Council of Governors
17th July 2025

Report	**Agenda Item 14.**	**Quality Accounts 2024/25**						
Purpose of the Report	Decision		Ratification		Assurance		Information	**X**
Accountable Executive	Sue Pemberton			Director of Nursing & Quality/Deputy Chief Executive				
Author(s)	Fiona Altintas			Deputy Director of Nursing, Quality and Governance				
Board Assurance Framework	BAF 1 Quality			**X**	BAF impact to 1,2,3,4,8,9 and 10			
	BAF 2 Safety			**X**				
	BAF 3 Operational			**X**				
	BAF 4 People			**X**				
	BAF 5 Finance							
	BAF 6 Capital							
	BAF 7 Digital							
	BAF 8 Governance			**X**				
	BAF 9 Partnerships			**X**				
	BAF 10 Research			**X**				
Strategic goals	Patient and Family Experience							**X**
	People and Culture							**X**
	Purposeful Leadership							**X**
	Adding Value							**X**
	Partnerships							**X**
	Population Health							**X**
CQC Domains	Safe							**X**
	Effective							**X**
	Caring							**X**
	Responsive							
	Well led							
Previous considerations	Extraordinary Audit Committee – 24th June 2025 Extraordinary Board of Directors – 24th June 2025 Quality & Safety Committee – 3rd July 2025							
Executive summary	The purpose of this report is to share the Quality Accounts for 2024/25. The Quality Accounts is a report that details the quality of services provided by the Countess of Chester. The Quality Accounts must be published on the Trust's website by the 30th of June 2025. Eight of the nine Quality priorities within Quality Account were achieved with the outstanding success being the reduction of C. Difficile infections. The account also sets out the nine quality priorities the Trust has agreed for the year 2025/26. The Account describes the successes and areas for improvement the Trust has identified, with focus on the Emergency Department, Infection prevention and Patient and Family Experience from our external scrutiny forums.							

	Compliance with National requirements for clinical audit is also included with 100% participation in the eligible national clinical audits and 100% of the national confidential enquiries. The Trust has presented the Quality Accounts to the Integrated Care Board and to the Health Overview and Scrutiny panel. It has also been shared with external stakeholders. It was approved at the Extraordinary Audit Committee and Board of Directors meetings on the 24th of June 2025 subject to final review and approval from the Quality and Safety Committee on 3rd July 2025.
Recommendations	The Council of Governors is asked to **note** the Quality Account and the scrutiny that has been undertaken.

Corporate Impact Assessment	
Statutory/regulatory requirements	CQC/Constitution/other regulation/legislation
Risk	No risk included on strategic risk register
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics
Communication	Not confidential

2024/25

Quality Accounts

Countess of Chester Hospital NHS Foundation Trust

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Part 1: Foreword

The Countess of Chester Hospital NHS Foundation Trust provides services to West Cheshire and to Welsh patients covered by Betsi Cadwaladr University Health Board. The Trust works collaboratively within the wider Cheshire and Merseyside Integrated Care System. Its services are provided from three locations:

- **The Countess of Chester Hospital**: providing 459 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 serves the local rural population.

The Trust employs over 6,258 staff (headcount) which includes temporary bank staff and provides acute emergency and elective services, primary care direct access services and obstetric services to a population of approximately 407,000. This includes 357,000 residents in Chester and West Cheshire, including Ellesmere Port and Neston as well as the Deeside area of Flintshire which has a population of approximately 50,000.

The Trust is a busy district general hospital and in 2024/25, there were 577,796 patient attendances (inpatient, outpatient and diagnostic) ranging from a simple outpatient appointment to major surgery. This is an increase of over 23,000 patient attendances compared to the previous year when there were 554,397.

The Countess of Chester Hospital is arranged into five clinical divisions: Urgent Care, Planned Care, Diagnostics & Clinical Support Services, Women & Children's and Therapies & Integrated Community Care. These divisions are supported by services including human resources, corporate, finance and digital & data Services.

1.1 Statement on Quality from the Chief Executive

The Countess of Chester Hospital NHS Foundation Trust is committed to ensuring that the services we provide are safe, kind, and effective. Our patients, service users and their families are at the heart of all we do.

The annual Quality Accounts for 2024/25 is an opportunity for us to share with you our achievements against the 2024/25 quality priorities and outline our intentions for 2025/26. Our staff have focused on improvement throughout the reporting period to ensure patients receive the best possible care.

There has been focused work to improve the experience of our patients in our urgent and emergency care facilities including the Emergency Department, noting the national challenges Emergency Departments are facing currently in ensuring patients are assessed timely and cared for in a safe environment.

How long our patients are waiting for treatment has also been a key focus area as the Trust continues to ensure that there are a minimal number of patients on our Referral to Treatment (RTT) Pathways waiting longer than 78 weeks. In addition, the divisions and specialties are managing their waiting times with the aim of reducing waits on pathways greater than 65 weeks.

We set ambitious quality priorities during 2024/25, and I am pleased to say that eight of the nine priorities have been achieved. The priority that we did not achieve was the number of C. difficile infections within the Trust, with a particular spike seen in Quarter two. Actions were identified and we have since seen a reduction in the number of reported cases and this will remain a focus into 2025/26.

Keeping our patients safe is vital and we have seen a continuous reduction in both falls and hospital acquired pressure ulcers. We aim to build on this improvement into 2025/26.

During 2024/25 we have successfully embedded the new NHS Patient Safety Incident Response Framework (PSIRF) and continue to support the national Learning from Patient Safety Events (LFPSE) platform. An independent audit from Mersey Internal Audit Agency (MIAA), provided an outcome of moderate assurance of the PSIRF principles in the Trust demonstrating the work that had been embedded during 2024/25.

The launch and embedding of the Patient and Family Experience Vision in 2024/25 sets out our commitment to improving the experience of our patients, families and carers. Better patient and family experience is associated with improved patient safety, improved clinical outcomes and higher patient satisfaction scores.

Jane Tomkinson OBE

Chief Executive

Neil Large

Chairman

1.2 Celebrating success at the Countess of Chester Hospital NHS Foundation Trust in 2024/25

Eight-year-old boy walks 20 miles in less than eight hours to smash his fundraising target for Countess of Chester Hospital Children's Ward

An 8-year-old boy raised more than £1,600 for the Countess of Chester Hospital's Children's Ward by walking an incredible 20 miles in under eight hours to give back to the place he received care from.

Charlie Perry-Hargreaves, from Ewloe, originally set out to raise £500 in aid of The Countess Charity, but more than tripled his fundraising goal thanks to an outpouring of community support.

Inspired by the time he has spent on the Children's Ward as an asthma patient, Charlie wanted to ensure other youngsters staying in hospital had access to more toys and games during their time there, so set himself the huge fundraising mission of walking 20 miles along the North Wales coastal path.

Already a keen walker, Charlie teamed up with his mum Vicky for the challenge and impressively completed the challenging route in just under eight hours.

Vicky said: "Charlie did incredibly well – just under eight hours from start to finish. He did not complain at any point, just cracked on with it.

"We were thrilled with the amazing response to his fundraising appeal and can't believe he smashed his target by so much!

And the staff on the children's ward have been equally as impressed by Charlie's efforts.

Nicky Lightfoot, Deputy Manager of the Children's Ward at the Countess of Chester Hospital, said: "We are amazed by what Charlie has achieved”.

"His determination and kindness will make a real difference to the children in our care, and his incredible donation will go a long way to bringing hours of joy to the children on our ward”.

New trans-nasal endoscopy service launched.

The Countess of Chester Hospital NHS Foundation Trust launched a new trans-nasal endoscopy service (TNE) in November 2024, giving patients a less invasive and safer, more comfortable experience.

The innovative new procedure allows the endoscopist to examine the oesophagus, stomach, and upper part of the small intestine without the need for sedation, which offers a safer option with fewer side effects.

It typically lasts up to 15 minutes and is performed using local anaesthetic, without the need for sedative drugs. Among the key benefits of the new service are faster recovery times, minimal gagging, and the ability for patients to speak with the endoscopist during the procedure.

These factors make TNE better tolerated for most patients, particularly those who may struggle with traditional endoscopy.

Steve McGoldrick, one of the Trust's Consultant Gastroenterologists said:

"Launching this new service is a really positive step for the Trust, as an effective alternative for diagnostic gastroscopy which can be carried out outside the usual endoscopy unit”.

The new service comes as the Trust continues to focus on improving patient care and experiences, as part of its long-term plan to transform local hospital care.

Blue Skies Balcony Nears Completion

The final stages of construction are underway on the Blue Skies Balcony attached to the intensive care unit. The balcony is for the benefit of the intensive care patients who are rehabilitating and beginning to regain full function after their admission.

The appeal, launched in 2021, as the nation was emerging from the challenges of the Covid-19 pandemic, quickly gained momentum as people understood and embraced the benefits of outdoor time for mental and physical health and wellbeing.

The new balcony will offer ICU patients, many of whom spend long periods recovering, exposure to natural light and the opportunity to complete rehabilitation physiotherapy in a much more natural environment.

This outdoor space will serve as a vital component of patient therapy, aiding in recovery by promoting mental wellbeing and offering a peaceful environment for patients and their families.

Construction of the balcony is due to be complete toward the end of April 2025 and it is hoped that patients will benefit from using it by early May 2025.

There is a great deal of excitement and anticipation of the opening of the balcony, and it will put us at the forefront of all the intensive care units across the region.

Whilst monies raised by the charity has funded the construction, the project has also been supported by Integrated Health Projects (IHP) – one of the lead construction companies currently building the Trust's new Women and Children's Building – who are providing labour and materials at a significantly subsidised rate as part of its commitment to giving back to the local community.

The support from IHP on this building is helping to ensure that every pound of charitable funding is used wisely and provides the best value possible for the Countess of Chester Hospital NHS Foundation Trust.

New online communication tool enables hospital patients to access their health information at all times.

Patients at the Countess of Chester Hospital NHS Foundation Trust are now able to access their health information anytime from anywhere with the launch of a new online patient engagement service.

The Patient Engagement Portal system aims to support a smoother hospital experience for patients, giving them an easily accessible place to view their appointments and letters, request alterations to their appointments if needed and access helpful health information, ensuring a more personalised, convenient, and effective hospital journey. Patients are able to access the portal via a web page accessible on a mobile phone, PC or tablet or they will be able to log in via the NHS app.

The different functionalities of the portal are being introduced to patients over a period of time and users will begin receiving more and more types of information from the hospital about their care online – some types of paper letters will continue to be sent out in the meantime or if a patient wants to opt out.

Dr Theresa Barnes, consultant rheumatologist and clinical lead for the Patient Engagement Portal system, said:

"We are thrilled to be able to offer this service to improve care as a way patients can access their health information and give them more control over their hospital care, with more features that will allow for greater personalised care conversations online between clinicians and patients to come in the future.

Nick Barlow, Executive Director Transformation at DrDoctor added:

“We are delighted that the Countess of Chester Hospital NHS Foundation Trust have chosen to partner with DrDoctor.

“Our technology is designed to fundamentally improve the way patients access and engage with their care, whilst supporting Trusts to increase efficiency, productivity throughout the patient journey.

“We have ambitious plans to continue enhancing this partnership through a phased rollout of advanced functionality, from direct messaging to automated appointment rescheduling.”

Chester MP officially opens SDEC facility.

Chester MP Samantha Dixon officially opened the Countess of Chester Hospital NHS Foundation Trust’s Same Day Emergency Care facility (SDEC) in May 2024. Since it opened in December 2022, the Same Day Emergency Care service, which is located at the front of the Countess of Chester Hospital, next to the Emergency Department, has welcomed over 28,000 patients through its doors, and provided fast and efficient assessments, allowing the Trust's A&E to prioritise the most critical and more complex cases.

There have been a number of improvements to support pressure on ED.

- SDEC has increased opening times from 8.30am to11.00pm Monday to Friday.
- There have been over 4000 additional attendances in SDEC over the last 12 months April 24 – March 25 compared to April 23 to March 24 which is a 30% increase.
- A focus on overnight identification of suitable patients to transfer from ED to SDEC as soon as SDEC opens at 8.30am.
- Working with NWAS and Single Point of Access to run a Call before Convey test of change to divert patients from ED to SDEC and community services. Initially this was for patients aged 65 and over, resulting in 66% of Call before Convey patients being diverted from ED from January to March 2025.

Staff wellbeing hub at Countess of Chester Hospital NHS Foundation Trust

Actor Ian Puleston-Davies said it was 'a huge honour' to officially open the new staff wellbeing hub at the Countess of Chester Hospital in May 2024.

The opening comes as the Countess of Chester Hospital NHS Foundation Trust marks Mental Health Awareness Week with a range of events based out of the hub aimed at bolstering staff's physical, mental, and financial wellbeing.

The Trust's dedicated staff wellbeing team will be available regularly to provide one-to-one wellbeing support from within the hub, and a calendar of workshops will be on offer for staff to access on topics including stress management, carers support and mental health awareness.

The hub, which has been funded through legacy gifts left in Wills to the Countess Charity, is part of the Trust's new wellbeing strategy, aimed at promoting the welfare of its people.

Officially opening the hub, Ian, who lives in Chester and is best known for his role as builder Owen Armstrong in the ITV soap Coronation Street, said he was thrilled to be asked to open the new hub at his local hospital, which he praised for the care he and his family have received in the past.

Providing safe, sustainable, patient-centred care is critically dependent on a healthy and engaged workforce with good mental and physical wellbeing which can reap significant benefits including improved patient experience and safety, reduced costs and professional and personal benefits for NHS staff.

Medication awareness campaign to streamline patient care and further improve safety.

The Countess of Chester Hospital NHS Foundation Trust launched a new campaign in October 2024 that raises awareness of green medicines bags in hospital, as part of a renewed effort to better inform patients about ways to help themselves during their hospital stay.

The Green Bag Scheme encourages patients to store all their personal, prescribed medication in a distinctive, sturdy green bag and bring it into hospital with them for both emergency and planned admissions. The medication can be used when patients are admitted to a ward and taken home again afterwards when the patient is discharged from hospital, reducing the risk of missing or delaying doses.

With overall aims to improve patient safety, reduce drug costs and waste and accurately keep track of patients' medications, it also acts as a physical reminder for patients to bring all their medications to hospital, ensuring a smoother process for both patients and staff.

Whilst green bags have been in place at the Trust for several years now, this new awareness raising campaign aims to educate the public and patients about the initiative to make bringing your medicines a regular part of anyone’s hospital check-list – bringing your medicines to hospital should feel as normal as checking off things like bringing in your slippers and pyjamas for a stay.

Clinical Research Unit and Mobile Research Bus

The Countess of Chester Hospital NHS Foundation Trust is transforming healthcare research and accessibility in the area with the launch of a new Clinical Research Unit (CRU) and Mobile Research Bus in December 2024.

The facility and bus are set to transform the Trust's research capabilities, providing patients with access to the latest treatments and trials.

Featuring two consultation rooms and an observation bay, the research unit, the first of its kind in West Cheshire, will enable the Trust to conduct a broader range of studies and additional trials, and further establish itself as a centre of research excellence.

Meanwhile, the mobile research bus complements the unit and is designed to bring clinical trials and healthcare opportunities directly to populations across Cheshire West and beyond, including in rural and deprived communities that may have previously been under-represented in medical studies.

One of only four research buses in the North West, the bus officially launched on Wednesday, December 11, and hit the road shortly afterwards: the Clinical Research Unit opened on the same day, and the first patient consultation took place, showing a modern-day approach to research and reiterating the Trust’s new five-year strategy to building care around the needs of patients.

By bringing research directly to local areas, the Trust is ensuring more people have access to cutting-edge medical innovations and currently have around 110 active trials across 24 specialties.

Both innovations mark a £300,000 overall investment into the Trust's research capabilities, including grants from the Northwest Coast Clinical Research Network where the Trust was one of five bids to win funding for the CRU.

Director of Clinical Research Dr Peter Bamford explained: "By bringing clinical trials and research closer to our local communities and making them more convenient, we can keep more participants involved in our studies, which leads to stronger and more reliable results.

"This not only improves the quality of our research but also helps us grow our commercial projects, drive innovation and build partnerships with industry leaders."

The new research units are the result of significant investment in research, bringing it to the forefront of the NHS's approach of tackling diseases and conditions, preventing ill-health and reducing health inequalities. The research and healthcare bus is a huge step forward in engaging with local communities and making sure patients can access trials and healthcare closer to home.

Work has already started on creating two more research hubs at Ellesmere Port and Tarporley Hospitals, and along with the CRU and the bus, they will create a research network within Cheshire.

First Sentio Hearing Implant in the Northwest of England has been performed at Countess of Chester Hospital

A successful implantation of the Sentio™ System in an adult patient has been performed at the Countess of Chester Hospital in March 2025, making it the first hospital in the Northwest of England to perform this groundbreaking procedure in an adult.

The Sentio System is a state-of-the-art hearing implant that offers patients with damage in the middle ear and ear canal a completely invisible and infection-free solution to repair their hearing.

Previous options have involved a permanent skin penetrating implant, however the Sentio System is an implant with a sound transmitter that is placed under the skin in the scalp, which in turn also

reduces the risk of infections or skin breakages, which is particularly beneficial for younger patients, such as those with active lifestyles and higher aesthetic expectations.

