

Safe. Kind. Effective



Countess of
Chester Hospital
NHS Foundation Trust

2025-26

Annual Report & Accounts

The Countess of Chester Hospital NHS Foundation Trust

Annual Report and Accounts 2025/26

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

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Performance overview

Safe. Kind. Effective

1. Performance Overview

Statement from the Chair and Chief Executive Officer

In 2025/26 we continued to deliver against the goals set out in the Trust's Transforming Care Together Strategy. Our strategy provides a clear direction for how we will provide care for our patients and families, and how our leadership role promotes a positive culture to look after and care for our patients, our population, and our people.

The Countess of Chester Hospital NHS Foundation Trust is committed to ensuring that the services we provide are safe, kind, and effective.

The embedding of the patient and family experience strategy has ensured a focus on our quality priorities, with local teams empowered to bring about change. Quality improvements are set out within our Quality Account including achievement of significant improvements within infection prevention control, falls, pressure ulcers, VTE assessments, sepsis screening and hydration.

The results from the national inpatient and staff surveys show progress is being made, this is positive but there is still more to do. We are launching a new Patient Engagement Framework in 2026/27 which sets out our commitment to listening to our patients, families and carers, and acting on the things that matter to them. We continue to listen to the feedback from our staff, providing health and well-being sessions, supporting and developing our staff networks, and celebrating successes through a range of mechanisms. During 2025/26 we have delivered a suite of management and leadership development programmes to support our staff in their roles and future ambitions. The Trust has launched a refreshed People Strategy 2025 – 2028 that reflects the unwavering commitment to creating an environment where every individual feels supported, valued, and inspired to thrive.

We have seen unprecedented demand for our emergency and urgent care services. We continue to make changes to the way we deliver urgent and emergency care, with improved access, rapid assessment and streaming of patients into the right facility. This is in the context of local challenges, as well as recognising the national challenges Emergency Departments are facing in ensuring patients are assessed timely and cared for in a safe environment.

How long our patients are waiting for treatment and diagnostics has been a key focus area as the Trust continues to reduce waiting lists. From a challenging starting position, the work undertaken through our divisions and specialist teams has

ensured we have met the national expectations for Referral to Treatment (RTT) Pathways and put us at the top for the most improved Trust nationally. Over the past 12 months, we have delivered significant savings to ensure delivery of our financial plan. The work we have undertaken on the medium term plan sets out the drivers to our underlying financial deficit with a challenging year on year improvement plan across the next 5 years to eradicate the deficit and ensure sustainability.

During the year, we opened our new Women's and Children's Building. Birth registrations have increased and feedback from families who have experienced these facilities has been very positive. The building is England's first NHS Net Zero facility, fully electric and powered by renewables, and ranks among the top ten percent most energy-efficient nationally.

The Trust refreshed its Green Plan, with priorities and targets set for 2025-28 aligned to NHS ambitions.

During 2025/26 we have been subject to significant regulatory oversight through NHS England and the Care Quality Commission. Our continued focus on tackling the long-standing challenges faced by the Trust has started to demonstrate sustainable improvement, which is notably recognised through the Trust's position in the National Oversight Framework league tables moving from 133/134 (segment 4) in Quarter 1 to 98/134 (segment 3) in Quarter 4.

The Annual Report provides an opportunity to set out the demonstrable improvements achieved in year to deliver our plans. We continue to work with partners to improve the flow of patients through our hospitals and strengthen the provision and delivery of urgent and emergency care.

The Trust has fully supported and cooperated with the work of the Thirlwall Inquiry throughout the Inquiry process, providing information, documentation, and statements. The Inquiry report is now expected to be published during 2026/27. The Trust also remains fully committed to continuing to support the ongoing Cheshire Police investigations.

Our staff, volunteers, and governors make a difference to our patients and their families every day and we would like to thank them for everything they do to provide high quality, safe and compassionate care.



Ms Jane Tomkinson OBE
Chief Executive Officer



Mr Neil Large MBE
Chair

About the Countess of Chester Hospital NHS Foundation Trust

The Countess of Chester Hospital NHS Foundation Trust employs 6,520 staff to provide care and treatment to a population of over 400,000 people living in Chester and West Cheshire which includes Ellesmere Port and Neston, as well as the Deeside area of Flintshire.

The Trust's services are provided from three locations:

- **The Countess of Chester Hospital:** providing 470 general and acute beds.
- **Ellesmere Port Hospital:** providing 60 beds as a rehabilitation, intermediate and outpatient facility.
- **Tarporley War Memorial Hospital:** a base for community services which serve the local rural population.

The Trust works collaboratively within the wider Cheshire and Merseyside Integrated Care System. Due to its location on the border with North Wales and the flow of patients, the Trust also works closely with the Betsi Cadwaladr University Health Board.

Structure of the Trust

During 2025/26, the Board of Directors comprised a Non-Executive Chair, Chief Executive Officer, Non-Executive Directors, and Executive Directors (voting and non-voting).

The Trust is arranged into five clinical divisions:

1. Urgent Care
2. Planned Care
3. Diagnostics and Clinical Support Services
4. Women and Children's
5. Therapies and Integrated Community Care

Each division has a triumvirate management structure which includes a Divisional Director, Associate Medical Director and Divisional Nursing Director. Divisions are supported by corporate service teams including human resources, finance, and digital services.

Our vision, values and strategic goals

The Trust's vision is to achieve outstanding care for our patients and families.

The Trust's values are:

- **Safe:** at the heart of everything we do
- **Kind:** always caring and compassionate
- **Effective:** services that are responsive to our patients needs

Our strategic goals are:

1. Creating a positive patient and family experience
2. Develop our people and culture
3. Provide purposeful leadership
4. Adding value
5. Actively seeking partnership opportunities
6. Proactive contribution to improving our population health

Our year at a glance

The Trust treats patients from England and some parts of Wales. During 2025/26, there were approximately 654,000 patient attendances (inpatient, A&E, outpatient and diagnostic) ranging from a simple outpatient appointment to major cancer surgery.

Our year in numbers



Performance	Service area
36,769	Hospital admissions (elective and non-elective)
485,350	Outpatient appointments (first and follow-up appointments)
92,760	Emergency Department (A&E) attendances
37,289	Day cases
1,843	Number of babies born
533	Number of beds
6520	Number of staff (including Bank staff)
130	Number of volunteers
124	Number of apprentices
4988	Number of Foundation Trust members
£418m	Income
£26.1m	Capital investment in services

Police Investigations and Thirlwall Inquiry

The Trust has supported and fully cooperated with the work of the Thirlwall Inquiry throughout the Inquiry process, providing information, documentation, and statements. The Inquiry report is now expected to be published during 2026/27.

A further Cheshire Police investigation is ongoing in respect of corporate manslaughter/ gross negligence manslaughter linked to the convictions of Lucy Letby.

The Trust remains fully committed to continuing to support the Inquiry process and the ongoing Cheshire Police investigation



Acting on Patient Feedback: Patient Experience

During 2025/26 the Trust has embedded the Patient and Family Experience Strategy and Vision (2024-2027) which is aligned to the Trust Strategy and empowers all staff to become leaders in patient experience. The strategy provides the tools and framework for improvement, with a commitment to continually improve the experience of patients, families, and carers while they are under our care and beyond.

The vision describes six critical components of a patient journey and at each step, the Trust has committed to a vision statement and a patient affirmation. The strategy was developed from listening and engagement events with staff and patient representatives, data analysis from concerns and complaints, and consultation with divisional leads and nursing leads. There have also been Patient and Family Experience Visions developed specifically for Maternity services and the Emergency Department (ED) taking into account the feedback from our patients through the national inpatient surveys.

There are several mechanisms available for patients and the public to share their feedback with us, including:

- National Care Quality Commission (CQC) survey program
- Friends and Family Test and comments
- NHS Choices
- Healthwatch (visits, go-sees, and engagement events)
- Non-Executive Director and Governor walkabouts
- Patient-Led Assessment of the Care Environment (PLACE)
- Concerns or complaints
- Social media feedback

Progress is monitored through a variety of routes including patient engagement events, ward accreditation, and listening to patient and family stories, along with quantitative data gathered from patient satisfaction surveys, including the national patient surveys, Healthwatch reports and the Friends and Family Test (FFT).

The trust has developed a new Trust-wide Patient Experience Improvement Framework to be implemented in April 2026. The objective of this is to embed continuous patient experience improvement across all divisions through quarterly activity, shared learning, and partnership working, ensuring patient voice informs service improvement and reduces inequalities in experience and access.

The overarching Quality, Safety and Experience Strategy was developed through engagement with stakeholders, an extensive review of feedback and themes from patients and relatives and a comprehensive review of incidents, risk and the current position against quality metrics. Our Quality, Safety and Experience Strategy comprise three pillars of priorities. The strategy describes 26 priorities within three pillars of priorities - Core priorities, Divisional priorities and Corporate priorities, with

all including a focus on improving patient safety and experience. Progress and actions are monitored through the Quality and Safety Committee and Quality Governance Group.

The Family and Friends Test (FFT) feedback by SMS text messaging and interactive voice mail continues across all Inpatient, Outpatient, Emergency Department, day case and Maternity services, with all services leads now receiving an automated monthly FFT feedback report. Summary reports are reported to Quality Governance Group and externally to NHS England.

Learning from patients and their families' experience provides vital information to ensure that we continually improve our services. Learning is shared Trust-wide through a variety of forums such as Learning and Sharing, Patient Safety Oversight Meeting, and Learning from Deaths. Weekly learning summaries are widely circulated, and patient stories are heard in a range of meetings and committees, ensuring that the patient's voice is at the heart of everything we do.

The development and implementation of an enhanced Ward Accreditation program also encompasses feedback from patients and their families/ carers. Senior Nurse walkabouts include engagement with patients and their families, asking them about their stay, and anything we could to improve their experience.

Ensuring patients and their families are involved in incident investigations is progressing with the implementation of the Patient Safety Incident Response Framework (PSIRF). Being open and transparent in our responses and in line with statutory and professional duty of candour requirements, being open about our mistakes and involving people in our learning responses further supports the principles of openness, fair accountability and learning.

Weekly divisional meetings focusing on complaints and concerns have supported the drive to reduce the response timeframes and provide more timely responses. Informal concerns have remained steady, although we have seen an increase in the last quarter of the year, and there are improvement plans in place to reduce the length of time taken to respond and resolve these. Learning from complaints and concerns is an integral agenda item in the monthly Safety Surveillance meeting, with triangulated themes from incidents and complaints/ concerns, and learning and actions shared.

Principal risks faced by the Trust

The Board of Directors considers and agrees the principal risks faced by the Trust through the Board Assurance Framework. A full refresh of the Board Assurance Framework and risk appetite was completed at the start of 2025/26.

The processes to identify and manage principal risks are detailed within the Annual Governance Statement section of this annual report



Strategic risks 2025/26

Strategic risks are identified within the Board Assurance Framework (BAF), which is regularly reviewed by the Board of Directors. Extracts of the BAF are also monitored through the relevant Assurance Committee.

The following table provides a summary of the Trust's strategic risks with the residual risk score following mitigating actions at the end of 2025/26.

Ref	Description	Residual risk score	Assurance Committee
BAF1	Failure to maintain quality of care would result in poorer patient & family experience	16	Quality & Safety
BAF2	Failure to maintain safety and prevent harm would result in poorer patient care and outcomes	16	Quality & Safety
BAF3	Inability to deliver operational planning standards , inability to address the backlog of patients waiting could result in poorer patient outcomes, and result in financial consequences to the Trust.	16	Finance & Performance
BAF4	Challenges in ensuring a high quality, engaged, diverse and inclusive workforce would affect our ability to deliver patient care	15	People
BAF5	Failure to deliver financial plan and underlying financial position could impact long term financial sustainability for the Trust and system partners	16	Finance & Performance
BAF6	Inability to achieve the capital programme within a challenging and uncertain operating environment and deliver an Estates Strategy that supports the provision of our services	15	Finance & Performance
BAF7	Failure to deliver transformative digital and data solutions and performant, secure and resilient infrastructure could impact on patient and staff experience and organisational productivity	15	Finance & Performance
BAF8	Failure to ensure effective corporate governance could impact our ability to comply with legislation and regulation.	8	Audit
BAF9	System working and provider landscape changes may present challenges in ensuring COCH is positioned as a strong system partner, with priorities aligned to system partners across Cheshire &	12	N/A (Reported to the Board)

Ref	Description	Residual risk score	Assurance Committee
	Merseyside.		
BAF10	Inability to deliver the Research and Innovation agenda to exploit future opportunities	12	N/A (Reported to the Board)

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

Consequence	Likelihood
5: catastrophic	5: almost certain
4: major	4: likely
3: moderate	3: possible
2: minor	2: unlikely
1: negligible	1: rare

The grading bands of risks are 1-3: very low, 4-6: low, 8-10: moderate, 10-12: high and 15-25: significant risk.

Going concern overview

After making enquiries, the Board of 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.

Performance Analysis

The Board of Directors and its Committees receive the Integrated Performance Report at each of its meetings. The report includes detailed exception reports, and performance against key quality, performance and well-led indicators. This includes actions being undertaken to address any issues and risks. The Board receives a winter resilience plan and ad-hoc reports pertaining to specific areas of operational risk. During 2025/26 the report was also expanded to include a section focussed on the new NHS Oversight Framework Metrics.

In 2025/26 the Trust made improvements across all elements of operational performance, including reducing elective waiting times and driving improvements across our urgent and emergency care pathways.

Key Performance Indicators, by month, 2025/26:

Metric	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
ED: Patients waiting no more than 4 hours (%)	60.8%	60.7%	63.7%	62.0%	64.5%	62.3%	64.7%	61.1%	62.0%	57.1%	60.0%	61.2%
ED: Patients waiting over 12 hours - Type 1 (%)	25.7%	25.8%	22.1%	20.9%	13.6%	25.4%	19.0%	22.0%	22.9%	27.6%	24.8%	23.9%
RTT: Incomplete pathways - Waiting up to 18 weeks (%)	47.1%	47.9%	48.9%	50.2%	48.3%	51.5%	52.2%	53.3%	54.7%	55.7%	58.4%	
RTT: Incomplete pathways - Waiting over 52 weeks (%)	6.6%	7.6%	8.3%	8.5%	9.0%	7.6%	7.0%	5.8%	4.3%	3.6%	3.2%	
Diagnostics Test Exceeding 6 Weeks Waiting Time (DM01)	13.4%	19.0%	18.4%	19.9%	26.1%	23.5%	25.3%	23.2%	23.7%	20.7%	13.4%	16.0%
Cancer Treatments: 28 Day FDS	84.3%	75.6%	75.6%	71.3%	71.3%	70.6%	77.9%	78.7%	80.3%	74.7%	83.8%	
Cancer Treatments: 31 Day Standard	88.7%	94.8%	96.8%	88.2%	94.0%	92.0%	92.8%	96.5%	96.1%	83.8%	93.7%	
Cancer Treatments: 62 Day Standard	80.8%	77.9%	71.1%	73.7%	74.7%	76.1%	73.1%	81.9%	76.4%	72.9%	76.0%	

Infection control targets		Target	Q1	Q2	Q3	Q4
Clostridium difficile		57	19	31	20	18
Methicillin-resistant Staphylococcus aureus (MRSA)		0	1	1	0	0
Waiting time targets		Target	Q1	Q2	Q3	Q4
Total time in Accident & Emergency/ Emergency Department		95%	59.7%	60.4%	57.9%	60.6%
% 18 weeks referral to treatment incomplete pathway		92%	48.5%	49.3%	50.6%	51.6%
Diagnostic six-week target		1%	16.9%	14.8%	10.4%	11.6%
Cancer targets		Target	Q1	Q2	Q3	Q4
28 Day Faster diagnosis (FDS) Target		75%	77.5%	80.1%	82.6%	81.4%
31 Day - Decision To Treat		96%	95.3%	94.7%	93.7%	93.1%
62 Day - First Treatment		85%	78.3%	79.0%	80.1%	74.8%

Infection Prevention & Control (IPC)

During 2025/26 we have achieved significant reductions in healthcare associated infections (HCAIs), driven by a collective focus on improvement work, enhanced monitoring of practice standards and strengthened risk and governance processes to learn from incidents where patients have developed a HCAI.

At the end of the year (2025/26), we have seen an overall reduction of 14% in reportable HCAI's including:

- 19% reduction in C.difficile cases
- 2% reduction in E.coli bloodstream infections
- 48% reduction in Klebsiella bloodstream infections
- 19% reduction in MSSA bloodstream infections

In contrast, the prevalence of community cases of E.coli, Klebsiella and MSSA bloodstream infections across the West Cheshire health economy has increased in comparison with the previous year. There have been reductions though in the community prevalence of C.difficile infections with 43% fewer reported cases compared with the previous year.

The focus in the Trust on C.difficile reduction has centered around standardising the clinical management and investigation of patients with suspected infective diarrhoea to ensure appropriate sampling. This has reduced the number of incidental cases identified from inappropriate testing.

The primary driver in reducing both E.coli and Klebsiella bloodstream infections has focused on the key risks that lead to these infections developing, targeting work on strengthening the processes around the prevention and management of urinary tract infections.

In addition, the Trust has managed a varied spectrum of cases of transmissible infections including measles, influenza, COVID-19 and norovirus. Maintaining effective HCAI surveillance, optimising patient placement and implementing transmission-based precautions has limited the patient and operational impact of these infections with only one outbreak of infection reported (norovirus) during December 2025.

The Infection Prevention Control Team have continued to deliver an enhanced programme of audit and education, including hand hygiene roadshows, promotion of 'World Patient Safety Day' and 'World Hand Hygiene Day' all of which have played a key part in advocating best practice as well as providing assurance of compliance with standards.

Emergency Department (ED)/ED access measure

NHS Operational Planning guidance for 2025/26 focused on 4 hour and 12-hour Emergency Department waits with the following targets:

- At least 78% of patients attending the emergency department receive treatment, are admitted or discharged within 4 hours.
- A higher proportion of patients admitted, discharged and transferred from ED within 12 hours across 2025/26 compared to 2024/25.

Whilst small improvements in 4-hour performance have been made in 2025/26 compared to 2024/25 (average performance over 2025/26 was 2.1% higher than 2024/25), the Trust still finished the year well below the national standard of 78%, delivering 61.2% in March 2026.

The average number of 12-hour breaches over the year was 22.3%, representing a reduction of 3.5% compared to the previous year. Despite these improvements, the Trust recognises that, in 2026/27, performance needs to improve considerably against the 12-hour standard.

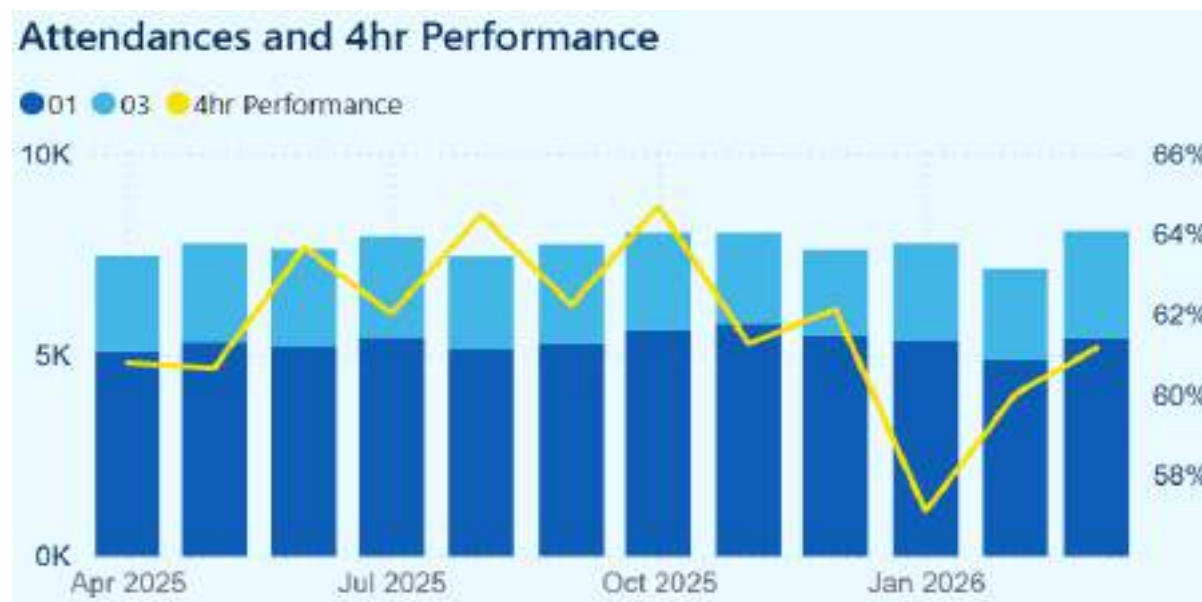
In 2025/26 attendances to the Emergency Department were 7% higher than the previous year. In addition, patients 'not meeting the criteria to reside' (NCTR) averaged 21.7%. Both these factors significantly contributed to increased congestion within the Emergency Department and impacted on our ability to meet the standards expected.

The Trust has benefited from several upgrades to the Emergency Department estate this year, all designed to improve patient experience and overall flow in the department:

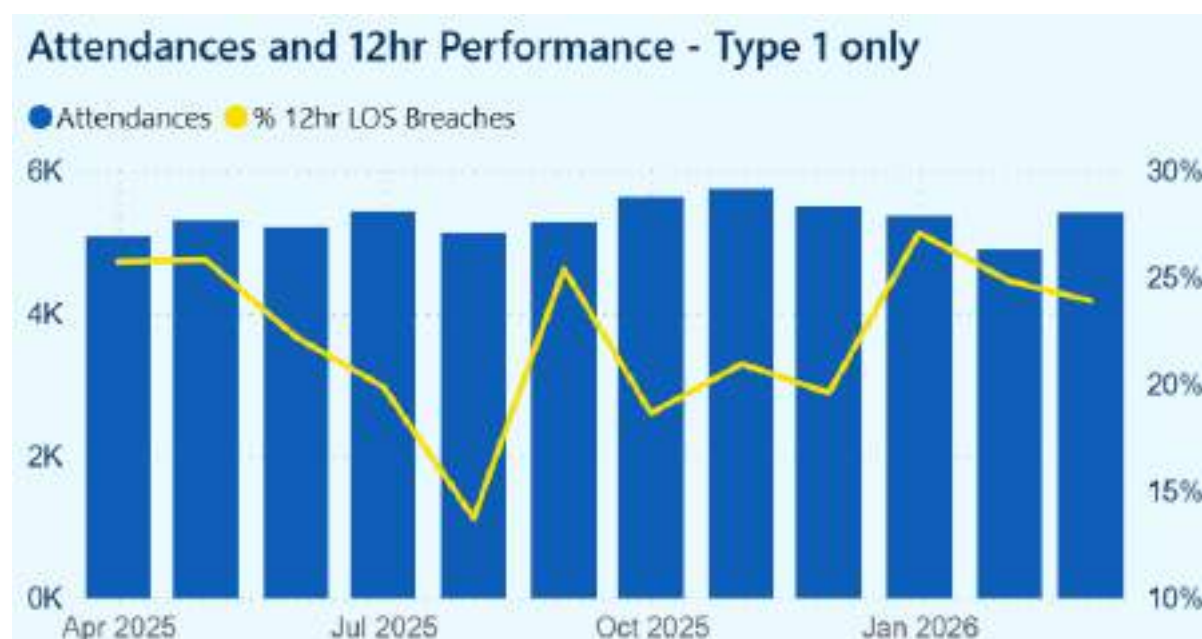
- Opening of a bespoke unit for patients with cognitive impairment such as dementia, learning disabilities, and mental health concerns (September 2025)
- Additional adult resuscitation space commissioned (November 2025)
- A new atrium opened at the front of the ED to facilitate rapid assessment of walk-in attendances and provide greater opportunities to stream patients to non-ED environments (December 2025)

The Trust continued to work with the 'Getting it Right First Time (GIRFT)' team in NHS England in progressing and delivering on improvements to Urgent and Emergency Care pathways, most notably in consistently reducing the time taken for initial assessment through redesigned streaming, triage and rapid assessment and treatment (RAT) pathways.

4-hour wait standard: % of attendances that were treated, discharged or admitted within four hours of arrival



12-hour wait standard: % of attendances that were treated, discharged or admitted within twelve hours of arrival

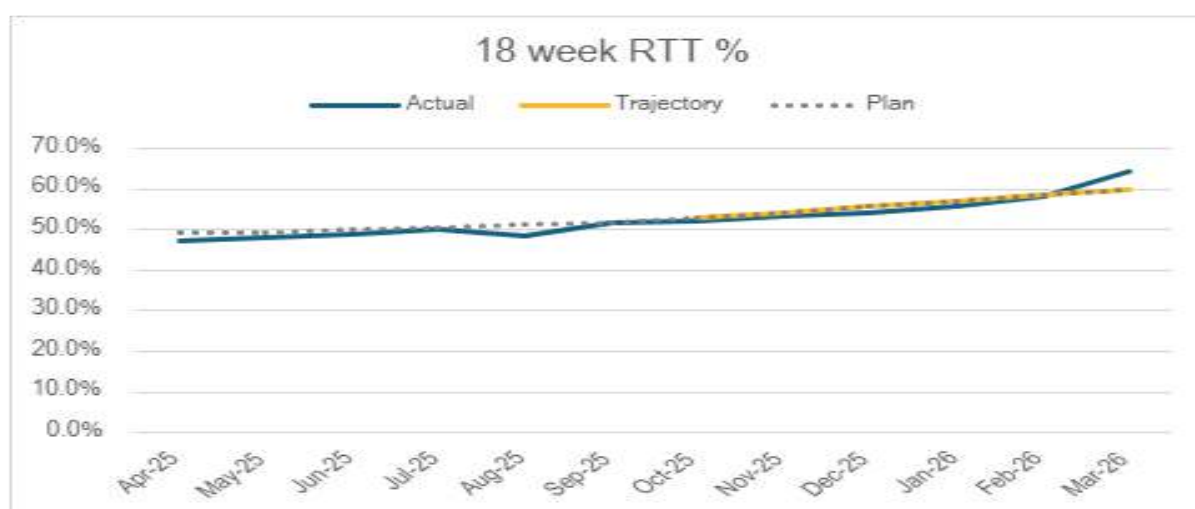


Referral to Treatment (RTT)

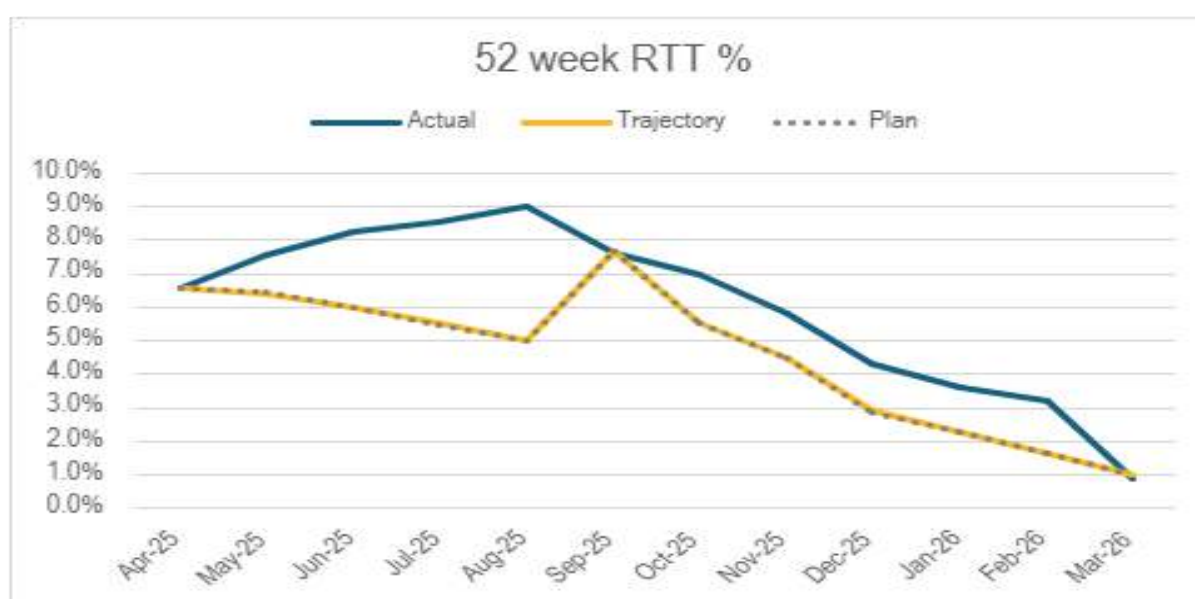
National NHS operational planning standards for referral to treatment focused on two key targets:

- Improve the percentage of patients waiting no longer than 18 weeks for definitive treatment to 60% by 31st March 2026.
- Reduce the proportion of people waiting over 52 weeks for definitive treatment to less than 1% of the total size waiting list by 31st March 2026.

The Trust over delivered against the 18-week target; with a March-end performance of 64.2%.



Similarly, the Trust achieved significant improvements in its RTT long wait pathways, reducing the >52 week % from 6.6% at the start of the year to 0.9 % by year end.



Looking ahead to 2026/27, the Trust will continue to focus on improving its 18-week referral to treatment compliance to deliver a year end performance of at least 67%, by March 2027, in line with 2026/27 NHS operational planning requirements.

Diagnostic waits

NHS Operational Planning guidance for 2025/26 did not give a specific target for the recovery of diagnostics, however all providers were asked to ensure at least 80% of all patients had their diagnostics test with 6 weeks. The main challenges for the Trust have been within the echocardiography service, however since August several initiatives have taken place within echocardiography and other modalities across radiology and endoscopy to improve the position. Performance has improved in the second half of the year, with March performance showing 83.7% of patients having their diagnostic test within 6 weeks.

Diagnostic tests exceeding 6 weeks waiting time (DM01) April 2025- March 2026:



Cancer standards

The Trust has demonstrated overall improvement in cancer waiting time performance during 2025/26, with delivery broadly in line with national planning targets despite significant and sustained demand pressures. Performance has improved across several tumour pathways, although challenges remain in achieving all national standards, particularly in the context of increasing system pressures, including increasing volumes of suspected skin cancer referrals.

Cancer waiting times are reported one month behind therefore the position given for each standard is the February 2026 month end position.

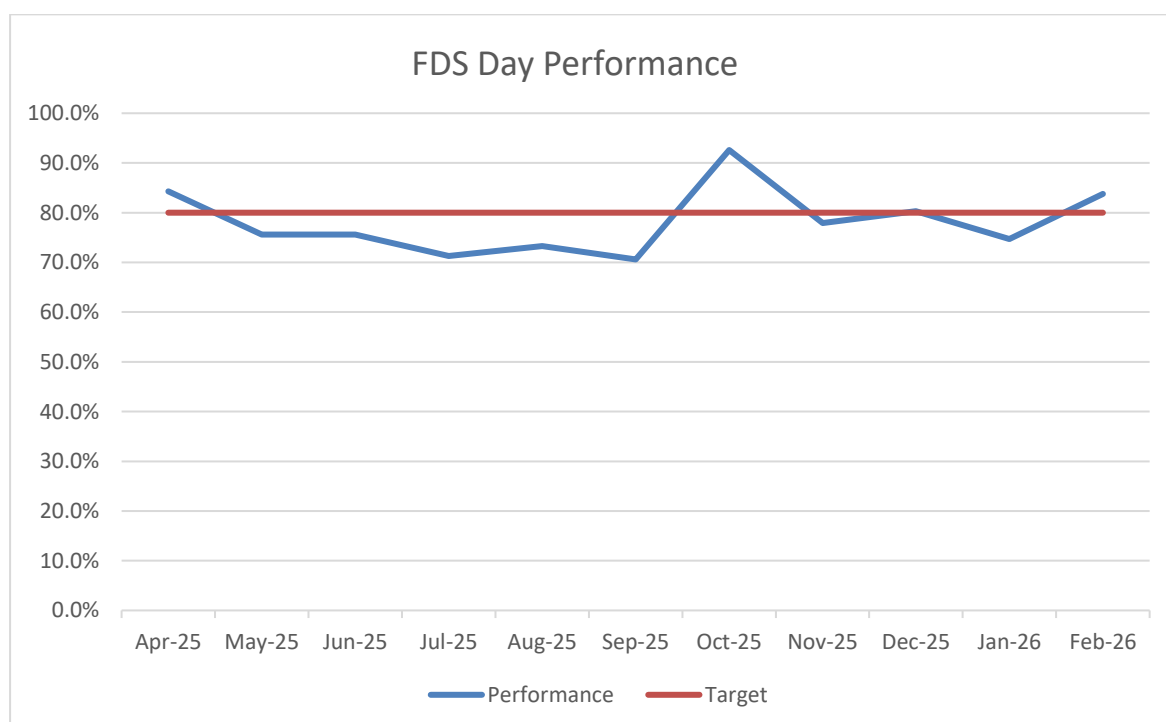
Faster Diagnosis Standard

The Faster Diagnosis Standard (FDS) requires that patients referred urgently with suspected cancer receive a definitive diagnosis or ruling out of cancer within 28

days. For 2025/26, the national target for FDS increased to 80%.

In February 2026 the trust achieved 83%. We have seen strong performance in some specialties, and in November 2025, the Trust was recognised as the highest-performing Trust in England for rapid diagnosis of bowel cancer over a four-month period. Performance improved from 31% of patients receiving results within four weeks in April 2023 to 93% by July 2025, representing a significant and sustained improvement.

For 2026/27, the NHS Operational Planning target for FDS remains to achieve an annual average of 80%

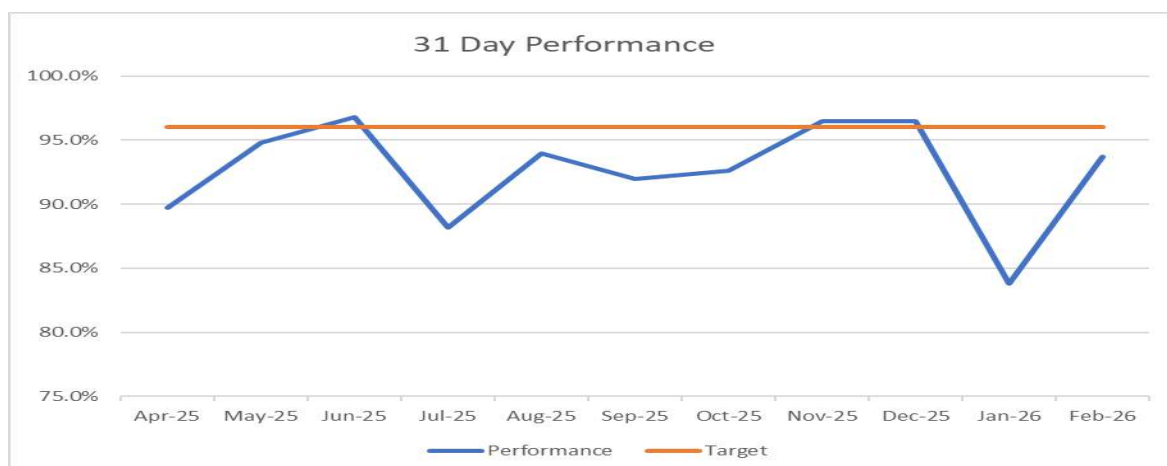


31-Day Decision to Treatment Standard

The 31-day standard requires that 96% of patients with a confirmed cancer diagnosis commence treatment within 31 days of a decision to treat.

