Countess of Chester Hospital NHS Foundation Trust

Meeting	**1 December 2020**		**Board of Directors**					
Report	**Agenda item 17d**		**Quality Account 2019/20**					
Purpose of the Report	Decision		Ratification	X	Assurance		Information	
Accountable Executive	Alison Kelly				Deputy CEO/Director of Nursing & Quality			
Author(s)	Liz Kanwar				Head of Quality			
Board Assurance Framework	Q1 Q, Q3	Safety Quality						
Strategic Aims								
CQC Domains	Safe, Effective, Caring , Responsive, Well Led							
Previous Considerations	Quality Governance Group – 26 August 2020 Quality & Safety Committee – 15 September 2020							
Summary	The annual Quality Account summarises the trust performance in relation to Clinical Audit & Research, Information Governance, Risk & Governance and Patient experience. In 2019/20 the trust identified 11 areas for improvement. At time of summarising the account: 5 had been achieved, 4 on track to reach the target and 2 where the target had not been met (sepsis- antibiotic administration within 1 hour and reduction in HCAI). These areas are included within the described priorities for 2020/21. The trust has produced a Clinical Strategy and Continuous Improvement Strategy to support the ambitions of the organisation. Examples of achievements highlighted in the account include the increased numbers of patients being seen at the Urgent Treatment Centre, from 17 per day to 25. In 'perfect week' 30 patients were reviewed each day. An increase of 13% of patients with cancer being seen within 7 days, and a development of a partial booking system across various specialties to give patients more choice with the aim of reducing Did Not Attend's (DNA's). COVID19 did have an impact on many of the initiatives identified for 2019/20.								

	Priorities Identified for 2020/21 Patient Safety • Reduction of incidents in respect of 'Failure to Rescue' • Increase the number of safety summits held per year • >95% Sustained Improvement across all clinical areas, against the clinical standards (within the Infection Prevention & Control/Covid-19 NHS Management Checklist Audit). Clinical Effectiveness: • Increase numbers of discharges each day across 7 days • Reduce the number of face to face outpatient follow up appointments, thus increasing the number of specialties using virtual outpatients consultations • 95% of patients will be moved 3 times or less during their hospital stay. Patient Experience: • The 'Think Family' model, an integrated approach to safeguarding will be implemented • All wards to be rated as either good or outstanding within the Safety Domain via the Ward Accreditation System • Create a Lived Experience Panel.
Recommendation(s)	The Board is requested to ratify the 2019/20 Quality Account, which includes the key priorities identified for 2020/21 and agree that the Chair and Chief Executive Officer sign the Statements of directors' responsibilities for the quality report, on behalf of the Board. .
Corporate Impact Assessment	
Statutory Requirements	Reflects metrics that influences safe care delivery to meet regulatory standards
Quality & Safety	Supports delivery of safe care and CQC requirements
NHS Constitution	Supports compliance with NHS Standards
Patient Involvement	N/A
Risk	Reflects key aspects of the Board Assurance Framework
Financial impact	N/A
Equality & Diversity	N/A
Communication	Document to be published on the website and intranet

NHS
Countess of Chester Hospital
NHS Foundation Trust

2019/20

Quality Account

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PART ONE

1.0 Summary Statement on Quality from the Chief Executive 2019/20

In my role as Chief Executive Officer, it is my pleasure to introduce you to the annual quality account for 2019/20. As I write the Trust has already dealt with the impact of the first phase of SARS-CoV-2 and is in the midst of a further surge in infections. Doubtless, the challenge posed by Covid-19 and the learning derived from how we responded will be the subject of much future reflection and reporting. For now it is perhaps worth reflecting on how we responded in the last month of the financial year covered in this report. In March 2020 everything changed and saw us increase by one third our intensive care capacity, redeploy hundreds of staff into different roles and learn all there was too know about how best to treat a new disease causing huge suffering nationally and across the world. At the same time, we did all we could to continue to care for our patients, including where possible transferring planned surgery and treatments to other healthcare providers less impacted by Covid-19, and transferring our outpatient appointments into telephone and video consultations.

Despite the challenges we faced in the latter part of 2019/20, we have made good progress in improving our services for our patients and local communities. I am proud of just how much our staff have achieved and hope this report serves as an open and honest account of where we have moved forward, and where we still have further improvements to make.

During 2019/20 we have made important progress this year in developing the Trust's provision of safe and timely services, particularly by reducing clinical variation. The Trust has worked hard to successfully increase the number of patients who are appropriately screened for sepsis to the Trust's target of 90%, and we have achieved a sustained improvement in compliance to the Sepsis 6 steps. These results have been achieved through re-launching a standardised pathway for adults in the Emergency Department and inpatient areas, as well as our participation in the fantastic Cheshire & Mersey Health & Care Partnership Sepsis Programme.

We have made excellent progress and are close to achieving other key targets for the year – including the implementation of e-observations and a sustained increase in compliance with NEWS2 scoring to recognise and respond to deteriorating patients – which is a testament to the hard work and determination of staff to strengthen the Trust's capacity for safe and effective care.

Understanding the high value and significant contribution which staff make to the effective running of services and provision of care, the Trust has increased its focus on developing a strong support network for colleagues across all teams. This has been with a view to supporting staff wellbeing and health. In particular, we have implemented an Employee Assistance Programme – providing 24 hours a day, seven days a week, and 365 days a year access to a confidential helpline to support with personal and professional concerns and problems – as well as guaranteed access to face-to-face counselling services to ensure that all colleagues are able to access the support they need, particularly during periods of high stress and activity.

Throughout, we have continued to work with our partners in the wider healthcare system, including Cheshire Care Communities, Cheshire and Mersey Health & Care Partnership and the Cheshire West Integrated Care Partnership to further develop approaches to the integrated provision of services in response to patient needs.

Despite our staff survey results remaining disappointing, we are now working hard to improve in the areas where we fall short of the standards to which we aspire. It remains an ongoing concern that staff do not think that the Trust has a strong safety culture – a point noted in the May 2019 Quality Account report. Moving forward, we remain committed to the creation of a "patient safety first" culture throughout the Trust and the recent national requirement to appoint a Patient Safety Champion, as well as the recent appointment of a Medical Examiner, will help us significantly in achieving an improved safety culture.

This has been an incredibly important year for research at the Trust. . Most significantly, the Trust has been working to inform and support the nation-wide SIREN study, which aims to strengthen our collective understanding of the COVID-19 virus and its patterns of transmission. Trust-wide recruitment for the SIREN study is paused for now, but 300 volunteers have already been recruited at the Countess for the trial, and participants – including myself – are continuing to have regular swab tests and follow ups on site at our testing centre. It is fantastic that so many colleagues have volunteered to be involved in the SIREN study; this willingness to engage with and support this research will enable us to develop our understanding and ability to suppress the virus and provide the safest and most effective patient care.

Unfortunately the Trust reported a Never Event in 2019/2020. In terms of lessons learnt, messages are sent Trust-wide in a timely manner following each weekly Serious Incident Panel. These messages are sent to all staff, not just clinical. In respect of the Never Event, immediate lessons learnt were shared with the relevant teams to promote shared learning and development. The Trust has further developed its processes for learning during the year with the establishment of safety summits designed to promote clinical conversations about significant events which have taken place at the Trust that all staff can learn from. Overall, whilst the Trust is disappointed to have had a Never Event, there has been a demonstrable change in ethos which has resulted in a sustained reduction in Never Events in recent years.

I am delighted to note the sustained and significant improvement in patient care and outcomes in the Trust's Emergency Department (ED) over the past six months, following a targeted focus on improving processes, governance and leadership in the Department. In particular, the ED has enhanced its delivery of timely, compassionate, efficient care, improving patient experiences and treatment.

We are now in the process of finalising our Trust 5 Year Corporate Strategy to agree our high level goals and aims as a Trust. It will incorporate a clear view of the Trust's relationship with the Integrated Care Partnership, and also with other parts of the Cheshire and North Wales health and social care economy. It will also define our approach to a range of considerations including our workforce, estates, digital strategy, education, and research & innovation. Most importantly, the Corporate Strategy will be supported by our newly developed Trust Clinical Strategy, which describes the shape and direction of our clinical services over the next five years.

Finally, thank you to everyone who has helped us put this Quality Account together and all those who have helped with their constructive feedback and comments, and to our staff who continue to work tirelessly to provide our patients with the highest quality of care.

I confirm that, to the best of my knowledge, the information in this document is accurate and has been complied with the requested requirements.

Dr Susan Gilby,

Chief Executive Officer

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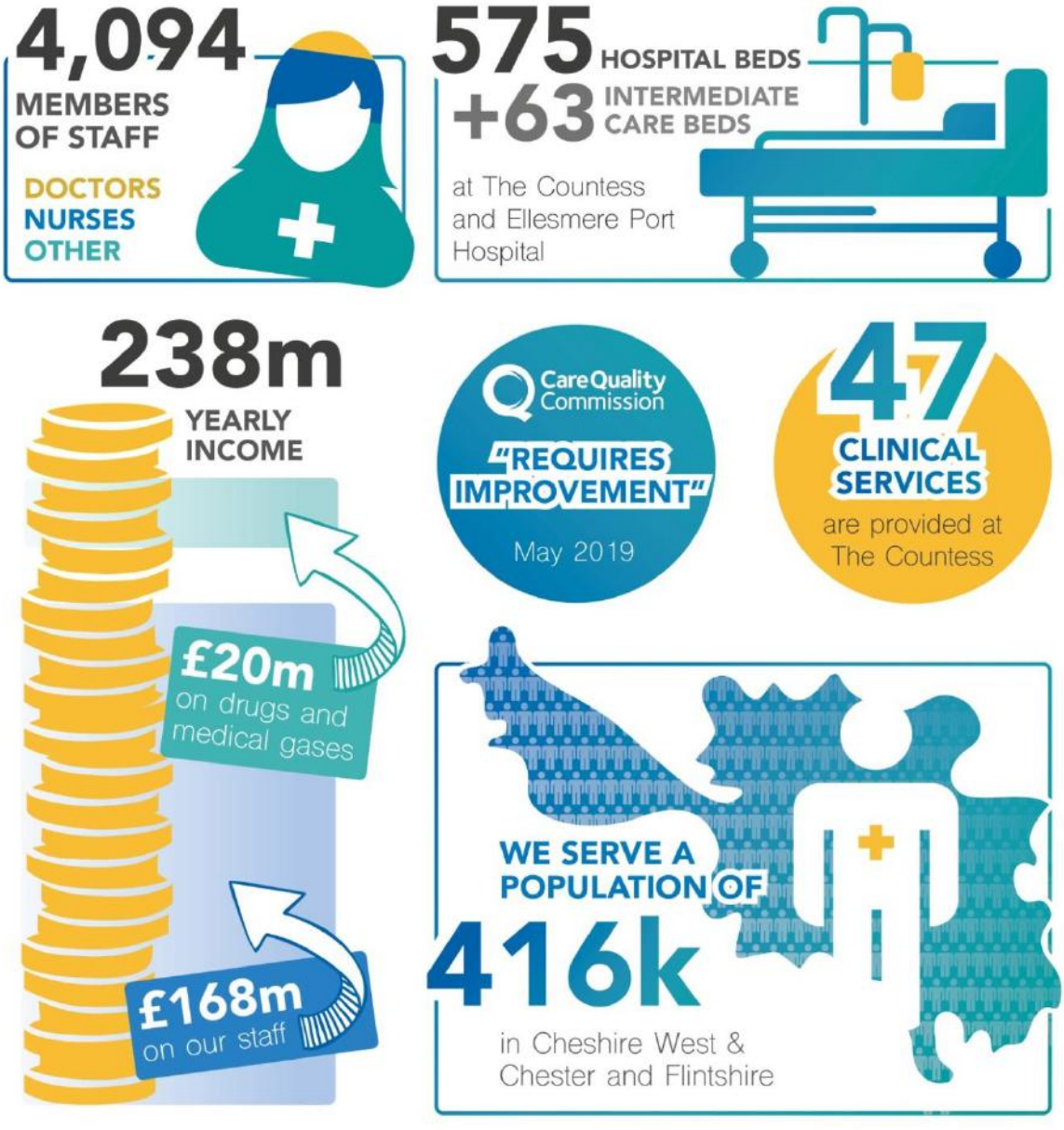
The Countess in NUMBERS 2019



PART TWO

2.1 Priorities for improvement and statements of assurance from the Board

2.2 Priorities for improvement in 2020/21

Our key priorities for improvement in 2020/21 have been chosen to reflect the three domains of quality defined as follows:

- **Patient Safety**: delivering safe services
- **Clinical Effectiveness:** delivering effective services
- **Patient Experience:** delivering kind and compassionate care

Patient Safety: To deliver safe services we will provide consistency in the care and treatments we deliver for all of our patients. Getting it right first time to ensure the right care and treatment is started at the right time in the patient's journey. We have set ourselves targets and trajectories for our safety measures. We will use statistical process control (SPC) charts, an analytical technique, to enable us to understand whether the changes we are making are resulting in improvement and in doing will guide us to take the most appropriate action. Our safety measures also reflect the findings of the Ward Accreditation System baseline assessment, progress and action will be monitored during repeat assessments throughout the year. We are committed to demonstrably improve to deliver safe services for our patients.

Our measures of success will be;

- Reduction of incidents in respect of 'Failure to Rescue'
- Increase the number of safety summits held per year
- >95% Sustained Improvement across all clinical areas, against the clinical standards (within the Infection Prevention & Control/Covid-19 NHS Management Checklist Audit)

Why is a reduction of 'Failure to Rescue' incidents Important?

'Failure to Rescue' essentially means failing to identify a patient when their condition has deteriorated. To support staff in recognising and responding to the deteriorating patient a specific clinical assessment tool is utilised. This advocates a system to standardise the assessment and response to acute illness and is a key element of patient safety and improving patient outcomes. The tool provides a score for each physiological observation taken and this is then aggregate into a total score which indicates the response needed. Six simple physiological parameters form the basis of the scoring system

1. Respiration rate
2. Oxygen saturation
3. Systolic blood pressure
4. Pulse rate

5. Level of consciousness or new confusion
6. Temperature

Once the observations have been taken and the score allocated, there is a graded response system for staff to follow to ensure a responder with the right knowledge and skills attends to direct the care and treatment needed. To deliver safe services we aim to ensure our clinical teams are appropriately recognising the patient when they are deteriorating, therefore providing opportunity to act in a timely manner to support the patient. Progress against our measure for success will be monitored through the Deteriorating Patient Group which reports to the Quality Governance Group.

Identification and recognition of sepsis is included in the above quality measure. If we are able to identify sepsis quickly and start the appropriate treatment it will help to save lives. We are committed to ensuring our patients have access to the right care and treatment for sepsis.

The Trust has followed the Cheshire & Mersey AKI Network programme for the management of Acute Kidney Injury (AKI) and has joined the Advancing Quality Alliance AKI improvement programme which ensures a standardised pathway of care for all patients diagnosed with AKI. The measures within this regional programme reflect National Institute for Health & Care Excellence (NICE) guidance.

Why are Patient Safety Summits important?

Patient safety summits have been designed to facilitate clinical conversations about significant events which have taken place in the Trust in which we can learn from. Holding such events is promoting a learning culture in which we can utilise the knowledge and skills of our staff to ensuring that our services are safe and continue to meet the needs of patients. Humans are fallible and mistakes can happen when working in complex environments, they are usually not the fault of only one person. If a problem has occurred establishing what has happened, discussing this with colleagues and learning from it will ensure continuous learning for all. Clinical colleagues are encouraged to attend patient safety summits with open minds and the willing to have an honest discussion about care at the Countess of Chester Hospital. The aim of these sessions is to have a collaborative approach in an informal environment where everyone can discuss ideas to improve our care. We held our first patient safety summit in February 2020 with great success and we plan to increase the frequency throughout 2020/21. Progress against this measure will be monitored by the Transformation Group which reports to the Finance and Performance Committee, a sub-committee of the Trust Board of Directors.

Why is sustained Improvement of >95% compliance so important in achieving the Covid-19 infection prevention & control standards?

Achieving the infection prevention standards (as set out in the Covid-19 NHSE/I Management checklist) is fundamental if we are to reduce healthcare acquired infections in our hospitals and keep patients safe. During 2019/20 we were disappointed with our performance in this area and it has highlighted the improvements required. Managing the Covid-19 pandemic has raised the awareness of the importance of compliance against

essential standards to avoid hospital transmission of infections. We will particularly focus on compliance against the following clinical standards, namely:

- PPE is available at point of use.
- PPE is stored in a clean, dry area.
- Staff are trained on how to put on and remove PPE.
- Staff observed to undertake hand hygiene as per WHO 5 moments, using either ABHR or soap and water.
- Hands are dried with disposable paper towels obtained from a dispenser that is located close to hand wash basins but beyond risk of splash contamination.
- Re-useable equipment (non-invasive) is dedicated to a single patient as much as possible and decontaminated after each use.

The above will form part of an on-going audit programme which supports the Covid-19 Board Assurance Framework and will be reported through the Infection Prevention & Control Strategy Group reporting to the Quality Governance Group up to the Quality & Safety Committee and ultimately to the Board

Clinical Effectiveness: To deliver effective services we will focus on the way in which we work, improving processes to meet the needs of our patients to provide them with the best possible care.

Our measures of success will be:

- Increase numbers of discharges each day across 7 days
- Reduce the number of face to face outpatient follow up appointments, thus increasing the number of specialties using virtual outpatients consultations
- 95% of patients will be moved 3 times or less during their hospital stay.

Why is Increasing our numbers of patient discharges important?

Ensuring our patients are discharged in a timely manner is key to their safety. Prolonging any patient stay in hospital longer than necessary is potentially putting patients at risk and is preventing patients from becoming independent. If patients are not discharged in a timely manner, then this poses bed capacity issues and therefore identifies risks for our emergency patients in a delay in being admitted to the most appropriate bed. We will ensure that our processes are continually improved to ensure patient pathways are expedited in line with their clinical care and our teams recognise the importance of this seven days a week.

Providing ownership and empowerment at ward level is key and criteria-led discharge (CLD) is a process to assist in the above. If a patient is deemed suitable for CLD, the lead clinician for the patients care should set out clinical criteria's that the patient must meet before they can be discharged safely. The criteria should be discussed with the patient and the multi-disciplinary team and documented clearly. When the patient meets all of the clinical criteria's set out by the lead clinician a competent member of the multi-disciplinary team is empowered to facilitate the patient discharge, without undue waits. According to the Royal College of Physicians 80% of hospital discharges are 'simple' so if we can utilise CLD

effectively we can improve patient flow across the hospital and therefore increase the numbers of patients discharged each day.

Progress against this measure will be monitored by the Transformation Group which reports to the Finance and Performance Committee, a sub-committee of the Trust Board of Directors.

Why is improving our Outpatients Services important?

The Countess of Chester Hospital offers a range of Outpatient Services across 2 main sites covering a wide range of specialties. The population we serve is increasing in number, and it is living significantly longer, with much greater co-morbidity challenges. With people living longer and many patients having multiple long-term illnesses there is a need for our Outpatient Services to be more flexible, meeting the needs of our patients, providing a better patient experience and clinical outcomes. If our Outpatient Services do not meet the needs of our patients, this can lead to high rates of do not attends (DNAs).

During 2019/20, the Trust started their Elective Care Transformation journey with NHS England and NHS Improvement by completing a 100 day challenge. In line with the NHS Long Term Plan and the Trusts Clinical Strategy, the overall aim of the programme was to reduce the number of face-to-face outpatient appointments by providing the right care, in the right place with the right skills, the first time. Considerable work has already been undertaken by four specialty teams collaborating with other providers to enable whole system transformation. This work will continue as we head into 2020/21, adopting the 100 day principles and developing a phase two of the programme. To ensure we are delivering effective services we will reduce our face-to-face follow up outpatient appointments by increasing the number of specialties who use virtual consultations. Progress against these measures will be monitored by the Transformation Group which reports to the Finance and Performance Committee, a sub-committee of the Trust Board of Directors.

Why is achieving 95% of our patients moving 3 times or less during their hospital stay important?

During 2019/20, particularly in managing the Covid-19 pandemic outbreak, we identified that our patients were being moved several times within ward/units and also from ward to ward, sometimes with no definitive reason. It is unacceptable to move patients late at night and also those who are most vulnerable. We have identified that a patient within a routine pathway will move from the Emergency Department to an assessment area then to a specialty ward. There will be some exceptions if patients' conditions change or deteriorate, in which case, a transfer to the Intensive Care Unit may be appropriate. However, we should expect the majority of our patients to only make the moves articulated above. The reduction of patient moves should have a positive outcome on infection rates and patient outcomes generally.

Progress against this measure will be monitored by the Quality Governance Group and will be reported to the Trust Board of Directors.

Patient Experience: to deliver kind and compassionate care we will involve our patients in their care, always treating them with dignity and respect to deliver high-quality care that's based around their individual needs.

Our measures of success will be;

- The 'Think Family' model, an integrated approach to safeguarding will be implemented
- All wards to be rated as either good or outstanding within the Safety Domain via the Ward Accreditation System
- Create a Lived Experience Panel

Why is a 'Think Family' model of Safeguarding important?

Safeguarding means protecting a person's right to live in safety, free from abuse and neglect and promoting the wellbeing of the adult. At the Countess of Chester Hospital, we have a dedicated team of professionals who support patients across the hospital who may have some additional needs that require specialist support for example: Dementia, Learning Disabilities and Mental Health. The team ensure lawful recognition and safe appropriate management is consistently in place however, all staff have a responsibility to safeguard people in our care. Going forward, we are committed to ensuring that our most complex and patients at risk are looked after under a 'Think Family' governance structure and model of care. In taking this model forward, it has been identified there is the requirement for our Adult Complex Care Team and our Safeguarding Children and Domestic Abuse Team to integrate into one service. This will enable the breadth and depth of knowledge and expertise in both of those teams to become a multidisciplinary team of experts supporting all elements of the 'Think Family' agenda. This reflects both local and national policy drivers in ensuring there is a holistic approach to supporting our most vulnerable adults and children.
We will continue to work with our colleagues across the Health and Care system to promote this model of care and share best practice and experiences. Progress against this measure for success will be monitored through the work plan of the 'Think Family' Strategy Group which reports to the Quality Governance Group.

Why is Ward Accreditation System important?

In response to the CQC Inspection (December 2018), internal and external audits and feedback from patients and their families it was clear there was a need to refocus on fundamental care standards to ensure consistent delivery across all services and specialties. At the Countess of Chester we are committed to improving and sustaining these fundamental standards of care through the 'Care Assurance Framework' (CAF) which is built into a newly formed 'Ward Accreditation System' (WAS). The CAF brings together a range of care standards to refocus all staffs attention on the requirements and expectations; it explicitly defines what 'outstanding' care delivery looks like. This system spans adult inpatients, paediatric inpatients, maternity services, adult critical care, neonates, outpatients, theatres and the emergency department. There are a core set of standards that apply to all areas, with additional measures added for relevant services. Each CAF has been designed using the CQC key lines of enquiry (KLOE) and (where relevant) can be mapped to the 28

regulations set out in the Health and Social Care Act (2008), regulatory activities, Regulations (2010) and the Care Quality Commission (Registration) Regulations (2009).

