Countess of Chester Hospital NHS Foundation Trust

Committee Chair's Report

9th November 2026 via Microsoft Teams

Committee	Finance & Performance Committee
Chair	Non-Executive Director, Mr M Oldham

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)*

- Month 6 Finance position confirming delivery of plan but only with non-recurrent mitigations. Key drivers to the year to date position are undelivered Cost Improvement Programme (CIP) £5.6m; industrial action costs £0.5m; and band 2 to 3 pressures £0.2m. Forecast remains to deliver the plan, notwithstanding there is a significant risk (circa £5-6m) that will need to be mitigated across the rest of the year.
- Transformation, Productivity, and CIP update confirming progress against the annual CIP target of £25.4m. The in-year CIP progress remains the most significant risk. A further update on delivery of the CIP action plan was provided including expectations, enablers from digital programmes, training, and risk aversion. Committee requested clarity on the tactical actions being implemented to mitigate the gap for the next meeting.
- Better Practice Payment Code performance deterioration following the transition to a new general ledger and the additional controls in place. An improvement plan and monthly trajectory has been established to return to 95% compliance by the end of April 2027.
- Committee approved the cash application for December 2026 circa £9m with approval delegated from the Board of Directors in September 2026. A further cash application is expected to be needed in March 2027.
- Digital and Data priorities and capacity pressures discussed
- Premises Assurance Model 2025/26 paper provided an overview of the assessment and return submitted to NHS England (NHSE) in September 2026. The paper included context to the areas requiring investment and the plan to improve compliance in these areas. Committee asked for further assurance on the hard FM non-compliance areas, risks and specific plans for actions.

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

- Winter plan presentation recognising this has been approved at the Board of Directors prior to NHSE submission.
- Emergency Preparedness Response & Resilience (EPRR) Annual Report demonstrating substantial compliance and a continued improved position of compliance with the breadth of core standards.
- Reviewed the operation performance through the Integrated Performance Report (IPR). Key challenges are significantly increased Emge nary Department (ED) attendances; continued high level of Non-Criteria to Reside (NCTR) patients and waiting list size against plan. Actions being progressed through new strategic system group and increased validation of the waiting list.
- Digital and data strategic programme update. This included the roll out of Lyrebird; Artificial Intelligence (AI) waiting list solution; and Electronic Patient Record (EPR) optimisation. Also contract extensions for DoctorDoctor and Teletracking. Risk

continues to be capacity challenges as priorities and additional requests continue to be made.

- Senior Information Risk Owner (SIRO) report including cyber security and alerts; extensive use of NHS England Cyber services; Freedom of Information (FOI) request and response compliance levels; and IG mandatory training compliance which has improved to 87%.
- Anchor Institution Annual Report 2025/26 bringing together an overview of delivery of the green plan, social value, prevention pledge and communities and partnerships.
- Received Chairs reports from sub committees and reporting groups.

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

- Request for FOI benchmarking remains open as priority focussed on responding to continued high levels of FOI requests.
- Planning approach for 2027/28 has commenced building on work previously undertaken to develop the 3 year Medium Term Plan, reflecting current performance and 2028/29 national expectations. National guidance and timetables awaited including Board assurance requirements. Committee keen to see budget setting guidance and CIP process as part of this.
- Presentation received on non-elective pressure and impact on finance and performance articulating the data and understanding of the increased demands, tangible productivity improvements and ongoing challenge in demonstrating this regionally and nationally. The Committee discussed the importance of benchmarking data to support the narrative and opportunities.
- Received the full business case for project 1 of the investment in energy and carbon measures under the public sector decarbonisation scheme not 4 grant funding and supported this for recommendation to the Board of Directors for approval.
- Commercial efficiency quarter 1 report provided an update on the Trust's median benchmark pricing and the work of the procurement team working with Divisions to review opportunities. Committee requested future sight on quarterly changes and comparisons to show impact and improvement trajectories.
- Approved sub-committee Terms of Reference.

Risks discussed and new risks identified

- Relevant Board Assurance Framework (BAF) and significant risk report noted recognising Quarter 2 BAF review in progress for November 2026 Board of Directors.
- Winter plan risks reviewed as part of the winter plan presentation and as noted at the Board there remains risk to the delivery of this plan including capacity, escalation, Trust mitigations and system partner support.
- Risks in digital and data strategic programme strategic programme update were discussed recognising the potential impact and implications across all areas including transformation, CIP, productivity, quality and safety, people etc. Programme risk management and reporting will need to continue to be further developed and embedded.
- Transformation reporting being reviewed and enhanced to provide further clarity on programme risk management.

Countess of Chester Hospital NHS Foundation Trust

Committee Chair's Report

6th October 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)*

- The Committee met in private session to receive an update regarding the Information Commissioner's Office (ICO) reportable data breach and the associated inappropriate access audit. Members reviewed the findings, management actions and progress to date, together with the wider context arising from NHS England communications and discussions within regional professional networks.

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

- The Committee received the Anti-Fraud Progress Report, noting ongoing work to refresh the fraud risk assessment, deliver fraud awareness training and review relevant policies. Members also received updates on participation in the National Fraud Initiative, fraud allegations and investigations, including three cases currently progressing through the Crown Prosecution Service.
- An update was received on the programme to address overdue policies. The Committee acknowledged the scale of the task and noted the positive progress being made in reducing a significant and longstanding backlog.
- The Committee reviewed the Provider Licence Compliance Checklist, which covered a range of licence requirements. This was considered within the context of the Trust's ongoing NHS England Enforcement Undertakings. Members noted previous Board updates on this matter and the expectation of further communication from NHS England.
- The Committee received assurance regarding the Trust's Freedom to Speak Up (FTSU) arrangements, including the transfer of oversight responsibilities from the National Guardian's Office to NHS England. Assurance was provided on the continued support of Executive and Non-Executive Director leads, the FTSU Guardian and Champion arrangements, training compliance, themes arising from speaking-up activity and reporting mechanisms. Progress was also noted in relation to dashboard and data development, together with the forthcoming Board self-assessment.
- The Committee received the Standing Financial Instructions Annual Procurement Waiver Report for 2025/26, which detailed the 59 waivers approved during the year, the rationale for their use and the ongoing work of the Procurement Team to support divisions and strengthen compliance.
- The Internal Audit Progress Report was reviewed, noting that fieldwork is currently underway in relation to medical staffing, data quality and the escalation of deteriorating patients (sepsis). Members noted that a significant number of audit

reviews are scheduled for reporting to the February 2027 Audit Committee, with some slippage in audit delivery having occurred during Quarter 2. Mersey Internal Audit Agency (MIAA) assured the committee that overall audit delivery for the year remains on track. The report also highlighted forthcoming audit events and briefings.

- The Internal Audit Follow-Up Report provided assurance that recommendations arising from previous audits are being implemented effectively, demonstrating strong progress in the closure of audit actions. Further assurance was provided through the Trust Audit Tracker regarding the completion and monitoring of agreed actions.

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

- The Committee reviewed agendas and Chair reports from recent Assurance Committee meetings, providing insight into committee effectiveness, key areas of focus and the assurances being provided across the governance structure.
- Members noted continued progress against the Risk Management Improvement Plan, including developments to Datix, delivery of training and a review of the Corporate Risk Register. A further update was requested for the next meeting, with the expectation that the remaining actions will be completed and transitioned into business-as-usual arrangements.
- The Committee received the governance organogram, setting out the Trust's committee structure and associated divisional governance arrangements.

Risks discussed and new risks identified

- The Committee reviewed Board Assurance Framework (BAF) Risk 8, including the importance of the Quarter 2 review incorporating learning from the Thirlwall Inquiry across the BAF. Discussion also focused on the regulatory compliance matrix and the identification and management of any remaining gaps as this work continues to develop.

PUBLIC – Board of Directors
24th November 2026

Policy	**Agenda Item 21.**	**Emergency Preparedness Response & Resilience (EPRR) Annual Report**						
Purpose of the Report	Decision		Ratification		Assurance	**X**	Information	
Accountable Executive	Karan Wheatcroft			Director of Governance & Risk				
Author(s)	Emma Binns			EPRR Manager				
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**				
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**
Previous considerations	Full paper to Finance and Performance Committee, November 2026							
Executive summary	The purpose of this report is to provide an executive overview of Emergency Preparedness, Resilience and Response (EPRR) preparedness within the Trust and an update on the compliance with the NHS England EPRR Core Standards 2025/2026. The report highlights the compliance against the 2025/26 Core Standards and the progress made following the 2024/25 submission. The action plan identifies the gaps within our EPRR work programme and provides a focus on the steps to be taken to achieve full compliance.							
Recommendations	The Board of Directors is requested to:- • Note the improvement in compliance with the EPRR Core Standards, the Trust remains at “substantial compliance”.							

	• Note the actions to be taken within the action plan and the progress made in embedding the EPRR agenda across the Trust.

Corporate Impact Assessment	
Statutory/regulatory requirements	CQC/Constitution/other regulation/legislation
Risk	Aligns with the Trust Risk Management Policy and National and Local Community Risk Registers for EPRR.
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics
Communication	Not confidential.

Emergency Preparedness Response & Resilience (EPRR) Annual Report

1.0 Executive Summary

1.1 The annual NHS England EPRR Core Standards Assurance is the minimum standard all providers and commissioners of NHS services are required to meet with regards to their Emergency Preparedness Resilience and Response (EPRR) portfolio. It forms the basis of assurance against NHS Resilience, seeking to understand whether organisations will be capable of maintaining critical services whilst responding to or managing a disruption. All findings ultimately report through to the Department of Health and Social Care (DHSC) and the Secretary of State for Health and Social Care.

1.2 There were 62 standards applicable to the Countess of Chester Hospital (CoCH) for 2025/26. The return along with supporting evidence was submitted in draft to the Cheshire & Merseyside Integrated Care Board (ICB) EPRR Team on the 2nd October and was self-assessed as **"substantially compliant"**. The Annual Self-Assessment Assurance process, which was reviewed by the NHS Cheshire and Merseyside EPRR Team aims to provide constructive feedback to allow for continuous development. The process is achieved by reviewing the evidence submitted against 5 randomly selected core standards from the 62.

The 5 standards that were randomly selected for CoCH were:

Core Standard:	Title:	Standard detail:
9	Collaborative planning	Plans and arrangements have been developed in collaboration with relevant stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.
24	Responder training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role
39	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for

49	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.
59	Decontamination capability availability 24 /7	The organisation has adequate and appropriate wet decontamination capability that can be rapidly deployed to manage self-presenting patients, 24 hours a day, 7 days a week (for a minimum of four patients per hour) - this includes availability of staff to establish the decontamination facilities There are sufficient trained staff on shift to allow for the continuation of decontamination until support and/or mutual aid can be provided - according to the organisation's risk assessment and plan(s) The organisations also have plans, training and resources in place to enable the commencement of interim dry/wet, and improvised decontamination where necessary.

1.3 A letter from the Director of Performance and Planning / AEO at Cheshire & Merseyside NHS was received by the Trust AEO, Karan Wheatcroft on the 30th with some advisory notes. The outcome and feedback are attached at 5.0. An action plan inclusive of recommendations has been included at appendix 1.

2.0 Legal and Regulatory requirements

2.1 The content of this report is directly applicable to requirements listed in:

- Civil Contingencies Act 2004.
- Emergency Preparedness Regulations 2005,
- Emergency Response and Recovery, 5th Edition, 2013, and
- associated Cabinet Office guidance.
- Expectations and indicators of good practice set for category 1 and 2 responders
- Section 46 of the NHS Act 2006, as amended by the Health & Social Care Act 2012.
- Health & Safety at Work Act 1974.
- Health and Care Act 2022.
- Equality and health inequalities legal duties.
- The National Risk Register.
- Skills of Justice NOS.
- Minimum Occupational Standards for NHS Emergency Preparedness, Resilience and Response (**MOS**).
- NHS England Business Continuity Management Framework (Service Resilience).
- NHS EPRR Framework, 2022.
- ISO 22301:2019 Security and resilience – Business continuity management
- NHS Constitution.
- NHS Standard Contract(s).
- NHS Core Standards for Emergency Preparedness, Resilience and Response.

- Other EPRR guidance available on the NHS England website.

2.2 Other applicable items include:

- The Counter Terrorism and Security Act 2015.
- Control of Major Accident Hazards Regulations 2015.
- Radiation Emergency Preparedness& Public Information Regulations 2001.
- Management of Health & Safety at Work Regulations 1999.
- Data Protection Act 2018.
- General Data Protection Regulations.
- Health Protection Legislation (England) Guidance 2010.
- Caldicott Principles.

3.0 EPRR Core Standards

3.1. Whilst there are a total of 73 standards and 11 domains, the applicability is dependent on the organisation's function and statutory requirements. COCH is rated against standards applicable to "Acute Providers". The overall assurance rating is reached via percentage of standards assessed as 'fully compliant'.

3.2. This year COCH was assessed against 62 standards, 56 of which were rated as 'fully compliant' and 3 were rated as 'partially compliant'. The assurance rating remains the same at **substantially compliant.** No standards were assessed as non-compliant.

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	11	11	0	0
Command and control	2	2	0	0
Training and exercising	4	4	0	0
Response	7	7	0	0
Warning and informing	4	4	0	0
Cooperation	4	4	0	0
Business Continuity	10	8	2	0
Hazmat/CBRN	12	11	1	0
CBRN Support to acute Trusts	0	0	0	0
Total	62	59	3	0

3.3. In 2025 the Trust achieved full compliance against 56 standards and partial compliance against 6 standards

The criteria between full, partial and non-compliance of standards is as follows:

Individual Standard Compliance level	Compliance Definition (Main return)
FULLY COMPLIANT	**Fully compliant** with the core standard.

PARTIALLY COMPLIANT	**Not compliant** with the core standard. However, the organisation's EPRR work programme demonstrates **sufficient evidence of progress and an action plan** is in place to achieve full compliance within the next 12 months.
NOT COMPLIANT	**Not compliant** with the core standard. The organisation's EPRR work programme shows compliance will **not** be reached within the next 12 months.

4.0 Process of assurance

4.1 The EPRR Manager completed the self-assessment spreadsheet, and over 160 pieces of evidence was cross referenced and submitted via the NHS Cheshire & Merseyside ICB Resilience Direct depository on the 2nd of October.

4.2 As highlighted above, the Trust have been fully assessed against 5 of the 62 Standards (selected at random as follows:

Domain 3 Duty to Maintain Plans - Collaborative Planning
Domain 6 Training & Exercising – Responder Training
Domain 9 Cooperation – Mutual Aid Arrangements
Domain 10 Business Continuity – Data Protection and Security Toolkit
Domain 11 Hazmat/CBRN – Decontamination capability availability 24 /7

4.3 Further evidence was requested in support of four of the standards, this was uploaded and agreed in the final report.

4.3 The EPRR work programme will be updated to incorporate the recommendations from this process where they cannot be rectified immediately.

4.4 Progress against this workplan will be overseen by the Emergency Preparedness Resilience and Response (EPRR) Strategy Group and the Finance & Performance Committee (F&P).

4.5 Summary of compliance against the NHS England EPRR Core Standards submitted by COCH.

ASSESSMENT			WORKPLAN		
Ref	**STANDARD**	**Self- assessed rating** *Fully compliant = 58* *Partially compliant = 2*	**Action Lead**	Projected date of completion **2026 /27**	 **2027/28**

Domain 1: Governance					
1	Senior Leadership	Fully compliant	CEO		
2	EPRR Policy Statement	Fully compliant	EPRR Manager		
3	EPRR board reports	Fully compliant			
4	EPRR work programme	Fully compliant			
5	EPRR Resource	Fully compliant	AEO/ EPRR Manager		
6	Continuous improvement	Fully compliant	EPRR Manager		
Domain 2: Duty to Risk Assess					
7	Risk assessment	Fully compliant	EPRR Manager		
8	Risk Management	Fully compliant			
Domain 3: Duty to Maintain Plans					
9	Collaborative planning	Fully compliant	EPRR Manager		
10	Incident Response	Fully compliant			
11	Adverse Weather	Fully compliant			
12	Infectious disease	Fully compliant			
13	New and emerging pandemics	Fully compliant			
14	Countermeasures	Fully compliant			
15	Mass Casualty	Fully compliant			
16	Evacuation and shelter	Fully compliant			
17	Lockdown	Fully compliant	EPRR Manager Head of Health & Safety Fire Safety Officer		
18	Protected individuals	Fully compliant			
19	Excess fatalities	Fully compliant			
Domain 4: Command and Control					
20	On-call mechanism	Fully compliant	EPRR Manager		
21	Trained on-call staff	Fully compliant			
Domain 6: Training & Exercising					
22	EPRR Training	Fully compliant	EPRR Manager		
23	EPRR exercising and testing programme	Fully compliant			
24	Responder training	Fully compliant			

25	Staff Awareness & Training	Fully compliant			
Domain 7: Response					
26	Incident Co-ordination Centre (ICC)	Fully compliant	EPRR Manager		
27	Access to planning arrangements	Fully compliant			
28	Management of business continuity incidents	Fully compliant			
29	Decision Logging	Fully compliant			
30	Situation Reports	Fully compliant			
31	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Fully compliant			
Domain 8: Warning and Informing					
33	Warning and informing	Fully compliant	Head of Comms/ EPRR Manager		
34	Incident Communication Plan	Fully compliant			
35	Communication with partners and stakeholders	Fully compliant			
36	Media strategy	Fully compliant			
Domain 9: Cooperation					
37	LHRP Engagement	Fully compliant	EPRR Manager/AEO		
38	LRF / BRF Engagement	Fully compliant			
39	Mutual aid arrangements	Fully compliant			
40	Arrangements for a multi area response	Fully compliant			
43	Information sharing	Fully compliant			
Domain 10: Business Continuity					
44	BC policy statement	Fully compliant	EPRR Manager		
45	Business Continuity Management Systems (BCMS) scope and objectives	Fully compliant			
46	Business Impact Analysis/Assessment (BIA)	Fully compliant			
47	Business Continuity Plans (BCP)	Partially compliant		Q3 - Q4	Q1 – Q4
48	Testing and exercising	Partially compliant			

49	Data Protection and Security Toolkit	Fully compliant	Cyber Security Senior Specialist		
50	BCMS monitoring and evaluation	Fully compliant	EPRR Manager		
51	BC audit	Fully compliant	AEO / EPRR Manager		
52	BCMS continuous improvement process	Fully compliant	EPRR Manager		
53	Assurance of commissioned providers / suppliers BCPs	Fully compliant	EPRR Manager Head of Operational Procurement & Supplies		
Domain 11: HazMat/ CBRNE					
55	Governance	Fully compliant	EPRR Manager Clinical EPRR Lead PDN ED		
56	Hazmat/CBRN risk assessments	Fully compliant			
57	Specialist advice for Hazmat/CBRN exposure	Fully compliant			
58	Hazmat/CBRN planning arrangements	Partially compliant			
59	Decontamination capability availability 24/7	Fully compliant			
60	Equipment and supplies	Partially compliant		Q3 – Q4	
61	Equipment - Preventative Programme of Maintenance	Fully compliant			
62	Waste Disposal Arrangements	Fully compliant			
63	Hazmat/CBRN training resource	Fully compliant			
64	Staff training - recognition and decontamination	Fully compliant			
65	PPE Access	Fully compliant			
66	Exercising	Fully compliant			

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5.0 ICB Feedback on assessed Core Standards

Core Standard	Domain	Standard Name	Standard Detail	Supporting information - including examples of evidence	Feedback	Comments
9	Duty to maintain plans	Collaborative planning	Plans and arrangements have been developed in collaboration with relevant stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.	Partner organisations collaborated with as part of the planning process are in planning arrangements Evidence • Consultation process in place for plans and arrangements • Changes to arrangements as a result of consultation are recorded	Advisory	Recommendation: Acknowledge there is a process available for consultation, however for awareness, the ICB has never received a plan for review as part of the plan consultation as stated in process.
24	Training and exercising	Responder training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	Evidence • Training records • Evidence of personal training and exercising portfolios for key staff	Advisory	Recommendation: Key staff with functional roles require CPD portfolios.

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39	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests Templates and other required documentation are available in ICC or as appendices to IRP • Signed mutual aid agreements where appropriate	Advisory	Recommendation: Update of Incident Response Plan to include reference to and align to the C&M Mutual Aid Agreement along with signposting to applicable templates located within. Review required of CBRNe Plan which begins a reference to the Mutual Aid Agreement (pg 34), however the paragraph appears unfinished on how to access, details of the process and how to request support. Please also be aware that the version control is not consistent.
49	Business Continuity	Data Protection and Secu-rity Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Evidence • Statement of compliance • Action plan to obtain compliance if not achieved	Agree	DSPT compliant

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59	Hazmat/CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate wet decontamination capability that can be rapidly deployed to manage self presenting patients, 24 hours a day, 7 days a week (for a minimum of four patients per hour) - this includes availability of staff to establish the decontamination facilities There are sufficient trained staff on shift to allow for the continuation of decontamination until support and/or mutual aid can be provided - according to the organisation's risk assessment and plan(s) The organisations also has plans, training and resources in place to enable the commencement of interim dry/wet, and improvised decontamination where necessary.	Documented roles for people forming the decontamination team - including Entry Control/Safety Officer Hazmat/CBRN trained staff are clearly identified on staff rotas and scheduling pro-actively considers sufficient cover for each shift Hazmat/CBRN trained staff working on shift are identified on shift board Collaboration with local NHS ambulance trust and local fire service - to ensure Hazmat/CBRN plans and procedures are consistent with local area plans Assessment of local area needs and resource	Advisory	Recommendation: Until CBRNe Plan has been fully reviewed, updated (including removal of organisations no longer in operation) and approved, consider changing to partial compliance. The ED staffing rota is not clear on which staff on shift are trained for decontamination procedures.

6.0 Next Steps

6.1 The EPRR Action Plan has been updated to include the recommendations and advisory comments received during the Core Standards process.

6.2 An exercise was conducted on the 18th September 2026, due to a delay in critical equipment being received, the exercise was held later than previously hoped. The CBRNe Plan and the Incident Response Plan are currently being reviewed to include the learning and actions from the exercise and it was unfortunate that this was unable to be completed prior to the Core Standards submission. The plans are scheduled for approval at the January 2027 EPRR Strategy Group meeting; however, these will be shared in early December for consultation and the EPRR Lead will ensure that the ICB are included within this process. Plans are regularly shared with other Trusts within the Cheshire & Merseyside region and overarching polices were initially shared with NHS England for feedback.

6.3 The EPRR Manager will continue to undertake the EPRR work programme and focus on the following areas:

- Review of existing and completion of outstanding Business Continuity Plans.
- Training & Exercising and completion of Commander portfolios
- Embedding of the EPRR agenda across the Trust
- CBRNe
- Maintenance of existing plans.
- Completing the outstanding actions from Exercise Hammond.

6.4 The Trust now has a suite of emergency plans, it is essential that these are maintained, reviewed, tested and aligned to the requirements of the Core Standards. Staff awareness and training is key to ensuring that a robust response can be delivered to a disruption to the organisation's critical services and to support this, training is extended to other departments and divisions.

6.5 The EPRR team will continue to develop and deliver exercises to ensure that the Trust has robust arrangements in place to respond to an incident of any nature and that staff are confident of their individual and departmental roles and responsibilities.

6.6 The Board is requested to note the contents of the report and the progress that has been made in relation to The Trust's compliance with the EPRR Core Standards process.

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Appendix 1 - Core Standards Action Plan including recommendations from the Core Standards Process 2026

Core Standard Title	Compliance Rating	Action required	Target Completion Date	Supporting documents in place
Business Continuity Plans (BCP)	**Partial**	Business Continuity Plans are in place across the majority of divisions within the Trust, support will be available from the EPRR Lead to develop those outstanding. All departments are also being asked to review their current BC Plans if they have not done so in the past 18 months and support will be available.	June 2027	BC Policy BC SOP BC Checklist Departmental BCPs Incident response Plan BC Monitoring Report
BC & EPRR Training & Exercising	Partial	The EPRR Manager is working with divisions to ensure that plans are tested and fit for purpose. An exercise schedule is being developed to support departments with their planning/scenario requirements.	September 2027	BC Policy BC SOP Departmental BCPs Debriefing Guidance Incident Response Plan

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				BC Monitoring Report
HAZMAT/CBRNe **Equipment and supplies**	**Partial**	The new decontamination equipment was delivered on the 4th of September and Exercise Hammond was held on the 18th of September. A debrief report was produced following the exercise along with an action plan specifically relating to the CBRNe element. The EPRR Lead, Clinical EPRR Lead and Decontamination/Major Incident Nursing Lead are reviewing the CBRNe Plan to include updated information relating to NHS guidance, equipment, storage arrangements and training materials. The review of the plan will be completed ahead of the NWAS Audit on the 3rd of December.	December 2026	CBRNe Plan EPRR Budget PRPS Suits (servicing certificates) ED Training Records ED Training Presentations.
Training & Exercising	**Partial**	Exercise Hammond was delivered in two parts: live play testing the new decontamination equipment and CBRNe plan and a desktop element testing the Major Incident action cards and response to a major trauma multi casualty incident. The feedback was positive from all that attended and this exercise enabled the finite detail to be examined rather than the process itself. The majority of staff members that participated were confident in their roles as they have	March 2027	CBRNe Plan ED Training Records ED Training Presentations.

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		previously been part of an exercise or have attended the EPRR training. A debrief report has been prepared and is attached at appendix 3. A recorded training session has been developed for clinical and nursing staff – this is being shared across divisions. Training is being rolled out to portering staff and other supporting departments to ensure they understand their role in the event of an incident. Refresher EPRR Training for On-Call Managers & Executive Team has been scheduled (the first session was delivered in September). One of the recommendations from the Core Standards process is to ensure that Strategic and Tactical Commanders have portfolios and the EPRR Lead will work on-call members to complete the portfolios.		
Incident Response Plan	**Partial**	The Incident Response Plan is currently under review to include the learning and recommendations from Exercise Hammond. Due to the delay in receiving essential equipment, the exercise and review of the plan was not completed in time for the Core Standards submission. Mutual Aid arrangements have been included within the new iteration and are available on the on-call website and within the ICC. The arrangements were implemented in the past 12 months during an incident within WUTH and key staff were aware of this.	December 2026	

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		Although the Incident Response Plan is included within the action plan as partial – there is a robust approved plan available that was tested in September and there is confidence that should the Trust need to respond to an incident, the plan is fit for purpose and staff and clinical departments are aware of their roles and responsibilities.		
EPRR Policy	**Full**	Following the recommendations from the MIAA Audit the EPRR reporting arrangements have been reviewed and EPRR Policy. The update also includes reference to the newly appointed AEO. This was approved at the Finance & Performance committee on the 22nd of September.	September 2026	MIAA Final Audit Report
ED Decontamination Rota	**Full**	'Decontamination' has now been added as a 'Skill' on **Health Roster** to every ED staff member who has attended Major Incident & Decontamination training. This will allow Nurse Team Leaders to easily identify which staff on shift have completed the training. In the event of an incident, this will enable swift and appropriate allocation of roles to the identified staff on shift.	October 2026	ED Rota

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PUBLIC – Board of Directors
24th November 2026

Report	**Agenda Item 22.**	**Anchor Institution Annual Report 2025/26**						
Purpose of the Report	Decision		Ratification		Assurance	**X**	Information	
Accountable Executive	Jonathan Develing			Director of Strategy and Partnerships				
Author(s)	Jonathan Develing			Director of Strategy and Partnerships				
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** 				
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	Finance & Performance Committee – 9th November 2026 People Committee – 16th November 2026							
Executive summary	This paper presents the integrated Anchor Institution Annual Report 2025/26 to the Board. The report summarises the work of the Anchor Institution Group and provides annual updates on the Trust Green Plan, NHS Prevention Pledge, Social Value, and Communities and Partnerships.							
Recommendations	The Board is asked to note the new approach to this integrated report by way of capturing the full range and scope of activates across the organisation that are not routinely reported through other routes and as assurance of progress of the Anchor Institution Group							

Corporate Impact Assessment	
Statutory/regulatory requirements	CQC/Constitution/other regulation/legislation
Risk	None
Equality & Diversity	Meets Equality Act 2010 duties & PSED 2 aims and does not directly discriminate against protected characteristics
Communication	Document to be published on website

Anchor Institution Annual Report 2025/26

1. Introduction

The Countess of Chester Hospital NHS Foundation Trust is recognised by the Integrated Care Board as an Anchor Institution.

Typically, an anchor institution has three component parts:

- Reducing our environmental impact. This is evidenced by our work to deliver our Green Plan
- Collaborate closely with local partners on targeted interventions to reduce health inequalities, promote earlier intervention and prevention. This is evidenced by our work to deliver the NHS Prevention Pledge
- Purchasing more locally for social benefit. This is evidenced by our work to deliver improved Social Value in the local economy and our communities and partnership endeavours also described in this report.

2. Background

The Trust's Anchor Institution Oversight Group meets every two months to coordinate activity related across the organisation. Rather than delivering programmes directly, it aligns complementary work across the Trust and with external partners.
The diagram below best describes how the group oversees the **now four workstreams** of the Group.



3. 2025/26 Annual Green Report

The Trust 2nd Green Plan renewal maintains the following 3 principles:

- Prioritising action that delivers world-leading patient care, improves population health, reduces inequalities, and addresses climate change and wider sustainability challenges.
- Helping organisations plan and invest responsibly while improving efficiency and delivering value for taxpayers.
- Ensuring every NHS organisation contributes to the NHS-wide ambition of achieving net zero carbon emissions, informed by lessons from delivery to date.

Whilst the challenge is huge, the benefits are even more so. To achieve Net Zero is pivotal and one of the three major milestones for us at COCH becoming totally 'Sustainable'

We should be rightly proud of our progress in Sustainability projects across the Trust, which include:

- The approach of 'sustainability by design' focusing on 'reduced energy consumption' in the Women & Children's building achieving BREAM excellence in design and build.
- 1st Trust in Cheshire & Mersey healthcare region to have a fully 'green' transport fleet.
- 1st Trust in the UK to achieve a new healthcare facility that meets the Net Zero UK Building Standards
- Confirmation of commitment to become an 'Anchor' institution by signing up to the Cheshire and Merseyside Anchor Institute Framework.
- The Sustainable Healthcare Academy has launched a new green skills initiative built specifically for those working in health and care. Delivered by Ofsted Outstanding LDN Apprenticeships, the new learning programme is underpinned by the Level 4 Corporate Responsibility & Sustainability Practitioner Standard
- The pharmacy homecare team facilitates the delivery of hospital only medicines directly to over 2400 patients within their own homes, supporting the green agenda by reducing the number of patients that travel to site to collect their prescriptions and decreasing the demand on the hospital infrastructure.
- We are working with our Executive Team and Finance colleagues to secure the offer of only zero-emission vehicles through the vehicle salary sacrifice schemes from December 2026 onwards (for new lease agreements). The previous twelve months show that our staff (116 staff members from a total of 124 staff members) have elected to acquire e-vehicles through the Trust vehicle lease scheme. The transition to e-vehicles rather than fossil fuel vehicles has very much begun and is making huge progress within our own staff base.
- Complete removal of desflurane as an anesthetic gas within the theatre environment

The Sustainability Lead as well as the Executive Director for Sustainability at the Trust continues to represent the Trust through numerous forums, panels and committees:

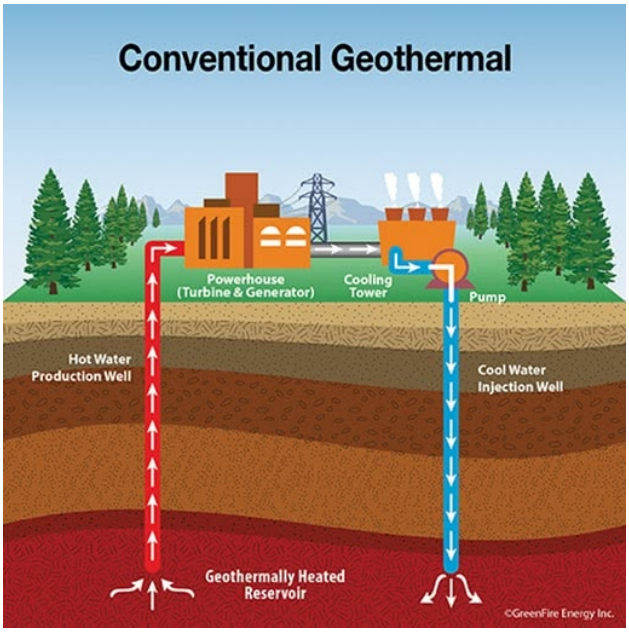
- Cheshire & Merseyside Sustainability Board
- Cheshire West Place Sustainability Committee
- Cheshire West and Chester Council (CWaC) Travel and Transport Collaborative (membership consists of CWaC, COCH, Chester University and Chester Zoo)
- CWAC Travel Demand Management group
- Northwest Regional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

Energy

Energy continues to be a huge challenge for the Trust, in terms of managing available capacity, consumption and obviously, cost. The year has seen much focus in these areas and whilst success has been seen in managing and creating available capacity, the focus is very much on driving down energy usage.

The Trust is working with partners and National bodies to explore the possibility of extracting geothermal energy from deep within the earth.

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



The extracted heat can support district heating for homes and businesses and, in some cases, generate electricity.

The Trust's approach makes a significant contribution to national objectives for heat networks, low-carbon energy alternatives and renewable energy use.

The project will run over the next three years and formally commenced in early 2025.
If successful, this single project could significantly reduce energy costs, improve the Trust's energy efficiency and make a major contribution to achieving net zero.

Travel & Transport
Travel and transport remain a key objective at our Trust, in providing improved options for travel as well as plans to improve the car parking infrastructure at both of our sites. We have made progress in this area against incredibly challenging external factors, local public transport service cuts, and cancellation of ineffective bus routes, all of which do not support an 'alternative' mode of travel.

