Public Board of Directors Meeting
30th September 2025

Report	**Agenda Item 13.**	**Freedom to Speak Up Report (FTSU)**						
Purpose of the Report	Decision		Ratification		Assurance	**X**	Information	
Accountable Lead	Cathy Chadwick			Chief Operating Officer				
Author(s)	Helen Ellis			Freedom to Speak Up Guardian				
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** **X** **X** **X**	BAF impact is that the Freedom to Speak Up Vision and Strategy offers a supportive framework to 'speak up' about issues in the workplace. This will contribute to the Trust's work to improve culture, morale and provide learning on how the Trust can improve services.			
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health							**X** **X** **X**
CQC Domains	Safe Effective Caring Responsive Well led							**X** **X** **X** **X** **X**
Previous considerations	Not applicable							
Executive Summary	This report provides assurance to the Trust Board that the Freedom to Speak Up (FTSU) arrangements at the Countess of Chester Hospital NHS Foundation Trust continue to reflect national best practice and support a culture of openness and psychological safety. Key highlights include: • **Increased staff engagement**: One hundred and thirty-seven concerns were raised in 2024-25, up from one hundred and nineteen the previous year. Nurses remained the most active group, with a notable rise in midwife engagement from 0% to 6.6% • **Positive cultural shifts**: A significant reduction in bullying and harassment concerns suggests earlier intervention and improved civility across the Trust. • **Quarter one update**: Twenty-one concerns were raised, with no reports of detriment or bullying. All cases were concluded, with several leading to swift resolution and learning. • **Governance and leadership**: Strong executive oversight continues, with regular reporting to the Board and sub-committees. Twenty-							

	nine of thirty-five actions in the FTSU Action Plan have been completed. • **Training compliance**: Most staff groups exceed the ninety percent compliance target for mandatory FTSU modules, though Estates and Ancillary staff remain below threshold. • **Champion network**: Over sixty champions support staff across the Trust, with plans to strengthen divisional hubs and recruit in underrepresented areas. • **Manager workshops**: Eighty-two managers have received FTSU training, now embedded in leadership development programmes. The FTSU Action Plan remains a key driver for ongoing development, improvement, and embedding best practice across the Trust.
Recommendations	The Board is asked to **note** the report and receive assurance that local FTSU arrangements are in place and continue to meet best practice.

Corporate Impact Assessment	
Statutory/regulatory requirements	CQC - Well Lead
Risk	BAF impact is that the Freedom to Speak Up Vision and Strategy offers a supportive framework to 'speak up' about issues in the workplace. This will contribute to the Trust's work to improve culture, morale and provide learning on how the Trust can improve services.
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 the agenda pack.

Freedom to Speak Up Report to: Trust Board (September 2025)

1. Introduction

This paper provides the Board with an update of the work of the Freedom to Speak Up (FTSU) Guardian and Champions in supporting the safety culture within the Trust, reflect on the progress made by the FTSU Network in empowering staff to speak up freely and to encourage ongoing positive cultural change. An overview of data for 2024-25 compared to the previous year and data for Q1 of this year will be provided in line with National Guardians Office (NGO) recommendations. An update on the progress of the FTSU Action Plan and mandatory training compliance together with information on the future of the NGO will be included.

2. Background

The concept of Freedom to Speak Up was derived from a review undertaken by Sir Robert Francis, which concluded in February 2015. The aim of the review was to assess the processes, mechanisms and cultures in place regarding speaking up across the NHS: this identified five key themes for improvement:

- Culture change
- Improved handling of cases
- Measures to support good practice
- Measures to support vulnerable groups
- Extending legal powers

These were underpinned with twenty identified principles and subsequent recommendations for all NHS organisations. This included the mandate for all NHS Trusts to have an appointed Freedom to Speak Up Guardian with the aim of promoting a consistent approach across the NHS and ensures that staff are encouraged and supported to raise concerns, free from detriment.

As part of the Care Quality Commission (CQC) inspection framework for the 'Well Led' domain, every NHS Trust is assessed in relation to its 'Speaking up Culture', under Key Line of Enquiry (KLOE 3). It examines leadership, management and governance that assure the delivery of high quality and person-centred care, supports learning and innovation and promotes an open and fair culture.

Our vision is to ensure that raising concerns becomes business as usual within the Trust, with staff feeling able to raise concerns and being confident that concerns will be addressed appropriately whilst always keeping the patient at the center of everything we do. Equally we want to learn from our mistakes and promote a culture of openness and transparency that ensures the positive experiences of patients and staff.

This document should be read in conjunction with the Trusts Freedom to Speak Up policy which can be accessed through the Trust's intranet site.

3. Purpose

The Board is asked to review the report and receive assurance that the FTSU arrangements in place continue to meet best practice and supports staff to raise concerns. This is done in the context of an evolving and maturing national agenda, that is learning from the collective experiences of FTSU Guardians, their champion networks and national guidance and directives.

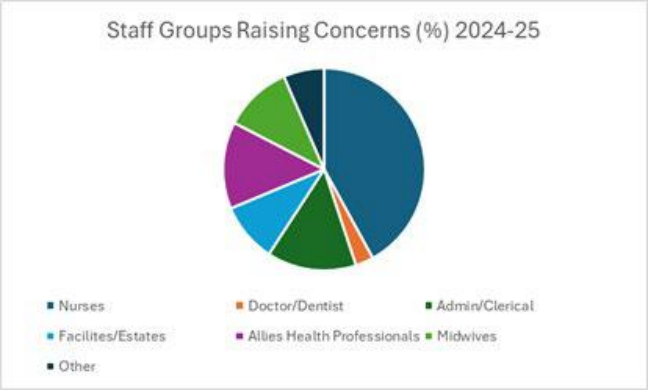
4. National Guardians Office

The National Guardian's Office is an independent, non-statutory body with the remit to lead culture change in the NHS in England and sponsored by the Care Quality Commission, NHS England and NHS Improvement. In July it was announced that as part of the 10 Year Health Plan for the NHS the NGO is to be abolished. Exact details of when this may happen or where FTSU may sit moving forwards are yet to be confirmed, however Freedom to Speak Up Guardians will remain in NHS provider organisations.

5. Overview of FTSU concerns 2024-25

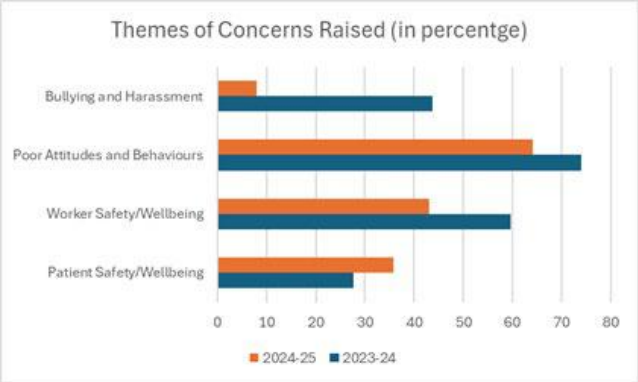
The trust has several safety reporting channels such as speaking directly to line managers, incident reporting and team and trust safety huddles. Issues raised in other channels are not logged as FTSU unless referred to or raised directly to the FTSU Guardian or champions.
There was an increase from 119 in the previous year to 137 concerns raised during 2024-25, with nurses remaining the highest percentage staff group to speak up.

Graph A: Staff Groups



This data is closely aligned to that from the previous year except for an increase in the number of midwives raising concerns, from 0% to 6.6%. Concerns raised by doctors and dentists remain low at less than 3%.

Graph B: Themes



Poor attitudes and behaviours continue to be a theme that runs through many concerns, but what is different is that alleged bullying and harassment concerns have reduced significantly.
It is difficult to identify exactly why this may have happened but possibly colleagues are raising concerns earlier before things get a chance to escalate. In addition, there has been significant work to improve culture and civility across the Trust and this may have contributed.

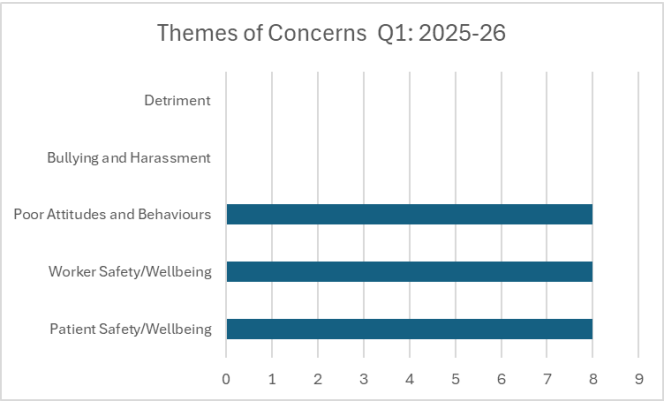
Other key Observations:

Managers raised 12% of all concerns in 2024-25. There were no concerns raised that alleged detriment this year in comparison to seven the previous year.
An increase in concerns raised anonymously from 0% - 2.2% was seen, however this remains significantly lower than the national average.
All but three cases have been concluded with two underdoing formal investigation.

6. Overview for Quarter 1: 2025-26

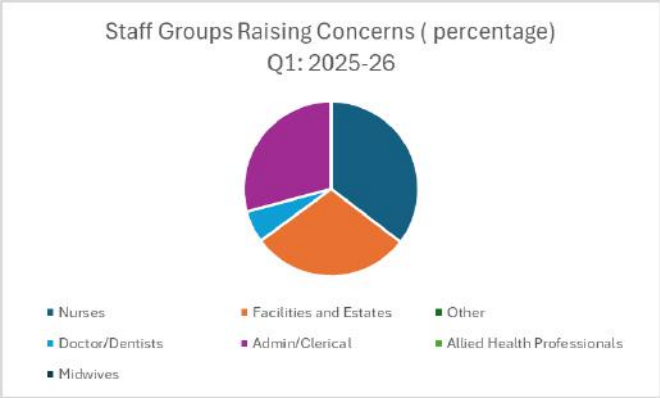
Number of cases brought to FTSU: 21, in comparison to 27 the previous year.

Graph C: Themes



There were no concerns raised anonymously or that cited detriment or bullying during this quarter.

Graph D : Staff Groups



Overview of FTSU Concerns, Actions, Status and Learning:

All concerns for Q1 have concluded.

Limited if any feedback from managers was cited in five concerns relating to either pay, job descriptions and responsibilities at work. All of these had been on-going for more than two months. Colleagues felt let down, unsupported and not listened to. Three stated they were already looking for other employment. All were rectified quickly once they were raised through FTSU.

One concern cited significant delays in processes that impacted on patient care, with a further two relating to changes in direct clinical care that was perceived to be detrimental to the wellbeing of patients.

One concern related to coding errors resulting in a perceived loss of income for the Trust, whilst a further six cited poor attitudes and behaviours from colleagues. Of these, four were longstanding concerns that had previously been shared with managers but had not resulted in any change in behaviours. Of the remaining two, both staff members felt unable to share their concerns with managers for fear of detriment.

The remaining six concerns relate to ongoing investigations.

7. Progress on Internal Assessments and Governance

Cathy Chadwick, Chief Operating Officer and Paul Jones Non-Executive Director continue to have executive leadership for FTSU. The Executive lead, Chief People Officer and the Guardian convene 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 reports are also submitted to the People Committee bi-annually, People and Culture Sub-Committee quarterly and the Audit Committee and Quality and Safety Committee annually.

8. Freedom to Speak Up Action Plan:

The Trust Board approved an updated FTSU Action Plan in January 2025 and continues to act as a driver for further service development and improvement. Progress is overseen by the People Committee, with progress reported to Board.
Of the thirty-five actions twenty-nine have been completed, with the remainder on target for completion by the end of the year.

9. FTSU Mandatory Training

'Speak Up' is now at 94.75% with 'Listen Up' at 89.94%, a slight increase from that reported in March 2025. The FTSU Action Plan requires a minimum of 90% compliance for each module. Facilities and Estates have seen continual improvement in compliance across both modules increasing to 74.58 % and 64.61% respectively. 'Follow Up' mandated for Board members currently stands at 100% compliancy.

Table 1: Compliance across Staff Groups

Staff Group	Speak Up Compliance %	Listen Up Compliance %
Add Prof Scientific and Technical	98.54%	93.43%
Additional Clinical Services	96.80%	90.79%
Administrative and Clerical	98.44%	95.11%
Allied Health Professionals	98.81%	94.05%
Estates and Ancillary	74.58%	64.61%
Healthcare Scientists	96.81%	90.43%
Medical and Dental	86.47%	79.82%
Nursing and Midwifery	98.91%	95.64%

10. Freedom to Speak Champions Network

The network of sixty champions continues to provide an alternative for colleagues wanting to either raise a concern or just understand more about Freedom to Speak. In addition, champions are a voice within their own teams, taking time to share information at local meetings and during new staff inductions. Some champions have recently decided that they no longer have the capacity to continue in this role and further training for new champions has been scheduled for October.

Work is currently underway to establish specialist and divisional champion hubs, bringing together champions working in similar areas to strengthen peer support, local knowledge and learning. This activity will also help to highlight where further champion recruitment is needed and identify any correlation between the numbers of concerns raised and the number of champions in any given area.

The network has representation of eight of the nine protective characteristics and engages with the

staff networks and the EDI lead. Working collaboratively helps to increase the knowledge and confidence of all colleagues within the Trust to speak up.

11. Workshops for Managers

In addition to the initial FTSU workshop for managers held in February a further four were delivered within the Therapies and TICC division during May and June. This means a total of 82 managers now have greater knowledge and understanding of best practice when colleagues raise concerns. This offer remains open to all other areas of the Trust.
In addition, FTSU is now an integral part of the Inspiring Leaders and First Line Managers Training.

12. Conclusion

The FTSU compliments existing policies and processes within the trust, providing an alternative channel for staff to speak confidentially or anonymously. The policy provides assurance that concerns will be escalated, and workers are supported during the process and investigations.

The FTSU Guardian, supported by the network of champions, continues to maintain engagement with colleagues across the organisation to raise the FTSU profile, support staff who have raised concerns, record and follow-up cases raised and wherever possible identify and disseminate learning. Quarterly data will continue to be submitted to the NGO until further guidance on new reporting channels is published.

Monthly Guardian blogs continue to be posted to all staff. The FTSU Action Plan with continue to be the driver for ongoing development and improvement.

The champion's network continues, providing colleagues with greater choices on how to raise concerns.

The FTSU guardian will continue to provide reports to the Board of Directors and its associated committees. The FTSU guardian will continue to maintain engagement with regional networks.

13. Recommendation

The Board is asked to **note** the report and receive assurance that local FTSU arrangements are in place and continue to meet best practice.

Committee Chair's Report
Monday 8th September 2025 at 14.00 – 17.00, Boardroom, 1829 Building

Committee	Quality & Safety (Q&S) Committee
Chair	Non-Executive Director, Prof A Hassell

Key discussion points and matters to be escalated from the discussion at the meeting:

Alert *(matters that the Committee wishes to bring to the Board's attention)*

- Actions need to be progressed at pace in our palliative care services. Need for improvements in record keeping and work being done on the action plan. One example is the risks associated with the lack of a 24/7 service which is heavily reliant on collaboration. Self-assessment view would be currently requiring improvement against CQC standards.
- **Section 29a** – Progress assurance received but significant risks remain in relation to Sepsis, IPC, Medical Devices (PAT Testing), equipment servicing and the 12-hour target.
- The Committee received the **Safeguarding quarterly report** with specific actions progressing to improve compliance with standards for:
  - Domestic abuse enquiry
  - 'This is me'/ Hospital Passport completion
  - Restraint
- **Cancer Services Report.** Some good metrics, but challenged in:
  - **Breast Surgery:** Workforce pressures were highlighted impacting capacity
  - **Skin:** Capacity issues due to the high denominator
  - **Radiology:** Capacity issues were highlighted within ultrasound and IR with mutual aid commencing in July

Assure *(matters in relation to which the Committee received assurance)*

- **Medical Devices** Report provided a comprehensive assessment and presentation of identified risks and planned mitigation.
- Improvements demonstrated in the management of the **Clinical Audit** process
- **Medicines Optimisation** Annual Report received.

Advise *(items presented for the Board's information)*

- Long standing risk on 2nd obstetric theatre resolved following move into the new Women's and Children's building.
- Significant improvements noted on e'discharge letters
- IR(ME)R regular report presented. There have been no new risks added to the risk register related to IR(ME)R or radiation protection. Risk 3416 regarding the Sentinel Lymph Node Biopsy Service has been closed as service has successfully moved to Clatterbridge Cancer Centre

Risks discussed and new risks identified

- Pace of progress on Section 29a action plan
- Ability to progress on Palliative Care improvements at pace

Countess of Chester Hospital NHS Foundation Trust

Board of Directors
30th of September 2025

Report	**Agenda 15.**	**Inpatient Survey Results**						
Purpose of the Report	Decision		Ratification		Assurance		Information	**X**
Accountable Executive	Sue Pemberton			Director of Nursing and Quality / Deputy Chief Executive				
Author(s)	Fiona Altintas			Deputy Director of Nursing, Quality & Governance				
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** **X**	Supports triangulation against quality and safety BAF risks.			
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health							**X** **X** **X** **X**
CQC Domains	Safe Effective Caring Responsive Well led							**X** **X** **X** **X** **X**
Previous considerations	N/A							
Executive summary	477 service users from Countess of Chester Hospital NHS Foundation Trust responded to the National In-patient survey (457 Reponses in the previous year). The response rate for Countess of Chester Hospital NHS Foundation Trust was 41.88%. From the respondents 94% had been through urgent care and 6% planned care. Although some sections/questions have changed; we can compare the overall sections to last year (2023), which demonstrates no overall change in all but one section, which was leaving hospital, which accounted for 58% of all worse/somewhat worse scores. There were 14 sections in total, including overall experience in which we rated about the same with an overalls core of 7.8.							

