Meeting of the Council of Governors in Public

Wednesday 15th July 2026, 14.00 – 16.00 in the Women & Children's Building Seminar Room

Chair	Mr N Large, Trust Chair
Apologies	Ms P Edwards, Saff Governor, Mr J Develing, Director of Strategic Partnerships, Dr N Scawn, Medical Director and Ms W Williams, Non-Executive Director
In attendance	Dr I Benton, Deputy Medical Director (on behalf of Dr Scawn), Ms L Hunter, Ward Manager – Ward 42

Time	Agenda Number	Agenda item	Lead	Page Number	Decision Required
14.00	1.	Welcome, apologies, and opening remarks (verbal)	Trust Chair		For noting
14.02	2.	Declarations of conflicts of interest with agenda items (verbal)	Trust Chair		For noting
14.03	3.	To approve the minutes of the Council of Governors held on the 15th April 2026 (attached)	Trust Chair	4 - 17	For approval
14.05	4.	To consider any matters arising and action log (attached)	Trust Chair	18	For noting
14.10	5.	Patient Story (to be presented on the day)	Ward Manager – Ward 42		For noting
14.20	6.	Trust Chair's Briefing (verbal)	Trust Chair		For noting
14.25	7.	Chief Executive Officer's Report (attached)	Chief Executive	19 - 25	For noting
14.30	8.	Year-end Performance Position (to be presented on the day)	Chief Finance Officer / Chief Operating Officer / Chief Digital & Data Officer		For noting
14.35	9.	Lead Governor Update – July 2026 (attached)	Lead Governor	26 - 28	For noting
14.40	10.	a) Membership & Engagement Committee Chairs report 15th June 2026 (verbal) b) Membership & Engagement Committee approved minutes 10th March 2026 (attached)	Committee Chair Committee Chair	 29 - 34	For assurance & noting For assurance & noting
14.45	11.	Future of Governors Update and Options (attached)	Trust Chair/ Director of Governance and Risk	35 - 47	For decision

15.55	12.	To receive Board updates: a) The recent Chair's reports of Board Sub-Committees (attached): • Chair's report from the Chair of the People Committee – 28th April 2026 • Chair's Report from the Chair of the Finance & Performance Committee – 29th April 2026 • Chair's report from the Chair of the Quality & Safety Committee – 7th May 2026 • Chair's Report from the Chair of the Audit Committee – 24th April 2026	Non-Executive Directors	48 - 49 50 - 52 53 - 54 55 - 56	For noting and discussion
15.25		b) Integrated Performance Report (IPR)** (slides to be presented on the day) • Operational Performance • Quality • Safety • Finance • People	Chief Operating Officer Director of Nursing & Quality/ Deputy Chief Executive Deputy Medical Director Chief Finance Officer Chief People Officer		For assurance
15.35	13.	To receive feedback from Governors (verbal)	Governors		For noting
15.40	14.	Non-Executive Director/ Governor Walkabouts Summary Report - Quarter 1 2026/27 (attached)	All Governors /Trust Chair	57 - 61	For noting
15.45	15.*	For noting: a) Council of Governors Workplan (attached)	Director of Governance and Risk	62- 64	For noting

		b) Council of Governors Photo Sheet (attached) c) Quality Account (attached)	Trust Chair Director of Nursing & Quality/Deputy Chief Executive	65 66 - 125	For noting For noting
15.55	16.	Any Other Business (verbal)	Trust Chair		For noting
16.00	17.	Close of meeting			

*Papers are 'for information' unless any governor's request a discussion
**Please note that the full Integrated Performance Report (IPR) – March 2026 is available within the 19th May 2026 Board of Directors papers - Board of Directors Meeting Packs | Countess of Chester Hospital

Next Meeting: Wednesday 14th October 2026 at 14.00 – 16.00, in the Women & Children's Building Seminar Room

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Minutes of the Council of Governors (in Public)

Wednesday 15th April 2026, 14.00 – 16.00, Seminar Room, Women & Children's Building

Members	15/04/2026	15/07/2026	21/10/2026	03/02/2027
Trust Chair (Chair), Mr N Large	☑			
Chester and Rural Cheshire				
Public Governor, Mr R Howe	☒			
Public Governor, Mr J Jones (Lead Governor)	☑ (part)			
Public Governor, Ms S Dunbar	☑			
Public Governor, Ms J Chillery	☒			
Public Governor, Ms L Jha	☑			
Public Governor, Ms S Cook	☒			
Public Governor, Mr R Taylor	☑			
Public Governor, Prof T Fisher	☑			
Ellesmere Port and Neston				
Public Governor, Dr K Chatterjee	☒			
Vacant position	N/A			
Vacant position	N/A			
Vacant position	N/A			
Flintshire				
Public Governor, Mr M Roberts	☑			
Public Governor, Ms C Holloway	☒			
Remaining England and Wales				
Public Governor, Mr D Cassidy	☒			
Partnership Organisations				
Partnership Governor Council for Voluntary Services, Mr D Foulds	☒			
Partnership Governor Cheshire West and Chester Council, Ms C Gahan	☒			
Partnership Governor Betsi Cadwaladr University Health Board, Mr P Tardivel	☑			
Partnership Governor University of Chester, Dr E Collins	☑			
Staff Governor				
Staff Governor Qualified Nurses/Midwives, Ms P Edwards	☒			
Staff Governor Qualified Nurses/Midwives, Ms C Finney	☑			
Staff Governor Doctors, Dr S Tueger	☒			
Staff Governor Allied Health Professionals, Mr R Gorman	☒			
Staff Governor Other Staff, Ms N Cottrell	☑			

In attendance	15/04/2026	15/07/2026	21/10/2026	03/02/2027
Chief Executive Officer, Ms J Tomkinson OBE	☑			

Chief People Officer, Ms V Wilson	☑ Via Microsoft Teams (part)			
Chief Operating Officer, Ms C Chadwick	☑ Via Microsoft Teams			
Director of Strategic Partnerships, Mr J Develing	☑ Via Microsoft Teams			
Director of Governance & Risk, Mrs K Wheatcroft	☑			
Non-Executive Director, Ms W Williams	☑			
Non-Executive Director, Mr A Hassell	☑			
Non-Executive Director, Ms S Corcoran	☑ Via Microsoft Teams (part)			
Non-Executive Director, Ms H Gunawickrema	☑ Via Microsoft Teams			
Non-Executive Director, Mr P Jones	☑			
Deputy Director of Nursing & Quality Governance, Ms F Altintas	☑			
Head of Facilities Services, Mr R Morrow	☑ (Item 4)			
Committee Secretary, Mrs C Jones	☑ (minutes)			

Formal Business		
Agenda Item Number	Item	Action
1.	**Welcome, apologies, and opening remarks** The Trust Chair, Mr N Large (NL) welcomed everyone to the meeting. Apologies were noted from Public Governors, Ms S Cook and Ms C Holloway and Staff Governor, Ms P Edwards. NL welcomed Partnership Governor, Dr E Collins to the Council of Governors and introductions were made around the table.	
2.	**Declarations of conflicts of interest with agenda items** There were no conflicts of interest declared in relation to the public meeting agenda items.	
3.	**To approve the minutes of the Council of Governors held on the 4th February 2026** The minutes of the meeting held on the 4th February 2026 were **approved** as a true and accurate record.	
4.	**To consider any matters arising and action log** Action 6-25/26 Public Governor, Prof T Fisher (TF) noted he had not yet met with the Director of Clinical Research, Dr P Bamford (PB).	

	Action 7-25/26 (Head of Facilities Services, Mr R Marrow in attendance for the item) Head of Facilities Services, Mr R Morrow (RM) shared a verbal update with Governors regarding Facilities Services, highlighting the following: • Facilities Services encompasses fourteen services, including four critical support services which are fundamental to healthcare delivery, domestics services, linen services, catering services and waste services. • Over the past 12 months, it has been a particularly busy and stressful period, with the Trust seeing over three hundred patients daily and each area must be cleaned after every patient to ensure a safe environment for the next. • The standards of cleanliness have been elevated beyond those seen in recent years. • Services have been secured from local providers, notably for linen, contributing to emission reductions which is a significant success story. The new linen service has demonstrated notable cost efficiencies. • The catering team supplies approximately seven hundred and fifty meals per day within the Trust, preparing fresh food to ensure optimal nutrition for patients. • Waste generation continues to increase with the costs of removal rising substantially (the cost was £219 per ton pre Covid-19 and it currently £490). The Trust is exploring onsite waste management solutions to achieve cost savings. • The team is pleased with the year's results with regards to Patient-Led Assessments of the Care Environment (PLACE) with the portfolio performing well overall, though there remains ongoing work. The combined efforts of Facilities, Estates, the Patient Advie and Liaison Service (PALS), nursing, and chaplaincy teams have contributed greatly to presenting an improved image of the Trust. • The project regarding Geothermal energy remains on track, with updates forthcoming. • The Green Plan was ratified in October 2025, aligning with NHS targets; this is a comprehensive document which will guide future actions and is available if required. Public Governor, Prof T Fisher (TF) addressed the Trust’s infrastructure, emphasising the significance of achieving net zero carbon goals. RM noted that legacy buildings constructed to lower standards in the early 1980s require substantial investment to reduce carbon emissions. It was noted that the new Women & Children’s building is the first public sector building to meet the net zero standard. Fuel is currently the largest contributor to carbon emissions; the potential success of the geothermal project will result in a substantial reduction. It was noted that there are planned window glazing replacements in the coming year to support ongoing sustainability efforts. RM continued that the hospital’s design prioritised evacuation and relies solely on natural ventilation, necessitating further improvements. TF discussed adopting modern techniques and his plans to consult Director of Clinical Research, Dr P Bamford (PB) regarding future developments. RM mentioned exploration of the Scandinavian 'passive energy' system for potential integration.	

	The Trust Chair, Mr N Large (NL) commended RM and the entire team for their passionate commitment to change and patient care within the Trust. The Chief Executive, Ms J Tomkinson (JT) noted RM's extensive personal effort in maintaining adequate linen stocks, recognised RM's leadership for driving positive outcomes across teams and expressing gratitude for these contributions. Public Governor, Mr R Taylor (RT) raised the possibility of linking waste management issues to incineration and geothermal initiatives. RM responded that incineration could be considered but requires approval from the local authority and relevant service providers and confirmed ongoing evaluation of alternative options. The Council of Governors **noted** the action log.	
5.	**Patient Story** A patient story was shared via video, highlighting consistently high standards of care, compassion and professionalism across Ward 47 and Ward 44. Particular commendation was given to named staff and teams for exemplary nursing care and support provided to the patient and family. The Council of Governors **noted** the Patient Story.	
6.	**Trust Chair's Briefing** The Trust Chair, Mr N Large (NL) informed the Council of Governors that Mr D Nash (DN) has been appointed as Director of Transformation & Productivity noting his confidence that DN will make an impact with regards to transformation over the coming months. NL updated positive Trust progress, including improvements in elective performance and urgent and emergency care while acknowledging continued work is required. There is strong patient feedback with regards to the Trusts compassionate care with NL stating the Trusts intention to further engage with staff following the recent staff survey results. NL raised the NHS Oversight Framework (NOF) and the improving picture for the Trust with the Trusts continued focus over the coming years in terms of improvements for staff and within Urgent Care and recognising the improvements required to manage non-criteria to reside (NCTR) patients and the support required from partners. NL detailed upcoming changes with regards to neighbourhood working, community partners and Health & Wellbeing Boards to join together to support complex challenges through the Integrated Care Board (ICB). NL thanked staff and the team for leading the Trust and for the strategic vision over the coming years noting that the Trust is in a good place although there is continued work to do. NL informed the Council of Governors that the Trust is not yet in a position to share the Care Quality Commission (CQC) inspection final report and as soon as	

	it was available it will be discussed at the Board of Directors and shared with Governors. NL noted regional/system changes including NHS England (NHSE) North West taking a more performance role with Kathy Cowell taking over as regional Chair for NHSE North West. NL informed the Governors that the Informal Governor and Chair meeting scheduled on the 6th May will be moving to the 7th May 2026. The Council of Governors **noted** the Trust Chair's Briefing.	
7.	**Chief Executive Officer's (CEO) Report** The Chief Executive Officer, Ms J Tomkinson (JT) noted the following highlights from the CEO report: • The Cheshire & Merseyside Provider Collaborative (CMPC) update addresses the role of provider collaboration, which now involves greater oversight rather than direct delivery, with distinct work programmes led by CMPC on behalf of the ICB. It is acknowledged that different professional groups require tailored leadership. JT has assumed responsibility for the people agenda to ensure a consistent flow of information aligned with the workplan. • A new Health and Wellbeing Strategy 2026 – 2030 has been developed to align with our own strategy, and engagement with localities regarding neighbourhoods will follow. • The Cheshire and Warrington combined authority is now up and running with new Chief Executive, Nick Workley. JT anticipated meeting soon with the new Chief Executive to discuss partnerships and population health. • Corridor care is referenced, emphasising the elimination of corridor care outside the Emergency Department (ED). Such care is provided in the Same Day Emergency Care Centre (SDEC), offering greater privacy and a plan to transition away from corridor care entirely. • PLACE reports are referenced as discussed by Mr R Morrow during his facilities update. • The Trust has received positive feedback from the NHS England Education Quality Assessment. Public Governor, Prof T Fisher (TF) raised the frailty unit. JT explained that it will facilitate patient flow from the ED or primary care into and out of the unit. Public Governor, Ms L Jha queried whether SDEC is relieving pressure on the ED. JT responded that the design prioritises swift movement for frailty patients and improvements in patient flow have commenced this week. Staff Governor, Ms C Finney (CF) has observed an enhanced patient experience and noted that SDEC's operations have improved. TF enquired about the longest stays for frail patients in SDEC. JT reported the longest previously was ten days, with ongoing efforts to expedite patient flow through the frailty unit. The Council of Governors **noted** the contents of this report.	

8.	**Lead Governor Update – April 2026** The Director of Governance & Risk, Mrs K Wheatrcroft (KW) noted that the shared update triangulates to items on the agenda with the Lead Governor, Mr J Jones (JJ) summarising his activities. Included is the Governor extract for the 2025/26 Annual Report for Governor oversight. The Trust Chair, Mr N Large (NL) thanked JJ for the update provided. The Council of Governors **noted** the contents of the report.	
9.	**Staff Survey** The Chief People Officer, Ms V Wilson (VW) highlighted the following from the shared NHS Staff Survey 2025 – Results and High-Level Actions paper: • The Staff Survey provides valuable insight into staff experiences within the Trust; however, it is only one indicator and should be viewed as a snapshot from winter 2025. • 84% of responses indicated no significant change compared to the previous year's survey. There is evidence of strengthened line management, reflecting ongoing efforts in this area. Nevertheless, dissatisfaction regarding increased work pressure and fatigue remains, which mirrors financial and operational challenges. This trend aligns with the national picture, suggesting staff across the country are experiencing similar hardships. • At Divisional level, results are consistent with previous years. Patient facing staff report poorer experiences than their non-patient facing counterparts. • Positive developments have been noted in some areas. • Engagement sessions were held with staff on the day the survey results were released, and priority areas are outlined in section six of the shared paper. It was noted that these actions use language that staff can relate to and include specific steps for improvement, which will be monitored through the year and be reported through the People Committee to enhance staff experience. Non-Executive Director, Ms W Williams (WW) informed the Council of Governors that the April 2026 People Committee meeting has been rescheduled, resulting in limited review of the results. WW noted that it is disappointing that survey completion rates did not increase and that investments in wellbeing initiatives are not seen. There is the need to assess whether these wellbeing measures are valued by staff and that feedback beyond the survey itself should also be considered by the People Committee to investigate any issues further. The Trust Chair, Mr N Large (NL) enquired about staff morale. Staff Governor, Ms N Cottrell (NC) responded that it can vary depending on the time of year and workload pressures and that ward pressures can result in lack of time to complete the survey. NC noted that the post survey engagement sessions were supportive, and the identified priorities are expected to help staff. Staff Governor, Ms C Finney (CF) noted that at the weekly and monthly Senior Nurse meetings there is a focus on empowering staff. However, pressures affect engagement, noting that meaningful communication is required. Priorities are expected to drive further engagement, especially among clinical teams, who appear most impacted.	

	Deputy Director of Nursing & Quality Governance, Ms F Altintas (FA) commented that the Trusts position is not significantly different from other Trusts, fatigue is widespread. FA noted that some Trusts incentivise survey completion and that day to day improvements in timely feedback may strengthen staff engagement across the Trust. The Trust Chair, Mr N Large (NL) remarked that unless pressures change, feedback will remain the same. A clear vision is essential for staff to understand the Trust's direction. (Lead Governor, Mr J Jones (JJ)) Partnership Governor, Mr P Tardivel (PT) commended the report, noting that learning rates are comparatively low, and improvement depends on continued focus in this area. Public Governor, Mr R Taylor (RT) observed that morale is directly linked to job satisfaction, asking if the appraisal process feeds into staff feedback. The Chief Executive, Ms J Tomkinson (JT) confirmed that appraisals are a relevant indicator. VW added that appraisal conversations and compliance have been measured over the past 12 months, with quality now being assessed. JT stated that the staff survey is aligned with objectives to ensure people feel positively about working at the Trust and confirmed that further efforts will continue. (VW left the meeting) The Council of Governors: • **Noted** the Trust's Staff Survey 2025 results. • **Noted** the analysis undertaken and areas for action identified. • **Noted** the Trust priorities identified in section 5. • Took **assurance** that the Trust continues to engage its staff in the completion of the staff survey, review and analysis of the survey results, and identification of appropriate actions, and will monitor progress via People Committee.	
10.	**<u>Cheshire and Merseyside Provider (CMPC) Collaborative Priorities</u>** Director of Strategic Partnerships, Mr J Develing (JD) presented CMPC Blueprint: Strategic Priorities, highlighting the following: • 1. Collaboration – Collaborative providers across Cheshire & Merseyside (C&M) are working together to improve outcomes for patients, address inequalities, enhance service quality, and reduce financial deficits in the system. There is now a formal duty for providers to collaborate rather than compete, ranging from informal partnerships to more structured alliances aimed at driving change. • 2. Service Chains – To ensure that local hospitals are not disadvantaged compared to tertiary hospitals and promote sharing of expertise and learning across specialist Trusts. Early discussions with Alder Hey have focused on adapting certain practices and leveraging specialist support through collaborative relationships. • 3. Fragility – Addressing service fragility at the C&M level involves developing centres of excellence that can help improve outcomes in areas facing	

	significant challenges. The C&M programme is actively exploring these solutions over the coming years. • 4. Community – Community services are coordinated collaboratively, such as through unified service elements with Wirral University Teaching Hospital NHS Foundation Trust (WUTH), following a blueprint that recommends consolidation to increase efficiency and proximity of care. • 5. Consolidation – Consolidating services at scale, both locally and across C&M, will yield benefits in procurement, value improvement, and cost reduction. Further development across all areas is planned. The Trust Chair, Mr N Large (NL) confirmed that contextually, as an NHS organisation, the Trust operates within the C&M system, maintaining some autonomy while engaging in ongoing collaboration. Recommendations will be made, and the Trust Board will decide how best to support both our organisation and the wider system, working closely with the Council of Governors and Board of Directors regarding any service changes. The ICB position is evolving, with NL noting that the ICB has taken on a more strategic leadership role, while performance management responsibilities have shifted to NHSE. The Chief Executive Officer, Ms J Tomkinson (JT) confirmed this alignment, acknowledging the period of transition and complexity. NL emphasised that, although challenging, these developments are exciting opportunities for progress. The Council of Governors **noted** the update.	
11.	**<u>Quality Priorities Update</u>** The Deputy Director of Nursing & Quality Governance, Ms F Altintas (FA) presented the Quality Priorities for 2026/27, highlighting the following: • An introduction to the three priority areas, Patient Safety, Clinical Effectiveness and Patient Experience. • The proposed priorities within Patient Safety. • The proposed priorities within Clinical Effectiveness. • The proposed priorities within Patient Experience. • The reporting metrices being supported by the Improvement Teams and presented quarterly to the Quality Governance Gorup (QGG). Non-Executive Director, Prof A Hassell (AH) informed the Council of Governors that FA reports the quality priorities via QGG through to the Quality & Safety Committee. Partnership Governor, Dr E Collins (EC) raised time from admission measures where patients experience corridor care. FA confirmed that it is detailed from time of decision to admit, noting that any patient over six hours will have a body map taken. Public Governor, Prof T Fisher (TF) noted that 90% of patients are screened for Sepsis querying the criteria that separates the other 10%. FA confirmed that the	

	Trust is not quite at the 100% target, 100% of patients should be screened for Sepsis. The Council of Governors **noted** and **approved** the Quality Priorities update.	
12.	**a) Membership & Engagement Committee (MEC) Chairs report 10th March 2026 and approved minutes 11th December 2025** Public Governor/MEC Chair, Mr M Roberts (MR) reported that, upon taking over as Chair of MEC, there was initially no meaningful Trust membership database and following collaborative efforts with Civica and the Director of Governance & Risk, Mrs K Wheatcroft (KW) and her team there is now a comprehensive database in place. MR noted that there was the need for increased Committee membership and Staff Governor, Ms N Cottrell (NC) and Public Governor, Prof T Fisher (TF) have now joined the MEC membership. MR expressed his initial reservations regarding the Non-Executive Director/ Governor walkabouts although his recent walkabout of Care of the Elderly was facilitated productively and resulted in valuable discussion and debrief due to positive engagement. MR added that he had visited the Macmillan centre that morning, observing continued progress and a positive attitude among staff. TF remarked that walkabouts can generate immediate, constructive feedback and advocated for expanding these activities, noting their considerable value. The Trust Chair, Mr N Large (NL) emphasised the importance of deepening involvement with MEC to ensure meaningful impact for Governors and the Trust. (Non-Executive Director, Ms S Corcoran left the meeting) The Council of Governors **noted** the Chairs report from the 10th March 2026 and approved the minutes from the 11th December 2025. **b) Membership & Engagement Committee Terms of Reference** The Council of Governors **approved** the terms of reference of the Membership & Engagement Committee.	
13.	**Governor Election Process Proposal** The Trust Chair, Mr N Large (NL) informed the Council of Governors that the Governor Elections Process proposal update will be shared in the private section of the meeting.	
14.	**Urgent Care Update** The Chief Operating Officer, Ms C Chadwick (CC) highlighted the following from the Urgent Care Update shared at the March 2026 Board of Directors:	

	• The update outlines the targets for 2026/7 and the subsequent three years. With all but two compliance plans submitted; the two main reasons for this were a desire to submit only credible plans and concerns about meeting targets within the allotted timeframe. The update specifies the final year target as 6% for the Cost Improvement Plan (CIP), indicating there is no option to stretch further to support compliance in the two areas where reports were not submitted which were, 4 hour and 12 hour ED performance metrics. • A new forum will be established to focus on flow improvements, with the Deputy Director of Nursing/Deputy Chief Executive, Ms S Pemberton (SP) and CC leading ED and admission guidance aspects. Anticipated outcomes include stabilising ED performance and reducing 12 hour wait times. • For years two and three, funding opportunities will be explored to accelerate compliance in these two areas. The CIP target will be reduced accordingly, allowing investment to support compliance and Divisions are currently developing plans regarding potential investments. • Consideration is being given to extending the short stay frailty unit and increasing advanced nurse practitioner positions. Registrar and Consultant numbers are also under review to ensure timely completion of daily tasks. • Each scheme is being evaluated by Divisions, and additional detail for the Board of Directors is being include, highlighting the expected impact on the 4 and 12 hour targets. Progress will be reviewed throughout the calendar year and reported to the Board and feedback provided to the Council of Governors. • The Trust believes that a credible plan has been submitted. The Trust Chair, Mr N Large (NL) noted the realistic view on what is achievable and although the Trust is not compliant in the first two years the Trust does not want to compromise safety and is managing flow and investing when able. The Trust requires support with regards to NCTR patients. Partnership Governor, Mr P Tardivel (PT) queried the modelling underpinning the trajectories for ED and how this was completed. CC confirmed that all plans are completed with Business Intelligence (BI) colleagues looking at urgent emergency care and in particular the number of attendances in ED, average length of stay and bed occupancy. NL thanked CC and her team for the referral to treatment (RTT) work taking place. The Council of Governors **noted** the progress against the plans to meet the 4 Hour and 12 Hour targets, within year 3 of the Medium Term Plan (MTP).	
15.	**<u>To receive Board updates:</u>** **a. <u>The recent Chair's reports of Board Sub-Committees:</u>** <u>Chair's report from the Chair of the People Committee – 10th February 2026</u>	

