to the responsibility of executive directors and relevant benchmarking information. Executive directors are subject to annual appraisal by the Chief Executive Officer who is in-turn appraised by the Trust Chair.

The contracts of employment of all executive directors, including the Chief Executive, are permanent and are subject to six months' notice of termination with the exception of the Director of Human Resources and Organisation Development who is employed on a fixed-term contract until August 2021 to support the people transformation programme.

Earn-back is in place for the Chief Executive and Executive Medical Director as per national guidelines and no other performance-related pay scheme (e.g. pay

progression or bonuses) is in operation within the organisation. As noted above, in line with national guidance, the Committee did not review earn back arrangements for 2019/20. There are no special provisions regarding early termination of employment.

All other senior managers, other than Executive Directors, are subject to Agenda for Change pay rates, terms and conditions of service, which are determined nationally.

There are three executives who were paid more than £150,000 in 2020/21, when the remuneration is considered on a pro-rata basis for the whole year. For the purposes of this disclosure, pay is defined as salary and fees, all taxable benefits and any annual or long-term performance-related bonuses, of which there were none during the year. We are satisfied that the remuneration is reasonable, following scrutiny by the Remuneration Committee.

Chris Hannah

Chris Hannah
Chair, Remuneration Committee
8 June 2021

Salary and pension entitlement of senior managers

Table 14 - Salary and pension entitlements of senior managers - 2020/21 and 2019/20

	Salary (bands of £5,000)	**Other taxable remuneration (to nearest £100)**	**Benefits in kind (to nearest £100)**	**Pension related benefits (bands of £2,500)**	**Total (bands of £5,000)**	Salary (bands of £5,000)	Other taxable remuneration (to nearest £100)	Benefits in kind (to nearest £100)	Pension related benefits (bands of £2,500)	Total (bands of £5,000)
	20/21	**20/21**	**20/21**	**20/21**	**20/21**	19/20	19/20	19/20	19/20	19/20
	(£000)	**(£)**	**(£)**	**(£000)**	**(£000)**	(£000)	(£)	(£)	(£000)	(£000)
Dr Susan Gilby - Chief Executive	225-230	-	-	-	225-230	220-225	-	-	-	220-225
Mr Simon Holden - Director of Finance	150-155	-	-	-	150-155	140-145	-	-	-	140-145
Dr Darren Kilroy - Medical Director	180-185	-	5,500	60-62.5	245-250	165-170	15,500	-	230-232.5	410-415
Mr David Coyle - Chief Operating Officer (20.07.2020)	115-120	-	-	-	115-120	-	-	-	-	
Mrs Alison Kelly – Director of Nursing & Quality/ Deputy Chief Executive	125-130	-	-	20-22.5	145-150	125-130	-	-	147.5-150	270-275
Mrs Alyson Hall - Director of Human Resources and Organisation Development (from 12.08.19)	100-105	-	100	-	100-105	50-55	-	-	-	50-55

Ms Cara Williams - Chief Digital Information Officer (01.05.2020)	95-100	-	-	35-37.5	130-135	-	-	-	-	
Mrs Susan Hodkinson - Director of People & Organisation Development (to 31.05.19)	-	-	-	-	-	20-25	-	-	20-22.5	40-45
Mrs Alyson Hall (HR Solutions by Design - Acting Director of People & Organisation Development (from 01.06.19 to 09.08.19)	-	-	-	-	-	25-30	-	-	-	25-30
Ms Lorraine Burnett - Operations Director (to 30.11.19)	-	-	-	-	-	70-75	-	-	27.5-30	95-100
Mr Stephen Cross - Director of Corporate and Legal Affairs (to 03.06.19)	-	-	-	-	-	10-15	-	1,570	-	15-20
Anna Collins - Director of Communication and Corporate Affairs (from 02.12.19 to 31.05.20)	60-65	-	-	125-127.5	185-190	25-30	-	-	-	25-30
Mrs Chris Hannah - Chair (from 01.04.21)	45-50	-	-	-	45-50	10-15	-	-	-	10-15
Sir Duncan Nichol – Chairman (to 31.03.20)	-	-	-	-	-	45-50	-	-	-	45-50
Mr Andrew Higgins - Non-Executive Director	10-15	-	-	-	10-15	10-15	-	-	-	10-15
Mrs Rachel Hopwood - Non-Executive Director (to 30.11.19)	-	-	-	-	-	5-10	-	-	-	5-10
Mr Ed Oliver - Non-Executive Director (to 31.08.19)	-	-	-	-	-	5-10	-	-	-	5-10
Mrs Ros Fallon - Non-Executive Director	10-15	-	-	-	10-15	10-15	-	-	-	10-15

Mr D Williamson - Non-Executive Director (from 01.11.19)	10-15	-	-	-	10-15	5-10	-	-	-	5-10
Mr Mark Adams - Non-Executive Director (from 01.01.20)	10-15	-	-	-	10-15	0-5	-	-	-	0-5
Ms Bridget Fletcher - Non-Executive Director (from 01.02.20)	10-15	-	-	-	10-15	0-5	-	-	-	0-5
Mr Paul Jones - Non-Executive Director (from 01.03.20)	10-15	-	-	-	10-15	0-5	-	-	-	0-5
Mr Ken Gill (from 11.01.21)	0-5	-	-	-	0-5	-	-	-	-	
Total directors remuneration	**1190-1195**	**-**	**5,600**	**242.5-245**	**1440-1445**	1105-1110	15,500	1,570	445-447.5	1495-1500

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid Director in their organisation and the median remuneration of the organisation's workforce:

Table 15

	2021	2020
Band of highest paid director's total remuneration	**225-230**	220-225
Median total remuneration	**26,641**	28,285
Ratio	**8.45**	7.88

Payments made to agency staff and bank staff have also been excluded as these mainly relate to payments made to cover absence of existing employees whose whole time, full year equivalent remuneration is already included in the calculation. To include the payments made to agency staff would distort the overall figures

The total remuneration includes salary and benefits-in-kind; it does not include employer pension contributions and the cash equivalent transfer value of pensions.

Pension-related benefits figures show the amount of annual increase in the future pension entitlement at the normal retirement age, in accordance with the HMRC method. The source information is provided by the NHSBSA.

Table 16 - Pension benefits

	Real increase in pension at age 60 (bands of £2,500)	**Real increase in pension lump sum at age 60 (bands of £2,500)**	**Total accrued pension at age 60 at 31.03.21 (bands of £5,000)**	**Lump sum at age 60 related to accrued pension at 31.03.21 (bands of £5,000)**	**Cash Equivalent Transfer Value at 31.03.21 (to nearest £1,000)**	Cash Equivalent Transfer Value at 31.03.20 (to nearest £1,000)	**Real increase in Cash Equivalent Transfer Value (to nearest £1,000)**
	2020/21	***2020/21***	***2020/21***	***2020/21***	***2020/21***	*2019/20*	***2020/21***
	(£000)	**(£000)**	**(£000)**	**(£000)**	**(£000)**	(£000)	**(£000)**
Dr Darren Kilroy - Medical Director	2.5-5	-	60-65	135-140	1,149	1,063	61
Mrs Alison Kelly - Director of Nursing and Quality/ Deputy Chief Executive	0-2.5	0-2.5	50-55	150-155	1,113	1,045	43
Ms Cara Williams - Chief Digital Information Officer (01.05.2020)	0-2.5	-	0-5	-	26	-	26
Anna Collins - Director of Communication and Corporate Affairs (from 02.12.19 to 31/05/20)	5-7.5	-	20-25	-	322	228	89

Table 17 - Other arrangements

	Salary (bands of £5,000)	**Other taxable remuneration (to nearest £100)**	**Benefits in kind (to nearest £100)**	**Pension related benefits (bands of £2,500)**	**Total (bands of £5,000)**	Salary (bands of £5,000)	Other taxable remuneration (to nearest £100)	Benefits in kind (to nearest £100)	Pension related benefits (bands of £2,500)	Total (bands of £5,000)
	2020/21					*2019/20*				
	(£000)	**(£)**	**(£)**	**(£000)**	**(£000)**	(£000)	(£)	(£)	(£000)	(£000)
Mr Tony Chambers (to 30.06.19)	**-**	**-**	**-**	**-**	**-**	35-40	-	-	-	35-40
Mrs Susan Hodkinson (to 30.09.20)	**-**	**-**	**-**	**-**	**-**	75-80	-	-	-	75-80
Ms Lorraine Burnett (to 30/08/20)	**35-40**	**-**	**-**	**10-12.5**	**45-50**	-	-	-	-	-
Alison Lee - Integrated Care Partnership Managing Director	**45-50**	**-**	**-**	**10-12.5**	**55-60**	45-50	-	-	15-17.5	65-70
Andrea Campbell - Integrated Care Partnership Chair	**10-15**	**-**	**-**	**-**	**10-15**	-	-	-	-	-

Alison Lee is the Cheshire West Integrated Care Partnership Managing Director and the Countess of Chester Hospital contributes 37.2% of her salary. This is the contribution shown above.

Andrea Campbell is the Cheshire West Integrated Care Partnership Chair and the Countess of Chester Hospital contributes towards her salary. This is the contribution shown above.

Lorraine Burnett stood down as Operations Director on 30 November 2019. She was still employed by the Trust from April 20 to August 20.

The benefit in kind is for a lease car scheme, a cycle to work scheme and a home technology scheme which are open to all members of staff. They are schemes whereby the employee agrees to reduce their salary for the full cost of the benefit. If an employee withdraws from a scheme this will have an effect of increasing their pay as they are not then sacrificing it for a benefit.

As non-executive members do not receive pensionable remuneration, there are no entries in respect of pensions for non-executive members.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capitalised value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme.

They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries. The NHS Pension scheme will not make a cash equivalent transfer once a member reaches the age of 60 and is then therefore, not applicable.

Real Increase in CETV - This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights.

This value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the benefit being a member of the pension scheme could provide.

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

Susan Gilby

Susan Gilby

Chief Executive Officer

8 June 2021

Staff report 2020/21

The Countess of Chester Hospital's key priorities for 2020/21 are based on our vision of delivering "NHS care locally that makes our staff and our community proud" *(the vision subsequently reviewed as part of the May 2021 Trust's Five Year Strategy)*. This vision is underpinned by our core values of Safe, Kind and Effective – whereby we focus on:

- Getting it right first time for all patients to ensure the right care and treatment is started at the right time in the patient's journey
- Continuing with the creation of the culture within The Countess of Chester Hospital that fosters the values and behaviour that patients, the public and staff expect; one where colleagues come to work, to both do their work and to improve their work and getting the right number of nursing and clinical staff with the right skills, to the right patient at the right time
- The way in which we work to ensure we improve the safety, quality and experience of patients.

In the last year our key area of focus has shifted to incorporate not only how we engage with colleagues, but also to acknowledge and support the importance of the health and wellbeing of all of our staff. Workforce wellbeing has always been a consideration, however the impact of the COVID-19 pandemic has thrown into sharp relief the need for all employers to better prioritise employee needs on a more holistic basis and we have started a new journey to help realise this. The Countess of Chester Hospital's People Strategy has been refreshed placing health and wellbeing priorities at its heart. The strategy will also be supported by an Education, Learning and Development Plan that will be informed by, as well as act as a key enabler for the next five years.

Organisational culture

We aspire to be one of the most clinically-led and engaged organisations in the NHS, with The Countess of Chester Hospital clinicians leading improvements and innovation activities.

Figure 11 - Behavioural standards

We have spent the last twelve months reviewing our leadership support offer and focusing on improving and promoting provision for staff wellbeing and support. Integrating our behavioural standards is an important part of this offer.

Compliance with mandatory training and core skills has been made clearer for colleagues through implementation of the Core Skills Training Framework. All mandatory training has been reviewed with new programmes being implemented from Autumn 2020. Work is continuing to improve the quality of the appraisal process with the intention to utilise technology in ways that our staff would expect of a modern employer. A revised performance appraisal process was recently introduced for Executive Directors which incorporates a 360-degree Feedback Survey to support improvements in our organisational leadership capability.

Partnering arrangements with the University of Chester and other educational providers remain a priority with new career development pathways established to prepare colleagues to take on promotion opportunities. This work has included a growth in apprenticeships at all levels and increased utilisation of

the apprenticeship levy. The Countess of Chester Hospital has seen its first cohort of Trainee Nursing Associates commence at the start of 2020 and the intention is to have a cohort of suitable staff commence every intake through the apprenticeship route.
The Countess of Chester Hospital continues to support, through the provision of placements, undergraduate students in all health-related programmes with significant numbers of nursing students from the University of Chester being supported. Significant work is in progress to increase placement capacity, particularly for pre-registration nursing students. To enable this, The Countess of Chester Hospital will be implementing a version of the CLiP (Collaborative Learning in Practice) model over the next 12 months. The Countess of Chester Hospital has opened up placements to other universities in the North West and also from Glyndwr University.

Our conventional recognition events went on hold during the COVID-19 pandemic. We acknowledged staff efforts through granting an additional day's annual leave and a 'thank you' pin badge; both as tokens of appreciation that cannot wholly demonstrate both our gratitude and pride at how consistently and tirelessly our staff have worked throughout this very difficult year. We will be changing our approach to recognition in the next year and are seeking staff views on how they would like to be recognised in alignment with the revised focus on improving staff engagement that we launched in September 2020: 'Your Voice Matters'. Through this work we aim to improve staff involvement at every level, and we are conscious of the need to improve both inclusion and equity in treatment of staff across all areas.

Our policies and procedures continue to be reviewed and developed, drawing on the feedback from our employees via our Staff Partnership Forum, Joint Local Negotiating Committee (JLNC), Junior Doctor Forum and Freedom to Speak Up Guardian. The Trust is committed to working in partnership with staff representatives and we recognise the contribution they make during times of significant organisational change, in helping us get the engagement and communication with our workforce right.

Retention of staff

Whilst The Countess of Chester Hospital recognises the need to retain staff and skills wherever possible, it acknowledges that circumstances and opportunities can arise that result in colleagues leaving. The Countess of Chester Hospital utilises an exit interview process where it captures the reasons for people leaving. Where patterns indicate potential concerns, the Equality and Diversity Manager, with support from Human Resources and our Staff Side colleagues, will investigate and, where appropriate we will take steps to improve the staff experience and in turn improve our retention rates. Staff turnover rates within the Trust have throughout 2020/21 remained lower than

our target of 10%, significantly contributing to closing some of our key vacancy gaps.

We have also been working with NHS Improvement in Cohort Four of the Recruitment and Retention workstream, to assess and implement further actions to improve the retention of nursing and midwifery colleagues particularly. This programme of work has had a positive impact on the turnover rate of our nursing and midwifery workforce reducing from 9.96% in 2018/19, to 8.23% in 2019/20 and subsequently 5.97% in 2020/21, although the 2020/21 reduction can be attributed in part to the COVID-19 pandemic.