	Trust has demonstrated improvement in some questions and in particular the two overall question responses demonstrating that 99% of patients responded that they were treated with kindness and compassion and 97% of patients said they were treated with respect and dignity overall. Picker is an approved contractor who work with 61 organisations and supports the Trust in the interrogation of the survey results. The Trust has shown favourable results in a variety of questions and patient responses. These include: • Mealtime help and food availability • Confidence and trust in doctors and have included the patient in conversation. • Confidence and trust in nurses and nurses included the patient in conversations • 99% of patients responded that they were treated with kindness and compassion • 97% of patients said they were treated with respect and dignity overall • 78 % of patients rated their overall experience as 7/10 or more – the highest score since 2021 It is imperative to note that the Trust, like all other Trusts, receive the results of the inpatient survey nearly 11 months after the survey cohort of patients is decided. The Countess of Chester has been on a significant improvement journey over the last 12-18 months and improving Friends and Family tests is a real-time reflection on how patients and their families feel about their journey through our wards and departments. In August 2025, our overall Friends and Family Test scores were 91.08% positive scores, with 3139 responses. Utilising both the results from the Inpatient survey with a focus on leaving hospital and the monthly Friends and Family Test, an action plan is in development and will be monitored through the Patient Experience Group.
T	The Committee is asked to • Note the contents of the paper • Note the actions identified to address areas for improvement. • Note the governance and monitoring of the action plan of the Patient Experience Group led by the Director of Nursing.

Corporate Impact Assessment	
Statutory/regulatory requirements	Respective codes of governance, statutory and regulatory quality requirements.
Risk	Failure to maintain quality of care would result in poorer patient & family experience.
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics
Communication	Not confidential

Inpatient Survey Results (2024)

1. Introduction

The Adult Inpatient Survey for 2024 was published in September 2025 - Adult inpatient survey 2024 - Care Quality CommissionThis National survey looks at the experiences of people who stayed at least one night in hospital as an inpatient during November 2024, and who were over 16 years or over at the time of their stay.

It is important to note, that the Trust like all other Trusts, receive the results of the inpatient survey, nearly 11 months after the initial data collection.

Between January and April 2025, 1,250 people at each participating NHS trusts were invited to take part in the survey. Responses were received from 477 (41.88%) people at Countess of Chester Hospital NHS Foundation Trust. 96% of respondents had been through an urgent care pathway, with the remaining 4% from planned care.

Questions included in the survey follow the journey of patients from admission to hospital, treatment and discharge.

2. Purpose

The purpose of this paper is to provide the Board of Directors with a summary of the 2024 Inpatient Survey results for the Countess of Chester, identifying themes and subsequent actions and monitoring of improvements and to outline how we are utilising the Friends and Family Test (FFT) to support and drive continuous improvements.

3. National feedback from the survey

Nationally, the results from the 2024 survey demonstrate some areas of improvement when compared to those from 2023. Of the 36 questions that were also asked in 2023, 17 show statistically significant improvement, 17 remain stable and 2 show statistically significant decline.

National Positive findings include Interactions with hospital staff, staff availability and overall experience. National Key areas for improvement are waiting times and care after leaving hospital.

Respondents with a disability or those living with frailty reported poorer experiences of inpatient care for all the questions analysed in the survey. Similarly, respondents with dementia, Alzheimer’s, a mental health condition, a neurological condition, or a condition which affects their physical mobility reported poorer experiences in most areas.

People who had an emergency admission to hospital also had poorer experiences than those with planned admissions.

In contrast, older people, male respondents, people who were in hospital for an elective admission, and those not considered frail generally reported better experiences across most areas of care.

4. Countess of Chester Inpatient Survey Results

Although some sections/questions have changed; (virtual wards being one) we can compare the overall sections to last year results (2023), which demonstrates no overall change in all but one section, which was 'leaving hospital' which accounted for 58% of all worse/somewhat worse scores (table 1).There are 14 sections of questions in total, including overall experience in which we rated 'about the same'

Table 1

Section	2023 results	2024 results
Admission to Hospital	About the same	About the same
The Hospital and ward	About the same	About the same
Basic Needs		About the same
Doctors	About the same	About the same
Nurses	About the same	About the same
Care and Treatment	About the same	About the same
Individual needs		About the same
Virtual Wards		About the same
Operations and Procedures	About the same	About the same
Leaving Hospital	About the same	Worse
Feedback on Care	About the same	About the same
Kindness and compassion	About the same	About the same
Respect and dignity	About the same	About the same
Overall Experience	About the same	About the same

Further interrogation demonstrates that there are 12 specific questions, when comparing them with those of other Trusts, that have generated a worse score.

- the trust's results were much worse than most trusts for 0 questions.
- **the trust's results were worse than most trusts for 7 questions.**
- **the trust's results were somewhat worse than most trusts for 5 questions**.
- the trust's results were about the same as most trusts for 33 questions.
- the trust's results were somewhat better than most trusts for 1 question.
- the trust's results were better than most trusts for 0 questions.
- the trust's results were much better than most trusts for 0 questions.

The Trust scored somewhat better than most trusts for 1 question (table 2)

The individual questions are detailed in tables 3 and 4

Table 2

Section		Question	Rating
Section 1	Admission to Hospital	How did you feel about the length of time you were on the waiting list before your admission to hospital?	**Somewhat Better**

Table 3

Section		**Question**	**Rating**
Section 1	Admission to Hospital	How long do you feel you had to wait to get to bed on a ward after you arrived at the hospital?	**Worse**
Section 1	Admission to Hospital	Thinking about the location(s) selected at Q6 / at the previous question, how long did you wait, in total, before you were admitted onto a ward?	**Worse**
Section 2	The Hospital and Ward	Were you ever prevented from sleeping at night by any of the following? Noise from other patients	**Somewhat Worse**
Section 4	The Doctors	When you asked doctors questions, did you get answers you could understand?	**Somewhat Worse**
Section 6	Your Care and Treatment	Thinking about your care and treatment, were you told something by a member of staff that was different to what you had been told by another member of staff?	**Somewhat Worse**

Table 4

Section		**Question**	**Action**
Section 9	Leaving Hospital	Did hospital staff discuss with you whether you would need any additional equipment in your home, or any changes to your home, after leaving the hospital?	**Worse**
Section 9	Leaving Hospital	Were you given enough notice about when you were going to leave hospital?	**Worse**
Section 9	Leaving Hospital	Before you left the hospital, were you given any information about what you should or should not do after leaving the hospital? This includes any verbal, written or online information.	**Worse**
Section 9	Leaving Hospital	Thinking about any medicine you were to take at home, were you given any of the following?	**Somewhat Worse**

Section 9	Leaving Hospital	Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	**Worse**
Section 9	Leaving Hospital	Did hospital staff discuss with you whether you may need any further health or social care services after leaving the hospital? Please include any services from a physiotherapist, community nurse or GP, or assistance from social services or the voluntary sector.	**Worse**
Section 9	Leaving Hospital	After leaving the hospital, did you get enough support from health or social care services to help you recover or manage your condition? Please include any services from a physiotherapist, community nurse or GP, or assistance from social services or the voluntary sector.	**Somewhat Worse**

5. Picker Interrogation

Picker is an approved contractor who work with 61 organisations and supports the Trust in the interrogation of the survey results. The trust has shown favourable results in a variety of questions and patient responses and the table below highlight the high rating and improving scores the trust has received. (Tables 5, 6and 7)

- Mealtime help and food availability outside of mealtimes has improved year on year since 2020
- 97 % of all responder's have confidence and trust in doctors and have been included the patient in conversation.
- 98% of responders have confidence and trust in nurses and 97% of patients responded that nurses included them in conversations
- 99% of patients responded that they were treated with kindness and compassion
- 97% of patients said they were treated with respect and dignity overall.
- 78 % of patients rated their overall experience as 7/10 or more – best score since 2021.

Table 5

		Historical				
		2020	2021	2022	2023	2024
Q14	Got enough help from staff to eat meals	85%	75%	78%	85%	86%
Q15	Able to get food outside of mealtimes	-	68%	75%	77%	79%

Table 6

		Historical				
		2020	2021	2022	2023	2024
Q17	Doctors answered questions in a way patient could understand	96%	95%	96%	94%	94%
Q18	Had confidence and trust in the doctors	98%	97%	98%	98%	97%

Q19	Doctors included patient in conversation	95%	97%	97%	97%	97%
Q20	Nurses answered questions in a way patient could understand	98%	97%	98%	97%	95%
Q21	Had confidence and trust in the nurses	98%	98%	98%	99%	98%
Q22	Nurses included patient in conversation	96%	97%	96%	96%	97%

Table 7

		Historical					Internal	
		2020	2021	2022	2023	2024	Trust	Site
Q46	Treated with kindness and compassion	-	-	-	100%	99%	99%	99%
Q47	Treated with respect and dignity overall	98%	97%	98%	100%	97%	97%	97%
Q48	Rated overall experience as 7/10 or more	86%	78%	76%	77%	78%	78%	78%

6. Friends and Family Test

		Historical					Internal	
		2020	2021	2022	2023	2024	Trust	Site
Q46	Treated with kindness and compassion	-	-	-	100%	99%	99%	99%
Q47	Treated with respect and dignity overall	98%	97%	98%	100%	97%	97%	97%
Q48	Rated overall experience as 7/10 or more	86%	78%	76%	77%	78%	78%	78%

In addition to the national survey results, the Trust utilises the Friends and Family Test. This is an important real time feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback, on their experience. Listening to the views of patients helps identify what is working well, what can be improved and how. The Trust receives a monthly report, which is shared with all wards and departments.

The FFT asks people about their overall experience of services they have used and offers a range of responses.

Table 4 and Graph 1 demonstrates that the Trust is marginally below the national average for both overall response rate and positive response rate for inpatients responders. It also shows that for August we are above the national average for positive feedback for the Emergency department.

Looking at graph 2, it is evident that although near to the national average for response rates, we need to improve our response rate to ensure we capture as much feedback as possible to allow for learning from those areas who receive consistently positive feedback and those areas that require improvement.

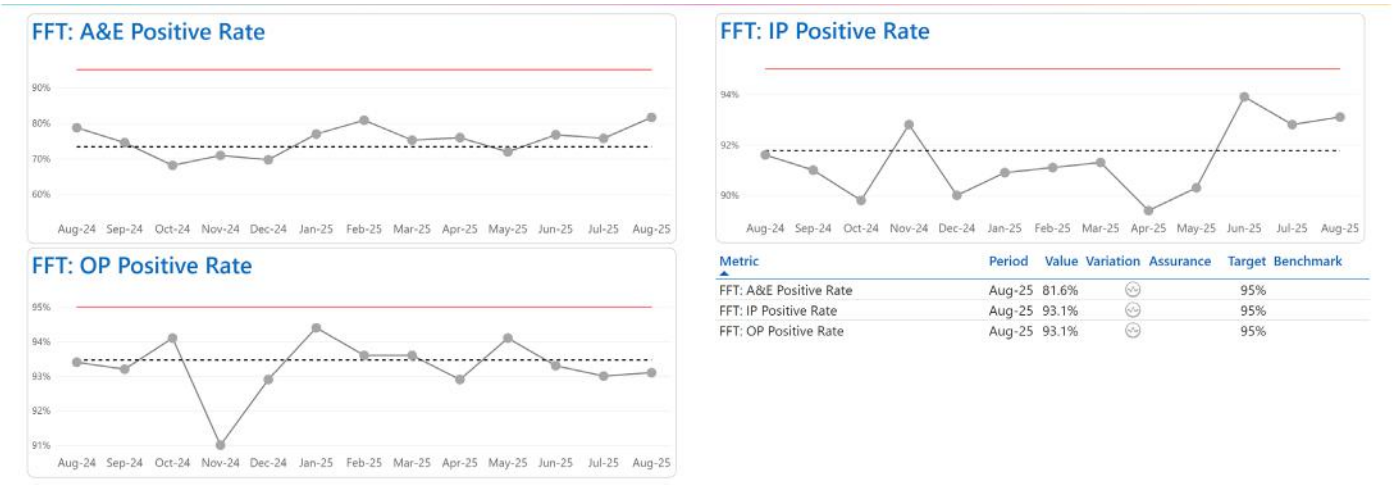
Image 1 shows that for August 2025 our overall Friends and Family Test scores was a 91.08% positive score, with 3139 responses (Image 1). This can also be broken down by ward, and staff can view all comments made.

With the reinvigorated Patient Experience group led by the Director of Nursing and extremely positive engagement from our ward managers and matrons, it provides an excellent platform for sharing the monthly reports from FFT and identifying themes and actions.

Table 4 – Trust FFT August 2025

	Trust Positive Response	Average National Positive	Trust Response Overall	Average National Response
FFT ED	86.1%	78%	11.9%	13%
FFT IP	93.1%	94%	22.8%	23%
FFT OP	93.1%	94%	9.2%	12%

Graphs 1



Graphs 2

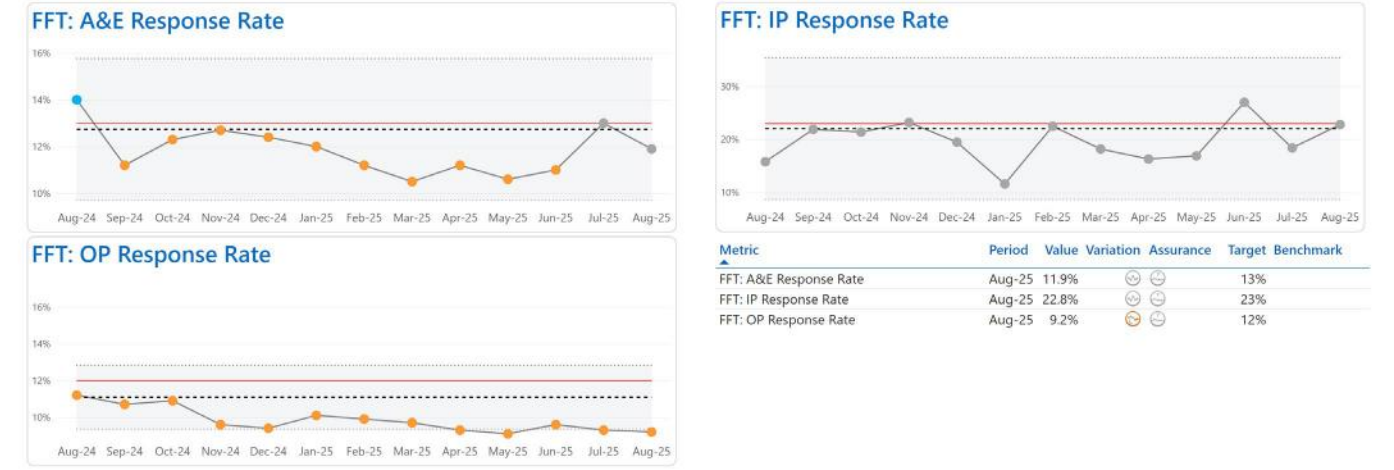
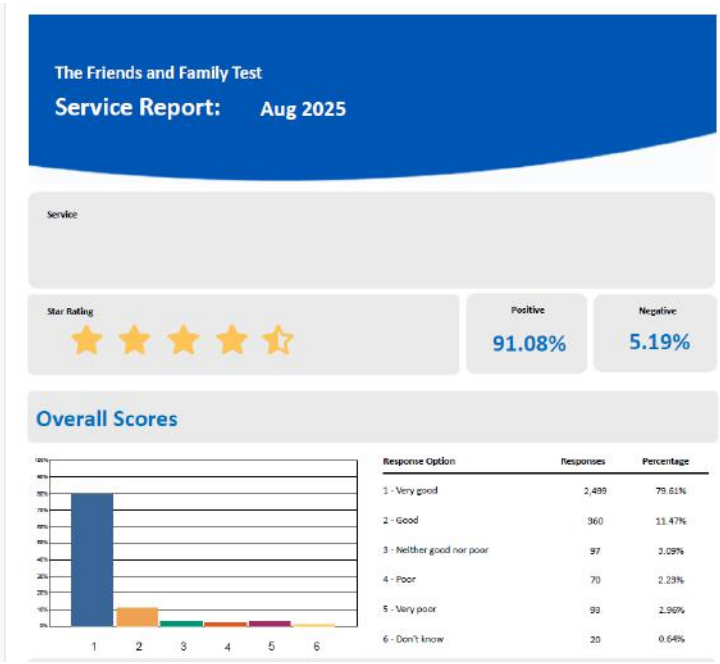


Image 1



7. Conclusion

The Inpatient Survey results are disappointing as our patient experience is not at the standard we would want. The immediate focus is to improve patient and family satisfaction and experience of any patient or family member who touches the Countess of Chester at any point of the healthcare journey.

Utilising both the results from the Inpatient survey, with a focus on leaving hospital, and the monthly Friends and Family Test, an action plan (Appendix 1) is in development, being split into 4 areas of focused improvement and will be monitored through the Patient Experience Group.

Trust has demonstrated improvement in some questions and in particular the two overall question responses demonstrating that 99% of patients responded that they were treated with kindness and compassion and 97% of patients said they were treated with respect and dignity overall.

Working closely with the Business Intelligence team we can identify areas with low response rates and areas where improvement is required in the positive response rates.

A task and Finish group has been established to review the way we capture the FFT, which currently is by text message or by written postcard and to look to move to iPad/tablets to capture feedback real-time as part of the discharge process in each ward or department.

The next Inpatient Survey cohort will be patients who spend one night in hospital in November 2025, with data collection running through January to April 2026, so it is crucial that there is a swift response to the survey results.

8. Recommendations

The Board of Directors are asked to

- Note the contents of the paper
- Note the development of an action plan
- Note the governance and monitoring of the action plan of the Patient Experience Group led by the Director of Nursing.

Appendix 1 - High level action plan

Theme from Inpatient Survey	Actions	Monitoring and Evidence
Admission	Significant work has been undertaken regarding length of time patients are waiting in the Emergency Department. Trust wide focus on patient flow	Integrated Performance Report – Emergency Department indicators
Noise sleeping (from other patients)	• Dementia care • This is me • Violence and Aggression steering group actions • Increase awareness of ward teams • Patient Flow – appropriate bed placement • Offer of ear plugs/eye masks • Monitoring of out of hours bed moves	• Violence and aggression steering group • Quality, Safety and Experience Strategy group • Patient Experience Group
Communication	Review and standardise Patient Information leaflets Ward managers touching base with every patient every day Matron and senior nurse walkabouts and subsequent actions Review of translation and Interpretation offer and services Review Friends and Family Test process to improve response rates which in turn provides timely patient feedback and identify any actions for improvement	• Quality, Safety and Experience Strategy group • Striving for Excellence Ward accreditation • Feedback from Senior Nurse Walkabouts • FFT Improvement Steering Group
Discharge	E- discharge task and finish to ensure timely and of good quality discharge summaries. Senior Nurse led Transfers of care meeting with Cheshire West Place. Infection Prevention, Tissue Viability, District nurses, therapy. Improve Discharge planning in collaboration with patients and family/carers including review of ward rounds- timing and attendance. Review Patient information Leaflets, what is available, sign posting to external services Follow up phone-calls – some areas are undertaking follow up calls for timely feedback of hospital stay and discharge Review, development and implementation of Discharge checklist Consistent standard	Transfers of care meeting – joint with CWP Friends and Family Test Improvement Steering Group Integrated Performance Report

Adult Inpatient Survey 2024

Site report

COUNTESS OF CHESTER HOSPITAL

June 2025

Adult Inpatient Survey 2024

Survey background

The Adult Inpatient Survey runs every year. All eligible organisations in England are required to conduct the survey.