- Our original Travel & Transport Strategy is due for refresh and is timely in line with the national NHS objective (develop a sustainable travel plan by December 2026, to be incorporated into the green plan (for example, as an annex), focusing on active travel, public transport and zero-emission vehicles, supported by a clear understanding of staff commuting) will take into account the results of the Trust staff Travel & Transport survey as well as meeting the NHS national objectives. This specific document has proved essential in the future planning of the Health Park in applying for any planning/building approvals from local authority

- Work is already underway both nationally and at a regional level to secure the objective (offer only zero-emission vehicles through vehicle salary sacrifice schemes from December 2026 onwards (for new lease agreements). NHS/E Transport as part of National Operations have confirmed that all vehicles offered through the NHS salary sacrifice scheme will be electric by the end of 2026 and all new vehicles owned or leased by the NHS will be zero emission by the end of 2027 (excluding ambulances).

- We will work with the Executive Team and Finance colleagues to offer only zero-emission vehicles through the salary sacrifice scheme for new leases from December 2026. Over the past 12 months, 116 of 124 participating staff chose electric vehicles, demonstrating strong progress in the shift away from fossil-fuel vehicles.

- During April 2025, we collectively secured a full fleet replacement (7 x vehicles) for our Trust which consists of 3 x e-vehicles and 4 x hybrid vehicles. Our all new 'Green Fleet' is now delivered and in full operation as part of Transport Services, the 1st Trust within the Cheshire & Mersey region to do so.

The Transport Services fleet collect samples from across the region from GP practices and transport to either our own blood sciences Trust unit or our partner laboratory in Bromborough.
The annual milage for this combined fleet is approx. 177,000 miles. The mix of fully electric and hybrid vehicles will make a substantial contribution to cost savings in the huge reduction in diesel costs associated with operating this size of fleet as well as a carbon emissions reduction.
Where previously our vehicles would return an average of 40 miles to the gallon, our new Hybrid vehicles will achieve 65+ miles to the gallon.
The fully e-vehicles are replacing 3 x vehicles who returned an annual mileage of 60,000 per year. The new fully electric variants will now no longer use revenue budget to purchase fossil fuel, good for cost saving and excellent toward Net Zero.

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

The ongoing success of this project and not without its challenges, has now become the first building within the NHS to achieve full compliance with the new NHS Net Zero Building Standard.

Achieving the position of first in NHS UK is absolute testament to this project and how it has been managed and built throughout, up to its handover to the Trust in summer 2025.

The NHS has been and is still facing some of its biggest challenges in its history, this achievement of 'first in NHS UK' is significant for our Trust considering such wider challenges.

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

Healthcare Associated Waste
During 2024/25, we wrote about our intent to radically change our approach to healthcare associated waste and how this is managed. This remains our commitment, with a formal senior project team fully established, to explore all areas and options in how we improve in this key area.

The technological advancement in 'hospital waste management' has moved on in leaps and bounds and create a real potential for our Trust to substantially reduce emissions as well as a reduction in revenue costs.

We are extremely optimistic that we will achieve our intent during the financial year 2026/27.

Climate Adaptation State of the Climate Report 2024

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

Met Office chief scientist, Professor Stephen Belcher said:
"The latest planetary health check tells us that earth is profoundly ill. Many of the vital signs are sounding alarms. Without serious efforts to heed the warnings, extreme weather events - such as drought, heatwaves and flooding - will continue to worsen."

The greatest climate risks to the health and care system in Cheshire & Mersey region are a.) risks to wellbeing from high temperatures; b.) river and surface flooding; c.) coastal flooding; d.) risks to building fabric.

Climate change has serious consequences for:

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

These issues particularly impact more vulnerable people and places. Understanding, anticipating, and adapting to these new challenges is essential to developing a more climate-resilient NHS.
The Trust Sustainability Lead has completed the training program 'Becoming Climate Resilient', funded by NHS England that allows attending candidates to explore the key concepts of climate adaptation, climate risk, and identify opportunities to build resilience towards a fairer, flourishing future.

As a Trust, the NHS/E Climate Change Risk Assessment Tool will be used to assess our current position during the period 2026/27 and produce a completed assessment and plan which will identify how we as a Trust mitigate against climate change.

The positional status will then determine our approach as part of a formal Trust Climate Adaptation Plan which will identify our key priorities in how we adapt to such changes.

The extremely long summer with long periods of sustained heat we experienced during 2026 has positioned us with a taste of how we must change, what we must change and why, and further, will help us to deliver on the critical and strategic document.

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

- our population and the potential impact to health from climate change,
- our staff and where they are populated/reside and their route of travel to the workplace

- and the utility and service companies that provide energy, water and daily supplies to our Trust.

To support development of its adaptation plan, the Trust is engaging staff and the wider community through a screening of the National People's Emergency Briefing, a film currently being shown in local venues and cinemas. The event is funded and facilitated by the National program and is associated with a research program at Bath university.

Green Plan Governance
The delivery of the Trust Green Plan is overseen by a designated board-level net zero lead, as well as with clearly identified operational support.

To oversee the full range of workstreams within the Trust we have a strategic delivery oversight group (Anchor Institution Group), bringing together the following interdependent workstreams provides cohesion and coordination of our combined efforts to become an Anchor Institution.

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

An oversight dashboard has been developed with clinical and operational leads identified for each workstream.

The Countess of Chester Hospital NHS Foundation Trust is an example of an organisation that recognises the wider role that it can play in the communities that it serves.

The Trust will use its systems leadership role to deliver those pledges within our direct control and to facilitate those pledges which require new ways of working in partnership with other NHS Providers, Place, Local authorities, and the voluntary and charitable sector.

The development of our Strategic Delivery Oversight Group provides a comprehensive and cohesive response to key interdependent workstreams and provides vital evidence of action and progress for the new single CQC assessment framework, which now includes substantiality as a line of enquiry as described below.

Assurance and Governance

KPI	2021 position	Current position and progress
KP1	The Trust did not have a formally nominated lead accountable for climate change adaptation planning and management.	Named accountable leads are now in place: • Director of Strategy and Partnerships – overall accountability and executive lead • Head pf Facilities – adaptation planning (work in progress) • Non-Executive Director – Sponsor The Trust is developing a long-term climate change adaptation plan, which will sit separately from the Business Continuity Plan. This reflects strengthened governance and clearer accountability arrangements.
KP2	The Trust had not fully addressed nitrous oxide waste, including waste from mixed nitrous oxide and oxygen.	• Nitrous oxide waste is now actively addressed, including mixed gas waste streams.

		• Controls and improvements have been implemented to reduce environmental impact.
KP3	The Trust did not have a digital meal ordering system in place for patients and opportunities to deliver healthier and lower-carbon menu options were not formally measured.	While a digital patient meal ordering system is still not in place, the Trust has: • Identified opportunities to make menu options healthier and lower carbon • Increased the proportion of fruit, vegetables, beans, pulses, and other lower-carbon ingredients • Implemented measurement through a third-party waste management solution, capturing data at pickup or off site
KP4	Sustainability and social value requirements were not consistently embedded in procurement processes.	• A minimum 10% weighting for Net Zero and Social Value is now included in every tender. • Carbon Reduction Plan (CRP) requirements are actively managed and applied to all new procurements valued over £5 million per annum (outside of framework procurement).
KP5	The Trust did not have an adaption plan.	• Adaptation considerations are now embedded through dedicated leadership • Green Leaders engagement • Ongoing development of adaptation planning and management processes • In support of the development of the adoption plan the Trust is hosting a screening of the National Peoples Emergency Briefing.

4. 2025/26 NHS Prevention Pledge Annual Report

The NHS Prevention Pledge continues to be recognised as an organisational priority at the Countess of Chester Hospital NHS Foundation Trust. Executive leadership is provided by the Executive Medical Director, with operational oversight from the Deputy Medical Director, supported by the Trust Improvement Team.

A robust governance and reporting structure continues to ensure Trust Board oversight, supported via the People and Organisational Development Sub-Board Committee, to provide assurance against delivery. The commitments within the Pledge are underpinned by the Trusts Continuous Improvement, People and Green strategies and associated plans. Task and Finish groups manage the delivery and report against agreed key performance indicators (KPIs).

During 2025–26, adoption of the NHS Prevention Pledge has continued to support delivery of the Trust's strategic objectives by embedding prevention, population health and wellbeing principles across core programmes of work.

The Trust strategy is underpinned by the overarching vision to "improve the lives of our community and provide excellence in health and care". The Prevention Pledge provides a practical framework through which this vision is translated into action, supporting delivery across the Trust's six strategic goals, particularly Leadership, Population Health, Value, Partnerships and Team Culture.

Prevention of ill health and population health
The Prevention Pledge continues to support a shift from traditional reactive models of care towards a stronger population health and prevention approach. Key areas of focus during 2025–26 have included the ongoing delivery and embedding of the Treating Tobacco Dependency Service (TTDS), promotion of physical activity and healthy lifestyles, and alignment with the Trust's Green Plan to support healthier environments for patients, staff and visitors.

These programmes contribute directly to reducing preventable illness and supporting long-term health outcomes.

Action to address health inequalities
Through the Prevention Pledge, the Trust has strengthened its focus on health inequalities, aligning activity with Core20PLUS5 and wider Cheshire and Merseyside population health priorities. Initiatives such as community outreach, partnership working and improved access to services (including research participation via the Mobile Research Bus) support engagement with underserved and vulnerable populations, helping to reduce variation in access, experience and outcomes.

The Trust recognises that health inequalities are unjust and avoidable differences in people's health. Whilst the causes of health inequalities are complex, research has shown that the main drivers are social determinants; that is the environments people live in, access to employment, the kind of start they had in life. Inequalities are also driven by the ways in which health services are designed, delivered, funded, and by the quality of clinical care received.

We recognise that the NHS plays a role in both mitigating against the impact of the wider determinants and in reducing healthcare-based inequalities. Addressing health inequalities will improve the quality of clinical care, patient outcomes and safety across the population and between specific groups.

The Trust actively collaborates with the local authority public health team and leverages joint data and digital initiatives throughout Cheshire and Merseyside. This partnership facilitates a comprehensive understanding of the region's health landscape and strengthens efforts to address health inequalities.

The Trust has undertaken significant work to improve data quality as published through our quality account and will develop this into routine reporting. By using the Cheshire and Merseyside Data into Action platform, the Trust obtains detailed insights into population health and access patterns. These analytics guide strategic decisions and proactive planning to improve future health services for the community.

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

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

Anchor institution practices and social value
The Prevention Pledge continues to underpin the Trust's progress as an anchor institution. During 2025–26, anchor activity has focused on local employment and skills development, apprenticeships, education partnerships, sustainability and social value. As one of the largest employers in the local

area, the Trust recognises its role in supporting economic, social and environmental wellbeing, and the Prevention Pledge provides a clear structure to coordinate and demonstrate this contribution.

Staff health and wellbeing
Staff wellbeing remains a core enabler of high-quality, safe patient care. The Prevention Pledge supports delivery of the Trust's Team Culture objective through continued investment in staff wellbeing hubs, access to health checks, mental wellbeing support and targeted wellbeing initiatives. These programmes contribute to improved staff experience, retention and engagement, while also modelling prevention-focused behaviours across the organisation.

Overall, the NHS Prevention Pledge continues to provide a coherent framework that aligns strategic intent with practical delivery, supporting the Trust to embed prevention, reduce inequalities, strengthen partnerships and improve wellbeing for both staff and the communities it serves.

Barriers and Challenges
During 2025–26, delivery of the NHS Prevention Pledge has continued to be impacted by workforce capacity pressures linked to the Trust's wider improvement and recovery priorities.

The Prevention Pledge has no dedicated management capacity. Although it is not intended to increase workload, collating information and participating in the wider network, while valuable, places additional pressure on a very small team. The Trust continues to mitigate this where possible by aligning Prevention Pledge activity with existing programmes of work and utilising system support and partnerships to maximize impact within available resources.

The scale and pace of improvement required places significant demand on clinical, operational and improvement capacity, limiting the ability to progress additional prevention-focused initiatives beyond agreed priorities.

Communications
Prevention Pledge activity and progress are regularly shared with staff through established internal channels, including weekly Trust bulletins, team briefs and targeted staff communications, helping to embed prevention as "everybody's business" across the organisation.

Dedicated intranet and SharePoint pages support key Prevention Pledge themes such as smokefree, sustainability, wellbeing and quality improvement, signposting staff to resources, campaigns and support.

Updates on Prevention Pledge commitments are also shared through internal presentations and staff engagement events, including wellbeing campaigns and improvement forums.

Example Internal Communications
Weekly Bulletin – 12/05/25: -Stroke Awareness Month -VE Day – Armed Forces Staff Network -Heart Health Checks in Wellbeing Hub -Health and wellbeing – NHS Games challenge 2025 -Mental Health Awareness Week -Spring into Summer Toolkit
Weekly Bulletin – 19/05/25: -Sun Awareness Month, Plastics /Dermatology team staff event. -World Human Milk Donation Day -Emergency Medicine Day: join our ED team -Diabetes Awareness week & Drop in sessions -Parent & Carers Staff Network drop-in clinic -New apprenticeship opportunity with the Sustainable Healthcare Academy

-Wellbeing garden opened -Step into Summer NHS games step challenge -NHS Cheshire and Merseyside approach to Biodiversity Net Gain
Weekly Bulletin – 04/08/25: -New Labour ward opened -Lauch of Countess wellbeing Community -Countess Country Park wins two awards -LGBTQ+ Staff Network - monthly drop-in clinic -World Breastfeeding Week
Email update and COCH comms poster – 07/08/25 Surgery Hero - digital prehabilitation
Team Brief – 02/10/26
Weekly Bulletin – 24/11/25: -Opening of Blue Skies balcony for ICU patients -Urgent Care Showcase Event -Celebrating Safeguarding week -Announcing COCH new Virtual tour -Winter Wellbeing Toolkit -Launch of 'Stream' – financial wellbeing app -Christmas boxes – sharing kindness at Christmas -Blue Christmas – bereavement, loss and grief session

External and public communications
Prevention-related activity aligned to the NHS Prevention Pledge is shared publicly via the Trust website and news pages, including initiatives linked to tobacco dependency, research engagement, wellbeing and sustainability.

Where appropriate, Prevention Pledge work is incorporated into wider Trust communications to the public, patients and partners to demonstrate impact and progress against population health and prevention priorities.

Example External Communications
Internet Page
Social Media

The Trust continues to align Prevention Pledge activity with the principles of All Together Fairer, with a focus on reducing health inequalities and improving equitable access to services. This includes contribution to Core20PLUS5 priorities, community outreach activity, and partnership working to address health inequalities and improve equitable access to services for populations experiencing disadvantage.

All Together Active (Physical Activity)
The Trust supports the All Together Active programme through delivery of initiatives that promote physical activity for staff, patients and visitors. Activity is embedded within the Trust's Green Plan and staff wellbeing offer, including active travel, participation in NHS Games challenges, promotion of movement and rehabilitation, and access to physical activity opportunities aligned to system priorities.

The Trust has supported the Countess of Chester Country Park achieving its eighth consecutive years Green Flag Award. With many varied trails and activities, the Park is used on a regular basis by the Country Park, Park run, attracting over 400 runners a week.

All Together Smokefree
The Trust continues to work closely with Cheshire & Merseyside to deliver the Treating Tobacco Dependency Service (TTDS) as part of the All Together Smokefree programme. This includes

ongoing pathway delivery, data submission, and collaboration with system partners to support smoking cessation for patients and staff, contributing to both prevention and health inequalities objectives.

NHS Green Plan
The Trust's Green Plan remains closely aligned with the NHS Prevention Pledge, supporting population health through improved environments, sustainable travel, greener food and drink choices, and staff engagement in sustainability initiatives. Green Plan delivery continues to contribute to prevention, wellbeing and anchor institution ambitions at both Trust and system level.

Anchor Institution Charter
The Trust continues to progress its anchor institution role, with Prevention Pledge activity aligned to social value, local employment, education partnerships, sustainability and community engagement. Work is overseen through the Anchor Institution Steering Group and aligns with Cheshire & Merseyside anchor priorities, supporting economic, social and environmental wellbeing across the local area.

Overall, the NHS Prevention Pledge helps bring everything together, supporting the Trust to align its prevention work with Cheshire & Merseyside population health and transformation programmes, share learning and contribute to wider system priorities.

The Trust is a core member of the Cheshire West Health and Wellbeing Board and takes a leadership role in the following forums across the borough including,

- Joint intelligence Group
- Transformation and collaboration group
- Health inequalities group
- Senior leadership groups
- Neighbourhood oversight groups

The Trust also works at scale across Cheshire and Merseyside through the CMPC provider collaborative and working closely with Wirral Hospitals in areas of mutual benefit.

The Trust continues to work in partnership with Cheshire and Wirral Partnership NHS Foundation Trust to support the provision of mental health services, alongside engagement with the Cheshire West Voluntary Services Mental Health Alliance.

A joint committee formed between CWP and the Countess supports the integration of our respective community teams and the deployment of these teams into the emerging neighbourhoods.

These partnerships have helped strengthen links with community and voluntary sector organisations, improve signposting and referral options, and support staff access to low-level mental health and wellbeing services, including organisations such as Able Futures, Chapter, Mentell, Motherwell Cheshire and Making Space.

Strong partnerships with education providers continue to support workforce development and social value. The Trust works closely with the University of Chester to develop alternative clinical roles and create clear career pathways for students and early-career healthcare professionals. Links with the University of Liverpool support postgraduate medical education, and opportunities continue to be explored through wider academic and innovation partnerships, including potential Knowledge Transfer Partnerships.

Through these education and training partnerships, the Trust has continued to grow apprenticeship opportunities across a range of roles and levels, supporting local employment,

skills development and the long-term sustainability of the workforce while contributing to wider prevention and anchor institution objectives.

The Trust has also commenced work with the Royal College of Nursing Foundation and is launching a compassionate Leadership programme in October of this year 2026.

5. 2025/26 Social Value Annual Report / Activity

Social value is typically divided into three main areas (often called the triple bottom line), hence the interrelationships between this and other programs within the AI Group.

- **Social Value**
  Improving individual and community wellbeing, health, and social equity.
- **Economic Value**
  Supporting local hiring, apprenticeships fair wages, training, and robust supply chains.
- **Environmental:** Protecting natural resources, reducing carbon emissions, and ensuring sustainability

The following section summarises the Trust's social value activity during 2025/26.

- Countess of Chester Country Park wins two awards:
  - Receiving its eighth consecutive Green Flag award as well as the Land Trust's Health Park of the Year Award. At the special celebration, representatives from COCH, CWP, Chester Zoo, the Wildlife Trust and Friends of the Country Park volunteers came together - a reminder of the wellbeing space we are fortunate to have on our doorstep. It also highlighted our joint commitment to community health and wellbeing.
- Chester Wetland Project, (06/05/26):
  - Chester Country Park has green light for creation of a 23-hectare site with reedbeds, shallow pools- help clean water, reduce flooding on paths and boost wildlife providing local people with a new green space.
- Trust Summer Social event, (13/06/26):
  - The Trust organised a Summer Social Event, held at the Countess of Chester Country Park to bring together staff and their families to promote well-being, connection and community. The event included guided nature walks and a range of health, wellbeing and family-focused activities, supporting both physical and mental wellbeing.
- Celebrating success:
  - Women's and Children's building won best architectural design for a healthcare facility at the Healthcare Design Awards and was shortlisted for NFRC UK Roofing Awards 2026. Recognised across the NHS as the first NHS facility in England to meet the NHS Net Zero Building Standard.
- The Mobile Research Bus supports local communities by providing advice, information and education on prevention and lifestyle. Where appropriate, individuals are signposted to onward clinical and non-clinical support services

- Falls Prevention Roadshow:
  - Team were out and about providing practical advice on bone health, medication safety, and strength and balance to people who might otherwise miss early support. Blacon Parade, (25/03/26) and the Grosvenor Garden Centre, (24/04/26). Plans for events with the Carers Trust & Malpas Community Kitchen in July and August.

    -
- Diabetes Awareness Week:, (08/06/26):
    - During Diabetes week the bus visited the Greyhound Retail Park and Chester Cathedral answering questions, running interactive sessions and offering basic diabetes screening tests.
- Raising Research Awareness – Clinical Trials Day, (19/05/26):
- Mobile Research Unit visiting COCH/EPH to introduce people to idea and importance of research in healthcare.
- Cancer Engagement Event, (09/06/26):
- Cancer Alliance provided an engagement session in the Wellbeing Hub – 123 Approach, Staff Network, Health inequalities support and the Cancer Academy.
- Community Pathfinders comms, (22/06/26):
- Comms have been shared with staff to support patients and families with discharge planning. This includes signposting to non-clinical support services such as wellbeing activities, support with managing at home, and access to financial advice once in the community.

Other Social Value Work Supporting our Local Communities

- SWAP Programme with the Jobcentre, (Mar'26):
    - 4 candidates took part in our SWAP programme in partnership with the Jobcentre.
- Healthcare Assistant Training:
    - Launched apprenticeship training for Healthcare Assistants.
- Volunteers:
    - 115 volunteers across the Trust, ranging in age from 16 to 92, support patients, visitors and staff in 28 different areas of the hospital.
- Apprenticeship Awards – celebrating our Apprentices
    - Joined our Nursing workforce to celebrate their achievements.
- Changes to medical work experience:
    - Provision of medical work experience via Prospective Medical Students Course – 29/06/26 – 03/07/26 for A-level students hoping to apply for medical school.
- World Art Day, (15/04/26).
    - Free Art Fair tickets at Fusion Art Fair 25-26th April at Chester Racecourse.
- Working with Local Art Class, (15/06/26):
    - Display created for W&C building by artists aged 16 to 82 years old from across Cheshire.

Installation of new Artwork in Ellesmere Port Hospital, a permanent home for an exhibition designed by Locally and Nationally renowned artist Nicholas Thompson previously displayed at Ellesmere Port Boat Museum.

5. 2025/26 Working in partnerships with People and Communities Annual Report

Statutory guidance sets out how foundation trusts should work in partnership with people and communities in this new collaborative environment.

The guidance aims to spread effective practice across all systems by building on the expertise and experience that exists and provides practical advice and signposts to further information including training and resources.

The guidance is based on ten principles, previously reported upon in 2024/25 has been refreshed to account for activity during 2025/26

Background
The Trust has adopted the Ten key principles and developed a response for each domain in conjunction with our Anchor Institution Group and with a range of stakeholders.

(i) Ensure people and communities have an active role in decision making and governance

Strengths
- The Trust has an active Council of Governors and promotes public membership, ensuring community voices inform strategic decision-making.
- Staff networks are used to listen to and empower groups including Black, Asian and Minority Ethnic (BAME), Women's, LGBTQ+, Enabled, Carers, Faith and Belief, and Armed Forces networks. The Trust has established more bespoke relations with the local armed forces and has signed the armed forces concordat. The local commander in chief has also presented at our clinical leadership event
- The Trust will also draw on its patient engagement groups and Equality, Diversity and Inclusion (EDI) groups. These forums bring together patients, families and representatives with specialist knowledge and lived experience, helping us to shape and improve current and future services.

Development Opportunities
- As the development of neighbourhood care matures the Trust will seek to support the left shift of activity from hospital to home. This is supported by our clinical strategy - `Transforming Care Together`
- Development of local provider collaboratives to drive the integration of acute, community and primary care services in line with the Ten-Year Plan.
- Targeted intervention in areas of higher inequality – for example the development of community diagnostic services at Ellesmere Port Hospital and Blacon, two of our most challenged populations.

(ii) Involve people and communities at every stage and give feedback to them about how it has influenced activities and decisions

Strengths
- The Patient and Family Experience Strategy is informed by feedback and focuses on dignity, safety, and compassion. Initiatives such as hospital tours for patients with learning disabilities help reduce anxiety and improve access.
- The Trust has mature Patient Adversity Liaison (PALS) services which is purposely located at the front entrance of the hospital
- The Trust provides Education, engagement events and listening groups
- Patient and family support and follow up calls post discharge,
- The Trust works with local schools and the Cheshire and Wirral Advisory Board (CWBAB) to inform skills for future growth.
- The Trust has listening rooms for patient and family feedback and we have a Multifaith chapel for staff and visitors to access

Development Opportunities
- The Trust is a leader on the use of intelligence tools for prioritising waiting list based upon health inequality and comorbidity. Known as C2AI this has been piloted in orthopaedics with positive feedback from patients and we would like to roll this into other surgical specialties.

(iii) Understand your community needs, experiences, ideas and aspirations for health and care, using engagement to find out if change is working

Strengths

- Community Home First**:** The programme, including Virtual Wards, Rapid Response Teams and high-acuity support, enables safe discharge and recovery at home. A multidisciplinary team works with local charities and care connectors to assess home readiness, arrange suitable equipment and identify any remedial works needed to support safe discharge.
- The Trust uses population health tools to develop service-specific approaches that support more local delivery. Informed by patient experience, this is helping to transform outpatient services and patient-initiated follow-up.
- The Trust has contributed to the local authority's Joint Strategic Needs Assessment and the Cheshire West Health and Wellbeing Board Strategy 2026.

Development Opportunities

- Changes to the Integrated Care Board's role, including the shift towards strategic commissioning, will require providers to strengthen system leadership and support integrated care in line with the three core aims of the NHS Ten-Year Plan.

(iv) **Build relationships based on trust, especially with marginalized groups and those affected by inequalities**

Strengths

- The Trust uses staff networks to listen to and empower groups including BAME, Women's, LGBTQ+, Enabled, Carers, Faith and Belief, and Armed Forces networks. It will also draw on patient engagement and EDI groups, bringing together patients, families and representatives with specialist knowledge and lived experience to help shape current and future services. Recent co-design work includes engagement on the new Women's and Children's Building, due to open in autumn 2025.

Development Opportunities

- The Trust has developed a health inequalities framework and is creating a bespoke reporting platform to monitor health inequalities and equality of access.

(v) Work with Healthwatch and the voluntary, community and social enterprise sector as key partners

Strengths

- The Trust is an active member of the Cheshire West Partnership Group and works with community partnerships and neighborhoods.
- The Trust also works with community health teams to support frailty and memory services and with Health watch cheshire who provide an independent voice for the people of west cheshire to help shape and improve local health services.
- North Wales Patient Forums – we will engage similar with the North Wales patient forums to ensure their voices are heard and listened to appropriately.

Development Opportunities

- The Trust has built in social value within its procurement process with a specific intent of securing products and supplies from local enterprises.
- The Trust has a well-established Anchor Institution Group that coordinates activities relating to or Green Plan, Social Value Approach and NHS Prevention Pledge

(vi) Provide clear and accessible public information

Strengths

- The Trust provides patients and communities with clear, effective information throughout their care journey, using both paper correspondence and increasingly advanced digital solutions.
- The Trust works with patients and communities through the Patient Engagement Group to make public information and leaflets relevant, accessible and easy to understand.
- The Trust has promoted a series of well-being initiatives as part of the NHS Prevention Pledge. This includes Mental Health Awareness Week, Mental Health training, Kind to mind website Launch, Alcohol, Support pilot, Heart Health checks, and NHS Veterans Aware Accreditation

Development Opportunities

- The Trust celebrates community contributions, including the launch of new services that support discharge and recovery at home, through its social media channels.
- Recognition of volunteers and staff involved in community health initiatives.

(vii) Use Community Centre approaches that empower people and communities making connections to what works already

- The Trust's Mobile Research Unit delivers a comprehensive programme of engagement events across Cheshire West.
- The Trust chairs the Countess of Chester Country Park Management Group, which oversees this award-winning park. The group brings together NHS and Land Trust property owners, country park volunteers, Chester Zoo, local artists and the Mid Cheshire Community Rail Partnership.

Development Opportunities

- As neighbourhood care develops, the Trust will support the shift of activity from hospital to home, aligned with its clinical strategy, Transforming Care Together.

(viii) Have a range of ways for people and communities to take part in health and care services

Strengths

- The Trust is rolling out 3 primary care research hubs in Tarporley Hospital, Ellesmere Post and Winsford. These hubs will provide access for local communities and primary care to partake in community-based research.
- Ellesmere Port Hospital is a diagnostic Hub with the full range of early intervention test now being offered through CT, MRI and Abdominal Aorta Aneurysm Screening. This is also offered at Tarporley Hospital.
- Service change consultations, in addition to work established range of meetings to engage with and put our communities at the heart of decision making we will also stand up a range of service change consultations to ensure patients are at the centre of every change we make to improve services
- The Trust is expanding the use of new technologies (Single Points of Access, Artificial Intelligence diagnostics in Dermatology) and remotely monitoring patient's conditions.

Development Opportunities

- Increasing the number of volunteers in the hospital
- Increase the preventative and opportune screening through our mobile research facility.
- NHS App presents significant opportunity for patient to become more empowered in managing their own health conditions.

(ix) Tackle system priorities and service reconfiguration in partnership with people and communities.

Strengths

- The Trust is a member of the Cheshire West partnership committee, Health and Wellbeing Board and Transformation Groups. Jointly these groups operate under the `Place plan` with a shared vision jointly develops by all partner and communities.
- The Trust has not undertaken any service reconfigurations; however, the development of the new Women's and Children's has had significant input from patients and families in its design and development of the care model.
- The Trust has the largest human Milk Bank services providing donated Breast milk to over 70 hospital Trust in England, Wales and Ireland.

Development Opportunities

- Integration of community services with Cheshire West Partnerships trust and further development of community and primary care services.

(x) **Learn from what works and build on the assets of all health and care partners – networks, relationships and activity in local places**

Strengths

- The Trust is working with Cheshire West Council's stakeholder group to develop a healthy weight strategy for Cheshire West.
- The Trust is working closely with the University of Chester on the new medical school, using this partnership to support its ambition to achieve teaching hospital status and, in future, university hospital status.
- The Trust is an active member of the health and wellbeing strategy group within the Cheshire and Wirral Business Advisory Group, supporting work to help children and young people move into employment.

Development Opportunities

- The Trust will adopt the NHS Ten-Year Plan by advancing its three core shifts: moving from analogue to digital solutions, shifting more care from hospital to community settings, and working with partners to strengthen prevention and early intervention.

6. Conclusion

This report focuses on the extensive activities of the Trust when mapped against the ten domains within National guidance. The report advances the 2025/26 activity and provides future opportunities which the Trust would wish to embrace.

7. Recommendation

The Board is asked to note the new approach to this integrated report by way assurance of progress of the Anchor Institution Group.

PUBLIC – Board of Directors
24th November 2026

Report	**Agenda Item 23.**	**Health Inequalities Annual report 2025/26**						
Purpose of the Report	Decision	**X**	Ratification		Assurance	**X**	Information	
Accountable Executive	Jonathan Develing			Director of Strategy and Partnerships				
Author(s)	Jonathan Develing James Jackson Denise Wood Jason Bradley			Director of Strategy and Partnerships Business Intelligence Manager Associate Director IM&T Chief Digital and Data Officer				
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research BAF 11 Transformation			**X** **X** **X** **X** **X** **X** **X**				
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 Directors							
Executive summary	This report sets out the Countess of Chester Hospital NHS Foundation Trust's response to NHS England's Statement on Information on Health Inequalities. It brings together an understanding of health needs in Cheshire West and analysis of access to Trust services across its wider catchment, including Flintshire and Deeside, to inform more equitable care.							

	The findings demonstrate the importance of interpreting hospital activity alongside population size, age, deprivation, and clinical need. Differences in demographic composition, incomplete recording and small cohorts mean that several findings indicate areas for investigation rather than confirmed causes of inequality. Clear priorities nevertheless emerge. • Outpatient non-attendance remains higher in more deprived communities despite overall improvement, • Older patients experience longer emergency department waits. Further work is needed to understand clinical complexity and explore alternative care settings. • The maternity and children's oral health analyses also identify patterns that warrant targeted investigation and prevention. • Further work on Community Paediatrics waiting times and cancer stage at diagnosis will strengthen understanding of access and outcomes within specific pathways. • The Trust faces a dual demand challenge: increasing urgent care activity among working-age adults and the longer-term growth in frailty, multimorbidity and support needs associated with an ageing population Each of the above are being taken forward through respective divisions within the organisation.
Recommendations	The Board of Directors is asked to **approve** the 2025/26 Health Inequalities Annual Report for publication; • Note the findings of this report as above. • Endorse the priorities for improving data quality, undertaking further pathway-level analysis and reducing avoidable inequalities in access, experience and outcomes; and request regular assurance on progress through the Trust's existing governance arrangements.

1. Executive summary

The 2025/26 Health Inequalities Annual Report brings together population health needs in Cheshire West and analysis of access, experience and outcomes across the Trust's wider catchment, including North Wales.

It sets out the Trust's response to NHS England's Statement on Information on Health Inequalities and uses Core20PLUS5 to identify priorities for more equitable care.

- **Local need:** Borough-wide deprivation averages mask significant disadvantage in individual communities. The report identifies 29,500 residents in 19 neighbourhoods within England's most deprived 10%.
- **Access and waiting times:** Outpatient non-attendance remains higher in more deprived groups despite overall improvement. Older patients experience longer ED waits. Community Paediatrics requires further pathway-level review.
- **Clinical priorities:** Maternity outcomes, smoking at delivery, children's oral health and inpatient activity for patients with learning disabilities and autism identify areas for further investigation and prevention.
- **Future demand:** Growth in working-age ED attendances and the longer-term ageing of the population create a dual challenge for capacity, workforce, discharge pathways and service configuration.
- **Assurance and limitations:** Differences in activity do not, by themselves, establish inequitable care or its causes. Population composition, clinical need, incomplete recording and small cohorts must be considered. The next phase is to improve data quality, undertake adjusted analysis and evaluate targeted interventions through existing governance arrangements.

2. Main themes

2.1 Population need and interpretation of the evidence

Cheshire West and Chester is less deprived than England overall but contains substantial pockets of deprivation.