Anand Muddaiah, Consultant ENT Surgeon and Clinical lead for Bone Conduction Hearing Implants (BCHI) at the Countess of Chester Hospital said: “We are thrilled to be the first in the Northwest to implant the Sentio System in an adult patient. This new technology offers a promising future for patients with hearing loss – cutting down their risk of future infections and giving them greater freedoms and confidence to lead active and healthy lifestyles.

“Sentio has only been approved in Europe for six months, so to be offering this procedure already at our local hospital marks a significant milestone for us and we are excited about the increased choice this now provides for our patients.”

This latest achievement is the result of a collaborative effort from a dedicated team of audiologists, theatre staff, anaesthetists, and surgeons, who worked tirelessly to ensure the procedure’s success.

Part 2: Priorities for improvement and statements of assurance from the Board

2.1 Priorities for improvement 2025/26

This Quality Account provides an opportunity to look back on last year's priorities (refer to Part 3) and to outline the intentions for 2025/26. This year's priorities build on those from 2024/25 and have been chosen following a stakeholder engagement session involving staff and public Governors. Learning has also been considered – as captured through a range of mechanisms, for example patient feedback, complaints, and patient safety incidents. This ensures that we continue to focus on what makes the biggest difference to patients and their families.

The Trust is committed to delivering the following priorities:

2025/26 Quality Priorities		
Delivering Safe Services	**Delivering Effective Services**	**Delivering Kind and Compassionate Care**
Priority 1: Reduce the incidence of Clostridium difficile (Cdiff) & E.coli healthcare associated infections	**Priority 1:** All eligible patients are assessed for risk of deep vein thrombosis (DVT)	**Priority 1:** Introduction of Patient Safety Partners to support the Patient Safety Incidence Response Framework (PSIRF)
Priority 2: Reduce the incidence of inpatient falls	**Priority 2:** All patients with suspected sepsis are assessed and diagnosed within recommended timeframes	**Priority 2:** Implementation of Martha's Rule
Priority 3: Reduce the incidence of Hospital Acquired Pressure Ulcers (HAPU)	**Priority 3:** Ensure all patients in hospital remain hydrated	**Priority 3:** Improve the overall experience for patients the maternity and children's departments

Delivering Safe Services
Priority 1: Reduce the incidence of Clostridium difficile (Cdiff) and E.coli healthcare associated infections
Cdiff is a type of bacteria that can cause diarrhoea. It often affects people who have been taking antibiotics. In healthcare settings these infections can be very serious. Reducing cases of Cdiff supports the responsibility to improve antibiotic prescribing. E. coli is the causative pathogen of approximately 80% of all antimicrobial resistant bloodstream infections in the UK and since the COVID-19 pandemic, case numbers have subsequently been rising annually. E.coli lives harmlessly in most people within their intestine but when present in other parts of the body (such as the urinary tract) can cause infections there which can lead to more complicated and

Delivering Safe Services

invasive blood stream infections.
Consequently, reducing these infections is part of the national 5-year strategy 'Confronting antimicrobial resistance 2024 to 2029' with a target of by 2029 to aim to prevent any increase in Gram-negative bloodstream infections in humans from the 2019 to 2020 financial year baseline.

How progress will be monitored, measured, and reported:

Metrics:

- Achieving greater than 90% compliance with antibiotic formulary prescribing
- Reduce by 10% the number of C difficile cases that were inappropriately sampled

Progress against this priority will be measured and monitored by the Infection Prevention and Control Group and received at the Quality and Safety Committee (Board committee).

Priority 2: Reduce the incidence of inpatient falls

Inpatient falls are one of the most frequent concerns to patient safety within an acute hospital environment. No fall is harmless, with psychological sequelae leading to lost confidence, delays in functional recovery and prolonged hospitalisation.

How progress will be monitored, measured, and reported:

Metrics:

- Reducing the number of inpatient falls by 10% from 2024/25 baseline
- Achieve greater than 90% of patients to have a documented falls risk assessment within 6 hours of hospital admission

Progress against this priority will be measured and monitored by the monthly Deconditioning Group and received at the Quality and Safety Committee (Board committee).

Priority 3: Reduce the incidence of Hospital Acquired Pressure Ulcers (HAPU)

Pressure ulcers have a significant impact on patients, causing pain and distress, reduced quality of life, and can extend a patient's stay.

How progress will be monitored, measured, and reported:

Metrics:

- 95% of patients will have a skin integrity assessment within 6 hours of hospital admission
- Reduce the incidence of HAPU by 20% from the 2024/25 baseline

Progress against this priority will be measured and monitored by the monthly Pressure Ulcer Improvement Group and received at the Quality and Safety Committee. (Board committee)

Delivering Effective Services

Priority 1: All eligible patients are assessed for risk of deep vein thrombosis (DVT)

Venous Thromboembolism (VTE) prophylaxis, which aims to prevent blood clots in the veins (deep vein thrombosis or DVT) and lungs (pulmonary embolism or PE), is crucial due to the high risk of morbidity and mortality associated with these conditions, particularly after surgery or injury.

Delivering Effective Services

How progress will be monitored, measured, and reported:

Metrics:

- All eligible patients will be risk assessed within 14 hours of hospital admission
- Appropriate prophylaxis will be administered with 14 hours of hospital admission

Progress against this priority will be measured and monitored by the Root Cause Analysis (RCA) meeting and received at the Quality and Safety Committee. (Board committee)

Priority 2: All patients with suspected sepsis are assessed and diagnosed within recommended timeframes

Sepsis treatment aims to rapidly address the underlying infection and its systemic effects, focusing on early antibiotic administration, fluid resuscitation, and supportive care to prevent organ damage and improve outcomes

How progress will be monitored, measured, and reported:

Metrics:

- All patients presenting at hospital will be assessed for the risk of sepsis
- Patients with a diagnosis of sepsis will receive antibiotics within the recommended timeframes

Progress against this priority will be measured and monitored by the monthly Sepsis Improvement Group and received at the Quality and Safety Committee (Board committee).

Priority 3: Ensure all patients in hospital remain hydrated

Effective hydration improves recovery times and reduces the risk of deterioration, kidney injury, delirium and falls.

How progress will be monitored, measured, and reported:

Metrics:

- All patients with a National Early Warning Score of 5 or more will be commenced on a fluid balance chart
- All patients diagnosed with Acute Kidney Injury (AKI) will be commenced on a fluid balance chart

This will be monitored through the Deteriorating Patient Group meeting and received at the Quality and Safety Committee (Board Committee).

Delivering Kind and Compassionate Care

Priority 1: Introduction of Patient Safety Partners to support the Patient Safety Incidence Response Framework (PSIRF).

Patient Safety Partners' involvement in organisational safety' allows the role that patients, carers and other lay people play in supporting and contributing to a healthcare organisation's governance and management processes for patient safety.

How progress will be monitored, measured, and reported:

Metrics:

- Appointment of Patient Safety Partners
- Patient Safety Partners integration in quality and safety programmes

Progress against this priority will be measured and monitored by the Patient Experience Operational Group and received at the Quality and Safety Committee (Board committee).

Priority 2: Implementation of Marthas Rule

"Martha's Rule," a patient safety initiative in English NHS hospitals, which allows patients, families, carers, and staff to request a rapid review from a critical care outreach team if they have concerns about a patient's deteriorating condition.

How progress will be monitored, measured, and reported:

Metrics:

- Trust wide introduction of Call 4 Concern
- Introduction of Patient Wellness Questionnaire for all adult inpatient areas.

Progress against this priority will be measured and monitored by the Deteriorating Patient Group and received at the Quality and Safety Committee (Board committee).

Priority 3: Improve the overall experience of patients attending maternity and children's services

Ensuring safe, compassionate, and person-centered care, addressing mental health, and improving communication and information sharing.

How progress will be monitored, measured, and reported:

Metrics:

Paediatrics:

- Parents felt that ward was suitable for the child age group
- Parents felt the room or ward was clean

Maternity:

- Found partner was able to stay with them as long as they wanted
- Reduced noise on postnatal ward night

Progress against this priority will be measured and monitored by the Women's & Children's Governance Group and received at the Quality and Safety Committee (Board committee).

2.2 Statements of assurance from the Board

During 2024/25 the Trust provided and/or sub- contracted 45 relevant health services. The Trust has reviewed all available data on the quality of care in each relevant health service. The income generated by the relevant health services reviewed in 2024/25 represents 100% of the total income generated from the provision of relevant health services by the Trust.

Clinical Audit and Confidential Enquiries

Annually NHS England publishes a list of national clinical audits and clinical outcome review programmes that advise the Trust to prioritise participation and inclusion in their Quality Accounts for that year. This will include projects that are ongoing and new items.

The Trust is committed to undertaking effective clinical audit across clinical services and recognises that this is a key element for providing high quality care. Clinical audit enhances patient care and safety and provides assurance of continuous improvement. The Trust has a well-structured clinical audit programme which is regularly reviewed. During 2024/25, 44 national clinical audits and 6 national confidential enquiries were relevant to health services that the Trust provides. The Trust participated in 100% of national clinical audits and was eligible to participate in 100% of the national confidential enquiries.

The national clinical audits and national confidential enquiries that the Trust participated in, and for which data collection was completed during 2024/25, are listed below.

National Audits & Clinical Outcome Review Programmes 2024/25	Eligible	Participation	Status
Adult Respiratory Support Audit	Yes	Yes	Completed
RCEM-Assessing cognitive impairment in older people	Yes	Yes	Active
Breast and Cosmetic Implant Registry	Yes	Yes	Continuous monitoring
Case Mix Programme: Intensive Care National Audit and Research Centre	Yes	Yes	Continuous monitoring
Elective Surgery: National Patient Reported Outcome Measures (PROMS)	Yes	Yes	Continuous monitoring
Epilepsy 12 – National Clinical Audit of Seizures and Epilepsies for Children and Young People	Yes	Yes	Continuous monitoring
Learning disability mortality review (LeDeR)- learning from lives and deaths of people with a learning disability and autistic people	Yes	Yes	Continuous Monitoring
Mothers and Babies Reducing Risk Through Audits and Confidential Enquiries across the UK (MBRACE- UK) Maternal Infant and New-born	Yes	Yes	Continuous Monitoring
Myocardial Ischaemia National Audit Project (MINAP)	Yes	Yes	Continuous monitoring
National Cancer Audit Collaborating Centre - National Audit of Metastatic Breast Cancer	Yes	Yes	Continuous monitoring
National Cancer Audit Collaborating Centre - National Audit of Primary Breast Cancer	Yes	Yes	Continuous monitoring
National Audit of Cardiac Rhythm	Yes	Yes	Continuous monitoring

National Audits & Clinical Outcome Review Programmes 2024/25	Eligible	Participation	Status
Management NACRM)			
National Audit of Care at the End of Life (NACEL)	Yes	Yes	Active
National Audit of Dementia (NDA)	Yes	Yes	Completed
National Audit of Inpatient Falls (NAIF)	Yes	Yes	Continuous monitoring
National Gastro-Intestinal Cancer Programme Bowel Cancer (NBOCA)	Yes	Yes	Continuous monitoring
National Cardiac Arrest Audit (NCAA)	Yes	Yes	Continuous monitoring
Hybrid Closed Loop Technologies 'HCLT' Apr24-Mar25	Yes	Yes	Continuous monitoring
National Diabetes Core Audit (NDA)	Yes	Yes	Continuous monitoring
National Diabetes Foot Care Audit	Yes	Yes	Continuous monitoring
National Diabetes Inpatient Safety Audit (NDISA)	Yes	Yes	Continuous monitoring
National Early Inflammatory Arthritis Audit (NEIAA)	Yes	Yes	Continuous monitoring
National Emergency Laparotomy Audit (NELA)	Yes	Yes	Continuous monitoring
National Heart Failure Audit (NHFA)	Yes	Yes	Continuous monitoring
National Hip Fracture Database (NHFD)	Yes	Yes	Continuous monitoring
National Joint Registry (NJR)	Yes	Yes	Continuous monitoring
National Lung Cancer Audit (NLCA)	Yes	Yes	Continuous monitoring
National Maternity and Perinatal Audit (NMPA)	Yes	Yes	Continuous monitoring
National Oesophagi-gastric Cancer (NOGCA)	Yes	Yes	Continuous monitoring
NRAP Adult Asthma Secondary Care	Yes	No	Continuous monitoring
NRAP Chronic Obstructive Pulmonary Disease (COPD)	Yes	No	Continuous monitoring
National Paediatric Diabetes Audit (NPDA)	Yes	Yes	Continuous monitoring
National Perinatal Mortality Review Tool	Yes	Yes	Continuous monitoring
National Pregnancy in Diabetes Audit (NPID)	Yes	Yes	Continuous monitoring
National Prostate Cancer Audit (NPCA)	Yes	Yes	Continuous monitoring
National Vascular Registry (NVR)	Yes	Yes	Continuous monitoring
Paediatric Asthma (Secondary Care)	Yes	Yes	Continuous monitoring
Emergency Medicine QIPs (RCEM): a) Care of Older People. b) Mental Health (Self-Harm)	Yes	Yes	Active
Sentinel Stroke National Audit Programme (SSNAP)	Yes	Yes	Continuous monitoring
National Major Trauma Registry N.M.T.R..	Yes	Yes	Continuous monitoring
UK Parkinson's Audit	Yes	Yes	Completed
BAUS Nephrostomy Audit	Yes	Yes	Active
National Comparative Audit of Blood Transfusion:	Yes	Yes	Active
National Neonatal Audit Programme (NNAP)	Yes	Yes	Continuous monitoring
Society for Acute Medicine Benchmarking Audit (SAMBA)	Yes	Yes	Completed

NCEPOD	Eligible	Participation	Status
NCEPOD Juvenile Idiopathic Arthritis	Yes	Yes	Completed

NCEPOD End of Life Care	Yes	Yes	Completed
NCEPOD rehabilitation following critical illness study.	Yes	Yes	Active
NCEPOD Emergency (non-elective) procedures in children and young people.	Yes	Yes	Active
NCEPOD: Blood sodium study- Hyponatraemia	Yes	Yes	Active
NCEPOD Acute limb Ischaemia (ALI)	Yes	Yes	Active

Other National /Regional Audits Participated in 2024/25 (not on the Quality Accounts List):

National Audits / Regional Audits
Avoiding Term Admissions in Neonates (ATAIN)
JAG quality of bowel preparation for colonoscopy audit
JAG endoscopy KPI audit
Advancing Quality: Sepsis
Advancing Quality: Acute Kidney Injury
Advancing Quality: Community Acquired Pneumonia
Advancing Quality: Elective Hip and Knee surgery
Re-usable v's single use laryngoscopes
Cappuccini Test (annual 2024)
Detection and management of hypertriglyceridaemia induced pancreatitis
Emergency Imaging Audit - Royal College of Radiology
National PATRN Paediatric National Database of Airway Management (PANDA)
National TRIC-MAN audit – antimicrobial stewardship and resistance in critical care
National Olfactory Dysfunction Audit 2024
National Audit - Management of Acute Appendicitis in pregnancy 'MAMA'
National SBO Action: conservative Small Bowel Obstruction management in the Absence of standard ConTrast agents ON outcomes
Historical shoulder replacements omitted from NJR
Global Femur Fracture Outcomes Study
National audit (BAUS) of Impact of Diagnostic Ureteroscopy on Radical Nephroureterectomy and compliance with standard of care practices (I-DUNC) Audit
Environmental Lessons Learned and Applied to the bladder cancer care pathway 'ELLA' audit for bladder cancer
National VERN Blood Loss, Anaemia and HaemoSTasis management in Major Vascular Surgery 'BLAST'
National VERN - ARM IschaEmia Study 'ARMIES'
Temporary IVC filter Retrieval Rate
BSE echo requestor survey
Maternal Audit on Thrombosis Outcome and Decision (MATRON)
Alcohol Related Liver Disease. Alert UK
Audit of patients with RA due to cirrhosis
The AVOID study
Breast Treatment unwarranted variation audit
An assessment of referrals for Carotid artery stenting from Countess of Chester Hospital
An audit on the management of rectal cancer management across Mersey
An audit to assess orthodontic treatment outcomes at Liverpool University Dental Hospital and the Countess of Chester Hospital
Regional Patch Testing Audit 2024
Annual Radiation doses for vascular patients
Depression and Anxiety among vascular staff and patients
Re-audit Vascular Ward Round compliance with SHINE
Lower limb surgical site wound infection after revascularisation
Activity Coding in Orthodontics: A Regional Audit
Ectopic maxillary canines: audit of referral timing and evaluation complexity of impactions
Outcomes of partial or total calcanectomies
Self-care behavior among diabetic patients
Outcomes of partial or total calcanectomies

National Audits / Regional Audits
Evaluation of Lipid Management for Secondary Prevention in Ischaemic Heart Disease Across Three NHS Hospital Sites

The reports of 44 national clinical audits were reviewed by the provider in 2024/25 and the Trust has taken and intends to take the following actions to improve the quality of healthcare provided:

Audit Title	Outcome /Actions
National Emergency Laparotomy Audit (NELA)	
National Emergency Laparotomy Audit (NELA)	The aim of the audit is to improve the outcomes of emergency laparotomy patients. **Sample:** 27741 cases in Year 9 Nationally. 166 cases by COCH. Please note that this 'data year' was extended to 16 months to align with future NHS financial years. **Findings:** • COCH outcomes compare favorably on a national level with regards to LOS/mortality rate • Best practice tariff criteria met (preoperative risk assessments and postoperative elderly care input) • Post operative input for elderly and frail patients significantly improved compared to Y8 and above the 40% target (this target incrementally increases each year from now on) • Amber rating – time to arrival in theatre. Remains consistent with the National figure but COCH has previously been green. This facet of care is often something that is open to interpretation. Further investigation to understand rationale for amber rating. • Red rating – consultant reporting CT scans prior to theatre. Again, reflective of the National picture but COCH has previously been rated amber. A significant number of these will be patient scans reported overnight by the radiology hub which is covered by registrars. The audit has shown significant assurance for the Trust.
National Neonatal Audit Programme (NNAP)	
National Neonatal Audit Programme (NNAP)	The audit assesses whether babies admitted to the neonatal unit receive consistent high-quality care in relation to the NNAP audit measures and are aligned to a set of professionally agreed guidelines and standards. **Standard Audit Against:** (see table below) **Evidence of improvement**

Individual Standards Assurance Level RAG Standard	Current Assurance RAG	Previous year Assurance Score
Antenatal steroids (Nat average 52.9%)	55.2%	
Antenatal magnesium sulphate (Nat average 85.1%)	60%	N/A
Deferred cord clamping (Nat average 68.3%)	58.8%	
Admission Temperature (Nat average 80.4%)	81.8%	
Parental consultation within 24 hrs of admission (Nat average 95.2%)	98.4%	
Parent inclusion on consultant ward round (Nat average 38.7%)	48.3%	
Neonatal nursing staff (Nat average 79.3%)	99.6%	
BPD (Nat average 40.1% developed BPD)	25%	
Breastmilk in first 2 days of life (Nat average 62%)	79.4%	
Breastmilk feeding at 14 days (Nat average 79.6%)	78.3%	
Breastmilk feeding at discharge (Nat average 63%)	64.3%	
Screening for ROP on time (Nat average 78.4%)	40%	

<table>
<tr><td></td><td>The Neonatal team have worked hard to ensure data is as accurate as possible. As a result of previous less favorable data around breast milk the 2023 data is now reflecting huge improvements in our breast milk within 48 hours – we are now a positive outlier from the national average.