In 2024, the survey ran in the same format as in 2023. However, for the 2020 survey there were several significant methodology changes:

- The survey mode changed from paper only to mixed mode. At the start of fieldwork, patients were only offered the option to complete the survey online, and later in fieldwork were provided with a paper questionnaire.
- The online survey was available in nine non-English languages and included accessibility settings.
- The sampling month changed from July to November.
- Patients were sent reminders to complete via SMS as well as post.
- The questionnaire was re-evaluated to reduce its length and ensure the content remained in line with current policy and practice.
- Materials such as letters and the multilanguage sheet were updated to reflect the new methodology.

As an approved survey contractor, we worked with 61 organisations on the Adult Inpatient Survey 2024. This report shows your results in comparison to the organisation's overall results and your performance historically.

Adult Inpatient Survey 2024

Methodology

The questionnaire used for the Adult Inpatient Survey 2024 was developed by the CQC and their Survey Coordination Centre. The CQC have comprehensive guidelines on which patients must be included in the survey, available here:

https://nhssurveys.org/wp-content/surveys/02-adults-inpatients/03-instructions-guidance/2024/Survey%20handbook.docx

A copy of the questionnaire can be found here:

https://nhssurveys.org/wp-content/surveys/02-adults-inpatients/02-survey-materials/2024/Core%20Questionnaire.docx

Reporting

The report uses “positive score” as its primary unit of measurement. Counts are also displayed, where relevant. This allows you to compare your results historically, and to the organisation’s overall results on a question-by-question basis, for all questions that can be positively scored.

For further information about positive scores, significant differences and sample sizes, please see Appendix 2.

How to use this report

When deciding which areas to act upon, a useful approach is to look at a particular section and follow these steps:

- Identify any key questions where you wish to highlight the results. The positive score summary is the first step to pick out any questions where the results are significantly different to the organisation's overall results. This allows you to feed back on where your site performs better than the average as well as where you may wish to focus improvement activities.

- Review your site's performance over time. Our report highlights significant changes from your previous survey and longer term trends over the last several years. Are there particular areas which have been improving or declining over time?

Overview of results

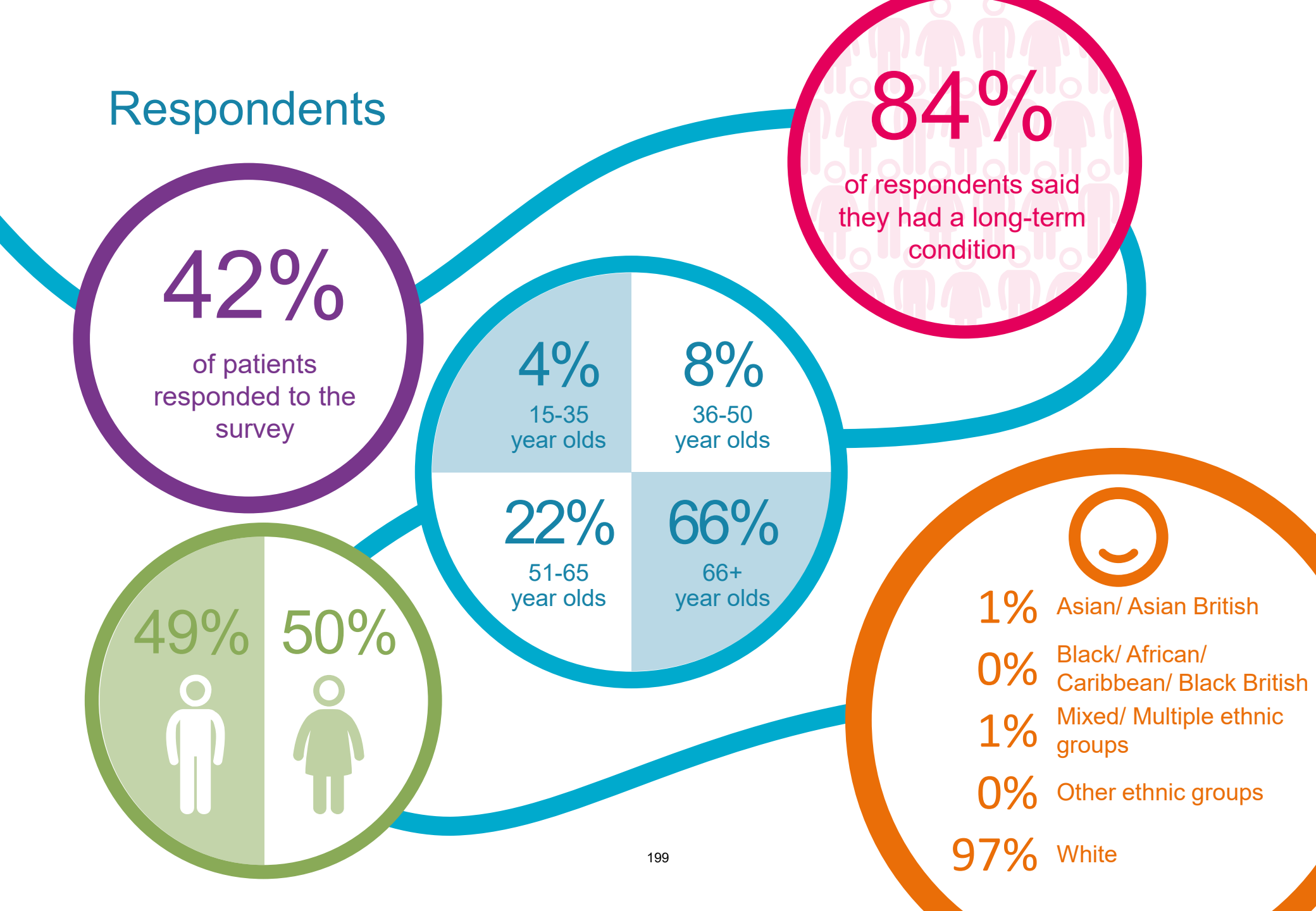
Survey activity

42% Overall response rate (total returned as a % of total eligible)

Response totals:

Outcome	Respondents
Invited	1250
Questionnaire returned completed	477
Sample member deceased prior to fieldwork	57
Sample member reported as having died	38
Sample member ineligible for participation in the survey	0
Sample member opted out or returned a blank survey	19
Questionnaire returned undelivered	16
No response received	643

Respondents



Positive score summary

Historical and organisation comparison

Historical comparisons

This section compares your latest results to your historical scores, as well as to the organisation's scores, across a 5 survey period.

How to read the tables

- These tables contain *positive scores:* higher scores indicate better performance. For an in-depth explanation of positive scoring, see Appendix 2.
- Coloured cells show where this year's score is *significantly different* to the score in the column to its left (e.g. last year's score, or the organisational average). Green cells indicate a significantly improved score, and red cells show a significantly worse score. For an in-depth explanation of significance testing, see Appendix 2.
- The left hand section of the table contains historical scores, which show all your positive scores for previous years.
- The right hand side of the table shows your score for this year vs. the average for your organisation.

Example Table:

		Historical					Internal	
		2020	2021	2022	2023	2024	Organisation	Site
Q2	Did not mind waiting as long as did for admission	59%	61%	67%	62%	62%	58%	64%
Q5	Did not have to wait too long to get to a bed on a ward	-	-	-	-	69%	74%	75%

ADMISSION TO HOSPITAL & THE HOSPITAL AND WARD (part 1 of 2)

		Historical					Internal	
		2020	2021	2022	2023	2024	Trust	Site
Q2	Did not mind waiting as long as did for admission	62%	63%	61%	76%	71%	71%	71%
Q4	Quality of information given while on waiting list to be admitted was very or fairly good	-	-	-	88%	83%	83%	83%
Q5	Did not have to wait too long to get to a bed on a ward	-	61%	61%	52%	50%	50%	50%
Q7	How long waited before been admitted onto a ward	-	-	-	-	73%	73%	73%
Q8	Not prevented from sleeping at night	-	-	-	36%	37%	37%	37%
Q10	Staff explained reasons for changing wards at night	79%	75%	72%	74%	79%	79%	79%

Key: '' = suppressed, '-' = question not asked, Empty cell = No historic data*

ADMISSION TO HOSPITAL & THE HOSPITAL AND WARD (part 2 of 2)

		Historical					Internal	
		2020	2021	2022	2023	2024	Trust	Site
Q11	Room or ward very or fairly clean	97%	97%	95%	95%	95%	95%	95%
Q12	Got enough help from staff to wash or keep clean	92%	89%	92%	90%	89%	89%	89%
Q13	Able to take own medication when needed to	88%	83%	75%	82%	85%	85%	85%
Q14	Got enough help from staff to eat meals	85%	75%	78%	85%	86%	86%	86%
Q15	Able to get food outside of meal times	-	68%	75%	77%	79%	79%	79%
Q16	Got enough to drink	96%	94%	92%	93%	92%	92%	92%

Key: '' = suppressed, '-' = question not asked, Empty cell = No historic data*

DOCTORS & NURSES

		Historical					Internal	
		2020	2021	2022	2023	2024	Trust	Site
Q17	Doctors answered questions in a way patient could understand	96%	95%	96%	94%	94%	94%	94%
Q18	Had confidence and trust in the doctors	98%	97%	98%	98%	97%	97%	97%
Q19	Doctors included patient in conversation	95%	97%	97%	97%	97%	97%	97%
Q20	Nurses answered questions in a way patient could understand	98%	97%	98%	97%	95%	95%	95%
Q21	Had confidence and trust in the nurses	98%	98%	98%	99%	98%	98%	98%
Q22	Nurses included patient in conversation	96%	97%	96%	96%	97%	97%	97%
Q23	Always or sometimes enough nurses on duty	93%	90%	87%	87%	88%	88%	88%

Key: '' = suppressed, '-' = question not asked, Empty cell = No historic data*

YOUR CARE AND TREATMENT (part 1 of 2)

		Historical					Internal	
		2020	2021	2022	2023	2024	Trust	Site
Q24	Staff did not contradict each other about care and treatment	70%	70%	65%	67%	64%	64%	64%
Q25	Was involved in decisions about care and treatment	80%	75%	78%	80%	78%	78%	78%
Q26	Right amount of information given on condition or treatment	81%	76%	78%	79%	75%	75%	75%
Q27	Felt able to discuss worries and fears with staff	88%	89%	90%	90%	91%	91%	91%
Q28	Given enough privacy when being examined or treated	98%	98%	99%	98%	99%	99%	99%
Q29	Staff helped control pain	97%	96%	97%	99%	**96%**	96%	96%

Key: '' = suppressed, '-' = question not asked, Empty cell = No historic data*

YOUR CARE AND TREATMENT (part 2 of 2)

		Historical					Internal	
		2020	2021	2022	2023	2024	Trust	Site
Q30	Staff helped when needed attention	97%	99%	98%	99%	98%	98%	98%
Q31_1	Hospital staff took into account language needs (Excluding respondents who answered using a smartphone)	-	-	-	-	89%	89%	89%
Q31_2	Hospital staff took into account cultural needs (Excluding respondents who answered using a smartphone)	-	-	-	-	81%	81%	81%
Q31_3	Hospital staff took into account religious needs (Excluding respondents who answered using a smartphone)	-	-	-	-	*	*	*
Q31_4	Hospital staff took into account accessibility needs (Excluding respondents who answered using a smartphone)	-	-	-	-	88%	88%	88%
Q31_5	Hospital staff took into account dietary needs (Excluding respondents who answered using a smartphone)	-	-	-	-	80%	80%	80%

Key: '' = suppressed, '-' = question not asked, Empty cell = No historic data*

LEAVING HOSPITAL (part 1 of 2)

		Historical					Internal	
		2020	2021	2022	2023	2024	Trust	Site
Q33	Information given about the risks and benefits of continuing treatment on a virtual ward	-	-	-	85%	68%	68%	68%
Q34	Enough information given about care and treatment while on a virtual ward	-	-	-	94%	80%	80%	80%
Q35	Felt involved in decisions about discharge from hospital	77%	73%	72%	73%	68%	68%	68%
Q36	Staff involved family or carers in discussions about leaving the hospital	-	-	56%	65%	**55%**	55%	55%
Q37	Staff discussed need for additional equipment or home adaptation after discharge	87%	88%	80%	85%	77%	77%	77%
Q38	Given enough notice about when discharge would be	89%	88%	85%	86%	83%	83%	83%
Q39	Given information about what they should or should not do after leaving hospital	-	77%	74%	72%	71%	71%	71%

Key: '' = suppressed, '-' = question not asked, Empty cell = No historic data*

LEAVING HOSPITAL (part 2 of 2)

		Historical					Internal	
		2020	2021	2022	2023	2024	Trust	Site
Q40	Understood information about what they should or should not do after leaving hospital	-	98%	95%	96%	98%	98%	98%
Q41	Given information about medicine at discharge	87%	87%	84%	83%	83%	83%	83%
Q42	Before leaving hospital knew what would happen next with care	82%	84%	81%	83%	80%	80%	80%
Q43	Staff told patient who to contact if worried after discharge	77%	68%	61%	70%	67%	67%	67%
Q44	Staff discussed need for further health or social care services after discharge	80%	78%	74%	79%	77%	77%	77%
Q45	Got enough support from health or social care professionals after discharge	81%	77%	73%	77%	74%	74%	74%

Key: '' = suppressed, '-' = question not asked, Empty cell = No historic data*

OVERALL

		Historical					Internal	
		2020	2021	2022	2023	2024	Trust	Site
Q46	Treated with kindness and compassion	-	-	-	100%	99%	99%	99%
Q47	Treated with respect and dignity overall	98%	97%	98%	100%	**97%**	97%	97%
Q48	Rated overall experience as 7/10 or more	86%	78%	76%	77%	78%	78%	78%

Key: '' = suppressed, '-' = question not asked, Empty cell = No historic data*

Appendix 1

Results poster

Adult Inpatient Survey 2024

COUNTESS OF CHESTER HOSPITAL Results

Thank you everyone who took part in the survey. Here are our top line results.

Place logo here

Most improved scores since 2023

- 79% Q10. Staff explained reasons for changing wards at night
- 79% Q15. Able to get food outside of meal times
- 85% Q13. Able to take own medication when needed to
- 98% Q40. Understood information about what they should or should not do after leaving hospital
- 78% Q48. Rated overall experience as 7/10 or more

Our views

78% Q48. Rated overall experience as 7/10 or more

97% Q47. Treated with respect and dignity overall

97% Q18. Had confidence and trust in the doctors

To find out more about the survey and our results please contact .....

Appendix 2

How your scores are calculated

How your scores are calculated (part 1 of 3)

Positive scoring

We use the concept of 'positive scores' as a summary measure, to help monitor your results over time and to show how the site compares to the organisation's overall results. The positive score shows the percentage of respondents who gave a favourable response to applicable questions. Not all questions will have a positive score; exceptions include background details such as gender, ethnic group, or age. There are five main types of positive scoring questions within the survey:

- Yes/No – Only the Yes response is counted as a positive (in positively phrased questions)
- 5 point scale – Positive scores report the percentage of people who were happy/satisfied with their experience (e.g. Strongly Agree + Agree / Very Satisfied + Satisfied)
- 3 point scale – Positive scores report the percentage of people who had some level of satisfaction with their experience (e.g. Yes, definitely, Yes, sometimes)
- Never – Where questions are in regards to physical violence, abuse or bullying, only the never option is counted as a positive score
- Reporting incidents – Where physical/verbal abuse or harassment is reported, all answer options for reporting the incident are added together to counts as a positive score

Example positive score table:

	Your organisation	All similar organisations
Base (all respondents)	200	1000
	100.0%	100.0%
Strongly disagree	20	113
	10.0%	11.3%
Disagree	35	226
	17.5%	22.65
Neither agree nor disagree	45	212
	22.5%	21.2%
***Agree**	**35**	346
	17.5%	34.6%
***Strongly agree**	**65**	103
	32.5%	10.3%

* We combine the positive responses to create a positive score for this question: 50%.

How your scores are calculated (part 2 of 3)

Suppression (low respondent numbers)

The questionnaires used include filtered questions, whereby only relevant questions are asked of respondents. So, for example, respondents reporting that their discharge was not delayed would not be asked subsequent questions about their delayed discharge.

Due to this filtering that the number of respondents in the subsequent questions sometimes drop below the required minimum for analysis. For respondent confidentiality these results are not shown in the report but replaced with the * symbol. This threshold is 30 respondents for the Adult Inpatient Survey 2024.

Routed questions

Routed questions are designed to make sure that respondents respond only to questions which are relevant to their experience. For example “Q1 Was your most recent overnight hospital stay planned in advance or an emergency?” routes patients whose admission was urgent or an emergency to Q5, and those whose stay was planned in advanced are asked further about this experience at Q2.

How your scores are calculated (part 3 of 3)

Rounding (percentages)

Throughout the report (with the exception of the Frequency Tables) partial percentages have been rounded to the nearest whole number.

- e.g. 12.8% is rounded up to 13%, while 5.3% would be rounded down to 5%.

Significance testing

We identify questions where there are significant differences between your site and the organisation average, or between your site this year and the previous survey.

By 'significant' difference, we mean that the finding is statistically reliable and we can be confident that the result reflects a real difference.

The calculation used to test the statistical significance of scores is the Agresti-Coull modification of the “z-test” (shown below). The Z-test calculates the differences between two proportions. Any result where the value of Z is greater than 1.96 is marked as “statistically significant”.