	Non-Executive Director, Ms W Williams (WW) informed the Council of Governors that no alerts required escalation, noting the breadth and scale of the People agenda and indicating positive implementation activity under the Chief People Officer, Ms V Wilson (VW) leadership. WW highlighted a substantive discussion regarding Freedom to Speak Up (FTSU), noting processes were considered sound, but the Committee sought stronger mechanisms to ensure organisational learning across areas. WW also described newly established People Committee Sub-Committees, noting they have become effective, analysing operational detail, and improving information flow and scrutiny, with thanks expressed to the Chairs of these Sub-Committees. Discussion acknowledged wider national whistleblowing concerns seen on social media and emphasised the importance of avoiding cultures that "closed ranks," while reinforcing multiple channels for reporting and the Trust's broader reporting culture and daily safety mechanisms. The Chief Operating Officer, Ms C Chadwick (CC) added clarification that the FTSU improvement focus related to triangulating learning across all channels FTSU, wellbeing, direct escalation routes and strengthening how learning was shared, not that there is an absence of speaking up. Chair's Report Finance & Performance Committee – 21st January 2026 and 25th February 2026 Non-Executive Director, Ms H Gunawickrema (HG) provided a high-level finance update, noting the paper shared with the Council of Governors was outdated due to the next Committee meeting now scheduled for the 29th April 2026. HG reported increased confidence from external assurance perspectives with the deficit support funding (DSF) reinstated. HG referenced submission of a five-year plan with monitoring commencing from April 2026/27 onwards. HG emphasised the transformation/cost improvement programme (CIP) journey and linked the appointment of the Director of Transformation & Productivity, Mr D Nash (DN) to managing costs and progressing improvement programmes. HG also described Committee assurance review work being submitted to Audit Committee and a planned refresh of Key Performance Indicators (KPIs) led by the Chief Finance Officer in collaboration with Executives and Non-Executive Directors. Chair's report from the Chair of the Quality & Safety Committee – 5th March 2026 Non-Executive Director, Prof A Hassell (AH) highlighted ongoing shortfalls against urgent care constitutional standards (four-hour and twelve-hour waits) while noting improvement over the past year and identifying sustained good performance areas. The Committee noted estate constraints within ED resuscitation against standards referenced by the Care Quality Commission (CQC) and described ongoing risk assessment scrutiny and mitigation work including building an additional paediatric resuscitation bay. It was noted that the Trust is committed to the developments of Patient Safety Partners with plans in review to move forward. Chair's Report Audit Committee – 3rd February 2026 The Trust Chair, Mr N Large (NL) noted that the Audit Chair, Non-Executive Director, Mr P Williams (PW) was unable to attend and took the Audit Committee Chair's Report as read. The Council of Governors **noted** the Committee Chair Reports.	

	b. Integrated Performance Report (IPR) No IPR detail was shared during the meeting, the Council of Governors can access the IPR detailed at the March 2026 Board of Directors via the website – Board of Directors Meeting Packs | Countess of Chester Hospital. **c. Integrated 5 Year Plan & Trust Priorities** The Chief Executive, Ms J Tomkinson (JT) informed the Council of Governors that she has held three separate Leadership Planning Briefings for 2026/27 to 2028/29 with Consultants and Clinical Leads. JT highlighted the following that was shared at these briefings: • National planning targets 2025/26 – Forecast Outturn, noting the improvements made since the information shared on the slide was detailed. • National planning targets 2026-27. • Quality and Safety Priorities 2026/27. • How the Trust has performed in quarters one, two and three of 2025/26, moving up ten places in ranking from quarter one to quarter three. • How the Trust has performed under significant regulatory oversight. • Our delivery agenda in 2026/27 to 2028/29. • The role of the Clinicians. Public Governor, Mr M Roberts (MR) queried if the loss off five hundred staff is from across all areas between now and 2028/29. JT confirmed all staff groups with natural wastage, but this is not always in the right areas. Partnership Governor, Dr E Collins (EC) raised digital transformation support. JT confirmed this will support with validation, which is currently manually, digital tools and artificial intelligence (AI) will move this forward. The Trust Chair, Mr N Large (NL) confirmed that the Trust is well positioned with regards to digital transformation. NL stated that while cutting staff may lower morale, the alternative is more detrimental. Partnership Governor, Mr P Tardivel (PT) noted a similar journey at Betsi Cadwaladr University Health Board querying whether the Trust is expecting to take five hundred posts out or whether the Trust will look at the services it offers. JT confirmed that the Trust is looking at services and the populations needs. Non-Executive Director, Prof A Hassell (AH) noted that in the two years he has been at the Trust the presentation shared is the most concise and informative to present the Trusts position. Public Governor, Prof T Fisher (TF) noted that as Governors they have responsibilities with regards to the performance of the Board of Directors raising the red outcome in a recent Board of Directors assessment. JT informed the Committee that the completed assessment template was triangulated with evidence with regards to the Boards decision making. The Trust has spoken with the Regional Chief Executive regarding the position. NL added that it is based on the history at the Trust rather than its current position and where it is going. **Action:** It was agreed for NL to share the NOF and Board of Directors assessment separately with the Council of Governors	**NL**

	NL noted that judgements, regarding the Trust, are made from the NOF which is updated on a quarterly basis. (CC left the meeting) The Council of Governors **noted** the update.	
16.	**<u>To receive feedback from Governors</u>** No feedback was shared on this occasion.	
17.	**<u>Non-Executive Director (NED)/ Governor Walkabouts Summary Report – Quarter 4 2025/26</u>** Public Governor, Mr M Roberts (MR) noted a productive walkabout to Wards 50 and 51, engaging with positive individuals who showed support for the visit. A debrief followed the walkabout between the Governors and NEDs in attendance. Non-Executive Director, Ms W Williams (WW) added that staff were extremely welcoming, raising that a particular patient was accompanied by a Social Worker who expressed appreciation for collaborative work with the Trust. The overall atmosphere was upbeat, and the visit was noted as positive. WW noted that staff were uncertain regarding the Board of Directors and Council of Governors and advised some increased awareness of the Board of Directors and Council of Governors within the Trust could support. Public Governor, Prof T Fisher (TF) suggested that the walkabout feedback from staff should be considered alongside the Staff Survey results as perspectives beyond the survey. Lead Governor, Mr J Jones (JJ) raised the visit to the new Women & Children's building where staff dedicated time to open discussion. It was observed that some mothers were reluctant to leave the new facility due to its quality, which may impact throughput. JJ noted that smoking outside the new building remains an issue. Public Governor, Ms L Jha (LJ) raised concerns regarding the Phlebotomy Service following the walkabout. The Trust Chair, Mr N Large (NL) indicated that these concerns have been shared with the Director of Nursing & Quality/Deputy Chief Executive, Ms S Pemberton (SP). LJ commented on the quietness of the new building. The Council of Governors **noted** the summary report from the recent NED/ Governor walkabouts.	
18.	**<u>For noting:</u>** The Council of Governors **noted** the: a) Draft Council of Governors Workplan. The Director of Governance & Risk, Mrs K Wheatcroft (KW), informed the Governors to let the team know if they wanted any items to be included in the workplan. b) Council of Governors Photo Sheet.	

19.	**<u>Any Other Business</u>** No items raised.	
20.	Close of meeting	

Next Meeting: Wednesday 15th July 2026 at 14.00 – 16.30, in the Women & Children's Building Seminar Room

Countess of Chester Hospital NHS Foundation Trust

Council of Governors Action Log

2026/27 updated July 2026

Action Number	Meeting Date	Allocated to	Agenda Item Number	Issue/ Action Raised	Action Details	Action Update/Outcome	Due Date	Status
6-25/26	4th Feb 2026	Public Governor, Prof T Fisher / Director of Clinical Research, Dr P Bamford	9a.	Research Update	It was agreed for Dr P Bamford and Prof T Fisher to meet outside of the meeting to discuss Research further and Trust links to Health Innovation.	**Update 5th March 2026** – An introduction e-mail was shared between Dr P Bamford and Prof T Fisher. **Update 11th March 2026** – Prof T Fisher contacted Dr P Bamford to meet. **Update 15th April 2026** – Prof T Fisher updated that he has not yet met with Dr P Bamford.	Apr-26	**Open**
7-25/26	4th Feb 2026	Committee Secretary	17.	Any Other Business	It was agreed that the Council of Governors will receive a Facilities Management update at a future meeting.	**Update 9th March 2026** – Presentation Update included on the April 2026 Council of Governors agenda. **Update 15th April 2026** – Facilities Management Update received at the 15th April 2026 Council of Governors – action closed.	Apr-26	**Closed**
1-26/27	15th Apr 2026	Trust Chair	15c.	Integrated 5 Year Plan & Trust Priorities	It was agreed for NL to share the NHS Oversight Framework (NOF) and Board of Directors assessment separately with the Council of Governors	**Update 7th July 2026** – NOF Update scheduled on the July 2026 Council of Governors agenda.	Jul-26	**Open**

PUBLIC – Council of Governors
15th July 2026

Report	**Agenda Item 7.**	**Chief Executive Officer's Report**						
Purpose of the Report	Decision		Ratification		Assurance		Information	**X**
Accountable Executive	Sue Pemberton			Deputy Chief Executive Officer				
Author(s)	Karan Wheatcroft			Director of Governance and Risk				
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 BAF 11 Transformation			**X** **X** **X** **X** **X** **X** **X** **X** **X** **X** **X**	Relevant across all BAF areas.			
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	-							
Executive summary	The purpose of this report is to provide an overview of the relevant local, regional, and national issues for consideration alongside the strategic objectives and wider Board agenda.							
Recommendations	The Board of Directors is asked to **note** the contents of this report.							

Corporate Impact Assessment	
Statutory/regulatory requirements	Contributes to the Trust compliance with Foundation Trust status.
Risk	Alignment with the Board Assurance Framework and Corporate Risk Register.
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.

Chief Executive Officer's Report

This report provides an update on local Trust matters and wider national, regional and system updates.

1. Countess of Chester Hospital NHS Foundation Trust recognised as one of the top ten most improved

On the 9th June, Jane Tomkinson, Chief Executive Officer was invited to 10 Downing Street, in recognition that our Trust is one of the ten most improved NHS Trusts in England.

Prime Minister, Sir Keir Starmer, and Secretary of State for Health and Social Care, James Murray, were keen to recognise the significant improvements we have made in patient care. They understood that progress on this scale is the result of many people working together with a shared purpose, embracing innovation and collaborating to deliver better care for patients.

We are incredibly proud of the collective effort, dedication, and passion of every single person working in our hospitals.

(Appended letter from Downing Street, which has been shared with all staff).

2. COCH NOF Rating (Q4) and Provider Capability Assessment

During 2025/26, the Trust demonstrated significant improvements made across all the targets and enhanced the financial stability. Our progress in the NHS Oversight Framework (NOF) from 133/134 at Q1 to 98/134 at Q4 demonstrates ongoing delivery which is testament to the work and commitment across all our teams.

In response, Louise Shepherd, NHS England Regional Director wrote to the Trust on the 30th June 2026 to confirm that the Provider Capability rating of the Trust (originally assessed in October 2025) has been improved to amber-red. The letter stated that this was due to the focus and sustained attention to address challenges relating to Urgent and Emergency Care (UEC) and financial delivery, resulting in the improvement to several metrics within the NOF positively moving the Trust to a ranking of 98/134.

We are anticipating a subsequent update to the NHSE enforcement undertakings placed on the Trust.

3. National Updates

On the 1st April 2026 Sir James Mackey issued a letter to Integrated Care Board (ICB) and Trust Chief Executive Officers setting out the priorities for 2026/27. This includes working together to ensure

- Clarity of strategic commissioning and how this will be developed
- Ambitions for neighbourhood care, and how this links to key challenges
- Agreement of areas for review and changes to financial flows and/or payment systems
- Consideration of areas of support or change from NHSE to help accelerate the pace of change.

The letter sets out the following areas of focus

1. Outpatient transformation
2. A step-change in reducing hospital bed-days for highest-risk cohorts
3. Scheduling and access reform for urgent care
4. Technology-enabled productivity improvements
5. The NHS App
6. Payment reform
7. Quality
8. Capability building and a focus on our people

4. Publication of National Inquiry reports into maternity and neonatal services

On the 24th June 2026, the Nottingham Maternity Review national inquiry report into systemic NHS maternity failures led by senior midwife Donna Ockenden was published. The review examined over 2,500 family cases and interviewed over 800 staff at the Nottingham University Hospitals NHS Trust spanning 2012 to 2025.

On the 30th June 2026, the Independent National Maternity and Neonatal Investigation report, led by Baroness Amos was published. The inquiry concluded that the English maternity system is "no longer fit to consistently deliver high-quality, compassionate care" and requires a total cultural and structural overhaul.

In response to the reports, NHS England has mandated ten urgent actions to improve maternity safety, focusing on patient voice, equality, staffing, and leadership.

The Trust is working through the learning from the Inquiries and assessing our position against the NHSE urgent actions, with any areas for improvement being identified and appropriate action taken. The Trust will continue to work with Regional and National colleagues as the NHS response to the recommendations progresses, with oversight provided through the Quality and Safety Committee.

5. Resident Doctor Settlement

On 29 June 2026, resident doctors formally voted to accept the Government's multi-year pay and jobs offer, following an online ballot by the British Medical Association. The agreement brings an end to more than three years of recurring industrial action and includes pay reform through changes to nodal points, reimbursement of mandatory training-related costs, improved access to specialty training places, contractual standardisation for locally employed doctors, and continued delivery of the NHS England ten-point plan to improve resident doctors' working lives. The settlement also establishes future working arrangements through an Industrial Relations Committee, intended to support more constructive engagement between resident doctors, government and NHS partners.

The Trust will continue to deliver local actions to improve the working conditions and experience of resident doctors, including through implementation of the ten-point plan, with ongoing engagement through medical leadership and postgraduate education routes.

6. Cheshire & Merseyside Provider Collaborative (CMPC) Leadership Board meeting

20th March 2026

CEOs attended the Leadership Board on 20th March 2026. This meeting included:

- Discussion on CMPC and Cheshire and Merseyside Integrated Care Board priorities.
- Progress in respect of the CMPC programmes and professional groups including elective recovery and transformation, diagnose to refer, community services, finance, contracts and procurement.
- Feedback on C&M ICB Strategic Commissioning strategy.
- Feedback from Providers on the UEC Board.
- Discussion on locum rates.

17th April 2026

CEOs attended the Leadership Board on 17th April 2026. This meeting included:

- An update on Neighbourhood plans.
- The UEC Strategy and priorities as set out by the Cheshire and Merseyside ICB Performance Lead.
- A presentation on enabling technology and at scale collaboration.
- Finance and contracts update.
- Next steps and planning and priorities.

7. Mental Health Tripartite Agreement

NHS Cheshire and Merseyside (NHS C&M) has established a tripartite agreement with the Countess of Chester Hospital NHS Foundation Trust (COCH) and Cheshire and Wirral Partnership NHS Foundation Trust (CWP) to address long waits for people presenting with mental health needs to the COCH's emergency department (ED). The agreement includes shared principles and ways of working.

The assurance against this will be reviewed through the Mental Health Steering Group with Chair's reports to the new Executive Led Discharge, UEC and Admission Avoidance Group, subsequently reporting through to Operational Management Board (OMB).

8. Medium Term Plan Acceptance

On 16th April 2026 the Trust received confirmation of acceptance of the Trust's Medium Term Plan (MTP) and 5 Year Integrated Delivery Plan from NHS England. The acceptance was with conditions due to the non-compliant UEC plan.

The letter sets out a summary of the delivery targets and includes areas for further review and/or action in respect of finance, activity and performance, urgent care, and population health.

9. Single Point of Access

Outpatient transformation is a key National priority, to ensure systems have streamlined pathways for referrals onto elective pathways. There is an ambition that by Q3 each system has at least 10 referral pathways managed by a Single Point of Access (SPoA). Patients on the selected pathways will be referred into a SPoA and then triaged to determine the most appropriate next step for the patient. The options will include Advice and Guidance, referral to a community provider, return to referrer or onward referral to an acute provider if the patient requires consultant led care. It is anticipated this will reduce the number of patients that are referred onto provider waiting lists, incurring long waits when their condition can be managed in another way.

In Cheshire and Merseyside this work is being led by the provider collaborative. The project is in its infancy and currently providers are being asked to provide data and information so priority pathways can be selected. Specialties for consideration include ENT (ear, nose and throat), Dermatology and Gynaecology. Further updates will be provided as this project progresses.

10. Celebrating our services: welcoming the Chief Nursing Officer for England

On the 10th April 2026, we were delighted to host Duncan Burton, Chief Nursing Officer for England, at our Trust. His visit was an opportunity to showcase the positive work happening across our teams. Duncan was given a tour of the Paediatric and Neonatal Units, where he spoke to a number of front-line colleagues about the new clinical environments and how they have positively impacted patient care and experiences. He also had the chance to see the improvements made to our Emergency Department including the new triage process, the improved paediatric areas and also the Millbrook Unit, our new dedicated space for patients with mental health care needs.

11. CQC Report

After a long wait, we have now received the Care Quality Commission's (CQC) draft report following their inspection of our services in October 2025. We have reviewed the report in detail and have provided evidence-based feedback to the CQC to ensure the report accurately reflects our services. The Trust has also sent a letter summarising out concerns and findings to the Interim Chief Executive Officer and Head of Hospital Inspections. Following a subsequent meeting with the CQC, we are now in the process of a further factual accuracy process.

12. Transforming People Services

NHS England's Transforming People Services programme continues to progress following approval of the Outline Business Case in February 2026. The programme will establish a new target operating model for People Services, bringing together more standardised processes, digital-first access, greater use of automation and AI (artificial intelligence), and a clearer focus on strategic business partnering and workforce transformation. All regions and providers are expected to begin preparedness activity, including policy standardisation, data quality improvement, capability development and planning for future operating models. This work is aligned to the 10 Year Health Plan and the Future Workforce Solution, and the Trust will

continue to engage through regional and national arrangements to ensure local plans remain aligned with the emerging model and opportunities for improvement, with ongoing progress monitored through the People Committee.

13. UK threat level

On 1st May 2026 the Trust received notification from NHS England that the Joint Terrorism Analysis Centre (JTAC) has advised that the UK Threat Level should be changed from SUBSTANTIAL (an attack is likely) to SEVERE (an attack is highly likely). This change in alert level has been cascaded to staff.

The Trust has Emergency Preparedness, Resilience and Response (EPRR) frameworks in place and will continue to review the updates and advice provided.

14. Board Leadership update

We are pleased to welcome Mark Oldham, Non-Executive Director to our Board of Directors. Mark brings extensive NHS finance experience to the Board and has joined the Trust on an interim basis whilst a full recruitment exercise takes place.

10 DOWNING STREET
LONDON SW1A 2AA

3 July 2026

THE PRIME MINISTER

Dear Jane,

I am writing to thank you for coming to Downing Street recently for the roundtable we hosted.

I would like to reiterate my thanks to you and everyone working in the Countess of Chester Hospital NHS Foundation Trust for the hard work you all do each day to care for the nation. In particular, the work you have put in to reduce the time patients wait for elective care has impacted the lives of so many. I look forward to seeing how you continue to improve the experience of patients across the country in the coming years.

The Health Secretary has relayed the discussion that was had at the roundtable. I wish you all the best on your continued outpatient work in Chester.

Thank you, once again, for taking the time to come to Downing Street, and for everything that you do.

All best wishes,

THE RT HON SIR KEIR STARMER KCB KC MP

Ms Jane Tomkinson

PUBLIC – Council of Governors
15th July 2026

Report	**Agenda Item 9.**	**Lead Governor Update – July 2026**						
Purpose of the Report	Decision		Ratification		Assurance		Information	**X**
Accountable Executive	Karan Wheatcroft			Director of Governance and Risk				
Author(s)	John Jones			Lead Governor				
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 BAF 11 Transformation			**X**	Supports the overarching governance arrangements.			
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health							**X**
CQC Domains	Safe Effective Caring Responsive Well led							**X**
Previous considerations	Not applicable.							
Executive summary	The purpose of this report is to provide key updates from the Lead Governor to the Council of Governors.							
Recommendations	The Council of Governors is asked to **note** the contents of the report.							

Corporate Impact Assessment	
Statutory/regulatory requirements	Governors are a key part of the NHS health and care act, code of governance and Trust constitution.
Risk	An overarching governance risk is included on the Board Assurance Framework.
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics
Communication	Document to be published as part of Council of Governors papers.

Lead Governor Update – July 2026

I would like to formally thank Sharon Cook, who as a Public Governor for Chester and Rural Cheshire has resigned due to other commitments.

Governors have welcomed the excellent news that the Trust, through its incredible hard work has now been placed nationally at 98 out of 134. A considerable positive move from the Trust previous ranking of 122; a 25% improvement. This is a huge achievement, and Governors want to formally note this recognition and thank all staff for their commitment and hard work in driving the performance of this Trust to this stage.

The Chair of the Board and I have continued to have regular 1-1 meetings where we are supported by the Director of Governance and Risk. Tony Fisher, the next Lead Governor for the Trust is now joining us at our monthly meetings.

The Chair has continued his regular informal communication briefing sessions with all Governors.

Governors continue to attend to observe the Trust Board meetings which are held in public.

I attended the Celebrating Midwives and Nurses event in May 2026. This was truly inspirational. The precis of each nominee demonstrated the care, compassion, empathy and amazing care that is being delivered across the Trust, and it was rewarding to see this recognised.

The Cheshire and Mersey Lead Governors met in May 2026 where Patrick Fraher – Assistant Director of Policy, Department of Health and Social Security (DHSS) joined us. Clause 29 of the Health Bill had its second reading in the House of Commons on the 1st June 2026. The clause would abolish the right of local people to become members of their NHS Trust and remove elected Council of Governors and move the appointment of NHS Foundation Trust Boards from local community Governors to the Secretary of State who would appoint Trust Chairs and Non-Executive Directors. In light of this potential change in legislation, the Chair of the Trust joined the Membership and Engagement Committee meeting held on the 15th June 2025 where a discussion took place to explore ways that the Trust can continue to grow engagement with local people. The Committee continues to review its workplan. *(A separate update is included in today's agenda regarding the Future of Governors Update and Options (agenda item 11.))*

The Non-Executive Directors and Governors walkabouts continue to be undertaken. We have had a number of highly informative and excellent walkabouts within the Trust including Emergency Department and Critical Care Unit, both of which again reflect the hard work and dedication of staff*. (A separate report is included within today's agenda regarding the Non-Executive Director/Governor Walkabouts Summary Report – Quarter 12026/2027 (agenda item 14.)).* I would like to take the opportunity to thank all the staff who give their time to both Non-Executive Directors and Governors when we undertake these valuable walkabouts.

As this is my last Council of Governors I have attached a personal statement below.

LEAD GOVERNOR PERSONAL STATEMENT

As this is my last Council of Governors meeting and after nine years as a Governor of the Trust including two as Lead Governor, I thought it timely to indulge in a quick reflection.

I could not have foreseen or imagined nine years ago what lay ahead and what the Trusts' journey would look like.