The Trust's planning catchment is 427,519 people, comprising 373,951 in Cheshire West and 53,568 in North Wales. Age and deprivation are closely interrelated in the patient's accessing services: average patient age is 46.2 years in the most deprived quintile and 56.5 years in the least deprived. Activity therefore needs to be assessed against population size, age and clinical need, rather than absolute volumes alone. Incomplete ethnicity and postcode recording, geographical coverage and small cohorts further limit interpretation.

The framework and detailed population evidence are in Appendices A–C.

2.2 Equitable access to planned and urgent care

Outpatient DNA rates have improved across deprivation quintiles but remain higher in more deprived communities. The reported reduction was 15.2% in Quintile 1, compared with 29.4% in Quintile 4 and 21.9% in Quintile 5.

The Diabetic Medicine DNA prediction trial provides an opportunity to identify barriers and offer proactive appointment support; evaluation is needed before judging its impact or extending it. In urgent care, older patients experience longer waits, while age and clinical complexity may contribute to apparent differences between population groups.

Supporting analyses are in Appendices C and E.

2.3 Clinical inequalities and prevention

The clinical analyses identify potential concentrations of risk rather than confirmed causes of inequality.

In maternity, the pre-term birth rate in IMD decile 1 was 111.5 per 1,000 births against a national reference of 77.2, and stillbirth rates were higher in the most deprived areas. Smoking at delivery also shows a deprivation gradient, reinforcing the importance of targeted cessation support.

Children's dental caries activity is concentrated in the most deprived quintile, although numbers are small. The learning disabilities and autism analysis highlight a need to examine deprivation, underlying need and access to community support.

Detailed clinical findings, qualifications and proposed further work are in Appendix E.

2.4 Changing demand and the future model of care

The Trust faces increasing ED demand among working-age adults alongside the longer-term growth in frailty, multimorbidity and support needs associated with an ageing population.

The report forecasts approximately 8% growth in average daily ED attendances in calendar year 2027; this is a forecast rather than realised activity.

Population projections to 2042 indicate that larger cohorts will move into older age bands. These changes have implications for urgent and elective capacity, specialist skills, rehabilitation, discharge support, estate and financial sustainability. Planning needs to consider both acute provision and sustainable community alternatives, with primary care, local authority and social care partners.

The detailed demand assessment is in Appendix D, with inpatient and outpatient activity in Appendix E.

2.5 Governance, improvement priorities and assurance

Health inequalities are embedded within the corporate and clinical strategies, service reviews and Anchor Institution Group.

The following section is provided as demonstrable evidence that the Trust is embedding health inequalities into everyday practice and across the full scope of activities.

Area	Summary
Leadership and Governance	Health inequalities are also embedded within the Trust's corporate and clinical strategies, 'Transforming Care Together' and 'Improving Lives.'
Healthcare Public Health	The Trust collaborates closely with the local authority's public health team and Joint Intelligence Board.
Service Reviews	Service reviews enable clinical teams to assess activity, performance, outcomes, costs, workforce and health inequalities, alongside clinical ambition, sustainability, and compliance with the evolving modern service frameworks.
Patient and Family Experience	The Trust's Patient and Family Experience Strategy, has helped improve quality and patient experience across a broad range of areas, many of which are now included in the NHS Oversight Framework.
Smoking Cessation	As part of the NHS Smokefree Pledge, patients, visitors, and staff must not smoke tobacco anywhere inside or outside on hospital grounds. Quit zones, support, role modelling, and our treatment tobacco dependency team are on hand to support
Staff Health and Wellbeing Strategy	There has been an additional focus over the last 12-months on reducing health inequalities for staff has seen the introduction of the enabled staff passport – providing a one stop document for disabled and neurodivergent staff to highlight support and reasonable adjustments they may require at work.
Research and Evaluation	The Trust collaborates with local universities and commercial partner whose work aligns with our values and principles. Its research strategy, "Research Matters: Better Care, Brighter Futures," commits the organisation to embedding research more fully, widening access to participation and delivering meaningful benefits for the patients and communities it serves.
Partnerships and Place-Based Approaches	The Trust is represented on the Cheshire West and Chester Health and Wellbeing Board and is a member of the Cheshire and Merseyside Provider Collaborative, which enables closer working between acute, community and mental health trusts.
Anchor Institution Group	The Countess of Chester Hospital NHS Foundation Trust is recognised by the Integrated Care Board as an Anchor Institution and published a separate annual report, that accounts for The Green Plan, Social Valie, NHS Prevention and Communities and Partnership reports.

3. Board recommendation

The Board of Directors is asked to **approve** the 2025/26 Health Inequalities Annual Report for publication;

- Note the findings of this report.
- Endorse the priorities for improving data quality, undertaking further pathway-level analysis and reducing avoidable inequalities in access, experience and outcomes; and request regular assurance on progress through the Trust's existing governance arrangements.

Appendix A — Reporting framework and policy context

Introduction

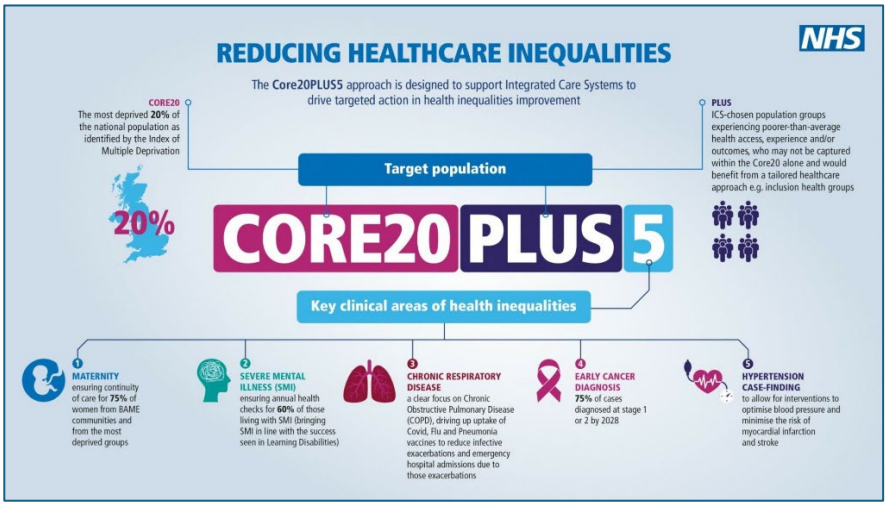
This is the 2025/26 Health Inequalities Annual Report for the Countess of Chester NHS Foundation Trust.

The report is presented as part of the statutory duty within NHS England's statement on inequalities and follows the conditions as described within the revised statement. The report therefore covers.

- An understanding of health needs
- Understanding healthcare access, experience, and outcomes,
- Improvement in data capture and analysis
- Using information on healthcare inequalities
- Publication of reports as part of the statutory duty

To provide a clear framework, the report focuses on Cheshire West residents and the national Core20PLUS5 approach to reducing healthcare inequalities.

Core20PLUS5 is a national NHS England framework designed to reduce healthcare inequalities across the health and care system.



The model breaks down its target focus into three core components:

- Core20: Represents the most deprived 20% of the national population, identified using the Index of Multiple Deprivation (IMD)
- PLUS: Refers to locally identified vulnerable or inclusion health groups that experience poorer-than-average health access or outcomes (such as ethnic minority communities, people with learning disabilities or autism, homeless populations, or coastal communities).

- 5: Highlights 5 key clinical areas prioritised for accelerated improvement to close the health gap. (see above)

Health Inequalities

The Health Foundation describe good health and wellbeing being `essential for happy, fulfilling lives`, and yet the existence of health inequalities in our population indicate that this opportunity is not available for all our residents.

We believe that as a provider of emergency, acute, specialist and planned care the Countess of Chester has a crucial role in addressing health inequalities, while also identifying opportunities for prevention, early diagnosis, and improved continuity of care.

For the purposes of this report health inequalities are defined as systematic, avoidable, and unfair differences in health status, access to healthcare, patient experience, and health outcomes between different population groups.

They are influenced by a complex interaction of socioeconomic circumstances, education, employment, housing, environment, ethnicity, disability and access to health and social care.

Reducing inequalities in access to and experience of healthcare, which contribute to wider health inequalities, is a priority for the NHS and the Countess of Chester Hospital NHS Foundation Trust.

From a hospital perspective, health inequalities are particularly important because we frequently encounter the consequences of disadvantage, including potentially preventable emergency admissions, advanced disease at diagnosis, complications associated with long-term conditions and difficulties maintaining continuity of care.

However, there are also opportunities to identify unmet needs, improve clinical pathways and connect patients with preventative and community-based support.

The Core20PLUS5 framework offers a practical method for translating the national ambition to reduce healthcare inequalities into local clinical action. This paper explores the framework's relevance to West Cheshire and considers how hospital services can improve equitable access, patient experience, and clinical outcomes.

In line with our Clinical Strategy, `Improving Lives` we believe that our hospital must begin to focus on services that responds to differing levels of need of the population. Targeted interventions, better use of population health data, co-production with communities and sustained collaboration with primary care, local authorities and voluntary sector organisations are essential to reducing avoidable inequalities.

NHS England Statement on Health Inequalities

In November 2023 NHSE released the NHS England’s Statement on Information on Health Inequalities (duty under section 13SA of the National Health Service Act 2006.

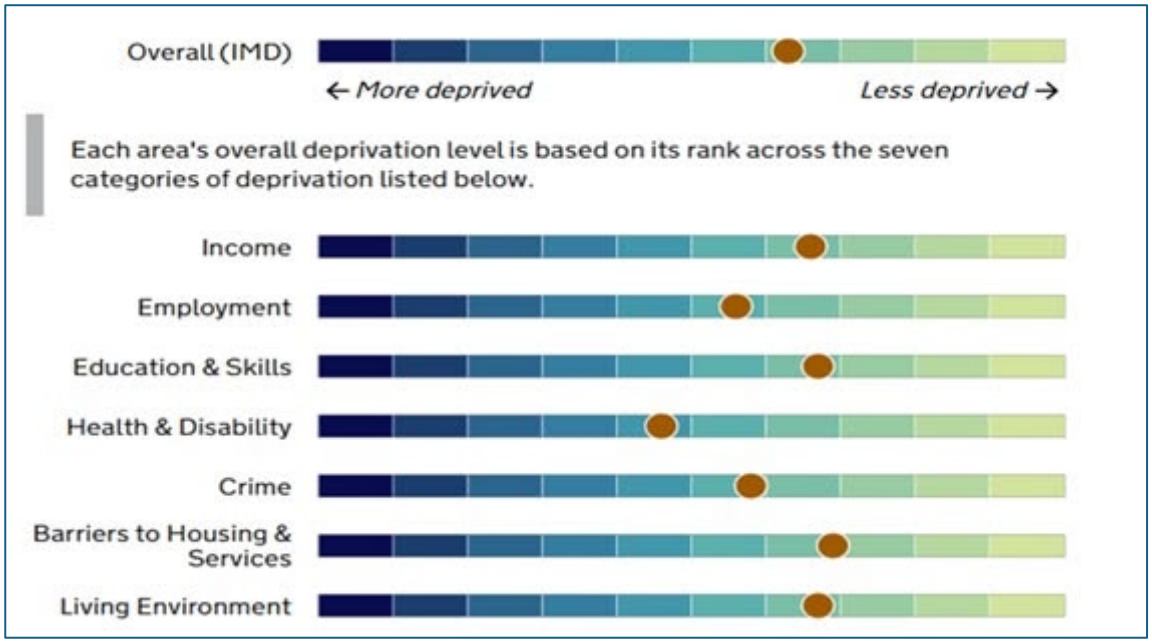
The statement affords Integrated Care Boards (ICBs) and NHS Foundation Trusts to identify key health inequalities information, set out how they have responded to the information and report appropriately.

Appendix B — Cheshire West population health and deprivation

An understanding of health needs of Cheshire West

Cheshire West and Chester (CW&C) have a less deprived population profile compared to England. The borough ranks 186 out of 296 local authority districts in England in terms of deprivation. CW&C has a more deprived rank than the neighbouring areas of Cheshire East and Warrington, which are ranked 231 and 199 respectively. Calculated using the rank of average rank measure, where 1 is the most deprived and 296 the least deprived local authority district.

Cheshire West and Chester are less deprived than 63% of local authority districts in England using the Overall Index of Multiple Deprivation (IMD). The Borough experiences the greatest level of relative deprivation in the 'Health and Disability' domain, compared to other types of deprivation.



Joint Strategic Needs Assessments

The Trust collaborates closely with the local authority's public health team and contributes to the Joint Intelligence Collaborative. This report acknowledges the team's work in developing Joint Strategic Needs Assessments (JSNAs) for the 33 identified priority areas.

Deprivation

The English Indices of Deprivation 2025 (IoD25) were published by the Ministry of Housing, Communities and Local Government (MHCLG) in October 2025.

The indices comprise seven different domains (or types) of deprivation, which are combined and weighted to create the overall Index of Multiple Deprivation (IMD) – the government's official measure of deprivation. The domains are:

- Income
- Employment
- Education, skills, and training
- Health and disability
- Crime
- Barriers to housing and services
- Living environment

The indices provide a set of relative measures of deprivation for small areas, called Lower layer Super Output Areas (LSOAs), across England. The indices rank each LSOA in England from most deprived to least deprived. There are 33,755 LSOAs in England, with an average population of 1,500.

Key headlines for Cheshire West and Chester (Cheshire West Residents)

The Index of Deprivation (IoD) 2025 shows that Cheshire West and Chester (CW&C) have a less deprived population profile compared to England, with the borough ranking 186 out of 296 local authority districts in terms of deprivation.

The Borough experiences the greatest level of relative deprivation in the 'Health and Disability' domain, compared to other types of deprivation.

There are however pockets of deprivation across the Borough, with 29,500 residents living in 19 neighbourhoods (LSOAs) that rank in the 10% most deprived neighbourhoods in England, based on the IMD.

Two of these neighbourhoods rank in the 1% most deprived areas in England. These neighbourhoods are in Lache and Westminster wards.

The highest levels of deprivation, based on the IMD, are found in primarily urban parts of the Borough.

Quintiles divide the rankings into five equal parts. 36 (16%) of CW&C LSOAs rank in quintile 1, the 20% most deprived LSOAs in England. The highest levels of deprivation are found in the urban areas of CW&C, primarily within the City of Chester, and the towns of Ellesmere Port, Northwich, and Winsford

The most deprived area in Cheshire West and Chester (CW&C) is in Lache ward, ranked 267 out of 33,755 areas (LSOAs) in England - placing it among the 1% most

deprived LSOAs nationally. Three of the five most deprived LSOAs in CW&C are in Winsford wards. Three of the ten most deprived LSOAs in CW&C are in Blacon ward and three are Ellesmere Port wards.

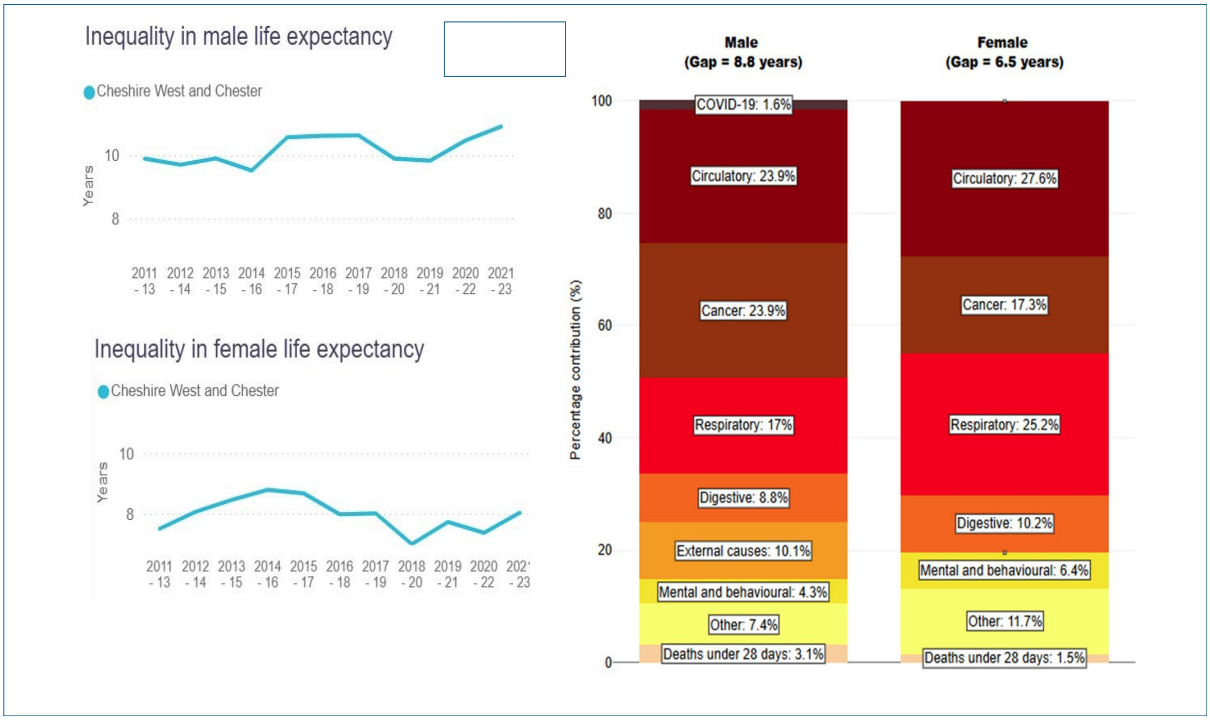
Ten most deprived lower super output areas (LSOAs) in Cheshire West and Chester according to the Index of Multiple Deprivation (IMD) 2025

CW&C Rank	LSOA code (2021)	LSOA name (2021)	Ward name	IMD Rank (1 is most deprived)	IMD Decile	IMD Percentile
1	E01018351	Cheshire West and Chester 044A	Lache	267	1	1
2	E01035368	Cheshire West and Chester 007I	Westminster	312	1	1
3	E01018748	Cheshire West and Chester 035C	Winsford Wharton	641	1	2
4	E01018740	Cheshire West and Chester 042C	Winsford Swanlow	692	1	3
5	E01018738	Cheshire West and Chester 040B	Winsford Over and Verdin	833	1	3
6	E01018524	Cheshire West and Chester 008B	Central and Grange / Sutton Villages	1223	1	4
7	E01018317	Cheshire West and Chester 031E	Blacon	1418	1	5
8	E01018311	Cheshire West and Chester 029C	Blacon	1533	1	5
9	E01018550	Cheshire West and Chester 011B	Wolverham	1801	1	6
10	E01018316	Cheshire West and Chester 031D	Blacon	2166	1	7

Life Expectancy in Cheshire West and Cheshire

Life expectancy is a key measure of a population's health and therefore the gap in life expectancy between the most and least deprived is a key measure of inequality.

There is an inequality in life expectancy of 8.8 years in Males and 6.5 years in females. This gap has widened since the COPVID pandemic and is the widest gap in males since this method was introduced in 2011-13.



- Female life expectancy in the most deprived areas of CW&C is lower in 2021-23 than in 2011-13 whilst increasing in the least deprived areas.
- Male life expectancy in the most deprived areas has also reduced in recent years.
- Breakdown of the life expectancy gap between the most and least deprived quintiles of Cheshire West and Chester by cause of death, 2022 to 2023.
- Biggest contributors to male gap in life expectancy are circulatory and cancer deaths. Together = 48%
- Biggest contributors to female gap in life expectancy are circulatory and respiratory deaths which together = 53%

Population Health - Ethnicity within Cheshire West and Chester

In England and Wales, there is an agreed list of ethnic groups used use when asking for someone's ethnicity. Whilst it is recognised that these ethnic groups do not represent how all people identify they are the groups associated within the Census, which happens every 10 years.

Cheshire West and Chester Ethnic Groups		
Ethnic group	Number	Percentage
Unavailable	993	0.28%
Asian or Asian British	11,749	3.26%

Black, Black British, Caribbean, or African	4,369	1.21%
Mixed or multiple ethnic groups	5,222	1.45%
Other ethnic groups	**6,371**	**1.77%**
Refused and not stated group	8,744	2.42%
White	**323,374**	**89.962%**

Increasingly the Trust is focussing how it can support the delivery of the National Ten-year plan and developing a suite of reports that focus on neighbourhood health as a means of aligning strategy and delivery of services. The following table describes the ethnicity within each of these neighbourhoods.

Neighbourhood	Unavailable	Asian or Asian British	Black, Black British, Caribbean, or African	Mixed or multiple ethnic groups	Other ethnic groups	Refused or not stated	White
Central Chester	0.7%	9.1%	13.5%	7.7%	9.1%	3.3%	12.1%
Chester East	0.0%	8.0%	17.4%	9.8%	9.9%	2.5%	11.1%
Chester South	3.4%	9.5%	13.1%	7.0%	8.6%	1.8%	13.0%
Ellesmere Port	1.7%	11.2%	14.5%	9.6%	16.5%	3.4%	15.2%
Frodsham and Helsby	4.3%	10.9%	14.1%	8.0%	8.8%	3.7%	13.2%
Neston and Willaston	0.0%	8.3%	17.2%	5.7%	6.4%	2.5%	11.4%
Rural	15.6%	11.5%	20.4%	4.0%	9.6%	4.8%	10.8%
Northwich	1.2%	8.0%	12.4%	6.0%	9.0%	3.3%	12.2%
Winsford	3.8%	8.2%	14.6%	5.0%	12.3%	3.4%	14.3%

Appendix C — Catchment, service utilisation and demographic analysis

An Introduction to understanding healthcare access, experience, and outcomes for the Countess of Chester (Trust catchment data)

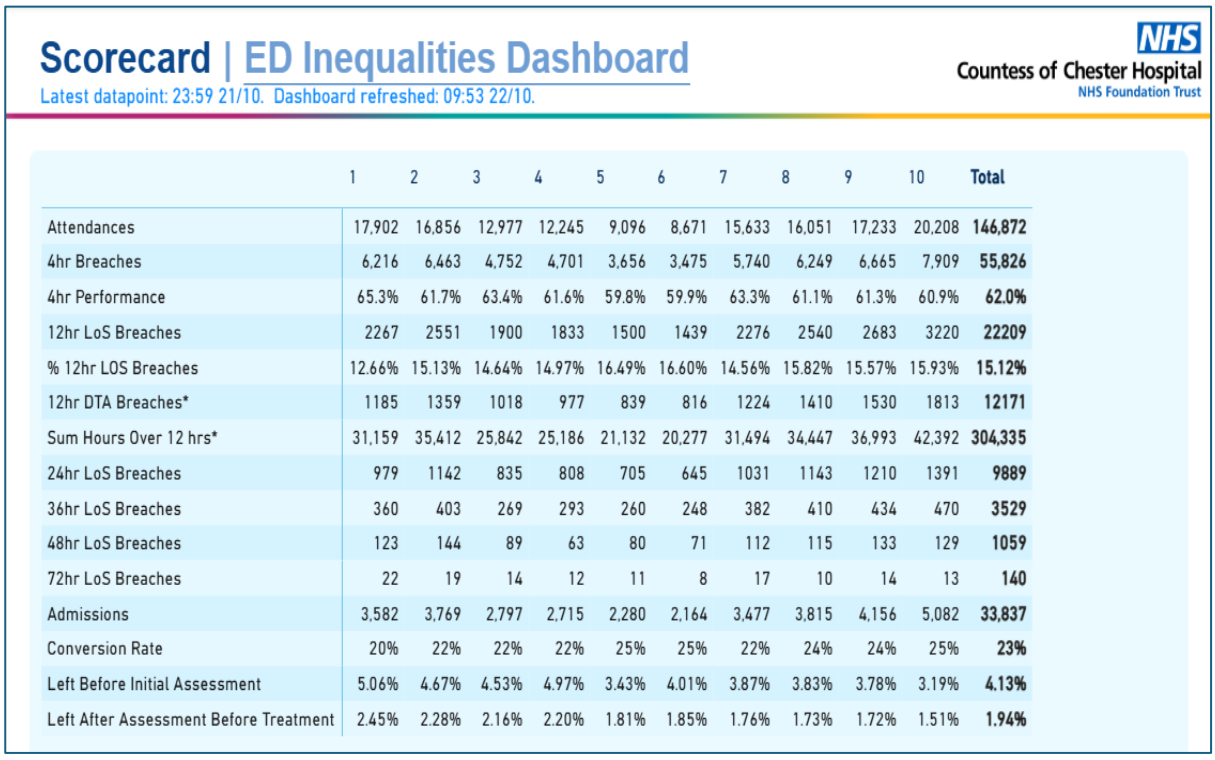
The Countess of Chester serves Cheshire West and a substantial population in Deeside and Flintshire, North Wales. For planning purposes, the Trust's total catchment population is 427,519, comprising 373,951 people in Cheshire West and 53,568 in North Wales.

The following access reports are provided using Trust catchment data.

The Trust has developed a range of dashboards monitoring health inequalities, including analysis of Emergency Department (ED) activity and performance, alongside the current Referral to Treatment (RTT) waiting list. These reports examine activity and outcomes by Index of Multiple Deprivation (IMD) decile, helping to identify potential differences in service utilisation and access to care. IMD Decile 1 represents an area of known deprivation, while Decile 10 represents the populations in the least deprived areas.

To aid understanding, each table includes **observational** commentary and a **concluding** section that interprets the data and outlines planned further work.

Emergency Department (ED)



Scorecard | ED Inequalities Dashboard

Latest datapoint: 23:59 21/10. Dashboard refreshed: 09:53 22/10.

NHS Countess of Chester Hospital NHS Foundation Trust

	1	2	3	4	5	6	7	8	9	10	Total
Attendances	17,902	16,856	12,977	12,245	9,096	8,671	15,633	16,051	17,233	20,208	**146,872**
4hr Breaches	6,216	6,463	4,752	4,701	3,656	3,475	5,740	6,249	6,665	7,909	**55,826**
4hr Performance	65.3%	61.7%	63.4%	61.6%	59.8%	59.9%	63.3%	61.1%	61.3%	60.9%	**62.0%**
12hr LoS Breaches	2267	2551	1900	1833	1500	1439	2276	2540	2683	3220	**22209**
% 12hr LOS Breaches	12.66%	15.13%	14.64%	14.97%	16.49%	16.60%	14.56%	15.82%	15.57%	15.93%	**15.12%**
12hr DTA Breaches*	1185	1359	1018	977	839	816	1224	1410	1530	1813	**12171**
Sum Hours Over 12 hrs*	31,159	35,412	25,842	25,186	21,132	20,277	31,494	34,447	36,993	42,392	**304,335**
24hr LoS Breaches	979	1142	835	808	705	645	1031	1143	1210	1391	**9889**
36hr LoS Breaches	360	403	269	293	260	248	382	410	434	470	**3529**
48hr LoS Breaches	123	144	89	63	80	71	112	115	133	129	**1059**
72hr LoS Breaches	22	19	14	12	11	8	17	10	14	13	**140**
Admissions	3,582	3,769	2,797	2,715	2,280	2,164	3,477	3,815	4,156	5,082	**33,837**
Conversion Rate	20%	22%	22%	22%	25%	25%	22%	24%	24%	25%	**23%**
Left Before Initial Assessment	5.06%	4.67%	4.53%	4.97%	3.43%	4.01%	3.87%	3.83%	3.78%	3.19%	**4.13%**
Left After Assessment Before Treatment	2.45%	2.28%	2.16%	2.20%	1.81%	1.85%	1.76%	1.73%	1.72%	1.51%	**1.94%**

Observations: ED attendances are concentrated in IMD deciles 1–2 and 7–10, with comparatively lower activity across deciles 3–6.

This demonstrates a variation in service utilisation across deprivation groups, reflecting the Trust's local population profile, including concentrations of deprivation in some communities and a substantial older population in more affluent areas.

Conclusions: These differences highlight the importance of considering population demographics and underlying clinical need when interpreting ED activity. The higher admission conversion observed in less deprived populations may partly reflect their older age profile, alongside differences in frailty, clinical complexity, and presenting conditions.

Similarly, the lower proportion of patients experiencing waits exceeding 12 hours in IMD decile 1 warrants further investigation to understand whether this reflects differences in patient characteristics, pathways, or operational factors.

Further age-adjusted analysis would help establish the extent to which demographic differences explain the variation observed, and whether there are underlying inequalities in access, treatment or patient flow that require attention.

Referral to Treatment (RTT)

Scorecard | RTT Current Waitlist Inequalities

Latest datapoint: 15:05 20 Oct 26. Dashboard refreshed: 15:05 20 Oct 26.

NHS Countess of Chester Hospital NHS Foundation Trust

	0	1	2	3	4	5	6	7	8	9	10	Total
Total Active Pathways	1617	2960	2649	2243	1989	1691	1968	3413	3160	3943	4533	**30166**
Total Patients waiting 0-18 weeks	876	1879	1661	1422	1316	1103	1295	2232	2097	2649	3124	**19654**
Total Patients waiting 19-40 weeks	665	859	784	661	561	481	553	971	905	1095	1213	**8748**
Total Patients waiting 41-52 weeks	52	136	137	113	88	69	90	149	116	146	144	**1240**
Total Patients waiting 53-65 weeks	21	59	44	35	16	28	23	40	32	33	37	**368**
Total Patients waiting 66-78 weeks	1	20	18	8	2	7	5	18	7	11	11	**108**
Total Patients waiting 78-104 weeks	1	6	5	4	6	3	2	3	3	9	3	**45**
Total Patients waiting over 104 weeks	1	1	0	0	0	0	0	0	0	0	1	**3**
Total < 52 Week Pathways	1593	2874	2582	2196	1965	1653	1938	3352	3118	3890	4481	**29642**
% < 18 Weeks	54.2%	63.5%	62.7%	63.4%	66.2%	65.2%	65.8%	65.4%	66.4%	67.2%	68.9%	**65.2%**
% > 52 Weeks	1.5%	2.9%	2.5%	2.1%	1.2%	2.2%	1.5%	1.8%	1.3%	1.3%	1.1%	**1.7%**
Median Weeks Waited	17	14	15	14	14	13	13	13	13	13	13	**14**
Median Age	36	44	47	48	55	56	57	54	57	58	61	**54**

IMD Decile 1 is the most deprived 10% of areas while IMD 10 is the least deprived. 0 refers to patients with no match or no postcode inputted against their record (Mostly Wirral/Warrington patients)

Observations: RTT activity demonstrates a broadly similar distribution to ED attendances, with substantial representation from IMD deciles 1–2, comparatively lower activity across the middle deciles and higher volumes again in deciles 9–10.

Patients without an assignable IMD decile appear more likely to breach the 18-week RTT standard. However, this group includes patients from geographical areas such as Wirral and Warrington and therefore cannot be interpreted as a single socioeconomic cohort.

Differences in age profile, specialty mix and clinical complexity may contribute to variations in waiting list performance, although the extent to which these factors explain the observed differences is not yet established.

Conclusions: The variation in 18-week performance highlights the need to understand whether patients from different socioeconomic backgrounds experience comparable access to elective care.

In particular, the higher breach rates observed among patients without an assignable IMD decile warrant further investigation to establish whether these reflect geographical differences, postcode data quality or variation in specialty-level waiting list performance. Further analysis will focus on comparing RTT performance within individual specialties and age groups, whilst accounting for geographical coverage. This would help identify whether any groups experience disproportionately longer waits and whether targeted improvements to elective pathways may be required.

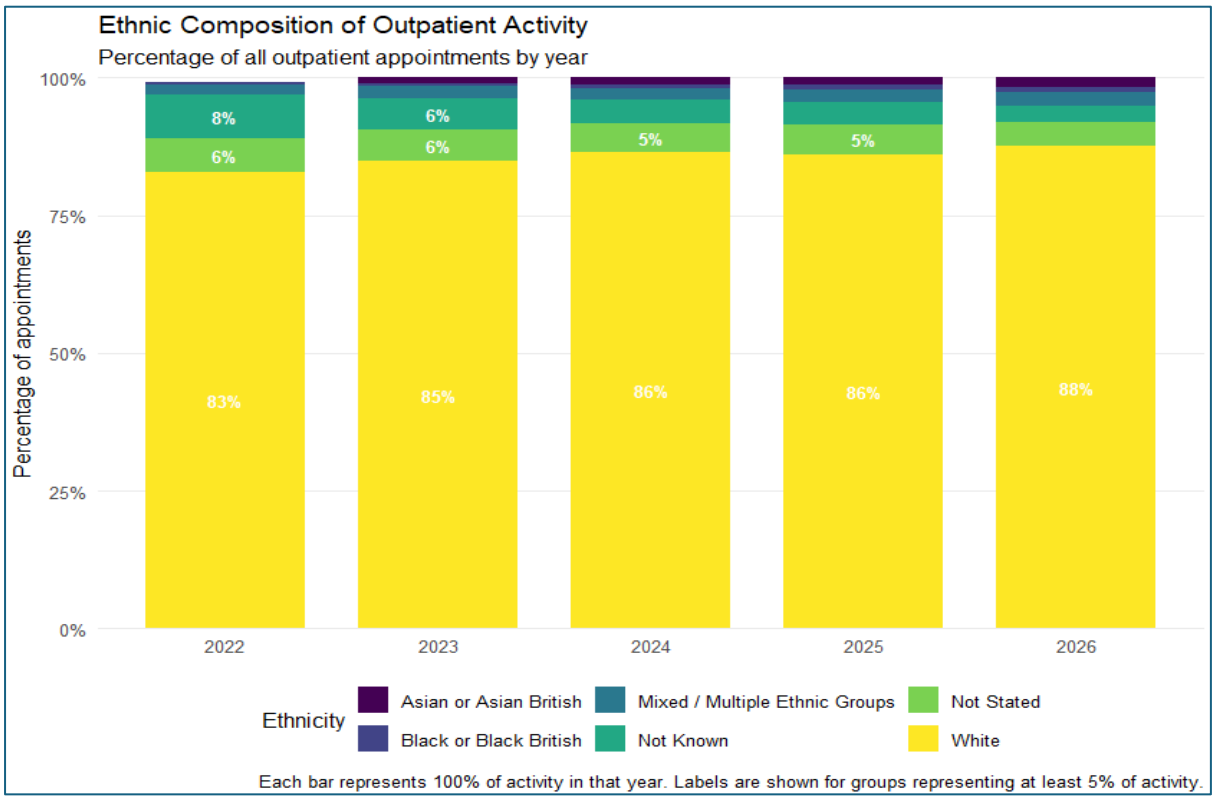
Cheshire West: Population Health, understanding our demographics.