Our staff turnover information can be viewed within the NHS workforce statistics, published by *NHS Digital* published data: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics

Attendance management

Supporting staff attendance remained high on our list of priorities particularly throughout the pandemic. In conjunction with our staff side colleagues, effective processes were implemented to support and address any emerging issues, as well as practical options to keep people fit, healthy and safe within their work environment:
Wellbeing and stress management, mindfulness courses, resilience sessions and counselling services remain available to everyone working at The Countess of Chester Hospital

Our on-line offer of support and wellbeing tools was expanded with many being tailored made in response to dealing with the challenges faced by many of our staff as a consequence of responding to the impact of COVID-19.

The Countess of Chester Hospital's ability to achieve the target for sickness absence continues to prove challenging which has been further exacerbated by the outbreak of COVID-19, which impacted on our staff absence rates from the beginning of March 2020/21. We were pleased, however to note that our staff absence rates remained lower than many other Acute Trusts within the Cheshire and Mersey region through the pandemic. Our sickness absence rates can be viewed within the NHS Digital published data: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

Staff health and wellbeing

Supporting the wellbeing of colleagues to enable safe, kind and effective care is delivered by The Countess of Chester Hospital's SEQOHS (Safe Effective Quality Occupational Health Service) accredited Occupational Health and Wellbeing Department, enabled through the Health and Wellbeing Strategy.

The Occupational Health Specialist Nurses have been responsive to staff emotional and psychological wellbeing needs during the pandemic, offering a response to direct calls for advice and guidance within one day; and working with the Head of OD to run a one month Listening Service to capture the thoughts and conversation needs of staff who do not necessarily require a therapeutic conversation. The Trust's Macmillan Support and Information Centre and the Spiritual Care centre have this year been actively open and receptive to staff who need some compassionate time out or a listening ear.

The Trust has been trialling outreach psychological support for staff impacted directly by COVID-19, from a neighbouring Trust. Pilot initiatives included a peer support group; and a self-book 1:2:1 consultant psychotherapy assessment service for doctors, with plans to expand further to critical care staff.

We recognise the need for colleagues to be able to access counselling, health advice, financial and legal advice, and have therefore agreed to extend our contract this year with the Employee Assistance Programme provider we contracted last year. This service also provides a 24-hour confidential telephone helpline, face-to-face counselling within five working days, an online health portal, and mobile phone health e-Hub App. Free virtual psychological wellbeing webinars from the EAP covering resilience, mindfulness, sleep and understanding trauma were made available and promoted through communications, as have been the varied apps and hubs offering particular health and wellbeing support this year.

The Health and Wellbeing Strategy acknowledges the benefit of a range of offerings for the workforce to engage in understanding their own, and other' wellbeing, and the Occupational Health and Wellbeing Department will continue to have qualified instructors who can deliver training for colleagues to become Mental Health First Aiders (MHFA England).

The Countess of Chester Hospital's 2020/21 staff flu vaccination campaign continued to meet the national target with over 80% of frontline Health Care Workers being vaccinated.

Employee health and wellbeing influences whether colleagues are able to work at their peak and are critical success factors for individual and organisational wellbeing and performance, and improved patient outcomes.

Equal opportunities policy

The Countess of Chester Hospital has policies in place to facilitate fair and non-discriminatory consideration for employment applications from all people and with regard to access to training, career development and promotion. The Countess of Chester Hospital sets this out in the Equal Opportunities Policy and in the Disability Equality Policy. The Countess of Chester Hospital also publishes detailed data on its employees and job applicants from protected groups within its annual Workforce Equality Analysis Report, as per the specific duties of the Equality Act (2010).

Table 18 - Gender breakdown of employees 2018/19 to 2020/21

Gender – employees	2018/19	2019/20	2020/21
Female	3,312	3,292	3,546
Male	770	802	831
Total	4,082	4,094	4,377

Table 19 - Gender breakdown of directors 2018/19 to 2020/21

Gender – directors	2018/19	2019/20	2020/21
Female	5	5	4
Male	3	2	4
Total	8	7	8

Table 20 - Staff cost analysis 2020/21 and 2019/20

Employee expenses	Total 2020/21	Permanently employed	Other	Total 2019/20
	(£000)	(£000)	(£000)	(£000)
Short-term employee benefits – salaries and wages	170,690	150,293	20,397	146,692
Post-employee benefits social security costs	15,021	13,367	1,654	13,021
Apprenticeship levy	747	665	82	688
Post-employee benefits employer contributions to NHS Pensions Agency	26,117	23,255	2,862	23,657
Other employment benefits	-	-	0	-
Termination benefits	-	-	0	-
Agency/contract staff	5,745	-	5,745	2,971
Total	**218,320**	**187,580**	**30,740**	**187,029**
Average number of persons employed	Total 2020/21	Permanently employed	Other	Total 2019/20
Medical and dental	495	217	278	475
Ambulance staff	1	1	-	1
Administration and estates	692	629	63	679
Healthcare assistants and other support staff	1,007	916	90	915
Nursing, midwifery and health visiting staff	1,077	948	129	1,010
Nursing, midwifery and health visiting learners	-	-	-	-
Scientific, therapeutic and technical staff	457	430	27	437
Healthcare scientists	136	127	9	131
Bank staff	299	-	299	242
Total	**4,164**	**3,268**	**895**	**3,891**

The Countess of Chester Hospital spent £674,000 on consultancy during 2020/21 (2019/20 - £810,000).

Staff Survey

The NHS Staff Survey is conducted annually. From 2018 onwards, the results from questions were grouped to give scores in 10 indicators. The indicator scores are based on a score out of 10 for certain questions with the indicator score being the average of those.

The response rate to the 2020 Staff Survey among The Countess of Chester Hospital staff was 42%, a large increase on the 29.7% response rate in the previous year. Scores for each indicator together with that of the survey benchmarking group, namely acute trusts[3] working with our survey provider (Quality Health) are presented below:

Table 21 - Staff Survey scores 2018 to 2020

	2018		2019		2020	
Indicator	**Trust**	**Benchmark group**	**Trust**	**Benchmark group**	**Trust**	**Benchmark group**
Equality, diversity and inclusion	9.20	9.06	9.20	9.06	9.1	9.1
Health and wellbeing	6.05	5.85	6.05	5.85	6.0	6.1
Immediate managers	6.70	6.72	6.70	6.72	6.7	6.8
Morale	5.98	6.06	5.98	6.06	6.2	6.2
Quality of appraisals	5.37	5.39	5.37	5.39	n/a	n/a
Quality of care	7.51	7.35	7.51	7.35	7.4	7.5
Safe environment – bullying and harassment	8.05	7.88	8.05	7.88	8.1	8.1
Safe environment – violence	9.37	9.44	9.37	9.44	9.4	9.5
Safety culture	6.32	6.53	6.32	6.53	6.6	6.8
Staff engagement	6.93	6.93	6.93	6.93	7.0	7.0
Team working	n/a	n/a	n/a	n/a	6.3	6.5

[3] n=128

As a result of the NHS Staff Survey in 2020, we know that we need to improve in many aspects of the key themes, and particularly in the area of increasing engagement and motivation. Priorities moving in to the next year will focus around developing leadership skills and manager capability; particularly as much of our leadership support work was placed on hold during the pandemic when it was difficult to release resources to undertake this development. We will also be improving our wellbeing support offer which will be closely integrated with our staff learning approach. We understand from the feedback that we have continued to struggle during the pandemic against the increasing levels of demand and activity to provide the level of care our colleagues that we aspire to.

In respect of overall staff engagement, The Countess of Chester Hospital recognises the need to do more to continue to improve this measure. As a result our focus will continue to be on encouraging participation in the systems and processes used to elicit their views and opinions; developing staff engagement is a key component of our newly refreshed People and OD Strategy. Much has already been done to start to involve colleagues in those matters which affect them by encouraging their contribution in the development of our Clinical and Corporate Strategies, but we will be building on this following lessons learning during the pandemic.

Off-payroll engagements

Off-payroll engagements are arrangements where an individual provides their services to the Trust, but, under HMRC rules, they are not paid through the Trust payroll. Typically, this is because the individual is working through a temporary staffing agency, or they are legitimately in business in their own right, and the legal nature of the arrangement between the Trust and the off-payroll individual is a commercial business arrangement, rather than one of employment.

The Trust makes use of off-payroll engagements in a number of circumstances:

- when there is a short term need that cannot be met from internal staffing resources, including bank staff
- when specialist expertise is required that is not available internally
- when there is difficulty recruiting to a post.

Table 22 – Highly paid off-payroll worker engagements as at 31 March 2021, earning £245 per day or greater

Number of existing engagements as of 31 March 2021*	32
Of which, the number that have existed:	
for less than one year at time of reporting	31
for between one and two years at time of reporting	0
for between two and three years at time of reporting	0
for between three and four years at time of reporting	0
for four or more years at time of reporting	1

*The revised national guidance requiring the inclusion this year of agency staff paid £245 per day or greater accounts for the higher number than recorded in previous annual reports.

Table 23 – All highly paid off-payroll workers engaged at any point during the year ended 31 March 2021 earning £245 per day or greater

Number of off-payroll workers engaged during the year ended 31 March 2021	
Of which:	
Not subject to off-payroll legislation	385
Subject to off-payroll legislation and determined as in-scope of IR35	0
Subject to off-payroll legislation and determined as out-of-scope of IR35	2
Number of engagements reassessed for compliance or assurance purposes during the year	1
Of which: number of engagements that saw a change to IR35 status following the consistency review	0

Table 24 - Off-payroll engagements of Board members, and/or, senior officials with significant financial responsibility, between 1 April 2020 and 31 March 2021

Number of off-payroll engagements of Board members, and/or, senior officials with significant financial responsibility, during the financial year	**0**
Total number of individuals that have been deemed 'Board members and/or senior officials with significant financial responsibility' during the financial year. This figure should include both off-payroll and on-payroll engagements.	22

Exit packages

Table 25 - Exit package costs by band 2020/21

Exit package cost band	**Number of compulsory redundancies**	**Number of other departures agreed**	**Total number of exit packages by cost band**
<£10,000	-	9	9
£10,000 - £25,000	-	3	3
£25,001 - £50,000	-	2	2
£50,001 - £100,000	-	3	3
£100,000 - £150,000	-	-	-
Total number of exit packages by type	**-**	**17**	**17**

Table 26 - Exit package costs by band 2019/20

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10,000	-	22	22
£10,000 - £25,000	-	1	1
£25,001 - £50,000	-	1	1
£50,001 - £100,000	-	1	1
£100,000 - £150,000	-	-	-
Total number of exit packages by type		**25**	**25**

Table 27 - Exit packages: non-compulsory departure payments 2019/20 and 2020/21

	2020/21 Agreements number	2020/21 Total value of agreements (£000)	2019/20 Agreements number	2019/20 Total value of agreements (£000)
Mutually agreed resignations (MARS) contractual costs	1	4	-	-
Non-compulsory payments in lieu of notice	11	103	22	117
Exit payments following Employment Tribunals or court orders	7	221	3	84
Non-contractual payments requiring HMT approval	-	-	-	-
Total	**19**	**328**	**25**	**201**

Facilities time

'Facilities time' is time provided to any employee who is an affiliated member of any trade union recognised by The Countess of Chester Hospital for the purpose of undertaking trade union duties and activities in accordance with the Trade Union and Labour Relations (Consolidation) Act 1992. Facility time covers the duties of a trade union or union learning representative on behalf of their members. It involves duties such as accompanying employees to disciplinary or grievance hearings. It also covers training received and duties carried out under the Health and Safety at Work Act 1974.

In response to the introduction of the Trade Union (Facility Time Publication Requirements) Regulations 2017 which came into effect on 1 April 2017, The Countess of Chester Hospital and Trade Union representatives work together to ensure The Countess of Chester Hospital complies with the requirement to publish information in relation to 'relevant union officials' and 'facility time'.

The table below illustrates the utilisation of facilities time within The Countess of Chester Hospital. It should be noted that The Countess of Chester Hospital seconds 0.8 full-time equivalent representative to act in capacity as Staff Side Chair who co-ordinates and liaises with all 16 individual trade unions recognised by The Countess of Chester Hospital on behalf of the various professions and staff associations.

Table 28 - Relevant union officials

Relevant union officials	Number of employees
Number of employees who were relevant union officials during 2020/21	17
Full-time equivalent employee number	16.71

Table 29 - Percentage of time spent on facility time

Percentage of time spent on facility time	Number of employees
0%	13
1-50%	3
51-99%	1
100%	0

Table 30 - Percentage of the total pay bill spent on paying employees who were relevant union officials for facility time during 2020/21

Percentage of pay bill spent on facility time	£
Total cost of facility time	£62,810.13
Total pay bill	£218,178,757
Percentage of the total pay bill spent on facility time	0.028%

Table 31 - Paid trade union activities

Paid trade union activities	%
Time spent on paid trade union activities as a percentage of total paid facility time hours	1.64%

Ill-health retirement

During 2020/21 there were three early retirements from the Trust agreed on the grounds of ill-health. For the previous year (2019/20) there were two early retirements. The estimated additional pension liabilities of these ill-health retirements will be £58,000 (£87,000 for 2019/20). The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division. This information was supplied by NHS Business Services Authority - Pensions Division.

Health and Safety

Health & Safety has underpinned the Trust's COVID-19 response over the last year. A significant programme of work has been undertaken to ensure the trust achieved and maintained its COVID Safe Employer status; for example, individual staff risk assessments to identify clinically extremely vulnerable staff, workspace assessments to manage office occupancy and the implementation of one way systems for staff and patients. In addition to the COVID-19 activities undertaken, the trust has maintained its core Health & Safety requirements.

Countering fraud and corruption policy

The Countess of Chester Hospital does not tolerate fraud, corruption or bribery within the NHS. We have an overarching Anti-Fraud, Corruption and Bribery Policy and Response Plan in place, produced by our Local Counter Fraud Specialist (LCFS), which was reviewed in 2019/20 and will be reviewed in April 2021/22. The aim is to eliminate all NHS fraud, corruption and bribery as far as possible, freeing up public resources for better patient care.

NHS Counter Fraud Authority (NHSCFA) is a special health authority charged with identifying, investigating, and preventing fraud and other economic crime within the NHS and the wider health group. As a special health authority focused entirely on counter fraud work, the NHSCFA is independent from other NHS bodies and directly accountable to the Department of Health and Social Care.

All instances where fraud, corruption and bribery are suspected are properly investigated by trained staff this being either the Local Counter Fraud Specialists or investigating officers employed by NHS CSA. Any investigations will be handled in accordance with the *NHS Counter Fraud Manual*. The manual provides guidance on NHSCFA investigative procedures, the responsibilities of LCFSs and information on how counter fraud work is monitored across the NHS to ensure that a common approach and best practices are adopted by all when allegations of fraud, bribery and corruption are investigated in the NHS. It also sets out in greater detail the procedural, technical and legislative considerations and requirements which have a bearing on investigations.

Code of Governance

Disclosures

The Board has overall responsibility for the administration of sound corporate governance throughout the organisation. The NHS Foundation Trust Code of Governance (the Code) is published to assist foundation trust boards with ensuring good governance and to bring together best practice from public and private sector corporate governance.