There have been many challenges – Covid-19, a number of reputational issues, numerous changes in leadership, the constant challenge of course for the ongoing need to deliver demanding targets – especially in activity and finance. But there have also been challenges which have delivered real positive change. The major investment and development in our buildings including the award-winning new Women's and Children unit, the upgrade to the Emergency Department, the SDEC and the refurbishment of the Stroke Ward.

The golden thread throughout all of this time though has been the constant professionalism and dedication of the staff delivering patient care 24/7 - 365 days a year. A big **thank you** to each and every member of the Trust's staff.

When I took over as Lead Governor, I was told that " the Trust would metaphorically put their arms around me to support me". Well the support has been excellent, and I want to thank the current "Top team" especially Karan and her team, together with all of the support staff in the Trust HQ Office.

I also want to thank the current Trust Chair – Neil, for his support and leadership to both myself and all Governors, which has been invaluable. I now particularly want to thank all of the Governors I have worked with over the last 9 years both past and present. The support we have all given each other has been tremendous.

I have experienced the highs and lows of this Trust over the last 9 years but am in no doubt that the Trust has now entered a new era. The building blocks are all there – the leadership, the drive, the dedication of the trust staff and the ambition to become Outstanding and within our sights (albeit another few years away). The recent announcement through the Quarter 4 National Operating Framework demonstrates the major positive steps forward that the Trust has achieved so far in its journey and the fact that the Trust is one of the top ten most improved across England is recognition of all the hard work. We are already seeing shorter waits for planned treatments and diagnostics, better performance in A&E and stronger performance across cancer standards. I have no doubt that the future will be equally demanding. However, at the end of the day the overriding purpose for why we are all here is to continually improve the services that this Trust delivers and ensure that the patient experience is the very best.

Clocking out of the Trust as a Governor does not mean that I won't be keeping a close eye on the Trust's journey as local resident and service user (hopefully not too frequently!!).

Finally, I want to wish Tony Fisher – the Trust's new Lead Governor and all of our existing Governors, who give their time freely, the very best for the future.

MEMBERSHIP AND ENGAGEMENT COMMITTEE MINUTES
Tuesday 10th March 2026 at 14.00 – 15.00
Via Microsoft Teams

Members	14/04/2025	03/07/2025	11/09/2025	11/12/2025	10/03/2026
Public Governor, Mr M Roberts (Chair)	☑	☑ (from 9.44am)	☑	☑	☑
Public Governor, Mr J Jones	☑	☑ (Chair)	☑	☑	☑
Public Governor, Ms S Dunbar	☑	☑	☑	☒	☑
Staff Governor, Mr S Higgitt	☑	☑	☒	N/A	N/A
Staff Governor, Ms N Cottrell	N/A	N/A	N/A	N/A	☑
Public Governor, Ms Chillery	N/A	N/A	N/A	N/A	☒

Attendees	14/04/2025	03/07/2025	11/09/2025	11/12/2025	10/03/2026
Trust Chair, Mr N Large	☑	N/A	N/A	N/A	N/A
Director of Governance, Risk & Improvement, Mrs K Wheatcroft	☑	☑	☑	☑	☑
Head of Corporate Governance, Mrs N Cleuvenot	☑ (minutes)	☑	☑ (minutes)	☒	☑
Communications Manager – Ms S Edwards	☑	N/A	N/A	N/A	N/A
Head of Communications, Ms H Taylor	N/A	☑	☑	☑	☑
Executive Office Manager, Mrs R Butterworth	N/A	☑ (minutes)	N/A	N/A	N/A
Committee Secretary, Mrs C Jones	N/A	N/A	N/A	☑ (minutes)	☑ (minutes)

Agenda Number	Agenda item	Lead
1.	**Welcome and apologies** The Chair opened the meeting, and apologies were noted from	
2.	**Declarations of Conflicts of Interest with agenda items** There were no conflicts of interest declared in relation to the agenda items.	
3	**To approve the minutes of the Membership & Engagement Committee on the 11th December 2025** The minutes of the last meeting held on 11th December 2025 were **approved** as a true and accurate record of the meeting.	
4.	**To consider any matters arising and action log** The Committee reviewed the action log noting the below updates: **Action 1** – KW raised the topic of a skills matrix for Governors, noting that, should the Committee wish to progress this, it would be necessary to determine	

Approved 15th June 2026

	the required information and establish a process for its collection. KW suggested considering whether a brief summary or bullet points would suffice, as well as how the information would be utilised. JJ proposed that this matter could be reviewed outside the Committee, with options brought forward for consideration at the next meeting. It was agreed for KW to consult with Company Secretaries regarding current practices and for JJ to raise the matter at the forthcoming Cheshire & Merseyside (C&M) Governor's meeting and report back on potential approaches. **Action 3** – Ms H Taylor (HT) advised that Primary Care Networks (PCN) are yet to complete the outstanding work. HT has been in contact with the Integrated Care Board (ICB) to clarify points of contact and network requirements, with the intention to incorporate member engagement activities in due course. It was agreed for Ms H Taylor to continue finalising PCN engagement requirements and update Mrs K Wheatcroft on progress. **Action 4 –** Mr M Roberts (MR) reported the possibility of appointing an additional member to the Committee and will confirm this in due course. Action closed. **Action 6 –** Ms K Wheatcroft (KW) noted considerable ongoing work around Trust signage. MR expressed concern regarding the use of silhouette images in Council of Governors photographs. HT confirmed that vacant posts currently use silhouettes and that not all Governors have suitable photographs. There is available wall space for a display board, but a review is required to assess the quality and availability of existing photographs and vacancies. There have already been attempts to arrange photography at scheduled meetings for Governors needing updated images. It was agreed to review outstanding Governor photographs and plan a coordinated approach for the next Council of Governors meeting to update photographs. The Governor photo sheet to be reviewed following the photograph update. MR queried the low number of Governors in the Ellesmere Port and Neston constituency. KW responded that this is influenced by the election process and efforts to increase interest in the area. Ms S Dunbar (SD) indicated that membership numbers in the area are good following the recent data cleanse, but this has not translated into members volunteering as Governors. Mr J Jones (JJ) acknowledged ongoing difficulties in recruiting from this area. KW agreed to address this issue under item 6 of the agenda. The Committee **noted** the action log updates.	**KW / JJ** **HT** **HT / KW**
5.	**<u>Membership Strategy Progress Update - Membership Database</u>** Mrs K Wheatcroft (KW) reported that work has commenced in accordance with the new membership strategy, which has been approved at Council of Governors and published on the Trust's website. Updates have also been incorporated into the membership database with a membership cleanse having taken place. Mrs N Cleuvenot (NC) noted that during the last Governor election process, efforts were made to identify the number of postal and digital members, with the	

Approved in June 2026

	majority being postal. Constituents were contacted for their preferred method of communication. Following proposals to the committee it was agreed that a membership cleanse would be conducted for individuals who had not participated or provided a digital form of contact. As a result, public membership has been reduced to 2,549 members across constituencies, with 4,989 staff members. This is expected to improve the targeting of communications and increase engagement. KW highlighted that there has been a significant period of limited communication with members. Maintaining effective communications is challenged by cost barriers, making electronic means the most efficient method confirming that written communications can still be provided upon specific request. The Committee: • **Noted** the updated staff and public membership numbers following the membership database cleanse. • **Supported** ongoing efforts to rebuild a digitally engaged and representative public membership.	
6.	**<u>Membership and Engagement Activity</u>** • <u>Feedback from engagement opportunities</u> • <u>Member communications</u> Mrs K Wheatcroft (KW) emphasised the need to review priorities and develop a plan to further engage with members noting that preparations have begun for the 2026 Annual Members Meeting (AMM). Mr M Roberts (MR) reported that while visiting the MacMillan Centre in the Trust, it became clear that staff were not aware of the role of Governors or the Council of Governors and highlighted the need to address this moving forward. Mrs N Cleuvenot (NC) observed the need for improved staff communications to support broader engagement with staff and the public. Ms H Taylor (HT) informed the group that previous communications regarding Governors have been conducted and expressed interest in sharing real-life examples of Governor activities, with plans to expand such communications. KW stated there is an established plan for Governor walkabouts throughout the year, aimed at strengthening relationships between the Non-Executive Directors and Governors. KW raised the question of how to collect content about Governors' activities to inform future communications, to which HT responded that content is needed for further outreach. MR requested information regarding the Freedom to Speak Up (FTSU) process and outcome stories. KW reported that an FTSU update was received at recent Informal Chair and Governor meeting to share processes and assurances and suggested that further assurance could be sought from the Council of Governors if required. KW clarified that FTSU processes are distinct from governors' roles and identities. Mr J Jones (JJ) recalled that during previous "Countess Matters" magazines, there was a comprehensive segment dedicated to Governors, and noted the missed opportunity to communicate their activities. JJ recommended that engaging in similar efforts in the future could help convey the Governors' message more effectively.	

Approved 5th June 2026

	The Committee **noted** the updates.	
7.	**Review of Governor Composition/ Constituencies** The Flintshire Governor replacement to be raised through the March 2026 Membership Engagement Committee Mrs N Cleuvenot (NC) reported that, following an informal Governors' meeting, governors had discussed filling the one remaining Flintshire vacancy. Two Flintshire seats had been filled at the previous election, but the second seat had become vacant again due to resignations. Governors sought guidance on the process to fill these vacancies. NC advised that a by election would be required to fill the seat. Mrs K Wheatcroft (KW) highlighted the ongoing challenge for the Committee in managing significant Council of Governors vacancies, despite considerable effort in the last election cycle. The financial impact of running another election for one seat in year was discussed. The Committee debated whether now is the appropriate time to proceed with filling the Flintshire vacancy. Mr J Jones (JJ) informed the Committee that future changes to legislation may mean that, from April 2027, having a Council of Governors may no longer be mandatory for Foundation Trusts, though individual Trusts may still choose to maintain one. JJ noted that the re-election process would resume in the summer and, at present, there is little point in pursuing the vacancy until the next election cycle. Mr M Roberts (MR) agreed with the approach of waiting for the next election cycle. Ms S Dunbar (SD) agreed that, while immediate action after the election would have been ideal, at this stage efforts should focus on promoting the Governor role in Flintshire and Ellesmere Port to encourage individuals to stand for election and raise awareness in those areas. SD proposed the use of stands at local supermarkets to promote the Governor position, though acknowledged this would require a time commitment from current Governors. KW supported this suggestion and indicated it could be incorporated into the Committee's awareness raising strategy for the Council of Governors. SD further questioned the extent to which Governors are actively promoting being a Governor in their local constituencies. KW agreed that utilising stands in different communities is a common and effective approach to generating membership and to communicate the role and activities of Governors. Ms H Taylor (HT) stated that, to her knowledge, the organisation has not undertaken supermarket promotional activities in the past five years. MR agreed this is an area that could be explored further. NC added that, as part of last year's election process, information sessions were held about the election process and role of Governors with the Chair and Lead Governor in attendance. These efforts could be further promoted among staff and members in future elections, including through digital sessions. SD noted that Partnership Governors could be utilised to gain access to other organisations to showcase the Governor role. The Committee **noted** the updates.	
8.	**Lead Governor Succession Planning**	

Approved 13th June 2026

	Mrs N Cleuvenot (NC) reported that, following succession planning, an expression of interest process was undertaken and brought to the Council of Governors. The appointment of Public Governor, Prof T Fisher (TF) was subsequently approved at the last Council of Governors meeting, with TF scheduled to assume the role from October 2026 with a handover period to be arranged. Mr M Roberts (MR) queried whether it is mandatory for a Lead Governor to be part of this Committee, noting that the Terms of Reference (TOR) allow for up to six Governors. NC confirmed that participation by the Lead Governor is not stipulated in the TOR. Mr J Jones (JJ) confirmed that he will remain as a member of the Committee and expressed no objection to TF joining. The Committee **noted** the update.	
9.	**Review Terms of Reference (TOR) – Membership and Engagement Committee** Mrs N Cleuvenot (NC) reported that, as part of the annual review process, the TOR were reviewed to ensure they remain fit for purpose. NC confirmed that the full TOR had been circulated, including one amendment pertaining to the membership strategy, specifically to review and monitor the implemented strategy. NC advised that the amended TOR will be submitted to the Council of Governors (COG) for approval. The Committee reviewed and **approved** the terms of reference for ratification at the next Council of Governors meeting.	
10.	**2026/2027 Committee dates to be confirmed** June 2026 (to report into July 2026 Council of Governors) September 2026 (to report into October 2026 Council of Governors) January 2027 (to report into February 2027 Council of Governors) It was confirmed that availability will be sought from the Committee Chair and then shared with members to set the 2026/27 Committee dates. The Committee **noted** the update.	
11.	**Membership Engagement Committee Workplan 2025/26** Mrs N Cleuvenot (NC) queried if the 2025/26 workplan captures all what is wanted by the Committee to continue with the same for 2026/27. Mr J Jones (JJ) and Mr M Robets (MR) approved to continue with the same workplan into 2026/27. NC noted that the workplan is on every committee meeting agenda and updates can be made through the year as required. The Committee **noted** the 2025/26 workplan and **approved** the continuation into 2026/27.	
12.	**Any other business** No items were raised.	

Approved 11th June 2026

13.	**Meeting Summary (include actions/items for escalation)** No items were raised for escalation.	
14.	**Close Meeting**	

Next Meeting: Monday 15th June 2026 at 11am – 12pm via Microsoft Teams

Approved 15th June 2026

PUBLIC – Council of Governors
15th July 2026

Report	**Agenda Item 11.**	**Future of Governors Update and Options**						
Purpose of the Report	Decision	**X**	Ratification		Assurance		Information	
Accountable Executive	Karan Wheatcroft			Director of Governance and Risk				
Author(s)	Karan Wheatcroft			Director of Governance and Risk				
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 BAF 11 Transformation			**X**	BAF impact – Linked to all areas of the BAF but specifically the actions within BAF 8.			
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health							**X**
CQC Domains	Safe Effective Caring Responsive Well led							**X**
Previous considerations	Private Board of Directors – 19th May 2026 Membership and Engagement Committee – 15th June 2026							
Executive summary	On 3 July 2025 the government published a 10-year health plan for England (10YHP) which included a statement confirming that "We will remove the requirement for FTs to have governors". Legislation is being developed with a timeframe to the 1 April 2027. The attached slides set out the guidance provided to date and our assessment of the options with a preferred option proposed to defer Governor Elections in 2026 whilst legislative changes and timeframes are confirmed. Our assessment concludes that in postponing the elections, the Trust can remain compliant with Governor numbers and whilst some risk remains there is a margin in the current establishment and this would be kept under review should there be further changes.							

Recommendations	The Council of Governors is asked to receive the update, discuss and **approve** the proposal which has been approved by the Board of Directors on 19th May 2026 and reviewed and approved by the Membership and Engagement Committee on 15th June 2026.

Corporate Impact Assessment	
Statutory/regulatory requirements	Meets the requirements of the Health and Social Care Act 2008 and in line with the Trust's Constitution.
Risk	BAF impact – Linked to all areas of the BAF but specifically the actions within BAF 8.
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics.
Communication	This is to be kept confidential

NHS
Countess of Chester Hospital
NHS Foundation Trust

Future of Governors update and options

Council of Governors, July 2026

Neil Large, Trust Chair
Karan Wheatcroft, Director of Governance & Risk

Future of Governors - Context

NHS
Countess of Chester Hospital
NHS Foundation Trust

- On 3 July 2025 the government published a 10-year health plan for England (10YHP). Page 81 said the following: "**We will remove the requirement for FTs to have governors**.
- The Health Bill was published 14th May 2026 and this **removes the statutory requirement for NHS Foundation Trusts to have a council of governors and formal membership structures**. Instead, it aims to introduce more flexible and dynamic arrangements for trusts to gather patient, staff, and stakeholder insight.
- This legislation is being developed with a timeframe to the 1 April 2027.
- Whilst legislative changes are awaited, the Trust is required to comply with legal and regulatory requirements including the Trust Constitution. This was further confirmed in a letter from NHS England on 6th May 2026.
- We continue to liaise closely with other Trusts through the Cheshire and Merseyside Provider Collaborative Company Secretary Group to understand Trust responses and action.

The following slides set out the guidance provided to date and our initial assessment of the options with a preferred option proposed to defer Governor Elections in 2026 whilst legislative changes and timeframes are confirmed.

The Health Bill - Governors

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NHS Foundation Trust

The specific impacts and governance changes proposed in the bill include:

- **Transfer of Oversight:** Most of the governance functions previously handled by councils of governors—such as appointing and removing the trust chair and non-executive directors—will be transferred directly to the Secretary of State.
- **Removal of Duplication:** The government argues that removing governors reduces bureaucracy and gives trusts greater autonomy to design community engagement that works best for them, rather than following a strict national framework.
- **Alternative Engagement:** While formal councils will no longer be legally mandated, trusts are still expected to put in place effective local arrangements for engaging patients, staff, and the public.
- **Broader Accountability Shifts:** Alongside removing governors, the bill also proposes abolishing NHS England and transferring local Healthwatch functions closer to integrated care boards, centralizing much of the system's accountability.

NHS Alliance Guidance (formerly NHS Providers)

Countess of Chester Hospital NHS Foundation Trust

What does this mean?

- If the Bill is passed, the statutory powers of governors will be removed, and all references to governors will be deleted from statute. The powers and functions of councils of governors will either be transferred elsewhere or deleted entirely.
- Once the law changes, there is no option for an FT to continue to have a ‘council of governors’ with the powers and functions that it currently has.
- The legal requirement to have public and staff FT members and constituencies will also cease when the Bill is passed
- There are currently no plans to legislate for an alternative accountability mechanism nor patient and public voice mechanism to replace either councils of governors nor the membership model. The 10-year plan expects FTs to "put in place more dynamic arrangements to take account of patient, staff and stakeholder insight“
- Councils of governors retain their legal functions and powers until the new law comes into force, and so routine activities such as elections, council meetings, inductions for new governors, essential governor training, and communications between the council and board should continue
- It is likely that some of the functions proposed to move to DHSC will in practice be undertaken by the NHS regional teams, which under current proposals will continue to exist as part of DHSC when NHSE is abolished

NHS Alliance Guidance (formerly NHS Providers)

NHS
Countess of Chester Hospital
NHS Foundation Trust

Opportunities

- FTs and councils may wish to discuss together whether to take options such as ‘right-sizing’ the council to reduce expenditure on any forthcoming elections. However attention must be paid to retaining a quorate council able to undertake its functions, which are vital to the running of an FT under current legislation.
- FTs and councils together may also wish to consider how public accountability and meaningful patient, staff and stakeholder voice should be enabled after the legislation has passed, particularly where such mechanisms do not already exist.
- Membership databases may be maintained after the Bill is passed, if desirable for ongoing patient and public engagement, as the original consent given to hold that personal data remains in force. However, to be compliant with data protection requirements, a communication should be sent to all existing members to advise them of a change in the legal basis for holding their data and an opt out provided.

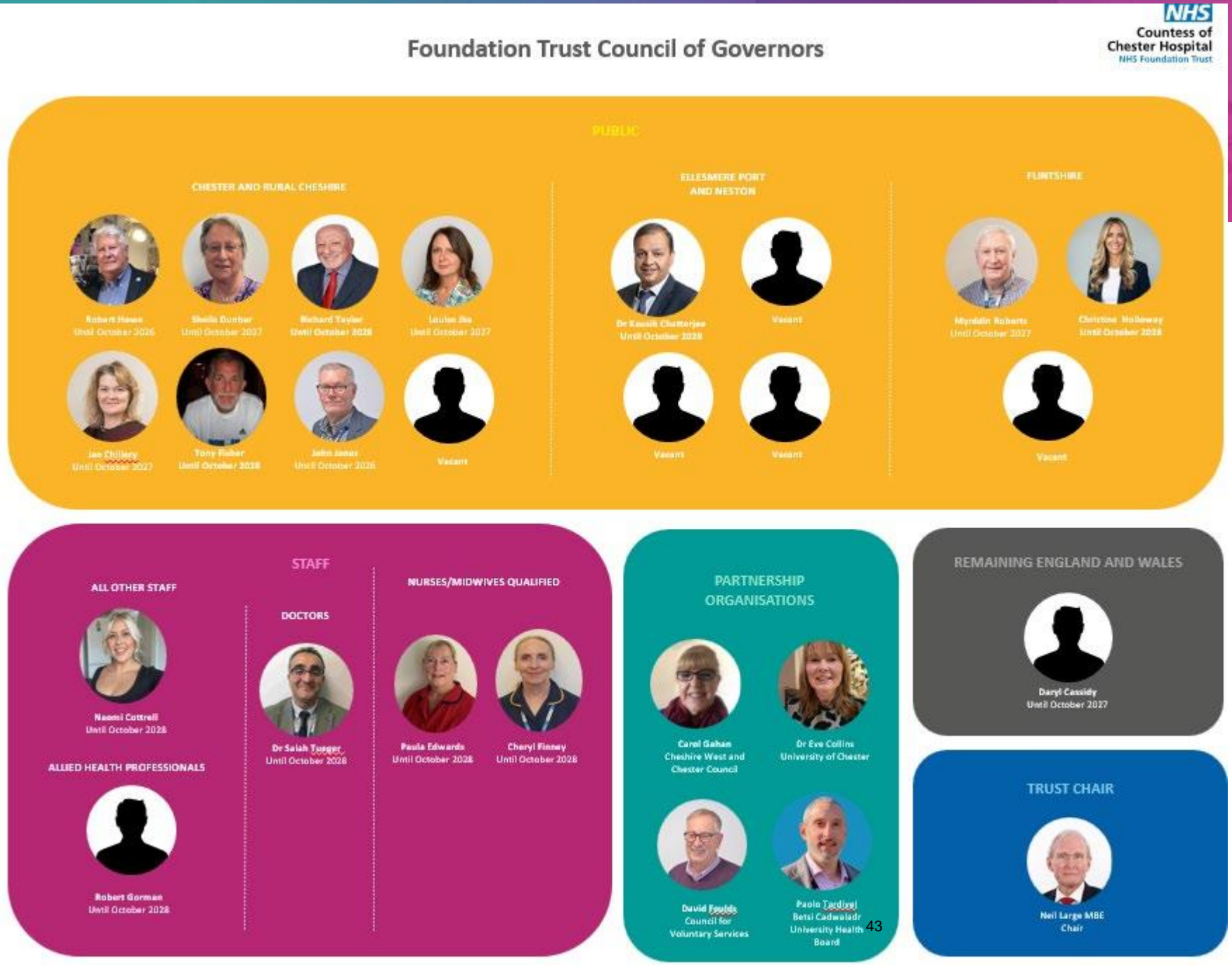
NHS Alliance Governor Election Guidance

Countess of Chester Hospital NHS Foundation Trust

NHS Alliance published some guidance regarding Governor elections (available via this link: https://nhsproviders.org/resources/navigating-uncertainty-around-councils-of-governors). The key points from the guidance are summarised below.