The form of the test for two proportions $\frac{n_1}{N_1}$ and $\frac{n_2}{N_2}$ is:

$$Z = \frac{(\tilde{p}_1 - \tilde{p}_2)}{\sqrt{\frac{\tilde{p}_1(1-\tilde{p}_1)}{N_1+2} + \frac{\tilde{p}_2(1-\tilde{p}_2)}{N_2+2}}}$$

where $\tilde{p}_1 = \frac{n_1+1}{N_1+2}$ and $\tilde{p}_2 = \frac{n_2+1}{N_2+2}$

n_1 = number with positive score, sample 1
n_2 = number with positive score, sample 2
N_1 = base size, sample 1
N_2 = base size, sample 2

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Picker

PUBLIC – Board of Directors
30th September 2025

Report	**Agenda Item 16.**	**Integrated Performance Report (IPR) – June 2025**						
Purpose of the Report	Decision		Ratification		Assurance	X	Information	
Accountable Executive	Cathy Chadwick Sue Pemberton Nigel Scawn Karen Edge Vicki Wilson		Chief Operating Officer Director of Nursing/Deputy CEO Medical Director Chief Finance Officer Chief People Officer					
Author(s)	Cathy Chadwick		Chief Operating Officer					
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 X X X X	This report covers 5 areas of the BAF and therefore changes in performance in any of the areas can affect risk score on the BAF.				
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health						X X X X X X	
CQC Domains	Safe Effective Caring Responsive Well led						X X X X X	
Previous considerations	Not applicable							
Executive summary	The purpose of this report is to: • Summarise the key performance indicators. • Assure the Board of the monthly oversight of Trust priorities against agreed targets. • Highlight areas of high or low performance. Areas of positive assurance: • A sustained reduction in ambulance turnaround times over 30 and 60 minutes • A reduction in the number of patients receiving care on the Emergency Department corridor • 0 never Events • 0 Steis reportable incidents in month							

	• Reduction in Hospital Acquired Pressure Ulcers • Exceeded the target for annual appraisal compliance • Exceeded the target for mandatory training compliance Areas requiring improvement: • Patient feedback – complaints open at month end • Emergency Medicine Performance • Total size of waiting list • 18-week RTT compliance
Recommendations	The Board of Directors is asked to consider and note the contents of the Report.

Corporate Impact Assessment	
Statutory/regulatory requirements	Monitors performance against key targets both quality and performance measures.
Risk	Report relates to 5 areas of the BAF risks
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics
Communication	Not confidential

NHS
Countess of Chester Hospital
NHS Foundation Trust

Integrated Performance Report

Report to end of August 2025

Data Quality Assurance Matrix (DQAM)

The DQAM 'kitemarking' has been added to the IPR from September 2025 to provide assurance on the quality of data included within the report.

The DQAM has been added to the report for the following metrics:

- Mixed Sex Accommodation (MSA) - substantial assurance
- VTE - substantial assurance

All metrics on the IPR will be reviewed by the end of the financial year.

The review is undertaken by the Data Governance team and reviews the following areas:

D - Data Capture & Robust Systems	Are there robust systems which have been documented according to data dictionary standards for data capture such that it is at a sufficient granular level?
Q - Quality - Timely & Complete	Is the data available and up to date at the time someone is attempting to use it to understand the data. Are all the elements of information needed present in the designated data source and no elements of needed information are missing?
M - Management of Sign Off and Validation	Is there a named responsible person apart from the person who produced the report who can sign off the data as a true reflection of the activity? Has the data been checked for validity and consistency?
A - Assurance - Audit & Accuracy	Are there processes in place for either external or internal audits of the data and how often do these occur (Annual / One Off)?

COCH IPR: What is an SPC chart?

Countess of Chester Hospital NHS Foundation Trust

A statistical process control (SPC) chart shows data over time. Process limits show how much variability there is in the data to the chart and patterns are highlighted to show where a change is statistically significant. If there is a target, this variability can be used to provide assurance on whether the target is likely to be met in future.

XmR chart

The most common SPC chart type is the XmR chart. Each data point is shown as a grey dot on a grey line. From this data, the mean is calculated and added between the dots as a solid line, and process limits are added as grey dashed lines. If there is a target, it is shown as a red dashed line.

Process limits

In a stable process, over 99% of data points are expected to lie between the process limits. For reporting, the upper and lower process limit values are usually given as the range of expected values going forward.

Special cause variation & common cause variation

Data naturally varies but if this variation is statistically significant, this is called special cause variation and the grey dots are instead shown as blue or orange, depending on whether a higher value is better or worse – blue is used for improving performance, orange for concerning performance. If not significant, the dots stay grey and this is called common cause variation.

The four rules used to trigger special cause variation on the chart, as advised by the Making Data Count team at NHS England, are:

- a point beyond the process limits
- a run of points all above or all below the mean
- a run of points all increasing or all decreasing
- two out of three points close to a process limit as an early warning indicator

Recalculations

After a sustained change, a recalculation may be added. This splits the chart with the mean and process limits calculated separately using the data before and after. This gives a more accurate reflection on the system as it currently stands.

Baselines

Baselines are commonly set as part of an improvement project, which are shown with solid line process limits. The mean and process limits are calculated from the data in this period and fixed in place for the data points afterwards. This will more easily show if a change has occurred. If a recalculation is later added, the fixed mean and process limits end and are recalculated from the data starting at this point.

Summary icons

Summary icons are shown in the top-right of the chart and explained on the *Icon Descriptions* page.

Ghosting

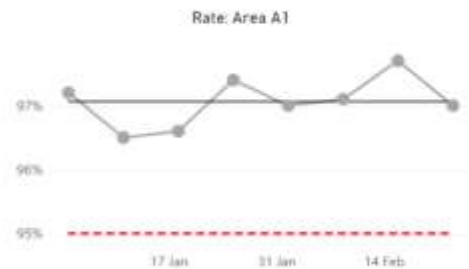
There is sometimes a need to remove a data point from the chart because it is a known anomaly – for example, a high referral count after a one-off migration – and will skew the data to render the chart meaningless. An alternative is to ghost the data point. The data point remains visible on the chart as a white dot but is excluded from all calculations.

Annotations

If a dot has a black circle around it, there is an annotation that can be viewed in a tooltip by placing the mouse cursor over it in the interactive version of the report.

Not enough data points?
An SPC chart requires enough data for a robust analysis. If there are too few data points, the SPC elements are not displayed.

Purple dots
It is not always possible to say that higher values are better or worse, for which purple is used instead of blue and orange.



COCH IPR: Scorecard SPC Icon Matrix

NHS Countess of Chester Hospital NHS Foundation Trust

Variance - Is the measure getting better/worse?	Assurance - Can the target be consistently achieved?			
	Consistently hits target	Target not consistently achieved or failed	Consistently fails target	No target set / insufficient data points
Special Cause Improvement	Reduction in Agency Shifts over Cap Rates: Nursing & Midwifery	Neonatal Deaths Sickness Absence Rate Annual Appraisal Compliance Mandatory Training Compliance	ED: Patients waiting no more than 4 hours (%) ED: Patients waiting no more than 4 hours - Type 1 (%) ED: Patients waiting over 12 hours (%) ED: Patients waiting over 12 hours ED: Patients waiting over 12 hours from decision to admit to admission Ambulance: Handovers 30-60 minutes Ambulance: Handovers 60+ minutes Patient Initiated Follow Up (%) E-Discharge Overall Compliance (within 24%)	SHMI - *no target, but indicator is "as expected"* Hospital Standardised Mortality Ration (HSMR) - *no target, but indicator banding is "as expected"*
Common Cause Variation	Patient Feedback: Complaints Opened In Month Eclampsia Maternal Deaths	RTT: Incomplete pathways - Waiting over 78 weeks RTT: Incomplete pathways - Waiting over 104 weeks Cancer Treatments: 31 Day Standard Cancer Treatments: 62 Day Standard Incidents: STeIS reported incidents Incidents: Never events Incidents: Mixed sex accomodation incidents Incidents: All incidents Incidents: All incidents with moderate harm and above Incidents: Medication incidents with harm Falls: All - Rate Per 1000 Bed Days Falls: With Harm - Rate Per 1000 Bed Days Pressure ulcers: Hospital acquired - Rate per 1000 bed days Infection Control: C.Difficile Cases FFT: A&E Response Rate FFT: IP Response Rate VTE: Assessment Completed Compliance Fill rates: Registered Staffing (%) Fill rates: Unregistered Staffing (%) Term Admission Rate Sections Rate PPH rate per 1000 births Tears rate per 1000 births Stillbirths Reduction in Agency Shifts over Cap Rates: Medical & Dental	RTT: Incomplete pathways - Waiting up to 18 weeks (%) RTT: Incomplete pathways - Waiting over 65 weeks Diagnostics Test Exceeding 6 Weeks Waiting Time (DM01) VTE: 14 Hour Compliance	Mortality - Total Inpatient Deaths - *no target, but value is in the normal range* Present On Admission Pressure Ulcers Rate Per 1000 Bed Days - *target to be identified* Patient Feedback: Concerns Open At Month End - *target to be identified* FFT - A&E Positive Rate - *Insufficient data points for assurance* FFT - IP Positive Rate - *Insufficient data points for assurance* FFT - OP Positive Rate - *Insufficient data points for assurance* Women Delivered - *no target, but value is in the normal range* Live Births - *no target, but value is in the normal range* Births in Co-located MLU - *no target, but value is in the normal range* Other Reduction in Agency Shifts over Cap Rates - *target to be identified*
Special Cause Concern	Staff Turnover Percentage	Cancer Treatments: 28 Day FDS Incidents: Medication incidents Infection Control: MRSA Cases Patient Feedback: Concerns Opened In Month FFT: OP Response Rate Better Payment Practice Code (value) Better Payment Practice Code (number)	RTT: Incomplete pathways - Total RTT: Incomplete pathways - Waiting over 52 weeks RTT: Incomplete pathways - Waiting over 52 weeks (%) RTT Wait for 1st OP Appt - % waiting <18 weeks Diagnostics: % waiting less than 6 weeks - All NC2R: Total Delayed Days Patient Feedback: Complaints Open At Month End	

NHS oversight framework published on 9th September. External data to be updated quarterly

Countess of Chester Hospital

TABLE 1: SCORED METRICS (Contributing to Segmentation)

Metric	Type	Latest MHS Value	Previous MHS value	*	Rank	Time period	Target or Threshold	Current Score				Overall Domain Score	Overall Domain Segment
								Score 1	Score 2	Score 3	Score 4		
ACCESS TO SERVICES DOMAIN													
% patients waiting <18 weeks (absolute)	Acute	48.89%	47.07%	↑	130/131	Jun-25	65%				3.98	3.21 (3.04)	4
% patients waiting <18 weeks (vs plan)	Acute	-1.00%	-2.90%	↓	109/131	Jun-25	0%			3.04			
% patients waiting >52 weeks	Acute	8.28%	6.55%	↓	131/131	Jun-25	1%				4		
% patients waiting >52 weeks (community)	Community	10.60%	8.04%	↓	65/80	Jun-25	-			3.43			
% urgent referrals diagnosed within 4 weeks	Acute	78.58%	80.96%	↓	44/118	Q1 2025/26	80%		2.34				
% patients treated within 62 days	Acute	76.51%	78.49%	↓	25/118	Q1 2025/26	75%	1					
% A&E patients seen within 4 hours	Acute	61.20%	59.80%	↑	119/123	Q1 2025/26	78%				3.9		
% A&E attendances >12 hours	Acute	24.45%	25.90%	↑	122/123	Q1 2025/26	0%				3.98		
EFFECTIVENESS & EXPERIENCE DOMAIN													
Summary Hospital Level Mortality Indicator	Acute	As Expected	As Expected	⇔	S2	Apr-24-Mar 25	As Expected		2			2.54 (2.67)	4
Discharge delays (bed days lost) - including zero days - metric has changed	Acute	1.80	N/A		120/126	Jun-25	-				3.86		
CQC inpatient satisfaction	Acute	2	2	⇔	S2	2023			2				
Urgent Community Response 2-hour performance	Community	81.76%	82.35%	↓	28/51	Q1 2025/26	70%		2.32				
PATIENT SAFETY DOMAIN													
Staff survey - raising concerns	Acute/Community	5.93	5.93	⇔	127/134	2024				3.84		3.22 (3.12)	4
CQC safe inspection score	Acute/Community	3	3	⇔						3			
MRSA infections (rate)	Acute	3	1	↓	55/134	Jul-24 - Jun-25	0			2.63			
C-Difficile infections (rate)	Acute	1.11	1.11	⇔	41/134	Jul-24 - Jun-25	<1		2.38				
E-Coli infections (rate)	Acute	1.33	1.2		104/134	Jul-24 - Jun-25	<1			3.46			
PEOPLE & WORKFORCE DOMAIN													
Sickness absence rate	Acute/Community	6.04%	6.76%	↑	116/134	Q4 2024/25	-			3.31		3.55 (3.63)	4
Staff survey engagement score	Acute/Community	6.48	6.48	⇔	125/134	Dec-24	-			3.8			
FINANCE & PRODUCTIVITY DOMAIN													
Combined finance score (planned vs variance)	All Trusts	2	N/A		S2	Q1 2025/26			2			2.61	4
Planned surplus/deficit	Acute/Community	-9.38%	-8.90%	↓	129/134	Apr-25	Breakeven/ Surplus				4		
Variance YTD to plan (NEW Sep 25)	Acute/Community	0	-		54/134	Jun-25		1					
Implied productivity level	Acute	0.55%	-0.27		99/134	Mar-25	4% Imp			3.21			

*** arrow denotes improvement or deterioration from previous score**

COCH IPR: Scorecard

NHS
Countess of Chester Hospital
NHS Foundation Trust

Operational Metrics	Period	Value	Variation	Assurance	Target
ED: Patients waiting no more than 4 hours (%)	Aug-25	64.5%			78%
ED: Patients waiting no more than 4 hours - Type 1 (%)	Aug-25	51.6%			78%
ED: Patients waiting over 12 hours	Aug-25	750			0
ED: Patients waiting over 12 hours from decision to admit to admission	Aug-25	332			0
Ambulance: Handovers 30-60 minutes	Aug-25	276			0
Ambulance: Handovers 60+ minutes	Aug-25	11			0
RTT: Incomplete pathways - Waiting up to 18 weeks (%)	Aug-25	48.3%			60%
RTT: Incomplete pathways - Total	Aug-25	34479			26110
RTT: Incomplete pathways - Waiting over 52 weeks	Aug-25	3103			0
RTT: Incomplete pathways - Waiting over 65 weeks	Aug-25	208			0
RTT: Incomplete pathways - Waiting over 78 weeks	Aug-25	7			0
RTT: Incomplete pathways - Waiting over 104 weeks	Aug-25	0			0
RTT Wait for 1st OP Appt - % waiting <18 weeks	Aug-25	46.4%			67%
Patient Initiated Follow Up (%)	Aug-25	4.2%			5%
Diagnostics: % waiting less than 6 weeks - All	Aug-25	73.9%			99%
Cancer Treatments: 28 Day FDS	Jul-25	71.3%			77%
Cancer Treatments: 31 Day Standard	Jul-25	88.2%			96%
Cancer Treatments: 62 Day Standard	Jul-25	73.7%			85%
NC2R: Total Delayed Days	Aug-25	3564			1740
E-Discharge Overall Compliance (within 24%)	Aug-25	71.2%			95%

Maternity Metrics	Period	Value	Variation	Assurance	Target
Women Delivered	Aug-25	152			
Live Births	Aug-25	153			
Births in Co-located MLU	Aug-25	3			
Term Admission Rate	Aug-25	4.57%			4.8%
Sections Rate	Aug-25	42.7%			45%
PPH rate per 1000 births	Aug-25	72.3			30
Tears rate per 1000 births	Aug-25	32.8			28
Eclampsia	Aug-25	0			0
Maternal Deaths	Aug-25	0			0
Stillbirths	Aug-25	0			0
Neonatal Deaths	Aug-25	0			0

Quality & Safety Metrics	Period	Value	Variation	Assurance	Target
Mortality: SHMI	Apr-25	90			
Mortality: Total inpatient deaths	Aug-25	82			
Incidents: STeiS reported incidents	Aug-25	0			0
Incidents: Never events	Aug-25	0			0
Incidents: Mixed sex accomodation incidents	Aug-25	1			0
Incidents: All incidents	Aug-25	1184			1155
Incidents: All incidents with moderate harm and above	Aug-25	42			40
Incidents: Medication incidents	Aug-25	113			108
Incidents: Medication incidents with harm	Aug-25	0			0
Falls: All - Rate Per 1000 Bed Days	Aug-25	5.15			4.87
Falls: With Harm - Rate Per 1000 Bed Days	Aug-25	0.06			0.1
Pressure ulcers: Hospital acquired - Rate per 1000 bed days	Aug-25	0.970			1.22
Pressure ulcers: Present on admission - Rate per 1000 bed days	Aug-25	3.58			
Infection Control: C.Difficile Cases	Aug-25	6			4
Infection Control: MRSA Cases	Aug-25	1			0
Patient Feedback: Complaints Opened In Month	Aug-25	17			40
Patient Feedback: Complaints Open At Month End	Aug-25	32			7
Patient Feedback: Concerns Opened In Month	Aug-25	346			229
Patient Feedback: Concerns Open At Month End	Aug-25	95			
FFT: A&E Positive Rate	Aug-25	81.6%			95%
FFT: IP Positive Rate	Aug-25	93.1%			95%
FFT: OP Positive Rate	Aug-25	93.1%			95%
VTE: Assessment Completed Compliance	Aug-25	92.4%			95%
VTE: 14 Hour Compliance	Aug-25	76.9%			95%

HR & Finance Metrics	Period	Value	Variation	Assurance	Target
Sickness Absence Rate	Aug-25	4.89%			5%
Staff Turnover Percentage	Aug-25	9.52%			10%
Annual Appraisal Compliance	Aug-25	83.5%			80%
Mandatory Training Compliance	Aug-25	91.0%			90%
Reduction in Agency Shifts over Cap Rates: Medical & Dental	Aug-25	128			120
Reduction in Agency Shifts over Cap Rates: Nursing & Midwifery	Aug-25	16			1200
Reduction in Agency Shifts over Cap Rates: Other	Aug-25	116			
Better Payment Practice Code (value)	Aug-25	93.3%			95%
Better Payment Practice Code (number)	Aug-25	90%			95%

COCH IPR: Operational Performance Summary

Owner: Cathy Chadwick - Chief Operating Officer

NHS
Countess of Chester Hospital
NHS Foundation Trust

Highlights:

ED: In August we sustained our improvements in performance across all access KPIs within the ED. ED 4-hour performance was 64.5%; an improvement of 2.5% compared to previous month. 12- hour performance continued to recover with a sharp reduction in the number of type 1 patients waiting over 12-hours in the ED to 13.6% representing a 7.4% improvement compared to previous month. Corridor care was virtually eliminated during August with only 2 instances of patients spending time on a corridor during their ED stay for the whole of August. Coupled with this, all ambulance handover time metrics significantly improved.