Wards and departments are assessed against the relevant CAF and an overall rating of the care delivered in that area will be given. For consistency with internal and external assurance the CQC methodology for assessment and scoring has been adopted. This provides a framework for wards and departments to measure themselves against, evaluate the care being delivered in their area and provide a structured approach to continuous improvement that is owned at ward level and led by the department. It achieves this by providing clear direction (a shared vision and purpose) and by empowering the team to take forward changes relevant to their area. This in turn will reduce unwarranted variation and standardises practices that can then be delivered consistently across all wards and departments. To ensure we are delivering safe care in the first instance, our ambition is that all wards consistently hold either a good or outstanding rating in the SAFE domain by the end of 2021. Progress against our measure for success will be monitored through the Nursing and Midwifery Performance & Assurance Group which reports to the Quality Governance Group.

Why is having a Lived Experience Panel (LEP) important?

People with experience of living with, or caring for someone with health/care issues are an invaluable resource to health and social care continuous improvement work. They not only bring their personal perspective of living with or supporting someone with health issues but can also offer many other skills, challenge and experiences. Their perspective and experience of our services is real and honest so involvement of people with lived experience is essential. We continually strive to make improvements to our services using feedback from our patients; we wish to take this further by recruiting Lived Experience Members (LEM) which will create a Lived Experience Panel (LEP) that will work alongside us when making improvements to our services. The LEM's will take an active role as a member of continuous improvement programmes and support us to promote and deliver a person centered approach to all continuous improvements projects. Therefore, to deliver kind and compassionate care we will involve our patients in their care by creating a LEP. Progress against this measure will be monitored by the Transformation Group which reports to the Finance and Performance Committee, a sub-committee of the Trust Board of Directors.

These priorities reflect the Trusts vision and form part of the wider 2020/21 programme of work through the Integrated Care Partnership, Cheshire system working, Cheshire & Mersey Health & Care Partnership and the design of the Trusts strategies.

Integrated Care Partnership (ICP)

We continue to work with our health and social care partners across Cheshire West to develop our Integrated Care Partnership (CWICP), hosted by the Countess of Chester Hospital, to transform how services are delivered through our Care Communities. Our focus has been on a number of areas including:

- Our Care Communities programme works to ensure high-quality care and support for local people, to prevent unnecessary hospital admissions and to support people to stay well in their community for longer.

- Enhanced Community Based Services Care and support should be delivered as close to home as possible and, where possible, people with complex health and care issues should be supported in their communities. To achieve this hospital and community-based care must be brought closer together.
- Long Term Care: Care Homes are central to our complex health and care system. In joining up health and care, our Long Term Care programme is focused on improving the care and experience of some of Cheshire West's most vulnerable residents.
- Healthy Lives: Our Healthy Lives programme supports all residents to reach their maximum health and wellbeing potential. By prioritising prevention and early detection of conditions most strongly related to health inequalities, we can help to reduce hospital admissions and support people to stay well for longer.

Cheshire system Working

As a Trust we recognise the need for working in partnership with the wider Cheshire system if services are to be financially sustainable in the future. In the last 12 months we have developed closer joint working with our partners across the Cheshire system in supporting three key areas of work:

- Grip and control;
- Collaboration at scale; and
- Transformation.

The Trust will have a key role in the delivery of programmes of work across all three portfolios, and will ensure change is led and supported where there are demonstrable benefits for our local population.

Cheshire & Mersey Health & Care Partnership

To transform our services and become sustainable, we need to mitigate demand, unwarranted variation, duplication, and cost. To achieve this we have continued to support the strategic work streams across Cheshire & Mersey where it has or will directly support the provision of care to our local population

Trust Strategies

We are in the process of finalising our Trust 5 Year Corporate Strategy to agree our high level goals and aims as a Trust. It will incorporate a clear view of the Trust's relationship with the ICP, and with all the other parts of the Cheshire and North Wales health and social care economy. It will define our approach to a range of considerations including our workforce, estates, digital strategy, education, and research & innovation.

The Corporate Strategy will be supported by our newly developed Trust Clinical Strategy, which describes the shape and direction of our clinical services over the next five years. This year we will develop individual specialty clinical plans that follow the goals of the Clinical Strategy. Further operational enabling strategies will be developed over the next 12 months that support the delivery of both the Corporate Strategy and the Clinical Strategy.

A new Continuous Improvement Strategy is also currently in development and will outline our plans to create the capacity and capability that is needed across the Trust to enable us to build and embed a culture of continuous improvement across the Trust. This means that we make improvement a daily routine activity and use improvement tools and techniques to solve the problems we face. Paul Batalden, Senior Fellow at the Institute for Healthcare Improvement and teacher at the Jönköping Academy in Sweden states, “everyone in healthcare really has two jobs when they come to work every day: to do their work and to improve it’’. The strategy, and the plans which underpin it, will be closely linked with the CQC domains of safe, effective, caring, responsive and well-led and is due to be launched later this year.

Electronic Patient Record (EPR) Replacement

The Trust is in the process of replacing its existing electronic patient record (EPR) which has been in place since 1999, and was planned to go live in September of this year. Due to the Covid-19 pandemic we will be pausing the existing implementation of the EPR replacement programme and extend our existing Meditech function beyond the originally anticipated switchover date. We will continue to provide a safe and reliable EPR function and a new date will be agreed when as soon as we are able to. Although the EPR replacement programme is being paused there is still work to do and continue. This is a complex programme of whole hospital clinical transformation, and is the largest strategic change the organisation has ever undertaken. EPR+ will transform the way we provide care for patients in all areas, and will make us a safer and smarter acute hospital, as we move towards becoming a more digitally mature organisation.

Transformation Programme

The Transformation Team are supporting the improvement of patient safety, quality and outcomes through a number of key work streams that sit within the Transformation Programme. Learning from our newly established Ward Accreditation System (WAS) and feedback from our Patient Experience Operational Group (PEOG) have assisted us in identifying our priorities for improvement. Our choices and those of the local population we serve are reflected in our priorities going forward.

PEOG gathers the views of patients, families and the public to support and where necessary direct improvements in clinical practice, service delivery and patient pathways. It provides a forum to engage with a range of hospital teams, patient representatives and Governors to review feedback and agree any actions needed in response.

Areas during 2019/20 included management and treatment of sepsis, recognition and response to the deteriorating patient; falls prevention and medication management. To support delivery of the regulatory actions the Trust established a Deteriorating Patient Group, completed a deep dive into falls and undertook a programme of estates work to support an improved delivery of medicines management. Maintenance and monitoring of the regulatory topics will be supported in future years by a Ward Accreditation System which commenced in January 2020 with an initial benchmarking assessment exercise, this highlighted topics that required further scrutiny and support to delivery of an improved

outcome as the programme becomes established, these will be supported by the Trusts continuous improvement agenda.

We recognise that having numerous action plans to address issues isn't the most effective way of progressing improvement. The priority is to understand the root cause of issues and ensuring we have robust systems and processes in place. We are developing a continuous improvement (CI) strategy using a range of quality improvement tools and techniques to support continuous improvement in the areas identified by the CQC. This will be supported by:

- The Ward Accreditation System;
- Continuous Improvement engagement sessions for staff;
- Ensuring our improvements are aligned with the Trust strategies;
- Building staff capability so staff are empowered and confident to improve services;
- Executive and senior leaders application and promotion of improvement methodology and;
- Utilising contacts and resources from other NHS Trusts who have successfully undertaken transformational change utilising a continuous improvement methodology.

A key theme identified from the Well Led inspection was that the Trust did not have fully effective systems for managing risk, that the risk management system did not connect to the Board Assurance Framework, that Committee reporting accountabilities were not clear, and that some issues raised in the last inspection had not been addressed in a timely manner, with gaps in governance and safety issues. The Trust had itself identified gaps prior to the CQC Inspection and commissioned an external governance review. Using the findings of the both CQC report and the external governance review during the past twelve months the Trust has:

- Developed and shared a clinical strategy
- Commenced a journey of stakeholder engagement to inform the Trusts corporate strategy
- Developed and operationalised a refreshed organisational meeting structure
- Undertook a review of the Board Assurance Framework (BAF) to drive the Board agenda and aligning the BAF to the Trust's risk management system
- Introduced Board paper cover template and reports from chairs' of committees into Trust Board
- Trust Board has signed off a Health Care Governance Hand book
- Director of Communications & Corporate Affairs appointed
- Trust Board undergone development via Trust Board facilitated workshops on topics to support the delivery of governance agenda to improve knowledge around use of data and assurance
- Statistical Process Control charts introduced to support performance report delivery

The new model of integrated governance has been implemented that provides oversight and realignment of all governance and risk processes, including quality governance, clinical governance, financial governance, information governance and staffing/people governance.

We have continued to take forward a number of developments to benefit patients, these include:

Safe; improving the safety of patients in our care

Improved compliance with NHS Improvement Patient Safety Checklist in the Emergency Department; this checklist provides assurance against the safety measures expected for patients being cared for within the Emergency Department and allows us to collect real time information to monitor patient safety. This process has been streamlined and relaunched with the nurse review of the patient being signed off by the ED Team Leader before the patient moves to an in-patient setting.

Ensuring lessons learnt are debated and shared Trust wide: The initiation of Trust wide Safety Summits are designed to be clinical conversations about significant events which have taken place at the Trust that staff can all learn from. The Trust will continue to use this format to engage staff in debates about care provided and how we can improve our patients' experience.

Develop a Ward Accreditation System within the Trust, to engage staff and empower leadership to ensure we deliver the highest standards of healthcare for our patient; All wards will be measured against a set of quality standards that will increase the quality of care in our wards. All assessments include a review of care records and documentation, real time observations of care given discussions with patients, carers and staff members. In addition, review of the ward quality metrics, staff training and appraisal data, complaints, incidents and safety thermometer data is included to ensure that the assessment process is not just 'a moment in time'.

Progressing with our Sepsis Quality Improvement programme; we recognise that despite significant work being undertaken regarding improving compliance against our Sepsis quality measures, further improvement is still required. In particular improvement is required in relation to the recognition and management of Sepsis and the timely administration of antibiotics. Work has included the re-launch of a standardised pathway for adults in the Emergency Department and inpatient areas and delivery of sepsis training for all staff with the '60-day Countess Sepsis Challenge' were members from all areas were encourage to take place as the Trust strove to raise awareness of sepsis and the treatment required within the first hour following diagnosis, actions included:-

- Pledging to train 600 members of staff on the 'Sepsis 6' in 60 days
- A Sepsis champion visiting work areas
- Opportunities for drop-in sessions to ensure access to training for all staff groups

The Trust has also joined the Cheshire & Mersey Health & Care Partnership (CMHCP) programme to support the early detection and treatment of sepsis for all non-elective admissions to hospital. This programme is supported by the Advancing Quality Alliance and provides a systematic, structured and evidence-based approach to standardising the best clinical interventions across patient pathways. The measures collected are aimed to ensure timely treatment across the patient pathway, with collaborative events to share best practice and learning. The CMHCP set a regional Composite Process Score target of 75% for all organisations which the Trust has exceeded scoring 80.3%.

The Trust joined NHS Improvements 'Moving to Good programme' this bespoke programme is designed to support trusts to achieve a 'Good' or 'Outstanding' rating at their next CQC inspection. The Trust is part of the third cohort which commenced in October 2019 and selected the following 3 objectives all of which are making progress:-

- To identify and demonstrate an improvement in recognising the deteriorating patient thus reducing patient harm :- Safety Objective
- To design & implement a framework to capture, report & demonstrate improvement in our patient experience based on patient feedback
- To create a continuous improvement (CI) strategy, introducing a formal CI methodology which is recognised across the Trust.

Improving ongoing compliance with the National Early Warning (NEWS2) track and trigger tool; this NHS England approved tool was introduced Trust wide in September 2018 to all adult inpatient wards and departments. The tool provides a score for physiological measurements already recorded in routine practice, when patients present to, or are being monitored in hospital. It supports staff to recognise if a patient's clinical condition is worsening and directs staff to respond quickly to any deterioration. Monthly audit is in place which has demonstrated improvements in compliance and that the tool has been applied to support escalation a patient's condition triggers an alert.

Kind; improving the experience of patients

Implementing an SBAR format handover/transfer; we recognise the importance of ensuring that when a patient moves to an assessment or specialty ward that their journey should ensure that key information is shared with staff who is taking over responsibility for their care. To support this following a pilot a transfer/handover of care document was launched.

Home for Lunch initiative was launched to aim to get as many patients as possible home earlier in the day which is better for our patient's recovery especially during the winter months.

Falls Quality Improvement Programme; significant work has continued in respect of standardising falls prevention measures across all adult inpatient areas. A new falls risk assessment has been implemented in the Emergency Department. The development of falls information to help reduce the risk of falls for low risk patients has also enhanced patient care and experience; this has been supported by the production of a staff information leaflet containing details about referral and support options available. One to one supervision policy has been updated and is assesses using a standardised template. However, it is recognised there is still much to do in reducing falls with harm.

Patient Flow; we have worked collaboratively with our local system to ensure patients do not stay in hospital longer than they need to. This work has resulted in a reduction in locally 'Stranded' patients. However, achieving compliance with the Emergency Department 4 hour standard has, and continues to be challenging, in a quest to to improve the processes focusing on patient transfers, handover and Teletracking and simultaneously unpicking any barriers or inefficiencies that may occur. The Trust ran a number of 'perfect weeks' to

support an improved patient journey. As part of the ongoing footprint work within the Emergency Department a number of changes took place that have improved flow and privacy and dignity an example being the establishing an ambulance handover bay and redefining the ambulatory majors department.

Further development of the Integrated Care Partnership; we have worked with our local system partners to bring together services and tailor their delivery to meet the needs of our local population. This means that there has been an increase in the number of patients being cared for out-of-hospital in a relevant setting with appropriate support services.

Effective; improving processes to benefit patients safety, quality & experience

Effective use of real time information to manage safe staffing against patient acuity and ward activity; we have continued to improved our processes using an evidence based tool to support professional judgement when making real time staffing decisions. This means we have been able to deploy staff to ward and department areas in the most need; basing this assessment on the acuity (severity of illness) and dependency (nursing need) of patients. A nursing and midwifery establishment review has been undertaken in quarter 4 of the 2019/20. This has provided an opportunity to strengthen the governance around safety, staff deployment and financial efficiency.

Establishment of an adult complex care team; the new model brings together the current Dementia, Adult Safeguarding and Learning Disability agendas to ensure lawful recognition and safe appropriate management is consistently in place. The newly created Adult Complex Care Team is creating a detailed work plan for the upcoming 12 months. This will include the development of an integrated 'Think Family' approach to safeguarding (covering both adults and children.

Outpatients; an improved booking process has resulted in greater choice for our service users and has demonstrated a reduction in patients failing to attend their appointment and a reduction in the number of lost follow up appointments.

Learning from Deaths; the 'Learning from Deaths' group and their work plan has gained momentum over the past year. This will continue to be an area of focus over the next reporting period to ensure full achievement against the national guidance. Improvements to practice identified through mortality reviews (inclusive of deaths within 30 days of discharge) and ensuring findings are routinely disseminated across the Trust will remain a key area of focus, as this supports learning and helps to direct improvements in patient care and experience. To support this agenda a dashboard has been developed that provides data on the numbers and types of reviews completed.

The Countess of Chester Hospital NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is to provide care, treatment and support, without any conditions attached to registration. The Care Quality Commission has not taken any enforcement action against the Countess of Chester Hospital NHS Foundation Trust during 2019/20. The Countess of Chester Hospital NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

2.2 Statements of assurance from the Board

During 2019/20 the Countess of Chester Hospital NHS Foundation Trust provided and/or sub-contracted 47 relevant health services.

The Countess of Chester Hospital NHS Foundation Trust has reviewed all the data available to them on the quality of care in all of these relevant health services

The income generated by the relevant health services reviewed in 2019/20 represents 100% of the total income generated from the provision of relevant health services by the Countess of Chester Hospital NHS Foundation Trust for 2019/20.

During 2019/20 46 national clinical audits and nine national confidential enquiries into patient outcome and death (NCEPOD) covered relevant health services that the Countess of Chester NHS Foundation Trust provides.

During that period the Countess of Chester Hospital NHS Foundation Trust participated in 93% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the Countess of Chester NHS Foundation Trust was eligible to participate in during 2019/2020 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Audits 2019/2020	**Eligible**	**Participated**	**% Submitted**
Trauma Audit & Research Network	Yes	Yes	84-100%
Head and Neck Cancer Audit	Yes	No	NA
Cardiac Rhythm Management	Yes	Yes	99.5%-100%
Acute Myocardial Infarction (MINAP)	Yes	Yes	Review 31/03/2021
Audit of Critical Care (ICNARC)	Yes	Yes	Review 31/03/2021
National Core Diabetes Audit	Yes	Yes	100%
National Diabetes Inpatients Audit	Yes	Yes	100%
National Diabetes Foot Care Audit	Yes	Yes	Review 31/03/2021
National Pregnancy in Diabetes Audit	Yes	Yes	100%
National Diabetes Transition	Yes	Yes	100%
National Heart Failure Audit	Yes	Yes	Review 31/03/2021
National Joint Registry	Yes	Yes	85%

National Lung Cancer Audit	Yes	Yes	100%
National Neonatal Audit Programme	Yes	Yes	Review 31/03/2021
National Ophthalmology Audit	Yes	No	NA
National Prostate Cancer Audit	Yes	Yes	60%
National Vascular Registry	Yes	Yes	>70%
National Oesophago-gastric Cancer Audit	Yes	Yes	>90%
National Elective Surgery Patient Reported Outcome Measures (PROMs)	Yes	Yes	Variable across 2 conditions
National Emergency Laparotomy Audit	Yes	Yes	100%
College of Emergency Medicine : RCEM Assessing Cognitive Impairment in Older People/Care in Emergency Department	Yes	Yes	100%
College of Emergency Medicine: RCEM Care of Children in Emergency Departments	Yes	Yes	100%
College of Emergency Medicine: RCEM Mental Health-Care in Emergency Departments	Yes	Yes	100%
BAUS Urology Audits: Female Stress Urinary Incontinence Audit	Yes	Yes	100%
BAUS Urology Audits: Nephrectomy Audit	Yes	Yes	Review 31/12/2020
BAUS Urology Audits: PCNL	Yes	Yes	Review 31/12/2020
Bowel Cancer	Yes	Yes	Review 31/12/2020
National Paediatric Diabetes Audit	Yes	Yes	Review 01/04/2020
Inpatient Falls	Yes	Yes	Review 31/03/2021
National Hip Fracture Database	Yes	Yes	Review 31/03/2021
Inflammatory Bowel Disease Programme	Yes	No	NA
Learning Disability Mortality Review Programme	Yes	Yes	Review 31/03/2021
National Audit of Dementia	Yes	Yes	100%
National Cardiac Arrest Audit	Yes	Yes	100%
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis	Yes	Yes	Review 31/03/2021
National Asthma & COPD Audit Programme	Yes	Yes	Review 31/03/2021

National Comparative Audit of Blood Transfusion Programme	Yes	Yes	Review 31/03/2021
Renal Registry	Yes	Yes	Review 31/03/2021
Sentinel Stroke National Audit Programme	Yes	Yes	Review 31/03/2021
MBRRACE	Yes	Yes	Review 31/03/2021
Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection	Yes	Yes	Review 31/03/2021
National Audit of Care at the End of Life (NACEL)	Yes	Yes	Review 31/03/2021
Epilepsy 12	Yes	Yes	Review 31/03/2021
National Neonatal Audit Programme (NNAP)	Yes	Yes	Review 31/03/2021
7 Day Service	Yes	Yes	100%
National Audit of Breast Cancer in Older People	Yes	Yes	Review 31/03/2021

The national confidential enquiries the Countess of Chester NHS Foundation Trust participated in during 2019/2020 are as follows:

NCEPOD 2019/20	Eligible	Participated	% Submitted
NCEPOD: Long Term Ventilation	Yes	Yes	100%
NCEPOD: Acute Bowel Obstruction	Yes	Yes	100%
NCEPOD: Pulmonary Embolism	Yes	Yes	100%
NCEPOD: Young People's Mental Health	Yes	Yes	100%
NCEPOD Peri-operative Diabetes	Yes	Yes	100%
NCEPOD Acute Heart Failure	Yes	Yes	100%
NCEPOD Children & Young People with Cancer	Yes	Yes	100%
NCEPOD Out of Hours Cardiac Arrests	Yes	Yes	100%
NCEPOD Dysphagia in Parkinson's Disease	Yes	Yes	100%

The reports of 4 national clinical audits were reviewed by the provider in 2019/2020 and the Countess of Chester NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided in relation to:

- National Hip Fracture Database
- National Lung Cancer Audit 2018 Annual Report (2017 Cohort)
- Adult Asthma section of the National Asthma and COPD Audit
- National Cardiac Rhythm Management Audit

National Hip Fracture Database

The National Hip Fracture Database (NHFD) is a nationwide audit within the NHS concerning the management and outcomes of patients with hip fractures. The NHFD aims to improve the quality and effectiveness of hip fracture care by enabling clinical teams to monitor their performance against agreed clinical standards. The NHFD report for 2018 was published in December 2019. The audit has been ongoing for 10 years, and the results can be seen live on the NHFD website. The number of patients in the national audit was 61,581. The number of patients contributed by the Countess of Chester Hospital NHS Foundation Trust was 310. The timeframe audited was between January and December 2018. Figures are regularly reviewed, both by the named Consultant in Orthopaedics and at the Orthopaedic Hip Fracture Group.

We were the best performing hospital in the North West, and 12th best performing hospital in the country during the audited period as measured by Best Practice Tariff. As a result, this generated £335,632 in revenue for the hospital, and nearly £100,000 more than had our performance been average.

The report promotes six key performance indicators, and mortality, and on every measure our performance is within the expected range. We have already either implemented the changes suggested to improve practice, or they are in the process of being implemented.

Key Performance Indicator	Countess performance	National performance
Assessment by Orthogeriatric specialist	99%	91%
Operation performed on day of, or after admission	91%	68%
NICE Compliant Surgery	77%	74%
Prompt mobilization	83%	81%
Not delirious post op	79%	70%
Return to original residence	76%	71%

We have seen a small decline in mortality over the year, in keeping with the rest of the country, but whilst our crude mortality rate is less than average (at 5.9%) our standardised rate is slightly higher (at 6.9%, compared with 6.1%).