In the United Kingdon we use broad high-level groups that break down into specific subcategories, these are used in this report and include.

- Asian, Asian British or Asian Welsh: Includes Indian, Pakistani, Bangladeshi, Chinese, and Other Asian.
- Black, Black British, Black Welsh, Caribbean, or African: Includes African, Caribbean, and Other Black.
- Mixed or Multiple ethnic groups: Includes combinations such as White and Black Caribbean, White and Black Asian, or other mixed backgrounds.
- White: Includes British, English, Welsh, Scottish, Northern Irish, Irish, Gypsy or Irish Traveller, Roma, and Other White.
- Other ethnic group: Includes Arab and any other background.

Understanding the demographic profile of Cheshire West and Chester (CWAC) is essential to being able to interpret any health inequalities across our hospital activity.

The local population is ageing, and most residents identify as White British, as defined in the national census. This is reflected when looking at our Outpatient activity since 2022:



Observations: White, Not Stated and Not known ethnic categories have accounted for approximately 90-95% of attendances each year. In 2026, a reduction in Not Stated and Not Known records has resulted in the White category accounting for roughly 88% of attendances, in line with the overall populace.

Conclusion: The demographic profile of CWAC is an important consideration when interpreting differences in hospital activity and outcomes. The relatively small representation of some ethnic minority groups within the local population means that their activity may appear proportionately low in hospital datasets, even where differences in access or outcomes exist. This makes it particularly important to consider activity relative to the underlying population rather than relying solely on absolute attendance numbers.

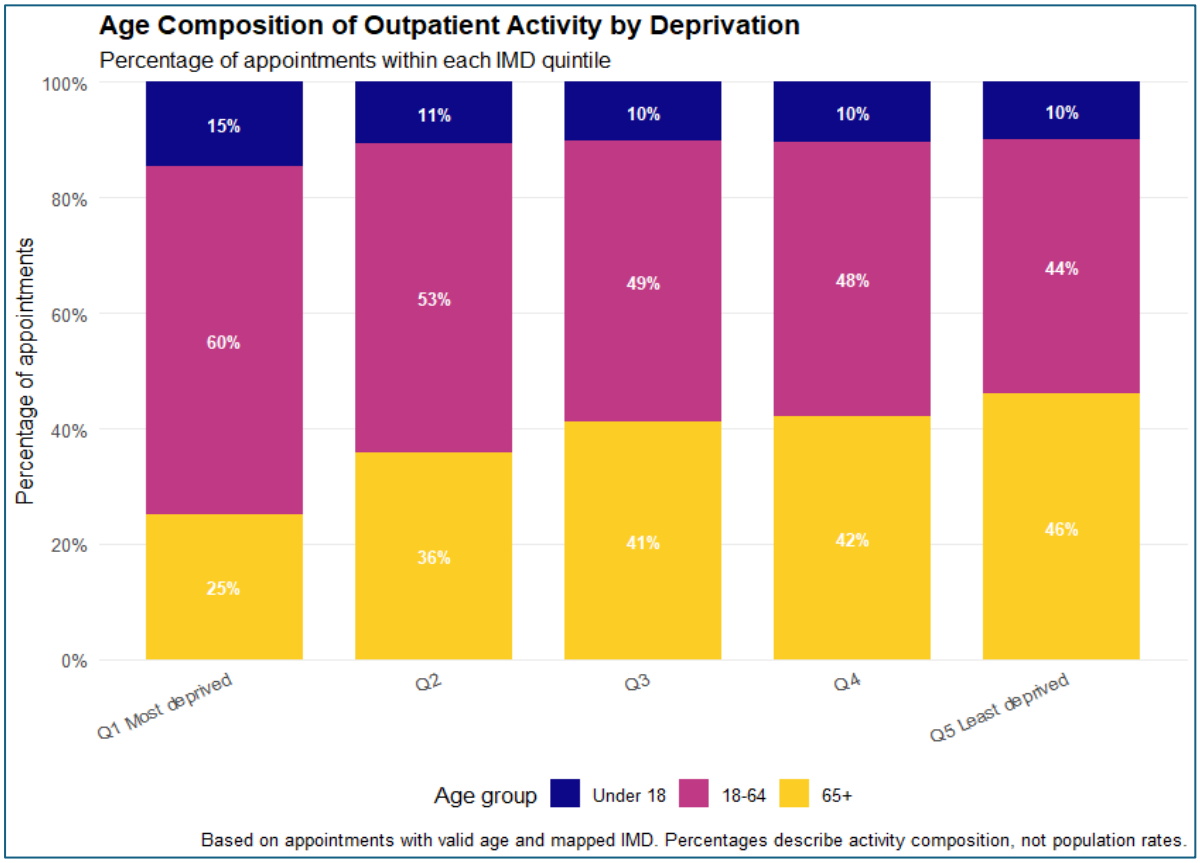
Emergency Department (ED) and inpatient activity broadly demonstrate similar ethnicity profiles; therefore, to avoid duplication, the subsequent analysis focuses on the differences in outcomes and activity patterns.

At a population level, approximately 90% of CWAC residents identify as White, with Asian British residents accounting for 3.26%, Not stated at 2.42% while other ethnic groups each represent less than 2% (CIPHA)

A key consideration is the relationship that age has on deprivation across our local population. CWAC includes a university population, with younger residents and

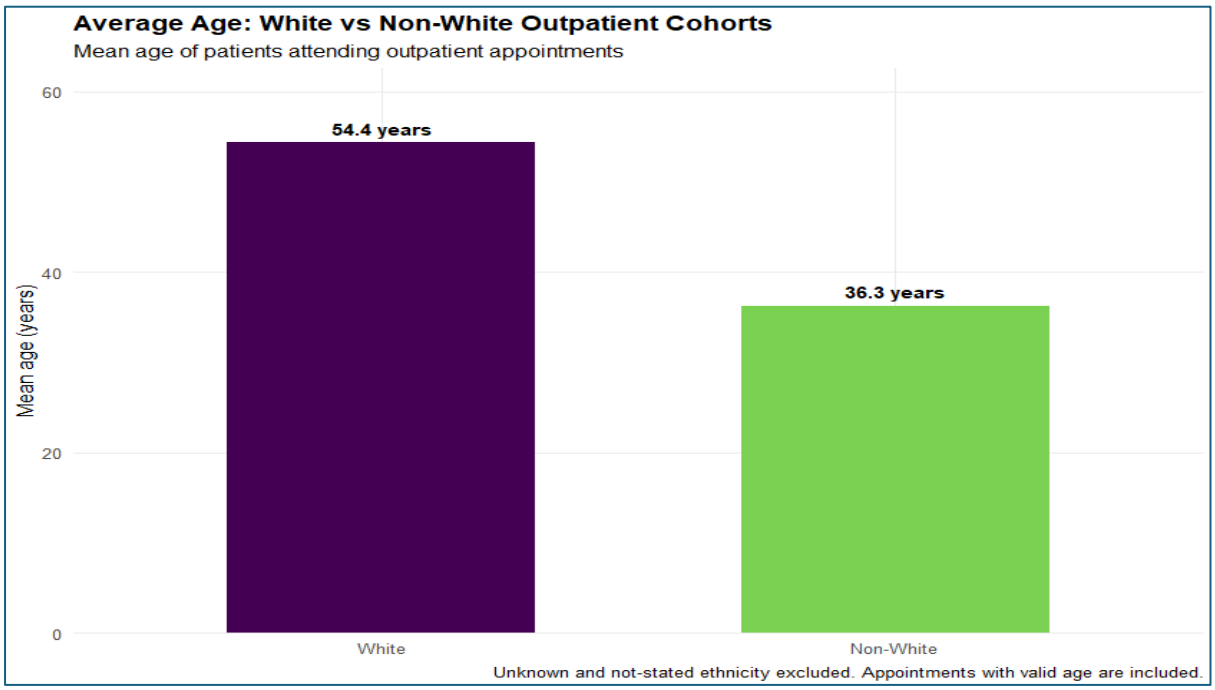
students more commonly represented in deprived areas, while older residents are more heavily represented in less deprived areas.

This pattern is reflected in our hospital activity, with a difference of more than 10 years in the average patient age between patients in the highest levels of deprivation and our least deprived population according to the Index of Multiple Deprivation (IMD) groups.



Observations: The age profile of activity varies substantially by deprivation. Patients aged 65 and over account for approximately 25% of activity in the most deprived quintile (Quint1), compared with close to 50% in the least deprived quintile (Q5). Separate analysis shows the average age of patients is 46.2 years in Quint1 and 56.5 years in Quint5, a difference of 10.3 years.

Conclusions: These demographic differences are important when interpreting variations in activity and outcomes, as age may influence clinical need as well as service utilisation and the apparent distribution of health inequalities.



Observation: Age also differs considerably between ethnic groups. Excluding records categorised as Not Known or Not Stated, the average age of the White cohort is approximately 18 years higher than that of the non-white cohort.

Conclusion: Taken together, these findings indicate that age, ethnicity, and deprivation are closely interrelated within the population accessing our services. The older white patient cohort is more heavily represented in less deprived areas, while ethnic minority cohorts are generally younger and more represented in heavily deprived areas. These differences provide important context for interpreting variation in hospital activity and outcomes. They also highlight the need to account for age and population composition when assessing whether observed differences represent inequalities in access, treatment, or outcomes, rather than differences arising from the underlying demographic profile.

Appendix D — Population change and future demand

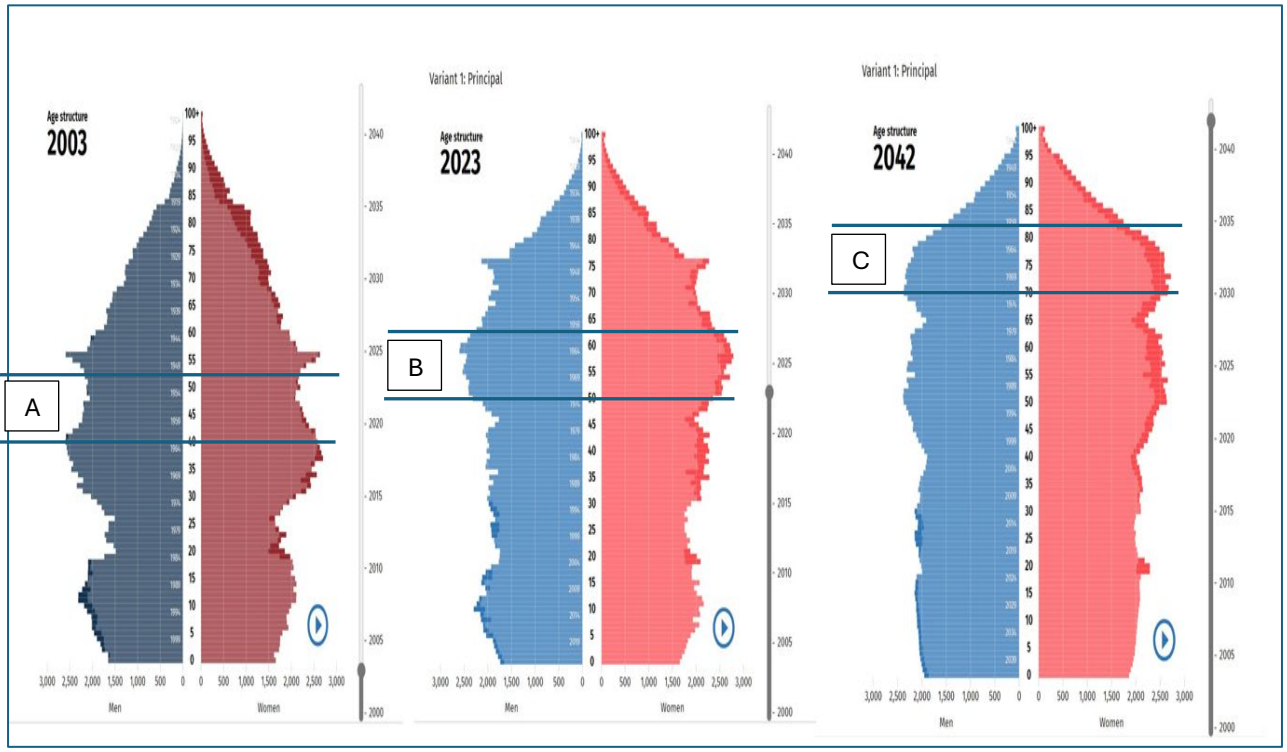
Population Demographics and Implications for Healthcare Demand

Whilst much of the preceding analysis has focused on current demographics and existing health inequalities, it is equally important that the Trust considers the future population it will be required to serve. Demographic projections for Cheshire West and Chester (CWAC) indicate a significant shift in the age profile of the local population over the coming decades, with important implications for the scale, complexity, and nature of future healthcare demand.

The Trust already serves a population with a relatively high proportion of older residents. However, the projected demographic changes suggest that this trend will

become increasingly pronounced, requiring the organisation to consider whether its current service configuration, workforce and estate are appropriately positioned to meet future needs.

The population pyramids below illustrate the changing age structure of CWAC across 2003, 2023 and the projected position in 2042.



Observations: The charts demonstrate the progressive ageing of larger population cohorts. In 2003, some of the largest population groups were concentrated around the 30–40 age range **(A).** By 2023, these larger cohorts had moved into the 50–60 age range, **(B)** with a comparatively smaller population across parts of the younger working-age demographic. By 2042, these same population groups are projected to have moved further into the 70–80 age range. **(C)**

This represents more than simply an increase in the number of older residents. It illustrates a structural change in the population, whereby the larger cohorts currently approaching older age will increasingly become the population groups with the greatest healthcare requirements.

At the same time, the relative size of younger working-age cohorts is projected to remain smaller, potentially creating additional pressures on the availability of both healthcare staff and the wider social care workforce.

Conclusions: These demographic changes are changing the way the Trust has had to respond with more dedicated areas for medical admissions, frailty, and emergency assessment. Furthermore, it is likely to have significant implications for the Trust's future

operating model. As the population ages, the prevalence of long-term conditions and multimorbidity is likely to increase.

Conditions such as cancer, cardiovascular disease, diabetes, dementia, respiratory disease, and musculoskeletal disorders are more prevalent in older populations, often requiring ongoing monitoring, specialist intervention, and coordinated care across multiple services.

Patients with multiple long-term conditions are also more likely to experience complex clinical presentations, increased medication requirements, and greater vulnerability to acute deterioration. This may translate into increased demand across emergency care, inpatient services, diagnostics, and outpatient follow-up, alongside a greater requirement for coordinated multidisciplinary care.

Increased demand for urgent and emergency care and inpatient capacity

Older patients are generally more vulnerable to the consequences of acute illness, infection, falls and other adverse health events. They may require more intensive assessment, treatment, and monitoring, with a greater likelihood of admission and longer recovery periods.

This has potential implications for emergency department demand, admission conversion rates, inpatient bed occupancy, and the availability of appropriate specialist environments. In particular, the Trust may experience increasing demand for older people's medicine, frailty services, acute geriatric assessment, and specialist inpatient provision.

The implications are not necessarily limited to an increase in overall activity, but also a change in the complexity and resource requirements associated with each episode of care. (Hospital and community).

Greater pressure on discharge pathways and rehabilitation services

An ageing population is likely to increase demand for rehabilitation, intermediate care and ongoing support following an acute hospital admission. Older patients may experience reduced mobility, functional decline, and loss of independence during periods of illness or hospitalisation, requiring additional support before they can safely return home.

Where sufficient community, social care or step-down capacity is unavailable, patients may remain in hospital beyond the point at which their acute medical treatment is complete.

This creates additional pressure on bed capacity, increases the risk of deconditioning and hospital-associated complications, and can contribute to delayed discharges.

The availability of community rehabilitation, domiciliary care, intermediate care beds, and appropriate long-term care provision will therefore become increasingly important in determining the Trust's ability to maintain patient flow.

Workforce capacity and future skills requirements

The changing population profile also presents a workforce challenge. As the proportion of older residents increases, the Trust is likely to require greater capacity and expertise in geriatric medicine, frailty, dementia care, rehabilitation, and the management of patients with multiple long-term conditions.

This may require a shift in workforce planning, including the development of specialist skills across nursing, medical, and allied health professional teams. It will also be important to consider how these requirements translate into the configuration of inpatient wards, specialist teams, and multidisciplinary working. The Trust has already begun to experience the operational impact of this demographic shift. Historically, the Trust operated two dedicated Care of the Elderly wards; however, in response to the changing needs of the population, additional inpatient areas have since been established with a focus on elderly medicine and the delivery of more specialised care.

Furthermore, a comparatively smaller working-age population could make recruitment and retention more challenging across the wider health and social care system, particularly as demand for services increases. Workforce planning will therefore need to consider not only the number of staff required, but also the changing clinical skill mix needed to deliver care safely and effectively.

Financial sustainability, estate, and service configuration

Increasing clinical complexity, longer inpatient stays, additional rehabilitation requirements, and greater demand for specialist services all have potential financial implications.

The Trust may need to consider whether its existing estate and bed configuration are appropriate for the future population, including the availability of frailty-friendly environments, appropriate inpatient facilities, rehabilitation capacity, and specialist older people's services.

This does not necessarily mean that increasing acute bed numbers will be the only or most appropriate response. There will also be opportunities to reduce avoidable admissions, strengthen community-based provision, improve supported discharge, and develop more proactive models of care. However, these approaches will require sufficient investment and capacity outside the acute hospital to be sustainable.

Strategic Considerations

The demographic projections highlight the importance of moving beyond a retrospective understanding of activity towards a more forward-looking approach to population health and service planning.

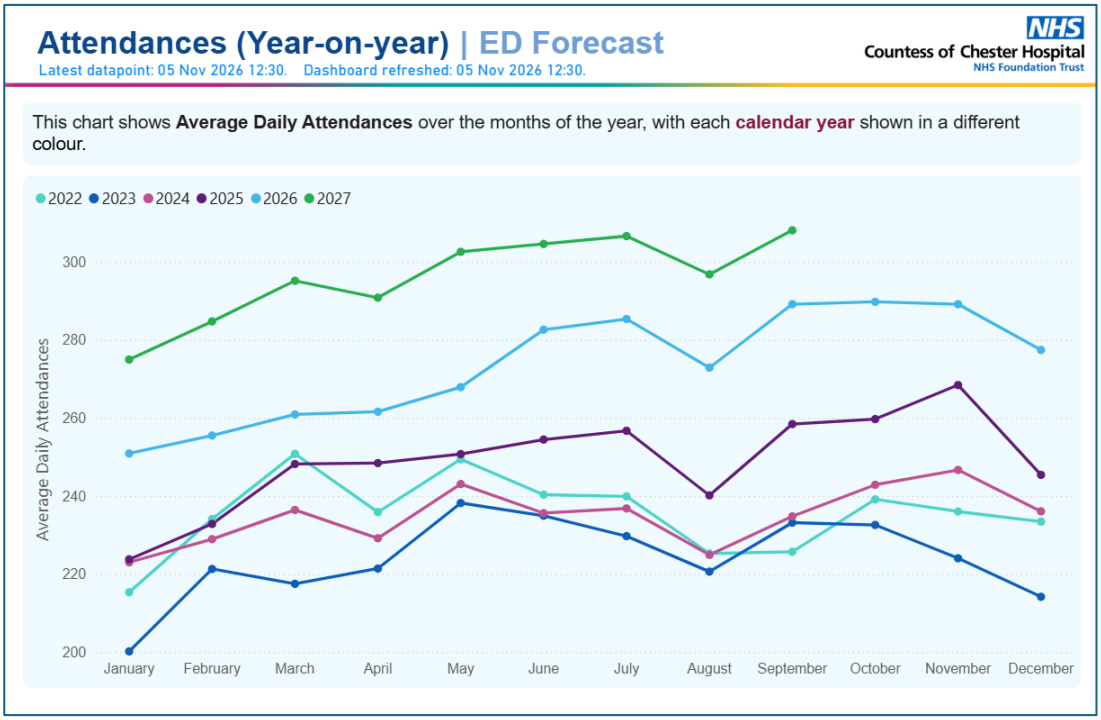
For the Trust, this means considering not only how much activity is currently being delivered, but how the age profile, clinical complexity and support requirements of the population are likely to change over the next 10–20 years.

This should inform future decisions regarding workforce planning, estate utilisation, inpatient capacity, specialist service development and collaboration with community and social care partners.

Ultimately, the challenge is not simply to accommodate a larger older population, but to ensure that the Trust's model of care evolves to meet the increasingly complex needs of that population, whilst maintaining access, quality, patient experience, and financial sustainability.

Translating Population Change into Current and Future Activity Demand

The demographic changes outlined above are not simply a future consideration; increasing demand is already evident within the Trust's activity. Emergency Department (ED) attendances have demonstrated a sustained upward trajectory, with average daily attendances increasing considerably in recent years. The latest forecasts suggest this trend will continue, with an anticipated increase of approximately 8% in average daily attendances during calendar year 2027.



Observations: The year-on-year comparison demonstrates a clear increase in average daily attendances since 2025. While some seasonal variation is evident across individual months, the overall trajectory indicates a sustained increase in demand rather than isolated periods of heightened activity. The 2026 figures show average daily attendances reaching approximately 289 by November, compared with around 260 in November 2025. The 2027 forecast indicates that this could increase further, reaching average daily attendances more than 300 during several months of the year.

Further analysis of ED activity by age group identified that much of the recent growth has been concentrated within the 18–54 population. This is an important finding, as it demonstrates that increasing demand is not solely attributable to an ageing population, but is also being driven by younger and working-age adults.

Conclusions: There are several potential factors that may contribute to this increase, including changes in population size, access to primary and community care, evolving healthcare-seeking behaviours and changes in the prevalence or complexity of presenting conditions. Other potential contributors include increased demand relating to mental health, injuries, long-term conditions, and patients requiring urgent assessment where alternative services may not be readily accessible.

It is important to establish whether this growth reflects an increase in the number of people accessing emergency services, changes in the frequency of attendance among existing patients, or changes in the clinical needs and acuity of those presenting.

Implications for future urgent and emergency care demand

The combination of increasing ED activity and an ageing population presents a dual challenge for the Trust. In the shorter term, sustained growth in working-age attendances is likely to place continued pressure on emergency department capacity, clinical staffing, diagnostics, and patient flow. In the longer term, the ageing of larger population cohorts is likely to introduce additional demand associated with frailty, multimorbidity, complex admissions and longer recovery periods.

This suggests that future emergency care planning cannot focus exclusively on the needs of an older population. The Trust will need to accommodate increasing demand across a broad range of age groups, whilst adapting its clinical pathways and workforce to manage the greater complexity associated with an ageing population.

The forecast increase also reinforces the importance of developing services that can manage demand outside the traditional emergency department setting, including appropriate urgent care alternatives, improved access to primary and community services, and more proactive management of patients with long-term conditions.

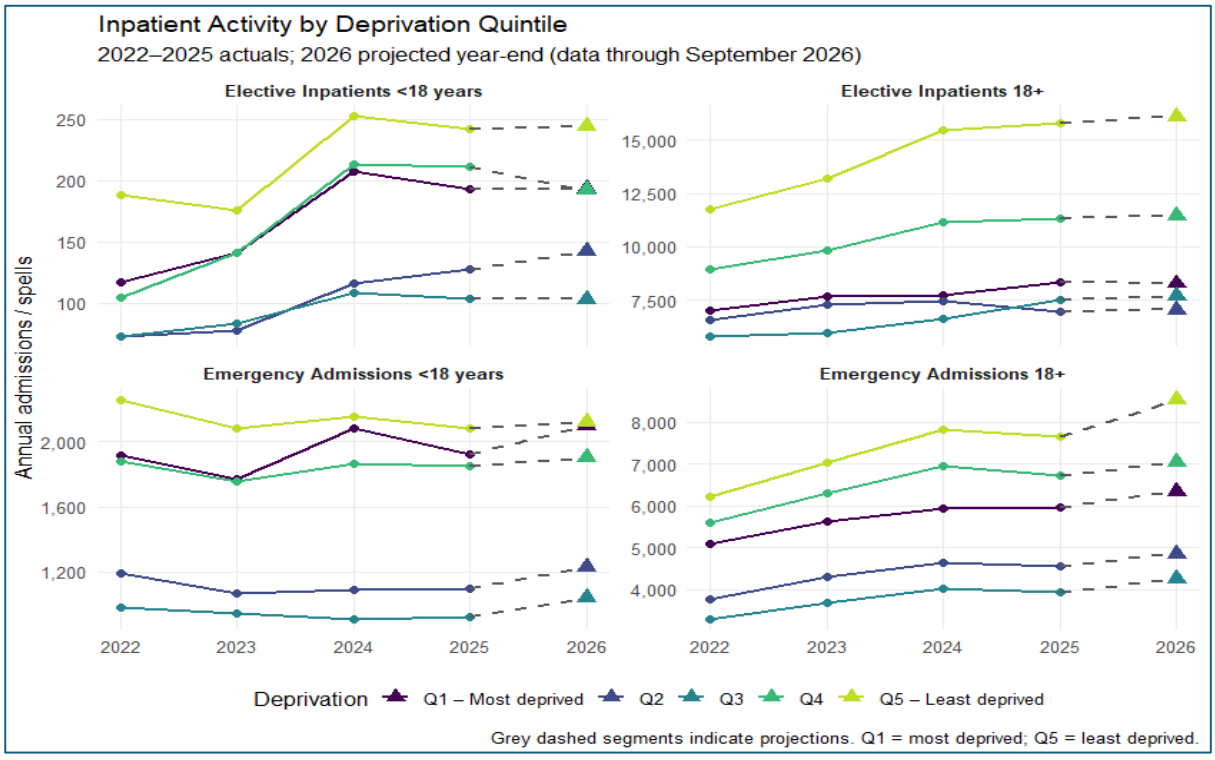
Strengthening these pathways may help reduce avoidable ED attendances and ensure emergency capacity remains available for patients who require acute hospital intervention.

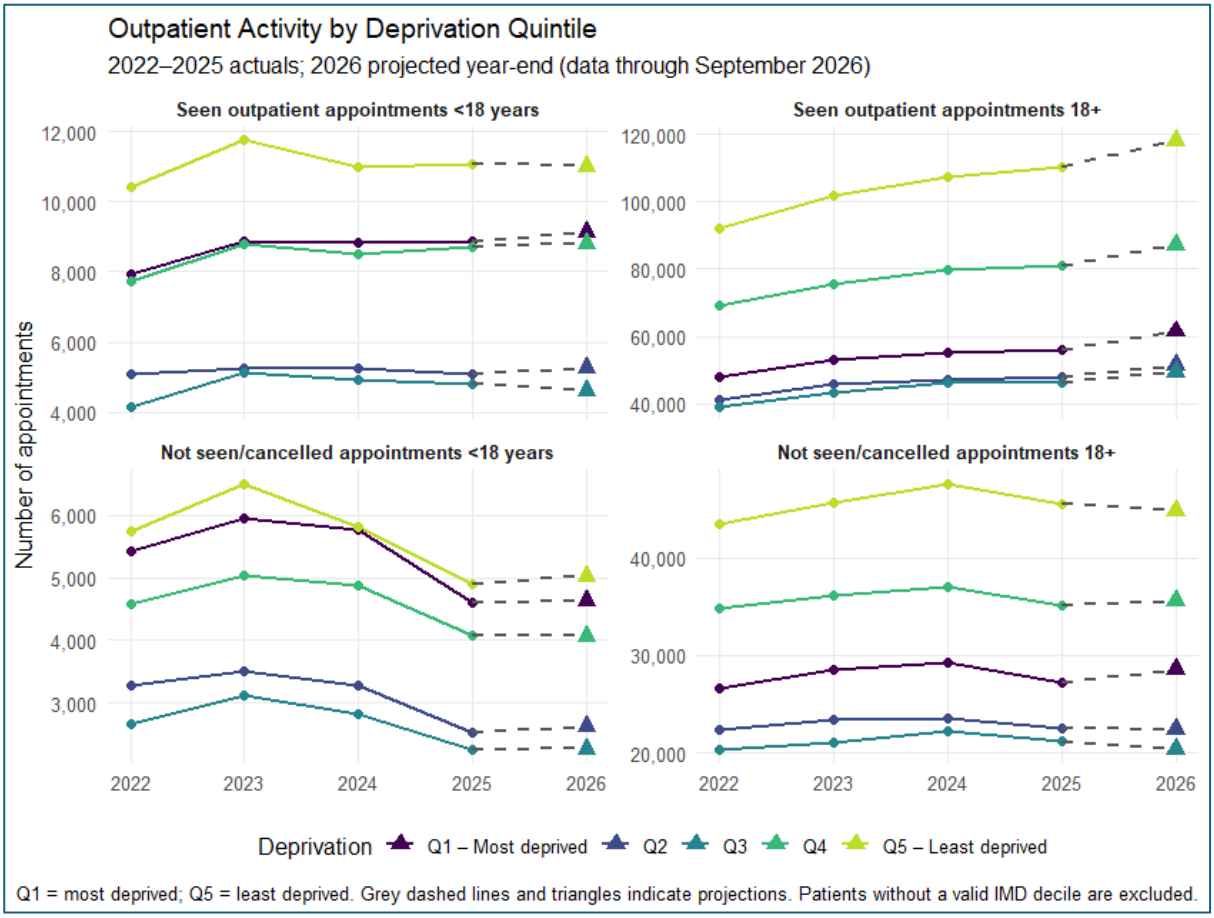
Importantly, these pressures are not isolated to emergency care. The same underlying demographic changes are likely to influence demand across planned and elective services, particularly as the population ages and the prevalence of conditions requiring specialist assessment, diagnostics, and treatment increases.

The following section therefore considers how these demographic and population changes are reflected in the Trust's elective activity, including the distribution of demand and potential inequalities in accessing our services.

Appendix E — Detailed activity, access and clinical outcomes

Current Levels of In Patient and Outpatient Activity





Inpatient activity

Elective admissions among adults have increased across most deprivation groups since 2022, with the highest volumes consistently observed in the least deprived quintile (Q5). Emergency admissions among adults have also generally increased, with projected 2026 activity suggesting further growth across all quintiles. This may reflect differences in population size, age profile, and healthcare needs, rather than deprivation alone.

For our child cohort, elective activity increased notably between 2023 and 2024, particularly in Q4 and Q1, before stabilising and declining slightly in 2025. Emergency admissions have remained comparatively stable over the period, with relatively minor changes between the deprivation groups. The 2026 projections indicate broadly similar activity levels to recent years in most groups.

Outpatients

Outpatient activity has seen an increase since 2022 amongst adults in all the deprivation quintiles, with the greatest absolute volumes in Q5 and Q4. The under 18 cohort seems to appear more stable overall, although activity increased between 2022 and 2023 before levelling off.

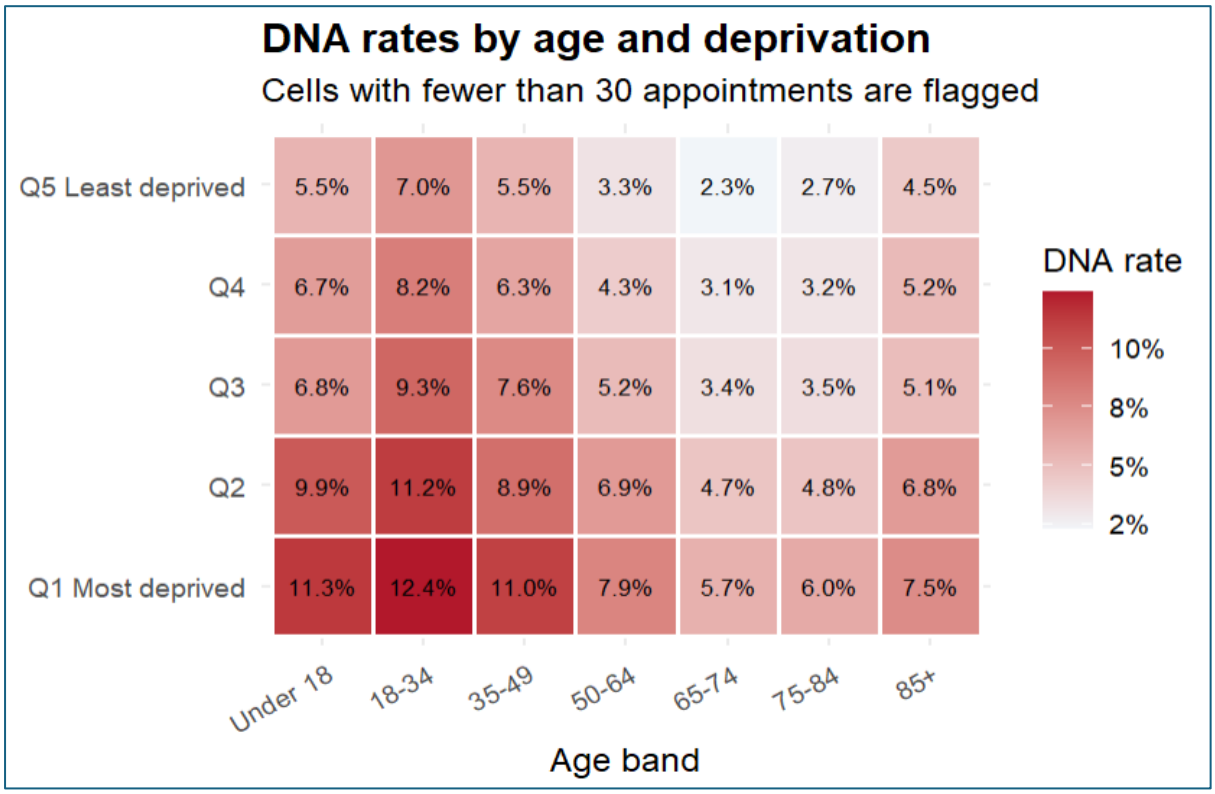
Not seen/cancelled appointments have generally declined since 2023 across both age groups. The reduction is particularly visible among under 18s in Q1 and Q5, while adult activity has also fallen from its 2024 levels in several quintiles.