In summary:

- *The **requirement to hold elections after every three-year term is in primary legislation***
- *Trusts are **still required to hold elections but can postpone these**. If postponing, trusts can co-opt a governor onto the Council of Governors but they won't have voting rights.*
- *Trusts (including Governors) **may opt to `right size' the Council of Governors** (I read this as agreeing to reduce the size of the Council of Governors whenever a vacancy arises so that elections aren't required) whilst maintaining the **minimum numbers for a council of Governors which are three staff, one local authority appointed (or two if university-affiliated, in which case the partner needs to be a university), and five (or six) public governors**. The legal minimum number of governors for a council is therefore nine governors, or 10 if university affiliated.*
- ***Governors still have statutory powers until any new legislation is passed** (due to come into law in April 2027 but likely to take longer). Once legislation is passed, the statutory powers will be abolished, as will the need to have a membership database*
- *While FTs can change the requirements in their constitutions, they should **remain compliant with the law***
- *Trusts need to **keep Governors informed** of the impact of the new Bill (if passed) on them and to have open and honest conversations about this.*



Current Position:

Chester and Rural

- 2 Terms of Office expire in Oct 26 (Robert Howe & John Jones)
- Good attendance/ engagement from Governors incl. new governors in 25/26

Ellesmere Port and Neston

- 3 Vacancies (unsuccessful campaign in 25/26)
- Only 1 Governor in post and inconsistent attendance

Flintshire

- 1 vacancy
- Good attendance/ plus a new governor

Remaining England and Wales

- Inconsistent attendance

Staff and Partnership Governors in place

Constitution Requirements

Countess of Chester Hospital NHS Foundation Trust

1.4 “An **elected governor shall hold office for a period of up to three years** commencing on the date notified to him/her by the trust following the election process” (is eligible for re-election but may not hold office for longer than 9 consecutive years)

6.3 Where the vacancy arises amongst the elected governors, the Trust Secretary shall, having consulted the Chair, either:

- call an election within three months to fill the seat for the remainder of that term of office; or
- invite the next highest polling candidate for that seat at the most recent election, who is willing to take office, to fill the seat until the next election, at which time the seat will fall vacant and subject to election; or
- **leave the seat vacant until the next elections are held provided that during such period**, the Council of Governors will continue to meet the requirement at paragraph 1 of Annex 3 of this constitution and can continue to meet the quorum requirements at paragraph 3.11 of Annex 7 of this constitution.

Annex 3 Composition of the COG

The **aggregate number of Public Governors is to be more than half of the total number** of members of the Council of Governors.

The Council of Governors shall be comprised of the following governors:

- 16 Public Governors (details of constituencies and numbers included)
- 5 Staff Governors from the following classes of the Staff Constituency (details of constituencies and numbers included)
- 6 Appointed Governors (Partnership Governors) details of partnership organisations (Betsi Cadwaladr University Health Board; Chester University; Cheshire West and Chester Council; North Wales Community Health Council – Local Flintshire Committee; Council for Voluntary Services; Organisation with strategic responsibility for commissioning NHS provider services

Annex 7 Standing orders for the practice and procedure of the COG

3.11.1 No business shall be transacted at a meeting of the Council of Governors unless at **least half of the Governors in post on the date of the meeting**

Initial Assessment

Countess of Chester Hospital NHS Foundation Trust

NHS Alliance Guidance

Minimum numbers for a council of Governors which are three staff, one local authority appointed (or two if university-affiliated, in which case the partner needs to be a university), and five (or six) public governors. The legal minimum number of governors for a council is therefore nine governors, or 10 if university affiliated.

- *3 staff (**5 in post until October 2028**)*
- *1 Local authority (**in post**)*
- *1 University (**in post**)*
- *5 public (**11 in post. Note: 2 terms expiring Oct 26, leaving 9 in post**)*

COCH Constitution Compliance

The aggregate number of Public Governors is to be more than half of the total number of members of the Council of Governors.

- *Public governors in post 11 (moving to 9 in October 2026)*
- *Other governors in post 7*
- *Need to maintain at least 8 public governors*

Currently compliant with numbers and composition in post.

Also technically compliant with holding elections albeit deferring the timing of these until legislative changes are known.

SUMMARY

In postponing the elections, the Trust can remain compliant with Governor numbers and whilst some risk remains there is a margin and this would be kept under review should there be further changes.

Options

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Option	Pros	Cons	Comments
1. Do nothing	• No action/ resources required	• Constitution non-compliance and risks to future decision making	
2. Continue with 2026 Governor Elections	• Constitution compliance	• Costs circa £7K (elections) plus time to administer process and induction • Uncertainty of future on roles and timing may impact applications	
3. Postpone Elections	• **Transparent decision** • **Cost avoidance for 2026 elections** • **Consistent approach with a number of other Trusts**	• **Timeframe uncertain (watch and wait)** • **Could be subject to public challenge** • **Would need to keep COG numbers under review if future vacancies arise**	**Preferred option**
4. 'Right size' COG (aligned to existing Governors in post)	• Constitution compliance • Clarity of COG composition maintained • Cost avoidance for 2026 elections	• Constituency reduction would be based on opportunity not need • Approval processes required through Board/ COG (timing TBC)	

Discussion

Do these slides provide the information needed to support Governors in understanding the changes?

Are the options clear?

Does the assessment include everything needed to support a decision?

What opportunities do this brings to development engagement?

Committee Chair's Report

28th April 2026

Committee	People Committee
Chair	Non-Executive Director, Ms W Williams

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)*

Plastics - The Committee wishes to draw the Board's attention to the ongoing position in relation to plastics, recognising the operational implications of the current arrangements and the need for continued oversight of service sustainability, workforce resilience and the impact on medical training.

Medical rate card - The Committee also wishes to highlight the continued challenge associated with the medical rate card, noting the implications for safe staffing, affordability and timely escalation decisions. Members recognised that inconsistency in application and continued reliance on escalation arrangements present an ongoing operational and financial risk.

Workforce Plan WTE reduction - The Committee reviewed progress against the workforce plan and wishes to highlight the scale of the required whole time equivalent (WTE) reduction, together with the continued dependence on transformation delivery and workforce controls to achieve the Trust's financial plan. Members noted that this remains a significant delivery challenge, with potential implications for service resilience, staff experience and the pace at which recurrent savings can be achieved.

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

Sub-committee updates:

- **Partnership Forum** - The Committee received assurance from Partnership Forum discussions, with themes including nurse staffing pressures, immigration rule changes and the ongoing Trust-wide job evaluation and re-banding programme. Staff-side representatives noted the actions underway to mitigate risk, whilst recognising that staffing pressures remain a material concern.
- **People & Culture (P&C) Sub-Committee -** The Committee was assured on work overseen through the P&C Sub-Committee, including the need to rationalise and prioritise Equality, Diversity & Inclusion (EDI) actions to maximise impact, the developing approach to reward and recognition, and the strengthening of Trust-wide communication and engagement. Progress against the Sexual Safety Charter was noted, with continued delivery and oversight through established governance.
- **Education, Learning and OD Sub-Committee (ELOD)** - An update from the ELOD Committee provided assurance on mandatory training compliance, appraisal quality improvement work and oversight of apprenticeship levy risks. The Committee noted that under-utilisation of student placement capacity can result in lost income and missed opportunities to support future workforce supply, and that this remains an area of focus.
- **Workforce Sub-Committee** - The update confirmed continued scrutiny of workforce Key Performance Indicators (KPIs) and improved visibility of performance, alongside ongoing challenges associated with medical and nursing

staffing gaps. The Committee noted that a new risk relating to nursing workforce sustainability has been added to the risk register, reflecting the sustained operational fragility in this area.

- **Joint Local Negotiating Committee (JLNC) -** The Committee received assurance from the JLNC discussions, including continued monitoring of junior doctor rate cards, industrial relations risks and the broader implications for staffing and service resilience.

Medical Job Planning - The Committee noted that the Trust has transitioned to a new electronic system and achieved near-universal engagement, with over 65% of job plans fully signed off. Initial modelling identified a potential cost pressure exceeding £1m; however, strengthened scrutiny and challenge has reduced this to an estimated £250k–£300k, with further work underway to complete sign-off and assure consistency.

Violence, Aggression and Staff Safety - The Committee also received assurance on work in relation to addressing violence and aggression, noting a reduction in reported incidents and progress in security staffing arrangements and incident review processes, alongside continued focus on staff support and feedback loops.

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

Staff Survey 2025 - The Committee noted the early engagement undertaken with colleagues following release of the 2025 staff survey headline findings, with feedback indicating that staff valued timely communication, opportunities to contribute and visible listening. The Committee also noted that Trust-wide priorities have now been agreed in response to the survey findings, with detailed action planning and delivery oversight continuing through the People Committee and the People & Culture Sub-Committee to support ongoing monitoring of progress and impact.

Employment Law Updates - The Committee noted a number of developments for the Board's information. This included emerging changes in employment legislation, particularly reforms relating to workplace harassment and third-party conduct, and the increasing legal expectation for employers to demonstrate that all reasonable steps have been taken to prevent harassment, including from patients and members of the public. The Committee noted that national guidance is still evolving and that preparatory work is underway locally to ensure compliance and reduce organisational risk.

Voluntary Redundancy - The Committee also noted progress in delivering workforce reductions through voluntary and mutually agreed exit schemes, with implementation approached carefully to minimise service impact.

Education & Training Centre Development - The Committee noted that outline plans for the education and training centre are progressing, recognising the importance of education infrastructure and placement capacity as enablers of workforce sustainability.

Risks discussed and new risks identified

The Committee noted the addition of a new nursing workforce sustainability risk to the risk register, reflecting continued workforce pressure and operational fragility. Wider risks relating to workforce sustainability, medical staffing and delivery of the workforce plan continue to be monitored through established governance arrangements.

Countess of Chester Hospital NHS Foundation Trust

Committee Chair's Report

29th April 2026 at 1.30pm via Microsoft Teams

Committee	Finance & Performance Committee
Chair	Non-Executive Director, Ms H Gunawickrema

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)*

- The Committee draw's the Board of Directors attention to the ongoing risk associated with Cost Improvement Programme (CIP) maturity and deliverability, including the need to maintain clear visibility of scheme development and to identify replacement mitigations where delivery becomes uncertain.
- The Committee also highlighted the importance of continued oversight of progress against the medium-term plan, including key financial and performance trajectories and associated Key Performance Indicators (KPIs), to enable early identification of any emerging slippage.
- In addition, the Committee noted the increasing volume of Freedom of Information requests, which is creating operational pressure on teams and increasing the risk of breaches and escalation.

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

- The Committee received assurance regarding the Trust's month 12 financial position, with delivery of the planned £14m deficit and completion of the capital programme within the financial year, supported by an improved cash position through deficit support funding.
- Assurance was also received in relation to the Board Assurance Framework (BAF) and high-risk reporting, with no material changes in finance risk scores and evidence of active review across financial sustainability, operational standards, digital risk and capital schemes.
- The Committee was further assured on Emergency Preparedness, Response and Resilience (EPRR), including improved performance against the 2025 North West Ambulance Service (NWAS), Chemical, Biological, Radiological and Nuclear (CBRN) audit, progress against the November 2025 annual action plan, and the expectation that receipt of decontamination equipment will support closure of the remaining red risks.
- Additional assurance was received on Urgent and Emergency Care performance, where year-end 4-hour and 12-hour performance had improved compared with the previous year, and on the current position in relation to cyber security, Data Security Protection Toolkit (DSPT) submission, audit tracking and the Healthcare Financial Management Association (HFMA) financial sustainability self-assessment, all of which demonstrated active management and continuing progress.

Advise *(items presented for the Board's information)*
• For the Board of Directors information, the Committee noted a number of strategic updates across Finance, Digital and Estates. These included progress on the digital and data strategic programme, including rollout planning for Ambient Voice Technology, implementation of the Ophthalmology Electronic Patient Record, development of AI governance arrangements, digital inclusion work and the development of an Emergency Department forecasting tool. • The Committee also noted that the Trust's Annual Plan and budget had been approved by the Board and accepted by NHS England, subject to conditions relating to oversight and scrutiny. In addition, the Committee considered the geothermal programme update and approved a direct-to-market procurement route for project 2 to maintain programme momentum following framework delays, noting that this was a procurement decision only and that a further business case would return before any final investment commitment. **Key decisions made** • The Committee agreed that future Senior Information Risk Owner (SIRO) reports should include comparative data from national tools and thematic summaries of cyber alerts. It also agreed that future CIP reports should include monthly and quarterly progress reporting to strengthen oversight of delivery and scheme maturity. • In relation to EPRR, the Committee agreed that routine updates would continue on a twice-yearly basis unless a more urgent issue required escalation. • The Committee noted that the Annual Plan item could now be closed at Committee level following Board approval and NHS England's acceptance of the medium-term plan. • It approved a direct-to-market procurement approach for project 2 of the geothermal programme, noting that this did not commit the Trust to final investment and that a further business case would return for approval. • The Committee also agreed to defer the Terms of Reference update to the next meeting to allow further review by members
Risks discussed and new risks identified
• The Committee discussed a broad range of current and emerging risks across finance, operational performance, digital and estates. A key area of focus was the ongoing risk to delivery of the CIP, particularly in relation to scheme identification, maturity, deliverability and the requirement to identify alternative mitigations where plans do not progress as expected. • Linked to this, the Committee considered the wider financial sustainability risk and the Trust's trajectory towards break-even by 2031, noting the importance of continued scrutiny of medium-term plan assumptions, milestones and associated KPIs. Operational performance risks were also discussed, including ongoing challenges in Urgent and Emergency Care and Referral to Treatment delivery, together with specific concern regarding ophthalmology backlog management, particularly glaucoma pathways where target dates and mitigations required further clarity. • In the digital domain, the Committee reviewed cyber security and information governance risks, including DSPT compliance, cyber alerts, infrastructure resilience and the pressure created by the significant increase in Freedom of

Information requests. Capital and infrastructure risks were noted in relation to the fire alarm programme, dialysis infrastructure and delivery of digital and estates schemes.

- The Committee also considered the potential impact of fuel shortages on workforce resilience and service continuity and noted delivery risk within the geothermal programme arising from procurement route changes and timetable slippage, albeit with mitigation plans in place.

Committee Chair's Report
7th May 2026

Committee	Quality & Safety 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)*

- Urgent and Emergency Care update report providing assurance on progress. This confirmed that the immediate Care Quality Commission (CQC) concerns have been addressed and actions embedded; quality and safety performance metrics continue to be monitored, and improvement driven; residual risk and mitigations continue to be delivered. This recognised there are still some challenges in consistency and sustainability of improvements in some areas, including Venous Thromboembolism (VTE), hand hygiene and risk assessment compliance. The Trust was recognised as one of the most improved for 4 hour performance, recognising there is more to do to meet the national targets.
- Committee were alerted to the current lack of compliance with the Medical Device Outcome Registry. This was introduced in March 2025, and the Trust is working closely with NHS England and progressing an action plan to improve this. There remains a lot of work to do across the management of medical devices, and the Committee also received assurance on progress as set out in the section below.
- Received the Sepsis Annual Report which summarised the improvements being made but recognised the continued challenges in meeting the standards, noting outcome data is good.

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

- Assurance report from Quality Governance Group (QGG), alerting a range of areas along with the actions progressing and assurance sought (e.g. medical devices, sepsis, VTE, transfusion, mortality reviews and rapid tranquillisation).
- Integrated Performance Report (IPR) Quality and Safety indicators reviewed, with a narrative cover paper providing a summary of the areas of good performance, areas of concern, forward look and improvements. This aligned to the Quality and Safety Committee agenda.
- Quarter 4 Perinatal update confirming achievement of all 10 Maternity Incentive Scheme year 7 standards, high compliance with Saving Babies Lives Care bundle, and that the Maternity outcomes signal system is now live. External assurance from the Regional Maternity Team and Local Maternity and Newborn System annual visit confirmed a strong safety culture, effective governance, high quality clinical environments and visible leadership. Small number of development areas are being progressed through agreed improvement plans.
- Quality Impact Assessment (QIA) report confirming completion of 117 QIAs (totalling £10.4m) in 2025/26. QIAs are required for schemes over £25K, with all approved by the Medical Director and Director of Nursing and Quality. Post implementation reviews are also being implemented and further developed with a recommendation that these will be reviewed through the new Transformation

Programme Board. The report is being developed to include assurance on Equality Impact Assessments (EIAs).

- Cancer harms reviews update showing progress against the outstanding reviews and improving processes to ensure timely review. Also received the chair's report from the Cancer Service Group with alerts around cancer harms reviews, and reduced target performance in January 2026.
- Medical devices review and action plan progress reported, noting some key actions taken to improve medical safety compliance, but still significant work to do to progress actions and improve compliance. Main areas relate to systems development, establishment of the medical devices oversight group (delayed due to the establishment and understanding of the new Clinical Audit & Effectiveness Group), and clear identification of the Trust decontamination lead.
- Infection Prevent & Control (IPC) Committee Chair's report including alerts in hand hygiene compliance with actions being taken Trust wide, Mandatory training compliance which has fallen just below the 90% threshold, environment and infrastructure risks, identification of a Trust decontamination lead (now resolved with the Deputy Director of Nursing and Quality Governance taking this role), and gaps in information systems to support data quality and surveillance with Electronic Patient Record (EPR) work ongoing to address this.

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

- Committee requested VTE paper to ensure sighted on the position and work in progress.
- The Committee received a patient story from the parent of a cancer patient who had received excellent care across a range of organisations. The support, in particular, from the Trust's cancer nurse was described as outstanding.
- Approved the Quality Accounts noting that these had been circulated in advance to the Non-Executive Directors and have been presented to the Audit Committee. These include the delivery against the 2025/26 priorities and the 2026/27 priorities.
- Verbal update on palliative and end of life care with actions being taken and a business case being developed to strengthen arrangements including 7/7 nursing. It was noted that the Care Quality Commission (CQC) report outcomes would be incorporated into action plans once a final report was received.

Risks discussed and new risks identified

- Risk assessment received on Emergency Department (ED) resuscitation spaces against the Health Building Note and Royal College of Emergency Medicine (RCEM) guidelines. Whilst there is recognition that the space is not fully compliant with the new building guidelines and isn't an optimal clinical space there are mitigations in place and the risk on the risk register is recorded as low. Strategic decision would be required to develop the estate further and there would be a negative impact reducing other clinical space within the department.
- Reviewed the high-risk report and Board Assurance Framework (BAF) extract in relation to the Committee responsibilities. Agreed the need for regular updates to the risks and whilst some of the CQC risks may be scored below 15 it was agreed to review the Divisional risk register for inclusion.

Committee Chair's Report

Audit Committee – 24th April 2026

Committee	Audit Committee
Chair	Non-Executive Director, Mr P Williams

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)*

- Head of Internal Audit Opinion 2025/26 providing an overall level of assurance as Substantial Assurance with a good system of internal control to meet the organisation's objectives and that controls are generally being applied consistently. Especially notable given the Countess of Chester's risk based approach to internal audit, whereby scrutiny is invited of areas known to be high and emerging risk.
- Mersey Internal Audit Agency (MIAA) has received notification of a 'generally conforms' outcome from its recent External Quality Assessment (EQA) against Global Internal Audit Standards. This is the highest rating achievable, thus giving the Board ongoing confidence in MIAA as its internal audit and counter fraud assurance partner.

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

- Quality Account received and approved for recommendation to Board of Directors. This includes a review of 2025/26 performance and the priorities set for 2026/27.
- Received Committee effectiveness annual reports from each of the Board Assurance Committees, as presented by the respective Non-Executive Director (NED) Committee Chairs. These confirmed operation in line with terms of reference (TOR) for Finance & Performance Committee, People Committee and Quality & Safety Committee. Actions noted including terms of reference and work plan updates, and key areas for focus for 2026/27.
- Approved the Audit Committee effectiveness annual report confirming compliance with TOR, Healthcare Financial Management Association (HfMA) checklist best practice, and noting the valuable work of both internal and external auditors.
- Received the Anti-Fraud Annual Report which included assurance on delivery of the anti-fraud plan and completion of the self-assessment against government functional standards for counter fraud with an overall rating outcome of Green.
- Assurance on compliance with declaration of interests with a year-end position of 95%.
- Received substantial assurance on Mersey and West Lancashire NHS Trust payroll provider through the sharing of an MIAA internal audit report for 2025/26.
- Risk management improvement plan progress was reflected in the MIAA internal audit risk management report, which provided moderate assurance.
- Annual accounts and annual report timetable update confirmed progress in line with timeframes, with accounts already submitted ahead of deadline and annual report significantly progressed to meet the submission timetable (5th May 2026).

- Internal audit progress report provided an update on delivery of the internal audit plan and outcomes from the assignments completed since the last meeting, including risk management processes (moderate assurance); data centre (moderate assurance); e-roster and bank (substantial assurance); theatre utilisation (substantial assurance); and Board Assurance Framework (BAF) processes meeting the required standards. Assurance also provided on the follow up of agreed action plans through the Countess-led internal audit recommendation tracker, and independent assurance on these from MIAA.

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

- Audit Committee TOR approved with changes to quality account responsibilities, committee names and global internal audit standards, for recommendation to the Board of Directors.
- Audit Committee reviewed the significant issues arising in finalising the financial statements for year ended 31st March 2026.
- Out of date policy recovery plan continues. Audit Committee will retain oversight of this plan until substantially complete.
- Received and approved the review of the accounting policies used in preparation of the financial statements for 2025/26.
- Approved the External Audit Plan and Strategy for year ended 31st March 2026. Committee asked for a written context to the increase in fees and rationale for clarity.

Risks discussed and new risks identified

- Received BAF and high-risk report relevant to the Committee.
- Committee enquired about the remaining audit action regarding the Estates Strategy in context of risk.

PUBLIC – Council of Governors
15th July 2026

Report	**Agenda item 14.**	**Non-Executive Director (NED)/ Governor Walkabouts Summary Report (Quarter 1)**						
Purpose of the Report	Approval		Ratification		Assurance		Information	**X**
Accountable Executive	Neil Large			Trust Chair				
Author(s)	Claire Jones			Committee Secretary				
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 BAF 11 Transformation			 **X** **X**	Visible leadership and triangulation of information.			
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**
Previous considerations	Individual walkabout reports reviewed by the Trust Chair.							
Executive summary	Non-Executive Directors (NEDs) and Governors undertake a series of walkabouts across the Trust's services and departments throughout the year. Walkabouts are intended to support visibility and understanding of the organisation. Visiting operational departments enables NEDs and Governors to have face to face conversations with staff (and patients if appropriate) to understand their services and the challenges they face. These visits provide staff with the opportunity to talk to NEDs and Governors about what it feels like to work within the Trust. Walkabouts provide the opportunity to: • Be visible across the organisation. • Understand services and roles. • Show support and recognition. • Listen to colleagues.							

	• Explain to staff the role of NEDs and Governors. A summary record is created for every walkabout and provided to the Trust Chair. To ensure completeness, a summary report has been completed for the walkabouts within quarter 1 for presentation to the Council of Governors. This summary report covers the following NED/Governor walkabouts: • Acute Stroke Unit and Ward 45 (1st April 2026) • Emergency Département (6th May 2026) • Critical Care Unit (3rd June 2026)
Recommendations	The Council of Governors is asked to **note** the summary report from the recent NED/Governor walkabouts.

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

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

1. Introduction

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

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

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

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

2. NED/ Governor Walkabouts

The following table provides a summary of the NED/Governor Walkabouts for quarter 1 2026/27.

Walkabout	Summary
Acute Stroke Unit and Ward 45 (1st April 2026) **Non-Executive Director(s):** Prof A Hassell – Non-Executive Director Ms S Corcoran – Non-Executive Director **Governor(s):** Ms S Dunbar – Public Governor Ms J Chillery – Public Governor	Those on the walkabout identified that areas were clean and organised (albeit Ward 45 was crowded) and that staff were kind and patient. Areas for attention were identified as – Ward 45 was impacted by equipment, and staff raised some patients distressing behaviors suggesting that staff required wellbeing support and possible training to support dealing with the behaviors. There are ongoing arrangements in place to support staff wellbeing and support patients and staff with complex needs. Observations from the walkabout: • Staff were welcoming, safe, kind and effective. • Acute Stroke Unit – space has improved since a recent move, staffing was an issue, staff raised the changing service users following Covid-19, the possibility of nurses supporting doctors further and that 50% of patient homes require cleaning before they can be safely discharged.