Despite our excellent overall assessment, there are still challenges in delivering the care for this vulnerable group of patients. The Clinical Lead for Orthopaedics is very keen to see an

improvement in the nutritional assessment of these patients, and the Matron is working with Orthopaedics to achieve this. The Clinical Lead is also concerned regarding the level of in-hospital acquired fractures, and also pressure sores.

We aspire to have a specialist ward area for hip fracture patients to be admitted to; reducing their time in the Emergency Department, allowing better provision of pain relief, better access to medical assessment, and focused physiotherapy services. The care for these patients will be co-delivered by our specialists in Elderly Care also, as described in the Trust's 5 year Clinical Strategy. To support this we need to implement Middle Grade Orthogeriatric cover.

ACTION REQUIRED	ACTION LEAD	TIMESCALE FOR ACTION	WHERE REPORTED
Middle grade Orthogeriatric cover	Consultant in Care of the Elderly	1 year	Group meeting
Concise Anaesthetic protocols	Anaesthetic lead	3 months	Group meeting
Continue to review audit data	Consultant in Orthopaedics	12 months	Group meeting
Improve nutrition assessment, pressure sore and in-hospital falls	Matron	6 months	Group meeting

National Lung Cancer Audit 2018 Annual Report (2017 Cohort)

The National Lung Cancer Audit (NLCA) was developed in response to the finding in the late 1990s that outcomes for lung cancer patients in the UK lagged behind those in other westernised countries, and varied considerably between organisations within the UK. The audit began collecting data nationally in 2005, and since then has become an exemplar of national cancer audit. In 2015 the Royal College of Physicians won the tender to run the audit for the next three-to-five years.

The NLCA annual report represents the culmination of nearly 2 years of patient care and follow up, data collection, data analysis and interpretation. Its purpose is to understand the current quality of care and outcomes for patients with lung cancer, to celebrate good practice and to highlight variability, to ensure that all patients have access to the very best care. The results published in the report demonstrate improving data quality, higher rates of surgical treatment, and higher rates of systemic anti-cancer treatment across both small cell lung cancer (SCLC) and non-small cell lung cancer (NSCLC), such that four out of our five key auditable measures have been achieved.

The number of patients in the National Lung Cancer Audit (NLCA) national audit was 39,205. The number of patients contributed by the Countess of Chester Hospital NHS Foundation Trust was 178. The timeframe audited was between 1st January and 31st July 2017. The report was published in May 2019 from the prospective audit. The audit was presented as

part of the annual performance review at the Lung Cancer Multidisciplinary Team meeting in May 2019 using live performance data.

Improving data quality and pathway redesign has led to an improved position on timeliness and reporting of activity as NLCA annual report is almost two years out of date. We continue to see sustained performance of Lung Cancer Nurse Specialist activity (better than average) despite under resourced.

The Countess of Chester Hospitals data completeness was above the national average on our performance status of 98.3% vs 85% national average, stage 98.3% vs 96% & forced expiratory volume in one second (FEV1) 93.8% vs 64%, pathological confirmation 69.1% vs 72%, assessed by Lung Cancer Nurse Specialist 92.1% vs 71% and Lung Cancer Nurse Specialist present at time of diagnosis 78.1 % vs 58%.

Metric	Result	Adjusted result [1]	National mean	95% significance [2]	99.8% significance [3]
Surgery in all NSCLC	14.4%	13.6%	18.4%	Not Significant	Not Significant
SACT [4] in stage IIIB/IV PS 0-1 NSCLC	65.6%	60.9%	65.0%	Not Significant	Not Significant
Chemotherapy in SCLC	80.0%	72.0%	70.7%	Not Significant	Not Significant
One Year Survival	41.8%	37.2%	36.7%	Not Significant	Not Significant

Data Source: National Lung Cancer Annual Report 2018

Areas for Review:
A National Spotlight audit in response to lower surgery rates is to be undertaken to determine if reduction due to improved access to Stereotactic ablative radiotherapy.

ACTION REQUIRED	ACTION LEAD	TIMESCALE FOR ACTION	WHERE REPORTED
NLCA data validity check and clinical review	Cancer Support Manager	Weekly	Lung MDT annual meeting
Pathway improvement / redesign towards NOLCP ongoing	Respiratory consultant	Phased implementation from Sept 2019	Cancer committee / Cancer performance monitoring

All recommendations and actions required are either complete or are pieces of work that are ongoing. The National Lung Cancer Pathway redesign work is reported through Cancer Committee.

Adult Asthma section of the National Asthma and COPD Audit

The National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) aims to improve the quality of care, services and clinical outcomes for patients with asthma and COPD, Healthcare Quality Improvement Partnership are the audit

body. The number of patients in the National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme (NACAP) was 10,242. The number of patients contributed by the Countess of Chester Hospital NHS Foundation Trust was 51. The timeframe audited was between March and November 2019 locally (national report November 2018 to March 2019) but it is a rolling audit. The report was completed on 15th January 2020. The written report of the audit was sent to the Urgent Care Governance Committee.

The Countess of Chester Hospital NHS Foundation Trust results of the NACAP audit (Asthma). Figures local (national):

Respiratory Review within 24 hrs:	14% (61.8%)
PEF within 1hr of arrival:	0% (27.6%)
Discharge bundle completed:	21% (31%)
Systemic steroids given within 4hrs of arrival:	64% (65.3%)
Smoking advice given:	100% (59%)
Inhaled steroids prescribed on discharge:	100% (89.1%)

In some areas we are exceeding the national figures for best practice, for example inhaled steroids on discharge and smoking cessation advice given. Completion of discharge bundles and provision of systemic steroids within four hours are similar to national levels although, these need to be improved and these have been addressed with the introduction of the British Thoracic Society discharge bundle paperwork on our Respiratory Ward. There is still work to be done regarding the first hour of admission / presentation in the acute areas where we score poorly in peak flow measurements and respiratory review in 24 hours.

In the North West, 9 out of 20 hospitals were compliant by submitting more than 80% to the audit. The Countess of Chester Hospital was one of those with a ‘green traffic light’ as we submitted 99% of data (UK total submission 75% on average).

ACTION REQUIRED	ACTION LEAD	TIMESCALE FOR ACTION	WHERE REPORTED
Peak Expiratory Flow (PEF) within 1 hr of arrival	Respiratory Consultant / Emergency Department Consultant/ Acute Medicine Consultant	6 months	Trust & National
Systemic steroids to be given within 4 hours of arrival	Consultant / Emergency Department Consultant/ Acute Medicine Consultant	6 months	Trust & National

The target date for the completion of recommendations and actions is November 2020. As this is a rolling audit the next report is due March 2020.

National Cardiac Rhythm Management Audit

The National Audit of Cardiac Rhythm Management (CRM) collects information about all implanted cardiac devices and all patients receiving interventional procedures for management of cardiac rhythm disorders aiming to improving the care of patients. The audit

is commissioned by the Healthcare Quality Improvement Partnership and clinical leadership is provided by the British Heart Rhythm Society.

The number of patients in the National Cardiac Rhythm Management Audit was 33,000. The number of patients contributed by the Countess of Chester Hospital NHS Foundation Trust was 245. The timeframe audited was between April 2016 and March 2017 and the audit completed in April 2018. The national report, including The Countess of Chester Hospital data was published 11th July 2019. The audit is available nationwide via an electronic booklet.

The data the Countess of Chester Hospital NHS Foundation Trust submitted was 100% complete. This was not reflected in the National Institute for Cardiovascular Outcome Research (NICOR) publication as the Countess of Chester Hospital NHS Foundation Trust is down as 90% NHS number submitted. NICOR were approached about this, and accepted it was a data issue on their end, but were unable to amend. All other data filed were 100% complete.

The Countess of Chester Hospital NHS Foundation Trust implant numbers easily achieve the required number per centre (>80/yr required) and all consultant operators are achieving required individual numbers (>20/yr).The Countess of Chester Hospital NHS Foundation Trust device re-intervention rate was not presented, but is not outside national figures. This will be presented on next year's audit, but we have no concerns.

ACTION REQUIRED	ACTION LEAD	TIMESCALE FOR ACTION	WHERE REPORTED
Continue current data submission	Cardiac Physiologist	Annually	Urgent Care Governance Committee

The reports of approximately 105 local and regional clinical audits were reviewed by the provider in 2019/2020. The Countess of Chester NHS Trust intends to take the following actions to improve the quality of healthcare provided, examples of this include:

The reports of two local clinical audits were reviewed by the provider in 2019/20 and Countess of Chester NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided

Antiplatelets for secondary prevention of cardiovascular disease in Vascular Surgery patients (Re-audit)

The aim of the audit was to:

- Re-audit the use of antiplatelet medications in vascular care
- Audit the efficacy of intervention-vascular teaching in August 2019

A retrospective review was undertaken of admission and discharge medications of all vascular ward patients from 12th August 2019 to 30th September 2019. A total of 127 patients were reviewed; 88 males and 29 females, with a Median age of 70. The Median length of stay was 5 days.

Summary of results:

- 66.97% of patients admitted on antiplatelet medication, and 94.4% discharged on antiplatelets
- Aspirin alone accounted for 34.6% and 29.1% on admission and discharge respectively, in comparison clopidogrel alone was prescribed for 14.96% and 26.77% patients
- 28.35% of patients had no antiplatelet on admission, however this reduced to 2.4% by discharge
- 2.4% (n=3)of patients discharged without antiplatelet, who had no prior contraindications: two held on medical grounds and one started after discharge on contacting GP
- 11.5% improvement on overall results of previous audit-demonstrating success of induction training

Recommendations/Actions:

- To continue induction training for junior doctors at every changeover
- Daily confirmation at ward rounds of inclusion of antiplatelets as part of discharge medication for vascular patients with peripheral vascular disease, and clear documentation of any contraindication in patient notes and e-discharge forms.

	Action	**Person Responsible**	**Date to be Completed**
1	Organise regular induction training for junior doctors on antiplatelet use as best medical therapy for peripheral vascular disease	Audit Lead(+SHO)	4 monthly(from April 2020)
2	Ensure re-audit of results is done regularly	Consultant in Vascular Surgery	4 monthly(from April 2020)

Changes in practice/lessons learnt:

- Increase in percentage of patients discharged home on clopidogrel, as first line antiplatelet, according to NICE guidelines
- Audit process afforded opportunity to find out and ensure a patient was prescribed antiplatelet after discharge

Lactate measurement in Sepsis

The aim of the audit was to identify if serial lactate measurements are done as per local Sepsis guidelines and if the initial lactate is >4mmol/L after fluid resuscitation. Also to find is there escalation to Critical Care if lactate persists to be >4mmol/L after adequate fluid challenge as per pathway.

Data was collected from 28th February 2019 until 31st May 2019. 128 patient case notes were audited; 65 males and 63 females who were between aged between 27 and 98 years old. The average age of the patient was 72 and the mean length of stay was 15 days (1-114 days). The Sepsis Pathway was used in 93 cases (72%).

Summary of results:

- Initial lactate checked in 102 patients - not done in 26 patients.
- Lactate >2mmol/L in 50 patients.
- 52% of patients with initial lactate >2.0mmol/L were alive at 30 days.
- Lactate>4.0mmol/L in 24 patients during their admission to The Countess of Chester Hospital but in six patients it was not clear why there was no referral to critical care as per policy.

Recommendations:

- The Surviving Sepsis Campaign recommends measuring serial lactates if >2.0mmol/L. The Countess of Chester Hospital policy for repeat lactate check is if >4.0 , Mortality increases with lactate >2.0, therefore threshold locally for repeat lactate should be >2.0
- Involvement of critical care in all patients if lactate>4.0 with documentation if referral not appropriate

	Action	Person Responsible	Date to be Completed
1	Email trust Sepsis lead if the Countess of Chester Hospital threshold for repeat lactate measurement can be changed to 2 or more rather than equal to or greater than 4	Consultant in Acute Medicine	Action Completed
2	Education of junior doctors working on call to document if Critical care referral not appropriate when lactate >4	All AMU consultant colleagues	On-going –as junior doctors rotate through acute medicine
3	Present findings at Medical Unit Meeting	Consultant in Acute Medicine	Action Completed

Lessons Learnt:

Sepsis management in the Emergency Department needs to be timelier especially with initiation of sepsis pathway and antibiotics within the hour.

Participation in Clinical Research

The number of patients receiving relevant health services provided or sub-contracted by the Countess of Chester Hospital NHS Foundation Trust in 2019/20 that were recruited during that period to participate in research approved by a research ethics committee was 778.

A proportion of the Countess of Chester Hospital NHS Foundation Trust's income in 2019/20, was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body we entered into a contract, agreement or arrangement with the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2019/20 and for the following 12-month period are available electronically at www.england.nhs.uk/wp-content/uploads/2019/03/CQUIN-Guidance-1920-080319.pdf

The Countess of Chester NHS Foundation Trust received £2,319k monetary income in 2019/20 conditional on achieving quality improvement and innovation goals. The monetary total for 2018/19 was £4,161k.

The reason for this variance was that CQUIN was 2.5% in 18/19 but reduced to 1.25% in 19/20.

The Countess of Chester Hospital NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is to provide care, treatment and support, without any conditions attached to registration.

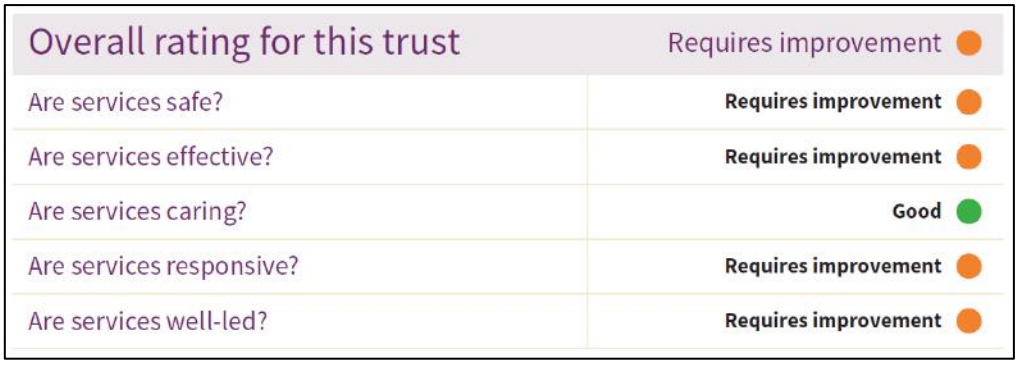
The Care Quality Commission has not taken any enforcement action against the Countess of Chester Hospital NHS Foundation Trust during 2019/20. The Countess of Chester Hospital NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

Our hospital works closely with regulators and commissioners to ensure we continuously strive for excellence and monitor our progress against local, regional and national standards of care. The Trust underwent a 'Well Led' Care Quality Commission (CQC) inspection in December 2018. This inspection process is part of a framework to judge whether a healthcare provider meets the fundamental standards of quality and safety.

We are disappointed to report that the CQC could not be assured that our current systems and processes were effective. They identified a number of areas for improvement including requirement notices against the following regulations:

- Regulation 10 (HSCA) (RA) Regulations 2014 Dignity & Respect
- Regulation 12 (HSCA) (RA) Regulations 2014 Safe Care & Treatment
- Regulation 18 (HSCA) (RA) Regulations 2014 Staffing
- Regulation 17 (HSCA) (RA) Regulations 2014 Good Governance

The Trust was rated as 'Requires Improvement' overall:



This rating was given for the following reasons:

- Safe, Effective, Responsive and Well Led domains were rated as 'Requires Improvement';
- Caring was rated as 'Good';
- Three core services were inspected, medical, surgical and urgent & emergency care, all three were rated as 'Requires Improvement', previously these had been rated 'Good';
- Rating of services not inspected at this time was also taken into account;
- The overall rating for the Trust regarding Well Led was 'Requires Improvement'; and
- The Trust's Use of Resources assessment was given a rating of 'Requires Improvement'.

We accepted the findings and have completed a programme of comprehensive actions to address the requirement notices received against the 18 regulations in all but one which remains at risk. This relates to nurse staffing where there is a recognised national gap between available nursing staff registered with the Nursing & Midwifery Council and national nurse staffing vacancies, to mitigate this risk the Trust has a wide-ranging programme of actions to address closing this gap some of which include bespoke recruitment events, increased us of social media platforms and an active recruitment and retention group. We are able to report that turnover in nursing staff has reduced in this reporting period.

To ensure that actions taken to address the requirement notices were embedded in practice a robust programme of audit was established with overall findings monitored by the Quality Governance Group. We are able to report that audit has demonstrated sustained compliance.

Clinical coding & data quality

Good quality information underpins the effective delivery of services, patients' pathways and supports staff to delivery safe care that meets the expectations of patients and the wider public. Reliable data of high quality is essential to ensuring decisions are made appropriately about service design and priority improvements.

The Countess of Chester Hospital NHS Foundation Trust submitted records during 2019/20 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. It is important when submitting this data to ensure the information is accurate, clear and completed. The following measures provide information on

our compliance against the standards required; which includes data from April 2019 to February 2020:

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

- 99.8% for admitted patient care
- 99.9% for outpatient care and
- 98.7% for accident and emergency care

Those which included the patient's valid General Medical Practice code was;

- 99.7% for admitted patient care;
- 99.8% for outpatient care; and
- 99.8% for accident and emergency care

The Countess of Chester Hospital NHS Foundation Trust will be taking the following actions to improve data quality during 2019/20

The Trust produces routine data which is subject to review and analysis in-line with good standards of corporate governance. The Trust uses a ClickView operational management tool to support the management and analysis of patients, and identify data quality errors. The terms of reference for the Trust Data Quality group are under review and will be clinically led. Data Quality is being reviewed as part of the migration of data for the EPR replacement system (Cerner).

Information Governance

Countess of Chester Hospital NHS Foundation Trust Information Governance Assessment Report overall score for 2019/20 was 'Standards not Met' and was graded 'Limited'.

In the past two years the Information Governance Toolkit has developed into the Data Security and Protection Toolkit which looks at compliance with the general data protection regulation and national data guardian standards. With this brings a heightened requirement to improve our technical controls around the security of data. Our compliance with information governance has not changed, however, as the toolkit has now become more technically focused, we have not had the time or resource to focus on these new requirements. We are currently meeting 36 of the 42 standards of the toolkit. This is something we are aware of and improvements are reflected within our action plan which will be implemented during 2020/21.

The Countess of Chester Hospital NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2019/20 by the Audit Commission.

Learning from Deaths

Reviewing the care of patients who have died in our hospital allows us to consider if anything could have been done differently or if care and treatment opportunities have been delayed or missed. Having a system in place to continuously review the care of patients who have died whilst in the hospital is essential to allow us to learn and improve.

During 2019/20 1,122 of the Countess of Chester Hospital NHS Foundation Trust patients died. The number of deaths in each quarter was:

- 242 in the first quarter
- 249 in the second quarter
- 314 in the third quarter
- 317 in the fourth quarter

By 31st March 2020, 329 case record reviews and 60 investigations had been carried out in relation to 1,122 of the deaths included above. In 2 cases a death was subject to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or investigation was carried out was:

- 76 in the first quarter
- 154 in the second quarter
- 78 in the third quarter
- 38 in the fourth quarter

Following review, 2 cases representing 0.17% of the total deaths during the reporting period were judged to be more likely than not to have been due to problems in the care provided to the patient at our hospital. In relation to each quarter, this consisted of:

- 0 representing 0% for the first quarter
- 1 representing 0.34% for the second quarter
- 1 representing 0.38% for the third quarter
- 0 representing 0% for the fourth quarter

These numbers have been estimated using the Royal college of Physicians methodology on Structured Judgement Reviews (SJR) and the Serious Incident Framework guidance

Review Method

Deaths are currently reviewed using 3 different methods:

- If questions arise in relation to the care of someone who has died then this maybe raised as a clinical incident and a 72 hour review will be undertaken using an SBAR (Situation, Background, Assessment & recommendation tool). These cases are reviewed at the Serious Incident Panel and if appropriate a formal Serious Incident (SI) investigation will be initiated which is carried out using Root Cause Analysis (RCA) methodology,
- A minimum of 10% of deaths should be reviewed using the Royal College of Physicians Structured Judgement Review (SJR) methodology. A SJR blends traditional, clinical-judgement based review methods with a standard format. The objective of this review method is to look for strengths and weaknesses in care process, to provide information about what can be learnt about the hospital systems where care goes well, and to identify points where there may be gaps, problems or difficulty in the care process. The quality of care is assessed against a scale of excellent, good, adequate, poor and very poor. Where the first review deems the care to have been poor or very poor the case is sent for a second review; and
- These reviews are undertaken by senior clinicians alongside members of the coding team. Any cases identified using this tool where care is deemed to be suboptimal are put forward for a formal structured judgement review.

Structure Judgement Review

The quality of care is assessed against a scale of excellent, good, adequate, poor or very poor. Each case has a single reviewer. The SJR breaks down the care into phases:

- Admission and initial care – first 24 hours (approximate)
- Ongoing care
- Care during a procedure / peri-operative care
- End of life care
- Assessment of care overall

Each phase of care is given an overall score:

Very poor care	= 1
Poor care	= 2
Adequate care	= 3
Good care	= 4
Excellent care	= 5

Research suggests that an overall score of 1 or 2 might happen in fewer than 10% of cases. An overall score of one or two will trigger a second-review process.

The SJR have identified areas for Countess of Chester Hospital NHS Foundation Trust to learn, the top themes include;

- Failure to detect the deteriorating patient,
- Lack of consideration of sepsis in patients,
- Failure to escalate patients who were deteriorating documentation especially procedural documentation (excluding the theatre environment

These themes identified have led to:

- Mersey Internal Audit Agency (MIAA): Escalation of a Deteriorating Patient Review
- NEWS policy update to take into account the new recommendations approved in June 2020 for dissemination
- Sepsis refocus on process for early identification and treatment
- Participation in the Cheshire & Mersey Health & Care Partnership sepsis programme

The most appropriate way to share this learning is currently being considered. Patient Safety Summits have been introduced Trust wide with the aim to discuss safety and share personal and organisational learning.

A priority has been getting robust data to direct the learning and the appropriate way to share and demonstrate that learning has occurred.
Other measures include:-

- Review of governance structure within the Trust and the lines of accountability and standardisation of reporting templates.

- Ward accreditation this has allowed the training and knowledge of policies to be demonstrated.
- Unexpected admission to critical care review to try to identify cases where care could have been better.

6 case record reviews and four investigations were completed during this reporting period that related to deaths during the previous reporting period which were not included in the 2019/20 reported figures. Two of these deaths are judged to be more likely than not to have been due to problems in care provided to the patient. This judgement is based on the findings of the Serious Incident Report's which were undertaken using formal RCA methodology. Taking this into account a revised estimate of the number of deaths during the previous reporting period judged to be more likely than not to have been due to problems in the care provided to the patient at our hospital has increased from 2 to 4.