RTT: Overall RTT 18-week compliance performance dipped to 48.3%, a 1.9% deterioration compared to July. This downturn in performance was also reflected in the % of open pathways waiting >52 weeks- 9% compared to 8.54% in July. Core capacity to deliver RTT improvements within a core number of specialties- ENT, Vascular and Dermatology remains an issue; however, they are being supported through (a) senior consultants validating the RTT waiting lists (Consultant Connect) and (b) external providers augmenting outpatient and theatre capacity through a combination of insourcing and outsourcing.

Cancer: 28-day Faster Diagnosis Standard (FDS) performance continued to decline, posting performance of 71.6%- a further deterioration of 4% compared to July and below the 77% target threshold. Under-performance primarily lies within Dermatology following a significant rise in skin 'fast-track' referrals since March '25. The Trust has engaged with an insourcing provider to augment cancer capacity within Dermatology since mid-July; 28-day FDS performance is expected to be back above target threshold by October '25.

Diagnostics: DM01 6-week performance declined by 4.2% to 73.9% primarily driven by performance reduction in echocardiography. The modality has an improvement action plan in place, however, the growth capacity required to improve performance has so far been unsuccessful despite a recent recruitment drive.

Areas of concern:

The pace of rolling out the additional RTT capacity provided through insourcing and outsourcing needs to be expedited; this is key to both delivery of RTT access targets by financial year and end and moving back on track with monthly performance recovery trajectories. In September, insourcing capacity for Dermatology will move from primarily supporting cancer access to long wait patients, ENT will continue to utilise insourcing for long waits. Outsourcing of Vascular activity will commence in October. However, key to delivery of a sustainable waiting list lies in the ICB implementing a revised policy for varicose veins referrals.

28-day Faster Diagnosis Standard (FDS) performance continues to deteriorate however this is expected to improve in September and deliver by October as a result of the additional insourcing capacity provided in July and August.

Echocardiography DM01 performance continues to drive the Trust's performance against DM01; the improvement action plan needs re-visiting as actions required have yet to be realised.

Forward look (with action):

September Board approval of Winter Plan.

ICB planned roll-out of interim Vascular referral policy and COCH implementing Vascular outsourcing.

Continuation of engagement with Consultant Connect within ENT, Dermatology and Vascular specialties.

COCH IPR: Operational Performance Scorecard

Countess of Chester Hospital NHS Foundation Trust

Operational Metrics	Period	Value	Variation	Assurance	Target	Benchmark
ED: Patients waiting no more than 4 hours (%)	Aug-25	64.5%			78%	Aug 25 | 75.9%
ED: Patients waiting no more than 4 hours - Type 1 (%)	Aug-25	51.6%			78%	Aug 25 | 62.0%
ED: Patients waiting over 12 hours (%)	Aug-25	9.55%			0%	
ED: Patients waiting over 12 hours	Aug-25	750			0	
ED: Patients waiting over 12 hours - Type 1 (%)	Aug-25	13.6%				Jul 25 | 8.3%
ED: Patients waiting over 12 hours - Type 1	Aug-25	708				
ED: Attendances	Aug-25	7447				
ED: Attendances - Type 1	Aug-25	5918				
ED: Attendances - Type 3	Aug-25	2249				
ED: Patients waiting over 12 hours from decision to admit to admission	Aug-25	332			0	
ED: Attendances with a stay in a corridor location	Aug-25	2				
ED: Attendances for mental health conditions	Aug-25	140				
ED: Mental Health patients waiting over 12 hours	Aug-25	48				
Avg Time To Ambulance Handover (mins)	Aug-25	21				
Ambulance: Handovers 30-60 minutes	Aug-25	276			0	
Ambulance: Handovers 60+ minutes	Aug-25	11			0	
Ambulance: Total Ambulance Arrivals	Aug-25	1516				
% of patients admitted following ED attendance - aged under 18	Aug-25	13.1%				
% of patients admitted following ED attendance - aged over 65	Aug-25	47.3%				
RTT: Incomplete pathways - Waiting up to 18 weeks (%)	Aug-25	48.3%			60%	Jul 25 | 61.3%
RTT: Incomplete pathways - Total	Aug-25	34479			26110	
RTT: Incomplete pathways - Waiting over 52 weeks	Aug-25	3103			0	
RTT: Incomplete pathways - Waiting over 65 weeks	Aug-25	208			0	
RTT: Incomplete pathways - Waiting over 78 weeks	Aug-25	7			0	
RTT: Incomplete pathways - Waiting over 104 weeks	Aug-25	0			0	
RTT: Incomplete pathways - Waiting over 52 weeks (%)	Aug-25	9%			1%	Jul 25 | 2.6%
RTT Wait for 1st OP Appt - % waiting <18 weeks	Aug-25	46.4%			67%	
Patient Initiated Follow Up (%)	Aug-25	4.2%			5%	Jul 25 | 3.4%
DNA Rates (%)	Aug-25	5.2%				Jun 25 | 6.4%

Operational Metrics	Period	Value	Variation	Assurance	Target	Benchmark
Advice and Guidance Utilisation Rate (%)	Jul-25	27.2%				Jun 25 | 34.0%
Advice and Guidance Diversion Rate (%)	Jul-25	19.3%				Jun 25 | 21.0%
Diagnostics: % waiting less than 6 weeks - All	Aug-25	73.9%			99%	Jul 25 | 78.1%
Diagnostics: % waiting less than 6 weeks - Magnetic Resonance Imaging	Aug-25	86.2%			99%	Jul 25 | 83.2%
Diagnostics: % waiting less than 6 weeks - Computed Tomography	Aug-25	94.1%			99%	Jul 25 | 89.0%
Diagnostics: % waiting less than 6 weeks - Non-obstetric ultrasound	Aug-25	79.6%			99%	Jul 25 | 80.9%
Diagnostics: % waiting less than 6 weeks - Barium Enema	Aug-25	100%			99%	Jul 25 | 81.6%
Diagnostics: % waiting less than 6 weeks - DEXA Scan	Aug-25	94%			99%	Jul 25 | 86.4%
Diagnostics: % waiting less than 6 weeks - Audiology - Adult Assessments	Aug-25	83.2%			99%	
Diagnostics: % waiting less than 6 weeks - Audiology - Paediatric Assessments	Aug-25	62.6%			99%	
Diagnostics: % waiting less than 6 weeks - Echocardiography	Aug-25	35.5%			99%	Jul 25 | 68.9%
Diagnostics: % waiting less than 6 weeks - Respiratory physiology - sleep studies	Aug-25	99.2%			99%	Jul 25 | 71.6%
Diagnostics: % waiting less than 6 weeks - Colonoscopy	Aug-25	62.6%			99%	Jul 25 | 72.6%
Diagnostics: % waiting less than 6 weeks - Flexi sigmoidoscopy	Aug-25	97.6%			99%	Jul 25 | 70.8%
Diagnostics: % waiting less than 6 weeks - Cystoscopy	Aug-25	95.9%			99%	Jul 25 | 73.0%
Diagnostics: % waiting less than 6 weeks - Gastroscopy	Aug-25	66.7%			99%	Jul 25 | 74.5%
Cancer Treatments: 28 Day FDS	Jul-25	71.3%			77%	Jul 25 | 76.6%
Cancer Treatments: 31 Day Standard	Jul-25	88.2%			96%	Jul 25 | 92.4%
Cancer Treatments: 62 Day Standard	Jul-25	73.7%			85%	Jul 25 | 69.2%
NC2R: Total Delayed Days	Aug-25	3564			1740	
E-Discharge Overall Compliance (within 24%)	Aug-25	71.2%			95%	

COCH IPR: Emergency Department Summary

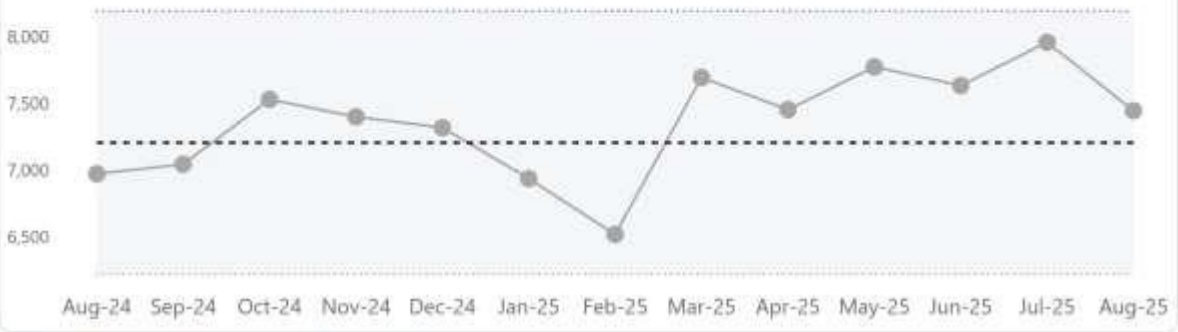
Owner: Cathy Chadwick - Chief Operating Officer

Countess of Chester Hospital NHS Foundation Trust

ED: Patients waiting no more than 4 hours (%)

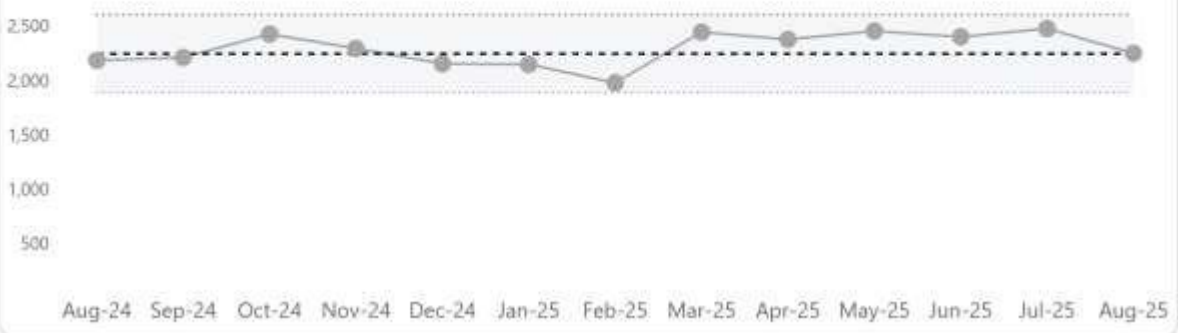
ED: Patients waiting no more than 4 hours - Type 1 (%)

ED: Attendances



ED: Attendances - Type 1

ED: Attendances - Type 3



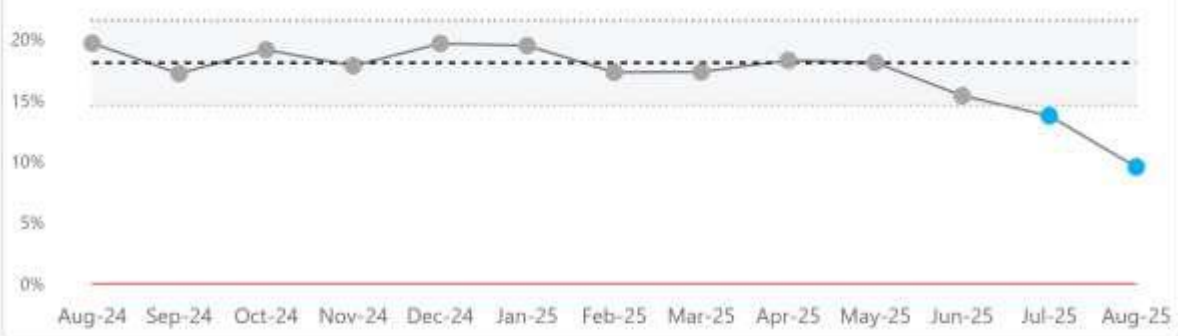
Metric	Period	Value	Variation	Assurance	Target	Benchmark
ED: Patients waiting no more than 4 hours (%)	Aug-25	64.5%			78%	Aug 25 | 75.9%
ED: Patients waiting no more than 4 hours - Type 1 (%)	Aug-25	51.6%			78%	Aug 25 | 62.0%
ED: Attendances	Aug-25	7447				
ED: Attendances - Type 1	Aug-25	5918				
ED: Attendances - Type 3	Aug-25	2249				

COCH IPR: Emergency Department Summary

Owner: Cathy Chadwick - Chief Operating Officer

NHS Countess of Chester Hospital NHS Foundation Trust

ED: Patients waiting over 12 hours (%)



ED: Patients waiting over 12 hours

ED: Patients waiting over 12 hours - Type 1 (%)

ED: Patients waiting over 12 hours - Type 1

ED: Patients waiting over 12 hours from decision to admit to admission

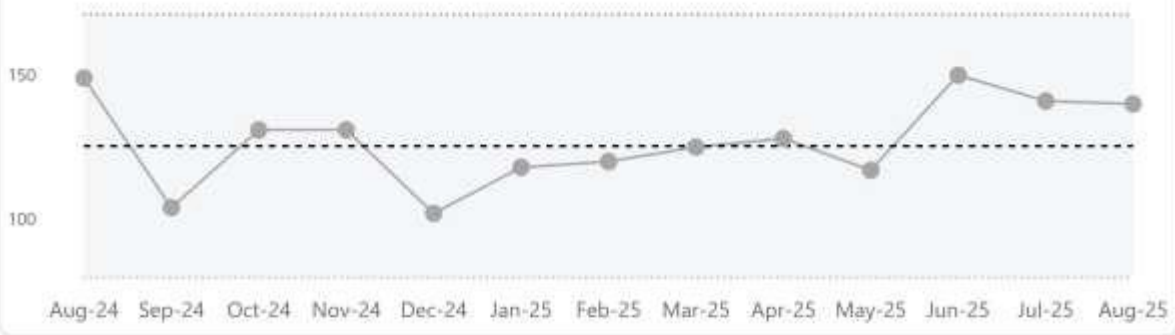
Metric	Period	Value	Variation	Assurance	Target	Benchmark
ED: Patients waiting over 12 hours (%)	Aug-25	9.55%			0%	
ED: Patients waiting over 12 hours	Aug-25	750			0	
ED: Patients waiting over 12 hours - Type 1 (%)	Aug-25	13.6%				Jul 25 | 8.3%
ED: Patients waiting over 12 hours - Type 1	Aug-25	708				
ED: Patients waiting over 12 hours from decision to admit to admission	Aug-25	332			0	

COCH IPR: Emergency Department Summary

Owner: Cathy Chadwick - Chief Operating Officer

Countess of Chester Hospital NHS Foundation Trust

ED: Attendances for mental health conditions

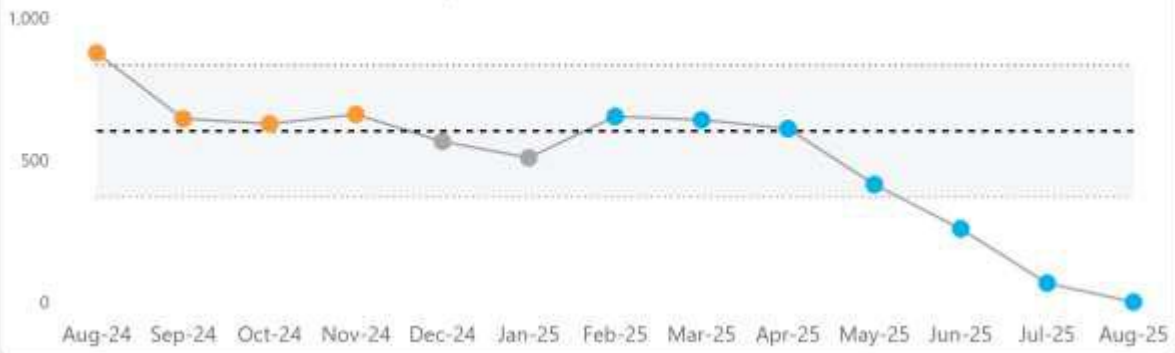


ED: Mental Health patients waiting over 12 hours

% of patients admitted following ED attendance - aged under 18

% of patients admitted following ED attendance - aged over 65

ED: Attendances with a stay in a corridor location



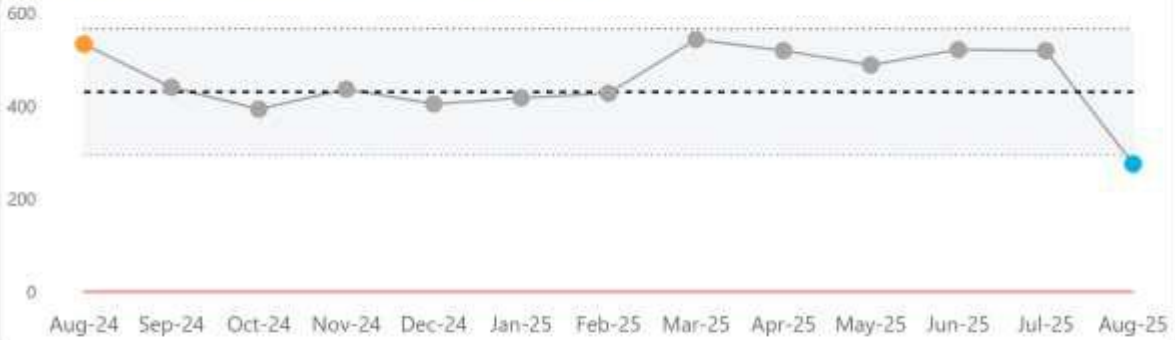
Metric	Period	Value	Variation	Assurance	Target	Benchmark
ED: Attendances for mental health conditions	Aug-25	140				
ED: Mental Health patients waiting over 12 hours	Aug-25	48				
% of patients admitted following ED attendance - aged under 18	Aug-25	13.1%				
% of patients admitted following ED attendance - aged over 65	Aug-25	47.3%				
ED: Attendances with a stay in a corridor location	Aug-25	2				