Comply or Explain

The Code is issued as best practice, but also contains a number of main principles, supporting principles and code provisions on a ‘comply or explain’ basis. The Trust has applied the principles of the NHS Foundation Trust Code of Governance, most recently revised in July 2014, based on the principles of the UK Corporate Governance Code issued in 2012. The Trust is compliant with all elements of the ‘comply or explain’ provisions of the Code of Governance.

Disclosure Statements

The Code contains a number of disclosure statements that the Board is required to include in the Annual Report. The disclosure statements contained in the Annual Report are based on the 2014 version of the Code of Governance, and the table

below shows how the Board has complied with those disclosures it is required to include in this Annual Report.

The table also includes a small number of specific additional requirements as set out in the NHS Foundation Trust Annual Reporting Manual, which directly relate to, or enhance the annual reporting requirements as set out in the NHS Foundation Trust Code of Governance.

Table 32 – Disclosures as per the FT Code of Governance

Provision	Requirement	Page(s)
A 1.1	The schedule of matters reserved for the Board of Directors should include a clear statement detailing the roles and responsibilities of the Council of Governors. This statement should 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 each of the Boards and which are delegated to the executive management of the Board of Directors.	**53-63**
A 1.2	The annual report should identify the Chairperson, the Deputy Chairperson (where there is one), the Chief Executive, the Senior Independent Director (see A.4.1) and the Chairperson and members of the Nominations, Audit and Remuneration Committees. It should also set out the number of meetings of the Board and those committees and individual attendance by Directors.	**38-52**
A 5.3	The annual report should identify the members of the Council of Governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead Governor.	**53-63**
	The annual report should include a statement about the number of meetings of the Council of Governors and individual attendance by Governors and Directors.	**59**
B 1.1	The Board of Directors should identify in the annual report each Non-Executive Director it considers to be independent, with reasons where necessary.	**39**
B 1.4	The Board of Directors should include in its annual report a description of each director's skills, expertise and experience. Alongside this, in the annual report, the Board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS Foundation Trust.	**42-45**
	The annual report should include a brief description of the length of appointments of the Non-Executive Directors and how they may be terminated.	**39**

B 2.10	A separate section of the annual report should describe the work of the Nominations Committee(s), including the process it has used in relation to Board appointments.	**60-61 &** **64-65**
	The disclosure in the annual report on the work of the Nominations Committee should include an explanation if neither an external search consultancy nor open advertising has been used in the appointment of a Chair or Non-Executive Director.	**N/A**
B 3.1	A chairperson 's other significant commitments should be disclosed to the Council of Governors before appointment and included in the annual report. Changes to such commitments should be reported to the Council of Governors as they arise and included in the next annual report.	**46**
B 5.6	Governors should canvass the opinion of the Trust's members and the public and for appointed governors the body they represent, on the NHS Foundation Trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the Board of Directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	**63**
	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.	**N/A**
B 6.1	The Board of Directors should state in the annual report how performance evaluation of the Board, its committees, and its directors, including the chairperson, has been conducted.	**38-39**
B 6.2	Where there has been external evaluation of the Board and/or governance of the Trust, the external facilitator should be identified in the annual report and a statement made as to whether they have any other connection to the Trust.	**N/A**
C 1.1	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS Foundation Trust's performance, business model and strategy. There should be a statement by the external auditor about their reporting responsibilities. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report).	**95-96**
C 2.1	The annual report should contain a statement that the board has conducted a review of the effectiveness of its system of internal controls.	**97 (AGS)**

C 2.2	A Trust should disclose in the annual report: (a) if it has an internal audit function, how the function is structured and what role it performs; or (b) if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes	**97 (AGS)**
C 3.5	If the Council of Governors does not accept the Audit Committee's recommendation on the appointment, reappointment or removal of an external auditor, the Board of Directors should include in the annual report a statement from the Audit Committee explaining the recommendation and should set out reasons why the Council of Governors has taken a different position	**N/A**
C 3.9	A separate section of the annual report should describe the work of the audit committee in discharging its responsibilities. The report should include: - the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed; - an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.	**50-51**
D 1.3	Where an NHS Foundation Trust releases an Executive Director, for example to serve as a Non-Executive Director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.	**N/A**
E 1.4	Contact procedures for members who wish to communicate with Governors and/or directors should be made clearly available to members on the NHS Foundation Trust's website.	**63**
E 1.5	The Board of Directors should state in the annual report the steps they have taken to ensure that the members of the board, and in particular the Non-Executive Directors, develop an understanding of the views of Governors and members about the NHS Foundation Trust, for example through attendance at meetings of the Council of Governors, direct face- to-face contact, surveys of members' opinions and consultations.	**54**
E 1.6	The Board of Directors should monitor how representative	**61-63**

	the NHS Foundation Trust's membership is and the level and effectiveness of member engagement and report on this in the annual report.	
	The annual report should include: - a brief description of the eligibility requirements for joining different membership constituencies - information on the number of members and in each constituency - a summary of the membership strategy, an assessment of the membership and a description of any steps taken during the year to ensure a representative membership.	**61-63**
	The annual report should disclose details of company directorships or other material interests in companies held by governors and/or directors where those companies or related parties are likely to do business, or possibly seeking to do business with the NHS Foundation Trust. As each NHS Foundation Trust must have registers of Governors and directors' interests which are available to the public, an alternative disclosure is for the annual report to simply state how members of the public can gain access to the registers instead of listing all the interests in the annual report.	**46**

Disclosures as per schedule 7 of the large and medium sized companies and groups regulations 2008

This section sets out those disclosures required as per Schedule 7 of the Large and Medium Sized Companies and Groups Regulations 2008 and where these have been reported on if they have not been included in the Directors' Report.

Table 33 – Disclosures as per schedule 7

Disclosure Requirement	Statutory Reference	Page
Any important events since the end of the financial year affecting the NHS Foundation Trust	7(1) (a) Schedule 7	**N/A**
An indication of likely future developments	7(1) (b) Schedule 7	**10-14 & 28**
An indication of any significant activities in the field of research and development	7(1) (c) Schedule 7	**N/A**
An indication of the existence of branches outside the UK	7(1) (d) Schedule 7	**N/A**
Policies applied during the financial year for giving full and fair consideration to applications for employment made by disabled persons, having regard to their particular aptitudes and abilities	10(3) (a) Schedule 7	**23-24 & 79**
Policies applied during the financial year for continuing the employment of, and for arranging appropriate training for, employees who have	10(3) (b) Schedule 7	**23-24 & 79**

become disabled persons during the period		
Policies applied during the financial year for the training career development and promotion of disabled employees	10(3) (c) Schedule 7	**23-24 & 79**
Actions taken in the financial year to provide employees systematically with information on matters of concern to them as employees	11(3) (a) Schedule 7	**74-82**
Actions taken in the financial year to consult employees or their representatives on a regular basis so that the views of employees can be taken into account in making decisions which are likely to affect their interests	11(3) (b) Schedule 7	**74-82**
Actions taken in the financial year to encourage the involvement of employees in the NHS foundation trust's performance	11(3) (c) Schedule 7	**74-82**
Actions taken in the financial year to achieve a common awareness on the part of all employees of the financial and economic factors affecting the performance of the NHS foundation trust	11(3) (d) Schedule 7	**74-82**
In relation to the use of financial instruments, an indication of the financial risk management objectives and policies of the NHS foundation trust and the exposure of the entity to price risk, credit risk, liquidity risk and cash- flow risk, unless such information is not material for the assessment of the assets, liabilities, financial position and results of the entity	6 Schedule 7	**107**

Other new and changed disclosures as required by the NHS foundation trust annual reporting manual 2020-21

The Annual Reporting Manual for 2020-21 requires a number of disclosures to be made in the Annual Report and to state where these have been reported on if they are not included in the Directors' Report. The following table sets out where these disclosures have been made.

Table 34 – Disclosures – other new and changed disclosures as required by the annual reporting manual

Disclosure Requirement	Page
New Requirement **Performance report: Equality of service delivery to different groups** There is a new requirement for the performance report to contain a summary of how equality of service delivery to different groups has been promoted through the organisation. Paragraph 2.21 of the ARM 2020-21	**23-24**
Changed Requirement **Staff report: Diversity and inclusion policies, initiatives and longer term ambitions** There is a new requirement for the staff report to contain information on diversity and inclusion policies, initiatives and longer term ambitions. Paragraph 2.83 of the ARM 2020-21	**23-24 & 79**
Changed Requirement **Staff report: Staff turnover** The staff report should provide information on staff turnover. In practice NHS foundation trusts can meet this requirement by providing a link to information published by NHS Digital. Paragraph 2.83 of the ARM 2020-21.	**77**
Annual governance statement: information governance The requirement to disclose incidents relating to information governance in the annual governance statement has been updated to reflect the Data Security Incident Reporting Tool.	**109**

NHS Oversight Framework

NHS Improvement's Oversight Framework provides the framework for overseeing providers and identifying potential support needs.

The framework looks at five themes:

1. Quality of care
2. Finance and use of resources
3. Operational performance
4. Strategic change
5. Leadership and improvement capability (well-led).

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

The Trust is currently in NHS Improvement's Segment 2: Providers Offered Targeted Support – Support needs identified in finance, use of resources and operational performance.

The oversight framework has not been monitored during 2020/21 as a result of the revised finance and operational framework in place. Current segmentation information for NHS trusts and foundation trusts is published on the NHS England & Improvement website.

Statement of the chief executive's responsibilities as the accounting officer of the Countess of Chester Hospital NHS Foundation Trust

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

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require [name] 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 Countess of Chester NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

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

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* (and the *Department of Health and Social Care Group Accounting Manual*) have been followed, and disclose and explain any material departures in the financial statements

- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

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

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

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

Susan Gilby

Susan Gilby
Chief Executive Officer
8 June 2021

Annual Governance Statement 2020/21

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of The Countess of Chester Hospital 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 Countess of Chester Hospital 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 on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the Countess of Chester Hospital 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 The Countess of Chester Hospital NHS Foundation Trust (the Trust) for the year ended 31 March 2021 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The overall responsibility for the management of risk lies with me as Chief Executive and Accounting Officer. I am supported in my role through the assurance committees of the Board of Directors, each under the chairmanship of a Non-Executive Director, with appropriate membership or input from members of the Executive Team. The Board's assurance committees comprise the Audit Committee, Quality & Safety Committee, and the Finance & Performance Committee. The delegation of responsibility for operational management of risk throughout the Trust sits with the Director of Nursing and Quality, albeit the totality of organisational risk remains with the Board.

The Trust's overall risk is managed through the Board's assurance committees reporting directly to the Board. The Trust's system of internal governance is supported by a governance structure that sees risk and associated mitigation being reported directly to the Quality and Safety Committee and the Finance and Performance Committee, from the Trust's operational governance groups. This

provides the mechanism for managing and monitoring all risks throughout the Trust and reporting to the Board of Directors.

The Audit Committee comprising of Non-Executive Directors, oversees the systems of internal control and the overall assurance process associated with managing risk. The Board of Directors receives the Chairs' highlight reports and minutes of the three Board Committees and receives assurances from the Quality and Safety Committee relating to the management of all serious untoward incidents, including Never Events, as well as receiving the monthly integrated performance report which includes performance on all quality and performance matters.

Of course, in year the usual cycles of business of the Trust Board and its Committees were disrupted as a result of the significant impact of both phases of the COVID-19 pandemic. In the first phase from March 2020, and in line with national guidance in order to respond to the very significant operational service pressures, the Board only transacted business critical matters. The role of the Quality & Safety Committee continued in a suitably truncated form, which also dealt with any Finance & Performance Committee matters that were deemed essential. Similar arrangements were put in place during the second phase of the COVID-19 pandemic from January 2021. I am pleased to report that following the easing of the peak of the activity associated with both phases of the pandemic it was possible to resume the normal cycles of business.

As reported in last year's Annual Governance Statement, following an external governance review completed in March 2019, revised governance arrangements had been agreed and implemented resulting in the revised structure of Board Committees described above and supported by refreshed terms of reference for Board Committees. With the majority of the governance review's twenty recommendations having been implemented by November 2019, the next phase of the governance improvement plan involves the delivery of a commissioned suite of governance training programmes aimed at improving the organisation's maturity in good governance supported by a third and final phase to embed practice. Shortly after the training programme commenced in late summer 2020, its delivery was paused due to COVID-19 restrictions and the second phase of the pandemic, and subsequently the programme has been developed as a complete online offering and which is planned to commence in the first quarter of 2021/22.

There are also established governance arrangements provided through the Divisional triumvirate team structure of medical staff, nursing and managers who hold regular monthly meetings with Executive Directors which provide a mechanism where divisional performance is reviewed and key risks to delivery of services identified. Again, the ability to hold the performance meetings was disrupted by the impact of the COVID-19 pandemic, and there are plans to imminently re-instate these meetings. During the pandemic a series of measures including the full range of emergency planning arrangements were put in place to operationally deal with the impact of the surges in activity.

There is a Risk Management Strategy in place which outlines the framework for managing risk across the organisation. Roles and responsibilities in relation to the identification of and management of risk are identified in this and other related

documents including the incident reporting policy. The delivery of risk management is supported by a central risk and safety team led by the Associate Director of Quality Governance, whilst Divisions and corporate teams are supported by a team of risk and safety leads.

The Risk and Control Framework

The Trust seeks to manage and mitigate risk as far as possible. However, it is understood that delivering healthcare carries inherent risks that cannot be completely eradicated but can be reduced through effective identification and mitigation where possible. The process begins with the systematic identification of risks via structured risk assessments. These risks are documented on Risk Registers which are held in the 'Datix' system – the electronic system of collating risks, incidents, complaints, clinical audit and claims.

All risks are assessed and scored using an approved scoring matrix which takes into account the potential likelihood, consequence, and overall severity of each risk. This results in each risk being awarded a score of between 1 (very low) to 25 (high). The effectiveness of the existing control measures is assessed, and associated gaps and action plans agreed and monitored to ensure management of the risk.

Following a risk assessment, the risk is entered onto the Datix Risk Register System and the owner of the risk, the ward or department manager, is identified. The Datix Risk Register System automatically generates a confirmation email to notify the identified risk owner about the risk. Low- scoring risks are managed by the area in which they are identified, whilst higher-scoring risks are managed at progressively higher levels in the organisation.

Throughout 2020/21 the Trust's Freedom to Speak Up Guardian has continued to raise the profile of raising concerns within the Trust and provide staff with advice and support to raise their concerns in relation to patient safety matters.

- The Board Assurance Framework/Strategic Risk Register

The Board Assurance Framework (BAF) monitors the major risks to delivery of the strategic priorities and objectives. In year the Board Assurance Framework was reviewed and updated as part of the external governance review and subsequently, resulting in a revised BAF in Quarters 3 and 4.