The data also shows a significant improvement in our thermoregulation data, showing we had better than national average results in 2023.

Learning points
The 2023 data have influenced our quality improvement projects that have been implemented in 2024

Changes in practice:
Preterm optimisation
This has continued to be embedded in practice across the perinatal team. The perinatal optimisation group became fully established in 2024. This allows “real time” review of preterm cases to ensure data is accurate and identify missed opportunities. This has then influenced education and training and QI work throughout the year.

Introduction of preterm optimisation trolley on labour ward to try and facilitate timely administration of antenatal optimisation bundle.
Thermoregulation
Change from last year now embedded - There is now a clear framework to optimise thermoregulation in infants being transferred to the neonatal unit.
Deferred Cord Clamping
Current guidelines are being reviewed to reduce the number of contra-indications to DCC. This should significantly decrease the number of infants who do not get optimal cord management.
ROP
Difficulties fulfilling the correct timeline for ROP screening. This has been due to needing externally commissioned ophthalmologist to attend the Trust and perform the screening. We are implementing an” in-house” paediatric ophthalmologist and investing in a specialist camera to improve access to timely screening.

The audit has shown significant assurance for the Trust.</td></tr>
<tr><td colspan="2">National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) Surgical & Medical / Child Health Programme</td></tr>
<tr><td>Completed studies during 2024/25:
• NCEPOD Juvenile Idiopathic Arthritis Transition from Child to Adult Health Services
• NCEPOD End of Life Care</td><td>Active studies during 2024/25
• NCEPOD rehabilitation following critical illness study.
• NCEPOD Emergency (non-elective) procedures in children and young people.
• NCEPOD: Blood sodium study-Hyponatraemia
• NCEPOD Acute limb Ischemia (ALI)</td></tr>
<tr><td colspan="2">JAG Quality of Bowel Preparation for Colonoscopy Audit</td></tr>
<tr><td>JAG Quality of Bowel Preparation for Colonoscopy Audit</td><td>The aim of the audit is to monitor the quality of bowel preparation for colonoscopy procedures, ensuring at least 90% of procedures have adequate bowel preparation. JAG aspiration target of 95% which the Trust met.

The audit has shown Full assurance for the Trust.</td></tr>
<tr><td colspan="2">National Paediatric Diabetes Audit</td></tr>
</table>

National Paediatric Diabetes Audit	**Audit aim:** To monitor standards in Paediatric Diabetes care. Requirement of Best Practice Tariff and peer review. **Findings:** **Health check completion** Key health check completion remains high. Current systems for identifying patients needing screening and capturing data are working well. We are not able to offer all patients 4 HbA1c measurements per year due to lack of consultant clinic capacity. This was also highlighted in the GIRFT review. There is not sufficient time in current Consultant job plans to offer additional clinics. Both clinic capacity and Consultant job plans are currently being looked at. HbA1c levels continue to improve. We are no longer an alarm level outlier for adjusted mean HbA1c. This is due to increased nursing, dietetic and psychology time within the service in recent years. Median HbA1c 63.5 (NW 61.0, E&W 60.0) Mean HbA1c 65.2, Adjusted mean HbA1c 66.1 The proportion of patients with high HbA1c continues to fall due to targeted additional support. **Other** 50% started carbohydrate counting at diagnosis. (E&W 87.6%) This has hugely improved from 8% in 2022-3 but remains below the E&W figure of 87.6%. The MDT had no dietetic support in 2022-3 and posts were recruited to in 2023-4. We expect the 2024-5 figure to have improved further. There is an increase in the number of children assessed (31.4%) as needing psychological support (26.8% NW, 28.4% E&W). This is likely to reflect some previous rationing of service when less psychological time is available with some catch up now. We have more children using hybrid closed loop insulin pumps (HCL) than other services. Assurance rating has increased from limited assurance to significant- Previously an alarm level outlier for HbA1c for multiple years. Now no longer the case.

Local Clinical Audits

To improve the quality of healthcare provided at the Trust, the reports of 142 local clinical audits were reviewed by the provider in 2024/25 compared to 87 in the previous year and the Trust intends to take the following actions to improve the quality of healthcare**:**

Audit Title	Outcomes/ Actions
Diagnostic & Clinical Support Services	
Re Audit into FNAC of Thyroid nodules Cycle 3	Audit Aims: 1.The BTA guidelines 2014 recommend that all thyroid nodules should have a U-score within the ultrasound report. 2. Diagnostic yield varies with technique, tissue and type of lesion. The standard range for diagnostic on cytology assessment is approximately 70%. **Findings:** 1. U Score was assigned to all thyroid nodules in 100% of the USG reports. 2. The Diagnostic yield was 79 % for FNAC thyroid on cytological assessment which meets the required standard of 70%. Cycle 3 showing full assurance. No actions as an audit cycle are complete.
Therapies & Integrated Community Care Division	
A review of outcomes measures following the introduction of the	**Audit Aims:** • 1) To evaluate the effectiveness of the VACOped® adjustable external equinus boot combined with an accelerated, functional management

VACOped® adjustable external equinus boot for the management of Achilles tendon ruptures	programme in the treatment of Achilles tendon ruptures. • 2) To compare the outcome measures obtained from patients treated using the VACOped® adjustable external equinus boot with those treated with Aircast boot and wedges. • 3) To compare the outcome measures obtained from patients treated using the VACOped® adjustable external equinus boot with those published by other foot and ankle centres. **Findings:** This audit substantiates and validates the use of the VACOped® boot as a cost-effective replacement for the Airstep® walker boot with wedges in the management of Achilles tendon ruptures as outlined in the 2022 COCH guidelines with both improved outcomes scores and both 4-6 and 9-12 months and a reduction in the re-rupture rate. It is acknowledged however that the success of Achilles tendon rupture management is not solely based on the prevention of complications and re-rupture but also the restoration of function which is influenced by tendon length. An improvement was not noted in the rate of apparent Achilles tendon lengthening but this may have been influenced by the relatively low surgical conversation rate and number of delayed presentation ruptures. The results compare very favorably with those published other foot and ankle centres. **Actions:** Only actions to come out of audit- Add to Foot and Ankle MDT meeting agenda the following: • Review of audit results • Review of surgical criteria • Review of management of delayed presentation patients • Introduction of radiology USS reporting template • Review of patient 9- and 12-month outcomes to potentially include date for return to work and sport Update action plan accordingly with outcome of above discussions – may involve updating guidelines and creating and disseminating radiology USS reporting template This audit has shown full assurance to the Trust.
Planned Care	
Adequacy for excisional margins of skin cancer lesions	**Audit Aims:** - To analyse if current margins of skin cancer excision surgeries are in accordance with the skin cancer management guidelines. - To analyse if current margins of skin cancer excision surgeries are adequate, confirmed with histological evidence. - To implement a change in practice to improve current standards of practice. **Findings:** All SCC and BCC lesions were excised, and completeness of excision was adequate as per Merseyside and Cheshire Skin Cancer Center Management Guidelines. 82.6% of patients were correctly diagnosed with the specific type of lesion before surgery. 100% of patients were treated by single excisional procedure. **Action:** Re-audit June 2025 This audit has shown full assurance to the Trust

Anaesthetic handovers to Theatre Recovery Teams	**Audit Aims:**
	To assess the quality and efficacy of the verbal and written handovers being provided by the Anaesthetics team when transferring patients from theatre to Recovery post-surgery.
	Audit results demonstrated 91% compliance of patient discharged with appropriate quantity of anticoagulant therapy
	
	Findings:
	Full assurance - 96.9% of handovers were structured, concise and accessible
	
	Actions:
	• Amendments to Cerner anaesthesia Handover tool as detailed above.
	• Amendment of 'Handover to Recovery' Tool to include additional details:
	  o Patient pre-op cognitive status
	  o Full Resuscitation/DNACPR Status
	  o Medications for administration in Recovery
	  o Blood products for administration in Recovery
	  o Amend Investigations to include common post-op Ix e.g. CXR, ECG, BM, Rotem
	  o Amendment to Cerner – relocation of 'Handover to Recovery' documentation from Anaesthesia Final Record to separate entry in documentation
	• Drafting of clear SOP for anaesthetic to Recovery team handover to provide clear written guidance on the transfer of patients from theatre to Recovery, including RCOA guidance on optimal monitoring and patient safety, as well as how to provide optimal Handover.
	
	This audit has shown full assurance of the Trust

Urgent Care	
Maintenance Rituximab	**Audit Aim:** To assess whether our experience of using maintenance rituximab is similar to the PRIMA study. **Findings:** Wide range of duration of treatment at time of audit. Modal number of cycles of treatment is the full 12 Discontinuation rates, 18%, similar to the initial PRIMA trial Treatment discontinued due to disease progression (2) and recurrent infections (2) Initial chemotherapy regime does not appear to influence maintenance **Actions:** • Continue current practice of offering maintenance rituximab • Re-audit in approximately 3 years. Assess over a longer period and include such variables as age. • Assess outcomes of patients who aren't given maintenance rituximab to compare. This audit shows significant assurance to the trust.
Audit of COCH practice compliance with trust anaemia guidance from SDEC	**Audit Aim:** The aim of the audit is to measure compliance with the trust guidance for treating iron deficiency anaemia in adult outpatient's department of the Countess of Chester Hospital. 90-100% compliance. **Findings:** A compliance rate of 92.86% with the guidance from the ambulatory care pathway was calculated. The formula used for this calculation: (Patients treated according to the guidance) / (total number of eligible patients) * 100 = compliance rate. **Action implemented:**

	Update senior doctor on findings and no major changes needed guidelines being reviewed Audit shows significant assurance.
Women and Children's	
High Risk Induction of Labour - Fetal Monitoring	**Audit Aim:** Following an ICB action this snapshot audit was commenced to examine if high risk inductions have a fetal monitoring plan and if the plan was followed appropriately. **Findings:** n=25 patients were audited within the time period (May-Jun 24). Documented Plan of Frequency of Fetal Monitoring 96% of patients had a plan in place within the notes for frequency of fetal monitoring. 1 of 25 did not. This patient started this IOL process, however, progressed to the need for Emergency Caesarean Section Therefore Fetal Monitoring was safe and appropriate. Fetal Monitoring Frequency Followed n=22 patients (x3 NA) 91% of patients had 6 hourly fetal monitoring during high-risk induction. 2 did not and below shows the gap between 6 hourly: • 11 hours (5 hr. late) • 7.5 hours (1.5hr late) All patients had an appropriate escalation of concerns with regards to fetal monitoring or maternal condition. **Actions implemented:** • Clear individualised management plan for all patients that are being induced including frequency of fetal monitoring • Ward managers address those cases that didn't have the plan followed and were required to communicate with staff members. This audit shows full assurance of the trust
A clinical audit to assess compliance with the NHSBSP standard of a clear demonstration of the inframammary angle on the MLO view in screening mammograms.	**Audit Aims:** 1. To assess the extent to which the practice of mammographers within a BSU comply with the NHSBSP standard for clearly demonstrating the inframammary angle in the MLO view. 2. To improve patient outcomes by identifying any areas of practice that require improvement or further training. **Findings:** Audit has shown significant assurance as overall clinically acceptable rates of IMA demonstration. **Action to re-audit in 12 months** This audit shows significant assurance to the trust

Local Audits

Local audits are undertaken across the organisation to provide local real-time results on aspects of nursing care and patient management.

There are currently 2 audit platforms utilised within the Trust as set out below along with a programme of ward accreditation.

Tendable

Tendable is used within the Trust by all inpatient areas including core wards, Maternity,

Paediatrics, and the Emergency Department. Currently there are 42 audits under the headings Falls, Skin Integrity, Nutrition, Infection Prevention Control, Medication, Observations and Assurance. These audits are completed in each area as stipulated by the audit type, either daily, weekly, or monthly. A divisional report is prepared by the quality matron at the start of the month with data from the preceding month and is sent to all ward managers, matrons, heads of nursing and the senior leadership team. The report includes details of all audits completed and the compliance achieved.

MEG

This tool is utilised by the Infection Prevention and Control team to monitor compliance with urinary catheters, venous access devices, hand hygiene and commode cleanliness. Reporting is real time and shared with Ward Managers and Matrons and reported through the Infection Prevention Control Assurance Group.

Ward Accreditation / Striving for Excellence Programme

The Trust has utilised the Care Assurance Framework tool (CAF) as part of the Ward Accreditation System (WAS) since 2019. The programme has recently undergone an evaluation assessment against the NHS England (2019) Guide to developing ward and unit accreditation programmes. The guide identified four examples of exemplary ward accreditation models, with the University College London (UCL) model being the preferred option. Developed around the Care Quality Commission (CQC), fundamental standards of care include key clinical indicators that are designed to provide assurance of the quality of clinical care that is delivered across the trust. Revising the framework was seen an opportunity to model the standards against the new CQC "WE" statements and standards, and a framework of 14 core standards across five domains has been developed. The standards are inclusive and clearly outline the ward-to-board process. This programme has been renamed 'Striving for Excellence' and includes a ward visit and presentation being required to fulfil the assessment. This model has been designed to support clinical teams to understand their data, to standardise processes across the Trust, reduce unwarranted variation and support teams to flourish using continuous improvement methodologies. The Striving for Excellence programme resumed in April 2024, with trials being completed in two areas. The roll out commenced in July 2024, prior to this, all-ward managers carried out self-assessments to understand the revised process and identify areas of strength and areas of opportunity.

Research

We are a research active Trust, and we continue to be committed to offering our patients and our local population opportunities to participate in clinical research.

The number of patients receiving relevant health services provided or sub-contracted by the Trust in 2024/25 that were recruited during that period to participate in research approved by a Research Ethics Committee was in excess of 1,057.

1,057 people were entered into 33 different trials. At any one time there are over 100 research studies running across the Trust. 21 new studies were opened during 2024/25.

Our aspiration as an organisation has been to grow our clinical research offering so that all of the communities we serve in Chester/Cheshire West, Cheshire East, South Wirral and across the border into Flintshire have access to first class research facilities. The opening of a new Clinical Research Unit (CRU) on the Countess of Chester Hospital site and the generous donation of a Mobile research Unit (MRU) to the Trust during 2024/25 puts the

Trust in a very strong position to offer opportunities and benefits to our underserved populations in more deprived and rural areas as well as increase the visibility and profile of research both within traditional healthcare settings of the hospital, health centres and general practices, and externally throughout our communities.

Commissioning for Quality and Innovation (CQUIN)

During 2024/25 the mandatory CQUIN scheme did not operate. NHS England has produced a list of optional indicators that can be used by any systems that have agreed to operate a local quality scheme during the pause.

The Trust chose to adopt the non-mandatory CQUIN: Assessment and documentation of pressure ulcer risk.