COCH IPR: Emergency Department Summary

Owner: Cathy Chadwick - Chief Operating Officer

Countess of Chester Hospital NHS Foundation Trust

Ambulance Handovers 30-60 minutes



Ambulance Handovers 60+ minutes

Total No of Ambulance Arrivals

Metric	Period	Value	Variation	Assurance	Target	Benchmark
Avg Time To Ambulance Handover (mins)	Aug-25	21				
Ambulance: Handovers 30-60 minutes	Aug-25	276			0	
Ambulance: Handovers 60+ minutes	Aug-25	11			0	
Ambulance: Total Ambulance Arrivals	Aug-25	1516				

Avg time to Ambulance handover

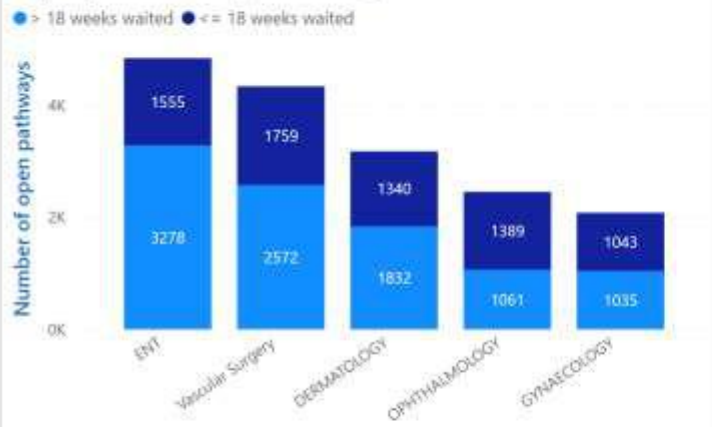
COCH IPR: RTT Overview

Owner: Cathy Chadwick - Chief Operating Officer

Countess of Chester Hospital NHS Foundation Trust

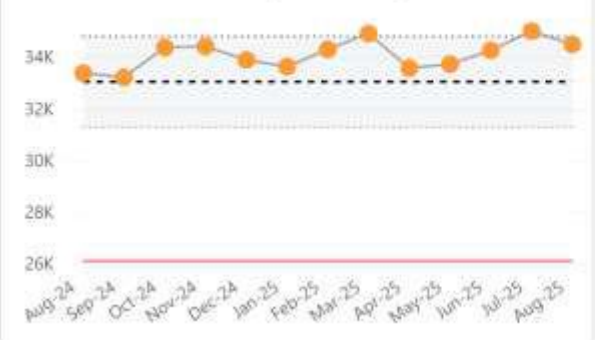
18 Week Referral To Treatment (RTT) Incomplete Pathways

Top 5 Specialties - Open Pathways



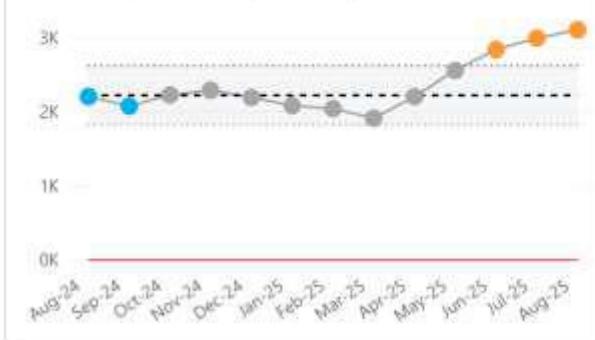
Metric	Period	Value	Variation	Assurance	Target	Benchmark
RTT: Incomplete pathways - Total	Aug-25	34479			26110	
RTT: Incomplete pathways - Waiting over 104 weeks	Aug-25	0			0	
RTT: Incomplete pathways - Waiting over 52 weeks (%)	Aug-25	9%			1%	Jul 25 | 2.6%
RTT: Incomplete pathways - Waiting over 65 weeks	Aug-25	208			0	
RTT: Incomplete pathways - Waiting over 78 weeks	Aug-25	7			0	
RTT: Incomplete pathways - Waiting up to 18 weeks (%)	Aug-25	48.3%			60%	Jul 25 | 61.3%

Total 18 Week RTT Incomplete Pathways

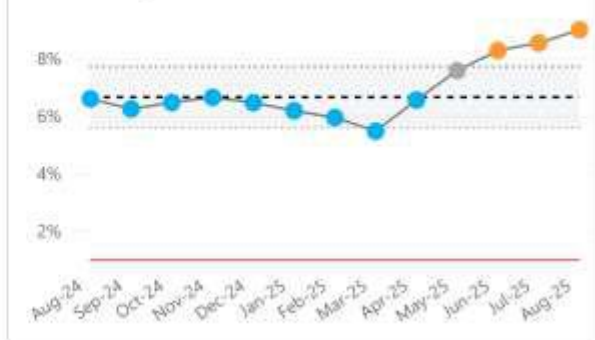


RTT Incomplete Pathways Waiting Over 65 Weeks

RTT Incomplete Pathways Waiting Over 52 Weeks



% Of Pathways Over 52 Weeks



COCH IPR: Outpatients

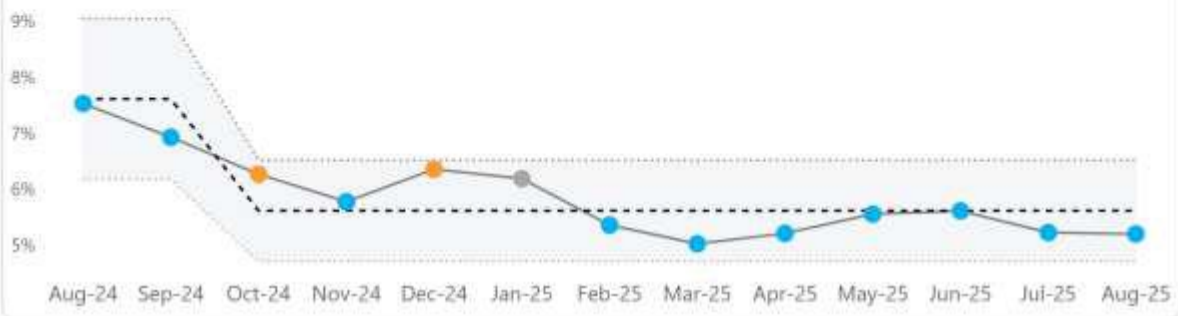
Owner: Cathy Chadwick - Chief Operating Officer

Countess of Chester Hospital NHS Foundation Trust

RTT Wait Time for 1st OPA

Patient Initiated Follow Up (%)

DNA Rates



Advice and Guidance Utilisation Rate (%)

Metric	Period	Value	Variation	Assurance	Target	Benchmark
Patient Initiated Follow Up (%)	Aug-25	4.2%			5%	Jul 25 | 3.4%
RTT Wait for 1st OP Appt - % waiting <18 weeks	Aug-25	46.4%			67%	
DNA Rates (%)	Aug-25	5.2%				Jun 25 | 6.4%
Advice and Guidance Utilisation Rate (%)	Jul-25	27.2%				Jun 25 | 34.0%
Advice and Guidance Diversion Rate (%)	Jul-25	19.3%				Jun 25 | 21.0%

Advice and Guidance Diversion Rate (%)

COCH IPR: Diagnostic Waits

Owner: Cathy Chadwick - Chief Operating Officer

NHS Countess of Chester Hospital NHS Foundation Trust

Diagnostics Test waiting less than 6 weeks (%)

% waiting less than 6 weeks	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25
All	87.8%	89.6%	92.2%	87.2%	83.0%	93.0%	89.3%	86.6%	81.0%	81.6%	80.1%	73.9%
Magnetic Resonance Imaging	99.7%	99.1%	98.3%	98.3%	98.1%	99.3%	99.2%	99.5%	97.7%	94.5%	94.3%	86.2%
Computed Tomography	100%	99.6%	98.4%	97.7%	96.6%	99.5%	97.8%	95.6%	95%	97.6%	95.1%	94.1%
Non-obstetric ultrasound	99.7%	95.4%	97.9%	87.8%	84.5%	98.8%	97.4%	92.5%	84.8%	87.5%	87.0%	79.6%
Barium Enema	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
DEXA Scan									100%	98.9%	96.6%	94%
Audiology - Adult Assessments	84.8%	86.6%	91.1%	74.9%	71.8%	89.7%	82.9%	77.8%	84.8%	92.9%	83.7%	83.2%
Audiology - Paediatric Assessments	66.3%	84.3%	80.6%	71.4%	65.8%	77.5%	64.0%	51.5%	44.5%	64%	73.3%	62.6%
Echocardiography	97.0%	93.7%	98.2%	95.2%	85.1%	78.4%	69.8%	73.8%	57.3%	53.6%	46.1%	35.5%
Respiratory physiology - sleep studies	97.0%	93.7%	98.2%	95.2%	85.1%	93.5%	97.4%	95.2%	90.3%	88.5%	99.2%	99.2%
Colonoscopy	59.6%	71.8%	83.6%	79.9%	77.5%	90%	72.4%	71.4%	67.0%	64.4%	69.6%	62.6%
Flexi sigmoidoscopy	87.5%	92.3%	90.6%	86.4%	79.7%	98.4%	93.8%	93.3%	97.2%	91.7%	100%	97.6%
Cystoscopy	66.0%	77.5%	87.4%	96.4%	99.1%	95.2%	94.9%	92.6%	95.7%	83.0%	96.8%	95.9%
Gastroscopy	49.6%	56.0%	59.5%	58.8%	54.7%	71.0%	68.8%	63.7%	64.7%	67.3%	62.9%	66.7%

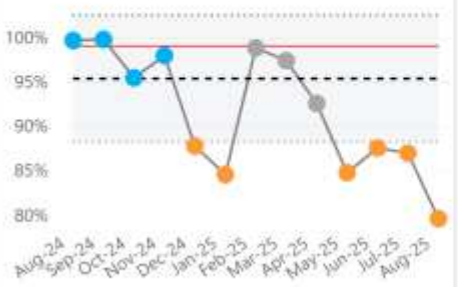
% waiting less than 6 weeks	Period	Value	Variation	Assurance	Target	Benchmark
All	Aug-25	73.9%			99%	Jul 25 | 78.1%
Non-obstetric ultrasound	Aug-25	79.6%			99%	Jul 25 | 80.9%
Audiology - Adult Assessments	Aug-25	83.2%			99%	
Echocardiography	Aug-25	35.5%			99%	Jul 25 | 68.9%
Colonoscopy	Aug-25	62.6%			99%	Jul 25 | 72.6%
Gastroscopy	Aug-25	66.7%			99%	Jul 25 | 74.5%

Diagnostic Waiting Times (DM01) Narrative

Metrics are for England only

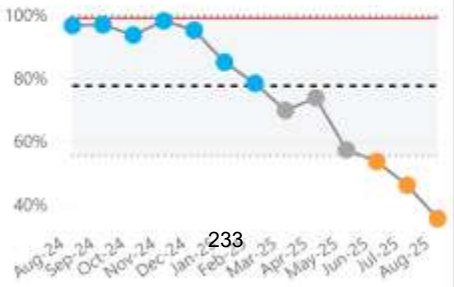
- **Paediatric Audiology** is currently not fully staffed due to maternity leave
- **Endoscopy** affected by annual leave but DM01 for colons and OGDs will be improved for September as we are doing more activity
- **CT** – Cardiacs are the reason for the breaches
- **MRI** – Capacity/Demand
- **Ultrasound** – Capacity/Demand – Particular struggle with MSK, currently looking at the region for any mutual aid support (in addition to the general USS we have being done in CDC Paddington)
- **DEXA** – Capacity/Demand – Next month this figure will increase. We only currently have 22 patients able to be scanned in EPH however the demand outweighs that. Routine wait time is currently 10+ weeks
- **Echo** DM01 staffing levels have been significantly impacted over the summer period due to annual leave or sickness, leading to reduced staff availability across the service. This has been further exacerbated by a lack of locum physiologists, as overtime provisions were recently ceased, limiting the department's ability to bring in temporary support. As a result, existing workforce gaps have widened at a time of increasing demand for echocardiography services, placing additional pressure on the remaining staff and affecting the department's capacity to meet diagnostic targets and service delivery expectations

Non-obstetric ultrasound - % Waiting less than 6 weeks



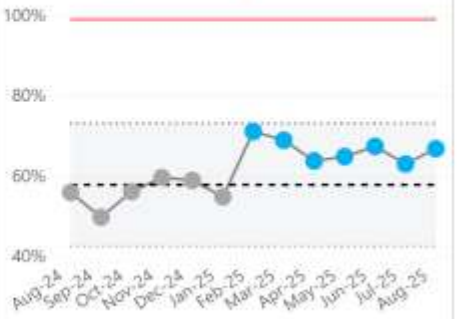
Audiology - Adult Assessments - % Waiting less than 6 weeks

Echocardiography - % Waiting less than 6 weeks



Colonoscopy - % Waiting less than 6 weeks

Gastroscopy - % Waiting less than 6 weeks



COCH IPR: Cancer Waiting Times

Owner: Cathy Chadwick - Chief Operating Officer

NHS Countess of Chester Hospital NHS Foundation Trust

Cancer Treatments: 62 Day Standard

Cancer Treatments: 31 Day Standard

Cancer Treatments: 28 Day FDS

Page Table Name	Period	Value	Variation	Assurance	Target	Benchmark
Cancer Treatments: 62 Day Standard	Jul-25	73.7%			85%	Jul 25 | 69.2%
Cancer Treatments: 31 Day Standard	Jul-25	88.2%			96%	Jul 25 | 92.4%
Cancer Treatments: 28 Day FDS	Jul-25	71.3%			77%	Jul 25 | 76.6%