Walkabout	Summary
	• Ward 45 – a well-ordered layout although concerns with regards to large equipment clutter; friendly staff, some patient abuse discussed due to their drug and alcohol issues, with distressing patient behaviours; and that Ellesmere Port Hospital was working well with the Ward.
Emergency Département (6th May 2026) **Non-Executive Director(s):** Ms W Williams – Non-Executive Director Ms S Corcoran – Non-Executive Director **Governor(s):** Mr John Jones – Lead Governor Ms Paula Edwards – Staff Governor	Those on the walkabout identified areas of good practice within Triage – Urgent Treatment Centre (UTC), Same Day Emergency Care (SDEC) and General Practitioner (GP) out of hours, Hospital at Home, Paediatrics triage and relative rooms. Areas for attention were identified as – Pat slide storage, resuscitation (resus) space requiring further cleaning. Observations from the walkabout: • Staff were welcoming and cheery, with the department calm and appearing cleaner than previously seen • Paediatric area clean and new. • Staff bare below the elbow and professional – some inconsistencies with the uniform policy. • Staff in the Millbrook Suite talkative and engaging. • Patient staff. • Training updates for staff noted with regards to areas such safeguarding, compassionate care and tracheostomy. • Fifty five patients in department when visited. • Promising ideas received from staff with regards to imaginative ways of working. Areas of housekeeping have been actioned by the Director of Nursing & Quality/Deputy Chief Executive.
Critical Care Unit (3rd June 2026) **Non-Executive Director(s):** Mr P Jones, Non-Executive Director **Governor(s):** M J Jones, Lead Governor Ms S Dunbar, Public Governor Prof T Fisher, Public Governor	Those on the walkabout identified areas of good practice with hand hygiene, a tidy working environment, welcoming and open unit and calmness and professionalism. Areas for attention were identified as – equipment storage and staff rest area/ kitchen upgrade. Observations from the walkabout: • Staff were welcoming with the relative mural an outstanding initiative. • No issues with regards to safety were observed. • Kindness. • A high degree of agility was demonstrated

Walkabout	Summary
	• Friends and Family accreditation was 100%. • A wonderful team spirit – working towards gold accreditation. • Items for escalation from the walkabout: • Staff awareness Items for escalation from the walkabout: • Staff concerns regarding use as potential isolation area due to winter pressures and associated impact due to Non-ICU Staffing requirements.

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

3. Recommendation

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

Countess of Chester Hospital NHS Foundation Trust

PUBLIC – Council of Governors Workplan

2026/27

Item		Frequency	Lead	Operational Lead	15th Apr 2026	15th Jul 2026	14th Oct 2026	3rd Feb 2027
1	Welcome and apologies for absence	Each meeting	Trust Chair	Trust Chair	✓	✓	✓	✓
2	Declarations of interest	Each meeting	Trust Chair	Trust Chair	✓	✓	✓	✓
3	Minutes of last meeting	Each meeting	Trust Chair	Director of Governance and Risk	✓	✓	✓	✓
4	Matters arising and action log	Each meeting	Trust Chair	Director of Governance and Risk	✓	✓	✓	✓
5	Patient Story	Each Meeting (to be presented on the day)	Director of Nursing & Quality /Deputy Chief Executive	Director of Nursing & Quality /Deputy Chief Executive	✓	✓	✓	✓
6	Trust Chair's Briefing	Each meeting (verbal update)	Trust Chair	Trust Chair	✓	✓	✓	✓
7	Chief Executive Officer's Report	Each meeting	Chief Executive Officer	Chief Executive Officer	✓	✓	✓	✓
8	Lead Governor Update	Each meeting	Lead Governor	Lead Governor	✓	✓	✓	✓
9	Staff Survey - Outcomes	Annually	Chief People Officer	Chief People Officer	✓			
10	Inpatient Survey - Outcomes	Annually *(as and when received)*	Director of Nursing & Quality /Deputy Chief Executive	Director of Nursing & Quality /Deputy Chief Executive				
11	Patient / Family Experience Update	Annually	Director of Nursing & Quality /Deputy Chief Executive	Director of Nursing & Quality /Deputy Chief Executive				✓

Item		Frequency	Lead	Operational Lead	15th Apr 2026	15th Jul 2026	14th Oct 2026	3rd Feb 2027
12	Anchor Institution Update	Twice annually	Director of Strategic Partnerships	Director of Strategic Partnerships		→	✓	✓
13	Membership & Engagement Committee Chairs report and approved minutes	Each meeting	Committee Chair	Director of Governance and Risk	✓	✓	✓	✓
14	Governor Election Process and Updates	Annually	Trust Chair	Director of Governance and Risk	✓ (proposal)	✓		
15	Board of Directors Business Items:							
	a) AAA reports from the Chairs of the Board of Directors Sub-Committees	Each Meeting	Director of Governance and Risk	Non-Executive Directors	✓	✓	✓	✓
	b) Integrated Performance Report • Operational Performance • Quality • Safety • Finance • People	Each meeting	Chief Operating Officer	Chief Operating Officer/ Director of Nursing & Quality/Deputy Chief Executive/ Medical Director/ Chief Finance Officer/ Chief People Officer	✓	✓	✓	✓
16	Feedback from Governors	Each meeting	Lead Governor	All Governors	✓	✓	✓	✓
17	Feedback from NED / Governor Walkabouts Summary Report	Each meeting	Trust Chair	Non-Executive Directors/ Governors	✓	✓ ✓	✓ ✓	✓ ✓
18	For noting:							
	a) Council of Governors Workplan	Each meeting	Director of Governance and Risk	Committee Secretary	✓	✓	✓	✓

Item		Frequency	Lead	Operational Lead	15th Apr 2026	15th Jul 2026	14th Oct 2026	3rd Feb 2027
	b) Council of Governors Photo sheet link/sheet	Each meeting	Director of Governance and Risk	Committee Secretary	✓	✓	✓	✓
	c) Link to the previous Board of Directors papers on the website	Each meeting	Director of Governance and Risk	Committee Secretary	✓	✓	✓	✓
	d) Quality Account	Annually	Director of Nursing & Quality/Deputy Chief Executive	Director of Nursing & Quality Governance		✓		
19	Any other business	Each meeting	Trust Chair	Trust Chair	✓	✓	✓	✓

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

Foundation Trust Council of Governors

Countess of Chester Hospital NHS Foundation Trust

PUBLIC

CHESTER AND RURAL CHESHIRE

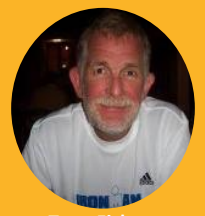
Robert Howe
Until October 2026

Sheila Dunbar
Until October 2027

Richard Taylor
Until October 2028

Louise Jha
Until October 2027

Jan Chillery
Until October 2027



Tony Fisher
Until October 2028

John Jones
Until October 2026

Vacant

ELLESMERE PORT AND NESTON

Dr Kausik Chatterjee
Until October 2028

Vacant

Vacant

Vacant

FLINTSHIRE

Myrddin Roberts
Until October 2027

Christine Holloway
Until October 2028

Vacant

STAFF

ALL OTHER STAFF

Naomi Cottrell
Until October 2028

ALLIED HEALTH PROFESSIONALS

Robert Gorman
Until October 2028

DOCTORS

Dr Salah Tueger
Until October 2028

NURSES/MIDWIVES QUALIFIED

Paula Edwards
Until October 2028

Cheryl Finney
Until October 2028

PARTNERSHIP ORGANISATIONS

Carol Gahan
Cheshire West and Chester Council

Dr Eve Collins
University of Chester

David Foulds
Council for Voluntary Services

Paolo Tardivel
Betsi Cadwaladr University Health Board

REMAINING ENGLAND AND WALES

Daryl Cassidy
Until October 2027

TRUST CHAIR

Neil Large MBE
Chair

PUBLIC – Council of Governors
15th July 2026

Report	**Agenda Item 15c.**	**Quality Accounts 2025/26**						
Purpose of the Report	Decision		Ratification		Assurance		Information	**X**
Accountable Executive	Sue Pemberton			Director of Nursing & Quality/Deputy Chief Executive				
Author(s)	Fiona Altintas			Deputy Director of Nursing, Quality and Governance				
Board Assurance Framework	BAF 1 Quality 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 BAF 11 Transformation			**X** **X** **X** **X** **X** **X** **X** 	BAF impact to 1,2,3,4,8,9 and 10			
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**
Previous considerations	Audit Committee – 24th April 2026 Quality and Safety Committee – 7th May 2026 Extraordinary – Private Board of Directors – 23rd June 2026							
Executive summary	This report presents the Quality Accounts for 2025/26 for the Countess of Chester Hospital NHS Foundation Trust, providing a comprehensive overview of quality performance for 2025/26, achievements against agreed priorities, and areas identified for continued improvement. The Quality Accounts are a statutory requirement to be published by 30th June 2026. The Trust has delivered strong performance across its quality priorities, with eight of nine priorities achieved in full, demonstrating sustained progress in improving patient safety, clinical effectiveness and patient experience. Significant improvements have been evidenced across key safety indicators, including reductions in healthcare associated infections, falls and pressure ulcers, alongside improvements in sepsis screening, VTE assessment and hydration processes.							

	The report highlights continued progress in delivering safe, effective and compassionate care. This includes improvements in urgent and emergency care pathways, strong performance in reducing waiting times, and high levels of patient confidence, dignity and compassion as reflected in national survey outcomes. The Trust has also maintained 100% participation in eligible national clinical audits and confidential enquiries, providing robust assurance of clinical quality and benchmarking performance The Quality Accounts also identify key areas requiring continued focus, notably Emergency Department performance, discharge processes, communication, and consistency in patient experience, reflecting both internal analysis and external stakeholder feedback Looking forward, the Trust has agreed a clear set of quality priorities for 2026/27, focused on reducing healthcare associated infections, improving patient safety outcomes, strengthening early diagnosis and treatment, and enhancing patient and family involvement in care and investigations. These priorities are aligned to delivering safe, effective and personalised care and responding to learning from patient experience, incidents and stakeholder engagement. The Quality Accounts have been subject to appropriate internal and external scrutiny, including review by the Audit Committee and Quality and Safety Committee, and engagement with system partners and stakeholders.
Recommendations	The Council of Governors is asked to **note** the Quality Account and note the scrutiny that has been undertaken.

Corporate Impact Assessment	
Statutory/regulatory requirements	CQC/Constitution/other regulation/legislation
Risk	No risk included on strategic risk register
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics
Communication	Document to be published as part of the agenda pack.

2025/26

Quality Accounts

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Part 1: Foreword

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

- **The Countess of Chester Hospital**
- **Ellesmere Port Hospital**
- **Tarporley War Memorial Hospital**

The Trust employs over 5,608 staff (headcount) which includes temporary bank staff and provides acute emergency and elective services, primary care direct access services and obstetric services to a population of approximately 407,000. This includes 357,000 residents in Chester and West Cheshire, including Ellesmere Port and Neston as well as the Deeside area of Flintshire which has a population of approximately 50,000.

The Trust is a busy district general hospital and in 2025/26, there were 587,523 patient attendances (inpatient, outpatient and diagnostic) ranging from a simple outpatient appointment to major surgery. This is an increase of over 9,000 patient attendances compared to the previous year when there were 577,796.

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

DRAFT

1.1 Statement on Quality from the Chief Executive & Chair

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

The annual Quality Accounts for 2025/26 provide an opportunity for us to share with you our achievements against the quality priorities and to outline our intentions for 2026/27. We are pleased to report that the focus on quality and safety across our teams has continued to demonstrate tangible improvements, ensuring patients and their families receive the best possible care.

We set ambitious quality priorities during 2025/26, and I am pleased to say that eight of the nine priorities have been achieved.

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

How long our patients are waiting for treatment has been a key focus area as the Trust continues to reduce waiting lists. From a challenging starting position, the work undertaken through our divisions and specialist teams has ensured we have met the national expectations for Referral to Treatment (RTT) Pathways and put us put us at the top for the most improved Trust nationally.

The Quality Accounts set out the achievement of significant improvements within infection prevention control, falls, pressure ulcers, VTE assessments, sepsis screening and hydration. The implementation of Call to Concern following Martha's rule has improved the escalation and management of deteriorating patients.

The Quality Account also showcases some of the services leading the way, including the Chester Milk Bank, and sterile services and endoscopy, as well as the investment in our facilities to improve patient care and experience, including the Blue Skies Balcony, new Women and Children's Building, investment in equipment and the establishment of research hubs.

The planned launch of a new Patient Engagement Framework in 2026/27 sets out our commitment to listening to our patients, families and carers, and acting on the things that matter to them.

Jane Tomkinson OBE — Chief Executive

Neil Large — Chairman

DRAFT

1.2 Celebrating success at the Countess of Chester Hospital NHS Foundation Trust in 2025/26

Patients benefiting from gold standard safety at the Countess of Chester Hospital

Patients receiving care at the Countess of Chester Hospital – including those having surgery, cancer treatment, tests to investigate symptoms, or urgent procedures – can be assured that the equipment used meets the highest safety standards in the NHS.

Both Sterile Services and Endoscopy – including an onsite dedicated Decontamination Unit – have achieved an impressive result in their latest inspection. The hospital was measured against strict safety and quality standards set by the UK Government for NHS services. These are the same standards used across the country to ensure patients receive safe, reliable care. The Countess of Chester Hospital passed with a perfect score: no issues raised, no improvements required, and no safety concerns identified. It's the first time in 20 years the hospital has achieved such a remarkable result in this area.

The Milk Bank at Chester wins two national awards for leading wellbeing care after baby loss

After baby loss, many parents still produce milk. This can be painful and feel confusing and isolating. Until recent years, there was no consistent national pathway to support families through this experience, and parents across the country told staff they often felt unprepared and unsure where to turn. NHS staff also said they needed clearer training and guidance to help families at such a difficult time.

The Milk Bank at Chester Team, based at the Countess of Chester Hospital, recognised this gap and wanted to offer families better support.

They created Memory Milk Gift, the UK's first full package of aftercare for lactation after baby loss. Instead of leaving families to navigate this alone, the programme provides gentle conversations,

clear information and ongoing emotional and wellbeing support. Parents can donate their milk in their baby's memory, keep a small amount as a keepsake, or choose what feels right for them.

Families who have taken part in the Memory Milk Gift say donating milk gave them a sense of purpose and a way to honour their baby – turning grief into legacy while knowing their experience mattered.

This work earned the team the Royal College of Midwives Educator of the Year Award, recognising the national training programme now used by midwives, nurses, milk banks, universities and charities.

The second award – Royal College of Midwives Multidisciplinary Team of the Year – went to the Advisory Board, who are also based at the Countess of Chester Hospital, for this same initiative. This group brings together midwives, neonatal nurses, bereavement specialists, milk bank staff, researchers, charities and bereaved parents. Together, they have:

- created the UK's first national guidelines for lactation and milk donation after baby loss
- developed practical teaching tools for hospitals, universities and milk banks
- supported more than 50 NHS Trusts to adopt and adapt the approach
- brought structure, clarity and care to support families

Their joined-up approach ensures families consistently receive emotional, physical and practical support throughout and after their milk journey – not just at the point of donation. Their work is now helping to shape national policy and raising the standard of bereavement care across the NHS.

Countess of Chester Hospital award for commitment to patient safety by the National Joint Registry

The Trust is celebrating being named as a National Joint Registry (NJR) Quality Data Provider after successfully completing a national data quality audit programme.

The NJR collects and monitors high-quality orthopaedic data on the performance of hip, knee, ankle, elbow and shoulder joint replacement in order to support patient safety, standards in quality of care, and overall value in joint replacement surgery, as well as to provide feedback on surgical performance to orthopaedic clinicians and joint replacement implant manufacturers.

The 'NJR Quality Data Provider' certificate scheme was introduced to offer hospitals a blueprint for reaching high-quality standards relating to patient safety and to reward those who have met the registry's high targets in the achievement of the quality of the data collected.

The annual NJR Data Quality Audit compares the number of joint replacement procedures submitted to the registry to the number of procedures that have been carried out and recorded in the local hospital Patient Administration System. The audit ensures that the NJR is collecting and reporting the most complete and accurate data possible in all hospitals performing joint replacement operations.

Countess of Chester Hospital receives major boost to eye care thanks to £200,000 fundraising appeal

A £200,000 community fundraising effort has transformed eye care at the Countess of Chester Hospital, with the arrival of a brand-new retinal scanner that makes tests quicker, easier and more accurate for thousands of patients.

The scanner, now in place at the Westminster Eye Centre, was purchased entirely through the Countess Charity's Retinal Scanner Appeal which saw patients, families, local businesses and other fundraisers unite to reach the full target within 12 months - supporting everything from coffee mornings to mountain climbs and parachute jumps.

Their efforts mean the hospital can now offer clearer, wider and more detailed images of the back of the eye, helping staff identify problems earlier and monitor conditions more effectively.

Hannah Bullock, Head Orthoptist at the Westminster Eye Centre, said: “This scanner will make a real difference to the people we care for. It gives us a much clearer and wider view of the back of the eye, which means we can spot problems earlier and give patients more certainty about what’s going on.

It also makes the whole experience easier - especially for children and people who find it hard to keep still - because the scan is so quick and comfortable”.

Opening of The Wilson Blue Skies Balcony

The new outdoor space gives critically ill patients safe access to sunlight and fresh air during recovery – thanks to community support and hospital partners.

Patients and families at the Countess of Chester Hospital are now benefitting from a unique new facility: The Wilson Blue Skies Balcony, which opened on 21 November 2025.

Made possible by donations to The Countess Charity’s Blue Skies Appeal – with additional support from IHP, contractors for the hospital’s new Women and Children’s Building – this dedicated outdoor space is directly connected to the Intensive Care Unit (ICU), giving the hospital’s most seriously ill patients safe access to fresh air and natural light during recovery.

The balcony was officially opened by Samantha Dixon MBE, Member of Parliament for Chester North & Neston, who joined former patients, hospital leaders, staff and supporters for the occasion.

The idea for the balcony came from staff, who recognised the benefit of access to daylight during long ICU stays. Research shows that time outdoors aids recovery, reduces delirium and improves mood. The new balcony allows beds and crucial equipment to be moved outside safely, so even the most unwell patients can benefit with full clinical support.

Dr Simon Ridler, ICU Consultant, said: “The ability to get our patients outside, even briefly, and expose them to natural light and countryside views will go a long way towards improving their recovery and their experience whilst in critical care. Previously, access to the outdoors involved the patient and team of staff leaving the ICU and having to navigate corridors and a lift to gain access to a downstairs garden area. Having this balcony directly off the unit makes it much easier and safer to transfer patients outside and will allow many more patients and their families to benefit from this. It puts us in the vanguard of intensive care in our region.”

New bone scanner at Ellesmere Port Hospital brings faster diagnosis and local care for patients at risk of 'silent' illness

Patients across Ellesmere Port and Chester can now get quicker, easier access to life-changing bone scans, thanks to a new state-of-the-art scanner at Ellesmere Port Hospital.

The Ellesmere Port facility is one of just 13 hospitals across England to receive the new equipment, as part of the Government's Plan for Change to reduce NHS waiting times. Between them, these sites will deliver an additional 29,000 scans each year.

The new DEXA (Dual-energy X-ray Absorptiometry) scanner, now up and running at the hospital, means people no longer have to travel miles for vital checks that can detect osteoporosis – often called the "silent disease" – before it leads to serious fractures.

Until now, there was no local facility for these scans. Patients were referred back to their GP, then sent on to hospitals 17 or even 32 miles away. For people in West Cheshire – especially those in areas where transport or travel costs are a barrier – this often-meant delays or missed appointments.

Dr Nigel Scawn, Medical Director at the Countess of Chester Hospital NHS Foundation Trust, said: "This new scanner will make a real difference to people locally, particularly women over 50 who are more at risk of osteoporosis after the menopause.

DRAFT

Countess of Chester Hospital opens first NHS net-zero building in England: Women and Children's Building

The Countess of Chester Hospital NHS Foundation Trust has announced a major national milestone in sustainable healthcare. Its new Women and Children's Building – located at the Countess of Chester Hospital site, which delivers maternity, neonatal, paediatric, and women's outpatient care, is the first completed NHS facility in England to be verified as compliant with the NHS Net Zero Building Standard, introduced by NHS England in 2023.

To meet NHS Net Zero Building Standard, the Women and Children's Building includes:

- Highly insulated walls, windows and roof to maintain constant indoor temperatures year-round, reducing the need for heating and cooling
- Solar panels that generate clean electricity on-site
- Smart lighting and ventilation systems that adjust automatically based on occupancy
- Eco-friendly building materials, responsibly sourced for minimal environmental impact
- A digital control system that tracks energy use and carbon emissions in real time

The Women and Children's Building opened on 8 September 2025 and stands as a symbol of what's possible when innovation, care, and climate action come together. With 66 beds, most of them single rooms with ensuite facilities, alongside a small number of shared four-bed spaces for those who prefer a more communal setting, the building delivers some of the Trust's most vital services. It is now home to over 500 staff, and is seeing an increase in bookings for maternity care.

Countess of Chester Hospital first district general hospital in Cheshire & Merseyside to launch virtual tour for patients

For some, the uncertainty of a hospital visit can cause such intense anxiety that it leads to delayed or avoided care. The National Autistic Society reports that around half of the people with autism experience high levels of anxiety related to hospital visits, with 51% finding waiting rooms particularly distressing.

This new digital tool seeks to ease those concerns by offering patients and carers the opportunity to explore the hospital environment in advance. Unlike traditional videos, the tour is fully

interactive, featuring 360° navigation, clickable hotspots, and access to key areas such as outpatient departments, waiting areas, X-Ray and endoscopy suites.

The initiative was developed in response to direct feedback from individuals with additional needs, who expressed concerns about navigating hospital settings. Created in collaboration with the hospital's Safeguarding and Complex Care Team, and designed by Bartex Design, the tool helps patients and families familiarise themselves with the environment, reducing anxiety and making visits feel more manageable.

Mark Bartram, founder of Bartex Design, said: "When my son was younger, every hospital visit was a battle. The unknown was terrifying for him – the corridors, the waiting rooms, the clinical spaces he couldn't picture. His anxiety would spiral before we even left the house. I remember thinking, if only he could see what was coming, it might take away some of that fear. That's why this project matters so much to me. It's not just a virtual tour; it's a lifeline for families like ours."

Funded by NHS Cheshire and Merseyside, this initiative is a key part of the Trust's Additional Needs Strategy, which is focused on making healthcare more inclusive for autistic individuals, as well as those living with dementia, learning disabilities, mental health conditions, and physical disabilities.

The launch of the virtual tour also aligns with the Trust's Patient and Family Experience Strategy, which emphasises the importance of listening to patients and acting on what matters most to them. It demonstrates the Trust's ongoing commitment to improving services.

Children in Chester no longer need to travel for life-saving breathing support thanks to Emily Ffion Trust donation

The memory of 21-month-old Emily Sowden, who sadly died from acute viral bronchiolitis in 2013, continues to help children at the Countess of Chester Hospital. Her family's charity, the Emily Ffion Trust, has recently donated near £17,000 to fund vital breathing equipment – bringing their total support of the hospital to over £65,000.

Thanks to this latest donation, the hospital now has an extended set of respiratory equipment. This includes ventilators, saturation monitors and nebulisers, ready to support children in the community, on the children's ward, or needing regular hospital visits as part of their everyday care. It means all local children with breathing conditions who need equipment to help them can now get the support they need quickly and close to home.

Before now, many families had to travel to Alder Hey Children's Hospital in Liverpool to access specialist equipment, a 44-mile round trip. That often-meant families missing school or work and added stress during an already worrying time. Now, families can simply visit their local hospital for the support they need.

John Sowden, Emily's father, said: "Once again we are delighted to provide funding to the Countess of Chester Hospital for what are very much needed pieces of critical equipment to help unwell children in the region.

Since losing Emily very suddenly in November 2013, we as trustees have received so much support from family, friends and people we've never met before, all with the aim to improve others chances to recover and live more comfortably from respiratory conditions.

Although none of this kit would have helped with Emily's particular condition, her name is attached to each piece of equipment, and we know that – even though she's no longer with us – she will continue to have a huge impact on the wellbeing of others".

Countess of Chester Hospital leads England in faster cancer diagnosis

The Countess of Chester Hospital has been named the best in England for quickly diagnosing bowel cancers for four months in a row – a remarkable achievement considering that just two years ago, far fewer patients were being seen within national waiting time standards.