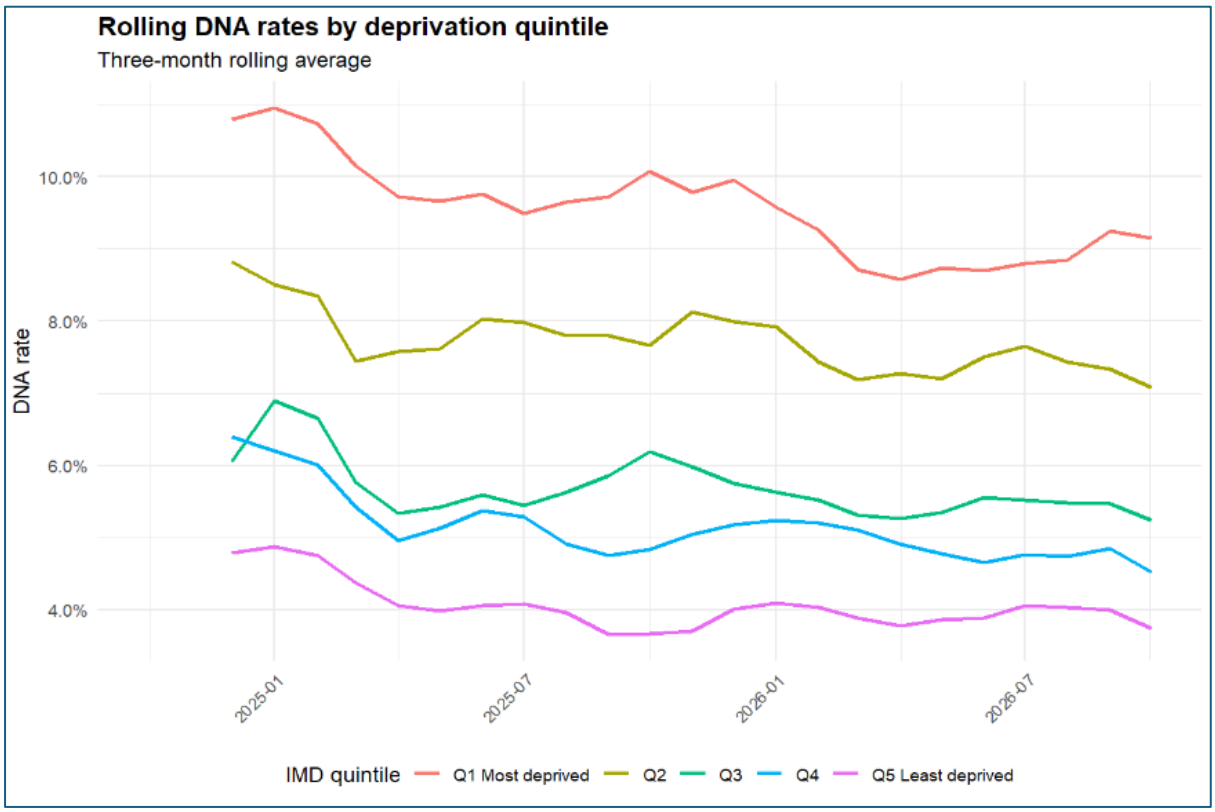
This indicates an improvement in our attendance patterns or changes in appointment volume, as the population of CWAC has increased in the same years.

Understanding healthcare access, experience, and outcomes

Elective recovery

The Trust has established mechanisms to monitor health inequalities in our outpatient services, including the Outpatient dashboard and the Did Not Attend (DNA) prediction tool. These provide insights into differences in appointment attendance across demographic groups and levels of deprivation, helping identify where targeted interventions may improve access to care.





Observations: Analysis of Outpatient DNA rates demonstrate a consistent relationship between deprivation and non-attendance, with more deprived groups generally experiencing higher DNA rates across age bands.

The highest rate was observed among patients aged 18-34 in the most deprived quintile (Quint 1), with a notable concentration of activity belonging to the 18-22 ages.

This may partly reflect the local student population, for whom factors such as changes of address, competing educational commitments, transport costs or difficulties managing appointments may present barriers to attendance.

Although DNA rates have declined across all deprivation quintiles, the scale of improvement has varied. Quint 1 recorded a 15.2% reduction, compared with 29.4% in Quint 4 and 21.9% in Quint 5.

Conclusions: This analysis suggests that, while overall performance has improved, the gap associated with deprivation remains a critical area for further work. Understanding the specific barriers experienced by patients in more deprived communities will be essential to developing interventions that improve attendance equitably.

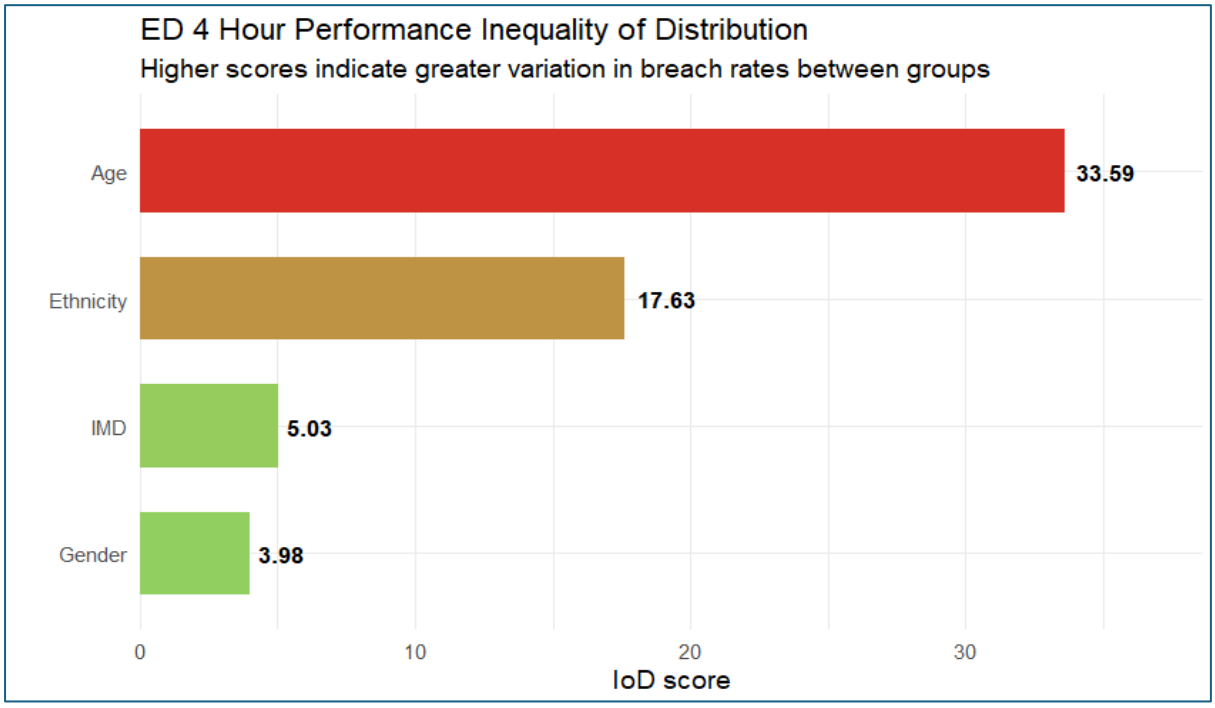
The Trust has also trialled a DNA prediction model within Diabetic Medicine. The model uses factors including previous attendance behaviour and deprivation to identify patients at increased risk of missing appointments.

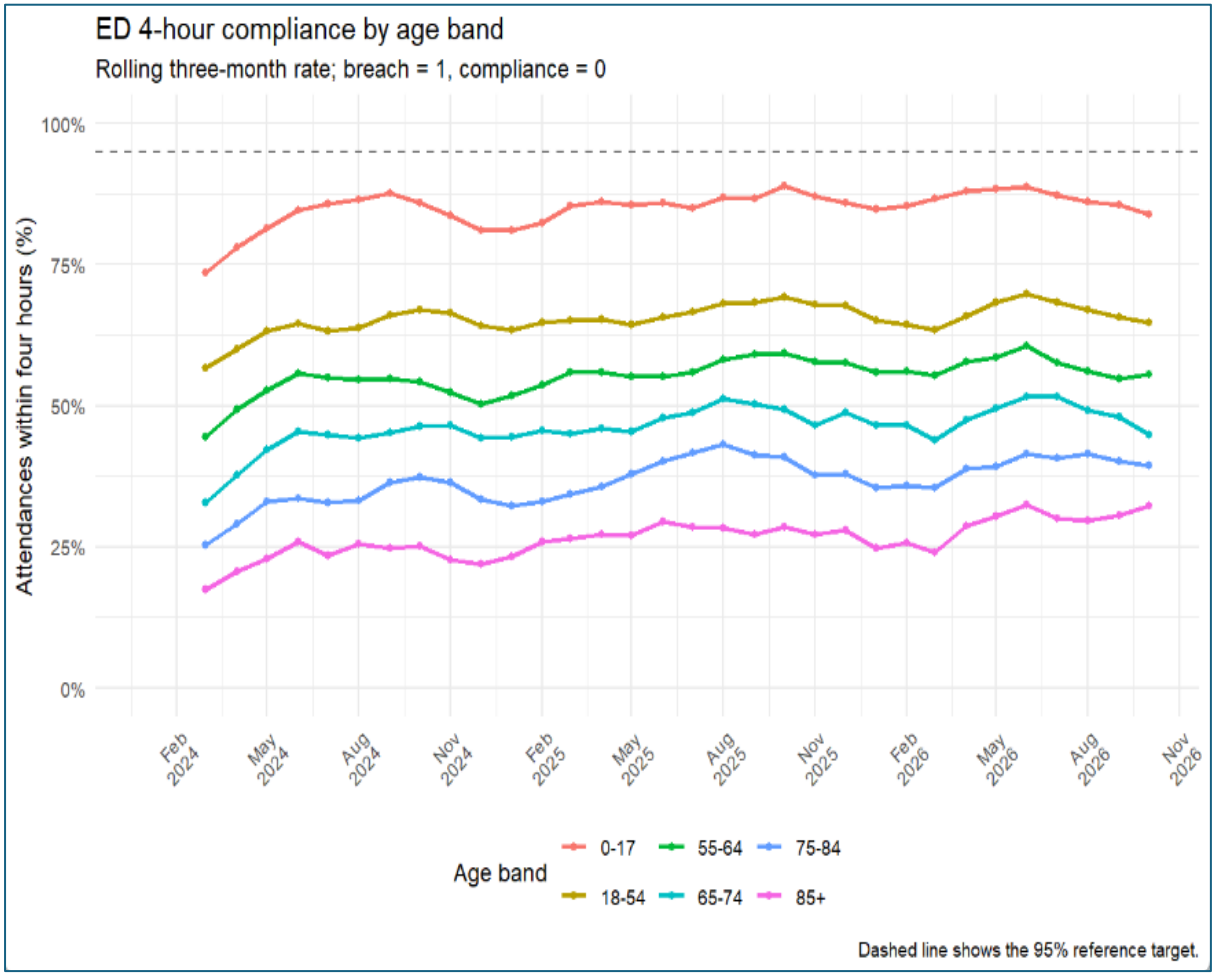
This creates an opportunity for targeted, proactive contact before an appointment, allowing staff to explore potential barriers and offer appropriate support. Evaluation will be important to determine whether these interventions reduce non-attendance and whether the benefits extend across deprivation groups.

Urgent Care

The Trust has used the Index of Disparity (IOD) to assess variation in key urgent care performance measures across age, gender, ethnicity, and deprivation groups. The IOD provides a summary measure of how much outcomes vary between population groups: higher scores indicate greater variation, while lower scores indicate more consistent outcomes. It helps identify where further investigation may be required, but does not, in isolation, explain the reasons for differences or establish that these differences are caused by inequality.

ED 4-hour performance:

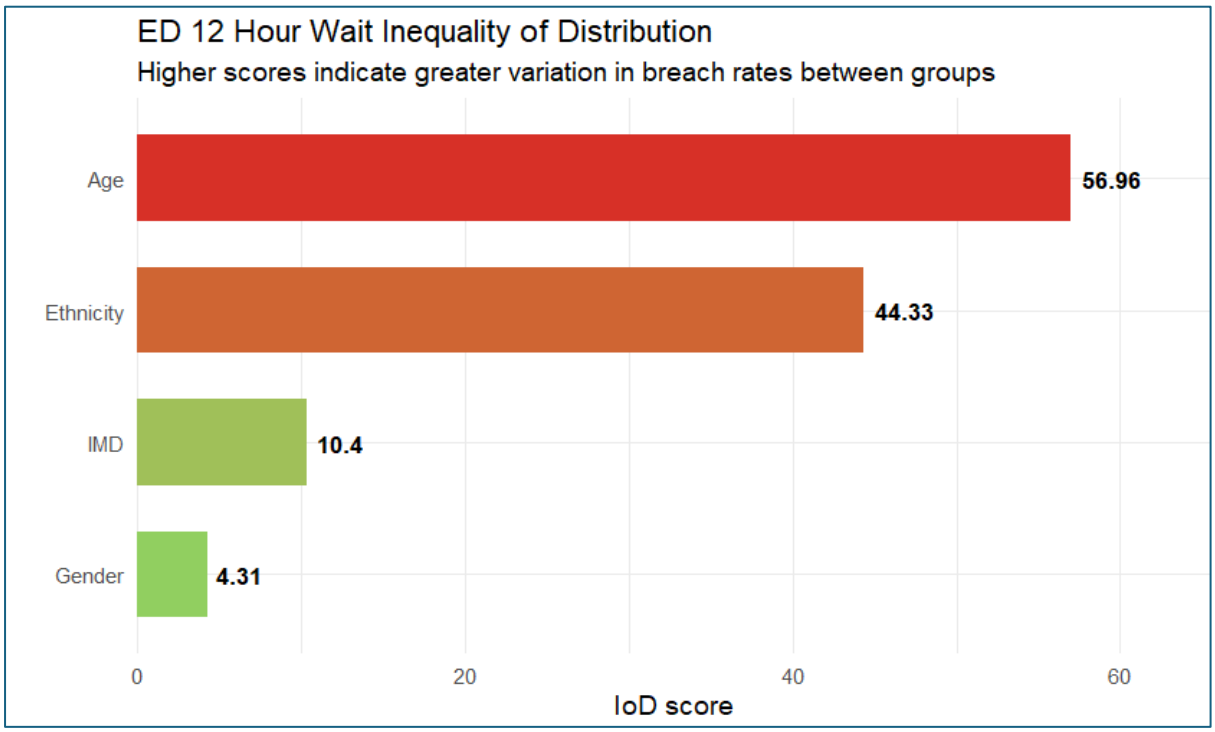


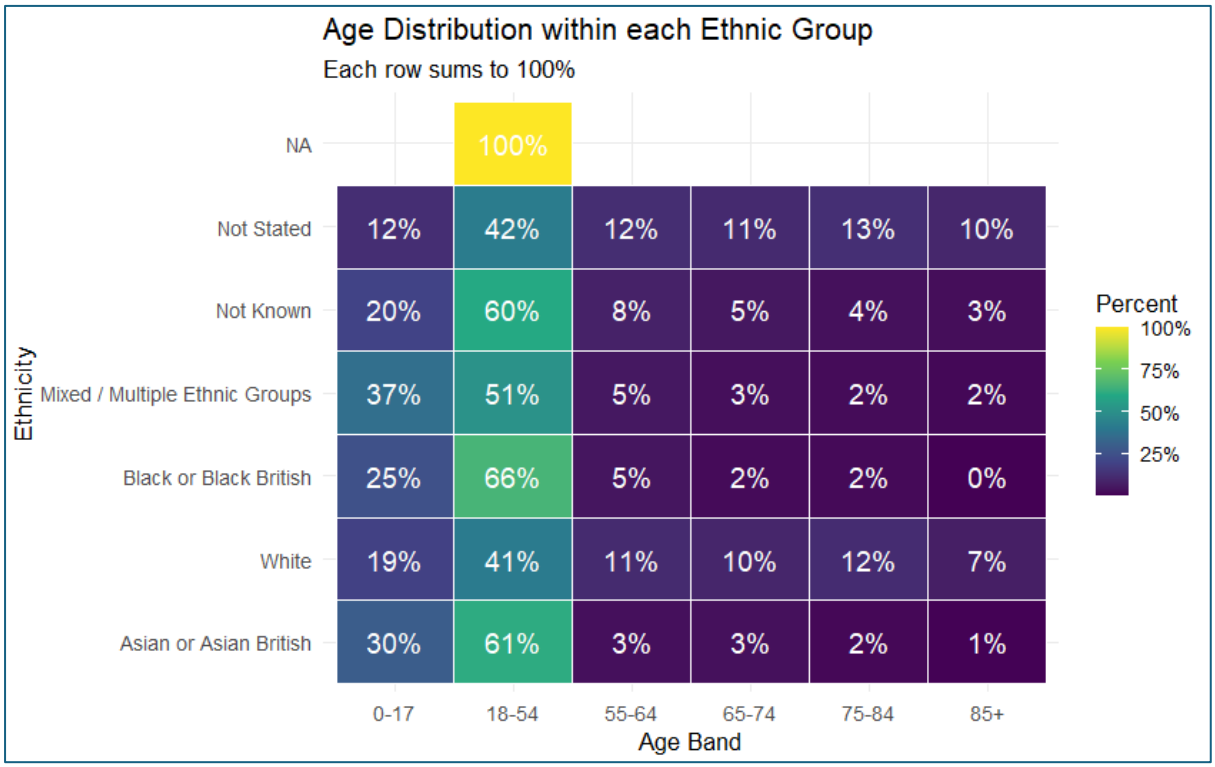


Observations: Analysis identifies variation in four-hour performance by age, with older patients more likely to experience longer stays in the Emergency Department (ED). We can see this demonstrated in the chart showing compliance by age band.

Conclusions: A potential explanation is the greater complexity of presentations among older patients, including frailty, multiple conditions and the need for more extensive assessment, diagnostic testing, and specialist input. Admission and discharge decisions may also require additional consideration of clinical risk, care needs and the availability of an appropriate onward care setting or inpatient bed.

These factors can extend the time required to reach a safe clinical outcome and increase the likelihood of breaching the four-hour standard. They may also contribute to longer waits among patients requiring admission, although further analysis would be needed to quantify the contribution of each factor. Understanding these differences is important to distinguish delays associated with clinical complexity from potentially avoidable variation in the care pathway.





Observations: The analysis also identifies variation in twelve-hour ED waits by ethnicity. However, the Trust's population analysis indicates that age is an important consideration when interpreting these findings. The White cohort has a substantially older age profile than several ethnic minority cohorts: approximately 60% of White patient attendances are aged under 55, compared with around 90% of patients in the

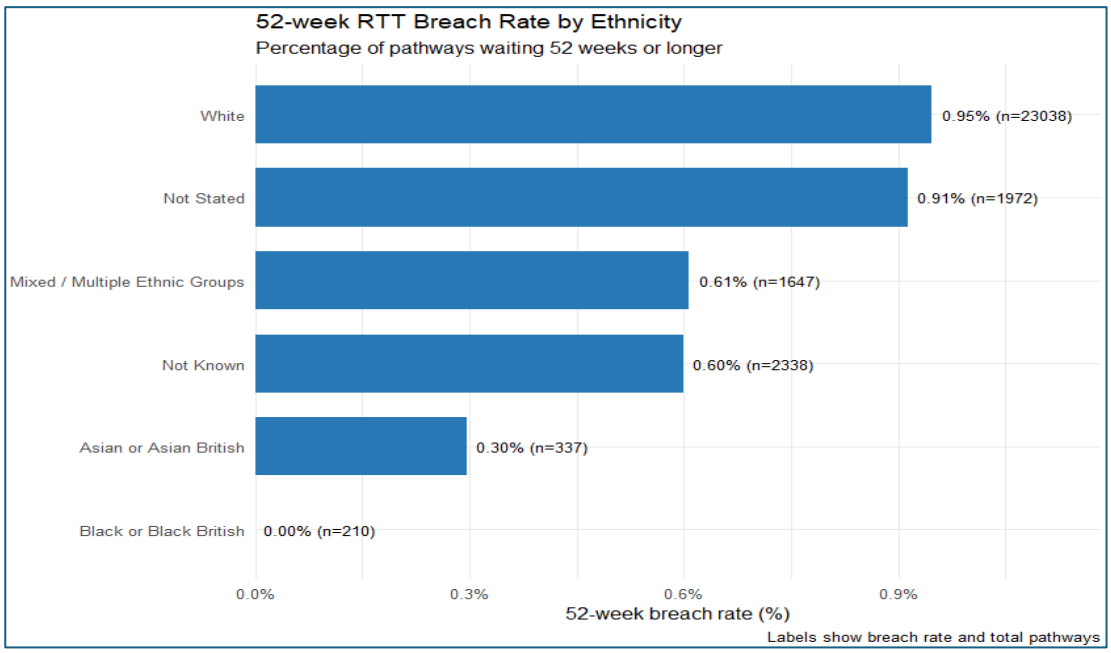
Black/Black British, Asian/Asian British, and Mixed ethnic groups. The remaining proportion in each group is aged 55 or over.

Conclusions: Given the relationship between older age, clinical complexity and prolonged ED stays, differences in age composition may contribute to the observed variation in waiting times by ethnicity. The analysis suggests that the older White patient cohort may be disproportionately represented among those experiencing longer waits. However, this should be treated as a potential explanation rather than a confirmed causal finding. Age-adjusted analysis would be required to establish how much of the observed ethnic variation remains after accounting for differences in population composition. Records with ethnicity recorded as Not Stated or Not Known should also be considered separately where appropriate.

This distinction is important for the Trust's health inequalities programme. Demographic differences may explain some observed variation, but they do not rule out differences in access, treatment, or experience between ethnic groups. Further analysis should therefore examine waiting times within comparable age groups, alongside admission status, clinical acuity and other relevant factors which will be done separately and added into existing reporting.

RTT analysis

Analysis of our current RTT waitlist exhibited no evidence of health inequalities, with Age being the highest IOD at 19.53, but this was heavily influenced by patients under 12 months not breaching. Analysis of the Community Paediatrics pathway is separate from this RTT breakdown, but if that was included, shows a higher proportion of waits for the 1-17 age band, likely associated with ADHD and autism pathways.



Please note: The number of 52-week breaches in the organisation is small and having just 1 breach in our non-white cohorts can suggest evidence of inequalities, the ethnicity breakdown above shows that all breakdowns are below 1%.

Implications and next steps

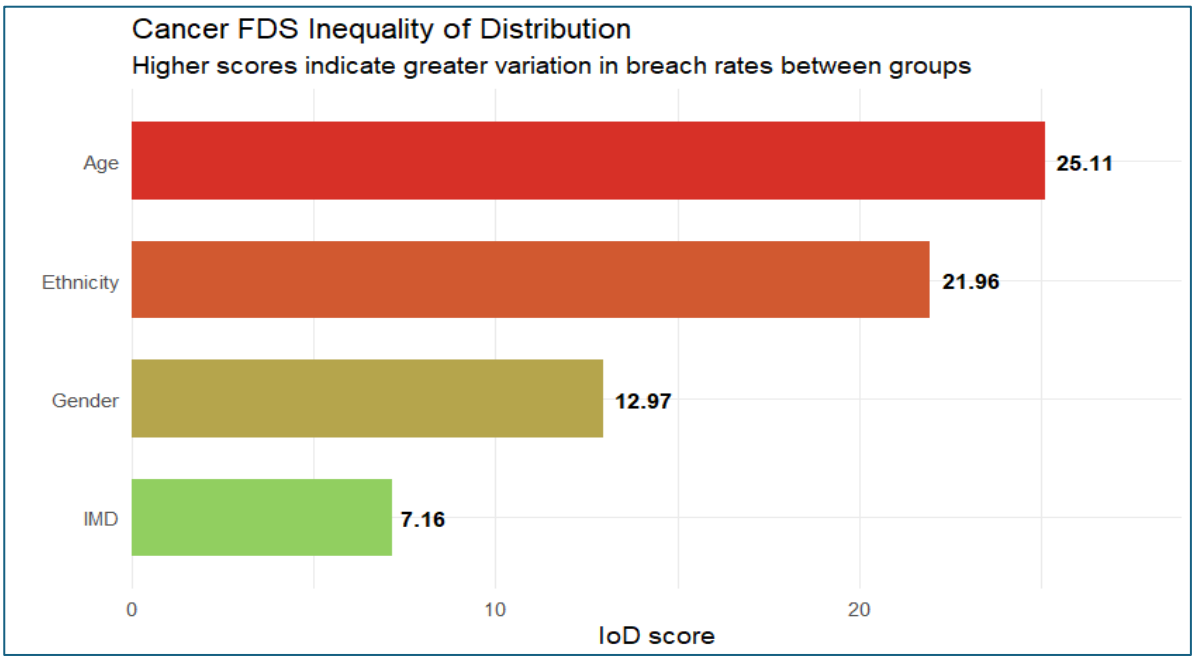
The analysis identifies two complementary priorities for the Trust: reducing avoidable barriers to accessing planned care and understanding the factors contributing to prolonged waits in urgent and emergency care. Outpatient DNA rates remain higher in more deprived groups despite improvement across all quintiles, supporting the case for targeted interventions and evaluation of the Diabetic Medicine prediction model and subsequent expansion to other specialities.

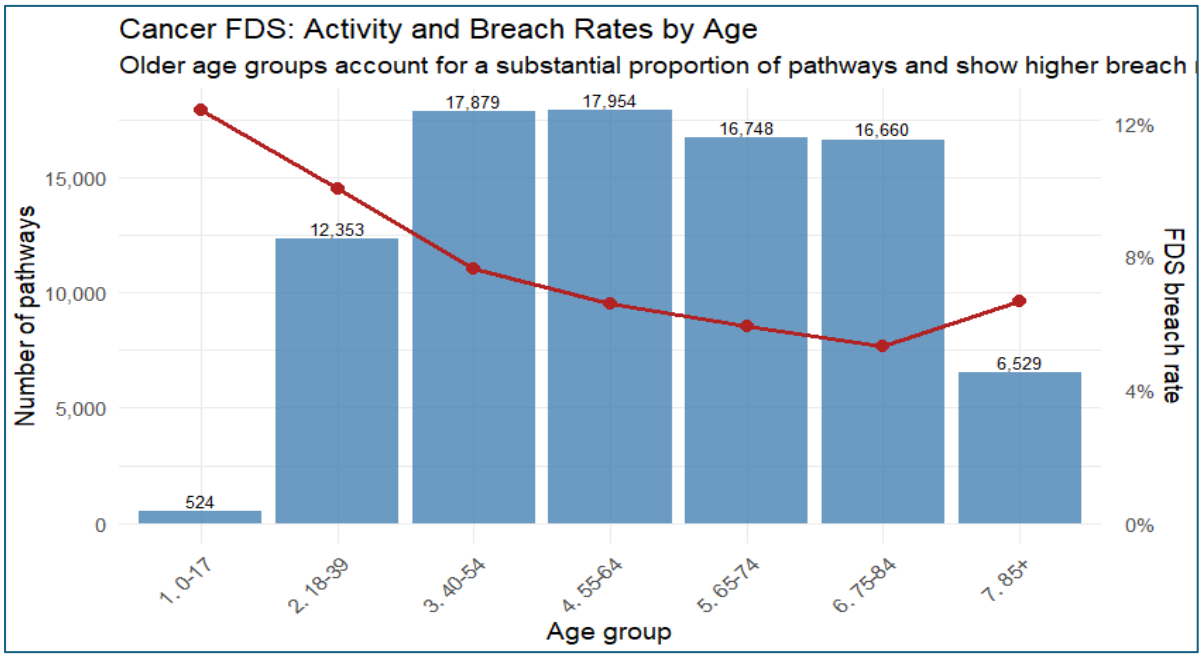
In urgent care, age and clinical complexity appear to be important considerations when interpreting differences in four-hour performance and twelve-hour waits. The Trust should build on this analysis by examining outcomes within comparable demographic groups, to distinguish the effects of population composition from potentially avoidable inequalities. For long outpatient waits, the concentration of cases in Community Paediatrics provides a clear focus for pathway-level review.

Together, these findings provide a basis for moving from describing variation in activity and outcomes towards identifying where targeted interventions are most likely to improve access, waiting times and equity of care.

Cancer

Analysis of the Trust's performance against the Cancer 28 Day Faster Diagnosis Standard (FDS) identified age and ethnicity as the demographic factors associated with the greatest variation in performance. However, the IOD scores were considerably lower than those observed for ED and RTT waiting times, indicating that variation between demographic groups was less pronounced for this measure.





Observations: Performance has improved across successive age groups, with higher compliance observed among older age bands up to the 85+ cohort. Performance then declined among patients aged 85 and over, potentially reflecting more complex diagnostic pathways, multiple health conditions or the additional investigations required to reach a diagnosis. This is a possible explanation rather than a confirmed cause and would require further investigation.

The 0–17 age group demonstrated relatively low activity but higher compliance. Given the smaller number of cases, results for this cohort should be interpreted cautiously, as

a slight change in the number of patients meeting the standard can have a proportionately greater impact on the reported rate.

The Trust does not currently routinely report cancer stage at diagnosis as part of this analysis. Exploring stage at diagnosis is planned for early 2027 and would provide an important additional dimension to the assessment of health inequalities. It could help establish whether differences in diagnostic performance are accompanied by variation in the stage at which cancers are identified, supporting a more comprehensive understanding of inequalities in cancer diagnosis and outcomes.

Conclusions: Overall, the findings suggest that variation in 28-day diagnostic performance by age and ethnicity is present but less pronounced than in some other operational measures. Further analysis, including cancer stage at diagnosis and age-adjusted comparisons between ethnic groups, will help determine whether the observed differences reflect population demographics, variation in diagnostic pathways or potentially avoidable inequalities in access to timely diagnosis. This analysis will be done separately and incorporated into existing reporting.

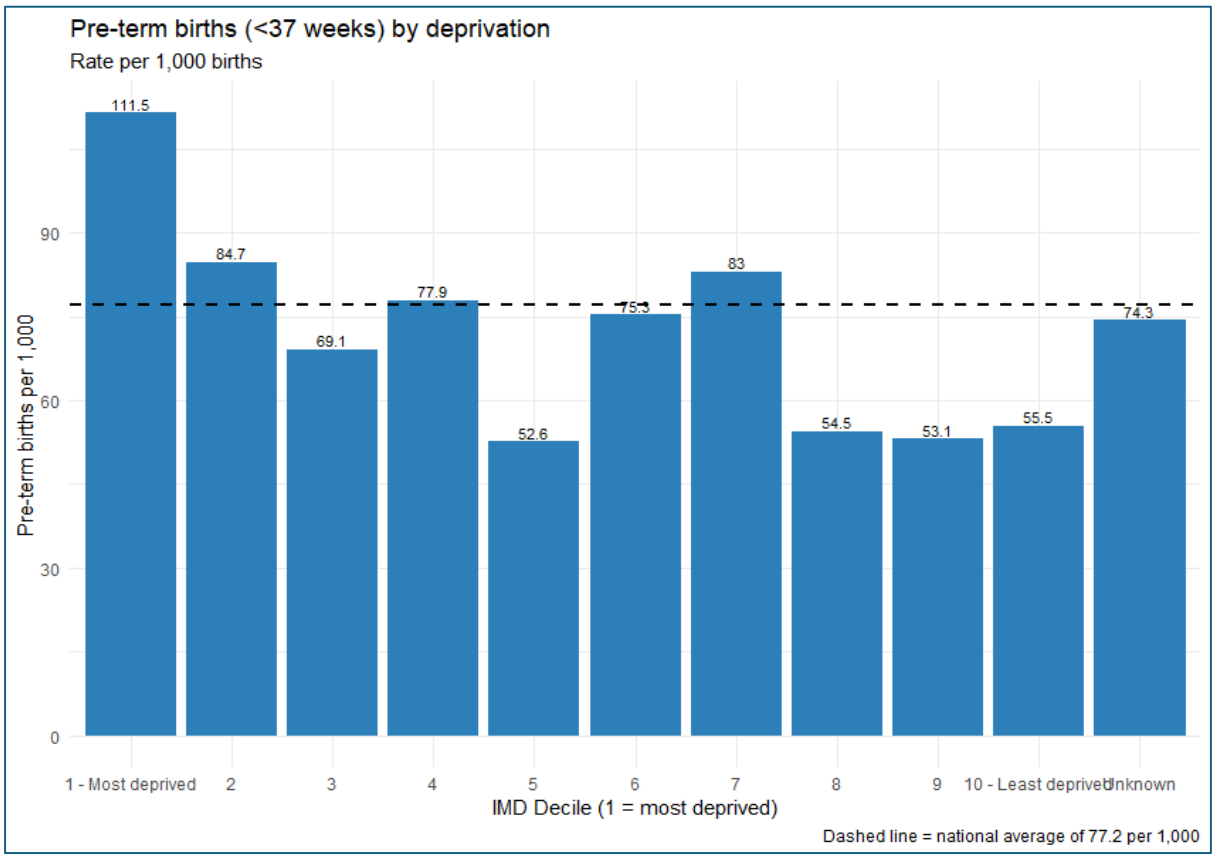
Core 20 Plus 5

Maternity Services

An analysis of deliveries at the Trust since 2022 examined variation in maternity outcomes by age, deprivation, and ethnicity. The findings identify potential inequalities in birth outcomes, particularly in relation to deprivation and ethnicity, and highlight areas where further investigation may help the Trust better understand differences in maternal and neonatal risk.