4 deaths representing 0.33% of deaths in 2018/19 judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using SJR

2 deaths representing 0.17% of the patient deaths during 2018/19 are judged to be more likely than not to have been due to problems in the care provided to the patient

As a Trust, the Countess of Chester Hospital has more than met the minimum requirement to review 10% of the deaths through a number of different methods. Looking at the last few years data 30% of deaths are consistently reviewed by the Trust.

The Countess of Chester Hospital aims to provide a good standard of care but also to prevent unnecessary deaths. SJR methodology does looks at overall standards of care but not specifically at the preventability of death. The Trust has been equating a low standard of care to preventability of death even though this might not necessarily be the case for some patients. Many Trusts have amended the SJR methodology to explicitly ask about preventability of death on a 5 point Likert scoring system in an effort to identify cases where the Trust has, on probability, contributed to the death. The investigation process does make decisions regarding the preventability of death and identifies learning to improve care and prevent death.

Lessons Learnt

Any lessons learned are discussed at the Learning from Deaths Group and a quarterly report is fed back to the Divisions through the hospital governance process and also to individual departmental clinical leads at departmental meetings. Any immediate concerns/lessons learned are fed back to the departments immediately following the review. It is clear; however, from the SJR's reviews and the short mortality review form that in the majority of cases the quality of care being provided is of a very high standard. From our learning we propose to take the following actions during 2020/21:

- SJRs to include an explicit statement regarding the preventability of death (regardless of care score and these to be investigated as appropriate);
- All mortality reviews within the Trust to be recorded on a central database, based on a national database pilot, to allow single point oversight;

- Increase personnel training for reviews of death;
- Increase the overall numbers of reviews of death occurring at the Countess;
- To ensure a more timely review of death and more timely review, and closure of action plans, from investigations;
- Centralise the learning from individual cases, also examining themes to maximise learning;
- Review all COVID 19 deaths at the Countess for categorisation of care and learning; and
- To implement ways of demonstrating continued memory of the learning.

2.3 Reporting against core indicators

The Countess of Chester Hospital NHS Foundation Trust considers that this data is as described for the following reasons; information has been taken from Meditech (our electronic patient record) and where available from Dr Foster (clinical benchmarking system) our data quality process including clinical validation has been followed. In October 2019 the Trust's clinical benchmarking system changed from Healthcare Evaluation Data (HED) to Dr Foster.

Indicator	2019/20	National Average	Where applicable – Best performer	Where applicable – Worst performer	2018/19	2017/18	2016/17
SHMI value and banding (most recent Dec 2018 to Nov 2019)	109.49 As expected	100.36	69.09	119.57	107 As expected	104 As expected	113 Above expected
% patient deaths coded for palliative care at diagnosis or specialty level; latest comparative information for period Jan 2019 to Dec 2019	36.0%	N/A			33.7%	36.3%	39.6%
Patient reported outcome scores for groin hernia surgery	Data not available	N/A			Data not available	6.21 Provisional	0.23
Patient reported outcome scores for varicose vein surgery	Data not available	N/A			Data not available	-13.87 Provisional	-1.23
Patient reported outcome scores for primary hip replacement surgery	Data not available	N/A			Data not available	11.34 Provisional	12.24

Indicator	2019/20	National Average	Where applicable – Best performer	Where applicable – Worst performer	2018/19	2017/18	2016/17
28 day readmission rate for patients aged 0-15 Source: Dr Foster Jan 2019 to Dec2019	**14.2%**	**9.9%**	**3.8%**	**16.0%**	**13.3%**	**11.9%**	**10.8%**
28 day readmission rate for patients aged 16 or over Source: Dr Foster Jan 2019 to Dec 2019	**6.9%**	**8.8%**	**5.5%**	**12.2%**	**5.8%**	**5.8%**	**5.9%**
Staff friends and family (Care) Latest national data Q2 2019/20* **	**70.5% (Q3)**	70.5%	87.4%	39.7%	**80.5% (Q4)**	**79% (Q2)**	**78% (Q4)**
VTE (annualised)*	**95.26%**		**N/A**		**94.7%**	**96.1%**	**96.8%**
C. Difficile Rate per HES 100,000 bed days**	**20.0 Total 14.6 Hospital onset 5.4 Community onset**				**16.4**	**15.3**	**12.5**
Number of Serious Incidents at L1	**34**	**N/A**			**50**	**78**	**48**

**** Reporting of VTE (annualised) may differ from previous reports; an ongoing review of our VTE reporting has recently taken place which is not yet complete.***

Indicator	2019/20	National Average	Where applicable – Best performer	Where applicable – Worst performer	2018/19	2017/18	2016/17
Number of Serious Incidents at L2	25	N/A			14	15	16
Number of Never Events	1	N/A			2	1	4
Rate of Serious Incidents at L1 Per HES 100,000 bed days	16.6	N/A			25.5	41.3	25.7
Rate of Serious Incidents at L2 per HES 100,000 bed days	12.2	N/A			7.1	8.0	8.0
Rate of Never Events per HES 100,000 bed days	0.5	N/A			1.0	0.5	2.1
Responsiveness to Patient Needs	Please refer to page 40						

*** Reporting of C. Difficile Rate per HES 100,000 bed days will differ from previous reports, the overall rate is shown and separated for hospital and community acquired C. Difficile.*

*** Staff friends and family (Care) Latest national data Q2 2019/20 – Quarter 4 reporting suspended due to COVID19

The Countess of Chester Hospital NHS Foundation Trust has taken the following actions to improve its performance in risk & patient safety, infection prevention and control and the Trust's responsiveness to the personal needs of its patients, and so the quality of its services.

Risk & Safety

Serious Incidents

During 2019/20 in line with the NHS England Serious Incidents Framework the Countess of Chester NHS Foundation Trust reported 60 incidents to our Commissioners and NHS England which equates to 0.48% of the 12,479 incidents reported in Datix, our risk management system. Each serious incident has a comprehensive Root Cause Analysis (RCA) investigation with recommendations to address any lessons learnt; their action plans are monitored via the relevant Divisional Governance Committees until completed. All RCA's are formally signed off by the local Clinical Commissioning Group.

In the reporting period 2019/20 the Trust trained an additional 25 staff to complement the 40 trained the previous reporting period in Root Cause Analysis methodology to support the Trusts ability to ensure a robust investigation process.

The top three categories of serious incidents reported in 2019/20 were -

- Slip/trips/falls
- Health Care Associate Infections (HCAI)/Infection control
- Treatment delay

Incident Category	Strategic Executive Information System Incident Type	Total Number of Incidents
Infection Control (IC)	HCAI/Infection control incident	9
IC Total		9
Serious Incidents	Apparent/actual/suspected self-inflicted harm	1
	Diagnostic Incident	2
	Maternity/Obstetric Incident: Baby Only	2
	Maternity/Obstetric Incident: Mother & Baby	2
	Medication Incident	1
	Slips/trips/falls	23
	Sub-optimal care of the deteriorating patient	9
	Surgical/invasive procedure incident	3
	Treatment delay	6
	Unauthorised absence	2
Grand Total		60

(Data source: Datix Risk Management System);

Number of serious incidents with severe harm/death

In 2019/20 the Trust reported 12,479 incidents into Datix. The table below shows the numbers of incidents that had a severe or death outcome as a percentage of that 12,479. In some of the incidences where the severity is reported as death the incident itself did not cause the actual death but played a contributory part.

Number of serious incidents with severe harm/Death	2019/2020
Death	16 (0.12%)
Severe (permanent or long term harm caused)	9 (0.07%)
Grand Total	25

(Data source: Datix Risk Management System)

Never Events

During this quality account year (2019/20) the Trust reported one never event, as follows;

Retained swab within theatre

The incident is subject to a robust investigation which will include an action plan to address any issues identified. The incident was reported to the Strategic Executive Information System (StEIS) and the 'duty of candour' was delivered within the required timescale.

Whilst the Trust is disappointed to have a Never Event in theatre during a complex and protracted surgical procedure the Trust is able to demonstrate a change in ethos within theatres and the successful sustained reduction in Never Events in recent years. This case is currently in the report production phase; however analysis from the Trust wide safety summit concluded that:-

- The swab itself was unrelated to the clinical outcome of the case;
- Staff handled a difficult situation very well;
- Never Events are not about blame, they represent an opportunity for collaborative and collective development and;
- The team felt very well supported with comprehensive debriefs afterwards in theatre.

Lessons Learnt

In year, the delivery of lessons learnt messages across the Trust has remained a focus. Shared analysis, learning and improvement identified from incidents, claims, complaints coroner's cases, audit and national safety alerts/learning across the Trust were delivered via the following routes:

- Governance Committee Reports

- Trust wide safety alerts and notifications
- Safety briefings in clinical areas
- Amendments to policy
- Weekly and Monthly meetings with Risk & Safety Leads to manage the incident process
- Newsletters
- Safety Summits
- Daily Safety Huddles
- Trust wide Safety briefs
- Mandatory training
- Screen savers

The Trust has further developed its processes for learning during the year with establishment of safety summits designed to be clinical conversations about significant events which have taken place at the Trust that staff can all learn from.

Duty of Candour

Whilst the Trust had previously implemented the duty of candour legislation work has continued in 2019/20 to ensure that duty of candour which is supported by a standalone policy is fully embedded as business as usual. The Risk & Safety Team have further developed processes to ensure that monitoring is in place by utilising and reporting through the Trust incident system, Datix. Compliance for serious incidents is reported monthly to Quality Governance Group.

All staff receive information at induction supported by a leaflet through the induction process. In order to ensure that staff are aware and understand the importance of duty of candour, it is discussed during the Trust welcome event and all mandatory training sessions. There is an information section dedicated to duty of candour guidance on the Trust's intranet pages.

For each new serious incident investigation, a Risk & Safety Lead continues to be appointed to provide support and advice.

Risk Management System

The Trust utilises Datix as its risk management system. Work has continued during 2019/20 to ensure that it supports productive risk management processes, all evidence in the form of reports; action plans and duty of candour are an example of some of the elements stored within this system. During 2019/20 dashboards built in the previous year based on incident data to help drive improvements where refreshed and utilised as part of robust risk management. This has allowed for easy analysis of themes and trends and shows at a glance how we are doing. Improved capability within Datix will remain a focus in the coming year to support our governance processes and clinical teams with the change to reporting categories from clinical and none clinical to who was affected.

Risk Assessment Training

Robust risk assessments help keep our patients, staff and visitors safe. In 2019/20 a well evaluated training session on risk assessment completion to help improve the overall quality of risk related activities was delivered to over 400 key staff.

National Safety Standards for Invasive Procedures

The Trust has continued to develop outputs that contribute to the National Safety Standards for Invasive Procedures (NatSSIPs) and will continue to work on the standards until fully achieved and embedded.

Comparing Incident Categories over the last three years

The information in the table below outlines the top three categories of patient safety incidents that the Trust declared in 2019/20 relating to the National Serious Incident Framework. These are adverse events where either unintended or unexpected incidents lead to harm for those receiving NHS healthcare and therefore are reported externally to our regulators. An open, transparent culture is important to readily identify trends and take timely, preventative action. The categories are broad subjects however; each incident is reviewed against set criteria to ensure robust investigation, identification of root causes, contributory factors, lessons learnt & recommendations.

The top three categories have remained unchanged and whilst infection control have seen a year on year gradual increase (this is also affected by the change in allocation of community C Difficile infections at the start of this reporting period) the remaining two categories of falls and treatment delays have both undergone a gradual reduction in cases following learning from serious incident investigations. To support the falls prevention programme which the Trust previously adopted and is made up of a number of nationally recognised interventions which will identify our patients most at risk of falling and supports staff to consistently applying a number of interventions known to reduce the risk of a fall has contributed to the reduction in falls with harm, a 'Deep Dive' into falls was commissioned by the Quality and Safety Committee in 2019 as part of consideration of the identification of risk at a ward level, to support the analysis Statistical Process control charts were utilised. This report is currently undergoing Trust sign off and recommendations will help support the Trusts ongoing drive to reduce the number of falls especially those with harm.

	2017/18	2018/19	2019/20
Treatment delay	10	7	6
HCAI	5	8	9
Falls with harm	31	26	23

(Data source: Datix Risk Management System);

Infection Prevention and Control

Infection prevention and control is an essential aspect of quality healthcare provision. Making certain that we have robust systems and processes embedded at all levels of the

organisation to ensure that avoidable infections do not occur, is crucial to routinely delivering safe, kind and effective care to patients.

In addition, antimicrobial resistance is recognised as an international threat, with the UK government being determined to ensure that access to working antimicrobials is sustainable into the future. This places an even greater focus on infection prevention as resistance to the drugs that we use to treat infections increases, rendering them ineffective.

The Trust is committed to maintaining the intensity of both infection prevention and control and antimicrobial stewardship, to ensure that risks associated with all healthcare associated infections are minimised, including infections such as C. difficile infection, MRSA bacteraemia and Gram-negative bloodstream infections, in support of the national objective to reduce the incidence of these infections. Monitoring and evaluation of the systems and processes aimed at reducing the risks associated with healthcare associated infection are essential to ensuring that high quality care is delivered in a safe and appropriate environment. Communication strategies play a key part in this, ensuring that resources are targeted appropriately and that the workforce remains informed, with learning and actions for improvement disseminated in real time.

During 2019/20, the Trust undertook a collaborative assessment with NHS Improvement as part of a healthcare associated infection review. This review provided a positive opportunity to identify what the Trust does well, as well as identifying areas where improvements in infection prevention and control could be achieved, in support of a continuous improvement programme.

The outcome of this assessment was a healthcare associated infection improvement plan that has been the focus of infection prevention and control activity and good progress was made towards achieving the objectives within this improvement plan within year. Some examples of the activity that has been undertaken include:

- Benchmarking local practice with other organisations to share ideas for improvement
- A review of the infection prevention and control assurance framework in alignment with the Health and Social Care Act (2008) Code of Practice on the prevention and control of infections and related guidance
- A review of the Infection Prevention Committee structure and associated governance processes
- Work to strengthen antimicrobial stewardship systems and processes
- Strengthening links between infection prevention and control and delivering the fundamentals of care
- A review of the link practitioner programme and how this role can support improvements in practice
- Improving methods for sharing learning from healthcare associated infection investigations
- Programmes of work to support environmental improvements, including maintenance and environmental cleaning
- Developing local processes to support improvements in compliance with MRSA screening policy

The emergence SARS-CoV-2 within year and the rapidly evolving COVID-19 infection pandemic also emphasises the requirement for infection prevention and control to be central to the delivery of healthcare, to minimise risks for patients, healthcare workers, visitors and the wider health economy.

The goal of infection prevention and control activity in response to the COVID-19 pandemic is to support the maintenance of essential healthcare services, by reducing the risk of transmission of this infection among patients and healthcare workers.

The aim is for:

- Rapid identification of cases through assessment and surveillance
- Early isolation (or cohorting if isolation is not possible) and referral for testing
- Clinical management to support recovery
- Adherence to standard infection prevention and control precautions plus transmission based precautions, to reduce the risks associated with transmission
- Early identification and sharing of any learning for continuous improvement

This approach to the management and control of COVID-19 infection is based on the fundamental principles of infection prevention and control and it is planned that the learning from this pandemic will be utilised to inform future infection prevention and control improvement plans for the Trust.

Trust's responsiveness to the personal needs of its patients during the reporting period

We have a Trust wide Patient Experience Operational Group (PEOG) to provide assurance that the views of patients, families and the public are sought to support and where necessary direct improvements in clinical practice, service delivery and patient pathways. It provides a forum to engage with a range of hospital teams, patient representatives and Governors to review feedback and agree actions needed in response.

PEOG delivers a work programme to support the implementation and sustainability of the Trust's Patient Experience Strategy, reporting directly to the Quality Governance Group to ensure a clear line of communication and accountability to the Trust Board. The mechanism for reporting and/or escalating any risks identified is in line with the existing governance structure and where necessary risks identified are included on the relevant risk register.

PEOG uses the experiences of patients and their stories to deliver a work programme centred on improving clinical practice, service delivery and patient pathways, to ensure:

- Individual's human rights are recognised to a standard of care that maintains patients' dignity, respect, equality and fairness;
- Patient experience is encompassed and embedded across services;
- Patient experience contributes to equitable and responsive services;
- Partnerships with users and carers are maintained and improved; and
- Care is provided in environments that promote patient recovery.

PEOG Objectives include;

- Ensuring that clear strategies are in place to demonstrate effective patient centred care (e.g. Patient Experience Strategy, Service User Involvement Strategy, Carer Involvement Strategy, Community Involvement Strategy and Equality, Diversity & Human Rights Strategy);

- Monitoring and improving service user experience based on feedback from patients, carers and relatives, using a range of internal and external sources of feedback;
- Receiving reports on progress from patient survey(s);
- Supporting clinical teams and specialties to develop improvement plans that reflect patients' feedback and respond to issues or concerns raised;
- Ensure that specialty action plans are being implemented and evidence of improvement in the service user experience is achieved;
- Sharing lessons learnt from patient feedback across the organisation; and
- Work in collaboration with partner agencies (e.g. Health Watch and PLACE) to improve patient experience, receive and note reports and monitor action plans developed in response.

During 2019/20 PEOG have continued to strengthen the assurance processes including information in the Integrated Board Report on the number of complaints open, number open past 40 days (expected response time) and the number of cases with interest from the Parliamentary and Health Service Ombudsman (PHSO). Improvement work in relation to these measures have delivered a sustained reduction in the number of complaints open past the 40 days (consistently under target) and the number of cases with interest from the PHSO. This suggests that complainants (from patients, families or advocates) are receiving a resolution to the complaint they have raised in a timely and meaningful way.

Activities & Deliverables

Learning from patient feedback & sharing lessons learnt; there are several mechanisms available for patients and the public to share their feedback with us, these include

- CQC survey programme;
- Friends & Family test & comments;
- NHS Choices;
- Health Watch (visits, go-sees and engagement events);
- GovRounds;(visits by Trust Governors)
- Patient Led Assessment of the Care Environment (PLACE);
- Patient Reported Outcome Measures (PROMs);
- Concerns or Complaints; and
- Facebook & Twitter feedback.

Each Division receives a report on patient experience feedback monthly, which identifies themes and trends to support improvement. Learning from complaints and concerns raised are triangulated at the Serious Untoward Incident Review panel and cascaded out to staff and teams through the mechanisms described in the risk and patient safety section.

GovRounds; This initiative has been designed by our Governors and is centred on gaining 'an impression' of a ward or department through the eyes of the patient and public. It uses the 15 Step methodology which has been tailored to sit within our trust values of Safe, Kind and Effective. We have received positive feedback in relation to the rounds by both the teams of Governors undertaking them and the wards and departments that have been visited. 8 areas have been visited during this reporting period and they include:

- Jubilee Day Surgery
- Ward 50 (Female Frailty)

- Ward 30 (Paediatrics)
- Estates Department
- Ward 34 (Care of the Elderly)
- Ward 53 (Vascular)
- Renal Unit
- Equipment Library and Decontamination Unit
- There had been plans to visit Ellesmere Port Hospital in March 2020 however; this was postponed due to Covid-19.

A report following each visit is completed by the Governors and shared with the ward or department and the relevant Divisional leads, PEOG hold a GovRound tracker so that the areas visited and any actions in response can be monitored. Teams are asked to share their experience of the round. All responses from the areas that the GovRound took place have commented that they have found the visits to be very worthwhile and supportive of the work the governors are doing, with many commenting how useful it is to have fresh eyes looking at things.

Patient Engagement; we have a number of patient and public involvement groups established to support specific pieces of work, disease conditions and/or people with a protected characteristic. These groups are run by the relevant service or lead who provide updates to PEOG who will support activities where necessary. A few examples of the groups available are:

- Research
- Stroke Research Support Group
- Obstetrics and Gynaecology patient focus group
- Maternity
- Equality and Human Rights group
- Disability Equality Group (DEG)
- Age and Safeguarding
- Gender and Sexuality
- Faith and Religion

Each group consist of key staff, stakeholders, charities and patient representatives, who discuss matters directly relating to patient care and they share their experiences of being a patient, advocate and/or carer.

National Survey Programme

We take part in a series of annual patient surveys as required by the Care Quality Commission (CQC) and NHS England for all NHS Acute Trusts in England. During this reporting period we have received 4 published CQC reports, 1 published NHS England report and we have participated in the following surveys:

Survey	Status	Publication Date
2018 Adult Inpatient	Completed	June 2019
2018 Cancer Patient Experience	Completed	September 2019
2018 Emergency and Urgent Care	Completed	October 2019
2018 Children & Young People	Completed	November 2019
2019 Maternity Services	Completed	January 2020
2019 Adult Inpatient	Sampled Aug-Sept	Expected June 2020

	2019	
2019 Cancer	Sampled April – June 2019	Expected September 2020

The purpose of these surveys is to understand what patients and service users think of healthcare services provided by us. The questionnaires used reflect the priorities and concerns of patients/service users and are based upon what is most important from the perspective of the person; they have been developed by the NHS Patient Survey Co-ordination Centre.

2018 Adult Inpatient *(published by the CQC June 2019)*

This survey looks at the experiences of people who are discharged from NHS acute hospitals. Data was collected on 1,250 recent inpatients at the Countess of Chester Hospital NHS Foundation Trust and the questionnaire was sent out to 1,193 patients who were eligible for inclusion. Responses were received from 504 patients in total giving a 42% response rate an improvement from the previous response rate of 38%.

Comparisons

A total of 62 questions from the survey can be positively scored. Of these 61 can be compared historically between the 2017 and 2018 surveys. Our results include every question where our organisation had the minimum required 30 respondents.

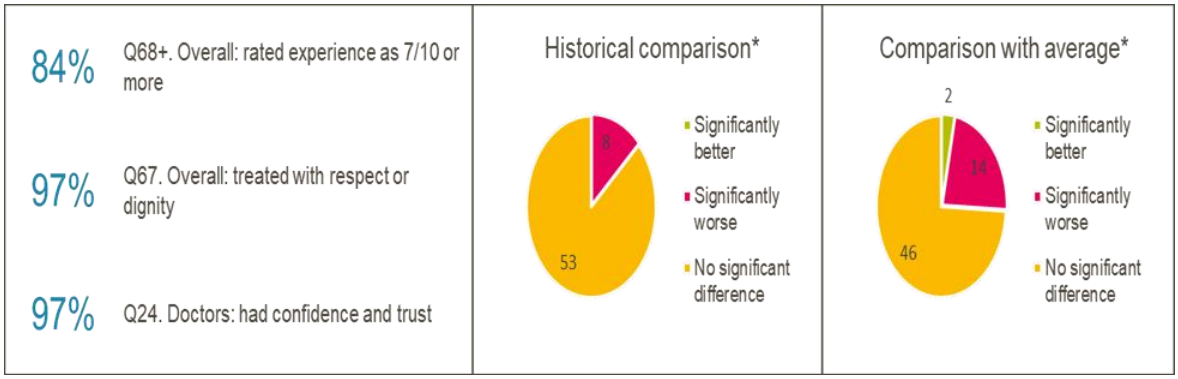


**Chart shows the number of questions that are better, worse, or show no significant difference*

Results

When reviewing the findings it is important to consider our position against the national CQC benchmark but also to track trends in performance over time. This allows for recognition of the areas that have improved since the previous survey and identifies those that are lower than the aspirations and/or expectations of the clinical teams despite being within the expected national comparison.