In April 2023, only 31 out of every 100 patients got their results within four weeks. By July 2025, that number had increased to 93 out of 100 – a huge improvement. This is part of the NHS's Faster Diagnosis Standard (FDS). It means people who are referred for suspected cancer should get a clear answer – either a diagnosis or the all-clear – within 4 weeks.

Within this journey, Endoscopy aims to book patients for their procedure within two weeks of the request, ensuring national standards for timely diagnosis are met and often exceeded.

For patients, this means:

- Less time waiting and worrying
- Quicker treatment, which can help people get better faster
- Better chances of survival
- Clearer and kinder care, with fewer delays

This achievement is especially important for communities who are most affected by bowel cancer. People living in more deprived areas – and those from Black, Asian, and mixed ethnic

backgrounds – are more likely to be diagnosed late or through emergency routes. Men are also slightly more likely than women to develop bowel cancer.

By improving how quickly patients are seen and diagnosed, the Countess of Chester Hospital is helping to close the gap and make cancer care fairer for everyone.

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

2.1 Priorities for improvement 2026/27

This Quality Account provides an opportunity to look back on last year's priorities (refer to Part 3) and to outline the intentions for 2026/27. The priorities for 2026/27 build on those from 2025/26 and have been chosen following a stakeholder engagement session involving staff and public Governors. Learning has also been considered – as captured through a range of mechanisms, for example patient feedback, complaints, and patient safety incidents. This ensures that we continue to focus on what makes the biggest difference to patients and their families.

The Trust is committed to delivering the following priorities:

2026/27 Quality Priorities		
Delivering Safe Services	**Delivering Effective Services**	**Delivering Kind and Compassionate Care**
Priority 1: Reduce the incidence of E coli and MSSA Healthcare Associated Infections.	**Priority 1:** All eligible patients are assessed for risk of deep vein thrombosis (DVT)	**Priority 1:** To ensure that patients are appropriately involved in patient safety investigations
Priority 2: Reduce the incidence of inpatient falls	**Priority 2:** All patients with suspected sepsis are assessed and diagnosed within recommended timeframes	**Priority 2:** Implementation of Patient Wellness Questionnaire across the organisation.
Priority 3: Reduce the incidence of Hospital Acquired Pressure Ulcers (HAPU)	**Priority 3:** All eligible patients to have a discharge checklist completed prior to discharge.	**Priority 3:** Implementation of Personalised Care to ensure care is delivered, based on what matters to the individual patient.

Delivering Safe Services

Priority 1: Reduce the incidence of E coli and MSSA Healthcare Associated Infections.

E.coli is the causative pathogen of approximately 80% of all antimicrobial resistant bloodstream infections in the UK and since the COVID-19 pandemic, case numbers have subsequently been rising annually. E.coli lives harmlessly in most people within their intestine but when present in other parts of the body (such as the urinary tract) can cause infections there which can lead to more complicated and invasive blood stream infections.

Methicillin-sensitive Staphylococcus aureus (MSSA) is a common bacterium found on the skin or in the nose that can cause infections when it enters the body, ranging from minor skin issues like boils to serious bloodstream infections

Consequently, reducing these infections is part of the national 5-year strategy 'Confronting antimicrobial resistance 2024 to 2029' with a target of by 2029 to aim to prevent any increase in

Delivering Safe Services

Gram-negative bloodstream infections in humans from the 2019 to 2020 financial year baseline

How progress will be monitored, measured, and reported:

Metrics:

- Reduction in the reported E.coli infections related to Urinary Tract Infections (UTI)/ catheter care
- Reduce the reported MSSA infections related to Intravenous (IV) lines

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

Priority 2: Reduce the incidence of inpatient falls

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

How progress will be monitored, measured, and reported:

Metrics:

- Reduce the number of inpatient falls
- 90% of inpatients have a documented falls risk assessment within 6 hours of admission
- Recording and reporting on preventative measures.

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

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

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

How progress will be monitored, measured, and reported:

Metrics:

- 90% of inpatients have a skin integrity assessment within 6 hours of admission.
- Improvement in compliance with the completion of body maps for patients with identified skin integrity issues.
- Any lapses in care identified in relation to HAPU will be reported quarterly.

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

Delivering Effective Services

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

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

Delivering Effective Services

How progress will be monitored, measured, and reported:

Metrics:

- 95% of all eligible patients being risk assessed for VTE within 14 hours of admission
- Improve the overall compliance of the administration of appropriate pharmacological thromboprophylaxis within 14 hours of admission

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

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

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

How progress will be monitored, measured, and reported:

Metrics:

- 90% of all eligible patients presenting at hospital are assessed for the risk of sepsis
- Improve compliance with the timely administration of antibiotics in patients with a diagnosis of sepsis

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

Priority 3: All eligible patients have a discharge checklist completed prior to discharge.

A discharge checklist is crucial for ensuring patient safety, reducing readmissions, and facilitating a smooth transition from hospital to home or community care.

How progress will be monitored, measured, and reported:

Metrics:

- All eligible patients will have a discharge checklist completed in the electronic patient record prior to being discharged from hospital.

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

Delivering Kind and Compassionate Care

Priority 1: To ensure that patients are appropriately involved in patient safety investigations

The inclusion of patients / relatives in patient safety investigations will enable perspectives and experiences to inform the investigation and support learning and development.

How progress will be monitored, measured, and reported:

Metrics:

- Evidence of patient and family being considered and involved in investigations related to patient safety incidents.

Progress against this priority will be measured and monitored by the Patient Experience Operational

Delivering Kind and Compassionate Care
Group and received at the Quality and Safety Committee (Board committee).
Priority 2: Implementation of Patient Wellness Questionnaire Martha's Rule is a major patient safety initiative providing patients and families with a way to seek an urgent review if their or their loved one's condition deteriorates, and they are concerned this is not being responded to. The questionnaire is designed to detect patient deterioration early by empowering patients and families to report changes in condition. It involves a daily check asking: "How are you feeling?" and "Do you feel any better or worse than yesterday?" **How progress will be monitored, measured, and reported:** Metrics: • Phased roll out of Patient Wellness Questionnaire (PWQ) for all adult inpatient areas. • Evaluate the responses in relation to PWQ scores and subsequent escalation processes. Progress against this priority will be measured and monitored by the Deteriorating Patient Group and received at the Quality and Safety Committee (Board committee).
Priority 3: Implementation of Personalised Care to ensure care is delivered, based on what matters to the individual patient. The implementation of personalised care will ensure that patients are the centre of all decisions in relation to their care. **How progress will be monitored, measured, and reported:** Metrics: • Develop an organisation-wide improvement plan to expans shared decision making in identified areas • Review how information systems, communication and education may support shared decision making, Progress against this priority will be measured and monitored by the Patient Experience Operational Group and received at the Quality and Safety Committee (Board committee).

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2.2 Statements of assurance from the Board

During 2024/25 the Trust provided and/or sub- contracted 44 relevant health services. The Trust has reviewed all available data on the quality of care in each relevant health service. The income generated by the relevant health services reviewed in 2025/26 represents 100% of the total income generated from the provision of relevant health services by the Trust.

Clinical Audit and Confidential Enquiries

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

The Trust is committed to undertaking effective clinical audit across clinical services and recognises that this is a key element for providing high quality care. Clinical audit enhances patient care and safety and provides assurance of continuous improvement.

The Trust has a well-structured clinical audit programme which is regularly reviewed. During 2025/26, 47 national clinical audits and 8 national confidential enquiries were relevant to health services that the Trust provides. The Trust participated in 100% of national clinical audits and was eligible to participate in 100% of the national confidential enquiries that we were eligible for.

The national clinical audits and national confidential enquiries that the Trust participated in, and for which data collection was completed during 2025/26, are listed below.

National Audits & Clinical Outcome Review Programmes 2025/26	Eligible	Participation	Status
Breast and Cosmetic Implant Registry	Yes	Yes	Continuous monitoring
Case Mix Programme (CMP) (ICNARC)	Yes	Yes	Continuous monitoring
Child Health Clinical Outcome Review Programme[1]	Yes	Yes	Active
RCEM-Care of Older People	Yes	Yes	Active
RCEM-Mental Health Self Harm	Yes	Yes	Active
RCEM-Time Critical Medications	Yes	Yes	Active
Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young People[1]	Yes	Yes	Continuous monitoring
National Audit of Inpatient Falls (NAIF)	Yes	Yes	Continuous monitoring
National Hip Fracture Database (NHFD)	Yes	Yes	Continuous monitoring
Learning from lives and deaths – People with a learning disability and autistic people (LeDeR)	Yes	Yes	Continuous monitoring
Maternal, Newborn and Infant Clinical Outcome Review Programme[1]	Yes	Yes	Continuous monitoring
National Diabetes Core Audit	Yes	Yes	Active
National Diabetes Footcare Audit (NDFA)	Yes	Yes	Active
National Diabetes Inpatient Safety Audit (NDISA)	Yes	Yes	Active
National Pregnancy in Diabetes Audit (NPID)	Yes	Yes	Active

Transition (Adolescents and Young Adults) and Young Type 2 Audit	Yes	Yes	Active
Gestational Diabetes Audit	Yes	Yes	Active
National Audit of Care at the End of Life (NACEL)	Yes	Yes	Active
National Audit of Metastatic Breast Cancer (NAoMe)[1]	Yes	Yes	Continuous monitoring
National Audit of Primary Breast Cancer (NAoPri)[1]	Yes	Yes	Continuous monitoring
National Bowel Cancer Audit (NBOCA)[1]	Yes	Yes	Active
National Lung Cancer Audit (NLCA)[1]	Yes	Yes	Active
National Oesophago-Gastric Cancer Audit (NOGCA)[1]	Yes	Yes	Active
National Prostate Cancer Audit (NPCA)[1]	Yes	Yes	Active
National Heart Failure Audit (NHFA)	Yes	Yes	Active
National Audit of Cardiac Rhythm Management (NACRM)	Yes	Yes	Active
Myocardial Ischaemia National Audit Project (MINAP)	Yes	Yes	Active
2025 Major Haemorrhage Audit	Yes	Yes	Completed
National Early Inflammatory Arthritis Audit (NEIAA)[1]	Yes	Yes	Continuous monitoring
National Emergency Laparotomy Audit (NELA)	Yes	Yes	Continuous monitoring
National Emergency Laparotomy Audit (NELA) No Laparotomy	Yes	Yes	Continuous monitoring
National Joint Registry	Yes	Yes	Continuous monitoring
National Major Trauma Registry	Yes	Yes	Continuous monitoring
National Maternity and Perinatal Audit (NMPA)[1]	Yes	Yes	Continuous monitoring
National Neonatal Audit Programme (NNAP)[1]	Yes	Yes	Continuous monitoring
National Obesity Audit (NOA)[1]	Yes	Yes	Active
Age-related Macular Degeneration Audit	Yes	Yes	Active
Cataract Audit	Yes	Yes	Active
National Paediatric Diabetes Audit (NPDA)[1]	Yes	Yes	Continuous monitoring
National Perinatal Mortality Review Tool (PMRT)	Yes	Yes	Continuous monitoring
National Respiratory Audit programme-NRAP-COPD Secondary Care	Yes	Yes	Continuous monitoring
National Respiratory Audit programme-NRAP-Adult Asthma Secondary Care	Yes	Yes	Continuous monitoring
National Respiratory Audit programme-NRAP-Children and Young People's Asthma Secondary Care	Yes	Yes	Continuous monitoring
National Vascular Registry (NVR)[1]	Yes	Yes	Active
Paediatric Intensive Care Audit Network (PICANet)[1]	Yes	Yes	Active
Sentinel Stroke National Audit Programme (SSNAP)[1]	Yes	Yes	Active

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UK Parkinson's Audit	Yes	Yes	Active

NCEPOD	Eligible	Participation	Status
Rehabilitation following critical illness-ICU	Yes	Yes	Action Plan Development
Emergency (non-elective) procedures in children and young people.	Yes	Yes	Action Plan Development
Blood sodium-Hyponatraemia	Yes	Yes	Action Plan Development
Acute limb Ischaemia	Yes	Yes	Action Plan Development
Acute Illness in people with a Learning Disability	Yes	Yes	Active
Stabilisation of the critically ill child	Yes	Yes	Active
Pleural Procedures	Yes	Yes	Active
Rib Fractures	Yes	Yes	Active

Other National /Regional Audits Participated in 2025/26 (not on the Quality Accounts List):

National Audits / Regional Audits
GLP-1 receptor agonist management in the perioperative setting (GLIMPSE). A national prospective multicentre service evaluation
SECURE Study: RSI Service Evaluation
Surveillance of Blood Stream Infections in Patients Attending ICUs in England
TRIC BLOCK - Service Evaluation Project
Isotretinoin Regional Audit 2025
Biologic Prescribing for Eczema in Adults
Audit for the use of Ritlecitinib in Severe Alopecia Areata
PANDORA- Acute pancreatitis national audit of practice
RESPOND (Rescue for emergency surgery patients observed to undergo acute deterioration)
IIH diagnosis and monitoring, a multicentre audit'
Current acute management of paediatric supracondylar fractures (CAMPS)
National VERN Surgical site infections in major amputation 'SIMBA' multicenter prospective audit 2025-2026
National VERN Surgical Site Infections in Major Lower Limb Amputation – Transmetatarsal Extension) 'SIMBA-T' 2025-2026
Adherence to Post EVAR Surveillance Protocol
Discharge and Follow-up for Vascular patients
Surgical Haemostasis and Reintervention in Theatres for Effective Management- A retrospective audit
Society of Acute Medicine Benchmarking Audit
Endoscopists Key Performance Indicators (KPI) audit 01/04/2025-30/09/2025
Evaluating patieNt aCcess tO fertility seRvices in the National Health ServicE (ENCORE): A National retrospective service evaluation study.
Avoiding Term Admissions in Neonates (ATAIN) 2025
Baby Friendly Initiative (BFI)
TULIPS (treatment of asymptomatic urinary infection (lower) infection in pregnancy screening)
BFI supplementation audit (Sept 25-Feb 26)
CALIBRE - an audit comparing the care provided during the induction of labour to national guidance

The reports of 47 national clinical audits were reviewed in 2025/26. The Trust has taken and/or intends to take the following actions to improve the quality of healthcare provided as set out below.

Audit Title	Outcome /Actions
MBRRACE-UK Perinatal mortality surveillance	
MBRRACE-UK Perinatal mortality surveillance 2024)	Seventh annual report of findings from reviews completed using the National Perinatal Mortality Review Tool (PMRT) in 2024. **Sample:** 4,166 reviews completed from January to December 2024. **Countess of Chester Results** • As part of Safety Action 1 of the Maternity Incentive Scheme for 2025 compliance to the required standards are presented to Perinatal Assurance & Improvement Board monthly. In addition, quarterly reports are presented to the Board of Directors to provide assurance. • Compliance with the standards is good. Particularly to note as a comparison to this National Report • 100% of parents were informed that there would be a review of their case and questions were sought. This is followed up on several occasions by the Midwifery Bereavement team as we recognise that bereaved parents will need these multiple opportunities to be involved in the review. • Issues with care identified are very similar themes to National reports, particularly in relation to antenatal and intrapartum care. This Trust has very few neonatal deaths due to the level of care provided by the Neonatal Unit therefore these are themes we rarely see. • Bereavement care at the Trust regularly achieves grading A, resulting as investment in the service with dedicated midwives and bereavement suite following earlier PMRT reviews. • PMRT panels are supported by a Multidisciplinary team and are well attended by all required groups of staff although administrative support is minimal. Additional expertise has been present when required for example neonatal nurses and Consultants, safeguarding leads and Consultant Perinatal Pathologist. • 100% of PMRT panels in 2024 had at least one external member on the panel resulting in vigorous and objective reviews. This is a result of support from the local maternity system but also on team members seeking support from local colleagues. • The reports comments on the quality of actions, with a low percentage of these being strong actions. It is noted that this is a common problem nationally and reflects some of the issues that are identified in the review which can be difficult to generate strong actions from. • To improve the strength of future actions we have added discussion of actions to the agenda for the PMRT review. Once developed and finalised they will be reviewed and agreed on by the Divisional Leadership team before being submitted to the final PMRT report The audit has shown ***Full Assurance*** for the Trust.
National Audit of Cardiac Rhythm Management (NACRM) April 24-March 2025	
National Audit of Cardiac Rhythm Management (NACRM) April 24-March 2025	The aim of the NACRM is to improve the care of patients who undergo pacemaker, implantable cardioverter-defibrillator (ICD), cardiac resynchronization therapy (CRT) and cardiac ablation procedures in the UK through the collection, analysis and dissemination of data relating to centres across the UK. It can assist with planning by health care providers and commissioners. The objective of this Executive Summary is to present the findings of the NACRM Annual Report as they relate to the Countess of Chester Hospital (COCH). **Standard Audit Against:**

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	Findings No specific figures have been given for the total number of CIED implants at COCH during 2024/25. There were 150 new pacemaker implants which exceeded the minimum number required by BHRS (>80 new pacemaker implants). The Trust achieved 100% compliance with NICE TA324 which recommends the use of dual chamber pacing (rather than single chamber pacing) to treat sick sinus syndrome (rank 14th in UK). The audit recommends hospitals aim to achieve this for 90% of relevant procedures and the national average was 82%. We achieved 100% compliance with NICE TA88 which recommends dual chamber pacing in AV block (rank 6th in UK). The audit recommends hospitals aim to achieve this for 90% of relevant procedures and the national average was 84%. Our 1-year re-intervention rate was 0.7 %. This is considerably below the national average of 4.4% for simple CIEDs. All operators performed well in excess of the minimum number of pacemaker implants required by BHRS to demonstrate competency (>35 new pacemaker implants.) There are no specific recommendations for the Countess of Chester Hospital. Our compliance with data collection is excellent and we more than satisfy requirements laid out by the British Heart Rhythm Society. In addition, we continue to meet NICE targets. According to the NACRM Annual Report, conduction system continues to expand with a further 4-fold increase in conduction system pacing (CSP) during 2024/2025 compared to 2023/2024. CSP involves targeting a right ventricular lead to sites in the natural conduction system of the heart rather than in conventional anatomical sites. It is hypothesised that such pacing may result in better outcomes than anatomical pacing and possibly even cardiac resynchronisation therapy. A number of staff at COCH have undergone training in this new technique and we hope to introduce a service in the next year. This is something that the Trust should fully support. The audit has shown ***Full Assurance*** for the Trust.
National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) Surgical & Medical / Child Health Programme	
Completed studies during 2025/26	Active studies during 2025/26 • NCEPOD Rehabilitation following critical illness-ICU • NCEPOD Emergency (non-elective) procedures in children and young people. • NCEPOD Blood sodium-Hyponatraemia • NCEPOD Acute limb Ischaemia • NCEPOD Acute Illness in people with Learning Disability • NCEPOD Stabilisation of the critically ill child • NCEPOD Pleural Procedures • NCEPOD Rib Fractures
JAG Endoscopists Key Performance Indicators (KPI) audit 01/04/2025-30/09/2025	
Endoscopists Key Performance Indicators (KPI) audit 01/04/2025-30/09/2025	To establish if endoscopists are meeting the Key performance indicators set by JAG (Joint Advisory Group). All endoscopist to achieve 90% and above to achieve standards as set out by

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	JAG The audit has shown ***Significant Assurance*** for the Trust.
Myocardial Ischaemia National Audit Project (MINAP) 1 April 2024-31 March 2025	
Myocardial Ischaemia National Audit Project (MINAP) 1 April 2024-31 March 2025	**Audit aim:** To compare the care provided for patients at COCH who present with myocardial infarction to standards set by the MINAP clinical audit. To ensure that the Trust maintains the standards of this mandated national audit **Findings:** 99% of eligible patients were discharged from hospital on all secondary prevention medications, with 100% discharged on aldosterone antagonists, above the expected 90% quality standard. Referral to cardiac rehab on discharge or referral to another hospital was just below the 85% expected target at 81%. However, due to difficulty obtaining data from other hospitals the actual figure may be higher. Patients referred to cardiac rehab from discharge from COCH did achieve the 85% quality standard at 98%. The audit has shown ***Significant Assurance*** for the Trust.

Local Clinical Audits

To improve the quality of healthcare provided at the Trust, the reports of 111 local clinical audits were reviewed in 2025/26 compared to 142 in the previous year. The Trust has taken and/or intends to take the following actions to improve the quality of healthcare, noting the full or significant assurance provided**:**

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

	Findings: This audit substantiates and validates the use of the VACOped® boot as a cost-effective replacement for the Airstep® walker boot with wedges in the management of Achilles tendon ruptures as outlined in the 2022 COCH guidelines with both improved outcomes scores and both 4-6 and 9-12 months and a reduction in the re-rupture rate. It is acknowledged however that the success of Achilles tendon rupture management is not solely based on the prevention of complications and re-rupture but also the restoration of function which is influenced by tendon length. An improvement was not noted in the rate of apparent Achilles tendon lengthening but this may have been influenced by the relatively low surgical conversation rate and number of delayed presentation ruptures. The results compare very favorably with those published other foot and ankle centres. **Actions:** Only actions to come out of audit- • Add to Foot and Ankle MDT meeting agenda the following: • Review of audit results • Review of surgical criteria • Review of management of delayed presentation patients • Introduction of radiology USS reporting template • Review of patient 9- and 12-month outcomes to potentially include date for return to work and sport Update action plan accordingly with outcome of above discussions – may involve updating guidelines and creating and disseminating radiology USS reporting template This audit has shown ***Full Assurance*** for the Trust.
Planned Care	
Adequacy for excisional margins of skin cancer lesions	**Audit Aims:** • To analyse if current margins of skin cancer excision surgeries are in accordance with the skin cancer management guidelines. • To analyse if current margins of skin cancer excision surgeries are adequate, confirmed with histological evidence. • To implement a change in practice to improve current standards of practice. **Findings:** All SCC and BCC lesions were excised, and completeness of excision was adequate as per Merseyside and Cheshire Skin Cancer Center Management Guidelines. 82.6% of patients were correctly diagnosed with the specific type of lesion before surgery. 100% of patients were treated by single excisional procedure. **Action:** Re-audit June 2025 This audit has shown ***Full Assurance*** for the Trust.
Anaesthetic Handovers to Theatre Recovery Teams	**Audit Aims:** To assess the quality and efficacy of the verbal and written handovers being provided by the Anaesthetics team when transferring patients from theatre to recovery post-surgery. Audit results demonstrated 91% compliance of patient discharged with appropriate quantity of anticoagulant therapy **Findings:** Full assurance - 96.9% of handovers were structured, concise and accessible

	Actions:
	• Amendments to Cerner anaesthesia Handover tool as detailed above.
	• Amendment of 'Handover to Recovery' Tool to include additional details:
	  ○ Patient pre-op cognitive status
	  ○ Full Resuscitation/DNACPR Status
	  ○ Medications for administration in Recovery
	  ○ Blood products for administration in Recovery
	  ○ Amend Investigations to include common post-op Ix e.g. CXR, ECG, BM, Rotem
	  ○ Amendment to Cerner – relocation of 'Handover to Recovery' documentation from Anaesthesia Final Record to separate entry in documentation
	• Drafting of clear SOP for anaesthetic to Recovery team handover to provide clear written guidance on the transfer of patients from theatre to Recovery, including RCOA guidance on optimal monitoring and patient safety, as well as how to provide optimal Handover.
	
	This audit has shown ***Full Assurance*** for the Trust.