Deprivation and birth outcomes

Analysis found that method of delivery and postpartum haemorrhage (PPH) rates were broadly similar across Index of Multiple Deprivation (IMD) deciles. However, stillbirth rates were higher among patients from the most deprived areas compared with the wider population. This warrants further investigation to establish whether the difference persists over time and after accounting for relevant clinical and demographic factors.

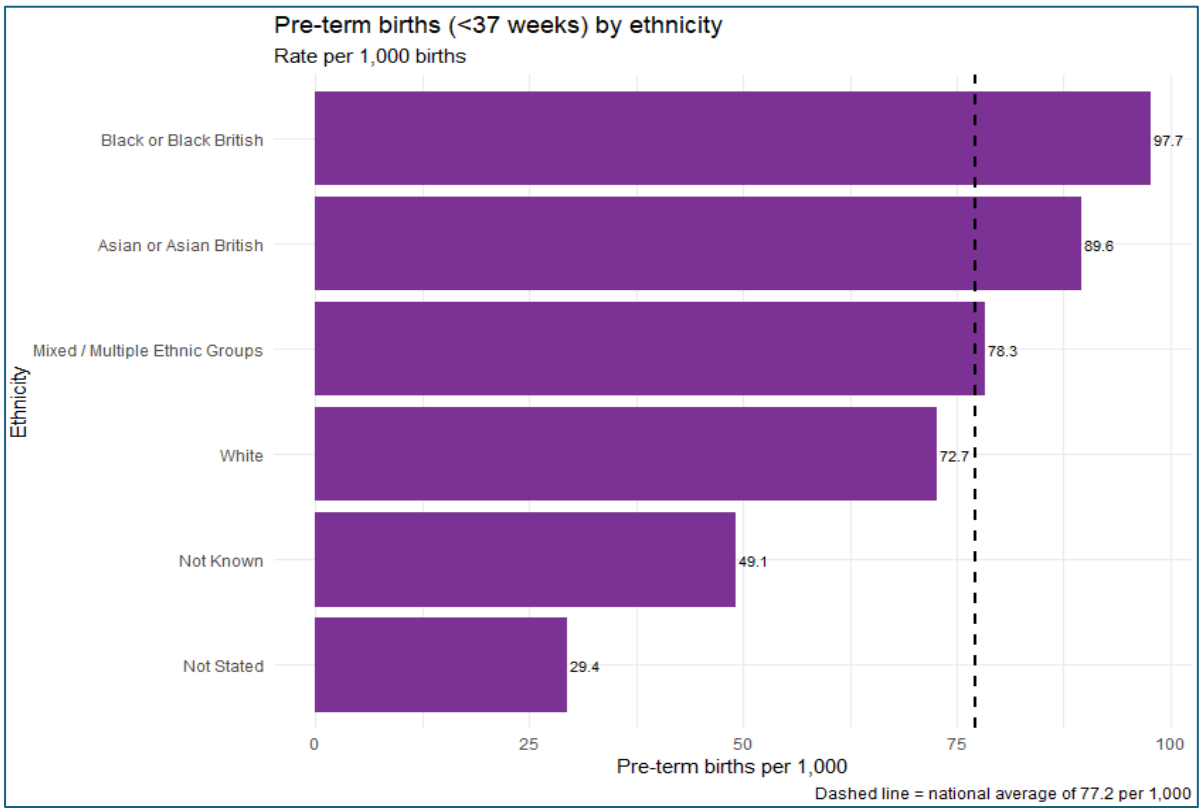


Observations: The analysis of pre-term births also demonstrates variation by deprivation. The rate in the most deprived decile (IMD 1) was 111.5 per 1,000 births, compared with the national reference rate of 77.2 per 1,000. Several other deciles were below the national average, including IMD 5 at 52.6 per 1,000 and IMD 8–10 at approximately 53–56 per 1,000. The pattern is not a uniform gradient across all deprivation deciles, but the elevated rate in IMD 1 suggests a potential concentration of risk among the most deprived communities.

Conclusions: These differences may reflect a combination of factors, including wider socioeconomic circumstances, maternal health, and existing clinical risk.

Deprivation can also be associated with differences in access to preventative support and the prevalence of risk factors for adverse pregnancy outcomes. However, the current analysis does not establish the causes of the observed variation, and differences in the number of births within each group should be considered when interpreting the rates.

Looking at ethnicity, this data follows our earlier analysis about the ethnic breakdowns by IMD:



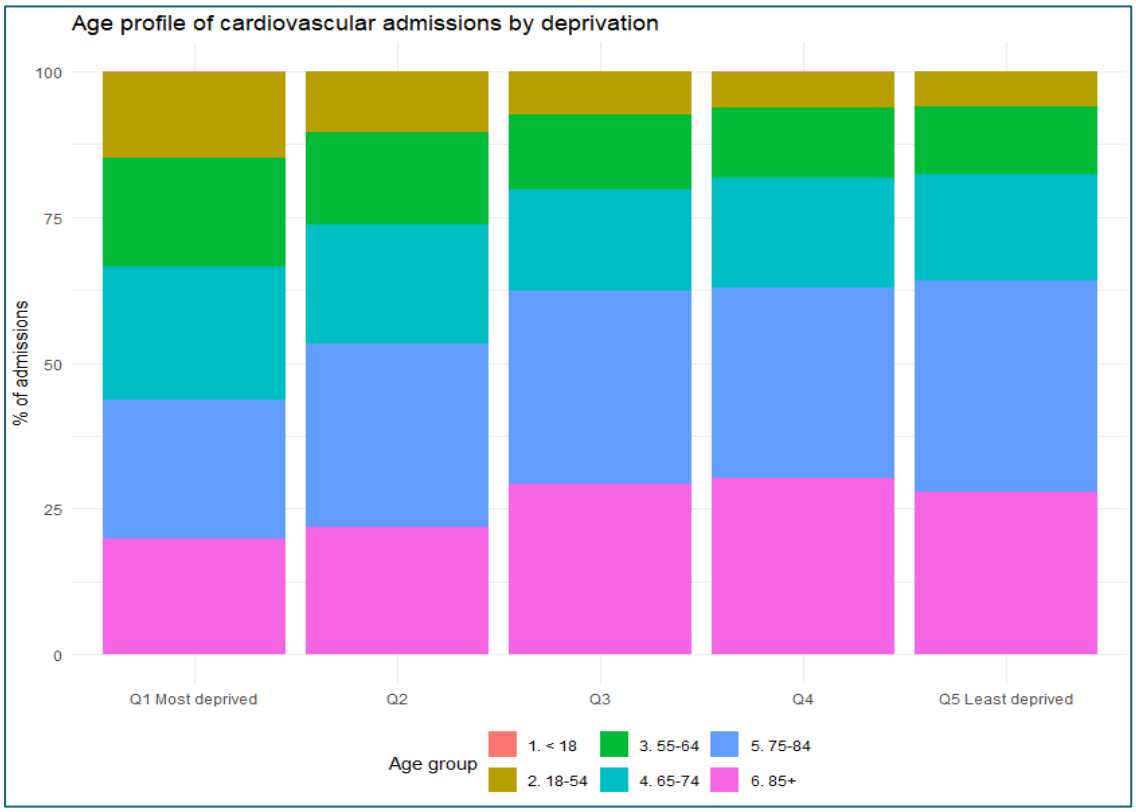
Observations: The ethnicity analysis identifies further variation in pre-term birth rates. The rate for Black/Black British patients was 97.7 per 1,000 births, while the rate for Asian/Asian British patients was 89.6 per 1,000. Both were above the national reference rate of 77.2 per 1,000. The rate for patients from Mixed or Multiple Ethnic Groups was 78.3 per 1,000, close to the national average, while the rate for the White group was 72.7 per 1,000.

Rates recorded for Not Known and Not Stated ethnicity were considerably lower, at 49.1 and 29.4 per 1,000 respectively. These categories should be interpreted cautiously, as they may reflect differences in data completeness or recording rather than genuine differences in clinical risk.

Further analysis identified a relationship between ethnicity and deprivation, with ethnic minority groups tending to be more represented in more deprived areas. This is an important consideration when interpreting the observed differences in pre-term birth rates, as deprivation and ethnicity are interrelated within the population accessing maternity services. However, this relationship alone does not establish that deprivation explains the differences by ethnicity, and both factors may be associated with other relevant clinical and demographic characteristics.

Mental Health: Whilst the Trust does not provide in patient mental health services our emergency department has seen significant increases in presentations with circa 140 attendances in August 2025. Psychiatric liaison services in the emergency department are provided for Cheshire and Wirral Partnership Trust.

Cardiovascular Disease:



Analysis of emergency admissions for cardiovascular disease highlights a notable distribution across deprivation groups, although this should be interpreted alongside the age profile of the patients admitted. The highest volume of activity was observed among patients from the least deprived quintile (Q5), accounting for 2,441 spells, compared with 1,428 spells in the most deprived quintile (Q1). Activity was also relatively high in Q4, with 2,009 spells.

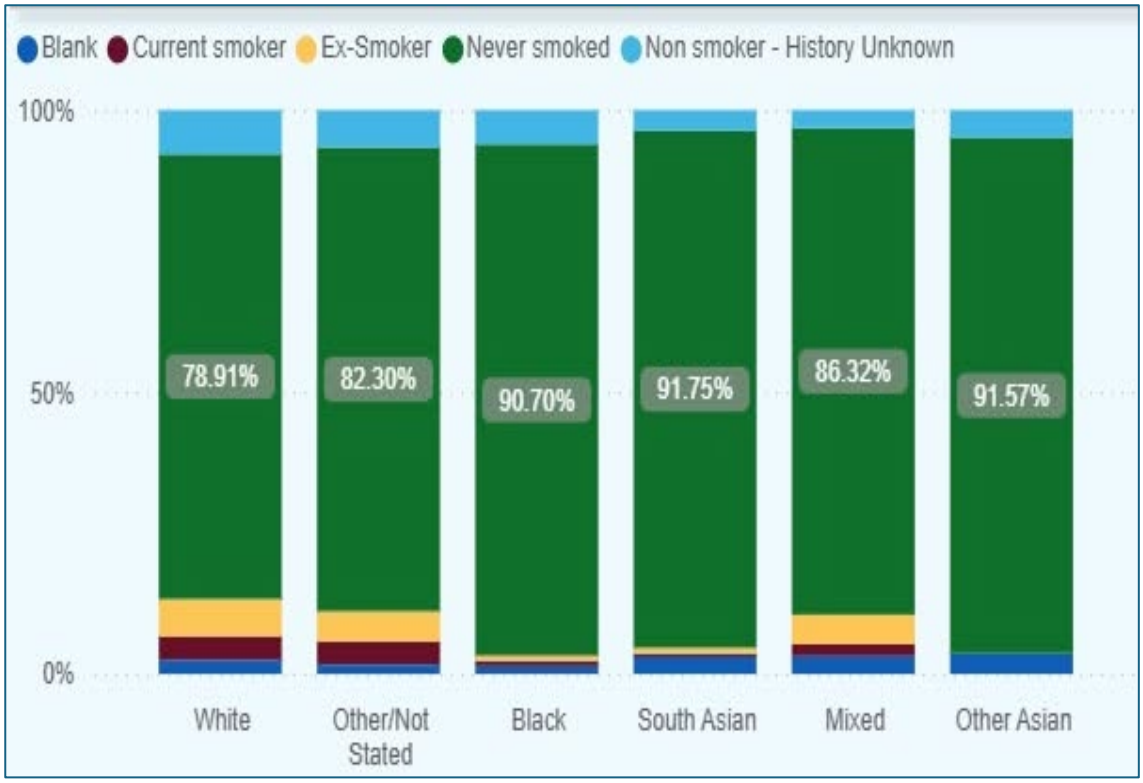
Repeat admission patterns were relatively consistent across deprivation groups. The proportion of patients experiencing two or more spells ranged from 31.7% in Q5 to 36.1% in Q1, suggesting that patients from more deprived areas may experience slightly greater levels of repeat hospital activity, despite lower overall admission volumes. The median number of spells per patient was one across all deprivation groups.

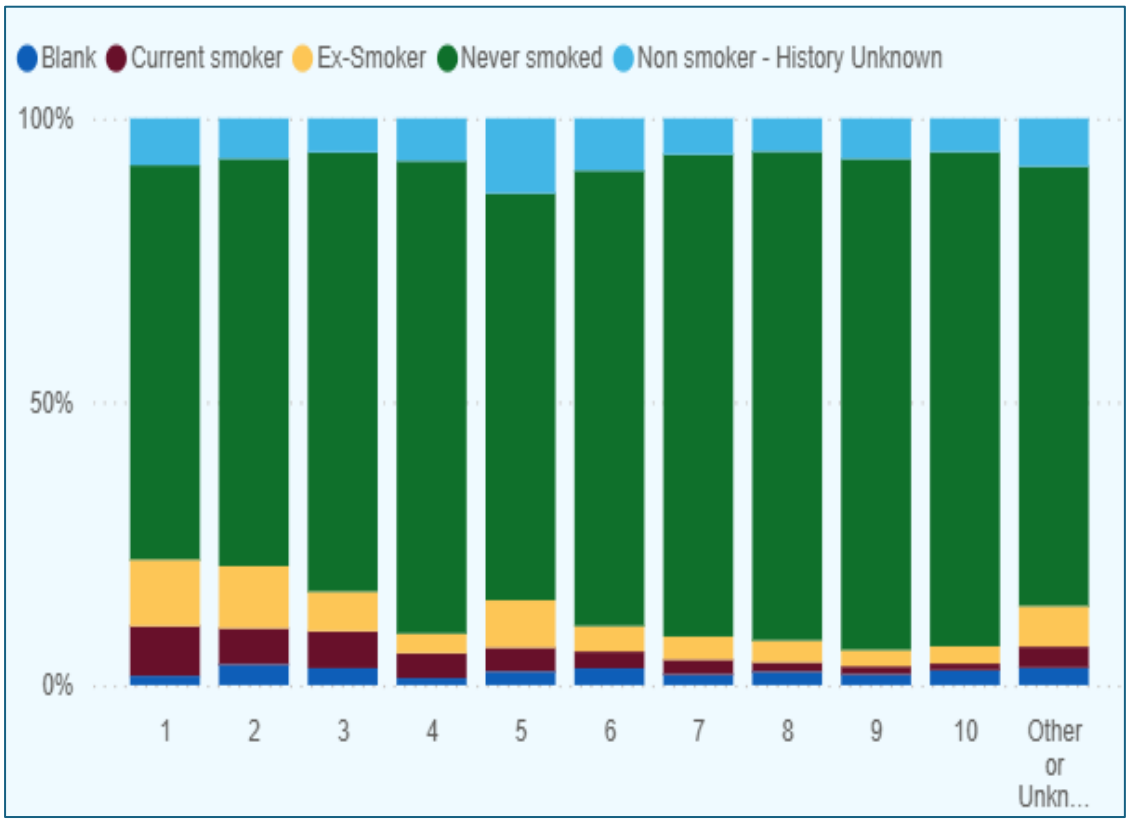
However, the higher volume of admissions among patients from less deprived areas appears to coincide with an older patient population, reflecting the demographic profile of the Trust's catchment area, where older residents are more heavily represented in the less deprived areas. Consequently, these findings should not be interpreted as indicating a greater underlying burden of cardiovascular disease among more affluent populations. Age is likely to be an important influencing factor, and age-standardised admission rates would be required to establish whether genuine inequalities exist between deprivation groups.

Respiratory disease, vaccinations, and smoking cessation

The Trust's previous analysis of cardiovascular disease and the broader review of respiratory disease identified potential differences in health outcomes across deprivation groups. However, further analysis by age and other demographic characteristics is required to understand these patterns fully.

This section therefore considers smoking status at delivery, using data from the maternity dashboard for the period from January 2024. This provides a further perspective on the relationship between deprivation and maternity outcomes, and links to the earlier analysis of pre-term births.



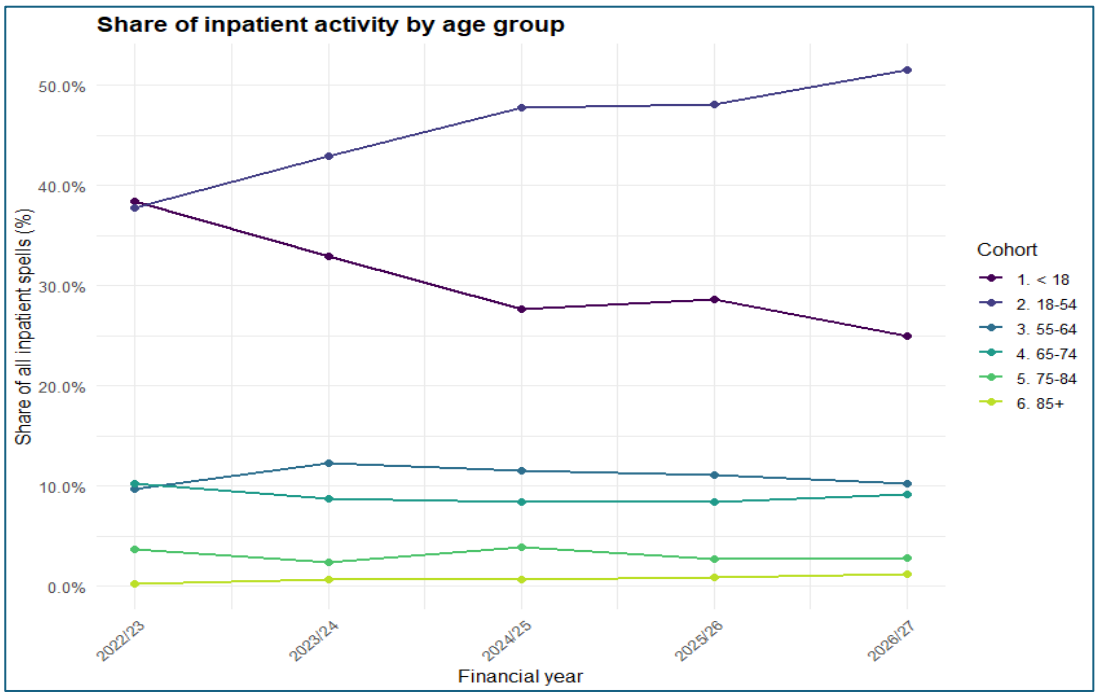


The analysis identifies a clear deprivation gradient in smoking status at delivery. Among women delivering who lived win the most deprived areas (IMD Decile 1). 8.73% were recorded as current smokers, compared with approximately 1.19% in the least deprived areas. This represents a substantial difference between the two groups, with the proportion of currents smokers generally decreasing as deprivation decreases.

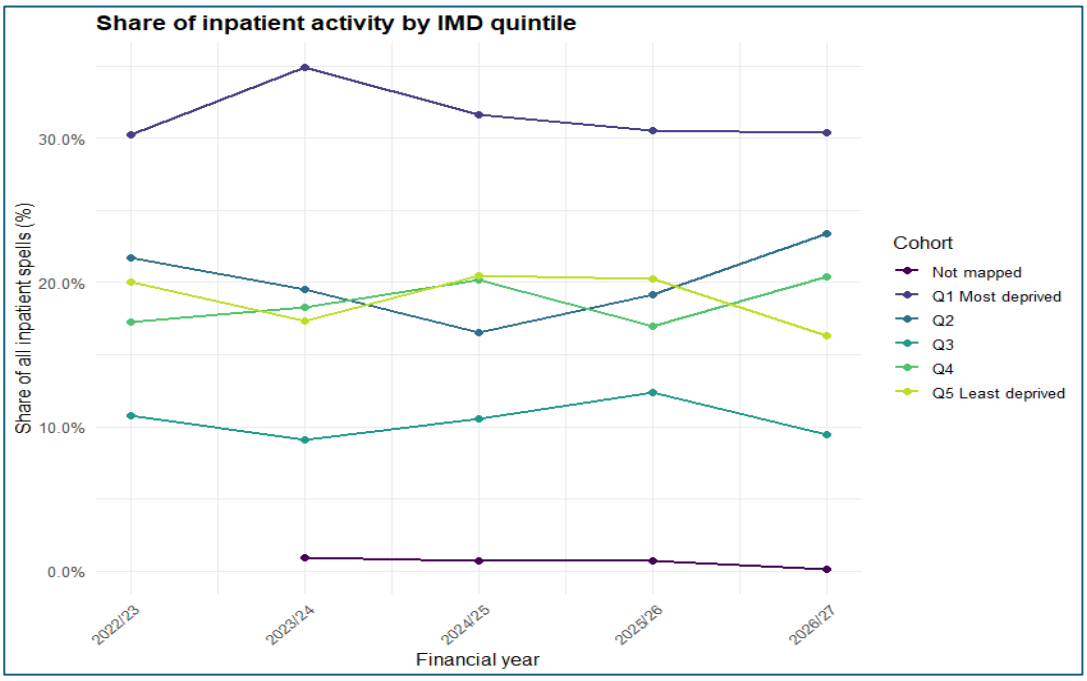
This pattern is important because smoking during pregnancy is a modifiable risk factor associated with adverse maternity outcomes, including pre-term births. The higher prevalence of smoking in the most deprived communities therefore provides relevant context for the earlier findings on pre-term births and reinforces the importance of targeted smoking cessation support.

Learning disabilities and autism

The Trust routinely monitors inpatient activity for patients with learning disabilities and autism to identify potential inequalities in service use.



Observation: Analysis by age group shows that the highest proportion of inpatient activity is among adults aged 18–54, followed by patients under 18. All remaining age groups account for approximately 10% or less of activity. Ethnicity analysis indicates that around 90% of recorded inpatient activity relates to White patients, broadly consistent with patterns observed across other Trust measures.



Analysis by Index of Multiple Deprivation (IMD) quintile identifies a notable disparity in inpatient activity. Approximately 30% of activity relates to patients from the most

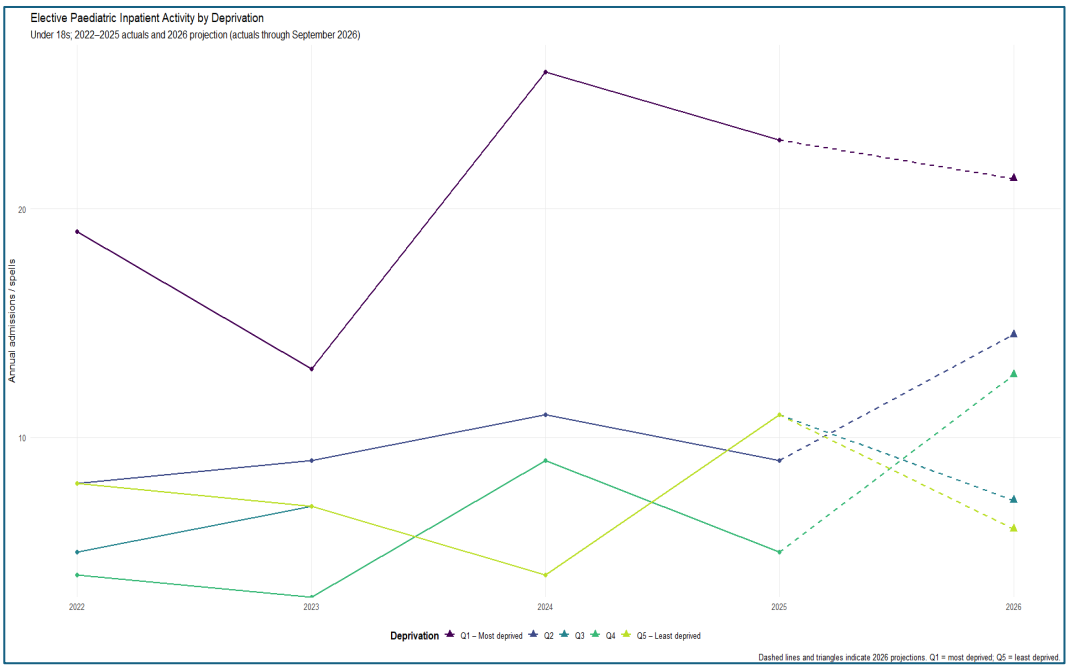
deprived quintile (Q1), compared with around 20% for Q2, Q3 and Q5. Q4 accounts for a comparatively low proportion, fluctuating around 10%.

Conclusions: The concentration of activity among patients from the most deprived areas may indicate an association between deprivation and the need for inpatient care. One potential explanation is that people with learning disabilities and autism living in deprived communities may experience greater barriers to accessing timely, appropriate community-based support, increasing the risk of their needs escalating to a level requiring inpatient admission. However, further investigation is needed to establish whether this pattern reflects differences in population demographics, underlying levels of need, access to community services or other factors.

The findings highlight an area for further investigation, particularly in understanding the relationship between deprivation, community support provision, and inpatient admission, to help inform opportunities for earlier intervention and more equitable access to care.

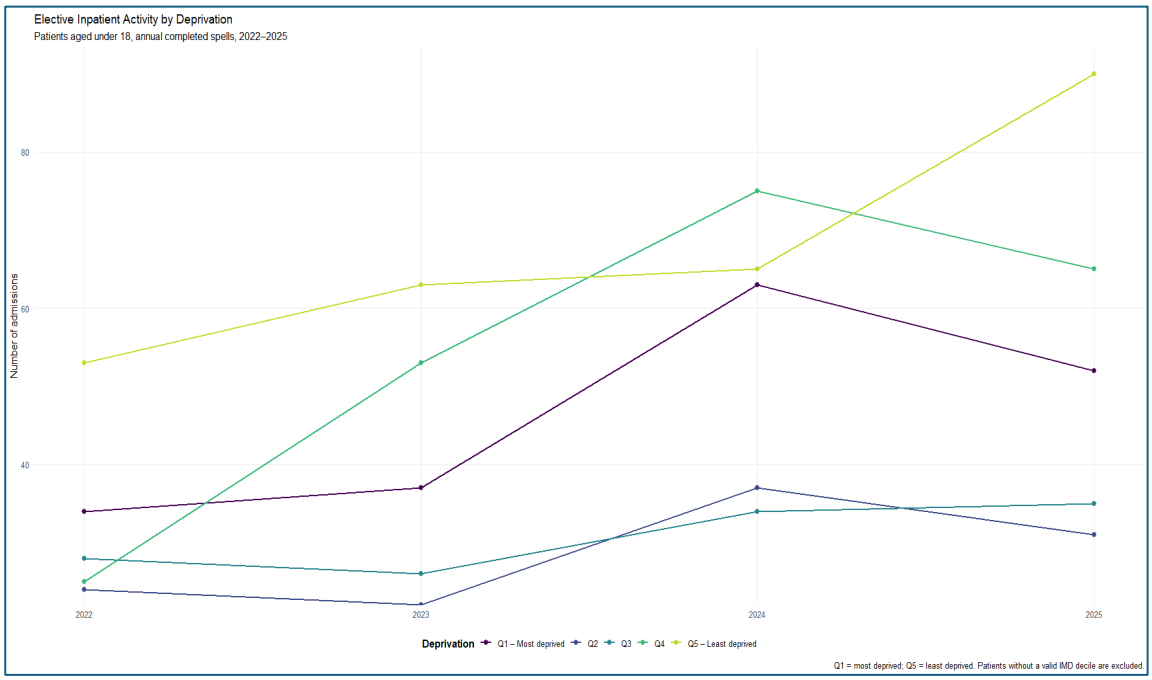
Core 20 plus for Children and Young People

Oral health is an important wider determinant of health, with established links to conditions managed within secondary care, including diabetes. Poor oral health and periodontal disease share risk factors with metabolic conditions, while elevated blood glucose can also increase the risk and severity of gum disease. Early identification and prevention of dental problems, particularly in children, therefore, represent an important opportunity to reduce future health needs and inequalities.



Observations: Analysis of Trust activity for patients aged under 18 with a diagnosis of dental caries (tooth decay) identified a notable concentration among children living in the most deprived areas. Although overall activity volumes are relatively small and should be interpreted with caution, the number of patients in the most deprived IMD

quintile (Q1) is almost equivalent to the combined total across the other four quintiles. This pattern may reflect inequalities in access to preventive dental care, oral health education, and timely treatment, alongside differences in exposure to risk factors such as diet, sugar consumption, and access to fluoride.



When the analysis is expanded to include diagnoses relating to impacted or embedded teeth, dentofacial anomalies and disorders of tooth development, the distribution changes, with greater activity observed among children from the least deprived areas.

These conditions may be more strongly influenced by developmental factors, the identification of clinical need and access to specialist dental services, including orthodontic assessment and treatment. Differences in referral pathways, the likelihood of seeking planned treatment and the ability to access dental services may also contribute to the observed pattern.

Conclusions: Taken together, the findings suggest that the relationship between deprivation and dental activity varies according to the type of condition being examined. The concentration of dental caries activity in the most deprived cohort is consistent with a potential inequality in oral health outcomes, while the higher activity for developmental and orthodontic conditions in less deprived areas may reflect differences in access to assessment and treatment rather than differences in underlying need alone.

Further investigation is warranted to establish whether these patterns reflect differences in disease prevalence, access to NHS and specialist dental services, referral practices, or the recording of diagnoses. Given the relatively small numbers and the focus on Trust activity rather than population-wide prevalence, the findings should be treated as an indication of potential inequalities rather than definitive evidence of differences in oral health across deprivation groups.

Countess of Chester Hospital NHS Foundation Trust

Public – Board of Directors
24th November 2026

Report	**Agenda item 24.**	**Digital and Data Strategy Development Update**						
Purpose of the Report	Decision	**X**	Ratification		Assurance		Information	
Accountable Executive	Jason Bradley			Chief Digital and Data Officer				
Author(s)	David Reilly			Director of Digital				
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: failure to ensure strong digital transformation and IT resilience could impact the delivery of services for patients and our workforce.			
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** **X**
Previous considerations	Not applicable							
Executive summary	The proposed Digital and Data Strategy 2026–2030 sets out how the Trust will use digital technology, data and innovation to support delivery of *Transforming Care Together* and its ambition to provide high-quality, safe and sustainable services. It recognises the need to move away from paper-based and disconnected systems and to provide patients, families and staff with reliable, efficient and accessible digital services.							

The strategy is centred on people and population need and is aligned with the national What Good Looks Like framework.

Delivery priorities include developing workforce capability; strengthening governance and user engagement; maintaining modern, resilient and secure infrastructure; optimising the EPR and improving interoperability; providing trusted data and analytics leading to insight and decision-making; enabling safe and clinically governed use of artificial intelligence; improving patient access and digital inclusion; and working with local, regional and national partners.

A phased roadmap supports implementation through 2030. Early priorities include the launch of AVT, migration to a new Ophthalmology EPR, AI-enabled waiting-list and coding solutions and further rollout of Microsoft Copilot. Subsequent phases include EPR cloud migration and upgrades, documentation reviews, HIMSS accreditation, electronic prescribing links to pharmacies rollout, telephony and infrastructure modernisation, regional order communications and LIMS (laboratory system) implementation, Cyber Assessment Framework alignment and review of the future EPR platform. A new financial system has been deployed and new national human resources system is, in development but a wider focus on our corporate services is required.

Delivery will be governed through established Trust arrangements, supported by external assessment and ongoing monitoring of benefits, risks, security, clinical safety, accessibility and sustainability. The strategy provides a clear direction of travel; detailed delivery plans, investment requirements, benefits and dependencies will continue to be developed and reported through the appropriate governance routes to provide assurance on progress.

Several programmes are already underway to support delivery of the early phases of the strategy. These include the rollout of Ambient Voice Technology, the introduction of artificial intelligence (AI) for clinical coding and waiting list validation, and the development of data science tools to predict admissions / discharges and missed appointments (DNAs).

	The Trust is also contributing to regional programmes, including the transition to a regional Laboratory Information Management System (LIMS). Close collaboration continues between the Trust's digital teams and those at Cheshire and Wirral Partnership, Wirral University Hospital Foundation Trust. The strategy development has been reviewed by MIAA and received a substantial assurance rating. The strategy has since been updated to include dedicated sections for Artificial Intelligence and patient and families following internal feedback. The strategy is currently undergoing final minimal design changes ahead of planned publication by the end of the calendar year.
Recommendations	The Board of Directors is requested to provide approval for publication of strategy pending final minimal design changes.

Corporate Impact Assessment	
Statutory/regulatory requirements	CQC
Risk	BAF impact is overall assurance on the progress in delivering effective Digital and Data Services whilst recognising that there are ongoing actions to continue to mitigate known risks.
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.



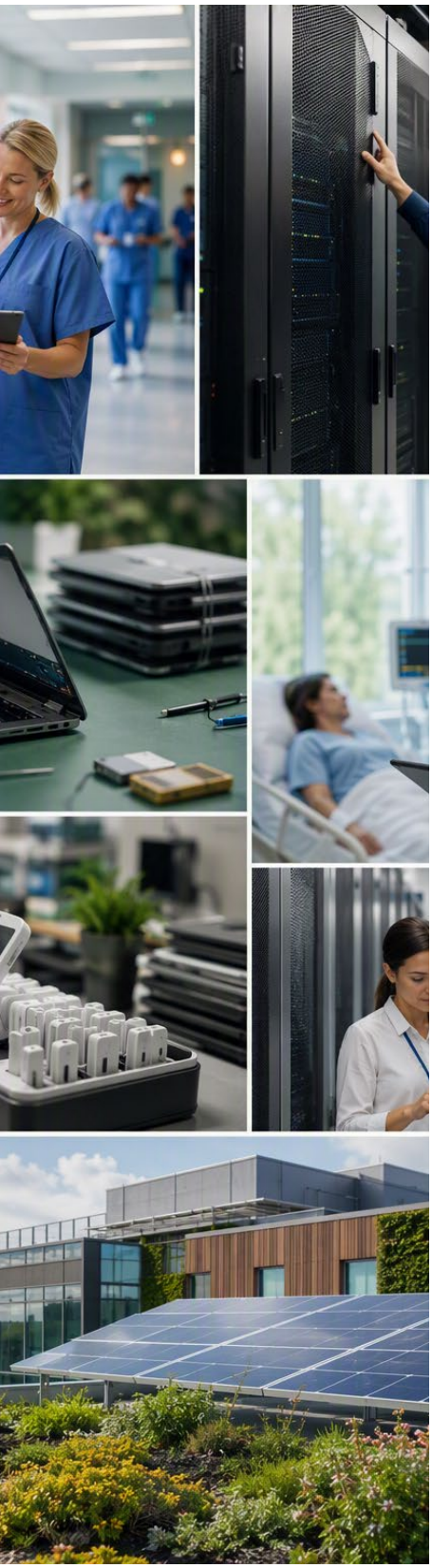
NHS
Countess of Chester Hospital
NHS Foundation Trust

DIGITAL AND DATA Strategy

2026–2030

Excellence in Digital and Data

Digital and Data Strategy



The Trust Strategy, "Transforming Care Together" sets out the ambition to become an outstanding organisation and a beacon of best practice and care, recognising that will be an improvement journey. The needs of our population have been changing, and in turn the needs of our service users including patients and staff have change as we progress into the digital age. Our users expect quick, efficient, mobile tools and services for accessing information.