The Board Assurance Framework:

  - Defines the principal organisational objectives
  - Defines the principal risks to the achievement
  - Identifies the controls by which these risks can be managed effectively
  - Identifies any gaps in controls to manage these risks effectively
  - Provides the positive assurance that the risks are being managed effectively

In addition to the Board of Directors considering the Board Assurance Framework quarterly, it is reviewed at each meeting of the Quality & Safety Committee and the Finance & Performance Committee for all relevant risks contained within the BAF and for any other risks that might be considered for escalation to the BAF. The BAF is also reviewed bi-annually by the Audit Committee in its role of reviewing the effectiveness of internal controls.

The Head of Internal Audit Opinion has confirmed that the Board Assurance Framework is structured to meet the NHS requirements and that it reflects the risks discussed by the Board. It is also recommended that there could be greater visibility given by the Board to the Board Assurance Framework and the steps described above will help address this requirement.

- The Major Risks Facing the Trust

The refreshed Board Assurance Framework has been helpful in continuing to provide clarity regarding current and evolving strategic risks that may impact upon the Trust's overall performance. The Board Assurance Framework/Strategic Risk Register ensures that key controls and assurances are continually reviewed, and action plans developed and monitored. The Trust's Integrated Performance Report also supports the on-going monitoring of performance, and associated improvement action plans, by the Board of Directors.

The current and emerging risks facing the Trust have their origins in the COVID-19 pandemic, particularly in relation to the impact that it has had on access and waiting times for planned care and the health and wellbeing of staff. The major risks facing the Trust which each have a residual risk score of 16 after mitigation are described in the Board Assurance Framework/Strategic Risk Register as follows:

- Access, waiting times, care pathways performance

  The impact of the sustained COVID-19 pandemic pressures on usual service delivery as a result of two major surges in COVID-19 patient admissions in the reporting period and the necessary infection prevention control requirements has resulted in increasing patient waits for access to services. Waiting lists have, of course, continued to be monitored throughout the pandemic and those patients presenting as a clinical priority have been treated. Nevertheless, there remains a substantial backlog of patients waiting to be seen and/or treated, despite a range of mitigation which has been put in place including independent sector provision and in-sourcing of services. This will remain a significant risk for the Trust for some time and it will continue to be committed to ensuring the recovery and restoration of service delivery and performance in line with NHSE/I requirements, recognising that a system-wide approach will be required.

- Business Continuity – Pandemic Flu/Virus

  Whilst the risk of a pandemic has played a part in the Trust's annual emergency planning and resilience response considerations, the emerging

and on-going risks associated specifically with the COVID-19 pandemic are now reflected in a specific risk within the Board Assurance Framework/Strategic Risk Register. Importantly, it records the steps that were taken at the height of the pandemic and those measures which continue to be in place. The Trust was pleased to be selected as a vaccination centre and the delivery of the programme in terms of its scope and uptake has been highly successful. Nevertheless, at the time of writing the Trust remains vigilant and the management of the impact of the pandemic will continue to be reported as a high and significant risk for the organisation.

- Workforce Capacity

Balancing the operational need for delivery of safe patient care with the resilience and health and wellbeing of the Trust's workforce during the pandemic has been recognised as a significant risk, particularly the resulting impact on staff capacity and availability. In recognition, a number of actions have been put in place including the provision of psychological first aiders to support healthcare staff at risk and a continued emphasis on staff retention and support.

- Safety – Infection Prevention & Control

The need to ensure that the Trust has sufficient systems, processes, and policies in place to effectively manage infection prevention and control was recognised as a significant risk during the pandemic. In particular, the impact of very high bed occupancies and the poor design of the estate and infrastructure affecting compliance with infection prevention and control requirements. Whilst this was managed during the pandemic, it has highlighted the need to ensure that the Trust's estates strategy and capital programmes adequately address ward maintenance and upgrades as a matter of urgency.

In addition, a dedicated Covid/Infection Prevention Control risk register/BAF was maintained and reviewed regularly by the Quality & Safety Committee. A supportive assurance review into infection prevention control measures was also undertaken during the pandemic by NHSE/I, and action plans agreed and their implementation monitored through the Quality & Safety Committee.

- Safety – Nursing & Midwifery Workforce

Nurse and midwifery recruitment and retention remains a significant risk which has been exacerbated during the pandemic. Nevertheless, some significant progress, as a result of effective mitigation, has been made including a successful programme of overseas nurse recruitment and agreement to flex the nurse establishment to account for turnover.

There are two other high risks that should be noted, each with high initial risk scores (i.e. above 15) and with varying residual risk scores, as follows:

- EPR+ Programme (Electronic Patient Record System)

As reported in last year's Annual Governance Statement, the Trust's electronic patient record system, Meditech, was due for renewal and a replacement system had been procured from the Cerner Corporation. The migration to the new system has commenced and is due for implementation in Quarter 2 of 2021/22. In order for the system to be implemented and 'go live' a number of key tasks and implementation gateways need to be successfully passed. Its successful implementation is critical to the Trust and given the size and complexity of such a change project there are a number of identified risks for which detailed mitigating actions are in place. In addition, the implementation of the programme is supported by a governance framework which reviews the on-going project implementation and risks. Based on learning from the implementation of similar electronic patient record systems, there is likely to be an impact on productivity at a time of switchover to the new system which will have an impact on the post COVID-19 recovery and restoration of service delivery and performance, although every effort will be made to minimise its effect through a series of mitigating actions.

- Cyber security (Digital Strategy)

Whilst the management of the risks of cyber security have been identified as a high priority, the pandemic has further emphasised the need to be vigilant and to continue to focus effort in this area. The Trust has, therefore, approved a Digital & Data Strategy (in January 2021) which provides for focus and investment on cyber security matters. In addition, and by way of further mitigation, a target operating model for the IM&T function is being developed, action plans in relation to previous cyber security audits continue to be progressed, and the NHS Data Security and Protection toolkit is completed annually.

- Quality Governance Arrangements

The Trust is committed to providing safe, effective and high quality care. The Director of Nursing and Quality is the Executive Lead for quality within the Trust. Working in close partnership with the Medical Director and supported by the Associate Director of Risk and Safety who manages the Risk and Safety team, the Director of Nursing and Quality has the overall responsibility for the delivery of the quality governance agenda for the Trust.

The effective governance of the quality agenda ensures a focussed and transparent approach to quality improvement within the Trust. All quality elements are reported through the appropriate operational quality and governance groups with the assurance being provided to the Board by the Quality and Safety Committee. The Transformation Group reports regularly into the Quality & Safety Committee and in December 2020 the Board agreed the Continuous Improvement (CI) Strategy and will receive regular updates on its progress. In 2020-21 CI training has been rolled out within the trust to equip 'champions' with 'lean' improvement methodologies.

Risks to delivery of the quality continuous improvement plans form a part of the on-going monitoring process within the governance systems. The Trust's process of on-going and continuous monitoring ensures that where risks in delivery are identified prompt decisions for remedial action can occur.

Our quality of care is incorporated into the national ~~Single~~ Oversight Framework that The Countess of Chester Hospital is assessed against by NHS Improvement. The framework looks at five themes: Quality of care; Finance and use of resources; Operational performance; Strategic change and Leadership and improvement capability (well-led).

In order to support the effective triangulation of quality, workforce, performance and financial indicators, the Trust's monthly Integrated Performance Report (IPR) is reviewed by the Quality and Safety Committee, Finance and Performance Committee and the Board of Directors. Agreed key indicators within the IPR provide the Trust with the triangulation of information to continuously monitor the quality of care and overall performance. In support of this there is also mortality and "learning from deaths" reviews, and a series of "deep dives" into specific key patient safety themes such as falls and pressure ulcer management.

At the Clinical Divisional level, the Divisional Medical Director, Associate Director of Nursing and Divisional Director work as a triumvirate to ensure good governance is an integral part of divisional business and that serious concerns and risks are escalated appropriately.

Ordinarily, the Quality Report which would form part of this annual report and accounts, provides more detailed information on the Trust's quality improvements in year and plans for continued improvement in the subsequent. However, for this year, because of the impact of the COVID-19 pandemic this is not a requirement.

- Care Quality Commission Compliance

The Countess of Chester Hospital is required to register with the Care Quality Commission (CQC) and at the time of this report it is fully compliant with the registration requirements.

A full Well-led CQC inspection was undertaken in December 2018 and the final published report in May 2019 resulted in the Trust receiving an overall rating of '*Requires improvement',* with specific ratings as follows:

  - Safe – Requires improvement
  - Effective – Requires improvement
  - Caring - Good
  - Responsive – Requires improvement
  - Well-led – Requires improvement

An unannounced inspection of three core clinical services (urgent and emergency services, medical and surgical) was undertaken in November 2019, followed by a formal well-led inspection in December 2019 resulting in an overall rating of '*Requires improvement'.* Following this the Director of Nursing and Quality provided regular reports to the Quality & Safety Committee relating to the response to the recommendations and action plan implementation. The Trust has continued to respond to the implementation and sustainability of actions as a result of the unannounced inspection and the announced well-led inspection.

- Compliance with NHS Licence

The Trust ensures compliance with NHS Foundation Trust Licence Condition FT4 Corporate Governance, i.e. that it complies with the required governance arrangements. The Board of Directors is satisfied that the Trust has established and implemented all requirements of the licence condition with no material risks identified. The Board of Directors, Audit Committee and other Board Committees all play a role in ensuring the Trust has robust and effective governance structures.

The Board of Directors, as required under NHS Foundation Trust condition 4(8)(b) assures itself of the validity of its Corporate Governance Statement. The Board of Directors reviews the Corporate Governance Statement every year to ensure that declarations being made can be supported with evidence. It considers the risks and mitigating actions that management provided to support the statements and determine, both from its own work throughout the year – particularly the testing of the controls set out in the Board Assurance Framework – and assurances provided from the work of internal, external auditors and other external audits or reviews, whether the statements are valid.

In year a detailed review of the Trust's Constitution was also undertaken, and the proposed amendments were subsequently approved by the Council of Governors and Board of Directors. Consequently, the Trust's Constitution has been updated in line with the model constitution and a number of proposed amendments have been made, including changes to the residency requirements for Non-Executive Directors, provision for the appointment of Associate Non-Executive Directors, clarification of terms of office for Non-Executive Directors which better aligns with good governance practice, and provision for the appointment of a seventh Non-Executive Director to enable a balanced Board.

- Risk management arrangements

There is a Risk Management Strategy in place which outlines the framework for managing risk across the organisation. Roles and responsibilities in relation to the identification of and management of risk are identified in this and other related documents including the incident reporting policy. The delivery of risk management is supported by a central risk and safety team led by the Associate Director of Quality Governance whilst Divisions and corporate teams are supported by a team of risk and safety leads.

The Clinical Divisions manage operational risks at a local level through Divisional Governance Committees, and each manager is responsible for oversight of their risk

registers, with risks escalated through the Senior Leadership Group. Divisional Governance Committees are chaired by Divisional Medical Directors who each have responsibility for providing leadership to, and oversight of, the achievement of the Division's objectives through the mitigation of risk and review of relevant assurance. The divisional risk and safety leads facilitate discussion and provide reports and updates on mitigations being implemented to address areas of concern.

Regular risk management training is provided and, in addition, twenty-five senior clinical leaders have been trained in the use of root cause analysis as a technique for investigating serious incidents. The Trust has also developed its processes for learning from serious incidents through safety summits designed to enable clinical conversations about significant events from which all staff can learn, although the frequency of these has been curtailed during the COVID-19 pandemic.

A weekly Serious Incident Panel is chaired by the Director of Nursing and Quality, with representatives from the Legal, Patient Experience and Risk Management teams. Themes and trends are shared via reports and reviews at the Quality Governance Group which is chaired by the Director of Nursing and Quality. The panel reviews all significant incidents, complaints, learning from inquests and legal claims. When an event is deemed significant enough to require formal investigation, in line with the Serious Incident Framework, it is reported externally via the Strategic Executive Information System (StEIS). These incidents, the quality of the review and report, and any subsequent action plans, are monitored internally via a monthly report to the Quality Governance Group and via the monthly Clinical Commissioning Group (CCG) serious incident meeting. We continue to revisit our systems and processes to ensure learning, and any necessary changes identified become business as usual.

Patient experiences and stories are shared across the Trust, including the Board of Directors, Council of Governors, Patient Experience Operational Group and new staff induction events. The Countess of Chester Hospital encourages patients and families to become involved in sharing their stories directly and are involved in quality improvement where appropriate.

Lessons learned are fed back to the nursing teams at ward managers' meetings and safety briefs to make sure relevant staff groups can act upon key learning and implement change. Medical staff present their findings at whole hospital rolling half days. These are monthly sessions when elective work is suspended so that clinical groups can attend joint learning sessions.

Medicines related incidents are reviewed at multi-professional monthly medication incident review meetings with findings fed back to clinical teams at safety briefings. There is also a clinical audit programme in place which continues to develop and includes subsequent audit on selected incidents to make sure that changes made as a result of an investigation have been effective. The Board has a view of the scope and effectiveness of the assurances that the clinical audit programme achieves through the clinical audit annual report to the Quality and Safety Committee and the Quality and Safety Committee Chair's report to Board of Directors.

- Our Workforce and Compliance with Developing Workforce Safeguards

The Board of Directors and Board Committees (Quality & Safety and Finance & Performance) receive regular reports detailing the staffing arrangements in place to provide assurance in respect of safety, sustainability and effectiveness. The reports detail areas of risk and mitigation strategies in relation to workforce. Workforce assurance is also provided through the Board Committees in respect of key workforce metrics, e.g. establishment data, sickness absence and turnover. The Trust has produced a new People Strategy 2021/26, which aligns to the NHS People Plan 2021, and which is expected to be launched in May 2021. In accordance with the recommendations of 'Developing Workforce Safeguards' the Trust will use a triangulated approach to maintaining assurance around workforce strategies and safe staffing systems. This approach will include utilising evidence based tools, e.g. establishment reviews, roster information together with professional judgement and patient outcome measures.

- Register of Interests

In accordance with the requirements of 'Managing Conflicts of Interests in the NHS' (June 2017), the Trust maintains a register of interests and during the year has published a register of Board member interests, including gifts and hospitality. The Trust has not published an up-to-date register of interests of all decision-making staff within the past twelve months, as required by the *Managing Conflicts of Interest in the NHS* guidance. However, following the updating and approval of a revised Conflicts of Interests Policy in February 2021, it is proposed to seek declarations of interest of key decision-making in accordance with the revised policy and via the electronic staff record.

- NHS Pension Scheme

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to meet all employer obligations contained within the Scheme regulations.

- Equality, diversity, inclusion and human rights

Control measures are in place to ensure that all the organisation's obligations under equality, diversity, inclusion and human rights legislation are complied with. Monitoring provides data which informs plans and strategies to achieve an inclusive workplace and make improvements to the working environment for all staff. The outcomes are reported to the Board annually, and the Equality and Diversity Action Plan is updated as appropriate.