Achieving 80% of acute and community hospital inpatients aged 18+ having a pressure ulcer risk assessment that meets NICE guidance with evidence of actions against all identified risks.
The Trust did not consistently achieve the CQUIN but have a dedicated improvement programme to reduce the risk of pressure ulcers. This programme is delivered across the organisation to improve the management of and recording of skin integrity.

CQUIN	Metric	Min/ Max	Quarter 1	Quarter 2	Quarter 3	Quarter 4
CQUIN	Assessment and documentation of pressure ulcer risk	65%- 80%	62%	56%	65%	58%

Care Quality Commission

The Trust works closely with regulators and commissioners to ensure that it continuously strives for excellence and to monitor its progress against local, regional, and national standards of care.

The Trust is required to register with the Care Quality Commission (CQC).

The Trusts have not participated in any special reviews or investigations by the CQC during

the reporting period.

The Trust continued to report against the CQC Improvement plan throughout 2024/25 via the Executive Directors Group and through regular reports to the Board of Directors.

Twice monthly CQC engagement calls occur between the Senior Nursing team and the CQC and additionally the Executive and senior teams have hosted two wider engagement events with a team from the CQC, including presenting updates to the CQC Improvement plan.

An unannounced inspection of urgent and emergency care services took place in February 2025, whilst the full report will be issued in 2025/26 the Trust received formal notification of a warning notice and action plans are being progressed at pace to deliver the improvements needed.

Data Governance

Good quality information underpins the effective and safe delivery of care. Reliable high-quality data is essential to ensuring decisions are made appropriately about service design and priority improvements. The Trust routinely produces data which is subject to review and analysis in line with good standards of corporate governance. Power BI reporting continues to be used as an operational management tool and to identify data quality errors.

A Data Quality policy is in place to maintain the quality of patient-related data. This is underpinned by a range of regular audit reports and initiatives such as validation of clinical and administrative data. This includes inpatient and outpatient waiting lists and the production of regular data quality reports to identify and collect missing data items and errors. Routine elective waiting time data (both inpatient and outpatient) are also produced, which is subject to review and analysis in-line with good standards of corporate governance. The Trust also has a Data Governance Group which is chaired by the Chief Digital & Data Officer**.** The group reviews data quality and associated workflows to ensure that NHS data standards are adhered to. A Data Quality tracker is used to monitor progress and ensure that appropriate governance is applied. This provides assurance to the Board of Directors that data is regularly validated and reviewed.

The Countess of Chester Hospital NHS Foundation Trust submitted records from 2024/25 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics. The following measures provide information on our compliance against the standards required.

The percentage of records in the published data which included the patient's valid NHS number was:

- 99.9% for admitted patient care
- 99.8% for outpatient care
- 95.1% for accident and emergency care

Those which included the patient's valid General Medical Practice code were:

- 100% for admitted patient care
- 100% for outpatient care
- 98.6% for accident and emergency care

The Countess of Chester Hospital NHS Foundation Trust is no longer subject to payment by results clinical coding audit by the Audit Commission. However, following the annual 2023/24 clinical coding audit by Mersey Internal Audit Agency (MIAA) the Trust received **substantial assurance** in relation to its clinical coding processes.

Information Governance

Information Governance (IG) is the way in which the Trust manages information and ensures that all information, particularly personal and confidential data, is handled legally, securely, efficiently, and effectively. IG provides a consistent framework for staff to deal with the many ways information is handled in line with Data Protection legislation.

The Trust Data Security and Protection Toolkit's (DSPT) overall score for 2024/25 was graded as 'Standards Met' by internal auditors based on a review of about 40% of the total Toolkit. The Trust's final position, submitted at the end 2024, was judged to be 'Standards Met' across the whole Toolkit.

Scoring against the toolkit is validated by two further internal audits that confirm the authenticity of the submissions. The Trust is currently going through the assessment process again with a considerably changed Toolkit that now incorporates returns from multiple areas of the Trust rather than just IG and the Digital and Data Team. Any areas of non-compliance will continue to be addressed and the focus for improvement for IG will be to maintain training compliance and reduce episodes where information may be breached. The Digital and Data Team continue to focus on improving our Networks and Cybersecurity processes.

Learning from deaths

The Medical Examiners scrutinises 100% of deaths by reviewing the overall accuracy of the death certificate and identifying cases for further review. Medical Examiners liaise closely with bereaved families or carers to give them the opportunity to share any concerns.

During 2024/5, 1,193 patients died at the Trust.

The number of deaths in each quarter was:

- 275 in the first quarter
- 276 in the second quarter
- 322 in the third quarter
- 320 in the fourth quarter.

By 31 March 2025, following Trust policy guidance on 'selection of cases for review',151 mortality reviews were undertaken. The number of deaths in each quarter for which a case record review or investigation was carried out was:

- 33 in the first quarter
- 30 in the second quarter
- 52 in the third quarter
- 36 in the fourth quarter.

The cases for review were ascertained using the Royal College of Physicians methodology on Structured Judgement Reviews (SJR) and the Patient Safety Incident Response Framework guidance.

Review method

The Trust reviews all deaths in line with its 'Mortality Review: responding to and learning from the death of patients under the management and care of the Trust' policy. Deaths are scrutinised using a range of mortality review tools.

- Specialty mortality and morbidity review

- Structured mortality review
- Thematic pathway reviews in response to mortality indices outlier status.

A Structured Mortality Review is an objective review method that looks for strengths and weaknesses in the care process, to provide information about what can be learnt about the hospital systems where care goes well, and to identify points where there may be gaps, problems, or difficulty in the care process. The quality of care is assessed against a scale of excellent, good, adequate, poor and very poor. Where the first review deems the care to have been poor or very poor, the case is sent for a second review. Second reviews are undertaken by senior clinicians alongside members of the coding team. If questions arise in relation to the care of someone who has died then this is raised as a clinical incident and a review is undertaken, following the Patient Safety Incident Response Framework policy.

The purpose of these reviews is to identify themes for learning for the organisation. Themes include documentation and record keeping, and the escalation of a deteriorating patient. The mortality surveillance group has been established, and key performance indicators will be monitored at the Quality and Safety Committee (Board Committee) to track progress. These and other themes identified in the deteriorating patient were also be taken forward through the Trust harms reduction programme.

Learning from coroners' inquests was also included in 2024/25 and presented at the Trusts newly formed Safety Surveillance monthly meeting.

Throughout the reporting period, the Trust has shared and spread the learning identified through monthly Patient Safety Summits, the Mortality Surveillance Group, the daily Patient Safety Huddle and the Divisional Governance Groups. The following actions are being progressed:

- A central database has been established and implemented to allow single point oversight
- A quality assurance process has been established to review Structured Mortality Reviews
- Implement ways of demonstrating continued memory of the learning line Patient Safety Incident Response Framework
- Individual mortality themed reviews where the national mortality indices indicate potential outlier status.

2.3 Reporting against Core Indicators

The Department of Health and Social Care specifies that the Quality Accounts includes information on a core set of outcome indicators, where the NHS is aiming to improve. All Trusts are required to report against these indicators using a standard format. NHS Digital makes the data available to NHS Trusts.

The Trust has more up-to-date information for some measures; however, in the main only data with specified national benchmarks from the central data sources are reported, therefore some information included in this report is from the previous year or earlier and the timeframes are included for clarity. It is not always possible to provide the national average and best and worst performers for some indicators due to the way the data is provided.

The Trust considers that the below data is as described with information taken from the trust electronic patient record (Oracle Cerner) and where available from Telstra Health (clinical benchmarking system). The data quality process, including clinical validation, has also been followed.

<table>
<tr><th>Indicator</th><th>2024/25</th><th>2023/24</th><th>2022/23</th><th>2021/22</th><th>National Average</th><th>Where applicable – best performer</th><th>Where applicable – worst performer</th></tr>
<tr><td>SHMI value and banding (most recent December 2023 to November 2024)</td><td>90.9 Within expected range</td><td>96.7 Within expected range</td><td>99.9 Within expected range</td><td>98.4 Within expected range</td><td>100.3</td><td>71.9</td><td>125.6</td></tr>
<tr><td>% Patient deaths coded for palliative care at diagnosis or specialty level; Source: NHS Digital (SHMI publication) December 2023 to November 2024</td><td>39%</td><td>44%</td><td>41%</td><td>31%</td><td colspan="3">N/A</td></tr>
<tr><td colspan="8">Our Standard Hospital Mortality Indicator (SHMI) has improved significantly and now falls within the expected range. There has been focused on improvement work on disease groups where the Trust was previously an outlier. This position has been sustained during the 12-month reporting period.</td></tr>
<tr><td>Patient reported outcome scores for primary hip recplacement surgery</td><td>Data not available</td><td>Data not available</td><td>Data not available</td><td>Data not available</td><td colspan="3">N/A</td></tr>
<tr><td>Patient reported outcome scores for Knee replacement surgery</td><td>Data not available</td><td>Data not available</td><td>Data not available</td><td>Data not available</td><td colspan="3">N/A</td></tr>
<tr><td>28-day readmission rate for patients aged 0-15 Source: Dr Foster Nov 2023 to Oct 2024</td><td>19.0%</td><td>18.8%</td><td>17.1%</td><td>14.8%</td><td>10.2%</td><td>3.7%</td><td>21.9%</td></tr>
</table>

Indicator	2024/25	2023/24	2022/23	2021/22	National Average	Where applicable – best performer	Where applicable – worst performer
28-day readmission rate for patients aged 16 or over Source: Dr Foster Nov 2023 to Oct 2024	**7.1%**	7.3%	6.9%	7.5%	8.1%	4.0%	13.1%
Paediatric readmission rates have increased and remain above the national average. This is likely due to the work undertaken in the department to avoid unnecessary hospital stays, where it is clear there is no intervention needed that cannot be provided in the community. Careful explanation of the signs to look out for that might require reattendance at the hospitals, along with written information, is given to families. This may be supported by a temporary 'open access' arrangement to the ward, by the Hospital at Home team.							
VTE (annualised) The percentage of patients who were admitted to hospital and who were at risk assessed for venous thromboembolism during the reporting period.	**89.8%**	81.2%	78.2%	-	N/A		
The threshold for completion of VTE was within 24 hours of admission prior to 2024/25, this was changed to within 14 hours of admission from 2024/25. Data for 2021/22 is not available due to the implementation and stabilization of the electronic patient record.							
C. Difficile Rate per HES 100,000 bed days**	**Total: 41.6** **Hospital onset: 33.1** **Community onset: 8.5**	Total: 40.7 Hospital onset: 31.7 Community onset: 9.0	Total: 51.4 Hospital onset: 40.4 Community onset: 10.9	Total: 31.4 Hospital onset: 22.5 Community onset: 8.9	N/A		
C. Difficile rates have increased in this reporting period. This increase has been seen across our 4 neighboring organisations. Each case has a multi-disciplinary investigation to establish if there is any learning. There has been no hospital transmission of C. Difficile.							
Number of Never Events	**2**	0	5	3	N/A		
Never Events are serious incidents that should not occur as there are strong systemic national policy and frameworks in place to prevent them from happening. Each of these incidents have been investigated under the NHS Serious Incident Framework and reported to the Strategic Executive Information System (StEIS).							
Rate of Never Events per HES 100,000 bed days	**1.0**	0	3.2	1.8	N/A		

Patient Safety Incidents

The Trust has transitioned from the Serious Incident Framework to the Patient Safety Incident Response Framework (PSIRF) during the reporting period, with extensive training, communication and education to support this new way of responding to incidents. A MIAA independent audit was carried out in quarter 4 for which the Trust received Moderate assurance for the evaluation of the operating effectiveness of controls and level of consistency in place for the management, recording, monitoring and reporting of incidents following the adoption of PSIRF. All divisions and departments are now utilising the learning response templates to identify learning from moderate and above harm incidents and take mitigating actions in real time, with a robust governance process embedded for oversight and transparency. There are a variety of Trust wide forums, for Learning and Sharing, that are available for all members of staff.

All associated policies relating to patient safety incidents have been updated to align to PSIRF principles, these include Duty of Candour; Reporting and Management of Patient Safety Incidents; Supporting and Involving People Involved in Patient Safety Incidents; Listening and Responding to Concerns and Complaints policy; Claims Handling policy; Disciplinary policy; and Freedom to Speak Up policy. Consideration has been given to how we will engage with minority groups (including the nine protected characteristics) and work will commence to address in 2025/26. The Trust published its PSIRF policy and plan on its website in early April 2024. This is being reviewed now for the year 2025/26.

A Quality, Safety and Experience Strategy has been developed and will be launched in early June 2025.

In addition, the National Reporting and Learning System (NRLS) was replaced by the Learning from Patient Safety Events (LFPSE) platform, and the DATIX, is connected to the service so now all patient safety incident reports are simultaneously uploaded to the LFPSE platform.

The Harms Improvement programs continued, also supporting the quality priorities set out in the previous year's priorities set out in 2024/25. We have demonstrated a continuous reduction in incidents with harm.

During 2024/25, 19 incidents requiring Patient Safety Incident Investigation (PSIIs) were reported including:
2 Never Events. This includes 2 Maternity diverts that we are mandated to report to StEIS. The first never event was reported in April 2024 and a second never event that occurred historically in 2012, but which was identified in quarter 4 in 2024/25 have both had full investigations undertaken.

National Safety Standards for Invasive Procedures / Local Safety Standards for Invasive Procedures (NatSSIPS /LocSSIPS)

The National Safety Standards for Invasive Procedures (NatSSIPs 1) were introduced in 2015 and built on the WHO (World Health Organisation) Safe Surgery checklist in 2009. NatSIPPs and LocSSIPs were developed to allow organisations to standardise and harmonise key elements of procedural care and reinforce the importance of education for safety.

NatSSIPs 2 are very much an evolution from NatSSIPs 1. This new, updated version of the safety standards will further improve patient safety by expanding the range of procedures to which the

safety checks apply and adding a further three steps to the WHO checklist. NatSSIPs2 also enables hospitals to apply a consistent and proportionate set of safety checks, depending on whether the patient is undergoing a major procedure undertaken in an operating theatre, or a minor procedure in an outpatient clinic.

A NatSSIPs steering group has been convened and is led by the Medical Director. The steering group are working Trust wide to ensure the NatSSIP remains as a priority for the Trust. Progress is monitored both through the Quality Governance Committee and the Quality and Safety Committee

Infection Prevention & Control

During 2024/25 a variety of healthcare associated infections have posed a challenge for the Trust. During the year, the Trust has managed outbreaks of norovirus and an increased prevalence of influenza, with visiting restrictions implemented during those episodes to assist in managing the risk posed to both patients and staff.

There has also been an increased prevalence of both C.difficile infections and gram-negative blood stream infections (including E.coli and Klebsiella), with targeted improvement work being undertaken as part of the Trusts 'Harms Improvement Programme' focusing on the key risks that lead to these infections developing. For C.difficile the targeted work focused on appropriate microbiology sampling, environmental cleanliness, and antimicrobial stewardship. In relation to E.coli work focused on strengthening the processes around the prevention and management of urinary tract infections.

Across the West Cheshire health economy, the prevalence of both C.difficile infections and E.coli bloodstream infections increased during the year. The increase in community cases was notable, with increases in C.difficile infections 40% higher than the previous year and E.coli bloodstream infections 19% higher than the previous year. The rise in cases associated with the Trust were lower with an 8% increase in C.difficile infections and an 11% increase in E.coli bloodstream infections

The Infection Prevention Control (IPC) Team have delivered a much-enhanced programme of audit and education, which has played a key role in providing assurance of compliance with the basic principles of IPC practice.

Pathogen	2024/25 NHSE threshold	2024/25 cases	Previous year (2023/24) cases
C.difficile	73	83	77
E.coli	51	61	54
Klebsiella	21	33	23
Pseudomonas aeruginosa	1	8	2
MSSA	N/A	32	20
MRSA	N/A	1	0

All HCAI related activity is monitored through the Infection Prevention and Control Assurance Committee and is received at the Quality Governance Group and Quality and Safety Committee.

Responsiveness to Patients Needs

There are several mechanisms available for patients and the public to share their feedback with the Trust. These include:

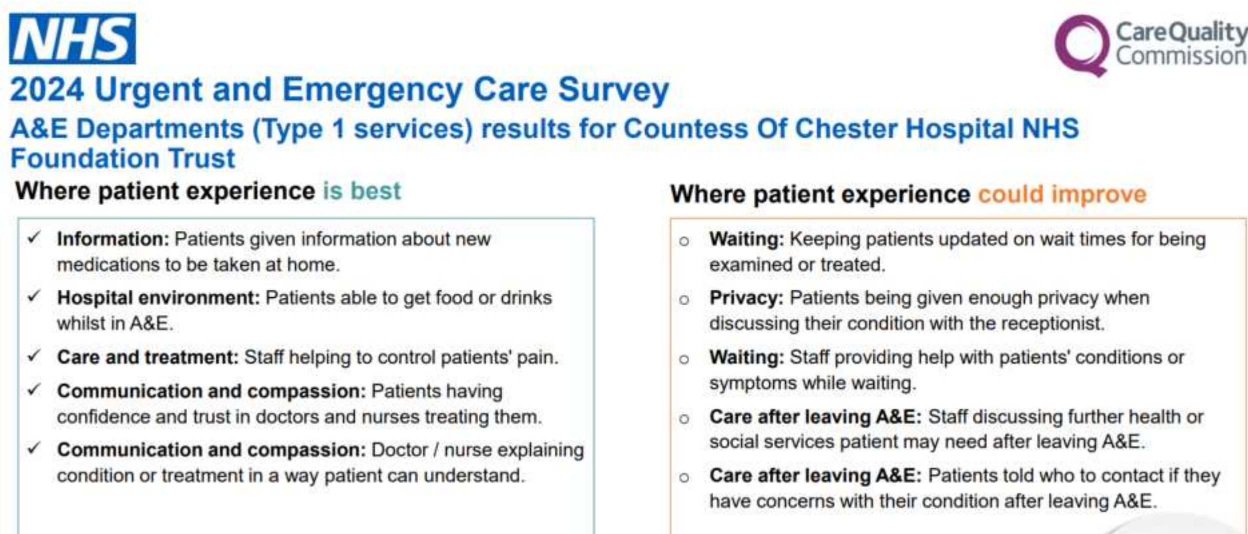
- National CQC survey programme
- Friends & Family test and comments
- NHS Choices
- Healthwatch (visits, go-sees, and engagement events)
- Non-Executive Director and Governors walkabouts
- Patient-Led Assessment of the Care Environment (PLACE)
- Concerns or Complaints/PALS
- Social media feedback
- Patient Engagement Groups.