The standard was achieved in June, November, and December 2025 however, Trust performance was below target in the other months, most notably in January.

High levels of demand to our skin cancer service has been the main contributor to underperforming against this target and the Trust have an improvement plan in place within the skin cancer service to improve waiting times and support consistent delivery of the 31-day target.

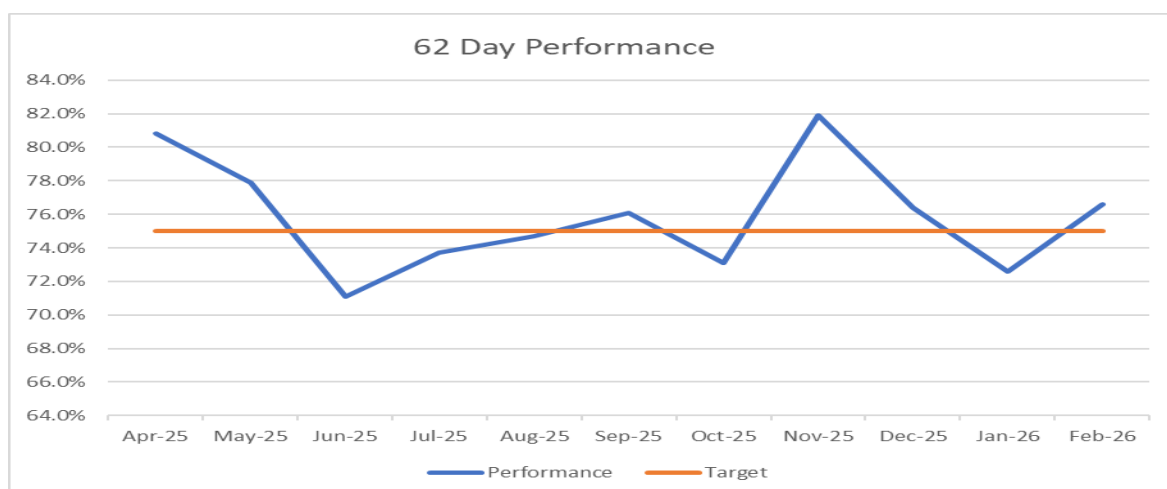


For 2026/27, the Trust target is to achieve 94% performance by March 2027.

62-Day Referral to Treatment

NHS Operational Planning guidance for 2025/26 required 75% of patients referred urgently by their GP commence first treatment within 62 days.

In February 2026 the Trust achieved 76.7% and an average performance for the Trust of 77%. The Trust met the 75% target in multiple months across the year and has maintained performance consistently above the national average



For 2026/27, the Trust target is to achieve 80% performance by March 2027.



Activity

The Trust saw an increase in activity in 2025/26 compared to the previous year. Productivity and delivery increased in several specialties from a combination of improvement work and targeted increased capacity to improve elective waiting times. Continuing to drive improvements across all points of delivery is a priority for the Trust in 2026/27.

The Emergency Department (ED) attendances increased by 8% compared to 2024/25, and demand continues to remain significantly higher than pre-COVID-19 pandemic levels, with 18.7% higher demand in 2024/25 than 2019/20. This has contributed to the pressures experienced in the Emergency Department (ED).

Metric	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	% Change 25/26 compared to 24/25
Elective Inpatients	4,318	2,837	2,968	2,990	2,830	2,869	2,968	3%
Elective Day Case Patients (Same day)	37,453	21,688	25,884	28,913	32,246	37,518	38,457	3%
Non-elective (urgent) Inpatients	30,562	25,612	30,763	29,583	32,886	33,900	34,032	0%
Outpatients - first attendances	116,595	80,850	111,357	109,209	129,234	135,155	135,084	0%
Outpatients - follow up attendances	295,174	219,976	240,381	247,067	271,726	279,322	278,546	0%
A&E Attendances	77,891	66,627	87,275	84,032	83,494	85,953	92,490	8%

Summary Hospital Mortality Indicator

Both Summary Hospital Mortality Indicator (SHMI) and the Hospital Standardised Mortality Ratios (HSMR) indicators continue to be analysed and reviewed within the Trust every month, via the Mortality Surveillance Group. The Trust remains in expected ranges.

To note, the inherent delay in reporting this data is due to the window that allows final coding data to be submitted to Hospital Episode Statistics (HES).

Countess of Chester Hospital SHMI:

	Countess of Chester Hospital SHMI	Trust with lowest SHMI	Trust with highest SHMI	Outlier alert level
December 2024 – November 2025	0.8840	0.7194	1.3183	As expected
April 2024 to March 2025	0.9089	0.7153	1.2539	As expected
April 2023 to March 2024	0.9550	0.7142	1.3193	As expected
April 2022 to March 2023	0.9847	0.7191	1.2074	As expected
April 2021 to March 2022	0.9591	0.6964	1.1942	As expected
April 2020 to March 2021	1.0422	0.6908	1.2010	As expected
April 2019 to March 2020	1.0752	0.6851	1.1997	As expected
April 2018 to March 2019	1.1055	0.7069	1.2058	As expected



Sustainability Progress in line with the Trust's Green Plan

In 2021, a mandate was issued for NHS England to achieve Net Zero by 2040. Each NHS Trust was mandated to produce a 'Green Plan', ratified by the Trust Board and becoming a public document. The Green Plan details how the trust will achieve Net Zero in a phased approach, with our first Trust Green Plan established for a period of three years (2022-2025)

Our 'refreshed' Green Plan has been developed in year and approved by the Trust Board for the period 2025 – 2028.

Despite the many challenges and pressures we face within our Trust and the wider NHS, these challenges also present new opportunities to deliver outcomes that are best for our patients, financially beneficial, and better for our planet. The refreshed Trust Green Plan maintains the following 3 principles:

1. Prioritising interventions that support world-leading patient care and population health, reduce inequalities, and tackle climate change and broader sustainability issues.
2. Supporting organisations to plan and make considered investments while increasing efficiencies and delivering value for taxpayers.
3. Ensuring every NHS organisation supports the NHS-wide ambition to reach net zero carbon emissions, reflecting on the learning from delivery to date

The funding to achieve Net Zero is by no means guaranteed, locally or nationally, which makes our objective all that more challenging. Whilst the challenge is huge, the benefits are even more so. To achieve Net Zero is pivotal and one of the three major milestones for us at COCH becoming totally 'Sustainable'

The other two milestones (our people & finance) will be achieved naturally as a consequence of us delivering a Trust that boasts Net Zero emissions

Whilst we have faced unprecedented demand from patients during 2025/26, along with sustained focus on reducing our costs, we have continued to make progress in our sustainability journey. We should be rightly proud of our progress in Sustainability projects across the Trust, which include:

- The approach of 'sustainability by design' focusing on 'reduced energy consumption' in the Women & Children's building achieving BREAM excellence in design and build.
- 1st Trust in Cheshire & Mersey healthcare region to have a fully 'green' transport fleet.

- 1st Trust in the UK to achieve a new healthcare facility that meets the Net Zero UK Building Standards.
- Confirmation of commitment to become an 'Anchor' institution by signing up to the Cheshire and Merseyside Anchor Institute Framework.
- The Trust will adopt the Sustainable Healthcare Academy green skills initiative for those working in health and care.
- The pharmacy homecare team facilitate the delivery of hospital only medicines directly to over 2,400 patients within their own homes, supporting the green agenda by reducing the number of patients that travel to site to collect their prescriptions and decreasing the demand on the hospital infrastructure.
- We are working with our Executive Team and Finance colleagues to secure the offer of only zero-emission vehicles through the vehicle salary sacrifice schemes from December 2026 onwards (for new lease agreements). The previous twelve months show that more of our staff (116 from a total of 124 staff members) have elected to acquire e-vehicles through the Trust vehicle lease scheme. The transition to e-vehicles rather than fossil fuel vehicles has very much begun.
- Complete removal of desflurane as an anesthetic gas within the theatre environment.
- Secured e-vehicles for the Trust Hospital @ Home as part of the Integrated Discharge Team who now only use the fully electrically powered e-vehicles.

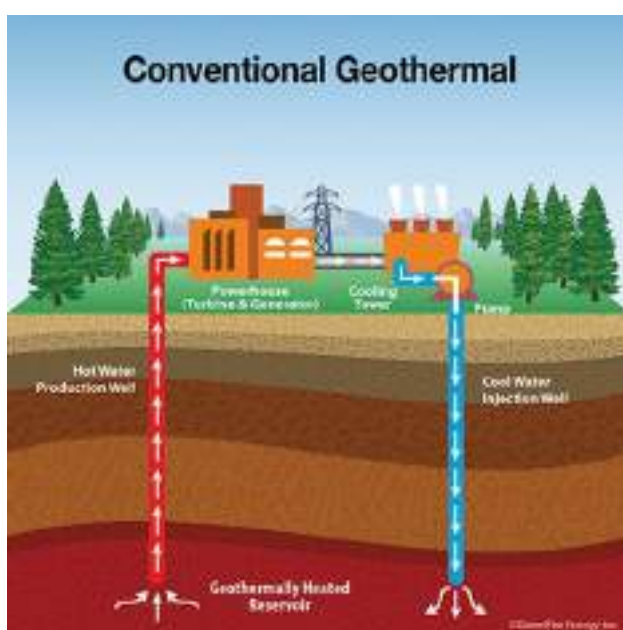
The Trust's Sustainability Lead as well as the Executive Director with lead responsibility for Sustainability continue to represent the Trust through numerous forums, panels and committees:

- Cheshire & Merseyside Sustainability Board
- Cheshire West Place Sustainability Committee
- Cheshire West and Chester Council (CWaC) Travel and Transport Collaborative (membership consists of CWaC, Countess of Chester Hospital NHS Foundation Trust, Chester University, and Chester Zoo)
- CWaC Travel Demand Management group
- Northwest Regional Estates Delivery Group
- Regional Bio-Diversity Working Group
- Regional Waste Working Group
- Regional Energy Working Group
- Submitting 'sustainability' progress data to Greener NHS (OKTA) quarterly submissions on four separate 'Green' themes
- Ad-hoc NHS England events directly connected to sustainability.

Energy

Energy continues to be a huge challenge for the Trust, in terms of managing available capacity, consumption and cost. This year has seen a greater focus in these areas and whilst success has been seen in managing and creating available capacity, the focus now is very much on driving down energy usage. The Trust continues to explore the possibility of extracting geothermal energy from deep within the earth.

Geothermal extraction is the process of harnessing heat from the Earth's interior for various uses, including heating, cooling, and electricity generation. It involves extracting thermal energy from hot rocks or underground fluids and converting it into usable forms of energy. This process can be achieved through different methods depending on the geothermal resource and its location. Deep geothermal systems involve drilling deep wells to reach hot rocks or underground fluids at depths of 500 meters to 1.5 kilometers down within the earth.



The extracted heat can be used for direct heating applications like district heating networks for domestic or commercial space heating, or in some cases, for power generation.

The approach our Trust is taking makes a huge impact on delivering the National objectives placed upon us (heat networks, low carbon energy alternative and renewable energy use). The project formally commenced in early 2025 and is planned to run over the next three years.

This project, if successful, cannot be understated in the potential to substantially reduce energy costs, help us become more energy efficient and achieve NET Zero.

Travel & Transport

Travel and transport remain a key objective at our Trust, in providing improved options for travel as well as plans to improve the car parking infrastructure at our sites. We have made progress in this area against incredibly challenging external factors, local public transport service cuts, and changes in bus routes, all of which impact on providing and promoting an 'alternative' mode of travel.

Our plans include:

- Our original Travel & Transport Strategy is due for refresh and this will be done in line with the national NHS objective **(develop a sustainable travel plan by December 2026, to be incorporated into the green plan, focusing on active travel, public transport and zero-emission vehicles, supported by a clear understanding of staff commuting)**. This will take into account the results of the Trust staff Travel & Transport survey as well as meeting the NHS national objectives. This specific document has proved essential in the future planning of the Health Park in applying for any planning/ building approvals from the local authority. In terms of positioning the Trust for any such future planning applications, it is critical that this document demonstrates progress and ambition in how it is managing travel and car parking demand at our sites.
- Work is already underway both nationally and at a regional level to secure the objective in respect of zero-emission lease vehicles **(offer only zero-emission vehicles through vehicle salary sacrifice schemes from December 2026 onwards, for new lease agreements)**. NHS England Transport as part of National Operations have confirmed that all vehicles offered through the NHS salary sacrifice scheme will be electric by the end of 2026 and all new vehicles owned or leased by the NHS will be zero emission by the end of 2027 (excluding ambulances). We will continue to build on the strong foundations achieved and work to secure the offer of only zero-emission vehicles through vehicle salary sacrifice schemes from December 2026 onwards.
- During April 2025, we collectively secured a full fleet replacement (7 x vehicles) for our Trust which consists of 3 x e-vehicles and 4 x hybrid vehicles. Our all new 'Green Fleet' is now delivered and in full operation as part of Transport Services, and we are the 1st Trust within the Cheshire & Mersey region to achieve this. The Transport Services fleet collect samples from across the region from GP practices and transport to either our own blood sciences Trust unit or our partner laboratory in Bromborough. The annual mileage for this combined fleet is approx. 177,000 miles. The mix of fully electric and hybrid vehicles will make a substantial contribution to cost savings in the huge reduction in diesel costs associated with operating this size of fleet as well as a carbon emissions reduction. The fully e-vehicles are replacing 3 x vehicles who returned an annual mileage of 60,000 per year. The new fully electric variants will no longer use revenue budget to purchase fossil fuel, good for cost saving and excellent toward Net Zero. This achievement, whilst important to our own Net Zero ambition, is 1.5 years ahead of the national objective **(decide to purchase, or enter new lease**

arrangements for, zero-emission vehicles only from December 2027 onwards).

New Healthcare Facilities

The new Women & Children's building in its initial design phase was set to achieve a Building Research Establishment Environmental Assessment Method (BREEAM) 'Excellent' rating. BREEAM is a widely recognised sustainability assessment method used for buildings, in the UK and internationally. It assesses the environmental, social, and economic performance of buildings throughout their lifecycle, from design and construction to operation and refurbishment.

The success of this project has led to the Women & Children's building becoming the first building within the NHS to achieve full compliance with the new NHS Net Zero Building Standard. Achieving the position of first in the NHS in England is testament to everyone involved in this project, throughout the build and up to its handover to the Trust in summer 2025.

Looking ahead, all new build projects and refurbishment projects within the portfolio of COCH will include provision for insulation and double-glazed windows as part of the scheme, further impacting our capacity to conserve heat and reduce energy costs.

Healthcare Associated Waste

We are committed to radically changing our approach to healthcare associated waste and how this is managed. This remains our commitment, with a senior project team now established to explore all areas and options in how we improve in this key area. The technological advancement in 'hospital waste management' has moved on significantly and creates an opportunity for our Trust to substantially reduce emissions as well as a reduction in revenue costs. We are optimistic that we will achieve our intent during the financial year 2026/27.

Climate Adaptation

The World Meteorological Organization (WMO) have published the latest State of the Global Climate Report, looking back at 2024. This report confirmed that 2024 was the warmest on record globally, and likely the first calendar year to be more than 1.5°C above the pre-industrial era, with a global mean near-surface temperature of 1.55 ± 0.13 .

Met Office chief scientist, Professor Stephen Belcher said:

“The latest planetary health check tells us that earth is profoundly ill. Many of the vital signs are sounding alarms. Without serious efforts to heed the warnings, extreme weather events - such as drought, heatwaves and flooding - will continue to worsen.”

The greatest climate risks to the health and care system in Cheshire & Mersey region are

- a. risks to wellbeing from high temperatures;
- b. river and surface flooding;
- c. coastal flooding; and
- d. risks to building fabric.

Climate change has serious consequences for:

- **delivery of healthcare service:** ranging from risks to hospital estate, supply chains and transport.
- **public health:** new pressures on the health system because of heatwaves, pests and diseases, heat exposure, and extreme weather events.

These issues particularly impact more vulnerable people and places. Understanding, anticipating, and adapting to climate challenges is essential to developing a more climate-resilient NHS.

The Trust Sustainability Lead has completed the training program ‘Becoming Climate Resilient’, funded by NHS England that provides candidates with a greater understanding of climate adaptation, climate risk, and identification of opportunities to build resilience.

During 2026/27, we will use the NHS England Climate Change Risk Assessment Tool to assess our position. The positional status will then determine our approach including the development of a Climate Adaptation Plan which will identify our key priorities in how we adapt to such changes.

Adaptation does not just consider our current buildings and infrastructure but shall assess:

- our population and the potential impact to health from climate change;
- our staff and where they are populated/reside and their route of travel to the workplace; and
- and the utility and service companies that provide energy, water and daily supplies to our Trust.

Green Plan Governance

The delivery of the Trust Green Plan is overseen by an Executive Director with responsibility for net zero, along with clearly identified operational support.

To oversee the full range of workstreams within the Trust we have now established a strategic delivery oversight group (Anchor Institution Group), bringing together the interdependent workstreams, and providing cohesion and coordination of our activities.



As a Trust, we have formally signed the Cheshire and Merseyside Anchor Institute Framework. The Framework was co-produced throughout 2020 and 2021, working with colleagues across the Cheshire and Merseyside Integrated Care Partnership, those from other systems and members of the public, and formally launched by the Integrated Care Board in 2022.

The purpose is to provide a framework that organisations who deliver services in Cheshire and Merseyside, can sign up to publicly demonstrate their commitment. The Framework aligns with existing work programs, such as the Marmot Programme, and is intended to be a process to pull together all the great examples of delivering social value across Cheshire and Merseyside, in one place.

By signing the document, the Trust will be required to deliver on all the priorities and be able to demonstrate this at the Anchor Assembly, which is made up of senior system leaders and will take place within a 12-month period of the Trust becoming a signatory. An oversight dashboard has been developed with clinical and operational leads identified for each workstream.

The Countess of Chester Hospital NHS Foundation Trust is an example of an organisation that recognises the wider role that it can play in the communities that it serves. The Trust will use its systems leadership role to deliver those pledges within our direct control and to facilitate those pledges which require new ways of working in partnership with other NHS providers, Place, Local Authority, and the voluntary and charitable sector.

The development of our Strategic Delivery Oversight Group provides a comprehensive and cohesive response to key interdependent workstreams and provides vital evidence of action and progress.

Health Inequalities

The Trust recognises that health inequalities are unjust and avoidable differences in people's health. Whilst the causes of health inequalities are complex, research has shown that the main drivers are social determinants; that is the environments people live in, access to employment, and the kind of start they had in life. Inequalities are also driven by the ways in which health services are designed, delivered, funded, and by the quality of clinical care received. We recognise that the NHS plays a role in both mitigating against the impact of the wider determinants and in reducing healthcare-based inequalities. Addressing health inequalities will improve the quality of clinical care, patient outcomes and safety across the population and between specific groups.

Understanding population needs

The Trust recognises the importance of a collaborative approach to Population Health. The Trust actively collaborates with the Local Authority Public Health Team and leverages joint data and digital initiatives through Cheshire and Merseyside. This approach facilitates a comprehensive understanding of the region's health landscape and strengthens efforts to address health inequalities.

Improving data quality, collection and analysis

The Trust has undertaken significant work to improve data quality as published through both our quality account and annual report, and we will develop this into routine reporting.

Data-Driven Service Planning

By using the Cheshire and Merseyside Data into Action platform, the Trust obtains detailed insights into population health and access patterns. These analytics guide strategic decisions and proactive planning to improve future health services for the community.

Understanding healthcare access and health inequalities

By analysing population health data, we can pinpoint where inequalities exist and collaborate with partners to create effective solutions. Using Core20plus5 risk groups and urgent care admission forecasts allow us to focus community services on early interventions.

Using information to act on health inequalities

C2AI and similar digital tools help monitor risk groups in various planned care specialties. The Trust has assessed health inequalities among staff using pay, sickness, food bank usage, and hardship indicators to inform a new wellbeing offer.

Publishing information on healthcare inequalities

Though the Trust has made progress capturing important indicators in the National health inequalities statement, further work is needed to assess impact before routine reporting can be developed and published.

Task Force on Climate-Related Financial Disclosures (TCFD)

NHS England's annual reporting manual now requires phased Task Forces on Climate-Related Financial Disclosures (TCFD) for NHS bodies, following HM Treasury's public sector guidance.

Local NHS bodies do not need to report scope 1, 2, or 3 greenhouse gas emissions under TCFD, as NHS England calculates these nationally.

Governance and strategy pillar

Delivery of the Trust's Green Plan is overseen by an Executive Director including responsibility as the net zero lead, in collaboration with non-executive leadership and identified operational support.

The Trust has established a strategic delivery oversight group (Anchor Institution Steering Group) to oversee the full range of workstreams, and providing cohesion and coordination of effort including:

- Green Plan
- NHS Prevention Pledge
- Social Value Pledges

The Board of Directors' responsibility includes strategic alignment, risk assessment and cultivation of sustainability culture. The strategic framework will be put into action through the Anchor Institution Steering Group, supported by staff-based sustainability groups, reporting via the Finance and Performance Committee to the Board.

The refreshed Trust Green Plan (2025 – 2028) is in line with National guidance and was approved by the Board of Directors in September 2025. This celebrates the successes to date and provides a robust approach in improving health outcomes, reducing costs, and continuing the journey to achieving net zero.

Metrics and target pillar

Measuring climate-related risks and opportunities requires clear metrics and targets aligned with national sustainability goals and global climate commitments. A key indicator is progress against the country's decarbonisation trajectory—typically benchmarked through targets such as 'clean energy sources electricity by 2035'.

An oversight dashboard has been developed with clinical and operational leads identified for each workstream, supporting the monitoring, providing assurance and delivery of net zero and Greener NHS priorities at region, Integrated Care System and provider level. In summary these workstreams and key lines of enquiry include:

- **Governance** - Board updates and reporting through the Trust's Anchor Steering group
- **Workforce** - staff awareness and training
- **Clinical leadership** - considerations of carbon impact of care delivery through a clinical lens, examples include anesthetic gases / dry inhalers and removal of nitrous oxides
- **Digital transformation** – use of cloud solutions, repurposing of hardware, using population health data to target earlier interventions.
- **Digital strategy** - commitment to meeting net zero ambitions as per National digital strategy, including introduction of Advanced Voice Technologies (AVT) technologies and Artificial Intelligence within diagnostics.
- **Travel and Transport** - move to Electric Vehicles (EV) within Trust fleet, travel incentive schemes, transport partnership and active travel. The Trust now had 100% electric vehicle fleet.
- **Estates and facilities** - the new Women and Children's development is the first NHS new build to be compliant with the net zero building standard.
- **Medicines Management** - inclusion within Cheshire and Merseyside network in reducing the use of antibiotics where appropriate.
- **Supply chain** - the inclusion of carbon reduction weighting and social value in all procurement
- **Food and nutrition** - reductions in food waste.
- **Climate changes adaptations** – as set out within this report.

Equality, Diversity and Human Rights

The Trust works to be an inclusive employer and provider of healthcare services. This is demonstrated through our Equality, Diversity and Inclusion (EDI) Strategy 2023 – 2026 which focusses on embedding equality for our patients, people and partners, making the Countess of Chester Hospital NHS Foundation Trust the place where everyone counts.

In 2025/26, we have continued to deliver our EDI Strategy with key achievements including:

- Additional training provided to the Women and Children's Division in relation to cultural competency and LGBTQIA+ to improve individualised care in maternity services.
- Ensuring individual nutrition and hydration assessments include religious and cultural needs.
- Continued compliance with all statutory and regulatory requirements as part of the Equality Act, the Trusts Public Sector Equality Duty and NHS England contract requirements.
- Implemented a People Governance Structure to ensure more robust reporting and monitoring of Workforce related EDI activity and its effectiveness.
- Growth of staff networks, with 7 networks now established including an Armed Forces and Military Veteran Network.
- Increased membership of staff networks, with EDI related campaigns including celebration of Chester PRIDE, Black History Month and International Women's Day.
- Continuing in our commitment to anti racism.
- Delivery of the Sexual Safety Charter, launching sexual safety training as a requirement for all Trust staff.

Public Sector Equality Duty

As part of the Trust's Public Sector Equality Duty, the Trust has met all statutory reporting requirements in 2025/26. The Trust has published the required reports on the Trust website ([available here: Equality, Diversity and Inclusion | Countess of Chester Hospital](#)) including:

- **NHS Equality Delivery System (EDS):** The report highlights the Trust's commitment to Equality, Diversity, and Inclusion (EDI) and provides a comprehensive summary of the annual EDS assessment for 2025. Across the 11 outcomes, the Trust has been graded as Excelling activity in 1, Achieving activity in 7, and Developing activity in 3. This demonstrates the significant amount of work ongoing in the Trust.
- **NHS Workforce Race & Disability Equality Standards:** The Trust published its annual NHS Workforce Race Equality Standard (WRES) and its annual NHS Workforce Disability Equality Standard (WDES) outcomes in 2025. Both the WRES and WDES reports show in year improvement against a number of indicators, indicating that the actions being taken continue to have a positive impact. When compared to the national average (previous year results), both the WRES and WDES reports show that the Trust remains below the national average across the majority of indicators, indicating that there is still significant work to do.
- **EDI Annual Report:** This report provides an overview of workforce diversity and highlights progress the Trust has made in promoting equality, diversity, and inclusion during the year. It also details future priorities and outlines

actions to be taken.

The outputs of these publications continue to direct our engagement with our patients, our workforce and our communities, and have been an integral part of the Trust's operational and strategic equality, diversity and inclusion agenda.

Modern Slavery

Modern Slavery and Human Trafficking Statement 2025/26

This statement is made pursuant to Section 54(1) of the Modern Slavery Act 2015 and outlines the steps taken by the Countess of Chester NHS Trust to prevent modern slavery and human trafficking in our operations and supply chains.

Our Commitment

The Countess of Chester Hospital NHS Trust is committed to a zero-tolerance approach to modern slavery and human trafficking. We recognise our responsibility to ensure that slavery and human trafficking do not occur within our organisation or through our suppliers.

Our People

We ensure all staff are recruited in line with NHS employment check standards, including identity, right to work, criminal record, and professional registration checks. All staff receive mandatory training in safeguarding, equality, and human rights, which includes awareness of modern slavery and how to report concerns.

Safeguarding

Modern slavery is recognised as a form of abuse under the Care Act 2014. Our safeguarding policies and procedures ensure that any concerns are addressed promptly and appropriately. Staff are trained to identify indicators of modern slavery and know how to escalate concerns.

Recruitment Practices

We only engage recruitment agencies listed on approved NHS frameworks and, for international recruitment, those on the Ethical Recruiters List. We monitor agency practices and maintain feedback mechanisms for temporary staff to raise concerns.

Policies Supporting This Statement

- Safeguarding Adults and Children Policies
- Recruitment and Selection Policies
- Whistleblowing ("Speak Up") Policy
- Right to Work and Pre-employment Checks



Financial Review for 2025/26

The Trust reported a £14.4m deficit position (before impairments and transfers by absorption) at the end of the 2025/26 financial year.

The Trust delivered the deficit agreed with NHS Cheshire and Merseyside Integrated Care Board (ICB) for the year and carried forward an underlying deficit of circa £39m.

Significant work has been undertaken during the year to improve financial governance with a continuing focus on financial sustainability. The Trust financial recovery plan/ financial strategy continues to be developed and delivered through the establishment of a Medium-Term Plan and in line with the over-arching Trust strategy.

NHS provider contracts are primarily based on an aligned payment and incentive (API) mechanism, comprising a fixed element for an agreed level of activity other than for elective activity and a variable element for elective activity.

Income and expenditure

The table below summarises the financial position before adjusting for impairments. These technical adjustments are removed to present a fairer financial position. The Trust's total income for 2025/26 was £420m. The majority of income comes from our main commissioner NHS Cheshire and Merseyside Integrated Care Board (ICB) at £317.6m, with £38.4m received from Betsi Cadwaladr University Health Board, and £24.1m from NHS England. A further £12.5m was received to fund training and education.

Throughout 2025/26, NHS provider contracts with English commissioners operated primarily on an aligned payment and incentive (API) mechanism, comprising a fixed element for an agreed level of activity other than for elective activity and a variable element for elective activity. Welsh contract income operated on a cost per case basis during 2025/26, meaning the majority of income was variable during 2025/26.

Income and expenditure (audited):

	2025/26	2024/25	2023/24	2022/23	2021/22
	£'000	£'000	£'000	£'000	£'000
Income	420.2	410.0	357.9	348.9	334.0
Expenditure	(420.0)	(406.7)	(376.6)	(363.6)	(325.1)
Operating Surplus/(Deficit)	0.2	3.3	(18.7)	(14.7)	8.9
Interest, Depreciation and Dividend	(13.0)	(11.3)	(11.3)	(11.0)	(9.3)

Surplus /(Deficit) before impairment	(12.8)	(8.0)	(30.0)	(25.7)	(0.4)
Impairments and reorganisation costs	(50.7)	(1.2)	(1.5)	(4.2)	(3.7)
Gains/(losses) from transfer by absorption			6.8		
Surplus /(Deficit) for the year	(63.4)	(9.2)	(24.7)	(29.9)	(4.1)

The income and expenditure position shown excludes impairments and donated assets/transfers. The adjusted financial performance is £14.4m for 2025/26 as shown in the table below:

	2025/26	2024/25
	£'000	£'000
Surplus /(Deficit) for the year	(63.4)	(9.2)
Add back all I&E impairment/(reversals)	50.7	1.2
Operating Surplus/(Deficit)	(12.8)	(8.0)
Remove capital donations/grants	(1.7)	(1.6)
Adjusted Surplus /(Deficit)	(14.4)	(9.6)

The Trust experienced pay and non-pay expenditure pressures on its budget during the year, with medical and clinical pay spend exceeding planned levels. This was driven by the need to maintain sufficient clinical capacity whilst covering vacancies and sickness. There was also a requirement to cover workload demand pressures, primarily within Urgent & Emergency Care. Consequently, the expenditure on medical agency staff was £1.7m for the year, with nurse agency expenditure of £0.6m for the year. The level of spend on agency staff has reduced by over £1.9m from 2024/25, which is in line with the NHS England guidance of reducing agency spend by 30% from 2024/25 levels. Overall agency spend in year is 0.8% of total bill (compared to 1.4% in 2024/25). Agency spend in year has fallen by £15.7m from 2022/23 figures (with 2022/23 spend being £18m and 6.9% of total pay bill).

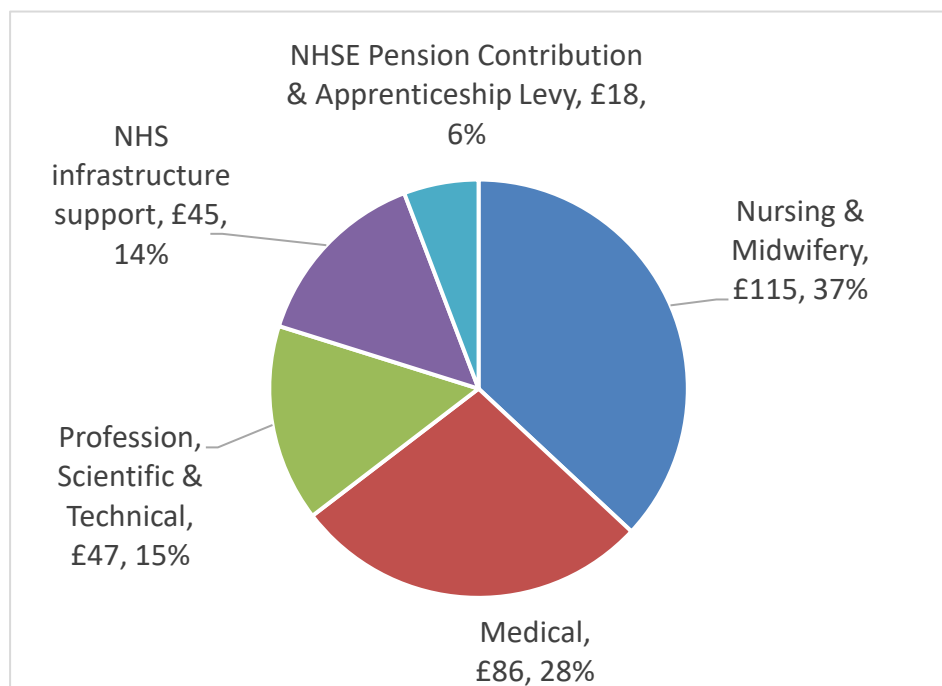
Additional costs were also experienced in relation to clinical supplies (driven by increases in activity and acuity of patients), and energy costs (driven by external market factors and the dual running of the new Women and Children's building). Although cost pressures had been experienced during the year in relation to resident doctor industrial action, non-recurrent centralised funding support was received. The costs incurred in respect of the public inquiry were funded centrally by NHS England.

The impairment in the year arises from the full revaluation of the Trust properties on 31st March 2026. Impairments are excluded from the measured financial performance of NHS organisations on the basis it doesn't reflect the underlying performance.

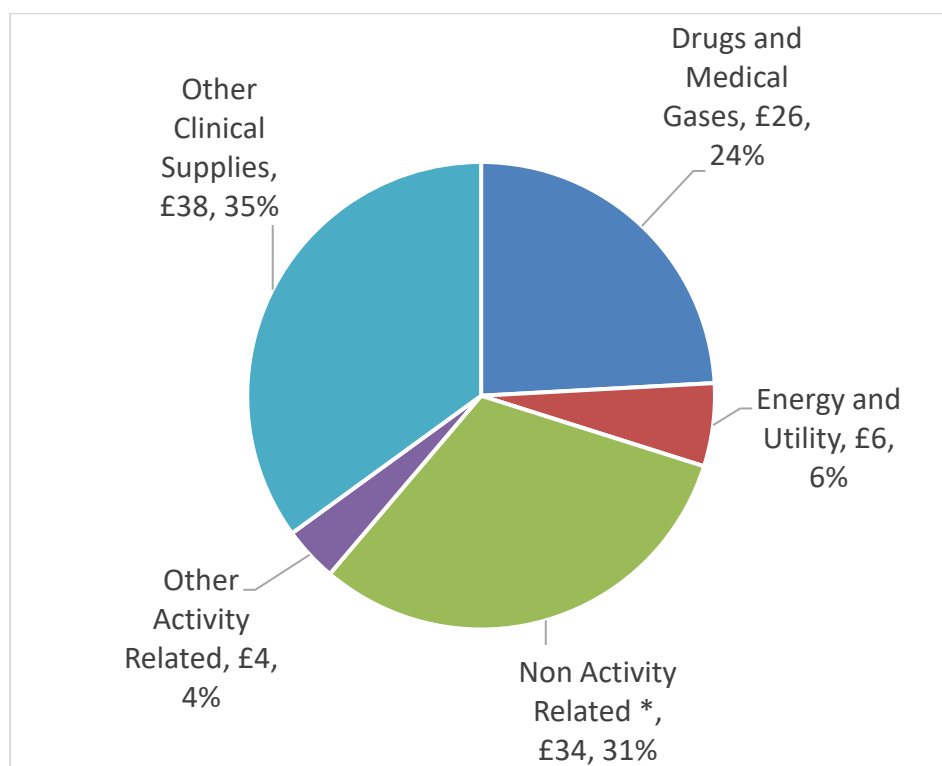
The majority of the Trust's expenditure is spent on clinical care, with staff

representing the largest proportion of spend at £311m.