The Equality Duty requires public bodies to have due regard to the need to eliminate discrimination, advance equality of opportunity, and foster good relations in the course of developing policies and delivering services. Equality analysis is completed on all policies, procedures, strategies and service developments. The Equality Delivery System is designed to specifically support service delivery that is fair, providing equality of access to employment and delivery that meets the needs of a diverse population.

- Sustainability

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

Review of economy, efficiency and effectiveness

- Financial Performance, Sustainability and Context

Resources are managed within a sound financial governance framework defined in the Corporate Governance Manual and Standing Financial Instructions.

Due to the COVID-19 pandemic, an interim financial regime was established across the NHS for the whole of 2020/21. The usual annual planning and contracting process, together with the requirement to deliver efficiency savings was suspended.

For the first six months (April to September 2020) the Trust was supported to breakeven through a process of 'top up' and 'true up', and in order to ensure that the cost of responding to the pandemic was met in full, additional funding of £16m was received for this period plus £1.4m in COVID-19 capital funding. For the remaining six months of the year (October to March 2020), an alternative financial framework was implemented where funding allocations were made available and delegated at a system level, requiring commissioners and providers to operate within a fixed allocation.

Throughout 2020/21, NHS provider contracts with English commissioners operated on a block contract basis, meaning the majority of income was fixed during 2020/21. Welsh contract income mirrored this arrangement for the first six months of the year, with a national risk sharing arrangement being in place for the second part of the financial year, linked to historic activity levels.

Additional funding totalling £20.49m was received for the period October 2020 to March 2021. The funding allocation was constructed of three elements, including core budget deficit funding of £11.9m, COVID-19 pandemic funding of £7.6m, and growth funding of £0.9m to cover the cost of elective care restoration programme (although the elective restoration programme was subsequently paused during Wave 3, and this element was subsequently released to support general revenue budgets). Additional costs associated with the Vaccination Programme, and Testing roll out, were funded outside the allocation on a reimbursement basis, which together with the COVID-19 pandemic expenditure remain subject to a separate audit in line with national guidance.

Overall financial performance is monitored by the Board of Directors, supported by the Finance and Performance Committee and other committees. As reported elsewhere, the frequency of formal committees and Divisional meetings has been reviewed in year and scaled back in response to the 'reducing the burden'

requirement. A finance report summarising the latest financial performance and financial risk was presented to the Board of Directors or Finance & Performance Committee as convened, together with regular updates on capital expenditure. Integrated performance reports, which provide data in respect of quality, constitutional targets and key operational risks were regularly presented and discussed.

The Trust had originally forecast a deficit of £5.2m against its additional allocation. The Trust delivered a £1.1m pre impairment deficit in 2020/21, although it carries forward an underlying deficit of £12 million heading into to 2021/22 as a result of the inability to deliver efficiency savings in year. As reported last year an advisor was engaged to support the further development of a financial turnaround programme (alongside implementing operational improvements), reporting to the Board of Directors via the Finance and Performance Committee. The work programme delivered by the Improvement Director mitigated risks in 2019/20 and identified further opportunities for 2020/21 to make progress in addressing this underlying position. These further opportunities that were identified will form part of the Trust's early consideration in 2021/22 of its financial turnaround programme.

The Trust remains an active member of the Cheshire health and care system and contributes to a number of system/ regional workstreams working to improve the economic, efficient and effectiveness of resources across a wider footprint. Whilst plans to deliver efficiency savings have been stalled due to the COVID-19 pandemic response, the system has worked effectively to deliver care on a 'mutual aid basis' as required and has helped in avoiding the need to cancel urgent treatment where possible.

Internal and external auditors provide assurance in respect of the internal control environment and the use of the organisation's resources. Audit findings and recommendations are monitored and progressed by the committees of the Board and the Audit Committee has an overarching overview for assurance purposes through the internal audit progress reports.

Any report which offers *Limited* assurance results in the development of a management action plan with an agreed timescale for improvement, and progress is monitored by the Audit Committee. Serious issues are escalated to the Board of Directors.

During 202/21, Mersey Internal Audit completed a series of governance checklists across Finance, Human Resources, Procurement and Governance to assess the level of risk and control during the COVID-19 pandemic response period. These were shared and discussed at the Audit Committee for assurance purposes and it was concluded the overall system of control was effective and sufficient. A separate review of counter fraud risks was conducted in year in conjunction with the Local Counter Fraud Specialist with new/emerging risks being incorporated into the local risk register for monitoring and review.

- Head of Internal Audit Opinion

The purpose of the Head of Internal Audit Opinion is to contribute to the assurances available to the Accounting Officer and the Board which underpin the Board's own

assessment of the effectiveness of the organisation's system of internal control. The Opinion has assisted in the preparation of this Annual Governance Statement.

The Head of Internal Audit Opinion for the year 2020/21 is as follows:

"The overall opinion for the period 1st April 2020 to 31st March 2021 provides *Moderate* Assurance, that there is an adequate system of internal control, however, in some areas weaknesses in design and/or inconsistent application of controls puts the achievement of some of the organisation's objectives at risk."

Although there were three core and risk based reviews for which substantial assurance was provided, four reviews received *Moderate* assurance and three reviews only *Limited* assurance.

The Head of Internal Audit Opinion acknowledges the context in which the Trust has operated this year due to the pandemic response and the fact that despite this the regulatory internal audit requirements have not changed. The Trust will, therefore, continue to progress those risk based reviews for which any recommended actions remain outstanding and the scrutiny of the Audit Committee will be supported in this through its regular review of the audit action tracker.

Information governance

The Trust is required to undertake a mandatory annual Data Security and Protection Toolkit (DSPT) self-assessment (previously IG Toolkit). The Data Security and Protection Toolkit draws together legislation and relevant guidance and presents them in a single standard as a set of requirements. The assessment enables the Trust to measure its compliance against National Data Guardian Data Security Standards to provide assurance to the organisation, patients and staff that information is handled correctly and protected from unauthorised access, loss, damage and destruction.

The Data Security and Protection Toolkit assessment provides an overall compliance score with each standard measured requiring multiple evidence standards to be met. The Trust's most recent DSPT submission to NHS Digital in September 2020 returned a *'Standards Not Met – plan in place' result,* identifying five areas of concern: Personal confidential data, Training, Continuity planning, Unsupported systems, and IT protection. An action plan is in place to address these gaps and to ensure full ongoing compliance with the General Data Protection Regulations (GDPR). This issue is high on the Informatics agenda and a key focus for the coming year. An improvement plan is in place which is monitored by the Information Governance Committee. Increasingly, the stipulations for compliance are technology-based with 60% of the assessment items having this emphasis. This means that the technology-related part of this topic will be addressed as part of the Informatics Steering Group and related governance. This is to ensure focus on the delivery of the necessary technical developments to comply with DSPT stipulations.

- Information governance incident reporting

No serious information governance incidents have occurred that required notification to the Information Commissioner's Office/Department of Health and Social Care in the Data Security Incident Reporting Tool in 2020/21.
Regular communication is shared on themes and trends regarding incidents. Learning is fed into the training and a programme of audit is in place to monitor compliance, which takes place across all areas of the Trust.

The Trust has a comprehensive approach to the requirements of the General Data Protection Regulation (GDPR). All existing data sharing agreements are not required to be updated with GDPR details unless there is a significant change, but, as a matter of diligence these are being updated as and when required. All new agreements are validated with full reference to GDPR and the Data Protection Act 2018 before being approved. Data Protection Impact Assessments are regularly created for all new projects and any changes to the way in which information is processed.

Data quality and governance

The key principle of the Trust's Data Quality Policy is to improve and maintain the quality of patient-related data. This is underpinned by a range of regular audit reports and initiatives such as regular validation of clinical and administrative data, in particular inpatient and outpatient waiting lists and the production of regular data quality reports to identify and collect missing data items and errors. To assure the data used in the Quality Account, the Trust has an Information Governance Committee. The group reviews data quality and associated workflows to ensure that NHS data standards are adhered to. This provides assurance to the Board that data is regularly validated and reviewed.

The Trust's Access Policy also provides the operational framework for the management of patients who are waiting for elective treatment. The policy reflects national guidance and is reviewed annually and agreed by NHS Cheshire CCG.

Routine elective waiting time data (both inpatient and outpatient) is produced, which is subject to review and analysis in-line with good standards of corporate governance. A Qlikview operational management tool is in place to better support the management and analysis of patients on an elective pathway.

An independent Referral to Treatment (RTT) Programme Manager has been appointed, who has reviewed the Access Policy, operational management of RTT and a training plan for both clinical and operational colleagues.

Importantly, in year as the Trust commenced the migration from the former electronic patient record, Meditech, to the new system, Cerner, it has been critical to ensure properly validated patient data on the Patient Treatment List (PTL) and this work has been supported by experienced data migration expertise as part of the EPR implementation programme as well as dedicated data validation resource. This work is also important in assisting the review of waiting lists as part of the Trust's recovery and restoration of activity performance post the COVID-19 pandemic. Investment in a Data Quality team has been approved to ensure that the strategic direction for improved data

quality is maintained.

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 work of the internal auditors, clinical audit, and the executive managers and clinical leads within The Countess of Chester Hospital NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee, and other Board committees, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

Work has been commissioned from the Internal Audit service as noted within the statement to review the adequacy of the controls and assurance processes in place and to develop improvements within the governance processes. The Trust is committed to the continuous improvement of its risk management and assurance systems and processes, to drive improved effectiveness and efficiency. My review is also informed by:

- The Head of Internal Audit's opinion and reports by Internal Audit, who work to a risk-based annual plan with topics that cover governance and risk management, service delivery and performance, financial management and control, human resources, operational and other reviews
- Opinion and reports from our external auditors
- Financial accounts and systems of internal control
- In-year submissions against performance to NHS Improvement
- Department of Health performance requirements/indicators
- Full compliance with the Care Quality Commission essential standards for quality and safety for all regulated activities across all locations
- Information governance assurance framework including the Data Security & Protection Toolkit
- Results of national patient and staff surveys
- Investigation reports and action plans following serious incidents
- The work of the Trust's Anti-Fraud Specialist who carries out a detailed workplan and specialist investigations

- Council of Governors reports and clinical audit reports

As reported above, during 2020/21 Internal Audit issued 8 completed reports relating to the 2020/21 Audit Plan with the following levels of assurance with three reports providing *Substantial* Assurance, four reports *Moderate* Assurance, and three reports *Limited* Assurance. There were zero no assurance opinions.

Conclusion

During the year, no significant control issues have been identified. Where *Moderate* or *Limited* assurance has been provided then actions are in place or have been taken to address the areas where these opinions were given. The Board of Directors, however, remains committed to developing a supportive learning culture for quality governance, continuous improvement and enhancement of the system of internal control as and when issues are identified.

Of course, I could not conclude this year's Annual Governance Statement without acknowledging the impact that the COVID-19 pandemic has had on the organisation and its staff. The staff have remained tireless in their commitment in providing safe and compassionate patient care to the many hundreds of patients who have been treated during the pandemic, the majority of whom have been suffering with coronavirus. This has inevitably had an impact on the usual performance and business of the organisation, although as can be seen from the contents of this Annual Governance Statement we have sought to maintain as much 'business as usual' as was possible and reasonable in the circumstances.

The task for the organisation now, as we look ahead, is to recover and restore as far as possible the service delivery and activity performance of the organisation that had been achieved prior to the very significant impact of the pandemic. To this end we will need to remain mindful of the part that our staff will once again have to play in enabling this recovery, and the paramount importance of their continued health and wellbeing.

Susan Gilby

Susan Gilby

Chief Executive Officer

8 June 2021

Annual Accounts

3. Annual Accounts

Countess of Chester Hospital NHS Foundation Trust

Annual Accounts

for the year ended 31 March 2021

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

Countess of Chester Hospital NHS Foundation Trust - Annual Accounts 2020/21

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

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

In our opinion the financial statements:

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

Basis for opinion

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

Going concern

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

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

Our conclusions based on this work:

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

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

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

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

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

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

As required by auditing standards, and taking into account possible pressures to meet financial improvement trajectory targets, we perform procedures to address the risk of management override of controls, in particular the risk that Trust management may be in a position to make inappropriate accounting entries and the risk of bias in accounting estimates and judgements such as asset valuations and impairments. On this audit we do not believe there is a fraud risk related to revenue recognition due to the temporary NHS funding arrangements that have been in place throughout the financial year and we do not believe there to be an incentive to manipulate other operating income streams that are material.

In line with the guidance set out in Practice Note 10 Audit of Financial Statements of Public Sector Bodies in the United Kingdom we recognised a fraud risk related to expenditure recognition, particularly in relation to year-end accruals.

We did not identify any additional fraud risks.

In determining the audit procedures we took into account the results of our evaluation and testing of the operating effectiveness of some of Trust-wide fraud risk management controls.

We also performed procedures including:

- Identifying journal entries and other adjustments to test based on risk criteria and comparing the identified entries to supporting documentation. These included entries made to unrelated accounts linked to the recognition of expenditure and other unusual journal characteristics.
- Assessing significant estimates for bias.
- Assessing the completeness of disclosed related party transactions and verifying they had been accurately recorded within the financial statements.
- Assessing the existence and accuracy of recorded expenditure through specific testing over year-end accruals.

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

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

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

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

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

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

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

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

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

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

Other information in the Annual Report

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

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

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

Annual Governance Statement

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

Remuneration and Staff Reports

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

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 95, the Accounting Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of their services to another public sector entity.

Auditor's responsibilities

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

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

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

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

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

We have nothing to report in this respect.

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

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

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

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

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

Statutory reporting matters

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

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

We have nothing to report in these respects.

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

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

CERTIFICATE OF COMPLETION OF THE AUDIT

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

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

24 June 2021

FOREWORD TO THE ACCOUNTS

Countess of Chester Hospital NHS Foundation Trust

These accounts for the year ended 31 March 2021 have been prepared by the Countess of Chester Hospital NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006.