The Trust-wide Patient Experience Operational Group (PEOG) continued throughout 2024/25 to provide assurance that the experience of patients, families and the public were sought to support and (where necessary) direct improvements in clinical practice, service delivery and patient care pathways.

The Group:

- provides a forum to engage with a range of hospital teams, patient representatives and Governors to review feedback and agree actions needed in response
- provides assurance regarding the delivery of the Trust's Patient and Family Experience Strategy
- monitors performance against a range patient experiences activities and metrics and provides assurance to the Quality Governance Group (QGG) on compliance.

The Trust takes part in a series of national patient surveys as required by the Care Quality Commission (CQC) and NHS England for all NHS acute Trusts in England. During this reporting period, the Trust received results for the Urgent and Emergency Care 2024 survey which demonstrated a response rate slightly above the national average and that the Trust scored 'about the same' as other trusts. It identified areas where patient experience was best and where patient experience could improve.



NHS

CareQuality Commission

2024 Urgent and Emergency Care Survey

A&E Departments (Type 1 services) results for Countess Of Chester Hospital NHS Foundation Trust

Where patient experience is best

- ✓ **Information:** Patients given information about new medications to be taken at home.
- ✓ **Hospital environment:** Patients able to get food or drinks whilst in A&E.
- ✓ **Care and treatment:** Staff helping to control patients' pain.
- ✓ **Communication and compassion:** Patients having confidence and trust in doctors and nurses treating them.
- ✓ **Communication and compassion:** Doctor / nurse explaining condition or treatment in a way patient can understand.

Where patient experience could improve

- **Waiting:** Keeping patients updated on wait times for being examined or treated.
- **Privacy:** Patients being given enough privacy when discussing their condition with the receptionist.
- **Waiting:** Staff providing help with patients' conditions or symptoms while waiting.
- **Care after leaving A&E:** Staff discussing further health or social services patient may need after leaving A&E.
- **Care after leaving A&E:** Patients told who to contact if they have concerns with their condition after leaving A&E.

Adult Inpatient 2023 survey results were published in August 2024 demonstrating a consistent picture with previous years. Most respondents reported a positive experience in their interactions with doctors and nurses, such as being treated with respect, dignity, kindness and compassion and being included in conversations. Discharges from hospital were highlighted as being a challenging part of a patient's experience along with experiences of hospital waiting times.

The National Cancer Patient Experience Survey 2023 results were published in July 2024 and again showed positive results. In all bar 5 questions, the Trust was in the expected range or above the expected range, Actions are in place to improve the 5 questions that were scored less than the expected range.

The Maternity 2024 report was published in November 2024 and shows continued improvements. In comparison with other Trusts we scored better than expected in three outcomes and about the same in all others.

The purpose of these surveys is to understand what patients think of healthcare services provided by the Trust, and actions plans are developed to drive improvements

The Trust also asked patients and service users to rate their overall experience by completing the Friends and Family Test (FFT). The Trust has re-introduced the FFT survey using SMS text and interactive voicemail messaging and postcards to increase the opportunity for all patients to provide feedback.

All patients discharged from the Emergency Department, patients who have completed an Outpatient clinic attendance, Day Case attendance or are discharged from a ward are asked to complete the Friends and Family Test question. People who are using Maternity Services are also asked on four occasions along their maternity pathway. Patients are also asked why they gave their rating, and to leave feedback on what is being done well and ways to improve.

During this reporting period responses from inpatients accessing services were just short of the 94% positive response rate national target. In the Emergency Department patients acknowledged the challenges in the Emergency Department care but communication and attention they received from staff as the most important component of their care. The Emergency Department exceeded the national target of positive responses in over 6 months of the year.

“Fantastic caring staff, welcoming and kind. it was a relaxing, homely ward, a special place
Ellesmere Port Hospital

‘Very good experience from start to finish. The procedure was explained to me in a way that was understood. The nursing staff who looked after me were fabulous.’
Surgery

‘Midwives and every member of staff were so approachable and supportive which made the whole planned c section experience a very calm, well organised experience which put me at ease the entire time!’
Obstetrics

‘The service I received was amazing as was the staff, thank you.’
Antenatal

*“***The Doctor in the A&E department was amazing with our son she couldn’t have done any better. Thank you**
Emergency Department

All feedback is regularly reviewed by service and clinical managers. Patients regularly report that staff are the most important component of their care.

The Trust has also engaged with external partners about the quality of care provided.

The Countess of Chester Hospital receives patient experience feedback on a quarterly basis from

Healthwatch. These comments are drawn from engagement with the public through various forms, including events at different locations, comment cards, meetings, online and telephone enquiries. The feedback is provided in verbatim format. Feedback received is anonymous, and in many cases the individual wants their comment to be noted by the organisation or provider. All feedback is reviewed.

The Non-Executive Directors (NEDs) and Governors have a rolling programme of walkabout visits across the Trust, spanning clinical and non-clinical areas. These visits provided an opportunity for the Non-Executive Directors and Governors to meet staff and patients, and observe the services provided.

The Trust has launched and embedded its Patient and Family Experience Vision. Each ward and department present their progress with the six steps of patient and family experience as part of the ward accreditation programme.

Culture and Civility

Delivering outstanding care for our patients is supported by staff feeling equally well cared for at work.

Embedding the themes of the NHS People Promise and increasing staff engagement and morale is important for the organisation and a culture of civility is a key part in achieving this.

We remain focused on our culture and following a period of staff engagement and development of supportive resources, we have launched a Trust civility statement.

‘We will always treat everyone with respect and kindness, be polite and professional, listen to them and help each other whenever we can’

We have launched a linked Civility Handbook, available both as a digital resource on the intranet and a pocket handbook for staff to have access to it away from a computer. We have also updated a number of our People policies to reference civility to enable action to be taken to address uncivil behaviours.

We are seeking to embed civility in all that we do and are supporting staff and teams with access to training in what incivility looks like, what might lead to uncivil personal behaviours and how to manage this for themselves. The training also includes how to be an active bystander and to positively take action to address incivility where they see it.
This training is available in a range of formats.

As a Trust we are committed to creating a positive working environment for our staff, to tackling uncivil behaviours and empowering our staff to take action on observing these behavior’s, encouraging escalation of issues as appropriate and providing support where needed.

Equality Delivery System

In August 2022, NHS England published a revised version of the Equality Delivery System (EDS). This is a tool that requires NHS organisations to collate evidence against several outcomes

relating to Equality, Diversity, and Inclusion (EDI) and health inequalities. The assessment has both employee and patient-facing elements. Evidence is then required to be graded by a range of key stakeholders. The Trust reported its EDS assessment report for 2024/25 in February 2025.

A comprehensive summary of the annual EDS assessment for 2024 demonstrated that the Trust has made significant progress, with 10 outcomes rated as "Achieving" and one outcome rated as "Developing," compared to the previous year when 7 outcomes were rated as "Developing" and 4 as "Underdeveloped"

A number of positive areas where highlighted through the assessment. While wellbeing initiatives have been strengthened, staff survey responses highlight areas needing further attention. Leadership efforts were evaluated across three outcomes, with an overall score of 6 (2 out of 3 for each outcome). Improvements in leadership visibility and accountability were noted as key contributors to this score.

Under Domain I, organisations are required annually to select 3 service areas to be assessed against 4 patients facing outcomes. To determine services to be reviewed under Domain 1, consideration was given to services that are performing well on EDI, as well as those relevant to the Core20Plus5 approach to tackling health inequalities. The services chosen to be reviewed were:

- Complaints Service
- Patient Safety Services
- Translation and Interpretation services

Under Domains II and III, the areas of Workforce Health & Wellbeing and Inclusive Leadership are assessed.

Undeveloped activity – **organisations score out of 0** for each outcome	Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped**
Developing activity – **organisations score out of 1** for each outcome	Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing**
Achieving activity – **organisations score out of 2** for each outcome	Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving**
Excelling activity – **organisations score out of 3** for each outcome	Those who score **33,** adding all outcome scores in all domains, are rated **Excelling**

The Trust received an overall rating of 'Developing' which is an improvement on the previous year. Whilst the Trust's overall rating has improved, there was recognition of the Trust's understanding and commitment to improving its position.

Part 3: Other information

3.1 Overview of progress made against our 2024/25 Quality Priorities

The tables below provide detail on achievement against each quality priority. Out of the nine quality priorities eight have been achieved in full, and the remaining one has been partially achieved and will continue to be monitored to achieve compliance.

Delivering Safe Services

Priority	Measure of success	Achievement	Progress update
Priority1: Reduce the Clostridium difficile (C diff) infections Data collection via the national HCAI data capture system.	Reduction in the number of Cdiff infections 2023/24 cases: 77	2024/25 NHSE Target: 73 2024/25 cases: 83	Across the West Cheshire Health Economy, the prevalence of both Cdiff infections increased during the year. The increase in community cases was notable, with increases in Cdiff infections 40% higher than the previous year. The rise in cases associated with the Trust were lower with an 8% increase in Cdiff infections.
Priority 2: Reduction in incidence on unwitnessed inpatient Falls Data collection via Datix Incident Reporting System.	Reduce the number of unwitnessed falls 2023/24 unwitnessed falls: 656	2024/25 unwitnessed falls: 615 173	There is clear evidence of strong and consistent work across the Trust in reducing falls, underpinned by a commitment from teams to deliver improvements with consistency, reliability, and long-term sustainability. While unwitnessed falls remain the most common category across all Divisions, we have achieved an organisational reduction in these incidents compared to the previous year. In 2023/24, there were 656 unwitnessed falls, compared to 615 in 2024/25 - a 6.25% reduction. It is important to note that the 2024/25 data includes an additional ward that was not operational in the previous year. The development of a dedicated falls dashboard, monitored through the Safer Mobility Steering Group, has enabled in-depth data analysis. This has supported Divisional teams in taking targeted action to reduce unwitnessed falls, including identifying high-incidence wards and peak times for falls. These insights have informed reviews of staffing models and the implementation of bay tagging processes to increase the visibility of patients at risk. The organisational scorecard continues to demonstrate year-on-year improvement in falls-related documentation. Notable progress includes increases in the number of patients with personalised falls care plans, timely medical reviews, and access to specialist falls prevention equipment.

Priority	Measure of success	Achievement	Progress update
			To further strengthen our approach, a Medical Devices Safety Officer has been appointed. This role will enhance the governance and management of falls prevention equipment across the Trust. Additional initiatives have focused on preventing deconditioning by promoting safer mobility and activity, as well as reducing the availability of caffeinated drinks, which can contribute to urinary urgency and increased fall risk. To support continuous learning, a post-falls review document has been integrated into Datix. This facilitates immediate review, reflection, and wider shared learning across the organisation to help prevent future incidents.
Priority 3: Continue reduction in pressure ulcers and Moisture Associated Skin Damage (MASD) including those who come in from nursing homes Data collection via Datix Incident Reporting System.		Pressure Ulcers 2024/25: 14.7% reduction in Hospital Acquired Pressure Ulcer (HAPU) compared to previous year. Pressure Ulcers On (POA)Admission has reduced by 29% MASD incident reported have increased	Collaboration work with the community Tissue Viability Team is in progress with an interorganisational Tissue Viability discharge proforma being used and a Wound Care passport is in development. With regards to Moisture Associated skin damage (MASD), a large amount of work is in progress with the development of a pathway for all clinical areas to be launched in the coming months to the delivery of a National MASD awareness event that was held in March. A full organisational Foam mattress audit has also been undertaken, with the results to follow shortly. Coming up in future months is a campaign called CPR for feet which the Tissue Viability Team aim to implement to encourage the prevention of pressure ulcers for heels. The new weekly Pressure Ulcer Review meeting now in place where each pressure ulcer is reviewed and any lapses in care identified. Increased confidence in reporting these and will use this year as a benchmark going forward.

Delivering Effectiveness Services

Priority	Measure of success	Achievement	Progress update
Priority 1: Braden assessment within 6 hours Data collection via Electronic Patient Record and PTL.	Increased number of patients having a Braden assessment within 6 hours 2023/24Braden 6 hours: 65.4%	2024/25: 74.67%	The Braden Scale is a risk assessment tool used in healthcare to predict the likelihood of a patient developing a pressure ulcer. It evaluates six key factors that contribute to pressure ulcer risk: sensory perception, moisture, activity, mobility, nutrition, and friction/shear. A lower total Braden Score indicates a higher risk of developing a pressure ulcer. The Pressure Ulcer Improvement group have driven the education to support the completion of Braden within 6 hours. The Trust has participated in the non-mandatory CQUIN: Assessment and documentation of pressure ulcer risk. Braden assessment consistently scored above 92% on the randomly sampled 100 patients per quarter. The Trust has seen a slow but steady improvement in the 6-hour target of all patients having a Braden assessment completed. At the end of the year our compliance was 74.67 (Broken down to 89.69% inpatient and 63.64% in the Emergency Department
Priority 2: MUST assessment within 6 hours Data collection via local Care Metric audit.	Increased number of patients having a MUST assessment within 6 hours 2023/24 results: MUST 6 hours overall: 8.1%	2024/25 MUST Assessment Within 6 Hours: 43.7% 24-hour target 67.33%	MUST' is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines which can be used to develop a care plan. There has been a Trust-wide focus on improving the MUST compliance, including the work undertaken in the compliance with the 6-hour internal Trust Target which has increased by 35% to an overall compliance of 43.7%. This can be broken down to inpatient compliance at 76.29% and in ED 19.9%. the national target compliance rate is set at completing a MUST within 24 hours – and for this national target the Trust compliance is 67.33%. There has been significant improvement in both Inpatient and ED compliance whilst recognizing there is still work to do to reach the National target. The increased awareness of the importance of MUST screening across the Trust in

Priority	Measure of success	Achievement	Progress update
			various educational forums has driven compliance.

Priority	Measure of success	Achievement	Progress update
Priority 3: Work towards 7-day Urgent Treatment Centres / minor services in Same Day Emergency Care	7 days working in urgent treatment centres / minor services in Same Day Emergency Care		In April 2024, the Urgent Treatment Centre moved to the first floor of the SDEC building. Over 25,000 patients have attended UTC in the last 12 months which equates to 30% of ED attendances overall. In August 2024, UTC opening hours increased to 7 days per week (8am-8pm minor illnesses and 8am-10pm minor injuries).

Delivering Kind and Compassionate Services

Priority	Measure of success	Achievement	Progress update
Priority1: Patient and Family Experience Strategy: Trust	Using the six steps every day to support our patients and focus on their personal experiences.	Clean and safe Environment Oliver McGowan Training Critical Care Diaries	PLACE (Patient Led assessment of the Care Environment) has been undertaken and provides an assessment of how an organization is performing against a range of non-clinical activities, all of which impact the patient experience. In the 2024 PLACE assessment, patient representatives reported an increased satisfaction overall, in particular the ward areas. The Trust is working with the regional teams against a trajectory for compliance with Oliver McGowan training in respect to the requirement for all staff to receive a minimum of live and interactive training that is co-produced and co-delivered by people with a learning disability. This is in addition to being a compulsory e-learning module for all staff. Current compliance with this is 89%

			Patient Diaries in Critical care: All Level 3 patients have a diary started on admission. The Critical care outreach team monitors the diaries whilst the patient is on ITU and then supports the patients receiving the diaries when stepped down from the Critical care. At the Critical care follow-up clinic the team, there is a discussion about their diary and how effective and helpful it was in their recovery. Feedback has been consistently positive
Priority 2: Patient and Family Experience Strategy: Emergency Department)	Using the six steps every day to support our patients and focus on their personal experiences.		The Emergency Department has focused on several key areas within the Patient and Family Experience Strategy. **Waiting times**, including updates on wait times and lack of refreshments while waiting The department is now utilising the recently implemented Tannoy system to provide updates to the waiting room regarding specific waiting times. There is also a scripted message to the whole department that details what patients should expect whilst in the department. This includes their named nurse introducing themselves, offering pain relief, how to raise a concern to the NTL and Matron assigned to that day. The housekeeper also uses Tannoy to inform the department when meals have arrived. This message asks all nurses to ensure that patients are sat up and ready to receive their meal. **Attitude of staff** The leadership team are compiling roles and responsibilities for all staff in order to enforce expectations of staff. The leadership team has commenced structured one-to-one meetings with all of the band 7's who each have a hierarchy of staff where they are accountable for relaying specific messages to staff. These changes will support the team in understanding expectations and in taking accountability. **Analgesia** The department has ordered drawers for medication carts which will be stocked with analgesia and antibiotics amongst other commonly administered medications. This will reduce time to queue for medications and mitigate

			unnecessary time and motion in leaving areas of the department to use the Omnicell.
Priority 3: Patient and Family Experience Strategy: Maternity	Using the six steps every day to support our patients and focus on their personal experiences.		Following the introduction of the Patient and Family Experience Strategy for Maternity Services, the division launched the Women's and Children's strategy in June 2024, with the appointment of the Maternity and Neonatal Voices Partnership lead which was successful in July 2024. A listening and engagement event was held in both Maternity and Paediatric services to learn from patients and families. Following the publication of the National Survey findings the division has increased its ward visiting times for birth partners. Maternity has maintained its high ratings in the Friends and Feedback Test (FFT) and is working towards improving the ratings in Paediatrics. Overall, there has been a reduction in the number of reported complaints and concerns raised.