Breakdown of pay expenditure 2025/26 (£m):



Breakdown of non-pay expenditure 2025/26 (£m):



* Non-Activity Related non-pay expenditure covers premises, establishments, NHS



Cost reduction and efficiency

In order to meet national priorities within the funding allocated, there is a requirement for NHS organisations to reduce their cost base and improve productivity. Financial plans for 2025/26 incorporated the national and regional requirement to deliver efficiencies.

The in year gap was delivered through the use of non-recurrent benefits such as vacancies, higher than anticipated interest receivable income (due to timing around payment of capital receipts) and higher than planned VAT rebate. The gap is the difference between the in-year and the target as outlined in the table. (£27.7m - £19.9m)

These could have been classified as non-recurrent CIP during the 2025/26 financial year but were not due to the Trust policy of only reporting recurrent schemes as CIP, to ensure transparency around CIP progress and financial sustainability.

A challenging minimum efficiency target of £27.7m was set for 2025/26.

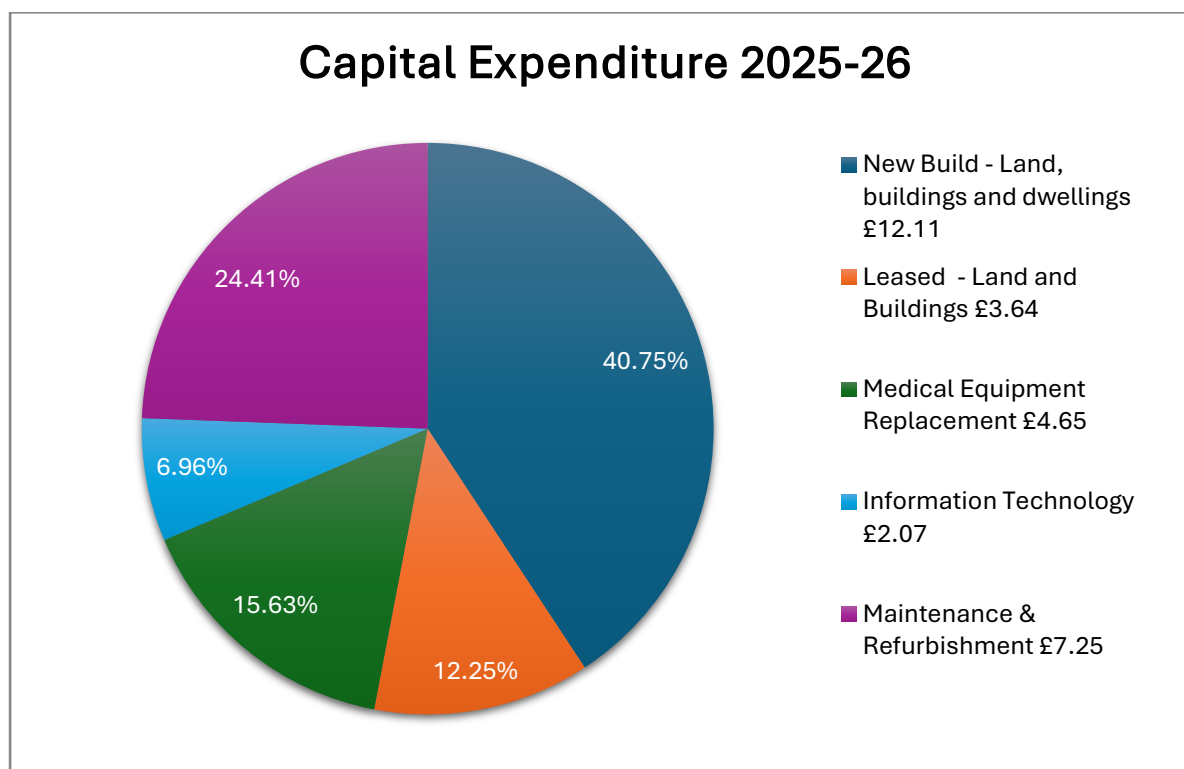
Description of efficiency schemes delivered in 2025/26: (Includes recurrent schemes starting in-year)

Description	In Year	Recurrent
Target	£ 27,700,000	£ 27,700,000
Income - Non-Patient Care	£ 52,500	£ 52,500
Income - Other	£ 4,559,848	£ 4,951,803
Income - Private Patient	£ 10,000	£ 20,000
Non-Pay - Clinical Service re-design	£ 14,166	£ 34,000
Non-Pay - Digital transformation	£ 545,125	£ 687,762
Non-Pay - Estates and Premises transformation	£ 394,971	£ 461,599
Non-Pay - Medicines efficiencies	£ 401,712	£ 569,753
Non-Pay - Other	£ 1,277,607	£ 1,759,346
Non-Pay - Pathology & imaging networks	£ 275,345	£ 369,637
Non-Pay - Procurement (excl drugs) - MDCC directly achieved	£ 224,457	£ 296,585
Non-Pay - Procurement (excl drugs) - MDCC through NHS Supply Chain	£ 96,814	£ 137,981
Non-Pay - Procurement (excl drugs) - non-clinical directly achieved	£ 340,576	£ 542,173
Non-Pay - Corporate services transformation	£ 31,923	£ 31,923
Non-Pay - Other	£ 8,992	£ 8,992
Pay - Agency - reduce the reliance on agency	£ 375,000	£ 375,000
Pay - Bank - increase bank activity and address costs	£ 337,634	£ 337,634
Pay - Corporate services transformation	£ 2,303,979	£ 2,826,361
Pay - Digital transformation	£ 51,412	£ 205,648
Pay - E-Rostering / E-Job Planning	£ 428,483	£ 453,483
Pay - Establishment reviews	£ 4,062,125	£ 4,738,340
Pay - Other	£ 961,570	£ 1,064,678
Total CIP achieved	£ 16,754,241	£ 19,925,200

Capital investment

Capital resources of £29.7 million were spent during 2025/26, including £10.5m on the new Women & Children's building. The breakdown of 2025/26 capital spend is shown in the chart below.

Capital expenditure 2025/26:



Capital expenditure for 2026/27 will be capped by NHS England and the Trust will be required to seek agreement to its plans from Cheshire & Merseyside Integrated Care Board and NHS England.



Accountability report

Safe. Kind. Effective

2. Accountability Report

Directors' Report 2025/26 Board of Directors

The Board of Directors sets the strategic direction of Trust and is responsible for establishing and maintaining an effective culture. The Board consists of a Non-Executive Chair, Chief Executive Officer, Executive and Non-Executive Directors.

The Board composition ensures the breadth of skills and expertise of both the Non-Executive and Executive Directors. Board members also bring a breadth of public and private sector experience.

The Board has led the development of the Trust's strategy and continues to monitor delivery against strategic goals and objectives.

The Board may delegate some of its powers to a sub-committee of the Board of Directors or to an Executive Director or officer of the Trust. The Scheme of Reservation and Delegation sets out the powers retained by the Board and those delegated to Committees or officers. Further guidance on the operation of the Trust is set out in the Trust's Constitution including Standing Orders, and the Standing Financial Instructions.

Executive and Non-Executive Directors have an annual appraisal, reviewing performance against objectives, leadership competencies, Trust values and progress against personal development plans.

The Board of Directors has seen a number of changes during the year.

The composition of the Board of Directors during 2025/26 was as follows:

Non-Executive Directors	
Neil Large, MBE Trust Chair	Appointed for a three-year term of office from 1 st July 2025.
Michael Guymer (Senior Independent Director to 31st October 2025)	Appointed for a three-year term of office from 1 October 2021. Re-appointed for a further three-year term of office and resigned 31 st October 2025.
Paul Jones (Deputy Chair from 9th	Appointed for a three-year term of office from 1 st March 2020 and re-appointed for a further three-year term of office from 1 st March 2023. Re-appointed for a further one-year term of office from 1 st March 2026.

Non-Executive Directors

February 2024)	
David Williamson	Appointed for a three-year term of office from 1 st November 2019 and re-appointed for a further three-year term of office from 1 st November 2022. Term of office ended 31 st October 2025.
Pam Williams	Appointed as Associate Non-Executive Director for a three-year term of office from 1 st November 2021 and then appointed as Non-Executive Director for a 3-year term of office from 1 st March 2022, appointed for a second 3 year term from 1 st March 2025. Resigned 31 st October 2025.
Professor Andrew Hassell (Senior Independent Director from 1st November 2025)	Appointed for a three-year term of office from 21 st January 2024.
Wendy Williams	Appointed for a three-year term of office from 21 st January 2024.
Sarah Corcoran	Appointed for a three-year term of office from 21 st January 2024.
Peter Williams	Appointed for a three-year term of office from 1 st November 2025.
Hasintha Gunawickrema	Appointed for a three-year term of office from 1 st November 2025.
Angela Simpson (University Appointed Non-Executive Director)	Appointed for a three-year term of office from 1 st January 2026.

Executive Directors

Jane Tomkinson OBE Chief Executive Officer	Substantive Chief Executive Officer from 1 st February 2024.
Karen Edge Chief Finance Officer	From 19 th February 2024.
Dr Nigel Scawn Medical Director	From 1 st September 2022.
Cathy Chadwick Chief Operating Officer	From 29 th March 2022.
Sue Pemberton Director of Nursing & Quality / Deputy Chief Executive Officer	Substantive Director of Nursing & Quality / Deputy Chief Executive from 1 st February 2024.

Executive Directors

Jonathan Develing Director of Strategy and Partnerships	Substantive Director of Strategic Partnerships from 1 st April 2024.
Jason Bradley Chief Digital and Data Officer	From 1 st May 2024.
Karan Wheatcroft	Substantive Director of Governance, Risk and Improvement from 10 th June 2024.
Vicki Wilson	Substantive Chief People Officer from 1 st July 2025.

Board effectiveness evaluation

A strong unitary Board is fundamental to the success of the Trust. The Trust has seen a significant period of change at Board level, across both Executive and Non-Executive Directors. 2025/26 brought greater stability in the Executive Team bringing strong leadership to addressing historic challenges and enabling sustainable improvement across a wide range of areas. Recruitment of Non-Executive Directors including the Trust Chair has taken place and the Board continues to undertake a programme of Board development.

The Board continues to evaluate its performance through appraisals (individually and collectively) and delivery of strategic objectives. Increasingly the Board has been required to provide Board assurance statements to support submissions to NHS England, ensuring consideration of key elements as part of its' work.

The effectiveness of the Board of Directors is demonstrated through the delivery of the Trust's strategy and is closely monitored by the Council of Governors throughout the year, through the information they receive, the Council of Governors meetings and in holding the Non-Executive Directors to account.

A Board development programme has been delivered in year with dedicated time to consider strategy, governance and organisation development. This has included external insights and unitary Board team development.

The Board has confirmed delivery of the actions from the well led peer review and CQC action plans with these now embedded within the Board and Assurance Committees. The Assurance Committees have also reported on their effectiveness in delivering their terms of reference to support the Board in discharging its responsibilities.



Attendance at Board of Directors and Board sub-committee meetings

Attendance at Board meetings held during 2025/26 and Board Committee meetings is set out below. This also reflects attendance of Board members who were in attendance but not members of the committee:

Name	Board of Directors	Audit Committee	Finance and Performance Committee	Quality and Safety Committee	Remuneration and Nominations Committee	People Committee
Trust Chair, Neil Large (substantive from 1 st July 2025)	6/6	N/A	N/A	N/A	6/6	N/A
Non-Executive Director David Williamson (until 31 st October 2025)	2/3	3/4	4/5	N/A	2/3	N/A
Non-Executive Director Paul Jones	6/6	1/1	6/6	4/4	6/6	N/A
Non-Executive Director Michael Guymer (until 31 st October 2025)	1/3	4/4	N/A	N/A	2/3	N/A
Non-Executive Director Pamela Williams- (until 31 st October 2025)	3/3	N/A	5/5	N/A	3/3	4/4
Non-Executive Director Wendy Williams	6/6	5/5	N/A	N/A	6/6	6/6
Non-Executive Director Prof Andrew Hassell	6/6	N/A	N/A	6/6	5/6	6/6
Non-Executive Director Sarah Corcoran	6/6	N/A	2/3	5/6	6/6	N/A
Non-Executive Director Peter Williams (from 1 st November 2025)	3/3	1/1	N/A	N/A	3/3	N/A
Non-Executive Director Hasintha Gunawickrema (from 1 st November 2025)	1/3	N/A	3/3	N/A	3/3	0/1

Name	Board of Directors	Audit Committee	Finance and Performance Committee	Quality and Safety Committee	Remuneration and Nominations Committee	People Committee
Non-Executive Director Angela Simpson (<i>from 1st January 2026</i>)	2/2	N/A	N/A	0/2	2/2	1/1
Chief Executive Officer Jane Tomkinson OBE	6/6	N/A	N/A	N/A	5/5	N/A
Director of Nursing & Quality/Deputy Chief Executive Sue Pemberton	6/6	N/A	N/A	6/6	N/A	N/A
Chief Finance Officer Karen Edge	6/6	5/5	6/6	N/A	N/A	N/A
Chief People Officer Vicki Wilson (<i>substantive from 1st July 2025</i>)	4/6	N/A	N/A	N/A	4/4	6/6
Chief Digital & Data Officer Jason Bradley	6/6	N/A	5/6	N/A	N/A	N/A
Chief Operating Officer Cathy Chadwick	4/6	N/A	5/6	5/6	N/A	5/6
Medical Director Dr Nigel Scawn	4/6	N/A	N/A	6/6	N/A	5/6
Director of Governance, Risk & Improvement Karan Wheatcroft	5/6	5/5	3/3	4/4	4/4	3/3
Director of Strategy & Partnerships Jon Develing	5/6	N/A	N/A	N/A	N/A	N/A

*To note, differing numbers of attendance for some Committees are reflective of individuals leaving/ joining the Trust and changes to Committee membership during 2025/26.

Board of Director profiles



Neil Large MBE **Chair from 1st March 2025**

Neil joined the Trust on 1st March 2025. He is an experienced NHS professional with extensive Board level experience who is passionate about the NHS, the patients it serves and its staff who deliver inspirational and dedicated care day in day out. A qualified accountant, Neil was appointed to his first board level post as Finance Director at Chester Health Authority before becoming its Chief Executive Officer. Neil also undertook the Chief Executive Officer role of the Family Health Services Authority in the early 1990s. In 2001 Neil was appointed Finance Director of the then newly-formed Cheshire and Merseyside Strategic Health Authority. Following retirement in 2006 he joined Liverpool Heart and Chest NHS Foundation Trust and subsequently acted as Chair from August 2009 to March 2022. During his tenure the Trust was rated 'outstanding' by the Care Quality Commission (CQC). Neil also served as a Non-Executive Director and Chair of Audit at The Christie NHS Foundation Trust from 2014 to 2021. Neil was awarded the MBE in the 2017 New Year Honours list for services to healthcare in both the NHS and charitable sectors where Neil has given many years of service as a Trustee at Tarporley Cottage Hospital and The Hospice of The Good Shepherd.



Paul Jones **Non-Executive Director and Deputy Chair**

Paul graduated in Mechanical Engineering from Manchester Metropolitan University, going on to work in the automotive industry for over 30 years. A Chartered Engineer by profession, he was primarily based in Cheshire, initially with Foden Trucks at Sandbach and from 2000 with Bentley Motors at Crewe. He has also completed assignments in USA, Germany and the Netherlands. He brings over 15 years of Board-level experience both as a Vehicle Line Director and latterly as Director of Product Management, with executive responsibility for all future Bentley product strategy. His current role is chief executive at the Northern Automotive Alliance, a not-for-profit trade association responsible for the activities of the automotive sector in the North of England. Paul is a fellow of the Institution of Mechanical Engineers and is also the current chair of its

Technical Strategy Board. Paul is the lead Non-Executive Director for Freedom To Speak Up and the Sustainability Strategy Group.



Professor Andrew Hassell
Non-Executive Director

Until his retirement from clinical practice in September 2021, Professor Hassell was a consultant rheumatologist at the Haywood Hospital in Stoke-on-Trent. He was also head of the School of Medicine at Keele University. Professor Hassell has also been a non-executive director at the University Hospital of North Midlands.



Wendy Williams
Non-Executive Director

Wendy has served on NHS Boards for over 20 years with her most recent role being the Deputy Chair of Cheshire Clinical Commissioning Group. She has held positions including the Chair of Clatterbridge Cancer Centre NHS Foundation Trust and three other NHS non-executive director positions.

Professionally working as a Change Director in both the private and public sectors, Wendy has led large scale change projects in several UK central government departments as well as private sector organisations in France, Germany and the USA. She now continues to coach executives on handling change and volunteers as a coach for various charity CEOs. Wendy has twice served as a school governor and has also been a member of a regional NSPCC Business Board.



Sarah Corcoran
Non-Executive Director

Sarah trained as a nurse in Manchester in the 1980s and after qualifying led a Stroke Care Development Unit. She then worked in a number of Trusts as a senior nurse involved in quality improvement and nursing management. In the course of this work, she developed an interest in patient and staff safety, how teams work together to maintain and improve safety, risk management and clinical governance. Sarah went on to work for 25 years in this field, and was a Director of Clinical Governance for a large Trust in the North West. She has worked across health systems locally and nationally to develop governance

structures, assurance processes and been involved in the delivery of safety projects across all specialties. She retired from her full-time NHS post in January 2022 and this is her first Non-Executive Director role.



Peter Williams
Non-Executive Director

Pete is a chartered internal auditor and chartered accountant. He started his career in external audit with Deloitte, before spending 15 years in a variety of private sector internal audit roles. Most recently he was a senior civil servant in HM Treasury, leading the Government Internal Audit Agency's provision of digital, data and technology, programme and project management and commercial and grants assurance across central government, including at the Department of Health and Social Care and a number of its arm's length bodies. He is a trustee of and audit committee member for the Road Safety Trust.



Hasintha Gunawickrema
Non-Executive Director

Hasintha is a Chartered Management Accountant and an alumna of Harvard Business School, bringing over 20 years of experience in the financial services sector across the UK, Europe, and Asia. She has held senior executive roles in major multinational banks and currently serves as a Non-Executive Director of a UK Building society. With a strong background in finance, risk management, service & operational management and technology transformation, Hasintha is passionate about using her expertise to help the Trust deliver outstanding care and equitable services for the communities it serves.

A committed advocate for leadership development, diversity, and inclusion, she has mentored emerging leaders and championed inclusive workplaces throughout her career. Hasintha is deeply motivated by the opportunity to contribute to the Trust's mission of providing the highest quality care in a safe environment with kindness at all times.



Angela Simpson-McEwan
Non-Executive Director

Angela is a Registered Mental Health Nurse who trained at the York School of Nursing in the 1980s. After qualifying, she specialised in acute in-patient mental health care, leading her team to achieve Nursing Development Unit accreditation for its innovative, research-informed, and patient-centred practice. This work led to a lecturing post at the University of York, where Angela began her academic career. She later completed a PhD at Newcastle University and progressed to become Professor and Head of Nursing, Midwifery and Health Professional Education. In 2018, Angela moved to Cheshire and is currently Pro Vice-Chancellor and Executive Dean of the Faculty of Health, Medicine and Society at University of Chester. With over 40 years' experience working within the NHS and higher education, she brings extensive expertise in health transformation, NHS workforce development, and the delivery of high-quality, evidence-based care.



Jane Tomkinson OBE
Chief Executive Officer

Jane has been Chief Executive Officer since February 2024.

Jane first joined the Trust as Acting Chief Executive Officer in December 2022 and held the position until she became the substantive Chief Executive Officer in February 2024. During this time, Jane provided senior leadership support to the Trust as well as to Liverpool Heart and Chest Hospital NHS Foundation Trust where she had been the Chief Executive Officer since 2013.

Since joining the NHS in 1990, Jane has held a number of executive level positions including Director of Finance at the Countess of Chester Hospital NHS Foundation Trust between 2004 and 2011. Whilst working at the Trust, Jane was awarded the prestigious Finance Director of the Year award by the Healthcare Financial Management Association. Following this role, Jane moved to work as a Finance Director at the North of England Strategic Health Authority. Jane was awarded an OBE for services to NHS finance in the Queen's New Year's Honours in 2016.

In addition to her NHS role Jane chairs the North West Coast Clinical Research Network and is an independent governor for Liverpool John Moores University.



Sue Pemberton

Director of Nursing & Quality / Deputy Chief Executive -

Sue became the Director of Nursing & Quality and the Deputy Chief Executive in February 2024. She is also the Director of Infection Prevention and Control and the Executive Lead For Safeguarding.

Sue started her career in the NHS in 1990 working as a nurse at Salford Royal Hospital when she qualified. She progressed to Assistant Director of Nursing at Salford Royal NHS Foundation Trust before joining Liverpool Heart and Chest Hospital NHS Foundation Trust as Deputy Director of Nursing in 2010. She went on to become the Director of Nursing and Quality at the Trust in May 2012. Sue is a Florence Nightingale scholar and has a passion for ensuring patients and their families receive the highest standards of care.



Karen Edge

Chief Finance Officer

Karen became Chief Finance Officer in April 2024.

Karen has worked in the NHS for 18 years having had a previous career in private sector finance. Karen is an experienced NHS finance leader and prior to joining the Trust, Karen was the Chief Finance Officer at Liverpool Heart and Chest Hospital NHS Foundation Trust. She has also previously held other senior leadership roles in local NHS Trusts including Acting Director of Finance and Deputy Director of Finance at Wirral University Teaching Hospitals NHS Foundation Trust and; Deputy Director of Finance at Mid Cheshire Hospitals NHS Foundation Trust.



Dr Nigel Scawn

Medical Director

Dr Nigel Scawn Joined the Trust as Medical Director in 2022. Prior to starting at the Countess, Nigel was the Deputy Medical Director and Lead for Patient Safety at Liverpool Heart and Chester Hospital.

Nigel qualified and worked as a pharmacist prior to studying medicine. Following his medical training he worked as a Consultant in Anaesthesia and Intensive Care at Arrowse Park Hospital before moving to Liverpool Heart and Chest Hospital where he was a Consultant for 22 years.



Cathy Chadwick
Chief Operating Officer

Cathy joined the Trust as Chief Operating Officer in March 2022.

Cathy has worked in the NHS for 19 years and has a Post Graduate Diploma in Healthcare Leadership. She has previously worked in large acute teaching trusts, mainly in the East Midlands and latterly as Deputy Chief Operating Officer at Liverpool University Hospitals NHS Foundation Trust. Cathy also currently works as the lead Chief Operating Officer, across Cheshire and Merseyside for Elective Restoration and she is passionate about improving cancer care for patients.



Karan Wheatcroft
Director of Governance, Risk and Improvement

Karan joined the Trust as Director of Governance, Risk and Improvement in June 2024.

With more than 20 years of experience working in the NHS, Karan brings a wealth of expertise in governance, risk and assurance arrangements at Board level. As Company Secretary, Karan leads the Trust's governance framework, regulatory and legal compliance, supporting the Board and Council of Governors in discharging their duties.

Karan also leads the Trust's legal, risk, improvement and communication teams, with a strong focus on organisational learning and continuous improvement.

Karan takes an active role in local and national networks, supporting developments, collaboration and joint working.



Jonathan Develing
Director of Strategic Partnerships

Jonathan joined the Trust as Director of Strategy and Partnerships in April 2024.

Jonathan started his NHS career in 1980 in general and psychiatric nursing, before moving into contract and systems management. He has considerable experience at a National and Regional level having worked as Regional Director of Operations and Delivery for NHS England (North) and as Chief Executive of NHS Wirral Clinical Commissioning Group. Jonathan joins the Trust from Liverpool Heart and Chest Hospital NHS Foundation Trust where he was Director of Strategic Partnerships. More recently Jonathan has also led the Cheshire and Merseyside systems wide approach to Cardiovascular Vascular Disease prevention.



Jason Bradley
Chief Digital and Data Officer

Jason has been Chief Digital and Data Officer since May 2024.

Jason has worked in the NHS since 1987 and has held a number of senior roles working in, and supporting, the NHS in the South West, London, Yorkshire and Cheshire Merseyside and at national level. Specialising in healthcare information technology and management, he has provided senior leadership for organisation-wide change management and transformation programmes involving the deployment of new technology, systems and analytics. Jason is also the Trust Senior Information Risk Officer (SIRO).



Vicki Wilson
Chief People Officer

Vicki joined the Trust as Interim Deputy Chief People Officer in June 2024 and became Chief People Officer in July 2025.

Vicki has 20 years' experience as a people professional in the NHS and joined the Trust from NHS Cheshire and Merseyside where she was Associate Director of Workforce. She has held a number of senior human resource and organisational development roles across Cheshire and Merseyside, including at Liverpool Heart and Chest NHS Foundation Trust, Mersey Care NHS Foundation Trust, Alder Hey Children's NHS Foundation Trust and the both the Royal Liverpool and Aintree University Hospitals (pre-merger).

A Chartered Fellow of the CIPD, Vicki is also a trained coach and mediator. Vicki leads the people agenda at the Trust and is passionate about making the Countess of Chester Hospital NHS Trust a great place to work for everyone, with significant focus on building a positive organisational culture through engaging, developing, and empowering staff.

Board of Directors – Leavers during 2025/26

David Williamson, Non-Executive Director (left the Trust 31st October 2025)

David joined the Board in November 2019, bringing 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 20 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.

Mick Guymer, Non-Executive Director and Senior Independent Director (left the Trust 31st October 2025)

Mick Guymer is a chartered accountant who had worked in the NHS for 40 years with 20 years' experience as a director of finance. He created NHS North West Procurement Development and has been a member of the NHS National Procurement Customer Board, for which he was also the Chairman of their Northern Board and a member of the NHS Supply Chain Medical Supplier Board. He has previously held a non-executive director role at a nearby acute NHS Trust.

Pam Williams, Non-Executive Director (left the Trust 31st October 2025)

Pam has a degree in economics and is a qualified accountant and member of the Chartered Institute of Public Finance and Accountancy. She has over 20 years' experience operating at Board level in a wide range of local authorities. Pam is an experienced Non- Executive Director in the NHS and other sectors and currently holds a position with Muir Group Housing Association.

Summary of declaration of interests of Directors

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 in place 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 NHS Foundation Trust website during 2025/26 and this can be accessed via the following link: [Register of Interests | Countess of Chester Hospital](#)

Directors have individually signed to confirm that they meet the Fit and Proper Persons Test and appropriate review of these declarations undertaken.

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 England 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
- 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 table below.

Better payment practice code - % payment within 30 days of receipt of undisputed invoices-target 95%:

Better payment practice code	2022/23	2022/23	2023/24	2023/24	2024/25	2024/25	2025/26	2025/26
	NHS	Non NHS	NHS	Non NHS	NHS	Non NHS	NHS	Non NHS
% Payment within 30 days of receipt (Volume)	82.40%	88.80%	86.90%	86.30%	96.92%	94.96%	88.86%	90.88%
undisputed invoices - target 95% (Value)	88.50%	88.70%	90.90%	88.70%	99.66%	94.74%	95.39%	88.69%

The reported volumes and values include invoices paid within 30 days after resolution of any disputes or queries with suppliers.

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

The income from the provision of health services is greater than the income from the provision of goods and services for other purposes, as required by Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012).

Cost allocation and charging requirements

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

NHS England's well-led framework

The information on the arrangements in place to govern quality, together with the arrangements in place to ensure that services are Well Led, are included 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 and families, stakeholders and partner relations can be found within the Performance Report section of this annual report.

Patient care

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



Ms Jane Tomkinson OBE
Chief Executive Officer
23rd June 2026



Governance Report

Focusing on Governance

The Trust is managed by the Board of Directors comprising a Chief Executive Officer, Chair, Non-Executive Directors and Executive Directors.

The Trust has a Council of Governors and the Governors are responsible for holding the Non-Executive Directors to account, individually and collectively, 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 for local people, helping to set the direction and shape the future of the hospital.

The Chair of the Board is also the Chair of the Council of Governors and is responsible for ensuring that the Board of Directors and the Council of Governors work together effectively. During 2025/26 there has been a significant focus on strengthening the relationship between the Board and the Council of Governors including communications, formal and informal meetings, and induction and development sessions. Governor elections were held independently governed in line with constitution rules to ensure representation across public and staff constituencies. Partnership governor changes also took place.

Board members attend and contribute to the formal Council of Governors meetings. Governors often attend to observe the public meeting of the Board of Directors. Non-Executive Directors and Governors do joint walkarounds to clinical and non clinical teams across the Trust, speaking to staff and patients, and observing the care provided.

Our Governance Structure

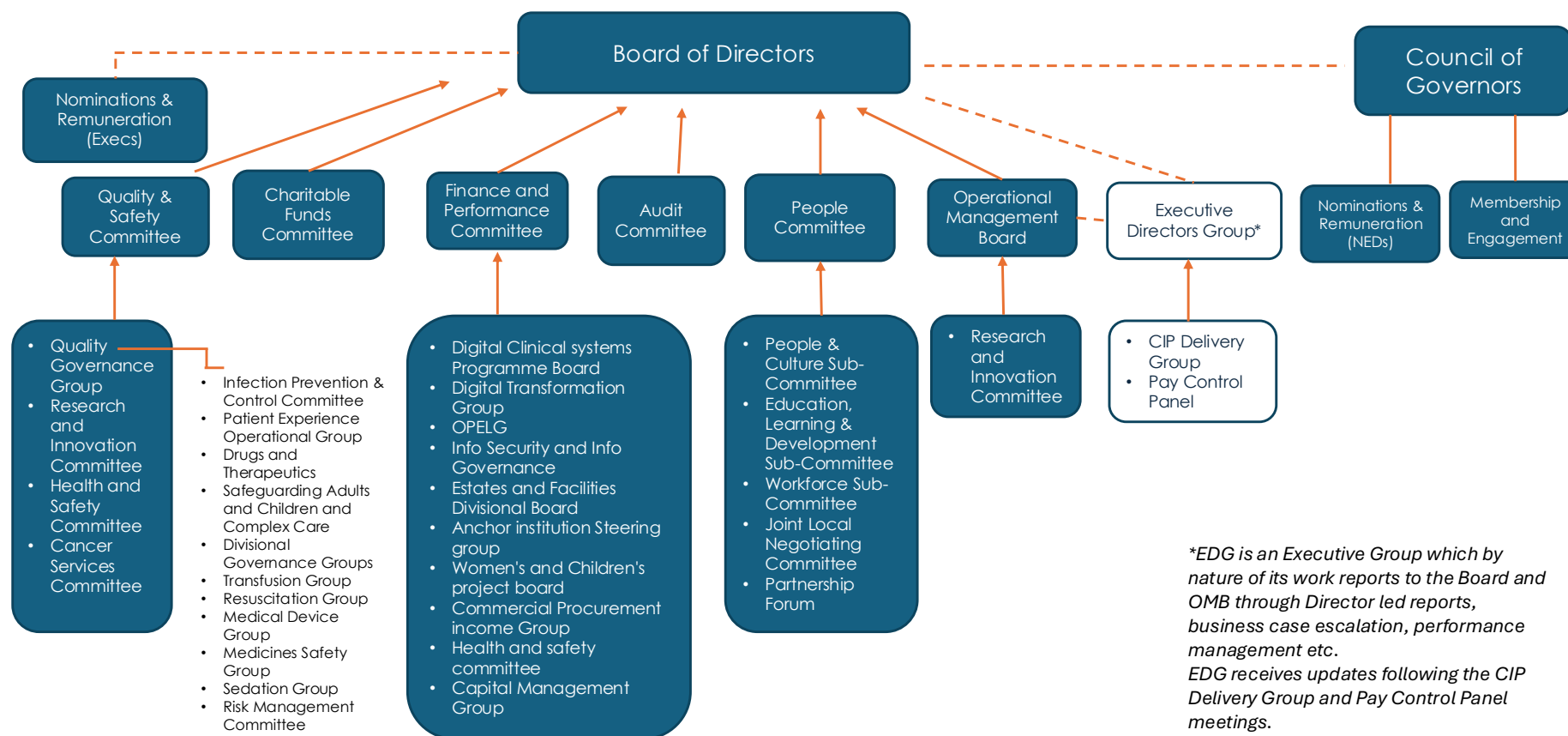
The Board of Directors has a number of formal assurance committees which report to the Board:

- Audit Committee
- Finance & Performance Committee
- People Committee
- Quality & Safety Committee
- Remuneration & Nominations Committee (Executive)

These committees, chaired by a Non-Executive Director, undertake a vital role on behalf of the Board. The Non-Executive Directors of the Board are confirmed as independent.

Trust Board Governance Structure

COCH Governance Organogram



Audit Committee

The Audit Committee has an overarching role in providing assurance to the Board on the Trust's overall governance, risk management and internal control arrangements. This includes arrangements for the preparation of Annual Accounts and Annual Report, the Annual Governance Statement and the Board Assurance Framework.

The Audit Committee consists of three independent Non-Executive Directors, at least one of whom (the Committee Chair) is a qualified accountant. In addition to the 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, and at least once a year. 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.

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

- Receiving assurance on the processes underpinning the Board Assurance Framework (BAF) and review of BAF 8 in respect of governance.
- Monitoring delivery of the Risk Management Improvement Plan and receiving updates on the Out-of-Date Policies Recovery Programme.
- Scrutiny of the Annual Governance Statement and triangulation with associated sources of assurance including provider licence and code of governance compliance.
- Received and considered Internal Audit Progress Reports at all meetings, along with assurance reports on key internal audit assignments.
- Monitored progress against internal audit recommendations through Audit Tracker and Follow-Up Reports.
- Received progress reports from Internal Audit and the draft Head of Internal Audit Opinion.
- Approved the Internal Audit Plan for the forthcoming year, including a 3 year strategic plan.
- Scrutinised External Audit reports, including ISA 260, significant risk updates, VFM assessments and technical updates.
- Approved the External Audit Plan for the forthcoming year.
- Considered the Indicative External Audit Risk Briefing for the forthcoming audit cycle.
- Reviewed Standing Financial Instructions amendments, procurement waiver reports, accounting policies, and bad debt write-offs to ensure financial governance.
- Approved or noted key financial reporting items, including the Annual Report, Annual Accounts, and Letter of Representation.

- Oversaw counter-fraud arrangements, reviewing the Annual Report, progress updates, thematic NHS Counter Fraud Authority reports, and approving the Anti-Fraud Workplan.
- Received assurance from other Board Committees (Quality & Safety, People, Finance & Performance) through agendas and Chairs' reports.
- Considered a range of external insight and benchmarking reports from internal and external audit providers to strengthen system learning and governance assurance.
- Approved updates to the Committee Terms of Reference and reviewed wider governance structures, including the governance organogram.

Quality and Safety Committee

The Quality and Safety Committee reports to the Board of Directors. The Committee is chaired by a Non-Executive Director and includes Non-Executive and Executive Director members along with a range of senior leaders. The Committee receives Chair reports from the Quality Governance Group to support it in meeting its' Terms of Reference.

During the year, the Quality and Safety Committee undertook the full range of its' responsibilities, including:

- Oversight of clinical quality performance through routine review of the Integrated Performance Report (IPR) covering safety, quality, and patient experience indicators.
- Monitoring implementation of CQC Urgent and Emergency Care (UEC) action plans to ensure sustained improvement.
- Consideration of external regulatory reports and compliance updates, including CQC, NHS England, and NICE compliance reporting.
- Reviewing and challenging Safety Surveillance and Learning Reports, identifying themes, trends, and learning from incidents.
- Oversight of mortality governance via routine Learning from Deaths and Mortality Surveillance Reports (quarterly and annual).
- Monitoring of serious incidents, harm reviews, and cancer pathways, receiving specific Cancer Harm Review updates and assurance reports.
- Receiving regular patient experience intelligence, including patient stories, complaints/ concerns annual reporting, Friends and Family Test (FFT) improvement work, Health Watch feedback and national Patient Experience Survey results (including Children's and Young People).
- Receiving assurance in respect of complaints management, and review of complaints themes, and Trust response times.
- Receiving and reviewing assurance on the processes for Quality Impact Assessments (QIAs) linked to Cost improvement/ transformation programmes, ensuring no unintended negative impact on patient care.