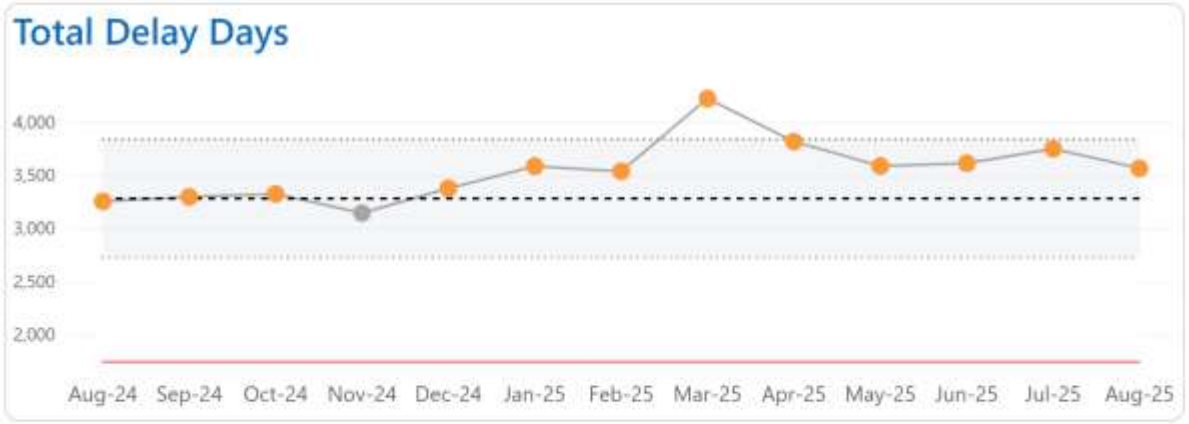
COCH IPR: Delayed Discharges

Owner: Cathy Chadwick - Chief Operating Officer

NHS Countess of Chester Hospital NHS Foundation Trust

ICB	Organisation Name	Number of providers submitting acceptable data	Number of patients discharged in total	Total bed days lost due to delayed discharge	% of patients discharged: Date of discharge is same as Discharge Ready Date	% of patients discharged: Date of Discharge is 1+ days after Discharge Ready Date	Number of patients discharged where, between the Discharge Ready Date and: No delay	1 day delay	2-3 day delay	4-6 day delay	7-13 day delay	14-20 day delay	21 days or more	% patients discharged where, between the Discharge Ready Date and: No delay	1 day delay	2-3 day delay	4-6 day delay	7-13 day delay	14-20 day delay	21 days or more	Average days from Discharge Ready Date to date of discharge (inc 0 day delays)	Average days from Discharge Ready Date to date of discharge (exc 0 day delays)
National	**ENGLAND**	**126**	**349,255**	**287,872**	**86.4%**	**13.6%**	**301,839**	**15,792**	**11,343**	**8,091**	**7,040**	**2,486**	**2,674**	**86.4%**	**4.5%**	**3.2%**	**2.3%**	**2.0%**	**0.7%**	**0.8%**	**0.8**	**6.1**
Regional	NORTH WEST	20	41,975	36,847	87.1%	12.9%	36,555	1,643	1,225	967	869	326	400	87.1%	3.9%	2.9%	2.3%	2.1%	0.8%	1.0%	0.9	6.8
Cheshire & Merseyside	ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	Acceptable	41	-	100.0%	0.0%	41	-	-	-	-	-	-	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	-	-
Cheshire & Merseyside	COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	Acceptable	1,585	2,776	88.5%	11.5%	1,403	24	23	24	40	24	47	88.5%	1.5%	1.5%	1.5%	2.5%	1.5%	3.0%	1.8	15.3
Cheshire & Merseyside	LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	Acceptable	650	69	97.5%	2.5%	634	4	4	5	3	-	-	97.5%	0.6%	0.6%	0.8%	0.5%	0.0%	0.0%	0.1	4.3
Cheshire & Merseyside	LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	Acceptable	4,646	5,369	83.3%	16.7%	3,872	217	183	150	128	31	65	83.3%	4.7%	3.9%	3.2%	2.8%	0.7%	1.4%	1.2	6.9
Cheshire & Merseyside	LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	Acceptable	193	41	89.6%	10.4%	173	11	6	2	1	-	-	89.6%	5.7%	3.1%	1.0%	0.5%	0.0%	0.0%	0.2	2.1
Cheshire & Merseyside	MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS TRUST	Acceptable	4,270	2,360	93.3%	6.7%	3,986	65	53	55	58	28	25	93.3%	1.5%	1.2%	1.3%	1.4%	0.7%	0.6%	0.6	8.3
Cheshire & Merseyside	THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	Acceptable	173	37	96.5%	3.5%	167	3	1	1	-	-	1	96.5%	1.7%	0.6%	0.6%	0.0%	0.0%	0.6%	0.2	6.2
Cheshire & Merseyside	THE WALTON CENTRE NHS FOUNDATION TRUST	Acceptable	295	-	100.0%	0.0%	295	-	-	-	-	-	-	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	-	-
Cheshire & Merseyside	WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST	Acceptable	1,533	3,075	81.5%	18.5%	1,249	45	51	51	66	28	43	81.5%	2.9%	3.3%	3.3%	4.3%	1.8%	2.8%	2.0	10.8
Cheshire & Merseyside	WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	Acceptable	1,246	784	89.5%	10.5%	1,115	36	38	22	19	8	8	89.5%	2.9%	3.0%	1.8%	1.5%	0.6%	0.6%	0.6	6.0
Cheshire & Merseyside	EAST CHESHIRE NHS TRUST	Unacceptable	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Cheshire & Merseyside	MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	Unacceptable	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Greater Manchester	MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	Acceptable	7,496	5,828	88.7%	11.3%	6,650	273	184	160	119	45	65	88.7%	3.6%	2.5%	2.1%	1.6%	0.6%	0.9%	0.8	6.9
Greater Manchester	NORTHERN CARE ALLIANCE NHS FOUNDATION TRUST	Acceptable	3,713	3,622	87.7%	12.3%	3,255	108	95	81	103	30	41	87.7%	2.9%	2.6%	2.2%	2.8%	0.8%	1.1%	1.0	7.9
Greater Manchester	STOCKPORT NHS FOUNDATION TRUST	Acceptable	2,190	1,842	81.1%	18.9%	1,776	159	106	63	58	15	13	81.1%	7.3%	4.8%	2.9%	2.6%	0.7%	0.6%	0.8	4.4
Greater Manchester	TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	Acceptable	1,350	1,051	93.4%	6.6%	1,261	17	16	17	14	12	13	93.4%	1.3%	1.2%	1.3%	1.0%	0.9%	1.0%	0.8	11.8
Greater Manchester	THE CHRISTIE NHS FOUNDATION TRUST	Acceptable	661	222	99.1%	0.9%	655	-	2	1	1	-	2	99.1%	0.0%	0.3%	0.2%	0.2%	0.0%	0.3%	0.3	37.0
Greater Manchester	BOLTON NHS FOUNDATION TRUST	Acceptable	2,226	1,954	86.0%	14.0%	1,915	78	71	66	54	27	15	86.0%	3.5%	3.2%	3.0%	2.4%	1.2%	0.7%	0.9	6.3
Greater Manchester	WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	Acceptable	1,749	1,681	82.3%	17.7%	1,440	102	75	55	46	15	16	82.3%	5.8%	4.3%	3.1%	2.6%	0.9%	0.9%	1.0	5.4
Lancashire & South Cumbria	EAST LANCASHIRE HOSPITALS NHS TRUST	Acceptable	2,712	926	86.8%	13.2%	2,353	211	98	29	14	3	4	86.8%	7.8%	3.6%	1.1%	0.5%	0.1%	0.1%	0.3	2.6
Lancashire & South Cumbria	LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	Acceptable	3,275	2,127	85.6%	14.4%	2,803	153	122	96	66	24	7	85.6%	4.7%	3.7%	3.0%	2.1%	0.7%	0.2%	0.6	4.5
Lancashire & South Cumbria	UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	Acceptable	1,971	3,083	76.7%	23.3%	1,512	137	97	77	77	36	35	76.7%	7.0%	4.9%	3.9%	3.9%	1.8%	1.8%	1.6	6.7
Lancashire & South Cumbria	BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	Unacceptable	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

Total Delay Days



Metric	Period	Value	Variation	Assurance	Target	Benchmark
NC2R: Total Delayed Days	Aug-25	3564			1740	

COCH IPR: E-Discharge

Owner: Nigel Scawn - Executive Medical Director

Countess of Chester Hospital NHS Foundation Trust

E-Discharge Overall Compliance (within 24%)

Metric	Period	Value	Variation	Assurance	Target	Benchmark
E-Discharge Overall Compliance (within 24%)	Aug-25	71.2%			95%	

Planned Care E-Discharge

Divisions	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25
Discharges added	1,065	937	1,030	1,142	1,018	986	1,008	932	980	948	1,036	959	1,090	989
Letters sent	1,160	1,173	937	1,188	1,341	994	920	816	899	828	896	956	1,075	960
Backlog size	798	623	682	613	373	349	423	546	621	735	875	871	866	915
Incomplete remaining	4	6	4	3	23	40	51	77	60	83	97	78	122	150
Within 24hr %	63.7%	52.9%	58.3%	64.9%	63.8%	59.9%	63.8%	61.2%	62.6%	63.2%	58.5%	63.2%	65.4%	59.8%

Urgent Care E-Discharge

Divisions	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25
Discharges added	1,470	1,313	1,345	1,538	1,452	1,418	1,496	1,314	1,343	1,326	1,390	1,390	1,610	1,487
Letters sent	1,593	1,320	1,364	1,461	1,389	1,420	1,504	1,409	1,368	1,278	1,444	1,489	1,535	1,556
Backlog size	255	285	236	300	390	342	336	266	236	268	249	137	191	148
Incomplete remaining		2		4	2	2	4	7	2	3	1	2		20
Within 24hr %	70.2%	64.0%	68.7%	65.0%	59.9%	58.5%	58.2%	64.5%	64.6%	63.1%	66.6%	74.2%	72.6%	72.8%

W&C E-Discharge

Divisions	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Apr 25	May 25	Jun 25	Jul 25	Aug 25
Discharges added	558	492	540	669	713	628	590	580	598	595	601	590	554	508
Letters sent	557	487	575	669	704	635	570	566	587	573	574	571	525	476
Backlog size	1,941	1,942	1,911	1,917	1,927	1,919	1,925	1,950	1,965	1,986	2,010	2,031	2,061	2,089
Incomplete remaining		2	8	4	3	3	8	18	21	18	24	26	27	33
Within 24hr %	84.1%	84.6%	88.3%	86.7%	85.7%	88.1%	88.8%	85.5%	86.8%	87.6%	86.4%	88.0%	86.3%	83.9%

Highlights:

·Consistent incident reporting and a reduction in moderate and above harm incidents in August
·Zero Steis reportable incidents in August
·CDIFF within threshold – however, 6 cases reported in August
·E-Coli Bloodstream infection – 1 case reported for August bringing us slightly above threshold
·Reduction in falls noted and continued reduction in falls with harm in August
·Continued Trust wide focus on patient flow
·Compliance of Braden, MUST and falls risk assessments under the target of 90% but improving picture.
·Reduction in Hospital Acquired Pressure Ulcer and Present On Admission Pressure Ulcers in August.
·Friends and Family Test – just under the national positive response rate apart from ED which is above national average. Improvements in all areas. – ED positive response 86% (78%), Inpatient 93.1% (94%), Outpatient 93.1% (94%). Inpatient response rate also improved.

Areas of Concern:

•Sepsis Screening compliance – Improvements will be demonstrated in Septembers IPR
•Patient Flow and Emergency Department performance and quality indicators - Strengthening the leadership in the emergency department – CQC Inspection Report
•New Pressure Ulcers (Cat 2 and Cat 3) continue to be a focus- weekly review and actions and initiatives ongoing
•Timely closure of complaints and concerns – increase in open complaints –challenges in complex complaints and waiting for family meetings – new process planned for end of September.

Forward Look (with actions):

•Inpatient Survey action plan and improvements and preparation for 2025 Survey
•Sepsis Improvements – September 2025
•Friends and Family Test Improvements – working with external partners and BI to develop hybrid approach- increase response rate and positive scores.
•CQC preparedness – senior nurse walkabouts

COCH IPR: Quality of Care and Nursing Scorecard

NHS
Countess of Chester Hospital
NHS Foundation Trust

Quality & Safety Metrics	Period	Value	Variation	Assurance	Target	Benchmark
Mortality: SHMI	Apr-25	90				
Mortality: HSMR	May-25	91.6				
Mortality: Total inpatient deaths	Aug-25	82				
Incidents: STeiS reported incidents	Aug-25	0			0	
Incidents: Never events	Aug-25	0			0	
Incidents: Mixed sex accomodation incidents	Aug-25	1			0	
Incidents: All incidents	Aug-25	1184			1155	
Incidents: All incidents with moderate harm and above	Aug-25	42			40	
Incidents: Medication incidents	Aug-25	113			108	
Incidents: Medication incidents with harm	Aug-25	0			0	
Falls: All - Rate Per 1000 Bed Days	Aug-25	5.15			4.87	
Falls: With Harm - Rate Per 1000 Bed Days	Aug-25	0.06			0.1	
Pressure ulcers: Hospital acquired - Rate per 1000 bed days	Aug-25	0.970			1.22	
Pressure ulcers: Present on admission - Rate per 1000 bed days	Aug-25	3.58				
Infection Control: C.Difficile Cases	Aug-25	6			4	
Infection Control: E-Coli Cases	Aug-25	1				
Infection Control: MRSA Cases	Aug-25	1			0	
Patient Feedback: Complaints Opened In Month	Aug-25	17			40	
Patient Feedback: Complaints Open At Month End	Aug-25	32			7	
Patient Feedback: Concerns Opened In Month	Aug-25	346			229	
Patient Feedback: Concerns Open At Month End	Aug-25	95				
FFT: A&E Positive Rate	Aug-25	81.6%			95%	
FFT: IP Positive Rate	Aug-25	93.1%			95%	
FFT: OP Positive Rate	Aug-25	93.1%			95%	
FFT: A&E Response Rate	Aug-25	11.9%			13%	
FFT: IP Response Rate	Aug-25	22.8%			23%	
FFT: OP Response Rate	Aug-25	9.2%			12%	
VTE: Assessment Completed Compliance	Aug-25	92.4%			95%	
VTE: 14 Hour Compliance	Aug-25	76.9%			95%	
Fill rates: Registered Staffing (%)	Aug-25	95.6%			95%	
Fill rates: Unregistered Staffing (%)	Aug-25	96.2%			95%	

COCH IPR: Mortality

Owner: Nigel Scawn - Executive Medical Director

Countess of Chester Hospital NHS Foundation Trust

SHMI

Mortality: HSMR

Mortality: Total inpatient deaths

Metric	Period	Value	Variation	Assurance	Target	Benchmark
Mortality: SHMI	Apr-25	90				
Mortality: HSMR	May-25	91.6				
Mortality: Total inpatient deaths	Aug-25	82				

COCH IPR: Nurse Staffing Fill Rates

Owner: Sue Pemberton - Deputy Chief Executive Officer and Director of Nursing

Countess of Chester Hospital NHS Foundation Trust

Fill rates: Registered Staffing (%)

Fill rates: Unregistered Staffing (%)

Metric	Period	Value	Variation	Assurance	Target	Benchmark
Fill rates: Registered Staffing (%)	Aug-25	95.6%			95%	
Fill rates: Unregistered Staffing (%)	Aug-25	96.2%			95%	

COCH IPR: Nurse Staffing Ward Breakdown

Owner: Sue Pemberton - Deputy Chief Executive Officer and Director of Nursing

NHS Countess of Chester Hospital NHS Foundation Trust

Staffing level summary	
100%	Exactly the number of staff planned for
Below 100%	Fewer staff than planned
Above 100%	More staff than planned

95% minimum required to ensure safe staffing
95-100 is the optimal balance.

Safer Staffing Levels - Aug 25

Ward Information			Staffing Rates						CHPPD					Falls		Skin Integrity	Medication	Staffing		Friends & Family		
Directorate	Ward	Occupancy	Total Reg	Total Unreg	Day Reg	Day Unreg	Night Reg	Night Unreg	Reg	Non-Reg	Actual	Planned	Nat Avg	Total	With Harm	HAPU	Admin Incs	Incidents	With Harm	Positive	Negative	Response
Urgent Care	Acute Medical Unit	50	98.00%	97.16%	97.08%	96.85%	99.66%	97.55%	4.4	4.0	8.4	8.6	9.7	7	0	3	2	4	0	92.11%	0.00%	15.83%
	Ward 33 Trinity Ward	34	90.67%	93.06%	83.73%	94.61%	99.06%	92.26%	3.2	3.5	6.8	7.4	27.0	5	1	3	5	0	0			
	Ward 40	11	97.77%	98.75%	96.94%	100.00%	100.00%	97.61%	3.6	4.2	7.8	7.9	15.9	0	0	0	1	1	0	92.31%	7.69%	8.39%
	Ward 42	16	105.71%	104.43%	94.64%	99.02%	119.59%	107.65%	5.0	6.0	11.0	10.4	15.0	2	0	0	0	1	0	96.00%	0.00%	34.25%
	Ward 43 Meadows Ward	16	105.67%	99.63%	98.34%	96.87%	131.67%	102.14%	3.3	4.3	7.5	7.3	8.0	3	0	0	2	0	0	100.00%	0.00%	106.90%
	Ward 44	28	95.07%	94.23%	89.52%	92.44%	101.63%	95.41%	3.2	3.4	6.6	7.0	13.7	4	0	2	4	0	0	97.56%	2.44%	93.18%
	Ward 45 Palace	25	102.88%	98.77%	97.28%	100.10%	111.68%	97.88%	3.4	3.2	6.6	6.5	8.1	7	0	0	2	0	0	88.24%	5.88%	50.00%
	Ward 50	28	88.67%	97.63%	75.24%	95.65%	103.23%	98.51%	3.6	3.7	7.3	7.8	8.7	9	0	2	0	1	0	88.24%	5.88%	44.74%
	Ward 51	28	98.63%	99.01%	88.77%	99.22%	108.38%	98.92%	3.8	3.7	7.5	7.6	8.1	5	0	0	2	0	0	100.00%	0.00%	13.89%
	Cardiology Unit	16	86.88%	88.40%	81.42%	81.87%	100.00%	100.13%	4.1	3.8	7.9	9.1	8.3	2	0	0	1	1	0	100.00%	0.00%	26.09%
	Respiratory Unit	38	97.22%	96.23%	95.53%	97.07%	99.65%	95.30%	4.3	4.1	8.4	8.7	7.1	3	0	0	5	4	0	100.00%	0.00%	17.43%
	Modular	20	90.39%	98.47%	84.12%	100.00%	104.78%	97.11%	2.9	3.0	5.9	6.2	8.1	6	0	0	1	0	0	100.00%	0.00%	10.00%
	Emergency Dept Team		91.52%	95.88%	89.79%	95.60%	96.05%	96.54%	-	-	-	-	-	6	0	1	16	3	1	100.00%	0.00%	11.51%
	Ward 60 Haematology Oncology Suite		93.04%	71.42%	93.04%	100.00%	100.00%	71.42%	-	-	-	-	-	0	0	0	0	0	1	92.31%	0.00%	16.05%
Planned Care	Renal Unit (Care)		97.72%	99.57%	97.72%	100.00%	100.00%	99.57%	-	-	-	-	-	0	0	0	0	0	1			
	Ward 41	29	94.43%	97.49%	87.29%	99.02%	102.18%	96.75%	3.5	3.6	7.0	7.3	8.1	5	0	1	0	2	0	100.00%	0.00%	42.86%
	Ward 52	28	95.87%	100.61%	92.67%	100.05%	99.67%	101.11%	3.4	2.6	6.1	6.2	8.7	3	0	0	1	1	0	100.00%	0.00%	14.71%
	Ward 53	28	98.23%	98.52%	93.09%	100.00%	106.45%	97.52%	3.4	3.3	6.7	6.8	8.1	5	0	0	1	0	0	84.38%	6.25%	38.55%
	Ward 54	28	100.31%	104.98%	85.07%	101.09%	137.37%	107.95%	3.0	3.2	6.2	6.0	9.1	0	0	0	0	1	0			
	Ward 56	28	90.15%	99.95%	86.45%	100.00%	100.00%	99.90%	3.2	4.2	7.4	7.8	6.2	0	0	0	0	1	0	96.30%	0.00%	22.22%
	Critical Care	15	87.51%	88.31%	87.44%	88.22%	88.42%	89.38%	-	-	-	-	-	1	0	0	3	1	0	0.00%	0.00%	
TICC	Bluebell Unit	24	99.53%	99.05%	98.25%	100.00%	101.08%	98.71%	3.0	3.4	6.5	6.5	8.1	3	0	0	0	0	0	100.00%	0.00%	125.00%
	EPH Stroke Rehab Unit Team	17	99.43%	96.01%	96.74%	100.00%	100.00%	94.57%	3.5	4.7	8.2	8.4	8.7	0	0	1	0	0	0	100.00%	0.00%	54.55%
	Poppy Unit	19	75.43%	111.12%	97.27%	95.05%	46.67%	96.71%	1.8	4.4	2.4	3.9	8.0	2	0	1	0	0	0	100.00%	0.00%	31.82%
W&C	Maternity Suite		93.92%	68.99%	93.78%	68.99%	94.15%	71.86%	33.1	1.9	35.2	2.7	9.0	0	0	0	0	0	1			
	NNU		94.03%	100.00%	105.05%	100.00%	79.13%	100.00%	20.9	0.0	22.2	0.0	8.7	0	0	0	0	0	1			
	Ward 29 & 30 Childrens' Unit	22	94.00%	110.93%	94.80%	123.21%	93.05%	123.96%	2.4	0.7	2.6	0.7	8.3	0	0	1	0	1	0			

Registered Staffing Fill Rate Narrative

Each Ward area has a breakdown of their registered and unregistered staffing, as well as the breakdown of these figures for Day and Night. The Care Hours Per Patient Day (CHPPD) is also displayed, the national average is taken from the average CHPPD for the wards speciality.

FFT Breakdowns for positive, negative and response rate are also given. This is based on the patient's discharge ward, i.e. the last ward of treatment. Our average response rate for Inpatient FFT is 20%, so there can be some wards/areas that do not get many responses, you also see a few patients responding multiple times, so that shows for some of the EPH areas where the response rate is over 100%.

FFT is split into 6 options, very good, good, neither, poor, very poor and "don't know", for positive we look at very good and good, and negative is poor and very poor, thus you can see that some of the % do not total 100%.