Susan Gilby

8 June 2021 Susan Gilby - Chief Executive Officer

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 March 2021

	NOTE	2020/21 Total £000	2019/20 Total £000
Operating Income from Patient Care Activities	2	**272,167**	246,140
Other Operating Income	2.4	**40,860**	25,760
Operating Expenses of Continuing Operations	3	**(318,877)**	(269,887)
Operating Surplus/(Deficit)		**(5,850)**	2,013
Net Finance Costs:			
Finance Income	7.1	**16**	120
Finance Expense - Financial Liabilities	7.2	**(464)**	(754)
PDC Dividends payable	1.14	**(1,329)**	(914)
Net Finance Costs		**(1,777)**	(1,548)
(Losses)/Gains of disposal of assets		**(304)**	(177)
SURPLUS/(DEFICIT) FOR THE YEAR		**(7,931)**	288
Other comprehensive income:			
Impairment losses on property, plant and equipment	1.6	**(246)**	-
TOTAL COMPREHENSIVE INCOME AND EXPENSE FOR THE YEAR		**(8,177)**	288

The notes on pages 11 to 46 form part of these financial statements

STATEMENT OF FINANCIAL POSITION AS AT 31 March 2021

	NOTE	31 March 2021 £000	31 March 2020 £000
NON-CURRENT ASSETS:			
Property plant and equipment	8	**105,704**	100,492
Receivables	11	**817**	696
Total Non-Current Assets		**106,521**	101,188
CURRENT ASSETS:			
Inventories	10	**1,972**	1,813
Trade and other receivables	11	**15,786**	15,301
Other investments	15.1	**-**	2,076
Cash and cash equivalents	15.2	**32,711**	12,173
Total Current Assets		**50,469**	31,363
CURRENT LIABILITIES:			
Trade and other payables	12	**(36,037)**	(24,035)
Borrowings	13	**(3,892)**	(28,665)
Provisions	14	**(1,166)**	(840)
Tax payables		**(4,166)**	(3,540)
Other liabilities	12.1	**(5,225)**	(4,147)
Total Current Liabilities		**(50,486)**	(61,227)
Total Assets less Current Liabilities		**106,504**	71,324
NON-CURRENT LIABILITIES:			
Borrowings	13	**(14,537)**	(18,408)
Provisions	14	**(2,119)**	(1,465)
Other liabilities	12.1	**(1,460)**	(1,526)
Total Non-Current Liabilities		**(18,116)**	(21,399)
Total Assets Employed		**88,388**	49,925
FINANCED BY:			
Public dividend capital		**115,141**	68,501
Revaluation reserve		**4,793**	5,039
Income and expenditure reserve		**(31,546)**	(23,615)
TOTAL TAXPAYERS' EQUITY		**88,388**	49,925

The notes on pages 11 to 46 form part of these financial statements

Signed

Susan Gilby

Susan Gilby - Chief Executive Officer
8 June 2021

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY 31 MARCH 2021

	Total	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve
	£000	£000	£000	£000
Taxpayers' Equity at 1 April 2020	49,925	68,501	5,039	(23,615)
Changes in Taxpayers' Equity for 2020/21				
Public Dividend Capital received	46,640	46,640	-	-
Public Dividend Capital repaid	-	-	-	-
(Deficit)/Surplus for the year	(7,931)	-	-	(7,931)
Revaluation gains/(losses) and impairment losses property, plant and equipment	(246)	-	(246)	-
Taxpayers Equity at 31 March 2021	**88,388**	**115,141**	**4,793**	**(31,546)**

	Total	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve
	£000	£000	£000	£000
Taxpayers' Equity at 1 April 2019	47,748	66,612	5,039	(23,903)
Changes in Taxpayers' Equity for 2019/20				
Public Dividend Capital received	1,889	1,889	-	-
Public Dividend Capital repaid		-	-	-
(Deficit)/Surplus for the year	288	-	-	288
Revaluation gains/(losses) and impairment losses property, plant and equipment		-		
Taxpayers Equity at 31 March 2020	**49,925**	**68,501**	**5,039**	**(23,615)**

The notes on pages 11 to 46 form part of these financial statements

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 March 2021

	2020/21	2019/20
	£000	£000
Cash flows from operating activities:		
Operating surplus/(deficit) from continuing operations	**(5,850)**	2,013
Operating surplus/(deficit)	**(5,850)**	2,013
Non-cash income and expense:		
Depreciation and amortisation	**5,533**	5,193
Income recognised in respect of capital donations	**(433)**	(121)
Impairments	**6,837**	-
Reversals of impairments	**-**	-
Amortisation of PPP credit	**(66)**	(66)
(Increase)/Decrease in Trade and Other Receivables	**3,747**	(4,453)
Increase in Inventories	**(159)**	(126)
Increase in Trade and Other Payables	**13,726**	1,231
Increase in Other Liabilities	**1,078**	1,595
Increase/(Decrease) in Provisions	**980**	503
Net cash generated from operations	**25,393**	5,769
Cash flows from investing activities:		
Interest Received	**16**	120
Proceeds from sales of investments	**2,076**	516
Purchase of Property, Plant and Equipment	**(23,558)**	(7,957)
Sales of property, plant and equipment	**-**	-
Receipt of cash donations to purchase capital assets	**61**	121
Net cash used in investing activities	**(21,405)**	(7,199)
Cash flows from financing activities:		
Public dividend capital received	**46,640**	1,889
Movement in loans from the Department of Health and Social Care	**(28,487)**	6,315
Capital element of Public Private Partnership obligations	**(103)**	(41)
Interest paid	**(304)**	(561)
Interest element of Public Private Partnership obligations	**(214)**	(183)
PDC Dividend paid	**(982)**	(1,249)
Net cash generated from financing activities	**16,550**	6,170
Increase/(Decrease) in cash and cash equivalents	**20,538**	4,739
Cash and Cash equivalents at 1 April	**12,173**	7,434
Cash and Cash equivalents at 31 March	**32,711**	12,173

The notes on pages 11 to 46 form part of these financial statements

NOTES TO THE ACCOUNTS

1 ACCOUNTING POLICIES

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2020/21 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to accounts.

1.1 Accounting Convention

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

1.1a Going Concern

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

1.2 Consolidation

These accounts are for The Countess of Chester Hospital NHS Foundation Trust alone.

The NHS Foundation Trust is the Corporate Trusteee to The Countess of Chester Hospital NHS Charitable Fund. The Foundation Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the Foundation Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the Charitable Funds and has the ability to affect those returns and other benefits through its power over the fund. However the transactions are immaterial in the context of the group and the transactions have not been consolidated. Details of the transactions with the charity are included in the related parties note.

1.3 Revenue from contracts with customers

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

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

Revenue from NHS contracts

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

2020/21

The main source of income for the Trust is contracts with commissioners for health care services. In 2020/21, the majority of the trust's income from NHS commissioners was in the form of block contract arrangements. During the first half of the year the trust received block funding from its commissioners. For the second half of the year, block contract arrangements were agreed at a Health Care Partnership level. The related performance obligation is the delivery of healthcare and related services during the period, with the trust's entitlement to consideration not varying based on the levels of activity performed.
The Trust has received additional income outside of the block and system envelopes to reimburse specific costs incurred and other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration

Comparative period (2019/20)

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

In 2019/20, the Provider Sustainability Fund and Financial Recovery Fund enabled providers to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds is accounted for as variable consideration

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 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.

Revenue grants and other contributions to expenditure

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

The value of the benefit received when accessing funds from the 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, the corresponding notional expense is also recognised at the point of recognition for the

Apprenticeship service income

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

Other income

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.

1.4 Expenditure on Employee Benefits

Short-Term Employee Benefits

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

Termination Benefits

Termination benefits are recognised as an expense when the Trust is committed demonstrably, without realistic possibility of withdrawal, to a formal detailed plan to either terminate employment before the normal retirement age, or to provide termination benefits as result of an offer made to encourage voluntary resignations in accordance with IAS 37. Termination benefits for voluntary resignations are recognised as an expense if the Trust has made an offer of voluntary resignation, it is probable that the offer will be accepted, and the number of acceptances can be estimated reliably. If the benefits are payable more than twelve months after the reporting period, then they are discounted to their present value.

Pension costs

Past and present employees are covered by the provisions of the two NHS Pensions Scheme. Both schemes are unfunded, defined benefit schemes that covers NHS employers, general practices and other bodies, allowed under the direction of the 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 schemes are accounted for as though they are defined contribution schemes. 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.

1.5 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.

1.6 Property, Plant and Equipment

1.6.1 Recognition

Property, plant and equipment is capitalised where;

- it is held for use in delivering services or for an 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; and
- the item has a 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.

- form 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.

1.6.2 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. Thereafter they are stated at cost less accumulated depreciation and any recognised impairment loss. All assets are measured subsequently at fair value.

Subsequent to their initial recognition, property, plant and equipment are carried at revalued amounts. Valuations are carried out by Cushman & Wakefield, professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Valuation Standards. These valuations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. In practice this is usually achieved by a full valuation exercise at least every five years, and an interim valuation in the intervening years if required. A full valuation was carried out in 2020/21.

Fair values are determined as follows:
Land and non specialised operational property - market value for existing use

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

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.

An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

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.

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.

Depreciation

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

Property, plant and equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use.

Useful economic 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:

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

Buildings, excluding dwellings	6 to 64 years
Dwellings	60 years
Plant and Equipment	5 to 15 years
Transport Equipment	5 to 5 years
Information Technology	5 to 10 years
Furniture & Fittings	5 to 10 years

Finance-leased assets (including land) are depreciated over the shorter of the useful life or the lease term, unless the trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Disposals

The gain or loss arising on the disposal or retirement of an asset is determined as the difference between the sales proceeds and the carrying amount of the asset and is recognised in the Statement of Comprehensive Income.

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 benefit or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or 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 in the revaluation reserve. 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.

1.6.3 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. 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 economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

1.6.4 Donated, Government Grant and Other Grant Funded Assets

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

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

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

1.6.5 Public Private Partnership (PPP) Transactions

PPP transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM are accounted for as 'on-Statement of Financial Position' by the Trust. In accordance with IAS 17 the underlying assets are recognised as property, plant and equipment at their fair value together with an equivalent finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment.
Where a significant part of the operators income derives from charges to users rather than payments from the Trust a deferred income credit is established and released to the Statement of Comprehensive Income over the life of the agreement.

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

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

1.7 Revenue grants and other contributions to expenditure

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.

1.8 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of investories is measured using the weighted average method.

In 2020/21, the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

1.9 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.

Derecognition

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

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 are classified as subsequently measured at amortised cost, fair value through income and expenditure or fair value through other comprehensive income.

Financial liabilities are classified as subsequently measured at amortised cost, fair value through income and expenditure or fair value through other comprehensive income and expenditure.

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.

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.

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).

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.

1.10 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

1.10.1 The Trust as Lessee

Where substantially all risks and rewards of ownership of a leased asset are borne by the trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

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

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

1.10.2 The Trust as Lessor

Finance leases

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

Operating leases

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

1.11 Provisions

The NHS Foundation 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 the discount rates effective for 31 March 2021.

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 0.95% in real terms.

Clinical Negligence Costs

NHS Resolution operates a risk pooling scheme under which the NHS Foundation Trust pays an annual contribution to NHS Resolution which in return settles all clinical negligence claims. Although the NHS Resolution is administratively responsible for all clinical negligence cases the legal liability remains with the NHS Foundation Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 14.1, but is not recognised in the NHS Foundation Trust's accounts.

1.12 Non-Clinical Risk Pooling

The NHS Foundation Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

1.13 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 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

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

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

1.14 Public Dividend Capital (PDC)

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

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

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

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

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.

1.15 Value Added Tax

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

1.16 Corporation Tax

The Countess of Chester Hospital NHS Foundation Trust is a Health Service body within the meaning of s519AICTA 1988 and accordingly is exempt from taxation in respect of income and capital gains within categories covered by this. There is a power for the Treasury to disapply the exemption in relation to the specified activities of a Foundation Trust (s519A (3) to (8) ICTA 1988). Accordingly, the Trust is potentially within the scope of Corporation Tax but there is no tax liability arising in respect of the current financial year.

1.17 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.

1.18 Foreign Exchange

The functional and presentational currencies of the Trust are sterling.

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

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

- monetary items (other than financial instruments measured at 'fair value through income and expenditure') are translated at the spot exchange rate on 31 March;
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

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

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

1.19 Third Party Assets

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

1.20 Critical Judgements in Applying Accounting Policies

In the application of the Trust accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates. The estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision accefts only that period, or in the period of the revision and future periods if the revision affects both current and future periods. The main area which requires the exercise of judgement is the calulation of provisions in note 14.1.

1.21 Key Sources of Estimation Uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the Statement of financial Position date, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year:
Asset valuation and impairments: the valuation of the Trust's Land and Buildings Excluding Dwellings is subject to significant estimation uncertainty, since it derives from estimates provided by the Trust's external valuers who base their estimates on local market data as well as other calculations to reflect the age and condition of the Trust's estate.

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 the individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the NHS Trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

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.

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

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

IFRS 16 Leases

IFRS 16 Leases will replace *IAS 17 Leases* , *IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2022, the trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The trust's incremental borrowing rate will be a rate defined by HM Treasury. Currently this rate is 0.91% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, the trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

The implementation date for IFRS 16 in the NHS was revised to 1 April 2022 in November 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity in from April 2021 and beyond, a quantification of the expected impact of applying the standard in 2022/23 is currently impracticable. However, the trust does expect this standard to have a material impact on non-current assets, liabilities and depreciation.

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

1.25 Standards issued or amended but not yet adopted in FReM

IFRS 14 Regulatory Deferral Accounts	Not EU endorsed. Applies to first time adopters after 1 January 2016. Therefore not applicable to DHSC Group bodies.
IFRS 16 Leases	Standard, as interpreted and adapted by the FReM, is to be effective from 1 April 2021.
IFRS 17 Insurance Contracts	Application required for accounting periods beginning on or after 1 January 2023, but not yet adopted by the FReM: early adoption is not therefore permitted.

1.26 Accounting standards, amendments and interpretations issued that have been adopted early

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

2 Income

2.1 Segmental Reporting

All of the Countess of Chester Hospital NHS Foundation Trust's activities are in the provision of healthcare, which is an aggregate of all the individual speciality 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 Countess of Chester Hospital NHS Foundation Trust's revenue originates with the UK Government. 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 of one broad combined nature and therefore on this basis one segment of 'Healthcare' is deemed appropriate.

The operating results of the Countess of Chester Hospital NHS Foundation Trust are regularly reviewed by the Trust's chief operating decision maker which is the overall Foundation Trust Board and which includes senior professional non-executive directors. The Trust Board review the financial position of the Countess of Chester Hospital NHS Foundation Trust as a whole in their decision making process, rather than individual components included in the totals, in terms of allocating resources. This process again implies a single operating segment under IFRS 8.

The finance report considered monthly by the Trust Board contains summary figures for the whole Trust together with graphical line and bar charts relating to different total income activity levels, and directorate expense budgets with their cost improvement positions.

Likewise only total balance sheet positions and cashflow forecasts are considered for the whole of the Countess of Chester Hospital NHS Foundation Trust. The Board as chief operating decision maker therefore only considers one segment of healthcare in its decision-making process.

The single segment of 'Healthcare' has therefore been identified consistent with the core principle of IFRS 8 which is to enable users of the financial statements to evaluate the nature and financial effects of business activities and economic environments

2.2 Total Income from activities

	NOTE	**2020/21 £000**	2019/20 £000
Income from activities	2.3	**272,167**	246,140
Other operating income	2.4	**40,860**	25,760
Operating Income from Continuing Operations		**313,027**	271,900

Operating Income from Patient Care Activities	**2020/21 £000**	2019/20 £000 Restated
Block contract / system envelope income	**249,827**	205,673
Other type of activity income	**13,494**	20,179
High cost drugs income from commissioners	**796**	12,969
Additional pension contribution central funding**	**7,929**	7,146
Income from activities - Commissioner Requested Services	**272,046**	245,967
Private patient income	**121**	173
Income from activities	**272,167**	246,140

*As part of the coronavirus pandemic response, transaction flows were simplified in the NHS and providers and their commissioners moved onto block contract payments at the start of 2020/21. In the second half of the year, a revised financial framework built on these arrangements but with a greater focus on system partnership and providers derived most of their income from these system envelopes. Comparatives in this note are presented to be comparable with the current year activity. This does not reflect the contracting and payment mechanisms in place during the prior year.