3.2 Performance against the relevant indicators and performance thresholds

Indicator	Target	Performance	Explanation
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	**92 %**	**48%** March 2025	National NHS Operational Planning standards in 2024/25 prioritised the reduction of RTT long waits and specifically focused on one key measure: the delivery of zero open RTT pathways over 65 weeks by the end of March 2025. The Trust made significant progress against this, finishing the financial year with zero RTT 65-week breaches due to lack of service capacity on the COCH site. Looking forward, the Trust will focus, in line with 25/26 NHS Operational Planning standards, on improving its overall RTT 18-week compliance to 60% by financial year end.
A&E: maximum waiting time of four hours from arrival to admission/ transfer/ discharge	**76%**	**60.1%** March 2025	The Trust delivered an annual average performance of 59.5%, however, performance did improve in quarter 4 (average of 60.6%). The Trust, along with West Cheshire system partners, developed and implemented an Urgent Emergency Care (UEC) programme to support patient flow improvements. Workstreams have been established to focus on specific points of a patient's hospital journey, starting in the community (admission avoidance') through to discharging of inpatients requiring ongoing health or social care services. Whilst involved in all the UEC programme workstreams, the Trust have led on initiatives to support: - increased utilisation of our Urgent Treatment Centre and Same Day Emergency Care Unit to minimise congestion within the ED - improving our Emergency Care triaging and streaming processes to enable patients to be seen quicker and in the best location. - Reducing our length of stay on the wards through improving the effectiveness of ward-based discharge processes.

All cancers: 62-day wait for first treatment	**85 %**	**77.8%** (February 2025, latest figures)	Whilst the Trust has not delivered against the 85% target, its performance continues to improve and has consistently been significantly better than the national provider average e.g. Feb 25: COCH- 77.8%, national average- 67%. Whilst all cancer tumour sites have ongoing improvement plans to support improved access to treatment, specific focus continues to be paid to supporting access to Urology cancer services.
Maximum 6-week wait for diagnostic procedures	**99 %**	**89.3%** March 2025	Overall diagnostic performance continues to perform well, despite various challenges. MRI and Barium enema diagnostics are achieving >99% as of March 2025. CT and Ultrasound are at 97.6% and 97.4% respectively. Both are challenged in terms of rising demand and workforce pressures. Plans are in place to address. Trust performance against the diagnostic standard (DM01) of having <1% of diagnostic referrals exceeding a 6-week waiting time is a pressure in some areas, but the numbers are reducing. The numbers of patients waiting over 6 weeks was 14.4% in February 2024 and was at 12.7% in March 2025.

3.3 Progress against seven-day hospital service

It is important to ensure timely access to expertise and diagnostic tests whenever patients may need them. The seven-day hospital services (7DS) clinical standards were developed to support hospitals to deliver high quality care and improve outcomes on a seven-day basis for patients admitted to hospital in an emergency. From 2018, all NHS Trusts have been required to report their activity and progress towards delivering high quality and consistent levels of service and care seven days a week. There are 10 defined standards for seven-day services, of which NHS England classifies four as key standards:

The four key standards are:

- Standard 2 – Time to first consultant review
- Standard 5 – Access to diagnostic tests
- Standard 6 – Access to consultant-directed interventions
- Standard 8 – Ongoing review by consultant twice daily if high dependency patients and daily for others.

The NHS is responsible for ensuring that these standards are met, and they are part of the NHS Standard Contract.

The current position at the Trust is as follows:

Standard 2: Time to consultant review: all emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of their admission to hospital.

- This standard is met for over 90% of patients.
  - Ears, Nose and Throat (ENT) provide a Mon-Fri service, with weekend consultants covering three sites so this is not currently achievable.

Standard 5: Diagnostics: hospital inpatients must have scheduled seven-day access to diagnostic services, consultant directed diagnostic tests and completed reporting will be available seven days a week.

- Microbiology: available on weekdays and weekends through formal arrangement. Ultrasound, MRI, and CT: available weekdays and weekends through a mix of on and off-site formal arrangements
- Echocardiography: available on weekdays, not routinely at weekends.

Standard 6: Consultant Directed Intervention: Hospital inpatients must have timely 24-hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines.

- Critical Care Consultant: available weekdays and weekends
- Interventional radiology: available weekdays and weekends through a mix of on and off-site formal arrangements
- Interventional Endoscopy: available on weekdays and weekends through a mix of on and off site by formal arrangement
- Emergency Surgery: available weekdays and weekends

- Emergency renal replacement therapy: available weekdays and weekends
- Urgent Radiotherapy: available weekdays and weekends through a mix of on and off-site formal arrangements
- Stroke thrombosis: available weekdays and weekends.
- Percutaneous Coronary Intervention: available weekdays and weekends off site through formal arrangement
- Cardiac pacing: available weekdays and weekends through a mix of on and off-site formal arrangements
- This standard is partially met.

Standard 8: Ongoing review by consultant twice daily for high dependency patients and once daily for other patients:

- This standard is met in Maternity via the required Ockenden Ward Rounds
- This standard is met for Critical Care
- This standard is partially met for all other inpatients.

3.4 Freedom to Speak Up

The Freedom to Speak Up Guardian holds a stand-alone post with ringfenced time allocated to undertake the duties as outlined by the National Guardians Office (NGO). Registered with the NGO, the FTSU Guardian engages with NGO annual update training and actively participates in the monthly Regional Guardians Network meetings. These provide learning and development, peer support and an opportunity to influence the national FTSU agenda. In addition, the FTSU Guardian is supported by both an Executive and Non-Executive Director lead, with quarterly reporting to the People Committee and a 6 monthly report to the Board of Directors.

In May 2023 an independent peer review of the FTSU arrangements was commissioned. Recommendations for further development were reported, all of which have been completed. The Board of Directors completed a self review toolkit against FTSU requirements during 2024/25. An ongoing review of the delivery of the FTSU strategy priorities will continue as part of the monthly meetings with the Executive Director lead with assurance provided through the reporting to the People Committee and the Board.

FTSU Activity

Cathy Chadwick, Chief Operating Officer and Paul Jones Non-Executive Director continue to support the FTSU Guardian. The Executive lead, Chief People Officer and the FTSU Guardian convene monthly to review cases of concern that have been escalated to HR services to ensure timely conclusions and improve greater triangulation of data that provides fuller triangulation meetings when cases of concern involve HR services. Support and service review meetings between the Executive lead and Guardian are held monthly as a minimum.

FTSU Mandatory Training

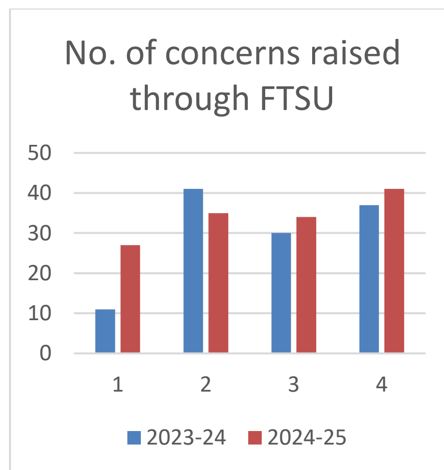
‘Speak Up’ training compliance is now at 92.43% with ‘Listen Up’ at 83.52% (an increase from 69.12%, from September 2024). The FTSU Action Plan indicates 90% compliance required.

'Follow Up' training which is mandated for Board members currently stands at 100% compliance.

Staff Group	Speak Up Compliance %	Listen Up Compliance %
Add Prof Scientific and Technic	97.08%	89,05%
Additional Clinical Services	94.46%	85.69%
Administrative and Clerical	95.93%	89.82%
Allied Health Professionals	98.18%	91.52%
Estates and Ancillary	60.79%	42.92%
Healthcare Scientists	94.90%	81.63%
Medical and Dental	88.94%	76.14%
Nursing and Midwifery	97.77%	90.71%

Assessment of FTSU Concerns 2024-25

The Trust has several safety reporting channels such as speaking directly to line managers, incident reporting and team and Trust safety huddles. Issues raised in other channels are not logged as FTSU unless referred to or raised directly to the FTSU Guardian or champions.



The themes of the FTSU concerns raised are categorised in line with the NGO guidelines and detailed in the table below with comparative data from the previous year.

Table A: Comparative Themes

Themes of concerns	Q1 (2023/24)	Q2	Q3	Q4	Q1 (2024/25)	Q2	Q3	Q4
Patient safety or quality	4	2	10	17	8	17	13	3
Worker safety or wellbeing	9	19	20	23	14	21	16	7
Bullying or harassment	5	19	10	18	6	4	1	0
Poor attitudes and behaviours	10	28	21	29	19	18	21	21
Detriment from speaking up	0	1	2	4	0	0	0	0

Half of all the concerns received by the guardian during the first three quarters of this year were raised by either a registered nurse or midwife.

There is a significant decrease in colleagues citing Bullying and Harassment as part of the concern raised during 2024-25 and with none citing detriment.

Poor attitudes and behaviours continue to be the largest cause for concern, with poor communication being identified as a contributory factor in all.

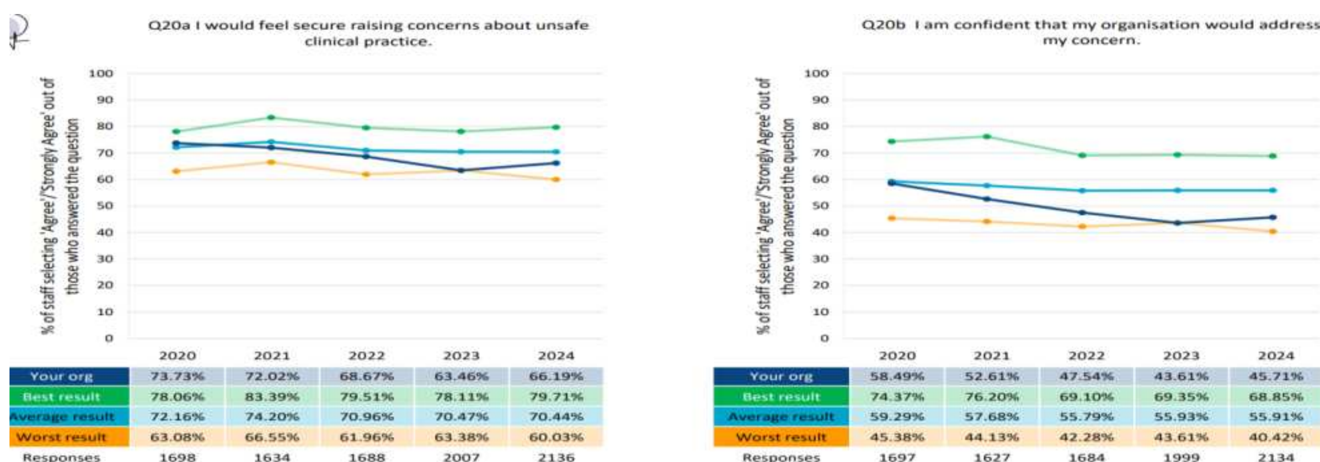
The fear of detriment has prevented further escalation of concerns in some cases.
Limited if any feedback from managers is the sole reason for reaching out to FTSU when concerns have previously been discussed at department/ward level.

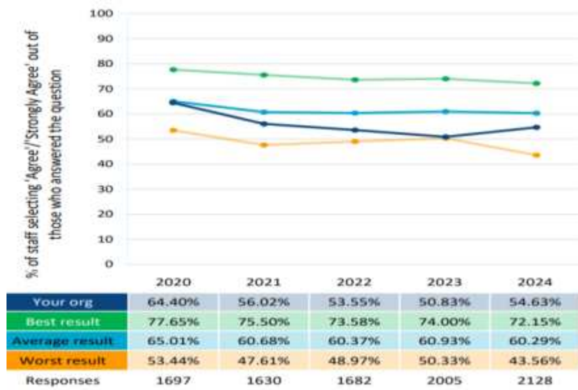
A total of five concerns were raised anonymously during this period, four of which related to one particular concern. This is below the national average as published by the NGO.

In February the first FTSU workshop for managers was held. The FTSU Process Chart underpinned the learning with a particular focus on listening, supporting, action and feedback. A further four sessions are planned for May/June at Ellesmere Port Hospital and will include managers from nursing and therapies. It is hoped that these will be rolled out across the wider Trust and go some way to addressing the process by which concerns are managed and feedback provided,

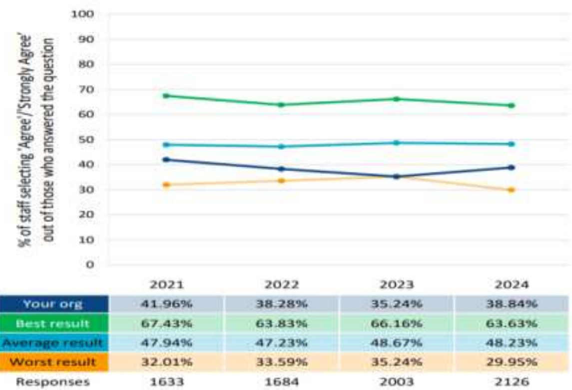
NHS Staff Survey

The 2024 NHS Staff Survey results were published and although the four questions within the survey do not specifically relate to Freedom to Speak Up, they do provide some insight into staff perception and therefore a valuable tool in which to consider how we might best improve speak-up culture.





	2020	2021	2022	2023	2024
Your org	64.40%	56.02%	53.55%	50.83%	54.63%
Best result	77.65%	75.50%	73.58%	74.00%	72.15%
Average result	65.01%	60.68%	60.37%	60.93%	60.29%
Worst result	53.44%	47.61%	48.97%	50.33%	43.56%
Responses	1697	1630	1682	2005	2128



	2021	2022	2023	2024
Your org	41.96%	38.28%	35.24%	38.84%
Best result	67.43%	63.83%	66.16%	63.63%
Average result	47.94%	47.23%	48.67%	48.23%
Worst result	32.01%	33.59%	35.24%	29.95%
Responses	1633	1684	2003	2126

These results are encouraging and suggest a more open and supportive culture is developing. However, there is still more that needs to be done to improve the confidence of our colleagues to speak up, how these concerns are responded to, the quality of feedback provided and identification and dissemination of learning.

Freedom to Speak Champions' Network

During 2024/24 the Champions network has increased 70 Champions.

Champions are required to have completed their mandatory training for FTSU, undertaken pre-training reading, gained support from their line manager through receipt of a signed 'Managers Pledge, attended a three-hour face to face group training session and be committed to the values of the Trust. There is then a requirement to attend bi-monthly network meetings and engage in bi-annual support one-to-one meetings with the guardian.

Having such a large and diverse network of champions supporting the work of the guardian provides an even greater choice for colleagues who are unsure who or how to raise a concern. Champions are a voice within their own teams, taking time to share information at team meetings and during new staff inductions.

During 2024 champions made 359 individual contacts with colleagues and undertook 51 activities that supported and promoted speaking up. In total these reached over 1,000 colleagues.

3.5 NHS doctors and dentists in training

Medical staff vacancies are monitored and managed by the divisions. Where national training posts are unfilled or occupied by less than fulltime trainees, the gaps are mitigated by a combination of long-term locum, bank, and agency staff. Due to the nature of the regional rotational posts, it is a constantly changing number. Where known workforce pressures exist, the Trust utilises locally employed doctors to support doctors in training rotas and to maintain a safe staffing establishment. The Trust has an excellent reputation for supporting locally employed doctors in integration into NHS jobs and in their aspirations to enter UK training programmes.

Working time and conditions are monitored and supervised by the Guardian of Safe Working.

ANNEX 1: Statements from commissioners, local health watch organisations and overview scrutiny committees

Statement from NHS Cheshire and Merseyside Integrated Care Board – Response to Quality Account April 2024 to March 2025

NHS Cheshire and Merseyside Integrated Care Board (ICB) have worked closely with Countess of Chester Hospital NHS Foundation Trust (COCH) throughout 2024/25 and recognise the achievements made with regards to quality throughout the year.