Urgent Care	
Maintenance Rituximab	Rituximab is a monoclonal antibody (biologic) that treats cancers like non-Hodgkin's lymphoma and leukemia, as well as autoimmune conditions such as rheumatoid arthritis and vasculitis. **Audit Aim:** To assess whether our experience of using maintenance rituximab is similar to the PRIMA study. **Findings:** • Wide range of duration of treatment at time of audit. • Modal number of cycles of treatment is the full 12 • Discontinuation rates, 18%, similar to the initial PRIMA trial • Treatment discontinued due to disease progression (2) and recurrent infections (2) • Initial chemotherapy regime does not appear to influence maintenance **Actions:** • Continue current practice of offering maintenance rituximab • Re-audit in approximately 3 years. Assess over a longer period and include such variables as age. • Assess outcomes of patients who aren't given maintenance rituximab to compare. This audit shows ***Significant Assurance*** for the Trust.
Audit of COCH practice compliance with Trust anaemia guidance from Same Day Emergency Care (SDEC)	**Audit Aim:** The aim of the audit is to measure compliance with the trust guidance for treating iron deficiency anaemia in adult outpatient's department of the Countess of Chester Hospital. 90-100% compliance. **Findings:** A compliance rate of 92.86% with the guidance from the ambulatory care pathway was calculated. The formula used for this calculation: (Patients treated according to the guidance) / (total number of eligible patients) * 100 = compliance rate. **Action implemented:** Update senior doctor on findings and no major changes needed guidelines being reviewed

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	Audit shows ***Significant Assurance*** for the Trust
Women and Children's	
High Risk Induction of Labour - Fetal Monitoring	**Audit Aim:** Following an ICB action this snapshot audit was commenced to examine if high risk inductions have a fetal monitoring plan and if the plan was followed appropriately. **Findings:** 25 patients were audited within the time period (May-Jun 24). Documented Plan of Frequency of Fetal Monitoring • 96% of patients had a plan in place within the notes for frequency of fetal monitoring. 1 of 25 did not. This patient started this IOL process, however, progressed to the need for Emergency Caesarean Section Therefore Fetal Monitoring was safe and appropriate. Fetal onitoring Frequency Followed 22 patients (x3 NA) • 91% of patients had 6 hourly fetal monitoring during high-risk induction. • did not and below shows the gap between 6 hourly: 11 hours (5 hr. late) 7.5 hours (1.5hr late) All patients had an appropriate escalation of concerns with regards to fetal monitoring or maternal condition. **Actions implemented:** • Clear individualised management plan for all patients that are being induced including frequency of fetal monitoring • Ward managers address those cases that didn't have the plan followed and were required to communicate with staff members. This audit shows ***Full Assurance*** for the Trust.
A clinical audit to assess compliance with the The NHS Breast Screening Programme (NHSBSP) standard of a clear demonstration of the inframammary angle on the Mediolateral Oblique (MLO) view in screening mammograms.	**Audit Aims:** 1. To assess the extent to which the practice of mammographers within a BSU comply with the NHSBSP standard for clearly demonstrating the inframammary angle in the MLO view. 2. To improve patient outcomes by identifying any areas of practice that require improvement or further training. **Findings:** Audit has shown significant assurance as overall clinically acceptable rates of IMA demonstration. **Action** Re-audit in 12 months This audit shows ***Significant Assurance*** for the Trust.

Local Audits

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

The Trust currently utilises the MEG audit platform to monitor compliance in local audits across the organisation. There are currently 40 audits built into the system, with the addition of the Striving for Excellence programme. This digital audit tool supports a paperless auditing process with real time reporting.

Key Benefits:

Local audit programmes in MEG:

Skin Integrity	Nutrition	Mattress Audit
Falls	Maternity	Mealtime Audit
Mouthcare Matters	Paediatrics	Palliative Care
Pain Assessments	Ophthalmology	Emergency Dept
NEWS2	Blood Transfusion	Medication
Infection Prevention & Control	Patient Safety Checklists	Daily checks

The audits are completed in each area as stipulated by the audit type, either daily or monthly. Reports are available to download from the tool in real-time. Ward & Divisional reports are prepared at the start of each month with data from the preceding month and are sent to all Ward Managers, Matrons, Heads of Nursing and the Senior Leadership Team. The report includes details of all audits completed and the compliance achieved.

Striving for Excellence Programme

The Trust has a comprehensive ward and departmental accreditation assessment tool, developed in alignment with the Care Quality Commission (CQC) "We" statements and quality standards. The tool incorporates key clinical indicators to provide assurance regarding the quality and consistency of clinical care delivered across the Trust.

To date, 38 wards and departments have been assessed through a structured accreditation process, which includes an observational ward or department visit and a presentation of performance data from the preceding six months. An overall accreditation score is then calculated based on these assessments. Currently the majority of the wards and departments have achieved a Silver rating having scored 80-90% from a White, Bronze, Silver and Gold scale. To achieve Gold status an area would be required to demonstrate and evidence consistent data reflecting 90% and above for a period of six months for mandated training and generic audits. This is something all areas are striving to achieve.

All assessments are completed electronically using the Trust's agreed audit system, MEG.

This accreditation model is designed to support clinical teams to understand and use their data effectively, standardise processes across the Trust, reduce unwarranted variation, and enable teams to thrive through the application of continuous improvement methodologies.

Research

We remain committed to offering our patients and local population the opportunity to participate in high quality clinical research. This commitment is underpinned by our new research strategy, *"Research Matters – Better Care, Brighter Futures (2025–2030)"*, which sets out our ambition to embed research as a core component of patient care and to expand access across all of the communities we serve.

At any one time, there are over 100 research studies active or in follow up across the Trust. The number of patients that were recruited to participate in research in 2025/26 was 742. These participants were enrolled into 50 different studies, with 29 new studies opened during the reporting period.

Over the past year, we have continued to strengthen our research infrastructure and delivery model. Building on the successful opening of our Clinical Research Unit (CRU) in December 2024, we have expanded our reach into the community through the development of Community Research Hubs. A hub has now been established at Ellesmere Port Hospital and this has been extensively used by One Ellesmere Port Primary Care Network (PCN). A further hub at Tarporley Memorial Hospital is due to open imminently. These hubs, alongside our Mobile Research Unit, significantly enhance our ability to deliver research closer to patients' homes, improving accessibility and supporting inclusion of underserved and rural populations.

We have also significantly increased our collaboration with the Cheshire and Merseyside Commercial Research Delivery Centre (CRDC), which has supported the growth of our commercial research portfolio. This has increased opportunities for patients to access cutting edge therapies and innovations through participation in life sciences research. As a result, commercial research activity at the Trust continues to grow, contributing to both improved patient outcomes and increased research income to support sustainable service development.

Partnership working remains central to our approach. We are continuing to strengthen collaboration with our primary care partners through the development of research active PCNs, supporting delivery of studies in community settings and widening access to research participation. In parallel, we intend to develop our strategic partnership with the University of Chester, working together to

develop research, education, and innovation opportunities, and supporting the long-term ambition of becoming a teaching and research active organisation.

Our aspiration remains to ensure that all communities across Chester, Cheshire West, Cheshire East, South Wirral, and neighbouring regions, including Flintshire, have equitable access to first-class research opportunities.

Through continued investment in infrastructure, partnerships, and workforce, we are well positioned to deliver on this ambition and to ensure that research continues to play a vital role in improving patient care and outcomes.

Care Quality Commission

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

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

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

Following an unannounced inspection of urgent and emergency care services in February 2025, the Trust received Section 29a warning notice and the CQC rated the services as inadequate. Immediate actions were taken including consistency in the use of documentation, culture expectations, cleaning standards, equipment and improvements to the environment. A comprehensive action plan was developed and delivered with oversight from the Quality and Safety Committee. The CQC re-inspected the UEC services alongside other services in October 2025 with the report anticipated in early 2026/27.

The Director of Nursing and Quality and Deputy Directors of Nursing have a fortnightly CQC engagement meeting to discuss, respond to and address any issues or concerns. To assure itself of performance and the Trust CQC registration requirements, the Trust's monthly Integrated Performance Report (IPR) is reviewed by the Board of Directors with extracts subject to deep dives through the assurance committees. Divisional risk and performance reports are presented monthly to the Operational Management Board. These reports provide a triangulation of quality, workforce, performance and financial indicators.

Data Governance

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

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

The Countess of Chester Hospital NHS Foundation Trust submitted records from 2025/26 to the Secondary Uses Service for inclusion in the national Hospital Episode Statistics. The following measures provide information on our compliance against the standards required.

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

- 99.9% for admitted patient care
- 99.8% for outpatient care
- 95.0% for accident and emergency care

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

- 100% for admitted patient care
- 99.9% for outpatient care
- 100% for accident and emergency care

The Trust undertakes an annual external audit of our clinical coding data. The audit by Countess of Mersey Internal Audit Agency (MIAA) provided substantial assurance in relation to its clinical coding processes.

Information Governance

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

The Trust Data Security and Protection Toolkit's (DSPT) overall score for 2024/25 was graded as 'Standards Met' by internal auditors based on a review of about 40% of the total Toolkit. The Trust's final position for 202425 , was judged to be 'Approaching Standards' across the whole toolkit , with an action plan to move towards 'Standards Met'.

The results for the 2025/26 Data Security & Protection Toolkit (DSPT) will not be available until July 2026.

Learning from deaths

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

During 2025/26, the number of patients who died at the Trust was 1,195. The number of deaths in

each quarter was:

- 265 in the first quarter
- 276 in the second quarter
- 319 in the third quarter
- 335 in the fourth quarter.

By 31 March 2026, following Trust policy guidance on 'selection of cases for review',112 mortality reviews were undertaken. The number of deaths in each quarter for which a case record review or investigation was carried out was:

- 34 in the first quarter
- 39 in the second quarter
- 30 in the third quarter
- 9 in the fourth quarter.

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

Review method

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

- Specialty mortality and morbidity review
- Structured mortality review
- Thematic pathway reviews in response to mortality indices outlier status.
- After Action Reviews or Patient Safety Incident Investigations (PSII)

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

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

Learning from coroners' inquests was also included in 2025/26 and presented at the Trusts Safety Surveillance monthly meeting and reported quarterly in the Safety Surveillance report.

Throughout the reporting period, the Trust has shared and spread the learning identified

through monthly Patient Safety Summits, the Mortality Surveillance Group, the daily Patient Safety Huddle and the Divisional Governance Groups. Further work will be progressed in 2026/27 to strengthen cross divisional learning, scrutiny of reviews and thematic analysis.

Significant work has been undertaken in 2025/26 to improve the preparation for coroner's inquest, timely investigations in line with the PSIRF when appropriate and engagement with families prior to any coronial inquest. Plans for 2026/27 include a review and refresh of the learning from deaths policy and implementing a Trust wide Learning from Deaths forum.

2.3 Reporting against Core Indicators

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

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

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

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Indicator	2025/26	2024/25	2023/24	2022/23	National Average	Where applicable – best performer	Where applicable – worst performer
SHMI value and banding (most recent November 2024 to October 2025)	88.8 Within expected range	90.9 Within expected range	96.7 Within expected range	99.9 Within expected range	100.3	71.9	125.6
% Patient deaths coded for palliative care at diagnosis or specialty level; Source: NHS Digital (SHMI publication) December 2023 to November 2024	38%	39%	44%	41%	N/A		
Our Standard Hospital Mortality Indicator (SHMI) has improved significantly and now falls within the expected range. There has been focused on improvement work on disease groups where the Trust was previously an outlier. This position has been sustained during the 12-month reporting period.							
Patient reported outcome scores for primary hip recplacement surgery	Data not available	Data not available	Data not available	Data not available	N/A		
Patient reported outcome scores for Knee replacement surgery	Data not available	Data not available	Data not available	Data not available	N/A		
28-day readmission rate for patients aged 0-15 Source: HED Jan 2025 to December 2025	21.20%	19.00%	18.80%	17.10%	10.20%	3.70%	21.90%
28-day readmission rate for patients aged 16 or over Source: HED Jan 2025 to December 2025	7.60%	7.10%	7.30%	6.90%	8.10%	4.00%	13.10%
Paediatric readmission rates have increased and remain above the national average. This is likely due to the work undertaken in the department to avoid unnecessary hospital stays, where it is clear there is no intervention needed that cannot be provided in the community. Careful explanation of the signs to look out for that might require reattendance at the hospitals, along with written information, is given to families. This may be supported by a temporary 'open access' arrangement to the ward, by the Hospital at Home team.							
VTE (annualised) The percentage of patients who were admitted to hospital and who were at risk assessed for venous thromboembolism during the reporting period.	82.70%	78.10%	81.20%	78.20%	N/A		
The threshold for completion of VTE was within 24 hours of admission prior to 2024/25, this was changed to within 14 hours of admission from 2024/25.							
Data for 2021/22 is not available due to the implementation and stabilization of the electronic patient record.							
C. Difficile Rate per HES 100,000 bed days**	Total: 32.8 Hospital onset: 24.5 Community onset: 8.3	Total: 41.6 Hospital onset: 33.1 Community onset: 8.5	Total: 40.7 Hospital onset: 31.7 Community onset: 9.0	Total: 51.4 Hospital onset: 40.4 Community onset: 10.9	N/A		
C. Difficile rates have increased in this reporting period. This increase has been seen across our 4 neighboring organisations. Each case has a multi-disciplinary investigation to establish if there is any learning. There has been no hospital transmission of C. Difficile							
Number of Never Events	4	2	0	5	N/A		
Never Events are serious incidents that should not occur as there are strong systemic national policy and frameworks in place to prevent them from happening. Each of these incidents have been investigated under the NHS Serious Incident Framework and reported to the Strategic Executive Information System (StEIS).							
Rate of Never Events per HES 100,000 bed days	2	1	0	3.2	N/A		

Patient Safety Response Framework (PSIRF)

The Trust has continued to embed the Patient Safety Incident Response Framework (PSIRF) during the reporting period, with extensive training, communication, education and learning platforms to support this new way of responding to incidents. The Trust is now fully utilising the PSIRF learning response templates to identify learning and take mitigating actions to reduce risk and harm in real time.

The Trust continues to see a strong incident reporting culture, with timely escalations and oversight daily. For all moderate and above harms, these are monitored and presented to a weekly Patient Safety Oversight meeting, providing a robust governance process for oversight, challenge and transparency. There are a variety of Trust wide forums, for Learning and Sharing, that are available for all members of staff.

The Trusts new Patient Safety Incident Plan has been endorsed by the Integrated Care Board Central Patient Safety Team.

The Trust continues to report Patient Safety Incidents to the Learning from Patient Safety Events (LFPSE) platform. All patient safety incidents reported on Datix are simultaneously uploaded to the

LFPSE platform.

A Quality, Safety and Experience Strategy has been developed and was launched in June 2025, describing core, corporate and divisional priorities, with a clear governance process for reporting in place. Patient and family engagement is paramount, and we include patients and their families in our investigation, making sure any questions they have, are answered. Reports and investigations are shared and patient and family meetings occur frequently to allow for face-to-face discussions regarding care and concerns.

The Trust is preparing to upgrade the Datix system to LFPSE Taxonomy 6, which will enable the Trust to cease reporting Patient Safety Incident Investigations to StEIS (Strategic Executive Information System)

During 2025/26, 9 patient safety incidents requiring a Patient Safety Incident Investigation (PSIIs) were reported including:

- Four Never Events – three under the category of 'Retained Object' and one under the category of 'Wrong Site Surgery'
- Three PSII were undertaken under the National PSIRF category for PSII – Unexpected Death
- A PSII was undertaken following a delay in diagnosis of cancer
- A cross organisational PSII was undertaken relating to the transfer of care of a critically ill patient

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

The original National Safety Standards for Invasive Procedures (NatSSIPs) were published in 2015 and built on the WHO (World Health Organisation) Safe Surgery checklist in 2009. NatSIPPs and Local Safety Standards for Invasive Procedures (LocSSIPs) were developed to allow organisations to standardise and harmonise key elements of procedural care and reinforce the importance of education for safety. NatSSIPs 2 are intended to share the learning and best practice to support multidisciplinary teams and organisations to deliver safer care.

NatSSIPs 2 consists of two inter-related sets of standards:

- The Organisational Standards are clear expectations of what Trusts and external bodies should do to support teams to deliver safe invasive care.
- The Sequential Standards are the procedural steps that should be taken where appropriate by individuals and teams, for every patient undergoing an invasive procedure.

The Trust has an established NatSIPP steering group with the aim to revise patient safety checklists to reflect NatSIPPs 2 guidance. These are being developed in a format to support integration within the electronic patient record. The provision of assurance in relation to safety checks completed across all areas that undertake invasive procedures has been completed in radiology, endoscopy, theatres, cardiology and ophthalmology. The consistent utilisation of LocSIPPs across all areas is currently being evaluated with local solutions developed to support patient safety.

Infection Prevention & Control

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

Across 2025/26 we have seen an overall reduction of 14% in reportable HCAI's including:

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

In contrast to the wider West Cheshire health economy, the prevalence of community cases of *E.coli* (10%), *Klebsiella* (63%) and *MSSA* (28%) bloodstream infections have increased in comparison with the previous year. There have been reductions though in the community prevalence of *C.difficile* infections with almost 50% fewer reported cases compared with the previous year.

The primary driver on reducing *C.difficile* has centered around standardising the clinical management and investigation of patients with suspected infective diarrhoea to ensure appropriate sampling, this has reduced the number of incidental cases identified from inappropriate testing.

The Trusts focus on reducing both *E.coli* and *Klebsiella* bloodstream infections has been on the key risks that lead to these infections developing, targeting work on strengthening the processes around the prevention and management of urinary tract infections.

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

The Infection Prevention Control (IPC) team have continued to deliver an enhanced programme of audit and education, including hand hygiene roadshows, promotion of 'World Patient Safety Day' and 'World Hand Hygiene Day' all which have played a key part in both advocating best practice and providing assurance of compliance with the basic principles of IPC.

Responsiveness to Patients Needs

There are multiple platforms, systems and processes for the Trust to receive feedback from patients, families and service users. Actions are taken, in response to feedback, and as a Trust we are improving triangulation and responsiveness to feedback in a meaningful way, that promotes learning, changes in practice and a change in culture that embraces patient and family experience to its fullest.

The platforms include:

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

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

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

There have been a variety of Patient Experience groups over the previous year to monitor progress and drive the patient and family experience agenda. It is recognised that improvements are required regarding improve stakeholder and patient and family engagement inclusion in these forums.

A newly developed Patient Experience Framework has been developed which will provide clarity of expectations and will support the Trusts Patient and Family Experience Vision. Clear expectations, timeframes and a reporting structure that will include the patients voice and engagement with both internal and external stakeholders are articulated in the report.

The divisions will be tasked with undertaking a patient engagement event/ review each month and reporting this to a central point to allow for information gathering and thematic analysis. A new committee will be formed, meeting quarterly, including both internal and external stakeholders, and sharing information with outcomes and actions from the previous quarterly engagement events.

The Trust's ward accreditation program embeds patient and family experience as part of the review process, with specific questions and the patient voice as an integral part of each ward review.

Patient Surveys

The Trust takes part in a series of national patient surveys as required by the Care Quality Commission (CQC) and NHS England for all NHS Acute Trusts in England.

During this reporting period, the Trust received results for the Inpatient Survey 2024 in which we scored 'about the same' as other trusts in 33 questions. It did identify areas for improvement where we scored worse than other Trusts and they relate in the main to discharge processes.

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.

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.

A total of ninety-seven service users (38% response rate) participated in the 2025 CQC National Maternity Survey. The Countess of Chester's results are broadly in line with national peers, with most indicators rated "about the same."

Key strengths include:

- Labour and Birth: Strong performance in compassionate care, multidisciplinary teamwork, and partner involvement, with five questions scoring significantly above the national average.

Key improvement priorities include:

- Antenatal Care: Lower scores for choice and personalized information, mental health support, and staff awareness of medical history.
- Postnatal Ward Care: Challenges with partner presence, discharge processes, and access to staff and information

Friends and Family Test

The Trust also asked patients and service users to rate their overall experience by completing the Friends and Family Test (FFT). The purpose of these surveys is to understand what patients think

of healthcare services provided by the Trust, and actions plans are developed to drive improvements.

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

During this reporting period responses from inpatients accessing services were just short of the 94% positive response rate national target and on occasions the inpatient positive responses were better than the national average. In the Emergency Department patients acknowledged the challenges in the Emergency Department care but positive feedback regarding communication and attention they received from staff was regarded as the most important component of their care. The Emergency Department exceeded the national target of positive responses in over 6 months of the year; however, the Trust acknowledges that improvements are still to be made, including overall response rates.

Some of the feedback from FFT:

- Staff very helpful and knowledgeable.
- Didn't have to wait to be seen.
- Next appointment booked before leaving the department.
- My husband attended A&E after an episode of rapid heart rate after mitral valve surgery.
- We were triaged quickly and from there we attended rapid assessment who noted my husband was in AF and was sent through to resus. There a Dr was waiting and he monitored my husband with an ECG, and bloods were taken.
- Everyone we came into contact with were kind, caring and professional. At a scary time, they were calm and friendly and put us at ease. We couldn't fault the care we had. A huge thank you.
- Although it took over 10 months to get the appointment, on the day service was prompt with very little waiting around. Practical advice was given and a follow up timeframe if needed
- All feedback is regularly reviewed by service and clinical managers. Patients regularly report that staff are the most important component of their care.
- Staff could not do enough for you! Everything was explained clearly and I was asked each time if I had any questions. Everything was double and treble checked and explained why you do this. It was very reassuring!
- Yes, very good care. Both during before and after my procedure! Staff made sure that I was ok before walking me to my husband to make sure that someone was taking care of me and that I left with care instructions and telephone numbers should I need to call of I have any problems

External partners

The Trust has also engaged with external partners about the quality of care provided. For example, between July and September 2025, 14 patient experiences were shared with Healthwatch regarding services at the Countess of Chester Hospital. Feedback spans a broad range of departments, including dermatology, rheumatology, ED, plastic surgery, mental health, ophthalmology, and endoscopy. It reflects a mixture of serious concerns about communication and waiting times alongside examples of excellent and compassionate care.

Healthwatch concluded that The Countess of Chester Hospital continues to receive mixed feedback from patients. While staff are consistently praised for their kindness and professionalism, systemic

issues (particularly communication failures, treatment delays, and inconsistent care coordination) remain significant barriers to patient satisfaction and safety. A renewed focus on timeliness, communication standards, and patient-centered planning will be key to improving experiences and rebuilding public confidence in the Trust.

Throughout the year, the complaints team has maintained a strong focus on improving learning and responsiveness across the organisation. Monthly attendance at the Trust's Safety Surveillance and Learning and Sharing meetings has enabled the collation and thematic analysis of incidents and complaints, which are shared with each division to support learning and service improvement. In addition, patient stories are gathered monthly and shared in various forums to highlight the patient experience and support a culture of compassionate care.

The Patient Advice & Liaison Service (PALS) team work closely with the divisions, holding weekly meetings with divisional leads to support timely response to complaints and concerns. It should be acknowledged that complaints are becoming more complex and family meetings are often held to support understanding and closure of complaints. Themes, learning and subsequent actions identified were:

- Communication Failures & Lack of Clear Information
- Delays / Access Issues & Care Coordination Problems,
- Concerns About Quality-of-Care Safety.
- Administrative Errors
- Prolonged Waits / Repeated Rescheduling.

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

Creating the Countess Culture

Creating and sustaining the right culture is central to everything we do at the Countess of Chester. Culture is the foundation of our success – shaping how we care for one another, how we perform, and how we deliver outstanding care to our patients and communities. It reflects both how people feel and how we behave. A positive culture is one that balances compassion with candour – ensuring kindness and respect are matched with clarity, consistency, and follow-through. Our aim is to foster a psychologically safe environment where people can speak up, learn from mistakes, and take responsibility with confidence and support.

To achieve our vision of being an outstanding place to work, we must build a culture where kindness, respect, and accountability sit side by side, and where every member of Team Countess feels safe, heard, and empowered to make a difference.

Over recent years, we have taken significant steps to strengthen leadership visibility, improve staff engagement, and promote civility and respect through initiatives such as our Civility Statement, Culture & Civility Handbook, and the High Performing Teams (TED) programme. These have helped to rebuild confidence and improve engagement. However, we acknowledge that deep-rooted cultural challenges remain. Inconsistent behaviours, variable accountability, and limited psychological safety in some teams continue to affect how people experience work.