- Receiving updates on maternity and perinatal services, including Maternity Incentive Scheme compliance, survey results, and quarterly maternity and perinatal updates.
- Oversight of safeguarding arrangements, reviewing quarterly Safeguarding and Complex Care reports covering adult and child safeguarding requirements.
- Receiving assurance on key clinical statutory areas, including Resuscitation Annual Reports, IR(ME)R compliance, medical devices safety, cleaning/estates standards, and discharge letter timeliness.
- Gaining assurance from Quality Governance Group (QGG) via quarterly Chair's Reports and minutes, supporting clinical governance oversight.
- Monitoring clinical risk, including regular review of the relevant extracts of the Board Assurance Framework (BAF) and high-risk reports throughout the year.
- Oversight of the quality and safety priorities, including Striving for Excellence updates, Trust clinical audit and assurance reports, and action tracking via the MIAA Audit Tracker.

Finance and Performance Committee

The Finance and Performance Committee reports directly to the Board. The Committee is chaired by a Non-Executive Director and includes Non-Executive and Executive Director members along with a number of senior leaders.

The role of the Finance and Performance Committee is to seek assurance 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, capital plans and performance.

During the year, the Finance and Performance Committee undertook the full range of its responsibilities including:

- Review and challenge of the Trust's financial position at every meeting, through monthly finance reports including performance against plan, forecasts, cash position updates, and cost improvement plans.
- Oversight and approval of key elements of financial strategy, including annual plans, budget-setting updates, and the 5-year integrated plan.
- Scrutiny of the delivery of efficiency programmes and cost improvement plans, including risks linked to delivery of these plans.
- Review and endorsement of major capital business cases, including theatres redevelopment, estates infrastructure, and Women & Children's building programme reports.
- Monitoring delivery of the Capital Programme, receiving regular Capital Management Group reports and assurance on capital spending and risks.
- Oversight of the Trust's operational performance, with review of the Integrated Performance Report (IPR), constitutional standards, including non-criteria to reside (NCTR) impact, Urgent and Emergency Care standards and service-level performance.

- Receiving assurance reports relating to Health & Safety, including annual and six-monthly safety updates, high-risk reports, RIDDOR updates and estates compliance.
- Oversight of delivery of the Estates priorities, including estates compliance, high-risk estates issues, and estates transformation updates.
- Receiving annual and interim updates on Emergency Preparedness, Resilience & Response (EPRR) compliance, including the Core Standards submission and action plans.
- Oversight of digital and data strategy, receiving regular updates on the Digital & Data Strategic Programme, Senior Information Risk Owner (SIRO) reports, cyber security, data governance and digital annual reporting.
- Receiving assurance on data quality systems and digital transformation, including Electronic Patient Records Programme (EPR) Board updates and Digital Clinical Systems assurance reports.
- Scrutinising procurement, including quarterly waiver reports, and procurement strategic updates.
- Reviewing progress against the Trust's Green Plan and sustainability objectives, including pre-Board approval of major sustainability scheme (e.g. geothermal bid).
- Monitoring organisational delivery through subsidiary groups' chair reports, including: Digital Transformation Group, Commercial Procurement Income Group, Estates & Facilities Divisional Group, Operations and Performance Executive Led Group, Anchor Institution Steering Group, Electronic Patient Records Programme Board and Information Governance & Cyber Security Committee.
- Review of the Board Assurance Framework and high-risk reports at every meeting, ensuring risk escalation on financial, operational, digital, and estates.

People Committee

The People Committee reports directly to the Board. The Committee is chaired by a Non-Executive Director and includes Non-Executive and Executive Director members along with a number of senior leaders.

The People Committee is responsible for ensuring the approval, oversight and scrutiny of the Trust's People Strategy; providing assurance to the Board on all aspects of workforce and organisational development supporting the provision of safe, high quality, patient-centered care; assuring the Board of compliance with key national and statutory workforce requirements; and developing, as necessary, strategic workforce recommendations for approval by the Board.

During the year, the People Committee undertook a wide range of responsibilities including:

- Keeping abreast of national and local People priorities through the Chief People Officer updates.
- Receiving a diverse range of staff stories with staff attending to provide their own personal reflections.

- Oversight and scrutiny of the delivery of the People Strategy 2025–2028, receiving updates, approving strategy elements, and monitoring progress across multiple meetings.
- Receiving assurance on the development and delivery of the Workforce Annual Plan, including workforce planning progress updates at each meeting.
- Review of compliance with statutory Equality, Diversity & Inclusion (EDI) duties, including NHS Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), Gender Pay Gap and Equality Delivery System (EDS) submissions.
- Reviewing the staff survey results, narrative themes, and action plans including deep dives on the survey, wellbeing data, and the People Promise programme.
- Receiving assurance regarding medical workforce governance, including safe working hours, revalidation, medical education, General Medical Council (GMC) National Training Survey results and Resident Doctor 10-Point Plan reports.
- Receiving quarterly reports from the Freedom to Speak Up Guardian, including concerns raised, thematic learning and triangulation.
- Reviewing bi-annual Nursing and Midwifery Safer Staffing reports, ensuring safe staffing levels and mitigation of workforce risks across clinical areas.
- Reviewing the Board Assurance Framework (BAF) and people-related high-risk reports in every meeting, ensuring risk oversight and clear escalation routes.

The Council of Governors

The Council of Governors and its 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. Governors are also responsible for representing the interests of the members, public and in respect of the staff Governors, their colleagues. Governors are responsible for regularly feeding back information about the Trust, its vision and its performance to members, the public and the stakeholder organisations including those that elected or appointed them.

The Council of Governors holds the Board of Directors to account in a variety of ways. This includes observing and appraising the performance of the Chair and Non-Executive Directors, analysis of the integrated performance reports, observing the Board of Directors' meetings, reviewing the Committee Chair's reports, and by challenging and raising questions. Governors and Non-Executive Directors also undertake monthly walkabouts across Trust wards and departments, to support visibility and allow triangulation with information received through reports and committee meetings.

The Trust continued to strengthen the relationship between the Board and the Council of Governors and supporting Governors to discharge their duties in 2025/26 through:

- Improvements to the information provided and forums for discussion including the introduction of regular informal meetings for Governors to meet with the Trust Chair.
- Clearer communication of key updates through direct briefings from the Trust Chair and discussion topics set for the informal meetings.
- A successful Governor election campaign strengthening the Council of Governors.
- Re-establishment of the Governor led Membership and Engagement Committee.

During 2025/26 the Council of Governors received updates on:

- National, regional and local updated through the Chief Executive Officer's report.
- Patient stories.
- Trust operational performance including elective recovery, waiting times and cancer.
- The Trust's financial position and delivery of the cost improvement programme.
- Regulatory compliance and reports including Care Quality Commission (CQC) and NHS England Enforcement Notice.
- Patient and Family Experience.
- National patient and staff survey results.
- Operations Hummingbird and Duet, and the Thirlwall Inquiry.
- Anchor Institute.
- Clinical Strategy.

In addition to the formal meetings of the Council of Governors, an induction and development session was held to include:

- **Roles and responsibilities:** supporting Governors to discharge their duties
- **Strategy:** engaging Governors in the Trust's delivery of the Transforming Care Together Strategy
- **Non-Executive Directors:** exploring the roles of Non-Executive Directors and Assurance Committees

The decisions taken by the Council of Governors in 2025/26 included:

- Appointment of the Trust Chair.
- Appointment of new Non-Executive Directors.
- Approval of changes to the Trust Constitution including the introduction of a new University appointed Non-Executive Director.
- Approval of a further term of office for the Deputy Chair/ Non-Executive Director.
- Approval of the appraisal process for the Chair and Non-Executive Directors and receiving the outcomes from these processes.
- Approval of a new Membership Strategy and process to support the cleansing of the Trust's membership database.
- Approval of the process for the succession and appointment of a new Lead

Governor.

We continue to work with our Council of Governors to strengthen communication and engagement, and maximise the valuable contribution that Governors make.

A view from John Jones, Lead Governor



2025/26 has again been a very challenging year for the Trust particularly in the areas of urgent care, waiting lists and the finances. However, all staff both clinical and non-clinical have as always risen to the challenges in their ongoing pursuance of excellent patient care.

All Governors have had a key part to play in monitoring the Trusts performance and being engaged in the review of the trusts strategic and operational risks. We do this by holding the Non-Executive Directors to account via various forums including our attendance at Board meetings held in public, their attendance at our Council of Governor meetings where they present on their particular portfolios, and we engage with them regularly when we all undertake the NED/ Governor hospital walkabouts which Governors find invaluable.

We have over the last year held regular Governor development sessions where both Executive Directors have led on certain topic areas and NEDs have presented on their own lead areas.

The Council of Governors meets formally four times each year. The governance of this meeting has been strengthened during the last year and a work plan developed which is reviewed at each meeting. This has enabled Governors to be much more focused.

To ensure that Governors are kept updated the new Trust Chair holds regular informal briefing sessions which all Governors are invited to.

Governors are members of the Trust's Nominations Committee and have as all Governors have over the last year been central to the appointment of the Trust's new Chair and in the appointment of the new Non-Executive Directors.

The Membership and Engagement Committee has been re-launched and a new Membership Engagement Strategy has now been developed and agreed. During the forthcoming year Governors aim to be more proactive in their engagement with members of our local communities.

A number of Governors terms of office came to an end in September 2025 and I would like to thank each of them for their commitment and involvement whilst here at the trust.

We also saw a significant number of new Governors join the Trust in September 2025 following elections in the summer and I would like to welcome them and look forward to working with them in the forthcoming year. We have again adopted our Governor Buddying scheme; this allows new Governors to align to a Governor who is already within the Trust for them to help and support them during the initial period of their tenure.

There is no doubt that the Trust continues to be under many pressures but there are also so many positive achievements which have taken place through 2025/26. It is perhaps unfair to single out any particular one but the Women's and Children new build has to be a wonderful example of what the Trust can and does do so well. Governors have been given such a privileged insight to the development of this build from the initial ground works, and I was fortunate in attending the official opening of this facility. Although the build is without doubt a great achievement perhaps feedback from a patient who recently had her baby delivered there perhaps sums it up best. She said "Although the building is absolutely fantastic what really made my experience exceptional was the staff who work there – all of them from the cleaning and reception staff through to the clinicians who so professionally delivered our baby safely – all were wonderful and made my experience so exceptional"

The above patient comments regarding the staff are reflected from patients' feedback across the Trust and I on behalf of Governors would like to thank all staff for their compassionate and dedicated care they deliver day in day out even during the most challenges times.

As we look forward to 2026/27 Governors continue to be fully committed to the ongoing development of the Trust. My term of office as both a Governor and as Lead Governor comes to an end in September 2026. We have already gone through a structured process to seek a new Lead Governor from September 2026.

Composition of Council of Governors

The total number of Governor positions established within the Constitution is 27, and our current composition is as follows:

Composition of Council of Governors

Constituency area	Number of Governors in post
Chester and Rural Cheshire	8
Ellesmere Port and Neston	1
Flintshire	2
Rest of England & Wales	1

Staff	5
Partnership organisations	4
Total	21

A photo sheet of the Council of Governors is available on the Trust's website - : [Foundation Trust Council of Governors | Countess of Chester Hospital](#)

The membership of the Council of Governors during 2025/26, for both elected and appointed Governors, and their length of tenure, is set out below.

Membership of Council of Governors

Governor/Constituency	Term of office
Public – Chester and Rural Cheshire	
John Jones	Re-elected in September 2023 for a third term of office for three years until October 2026. Lead Governor from 1 st September 2024.
Lucy Liang	Term ended in October 2025.
Timothy Wheeler	Resigned June 2025 (left in year).
Robert Howe	Elected October 2023 for three years until October 2026.
Jan Chillery	Elected October 2024 for three years until October 2027.
Sheila Dunbar	Elected October 2024 for three years until October 2027.
Louise Jha	Elected October 2024 for three years until October 2027.
Richard Taylor	Elected October 2025 for three years until October 2028.
Sharon Cook	Elected October 2025 for three years until October 2028.
Prof Tony Fisher	Elected October 2025 for three years until October 2028.
Public – Ellesmere Port and Neston	
Brian Jones	Term ended September 2025.
Dr Kausik Chatterjee	Elected October 2025 for three years until October 2028.
<i>Three vacant positions as at 2nd March 2026</i>	
Public – Flintshire	
Ruth Overington	Re-elected in September 2022 for a third term of office for three years until September 2025.

Governor/Constituency	Term of office
Myrddin Roberts	Elected in October 2024 for three years until October 2027.
Christine Holloway	Elected October 2025 for three years until October 2028.
<i>One vacant position as at 2nd March 2026</i>	
Public – The Rest of England & Wales (formerly Wider Area)	
Daryl Cassidy	Elected in October 2024 for three years until October 2027.
Partnership organisation appointed governors	
David Foulds Voluntary Services	Appointed November 2020.
Carol Gahan Cheshire West and Chester Council	Appointed June 2023.
Paolo Tardivel Betsi Cadwaladr University Health Board	Appointed February 2026.
Dr Eve Collins University of Chester	Appointed March 2026.
Dr Kate Knight University of Chester	Appointed in May 2024 and stood down February 2026.
Staff Governors	
Nurses / Midwives Qualified:	
Angel Lewis-Aaron Maria Woodward Dadirai Kambasha Paula Edwards	October 2023 to September 2025 (4 Governors on a job sharing basis). A full staff governor election took place in September 2025 to ensure constitution compliance.
Paula Edwards	Reappointed October 2025 for 3 years to October 2028
Cheryl Finney	Appointed October 2025 for 3 years to October 2028
Jayne Caple	October 2023 to September 2025. A full staff governor election took place in September 2025 to ensure constitution compliance.
Robert Gorman	Appointed October 2025 for 3 years to October 2028
Doctors:	
Dr Salah Tueger	Appointed October 2023. A full staff governor election took place in September 2025

Governor/Constituency	Term of office
	to ensure constitution compliance. Reappointed October 2025 for 3 years to October 2028
Chris Price Stephen Higgitt	October 2023 to March 2025 (job share) October 2023 to September 2025. A full staff governor election took place in September 2025 to ensure constitution compliance.
Naomi Cottrell	Appointed October 2025 for 3 years to October 2028

Election of Council of Governors

A notice of election was published in July 2025 in the following constituencies:

Public:

- Chester City and Rural Cheshire
- Ellesmere Port and Neston
- Flintshire

Staff:

- Medical
- Nursing and Midwifery
- AHP, Technical and Scientific
- Other

An election was held in the summer of 2025 with the results announced at the Annual Members Meeting held on 3rd October 2025. The election was as follows.

Public

- Chester City and Rural Cheshire – the election was conducted using the single transferable vote electoral system and three candidates were elected.
- Ellesmere Port and Neston – one candidate elected unopposed, three vacant positions remain.
- Flintshire – the election was conducted using the single transferable vote electoral system and two candidates were elected.

Staff:

- Medical - the election was conducted using the single transferable vote electoral system and one candidate was elected.
- Nursing and Midwifery – two candidates elected unopposed.
- AHP, Technical and Scientific – one candidate elected unopposed.
- Other - the election was conducted using the single transferable vote electoral system and one candidate was elected.

Elections were held in accordance with the model election rules and were undertaken

independently by Civica Election Services (CES).

Attendance at Council of Governors' meetings

There have been four public meetings of the Council of Governors' and six private meetings held during 2025/26.

The Governor attendance at the public and private meetings is shown below, along with expenses of Governors:

	Public	Private	Governors' expenses 2025/26
Neil Large – Trust Chair	1/4	5/6	N/A
Paul Jones – Non-Executive Director (Chaired the June 2026 meeting for Neil Large)	N/A	1/1	N/A
Robert Howe	0/4	1/6	N/A
John Jones (Lead Governor)	4/4	6/6	N/A
Lucy Liang (till October 2025)	2/2	3/3	N/A
Sheila Dunbar	3/4	5/6	N/A
Tim Wheeler (till June 2025)	1/1	0/1	N/A
Jan Chillery	3/4	5/6	N/A
Louise Jha	4/4	5/6	N/A
Sharon Cook (from October 2025)	1/2	1/3	N/A
Richard Taylor (from October 2025)	2/2	3/3	N/A
Prof Tony Fisher (from October 2025)	2/2	2/3	N/A
Brian Jones (till September 2025)	2/2	1/3	N/A
Dr Kausik Chatterjee (from October 2025)	0/2	0/3	N/A
Ruth Overington	2/2	3/3	N/A
Myrddin Roberts	4/4	3/5	N/A
Chris Holloway (from October 2025)	2/2	2/3	N/A
Ian Gibbons (from October	1/1	0/1	N/A

	Public	Private	Governors' expenses 2025/26
2025)			
Daryl Cassidy	0/4	0/6	N/A
David Foulds	3/4	4/6	N/A
Cllr Carol Gahan	2/4	2/6	N/A
Karen Chambers (till November 2025)	2/2	0/3	N/A
Paolo Tardivel (from February 2026)	1/1	0/1	N/A
Dr Eve Collins (from March 2026)	0/0	0/0	N/A
Dr Kate Knight (till February 2026)	0/3	0/5	N/A
Paula Edwards*	2/4	2/6	N/A
Stephen Higgitt* (till September 2025)	2/2	3/3	N/A
Ashley Jayne Caple* (till September 2025)	0/2	1/3	N/A
Angela Lewis-Aaron* (till September 2025)	0/2	0/3	N/A
Dadirai Kambasha (till September 2025)	0/2	0/3	N/A
Chris Price (till May 2025)	0/1	0/1	N/A
Dr Salaheddin Tueger	3/4	1/6	N/A
Maria Woodward* (till September 2025)	0/2	0/3	N/A
Cheryl Finney (from October 2025)	2/2	2/6	N/A
Robert Gorman (from October 2025)	0/2	0/3	N/A
Naomi Cottrell (from October 2025)	2/2	3/3	N/A

*To note attendance recognises the job share arrangements in place at the time.

Starter and leaver dates have been included in the table for context and in some instances the low attendance is reflective of these dates.

Governors' Nominations Committee

Non-Executive Directors, including the Trust Chair, are appointed by the Council of Governors for the specified term – subject to re-appointment thereafter at intervals of no more than three years, and are subject to the National Health Service Act 2006 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 Governors and the Trust Chair. Where the decision pertains to the role of the Trust Chair, the Deputy Trust Chair will attend instead.

During 2025/26, the Governor's Nominations Committee were asked to consider and approve the appointment of an interim Trust Chair and subsequently the substantive Trust Chair. In addition the committee were asked to review and approve extending the term of one Non-Executive Director and the appointment of three new Non-Executive Directors for recommendation to the full Council of Governors for formal approval.

Membership

The members of the 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 last updated in August 2025, 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:

1. Chester and Rural Cheshire
2. Ellesmere Port and Neston
3. Flintshire
4. The rest of England and Wales

Staff membership

The staff constituency is divided into four classes as follows:

1. Doctors
2. Nursing and midwifery
3. Allied healthcare professionals and technical/scientific
4. Other staff groups

The Governor led Membership and Engagement Committee was re-established in 2025/26 and supported the development of a new membership strategy.

Membership size and movements

In 2025/26 the Council of Governors supported a proposal for a data cleanse of the Trust's Membership Database, recognising the challenges faced with historic membership, limited email addresses and increasing costs in managing elections and communications. This data cleanse was undertaken alongside the elections with members in the two constituencies that went to a vote being asked to confirm their membership and communication preferences. This process resulted in a significant reduction in public members.

Public Membership changes in 2025/26 are shown in the following table.

Changes in membership

Public constituency	2024/25	2025/26
At year start	5,417	5,369
New members	41	21
Members leaving*	89	2,845
At year end	5,369	2,545

**The members leaving figure also includes deceased members.*

All substantive staff are classed as members on appointment. There were 4,988 staff members at the end of March 2026, compared with 5,032 staff members at the end of March 2025.

Current and future engagement with members

The Trust engages with its members via:

- Social media
- Trust website
- Participating in governor elections and notice of elections
- Annual Member's Meeting

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 Trust's website: www.coch.nhs.uk



Remuneration Report 2025/26

Annual Statement of Remuneration

The Remuneration Committee (Executive) is responsible for the appointment of the Chief Executive Officer (also subject to Council of Governor approval) and other Executive Directors of the Board of Directors. It reviews and recommends the terms and conditions of service for the Executive Directors and reviews their performance. The Remuneration Committee (Executive) also ensures levels of remuneration are appropriate for the roles, aligned with national benchmarks. The Committee has oversight of the Trust's senior management pay framework and reviews the arrangements for the Very Senior Managers (VSMs) who are not subject to Agenda for Change terms and conditions.

The Committee is chaired by the Trust Chair and includes all Non-Executive Directors. The Chief Executive Officer, Chief People Officer and Director of Governance, Risk and Improvement attend by invitation to support the Committee and ensure the Committee is apprised of relevant internal or external advice, data or information. These officers are not present where discussions relate to their appraisal, terms and conditions or appointment.

The Remuneration Committee (Executive) met on 6 occasions during 2025/26. The Committee fulfilled its role through:

- Receiving and reviewing the appraisals for the Chief Executive Officer and Executive Directors for 2024/25.
- Discussing and approving the Chief Executive Officer and Executive Director objectives for 2025/26.
- Reviewing the Executive Team succession planning and seeking further details on the risks, mitigations and depth of succession planning within the organisation.
- Appointment of the Chief People Officer and the Director of Transformation and Productivity.
- Approval of changes to the Executive Team structure including the establishment of an Interim Director of Delivery.
- Approval of retire and return requests in compliance with national guidance.
- Approval of a Mutually Agreed Resignation Scheme (MARS) and a Voluntary Redundancy Scheme.
- Review of the revised national VSM framework and approving the application of the national pay award for VSM staff.

The contracts of employment of all Executive Directors, including the Chief Executive Officer, are permanent and are subject to six months' notice of termination.

Service contract obligations and policy on payment for loss office

All Executive Directors are employed on permanent or fixed term contracts and are required to give six months' notice to terminate their contract. In line with NHS Employers' guidance, the notice period for the Trust's Very Senior Managers (VSMs) is three to six months. Payment for loss of office is covered within contractual notice periods and standard employment policies and legislation.

Trust's consideration of employment conditions

Other members of staff who are not Board members are employed on agenda for change terms and conditions and any percentage pay increases are applied in accordance with national agreements. The Remuneration Committee agrees senior managers pay and conditions following consideration of benchmarking information on comparable roles. Employees of the Trust are not consulted on senior manager remuneration.

Very Senior Manager (VSM) Pay Framework compliance

The Trust has complied in full with the NHS Very Senior Manager (VSM) pay framework during the reporting period. All remuneration decisions have been made in accordance with the framework, where national approval is required, appropriate approval is sought and obtained. The Trust confirms that there were no departures from the VSM pay framework in the year.

Salary and pension entitlement of senior managers

Salary and pension entitlements of senior managers- 2025/26 (audited) and 2024/25 (audited)

	Salary	Other taxable benefits	Pension related benefits	Total	Salary	Other taxable benefits	Pension related benefits	Total
	(bands of £5,000)	To nearest £100	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	To nearest £100	(bands of £2,500)	(bands of £5,000)
	2025/26 £000	2025/26	2025/26 £000	2025/26 £000	2024/25 £000	2024/25	2024/25 £000	2024/25 £000
Mrs Jane Tomkinson - Chief Executive Officer	235-240	10,700	-	245-250	230-235	7,100	-	240-245
Mrs Karen Edge - Director of Finance	160-165	-	52.5-55	215-220	155-160	-	130-132.5	285-290
Dr Nigel Scawn - Medical Director (from 01.09.22)	245 -250	-	60-62.5	305-310	245 -250	-	67.5-70	310-315
Sue Pemberton Director of Nursing & Quality - Assistant Chief Executive	180-185	-	-	180-185	175-180	-	-	175-180
Mrs Karan Wheatcroft - Director of Governance, Risk & Improvement (from 10.06.24)	140-145	-	137.5-140	280-285	110-115	-	70-72.5	180-185
Jonathan Develing Director of Strategy & Partnerships	105-110	9,900	-	115-120	130-135	8,200	-	140-145
Mr Jason Bradley - Chief Digital and Data Officer	145-150	-	35-37.5	180-185	130-135	-	30-32.5	160-165

	Salary	Other taxable benefits	Pension related benefits	Total	Salary	Other taxable benefits	Pension related benefits	Total
	(bands of £5,000)	To nearest £100	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	To nearest £100	(bands of £2,500)	(bands of £5,000)
	2025/26 £000	2025/26	2025/26 £000	2025/26 £000	2024/25 £000	2024/25	2024/25 £000	2024/25 £000
Mrs Laura Leadsom Acting Director of Corporate Affairs (to 09.06.24)	-	-	-	-	15-20	-	-	15-20
Cathy Chadwick - Chief Operating Officer	160-165	-	-	160-165	150-155	-	-	150-155
Mrs Debbie Herring - Acting Chief People Officer (from 01.05.24 to 31.12.24)	-	-	-	-	95-100	-	-	95-100
Mr Mark Dale - Acting Chief People Officer (to 19.05.24)	-	-	-	-	15-20	-	5 -7.5	20-25
Ms Vicki Wilson - Chief People Officer (Acting to 30.06.25-Substantive from 01.07.25)	120-125	10,500	67.5-70	200-205	25-30	2,400	7.5-10	35-40
Ian Haythornthwaite - Chair (to 14.02.25)	-	-	-	-	40-45	4,300	-	40-45
Mr Neil Large - Chair (from 01.03.25)	50-55	400	-	50-55	0-5	-	-	0-5
D Williamson - Non- Executive Director (to 31.10.25)	5-10	-	-	5-10	10-15	-	-	10-15

	Salary	Other taxable benefits	Pension related benefits	Total	Salary	Other taxable benefits	Pension related benefits	Total
	(bands of £5,000)	To nearest £100	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	To nearest £100	(bands of £2,500)	(bands of £5,000)
	2025/26 £000	2025/26	2025/26 £000	2025/26 £000	2024/25 £000	2024/25	2024/25 £000	2024/25 £000
Paul Jones - Non-Executive Director	10-15	-	-	10-15	10-15	-	-	10-15
Mick Guymer - Non-Executive Director (to 31.10.25)	10-15	-	-	10-15	10-15	-	-	10-15
Pam Williams Non-Executive Director	5-10	-	-	5-10	10-15	-	-	10-15
Sarah Corcoran	10-15	300	-	10-15	10-15	-	-	10-15
Andrew Hassell	10-15	-	-	10-15	10-15	-	-	10-15
Wendy Williams	10-15	-	-	10-15	10-15	-	-	10-15
Peter Williams (from 01.11.25)	5-10	-	-	5-10	-	-	-	-
Hasintha Gunawickrema (from 01.11.25)	5-10	-	-	5-10	-	-	-	-
Angela Simpson (from 01.01.26)	0-5	-	-	0-5	-	-	-	-
Total Director Remuneration	1650-1655	31,800	360-362.5	2,045-2,050	1,640-1,645	22,000	315-317.5-245	1,980-1,985

For all of the Directors who were in post for part of the financial year 2025/26 the salary included in the table is for the period they were in post only.

Ms Vicki Wilson was appointed to Chief People Officer on 1st July 2025, prior to that she was Acting Chief People Officer from the 1st January 2025. During the time she was Acting Chief People Officer she was on secondment from Cheshire and Mersey ICB and the pay information included in the table above is for her full pay which has been paid for by the Trust, for the full financial year.

Other taxable benefits include travel expenses between home and COCH, and benefits in kind such as salary sacrifice lease cars.

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.

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.

	Real increase in Pension at age 60	Real increase in pension lump sum at age 60	Total accrued pension at age 60 at 31 March 2026	Lump sum at age 60 related to accrued pension at 31 March 2026	Cash equivalent transfer value at 31 March 2026	Cash equivalent transfer value at 31 March 2025	Real increase in cash equivalent transfer value
	(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	(to nearest £1,000)	(to nearest £1,000)	(to nearest £1,000)
	2025/26 £000	2025/26 £000	2025/26 £000	2025/26 £000	2025/26 £000	2024/25 £000	2025/26 £000
Dr Nigel Scawn - Medical Director	2.5-5	-	100-105	255-260	313	225	53
Karen Edge - Director of Finance	2.5-5	0-2.5	45-50	100-105	196	1008	-

	Real increase in Pension at age 60	Real increase in pension lump sum at age 60	Total accrued pension at age 60 at 31 March 2026	Lump sum at age 60 related to accrued pension at 31 March 2026	Cash equivalent transfer value at 31 March 2026	Cash equivalent transfer value at 31 March 2025	Real increase in cash equivalent transfer value
	(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	(to nearest £1,000)	(to nearest £1,000)	(to nearest £1,000)
	2025/26 £000	2025/26 £000	2025/26 £000	2025/26 £000	2025/26 £000	2024/25 £000	2025/26 £000
Mark Dale - Acting Chief People Officer (to 19.05.24)	-	-	-	-	-	65	-
Mrs Karan Wheatcroft - Director of Governance, Risk & Improvement	5-7.5	7.5-10	45-50	110-115	955	807	116
Mr Jason Bradley - Chief Digital and Data Officer	2.5-5	-	35-40	100-105	915	844	38
Ms Vicki Wilson - Chief People Officer	2.5-5	7.5-10	20-25	45-50	389	308	61

Jane Tomkinson, Sue Pemberton, Jonathan Develing, and Cathy Chadwick chose not to be covered by the pension arrangements during the reporting period.

Karan Wheatcroft, Director of Governance, Risk & Improvement, joined the Trust on 10th June 2024. The disclosure in the 2024/25 Annual Report reflected remuneration and pension benefits for the period of employment during that financial year only. In the current year, the comparative disclosure has been revised, with the pension figure annualised to reflect a full-year equivalent value.

In accordance with the Group Accounting Manual (GAM), negative values are substituted with a zero.

Other arrangements (audited)

	Salary	Pension related benefits	Total	Salary	Pension related benefits	Total
	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)
	2024/25 £000	2024/25 £000	2024/25 £000	2023/24 £000	2023/24 £000	2023/24 £000
Hilda Gwilliams (seconded to North Cumbria Integrated Care NHS FT to 09.04.25)	0-5	-	0-5	160-165	-	160-165

Hilda Gwilliams was on secondment to North Cumbria Integrated Care (from 6th November 2023 to 9th April 2025)

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.

Cash Equivalent Transfer Value (CETV) figures are calculated using the guidance on discount rates for calculating unfunded public service contribution rates that was extant on 31 March 2023. HM Treasury published updated guidance in March 2023; this guidance will be used in the calculation of 2025/26 CETV figures.

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.

Once a member reaches normal pensionable age (NPA) in the 1995 Pension scheme the NHS Pension Scheme will not make a

cash equivalent transfer and is therefore not applicable. NPA is age 60 in the 1995 Section, age 65 in the 2008 Section or State Pension age or age 65, whichever is the later, in the 2015 Scheme.

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.

Pay Ratios *(audited)*

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

The banded remuneration of the highest-paid director in the organisation in the financial year 2025-26 was £245,000-250,000 (2024-25, £245,000-250,000). This is a change between years of 0% (2024-25, 5%). The highest paid director did not receive any performance pay/bonuses in 2025/26 or 2024/25.

For employees of the Trust as a whole, the range of remuneration in 2025-26 was from £15,935 to £249,349 (2024-25 £23,615 to £246,419). The percentage change in average employee remuneration between 2024/25 and 2025/26 is 4.75% (2023/24 to 2024/25 5.24%). No employees received remuneration in excess of the highest-paid director in 2025-26.

The remuneration of the employee at the 25th percentile, median and 75th percentile is set out below. The pay ratio shows the relationship between the total pay and benefits of the highest paid director (excluding pension benefits) and each point in the remuneration range for the organisation's workforce.

	2025/26			2024/25		
	25 th percentile	Median	75 th percentile	25 th percentile	Median	75 th percentile
Total pay and benefits excluding pension benefits	£28,152	£36,096	£46,580	£26,614	£33,419	£44,962
Pay and benefits excluding pension: pay ratio for highest paid director	9:1	7:1	5:1	9:1	7:1	5:1

The total remuneration comprises salary only, it does not include employer pension contributions and the cash equivalent transfer value of pensions. There is only one calculation shown as the Trust does not pay performance pay and bonuses or taxable benefits.

Please note that the 2024/25 percentile and pay ratio calculations included Non-Executive Directors, whereas the 2025/26 calculations excluded them to reflect updated DHSC GAM requirements.



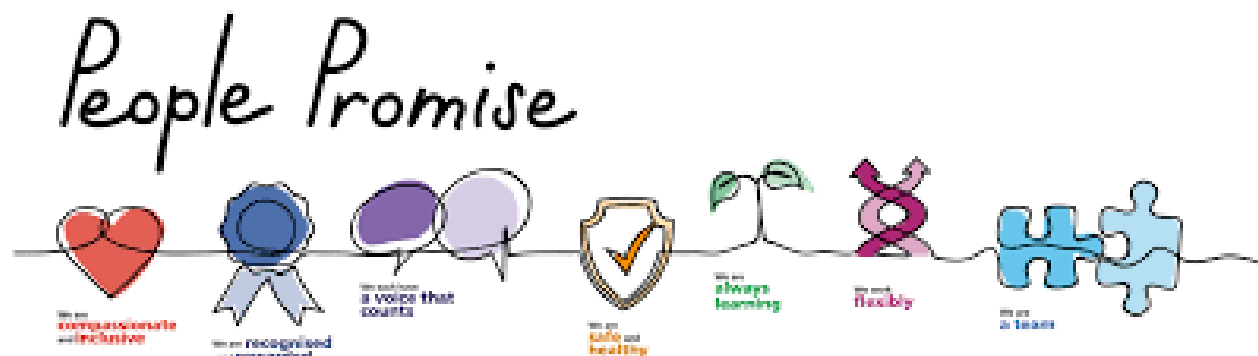
Ms Jane Tomkinson OBE
Chief Executive Officer
23rd June 2026

Staff Report 2025/26

In November 2025, the Trust launched a refreshed People Strategy 2025 – 2028 that reflects the unwavering commitment to creating an environment where every individual feels supported, valued, and inspired to thrive. The vision as set out in the strategy is to be not only a provider of outstanding care, but also an exceptional place to work. It will achieve this through a focus on four key themes: looking after our people, creating a sense of belonging, developing our people to their best, and building the future workforce. A copy of the Trusts People Strategy can be found on Trusts website [here](#).



Supporting the delivery of the strategy, the Trust has continued to embed the Staff Civility Charter (developed in partnership with staff across the organisation in 2024) and the NHS People Promise, with all work continuing to be aligned to the established Trust values of Safe, Kind and Effective.







Retention of staff

As an Anchor institution the Trust works closely with local place-based health and social care providers to improve the employment prospects for individuals in the local area wishing to join the sector who may have barriers to employment. The Trust has continued working with local colleges and job centres, providing targeted support and programmes for candidates wishing to join our organisation.