The overall findings largely reflect the national position and shows that overall patient experience has remained consistent, with improvement noted in one area, whilst two areas have shown some decline. The table below compares our latest results to the average (of similar organisations).

	Organisation type	
Question	**Average**	**Organisation**
Overall: treated with respect or dignity	98%	97%
Overall: rated experience as 7/10 or more	85%	84%
Overall: asked to give views on quality of care	14%	7%
Overall: received information explaining how to complain	20%	14%
Overall: well looked after by non-clinical hospital staff	98%	100%

Have we improved?
Analysis shows that from the last survey findings we have demonstrated improvements in a numbers of areas mainly relating to discharge:

	Most improved from last survey
82%	Q64+. Discharge: staff discussed need for additional equipment or home adaptation
14%	Q52. Discharge: delayed by no longer than 1 hour
56%	Q58+. Discharge: told side-effects of medications
80%	Q15. Hospital: not bothered by noise at night from staff
59%	Q60+. Discharge: told of danger signals to look for

2018 Cancer Patient Experience *(published by NHS England in summer 2019)*

The National Cancer Survey has been designed to monitor national progress on cancer care; to provide information to drive local quality improvements; to assist commissioners and providers of cancer care; and to inform the work of the various charities and stakeholder groups supporting cancer patients. 230 of our patients responded to the survey giving a 64% response rate (in line with the national average).

The survey asked patients 54 questions relating to their care, treatment and experience and of these we scored:

- Above the national average in 1
- Below the national average in 7

Highest scoring question

Question	2018 Score	National Average
Q2) Patient thought they were seen as soon as necessary	*90%*	*84%*

Lowest scoring questions

Questions scoring below expected range	*2018 % Score*	*National Average %*
Q26) Staff explained how operation had gone in an understandable way	66	79
Q31) Patients had confidence and trust in all ward nurses	66	75
Q33) All staff asked patient what name they prefer to be called by	57	69
Q36) Hospital staff definitely did everything to help control pain	74	84
Q37) Always treated with respect and dignity by staff	77	89
Q41) Patient was able to discuss worries or fears with staff during visit	61	71
Q47) Beforehand patient had all information needed about chemotherapy treatment	74	84

Following this feedback the Lead Nurse for Cancer has designed an action plan to progress improvements in relation to what our patients have fed back. This plan has been shared with the PEOG group and forms part of a wider action plan for Cheshire & Merseyside Cancer Alliance.

2018 Emergency and Urgent Care *(published by the CQC in October 2019)*

This survey looked at people's experiences of using Type 1 (major A&E) and Type 3 (urgent care centres, minor injury units, urgent treatment centres) urgent and emergency care services, from decision to attend to leaving. Understanding their experiences is essential to improving services and delivering high-quality care. Data was collected on 950 patients at the Countess of Chester Hospital NHS Foundation Trust and the questionnaire was sent out to 914 patients who were eligible for inclusion. Responses were received from 302 patients in total giving a 33% response rate an improvement from the previous response rate of 28%.

Comparisons

A total of 35 questions from the survey can be positively scored. Of these 28 can be compared historically between the 2018 and 2016 surveys. Our results include every question where our organisation had the minimum required 30 respondents.

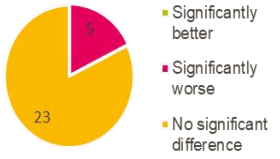
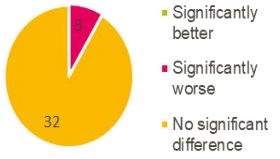
		Historical comparison*	Comparison with average*
80%	Q46. Rated care as 7/10 or more		
95%	Q45. Treated with respect and dignity		
96%	Q15. Doctors and nurses listened to patient		

**Chart shows the number of questions that are better, worse, or show no significant difference*

Results

The results below outline our top and bottom 5 scores compared to the average.

	Top 5 scores (compared to average)
79%	Q42. Told about symptoms to look for
61%	Q41. Family or home situation considered
77%	Q43. Told who to contact if worried
86%	Q8. Waited under an hour in A&E to speak to a doctor/nurse
87%	Q16. Doctor or nurse discussed anxieties or fears about condition or treatment

	Bottom 5 scores (compared to average)
49%	Q39. Told side-effects of medications
77%	Q9. Waited under two hours to be examined by a doctor/nurse
85%	Q20. Family, friend or carer able to talk to a doctor
29%	Q10. Examination not delayed
91%	Q33. A&E department was very or fairly clean

2018 Children & Young People (published by the CQC in November 2019)

The 2018 children and young people's patient experience survey asked children and young people about the quality of their care in hospital during November and December 2018. Respondents were children and young people aged 8 to 15 and their parents, and the parents of children aged 0 to 7. Data was collected on 1,028 patients at the Countess of Chester Hospital NHS Foundation Trust and the questionnaire was sent out to 1,013 patients who were eligible for inclusion. Responses were received from 179 patients in total giving an 18% response rate and decrease from the previous response rate of 24%.

Comparisons

A total of 64 questions from the survey can be positively scored. Of these 61 can be compared historically between the 2016 and 2018 surveys. Our results include every question where our organisation had the minimum required 30 respondents.

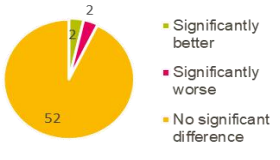
		Historical comparison*	Comparison with average*
91%	P68. Parent felt well looked after by staff		
98%	C67. Child felt well looked after in hospital		
95%	P24. Staff agreed a plan with parent for their child's care		

**Chart shows the number of questions that are better, worse, or show no significant difference*

Results

The results below outline our top and bottom 5 scores compared to the average.

	Top 5 scores (compared to average)
84%	P15. Parent felt that Wi-Fi was good enough for child to do what they wanted
97%	C16. Child felt that Wi-Fi was good enough for them to do what they wanted
92%	C12. Child felt that there was enough things to do in hospital
98%	C67. Child felt well looked after in hospital
86%	P40. Child liked the hospital food

	Bottom 5 scores (compared to average)
45%	P43. Parents were able to prepare food in the hospital if they wanted to
57%	P45. Overnight facilities for parents/ carers rated as good or very good
77%	P42. Parent had access to hot drinks facilities in the hospital
60%	P33. Staff did not give conflicting information
86%	P70. Parent rated experience as more than 7/10

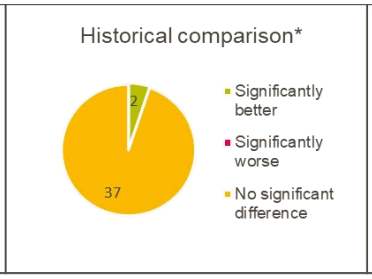
2019 Maternity Services (published by the CQC in January 2020)

NHS maternity services provide care and support to women before giving birth (antenatal care), during the birth and in the six to eight week period after the birth (postnatal care). Understanding the experiences of the women who use them is essential to providing high-quality care. This survey asked women about their experiences of care during labour and birth, as well as the quality of antenatal and postnatal support they received. 300 patients at the Countess of Chester Hospital NHS Foundation Trust were invited to complete the survey. The questionnaire was sent out to 297 patients who were eligible for inclusion. Responses were received from 108 patients in total giving a 36% response rate an improvement from the previous response rate of 32%.

Comparisons

A total of 39 questions were asked in the 2018 and 2019 surveys, which have been used for historical and overall comparisons. Our results include every question where our organisation had the minimum required 30 respondents.

98%	C20. Treated with respect and dignity
99%	C21. Had confidence and trust in staff (during labour and birth)
98%	C19. Involved enough in decisions about their care (during labour and birth)



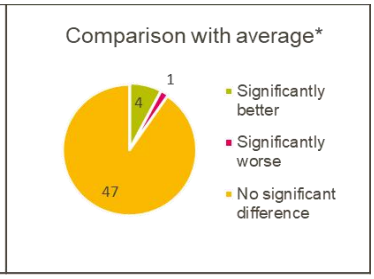


**Chart shows the number of questions that are better, worse, or show no significant difference*

Results

The results below outline our top and bottom 5 scores compared to the average.

	Top 5 scores (compared to average)
88%	F17. Received support or advice about feeding their baby during evenings, nights or weekends
90%	F7. Felt midwives aware of medical history (postnatal)
67%	D2. Discharged without delay
80%	F6. Saw the midwife as much as they wanted
86%	F14. Told who to contact for advice about mental health

	Bottom 5 scores (compared to average)
41%	D7. Found partner was able to stay with them as long as they wanted
84%	B4. Offered a choice of where to have baby
95%	B9. Had enough time to ask questions during antenatal check-ups
86%	C1. Felt that they were given appropriate advice and support at the start of labour
95%	D6. Treated with kindness and understanding

Responsiveness to Staff Feedback

Staff Friends and Family Test

We are committed to listening to the views of our staff as well as the patients and public from across our community. Staff have a first-hand experience of what our services are like and valuable information relating to the care and treatment provided by the hospital can be sort by exploring the views of our people working within the organisation. A simple way to gather intelligence in relation to this, is the staff Friends & Family test, this is a short quarterly survey were staff are asked if they would recommend our hospital to their family and friends for care or treatment. The 2019/20 results can be seen below (quarter three data was taken from the national staff survey). Quarter 4 reporting was suspended due to COVID19.

This gives a mean average of 70% of respondents said they were either likely or extremely likely to recommend our hospital to friends and family for care or treatment. For the three reporting periods available the findings are consistent with the national average.
We will develop our approach to staff engagement to understand variances within the Trust and improve staff satisfaction and motivation.

National NHS Staff Survey

One way that we monitor staff engagement is through the national NHS Staff Survey which is conducted each year by the Trust, the results of which are used by the Care Quality Commission, our regulators, our commissioners and others to assess our performance. Our results are published nationally on our website. In addition to this, we also monitor the views of our staff on a quarterly basis against key indicators via the national Staff Friends and Family Test.

This year, we changed our approach to the NHS Staff Survey. Instead of undertaking another sample survey as we did in 2018, the Trust opted instead to run a full survey of all our staff. This year, we also utilised the electronic option enabling staff to complete the

survey online. This was in response to feedback we received from many of our staff who felt the online version would be easier to complete and return than the paper survey version which had been used in previous years.

We surveyed a total of 3,927 staff (this excluded bank & agency workers). The key headlines from the survey were as follows:

- 1,155 members of staff completed the survey
- This equates to a response rate for the Trust of 29.7%
- The Trust response rate was below the national average (48%)

This year's survey focused on a number of indicators, presented in the form of eleven main themes:

- Equality, diversity & inclusion
- Health and wellbeing
- Immediate managers (which includes providing support and feedback)
- Morale
- Quality of appraisals
- Quality of care
- Safe environment - bullying and harassment
- Safe environment - violence
- Safety culture
- Staff engagement
- Team working

The results from the survey are reported as **performed better, equal** or **lower than** the acute average in indicators as follows (all scores are marked out of 10):

Higher than the acute average in one indicator

- Equality Diversity & Inclusion – 9.2 v 9.0

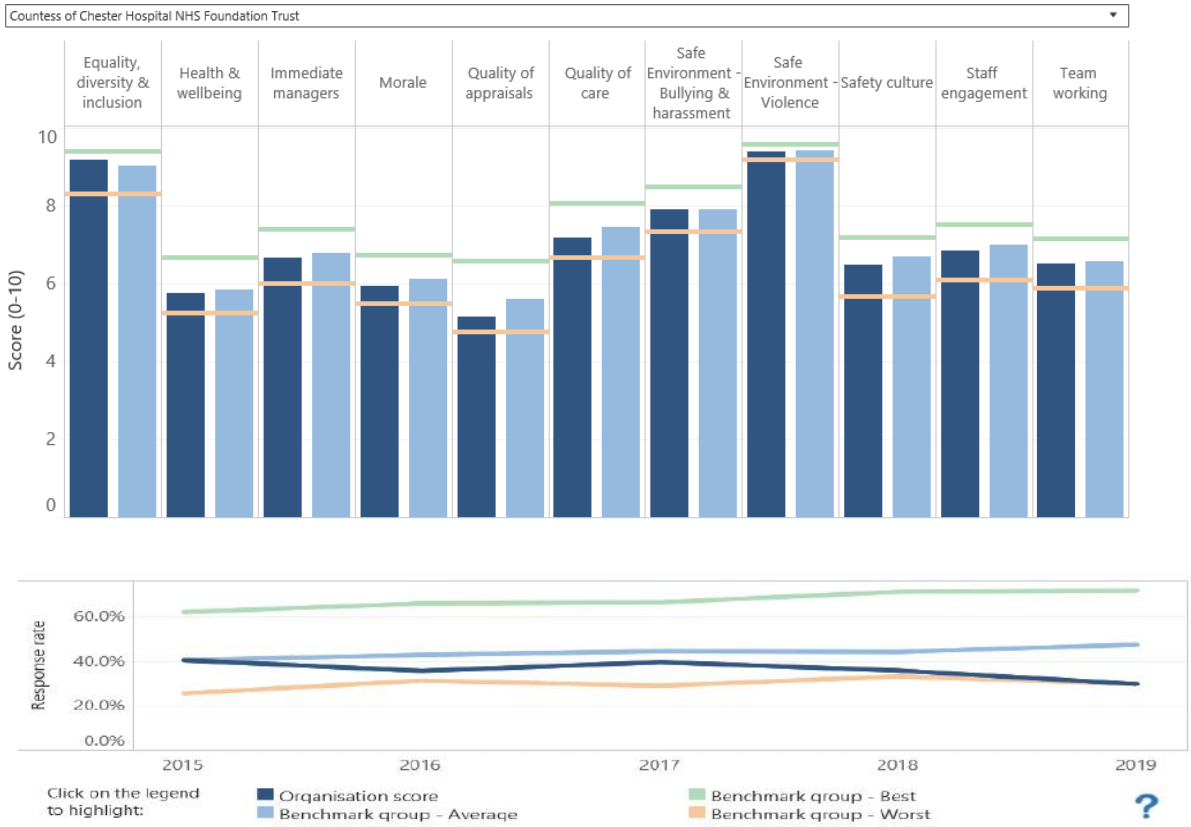
Equal to the acute average in two indicators

- Safe Environment Bullying and Harassment – 7.9
- Safe environment violence – 9.4

Lower than the acute average in eight indicators

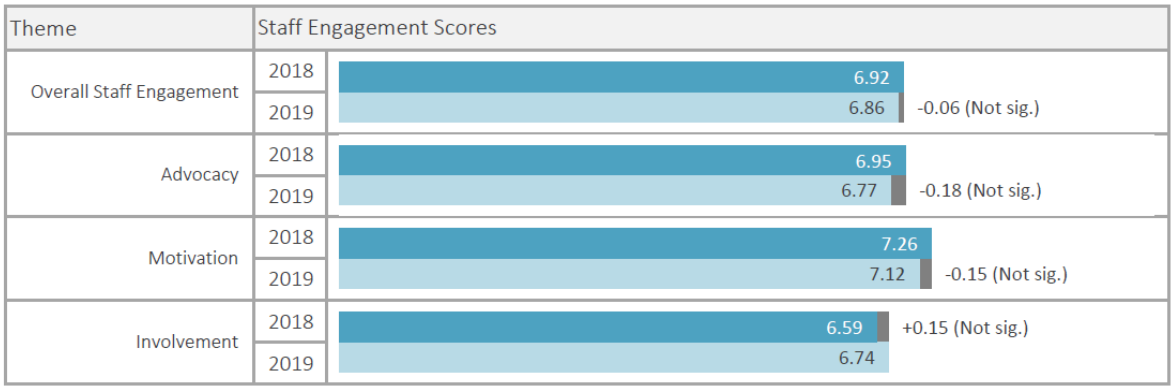
- Morale – 5.9 v 6.1
- Quality of appraisals – 5.2 v 5.6
- Quality of Care – 7.2 v 7.5
- Safety Culture – 6.5 v 6.7
- Staff engagement – 6.9 v 7.0
- Health and Wellbeing – 5.8 v 5.9
- Immediate Managers – 6.7 v 6.8
- Team Working – 6.5 v 6.6

The key domain showing a lower than acute average score which, whilst not statistically significant, showing the largest gap is Quality of Appraisals – 5.2 v 5.6



Staff Engagement

Presented below are the engagement scores for each of the themes that comprise overall staff engagement. Engagement scores from 2018 have also been put in for comparison. The percentage difference between the 2018 and 2019 scores are represented by the coloured gap between the bars. Significant differences between the years have also been indicated.



Bottom Five Ranking Scores 2019

1	11g	Have you put yourself under pressure to come to work?	94%
2	9d	Senior managers act on staff feedback.	26%
3	9c	Senior managers here try to involve staff in important decisions.	27%
4	4g	There are enough staff at this organisation for me to do my job properly.	29%
5	9b	Communication between senior management and staff is effective.	35%

What our staff have told us as a result of the NHS Staff Survey in 2019 is that we need to improve in many aspects of the key themes, and particularly in the area of increasing engagement and motivation.

The NHS Staff Survey also shows that our staff are telling us that the Trust is struggling to provide the level of care they and we aspire to against the increasing levels of demand and activity, which is comparable with the national results. Looking ahead, we have to do more to focus on our safety culture, particularly the reporting of near misses, staff engagement, the pressure colleagues put themselves under to attend work, the quality of our appraisals, the communication and involvement of colleagues across the Trust regarding decisions that affect their work, and to continue to create an environment free from discrimination, bullying and harassment.

Top Ranking 5 Scores in 2019

1	12c	Experienced physical violence at work from other colleagues in the last 12 months.	1%
2	12b	Experienced physical violence at work from managers in the last 12 months.	1%
3	16c	The last time you saw an error, near miss or incident that could have hurt staff or patients / service users, did you or a colleague report it?	97%
4	15a	Experienced discrimination at work from patients / service users, their relatives or other members of the public in the last 12 months.	4%
5	18a	If you were concerned about unsafe clinical practice, would you know how to report it?	95%

It is encouraging to see that despite scoring below the average for safety, a large majority of incidents are being reported, and knowledge of how to report unsafe practice stands at 95%.

In respect of overall staff engagement, the Trust recognises the need to do more to encourage our staff to participate in the systems and processes used to elicit their views and opinions to help improve the future direction of the organisation and this has been identified as a key area for improvement on 2020/21. Much has already been done to start to involve staff in those matters which affect them by encouraging their contribution in the development of our Clinical and Corporate Strategies.

PART THREE

3.0 Other Information

3.1 An overview of the quality of care offered based on 2019/20 performance

Our key priorities for 2019/20 were chosen to reflect three domains of quality defined as;

- **Safe:** Delivering safe services by reducing clinical variation
- **Kind:** Delivering kind and compassionate care to patients and our staff
- **Effective:** Delivering effective services by reducing process variation

Delivering safe services by reducing clinical variation; we focused on providing consistency in the care and treatment we deliver to our patients. Getting it right first time for all our patients to ensure the right care and treatment is started at the right time in the patient's journey. In particular we concentrated on how we recognise and respond to the deteriorating patient, how we treat patients with sepsis, reducing healthcare associated infections and preventing patient falls whilst in hospital.

Delivering kind and compassionate care to patients and our staff; we focused on the health and wellbeing of our staff so they were able to work at their peak and deliver services that are safe, kind and effective for our patients.

Delivering effective services by reducing process variation; we focused on the way in which we worked to ensure we improved the safety, quality and experience for our patients. In particular we focused on improving processes within the Emergency Department, Maternity Services, Cancer Services, Outpatient and Theatres.

What did we achieve?
Out of the key priorities chosen for 2019/20, 5 have been achieved in full, with a further 4 close to target, however 2 have achieved the target set.

Key priorities 2019/20	On plan/ achieved	Close to target	Behind plan
Delivering safe services by reducing clinical variation			
Increased compliance with NEWS2 scoring (recognising and responding to the deteriorating patients)			
Implementation of e-observations			
Increase in the number of patient who are appropriately screened for sepsis (target 90%)			
Increase in the number of patients with sepsis who are given antibiotics within 1 hour of diagnosis (target 90%)			
Improved compliance to the Sepsis 6			
Sustained compliance against 'Fall Prevention Measures'			
Reduction in the number of falls that result in harm to patients in our care			

Reduction in the number of healthcare associated infections			
Delivering kind and compassionate care to patients and our staff			
Implement an Employee Assistance Programme (EAP)			
Provide staff with access to face to face counselling within 5 working days			
Provide staff with access to a telephone helpline (offering expert support and advice) 24 hours per day, 365 days per year			

We focused on providing consistency in the care and treatment we deliver to our patients. Getting it right first time for all our patients to ensure the right care and treatment is started at the right time in the patient's journey.

Our measures of success included;

- Increased compliance with NEWS2 scoring (recognising and responding to the deteriorating patients)
- Implementation of e-observations
- Increase in the number of patient who are appropriately screened for sepsis
- Increase in the number of patients with sepsis who are given antibiotics within 1hour of diagnosis
- Improved compliance to the Sepsis 6
- Sustained compliance against 'Fall Prevention Measures'
- Reduction in the number of falls that result in harm to patients in our care
- Reduction in the number of healthcare associated infections

Recognising and responding to the deteriorating patients

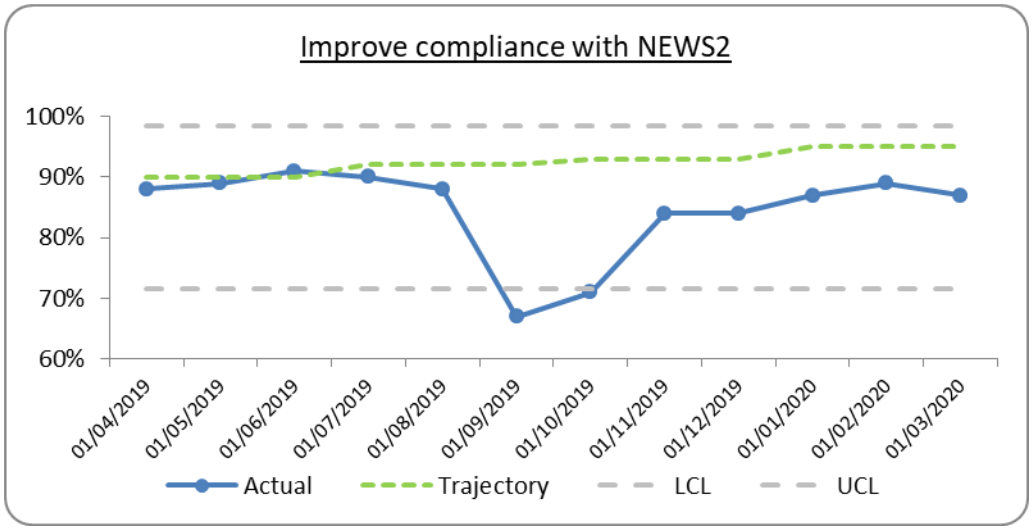
It is important to have a standardised approach to the monitoring and recording of patient's physiological observations whilst they are in hospital, as these observations indicate how sick the patient is. Staff need to take observations at a frequency that is appropriate to the patient's severity of illness and take action in response to the findings to ensure that the right level of care and treatment is provided in a timely manner. This is particularly important for patients who are experiencing atypical observations (deviation from the norm), those who have a worsening trend or those who suffer a sudden deterioration. The tool provides a score for each physiological observation taken and this is then aggregate into a total score which indicates the response needed. Six simple physiological parameters form the basis of the scoring system:

1. Respiration rate
2. Oxygen saturation
3. Systolic blood pressure
4. Pulse rate
5. Level of consciousness or new confusion
6. Temperature

Once the observations have been taken and the score allocated, there is a graded response system for staff to follow to ensure a responder with the right knowledge and skills attends to direct the care and treatment needed. We aimed to increase our compliance with NEWS2 scoring during 2019/20.