**The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and

The Terms of Authorisation set out the goods and services that the Trust is required to provide (Commissioner Requested Services). All of the income from activities before private patient income shown above is derived from the provision of Commissioner Requested Services.

All other income arises from non-mandatory services.

2.3 Income from Patient Care Activities (by source)	**2020/21**	2019/20
	£000	£000
Income from patient care activities received from:		
NHS England	**24,755**	19,959
Clinical commissioning groups	**212,824**	190,987
NHS Foundation Trusts	**8,061**	8,698
NHS Trusts	**45**	155
Local authorities	**796**	434
Department of Health and Social Care	**67**	-
NHS other (including Public Health England)	**24,977**	24,807
Non NHS: private patients	**121**	173
Non NHS: overseas patients (non-reciprocal, chargeable to patient)	**19**	70
Injury cost recovery scheme	**122**	814
Non NHS: other	**380**	43
	272,167	246,140

2.4 Other Operating Income	**2020/21**	2019/20
	£000	£000
Research and development	**693**	684
Education and training	**8,549**	8,253
Charitable contributions to expenditure	**457**	242
Non-patient care services to other bodies	**1,788**	2,032
Reimbursement and top up funding	**20,784**	-
Provider sustainability fund / Financial recovery fund / Marginal rate emergency tariff funding (PSF/FRF/MRET)	**-**	8,317
Car parking	**153**	1,642
Catering	**642**	1,249
Other income	**3,137**	3,275
Contibutions to expenditure - receipt of donated equipment	**478**	-
Contributions to expenditure - consumables donated from DHSC group bodies for COVID response	**4,113**	-
Amortisation of PPP deferred credits	**66**	66
	40,860	25,760

2.5 Directly Invoiced Overseas Visitors	**2020/21**	2019/20
	£000	£000
Income recognised this year	**19**	70
Cash payments received in-year (relating to invoices raised in current and previous years)	**19**	19
Amounts added to provision for impairment of receivables	**(4)**	(37)
Amounts written off in-year	**22**	63

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

	2020/21 £000	2019/20 £000
Revenue recognised in the reporting period that was included in contract liabilities at the previous period end	**4,081**	2,486
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	-	-

3 Operating expenses	**2020/21**	2019/20
	£000	£000
Operating expenses comprise:		
Purchase of healthcare from non-NHS and non-DH bodies	**687**	247
Staff and executive directors costs	**217,992**	186,741
Remuneration of non-executive directors	**131**	122
Drug Costs	**20,279**	20,355
Supplies and services (excluding drug costs)		
- clinical	**31,463**	26,934
- general	**4,407**	3,341
Establishment	**2,120**	2,333
Transport	**238**	177
Premises	**15,704**	12,205
Supplies and services notional cost of equipment donated for COVID	**106**	-
Depreciation & Amortisation	**5,533**	5,193
(Decrease)/Increase in bad debt provision	**149**	31
Provisions arising / released in year	**-**	(99)
Audit fees - statutory audit	**84**	61
Other services: audit related assurance services	**-**	1
Other services: other	**-**	-
Contribution to clinical negligence scheme	**7,707**	7,684
Consultancy	**674**	810
Internal audit costs	**88**	93
Training courses	**438**	571
Notional training funded from apprenticeship fund	**340**	258
Insurance	**67**	38
Impairment of property, plant and equipment	**6,837**	-
Other	**3,833**	2,791
	318,877	269,887

4 Arrangements containing an operating leases		
Minimum lease payments	**4,464**	2,891
	4,464	2,891

4.1 Total future minimum operating lease payments		
- Payable:		
- not later than one year;	**4,099**	1,630
- later than one year and not later than five years;	**4,163**	5,473
- later than five years.		-
Total	**8,262**	7,103

The Trust has short term operating leases for various types of equipment usually on a short term basis and the payments for these are included in the minimum lease payments for the financial year.

The Trust is also committed under contract for five managed service contracts which provide equipment as part of the contract. These contracts have between 1 and 5 years left before expiry, with an opportunity to extend to 10 years. Also included are a number of lease cars and vans. These leases are for a period of three years.

5 Employee Expenses and Numbers

5.1 Employee expenses

	2020/21 £000	2019/20 £000
Short term employee benefits - salaries and wages	**170,690**	146,605
Social security costs	**15,021**	13,021
Apprenticeship levy	**747**	688
Employer's contributions to NHS pensions	**18,188**	16,511
Pension cost - employer contributions paid by NHSE on provider's behalf (6.3%)	**7,929**	7,146
Other Employment Benefits	**-**	-
Temporary staff (including agency)	**5,745**	2,971
Total staff costs	**218,320**	186,942
Of which		
Costs capitalised as part of assets	-	306

5.2 Retirements due to ill-health

During 2020/21 (prior year 2019/20) there was 3 (2) early retirement from the Trust agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £58,000 (£87,000). The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division. This information was supplied by NHS Business Services Authority - Pensions Division.

5.3 Executive Directors Remuneration

	2020/21 £000	2019/20 £000
Executive Directors Remuneration	**1,069**	870
Employers contributions for national insurance	**139**	108
Employer contributions to the pension scheme	**61**	62

There are a total of 7 Executive Directors in total at the end of the financial year, 3 to whom benefits are accruing under defined benefit pension schemes. For further information please see the remuneration report on page 64 of the annual report.

5.4 Losses and Special Payments

NHS Foundation Trusts are required to record cash payments and other adjustments that arise as a result of losses and special payments. In the year the Trust had 132 (2019/20 233) separate losses and special payments, totalling £391,000 (2019/20 £341,000). These losses were mainly due to bad debts and damage/loss of property, and are reported on an accruals basis.

6 Pension Costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2021, is based on valuation data as 31 March 2020, updated to 31 March 2021 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The employer contribution rate for 2019/20 is 20.6% of pensionable pay. The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap that was set out following the 2012 valuation. In January 2019. the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling to the McCloud case.

The Government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The Government has set out that the costs of remedy of the discrimination will be included in this process. HMT valuation directions will set out the technical detail of how the costs of remedy will be included in the valuation process. The Government has also confirmed that the Government Actuary is reviewing the cost control mechanism (as was originally announced in 2018). The review will assess whether the cost control mechanism is working in line with original government objectives and reported to Government in April 2021. The findings of this review will not impact the 2016 valuations, with the aim for any changes to the cost cap mechanism to be made in time for the completion of the 2020 actuarial valuations.

6.1 Auto-Enrolement

The Pensions Act 2008 introduced automatic enrolment of eligible workers into a qualifying workplace pension scheme. The NHSPS is such a scheme and the legislation took effect from 2013. This took effect for the Countess of Chester NHS Foundation Trust from July 2013.

The Trust has a duty to automatically enrol eligible works, between the ages of 22 and State Pension age subject to certain pay criteria. For the Countess of Chester Hospital NHS Foundation Trust the number of enrolments and conributions are immaterial.

7 Net Finance Costs

7.1 Finance Income

	2020/21	2019/20
	£000	£000
Interest on loans and receivables	**16**	120

7.2 Finance Costs

	2020/21	2019/20
	£000	£000
Interest on Loans from the Department of Health and Social Care	**250**	571
Interest on obligations under PPP contracts:		
- finance cost	**105**	108
- contingent finance cost	**109**	75
Total	**464**	754

8 Property Plant and Equipment

8.1 Fixed Asset Movement 2020/21

	Land	Buildings Excluding Dwellings	Dwellings	Payments on Account and Assets Under Construction	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings	Total 31 March 2019
	£000	£000		£000	£000	£000	£000	£000	£000
Cost or valuation									
At 1 April 2020	3,086	68,633	2,591	10,966	35,404	20	9,935	4,812	**135,447**
Additions - purchased	-	2,167	-	8,699	5,668	16	1,030	119	**17,699**
Additions - donated and grant funded	-	-	-	-	433	-	-	-	**433**
Reclassifications	-	8,757	-	(10,017)	382	9	428	441	**-**
Impairments / Reversals	1,741	(13,123)	-	-	-	-	-	-	**(11,382)**
Other in year revaluation	-	-	-	-	-	-	-	-	**-**
Disposals	-	-	-	-	(2,017)	-	-	-	**(2,017)**
At 31 March 2021	**4,827**	**66,434**	**2,591**	**9,648**	**39,870**	**45**	**11,393**	**5,372**	**140,180**
Accumulated depreciation									
At 1 April 2020	-	2,000	744	-	20,904	20	7,324	3,963	**34,955**
Impairments / Reversals	-	(4,299)	-	-	-	-	-	-	**(4,299)**
Other in year revaluation	-	-	-	-	-	-	-	-	**-**
Disposals	-	-	-	-	(1,713)	-	-	-	**(1,713)**
Provided during the year	-	2,299	62	-	2,031	5	915	221	**5,533**
At 31 March 2021	**-**	**0**	**806**	**-**	**21,222**	**25**	**8,239**	**4,184**	**34,476**
Net book value									
- Purchased at 1 April 2020	1,976	65,223	-	10,966	13,869	-	2,612	848	**95,495**
- PPP Obligations at 1 April 2020	1,110	-	1,847	-	-	-	-	-	**2,957**
- Donated at 1 April 2020	-	1,410	-	-	630	-	-	-	**2,040**
Total at 1 April 2020	**3,086**	**66,633**	**1,847**	**10,966**	**14,500**	**-**	**2,612**	**848**	**100,492**
Net book value									
- Purchased at 31 March 2021	3,717	65,078	-	9,648	17,695	20	3,155	1,187	**100,500**
- PPP Obligations at 31 March 2021	1,110	-	1,785	-	-	-	-	-	**2,895**
- Donated at 31 March 2021	-	1,356	-	-	953	-	-	-	**2,309**
Total at 31 March 2021	**4,827**	**66,434**	**1,785**	**9,648**	**18,648**	**20**	**3,155**	**1,187**	**105,704**

8.2 Net Book Value of Assets held under PPP Obligations

PPP Arrangements	2020/21 £000	2019/20 £000
Cost or valuation at 1 April	**4,033**	4,033
Cost or valuation at 31 March	**4,033**	4,033

	2020/21 £000	2019/20 £000
Depreciation at 1 April as previously stated	**1,076**	1,014
Accumulated depreciation at 1 April as restated	**1,076**	1,014
Provided during the year	**62**	62
Accumulated depreciation at 31 March	**1,138**	1,076
Net Book Value under PPP obligations at 31 March	**2,895**	2,957

In 2005/06, the Trust entered into a Public Private Partnership with Frontis Homes Limited, a registered social landlord, to provide our staff accommodation and on-call facilities. The £5.9m scheme has significantly improved the quality of the previous accommodation, and increased the ability of the Trust to continue to attract the best staff. The Trust will contribute annually toward the cost of the rent and services to be provided for the on-call facility. The term of the agreement is 40 years.

9.1 Gross PPP Obligations

	31 March 2021 £000	31 March 2020 £000
Gross PPP Liabilities	**2,917**	3,125
of which liabilities are due:		
Not later than one year	**208**	208
Between one and five years	**695**	695
After five years	**2,014**	2,222
Finance charges allocated to future periods	**(983)**	(1,088)
Net PPP Liabilities	**1,934**	2,037
Not later than one year	**108**	103
Between one and five years	**340**	323
After five years	**1,486**	1,611
	1,934	2,037

	31 March 2021 £000	31 March 2020 £000
9.2 Total Future Payments in respect of PPP Arrangements.		
of which due:		
- not later than one year;	**452**	441
- later than one year and not later than five years;	**1,925**	1,878
- later than five years.	**8,088**	8,587
Total future payments committed	**10,465**	10,906

9.3 Analysis of Amounts Payable to Service Concession Operator

Unitary payment payable to service concession operator	31 March 2021 £000	31 March 2020 £000
Consisting of:		
Interest Charge	**105**	108
Repayment of finance lease liability	**103**	41
Service element	**124**	206
Contingent rent	**109**	75
	441	430

		31 March 2021	31 March 2020
		£000	£000
10	**Inventories**		
	Drugs	**1488**	1306
	Consumables	**484**	507
		1,972	1,813

		31 March 2021	31 March 2020
		£000	£000
10.1	**Inventories recognised in expenses**	**24,969**	21,639
	Write-down of inventories recognised as an expense	**124**	91
	Total Inventories recognised in expenses	**25,093**	21,730

11 Trade and Other Receivables

	31 March 2021 £000	31 March 2020 £000
Current		
Contract receivables	**8,215**	9,946
Allowance for impaired contract receivables/assets	**(479)**	(424)
Amounts due in respect of NHS Improvement Sustainability and Transformation Fund (STF)	**-**	2,563
PDC Dividend Receivable	**157**	504
VAT recoverable	**603**	293
Other receivables	**451**	443
Accrued Income	**-**	-
Prepayments	**6,839**	1,976
Total Current Trade and Other Receivables	**15,786**	15,301
Non-Current		
Clinician pension tax provision reimbursement funding from NHSE	**817**	696
Total Non-Current Receivables	**817**	696
Of which receivables from NHS and DHSC group bodies:		
Current	**6,837**	11,112
Non-current	**817**	696

The majority of trade is with other NHS organisations, which are funded by government, therefore no credit scoring of them is considered necessary.