The trust continues to supporting the recruitment & retention of Health Care Support Workers and Allied Health Professionals. These roles are crucial to supporting patient flow and discharge into the community.

Our Rostering services have received Substantial Assurance from our internal auditors, Mersey Internal Audit Agency regarding its governance and processing of its services. While the Payroll service was successfully transferred to Mersey & West Lancashire NHS Foundation Trust during 2025.

The Trust continues to support our staff through the People Promise agenda with actions linked to our Staff Survey outcomes.

The Trust has significantly improved the on-boarding experience for new hires, digitising the process completely to streamline and further enhance the digital maturity of the organisation.

In response to the Thirlwall Inquiry the People and Organisation Development function is positioned to continue to support the Trust to respond and engage with the ongoing process as necessary but also support those staff impacted, alongside embedding identified learning across our processes and practices.

The team are focused on supporting effective workforce planning to meet the ever-changing operational workforce demands within the context of a challenging financial position. The vacancy and establishment control process are continuously reviewed to ensure appropriate challenge and assurance can be provided. In addition, the Trust constantly considers the potential impact of newly developed roles across the organisation.

Whilst the Trust recognises the need to retain staff and skills wherever possible, it acknowledges that circumstances and opportunities can arise that result in colleagues leaving. The Trust utilises an exit interview process where it captures the reasons for people leaving. This process is being further developed to support the Trust's understanding of reasons for leaving to enable learning opportunities.

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>



Staff health and wellbeing

The Trust has moved into its third year of the staff well-being strategy, with the well-being hub and service continuing to see growth in staff accessing support.

Between April 2025 and March 2026 there has been 556 members of staff accessing 1:1 wellbeing support from the wellbeing service equating to 923 hours of support being provided. Additionally, 276 members of staff have accessed one off well-being information/ signposting from the well-being service.

The Well-being service continues to provide support across all Trust sites with the addition this year of the new rapid response/community team hubs. With the team providing drop in and staff support at Custom House alongside Chester, Ellesmere Port and the existing offer for staff at Tarporley.

The Well-being service has continued to provide preventative as well as responsive services through a number of initiatives including drop-ins offered within wards and departments to improve accessibility. Between April 2025 and March 2026, 41 drop ins have been provided to teams with 76 staff accessing support within their work area.

The well-being team has continued to offer well-being focused workshops to teams across the Trust covering topics including stress management, emotional resilience, mental health awareness, and mental health first aid. Between April 2025 and March 2026, the wellbeing service delivered 45 Well-being workshops with 599 members of staff attending and an additional 35 Mental health First Aiders trained at the Trust.

The Well-being team have continued to work collaboratively with departments from across the trust and externally to offer health promotion and prevention events throughout the year including diabetes risk checks focused on health inequalities of staff from black and south east Asian ethnicity through collaboration with our REACH staff network, blood pressure checks through collaboration with our cardiac rehab and heart failure teams, cervical screening in collaboration with CWP. In total 449 members of staff have engaged in the events between April 2025 and March 2026

Additional new partnerships have enabled the well-being service to offer broader access to specialised support for our staff including the development of menopause cafes, alcohol support, miscarriage, and baby loss, and those impacted by the sudden death of a young person. The launch of the well-being community in summer 2025 has helped to promote wider existing wellbeing roles at the trust and provide greater accessibility for staff within their work area.

Our Employee Assistance Programme has been accessed by 337 members of staff for in moment support between April 2025 and February 2026 (Full data to cover period January-March 2026 not available at time of report) with 46 (Full data to cover period January-March 2026 not available at time of report) members of staff accessing structured counselling through the service either face to face or digitally with the most common reason for accessing the service being anxiety, low mood, and bereavement. There are now 236 members of staff that have downloaded the Health Assured Wisdom well-being App with 119 support requests completed



through the app.

The Occupational Health Service continued to deliver a high-volume service in 2025/26, with 1,346 consultations provided for 1,279 staff members referred to the occupational health service; 7 ill health retirement applications assessed; 465 general advice calls responded to; 1,224 new starters having pre-placement health assessments; 591 staff contacted following a work injury or potential workplace exposure to infection, plus many other advisory and supportive case interactions.

Themes for occupational health advice are mainly for mixed general medical, surgical and neurological health conditions (38% of consultations), followed by stress (19%), mental health (18%) and musculoskeletal problems (15%); and 42% of consultations involve at least one long term health condition or impairment lasting 12 months or more; 352 staff were visited in targeted areas to carry out skin health surveillance checks. From an Infection Prevention & Control perspective, 1,873 blood tests were ordered to screen staff for immunity to certain infectious diseases; 1026 occupational vaccinations were given across the year and, during the mass seasonal vaccination autumn/ winter campaign, 2,401 flu jabs were administered.

The Trust achieved a flu vaccine uptake of 51%. The NHS England Urgent and Emergency Care Plan priority action to improve flu uptake rates from the previous year by 5 percentage points was achieved (51% uptake against last year's 46%); and the Cheshire & Merseyside Integrated Care Board regional target to vaccinate 50% of frontline staff before December was achieved.

The Trust's Occupational Health Service was successful at annual external reaccredited as a Safe, Effective Quality Occupational Health Service (SEQOHS), with the assessors noting that the service maintains a good governance structure and ensures a timely review of clinical policies, procedures and protocols to underpin clinical practice.

The Trust's level of absence rates reduced and can be viewed within the NHS Digital published data:

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

Employee Education and Development

In 2025, the Trust delivered a suite of Management and leadership development programmes, including aspiring first line managers, first line managers, new consultants and senior medical leaders. This also included the design and delivery of a Manager Essentials workshop to all line managers, with over 200 managers attending in year. Managers are further being supported by an underpinning skills development programme that commenced in October 2025.

The Trust also facilitated access to external leadership development via the NW Leadership Academy including the Deputy and Aspiring Director Development Programme and Divisional Team Coaching.



Continuing to provide a variety of bespoke organisational development interventions, the Trust has provided Team RESET, sessions supporting our urgent care division as well as Team Development interventions across the Trust.

The Trust has reviewed their approach to Staff Survey Results, designing a more robust and comprehensive data package for our divisional leadership teams enabling development of action plans at local levels.

The Trust continues to remain aligned to the National Core Skills Training Framework providing clear assurance for mandatory training compliance. The Trust remains actively involved in the ongoing national review of the Core Skills Training Framework. In June 2025 the Trust reached target compliance of 90% and has continued to maintain compliance above this target since.

Practice placements for undergraduate students in all health-related professional programmes continue to be provided. Significant numbers of nursing students from the University of Chester are supported throughout their three-year programme, with the Trust having capacity to support 220 students at any one time. On average the Trust provides placements for 130 student doctors from the University of Liverpool on 2nd, 3rd, 4th and 5th year placements each month. The Medical Education Department were successful in gaining approval to increase faculty at the Trust to support the provision of placements of student doctors from the recently formed University of Chester Medical School. Placements have been provided for both first and second year students from the University of Chester Medical School and third year students will also be on placement from September 2026. Placements continue to be provided to students from other universities across the Northwest including Edgehill University and Liverpool John Moores University.

The Trust continues to support apprenticeships as an important route for workforce development and career progression. Apprenticeships remain a key focus, and work is ongoing with divisions to identify sustainable opportunities that support both service delivery and staff development. There has been a focus on developing opportunities across Nursing at entry level and Estates and Facilities.

Volunteer recruitment has continued to increase, with a strong focus on ensuring volunteers are placed in high quality, meaningful roles that enhance both patient and staff experience. There has been a continued effort to broaden the range of volunteer opportunities available across the Trust. Volunteers support services at both the Countess of Chester Hospital and Ellesmere Port Hospital and remain invaluable in helping to improve patient experience across our sites.

Gender Pay Gap Report

The Trust submitted its Gender Pay Gap data (GPG) for 2025. A copy of the report can be found on the Trust website [here](#).

We recognise there is still further work to do in relation to closing the gender pay gap. The Trusts Gender Pay Gap remained unchanged in year at 26% in favour of male staff. In relation to spread of male and female employees across pay quartiles,

there continues to be significantly more females employed within the Trust when compared to males. The gender pay gap average value of bonus pay had a gender pay gap difference of 63.63% in favour of male colleagues.

Staff cost analysis 2025/26 (audited) and 2024/25 (audited)

Employee expenses:

	Total 2025/26	Permanently employed	Other	Total 2024/25
	£000	£000	£000	£000
Short term employee benefits – salaries and wages	235,032	215,701	19,331	227,373
Post employee benefits social security costs	29,211	27,686	1,525	21,971
Apprenticeship Levy	1,168	1,107	61	1,083
Post employee benefits employer contributions to NHS Pensions Agency	42,872	40,563	2,309	40,284
Other employment benefits	-	-	-	-
Termination benefits	503	503	-	-
Agency/contract staff	2,325	-	2,325	4,189
Total gross staff costs	311,111	285,560	25,551	294,900
Recoveries in respect of seconded staff	-	-	-	-
Total staff costs	311,111	285,560	25,551	294,900
Of which costs capitalised as part of assets	403	403	-	380

Average number of persons employed 2025/26 (audited) and 2024/25 (audited)

	Total 2025/26	Permanently employed	Other	Total 2024/25
Medical and dental	562	299	263	574
Ambulance staff	1	1	-	1
Administration and estates	762	737	25	786
Healthcare assistants & other support staff	1,016	1,002	14	1,010
Nursing, midwifery & health visiting staff	1,469	1,412	57	1,443
Nursing, midwifery & health visiting learners	-	-	-	-
Scientific, therapeutic and technical staff	579	565	14	570
Healthcare scientists	213	206	7	214
Bank staff	333		333	327
Total	4,935	4,222	713	4,924
Number of employees (WTE) engaged on capital projects	5			6

To note, this data is based on staff employed by the Trust within the 2025/26 financial year (and includes part time staff).

The Trust spent £154,000 on consultancy fees during 2025/26.

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

Highly-paid off-payroll worker engagements as at 31 March 2026 earning £245 per day or greater:

No. of existing engagements as of 31 March 2026	3
Of which, the number that have existed:	
for less than one year at time of reporting.	1
for between one and two years at time of reporting.	1
for between two and three years at time of reporting.	1
for between three and four years at time of reporting.	0
for four or more years at time of reporting.	0

All highly-paid off-payroll workers engaged at any point during the year ended 31 March 2025 earning £245 per day or greater:

Number of off-payroll workers engaged during the year ended 31 March 2026	
Of which:	
Not subject to off-payroll legislation	32
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	0
Number of engagements reassessed for compliance or assurance purposes during the year	0
Of which: number of engagements that saw a change to IR35 status following review	0

Off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2025 and 31 March 2026:

Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. This figure must include both off-payroll and on-payroll engagements.	17

Exit packages

Exit package costs by band 2025/26 (audited):

Exit package cost band	2025/26	2025/26	2025/26
	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10,000	-	12	12
£10,000 – 25,000	-	6	6
£25,001 – 50,000	-	4	4
£50,001 – 100,000	-	4	4
£100,000 – 150,000	-	1	1
£150,001 - £200,000	-	-	-
>£200,000	-	1	1
Total number of exit packages by type	-	28	28

Exit package costs by band 2024/25 (audited):

Exit package cost band	2024/25	2024/25	2024/25
	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10,000	-	21	21
£10,000 – 25,000	1	6	7
£24,001 – 50,000	1	5	6
£50,001 – 100,000	-	3	3
£100,000 – 150,000	-	-	-
Total number of exit packages by type	2	35	37

Exit packages: non-compulsory departure payments 2025/26 (audited) and 2024/25 (audited):

	2025/26	2025/26	2024/25	2024/25
	Agreements number	Total value of agreements	Agreements number	Total value of agreements
		£000		£000
Voluntary redundancies including early retirement contract costs	9	503	-	-
Mutually agreed resignations (MARS) contractual costs	4	117	12	406
Contractual payments in lieu of notice	13	52	22	131
Exit payments following Employment Tribunals or court orders	1	4	1	3
Non-contractual payments requiring HMT approval	1	1,400	-	-
Total	28	2,077	35	540

Staff Survey Results

Staff experience and engagement

The Trust recognises that well-engaged employees are crucial to organisational success, particularly with respect to high-quality patient outcomes and staff experience. One of the key metrics of staff experience is the NHS Staff Survey.



NHS staff survey

The NHS staff survey is conducted annually. Since 2021/22 the survey questions align to the seven elements of the NHS 'People Promise' and retains the two previous themes of engagement and morale. All indicators are based on a score out of 10 for specific questions with the indicator score being the average of those.

A copy of our 2025 NHS Staff Survey Results can be found on the national survey website [here](#).

The response rate to the 2025 survey was 44.4% for our substantive workforce (compared to 44.6% in 2024). A full analysis of results has been undertaken at Trust level with divisional analysis and action planning ongoing in 2026. The Trust acknowledges that staff report a poorer experience relative to our comparators and that feedback remains below the national average for our comparator group. In response to the 2024 results, focused attention was given to improving flexible working and staff experience of line managers that has led to improved scores in these areas within the 2025 report, however significant work continues to be undertaken to improve staff experience within the Trust.

Future priorities and targets

At a Trust Level, our 2025 NHS Staff Survey results demonstrate that we have a good understanding of staff experience and the areas where we need to do more, and these align with our existing plans. The Trust has agreed the following priority areas for 2026:

- Make work feel manageable again
- Strengthen staff voice, involvement and the standards we uphold together
- Support individual, team and organisational learning
- Ensure people feel valued every day

Ill health retirements *(audited)*

During 2025/26 there were 5 (prior year 2024/25, 9) early retirements from the Trust agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £762,000 (c.f. £977,000 in 2024/25). The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division, who supplied this information.



Health and safety

During the 2025/26 reporting period, the Trust has continued to strengthen and mature its Health & Safety function, building on the solid foundations established in the previous year. All key Health & Safety policies have been comprehensively reviewed and revised to ensure alignment with current legislation, best practice, and organisational priorities. This has supported a more consistent and robust approach to safety management across all sites, reinforcing the Trust's commitment to providing a safe environment for patients, staff, and visitors.

The Health & Safety Committee is now well established, meeting on a quarterly basis with strong and consistent attendance from key stakeholders. The committee continues to provide effective oversight, governance, and strategic direction for Health & Safety matters across the Trust. In parallel, reporting processes have been significantly streamlined, enabling more timely, transparent, and proactive engagement with the Board and wider stakeholders. This has improved the visibility of key risks, actions, and compliance issues, supporting informed decision-making at all levels.

Further improvements have been made to systems and resources supporting Health & Safety delivery. The centralised COSHH management system is in the process of being reintroduced, strengthening the Trust's approach to the safe management of hazardous substances. In addition, the Health & Safety team structure has been enhanced through the introduction of a Safety, Health and Environment Apprentice, increasing capacity and supporting future workforce development within the function.

The Health & Safety team has also provided significant support to Estates and Capital Projects, ensuring that compliance with Health & Safety regulations is achieved across a wide range of projects and operational activities. This collaborative approach has been instrumental in maintaining high safety standards while supporting the Trust's ongoing development and infrastructure improvements. Overall, the Trust has made substantial progress during 2025/26, with clear improvements in governance, systems, and staff capability. Continued focus on training, risk assessment quality, and cross-departmental collaboration will be essential to sustaining this momentum and further strengthening the Trust's proactive safety culture in the year ahead.

Countering fraud and corruption policy

The Trust does not tolerate fraud, corruption or bribery within the NHS. An overarching Anti-Fraud, Corruption and Bribery Policy and Response Plan is in place, produced by the Local Counter Fraud Specialist (LCFS), and reviewed in October 2025. The aim is to eliminate all NHS fraud, corruption and bribery as far as possible, freeing up public resources for better patient care.



The 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 CFA. Any investigations are 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.

On 1st September 2025, the Economic Crime and Corporate Transparency Act (ECCTA) introduced a new corporate offence of Failure to Prevent Fraud. In response, the Trust updated its Anti-Fraud, Corruption and Bribery Policy and Response Plan to reflect the new legislative requirements. Other relevant Trust policies were also reviewed and updated, where necessary, to ensure clarity of roles and responsibilities in light of the new offence. Awareness was further strengthened through targeted Board training and an All Staff Briefing, supported by a Chief Executive Officer statement issued to relevant staff groups to reinforce organisational responsibilities and expectations.





Code of Governance for NHS Provider Trusts

The Code of Governance for NHS Provider Trusts sets out a common overarching framework for the corporate governance of NHS trusts and foundation trusts.

Disclosures

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

The code covers:

- Board leadership and purpose
- Division of responsibilities
- Composition, succession and evaluation
- Audit, risk and internal control
- Remuneration

Comply or explain

The Code is issued as best practice, containing main principles, supporting principles and code provisions which Trusts are expected to abide by on a 'comply or explain' basis.

The Countess of Chester Hospital NHS Foundation Trust has applied the principles and code provisions of the Code of Governance for NHS Provider Trusts (the Code). The Trust undertook an annual assessment against compliance with the Code in 2025/26.

The Trust remains compliant with the majority of the areas set out within the code.

The code is assessed on the basis of comply or explain. In 2024/25 the Trust declared partial compliance in 7 areas with mitigations and actions in place. The majority of these areas are now compliance following action in 2025/26 including alignment of objectives, use of C2AI tools for health inequalities, re-establishment of the Membership and Engagement Committee, separation of the Audit Committee Chair and Senior Independent Director roles, review of Board composition and voting Directors, and inclusion of the Board diversity within the EDI priorities.

For 2025/26 there are 2 conditions with partial compliance which relate to:

- **D.2.3 – External audit:** The decision to extend the External Audit contract beyond 10 years. This decision was fully assessed and supported by the Council of Governors.
- **C.2.1 – Board succession planning:** It is noted that whilst the Remuneration and Nomination Committee (Executive) has reviewed the succession plan

there is more work to do to provide assurance on the effectiveness of Board succession planning within the Trust to mitigate the risks.

The detailed annual assessment was presented to the Audit Committee in February 2026 and the Board of Directors in March 2026.

Disclosure statements

Disclosures as per the Code of Governance for NHS Provider Trusts

Provision	Requirement	Page(s)
A.2.1	The board of directors should assess the basis on which the trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB, and place-based partnerships. The board of directors should ensure the trust actively addresses opportunities to work with other providers to tackle shared challenges through entering into partnership arrangements such as provider collaboratives. The trust should describe in its annual report how opportunities and risks to future sustainability have been considered and addressed, and how its governance is contributing to the delivery of its strategy.	33 120
A.2.3	The board of directors should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the trust's vision, values and strategy, it should seek assurance that management has taken corrective action. The annual report should explain the board's activities and any action taken, and the trust's approach to investing in, rewarding and promoting the wellbeing of its workforce.	31 93
A.2.8	The board of directors should describe in the annual report how the interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision-making, and set out the key partnerships for collaboration with other providers into which the trust has entered. The board of directors should keep engagement mechanisms under review so that they remain effective. The board should set out how the organisation's governance processes oversee its collaboration with	2 5 30 31 93

Provision	Requirement	Page(s)
	other organisations and any associated risk management arrangements.	
B.2.6	The board of directors should identify in the annual report each non-executive director it considers to be independent. Circumstances which are likely to impair, or could appear to impair, a non-executive director's independence include, but are not limited to, whether a director: • has been an employee of the trust within the last two years • has, or has had within the last two years, a material business relationship with the trust either directly or as a partner, shareholder, director or senior employee of a body that has such a relationship with the trust • has received or receives remuneration from the trust apart from a director's fee, participates in the trust's performance-related pay scheme or is a member of the trust's pension scheme • has close family ties with any of the trust's advisers, directors or senior employees • holds cross-directorships or has significant links with other directors through involvement with other companies or bodies • has served on the trust board for more than six years from the date of their first appointment • is an appointed representative of the trust's university medical or dental school. Where any of these or other relevant circumstances apply, and the board of directors nonetheless considers that the non-executive director is independent, it needs to be clearly explained why.	50
B2.13	The annual report should give the number of times the board and its committees met, and individual director attendance.	48
B2.17	For foundation trusts, this schedule should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved.	62-70

Provision	Requirement	Page(s)
	The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by the board, the council of governors, board committees and the types of decisions which are delegated to the executive management of the board of directors.	
C2.5	If an external consultancy is engaged, it should be identified in the annual report alongside a statement about any other connection it has with the trust or individual directors.	97-98
C2.8	The annual report should describe the process followed by the council of governors to appoint the chair and non-executive directors. The main role and responsibilities of the nominations committee should be set out in publicly available written terms of reference.	77
C4.2	The board of directors should include in the annual report a description of each director's skills, expertise and experience.	50
C4.7	All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years, according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the trust or individual directors.	126-130
C4.13	The annual report should describe the work of the nominations committee(s), including: - the process used in relation to appointments, its approach to succession planning and how both support the development of a diverse pipeline - how the board has been evaluated, the nature and extent of an external evaluator's contact with the board of directors and individual directors, the outcomes and actions taken, and how these have or will influence board composition - the policy on diversity and inclusion including in relation to disability, its objectives and linkage to trust vision, how it has been implemented and progress on achieving the objectives	33-35 80

Provision	Requirement	Page(s)
	- the ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and how far the board reflects the ethnic diversity of the trust's workforce and communities served - the gender balance of senior management and their direct reports.	
C5.15	Foundation trust governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	68-70
D2.4	The annual report should include: - the significant issues relating to the financial statements that the audit committee considered, and how these issues were addressed - an explanation of how the audit committee (and/or auditor panel for an NHS trust) has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor; length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans - where there is no internal audit function, an explanation for the absence, how internal assurance is achieved and how this affects the external audit - an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services.	64-65
D2.6	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy.	98-99

Provision	Requirement	Page(s)
D2.7	The board of directors should carry out a robust assessment of the trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the annual report.	9
D2.8	The board of directors should monitor the trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The board should report on internal control through the annual governance statement in the annual report.	116-130
D2.9	In the annual accounts, the board of directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern. Trusts should refer to the DHSC group accounting manual and NHS foundation trust annual reporting manual which explain that this assessment should be based on whether a trust anticipates it will continue to provide its services in the public sector. As a result, material uncertainties over going concern are expected to be rare.	11
E2.3	Where a trust releases an executive director, e.g. to serve as a non-executive director elsewhere, the remuneration disclosures in the annual report should include a statement as to whether or not the director will retain such earnings.	N/A
Appendix B, para 2.3 (not in Schedule A)	The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor.	72-74
Appendix B, para 2.14 (not in Schedule A)	The board of directors should ensure that the NHS foundation trust provides effective mechanisms for communication between governors and members from its constituencies. Contact procedures for members who wish to communicate with governors and/or directors	78

Provision	Requirement	Page(s)
	should be clear and made available to members on the NHS foundation trust's website and in the annual report.	
Appendix B, para 2.15 (not in Schedule A)	The board of directors should state in the annual report the steps it has taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, e.g. through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.	68
Additional requirement of FT ARM resulting from legislation	If, during the financial year, the Governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report. This is required by paragraph 26(2)(aa) of schedule 7 to the NHS Act 2006, as amended by section 151 (8) of the Health and Social Care Act 2012. * Power to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the foundation trust's or directors' performance). ** As inserted by section 151 (6) of the Health and Social Care Act 2012)	N/A

NHS Oversight Framework 2025/26

A new NHS Oversight Framework (NOF) was introduced by NHS England (NHSE) in 2025/26. This was initially launched as a 1 year framework for overseeing providers and identifying potential support needs which will be reviewed for 2026/27. The framework covers six themes:

1. access to services
2. effectiveness and experience of care
3. patient safety
4. people and workforce
5. finance and productivity
6. *improving health and reducing inequality (not currently scored within the NOF)*



The NOF uses a 1–5 segmentation model to determine support needs, ranging from maximum autonomy (Segment 1) to mandated intensive support (Segment 5).

The Countess of Chester Hospital NHS Foundation Trust was placed in segment 4 of the NOF for Q1 2025/26 ranking 133/134 Trusts. The NHS England provider capability assessment for Q2 resulted in a Red rating, with the definition applied that there are ‘Material or long-running concerns across key areas that trust management has been unable to grip’. It is important to note that the Trust had clear improvement plans and Board assurance processes in place to monitor these. The Trust was not placed into any further intervention programmes. We are pleased to report that the Q4 position for 2025/26 showed a continued improvement with a significant rise to 98/134 resulting in the Trust moving positively into segment 3. NHS England has confirmed that the Trust’s capability assessment will now be reviewed in Q1 2026/27.

The Trust welcomes the opportunity for further support as we tackle the longstanding challenges faced by the Trust.



Statement of Accounting Officer's responsibilities

Statement of the Chief Executive Officer's responsibilities as the Accounting Officer of the Countess of Chester NHS Foundation Trust

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

NHS England has given Accounts Directions which require the Countess of Chester Hospital 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 the 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 Directions issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis.
- Make judgements and estimates on a reasonable basis.
- State whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care Group Accounting Manual) have been followed. 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.
- 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. 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 Foundation Trust'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*.



Ms Jane Tomkinson OBE
Chief Executive Officer
23rd June 2026





Annual Governance Statement 2025/26

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 ongoing 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 NHS Foundation Trust for the year ended 31 March 2026 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

I am accountable for risk management across the organisation, financial and clinical activities. In 2025/26, the responsibility for risk management was delegated to the Director of Governance, Risk & Improvement, supported by the Deputy Director of Nursing Quality and Governance.

I am supported in my role through the assurance committees of the Board of Directors. The Audit Committee has an overarching role in respect of governance, risk management and internal control. The Quality & Safety Committee, Finance & Performance Committee and the People Committee oversee the risks related to their respective areas of responsibility. The Board of Directors receives Chair's Alert, Assure and Advise (AAA) reports from each of the Board assurance committees. Specific assurances are provided by the Quality and Safety Committee relating to the management of incidents, including Never Events and those requiring Patient Safety Incident Investigation (PSIIs).

A new Accountability Framework was launched in year setting out the governance and performance expectations, with divisional governance led by triumvirate leadership teams of medical, nursing and operational directors. In addition to divisional governance meetings, the monthly Operational Management Board provides a mechanism where divisional performance is reviewed and key risks to



delivery of services are identified and monitored. The Risk Management Committee has been embedded during 2025/26 to provide assurance on the effectiveness of risk management to the Quality Governance Group which reports to the Quality and Safety Committee.

Internal audit supported the independent assessment of the risk maturity of our clinical divisions with priorities developed and progress in year including the need for a refreshed training programme. A new guide to risk management has been developed and cascaded. Risk management training has been provided in year through a variety of forums. A refreshed risk management training module and training needs analysis rolled out in quarter 4. Training support staff to identify, assess, manage and monitor risks in line with the Risk Management Policy. This training is open to all staff and includes how to use the Datix risk module.

There are defined roles and mechanisms through which alerts and external recommendations are communicated and acted upon (for example, Central Alerting System, NHS England and the Health and Safety Executive). These are currently recorded and reported through the Datix assurance module. The appointment of a Medical Device Safety officer this year has substantially improved the processes, management and outcomes of Field Safety Notices, CAS alerts and Patient Safety Alerts, providing assurance and oversight of monitoring and management of the required actions.

The Trust continued to embed the Patient Safety Incident Response Framework (PSIRF) in 2025/26 and received moderate assurance following the MIAA review. Quarterly reports to Quality Governance Group and the Quality and Safety Committee provide assurance that the Trust is a learning organisation and has robust governance and assurance structures in place to identify and highlight risk, identify themes and present changes in practice whose progress can be monitored and a forum for escalation of any concerns.

The Risk and Control Framework

Risk Management Arrangements

The Risk Management Policy outlines the framework for managing risk, including roles and responsibilities for the identification and management of risk.

The Board of Directors set the risk appetite for the Trust, with the Board Assurance Framework used as a key tool for identifying, assessing, managing and mitigating strategic risks.

Risks are identified from a wide range of sources. These risks are documented on risk registers which are held in the Datix system – the electronic system for recording and managing risks, incidents, complaints, clinical audit and claims. All risks are assessed and scored using an approved 5x5 scoring matrix which assesses the likelihood, consequence, and overall severity of each risk. This results in each risk being awarded a score of between 1 (very low) to 25 (significant). The effectiveness of the existing control measures is assessed, and associated gaps and action plans agreed and monitored to ensure management and mitigation of the risk.



Each risk has a risk owner. The Datix Risk Register System automatically generates a confirmation email to notify the identified risk owner about the risk. Risks are escalated and managed at an appropriate level based on the risk score as set out in the Risk Management Policy.

The Board of Directors and the Operational Management Board receives a high risk report on all risks with a residual score of 15 and over. The Operational Management Board also receives Divisional risk and performance reports. The Risk Management Committee reviews risks with a residual score of 10 and over.

During 2025/26 the Trust progressed the delivery of the risk management improvement plan to further develop processes, culture and reporting. This included Datix system developments, dashboards and training. A range of governance and risk sessions continued to be delivered through the aspirant leaders and managers essentials training courses to increase awareness, understanding and accountability.

The Trust ensures compliance with the NHS Foundation Trust provider licence including the governance requirements. The Board of Directors, Council of Governors, Audit Committee and other Board Committees all contribute ensuring the Trust has robust and effective governance structures.

The Trust received further NHS England enforcement undertakings in November 2025. These related to financial plan delivery, operational UEC operational performance standards and UEC CQC warning notice. These indicators directly correlate to the published rankings in the new NHS Oversight Framework. The Board of Directors is satisfied that the Trust continues to progress the plans to ensure all the requirements of the licence are fulfilled.

The Board of Directors and Council of Governors approved a revised Trust Constitution which had been updated for Board composition including the provision for an appointed University Non-Executive Director.

Incident Reporting

During 2025/26, 9 incidents requiring Patient Safety Incident Investigation (PSIIs) were reported including 4 Never Events. Full investigations and learning have been completed.

Incident reporting is in line with the Trusts Patient Safety Incident Response Framework (PSIRF) policy. PSIRF focusses on learning and improvement through a range of responses including PSIIs, Swarms, After Action Reviews, and thematic reviews.

A positive culture of incident reporting is evident, with on average between 40-50 incidents reported daily. Being open with those involved with and affected by incidents is essential and the Trust continues to strengthen how it communicates with patients, families and staff, in line with the Duty of Candour and to ensure their views are incorporated into incident responses. Incident response outcomes and learning



statements are shared with families, commissioners, Cheshire and Merseyside Integrated Care Board, Cheshire West Place colleagues, and regulatory bodies.

The Trust holds a weekly Patient Safety Learning Oversight Meeting which is dual chaired by the Deputy Director of Nursing & Governance and the Deputy Medical Director & Patient Safety Lead. Representatives from the Divisional triumvirates, Legal Department, Patient Experience and Risk teams are in attendance. These groups provide a governance structure for the review and management of incidents as well as decisions on the incident responses including any PSIs (Patient Safety Incident Investigations). Partners from Cheshire and West Place are invited to attend for oversight and transparency of any PSII.

The Trust has a Quality, Safety and Experience Strategy which was developed through engagement with stakeholders, an extensive review of feedback and themes from patients and relatives and a comprehensive review of incidents, risk and the current position of the previous Harms Improvement Program. Our Quality, Safety and Experience Strategy comprise three pillars of priorities: – Core priorities, Corporate priorities and Divisional priorities. The reporting governance for this strategy is through Quality Governance Group.

The new Organisation Learning Policy sets out how the Trust cascades learning from incidents across the organisation through a variety of forums and routes. These include:

- Lessons learned are fed back to the nursing teams at ward managers' meetings and safety briefs to ensure relevant staff groups can act upon key learning and implement change. Learning is shared across the organisation in various formats to bring individuals together to optimise patient outcomes.
- The Trust also facilitates a monthly Patient Safety Summit as a forum for all staff to explore, share and learn about all aspects of patient safety. The theme for each summit reflects issues raised and incidents reported which also links into patient safety initiatives.
- The Trust produces a weekly 'Lessons Learned @COCH' update which highlights the learning from incidents, local audits and quality improvement groups.
- The Grand Round supports the delivery of ongoing education, learning and collaborative working for clinicians.
- Learning and Sharing Forum dedicated to sharing learning across the Trust and providing a forum for safety surveillance – themes, trends and learning to be shared.
- Daily Trust Safety Huddles provides a forum for issues to be raised and resolved quickly.

The Clinical Audit Programme includes subsequent audit on identified themes from specific 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 with a Chair's report to the Board of Directors.



To ensure that the patient is at the heart of everything we do, patient experiences and stories are shared across the Trust, including at meetings of the Board of Directors, Council of Governors, Operational Management Board and the monthly whole hospital Team Brief. The Trust has embedded the Patient and Family Experience Strategy, with teams empowered to develop local priorities for patient and family experience. A structured programme of patient engagement events is being developed for 2026/27.

Learning from Patient Safety Events (LFPSE) is a new national NHS service for the recording and analysis of patient safety events that occur in healthcare. The service introduces a range of innovations to support the NHS to improve learning from the over 2.5 million patient safety events recorded each year, to help make care safer. The Trust incident reporting system – DATIX is connected to the LFPSE service and incidents identified as a patient safety incident are uploaded to this service.

The Board Assurance Framework

The Board Assurance Framework (BAF) sets out the way to delivery of the strategic goals. The BAF is regularly reviewed by the Board and updated throughout the year. Progress against strategic objectives has been aligned within the BAF providing clear triangulation for the Board.

The BAF:

- defines the principal risks to the achievement of the organisation's strategic goals
- identifies the controls by which these risks can be effectively managed
- sets out the assurances that are received in respect of each risks
- identifies any gaps in controls or assurances, and any actions being taken to close these gaps
- includes the target risk score aligned to the organisation's risk appetite

The assurance committees reviewed extracts of the BAF relevant to their role.

Internal Audit provided independent assurance to the Audit Committee, confirming that the BAF meets NHS requirements.

Key Risks

During 2025/26 the Trust has faced and continues to face a number of key risks as set out in the Board Assurance Framework.

- **Underlying long term Trust financial sustainability**

The Trust planned, reported and delivered the planned deficit for 2025/26. Whilst the Trust is delivering significant recurrent CIP, there is an ongoing challenge in terms of the underlying run rate deficit position. The draft financial plan for 2026/27 remains a deficit position, including a challenging savings target of c6% aligned to national and local requirements. The Cost Improvement Program (CIP) will build on the work undertaken in 2025/26 including a more transformational approach and will contribute to improving the underlying deficit



over the next 3-5 years in line with the agreed deficit reduction trajectory in the Medium Term Plan.

- **Staff Engagement**

Workforce related risks that could impact delivery of the integrated plan are largely driven by the scale and pace of operational demand and the extent of ongoing service transformation. The Trust has made positive progress in strengthening staff engagement and organisational culture through visible leadership, active listening, and targeted initiatives. However, sustaining these improvements and mitigating the effects of operational pressures will remain challenging within a financially constrained environment.

Results from previous national staff surveys show encouraging improvements, but it is evident that continued workload pressures and capacity constraints will influence staff experience and may limit the ability to maintain engagement over time. The embedding of the Civility Charter and zero tolerance campaigns, strengthened staff networks, and the continued development of Freedom to Speak Up are all positive developments. Nonetheless, further work is required to deepen staff engagement and enhance culture to support the Trust in delivering new models of care and achieving planned efficiency improvements.

- **Delivering safety and quality, and avoiding harm**

The Trust has continued to progress a wide range of quality improvement and harm reduction programmes. Quality governance including incident reporting, management of complaints and concerns, claims and Coroners cases have all been strengthened with a clear focus on learning and improving the quality of care for patients. The new patient and family experience strategy has been embedded across the Trust with clear priorities identified in each area.