What have we achieved?

Improving our compliance with the National Early Warning (NEWS2) track and trigger tool is ongoing. This NHS England approved tool was introduced Trust wide in September 2018 to all adult inpatient wards and departments. Monthly audits are in place which has demonstrated improvements in compliance and that the tool has been applied to support escalation a patient's condition triggers an alert. During the first quarter of the year we successfully improved our NEWS2 compliance however, the compliance dropped significantly in September 2019. After a review we believe this was due to alterations to the audit and validation of the audits. When completing observations staff must provide a clear date, time and initial this. The date and time provided is a clear audit of whether we fail to rescue or when the last observations are done, but during the review of September's audit there were a number of instances where it was unclear. Clear guidance was communicated and laminated charts of how to complete observations were created and tested on one ward before being rolled out to all wards. Following this compliance was once again improved. A session on NEWS2 training has now also been introduced as a session on clinical mandatory training.



Data Source: Clinical Audit

We recognise that there are still improvements to be made with our NEWS2 compliance. We are committed to make improvements to keep our patients safe.

Implementation of e-observations

Several studies have demonstrated that paper based observation scoring systems have a high error rate. This can happen for a variety of reasons and is complex and multi-factorial.

Some of the reasons identified have been attributed to calculation errors when adding up the score, which in turn results in the score triggering the appropriate clinical response. This puts acutely unwell patients at risk of delays in treatment and/or failure to rescue. Implementing an electronic solution (through e-observations) has demonstrated a significant reduction in the error rate in other hospitals. We have designed a roll out plan for 2019/20 to bring in equipment in a phased approach that automatically adds up the patients observation score and prompt the staff based on that score to take the most appropriate action.

What have we achieved?

We are currently in the process of deploying the equipment required for e-observations. With the help of Fundraising the Trust has purchased 115 Welch Allyn Spot Connex monitors that collate all haemodynamic observations in to one screen reducing transcription errors. The equipment takes blood pressures readings on inflation only which is more comfortable for patients and has a large battery which means the equipment is more mobile. We plan to update all devices with the early warning scoring by May 2020. Observations will be taken electronically and the early warning scoring will be calculated on to screen providing clear decision making support for escalation of deteriorating patients. The studies demonstrated that this reduces calculation errors for early warning scoring to less than 1%. When we go live with our replacement EPR all devices will integrate with the new EPR. This will save staff time in completing paper observation charts and further reducing transcription errors to less than 1%. A dashboard will be created and populated automatically with patient information. Critical care outreach teams will be able to identify most rapidly deteriorating patients and direct resources more effectively.

Although we haven't fully implemented e-observations as planned, we are close to meeting our target to ensure safe effective care is delivered for our patients**.**

Sepsis

Every year in the UK 44,000 people die as a result of sepsis, this equates to one death every 5 minutes. Sepsis now carries a higher mortality rate than bowel cancer, breast cancer and prostate cancer combined. In order to effectively treat sepsis the first hurdle is early recognition. A large amount of work has been undertaken during 2019/20 to improve compliance against the national 'screening' and 'timely treatment' measures for sepsis. These measures are important to track and maintain as they provide an indication of how well we recognise and respond to sepsis..

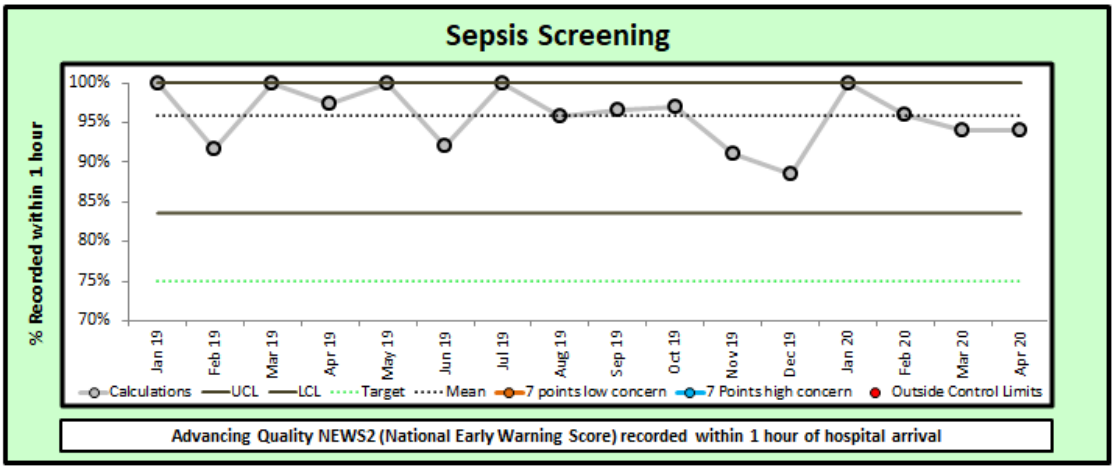
During 2019/20 we aimed to make improvements in compliance to reach the national target for the number of patients who are appropriately screened for sepsis and for administering antibiotics within one hour of diagnosis. We joined the Cheshire & Mersey Health & Care Partnership Sepsis Programme to allow routine monitoring and benchmarking with regional organisations, as well as sharing learning and areas of best practise.

What we have achieved?

- Re-launched a standardised pathway for adults in the Emergency Department and inpatient areas

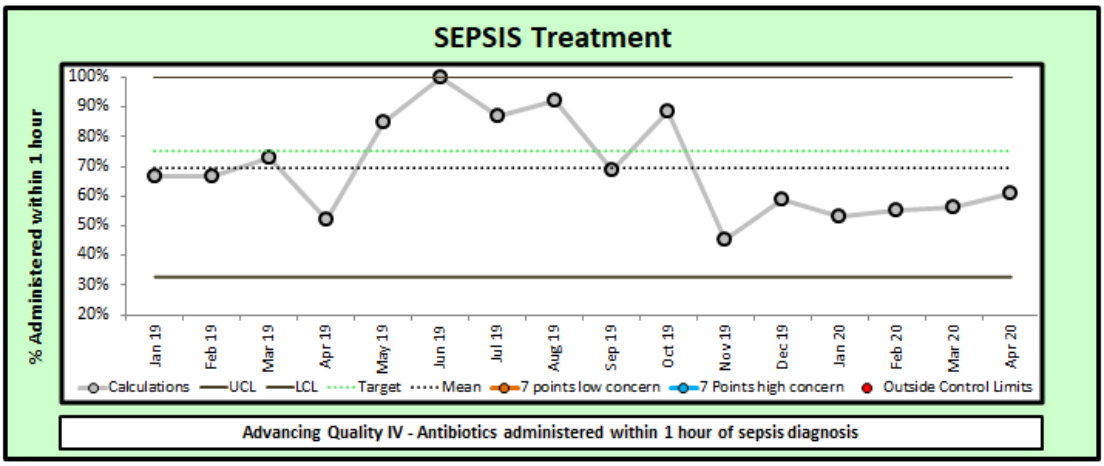
- Sepsis response kits available to all areas – unique design allows for the response kit to double as teaching aid and focal point for sepsis awareness training
- Sepsis awareness provided on induction for registered nurses and nursing assistants
- Sepsis awareness provided on Skills Update for Nurses and contained within ALERT course
- Participation in the Cheshire & Mersey Health & Care Partnership Sepsis Programme

As you will see in the graphs below, the screening for sepsis has remained above 90% for the majority of the year.



Data Source: Business Intelligence

The administration of antibiotics within 1 hour of sepsis diagnosis is the imperative in patient recovery times. The trust has undertaken significant work to ensure that patients are receiving timely treatment but have not as yet achieved the target. The results from January 2020 will not to be utilised in formal reporting due to the impact of Covid19.



Data Source: Business Intelligence

Cheshire & Mersey Health & Care Partnership Sepsis Programme

The Cheshire & Mersey Health & Care Partnership programme examines a sample of patients diagnosed with sepsis and the care they have received.

AQ Measures

- National Early Warning Score (NEWS2) recorded within 1 hour of hospital arrival
- Blood cultures taken within 1 hour of sepsis diagnosis
- Antibiotics administered within 1 hour of sepsis diagnosis
- Serum lactates within 1 hour of sepsis diagnosis
- IV fluids commenced within1 hour of sepsis diagnosis
- Senior Review within 2 hours of sepsis diagnosis

The regional target set for 2019 sepsis performance was a Composite Process Score (CPS) of 75%. The trust exceeded this by achieving 80.3%.

To improve compliance the Sepsis care we set up a Trust initiative to train 600 staff in 60 days ahead of World Sepsis Day on 13th September 2019. We exceeded our target of training 600 staff and actually trained 900 staff in 60 days. On World Sepsis day staff hosted Sepsis stands around the Trust to promote awareness and education of Sepsis and held a competition for people to guess how many people around the Trust have been trained on the 'Sepsis 6', following the pledge to train 600 members of staff in 60 days. Our Sepsis Lead also hosted a session at the Grand Round (an education session for clinicians). The Sepsis lead said, “Sepsis is a life threatening but treatable illness. The first step to life-saving treatment is to spot it. Together we can beat it”.

Falls

When patients are in hospital it is important to for them to mobilise as soon as their recovery allows. Patients who do get out of bed, get dressed and start moving early are more likely to make a full recovery and return to their usual place of residence. As patients start their rehabilitation they may require additional support from physiotherapy staff and the use of equipment (such as walking aids), this in turn can increase the risk of the person slipping, tripping or falling whilst in hospital. As it is so important not to restrict a person from mobilising it means we need to put measures into place to reduce the risk of the person from falling. We have implemented the national 'FallSafe' programme, which is made up of a number of nationally recognised interventions including:

- Assessing if the person has a history of falls and/or has a fear of falling;
- Ensuring patients call bells are within reach;
- Ensuring patients have appropriate footwear whilst in hospital;
- Undertaking a cognitive assessment (to identify confusion);
- Identifying patients at risk of delirium;
- Undertaking a simple visual assessment (none diagnostic);
- Ensuring a lying and standing blood pressure is taken; and
- Ensuring patient medications are reviewed.

During 2019/20 we focused on increasing compliance to reduce the risk of falls across three high impact actions which reflected the Commissioning for Quality and Innovation (CQUIN) as well as reducing the number of falls that result in harm to patients in our care.

1. Lying and standing blood pressure (BP) - Recorded at least once

2. No hypnotics, antipsychotics or anxiolytics given during stay (or rationale provided)

3. Mobility assessment documented within 24 hours of patient admission to an inpatient unit recording walking aid requirements

What have we achieved?

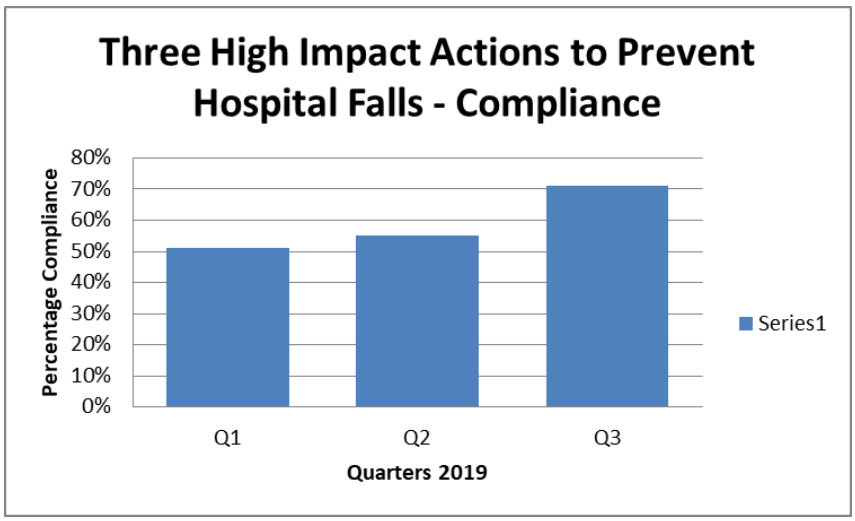
Lying and standing blood pressure (BP) - Recorded at least once; ward managers are able to print a compliance risk list to see which patients have had a lying and standing BP completed. To support the staff in improving the compliance wards have been supplied with lying and standing BP lanyards for the blood pressure machines which clearly show the correct process for completing the observation.

No hypnotics, antipsychotics or anxiolytics given during stay (or rationale provided); compliance against this measure is reliant on good documentation. Currently, at the Countess of Chester Hospital NHS Foundation Trust we document into multiple systems. These are paper based and electronic, this is set to change with the introduction of a new Electronic Patient Record System and will help improve our compliance.

Mobility assessment documented within 24 hours of patient admission to an inpatient unit recording walking aid requirements; we currently provide five days a week provision of

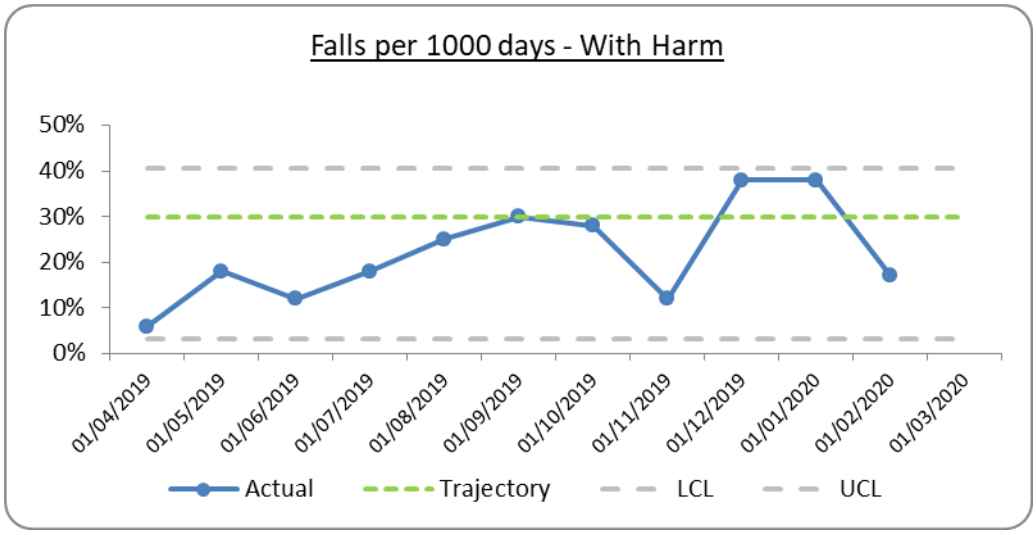
mobility aids, this can be provided seven days a week however, adequate storage for equipment is required. We have provided a guide to sizing frames out of hours and staff can use this to provide their inpatients with a frame/walking aid over the weekend if required. A review of the pre-existing falls assessment has now been completed and this allows staff to enter if the required mobility aid is available or has been provided. This change in practice occurred in July 2019 and we expect to continue to see improved compliance in this area as a result.

To capture compliance against these measures audits were completed. Data was used from patients who were aged 65 and over and who had a length of stay of at least 48 hours. We aimed to use a sample size of 100 patients per quarter to audit the compliance; we only averaged a sample size of 76 patients. This was due to the amount of clinical time it takes to carry out the audit and assess whether the patient met the relevant criteria; we are currently working with the Clinical Commissioner Group to reduce the sample size requirements. Our target was 80% compliance, as you can see from the table below we just missed out on achieving our aim in quarter three. Data for quarter 4 was not submitted due to the Covid-19 pandemic.



Data Source: Clinical Audit

To support the falls prevention programme a ‘Deep Dive’ into falls was commissioned by the Quality and Safety Committee in 2019 as part of consideration of the identification of risk at a ward level. This report is currently undergoing Trust sign off and recommendations will help support the Trusts ongoing drive to reduce the number of falls, especially those with harm.



(Data source: Datix Risk Management System)

It is also known that Cheshire West is an outlier for falls with harm. Work is ongoing to understand why our local population are an outlier when it comes to falls with harm.

We are committed to reducing the number of falls especially those with harm; we are taking the following actions to improve:

- Staff being clear regarding their role and responsibilities for the reporting of falls incident;
- All patients' aged over 65 years have a lying and standing blood pressure performed as soon as practicable following admission, and that actions are taken if there is a substantial drop in blood pressure on standing;
- All patients aged over 65 years have a medication review, looking particularly for medications that are likely to increase risks of falling;
- All patients aged over 65 years have a mobility assessment completed within 24hrs and an appropriate walking aid provided if required;
- All patients aged over 65 are provided with a falls prevention leaflet;
- Access to supportive footwear through the slipper bank;
- Raising awareness of bedrail use-when and when not to use them and;
- Staff receiving falls risk awareness training on induction.

Healthcare Associated Infections

Ensuring that avoidable healthcare associated infections (HCAI) do not occur is an essential aspect of quality healthcare provision. Infection prevention and control practices are fundamental to protecting patients, visitors and staff and routinely following standard infection prevention and control precautions can help to prevent the transmission (spread) of infection. These precautions include:

- Hand hygiene;
- Personal protective equipment (PPE);
- Environmental cleaning;
- Decontamination of equipment;

- Preventing sharps injury; and
- Waste disposal and linen management.

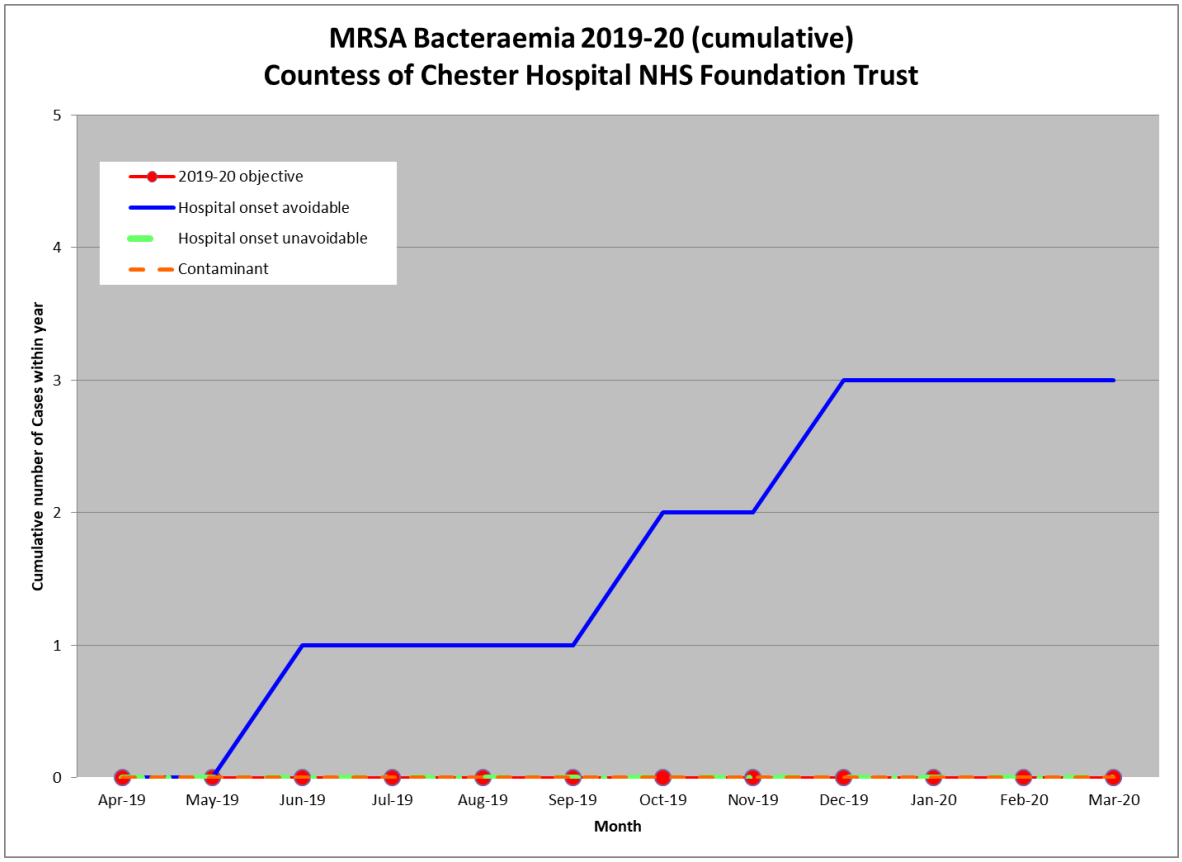
These standard precautions apply in all areas and situations across the hospital and it is important to remember that we are committed to reducing risks associated with all infections, not just those infections that are included within national reduction strategies. This standard application of prevention measures in combination with additional transmission based precautions for specific infections e.g. diarrhoeal or respiratory illness, works in combination to minimise the risk of infection spreading.

The rise in antimicrobial resistance (this is where infections become resistant to the drugs that may be routinely used to treat them) is a well-recognised threat to healthcare. The United Kingdom government are committed to ensuring that measures are in place to ensure that the NHS has access to working antimicrobials (drugs such as antibiotics) and that we can continue to provide these treatments in the future. This places an even greater emphasis on infection prevention and control, as increasing resistance to the medications that we use to treat infections can render these drugs ineffective. Infection prevention and control plays a key role in supporting this national strategy (to tackle antimicrobial resistance), as reducing the number of infections that occur, reduces the need for antimicrobials to be used.