COCH IPR: VTE Compliance

Owner: Nigel Scawn - Executive Medical Director

Countess of Chester Hospital NHS Foundation Trust

VTE: Assessment Completed Compliance

VTE: 14 Hour Compliance

Metric	Period	Value	Variation	Assurance	Target	Benchmark
VTE: 14 Hour Compliance	Aug-25	76.9%			95%	
VTE: Assessment Completed Compliance	Aug-25	92.4%			95%	

DQAM Narrative

The DQAM 'kitemarking' has been added to the IPR from September 2025 to provide assurance on the quality of data included within the report. **Following the Data Governance assurance process ('kitemarking') this metric has substantial assurance.**

VTE Compliance Narrative

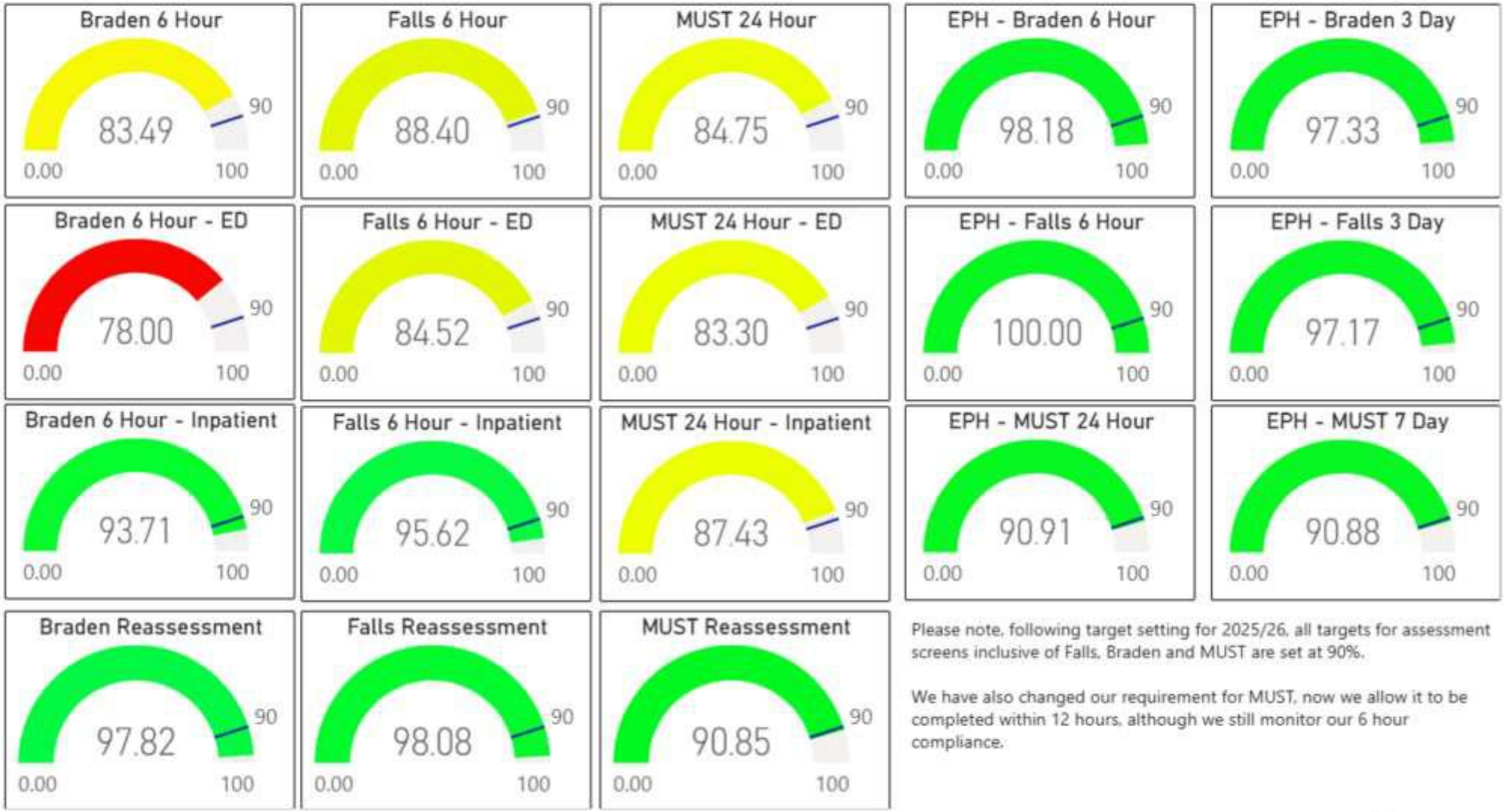
Following the return of the national submission for VTE, a review of the data capture and definitions was undertaken. Following this it was identified that in order for a VTE assessment to be classed as valid, the result of a patient being at risk must be finalised on the system. This has resulted in a drop in compliance but is a more accurate reflection of patient care. Compliance is closely monitored on weekly reports

COCH IPR: Assessment screening compliance

Owner: Sue Pemberton - Deputy Chief Executive Officer and Director of Nursing

NHS Countess of Chester Hospital NHS Foundation Trust

Aug-25



Please note, following target setting for 2025/26, all targets for assessment screens inclusive of Falls, Braden and MUST are set at 90%.

We have also changed our requirement for MUST, now we allow it to be completed within 12 hours, although we still monitor our 6 hour compliance.

Assessment Screening Compliance Narrative

The above shows the monthly position and it is split between overall performance, ED and Inpatient, this is due to the clock starting from the time a patient has a decision to admit in ED, so if the patient spends the majority of their first 6 hours in ED, they are assigned to ED.

COCH IPR: Serious incidents

Owner: Sue Pemberton - Deputy Chief Executive Officer and Director of Nursing

Countess of Chester Hospital NHS Foundation Trust

Incidents: STeiS reported incidents

Incidents: Never events

Incidents: Mixed sex accomodation incidents

Metric	Period	Value	Variation	Assurance	Target	Benchmark
Incidents: STeiS reported incidents	Aug-25	0			0	
Incidents: Never events	Aug-25	0			0	
Incidents: Mixed sex accomodation incidents	Aug-25	1			0	

DQAM Narrative

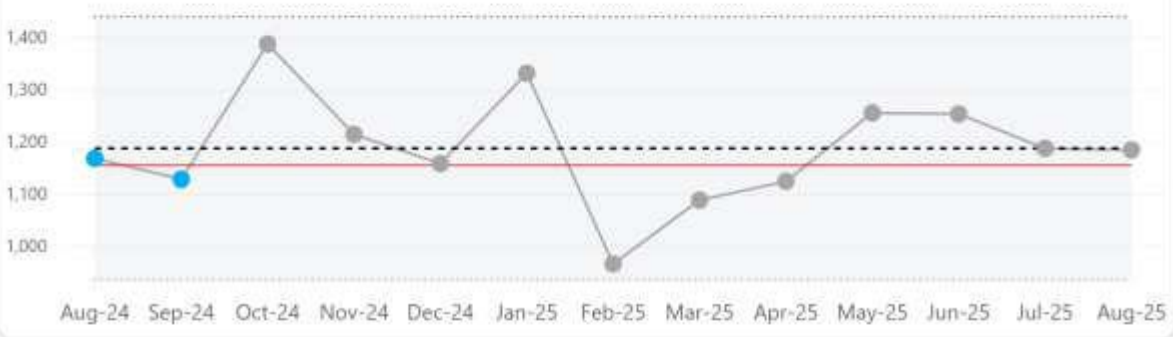
The DQAM 'kitemarking' has been added to the IPR from September 2025 to provide assurance on the quality of data included within the report. **Following the Data Governance assurance process ('kitemarking') this metric has substantial assurance.**

COCH IPR: Incidents

Owner: Sue Pemberton - Deputy Chief Executive Officer and Director of Nursing

Countess of Chester Hospital NHS Foundation Trust

Incidents: All incidents



Incidents: Medication incidents

Incidents: All incidents with moderate harm and above

Incidents: Medication incidents with harm

Metric	Period	Value	Variation	Assurance	Target	Benchmark
Incidents: All incidents	Aug-25	1184			1155	
Incidents: All incidents with moderate harm and above	Aug-25	42			40	
Incidents: Medication incidents	Aug-25	113			108	
Incidents: Medication incidents with harm	Aug-25	0			0	

COCH IPR: Falls

Owner: Sue Pemberton - Deputy Chief Executive Officer and Director of Nursing

Countess of Chester Hospital NHS Foundation Trust

Falls: All - Rate Per 1000 Bed Days

Falls: With Harm - Rate Per 1000 Bed Days

Falls Split By Harm Caused

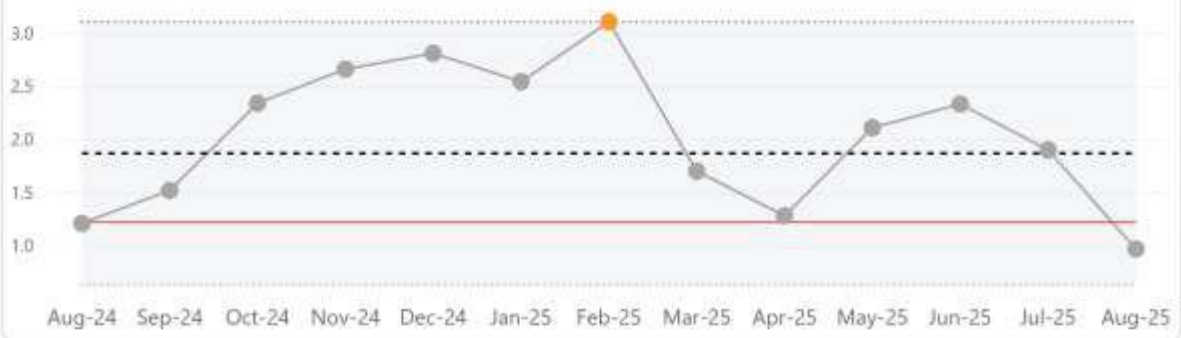
Metric	Period	Value	Variation	Assurance	Target	Benchmark
Falls: All - Rate Per 1000 Bed Days	Aug-25	5.15			4.87	
Falls: With Harm - Rate Per 1000 Bed Days	Aug-25	0.06			0.1	

COCH IPR: Pressure Ulcers

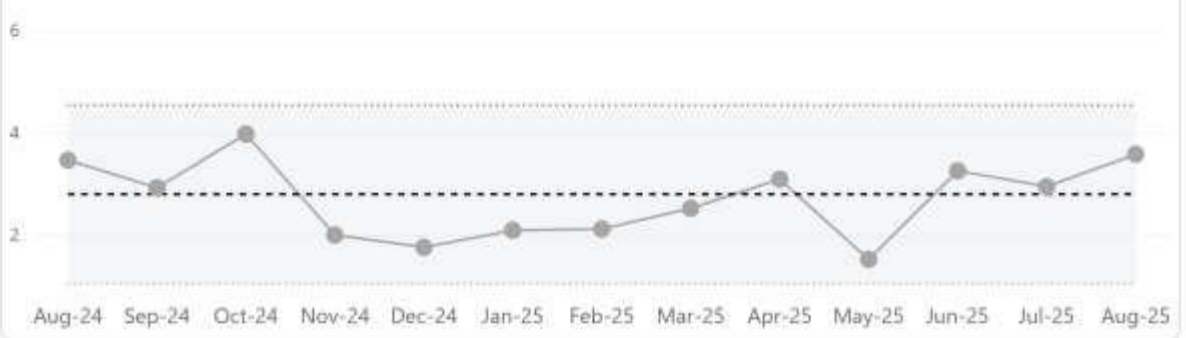
Owner: Sue Pemberton - Deputy Chief Executive Officer and Director of Nursing

Countess of Chester Hospital NHS Foundation Trust

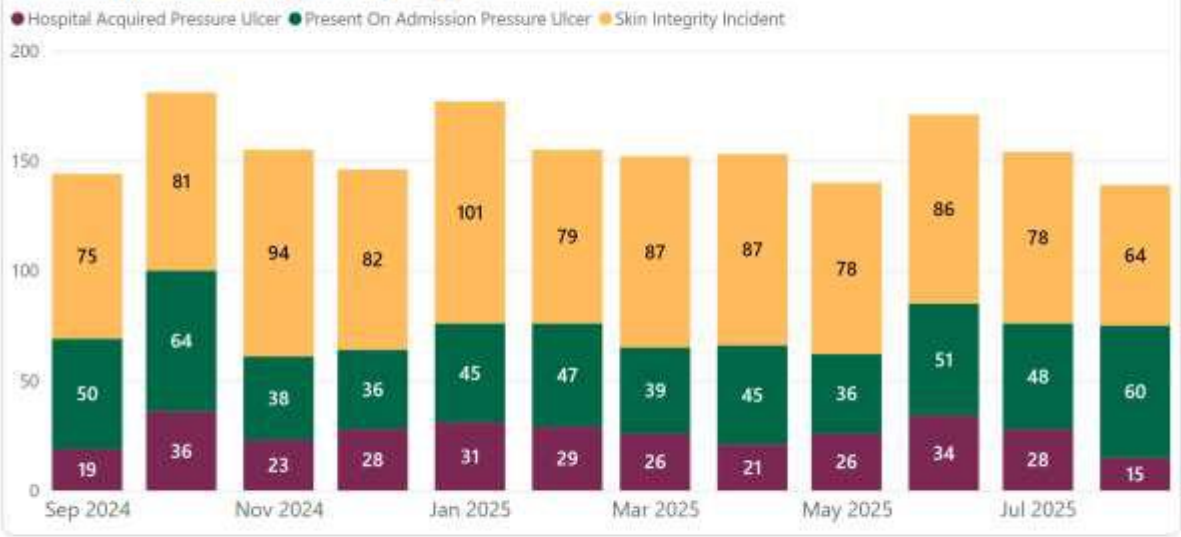
Pressure ulcers: Hospital acquired - Rate per 1000 bed days



Pressure ulcers: Present on admission - Rate per 1000 bed days



Pressure Ulcers split by Type



Metric	Period	Value	Variation	Assurance	Target	Benchmark
Pressure ulcers: Hospital acquired - Rate per 1000 bed days	Aug-25	0.970			1.22	
Pressure ulcers: Present on admission - Rate per 1000 bed days	Aug-25	3.58				

Pressure Ulcers Narrative

Considerable work has been done to move our Pressure Ulcer reporting in line with national standards, the Trust has finalised what we consider a Pressure Ulcer and what is considered a Skin Integrity Incident. This new methodology dates back to April 2024 explaining the step changes in place. The chart on the right is inclusive of all Skin Integrity Incidents. We have now amended our reporting again in line with national guidance, Deep Tissue Injuries will now sit under Skin Integrity but will not be part of our Pressure Ulcer numbers.

The target for 2024/25 was to reduce Hospital Acquired Pressure Ulcers by 20%, we finished 2024/25 with a 15.6% reduction overall. The target for 2025/26 remains a 20% reduction.

In August 2025 we saw 139 skin integrity incidents, of which 75 counted as Pressure Ulcers. The Pressure Ulcer figure comprised of 15 Hospital Acquired and 60 Present On admission, which means that 20% of our pressure Ulcers were hospital acquired.

COCH IPR: Infection Control

Owner: Sue Pemberton - Deputy Chief Executive Officer and Director of Nursing

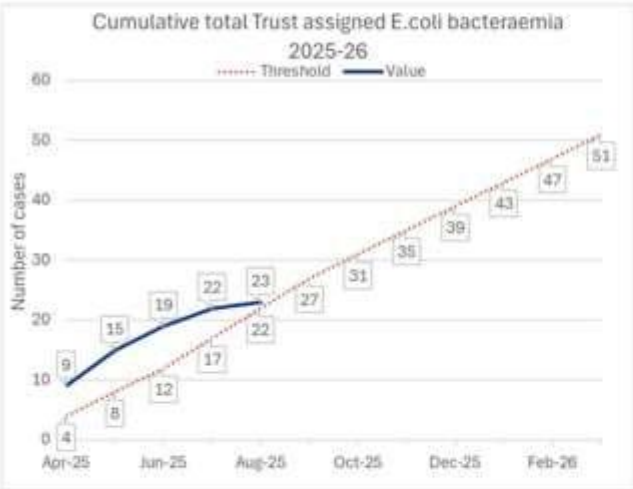
Countess of Chester Hospital NHS Foundation Trust

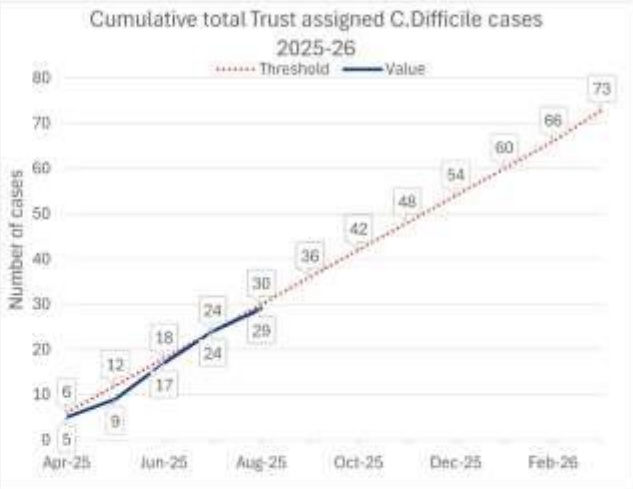
Infection Control: C.Difficile Cases

Infection Control: E-Coli Cases

Infection Control: MRSA Cases

Metric	Period	Value	Variation	Assurance	Target	Benchmark
Infection Control: C.Difficile Cases	Aug-25	6			4	
Infection Control: E-Coli Cases	Aug-25	1				
Infection Control: MRSA Cases	Aug-25	1			0	





COCH IPR: Sepsis

Owner: Nigel Scawn - Executive Medical Director

Countess of Chester Hospital NHS Foundation Trust

Sepsis Narrative

From August-24 there has been a change in the metrics we record for Sepsis, the guidance has changed from SepsisNEWS to SepsisNICE, the metrics we report on the SOF are similar with the exception of treatment where instead of having a 1 hour window, we are measured against 1 hour targets for severe cases, and 3 hour targets for moderate cases. The step change in the SPC chart demonstrates this change.

Work is ongoing with relevant clinicians and sepsis lead to ensure we have these sepsis metrics readily available via real time reporting. We have now requested the relevant changes with Cerner on the front end, once these changes have been actioned, reporting should follow.