- **Access, waiting times, care pathways and constitutional performance**

The Trust remains focused on operational performance and monitors progress through the Strategic Oversight Framework and reporting structures. The Trust has been challenged with compliance against the 28 Day Faster Diagnosis Standard cancer standard this year due to a large increase in suspected cancer referrals for certain clinical services. In the latter part of the year, we have seen performance improve again and we have seen improved performance in the 62 Day Standard, and performance against the 31 Day Standard has either met the standard or been very close to meeting the standard each month. The Trust has remained under our target number of pathways over 62 days being tracked on a suspected cancer pathway. Improvements have been sustained in elective waiting times with increases in productivity and efficiency. The Trust has reduced long waits and broadly met all targets associated with this cohort of patients. Diagnostic waiting times have been more challenged this year with pressures on specific workforce groups. The modalities with the greatest challenges are Echocardiogram and Non-Obstetric Ultrasound. Both services now have plans in place with recovery forecasted by the end of the financial year. Endoscopy modalities have seen a significant improvement after years of challenges.



Our non-elective performance has been challenged throughout the year and the main effects of this are seen within Urgent and Emergency Care. Flow through our hospital wards remain challenged due to the high number of patients that do not meet the criteria to reside, with patients remaining in our care whilst arrangements are made to discharge them to an appropriate setting for the care that they need. The lack of flow out of the hospital means that patients are waiting longer in our Emergency Department. The Trust has a full action plan to drive improvements across all these areas, and we have extended opening hours in our Urgent Treatment Centre alongside extended use of our Same Day Emergency Care building. We have made progress on ambulance handovers and have seen significant reductions in corridor care. We have delivered capital projects to increase capacity in our discharge lounge, increased capacity in the Urgent Treatment Centre, built an area in the Emergency Department for patients with additional health needs and increased capacity in the resuscitation suite, and we are in the final stages of finishing the work to give a dedicated paediatric resuscitation bay. In addition, we continue to work with external partners to explore solutions to improve patient flow, care and experience.

- **Public Confidence in the Trust**

There is an ongoing risk to ensuring patients and the wider public have confidence that the Trust's services are safe, effective and well led in the light of the Letby verdict, ongoing police investigations and the Public Inquiry. The Trust has continued to focus on the learning from these events and made significant improvements to the governance, culture and underpinning systems and processes. Throughout 2025/26 the Trust and our staff have made significant contributions to the Thirlwall Inquiry and supported the ongoing police investigations.

Care Quality Commission compliance

The Countess of Chester Hospital is registered with the Care Quality Commission (CQC) and at the time of this report is compliant with the registration requirements.

An unannounced inspection of the core services was undertaken in October 2023 over 3 days, with a well led inspection taking place in November 2023. The report was published in February 2024 resulting in an overall rating of 'requires improvement'. Improvement was noted in the maternity core service and the Trust well led rating improved from Inadequate to Requires Improvement.

In 2025/26 significant progress continued to be made against the comprehensive CQC and well led action plan. In January 2026, the Board were satisfied that the remaining actions were embedded within governance mechanisms with assurance continuing to be provided through the assurance committees. The implementation of action plans has focused on ensuring sustainable improvements.

Following an unannounced inspection of urgent and emergency care services in February 2025, the Trust received formal notification of a warning notice and the CQC rated the services as inadequate. Immediate actions were taken including the consistency in the use of documentation, culture expectations, cleaning standards,



equipment and improvements to the environment. A comprehensive action plan was developed and delivered with oversight from the Quality and Safety Committee. The CQC re-inspected the UEC services alongside other services in October 2025. We are awaiting the conclusion of this report from the CQC.

The Director of Nursing and Quality and Deputy Directors of Nursing have a fortnightly CQC engagement meeting to discuss, respond to and address any issues or concerns.

To assure itself of performance and the Trust CQC registration requirements, the Trust's monthly Integrated Performance Report (IPR) is reviewed by the Board of Directors with extracts subject to deep dives through the assurance committees. Divisional risk and performance reports are presented monthly to the Operational Management Board. These reports provide a triangulation of quality, workforce, performance and financial indicators.

Our workforce compliance and safeguards

The Board of Directors and People Committee receive assurances in respect of workforce metrics, safety, sustainability and effectiveness e.g. establishment data, sickness absence and turnover and staff experience measures. The reports detail areas of risk and mitigation.

A new People Strategy (2025-28) was approved by Trust Board and launched in November 2025. The People Strategy outlines four key themes aligned to the NHS People Plan and sets out the Trust's commitment to creating an inclusive, supportive, and high-performing workplace where all staff feel valued, empowered, and prepared for the future. Influenced directly by staff feedback, the strategy emphasises shared responsibility for culture, civility, leadership, and continuous improvement, ensuring the Trust becomes a great place to work and deliver outstanding care.

In accordance with the recommendations of 'Developing Workforce Safeguards' the Trust uses a triangulated approach to maintaining assurance around workforce strategies and safe staffing systems. This approach utilises evidence-based tools, e.g. establishment reviews, and roster information together with professional judgement and patient outcome measures.

The Trust has a comprehensive dashboard that is used as a live tool throughout the day to assess safe nurse staffing levels and take appropriate action.

Register of Interests

The register of interests for decision-making staff (as defined by the Trust in line with NHS Managing Conflicts of Interest guidance) is published on the Trust's website.

Decision-making staff at the Trust, includes band 8d and above staff, all Board members, all Procurement Department staff and Pharmacy staff at band 5 and over. Decision makers are required to complete their declarations of interest annually via the Electronic Staff Records system (ESR) including any nil returns. Any staff



members who do not have access to ESR are required to complete a Conflict of Interest Declaration Form.

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

Building on the progress and foundations of the Trust's 2023–2026 Equality, Diversity & Inclusion (EDI) Strategy, the Trust has adopted a fully integrated, organisation-wide approach to embedding EDI, ensuring it is woven throughout the People Strategy and recognised as a collective responsibility shared by all colleagues.

To support this transition, the Trust has strengthened its EDI governance arrangements through the establishment of the People & Culture Sub-Committee, which provides dedicated oversight of culture, inclusion, civility and workforce experience and reports directly into People Committee. This enhanced governance structure ensures that EDI considerations are consistently integrated into People Strategy delivery, operational priorities and organisational risk and performance oversight.

Alongside this, the Trust has developed an integrated EDI Action Plan that consolidates all actions arising from statutory and regulatory obligations (including EDS2, WRES, WDES and Gender Pay Gap reporting) into one coherent framework. This unified approach enhances accountability, visibility and alignment with the Trust's ambition to foster an inclusive and diverse workplace where all colleagues feel respected, valued and treated fairly.

The Trust has control measures in place to ensure that it complies with all of its obligations in respect of equality, diversity and human rights legislation.

Equality Impact Assessments remain embedded within core business processes, with all Trust-wide policies, procedures and service redesigns subject to equality analysis. The Trust has now established seven Staff Networks which continue to be central to shaping an inclusive organisational culture, providing safe spaces for colleagues, promoting lived-experience-led insight, and helping to embed inclusive values across teams.

Through these strengthened governance arrangements and the integration of EDI into the People Strategy, the Trust is reinforcing its long-term commitment to embedding and mainstreaming equality, diversity and inclusion in everything we do.



Sustainability and climate change

The refreshed Trust Green Plan 2025-2028 has been Board ratified and sets out the priority actions as part of NHS Net Zero.

The Trust Sustainability Lead has completed specific NHS/E training programs during the second half of 2025 which will greatly assist in completing the Climate Change Risk assessments and position the Trust in being able to manage all areas of Climate adaptation.

In so doing, the Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

The Trust continues to collaborate with other regional and wider national trusts to provide competence and strategy to develop capabilities for climate adaptation and any necessary response as part of the now completed NHS England northern pilot. The completed pilot project is pivotal in enabling comprehensive risk assessments and mitigation strategies that further protect our Trust from extreme weather events. The Trust's Sustainability Lead is the representative as part of this pilot and will report through the Sustainability Strategy Group progress, risks and mitigation strategies.

This approach assists greatly in the development of the management plan which takes account of UK Climate Projections 2018 (UKCP18), and in turn will ensure its obligations under the Climate Change Act and the Adaptation Reporting requirements will be complied with.

The Climate Adaptation Plan will accompany the refreshed Trust 2025-2028 Green Plan as a standalone document and positions the Trust on all future expansion projects as we look to increase and extend our healthcare footprint to support our population.

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

Resources are managed within a financial governance framework defined in the Corporate Governance Manual and Standing Financial Instructions. Additional grip and control measures have been operating in 2025/26 to support the Trust's delivery of its financial plan including a significant cost improvement programme.

The Trust's financial regime is based on Integrated Care System allocations and the NHS Payment System. NHS provider contracts are primarily based on an aligned payment and incentive (API) mechanism, comprising a fixed element for an agreed level of activity other than for elective activity and a variable element for elective activity.

Overall financial performance is monitored by the Board of Directors, supported by the Finance and Performance Committee. A finance report summarising the latest financial performance and financial risk is presented to the Board of Directors and the Finance & Performance Committee, together with regular updates on capital



expenditure. The Integrated Performance Report, which provide data in respect of quality, constitutional targets and key operational risks are regularly presented and discussed.

The Trust recognises it has a significant underlying financial deficit. Work has been undertaken on improving financial governance and focusing on financial sustainability. The Trust has adapted its approach to delivery of Cost Improvement programmes, focusing on identifying variation, productivity opportunities and reduction of waste in addition to strengthening governance and reporting arrangements. The Trust along with the Cheshire & Mersey Integrated Care System has been supported by PwC in financial recovery and sustainability and has undergone a number of reviews relating to financial improvement opportunities which have been considered by the Board and enacted where supported.

The Trust is an active member of the Cheshire & Mersey Integrated 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.

Internal and external auditors provide assurance in respect of the internal control environment and the use of the organisation's resources. Audit report recommendations result in the development of a management action plan with an agreed timescale for improvement, and progress is monitored via the Audit Committee and other relevant sub-committees of the Board. The Audit Committee receives assurance on progress through the internal audit progress reports. The Executive Directors attend Audit Committee meetings as required to account for progress against internal audit reviews where limited assurance has been given.

The 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 the Annual Governance Statement.

The Head of Internal Audit Opinion for the year 2025/26 is as follows:

The overall opinion for the period 1st April 2025 to 31st March 2026 provides substantial assurance, that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.

A summary of the reviews performed in the year is provided below:

Review	Assurance opinion
System oversight framework data quality: complex patient discharge	Limited
Data Centre	Moderate

Review	Assurance opinion
Risk Management Processes	Moderate
Key Financial Transactional Processing Controls	Substantial
Digital and Data Strategy	Substantial
Managing Conflicts of Interest	Substantial
Fit and Proper Persons	Substantial
Theatre Utilisation	Substantial
AfC E-Roster and Bank	Substantial
Board Assurance Framework	N/A - Met Requirements
Divisional Governance	N/A - Mapping
Community Collaborative – Joint Governance Arrangements	N/A - Advisory

Information Governance and Data Quality

Information Governance

The Trust is required to undertake a mandatory annual Data Security and Protection Toolkit (DSPT) self-assessment. The DSPT 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, cyber security and data protection regulation 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 (DSPT) assessment provides an overall compliance score. The Trust's most recent DSPT submission to NHS Digital in June 2024 returned an *Approaching Standards* result. An internal audit of the DSPT process noted "high confidence in self assessment accuracy" and highlighted four areas for improvement.

An improvement plan is in place which is monitored by the Information Governance and Cyber Security Committee and the Trust has maintained training compliance at 88%. Training has been provided for our Information Asset Owners (IAOs) on their accountability, but a formal process for allocating IAOs has been enacted during the year.



Information Governance Incident Reporting

The Trust has a comprehensive approach to the requirements of the UK General Data Protection Regulation (GDPR). We have continued to update existing Data Sharing Agreements (DSA) and complete Data Privacy Impact Assessments (DPIA) as required. All new agreements are validated with full reference to UK GDPR and the Data Protection Act 2018 before being approved. DPIAs are regularly created for all new projects and any changes to the way in which information is processed.

3 information governance incidents have occurred that were notified to the Information Commissioner's Office (ICO) / Department of Health and Social Care in the Data Security Incident Reporting Tool in 2025/26. No follow up investigations have been requested by the ICO at this time.

Regular communication is shared on themes and trends regarding incidents and training is targeted to reflect this. We audit user's access to their own data which constitutes a breach of Trust regulations and also GDPR. This means that when anyone accesses their own records appropriate action in line with the Trust disciplinary policy can be taken.

Data Quality

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 a Data Governance Group that is chaired by the Chief Digital & Data Officer and meets fortnightly. The group reviews data quality and associated workflows to ensure that NHS data standards are adhered to. A Data Quality action plan is in place to monitor progress and ensure that appropriate governance is in place. This provides assurance to the Board via the Finance & Performance Committee.

A data quality assurance programme was introduced in 2025/26 to assess each of the core metrics in our Integrated Performance Report (IPR) for data capture processes, quality, management sign off and assurance.

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 updated. An intensive Referral to Treatment (RTT) training programme was put in place to ensure all current staff, and new starters have an understanding in the application of RTT.

The Trust produces routine data which is subject to review and analysis in-line with good standards of corporate governance. The ongoing development of a Data Hub and reporting platform is being used as an operational management tool to support the management and analysis of patient data, and to identify data quality errors.



The Trust completed a successful upgrade to Cerner, the Trust's Electronic Patient Records system during 2025/26 and continues to optimise the use of this system through a prioritised improvement programme.

Data quality will continue to remain a high priority focus for the Trust to ensure accurate, timely data to support the effective running of the Trust.

Review of Effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control.

My review is informed by:

- the Head of Internal Audit's opinion and reports by Internal Audit, who provide assurance through 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
- the work of the Executive Directors and Senior Leaders within the Countess of Chester Hospital NHS Foundation Trust who have responsibility for the development, application and maintenance of the internal control framework.
- opinion and reports from our external auditors.
- financial accounts, in year financial performance and adherence to our financial framework.
- in-year reviews, monitoring and scrutiny through submissions to NHS England and Cheshire and Merseyside Integrated Care Board.
- regulatory response and delivery of action plans.
- performance against national and regional requirements, indicators and benchmarking.
- results of national patient and staff surveys.
- incident responses reports, action plans and learning from incidents
- information governance assurance framework including the Data Security and Protection Toolkit.
- the work of the Trust's Anti-Fraud Specialist.

The Trust is committed to an improvement journey to outstanding underpinned by strong leadership and effective internal control, governance and risk management.

A significant amount of work has been taking place right across our services and we are seeing improvement in the quality and safety of our services, our financial sustainability and operational effectiveness

The Trust continues to focus on the improvements that will strengthen the effectiveness of the system of internal control.

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 assurance committees.



Conclusion

The Trust has not identified any significant internal control issues. We remain committed to tackling the long-standing challenges faced by the Trust, with improvement plans focused on delivering high quality patient care, supporting our staff, financial stability, along with our risk management and governance frameworks.

We have strengthened our arrangements, ensuring that we listen to and act on feedback from our staff, and patients and their families.

We continue to work with our regulators and system partners. We have contributed to the Thirlwall Public Inquiry through full and transparent disclosure of information, and continue to support the ongoing police investigations.

We have accepted the outcome of the employment tribunal, the failings of the Trust in this case and the learning which had already been implemented.



Ms Jane Tomkinson OBE
Chief Executive Officer
23rd June 2026



The Countess of Chester Hospital NHS Foundation Trust

Annual Accounts for the year ended 2025/26

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 for the year ended 31 March 2026

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 2025/26

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FOREWORD TO THE ACCOUNTS

Countess of Chester Hospital NHS Foundation Trust

These accounts for the year ended 31 March 2026 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.

A handwritten signature in grey ink, appearing to read 'Jane Tomkinson', is positioned above the printed name.

23 June 2026

Jane Tomkinson - Chief Executive Officer

**STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED
31 March 2026**

		2025/26	2024/25
	NOTE	Total £000	Total £000
Operating Income from Patient Care Activities	2	394,498	378,949
Other Operating Income	2.4	25,710	31,086
 Operating Expenses of Continuing Operations	 3	 (480,410)	 (417,545)
Operating (Deficit)/Surplus		(60,202)	(7,510)
Net Finance Costs:			
Finance Income	6.1	1,468	1,304
Finance Expense - Financial Liabilities	6.2	(502)	(354)
PDC Dividends payable	1.15	(3,977)	(2,372)
Net Finance Costs		(3,011)	(1,422)
(Losses)/on disposal of assets		(203)	(250)
Gains/(losses) from transfers by absorption		-	-
 DEFICIT FOR THE YEAR		 (63,416)	 (9,182)
 Other comprehensive income:			
Impairment losses on property, plant and equipment	1.6	(262)	(150)
Revaluations	1.6	3,764	-
 TOTAL COMPREHENSIVE INCOME AND EXPENSE FOR THE YEAR		 (59,914)	 (9,332)

The notes on pages 6 to 44 form part of these financial statements

**STATEMENT OF FINANCIAL POSITION AS AT
31 March 2026**

	NOTE	31 March 2026 £000	31 March 2025 £000
NON-CURRENT ASSETS:			
Intangible assets	7	4,577	5,414
Property plant and equipment	8	200,743	230,307
Right of use assets	9	3,446	4,654
Receivables	12	373	409
Total Non-Current Assets		209,138	240,784
CURRENT ASSETS:			
Inventories	11	1,616	1,503
Trade and other receivables	12	14,869	15,139
Other investments	16.1	-	-
Cash and cash equivalents	16.2	31,596	28,178
Total Current Assets		48,081	44,820
CURRENT LIABILITIES:			
Trade and other payables	13	(45,823)	(50,179)
Borrowings	14	(2,838)	(2,208)
Provisions	15	(612)	(1,698)
Tax payables		(8,061)	(7,794)
Other liabilities	13.1	(3,924)	(3,545)
Total Current Liabilities		(61,258)	(65,424)
Total Assets less Current Liabilities		195,961	220,180
NON-CURRENT LIABILITIES:			
Borrowings	14	(7,473)	(11,426)
Provisions	15	(783)	(850)
Other liabilities	13.1	(1,130)	(1,196)
Total Non-Current Liabilities		(9,386)	(13,472)
Total Assets Employed		186,575	206,708
FINANCED BY:			
Public dividend capital		341,730	301,948
Revaluation reserve		12,545	9,044
Income and expenditure reserve		(167,700)	(104,284)
TOTAL TAXPAYERS' EQUITY		186,575	206,708

The notes on pages 6 to 44 form part of these financial statements

Signed



Jane Tomkinson - Chief Executive Officer
23 June 2026

Countess of Chester Hospital NHS Foundation Trust - Annual Accounts 2025/26

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY 31 MARCH 2026

	Total £000	Public Dividend Capital £000	Revaluation Reserve £000	Income and Expenditure Reserve £000
Taxpayers' Equity at 1 April 2025	206,708	301,948	9,044	(104,284)
Changes in Taxpayers' Equity for 2025/26				
Public Dividend Capital received	39,782	39,782	-	-
Public Dividend Capital repaid	-	-	-	-
(Deficit)/Surplus for the year	(63,416)	-	-	(63,416)
Transfers by absorption: transfers between reserves	-	-	-	-
Revaluation gains/(losses) and impairment losses property, plant and equipment	3,501	-	3,501	-
Taxpayers Equity at 31 March 2026	186,575	341,730	12,545	(167,700)

	Total £000	Public Dividend Capital £000	Revaluation Reserve £000	Income and Expenditure Reserve £000
Taxpayers' Equity at 1 April 2024	127,527	213,435	9,194	(95,102)
Changes in Taxpayers' Equity for 2024/25				
Public Dividend Capital received	88,513	88,513	-	-
Public Dividend Capital repaid	-	-	-	-
(Deficit)/Surplus for the year	(9,182)	-	-	(9,182)
Revaluation gains/(losses) and impairment losses property, plant and equipment	-	-	-	-
	(150)		(150)	
Taxpayers Equity at 31 March 2025	206,708	301,948	9,044	(104,284)

The notes on pages 6 to 44 form part of these financial statements

**STATEMENT OF CASH FLOWS FOR THE YEAR ENDED
31 March 2026**

	2025/26 £000	2024/25 £000
Cash flows from operating activities:		
Operating deficit from continuing operations	(60,202)	(7,510)
Operating deficit	(60,202)	(7,510)
Non-cash income and expense:		
Depreciation and amortisation	9,758	9,631
Income recognised in respect of capital donations	(1,752)	(1,777)
Impairments	50,659	1,215
Reversals of impairments	-	-
Amortisation of PPP credit	(66)	(66)
(Increase)/Decrease in Trade and Other Receivables	42	2,271
Increase in Inventories	(113)	187
Increase/(Decrease) in Trade and Other Payables	2,269	4,637
Increase/(Decrease) in Other Liabilities	379	(2,127)
Increase/(Decrease) in Provisions	(1,153)	365
Net cash generated from operations	(179)	6,826
Cash flows from investing activities:		
Interest Received	1,468	1,304
Proceeds from sales of investments	-	-
Purchase of intangible assets	-	-
Purchase of Property, Plant and Equipment	(32,525)	(77,283)
Sales of property, plant and equipment	20	-
Receipt of cash donations to purchase capital assets	1,752	1,777
Net cash used in investing activities	(29,285)	(74,202)
Cash flows from financing activities:		
Public dividend capital received	39,782	88,513
Movement in loans from the Department of Health and Social Care	(1,801)	(1,801)
Capital element of lease liability repayments	(856)	(765)
Capital element of Public Private Partnership obligations	(123)	(73)
Interest paid on DHSC Loans	(80)	(104)
Interest element of lease liability repayments	(193)	(52)
Interest element of Public Private Partnership obligations	(234)	(199)
PDC Dividend paid	(3,613)	(2,307)
Net cash generated from financing activities	32,882	83,212
Decrease in cash and cash equivalents	3,418	15,836
Cash and Cash equivalents at 1 April	28,178	12,342
Cash and Cash equivalents at 31 March	31,596	28,178

The notes on pages 6 to 44 form part of these financial statements

NOTES TO THE ACCOUNTS

1 ACCOUNTING POLICIES

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

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

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

1.2 Consolidation

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

The NHS Foundation Trust is the Corporate Trustee to The Countess Charity. 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 Welsh Health Bodies

The Trust receives income from Wales for providing care to Welsh patients, ensuring vital cross-border healthcare support. In 25/26, this income is 100% variable payments based on patient care activity levels.

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Revenue from NHS contracts

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

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

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

The Trust also receives income from commissioners under the Best Practice Tariff (BPT) scheme. Delivery under this scheme is part of how care is provided to patients. As such BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner and are accounted for as a variable consideration under IFRS15. Payment for BPT on non-elective services is included in the fixed element of API contracts with adjustments for actual achievement being made at the end of the year. BPT earned on elective activity is included in the variable element of API contracts and paid in line with actual activity performed.

Where the relationship with a particular integrated care board is expected to be a low volume of activity (annual value below £0.5m), an annual fixed payment is received by the provider as determined in the NHSPS documentation. Such income is classified as 'other clinical income' in these accounts.

NHS injury cost recovery scheme

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

Apprenticeship service income

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

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 Schemes. 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 scheme is accounted for as though it is a defined contribution scheme. The cost to the Trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

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

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.

1.6.1 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 is carried out in 2025/26.

Current values in existing use are determined as follows:

Land and non specialised operational property - market value for existing use

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

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

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

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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.

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	5 years to 60 years
Dwellings	60 years
Plant and Equipment	5 to 15 years
Transport Equipment	5 years
Information Technology	5 to 10 years
Furniture & Fittings	5 to 10 years

Revaluation Gains and Losses

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

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

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

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic 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 and the assets are not revalued except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

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

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.

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 HM Treasury's FReM 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.

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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.

IFRS 16 liability measurement principles have not been applied to the PPP liabilities in these financial statements on the grounds of materiality.

1.7 Intangible Assets

Recognition

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

Internally Generated Intangible Assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised. Expenditure on development is capitalised where it meets the requirements set out in IAS 38.

Software

Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset where it meets recognition criteria.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management. From 1 April 2025, subsequent measurement of intangible assets is at cost less amortisation.

Prior to 1 April 2025, intangible assets were held under a revaluation approach reflecting current value in existing use.

Revaluation gains and losses and impairments were treated in the same manner as for property, plant and equipment. On 1 April 2025, the carrying value of these assets was carried forward as 'deemed cost' and any related revaluation surpluses in the revaluation reserve were transferred to the I&E reserve. Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

Amortisation

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

Useful lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset, as follows:

Software licences & Information Technology	10 years
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1.8 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 statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

1.9 Inventories

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

1.10 Financial Assets and Financial Liabilities

Recognition

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

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

Classification and measurement

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

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

Financial assets 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.

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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.

1.11 Leases

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

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

1.11.1 The Trust as Lessee

Initial Recognition and measurement

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

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

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

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.81% applied to new leases commencing in 205 and 5.32% to new leases commencing in 2026.

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

Subsequent Measurement

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

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

1.12 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 2026.

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

Clinical Negligence Costs

NHS Resolution operates a risk pooling scheme under which the 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 15.1, but is not recognised in the NHS Foundation Trust's accounts.

1.13 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.

1.14 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 in note 15.2

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.

1.15 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.

1.16 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.

1.17 Corporation Tax

The Countess of Chester Hospital NHS Foundation Trust is a Health Service body within the meaning of s519A ICTA 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.

1.18 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.

1.19 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.

1.20 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.

1.21 Transfer of Assets from Other NHS Bodies

For assets that have been transferred to the Trust from another NHS body, the transaction is accounted for as a transfer by absorption. The asset transferred is recognised in the accounts using the book value as at the date of transfer. The asset is not adjusted to fair value prior to recognition. The gain corresponding to the asset transferred is recognised within income, but not within operating activities.

For property, plant and equipment assets and intangible assets, the cost and accumulated depreciation / amortisation balances from the transferring entity's accounts are preserved on recognition in the Trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the Trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

1.22 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 affects 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 calculation of provisions in note 15.

1.23 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. The valuation in 2025/26 is a full valuation exercise. There are no significant changes in assumptions adopted for 31st March 2026 valuation.

1.24 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.

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.

1.25 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

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

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

IFRS 18 Presentation and Disclosure in Financial Statements

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

IFRS 19 Subsidiaries without Public Accountability: Disclosures

The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

The following future changes to adaptations and interpretations of IAS 16 for the public sector are also not yet adopted:

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

From 2026/27 NHS bodies' valuation methodology will be a mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years. The requirement in IAS 16 to revalue an asset when its fair value differs materially from its carrying value is being withdrawn for the public sector. Given the variation in PPE valuations in any given year, and future changes in indices, it is not possible to quantify the impact of applying these changes in future periods. PPE and right of use assets currently subject to revaluation have a total book value of £155m as at 31 March 2026

The current accounting policy for property assets measures the cost of replacing the service potential using a 'modern equivalent asset'. This policy is not changing. In deriving the modern equivalent asset, the Trust and its valuers currently adopt an 'alternative site' assumption for all of its specialised buildings, meaning the replaced service potential may be in a different location. The option of using this assumption is being withdrawn for NHS bodies from 1 April 2028. Therefore the hypothetical modern equivalent asset will change to be located on current sites in asset valuations from 2028/29. Assets valued on an alternative site basis have a total book value of £155m at 31 March 2026.

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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 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 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	2025/26 £000	2024/25 £000
Income from activities	2.3	394,498	378,949
Other operating income	2.4	25,710	31,086
Operating Income from Continuing Operations		420,208	410,035
Operating Income from Patient Care Activities		2025/26 £000	2024/25 £000
Income from commissioners under API contracts - variable element*		81,562	67,979
Income from commissioners under API contracts - fixed element*		234,247	231,516
Other type of activity income		39,100	11,290
High cost drugs income from commissioners		19,658	17,318
Additional pension contribution central funding**		16,788	15,936
Income from commissioners under API contracts*		3,069	-
Agenda for change pay offer central funding***		-	855
Other clinical income		-	33,974
Income from activities - Commissioner Requested Services		394,424	378,868
Private patient income		74	81
Income from activities		394,498	378,949

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2025/26 NHS Payment Scheme documentation.

**Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.38% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%) and related NHS England funding (9.4%) have been recognised in these accounts.

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

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)	2025/26	2024/25
	£000	£000
Income from patient care activities received from:		
NHS England	24,052	23,857
Integrated care boards	319,870	305,348
NHS Foundation Trusts	10,613	11,232
NHS Trusts	77	58
Local authorities	118	107
Department of Health and Social Care	-	-
NHS other (including Public Health England)	38,482	35,017
Non NHS: private patients	74	81
Non NHS: overseas patients (non-reciprocal, chargeable to patient)	198	237
Injury cost recovery scheme	716	533
Non NHS: other	298	2,479
	394,498	378,949
2.4 Other Operating Income	2025/26	2024/25
	£000	£000
Research and development	1,002	1,011
Education and training	13,078	12,246
Charitable contributions to expenditure	1,752	1,905
Non-patient care services to other bodies	805	1,261
Car parking	1,794	1,598
Catering	1,042	1,048
Other income	6,171	11,951
Amortisation of PPP deferred credits	66	66
	25,710	31,086
2.5 Directly Invoiced Overseas Visitors	2025/26	2024/25
	£000	£000
Income recognised this year	198	237
Cash payments received in-year (relating to invoices raised in current and previous years)	80	57
Amounts added to provision for impairment of receivables	203	67
Amounts written off in-year	72	25

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

	2025/26 £000	2024/25 £000
Revenue recognised in the reporting period that was included in contract liabilities at the previous period end	<u>3,369</u>	<u>5,606</u>
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	<u>-</u>	<u>-</u>

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3 Operating expenses	2025/26	2024/25
	£000	£000
Operating expenses comprise:		
Purchase of healthcare from non-NHS and non-DH bodies	3,675	1,114
Staff and executive directors costs	310,656	294,389
Remuneration of non-executive directors	159	156
Drug Costs	26,480	28,526
Supplies and services (excluding drug costs)		
- clinical	38,222	37,134
- general	4,141	4,857
Establishment	2,288	2,635
Transport	203	230
Premises	14,515	14,342
Supplies and services notional cost of equipment donated for COVID	-	-
Depreciation & Amortisation	9,758	9,631
(Decrease)/Increase in bad debt provision	227	158
Provisions arising / released in year	-	-
Audit fees - statutory audit	247	159
Other services: audit related assurance services	-	-
Contribution to clinical negligence scheme	9,467	9,350
Consultancy	154	489
Legal Fees	978	6,564
Internal audit costs	123	105
Training courses	794	748
Expenditure on short term leases	4,107	3,973
Expenditure on low value leases	-	-
Notional training funded from apprenticeship fund	567	587
Insurance	47	54
Impairment of property, plant and equipment (changes market price)		
	50,659	1,215
Other	2,943	1,129
Related to continuing operations	480,410	417,545

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4 Employee Expenses and Numbers

4.1 Employee expenses	2025/26 £000	2024/25 £000
Short term employee benefits - salaries and wages	235,032	227,373
Social security costs	29,211	21,971
Apprenticeship levy	1,168	1,083
Employer's contributions to NHS pensions	26,084	24,348
Pension cost - employer contributions paid by NHSE on provider's behalf (6.3%)	16,788	15,936
Other Employment Benefits	-	-
Termination Benefits	503	-
Temporary staff (including agency)	2,325	4,189
Total staff costs	311,111	294,900
Of which		
Costs capitalised as part of assets	403	380

4.2 Retirements due to ill-health

During 2025/26 (prior year 2024/25) there were 5 (9) early retirements from the Trust agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £762,000 (£977,000). 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.

4.3 Executive Directors Remuneration	2025/26 £000	2024/25 £000
		Reanalysed
Executive Directors Remuneration	1,543	1,503
Employers contributions for national insurance	220	193
Employer contributions to the NHS pension scheme	118	100

There are 5 Executive Directors included in the above to whom benefits are accruing under defined benefit pension schemes. For further information please see the remuneration report on page 80 of the annual report.

4.4 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 91 (2024/25 113) separate losses and special payments, totalling £1,571,000 (2024/25 £450,000). This includes an Employment Tribunal settlement that the Trust was obliged to pay of £1,400,000

The remaining losses were mainly due to bad debts and damage/loss of property, and are reported on an accruals basis.

5 Pension Costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2026, is based on valuation data as 31 March 2024, updated to 31 March 2026 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

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5.1 Auto-Enrolment

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 contributions are immaterial.