With regards to 2024/25 achievements, we note the launch of the trans-nasal endoscopy service and the impact this has on patient experience and length of stay. The blue skies balcony for patients on the intensive care unit is really positive and will support patients and families during a difficult time, we look forward to hearing about its progress in the 2025/26 account.

The opening of the Same Day Emergency Care (SDEC) unit in May 2024 has provided great opportunities to support the pressures on the Emergency Department and improve the experience for patients.

The Trust's commitment to the implementation of the Patient Safety Incident Response Framework (PSIRF) is appreciated, we will continue to support COCH as the framework is embedded and we value the development of Patient Safety Partners being recognised as a Quality Priority for 2025/26. The achievements against the identified quality priorities have been built on significant work, fully achieving eight out of the nine priorities. We will be working with COCH throughout 2025/26 to support completion of the final priority related to the reduction of clostridium difficile infections.
The collaborative work with the community Tissue Viability Team to address Pressure Ulcer reduction is positive and reflected in the reduced numbers of Pressure Ulcers on admission. This is further supported by the work within the Trust related to the compliance with Braden assessment tool being completed within six hours.

The patient and family experience work that has been undertaken across the Trust, within the Emergency Department and the Maternity division reflects a positive culture of engaging and listening to patients and their families and improving their experience, this is reinforced the reduction in complaints.

The Trust active clinical audit programme and use of appropriate data collection has been described within the account and assures oversight of clinical effectiveness. The improvement journeys described around; The Neonatal Unit, Paediatric Diabetes Service, excisional margins of skin cancer and anaesthetic handovers to theatre recovery teams, are each commendable. We will work closely with the Trust to understand more of the clinical audit findings requiring action during 2025/26 and support this delivery to allow further improvement journeys to be presented in the next quality account.

The Trust's open learning culture is evident in the account, which outlines a number of learning opportunities, as well as effective practice, that have been identified in relation to mortality. We will again work closely with the Trust to oversee the improvements made against these opportunities for improvement.

Finally, it is recognised that the individual effort of staff and teams within the Trust make a huge impact to patient care. This is strongly recognised within the account through the highlighted achievements and patient feedback. It is also positive to see the recognition of the importance of a healthy and happy workforce with the opening of the staff wellbeing hub with a dedicated team to provide wellbeing support.

Chris Douglas MBE (she/her)
Executive Director of Nursing & Care
NHS Cheshire and Merseyside ICB

Statement from Healthwatch Cheshire

Due to the timeframe in the Trust sharing the Quality Accounts, Healthwatch could not comment.

Statement from Health Scrutiny Committee, Cheshire West and Chester Council

As Chair of Cheshire West and Chester Council's Health Overview and Scrutiny Committee, I am writing to submit the Committee's statement which is to be included in the Countess of Chester Hospital NHS Foundation Trust's Quality Accounts for 2024/25. The draft Quality Account for 2024/25 were considered by the Health Overview and Scrutiny Committee at its meeting held on 17 June 2025.

The Scrutiny Committee were grateful to yourself and your senior officers who took the time out of their busy schedules to attend the meeting and for presenting the accounts and for answering questions.

I would like to make following comments:

Whilst the Quality Accounts for 2024/25 were very detailed and comprehensive, the Scrutiny Committee did not find them, as laypeople, easy to read and understand. It was felt that some of the statements were vague and lacked evidence on what improvements the Trust had actually made during that financial year compared to the previous year and whether the prioritises from last year had been achieved. The accounts included lots of statements but there was limited evidence to justify and support them. Healthwatch Cheshire also commented on who the intended audience of the accounts were and the Scrutiny Committee requested that for next year the format and style be reviewed so that clear evidenced improvements could be included. The Trust assured the Scrutiny Committee that its improvements were regularly monitored through its Business Intelligence Dashboard.

The Scrutiny Committee was disappointed to hear that following an unannounced inspection of urgent and emergency care services, which took place in February 2025, a formal notification of a warning notice had been received. Members were assured however, that an Action Plan had been progressed at pace to deliver the improvements needed and the Committee requested a further update on this be presented to the 10 September 2025 Committee meeting.

Members were pleased to hear from the Trust's presentation that many improvements had been made during 2024/25 including in the reduction of falls and pressure ulcers, the number of patients receiving the MUST assessment within 6 hours had increased aswell as several areas within the delivering kind and compassionate services priority.

Several Members of the Scrutiny Committee had visited the hospital's new Same Day Emergency Care Unit (SDEC) in March 2025 and were very impressed with the facility and were pleased to hear that it had already treated over 28,000 patients. They were also pleased to hear that the Countess' Urgent Treatment Centre was now operating 7 days per week. However, concerns were raised that wait times in the Emergency Department (ED) were still long and that the SDEC, at busy times, appeared to being used to accommodate Emergency Department Patients overnight, to reduce wait times in the ED Unit and as an overflow facility. The Committee did note that the number of patients at the Countess' ED Unit had increased last financial year and in Cheshire West there were no "walk-in" facilities available. A breakdown on the percentage and number of patients referred to SDEC from A&E, GPs and Ambulances was requested. Healthwatch Cheshire also advised that it too had been made aware of long waits in the Countess' Emergency Department and SDEC. The Trust mentioned that it had trialled SDEC opening over the weekend but found it wasn't receiving patients from GP's during this trial period. The Committee has subsequently requested details of this trail and its findings and how this was

communicated to the GPs prior to commencement.

Given the long waits in the Countess' Emergency Department assurance was given that all new patients were being triaged within 15 minutes of their arrival, especially those with suspected Sepsis. The Committee has subsequently requested that it receives the data to support that patients are being triaged within 15 minutes.

The increase in the number of patients the Trust had treated/cared for during 2024/25 was noted by the Committee and that some of the 23,000 patient increase was a result of the Coronavirus Pandemic, in that their outpatient services during 2021 and 2022 had not been as productive but has since been on a recovery journey.

The Scrutiny Committee was pleased to hear that the Trust was working with partners to reduce the number of patients who come under the Non Criteria to reside

at the hospital but Members still felt the numbers were still high and that there was a mis-match of information provided regarding the figures.

Patient flow around the hospital and Ambulance Handover times (as reported in North West Ambulance Services' Quality Accounts 2024/25) were still a concern for the Committee. Handover times during the Winter Peak had reached 110 minutes but the Trust assured members that these were now averaging 30 minutes. During their recent visit to the Emergency Department, Scrutiny Councillors had witnessed patients being cared for in corridors but assurance was provided that there were very few patients in corridors today. A concern was also raised around the challenges patients experience with on-site parking and accessing the Emergency Department especially with sick and immobile patients.

The Committee was pleased to hear about the Trust's new online communication tool which enabled hospital patients to access their health information at all times. NHS England had mandated Trusts to implement the new system and assurance was provided that support was available to those less enabled patients to access their records.

Following a question relating to the 'selection of cases for review', 69 mortality reviews which were undertaken in March 2024 compared to the 151 in March 2025, the Trust confirmed that any mortality incidents at their hospital were reviewed by the Medical Examiner and that following the implementation of a new process, more Mortality reviews were now being undertaken.

The Quality Accounts referred to patient hydration being a priority for 2025/26 and the Trust advised that this was a result of some reviews which had identified an increase of patients with E.Coli infections and issues relating to catheters being fitted.

A question was raised by the Committee as to why the Trust had only achieved 40% of the target for National Neonatal Audit Programme (NNAP) - screening for ROP on time when the national average was 78.4% and a report back on this was requested.

Due to time constraints at the meeting on 17 June, there were several questions which the Scrutiny Committee did not get chance to ask but written responses have been requested.

Following the Care Quality Commission's inspection in October/November 2023 where the Trust received a "requires improvement" judgement, the Health Overview and Scrutiny Committee has recently had oversight of progress made with implementation of its Improvement Plan. The Committee will request that it receives its next update on 10 September 2025, and it has also asked for an update on inspection of urgent and emergency care services. Due to the ongoing criminal investigation into incidents at the Maternity/Neonatal Hospital, the Health Overview and Scrutiny Committee has not included anything in relation to this topic on its agenda until after the appeals/investigations have concluded.

Despite the above comments, the Health Overview and Scrutiny Committee agreed that the Countess of Chester Hospital Trust had made good progress and delivered many achievements during 2024/25 but it felt more still could be achieved. The Committee was pleased to hear that the Trust was very responsive to any recommendations for improvement made by Cheshire Healthwatch.

The Health Overview and Scrutiny Committee would like to formally put on record its thanks and appreciation to all the staff who work across the Trusts' sites and for their dedication and hard work in caring for our Cheshire West residents. The Committee acknowledges the ongoing pressures and financial challenges the NHS and Trust are currently facing. The Scrutiny

Committee hopes that the Trusts accepts its comments and Members look forward to receiving further updates in the near future.

Katie Kendrick

Councillor Katie Kendrick OBE

Chair

Health Overview and Scrutiny Committee.

ANNEX 2: Statements of directors' responsibilities for the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS England has issued guidance to NHS Foundation Trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS Foundation Trust boards should put in place to support the data quality for the preparation of the Quality Report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- The content of the Quality Report meets the requirements set out in the NHS foundation Trust annual reporting manual 2024/25 and supporting guidance Detailed Requirements for Quality Reports 2024/25
- The content of the Quality Report is not inconsistent with internal and external sources of information including.
    - Board minutes and papers for the period April 2024 to March 2025
    - Papers relating to quality reported to the board over the period April 2024 to March 2025
    - feedback from commissioners,
    - feedback from governors,
    - feedback from local Healthwatch organisations
    - feedback from Overview and Scrutiny Committee
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
    - the 2022 national patient survey, published in 2024.
    - the 2023/24 Head of Internal Audit's annual opinion over the Trust's control environment
    - Care Quality Commission Inspection, published 2024
- The Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered.
- The performance information reported in the Quality Report is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice.
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- The Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report

The directors confirm to the best of their knowledge and belief they have complied with the

above requirements in preparing the Quality Report.
By order of the board 30th June 2025:

Jane Tomkinson OBE

Chief Executive

Neil Large

Chairman

Countess of Chester Hospital NHS Foundation Trust

Council of Governors
17th July 2025

Report	**Agenda Item 16.**	**Council of Governors action plan update**						
Purpose of the Report	Decision		Ratification		Assurance	X	Information	
Accountable Executive	Karan Wheatcroft			Director of Governance, Risk and Improvement				
Author(s)	Karan Wheatcroft			Director of Governance, Risk and Improvement				
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research			X (BAF 8 Governance)	Supports the overarching governance arrangements.			
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health							X (Purposeful Leadership)
CQC Domains	Safe Effective Caring Responsive Well led							X (Well led)
Previous considerations	The action plan was agreed at the Council of Governors (COG) on the 21st November 2024 and progress against this reported to the COG on 13th February 2025 and 23rd April 2025.							
Executive summary	The purpose of this report is to provide an update on further progress against the action plan from the Council of Governors Workshop held on 17th October 2024. Progress includes: • Annual calendar key dates 2025/26 circulated. • Governor information pack developed through the Membership and Engagement Committee. • Membership and Engagement Committee in place and updates provided to COG meetings.							
Recommendations	The Council of Governors is asked to note the progress against the COG action plan.							

Corporate Impact Assessment	
Statutory/regulatory requirements	Governors are a key part of the NHS health and care act, code of governance and Trust constitution. The paper supports Governors to fulfil their role as described in the addendum to statutory duties, reference guide for NHS foundation trust governors.
Risk	An overarching governance risks is included on the Board Assurance Framework.
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics
Communication	Document to be published as part of Council of Governors papers.

Countess of Chester Hospital
NHS Foundation Trust

COG workshop action plan update

1. Introduction

A workshop was held with the Council of Governors on the 17th October 2024. This was attended by 12 Governors, including public, staff and partnership governors.

The workshop was led by the Trust Chair and the Director of Governance, Risk and Improvement, and supported by the Lead Governor and Deputy Director of Governance and Risk.

An action plan was developed and agreed at the Council of Governors meeting 21st November 2025 with progress updates reported to subsequent meetings.

2. Purpose

This paper provides an update on progress against the action plan.

3. Action Plan Progress

The following provides a high level summary of progress since the previous update reported in April 2025:

- Annual calendar key dates 2025/26 circulated.
- Governor information pack developed through the Membership and Engagement Committee.
- Membership and Engagement Committee in place and updates provided to COG meetings.

The full action plan is included in Appendix A.

4. Conclusion

The workshop discussions captured valuable feedback which in turn has supported the development of a prioritised action plan. Progress is being demonstrated, and we will continue to work with Governors to support them in fulfilling their roles and increase engagement and involvement in driving this forward.

Progress against the action plan will continue to be reported to the formal Council of Governor meetings.

5. Recommendations

The Council of Governors is asked to consider progress against the COG action plan.

Appendix A – Action Plan Progress

Action Details	Responsible Officer	Date	Progress
1. Annual calendar of activities to be agreed and provided to all Governors.	Director of Governance, Risk and Improvement	Revised to May 2025	**Complete:** 2025/26 key dates circulated.
2. Annual walkabout schedule to be provided to all Governors to ascertain availability against planned dates / times.	Director of Governance, Risk and Improvement	November 2024	**Complete:** The 2025 schedule has been collated and this has been shared with Governors to confirm their attendance.
3. COG workplan to be reviewed and refreshed. To include greater NED involvement in agenda items; summary of walkabout feedback; strategy updates.	Trust Chair	November 2024	**Complete:** Draft updated workplan to be presented to November COG meeting.
4. Monthly Governor Newsletter to be produced.	Trust Chair/ Director of Governance, Risk and Improvement	December 2024	**Complete:** Governor newsletter developed and implemented to provide a focused summary of key communications for Governors.
5. Access to key information for Governors.	Director of Governance, Risk and Improvement	September 2025	**In progress:** Governor information pack developed through the Membership and Engagement Committee (July 2025). Further consideration needed on types of information.
6. Patient and family engagement events dates for Governor attendance.	Director of Governance, Risk and Improvement	~~May 2025~~ Revised to September 2025	**In progress:** Liaising with the Deputy Director of Nursing, Quality Governance regarding linking Governors into these events once established.
7. Committee 'observation' to be reviewed and process/ role agreed.	Trust Chair/ Lead Governor	January 2025	**Complete:** Paper provided to COG (Feb 2025) and approach agreed.
8. Buddy system to be re-established for new governors.	Lead Governor	Complete	**Complete**: In place
9. Membership and engagement group role/ activity to be further developed.	Director of Governance, Risk and Improvement/ Lead Governor	~~March 2025~~ Revised to Sept 2025	**Complete:** Membership and Engagement Committee in place and updates provided to COG meetings.
10. Plan for recruitment to vacant Governor posts and review of the composition of the Council of Governors.	Trust Chair/ Director of Governance, Risk and Improvement	March 2025	**Complete**: Election proposal paper in COG papers (April 2025).

NHS
Countess of Chester Hospital
NHS Foundation Trust

Council of Governors
17th July 2025

<table>
<tr><td>Report</td><td>Agenda item 17b.</td><td colspan="6">Non-Executive Director (NED)/Governor Walkabouts Summary Report (Quarter 1)</td></tr>
<tr><td>Purpose of the Report</td><td>Approval</td><td></td><td>Ratification</td><td></td><td>Assurance</td><td></td><td>Information X</td></tr>
<tr><td>Accountable Executive</td><td colspan="3">Neil Large</td><td colspan="4">Trust Chair</td></tr>
<tr><td>Author(s)</td><td colspan="3">Karan Wheatcroft</td><td colspan="4">Director of Governance, Risk and Improvement</td></tr>
<tr><td>Board Assurance Framework</td><td colspan="3">BAF 1 Quality
BAF 2 Safety
BAF 3 Operational
BAF 4 People
BAF 5 Finance
BAF 6 Capital
BAF 7 Digital
BAF 8 Governance
BAF 9 Partnerships
BAF 10 Research</td><td>

X

X

</td><td colspan="3">Visible leadership and triangulation of information.</td></tr>
<tr><td>Strategic goals</td><td colspan="6">Patient and Family Experience
People and Culture
Purposeful Leadership
Adding Value
Partnerships
Population Health</td><td>X
X
X</td></tr>
<tr><td>CQC Domains</td><td colspan="6">Safe
Effective
Caring
Responsive
Well led</td><td>X
X
X</td></tr>
<tr><td>Previous considerations</td><td colspan="7">Individual walkabout reports reviewed by Trust Chair.</td></tr>
<tr><td>Executive summary</td><td colspan="7">Non- Executive Directors (NEDs) and Governors undertake a series of walkabouts across the Trust’s services and departments throughout the year.

Walkabouts are intended to support visibility and understanding of the organisation. Visiting operational departments will also enable NEDs and Governors to have face to face conversations with staff (and patients if appropriate) to understand their services and the challenges they face. These visits provide staff with the opportunity to talk to NEDs and Governors about what it feels like to work at CoCH. Walkabouts provide the opportunity to:
• Be visible across the organisation
• Understand services and roles</td></tr>
</table>

Countes of Chester Hospital
NHS Foundation Trust

	• Show support and recognition • Listen to colleagues • Explain to staff the role of NEDs and Governors A summary record of the walkabout is produced and this is shared with the Trust Chair. For completeness it has been agreed that a summary report will be produced and reported to the Council of Governors. This is the first summary report and covers the following NED/Governor walkabouts: • Coronary Care Unit and Respiratory Support Unit (2nd April 2025) • Security (7th May 2025) • Cardiology Day Suite (4th June 2025) • Emergency Department (4th June 2025)
Recommendations	The Council of Governors is asked to **Note** the summary report from the recent NED/Governor walkabouts.