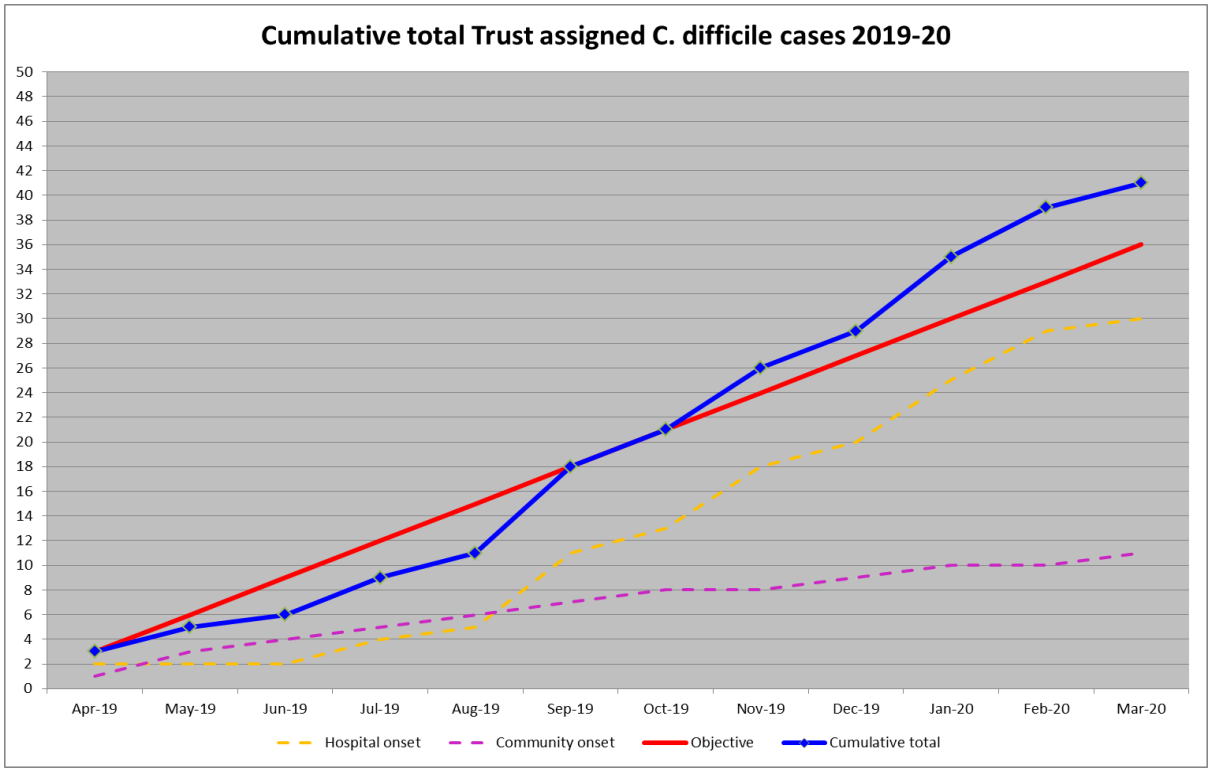
For 2019/20, it is disappointing that we reported:

- 3 avoidable cases of MRSA bloodstream infections against an objective of zero avoidable cases within year;
- 41 cases of Clostridium difficile infection, against an objective of no more than36 cases within year; and
- An overall average hand hygiene compliance of 97%, with compliance falling below the 95% threshold on one occasion.

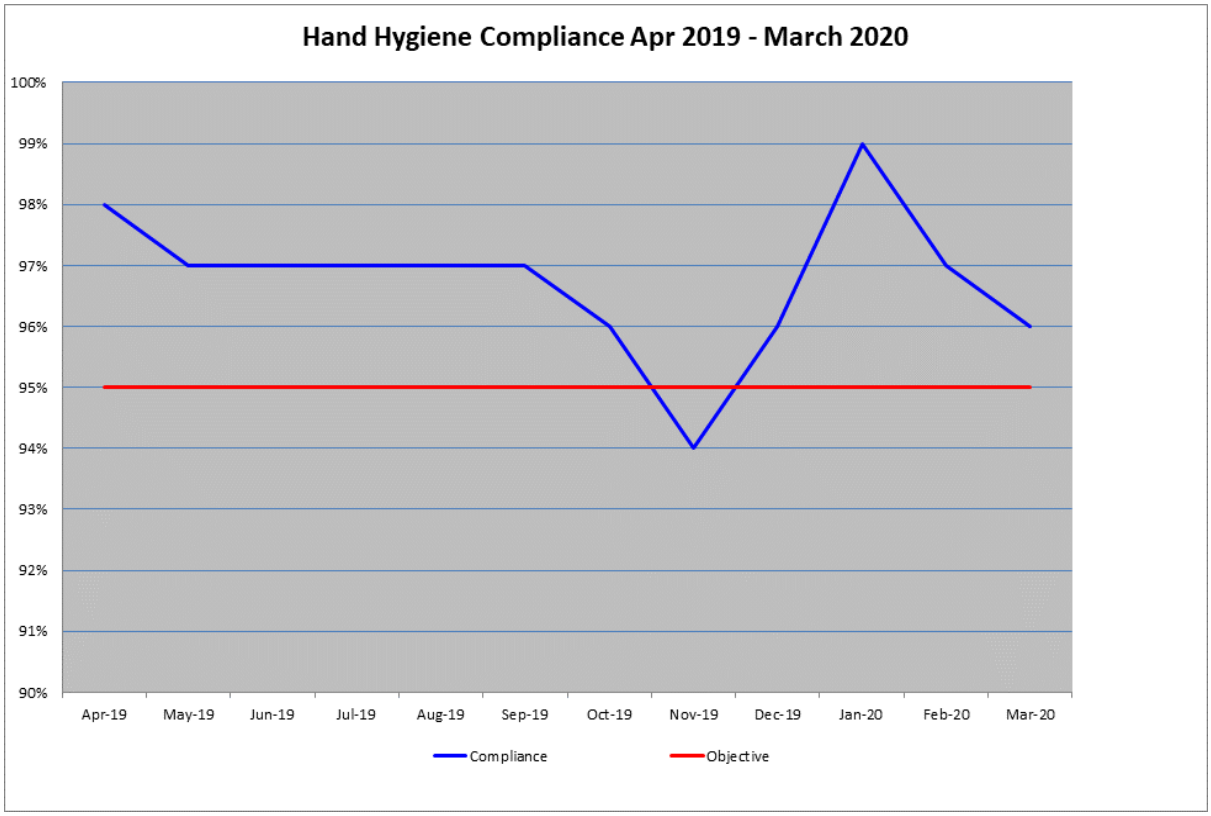
The Trust has also continued to support the Clinical Commissioning Group with whole health economy improvements to reduce risks associated with Gram-negative bloodstream infections, as part of the national improvement programme for these infections



Data Source : IPC Team



Data Source: IPC Team



Data Source: IPC Team

Continuous improvement in infection prevention and control remains a key priority for the Trust and working collaboratively with NHS Improvement within year has focussed on re-enforcing and developing existing infection prevention and control risk reduction measures including:

- Antimicrobial stewardship;
- Infection prevention and control policy supported by training and education;
- Robust programmes for audit, surveillance and investigation for early risk identification and action;
- A clean and appropriate environment for healthcare delivery, including appropriate decontamination of equipment; and
- Sharing learning through effective communication to support real-time improvement.

In addition, investigation for certain infections can provide valuable learning for focussed improvement, including process redesign and consideration of doing things differently. Rapid sharing of any learning from investigations has been a core theme within year and varied methods of communicating information have been used, to maintain awareness.

As a result of this, an IPC/HCAI Improvement Plan was developed within year, identifying priority areas for consideration, planning and action and good progress was made within year against the set objectives.

Moving forwards into 2020/21 this improvement plan will be refreshed to incorporate the learning and improvements that have been identified through the Trust's response to the COVID-19 pandemic, including further development and review of the:

- infection prevention and control assurance framework in alignment with the Health and Social Care Act (2008) Code of Practice on the prevention and control of infections and related guidance
- Infection Prevention and Control Strategy Group
- systems and processes for antimicrobial stewardship
- programmes of work to support environmental improvements, including maintenance and environmental cleaning
- methods for sharing learning from healthcare associated infection investigations

This will continue to drive infection prevention and control improvement at all levels of the organisation, with regular monitoring and oversight on progress taking place through the Infection Prevention and Control Strategy Group and established governance systems.

Delivering kind and compassionate care patients and our staff; focused on the health and wellbeing of our staff so they are able to work at their peak and deliver services that are safe, kind and effective for our patients. Our vision is to become recognised as a Trust offering best practice in relation to staff health and wellbeing which in turn will support financial efficiency, productivity, recruitment and retention and the delivery of quality care and experience to our patients.

Our measures of success included;

- Implement an Employee Assistance Program (EAP)
- Provide staff with access to face to face counselling within 5 working days
- Provide staff with access to a telephone helpline (offering expert support and advice) 24 hour per day, 365 day per year

Employee Assistance Programme

Working in healthcare can be stressful for staff particularly in a hospital setting, with busy wards and departments, growing workloads to meet an increasing demand and the complexity of the patient case mix. We are committed to supporting our staff to improve morale, increase motivation and support them to remain in work. During 2018/19 we aimed to implement an Employee Assistance Programme to provide staff the support they needed, quickly.

What have we achieved?

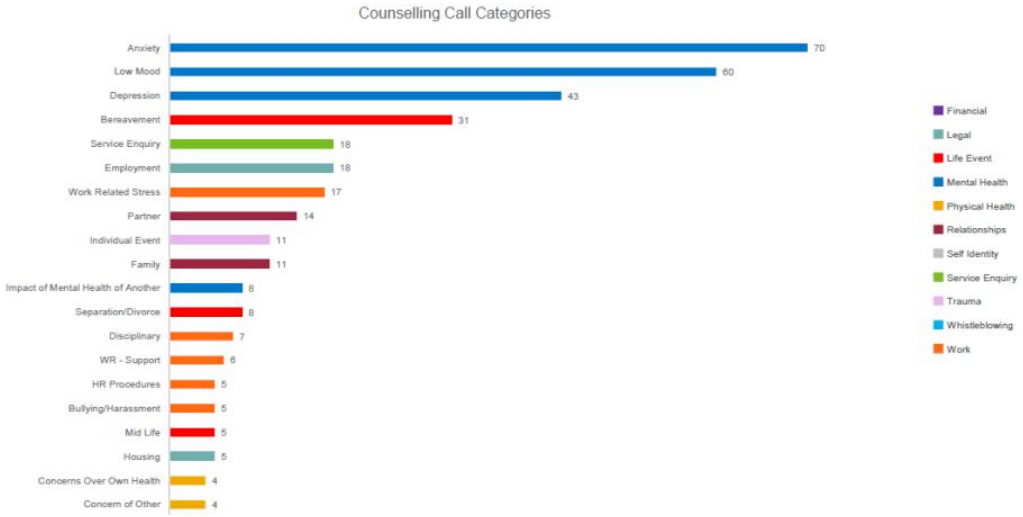
In April 2019 The Countess signed up to a new partnership to provide staff with complimentary access to an enhanced Employee Assistance Programme (EAP). Provided by Health Assured, EAP provides 24 hours a day, seven days a week, and 365 days a year access to a confidential helpline to support staff with personal and professional problems that could be affecting home life or work life, health and general wellbeing. Health Assured offer onsite face to face counselling and further benefits to staff and their families in relation to specific advice such as debt, addictions and critical incident. Managers are also able to access coaching, consultancy and support. The EAP means our staff do not have to wait for staff counselling as EAP provides access to face to face appointments for staff within 5 days,

as well as telephone sessions and online support. This in turn promotes earlier returns to work and contribute to an overall reduction in sickness absence.

Our utilisation of EAP, within the reporting period (April – December 2019), was 12.2%, calculated as counselling and advice calls against employee headcount of 4,093.

A total of 374 calls have been logged. 35 of these were advice calls. Advice calls account for 9.4% of all calls. Employment was the most common reason, accounting for 51.4% of overall advice engagement. This was followed by Landlord & Tenant 11.4% and Divorce & Separation (Legal) 11.4%.

339 of the logged calls were counselling calls and account for 90.6% of all calls. Anxiety was the most common reason, accounting for 20.6% of overall counselling engagement. This was followed by Low Mood 17.7% and Depression 12.7%.



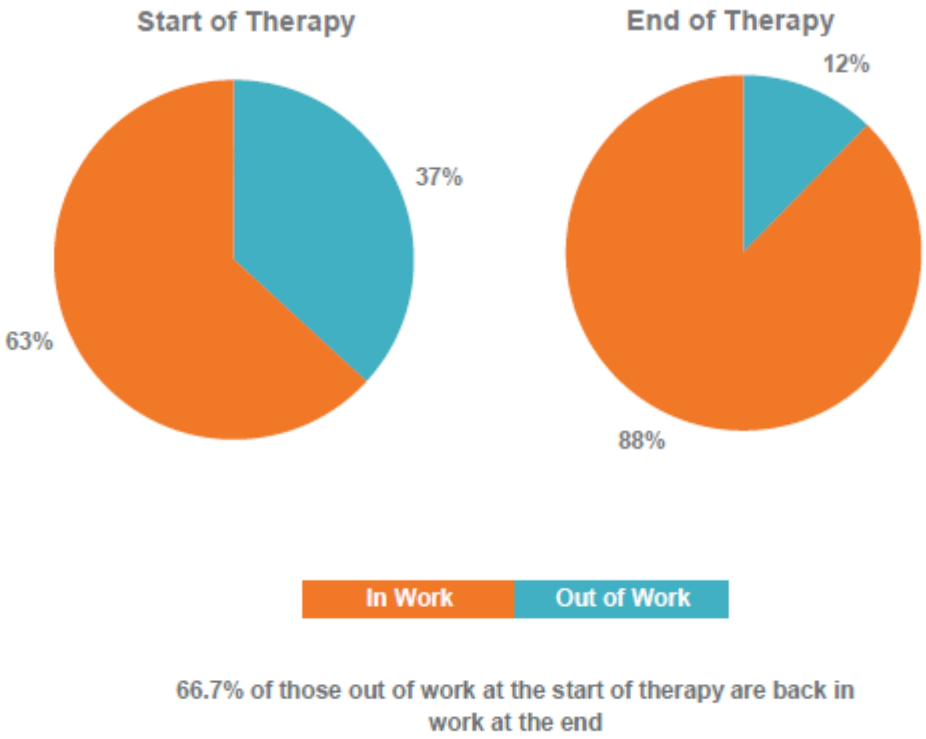
Data Source: Health Assured

In terms of formal counselling engagement there has been:

- 51 referrals for face-to-face counselling, with a total of 223 sessions being delivered
- 10 referrals for structured telephone counselling, with a total of 41 sessions being delivered
- 2 referrals for online counselling, with a total of 0 sessions being delivered

After engaging in structured therapy, the Generalised Anxiety Disorder average score reduced from 2.0 to 1.1 and the average Patient Health Questionnaire score reduced from 1.6 to 0.8.

The Workplace Outcomes Suite demonstrates the value of the EAP and the positive impact that the service is having on employees. At the start of therapy 36.8% of employees were out of work, after engaging in therapy this reduced to 12.3% with 66.7% of employees returning to work. We are proud that our three aims for 2019/20 were fully achieved.



Data Source: Health Assured

Delivering effective services by reducing process variation; we have focused on the way in which we work to ensure we improve the safety, quality and experience of our patients. In particular we concentrated on improving processes, governance and leadership with a focus on patient experience within our Emergency Department, Maternity Services, Cancer Services, Outpatients and Theatres.

Our measures of success included;

- Increase the number of patients that are treated in the Urgent Treatment Centre to 35-45 per day
- An increase in the percentage of suspected cancer patients seen within 7 days
- An increase in the percentage of patients beginning their first treatment for cancer within 62 days following an urgent GP referral for suspected cancer
- 20% of women booking their maternity care with us will be offered the continuity model
- Increase the number of specialities using partial booking
- Reduce the number of 'do not attend' (DNAs) for review outpatient appointments for 'Partial Booking' specialities
- Improve the start times across our operating theatres
- Improve the number of cancellations on the day of surgery
- Increase operating theatre utilisation

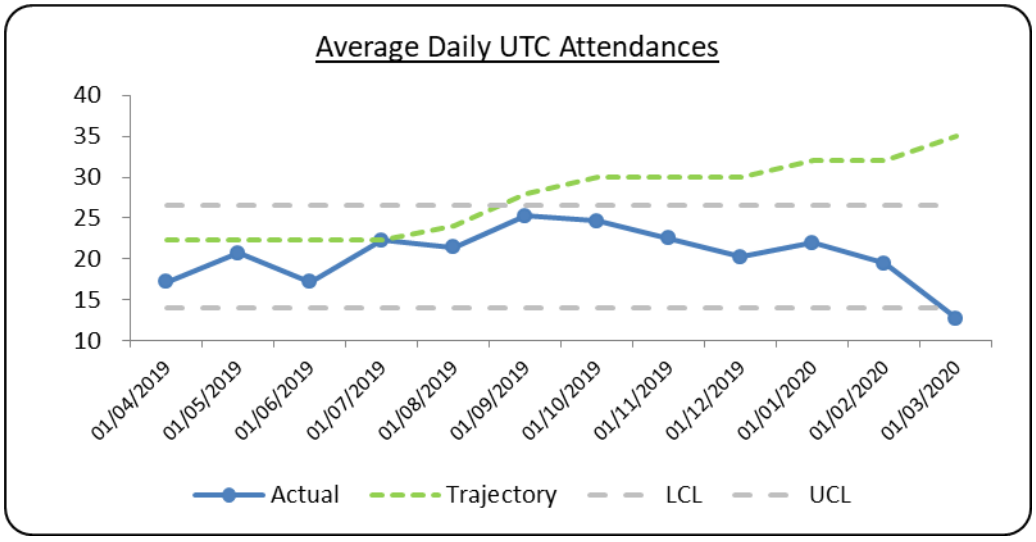
Urgent Treatment Centre

The Urgent Treatment Centre (UTC) was opened in October 2017 to provide patients quicker access to urgent care and treatment provided safely outside of the Emergency Department (ED). With approximately 220 daily attendances to ED utilising the UTC helps to

ease the workload for the ED ensuring patients are seen in an appropriate location and helps to avoid long waits. We know that more of our ED patients could utilise the UTC and are committed to improve their experience by maximising how we use the centre. We recognise the need to work with external partners to increase activity into the UTC and which contribute to an improvement in achieving the 4 hour national standard. We set ourselves a target to increase the number of patients that are treated in the UTC to 35 to 40 per day during 2019/20.

What have we achieved?

We started the year seeing on average 17 patients per day. Due to a number of focused activities outlined below the numbers increased and during September we were seeing on average 25 patients per day across the month. The dip in performance in March was in relation to the Covid-19 pandemic.



Data Source: Meditech (Electronic Patient Record)

We started the year completing a 'perfect week'. The aim of the week was to have a collective focus on rapidly improving patient flow across the Trust to produce a step-change in performance, safety and patient experience. One of these focuses was increasing the number of patients treated in the UTC; during the week we treated 30 patients per day in the UTC on two occasions. We also worked with the Emergency Care Intensive Support Team (ECIST) from NHS Improvement who supported the Trust and local partners better understand the suitability and scope of the clinical provision and its impact on patients. A number of exercises were completed such as a process mapping session to understand the current streaming process and a number of plan-do-study-act (PDSA) cycles to test changes before being implemented. From the process mapping session an ED consultant created, and has held a number of streaming education sessions to help staff identify where best for the patients to be seen and treated. One of the PDSA cycles completed was to test if delivering the UTC from with the ED increased the number of patients seen however; space within the ED was an issue. It was felt that as the UTC is located away from the ED it was not always utilised the best it could, therefore within the new build ED it is planned to relocate the UTC within the department.

Although we did not achieve our target of 35 – 40 patients daily, commissioner led audits have been completed to see from the number of patients seen within ED how many of these could have been treated in the UTC. The numbers for this were small on average 5 patients within the ED could have been treated within the UTC. The UTC is staffed between the hours of 9am to 9pm Monday to Sunday and we will continue to work collaboratively with our partners to ensure our patients are seen in an appropriate location to receive the treatment they require.

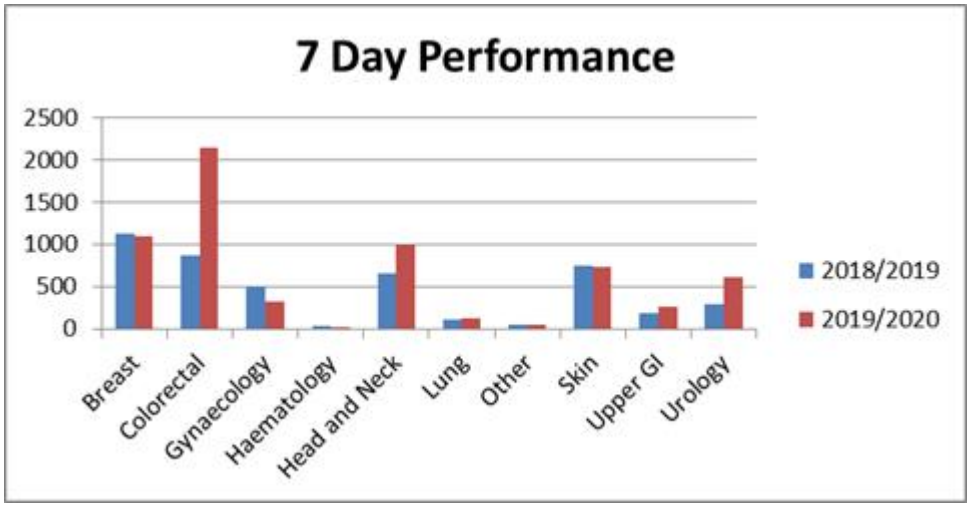
Reducing the waiting times for patients on cancer pathways

We currently see around 97% of patients with suspected cancer for their first appointment within 14 days of referral from a GP but we wanted to improve this further and we aimed to reduce the time to first outpatient appointment for patients on cancer pathways by increasing the number of patients seen within 7 days. To support the achievement of this objective we aimed to work with Primary Care colleagues to ensure that patients understand that they are on a suspected cancer pathway, and are available for appointments at short notice. We also continued to implement different pathway models including telephone consultations with Clinical Nurse Specialists (where appropriate). Earlier contact with clinical professionals provide patients with more timely access to diagnostics and will enable a faster outcome (diagnosis of cancer or ruling out of cancer).

During 2019/20 we aimed to increase the percentage of suspected cancer patients who are seen within 7 days and to increase the percentage of patients beginning their first treatment for cancer within 62 days, following an urgent GP referral for suspected cancer.

What have we achieved?

The Trust has shown an improvement in the number of patients seen within 7 days. Figures for 2018/2019 showed that 39.2% of patients were seen within 7 days whereas the figures for 2019/2020 is showing 52.2% of patients had their first appointment within this time frame. The main areas of improvement have been seen in Colorectal, Head & Neck, Lung and Urology. The introduction of Cancer Nurse led telephone clinics for first appointment has shown an improvement in both Colorectal (46% increase) and Urology (32.5% increase), so allowing for patients to be contacted, assessed and first diagnostic tests ordered. The Lung team have implemented and improved the Lung Optimal Pathway allowing patients to attend for first appointment after initial diagnostics undertaken. Improvement work within Head and Neck has been supported with the recruitment of a Cancer Nurse Specialist, review of clinic templates and more recently a new Neck Lump clinic.