Our data and staff feedback show that we are a culture in transition. To sustain progress, we must move beyond surface-level interventions. We will take a structured and evidence-based approach to developing the Countess Culture. Guided by the King's Fund Culture Framework and

the NHS Culture and Leadership Programme (CLP), we will focus on strengthening six key characteristics of a healthy culture: vision and values, goals and performance, support and compassion, learning and innovation, effective teamwork, and collective leadership. This approach will be practical and embedded within our existing systems and processes, including leadership development, appraisals, team engagement, and staff experience processes, ensuring every leader models the values and behaviours we expect.

We will build capability across our organisation to hold constructive, compassionate conversations that promote both learning and accountability. Visible leadership, proactive listening, and partnership working with Staff Side and staff networks will remain at the heart of this work.

Equality Delivery System

In August 2022, NHS England published a revised version of the Equality Delivery System (EDS). This is a tool that requires NHS organisations to collate evidence against several outcomes relating to Equality, Diversity, and Inclusion (EDI) and health inequalities. The assessment has both employee and patient-facing elements. Evidence is then required to be graded by a range of key stakeholders. The Trust reported its EDS assessment report for 2025/26 in February 2026.

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

- Nutrition and Hydration
- Birthing Debriefs/Maternity and Neonatal Voices
- Emergency Department

Under Domain I the Trust scored as Developing. Under Domains II and III, the areas of Workforce Health & Wellbeing and Inclusive Leadership are assessed. The Trust has maintained their EDS grading in year for Domains II and III, demonstrating that they are achieving activity against 7 out of 8 outcomes. Where the Trust has been graded as developing activity in relation to staff advocacy, the process recognised the in-year improvement in staff survey advocacy scores (2024 results), however felt that there needed to be more sustained improvement in line with the technical guidance before a higher grade could be applied

The EDS Overall rating for the Trust was a Developing rating, with recognition that the Trusts was one point from recurring an Achieving rating.

EDS Organisation Rating (overall rating): 21 (Developing)
Organisation name(s): Countess of Chester Hospital NHS Foundation Trust
Those who score **under 8,** adding all outcome scores in all domains, are rated **Undeveloped**
Those who score **between 8 and 21,** adding all outcome scores in all domains, are rated **Developing**
Those who score **between 22 and 32,** adding all outcome scores in all domains, are rated **Achieving**
Those who score **33,** adding all outcome scores in all domains, are rated **Excelling**

To drive improvement for 2026, for staff with protected characteristics, the Trust has identified a series of targeted actions informed by the evidence review, wider EDI metrics and the EDS technical framework.

For patients the newly developed Patient Experience Improvement Framework will support the improvement required for the Trust to achieve an achieving activity score. There are clear governance and monitoring frameworks in place.

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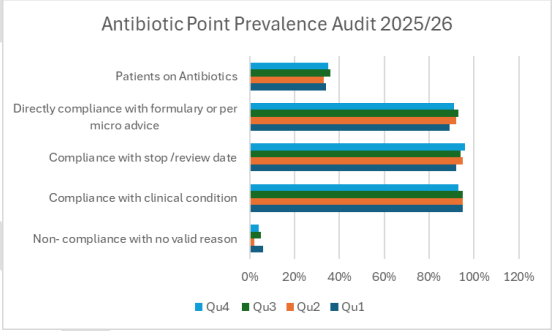
Part 3: Other information

3.1 Overview of progress made against our 2025/26 Quality Priorities

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

Delivering Safe Services

Priority	Measure of success	Achievement	Progress update
Priority1: Reduce the incidence of Clostridium difficile (Cdiff) & E.coli healthcare associated infections Data collection via the national HCAI data capture system.	Achieving greater than 90% compliance with antibiotic formulary prescribing Reduce by 10% the number of Cdiff cases that were inappropriately sampled		The Trust has consistently achieved the 90% compliance with antibiotic formulary prescribing for 2025/26.  <u>Clostridium difficile</u> C.difficile sampling: Year-end position for 2025-26: The average for inappropriate sampling (patients who subsequently tested C.difficile toxin positive & had been receiving laxatives) was 13% (9/67). This demonstrates a significant reduction in comparison with 2024-25 when 36% of cases had received laxatives prior to specimen collection. Annual NHSE threshold of no more than 73 cases within the year was also achieved with 67 cases reported in 2025-26. <u>E.coli</u> Position at end for 2025-26 (v threshold trajectory) was +9 cases, with a total of 60 cases reported in the year v NHSE annual threshold to not exceed 51 cases. There was an overall reduction (of 1 case) across the year in comparison with 2024-25 when 61 cases were reported.

<table>
<tr><th>Priority</th><th>Measure of success</th><th>Achievement</th><th>Progress update</th></tr>
<tr>
<td>Priority 2:
Reduce the incidence of inpatient falls.

Data collection via Datix Incident Reporting System.</td>
<td>Reducing the number of inpatient falls by 10% from 2024/25 baseline

Achieve greater than 90% of patients to have a documented falls risk assessment within 6 hours of hospital admission</td>
<td>2024/25 Falls reported:1,079

2025/26 Falls reported:1,007</td>
<td>The Trust has achieved a 7% reduction in falls from the baseline of 2024/25. The Trust reported there were 1007 falls against a reduction target of 1079. 71.5% of the falls reported during this period were reported as ‘no harm’.

Ongoing improvement work has supported safer mobility with the Trust linking with ‘Health box’ and ‘Steady on your Feet’ to promote improved mobility and awareness of safety hazards in the home. The Same Day Emergency Care (SDEC) team have supported falls reduction utilising the prevention bus which operates in the community.

Compliance with risk assessment of patients on admission to hospital has improved over the last 12 months, demonstrating a 25.5% improvement in compliance over the last 12 months.

<table>
<tr><th>Falls Assessment</th><th>ED</th><th>Inpatients</th></tr>
<tr><td>Assessment within 6 hours</td><td>71.1%</td><td>93.4%</td></tr>
<tr><td>Assessment within 24 hours</td><td>96.1%</td><td>97.3%</td></tr>
</table>

Inpatient falls and local assessment results are discussed monthly at the Safer Mobility meeting. The use of electronic technology has been embedded across the organisation to allow for early detection of gait changes and rapid alerts to caregivers.</td>
</tr>
</table>

<table>
<tr><th>Priority</th><th>Measure of success</th><th>Achievement</th><th>Progress update</th></tr>
<tr>
<td>Priority 3: Reduce the incidence of Hospital Acquired Pressure Ulcers (HAPU)

Data collection via Datix Incident Reporting System.</td>
<td>•95% of patients will have a skin integrity assessment within 6 hours of hospital admission

•Reduce the incidence of HAPU by 20% from the 2024/25 baseline</td>
<td></td>
<td>The Braden Scale is an evidence-based tool used to assess a patient's risk of developing pressure ulcers by evaluating six subscales: sensory perception, moisture, activity, mobility, nutrition, and friction/shear.

Braden compliance 2025/26:
<table>
<tr><th>Braden compliance</th><th>ED</th><th>Inpatient</th></tr>
<tr><td>Within 6hrs</td><td>66.5%</td><td>91.9%</td></tr>
<tr><td>Within 24hrs</td><td>95.3%</td><td>96.6%</td></tr>
</table>
Over the last year the 95% overall target of a skin assessment has not been achieved consistently within 6 hours but has been achieved over a 24-hour period and overall. There has been a 26.9% improvement in compliance in Braden compliance over the last 12 months. It is acknowledged that there are still areas for improvement and with the body maps now being available within the electronic patient records, the expectation that continued improvements in compliance will be achieved.

Although the internal target of a 20% reduction in HAPU has not been achieved, we can demonstrate an 8.25% reduction in Category 2 HAPU, which is extremely positive.

The Moisture Associated Skin Damage (MASD) pathway was launched in July 2025.

Check, Protect, Refer (CPR) for feet has been rolled out on the Care of the Elderly wards.

All Category 3 and Category 2 HAPU are reported weekly to the Director of Nursing and Deputy Director of Nursing, Quality and Governance and now divisional managers and Heads of Nursing weekly.

The weekly Pressure Ulcer Review meeting continues with the biggest trend being</td>
</tr>
</table>

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Priority	Measure of success	Achievement	Progress update
			delays in dynamic mattresses in ED which is currently being rectified through an allocated area for a "Prevention Station" ensuring that a bedframe and dynamic mattress is available on arrival into the Trust. The key consistent. message across the Trust is the need for prevention. Investment has been made into ED with 35 new Trezzo mattresses. The TV Skin MEG audit is completed monthly and allows for visibility at ward level and real time feedback of issues. Routine communication with ward managers highlights key areas for improvement and offering support. The service also provides an annual conference which 120 delegates attended last year along with bespoke training sessions for clinical areas such as maternity.

Delivering Effectiveness Services

Priority	Measure of success	Achievement	Progress update
Priority 1: All eligible patients are assessed for risk of deep vein thrombosis (DVT)	All eligible patients will be risk assessed within 14 hours of hospital admission Appropriate prophylaxis will be administered with 14 hours of hospital admission		VTE data collection quantifies the numbers of hospital admissions (aged 16 and over at the time of admission) who are being risk assessed for VTE within 14 hours of admission, to identify those who should be given appropriate prophylaxis based on guidance from the National Institute for Health and Care Excellence (NICE). There is an operational standard of 95% compliance of admitted patients aged 16 and over being assessed for VTE on admission each month. The Trust VTE 14-hour compliance has been improving since December 2025, with the Trust achieving the 95% compliance target in the last week of February 2026. The ordering and administration of VTE within the 14-hour period remains a challenge for the Trust.

Priority	Measure of success	Achievement	Progress update
			Actions are being taken to support improvement: • VTE group reconvened • Education in relation to prevention • VTE incidents reporting • Review digital action plan
Priority 2: All patients with suspected Sepsis are assessed and diagnosed within recommended timeframes .	All patients presenting at hospital will be assessed for the risk of sepsis Patients with a diagnosis of sepsis will receive antibiotics within the recommended timeframes %		The Trust introduced a sepsis screening tool in June 2025 to ensure that all patients with elevated NEWS2 score on arrival at the Emergency Department or as an inpatient were screening for sepsis. Compliance with the completion of this tool is now consistently >95%. The Trust undertakes a fortnightly review of all patients attending ED to assess antibiotic compliance against national standards. This audit is also completed for inpatients on a monthly basis. Compliance with antibiotic administration is variable 50-80% with improvement initiatives being implemented to ensure patients receive timely treatment.
Priority 3: Ensure all patients in hospital remain hydrated.	All patients with a National Early Warning Score of 5 or more will be commenced on a fluid balance chart All patients diagnosed with Acute Kidney Injury (AKI) will commence on a fluid balance chart		The Critical Care Outreach Team (CCOT) undertake a NEWS2 audit across all inpatient areas monthly. Included within this audit is the fluid balance element. Education of staff is undertaken as part of the evaluation process to ensure that any patient with an elevated NEWS score commenced on a fluid balance chart. Local audit data is shared across the organization to ensure visibility and continuous learning. As part of the monitoring of Acute Kidney Injury (AKI) the audit sample examines the number of patients who have been commenced on a fluid balance chart (urine output recorded) within 24 hours of the first recorded AKI alert. Data from May 2025-Jan 2026 demonstrates improved compliance with increasing number of patients audited being commenced on a fluid balance chart. • AKI 3: 70% • AKI 2: 58% A monthly audit and meeting of multidisciplinary team actively initiate actions to improve compliance.

Delivering Kind and Compassionate Services

Priority	Measure of success	Achievement	Progress update
Priority1: Introduction of Patient Safety Partners to support the Patient Safety Incidence Response Framework (PSIRF)	Appointment of Patient Safety Partners Patient Safety Partners integration in quality and safety programmes.		The Trust has focused on strengthening its Patient and Family Experience Strategy during 2025/26. And in April 2026 the Patient Experience Improvement framework was launched. The introduction of Patient Safety Partners was paused whilst the improvement framework was developed. The aim is to embed continuous patient experience improvement across all divisions through quarterly activity, shared learning, and partnership working, ensuring patient voice informs service improvement and reduce inequalities in experience and access. The divisions will are now tasked with undertaking a patient engagement event/review monthly and report to a central point to allow for information gathering and thematic analysis. Each quarterly activity should result in at least one improvement action or learning outcome. The Trust will actively seek to source Patient safety Partners and has engaged with other organisations who have successfully embedded the Patient Safety partner role.
Priority 2: Implementation of Martha's Rule	Trust wide implementation of: Call for Concern Introduction of Patient Wellness Questionnaires	Call for Concern successfully embedded on all inpatient wards. Patient Wellness Questionnaire trialed across trust and implemented in one ward area.	Call for Concern (C4C) is a 24/7 patient safety service, often part of Martha's Rule, allowing patients and families to request an urgent review from a critical care team if a patient's condition worsens and concerns are not being addressed by the ward staff. This process has been embedded across the Trust with data collection and analysis being undertaken to identify themes and areas for improvement. Work is underway with the Patient Advice & Liaison Service (PALS) to understand the non-clinical themes that have arisen from calls. The Patient Wellness Questionnaire has been tested across all inpatient areas to assess the ease of use and value to patients, relatives and staff. The questionnaire has now been incorporated into the electronic patient record to allow daily collection and collation of patient scores. A trial is currently underway in

			several wards across differing specialties. There has been no reported increase in referrals to the critical care outreach team at this time following the implementation process.
Priority 3 : Improve the overall experience for patients the maternity and children's departments	<u>Paediatrics</u>: Parents felt that the ward was suitable for the child age group Parents felt the room or ward was clean <u>Maternity:</u> Found partner was able to stay with them as long as they wanted		<u>Paediatrics</u> We continue to receive excellent feedback from our children and families regarding the environment in the new Women and Children's build. The new facilities have been well received by both children and the parents/carers. We now have 22 individual rooms all with accessible ensuite bathrooms and a pull-down parent/carers bed. This has had a positive impact on the patient and families stay. We can offer continuous monitoring to 12 of those rooms and all rooms are climate controlled. We have excellent play facilities for all ages and a sensory room. Parents/carers as well as having beds now have their own sitting room where they can prepare food and have a hot drink. We also provide meal vouchers for parents/carers and this is thanks to Sophies Legacy, a charity that ensures all parents and carers have access to a hot meal whilst their child is an inpatient. We have name boards in each room, displaying the names of those nurses and clinicians who are looking after them. Feedback for staff remains very positive, with children made to feel at ease and supported through their stay. We continue to monitor these metrics through friends and family data, Maternity & Neonatal Voices Partnership (MNVP) feedback, daily senior nurse walk arounds, engaging with children and their families to identify any issues. Additionally, we continue to monitor any concerns or complaints received. Infection Prevention audits continue, the results of which are very positive. We also act upon feedback / issues highlighted by families and the Infection Prevention & Control (IPC) team. <u>Maternity</u> • The Women and Children's new build opened September 2025

			• Visiting hours for partners and birthing partners increased to 24 hours a day 7 days a week, from September 2025 • The introduction of pink wrist bands for all partners and birthing partners supported newborn security and made it clearer to identify visitors entering and exiting the ward environments • Visitors remain signing in and out of the ward area with the support of a ward clerk • All single side rooms have en-suite facilities and a pull out bed • Kitchen / beverage areas available to make refreshments • Patient feedback has improved in relation to this improvement

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3.2 Performance against the relevant indicators and performance thresholds

Indicator	Target	Performance	Explanation
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	**60% March 2026** **<1% March 2026**	**63.8%*** March 2026 1.2%* March 2026 *unvalidated figures; March RTT submission will be made 28/04/26	The Trust delivered improvements on its RTT 18-week compliance (starting the year on 48.5%) and delivered end of year performance above target. Similarly, the Trust significantly reduced its RTT long wait pathways; reducing the >52 week % from 6.6% at the start of the year to 1.2% by year end.
A&E: maximum waiting time of four hours from arrival to admission/ transfer/ discharge ED: higher number of patients admitted, discharged or transferred from ED within 12 hours across 25/26 compared to 24/25	**78% March 2026** **12 hours breaches <25.84%**	**61.2% March 2026** **22.33% Average for 25/26**	Whilst small improvements in 4-hour performance have been made within 25/26 compared to 24/25 (average performance over 25/26 was 2.1% higher than previous year), the Trust still finished the year well below the national standard of 78%. The Trust did reduce the average number of 12 hour breaches by 3.51%. However, it remained an outlier in performance compared with peers. In 25/26 attendances to ED were 7% above previous year. In addition, No Criteria To Reside (NCTR) averaged 21.7%. Both these factors significantly contributed to increased congestion within the ED.
All cancers: 62-day wait for first treatment	**75 %**	**76.6%** (February 2026, latest figures)	Whilst the Trust has not delivered against the 75% target, consistently during 2025/26, we are working to improve this and continue to improve performance. We have continued to perform significantly better than the national provider's average e.g. Feb 26: COCH- 76.6%, national average- 67%. Whilst all cancer tumour sites have ongoing improvement plans to support improved access to treatment, specific focus continues to be paid to supporting access to Urology and Gynaecology cancer services.
Maximum 6-week wait for diagnostic procedures			*Unvalidated position will be available on Wednesday 22nd April 2026.*

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3.3 Progress against seven-day hospital service

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

The four key standards are:

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

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

The current position at the Trust is as follows:

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

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

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

- Microbiology: available on weekdays and weekends through formal arrangement. Ultrasound, MRI, and CT: available weekdays and weekends through a mix of on and off-site formal arrangements
- Echocardiography: available on weekdays, not routinely at weekends.
- Emergency diagnostic endoscopy access 7-days a week with a Gastroenterologist on-call

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

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

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

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

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

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3.4 Freedom to Speak Up (FTSU)

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'. It examines leadership, management and governance that assure the delivery of high quality and person-centered 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.

FTSU Activity: April 2025 – December 2025

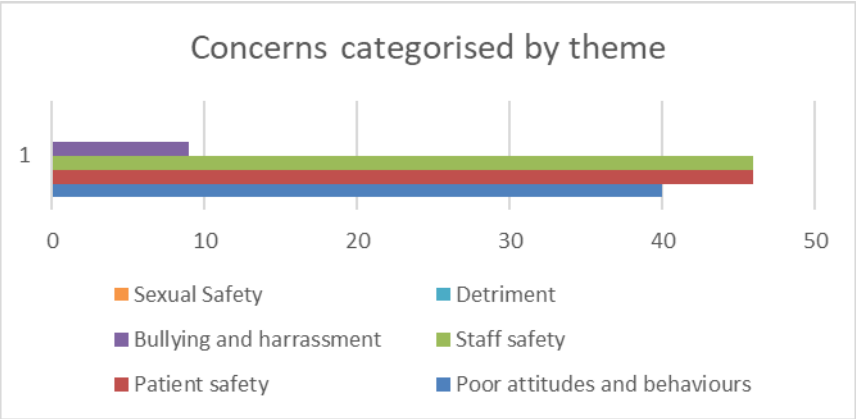
The Trust has several safety reporting channels such as speaking directly to line managers, incident reporting and team and Trust safety huddles. Issues raised in other channels are not logged as FTSU unless referred to or raised directly to the FTSU Guardian.

During the reporting period 85 concerns were raised, a reduction of 11% for the same period last year.

Of those reporting concerns over 96% were raised by colleagues in non-management positions. 87% of those colleagues reported that they were satisfied with the support offered through FTSU, however this does not indicate satisfaction with the outcome. The remaining 13% did not respond to the survey.

Q3 saw the highest number of concerns (41), however 16 of those related to the same concern. In Q1 76% of concerns were raised by colleagues in non-clinical posts, whilst in Q2 and Q3 only 10% were raised by the same cohort.

Concerns are categorised in line with Nations Guardian Office recommendations. It is important to recognise that most concerns contain more than one element.



This year we have included a category for concerns that report an element of sexual safety. This feeds into the People & Culture Sub-Committee.

Other Key Observations:

- All concerns during this period have been concluded with agreement from those that raised the concern.
- Nurses and clinical support staff raise more concerns than any other staff group, a similar pattern to other years.
- Only 3 concerns were reported anonymously, a reduction of 2 from the previous year.

FTSU Mandatory Training

'Speak Up' is now at 95.99% with only Medical and Dental (92.54%) and Estates and Facilities (78.57%) recording less than 95%. 'Listen Up reached 92.15% an increase from 89.94% when last reported. Medical and Dental and Estates and Facilities compliance has significantly increased, however it still does not meet the target of 90% set within the FTSU action plan. 'Follow Up' mandated for Board members currently stands at 100% compliance.

FTSU Champions

The network of over 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. Champions training is held three times a year and facilitated by the FTSU Guardian.

Nine Divisional Hubs have been established, bringing together champions working in similar areas. This strengthens peer support, local knowledge and learning. Hub details have been shared with Divisional Directors for dissemination and uploaded onto the FTSU intranet page.

Data relating to concerns within each division will be shared quarterly with Directors to help triangulate themes, trends and learning with those concerns shared with managers.

The network continues to represent diversity and works collaboratively with the EDI agenda. Champions are working towards 100% compliance with Sexual Safety training by the end of February. Data is now collected from individuals who speak up regarding gender, disability and ethnicity and this will be shared quarterly with the EDI lead.

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3.5 NHS doctors and dentists in training

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

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

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

Statement from NHS Cheshire and Merseyside Integrated Care Board – Response to Quality Account April 2025 to March 2026

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Statement from Healthwatch Cheshire

Healthwatch Cheshire welcomes the clear focus within the Quality Accounts on improving patient safety, patient experience and access to care across the Countess of Chester Hospital NHS Foundation Trust. The report demonstrates a strong commitment to partnership working across hospital, community and care home settings, with a continued emphasis on supporting people to receive care closer to home wherever possible. Initiatives such as care home staff training, the introduction of local diagnostic services, improved respiratory support for children locally, and developments in virtual access for autistic patients and people with additional needs are particularly positive from a patient and community perspective. Healthwatch Cheshire has heard directly through Enter and View activity and patient feedback how valuable joined-up services, compassionate staff support and improved local access to care are for patients, families and carers.

The report also highlights a number of significant achievements around patient safety, cancer diagnosis times, infection prevention, falls reduction and personalised care. The Trust should be commended for recognising the importance of involving patients and families more directly in safety investigations and care planning, alongside the development of the Patient Engagement Framework and Patient Wellness Questionnaire linked to Martha's Rule. The strong emphasis on kindness, dignity and compassionate care reflected within patient survey results is encouraging, particularly given the ongoing pressures facing acute services nationally.

Healthwatch Cheshire also welcomes the Trust's acknowledgement of the areas where further improvement is required. Feedback received from patients continues to identify concerns around communication, discharge planning, waiting times, care coordination and administrative processes. It is positive that the Trust recognises these themes and has identified them within future priorities and improvement plans. From a patient perspective, maintaining clear communication, involving patients and families in decisions, and ensuring people feel informed and supported throughout their care journey will remain essential in improving confidence and overall experience. Continued engagement with patients, carers, community organisations and external partners will be important to ensure that improvement work remains focused on what matters most to local people.

Diane Brown 14/05/26

Statement from Health Scrutiny Committee, Cheshire West and Chester Council

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

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

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

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

- The content of the Quality Report meets the requirements set out in the NHS foundation Trust annual reporting manual 2025/26 and supporting guidance Detailed Requirements for Quality Reports 2025/26
- The content of the Quality Report is not inconsistent with internal and external sources of information including.
    - Board minutes and papers for the period April 2025 to March 2026
    - Papers relating to quality reported to the board over the period April 2025 to March 2026
    - feedback from commissioners,
    - feedback from Governors,
    - feedback from local Healthwatch organisations
    - feedback from Overview and Scrutiny Committee
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
    - the 2024 national patient survey, published in 2025
    - the 2025/26 Head of Internal Audit's annual opinion over the Trust's control environment
    - Care Quality Commission Inspection, published in 2025
- The Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered.
- The performance information reported in the Quality Report is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice.
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- The Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report. By order of the board 30th June 2026:

Jane Tomkinson OBE — Chief Executive

Neil Large — Chairman

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