Corporate Impact Assessment	
Statutory/regulatory requirements	Contributes to the Trust compliance with code of governance.
Risk	None.
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics
Communication	Not applicable.

Countess of Chester Hospital
NHS Foundation Trust

Non-Executive Director (NED)/Governor Walkabouts Summary Report (Quarter 1)

1. Introduction

Non- Executive Directors (NEDs) and Governors undertake a series of walkabouts across the Trust's services and departments throughout the year.

Walkabouts are intended to support visibility and understanding of the organisation. Visiting operational departments also enables NEDs and Governors to have face to face conversations with staff (and patients if appropriate) to understand their services and the challenges they face. These visits provide staff with the opportunity to talk to NEDs and Governors about what it feels like to work at CoCH. Walkabouts provide the opportunity to:

- Be visible across the organisation
- Understand services and roles
- Show support and recognition
- Listen to colleagues
- Explain to staff the role of NEDs and Governors

A summary record of the walkabout is produced, and this is shared with the Trust Chair. For completeness it has been agreed that a summary report will be produced and reported to the Council of Governors, and this is the first summary report.

2. NED/ Governor Walkabouts

The following table provides a summary of the NED/ Governor Walkabouts during Q1 (April to June 2025).

Walkabout	Summary
Coronary Care Unit and Respiratory Support Unit (2nd April 2025) **Non-Executive Director(s):** Pam Williams **Governor(s):** Jan Chillery - Public Governor	• Staff show genuine concern for patients and their individual needs. Ward accreditation Gold scores. • We observed patients being cared for with kindness. The wards felt calm and well managed. Family and Friends feedback is good. • There is good team working. • Evidence of patient information, training and development and support for international nurses being further developed. • Staff understood the needs but found it challenging when moved around the hospital. • There are some long stay patients awaiting packages of care. • Awareness of safety, quality and reducing harm.
Security (7th May 2025) **Non-Executive Director(s):** Neil Large – Interim Trust Chair **Governor(s):**	• Goodwill in the team to cover shifts. • Challenges with absence and vacancies within the team along with headcount reductions. • Important to support staff welfare. • Keen to remain calm and de-escalate situations.

Walkabout	Summary
Jan Chillery - Public Governor Paula Edwards - Staff Governor	• Safety vests and cameras used by the Team. • Not always aware of situation before they arrive which can be difficult.
Cardiology Day Suite (4th June 2025) **Non-Executive Director(s):** Andrew Hassell **Governor(s):** Ruth Overington – Public Governor Sheila Dunbar – Public Governor Louise Jha – Public Governor	• Team has focussed on reducing waiting times from 1 year to 6 weeks. • Services include same day pacemaker, and virtual wards to keep people at home. • Not an ideal space for escalation and specialist presence in A&E may be more beneficial. • Further opportunity for integration with community and collaboration with other organisations (for complex cases). • Clean, tidy and nice environment for patients. • Staff were seen to be supportive and patients seemed happy.
Urgent and Emergency Care (4th June 2025) **Non-Executive Director(s):** Neil Large – Interim Trust Chair **Governor(s):** John Jones - Lead Governor Kate Knight - Partnership Governor Myrddin Roberts - Public Governor Carol Gaham - Public Governor	• Visit included A&E Department, Urgent Care Centre (UCC) and Same Day Emergency Care (SDEC). • Welcoming, Staff wearing ID on the whole, Patient feedback, Staff feedback very positive. • The team spoke of a lot of changes coming and they were positive about that. • Potential opportunities to further utilise the SDEC facility particularly extending the opening hours. • Staff wanted support on digital learning platforms, sepsis management and streaming models. • We recognised that joint working with partner organisations need to be advanced rapidly to seek potential resolutions to some of the ongoing issues. *A number of challenges were noted with an update to be provided to Governors in September 2025, including ISL support for mental health patients, staff training compliance, clarification on internal referrals, infection control, care and compassion work, staff covering corridor care and use of Agency staff.*

Whilst walkabouts are not intended to produce action plans, there may on occasion be items to be followed up and these will be included in the table and an update provided as required.

3. Recommendation

The Council of Governors is asked to **Note** the summary report from the recent NED/Governor walkabouts.

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Council of Governors
17th July 2025

<table>
<tr><td>Report</td><td>Agenda item 17c.</td><td colspan="7">Non-Executive Director (NED)/Governor Walkabout Guidance</td></tr>
<tr><td>Purpose of the Report</td><td>Approval</td><td></td><td>Ratification</td><td></td><td>Assurance</td><td></td><td>Information</td><td>X</td></tr>
<tr><td>Accountable Executive</td><td colspan="3">Neil Large</td><td colspan="5">Trust Chair</td></tr>
<tr><td>Author(s)</td><td colspan="3">Nusaiba Cleuvenot</td><td colspan="5">Head of Corporate Governance</td></tr>
<tr><td>Board Assurance Framework</td><td colspan="3">BAF 1 Quality
BAF 2 Safety
BAF 3 Operational
BAF 4 People
BAF 5 Finance
BAF 6 Capital
BAF 7 Digital
BAF 8 Governance
BAF 9 Partnerships
BAF 10 Research</td><td>

X

X

</td><td colspan="4">Visible leadership and triangulation of information.</td></tr>
<tr><td>Strategic goals</td><td colspan="7">Patient and Family Experience
People and Culture
Purposeful Leadership
Adding Value
Partnerships
Population Health</td><td>X
X
X

</td></tr>
<tr><td>CQC Domains</td><td colspan="7">Safe
Effective
Caring
Responsive
Well led</td><td>X
X
X

</td></tr>
<tr><td>Previous considerations</td><td colspan="8">Not applicable</td></tr>
<tr><td>Executive summary</td><td colspan="8">Non- Executive Directors (NEDs) and Governors undertake a series of walkabouts across the Trust's services and departments throughout the year. The guidance for walkabouts has been updated to provide clarity on purpose and feedback, including a simplified form.</td></tr>
<tr><td>Recommendations</td><td colspan="8">The Council of Governors is asked to Note the revised NED/ Governor walkabout guidance.</td></tr>
</table>

Corporate Impact Assessment	
Statutory/regulatory requirements	Contributes to the Trust compliance with code of governance.
Risk	None.
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics
Communication	Not applicable.

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Non-Executive Director & Governor Walkabout Guidance

Purpose

Walkabouts are intended to support visibility and understanding of the organisation. Visiting operational departments will also enable NEDs and Governors to have first-hand face to face conversations with staff (and patients if appropriate) to understand their services and challenges they face. These visits provide staff with the opportunity to talk to NEDs and Governors about what it feels like to work at CoCH. Walkabouts provide the opportunity to:

- Be visible across the organisation
- Understand services and roles
- Show support and recognition
- Listen to colleagues
- Explain to staff the role of NEDs and Governors

Approach

Considering the above and thinking about how best to develop engagement with the workforce, it is important that walkabouts are conducted in a structured way.

A programme of visits will be established each year across clinical and non-clinical departments. Visits will consist of one NED and up to three governors per visit. NEDs and Governors will be provided with the schedule of visits in advance and can register their interest by emailing the Committee Secretary - coch.cochboardandcommittees@nhs.net. The Director of Nursing and Quality/Deputy CEO will be consulted on the detail of the programme with particular emphasis on ensuring the programme complements other planned visits.

It is inevitable that during these visits staff will rightly raise issues that NEDs and Governors will be aware of and likewise there will be others e.g. operational issues that NEDs and Governors will not be sighted on. Many of these will be day to day matters that Executives and Managers will be dealing with as part of the normal running of the hospital. NEDs and Governors should not stray into operational management as many issues of this nature should/ would have been raised by staff with their line managers. So, where staff raise issues the immediate response should be to ask have they:

- reported the issues to their line managers
- escalated the issue where they feel they have not been heard or there has been no action
- entered the issue in the risk register
- attended the daily safety huddles to raise concerns
- used the Trusts various means to raise concerns including FTSU

It would undermine the management arrangements if NEDs and Governors were seen to take away problems and for them to appear to be resolved by this means, so pushing back as above is important without being dismissive of concerns that are raised. NEDs must use their judgement in picking up concerns that rightly should be escalated and the Chair

should be immediately contacted if this is the case and in his absence the CEO or Director of Governance, Risk & Improvement or in their absence the appropriate Executive Director. NEDs and Governors are provided with prompts (Appendix A) which can be used to guide them through their visits. The walkabout feedback proforma (Appendix B) also includes a field to record the items that will/ have been escalated via the Chair.

Reporting
After each visit NEDs and Governors will discuss their findings and complete a proforma (Appendix B) and email these to the Committee Secretary & Chair coch.cochboardandcommittees@nhs.net and Trust Chair neil.large@nhs.net

The Trust Chair will escalate to the relevant leads as appropriate, with a summary report of visits reported to the Council of Governors.

Appendix A – Prompts for NED/Governor Walkabouts

The following is **NOT a checklist** but provides prompts to guide the NEDs and Governors on observations they make during their visits.

a) Welcoming

- General feeling as you enter the area?
- Interactions between staff/patients/visitors?
- Visible and useful information on display?
- Friendliness of the team?
- Accessibility, including for those with additional needs or disabilities?

b) Safe

- Are all clinical staff bare below the elbows (no wristwatches, jewellery etc.)?
- Is the area and equipment visibly clean (no splashes/dust etc)?
- Is the environment well maintained, appropriate (e.g., non-slip) and clean?

c) Kind

- What did I observe from staff interaction with each other and with patients and families?
- How is dignity and privacy being respected?
- Did I observe good team working taking place?
- Do staff receive patient feedback and what does this say?
- Is information about how to complain and compliment visible?

d) Effective

- Does the ward feel calm (even if it is busy)?
- Is essential information about each patient clearly visible (even where names are anonymised)?
- Is there clear signage to rooms, toilets etc?

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Appendix B – Feedback Proforma

Non-Executive Director and Governor Walkabout Feedback Form

Area and Team(s) visited:	
Who did we meet:	**Non-Executives/Governors Present:**

Overall Comments by the Non-Executives/Governors of the visit

Identified areas of good practice:	
Identified areas that require attention:	
Welcoming:	
Safe:	
Kind:	

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Effective:
Additional comments/feedback: ** please include feedback provided by patients and families (if available)*
Items for escalation:

Once Completed please send this form through to Claire Jones, Committee Secretary - coch.cochboardandcommittees@nhs.net and Trust Chair neil.large@nhs.net

This feedback will be collated into a summary report to the Council of Governors.

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Council of Governors Workplan
2025/26

Item		Frequency	Lead	Operational Lead	23rd Apr 2025	17th Jul 2025	22nd Oct 2025	29th Jan 2026
1	Welcome and apologies for absence	Each meeting	Trust Chair	Trust Chair	✓	✓	✓	✓
2	Declarations of interest	Each meeting	Trust Chair	Trust Chair	✓	✓	✓	✓
3	Minutes of last meeting	Each meeting	Trust Chair	Director of Governance, Risk and Improvement	✓	✓	✓	✓
4	Matters arising and action log	Each meeting	Trust Chair	Director of Governance, Risk and Improvement	✓	✓	✓	✓
5	Patient Story	Each Meeting (to be presented on the day)	Director of Nursing & Quality /Deputy Chief Executive	Director of Nursing & Quality /Deputy Chief Executive	✓	✓	✓	✓
6	Trust Chair's Briefing	Each meeting (verbal update)	Trust Chair	Trust Chair	✓	✓	✓	✓
7	Chief Executive Officer's Report	Each meeting	Chief Executive Officer	Chief Executive Officer	✓	✓	✓	✓
8	Lead Governor Update	Each meeting	Lead Governor	Lead Governor	✓	✓	✓	✓
9	Staff Survey - Outcomes	Annually	Chief People Officer	Chief People Officer	✓			
10	Inpatient Survey - Outcomes	Annually	Director of Nursing & Quality /Deputy Chief Executive	Director of Nursing & Quality /Deputy Chief Executive	✓			
11	Patient / Family Experience Update	Annually	Director of Nursing & Quality /Deputy Chief Executive	Director of Nursing & Quality /Deputy Chief Executive				✓

Item		Frequency	Lead	Operational Lead	23rd Apr 2025	17th Jul 2025	22nd Oct 2025	29th Jan 2026
12	Anchor Institution Update	Twice annually	Director of Strategic Partnerships	Director of Strategic Partnerships		✓		✓
13	Membership & Engagement Committee Chairs report and approved minutes	Each meeting	Committee Chair	Director of Governance, Risk and Improvement	✓	✓	✓	✓
14	Governor Election Process and Updates	Annually	Trust Chair	Director of Governance, Risk and Improvement	✓ (proposal)	✓		
15	Council of Governors Action Plan Update	Each meeting	Director of Governance, Risk and Improvement	Director of Governance, Risk and Improvement	✓	✓	✓	✓
16	Board of Directors Business Items:							
	a) Board of Directors meeting date (minutes) and Board of Directors meeting date (agenda)	Each Meeting	Director of Governance, Risk and Improvement	All Executive Directors	✓	✓	✓	✓
	b) AAA reports from the Chairs of the Board of Directors Sub-Committees	Each Meeting	Director of Governance, Risk and Improvement	Non-Executive Directors	✓	✓	✓	✓
	c) Strategic Oversight Framework Report • Operational Performance • Quality • Safety • Finance • Human Resources & People	Each meeting	Chief Operating Officer	Chief Operating Officer/ Director of Nursing & Quality/Deputy Chief Executive/ Medical Director/ Chief Finance Officer/ Chief People Officer	✓	✓	✓	✓
17	Feedback from Governors	Each meeting	Lead Governor	All Governors	✓	✓	✓	✓
18	Feedback from Council of Governor Workshops		Trust Chair / Director of	Trust Chair/ Director of			✓	✓

Item		Frequency	Lead	Operational Lead	23rd Apr 2025	17th Jul 2025	22nd Oct 2025	29th Jan 2026
			Governance, Risk & Improvement	Governance, Risk & Improvement				
19	Feedback from NED / Governor Walkabouts Summary Report	Each meeting	Trust Chair	Non-Executive Directors/ Governors	✓	✓ ✓	✓ ✓	✓ ✓
20	For noting:							
	a) Council of Governors Workplan	Each meeting	Director of Governance, Risk & Improvement	Committee Secretary	✓	✓	✓	✓
	b) Council of Governors Photosheet link/sheet	Each meeting	Director of Governance, Risk & Improvement	Committee Secretary	✓	✓	✓	✓
21	Any other business	Each meeting	Trust Chair	Trust Chair	✓	✓	✓	✓
Private Section of the meeting:								
22	Minutes of the previous meeting	Each meeting	Trust Chair	Committee Secretary	✓	✓	✓	✓
23	Private Board of Directors Summary Report	Each meeting	Trust Chair	Head of Corporate Governance	✓	✓	✓	✓
24	Nomination Committee reports	As required	Trust Chair	Head of Corporate Governance				
25	Chair and Non-Executive Director Appraisal Process	Annual	SID/ Trust Chair	Director of Governance, Risk and Improvement				✓
26	Chair and Non-Executive Director Appraisal outcomes and Objectives	Annual	SID/ Trust Chair	Director of Governance, Risk and Improvement		✓		

→ indicates original position of item on workplan and intention to defer and reschedule

Foundation Trust Council of Governors

NHS Countess of Chester Hospital NHS Foundation Trust

PUBLIC

CHESTER AND RURAL CHESHIRE

Robert Howe
Until October 2026

Sheila Dunbar
Until October 2027

Lucy Liang
Until October 2025

Louise Jha
Until October 2027

Jan Chillery
Until October 2027

Vacant

John Jones
Until October 2026

Vacant

ELLESMERE PORT AND NESTON

Brian Jones
Until September 2025

Vacant

Vacant

Vacant

FLINTSHIRE

Myrddin Roberts
Until October 2027

Ruth Overington
Until September 2025

Vacant

STAFF

ALL OTHER STAFF

Stephen Higgitt
Until October 2026

ALLIED HEALTH PROFESSIONALS

Ashley Jayne Caple
Until October 2026

DOCTORS

Dr Salah Tueger
Until October 2026

NURSES/MIDWIVES QUALIFIED
(2 positions with 4 Governors on a job sharing basis)

Paula Edwards
Until October 2026

Dadirai Kambasha
Until October 2026

Angel Lewis-Aaron
Until October 2026

Maria Woodward
Until October 2026

PARTNERSHIP ORGANISATIONS

Carol Gahan
Cheshire West and Chester Council

Dr Kate Knight
University of Chester

David Foulds
Council for Voluntary Services

Karen Chambers
Flintshire County Council

REMAINING ENGLAND AND WALES

Daryl Cassidy
Until October 2027

TRUST CHAIR

Neil Large MBE
Interim Chair