6 Net Finance Costs

6.1 Finance Income	2025/26 £000	2024/25 £000
Interest on loans and receivables	<u>1,468</u>	<u>1,304</u>
6.2 Finance Costs	2025/26 £000	2024/25 £000
Interest on Loans from the Department of Health and Social Care	81	103
Interest on lease obligations	187	52
Interest on obligations under PPP contracts:		
- finance cost	83	87
- contingent finance cost	151	112
Total	<u>502</u>	<u>354</u>

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7 Intangible Assets

7.1 Movement 2025/26

	Software Licences & Information Technology	Total
	£000	£000
Cost or valuation		
At 1 April 2025	8,365	8,365
Additions - purchased / internally generated	-	-
At 31 March 2026	8,365	8,365
Accumulated amortisation		
At 1 April 2025	2,951	2,951
Provided during the year	837	837
At 31 March 2026	3,788	3,788
Net book value		
- Purchased at 1 April 2025	5,414	5,414
Total at 1 April 2025	5,414	5,414
Net book value		
- Purchased at 31 March 2026	4,577	4,577
Total at 31 March 2026	4,577	4,577

7.2 Movement 2024/25

	Software Licences & Information Technology	Total
	£000	£000
Cost or valuation		
At 1 April 2024	8,365	8,365
Additions - purchased / internally generated	-	-
At 31 March 2025	8,365	8,365
Accumulated amortisation		
At 1 April 2024	2,115	2,115
Provided during the year	836	836
At 31 March 2025	2,951	2,951
Net book value		
- Purchased at 1 April 2024	6,250	6,250
Total at 1 April 2024	6,250	6,250
Net book value		
- Purchased at 31 March 2025	5,414	5,414
Total at 31 March 2025	5,414	5,414

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8 Property Plant and Equipment

8.1 Movement 2025/26

	Land	Buildings Excluding Dwellings	Dwellings	Payments on Account and Assets Under Construction	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings	Total
	£000	£000		£000	£000	£000	£000	£000	£000
Cost or valuation									
At 1 April 2025	6,529	77,785	2,591	114,410	47,431	42	22,054	6,291	277,133
Transfers by absorption	-	-	-	-	-	-	-	-	-
Additions - purchased	-	5,236	-	10,129	4,205	-	2,067	2,681	24,318
Additions - donated and grant funded	-	-	-	1,312	440	-	-	-	1,752
Revaluations	-	3,764	-	-	-	-	-	-	3,764
Reclassifications	-	121,987	-	(122,096)	-	-	-	109	-
Impairments / Reversals	(26)	(54,010)	-	-	-	-	-	-	(54,036)
Disposals	-	-	-	-	(1,506)	-	-	-	(1,506)
At 31 March 2026	6,503	154,762	2,591	3,755	50,570	42	24,121	9,081	251,424
Accumulated depreciation									
At 1 April 2025	-	-	1,054	-	25,412	29	15,416	4,915	46,826
Impairments / Reversals	-	(3,114)	-	-	-	-	-	-	(3,114)
Disposals	-	-	-	-	(1,206)	-	-	-	(1,206)
Provided during the year	-	3,114	62	-	3,009	4	1,713	275	8,177
At 31 March 2026	-	(0)	1,116	-	27,215	33	17,129	5,190	50,683
Net book value									
- Purchased at 1 April 2025	5,419	75,438	-	114,390	20,934	13	6,638	1,377	224,209
- PPP Obligations at 1 April 2025	1,110	-	1,537	-	-	-	-	-	2,647
- Donated at 1 April 2025	-	2,347	-	20	1,084	-	-	-	3,451
Total at 1 April 2025	6,529	77,785	1,537	114,410	22,018	13	6,638	1,377	230,307
Net book value									
- Purchased at 31 March 2026	5,393	152,408	-	2,443	21,978	9	6,993	3,892	193,116
- PPP Obligations at 31 March 2026	1,110	-	1,475	-	-	-	-	-	2,585
- Donated at 31 March 2026	-	2,354	-	1,312	1,376	-	-	-	5,042
Total at 31 March 2026	6,503	154,762	1,475	3,755	23,354	9	6,993	3,892	200,743

8.2 Movement 2024/25

	Land	Buildings Excluding Dwellings	Dwellings	Payments on Account and Assets Under Construction	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings	Total
	£000	£000		£000	£000	£000	£000	£000	£000
Cost or valuation									
At 1 April 2024	6,114	78,787	2,591	41,008	45,119	42	20,148	6,191	200,000
Transfers by absorption	-	-	-	-	-	-	-	-	-
Additions - purchased	-	906	-	75,180	2,595	-	1,906	201	80,788
Additions - donated and grant funded	-	1,209	-	-	461	-	-	-	1,670
Reclassifications	-	1,648	-	(1,778)	-	-	-	130	-
Impairments / Reversals	415	(4,765)	-	-	-	-	-	-	(4,350)
Disposals	-	-	-	-	(744)	-	-	(231)	(975)
At 31 March 2025	6,529	77,785	2,591	114,410	47,431	42	22,054	6,291	277,133
Accumulated depreciation									
At 1 April 2024	-	-	992	-	23,188	25	13,491	4,826	42,522
Impairments / Reversals	-	(2,985)	-	-	-	-	-	-	(2,985)
Disposals	-	-	-	-	(597)	-	-	(129)	(726)
Provided during the year	-	2,985	62	-	2,821	4	1,925	218	8,015
At 31 March 2025	-	-	1,054	-	25,412	29	15,416	4,915	46,826
Net book value									
- Purchased at 1 April 2024	5,004	77,554	-	41,009	21,199	17	6,657	1,366	152,806
- PPP Obligations at 1 April 2024	1,110	-	1,599	-	-	-	-	-	2,709
- Donated at 1 April 2024	-	1,233	-	-	731	-	-	-	1,964
Total at 1 April 2024	6,114	78,787	1,599	41,009	21,930	17	6,657	1,366	157,479
Net book value									
- Purchased at 31 March 2025	5,419	75,438	-	114,390	20,934	13	6,638	1,377	224,209
- PPP Obligations at 31 March 2025	1,110	-	1,537	-	-	-	-	-	2,647
- Donated at 31 March 2025	-	2,347	-	20	1,084	-	-	-	3,451
Total at 31 March 2025	6,529	77,785	1,537	114,410	22,018	13	6,638	1,377	230,307

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9 Leases

9.1 Right of use assets - 2025/26

	Property (land and buildings) £000	Plant & machinery £000	Transport equipment £000	Total £000	Of which: leased from DHSC group bodies £000
Valuation / gross cost at 1 April 2025 - brought forward	6,527	682	57	7,266	4,945
Additions	717	-	108	825	-
Disposals / derecognition	(4,945)	-	-	(4,945)	(4,945)
Remeasurements of the lease liability	2,928	-	-	2,928	-
Valuation/gross cost at 31 March 2026	5,227	682	165	6,074	0
Accumulated depreciation at 1 April 2025 - brought forward	1,914	643	55	2,612	530
Provided during the year	703	25	16	744	198
Disposals / derecognition	(728)	-	-	(728)	(728)
Accumulated depreciation at 31 March 2026	1,889	668	71	2,628	0
Net book value at 31 March 2026	3,338	14	94	3,446	(0)
Net book value of right of use assets leased from other NHS providers	-	-	-	-	-
Net book value of right of use assets leased from other DHSC group bodies	-	-	-	-	-

9.2 Right of use assets - 2024/25

	Property (land and buildings) £000	Plant & machinery £000	Transport equipment £000	Total £000	Of which: leased from DHSC group bodies £000
Valuation / gross cost at 1 April 2024 - brought forward	6,527	682	57	7,266	4,945
Prior period adjustments	-	-	-	-	-
Valuation / gross cost at 1 April 2024 - restated	6,527	682	57	7,266	4,945
Additions	-	-	-	-	-
Remeasurements of the lease liability	-	-	-	-	-
Valuation/gross cost at 31 March 2025	6,527	682	57	7,266	4,945
Accumulated depreciation at 1 April 2024 - brought forward	1,253	536	45	1,834	332
Provided during the year	661	107	10	778	198
Accumulated depreciation at 31 March 2025	1,914	643	55	2,612	530
Net book value at 31 March 2025	4,613	39	2	4,654	4,415
Net book value of right of use assets leased from other NHS providers	-	-	-	-	-
Net book value of right of use assets leased from other DHSC group bodies	4,415	-	-	4,415	4,415

Countess of Chester Hospital NHS Foundation Trust - Annual Accounts 2025/26

9.3 Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the statement of financial position. A breakdown of borrowings is disclosed in note 14

	2025/26 £000	2024/25
	-	
Carrying value at 31 March 2025	4,709	5,474
Prior period adjustment	-	-
Lease additions	825	-
Lease liability remeasurements	2,928	-
Interest charge arising in year	187	52
Early terminations	(4,287)	-
Lease payments (cash outflows)	(1,049)	(817)
Other changes	-	-
Carrying value at 31 March 2026	3,313	4,709

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure. These payments are disclosed in note 3. Cash outflows in respect of leases recognised on-SOFP are disclosed in the reconciliation above.

	Of which leased from DHSC group bodies		Of which leased from DHSC group bodies	
	Total 31 March 2026 £000	31 March 2026 £000	Total 31 March 2025 £000	31 March 2025 £000
9.4 Maturity analysis of future lease payments at 31 March 2026				
Undiscounted future lease payments payable in:				
- not later than one year;	900	-	376	279
- later than one year and not later than five years;	2,538	-	1041	893
- later than five years	372	-	3794	3794
Total gross future lease payments	3,810	-	5,211	4,966
Finance charges allocated to future periods	(497)	-	(502)	(498)
Net lease liabilities at 31 March 2026	3,313	-	4,709	4,468
Of which:				
- Current	900	-	275	181
- Non-Current	2,413	-	4434	4287

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10 Net Book Value of Assets held under PPP Obligations

PPP Arrangements	2025/26 £000	2024/25 £000
Cost or valuation at 1 April	4,033	4,033
Cost or valuation at 31 March	4,033	4,033
	2025/26 £000	2024/25 £000
Depreciation at 1 April as previously stated	1,386	1,324
Accumulated depreciation at 1 April as restated	1,386	1,324
Provided during the year	62	62
Accumulated depreciation at 31 March	1,448	1,386
Net Book Value under PPP obligations at 31 March	2,585	2,647

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.

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10.1 Gross PPP Obligations

	31 March 2026 £000	31 March 2025 £000
Gross PPP Liabilities	2,014	2,222
of which liabilities are due:		
Not later than one year	208	208
Between one and five years	814	814
After five years	992	1,200
Finance charges allocated to future periods	(528)	(611)
Net PPP Liabilities	1,486	1,611
Not later than one year	131	125
Between one and five years	575	547
After five years	780	939
	1,486	1,611

	31 March 2026 £000	31 March 2025 £000
10.2 Total Future Payments in respect of PPP Arrangements.		
of which due:		
- not later than one year;	512	499
- later than one year and not later than five years;	2,177	2,124
- later than five years.	5,399	5,964
Total future payments committed	8,088	8,587

10.3 Analysis of Amounts Payable to Service Concession Operator

	31 March 2026 £000	31 March 2025 £000
Unitary payment payable to service concession operator		
Consisting of:		
Interest Charge	83	87
Repayment of finance lease liability	125	73
Service element	140	215
Contingent rent	151	112
	499	487

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	31 March 2026	31 March 2025
	£000	£000
11 Inventories		
Drugs	1019	1304
Consumables	597	199
	<u>1,616</u>	<u>1,503</u>
	31 March 2026	31 March 2025
	£000	£000
11.1 Inventories recognised in expenses	26,887	28,110
Write-down of inventories recognised as an expense	127	134
	<u>27,014</u>	<u>28,244</u>
Total Inventories recognised in expenses	27,014	28,244

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12 Trade and Other Receivables	31 March 2026	31 March 2025
	£000	£000
Current		
Contract receivables	9,939	8,192
Allowance for impaired contract receivables/assets	(690)	(496)
PDC Dividend Receivable	-	264
VAT recoverable	-	-
Other receivables	2,133	1,859
Clinician pension tax provision reimbursement funding from NHSE	6	5
Prepayments	3,481	5,315
Total Current Trade and Other Receivables	14,869	15,139
Non-Current		
Clinician pension tax provision reimbursement funding from NHSE	373	409
Total Non-Current Receivables	373	409
Of which receivables from NHS and DHSC group bodies:		
Current	6,481	4,555
Non-current	373	409

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

12.1 Allowance for Credit losses 2025/26

	31 March 2026	31 March 2025
	£000	£000
Contract receivables and contract assets		
Allowances as at 1 Apr - brought forward	496	564
New allowances arising	460	334
Reversals of allowances	(233)	(176)
Utilisation of allowances (write offs)	(33)	(226)
At 31 March 2026	690	496

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13 Trade and Other Payables

	Current		Non-current	
	31 March 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
Trade payables	16,461	17,030	-	-
Capital payables (including capital accruals)	6,423	12,879	-	-
PDC dividend payable	100	-	-	-
NHS Pension Scheme	3,729	3,419	-	-
Other payables	2,765	1,594	-	-
Accruals	16,345	15,257	-	-
Total	45,823	50,179	-	-
Of which payable to NHS and DHSC group bodies:				
Current	8,072	5,282	-	-

13.1 Other Liabilities

	Current		Non-current	
	31 March 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
Deferred Income	3,858	3,369	-	-
Deferred Grants	-	110	-	-
Deferred PPP Credits	66	66	1,130	1,196
Total	3,924	3,545	1,130	1,196

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14 Borrowings

	Current		Non-current	
	31 March	31 March	31 March	31 March 2025
	2026	2025	2026	2025
	£000	£000	£000	£000
Loans from the Department of Health and Social Care	1,807	1,808	3,705	5,506
Obligations under PPP Contracts	131	125	1,355	1,486
Lease liabilities	900	275	2,413	4,434
Total	2,838	2,208	7,473	11,426

Schedule of Borrowing	Date Started	Date to be completed	Interest Rate	Loan Amount £000	Amount outstanding (excluding interest accrued) £000
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	-
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	1,882
Loan 5 - Normal course of business capital loan	Oct-14	Nov-21	1.36%	11,000	-
Loan 6 - Normal course of business capital loan	Sep-17	Aug-32	1.03%	8,090	3,624
					5,506

14.1 Reconciliation of liabilities arising from financing activities - 2025/26

	Loans from DHSC £000	Lease Liability £000	PPP schemes £000	Total £000
Carrying value at 1 April 2025	7,314	4,709	1,611	13,634
Cash movements:				
Financing cash flows - payments and receipts of principal	(1,801)	(856)	(123)	(2,780)
Financing cash flows - payments of interest	(80)	(193)	(86)	(359)
Non- cash movements:				-
Additions	-	825	-	825
Lease liability remeasurements	-	2,928	-	2,928
Interest charge arising in year	79	187	84	350
Change in effective interest rate	-	-	-	-
Early terminations	-	(4,287)	-	(4,287)
Changes in fair value	-	-	-	-
Carrying value at 31 March 2026	5,512	3,313	1,486	10,311

14.2 Reconciliation of liabilities arising from financing activities - 2024/25

	Loans from DHSC £000	Lease Liability £000	PPP schemes £000	Total £000
Carrying value at 1 April 2024	9,116.00	5,474.00	1,684.00	16,274.00
Cash movements:				
Financing cash flows - payments and receipts of principal	(1,801.00)	(765.00)	(73.00)	(2,639.00)
Financing cash flows - payments of interest	(103.00)	(52.00)	(87.00)	(242.00)
Non- cash movements:				-
Additions	-	-	-	-
Lease liability remeasurements	-	-	-	-
Application of effective interest rate	102.00	52.00	87.00	241.00
Change in effective interest rate	-	-	-	-
Changes in fair value	-	-	-	-
Carrying value at 31 March 2025	7,314	4,709	1,611	13,634

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	Current	Non Current	Current	Non Current
15 Provisions	31 March	31 March	31 March	31 March 2025
	2026	2026	2025	31 March 2025
	£000	£000	£000	£000
Pensions - Early Departure Costs	20	79	19	95
Pensions - Injury Benefit	25	330	26	346
Legal Claims	561	1	1,648	-
Restructuring	-	-	-	-
Other	-	-	-	-
Equal pay	-	-	-	-
Clinician pension tax reimbursement	6	373	5	409
	612	783	1,698	850

	Pensions - Early Departure Costs	Pensions - Injury Benefit	Legal Claims	Other	Clinician Pension Tax Reimbursement	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2025	114	372	1,648	-	414	2,548
Arising during the year	5	54	227	-	(24)	262
Utilised during the year	(20)	(54)	(461)	-	(6)	(541)
Change in Discount Rate	-	(17)	-	-	(29)	(46)
Unwinding of Discount Rate	-	-	-	-	24	24
Reversed unused	-	-	(852)	-	-	(852)
At 31 March 2026	99	355	562	-	379	1,395

Expected timing of cashflows:

- not later than one year	20	25	561	-	6	612
- later than one year and not later than five years	78	95	-	-	54	227
- later than five years	1	235	1	-	319	556
	99	355	562	-	379	1,395

15.1 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. 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 this year to reflect more accurate information and up to date information. The net impact on the Trust surplus is therefore nil.

Other

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

£151,229,000 is included in the provisions of the NHS Litigation Authority at 31/3/26 in respect of clinical negligence liabilities for the Trust (31/3/2025 £139,917,000).

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

15.2 Contingent Liabilities

The Trust is subject to ongoing external processes, including the Thirlwall Inquiry and a related police investigation following the outcome of the Letby verdict. At the reporting date, it is not possible to determine the outcome, impact or any future liability in respect of this matter. No provision has therefore been recognised in the financial statements.

The outcome, timing and any financial implications remain uncertain and will depend on the conclusions of these processes.

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16.1 Other Investments

	31 March 2026 £000	31 March 2025 £000
Balances at 1 April	-	-
Net change in year	-	-
Other Investments	-	-

16.2 Cash and cash equivalents

	31 March 2026 £000	31 March 2025 £000
Bank balances at 1 April	28,178	12,342
Net change in year	3,418	15,836
Cash and cash equivalents in the statement of cash flows at 31 March	31,596	28,178
Broken down into:		
Cash at commercial banks and in hand	140	234
Cash with the Government Banking Service	31,456	27,944
Total cash and cash equivalents as in SoFP	31,596	28,178

Cash and cash equivalents at 31 March 2026 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.

Countess of Chester Hospital NHS Foundation Trust - Annual Accounts 2025/26

17.1 Capital Commitments

	31 March 2026	31 March 2025
Contractual Capital Commitments at 31 March not otherwise included in these financial statements:	£000	£000
Property, Plant and Equipment	<u>309</u>	<u>6,713</u>

17.2 Events After the Reporting Date

There are no disclosable events after the reporting date

18 Third Party Assets

The Trust held £12,000 In the Bank (2024/25 £12,000) which relates to monies held by the NHS Foundation Trust on behalf of patients.

19 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 2025/26 the Trust has received £682,000 (2024/25 £240,000 total) payments from a number of charitable funds for which the Trust acts as Corporate Trustee. . In addition we received grant funding from Salix Finance who administer funds on behalf of the Department for Energy Security and Net Zero of £1,1,312,000 as a contribution towards the purchase of capital assets.

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.

	2025/26 Income £000	2025/26 Expenditure £000	2025/26 Current Receivables £000	2025/26 Current Payables £000
Value of transactions with:				
Department of Health	363	-	-	-
Other NHS Bodies	352,675	19,544	6,474	7,805
Other WGA Bodies	38,615	75,215	45	14,955

Countess of Chester Hospital NHS Foundation Trust - Annual Accounts 2025/26

19 Related Party Transactions (continued)

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

	2025/26	2025/26	2025/26	2025/26
	Income	Expenditure	Current	Current
	£000	£000	receivables	payables
			£000	£000
Alder Hey Childrens NHS Foundation Trust	226	114	6	564
Cheshire and Wirral Partnership NHS Foundation Trust	1,521	1,122	542	804
Lancashire Teaching Hospitals NHS Foundation Trust	96	220	54	8
Liverpool Heart and Chest Hospital NHS Foundation Trust	99	184	-	187
Liverpool University Hospitals NHS Foundation Trust	282	946	69	1,004
Liverpool Women's NHS Foundation Trust	56	(3)	55	32
Manchester University NHS Foundation Trust	695	87	218	60
Mid Cheshire NHS Foundation Trust	425	22	40	16
Northern Care Alliance NHS Foundation Trust	11	5	4	3
Northumbria Healthcare NHS Foundation Trust	22	-	4	17
The Christie NHS Foundation Trust	-	2	-	0
Sheffield Teaching Hospitals NHS Foundation Trust	24	78	5	39
The Clatterbridge Cancer Centre NHS Foundation Trust	778	7	150	10
The Walton Centre NHS Foundation Trust	198	102	42	126
Warrington and Halton Hospitals NHS Foundation Trust	192	617	36	384
Wirral University Teaching Hospital NHS Foundation Trust	7,877	4,474	3,132	1,788
Mersey and West Lancashire Teaching Hospitals NHS Trust	168	465	9	161
University Hospitals of North Midlands NHS Trust	33	-	8	11
NHS Cheshire and Merseyside ICB	317,649	13	1,750	790
NHS Greater Manchester ICB	457	-	-	-
NHS Lancashire and South Cumbria ICB	240	-	-	-
NHS North East and North Cumbria ICB	88	-	-	-
NHS Shropshire, Telford and Wrekin ICB	474	(3)	-	-
NHS Staffordshire and Stoke-on-Trent ICB	98	-	-	-
NHS West Yorkshire ICB	82	-	-	-
NHS England (core)	12,089	3	-	24
NHS England - Central Specialised Commissioning Hub	3,496	-	-	-
NHS Business Services Authority	-	77	-	173
NHS England North West Regional Office	4,155	-	-	-
NHS Resolution	19	9,470	-	-
UK Health Security Agency	-	465	-	59
Care Quality Commission	-	198	-	-
NHS Property Services	177	525	290	1,367
HM Revenue & Customs - Other	-	30,379	-	6,607
National Health Service Pension Scheme	-	42,872	-	3,729
Welsh Health Bodies - Betsi Cadwaladr University Local Health Board	38,431	19	8	1,658
NHS Blood and Transplant	7	1,298	2	181
Cheshire West and Chester Unitary Authority	128	595	-	1,307
Wrexham University	-	9	-	2

Jane Tomkinson was the Chair of Clinical Research Network North West Coast, part of the National Institute for Health and Care Research. The network is hosted by Liverpool University Hospitals NHS Foundation Trust and this funding is included in the figures set out above. Professor Andrew Hassell - Non Executive Director was a Non Executive Director at the University Hospital of North Midlands until January 2026. All transactions with the Trust are as included above.

Countess of Chester Hospital NHS Foundation Trust - Annual Accounts 2025/26

20 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 its capital expenditure from internally generated funds or funds made available from Government, in the form of additional Public Dividend Capital, under an agreed limit. In addition, the Trust 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.

21 Auditor's Liability Limitation Agreements

As determined in the engagement letter with KPMG LLP, external Auditor's to the trust, the liability of either party under or in connection 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.

	2025/26 £000	2024/25 £000
Limitation on Auditor's Liability	2,000	2,000

22 Carrying values of financial assets

	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through SOCI £000	Total book value £000
Carrying values of financial assets as at 31 March 2026				
Trade and other receivables excluding non financial assets	11,761	-	-	11,761
Other investments / financial assets	-	-	-	-
Cash and cash equivalents at bank and in hand	31,596	-	-	31,596
Total at 31 March 2026	43,357	-	-	43,357

	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through SOCI £000	Total book value £000
Carrying values of financial assets as at 31 March 2025				
Trade and other receivables excluding non financial assets	9,969	-	-	9,969
Other investments / financial assets	-	-	-	-
Cash and cash equivalents at bank and in hand	28,178	-	-	28,178
Total at 31 March 2025	38,147	-	-	38,147

22.1 Carrying value of financial liabilities

	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 2026			
Loans from the Department of Health and Social Care	5,512	-	5,512
Obligations under finance leases	3,313	-	3,313
Obligations under PFI, LIFT and other service concession contracts	1,486	-	1,486
Other borrowings	-	-	-
Trade and other payables excluding non financial liabilities	41,994	-	41,994
Other financial liabilities	-	-	-
Provisions under contract	-	-	-
Total at 31 March 2026	52,305	-	52,305

22 Carrying values of financial assets (continued)

	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 2025 under IAS 39			
Loans from the Department of Health and Social Care	7,314	-	7,314
Obligations under finance leases	4,709	-	4,709
Obligations under PFI, LIFT and other service concession contracts	1,611	-	1,611
Other borrowings	-	-	-
Trade and other payables excluding non financial liabilities	46,760	-	46,760
Other financial liabilities	-	-	-
Provisions under contract	-	-	-
Total at 31 March 2025	60,394	-	60,394

	31 March 2026 £000	31 March 2025 £000
Maturity of financial liabilities		
In one year or less	44,961	49,226
In more than one year but not more than five years	6,313	5,546
In more than five years	2,206	6,965
Total	53,480	61,737



Auditor's Annual Report 2025/26

Countess of Chester Hospital NHS Foundation Trust

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June 2026

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This report is addressed to Countess of Chester Hospital NHS Foundation Trust (the Trust), as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state, those matters we are required to state to them in an auditors’ annual report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Countess of Chester Hospital NHS Foundation Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

We take no responsibility to any member of staff acting in their individual capacities, or to third parties.

External auditors do not act as a substitute for the audited body’s own responsibility for putting in place proper arrangements to ensure that public business is conducted in accordance with the law and proper standards, and that public money is safeguarded and properly accounted for, and used economically, efficiently and effectively.





01 Executive Summary

Executive Summary

Purpose of the Auditor’s Annual Report

This Auditor’s Annual Report provides a summary of the findings and key issues arising from our 2025-26 audit of the Countess of Chester Hospital NHS Foundation Trust (the ‘Trust’). This report has been prepared in line with the requirements set out in the Code of Audit Practice published by the National Audit Office and is required to be published by the Trust alongside the annual report and accounts.

Our responsibilities

The statutory responsibilities and powers of appointed auditors are set out in the Local Audit and Accountability Act 2014. In line with this we provide conclusions on the following matters:



Accounts - We provide an opinion as to whether the accounts give a true and fair view of the financial position of the Trust and of its income and expenditure during the year. We confirm whether the accounts have been prepared in line with the Group Accounting Manual prepared by the Department of Health and Social Care (DHSC).



Annual report - We assess whether the annual report is consistent with our knowledge of the Trust. We perform testing of certain figures labelled in the remuneration report.



Value for money - We assess the arrangements in place for securing economy, efficiency and effectiveness (value for money) in the Trust’s use of resources and provide a summary of our findings in the commentary in this report. We are required to report if we have identified any significant weaknesses as a result of this work.



Other reporting - We may issue other reports where we determine that this is necessary in the public interest under the Local Audit and Accountability Act.

Findings

We have set out below a summary of the conclusions that we provided in respect of our responsibilities:

Accounts	We issued an unqualified opinion on the Trust’s accounts on 26 June 2026. This means that we believe the accounts give a true and fair view of the financial performance and position of the Trust. We have provided further details of the key risks we identified and our response on pages 7-9.
Annual report	We did not identify any significant inconsistencies between the content of the annual report and our knowledge of the Trust. We confirmed that the annual report has been prepared in line with the NHS Group Accounting Manual (GAM) and the Foundation Trust Annual Reporting Manual (the ARM).
Value for money	We are required to report if we identify any matters that indicate the Trust does not have sufficient arrangements to achieve value for money. We have not identified any new significant weaknesses during the year. In the prior year we identified one significant weakness relating to governance, specifically the failure to implement or achieve progress on recommendations raised as a result of previous regulatory inspections of Urgent and Emergency Care services. Whilst progress has been demonstrated and no further enforcement action has been taken, ongoing operational challenges and the absence of final regulatory confirmation limits the ability to conclude whether improvements have been fully embedded and sustained, and therefore the significant weakness raised in the prior year remains open. We have provided further detail on page 18.
Other reporting	We did not consider it necessary to issue any other reports in the public interest.

02 Audit of the Financial Statements

Audit of the financial statements

KPMG provides an independent opinion on whether the Trust's financial statements:

- Give a true and fair view of the state of the Trust's affairs as at 31 March 2026 and of its income and expenditure for the year then ended;
- Have been properly prepared in accordance with the accounting policies directed by NHS England with the consent of the Secretary of State in February 2026 as being relevant to NHS Foundation Trusts and included in the Department of Health and Social Care Group Accounting Manual 2025/26; and
- Have been prepared in accordance with the requirements of the National Health Service Act 2006 (as amended).

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. 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.

Audit opinion on the financial statements

We have issued an unqualified opinion on the Trust's financial statements before 26 June 2026.

The full opinion is included in the Trust's Annual Report and Accounts for 2025/26 which can be obtained from the Trust's website.

Further information on our audit of the financial statements is set out overleaf.

Audit of the financial statements

The table below summarises the key risks that we identified to our audit opinion as part of our risk assessment and how we responded to these through our audit.

Significant Risk – Fraud Risk From Expenditure Recognition - understatement	Procedures undertaken	Findings
<i>Liabilities and related expenses for purchases of goods or services are not completely recorded in the correct accounting period</i> As the Trust is set a financial performance target by NHSE there is a risk that non-pay expenditure, excluding depreciation, may be manipulated in order to report that the control total has been met. The Trust's financial plan for 2025/26 sets out a planned deficit of £14.4m, incorporating £19.6m of non-recurrent deficit support funding and a recurrent savings requirement of £27.7m. At month 8, the Trust is reporting a year-to-date deficit of £22.2m; however, it continues to forecast delivery of the planned year-end position. The setting of a control total can create an incentive for management to understate the level of non-pay expenditure compared to that which has been incurred. We consider this would be most likely to occur through understating year-end manual non-pay accruals, for example to push back expenditure to 2026/27 to mitigate financial pressures in the current year.	- We evaluated the design and implementation of controls for developing manual non-pay expenditure accruals at the end of the year to verify that they have been completely and accurately recorded; - We inspected a sample of expenditure invoices and payments made, in the period around 31 March 2026, to determine whether expenditure has been recognised in the correct accounting period and whether accruals were complete; - We inspected a sample of cash expenditure recorded in the bank statement in the post balance sheet period and reviewed associated evidence including invoices where applicable to test for unrecorded liabilities; - We selected a sample of year end accruals and inspected evidence of the actual amount paid after year end and other supporting information in order to assess whether the accruals have been accurately recorded; - We inspected journals posted as part of the year end close procedures that decrease the level of expenditure recorded in order to critically assess whether there was an appropriate basis for posting the journal and the value can be agreed to supporting evidence; - We performed a retrospective review of prior year accruals in order to assess the completeness and accuracy with which accruals had been recorded at 31 March 2025 and consider the impact on our assessment of the accruals at 31 March 2026; and - We performed a year on year comparison of a sample of the largest accruals in the prior year and current year and challenge management where the movement is not in line with our understanding of the entity.	We have not identified any material misstatements relating to this risk. Through our assessment of the design of controls for ensuring the completeness of manual expenditure accruals at the end of the year, we noted that the Trust has high level controls in place designed to detect omission of accruals (such as review of management accounts). However, as these controls are not formally documented and designed to a minimum required level of precision, they do not meet the management review control requirements as defined by Auditing Standards. As such we deem the control ineffective. Whilst we are not raising a formal control observation in this regard, and the Trust considers its existing controls to be proportionate to address the associated risk, as the accruals balance is associated with a significant risk we are required to bring this matter to your attention.

Audit of the financial statements

The table below summarises the key risks that we identified to our audit opinion as part of our risk assessment and how we responded to these through our audit.

Significant Risk – Management Override of Controls	Procedures undertaken	Findings
Management override of controls We are required by auditing standards to recognise the risk that management may use their authority to override the usual control environment.	- In line with our methodology, evaluated the design and implementation of controls over journal entries and post closing adjustments; - Assessed accounting estimates for biases by evaluating whether judgements and decisions in making accounting estimates, even if individually reasonable, indicate a possible bias; - Assessed the appropriateness of changes compared to the prior year to the methods and underlying assumptions used to prepare accounting estimates; - Assessed the business rationale and the appropriateness of the accounting for significant transactions that are outside the component's normal course of business, or are otherwise unusual; and - Analysed all journals through the year and focussed our testing on those with higher risk characteristics that make them susceptible to fraud, and performed procedures to test the appropriateness of these entries and adjustments.	We have not identified any material misstatements relating to this risk. In light of the fact no automated controls exist that we can place reliance on to mitigate the risk of management override, we have assessed the design and implementation of manual controls. Management's journal control, whilst it does demonstrate a degree of segregation of duties, it does not meet the management review control criteria as stipulated by auditing standards. As such we deem the control ineffective. Whilst we are not raising a formal control observation in this regard, and the Trust considers its existing controls to be proportionate to address the associated risk, as journals are associated with a significant risk we are required to bring this matter to your attention.

Audit of the financial statements

The table below summarises the key risks that we identified to our audit opinion as part of our risk assessment and how we responded to these through our audit.

Significant Risk – Valuation of Land and Buildings	Procedures undertaken	Findings
<i>The carrying amount of revalued Land & Buildings differs materially from the fair value</i> Land and buildings are required to be held at fair value. As hospital buildings are specialised assets and there is not an active market for them, they are usually valued on the basis of the cost to replace them with a 'modern equivalent asset (MEA)'. 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. The value of the Trust's land and buildings at 31 March 2025 was £84.3m, of which £77.8m are valued as specialised assets at depreciated replacement cost. During the year, the Trust completed construction of the new Women and Children's Building, with an estimated initial asset value of £110m. The building is expected to incur a significant impairment when it is assessed for fair value at year-end. The Trust is due to undertake a full revaluation of its land and buildings in year. The last full revaluation took place in 2020/21. The risk is perceived to be increased due to the full revaluation taking place, with particular focus on the estimation uncertainty of certain core assumptions which drive the valuer's calculations, including: Obsolescence Factor and Floor Areas.	- We critically assessed the independence, objectivity and expertise of Cushman and Wakefield, the valuers used in developing the valuation of the Trust's properties at 31 March 2026; - We inspected the instructions issued to the valuers for the valuation of land and buildings to verify they are appropriate to produce a valuation consistent with the requirements of the Group Accounting Manual; - We compared the accuracy of the data provided to the valuers for the development of the valuation to underlying information, such as floor plans, and to previous valuations, challenging management where variances are identified; - We evaluated the design and implementation of controls in place for management to review the valuation and the appropriateness of assumptions used; - We challenged the appropriateness of the valuation of land and buildings; including any material movements from the previous revaluations. We challenged key assumptions within the valuation, including the use of an obsolescence factor and assumptions of how a modern equivalent asset would be developed, as part of our judgement; - We performed inquiries of the valuers in order to verify the methodology that was used in preparing the valuation and whether it was consistent with the requirements of the RICS Red Book and the GAM; - We agreed the calculations performed of the movements in the value of land and buildings and verified that these have been accurately accounted for in line with the requirements of the GAM; and - Disclosures: We considered the adequacy of the disclosures concerning the key judgements and degree of estimation involved in arriving at the valuation.	We have not identified any material misstatements relating to this risk. We have reiterated the recommendation from previous audits regarding management's review of property valuations, which has been assessed as a significant risk again in the current year. While the Trust has established high-level processes to support the reasonableness of land and building valuations, these are not formally documented and lack the precision required to operate as a Management Review Control (MRC) under auditing standards. Management has indicated reliance on the work and professional judgement of an external valuer to support valuation accuracy. Although this does not give rise to a formal control observation, and management considers the current approach proportionate, we are required to draw this matter to your attention given the materiality and significance of valuation balance.

03 Value for Money

Value for Money

Introduction

We are required to consider whether the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources or 'value for money'. We consider whether there are sufficient arrangements in place for the Trust for the following criteria, as defined by the National Audit Office (NAO) in their Code of Audit Practice:

 **Financial sustainability:** How the Trust plans and manages its resources to ensure it can continue to deliver its services.

 **Governance:** How the Trust ensures that it makes informed decisions and properly manages its risks.

 **Improving economy, efficiency and effectiveness:** How the Trust uses information about its costs and performance to improve the way it manages and delivers its services

Approach

We undertake risk assessment procedures in order to assess whether there are any risks that value for money is not being achieved. This is prepared by considering the findings from other regulators and auditors, records from the organisation and performing procedures to assess the design of key systems at the organisation that give assurance over value for money.

Where a significant risk is identified we perform further procedures in order to consider whether there are significant weaknesses in the processes in place to achieve value for money.

We are required to report a summary of the work undertaken and the conclusions reached against each of the aforementioned reporting criteria in this Auditor's Annual Report. We do this as part of our commentary on VFM arrangements over the following pages.

We also make recommendations where we identify weaknesses in arrangements or other matters that require attention from the Trust.

Summary of findings

	Financial sustainability	Governance	Improving economy, efficiency and effectiveness
Commentary page reference	13-15	16-19	20-21
Identified risks of significant weakness?	Yes	Yes	Yes
Actual significant weakness identified/Ongoing significant weakness	No	Yes*	No
2024-25 Findings	No significant weakness identified	Significant weakness in arrangements identified	No significant weakness identified
Direction of travel			

*Significant weakness raised in the prior year remains open.

Significant weaknesses followed up from the prior year

A significant weakness surrounding governance was identified in the previous year and remains in the current year. In line with guidance, we have not raised a new recommendation this year but have followed up the progress in implementing the recommendation previously raised, see page 26.

On page 17-18, we have set out commentary on the significant weakness and other findings identified in the prior year and whether the recommendations to address the weaknesses have been satisfactorily implemented.

Value for Money

NATIONAL CONTEXT

In July 2025 the Department of Health and Social Care published the 10 year plan for the NHS. This sets the strategic direction that is planned to be taken for the health service, with a focus built around three key shifts:

- From hospital to community;
- From analogue to digital; and
- From sickness to prevention.

A number of structural changes are planned to support the implementation of the strategy between 2025 and 2027, with NHS England taking greater responsibility for the management of financial performance of providers within the sector and a reduced role for managing finances at an integrated care system level.