Whilst we have implemented new digital systems in a number of areas, there are a number of services that remain reliant on paper or individual systems that do not integrate well either within the Trust or with our partner organisations.

This strategy is focussed on our people and population and how we used digital and data to enable effective and efficient services, harnessing innovation, and ensuring a sustainable service provision.

Lord Darzi sets out a major theme for the forthcoming 10 year plan as "There must be a major tilt towards technology to unlock productivity"*, in particular supporting staff who work outside of hospital, and recognising the enormous potential of AI. The challenge is to ensure that technology reshapes services, whilst not adding to the workload of clinicians.

*https://www.gov.uk/government/publications/independent-investigation-of-the-nhs-in-england/summary-letter-from-lord-darzi-to-the-secretary-of-state-for-health-and-social-care



Digital and Data Strategy

"Excellence in Digital and Data"

- **For our people, our patients and population, and our partners**
- **Enabling delivery of high quality, safe, health and care services**

Through

Effective, efficient, connected systems for our users

Reliable, responsive, secure technology

Accurate data to support effective decision making

Developing our staff and teams

Leadership, within the Trust, across Place, C&M and beyond

Partnerships: Oracle Health sites, BI / Coding, Cyber Security

The Trust Strategy



Transforming Care Together

The Digital and Data Strategy enables the Trust's improvement journey by connecting people, care, technology and information.

Strategic goals and objectives

1 Purposeful Leadership

2 Create a positive Patient and Family Experience

3 Proactive contribution to improving our Population Health

4 Adding Value

5 Actively seeking partnership opportunities

6 Develop a strong Team Culture

What Good Looks Like

The What Good Looks Like (WGLL) programme draws on local learning. It builds on established good practice to provide clear guidance for health and care leaders to digitise, connect and transform services safely and securely. This will improve the outcomes, experience and safety of our citizen.

WGLL is directed at all NHS leaders, as they work with their system partners, and sets out what good looks like at both a system and organisation level. It describes how arrangements across a whole ICS, including all its constituent organisations can support success.

The WGLL Framework has seven measures of success:



Delivering our Strategy



People

- We will invest in our workforce to enable them to deliver innovative solutions that meet the needs of our trust.
- We will empower our service users to enable the ultimate user experience.
- We will continue to invest in and improve our HR, finance and estates systems.
- Through our Patient Experience Portal, we will allow our patients and families to interact with our services and access their information when they need to.
- We will use external assessments to hold ourselves to account.

Process

- We will operate in an inclusive manner to ensure all needs from our services are considered.
- We will work with our divisional colleagues to gather requirements and develop solutions that meet their needs.
- We will ensure the equipment we provide allows staff to carry out their responsibilities.
- We will ensure our governance processes are robust.

Delivering our Strategy



Infrastructure and Security

- We will ensure our systems are protected with the latest security mitigations.
- We will proactively monitor our services and act as appropriate.
- We will ensure our underlying technologies are fit for purpose and modern.
- We will ensure that our workforce can work across clinical locations and from home.
- We will develop an infrastructure strategy that considers the latest developments in technology.
- We will assess ourselves against national standards such as the Data Security Protection Toolkit and ensure we follow any provided recommendations.

Applications

- We will work with trust colleagues to deliver EPR optimisations in a safe manner.
- We will ensure our EPR is kept updated with the latest software releases.
- For our none EPR systems we will work with services, to ensure data is seamlessly transferred across systems.
- We will reduce clicks and unnecessary logons at every opportunity.
- We will ensure our systems are interoperable allowing data to seamless flow across platforms.

Delivering our Strategy



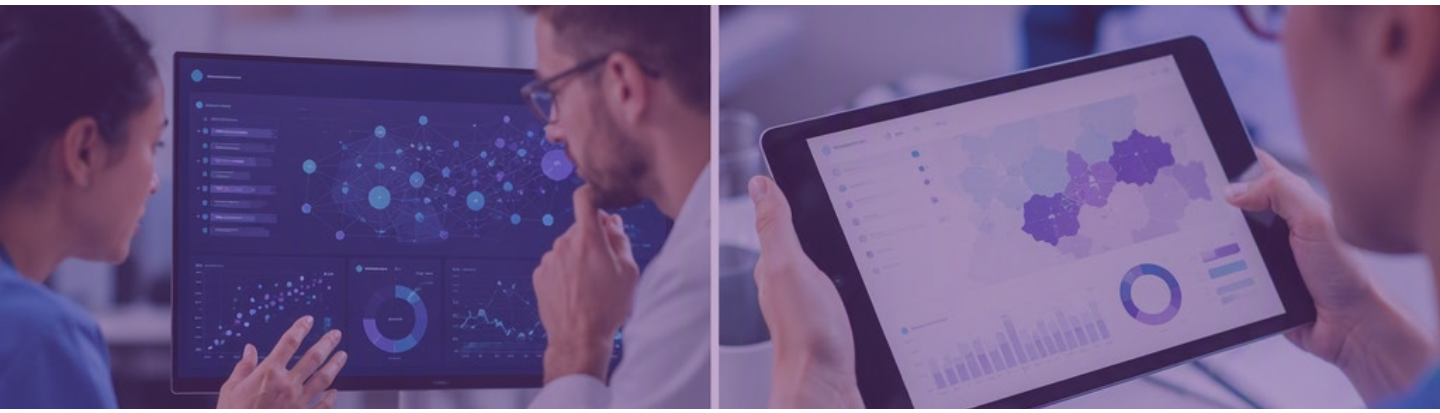
Innovation

- We will work with regional, national and industry colleagues to develop innovative solutions.
- We will ensure our technology roadmaps consider the latest technological developments
- We will continue to challenge ourselves
- We work to a “no idea is a bad idea” approach.
- We will review the latest bleeding edge technology advancements such as Artificial Intelligence.

Sustainability (Green)

- Digital and Data services will participate in the trusts Anchor institution programme.
- We will work with our suppliers to ensure our new technologies and solutions use sustainable materials.
- We will work with suppliers to offset our carbon footprint
- We will actively recycle our old devices and hardware in a safe and secure manner.

Delivering our Strategy



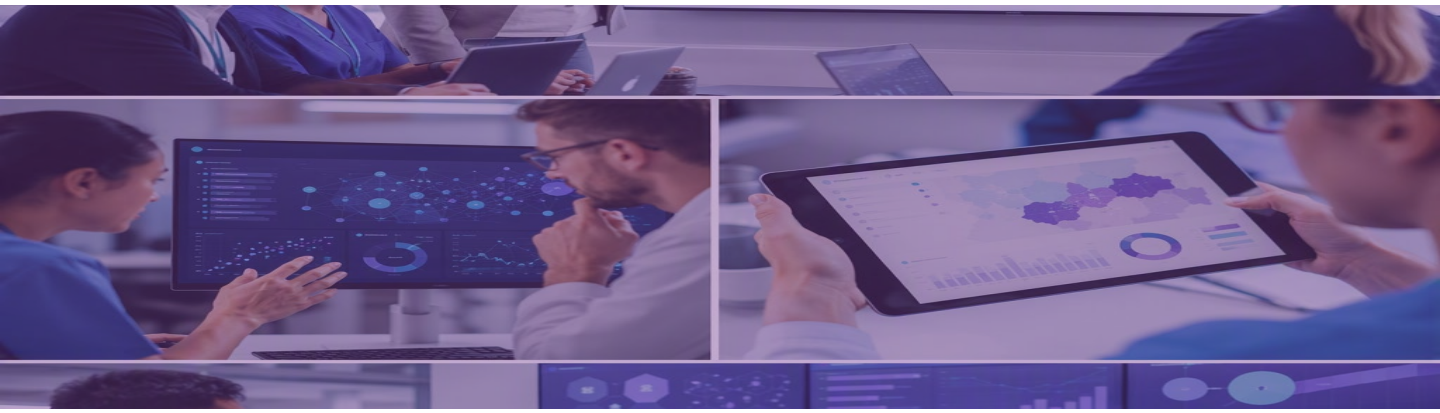
Data and Analytics

- We will ensure that the right people can access the right data at the right time.
- We will ensure our data is consistent and validated
- We will provide our users with the ability to integrate data in an easy manor.
- Development of data science capability
- Performance and benchmarking

Partnerships

- Digital and Data services leads will help develop place and regional strategic discussions.
- We will actively work with our place-based colleagues to provide streamlined digital patient pathways.
- We will collaborate with other provider collaborative partners to help develop services.
- We will help to develop and implement plans to enable neighbourhood working.
- We will participate in national working groups to drive digital developments.
- We will ensure the Trust is represented at ICB forums.

Delivering our Strategy



Artificial Intelligence

- We will work with clinical and operational colleagues to identify safe and effective uses of artificial intelligence.
- We will ensure AI solutions are clinically validated, transparent and subject to robust governance.
- We will use AI to support earlier diagnosis, prioritisation and more personalised care.
- We will equip our workforce with the skills to use AI safely and confidently.
- We will monitor the impact of AI to ensure it improves outcomes and reduces health inequalities.
- We will align with national AI guidance and policies.

Patients and Families

- We will involve patients and families in the design and evaluation of new patient facing solutions.
- We will explain clearly when AI is used and how it supports clinical decisions.
- We will protect patient data and ensure our systems are safe and secure.
- We will ensure there is free and reliable internet access across our facilities.
- We will ensure our patient correspondence are offered in formats that are accessible to everyone

Roadmap to delivery

2031-Beyond

Platform consolidation

Ongoing implementation of latest technologies.



2029/30

Future platform

EPR contract review, cloud infrastructure and full CAF alignment. Move to a new EPR platform, subject to supplier readiness.

2028/29

Regional LIMS go-live

EPR upgrade; virtual infrastructure and network refresh. Regional order comms and LIMS go live.

2027/28

Scale and migrate

AI enablement; regional order comms and LIMS preparation. EPR cloud move and upgrade, HIMSS accreditation, EPS rollout, usability survey and telephony migration. Neonatal CCTV procurement and implementation.

2026/27

Launch of AVT,

Move to new Ophthalmology EPR, implementation of AI waiting list and coding solutions and further roll out of Copilot.

PUBLIC – Board of Directors
24 November 2026

Report	**Agenda Item 25.**	**People Strategy 2025–2028: Year 1 Delivery Review and Year 2 Priorities**						
Purpose of the Report	Decision		Ratification		Assurance	**X**	Information	
Accountable Executive	Vicki Wilson			Chief People Officer				
Author(s)	Vicki Wilson			Chief People Officer				
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research BAF 11 Transformation			**X**	BAF impact is to develop a great workplace culture, staffed by effective and motivated staff to deliver the very best patient care.			
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health							**X** **X** **X** **X** **X**
CQC Domains	Safe Effective Caring Responsive Well led							**X** **X** **X**
Previous considerations	People Committee – 14 October 2025 Board of Directors –25th November 2025 OMB - 22 January 2026 People Committee – 9 February 2026 People Committee – 16 November 2026							
Executive summary	This report provides the Board of Directors with a review of Year 1 delivery of the People Strategy 2025–2028 and the proposed priorities for Year 2, drawing on implementation evidence and the dashboard position at September 2026. The strategy was approved by the People Committee in October 2025 and ratified by the Board in November 2025. Year 1 has established important foundations across staff wellbeing, leadership and culture, staff development and workforce planning. Progress includes expanded wellbeing provision, increased recorded flexible working arrangements and apprenticeship participation, continued team development, and implementation of workforce planning and digital systems. These developments support the Trust's ambition to provide a							

	working environment that enables safe, effective and sustainable patient care. Assurance is stronger on implementation and uptake than on sustained outcomes. The Q2 deterioration in absence, appraisal, Management Essentials completion and workforce variance needs to be understood in the context of significant operational pressures. These are affecting both staff wellbeing and the capacity to deliver planned workforce and development activity. The position reinforces the importance of the strategy, while demonstrating that its benefits depend on addressing the conditions in which colleagues work. Annual staff survey findings provide additional context, but do not constitute a direct assessment of Year 1 delivery. The principal strategic risk is that implementation does not translate into sustained improvement in staff experience, culture and workforce sustainability. Year 2 should therefore prioritise embedding delivery, responding to adverse trends and demonstrating measurable improvement. This requires clear organisational accountability, agreed milestones, an assessment of resource requirements and stronger outcome measures.
Recommendations	The Board of Directors is asked to: • **Receive assurance** on progress against the Year 1 delivery objectives of the People Strategy. • **Note** the mixed outcome position and the areas requiring further attention identified in the Q2 dashboard. • **Support** the proposed Year 2 priorities, including clearer accountability, consideration of resource requirements and stronger measurement of impact.

Corporate Impact Assessment	
Statutory/regulatory requirements	Legal, regulatory and statutory requirements aligned to people.
Risk	This report supports assurance against BAF 4 People. The principal risk is that delivery does not translate into sustained improvement in staff experience, culture and workforce sustainability. Operational pressures may further constrain delivery and its intended benefits.
Equality & Diversity	Inclusion and equitable staff experience are central to the strategy. Delivery should be assessed through evidence of access, progression, representation and staff experience, including whether improvements are shared consistently across the workforce.
Communication	Document to be published as part of the agenda pack.

People Strategy 2025–2028: Year 1 Delivery Review and Year 2 Priorities

1. Introduction

This report reviews delivery against the Year 1 commitments of the People Strategy 2025–2028 and sets out the proposed priorities for Year 2. Drawing on progress and performance information to September 2026, it highlights achievements, areas requiring further attention and the implications for staff experience, culture and workforce sustainability.

2. Background

The People Strategy sets out the Trust's ambition to be an outstanding place to work, with compassion, respect, inclusion and accountability at the heart of its culture. It reflects colleagues' priorities for wellbeing, opportunities to develop and a working environment where people feel safe, valued and able to speak up.

The strategy is intended to support the workforce and organisational culture needed to deliver safe, effective and sustainable services. Its success therefore depends not only on completing planned activities, but on demonstrating improvement in staff experience, leadership practice, workforce capability and deployment.

The three-year delivery plan established specific Year 1 commitments focused on strengthening foundations and improving consistency. Priorities for Years 2 and 3 were intended to be refined through annual review, informed by delivery progress, evidence of impact and emerging organisational needs. This review provides the basis for the proposed Year 2 focus.

3. Progress against Year 1 Objectives

Delivery

Year 1 activity has primarily focused on establishing the core interventions and systems identified in the strategy. The evidence demonstrates delivery across all five strategic strands, but the position is not uniform. Some commitments have been established, while others require wider rollout or more consistent application. Completion of an enabling action should not be interpreted as evidence that its intended benefit has been achieved.

The following sections summarise progress against the Year 1 commitments, including areas where implementation remains in progress.

Creating the Countess culture

The discovery and design phases of the Culture and Leadership Programme have been completed. Delivery is progressing through targeted interventions and the RCN Foundation compassionate leadership partnership, providing a foundation for further work on leadership practice and organisational culture.

The next stage is to demonstrate how these interventions influence colleagues' everyday experience. Annual staff survey findings and more current People Pulse feedback should be considered alongside wider strategy measures. At this stage, assurance relates principally to programme development and implementation rather than sustained cultural improvement.

Looking after our people

Access to wellbeing and occupational health support has expanded through individual support, workshops, targeted team interventions and clearer routes to advice and self-referral. Recorded flexible working arrangements increased from 782 in April 2026 to 888 at Q1 and 1,096 at Q2. These developments demonstrate increased provision and uptake, but further evaluation is needed to assess accessibility, consistency and contribution to improved wellbeing.

Staff safety arrangements have been strengthened through the Violence and Aggression Group, standardised support processes, refreshed training and proactive follow-up following reported incidents. Further measures are needed to establish whether prevention, debriefing, support and learning are applied consistently.

Management Essentials has been developed and launched. Reported completion increased in Q1but subsequently fell Q2 with competing service demands affecting managers' capacity to participate. Increasing completion therefore requires attention to the practical arrangements that enable attendance, alongside continued rollout of the programme.

Expanded wellbeing provision has not yet translated into lower absence. Operational pressures are contributing to the increase in sickness, particularly among nursing colleagues, where the demands of service delivery are affecting staff health and wellbeing. Access to support remains important but must sit alongside action to address work-related pressures rather than being treated as a sufficient response in itself.

Creating a sense of belonging

The reward and recognition offer has broadened, staff network governance has developed, and Staff Side representation has increased. Civility and Respect messages have been reinforced through communications, appraisal and management development. These actions provide foundations for a more inclusive and respectful working environment.

Formal case numbers do not, on their own, establish the quality of workplace culture. No bullying and harassment employee-relations cases were recorded in Q1 or Q2, with two grievances in each quarter. These figures should be considered alongside staff survey findings, People Pulse feedback and speaking-up information.

Freedom to Speak Up concerns increased from 29 at Q1 to 36 at Q2. This movement should not be interpreted in isolation as either improvement or deterioration. The emphasis should remain on understanding barriers to speaking up, responding to concerns, providing feedback and demonstrating organisational learning.

Developing our people to be their best

Appraisal processes have been strengthened through revised documentation, guidance, training and feedback. Team development has also expanded, with increased use of the TED tool and follow-up activity. These developments demonstrate continued implementation, but evidence of improved appraisal quality and team experience remains important.

Appraisal compliance fell in September 2026 going below the 80% target. Immediate service demands are limiting the time available for appraisal conversations. Recovery needs to address this constraint without reducing appraisal to a completion exercise. The 2025 Staff Survey finding that 20.75% of respondents felt appraisal definitely helped them improve their work underlines the continuing need to improve the quality and value of these conversations.

Year 2 should build on these foundations by improving completion and quality, using repeat team feedback to assess change, and linking development more clearly to talent management, succession planning and future workforce requirements.

Building the future workforce

Progress has been made in medical and wider electronic rostering, medical job planning and apprenticeship pathways. The medical e-roster programme has reached soft launch, with the first cohort covering 11 specialties prepared for operational rollout; this represents progress rather than completion of Trust-wide implementation.

The 2026/27 annual workforce plan has been completed and submitted. The variance from plan (ie. greater WTE workforce than planned) in Q1 widened in Q2, reflecting the challenges of delivering the planned position under sustained service pressure. This should be assessed alongside activity, deployment and financial performance to distinguish immediate operational requirements from longer-term workforce needs and inform the response.

Apprenticeship participation increased in Q1 and again in Q2, with the healthcare support worker pathway introduced. Future assurance will consider programme completion, progression and the contribution of these pathways to identified workforce needs.

Impact

The dashboard shows positive movement in several measures alongside areas requiring further attention. Annual comparisons provide useful context, but cannot establish the strategy's contribution to changes or be treated as equivalent to within-year performance.

Between Q1 and Q2, mandatory training compliance improved from 88.43% to 89.32%, although it remained below April's 90.36%. Annualised turnover was 7.06%, compared with 7.66% in April and 6.98% at Q1. Uptake increased in flexible working, apprenticeships and some wellbeing provision.

Sickness absence increased from 5.48% to 5.64%, and the reported stress-related absence measure rose from 1.96% to 1.99%. Alongside lower appraisal and Management Essentials completion and the widening workforce variance, this presents a mixed outcome position. These measures are influenced by the operational environment as well as strategy delivery; they should therefore be interpreted together, rather than as isolated indicators of the effectiveness of individual interventions.

Overall, the evidence supports assurance on implementation and participation, but sustained improvement across the intended outcomes remains to be demonstrated. Year 2 reporting will seek to strengthen outcome measures and establish clearer baselines and targets to support assessment of sustained improvement.

Risks

The principal risk is that sustained service pressure both increases the need for staff support and reduces the capacity to undertake the development and improvement activity intended to strengthen the workforce. This could limit progress despite established interventions. Oversight should therefore consider operational and people risks together, ensuring that the response addresses working conditions as well as delivery of the strategy.

Gaps in measures for violence and aggression, organisational learning and longer-term workforce development further limit assurance. The widening workforce variance also requires explanation of its distribution and implications; the aggregate figure alone does not establish the operational or financial position.

The Year 2 delivery plan should identify corrective action, accountable leads, milestones and intended outcomes. Resource and People Services capacity requirements should be assessed explicitly, distinguishing what can be delivered within existing resources from any proposal requiring a separate decision.

4. Priorities for Year 2

The strategy's priorities remain enduring, but Year 2 delivery should build on the foundations established in Year 1 and respond to emerging organisational needs and opportunities. The emphasis is on embedding leadership and culture change, strengthening prevention and inclusion, and connecting staff development more closely to future workforce requirements.

The RCN Foundation partnership provides an opportunity to embed compassionate leadership across wider management and leadership development. The Board's focus on succession planning will also inform a more coherent approach to appraisal, talent management and leadership pipelines, alongside longer-term workforce planning aligned to the Clinical Strategy and the development of new roles and career pathways.

Year 2 should place greater emphasis on making staff support and development achievable within demanding services. This includes enabling meaningful appraisal and management development, targeting preventative wellbeing activity where pressures are greatest, and connecting workforce planning more closely with operational delivery. Violence and aggression prevention and flexible working remain priorities, alongside ensuring that staff feedback and speaking up lead to visible action and organisational learning.

Anti-racism will be a central Year 2 priority, with a clear focus on progressing the Anti-Racism Framework, strengthening leadership ownership and accountability, and addressing inequalities in recruitment, progression and staff experience. This must extend beyond awareness and campaigning to challenge discriminatory behaviours and practices, ensure lived experience informs decisions, and demonstrate tangible change through delivery and outcome measures.

Delivery will require clear organisational accountability, sufficient People Services capacity and appropriate investment. The supporting delivery plan should identify accountable leads, milestones, resource requirements and intended outcomes, with stronger measures to assess impact.

The table below summarises the proposed focus for Year 2, with supporting objectives detailed in Year 2 plan (Appendix 1).

Priority	Proposed Year 2 emphasis
Create the Countess culture	Embed compassionate, inclusive and collective leadership and shared accountability in everyday practice, translating culture work into a more consistent staff experience.

Looking after our people	Move towards a more proactive approach to staff health, wellbeing and safety, focusing on preventing violence and aggression, reducing work related stress and supporting flexible working.
Shared sense of belonging	Progress the Anti-Racism Framework, strengthening leadership accountability and action on inequalities in recruitment, progression and staff experience, informed by staff voice and lived experience.
Develop our people	Improve appraisal quality and team development, and establish a Trust-wide approach to talent management and succession planning
Future workforce	Shift towards longer-term workforce planning aligned to the Clinical Strategy, developing the roles, skills and career pathways needed for sustainable services.

5. Conclusion

Year 1 has established important foundations for delivery of the People Strategy, with progress in wellbeing provision, flexible working, apprenticeships, team development and workforce systems. The Board can take assurance on implementation and uptake, although sustained improvement across the intended outcomes is not yet demonstrated.

In Year 2, our focus will be on embedding delivery, addressing adverse trends and demonstrating improvement in staff experience, culture and workforce sustainability, supported by clear accountability, appropriate investment and stronger measurement.

6. Recommendation

The Board of Directors is asked to:

- **Receive assurance** on progress in implementing the Year 1 commitments of the People Strategy, recognising the limitations of current evidence on sustained outcomes.
- **Note** the mixed performance position and remaining assurance gaps, including the impact of operational pressures.
- **Note** the proposed Year 2 priorities and the conditions necessary for delivery: shared organisational accountability, sufficient People Services capacity, adequate resources and stronger outcome measurement.

People Strategy – year 2 objectives

Countess of Chester Hospital NHS Foundation Trust

Appendix 1: Year 2 objectives

Strand	Workstream	What will good look like?	Year 2	KPIs
Creating the Countess Culture	Culture & Leadership	An outstanding place to work with a culture where every colleague feels safe, valued and accountable – proud to work for Team Countess, confident to speak up, consistently living our values and delivery outstanding care.	Implementation of Leadership Strategy and RCNF Compassionate Leadership Programme.	• Improved staff survey scores in relation to FTSU, engagement, leadership behaviours, feeling valued. • Reduction in ER cases
Looking after our people	Health & wellbeing	Our people are safe, competent, healthy and well in their mental and physical wellbeing. Comprehensive health and wellbeing offer available including physical, mental and financial wellbeing to all staff.	Facilitate proactive health checks for staff.	• Reduction in sickness absence rate and in stress related absences • Increased uptake of well-being initiatives • Reduction in V&A incidents against staff. • Increased number of standardised debriefs & reporting learning. • Improved staff well-being scores in surveys • Increased uptake of flexible working opportunities • All managers having completed Management Essentials programme
	Violence & aggression	The Trust consistently takes a robust approach to violence and aggression against staff, taking active steps to minimize risk and ensuring learning from incidents and support to staff.	Expansion of training and support for staff to manage V&A and embedding of learning approach.	
	Flexible working	People are able to work flexibly in a way that balance home and work commitments. Flexible working by default and increase in number of people working flexibly.	Expand types of flexible working making use of digital systems to support teams (eg team rostering)	
	Management & Leadership Development	Managers have the essential skills and knowledge to support staff and demonstrate a compassionate leadership approach. All managers undertake Management Essentials programme and access relevant leadership development.	Expand roll out to include aspiring managers.	
Creating a sense of belonging	Staff Experience	People are proud to work here, feel supported, recognised, equally valued and feel that they belong (improved staff experience measures, increased engagement with reward and recognition programmes).	Increase Trust wide engagement with R&R initiatives. Further increase number and diversity of campaigns supported. Progress Anti-Racism Framework accreditation and adoption of the Race	• Increased engagement with R&R programmes • Improved staff engagement and experience scores • Reduction in cases of bullying, discrimination, or behaviour related

Strand	Workstream	What will good look like?	Year 2	KPIs
	Equality, Diversity & Inclusion (EDI)	A strong stance against bullying, harassment, and discrimination, with clear reporting mechanisms and accountability. Representation at all levels and addressing disparities in recruitment, pay, progression and experience. Reduction in cases of bullying and harassment or behaviour related incidents.	Health Observatory's seven principles, with clear leadership accountability and action to address inequalities in recruitment, progression and staff experience.	incidents, particularly in relation to minority staff groups. • Higher representation of diverse groups in more senior roles
	Engagement and empowerment	Expand and empower staff networks, ensuring diverse voices are heard and influence decision-making. Increased Staff Side representatives and Staff Side engagement. People feel able to speak up and understand the positive contribution speaking up makes (increase in staff feedback and FTSU).	Enhance the role of staff networks and partnership working arrangements in influencing organisational decision making and driving cultural change. Improve sharing of organisational learning from speaking up.	• Increased engagement in Staff Networks • Increased Staff Side representatives and Staff Side engagement • Increase in staff feedback and speaking up, including FTSU.
Developing our people to be their best	Performance management Team Development Talent Management & Succession Planning Organisational learning	All colleagues participating in meaningful appraisals (increase in appraisal completion & effectiveness ratings). Development for all colleagues to build on their potential. High performing individuals and teams (improved TED scores). Clear, fair development and progression opportunities, with succession plans and leadership pipelines for key roles aligned to future workforce needs. Regular and proactive learning when things don't go as expected and celebrating and learning from successes.	Further enhance appraisal process based on learning from quality of appraisal feedback analysis. Expand rollout of High Performing Teams / TED tool across organisation. Establish a Trust-wide approach to talent management and succession planning, linked to appraisal, leadership development and future workforce requirements. Celebrating and learning from successes and promote awareness across all areas of the organisation.	• Increased appraisal compliance and improved feedback on quality of appraisals • Increased mandatory training scores • Expand use of TED across all teams and increase in TED scores. • Proportion of identified key roles with succession plans and associated development actions. • Increased instances of organisational learning. • Improved staff survey scores in 'we are always learning' and 'we are a team'.
Building the future workforce	Workforce planning	Our services are appropriately staffed and financially sustainable (workforce plan). Our workforce plans look to the future, are agile and support the Transforming Care Together and the Trust's Clinical Strategy.	Increase e-rostering level of attainment. Use of job plans in other clinical areas, eg specialist nursing. Development strategic workforce plan, aligned to Clinical Strategy.	• Levels of attainment for nursing & medical workforce • % clinical staff with job plans • Annual workforce plan on track. • Long term strategic workforce plan which is aligned to the Trust's future Clinical Strategy.

Strand	Workstream	What will good look like?	Year 2	KPIs
	Building career pathways	Increased use of apprenticeships for clinical and entry level roles and increase in advanced practice and new roles. Improved links between widening participation activities and future workforce needs.	Increase in advanced practice and new roles and development of clear career pathways for nursing. Development of additional apprenticeship programmes in E&F, admin and digital.	• Growth in apprenticeships and training placements. • Increase in advanced practice and new roles. • Improvement in vacancy and turnover rates for high turnover roles. • Reduction in premium rate temporary staffing

Countess of Chester Hospital NHS Foundation Trust

Committee Chair's Report
16th November 2026

Committee	People Committee
Chair	Non-Executive Director, Ms S Corcoran

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)*

- Staff experience and the challenge in driving improvement with meaningful actions recognising a range of interventions and organisational challenges, understanding causation.
- Workforce Race Equality Standard (WRES) / NHS Workforce Disability Equality Standard (WDES) and Equality, Diversity & Inclusion (EDI) integrated action plan progress against priorities. Noting clarity of risks and understanding to be reported to the Board.
- People Strategy year 2 priorities agreed and require Board and Trust-wide commitment and ownership to deliver.

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

- Partnership Forum chair's report including alert to the Committee relating to nursing and midwifery job evaluation programme with a plan and engagement cycle agreed. Meeting also covered policy approvals, Cost Improvement Programme (CIP), employee relations,
- People and culture sub-committee chair's report with alerts to the Committee for staff experience and challenge in improving this; WRES and WDES reports; delays in progress against actions in EDI integrated action plan. Committee also received update on reward and recognition; staff networks; people and culture dashboard; and risks.
- Education, training and learning sub-committee chair's report including an alert for mandatory training and appraisal compliance with both performing below required levels. Committee also received assurance on apprenticeship levy; national education and training survey (NETs); improvement plans; and risks.
- Workforce sub-committee chair's report with alerts for workforce plan delivery; CIP delivery; and nursing workforce gaps and temporary staff. Assurances received on medical temporary staffing controls; approach to engagement on sickness absence policy and management; and locally employed doctor contract review progressing.
- Joint Local Negotiating Committee (JLNC) committee chair's report with alerts on progress on job planning in year; resident doctor exception reporting; and medical workforce gaps.
- Received EDI update including WRES, WDES and gender pay gap reports for approval for publication. Some year on year improvement in some measures, but majority continue to track below national average and greater progress is needed. Recovery plan needed on EDI action plan to progress in agreed timelines.

Committee requested a clear understanding of prioritisation and the actions that will make the biggest difference.

- People Strategy 2025-28 year 1 delivery and year 2 priorities. Committee discussed importance of wider Board update and discussion. Committee supported the plan priorities and continued review and refinement of KPIs and outcome measures.
- General Medical Council (GMC) national training survey 2026 results providing assurance on a range of improvements, along with areas requiring action including specific specialities. Emergency Medicine remains in intensive support framework but with improvement from level 2 to level 1, and three other specialities are identified as under observation. Work being undertaken to understand speciality results, support and action required with updates to be provided through the Education, Leaning and Organisational Development Sub Committee.
- Annual schedule of People related policies and forward schedule for review, demonstrating improved recovery on out of date policies and improved governance looking forward.
- Violence and Aggression (Quarter 2) update showing an increase in incidents of abuse of staff by patients/ third party. The paper included themes and locations of increased incidents. Actions continue to be progressed and embedded including yellow and red card processes, staff support, patient centred care, and location of patient cohorts.

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

- Continuing to review the use and state of the Education and Training Centre and report to be developed for end 2026/27.
- Chief People Officer (CPO) report included an update on consultant industrial action which has been paused; national updates on transforming people services and staff standards; new north west ELEVATE career and talent management hub to support succession risks; and NW race Equity anti-racism framework accreditation.
- Attendance at committee to be reviewed and action to support increased participation.
- Anti racism oversight including staff story; importance of tackling racism; CoCH workforce diversity; staff survey and WRES/WDES context; incidents; anti-racism work within the Trust; national context and the Lord Mann review; Trust priorities and measures for success. Committee discussed the importance of staff wellbeing. Delivery plan to be presented to the Committee in February 2027.
- Staff experience update recognising triangulation with other papers and the need to ensure a clear focus on priorities.
- Culture and leadership update including development of the RCN Foundation Compassionate Leadership partnership; national NHS management and leadership framework; and ongoing management and leadership training.
- Workforce annual planning 2026/27 update with the Committee supporting a revised more meaningful internal trajectory recognising the current position, drivers and forward look, noting this will not amend the national submitted plan. Committee requested planned and unplanned workforce changes to be clearly identified on graphical representations for transparency.

• Workforce metrics performance (August 2026 data) including targeted work on sickness absence; staff unavailability levels; reduction in mandatory training compliance; variable pay increase.
Risks discussed and new risks identified
• Reviewed the Board Assurance Framework (BAF) and high risks relevant to the People Committee. • Committee requested an overview of the planning approach for industrial action to understand the processes and assurance on preparedness for potential future action.