11.1 Allowance for Credit losses 2020/21

	31 March 2021 £000	31 March 2020 £000
Contract receivables and contract assets		
Allowances as at 1 Apr - brought forward	**424**	509
New allowances arising	**249**	250
Changes in existing allowances	**-**	-
Reversals of allowances	**(100)**	(219)
Utilisation of allowances (write offs)	**(94)**	(116)
At 31 March 2021	**479**	424

12 Trade and Other Payables	Current		Non-current	
	31 March 2021	31 March 2020	**31 March 2021**	31 March 2020
	£000	£000	**£000**	£000
Trade payables	**20,633**	17,442	-	-
NHS Pension Scheme	**2,569**	2,313	-	-
Other payables	**3,512**	2,028	-	-
Accruals	**9,323**	2,252	-	-
Total	**36,037**	24,035	-	-
Of which payable to NHS and DHSC group bodies:				
Current	**4,348**	3,847	-	-

12.1 Other Liabilities	Current		Non-current	
	31 March 2021	31 March 2020	**31 March 2021**	31 March 2020
	£000	£000	**£000**	£000
Deferred Income	**5,159**	4,081	**-**	-
Deferred PPP Credits	**66**	66	**1,460**	1,526
Total	**5,225**	4,147	**1,460**	1,526

13 Borrowings

	Current		Non-current	
	31 March 2021	31 March 2020	**31 March 2021**	31 March 2020
	£000	£000	**£000**	£000
Loans from the Department of Health and Social Care	**3,784**	28,562	**12,711**	16,474
Obligations under PPP Contracts	**108**	103	**1,826**	1,934
Total	**3,892**	28,665	**14,537**	18,408

Schedule of Borrowing	**Date Started**	**Date to be completed**	**Interest Rate**	**Loan Amount £000**	**Amount outstanding (excluding interest accrued) £000**
Loan 8 - Interim revenue loan	Jan-18	Jan-21	1.50%	1,724	-
Loan 9 - Interim revenue loan	Feb-18	Feb-21	1.50%	1,305	-
Loan 10 - Interim revenue loan	Mar-18	Mar-21	1.50%	3,720	-
Loan 11- Interim revenue loan	Dec-18	Dec-21	1.50%	1,638	-
Loan 12 - Interim revenue loan	Jan-19	Jan-22	1.50%	1,578	-
Loan 13 - Interim revenue loan	Mar-19	Mar-22	1.50%	3,506	-
Loan 14 - Interim revenue loan	Apr-19	Apr-22	1.50%	1,580	-
Loan 15 - Interim revenue loan	May-19	May-22	1.50%	1,866	-
Loan 7 - Interim capital loan	Oct-19	Sep-34	0.40%	7,551	-
					-
Loan 1 - Normal course of business capital loan	Mar-10	Mar-20	3.09%	6,000	-
Loan 2 - Normal course of business capital loan	Mar-12	Sep-21	2.46%	5,000	266
Loan 3 - Normal course of business capital loan	Mar-13	Mar-18	0.48%	4,500	-
Loan 4 - Normal course of business capital loan	Mar-13	Sep-27	1.39%	16,800	8,098
Loan 5 - Normal course of business capital loan	Oct-14	Nov-21	1.36%	11,000	1,695
Loan 6 - Normal course of business capital loan	Sep-17	Aug-32	1.03%	8,090	6,417
					16,476

On 2 April 2020, the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 were extinguished and replaced with the issue of Public Dividend Capital (PDC) to allow for their repayment. Outstanding interim loans totalling £24,468,000 loan principal and £44,000 interest accrual as at 31 March 2020 in these financial statements were repaid with an effective date of 1 April 2020.

Events After The Reporting Period

13.1 Reconciliation of liabilities arising from financing activities

	Loans from DHSC £000	PPP schemes £000	Total £000
Carrying value at 1 April 2020	45,036	2,037	**47,073**
Cash movements:			
Financing cash flows - payments and receipts of principal	(28,487)	(103)	**(28,590)**
Financing cash flows - payments of interest	(304)	(105)	**(409)**
Application of effective interest rate	250	105	**355**
Carrying value at 31 March 2021	**16,495**	**1,934**	**18,429**

14 Provisions	Current 31 March 2021 £000	Non Current 31 March 2021 £000	Current 31 March 2020 £000	Non Current 31 March 2020 £000
Pensions - Early Departure Costs	**15**	**141**	15	151
Pensions - Injury Benefit	**28**	**627**	28	618
Legal Claims	**588**	**(0)**	647	-
Other	**535**	**535**	150	-
Clinician pension tax reimbursement	**-**	**817**	-	696
	1,166	**2,119**	840	1,465

	Pensions - Early Departure Costs	Pensions - Injury Benefit	Legal Claims	Other	Clinician Pension Tax Reimbursement	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2020	167	646	647	150	696	**2,306**
Arising during the year	5	-	495	1,070	-	**1,570**
Utilised during the year	(16)	(37)	(305)	(150)	-	**(508)**
Change in Discount Rate	-	45	-	-	121	**166**
Reversed unused	-	-	(249)	-	-	**(249)**
At 31 March 2021	**156**	**654**	**588**	**1,070**	**817**	**3,285**
Expected timing of cashflows:						
- not later than one year	15	28	588	535	-	**1,166**
- later than one year and not later than five years	63	116	-	535	-	**714**
- later than five years	78	510	-	-	817	**1,405**
	156	**654**	**588**	**1,070**	**817**	**3,285**

14.1 Provisions

Pensions - Early Departure Costs

Provisions for capitalised pension benefits are based on tables provided by the Office for National Statistics, reflecting years to normal retirement age and the additional pension costs associated with early retirement. No further capitalisations of pension benefits have been applied during the financial year. This provision relates to two former employees.

Pensions - Injury Benefit

Permanent Injury Benefits are payable to eligible individuals, and are calculated in the same way as capitalised pension benefits. The calculations are based on current payments in relation to expected life tables as issued by the Office for National Statistics. These are discounted using the Treasury published discount rate.

Legal claims

Legal claims consist of amounts due as a result of third party and employee liability claims. The values are based on information provided by the Trust's solicitors and the NHS Litigation Authority.

Clinician Pension Tax Reimbursement

During the year the UK Government committed to pay the pension tax costs of clinicians working additional sessions. The agreed mechanism was that the tax charge arising would be rolled over into the NHS pension scheme under the 'Scheme Pays' rules and on retirement of the individual concerned, when the impact of the tax charge crystallises, the pension scheme will charge the Trust for the cost of enhancing the pension back to its pre-rolled over tax value. The Trust will then recharge NHS England (or whichever successor body exists at the time) with the cost. The amount that is due at 31 March 2020 is very difficult to estimate, but NHS England have provided Trusts with a methodology for calculating the maximum likely provision and this has been included in the accounts along with a corresponding debtor to NHS England. This was amended due to the change in discount rate as notified by NHS England. The net impact on the Trust surplus is therefore nil.

Other

The other provision relates to outstanding pay reform assimilations and changes in legislation.

£159,437,000 is included in the provisions of the NHS Litigation Authority at 31/3/21 in respect of clinical negligence liabilities for the Trust (31/3/2020 £158,129,000)

The provisions for legal claims are calculated by reference to expected cash flows discounted back at the relevant current Treasury discount rate.

15.1 Other Investments

	31 March 2021	31 March 2020
	£000	£000
Balances at 1 April	**2,076**	2,591
Net change in year	**(2,076)**	(515)
Other Investments	**-**	2,076

Other investments at 31 March 2020 represented amounts held in a designated deposit account set up as part of a funding agreement to deliver a new Neonatal Unit. The funds have been released as the construction has been successfuly delivered.

15.2 Cash and cash equivalents

	31 March 2021	31 March 2020
	£000	£000
Bank balances at 1 April	**12,173**	7,434
Net change in year	**20,538**	4,739
Cash and cash equivalents in the statement of cash flows at 31 March	**32,711**	12,173
Broken down into:		
Cash at commercial banks and in hand	**522**	524
Cash with the Government Banking Service	**32,189**	11,649
Total cash and cash equivalents as in SoFP	**32,711**	**12,173**

Cash and cash equivalents at 31 March 2021 are held in instant access bank accounts, short-term money market investments and other deposit accounts denominated in sterling. They attract interest at rates based on LIBOR or equivalent market or public sector rates. The carrying amounts are equivalent to their fair values.

16.1 Capital Commitments

	31 March 2021	31 March 2020
Contractual Capital Commitments at 31 March not otherwise included in these financial statements:	**£000**	£000
Property, Plant and Equipment	-	118

16.2 Events After the Reporting Date

There are no disclosable events after the reporting date

17 Third Party Assets

The Trust held £3k In the Bank (2019/20 £0) which relates to monies held by the NHS Foundation Trust on behalf of patients.

18 Related Party Transactions

The Countess of Chester Hospital NHS Foundation Trust is a public interest body Authorised by NHS Improvement the Independent Regulator for NHS Foundation Trusts.

In 2020/21 the Trust has received £457,000 (2019/20 £242,000 total) payments from a number of charitable funds for which the Trust acts as Corporate Trustee.

In response to the COVID crisis the Trust also received £478,000 in medical equipment donated assets from NHSI/NHSE

Other NHS entities that interact with the Countess of Chester Hospital NHS Foundation Trust are regarded as related parties. The transactions are in the normal course of business and are on a arms length basis. During the year the Countess of Chester Hospital NHS Foundation Trust had a number of material transactions with other NHS entities which are listed below.

The amounts outstanding are unsecured and will be settled in cash. No guarantees have been given or received.

	2020/21 Income £000	2020/21 Expenditure £000	2020/21 Current Receivables £000	2020/21 Current Payables £000
Value of transactions with:				
Department of Health	90	-	-	-
Other NHS Bodies	270,725	16,570	6,680	4,500
Other WGA Bodies	25,858	42,937	603	6,855

18 Related Party Transactions (continued)

Material Related Party transactions with Other NHS Bodies are further detailed below:

	2020/21 Income £000	2020/21 Expenditure £000	2020/21 Current receivables £000	2020/21 Current payables £000
Alder Hey Childrens NHS Foundation Trust	299	347	155	51
Cheshire and Wirral Partnership NHS Foundation Trust	1,498	699	372	316
Liverpool Heart and Chest Hospital NHS Foundation Trust	65	118	5	57
Liverpool University Hospitals NHS Foundation Trust	763	837	401	788
Mid Cheshire NHS Foundation Trust	270	7	32	3
The Clatterbridge Cancer Centre NHS Foundation Trust	423	(2)	43	3
The Walton Centre NHS Foundation Trust	127	17	23	2
Warrington and Halton Hospitals NHS Foundation Trust	249	784	11	146
Wirral Community Health and Care NHS Foundation Trust	185	-	24	-
Wirral University Teaching Hospital NHS Foundation Trust	6,253	4,121	1,332	1,258
East Cheshire NHS Trust	167	1	44	2
St Helens and Knowsley Hospital Services NHS Trust	69	97	12	157
NHS Cheshire CCG	181,455	70	211	181
NHS Halton CCG	1,538	-	4	-
NHS Liverpool CCG	20,741	-	40	9
NHS Shropshire CCG	629	-	-	-
NHS St Helens CCG	170	-	-	-
NHS Warrington CCG	1,873	-	-	-
NHS Wirral CCG	6,535	-	-	-
NHS England (core)	26,217	9	3,369	-
NHS England - Central Specialised Commissioning Hub	580	-	-	-
North West Regional Office	11,242	-	40	-
Public Health England	-	269	23	-
Health Education England	8,722	-	-	49
NHS Resolution	-	7,707	-	-
Care Quality Commission	1	167	-	-
NHS Property Services	170	886	364	1,216
HM Revenue & Customs - VAT	-	-	603	-
HM Revenue & Customs - Other	-	15,768	-	4,166
National Heath Service Pension Scheme	-	26,117	-	2,570
Welsh Health Bodies - Betsi Cadwaladr University Local Health Board	24,903	-	-	-
NHS Blood and Transplant	17	881	-	16
Cheshire East Unitary Authority	401	-	-	-
Cheshire West and Chester Unitary Authority	440	135	-	99

19 Financial Instruments

Disclosure is required under International Accounting Standards of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. The Countess of Chester Hospital NHS Foundation Trust actively seeks to minimise its financial risks. In line with this policy, the Trust neither buys nor sells financial instruments. Financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

Market Risk

Interest-Rate Risk

All of the Trust's financial liabilities carry nil or fixed rates of interest. In addition, the only element of the Trust's assets that are subject to a variable rate are short term cash investments. The Trust is not, therefore, exposed to significant interest-rate risk. Interest rate profiles of the Trust's relevant financial assets and liabilities are shown in notes 12 and 15.

Foreign Currency Risk

The Trust has negligible foreign currency income or expenditure.

Credit Risk

The Trust operates primarily within the NHS market and receives the majority of its income from other NHS organisations, as disclosed in note 18. There is therefore little risk that one party will fail to discharge its obligation with the other. Disputes can arise, however, around how the amounts owed are calculated, particularly due to the complex nature of the Payment by Results regime. For this reason the Trust makes a provision for irrecoverable amounts based on historic patterns and the best information available at the time the accounts are prepared. The Trust does not hold any collateral as security.

Liquidity Risk

The Trust's net operating costs are incurred under three year agency purchase contracts with local Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. The Trust receives such contract income in accordance with Payment by Results (PBR), which is intended to match the income received in year to the activity delivered in that year by reference to the National Tariff procedure cost. The Trust received cash each month based on an annually agreed level of contract activity and there are quarterly payments made to adjust for the actual income due under PBR. This means that in periods of significant variance against contracts there can be a significant cash-flow impact. The Trust has adequate liquidity to deal with these variances.

The Trust finances it's capital expenditure from internally generated funds or funds made available from Government, in the form of additional Public Dividend Capital, under an agreed limit. In addition, the Trust has borrowed from the Department of Health Financing Facility and may also borrow commercially in order to finance capital schemes. Financing is drawn down to match the capital spend profile of the scheme concerned and the Trust is not, therefore exposed to significant liquidity risks in this area.

20 Auditors Liability Limitation Agreements

As determined in the engagement letter with KPMG, external auditors to the trust, the liability of either party under or in connnection with the contract, whether arising in contract, tort, negligence, breach of statutory duty or otherwise, shall not exceed the sum of £2 million in any one year.

	2020/21	**2019/20**
	£000	£000
Limititation on Auditors Liability	**2,000**	2,000

21 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2021	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total book value £000
Trade and other receivables excluding non financial assets	8,030	-	-	**8,030**
Other investments / financial assets	-	-	-	**-**
Cash and cash equivalents at bank and in hand	32,711	-	-	**32,711**
Total at 31 March 2021	40,741	-	-	**40,741**

Carrying values of financial assets as at 31 March 2020	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total book value £000
Trade and other receivables excluding non financial assets	12,024	-	-	12,024
Other investments / financial assets	2,076	-	-	2,076
Cash and cash equivalents at bank and in hand	12,173	-	-	12,173
Total at 31 March 2020	26,273	-	-	26,273

Carrying value of financial liabilities

Carrying values of financial liabilities as at 31 March 2021	Held at amortised cost £000	Held at fair value through the I&E £000	Total book value £000
Loans from the Department of Health and Social Care	16,495	-	**16,495**
Obligations under finance leases	-	-	**-**
Obligations under PFI, LIFT and other service concession contracts	1,934	-	**1,934**
Other borrowings	-	-	**-**
Trade and other payables excluding non financial liabilities	33,468	-	**33,468**
Other financial liabilities	-	-	**-**
Provisions under contract	-	-	**-**
Total at 31 March 2021	51,897	-	**51,897**

	Held at amortised cost £000	Held at fair value through the I&E £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2020 under IAS 39			
Loans from the Department of Health and Social Care	45,036	-	45,036
Obligations under finance leases	-	-	-
Obligations under PFI, LIFT and other service concession contracts	2,037	-	2,037
Other borrowings	-	-	-
Trade and other payables excluding non financial liabilities	21,723	-	21,723
Other financial liabilities	-	-	-
Provisions under contract	-	-	-
Total at 31 March 2020	68,796	-	68,796

Maturity of financial liabilities	**31 March 2021 £000**	**31 March 2020 restated* £000**
In one year or less	**37,631**	50,665
In more than one year but not more than five years	**8,362**	12,316
In more than five years	**7,676**	7,884
Total	**53,669**	70,866

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