It is anticipated that all provider trusts will become foundation trusts and a scheme to pilot 'advanced' foundation trusts was launched during the year, with greater freedoms available for the management of finances as well as the leadership for accountable health organisations available to those providers in the highest performing segment of NHS England's oversight framework.

While revised structures were implemented there continued to be a focus on improving performance in key operational areas, including reducing referral to treatment backlogs and ambulance waiting times. Nationally the proportion of elective patients waiting less than 18 weeks improved from 60% to 65% during 2025-26, though 1.3% of patients continued to wait over 52 weeks to commence treatment. Eliminating long waiters forms a key part of the priorities for the NHS in the year and moving into 2026-27.

Nationally ambulance response times also improved and reduced to the lowest level since 2021 for category 2 response times, reflecting serious but not life threatening conditions that require ambulance support. The target for this standard remains 18 minutes, which has not been met since 2021.

LOCAL CONTEXT

The Countess of Chester Hospital NHS Foundation Trust is a district general hospital which employs 4,930 staff (headcount) to provide care and treatment to a population of over 400,000 people living in Chester and West Cheshire, including Ellesmere Port and Neston as well as the Deeside area of Flintshire.

The Trust is part of the Cheshire and Merseyside Integrated Care System (ICS).

For 2025/26, the Trust operated within a continued challenging financial environment, with a planned deficit of £14.4m supported by £19.6m of non-recurrent deficit support funding (DSF) and a Cost Improvement Programme (CIP) target of £27.7m of recurrent efficiencies.

The Trust continued to face significant financial pressures during the year, particularly in medical and clinical staffing, reflecting the need to maintain safe service delivery, respond to sustained demand—most notably within Urgent and Emergency Care—and manage workforce gaps. While the Trust has progressed its financial recovery plans, including delivery of CIP schemes and strengthened financial governance, the scale of recurrent efficiencies required and operational dependencies mean that delivery risk remains.

Based on draft financial statements, the Trust reported a deficit position of £14.4m, consistent with the control total agreed with the ICB, having secured the planned DSF.

Work undertaken during the period indicates that the Trust has continued to respond to recommendations arising from external reviews, including the PwC review commissioned by the ICB in 2024/25. Recommendations have been consolidated into a single improvement programme aligned to NHSE requirements, with implementation ongoing and progress monitored through established governance structures.

The Trust has also continued to invest in its estate and infrastructure, with capital resources of £29.7 million incurred during 2025/26, including £10.5 million in respect of the new Women and Children's building. This state-of-the-art, family-centred facility opened in September 2025, providing modern maternity, neonatal, paediatric and women's outpatient services, and supporting improvements in patient experience and clinical capacity.

Financial Sustainability

How the Trust plans and manages its resources to ensure it can continue to deliver its services.

We have considered the following in our work:

- How the Trust ensures that it identifies all the significant financial pressures that are relevant to its short and medium-term plans and builds these into them;
- How the Trust plans to bridge its funding gaps and identifies achievable savings;
- How the Trust plans finances to support the sustainable delivery of services in accordance with strategic and statutory priorities;
- How the Trust ensures that its financial plan is consistent with other plans such as workforce, capital, investment, and other operational planning which may include working with other local public bodies as part of a wider system; and
- How the Trust identifies and manages risks to financial resilience, e.g. unplanned changes in demand, including challenge of the assumptions underlying its plans

Financial Plan 2025-26

The Trust's 2025/26 financial plan was developed through a structured governance process involving divisional budget-setting sessions, executive challenge, and scrutiny through the Operational Management Board and Finance & Performance Committee (F&PC), before approval by the Trust Board. The financial planning process involved each division reviewing current expenditure run-rates against recurrent budgets to identify cost pressures, essential safety investments, and expected activity levels for 2025/26. Plans were prepared on the basis of recurrent rollover budgets, adjusted for the full-year impact of 2024/25 investments and efficiencies.

The Trust's 2025/26 plan was predicated on receiving £19.6 million of non-recurrent deficit support funding (DSF) and delivering a planned deficit of £14.4 million, equivalent to an adjusted underlying deficit of £34 million. Key assumptions—including continuation of high-cost drug funding arrangements, inflation aligned to national guidance, income of £382 million to support activity levels, and capital expenditure of £5.5 million plus programme-specific allocations—were reviewed as part of the planning process.

Efficiency plans

As part of the annual budget-setting cycle, budget holders were required to identify realistic cost improvement opportunities by reviewing run-rate expenditure against recurrent budgets. Divisions assessed cost pressures, essential safety investments and planned activity levels, with updates reviewed by the Operational Management Board, Finance & Performance Committee, Executive Directors Group and the Trust Board. This process resulted in a £27.7 million recurrent efficiency requirement, allocated through agreed principles such as reductions in corporate and clinical headcount, non-pay budgets, and workstream targets based on national, regional and Trust-wide opportunities.

Progress against the cost improvement programme (CIP) is overseen through a structured governance framework centred on the CIP Recovery Group, chaired by the Chief Executive Officer, which provides the formal mechanism for assessing scheme quality impacts, reviewing Trust-wide interdependencies, and commissioning or decommissioning projects. The group reports into the Operational Performance Executive Led Group (OPELG) and functions as the primary forum for monitoring delivery risk and organisational oversight of the efficiency programme.

Monitoring is supported by a RAG-rated system that highlights divisions at elevated risk of under-delivery, enabling targeted support from the Recovery Group and the Finance Department. The Improvement Office provides operational input into scheme development and implementation, acting as the link between clinical, operational and finance teams to ensure documentation, governance standards and Quality Impact Assessments (QIA) are consistently applied. Director of Transformation and Productivity is the designated lead officer for CIP, and overall progress—including recurrent delivery performance and any risk to the underlying financial position—is routinely reported through established financial and operational governance channels, including monthly updates to senior committees and the Board.

Financial Sustainability

Consistency between financial and operational plans

The Trust ensures consistency between its financial, workforce and operational plans through an integrated planning process that requires budget holders and divisional leadership teams to review baseline expenditure, workforce requirements, activity levels and cost pressures as part of the annual budget-setting cycle, supported by monthly finance–budget holder meetings to address variances. Development of the 2025/26 financial plan involved each division assessing run-rate expenditure against recurrent budgets, incorporating required workforce changes—such as corporate and clinical headcount reductions—and aligning activity assumptions with operational capacity.

Assessing and managing financial sustainability risk

The Trust assesses its financial sustainability risks through a comprehensive monthly financial monitoring framework that provides clear visibility of performance against plan at cost-centre, divisional and organisational level. Monthly financial reports presented to the Finance & Performance Committee and the Board set out the planned deficit, year-to-date performance, underlying variances, and emerging risks. These insights enable management to understand the root causes of financial pressures and take timely corrective action, ensuring that the Board maintains ongoing visibility of risks to financial sustainability.

Financial sustainability risks are managed through a combination of strengthened grip-and-control measures, continuous CIP oversight, and formal risk-management processes embedded within the Trust's governance structure. The Trust operates weekly CEO-chaired CIP Delivery Group meetings supported by the service improvement team. Monthly reports to the F&PC and Board highlight under-delivery, emerging pressures and any funding issues. In parallel, high-scoring financial risks are recorded in the BAF Register and monitored regularly by the Board / Committees.

2025/26 Outturn and CIP achievement

Based on the M12 draft accounts, the Trust reported a deficit of £14.4m, in line with its initial financial plan, and successfully secured the planned £19.6m of DSF. As agreed with the ICB, this position reflects the carrying forward of an underlying deficit of c.£34m.

In relation to the CIP, the Trust delivered £16.8m against a target of £27.7m, all recurrent savings, resulting in an in-year shortfall of £10.9m, with under delivery mitigated by non-recurrent benefits, such as higher than planned interest receivable, value added tax (VAT) rebate and release of the annual leave accrual. The schemes delivered in 2025/26 have a full-year effect of £19.9m. Of the in-year shortfall, £7.8m relates to identified schemes that have been deferred, with the associated savings carried forward into 2026/27.

Key financial and performance metrics:	2025-26	2024-25
Planned surplus/(deficit)	(£14.4m)	(£9.6m)
Actual surplus/(deficit)	(£14.4m)	(£9.6m)
Planned CIP as a % of spend	5.9%	5%
- Recurrent	£27.7m	£19.8m
- Non-recurrent	£0m	£0m
Actual CIP as a % of spend	3.5%	5%
- Recurrent	£16.8m	£11.9m
- Non-recurrent	£10.9m	£7.9m
Year-end cash position	£31.5m	£28.2m

Financial Sustainability

2026/27 and medium-term financial sustainability

Based on the financial strategy set out in the Trust's '5 year Integrated Plan', NHS has approved the Trust's medium-term plan, which sets out a clear trajectory to eliminate the underlying deficit and achieve a break-even position over a five-year period (by 2030/31). The 2026/27 financial plan reflects a planned deficit of £21.9m, with an underlying deficit of £44.8m at the start of the year, supported by a CIP target of c.£25m. At the start of the year, only c.31% of schemes are assessed as deliverable (fully developed, transacted or in progress), with the remaining c.69% classified as opportunity or pre-pipeline. This indicates that a significant proportion of the savings target has yet to be fully developed, increasing delivery risk and reliance on the successful progression of early-stage schemes.

The planned cash balance for the end of 2026/27 is £9.9m, which includes £21.9m in DSF support.

Over the medium term, the strategy is underpinned by a sustained deficit reduction trajectory, requiring c.2% annual efficiency improvements alongside delivery of recurrent CIP, with the deficit reducing progressively to break-even by the end of the five-year planning period.

Conclusion

We note that the Trust's financial position has been reported transparently to the F&PC and Board throughout the year. The Trust achieved its planned deficit position, contained its underlying deficit within the level agreed with the ICB, and secured the expected DSF. While delivery of the CIP was below the planned level, the Trust achieved c.60% of its target of all recurrent savings and has identified the majority of schemes relating to the shortfall, which have been carried forward into the next financial year. In addition, the Trust's medium-term strategy sets out a clear and structured financial recovery trajectory, aligned to national expectations, combining operational efficiencies, transformational savings and system-wide support to restore financial sustainability.

We also refer to our detailed commentary on pages 22 and 23, which sets out the actions taken by the Trust in response to identified issues, and our assessment supporting the conclusion that financial sustainability does not represent a significant weakness in the Trust's arrangements.

Governance

How the Trust ensures that it makes informed decisions and properly manages its risks.

We have considered the following in our work:

- how the Trust monitors and assesses risk and how the body gains assurance over the effective operation of internal controls, including arrangements to prevent and detect fraud;
- how the Trust ensures effective processes and systems are in place to ensure budgetary control; to communicate relevant, accurate and timely management information (including non-financial information where appropriate); supports its statutory financial reporting requirements; and ensures corrective action is taken where needed, including in relation to significant partnerships;
- how the Trust ensures it makes properly informed decisions, supported by appropriate evidence and allowing for challenge and transparency; and
- how the body monitors and ensures appropriate standards, such as meeting legislative/regulatory requirements and standards in terms of management or Board members' behaviour

Risk Management

The Trust has a structured and embedded approach to risk identification, monitoring and management, supported by its Risk Management Policy and regular use of the Board Assurance Framework (BAF). Strategic risks are captured and assessed through the quarterly BAF, which details risk scores, controls, assurances, gaps and associated action plans, while high-scoring operational risks are recorded within the Datix system and summarised through the High Risk Report for committee and Board oversight.

These processes operate within a clear governance structure, with the Board of Directors retaining overall accountability and key committees—such as the F&PC and Quality & Safety Committee—providing scrutiny in line with their terms of reference. Non-Executive Directors play an active role in challenging risk scores and seeking assurance over the adequacy of controls, with regular reporting from risk owners and committee chairs enabling transparent escalation and monitoring across divisional, corporate and Board-level forums.

Internal audit work undertaken during the year has concluded that there is an overall adequate system of internal control in relation to risk management systems and processes. A high-risk recommendation has been raised in relation to strengthening the review of risks, including ensuring that risks are clearly and consistently described, supported by appropriate mitigating actions, and that associated controls are fully documented and subject to regular review in line with the Risk Management Policy and supporting guidance.

Governance Structures

In February 2026, as part of provider capability assessment, NHS England rated the Trust Board's overall capability as 'Red', reflecting concerns identified through a retrospective review of delivery and longstanding issues in governance, performance and financial management. However, subsequent evidence indicates that this rating does not fully reflect the improvements made during the latter part of the year. The Trust has demonstrated progress in strengthening governance and risk management arrangements, delivering against key aspects of the NHS England enforcement undertakings, and improving financial management. This is further supported by an improved NHS Oversight Framework position, with the Trust moving from Segment 4 to Segment 3.

Notwithstanding this progress, some delivery and sustainability risks remain, particularly in relation to UEC operational performance and the embedding of improvements. The 'Red' rating should therefore be interpreted in the context of historical performance, alongside evidence of an improving trajectory in organisational capability and delivery.

Governance

Prevention and detection of fraud

The Trust maintains an overarching Anti-Fraud, Corruption and Bribery Policy and Response Plan, developed and supported by the MIAA Local Counter Fraud Specialist (LCFS). Executive responsibility for oversight rests with the Director of Finance, who monitors compliance and activity through the Audit Committee. The LCFS provides an Annual Counter-Fraud Report to the Audit Committee, setting out the work undertaken during the year, key findings, and a self-assessment against national NHS counter-fraud standards. The Trust has also appointed a Counter Fraud Champion who works closely with the LCFS to promote awareness and strengthen the fraud-prevention culture. Staff are signposted to the Trust's Code of Conduct, Whistleblowing Policy, and the Freedom to Speak Up Guardian, all of which are available on the intranet and provide confidential routes for reporting concerns, including suspected fraud or misconduct.

Financial planning and monitoring

Our commentary on the review and approval of the 2025/26 financial plan is set out on page 13. In relation to in-year budget monitoring, financial forecasts are prepared using run-rate analysis and known cost impacts discussed through regular meetings with budget holders. The Trust has clear processes for identifying divisional overspends and holding managers to account, supported by routine variance analysis and agreed corrective actions. Throughout the year, financial performance has been monitored through monthly reporting to both the Board and the F&PC, where results are scrutinised, risks highlighted and mitigating actions formally considered.

Monitoring compliance with laws and regulations

Compliance with statutory and regulatory requirements is reported through the Annual Report and Annual Governance Statement, both reviewed by the Board and Audit Committee. The Trust also undertakes an annual self-assessment against the NHS Provider Licence, with the outcomes considered by the Audit Committee and Board. Oversight of the effectiveness of internal control is provided through the Audit Committee, supported by the internal audit programme delivered by MIAA, whose annual work plan is approved and monitored by the Committee. Review of Audit Committee papers shows that internal audit reports routinely identify control improvements and provide assurance where appropriate.

Staff guidance on expected standards of conduct is set out in the Trust's Standards of Business Conduct, Behaviour Standards and Whistleblowing policies, all accessible via the intranet, alongside the Conflict of Interest policy—which incorporates gifts and hospitality arrangements and is overseen by the Audit Committee. Governance decision-making is supported through a structured committee framework, with each Board sub-committee chaired by a Non-Executive Director and operating to defined terms of reference, providing clear lines of accountability and scrutiny in reporting to the Board.

Key decision making

The Trust ensures that key decisions receive appropriate scrutiny through a structured governance framework in which the Board is supported by its assurance committees—most notably the F&PC. Committee papers and agendas demonstrate that Executive leads present detailed proposals for review, covering service redesign, workforce, operational performance and capital investment.

Non-Executive Directors provide independent challenge, questioning the robustness of underlying assumptions, procurement compliance, financial implications and operational impact. Committee minutes show this scrutiny in practice, including confirmation of workforce stability, enquiry into procurement processes for capital schemes, and challenge regarding divisional planning and financial risks. Where decisions require escalation, the FP&C uses its Chair's Report to highlight matters needing Board oversight.

Governance

Care Quality Commission (CQC) – Warning Notice

As part of our risk assessment, we identified a significant governance risk relating to the CQC Warning Notice issued in April 2025 and subsequently reported in the CQC's inadequate inspection report published in August 2025, following an inspection of urgent and emergency care services conducted between January and May 2025. At the planning stage, we noted that while the Trust had undertaken a considerable level of improvement activity, the CQC had reported that actions were not yet fully embedded or sustained across services, and that several regulatory breaches identified in previous inspections remained unaddressed. We also noted that the Trust was subject to a further inspection during 2025/26, with no additional Warning Notice issued.

During the year, in line with our response to the risk, we obtained and reviewed available information provided by senior management and governance reporting to understand the Trust's progress in responding to the CQC findings. This indicated that the Trust has taken a structured approach to delivering improvement actions, particularly within Urgent and Emergency Care (UEC) services, including strengthening governance arrangements, enhancing clinical oversight, and embedding more formalised monitoring and reporting processes. There is evidence that these actions are being tracked through established governance structures, with increased focus on performance management, internal assurance, and alignment with wider organisational priorities.

The information reviewed indicates improving trends across a number of areas highlighted in the Warning Notice, including sepsis management, infection prevention and control, patient experience measures, and timeliness of initial assessment within emergency care pathways. Improvements in operational processes, such as streaming and rapid assessment models, have also contributed to increased efficiency within UEC.

However, despite the progress made during the year, performance remains below expected standards in a number of key areas, including mental health assessment timeliness, compliance with care planning and risk assessment processes, and delivery against national access and flow standards, including 4-hour and 12-hour performance. In addition, staffing pressures remain within paediatric emergency services, where the service continues to operate below full establishment despite mitigating actions.

Conclusion

Whilst the absence of further enforcement action and the progress demonstrated indicate that the Trust has responded proactively to the CQC findings, the available evidence suggests that improvements are still in the process of being embedded and sustained across all UEC services. Furthermore, the final CQC report, in relation to the further inspection undertake in 2025/26, has not yet been issued, and therefore independent regulatory confirmation of sustained improvement remains outstanding. Given the continuing performance challenges and the need for demonstrable and sustained improvement across all domains, we have concluded that the significant weakness raised in the prior year remains open. Accordingly, we have followed up on the recommendation raised in the prior year in relation to governance arrangements in the areas of concern identified by the CQC (see page 26). However, in light of the progress made and the ongoing nature of improvement activity, no new significant weakness or recommendations have been raised as part of our current year work.

Governance

	2026	2025
Control deficiencies reported in the Annual Governance Statement	None	None
Head of Internal Audit Opinion	Substantial Assurance	Substantial Assurance
Oversight Framework segmentation	3	3
Care Quality Commission rating	Requires Improvement	Requires Improvement

Improving economy, efficiency and effectiveness

How the Trust uses information about its costs and performance to improve the way it manages and delivers its services

We have considered the following in our work:

- how financial and performance information has been used to assess performance to identify areas for improvement;
- how the Trust ensures effective processes and systems are in place in order to develop their cost saving efficiency saving program;
- how the Trust evaluates the services it provides to assess performance and identify areas for improvement;
- how the Trust ensures it delivers its role within significant partnerships and engages with stakeholders it has identified, in order to assess whether it is meeting its objectives; and
- where the Trust commissions or procures services, how it assesses whether it is realising the expected benefits.

Assessing Value for money

The Trust's approach to assessing Value for Money has been strengthened through the introduction of a structured benchmarking framework, complementing its annual participation in corporate benchmarking, reference costs, Model Hospital and Get it right first time (GIRFT). The framework sets out a phased programme across both corporate areas and selected clinical specialties, requiring service leads to review benchmarking intelligence, validate unwarranted variation, and identify improvement opportunities. Wave 1 (June–mid-August) focuses on evidence gathering, GIRFT gap analysis and baseline review, while Wave 2 progresses into developing and delivering improvement plans. Clear governance milestones are built into the process, including Operational Management Board sign-off, engagement with clinical leads, deep-dives in highlighted corporate functions, and reporting to Executives, OPELG and the Board.

Alongside this, the Trust's non-financial performance is monitored through the Strategic Oversight Framework, with key indicators reported to the Board and its committees using statistical process control charts. The Business Intelligence team provides assurance on data quality through routine validation before incorporation into Board-level reporting. Collectively, these arrangements demonstrate that the Trust has a defined and systematic process for scrutinising benchmarking information and for ensuring that identified variation informs improvement plans aimed at enhancing service quality, patient outcomes and financial sustainability.

Partnership working

The Trust engages with system partners through a range of national and regional forums and is an active member of the NHS Confederation, NHS Providers and Healthcare Financial Management Association (HFMA), drawing on Model Hospital benchmarking to support improvement in efficiency and effectiveness. Activities and developments within the Cheshire & Merseyside Integrated Care System (ICS) are routinely communicated to the Board. As part of the annual planning cycle, the Trust submits its financial plans to the ICS for consolidation at system level, ensuring alignment with system-wide assumptions and expectations. The ICS works collaboratively with providers to establish consistent planning parameters, and the Trust reviews and incorporates ICS-led requirements—including acceptance of system stretch targets—into organisational plans. ICS proposals with a direct impact on service delivery or cost base are assessed through the Trust's internal planning and governance processes.

Engagement with wider system partnerships is monitored and reported through established governance structures. The Board Assurance Framework confirms that Executive Risk Leads provide regular updates to Board sub-committees on Trust and ICS performance, alongside the Trust's monthly reporting to the ICS. Minutes of the 2026 Public Board meetings evidence direct participation in regional collaborative forums, including attendance at the Cheshire & Merseyside Provider Collaborative Leadership Board, where system programmes—such as the 2025/26 digital programme and the cross-system roll-out of ambient voice technology.

Improving economy, efficiency and effectiveness

CQC Action plan

The Trust remains subject to enhanced regulatory oversight following the CQC inspection of UEC services in early 2025, which resulted in a Section 29A Warning Notice highlighting significant weaknesses across governance, service quality and operational performance. This also resulted in the publication of an inadequate rating for the Trust's UEC Service in August 2025, whilst the overall Trust remained 'Requires Improvement'.

NHS England Enforcement Undertaking

NHS England issued Enforcement Undertakings in November 2025, requiring the Trust to deliver improvements across financial planning, compliance with funding conditions, urgent and emergency care performance (including A&E access and 12-hour waits), quality governance arrangements, and regulatory reporting and oversight.

During the year, the Trust has implemented a structured and coordinated response to these requirements, supported by strengthened governance, oversight and reporting arrangements. Evidence from Board and Committee reporting indicates that progress against both the CQC Improvement Plan and NHS England Undertakings is subject to regular monitoring, with clearly defined improvement programmes, strengthened financial controls, and enhanced alignment to the Board Assurance Framework. These arrangements have improved visibility over delivery, risk and performance, and provide a more robust framework for oversight and challenge.

Based on our review, we have assessed that the Trust has delivered against the majority of the requirements set out within the NHS England Enforcement Undertakings. In particular, the Trust has:

- i. Delivered its 2025/26 financial plan and strengthened financial governance through an agreed medium-term strategy.
- ii. Complied with DSF conditions and reporting requirements.
- iii. Implemented comprehensive quality governance improvements in response to the Section 29A Warning Notice, including strengthened clinical oversight and patient safety processes.
- iv. Established effective reporting and regulatory engagement arrangements, supported by regular updates to NHS England and Board-level escalation mechanisms.

These achievements demonstrate appropriate and timely action to address the underlying governance, financial and quality weaknesses that led to regulatory intervention.

Notwithstanding this progress, performance improvement within UEC remains a residual area of risk, with national A&E performance standards and 4 and 12-hour wait targets not yet fully achieved. However, this is being actively managed through clearly defined recovery plans, strengthened governance oversight, and ongoing monitoring through established assurance mechanisms.

Conclusion

Overall, the Trust has demonstrated credible progress, supported by strengthened governance arrangements and enhanced assurance over performance and risk management. While a residual risk remains in relation to the sustainability of operational performance improvements, we do not consider the NHS England Enforcement Undertakings to represent a significant VFM weakness, in line with the expectations of the NAO Code of Audit Practice.

Further detail is set out on pages 24 and 25, which outline the actions taken by the Trust in response to the identified issues and our assessment underpinning the conclusion that arrangements for securing economy, efficiency and effectiveness have improved and do not give rise to a significant weakness.

Significant Value for Money Risk

1 Financial Sustainability and Delivery of the Medium-Term Financial Plan

Risk that value for money arrangements may contain a significant weakness linked to Financial Sustainability

Significant Value for Money Risk

Background and value for money risk

The Trust continues to face material financial sustainability pressures. While an underlying deficit of £34.0m was partly mitigated in the financial plan through assumed non-recurrent deficit funding of £19.6m, uncertainty over the receipt of this funding has resulted in a Month 10 forecast deficit of £29.1m, significantly adverse to the planned position of £14.4m.

In addition, delivery of the Trust's significant £27.7m CIP remains challenging, with £12.7m achieved against a Month 10 plan of £21.8m.

These factors highlight ongoing structural financial challenges and increase the risk to the Trust's ability to achieve financial stability in short and medium term. There is a risk that unidentified savings/funding gaps in financial planning could substantially threaten the delivery of the plan. We consider this to be a risk of significant weakness in arrangements over financial sustainability.

Our response

We have reviewed:

1. the arrangements in place to monitor the Trust's financial position throughout the year, including the effectiveness of challenge, scrutiny, and oversight by the Board and its sub-committees;
2. agreed plans and correspondence with NHS England to understand the key issues affecting the Trust's ability to secure deficit funding and management's plans to address any shortfall;
3. the governance, planning, and monitoring of the Trust's efficiency programme, including the maturity of identified schemes, the balance between identified and unidentified savings, and whether the arrangements support informed and timely decision-making;
4. the Trust's progress in responding to recommendations arising from relevant external reviews; and
5. the robustness of the arrangements underpinning the development of the 2026/27 financial plan, including the associated savings assumptions.

Our findings

We identified:

- Financial monitoring and oversight arrangements were operating effectively throughout the year, with regular and detailed scrutiny of the financial position by the F&PC and Board, supported by clear reporting of variances, risks and mitigating actions, and evidence of timely challenge and corrective action where required.
- The Trust responded appropriately to the in-year withholding of deficit support funding, strengthening financial control, enhancing oversight and engaging closely with NHS England through formal review processes, which contributed to restored confidence, reinstatement of funding, and acceptance of the Trust's forward financial plans.
- Governance and monitoring arrangements over the CIP were structured and well established, with clear executive oversight, regular scheme-level reporting and escalation processes in place; however, delivery slippage and the maturity of some schemes continued to represent an area of financial sustainability risk.

Significant Value for Money Risk

1 Financial Sustainability and Delivery of the Medium-Term Financial Plan (continued)

Risk that value for money arrangements may contain a significant weakness linked to Financial Sustainability

Significant Value for Money Risk

Background and value for money risk

The Trust continues to face material financial sustainability pressures. While an underlying deficit of £34.0m was partly mitigated in the financial plan through assumed non-recurrent deficit funding of £19.6m, uncertainty over the receipt of this funding has resulted in a Month 10 forecast deficit of £29.1m, significantly adverse to the planned position of £14.4m.

In addition, delivery of the Trust's significant £27.7m CIP remains challenging, with £12.7m achieved against a Month 10 plan of £21.8m.

These factors highlight ongoing structural financial challenges and increase the risk to the Trust's ability to achieve financial stability in short and medium term. There is a risk that unidentified savings/funding gaps in financial planning could substantially threaten the delivery of the plan. We consider this to be a risk of significant weakness in arrangements over financial sustainability.

Our response

We have reviewed:

1. the arrangements in place to monitor the Trust's financial position throughout the year, including the effectiveness of challenge, scrutiny, and oversight by the Board and its sub-committees;
2. agreed plans and correspondence with NHS England to understand the key issues affecting the Trust's ability to secure deficit funding and management's plans to address any shortfall;
3. the governance, planning, and monitoring of the Trust's efficiency programme, including the maturity of identified schemes, the balance between identified and unidentified savings, and whether the arrangements support informed and timely decision-making;
4. the Trust's progress in responding to recommendations arising from relevant external reviews; and
5. the robustness of the arrangements underpinning the development of the 2026/27 financial plan, including the associated savings assumptions.

Our findings

- The Trust has made a structured and proportionate response to recommendations arising from external review, with formal action planning, defined ownership and ongoing monitoring through governance forums, demonstrating progress in strengthening the control environment while taking a pragmatic approach to recommendations affected by operational or system-wide constraints.
- The 2026/27 financial planning framework was broadly robust and aligned with national expectations, with NHS England accepting the Trust's medium-term financial plan and the majority of savings now supported by identified recurrent schemes; notwithstanding this, continued focus is required to mature and deliver the remaining CIP schemes in order to achieve the planned financial trajectory.

Conclusion

Based on the findings above we have not identified any significant weaknesses in financial sustainability arrangements.

Significant Value for Money Risk

2 Regulatory Intervention and Service Performance Improvement Risk

Risk that value for money arrangements may contain a significant weakness linked to securing economy, efficiency and effectiveness

Significant Value for Money Risk

Background and value for money risk

The CQC inspected UEC services between January and March 2025, resulting in the issue of a Section 29A warning notice in April 2025 requiring significant improvements across dignity, safeguarding, premises and equipment, governance and staffing.

In response, NHS England issued Enforcement Undertakings in November 2025, replacing earlier undertakings and requiring the Trust to (i) deliver the agreed 2025/26 financial plan, (ii) improve A&E performance and reduce 12-hour waits, (iii) implement robust action plans for UEC performance and mental health delays, and (iv) maintain an overarching CQC action plan addressing the Section 29A concerns.

Failure to take appropriate action or secure improvement in areas where a regulatory body has identified weaknesses in terms of cost/effectiveness or service performance could indicate a significant weakness in the Trust's arrangements for securing economy, efficiency and effectiveness when assessed against the expectations of the NAO Code of Audit Practice.

Our response

We performed the following procedures:

1. Review relevant reports and correspondence with NHS England and the CQC to understand required improvements and the current view of Trust progress;
2. Assess Board and Committee oversight by reviewing minutes, action logs and reporting cycles for evidence of regular monitoring, challenge and escalation of issues linked to these findings;
3. Evaluate the robustness and delivery of key improvement plans (financial, ED performance, CQC Section 29A), checking ownership, timelines, resourcing and progress against milestones; and
4. Triangulate assurance through Internal Audit findings, Board Assurance Framework (BAF) / High Risks Report entries and NHS England and CQC feedback to confirm the reliability of governance and assurance processes.

Our findings

- The Trust had a clear understanding of the requirements arising from the CQC Warning Notice and NHSE Enforcement Undertakings, with structured action taken across financial planning, funding compliance, quality governance, performance improvement, and regulatory reporting.
- Board and Committee arrangements were found to provide structured oversight, with regular reporting, defined escalation routes, and evidence of challenge and monitoring of progress against regulatory actions, supported by integration with the Board Assurance Framework.
- Evaluation of key improvement plans demonstrates that the Trust has delivered against the majority of required actions, including financial plan delivery, compliance with funding conditions, and implementation of quality governance improvements; however, delivery against operational performance targets (notably A&E and 4/12-hour waits) remains a residual area of risk.

Significant Value for Money Risk

2 Regulatory Intervention and Service Performance Improvement Risk (Continued)

Risk that value for money arrangements may contain a significant weakness linked to securing economy, efficiency and effectiveness

Significant Value for Money Risk

Background and value for money risk

The CQC inspected UEC services between January and March 2025, resulting in the issue of a Section 29A warning notice in April 2025 requiring significant improvements across dignity, safeguarding, premises and equipment, governance and staffing.

In response, NHS England issued Enforcement Undertakings in November 2025, replacing earlier undertakings and requiring the Trust to (i) deliver the agreed 2025/26 financial plan, (ii) improve A&E performance and reduce 12-hour waits, (iii) implement robust action plans for UEC performance and mental health delays, and (iv) maintain an overarching CQC action plan addressing the Section 29A concerns.

Failure to take appropriate action or secure improvement in areas where a regulatory body has identified weaknesses in terms of cost/effectiveness or service performance could indicate a significant weakness in the Trust's arrangements for securing economy, efficiency and effectiveness when assessed against the expectations of the NAO Code of Audit Practice.

Our response

We performed the following procedures:

1. Review relevant reports and correspondence with NHS England and the CQC to understand required improvements and the current view of Trust progress;
2. Assess Board and Committee oversight by reviewing minutes, action logs and reporting cycles for evidence of regular monitoring, challenge and escalation of issues linked to these findings;
3. Evaluate the robustness and delivery of key improvement plans (financial, ED performance, CQC Section 29A), checking ownership, timelines, resourcing and progress against milestones; and
4. Triangulate assurance through Internal Audit findings, Board Assurance Framework (BAF) / High Risks Report entries and NHS England and CQC feedback to confirm the reliability of governance and assurance processes.

Our findings

- Triangulation across internal audit, governance reporting, BAF and regulatory feedback indicates that governance and assurance processes have strengthened, with clear ownership of actions, ongoing performance monitoring, and established mechanisms to provide reliable oversight of delivery and risk management.

Conclusion

Based on the findings above we have not identified any significant weaknesses in securing economy, efficiency and effectiveness arrangements.

Prior year findings

Significant weaknesses followed up from the prior year

In our annual auditor's report for the financial year 2024-25 we reported that the Trust had a significant weakness in arrangements over Governance. As required by the Code of Audit Practice we have revisited this issue and set out in the table below an update in regards to the arrangements in this area.

#	Recommendation raised in 2024/25	Management Response from 2024/25	Current status
1	Failure to implement or achieve progress on recommendations raised Although we recognise that a significant amount of work has been undertaken to respond to the findings of the Warning Notice, we note that the CQC has specifically identified that the Trust has not embedded and sustained improvements within the service or addressed breaches of regulation identified in previous inspections. Failing to implement or achieve progress on recommendations raised from a regulator or inspectorate is indicative of a significant weakness in line with NAO's Code of Audit Practice. Recommendation Depending on the outcome of the factual accuracy process with the CQC and the conclusions reached in the CQC's final report, the Board should ensure that significant improvements are made to governance arrangements in the areas of concern raised by the CQC in their final report. Further the Board must gain assurance over the completion of actions identified as a result of this inspection and previous inspections. Progress should be monitored and scrutinised by the appropriate project groups and the Trust's Board to ensure the actions taken to address the issues raised are embedded and sustained.	The Trust has made significant improvements in respect of Urgent and Emergency Care Services. We took immediate actions in response to the Warning Notice. We recognise there is more to do. Whilst we are in the process of responding to the factual accuracy of the draft CQC report, we are continuing to drive forward our UEC improvement plan. We are engaging with Partners to support us in respect of the demand and flow through our hospital.	The Trust has made significant and demonstrable progress in responding to the CQC Warning Notice and associated regulatory requirements during 2025/26. This includes the implementation of structured improvement programmes across UEC services, strengthened governance and oversight arrangements, and enhanced monitoring of performance, risks and delivery through Board and Committee reporting. There is also evidence of improvements across a number of operational and quality indicators and increased alignment between regulatory actions and wider organisational performance management. Notwithstanding this progress, improvements are not yet fully embedded or consistently sustained across all services, with ongoing challenges remaining in key operational areas, including UEC performance and aspects of governance reflected in the 'well-led' domain. In addition, the absence of a final CQC report means independent regulatory confirmation of sustained improvement remains outstanding. Accordingly, while meaningful progress has been made, the recommendation remains open and in progress, as further work is required to ensure that improvements are fully implemented, embedded and sustained over time. Continued Board oversight and monitoring of delivery will be critical to achieving this. Management response 2025/26 The Trust continues to drive forward the improvements in UEC, with oversight from the Quality and Safety Committee. Our action plans will be reviewed and revised as required following receipt of the final CQC report from the latest inspection.



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