PUBLIC – Board of Directors
24th November 2026

Report	**Agenda Item 27a.**	**Equality, Diversity & Inclusion (ED&I) Report (including 2026 WRES, WDES and Gender Pay Gap)**						
Purpose of the Report	Decision	**X**	Ratification		Assurance		Information	**X**
Accountable Executive	Vicki Wilson			Chief People Officer				
Author(s)	Liz Pritchard			Deputy Chief People Officer				
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research BAF11 Transformation			**X**	BAF 4 People: reduce the risk that inequity in staff experience undermines engagement, retention and safe patient care.			
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health							**X** **X**
CQC Domains	Safe Effective Caring Responsive Well led							 **X**
Previous considerations	People Committee – 16 November 2026 (verbal update to be provided).							
Executive summary	This paper reports the Trust's 2026 Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) and Gender Pay Gap (GPG) results. Due to the rescheduling of People Committee, this paper was prepared before the Committee's consideration of the full EDI report and does not reflect its discussion. A verbal update will be provided at the meeting. WRES: harassment and discrimination between colleagues have fallen, but harassment of Global Majority staff by patients and the public (36.0%) and the shortlisting disparity (1.68) have worsened. These are the focus of the Trust's anti-racism priorities. WDES: processes have improved, with more disabled staff receiving reasonable adjustments and fewer entering capability processes. However, disabled staff feel less valued and less engaged, and harassment from the public remains above the national average.							

	Gender pay gap: the mean gap has reduced from 26.0% to 24.6% and the mean bonus gap from 63.4% to 56.1%, both in favour of men. The gaps are largely driven by the higher proportion of men in senior medical roles.
Recommendations	The Board of Directors is asked to: • **Note** the 2026 WRES, WDES and Gender Pay Gap results, and the verbal update on People Committee's consideration of the full EDI report. • **Approve** publication of the WRES, WDES and Gender Pay Gap reports, subject to data validation. • **Note** that this report fulfils the Lord Mann review expectation (Recommendation 3) that WRES is discussed at a public Board meeting at least annually.

Corporate Impact Assessment	
Statutory/regulatory requirements	Equality Act 2010 and Public Sector Equality Duty; Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 (gender pay gap); WRES and WDES (NHS Standard Contract); CQC well-led
Risk	Supports BAF 4 People and Risk 3323 (inequitable experience for staff with protected characteristics; score 9).
Equality & Diversity	Reports directly on equity of experience and outcomes by race, disability and sex.
Communication	WRES and WDES reports to be published on the Trust website following approval. Gender pay gap to be published on the Trust website and the government reporting service by 30 March 2027.

Equality, Diversity & Inclusion (ED&I) Report (including 2026 WRES, WDES and Gender Pay Gap)

1. Introduction

This paper provides formal reporting to the Board of the Trust's 2026 WRES, WDES and Gender Pay Gap results, and seeks approval for publication. The detailed EDI report, including action plans, is due to be considered by People Committee on 16 November 2026. Because the Committee was rescheduled, this paper does not reflect its discussion; a verbal update will be provided.

2. Background and Context

Workforce EDI reporting shows where staff representation, access to opportunity, treatment and experience differ between groups. Its value lies in informing targeted action and showing whether that action is improving outcomes.

The Trust has progressed a range of EDI initiatives, but improvement is not yet consistent across all measures. Meeting reporting requirements provides assurance of compliance, not of impact. Stronger delivery, ownership and oversight are needed to build a culture where staff feel they belong and discrimination, bullying and abuse are not accepted.

3. Data sources and reporting periods

Trust figures are from the 2026 WRES and WDES submissions. Workforce indicators use data for 1 April 2025 to 31 March 2026, with representation and Board figures as at 31 March 2026. Staff experience indicators use the 2025 NHS Staff Survey. National comparators are from the 2025 national reports, covering 2024/25 and the 2024 Staff Survey, so are a year behind the Trust's figures. Gender pay gap figures are based on the statutory snapshot of 31 March 2026. Board percentages are based on small numbers, so a single change in membership has a large effect.

4. Workforce Race Equality Standard

Work on internal culture is having an effect: harassment and discrimination between colleagues have fallen, and belief in equal career opportunities has improved. Two areas have worsened. Harassment of Global Majority staff by patients and the public is now seven points above the national average, and white applicants are more likely to be appointed from shortlisting. These are the focus of the Trust's anti-racism priorities, considered elsewhere on this agenda.

Indicator	2024/25	2025/26	National 2024/25	Position
1. Global Majority workforce	18%	19%	28.6%	Increasing; below national
2. Shortlisting to appointment (white vs Global Majority)	1.62	1.68	1.77	Worsened
3. Entry to formal disciplinary (Global Majority vs white)	0.53	0.97	1.11	Near parity
4. Access to non-mandatory training and CPD	0.95	0.91	1.02	No Global Majority disadvantage
5. Harassment from patients and public (Global Majority)	34.4%	36.0%	29.0%	Worsened; above national
6. Harassment from staff (Global Majority)	27.8%	21.5%	24.1%	Improved; below national
7. Belief in equal opportunities for progression	37.7%	41.5%	49.1%	Improved; below national
8. Discrimination from managers or colleagues	22.6%	17.5%	14.7%	Improved; above national

Indicator	2024/25	2025/26	National 2024/25	Position
9. Board vs workforce representation gap	−18 pts	−12.4 pts	−13.4 pts	Improved (Board 6.6%)

5. Workforce Disability Equality Standard

Processes for disabled staff are improving: more report that reasonable adjustments have been made, more report harassment when it happens, and the likelihood of entering capability processes has fallen, though it remains above parity. These improvements have not yet translated into experience. Disabled staff feel less valued, less engaged and less confident about career progression, and harassment from the public remains above the national average.

Metric	2024/25	2025/26	National 2024/25	Position
1. Disabled staff in workforce	5.7%	6.4%	6.7%	Increasing; below national
2. Shortlisting to appointment (non-disabled vs disabled)	0.99	0.92	0.95	No disabled disadvantage
3. Entry to formal capability (disabled vs non-disabled)	1.62	1.43	—	Improved; above parity
4a. Harassment from the public	33.0%	33.5%	29.1%	Above national
4b. Harassment from managers	16.3%	15.3%	14.1%	Improved; above national
4c. Harassment from colleagues	26.8%	25.0%	24.5%	Improved; above national
4d. Reported most recent harassment	51.5%	59.8%	53.2%	Improved; above national
5. Belief in equal opportunities for progression	42.7%	41.9%	47.8%	Declined; below national
6. Pressure to come to work when unwell	27.6%	27.7%	27.2%	Unchanged
7. Feel the Trust values their work	27.0%	26.8%	32.1%	Below national
8. Reasonable adjustments made	65.3%	71.6%	73.7%	Improved; below national
9a. Engagement score (out of 10)	6.19	5.84	6.29	Declined; below national
10. Board vs workforce representation	0 pts	+6.9 pts	+0.7 pts	Board 13.3% disabled

6. Gender Pay Gap

The mean gender pay gap has reduced but remains substantial. The much smaller median gap (4.1%) shows the mean is driven by a relatively small number of high-earning roles: men make up 22% of the workforce but 33% of the upper pay quartile, largely reflecting the senior medical workforce. The bonus gap mainly reflects historic Clinical Excellence Awards, over which the Trust has limited influence. The largest gap within the Trust's control is among locally employed doctors (15.4%), where further analysis is a priority.

Measure (snapshot 31 March)	2025	2026
Mean gender pay gap	26.0%	24.6%
Median gender pay gap	—	4.1%
Mean bonus gap	63.4%	56.1%
Median bonus gap	—	0.0%

Measure (snapshot 31 March)	2025	2026
Men as share of workforce / upper pay quartile	—	22.4% / 33.0%

7. Next Steps and Actions

Priorities from the reports will be incorporated into the Integrated EDI Action Plan. These include inclusive recruitment and Board representation (WRES), a Trust-wide Reasonable Adjustments Policy and oversight of capability processes (WDES) and pay-equity analysis focusing on locally employed doctors (GPG).

Following approval, the WRES and WDES reports and action plans will be published on the Trust website. The gender pay gap will be published on the Trust website and the government reporting service by the statutory deadline of 30 March 2027.

8. Recommendation

The Board of Directors is asked to:

1. **Note** the 2026 WRES, WDES and Gender Pay Gap results, and the verbal update on People Committee's consideration of the full EDI report.
2. **Approve** publication of the WRES, WDES and Gender Pay Gap reports, subject to data validation.
3. **Note** that this report fulfils the Lord Mann review expectation (Recommendation 3) that WRES is discussed at a public Board meeting at least annually.

Public – Board of Directors
24 November 2026

Report	**Agenda Item 27b.**	**Becoming an Anti-Racist Organisation (including response to the Lord Mann Review)**						
Purpose of the Report	Decision	**X**	Ratification		Assurance		Information	
Accountable Executive	Vicki Wilson			Chief People Officer				
Author(s)	Vicki Wilson			Chief People Officer				
Board Assurance Framework	BAF 1 Quality BAF 2 Safety BAF 3 Operational BAF 4 People BAF 5 Finance BAF 6 Capital BAF 7 Digital BAF 8 Governance BAF 9 Partnerships BAF 10 Research BAF 11 Transformation			**X**	BAF impact is to reduce the risk that racism and inequity undermine staff experience, retention and safe patient care, by building an inclusive culture where Global Majority colleagues are safe, fairly treated and able to progress..			
Strategic goals	Patient and Family Experience People and Culture Purposeful Leadership Adding Value Partnerships Population Health						**X** **X** **X** **X** **X**	
CQC Domains	Safe Effective Caring Responsive Well led						**X** **X** **X**	
Previous considerations	Board development – 20 October 2026							
Executive summary	The Board is asked to make a public commitment to anti-racism by adopting the NHS Race and Health Observatory's seven principles and approving the Board anti-racism statement (Appendix 1) for immediate publication. The paper also sets out the Trust's response to the Lord Mann review and to the new duty, from 30 October 2026, to take all reasonable steps to prevent harassment of staff by third parties. The 2025/26 WRES shows that harassment and discrimination between colleagues have fallen. However, harassment, bullying and abuse of Global Majority staff by patients and the public has risen to 36%, seven points above the national average, and the shortlisting disparity has widened to 1.68. These are the main areas of focus. Four priorities will drive delivery: Board leadership and accountability; listening, acting and building trust; tackling evidenced inequalities; and							

	developing anti-racist leadership. Anti-racism will be a whole-Board responsibility, with a twice-yearly report to Board. The Trust has applied for North West Anti-Racist Framework Bronze accreditation, with feedback expected in December 2026. A delivery plan will be co-produced with staff networks and presented to People Committee in February 2027. Making meaningful progress will depend on appropriate capacity, and resource requirements will be identified through the delivery plan.
Recommendations	The Board of Directors is asked to: • **Approve** adoption of the seven anti-racism principles and the Board anti-racism statement at Appendix 1 for publication. • **Agree** that anti-racism is a whole-Board responsibility, supported by People Committee, with the Chief People Officer as Executive lead. • **Approve** the four priorities and the Trust's response to the Lord Mann recommendations. • **Agree** twice-yearly Board reporting, with the delivery plan and targets presented to People Committee.

Corporate Impact Assessment	
Statutory/regulatory requirements	Equality Act 2010 and Public Sector Equality Duty; Employment Rights Act 2025 third-party harassment duty (from 30 October 2026); WRES and the Violence Prevention and Reduction Standard (NHS Standard Contract); NHS Staff Standards and NHS Oversight Framework; CQC well-led.
Risk	Supports BAF 4 People. The principal risk is that commitment does not translate into measurable improvement, particularly in racism from patients and the public and in recruitment outcomes. Where the Trust cannot evidence all reasonable steps to prevent third-party harassment, there is a risk of legal claims.
Equality & Diversity	Directly addresses race inequality in employment, including antisemitism and anti-Muslim hostility. Actions should consider how race intersects with other protected characteristics.
Communication	Document to be published as part of the agenda pack.

Becoming an Anti-Racist Organisation
(including response to the Lord Mann Review)

1. Introduction

This paper asks the Board to make a clear, public commitment to anti-racism and to agree how that commitment will be led, delivered and held to account.

It responds to the People Strategy 2025–2028 Year 1 review, which identified anti-racism as a central Year 2 priority. That review was explicit that the work must extend beyond awareness and campaigning: it must challenge discriminatory behaviours and practices, ensure lived experience informs decisions, and demonstrate tangible change through outcome measures.

It also sets out the Trust's response to the Lord Mann review and to new legal duties on harassment.

The paper includes the Board anti-racism statement for approval and publication. It does not set out a full action plan; it establishes the commitment, priorities and governance, so that a delivery plan can be co-produced with Global Majority colleagues and brought to People Committee.

2. Why tackling racism matters

Tackling racism is a leadership, workforce and patient safety responsibility, not a discretionary programme.

- **Staff wellbeing and retention.** Staff who experience racism are more likely to report stress, disengage and leave; we cannot afford to lose skilled colleagues to avoidable harm.
- **Patient safety and quality.** Teams where people feel unsafe to speak up deliver less safe care. A culture that tolerates racism towards staff also risks tolerating unequal treatment of patients.
- **Fairness and talent.** Our workforce is increasingly diverse, including a large internationally recruited cohort. Barriers to recruitment and progression waste talent and narrow our leadership pipeline.
- **Legal and regulatory duty.** The Equality Act 2010 and Public Sector Equality Duty require us to eliminate discrimination and advance equality. WRES, the EDI Improvement Plan, the new NHS Staff Standards and the NHS Oversight Framework all increase scrutiny of how we act.
- **New harassment protections from 30 October 2026.** Under the Employment Rights Act 2025, employers are now liable for harassment of staff by third parties, such as patients, relatives and visitors, unless they have taken all reasonable steps to prevent it. This covers racial harassment, not only sexual harassment, and a single incident can give rise to a claim. The duty to prevent sexual harassment has also been strengthened to "all reasonable steps". The Trust must be able to evidence the preventative steps it takes, making the actions in this paper a legal as well as a moral requirement.
- **Trust with our communities.** Patients and staff need confidence that racism, including antisemitism and anti-Muslim hostility, will be named, investigated and acted on.

3. Context

National: the NHS Race and Health Observatory seven principles

The NHS Race and Health Observatory has developed seven principles to help NHS organisations turn anti-racist pledges into practical action. They address structural, institutional and interpersonal racism, to protect staff and improve patient safety. Adopting them is Recommendation 1 of the Lord Mann review; NHS England has signed up and asked every NHS organisation to do the same.

Principle	What it means	What it means for the Trust
1. Name racism	Identify racial disparities explicitly and speak openly about discrimination and its evidence	Use the word racism, not euphemisms; name antisemitism and anti-Muslim hostility as forms of racism
2. Demonstrate leadership	Leaders at every level model anti-racist behaviour and take responsibility for cultural change	Board and senior leaders visibly own anti-racism and are held to account for it
3. Focus on data and evidence	Collect, use and evaluate high-quality race equality data; good intentions are insufficient	Report ethnicity data routinely to Board, improve declaration rates and publish progress
4. Value lived experience insight	Listen to those who experience racism and co-design solutions with them	Global Majority colleagues and staff networks shape priorities and judge progress
5. Use evidence-based interventions	Use proven approaches that recognise intersectionality, and share what works	Test policies and processes for bias and act on the processes behind each disparity
6. Foster transparency and accountability	Set measurable goals, report on impact and hold people and the institution to account	Public reporting, Board scrutiny and anti-racism objectives in appraisals
7. Promote wellbeing and cultural safety	Make the workplace psychologically and physically safe for racially minoritised staff	Consistent support for staff who experience racism and safe routes to speak up

Public adoption means a Board statement on the Trust website, communication to all staff and partners, and an annual public report of progress against each principle.

Regional: the North West Anti-Racist Framework

The NHS North West Race Equity Assembly (formerly the BAME Assembly) was established in July 2020 as a strategic advisory group of senior Black, Asian and minority ethnic NHS leaders. Its anti-racism framework provides a structured route for organisations to assess and evidence progress in reducing racial inequality in their workforce and services. It aligns with the EDI Improvement Plan, EDS 2022 and WRES.

The framework has three levels — Bronze, Silver and Gold. Bronze demonstrates foundations: visible Board commitment, an executive anti-racism sponsor, an anti-racism statement and a plan. Silver requires those foundations to be embedded in practice, for example equality objectives in the appraisals of managers and senior clinicians.

The Trust has applied for Bronze accreditation, as committed in the Year 2 People Strategy objectives, and expects feedback in December 2026. The outcome will be reported to People Committee and Board. Any feedback will be addressed in Q4 2026/27 alongside a Silver action plan aligned to the four priorities, with a Silver submission in 2027/28 once the Assembly confirms dates.

Local: the People Strategy

Year 2 of the People Strategy places anti-racism within the ‘Creating a sense of belonging’ strand. Its stated outcomes include a strong stance against discrimination, representation at all levels, and action on disparities in recruitment, pay, progression and experience. Its KPIs include fewer

bullying, discrimination and behaviour-related cases among minority staff groups, and higher Global Majority representation in senior roles.

4. Where we are now

The Trust has made progress, but Global Majority colleagues' experience and outcomes are not yet equitable.

Year 1 of the People Strategy laid foundations. It developed staff network governance, increased Staff Side representation, and reinforced Civility and Respect through communications, appraisal and management development.

In the past year the Trust has added racism to its Violence and Aggression policy, refreshed the support offer for staff who experience it, launched the Zero Acceptance campaign, and led the Cheshire and Merseyside anti-racism round table. It is also introducing ethnicity pay gap reporting in 2027. Two integrated EDI action plan actions are overdue: equity in formal HR processes and EDI objectives for Band 8a and above. Both are covered by Priorities 3 and 4, with revised timescales in the delivery plan.

The 2025/26 WRES results suggest that work on internal culture is having an effect. Harassment from colleagues fell to 21.5%, now below the national average, and discrimination from managers and colleagues fell to 17.5%. Global Majority colleagues still have a poorer experience than white colleagues, and discrimination remains above the national average, so this progress needs to be sustained.

The results also show where culture work alone is not enough.

- **Patients and the public.** Harassment, bullying and abuse of Global Majority staff by patients and the public has risen to 36.0%, seven points above the national average. Protecting them needs firmer action on patient behaviour and stronger support for staff, not only awareness.
- **Recruitment and progression.** The shortlisting disparity has widened to 1.68. Fewer than half of Global Majority colleagues believe they have equal opportunities to progress. Global Majority colleagues make up 19% of the workforce but re not reflected on the Board. This points to barriers in recruitment and progression processes that will not shift without deliberate changes to how decisions are made.

These two areas are the main focus of this approach.

What staff tell us directly confirms there is more to do. Datix incidents, Freedom to Speak Up concerns and staff network feedback show that colleagues continue to experience racism from patients and the public, and from colleagues. Some colleagues tell us they do not report racism because they do not believe action will follow. We need to do more, and be seen to do more, to address it.

The table below sets out the Trust's current position against key race equality indicators. It provides the baseline against which progress will be measured, and it informs the specific inequalities targeted under Priority 3.

Indicator	Measure	Source	Baseline 2025/26 (2024/25)	National 2024/25	Direction (Target TBC)
Recruitment	Likelihood of white applicants being appointed from shortlisting relative to Global Majority applicants	WRES 2	1.68 (1.62)	1.77	Towards 1.0
Employee relations	Likelihood of Global Majority staff entering formal disciplinary relative to white staff	WRES 3	0.97 (0.53)	1.11	Maintain at parity
Patients and public	Global Majority staff experiencing harassment, bullying or abuse from patients and the public	WRES 5	36.0% (34.4%)	29.0%	Reduce
Bullying and harassment	Global Majority staff experiencing harassment, bullying or abuse from staff	WRES 6	21.5% (27.8%)	24.1%	Reduce
Discrimination	Global Majority staff experiencing discrimination from managers or colleagues	WRES 8	17.5% (22.6%)	14.7%	Reduce
Progression	Global Majority staff believing the Trust provides equal opportunities for career progression	WRES 7	41.5% (37.7%)	49.1%	Increase
Representation	Board representation compared with workforce (Board 6.6%; workforce 19%)	WRES 9	−12.4 pts (−18 pts)	−13.4 pts	Close the gap
Accreditation	North West Anti-Racist Framework accreditation	Framework assessment	Bronze applied for	—	Bronze secured; Silver plan in place

5. The Lord Mann Review

The Lord Mann review found racism, including antisemitism, is persistent and in places normalised across the NHS, and called for a system-wide reset in leadership, accountability and staff protection.

The review of antisemitism and other forms of racism in the NHS was published on 4 June 2026 and makes 36 recommendations. 13 require action by NHS trusts and their boards; the remaining 23 are for DHSC, NHS England, regulators, medical schools and other national bodies. The government and NHS England accepted all recommendations made to them, and NHS England wrote to trusts on 4 June setting out immediate actions.

Key findings

- Racism and antisemitism are widespread and in some cases normalised across NHS settings.

- Black and minority ethnic staff, and Jewish staff, are more likely to experience discrimination from colleagues, managers and the public.
- Organisational responses vary in leadership, culture and practice.
- Arrangements for reporting and investigating racism are not always clear, consistent or effective.

The 13 recommendations for the Trust and our response

The table sets out each recommendation that applies to the Trust, what it requires, and what we will do. Progress will be tracked by People Committee and reported to Board.

Rec	What the recommendation requires	What the Trust will do	Lead	Timescale	Status
1	Adopt the RHO seven anti-racism workforce principles, recognising antisemitism as a form of racism	Board to adopt the principles and approve the Board anti-racism statement (Appendix 1) for immediate publication	Chief People Officer	November 26	For approval
3	Develop a robust WRES action plan with specific, measurable targets; apply “explain or reform” to persistent inequalities; publish the plan and discuss it at a public Board at least annually; review staff survey data for Jewish staff alongside WRES	Refresh WRES action plan with targets; present at public Board annually; add Jewish staff survey data to the indicator report (Priority 3)	Chief People Officer	March 27	In progress
4	Boards held accountable for race equality and staff experience metrics through the new NHS Oversight Framework staff standards score, with metrics made public	Include NOF staff standards metrics in the Board report; gap analysis against the NHS Staff Standard on racism	Chief People Officer	December 26	In progress
5	Board-level oversight of all investigations related to racism: annual reporting on volume, themes, outcomes and timescales, deep dives into hotspots, and assurance that recommendations are implemented	Racism-related investigations (volume, themes, outcomes and timescales, and implementation of recommendations) reported annually through the twice-yearly anti-racism report to Board, with deep dives into hotspots commissioned via People Committee (Priority 1).	Chief People Officer	May 27	For approval
7	All Board members and senior leaders have explicit, measurable EDI	Anti-racism objective in every executive, non-executive and senior	Chair / Chief Executive	July 27	For approval

Rec	What the recommendation requires	What the Trust will do	Lead	Timescale	Status
	objectives in their performance goals, assessed against the RHO principles	leader appraisal (Priority 1)			
8	Employers set clear local policies on what political identifiers are acceptable, to ensure patients feel safe	Review uniform, dress and social media policies; update when national uniform guidance is published	Chief People Officer	TBC	Awaiting national guidance
9	All staff, volunteers and sub-contracted staff are aware of and can easily access the expectations on them on anti-racism and inclusion	Communicate expectations at induction, in contracts, volunteer agreements and contractor terms; include in Board statement launch	Chief People Officer	January 27	In progress
12	PALS and complaints handlers trained to identify and handle complaints about racism, with clear routes to share themes with leadership	PALS and complaints staff to complete the national eLearning for complaints handlers once released by NHS England. Complaints themes on racism included in Board reporting.	Executive Director of Nursing	TBC	Awaiting national e-learning
13	Build skills and cultural capability in trusts to investigate racial harassment and discrimination and support staff, using the national investigation framework	Train investigators and managers; adopt the national framework when published; set out support for those affected (Priority 2)	Chief People Officer	TBC	In progress
14	Take account of the ACAS code and use early intervention and resolution	Review Bullying & Harassment, grievance and disciplinary policies to strengthen emphasis on early resolution routes and the Macpherson principle	Chief People Officer	July 27	In progress
27	Employers implement national guidance to protect staff from violence and discrimination by patients and the public, including when care can be withdrawn, and take firm action	Strengthen the zero-tolerance process and staff support for racism from patients and the public and include racist abuse in Board assurance against the Violence Prevention and Reduction Standard.	Executive Director of Nursing / Chief People Officer	Ongoing	In progress
32	Updated mandatory EDHR training, including antisemitism and anti-	Monitor EDHR and new bitesize module compliance by division;	Chief People Officer	TBC	Awaiting updated

Rec	What the recommendation requires	What the Trust will do	Lead	Timescale	Status
	Muslim hostility, completed by all staff	report to People Committee.			national training.
34	Mandatory training for trust chairs and chief executives on antisemitism, anti-racism and the Macpherson principles within 6 months	Chair and Chief Executive to complete; whole Board to undertake new national anti-racism training when available	Chair / Chief Executive	March 27	Awaiting launch of national training.

6. Proposed approach: our four priorities

Four priorities will translate the seven principles into action at the Countess, respond to the Mann review and support our Bronze application and ambition to progress to Silver. The four priorities below are designed to build on what is improving, close the remaining gap with white colleagues, and tackle the areas where inequity is entrenched. They extend the Trust's response to racism from patients and the public, alongside action on internal culture and processes. Each is deliberately focused, so that progress can be evidenced rather than asserted.

Priority 1: Board leadership and accountability

Anti-racism is an explicit responsibility of the whole Board, supported by People Committee but not owned solely by it. The Chief People Officer is the executive lead.

- Publicly adopt the seven principles and publish the Board anti-racism statement (Appendix 1)
- Complete the North West Anti-Racist Framework Bronze accreditation, to which the Trust is already committed, and set out the route to Silver.
- Give every Board member an anti-racism objective in their appraisal, so that ownership sits with the whole Board rather than a single champion (Mann Recommendation 7.).
- Receive a twice-yearly anti-racism report covering progress against the action plan and framework criteria; outcomes (WRES, Staff Survey and racism-related investigations annually, with in-year data at mid-year); the race equality risk within BAF 4; and Global Majority colleagues' own assessment of progress.

Priority 2: Listen, act and build trust

Staff will only believe our commitment when they see us act on what they tell us.

- Establish a consistent way for Global Majority colleagues to shape priorities and judge whether actions are making a difference, co-producing the delivery plan with staff networks and trade unions.
- Strengthen psychological safety, and confidence in both raising and responding to racism, including through Freedom to Speak Up and an accessible incident reporting pathway, closing the loop with every person who reports.
- Provide a consistent support offer for staff who experience racism, from colleagues or from patients and the public.
- Show clearly what has changed as a result of staff feedback.
- Support network leads with protected time, so responsibility does not fall on Global Majority colleagues.

Priority 3: Tackle evidenced inequalities

The Trust's data shows inequalities for Global Majority colleagues in the four areas below. For each, the Trust will review the processes behind the disparity, not only the outcome, so that practice changes. Targets will be agreed with staff networks, with progress reported through the twice-yearly anti-racism report to Board.

Priority area	Indicators	Source
Recruitment and progression	Likelihood of appointment from shortlisting by ethnicity; access to non-mandatory training and CPD; internal promotions by band and ethnicity; perception of equal opportunity	WRES 2, 4, 7; ESR; TRAC
Employee relations processes, including bullying, harassment and discrimination	Likelihood of entering formal disciplinary; grievance, dignity at work and capability cases by ethnicity; case outcomes and duration; bullying, harassment and discrimination reported by staff	WRES 3, 6, 8; ER case tracker; Staff Survey
Racism from patients, the public and colleagues	Racist incidents reported; action taken and outcome; support offered; Freedom to Speak Up concerns citing race	Datix; WRES 5; FTSU
Senior leadership representation	Representation at Band 8a and above, and Board, against workforce and local population	WRES 1, 9; ESR

Priority 4: Develop actively anti-racist leadership

Every leader will understand racism, recognise bias and act when they see it. Addressing racism is a leadership and organisational responsibility, not something Global Majority colleagues are expected to fix.

- **Board development:** anti-racism in the Board development programme, plus the new national anti-racism training when available.
- **Leadership programmes:** anti-racism and allyship content in senior leadership and management development, with *Your Future, Your Way* as one contribution.
- **Appraisals:** an anti-racism objective in every Board, executive, senior leader and manager appraisal, as Silver requires.
- **Recruitment and talent:** diverse interview panels for Band 8a and above, inclusive job descriptions, debiased shortlisting, and anti-racism embedded in talent management and succession, aligned with the Year 2 talent and succession work.
- **Investigators and managers:** training to recognise and respond to racism, and to apply the Macpherson principle when racism is alleged.

Delivering the priorities

The Board's commitment will need to be matched by the capacity to deliver it. Resource requirements will be identified as the delivery plan is developed and considered by the Executive team.

Mapping of priorities to the seven principles

The table below shows how each of the four priorities delivers the NHS Race and Health Observatory's seven principles, with every principle addressed by at least one priority.

RHO principle	P1 Board leadership	P2 Listen, act, build trust	P3 Evidenced inequalities	P4 Anti-racist leadership
1. Name racism	●		●	●
2. Demonstrate leadership	●			●
3. Data and evidence	●		●	
4. Lived experience		●	●	
5. Evidence-based interventions			●	●
6. Transparency and accountability	●	●	●	
7. Wellbeing and cultural safety		●		●

7. Measures of success

Success will be judged against the indicators in section 4, using 2025/26 as the baseline. Targets will be developed with staff networks following Board approval and presented to People Committee with the delivery plan in February 2027. Progress will be reported through the twice-yearly anti-racism report to Board.

8. Conclusion

Adopting the seven principles and the North West framework gives the Trust a clear, evidence-based standard to be held to, and positions us to respond fully to the Lord Mann review and our new legal duties. The test of the commitment will be whether Global Majority colleagues see and feel the difference.

Subject to the Board's approval, the Board anti-racism statement (Appendix 1) will be published on the Trust website and shared with staff, trade unions, patients, and system partners. The delivery plan will follow, co-produced with staff networks and Global Majority colleagues and presented to People Committee in February 2027, with the first Board progress report in March 2027.

9. Recommendation

The Board of Directors is asked to:

- **Approve** adoption of the seven anti-racism principles and the Board anti-racism statement at Appendix 1 for publication.
- **Agree** that anti-racism is a whole-Board responsibility, supported by People Committee, with the Chief People Officer as executive lead.
- **Approve** the four priorities and the Trust's response to the Lord Mann recommendations.
- **Agree** twice-yearly Board reporting, with the delivery plan and targets presented to People Committee.

Appendix 1

Anti Racism Statement
Countess of Chester Hospital NHS Foundation Trust

At the Countess of Chester Hospital NHS Foundation Trust, we are committed to being an actively anti-racist organisation. Everyone who works with us, receives our care or visits our services will be treated with dignity, compassion and respect, and should feel safe, valued and included. Good intentions are not enough; our commitment will be shown through sustained action.

Our ambition is a Trust where race does not determine anyone's experience of work, opportunity to progress or quality of care. Anti-racism will be a core responsibility of every leader, embedded in how we make decisions, and the Board will hold itself and our leaders to account for progress.

By 2029, we will have delivered substantial, sustained and measurable reductions in racial inequalities across staff experience, employment opportunities and patient care, and we will publish our progress every year. We will challenge racism consistently, whether it comes from colleagues, patients or visitors, so that staff and patients feel safe to raise concerns and confident they will be heard and acted on.

24 November 2026

PUBLIC – Board of Directors
24th November 2026

Report	**Agenda Item 28***	**Council of Governors Report – November 2026**						
Purpose of the Report	Decision		Ratification		Assurance		Information	**X**
Accountable Executive	Karan Wheatcroft			Director of Governance and Risk				
Author(s)	Nusaiba Cleuvenot			Head of Corporate 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** **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**
CQC Domains	Safe Effective Caring Responsive Well led							**X**
Previous considerations	Not applicable.							
Executive summary	The purpose of this report is to provide a summary of items discussed at the Council of Governors meetings.							
Recommendations	The Board of Directors is asked to **note** the report and the activity during this period.							

Corporate Impact Assessment	
Statutory/regulatory requirements	Meets 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	Not confidential.

Council of Governors Report

1. PURPOSE

This report provides a summary update of recent activity related to the Council of Governors (CoG).

2. BACKGROUND

The Council of Governors meetings are held on a quarterly basis. In between, informal Governor meetings are held, led by the Chair.

3. CURRENT POSITION

3.1 Council of Governors Meeting

A full Council of Governors meeting was held on 15th July 2026, and key items included the following:

- CEO Report
- Lead Governor Update
- Future of Governors Update
- Membership and Engagement Committee Chair's report and Minutes
- Board Sub-Committee Chair's reports
- Integrated Performance Report
- NED/Governor Walkabout Summary report
- Year- end Performance position
- Quality account (included in noting pack)

Following the public Council of Governors, a meeting was held in Private where governors noted the NED Appraisal Outcomes and approved the NED recruitment and succession plans. They also received and noted the preceding Private Board summary reports.

3.2 A full Council of Governors meeting was held on 21st October 2026, and key items included the following:

- CEO Report
- Lead Governor Update – including reference to the Health Bill and the Future of Governors
- Anchor Institution
- Patient Experience Presentation
- Membership and Engagement Committee Chair's report and Minutes
- Board Sub-Committee Chair's reports
- Integrated Performance Report

- NED/Governor Walkabout Summary report

3.3 Council of Governors Workshops and Informal Meetings

The Trust Chair has implemented regular informal meetings for Governors to promote engagement and facilitate information exchange. These sessions allow the Chair to share updates on current Trust activities between the quarterly Council of Governors meetings and offer Governors an additional forum to discuss issues beyond the set agenda, raise questions, and provide feedback.

Since the last update, further informal Chair and Governor meetings took place on 2nd September and 4th November 2026.

4. RECOMMENDATIONS

The Board of Directors is asked to **note** the report and the activity during this period.