Data Source: Meditech (Electronic Patient Record)

The Trusts 62 day performance has seen a small decrease from 83.93% last year to 82.71%. In the past year the Trust has seen on average 8% increase in referrals each month. The challenges in achieving this target continues to be diagnostic capacity particularly in endoscopy, which has been influenced by an increase of approx. 21% in referrals in Colorectal and 13% in Upper GI compared to last year. These tumour sites have a direct impact on Endoscopy for diagnostic procedures and also create capacity issues for specific tests in Radiology. There have been workforce issues in particular tumour groups in recruitment of consultant posts which has seen a reduction in capacity across the pathway for appointments, diagnostic and theatre capacity.

Work continues across all tumour groups to improve pathways and positive improvements have been seen in Head and Neck with a new Neck Lump clinic, allowing first diagnostics on day of clinic, introduction of telephone clinics for first appointments in a few tumour groups, and work is ongoing with the CCG to implement the FIT pathway which will allow an initial diagnostic screening of patients by the GP.

Continuity of Carer Model

Continuity of Carer (CoC) means that women have consistency in the midwife that provides care for her and her baby throughout her maternity journey we promised that 20% of women booking their maternity care with us will be offered the continuity model. Better Births (a report from the National Maternity Review 2016), and the Five Year Forward View of the NHS Maternity Services in England 2014, set out a vision for maternity services to be safe and personalised. At the heart of this vision was the ambition that women should have provision of care by a known midwife throughout their pregnancy, labour, birth and postnatal period. This continuity has shown to improve health outcomes and safety for ladies and their babies and has demonstrated greater satisfaction levels.

What have we achieved?

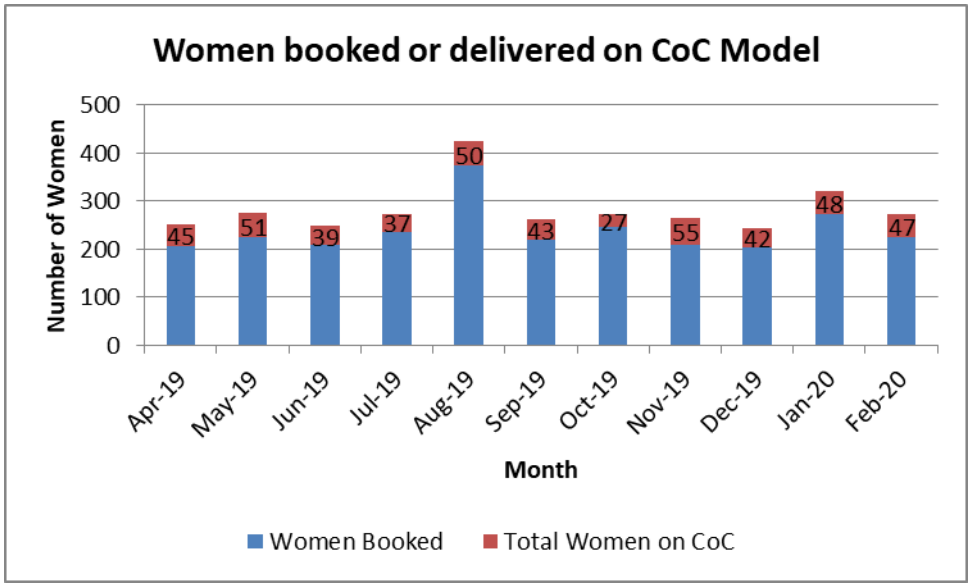
We have developed a model to meet the needs of our local population with a focus on offering the CoC model to women who require low risk (i.e. no medical conditions or complications of previous or current pregnancy) Midwifery-Led Care.

We have a community based team of five midwives, named the Rowan Team, who are able to provide all aspects of care at home or in the Midwife Led Unit (increasing choices for local women, providing a 'home from home' environment). Every woman has a named midwife who provides continuity throughout the pregnancy, birth and postnatal care. The named midwife sees the woman and family for the majority of the pregnancy but the team also offer 'Meet the Midwives' where the whole team can be met and a 'buddy' will be identified. If for any reason the named midwife is not available the midwife will still be known by the woman. The Rowan team provide antenatal education classes and hold clinics in local 'hubs' and children centres, as well as providing home visits.

Midwifery-Led Care is provided almost entirely by midwives however, if there are concerns or complications midwives will refer to another specialist. If for any reason the care cannot continue as Midwifery-Led Care, 'Shared Care' with a consultant will be provided. If the woman requires an elective caesarean section the team will still offer ladies booked through CoC, their named midwife to be present at the birth.

We set ourselves a target to offer 20% of women to book onto the CoC model. We captured this data monthly and included; women who were booked for CoC at their first appointment, and women added during their pregnancy.

Data for March 2020 is not available as the Rowan team had to dismantle to support staffing gaps due to Covid-19.

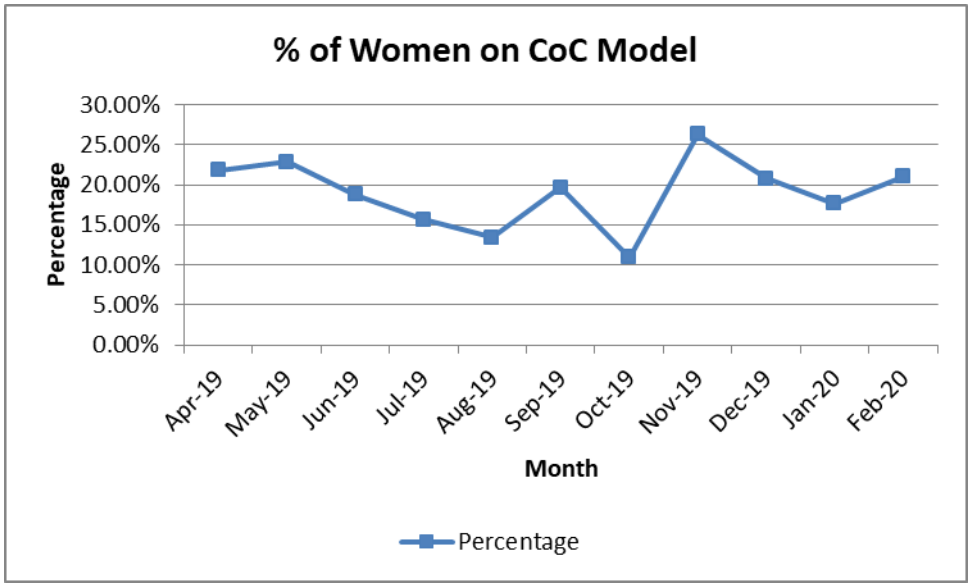


Data Source: Meditech (Electronic Patient Record)

In total we booked 2,618 women for care at the Countess during the reporting period (April 2019 – February 2020) and of those 484 women were all provided the CoC model. This means that in total 18.48% of women were booked for CoC, just missing our target of 20% for the year. However, you will see that we met our target of 20% on five occasions throughout the year.

''I had my community midwife Helen there with me which was so comforting, especially as Helen was also my midwife with my daughter 2 years ago. I've built up a fantastic relationship and I felt at ease throughout my whole pregnancy and that I could always call for help no matter how silly I felt. Honestly, I could write a book with how happy I am. I can't recommend Helen and the staff at the Countess enough''

You will also notice that during August we had an increase in maternity bookings. One To One Midwives, an independent company that provided midwifery services, went into administration in July 2019 this meant we saw a dramatic increase in the number of women being booked into our care which had an impact on our community midwives as they had largely increased caseloads. As you can see the data stabilised again finishing off the year by meeting our target.



Data Source: Meditech (Electronic Patient Record)

Due to the success of the CoCH model we are looking to increase the numbers of midwives in the Rowan Team to eight within the next financial year, enabling us to offer CoCH to more women and branching out from the geographical area. We will continue to monitor the progress of this important project and work with maternity voices partnership (MVP) to develop services which are truly based around the needs of women.

Partial Booking

When a service user attends the outpatients department and they need a 'review' or 'follow up' appointment at a future date, we book the patient into the next available clinic slot within the relevant time scale (as advised by the clinician) but this can sometimes be 6 to 12 months in advance. If appointments are made too far in advance the chances that the patient cannot attend the appointment or the hospital may need to rearrange the appointment increases and as a result appointment slots may be lost and/or not utilised. Partial Booking offers a system where the patient will be sent a reminder text or letter 6 weeks before their appointment is due and they will be asked to phone the hospital to arrange a mutually convenient appointment date.

The benefits of using a 'Partial Booking' system include:

- We are offering the patient more choice (appointment date and time)
- We will be reducing Do Not Attends (DNAs) and cancellations
- We will be reducing rework for appointments staff
- We will be improving patient experience (reducing complaints)

We aimed to increase the number of specialties using partial booking and roll out across all specialties during 2019/20 to reduce the number of 'review' outpatient appointment DNAs.

What have we achieved?

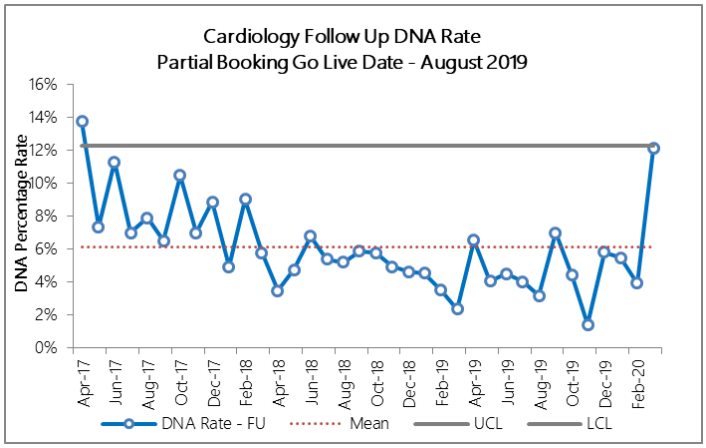
A partial booking roll out plan was created which initially included 30 specialities. Seven of these were identified as not suitable due to the complexity of the patient pathways and four have been put on hold due to workforce and capacity issues within the specialities. This

meant that there were 19 specialities identified suitable for partial booking, seven specialties went live during 2019/20 with one speciality already going live in 2018.

Speciality	Partial Booking Go Live Date
Rheumatology	August 2018
Cardiology	August 2019
Gastroenterology	October 2019
Hepatology	October 2019
Pain	October 2019
ENT	December 2019
Paediatrics	February 2020
Trauma & Orthopaedics	March 2020

We had set ourselves an ambitious target to have all specialities live on partial booking as a huge amount of preparation work is needed for each speciality before it can go live. This includes staff training and validating the queue (patient waiting list). We reset our target to have all specialities suitable for partial booking live by August 2020.

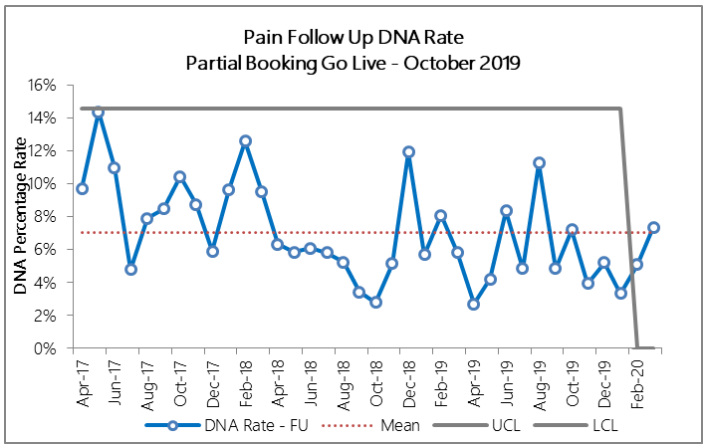
For the specialities that did go live with partial booking during 2019 (as Paediatrics and Trauma & Orthopaedics have only just gone live there is currently no data as the first appointments are currently six weeks ahead of the go live date), a reduction in DNAs can be seen for the majority of specialities. The data and dashboard for Hepatology is currently in development.



Data Source: Meditech (Electronic Patient Record)

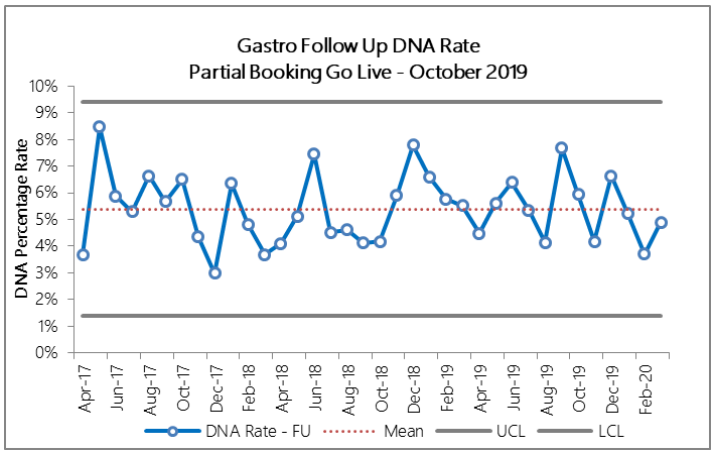
Cardiology partial booking went live in August 2019, as you can see from the graph above there was a successful decrease in the percentage of DNAs, in November this dropped to just 1.42%. The DNAs continued to stay below the average of 6.9% until March 2020 when

they more than doubled the average however, we are confident that this was due to the Covid-19 outbreak.



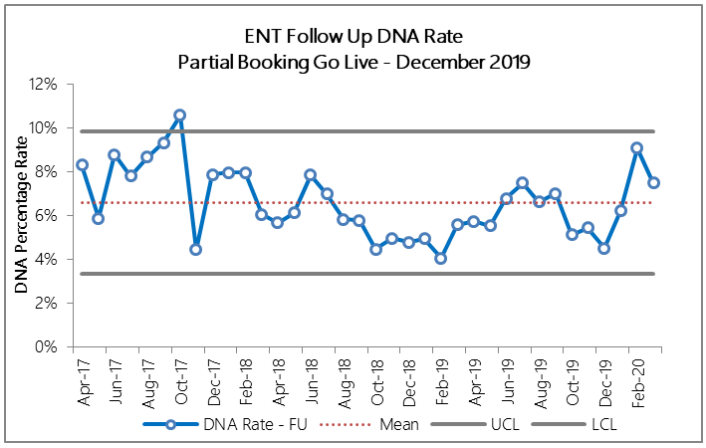
Data Source: Meditech (Electronic Patient Record)

Pain went live with partial booking in October 2019 when DNAs were sitting at an average of 7.21%. Following go live, the DNA decreased sitting at 3.33% in January. There was a slight increase in February but still comfortably below the average of 7.03%. Again we see a slight increase in March's data which we believe to be related to the pandemic.



Data Source: Meditech (Electronic Patient Record)

Gastroenterology also went live with partial booking in October 2019, DNA rates were averaging 5.39%. A reduction was seen following go live and in November rates dropped to 4.17% however, this rate did not sustain and in December we saw a peak in DNAs. This has successfully dropped below the average for the last three consecutive months.



Data Source: Meditech (Electronic Patient Record)

ENT went live with partial booking in December 2019 where the DNA rate was sitting below the average 6.6%. Unfortunately we have seen an increase in the number of DNAs. We will work with the speciality when the outpatient services resume following the pandemic to improve.

We are pleased that we achieved an increase in of the number of specialties using partial booking however; we recognise there is still a way to go. The partial booking roll out will continue but due to covid-19 we have had to postpone any further roll out until the outpatients functions return to normal. Work on validating the queue can continue during this time to prepare for the continued roll out.

Operating Department Improvements

Operating Department improvements are essential to ensure that the environment is efficient and effective when it comes to the delivery of patient care.

It is very frustrating for patients and the hospital if operations are cancelled on the day of surgery. When preparing for an operation many patients will have changed their usual routine (at work and/or at home) and may have built up physically, emotionally and spiritually for the procedure planned. The inconvenience caused can result in missed medications, unnecessary starvation and additional anxiety and distress for patients and a loss in theatre time for the hospital. Operations are cancelled on the day of surgery for a variety of reasons, the most common is due to the availability of beds within the hospital but there are also other common themes, these include;

- Consent and patients understanding of procedure
- Patient has not received and/or followed the pre-operative advice
- Procedure is no longer required
- Patient not arriving

We set out to improve the number of cancellations on the day of surgery as well as improving the start times across our operating theatres and increasing operating theatre utilisation.

What have we achieved?

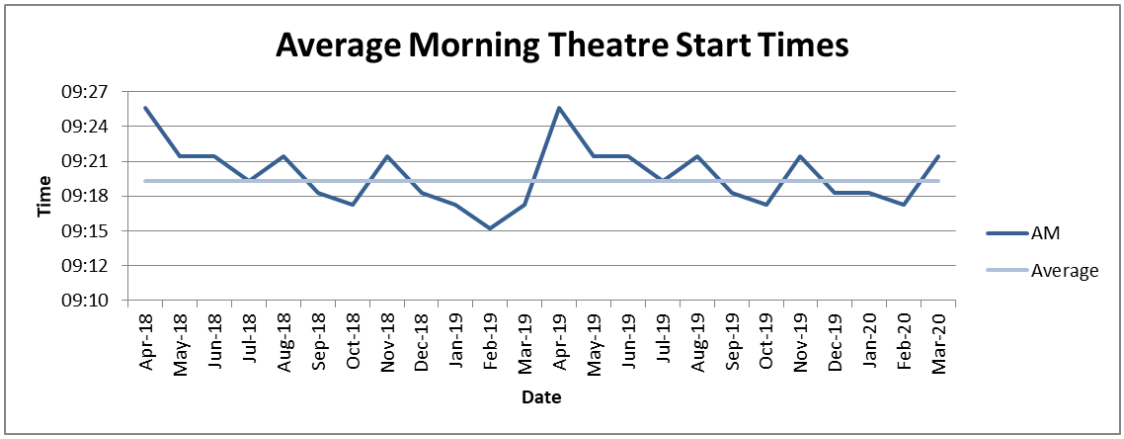
We are pleased that we have seen an improvement in the number of cancellations on the day of surgery that we have had. On average we have had 188 cancellations per month during 2019/20, down from 203 per month in 2018/19. A new process has been actioned which requires all potential cancellations now have to be escalated through a dedicated escalation process for both clinical and none clinical cancellations. Before any patient is cancelled the Theatres Matron, Theatres Service Manager and the Planned Care Manager of the day are informed to ensure robust exploration of other options has taken place.

Failed to Attends (or FTAs – when a scheduled patient does not come in as planned and fails to tell us) have dropped across all theatres too during 2019/20, we now average 9.6 FTAs per month, down from 10.16 in 2018/19. This reduction will be partly due to a robust reminder service being in place via both text messaging and automated calls.

By reducing our cancellations we would expect to see an increase in operating theatre utilisation however, the number of sessions used has dropped slightly year on year. During 2019/20 we have used 89.5% of available sessions (90.5% in 2018/19). This number has been impacted by the Covid-19 pandemic in March 2020 as well as losing some Day Case capacity in December 2019 when a car struck the building causing structural damage to one of the theatres.

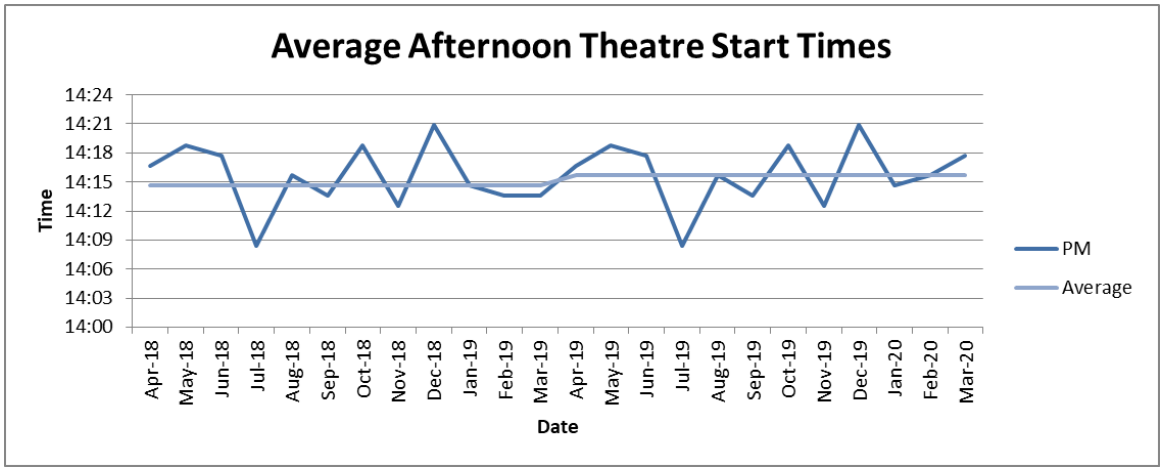
We have also seen a drop in session utilisation (measured from first patient in to last patient out) from 80.5% to 77.3% however; if we exclude March 2020 (Covid19 period) this improves slightly to 78.8%. There are a number of contributing factors to this drop in performance (activity has stayed reasonably similar year on year dropping 0.6% in 2019/20 compared to the same period in 2018/19) including seeing more complex patients with longer anaesthetic times.

We set out to improve start times across our operating theatres to maximise theatre utilisation. In 2018/19 our average start time in all of the 15 theatres was 09:20 for the morning list and 14:16 for the afternoon list, during 2019/20 reporting period the morning session stayed the same and the afternoon list has increased by a minute.



Data Source: Qlikview

In the morning we now identify ‘golden patients’, these are patients who we know will either have to go through to theatre (i.e. cancers patients) or those who are day case, to allow us a fast start. These patients are changed ready for theatre as early as possible to allow a timely ‘call for’ between 08:30 and 08:45. We believe this will contribute to better start time across theatres in the morning.



Data Source: Qlikview

We have seen a minute increase in the average afternoon start times and we believe this stems from overruns from the morning. This can be due to multiple factors such as the late start time in the morning and accommodating complex patients being operated on in the morning. We will continue to improve our average start times and we will continue to monitor this via the recently formed Theatre Resource Group.

3.2 Performance against the relevant indicators and performance thresholds

Indicators

Indicator	Target	Performance	Explanation
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	**92 %**	**84.1%** March 2020	See page 73 for further information
A&E: maximum waiting time of four hours from arrival to admission/ transfer/ discharge	**95%**	**81.7%** Overall 19/20 performance	Throughout the year there were a series of continuous improvement events across a range of key areas including workforce, and patient flow. In December 2019 this was elevated into a more intensive Improvement Programme delivering significant changes in pathway,

			process, workforce and environment which resulted in marked improvement in performance February & March 2020
All cancers: 62-day wait for first treatment from: Urgent GP referral for suspected cancer	**85 %**	**82.67%** (YTD at Feb 2020, latest figures)	See page 74 for further information
All cancers: 62-day wait for first treatment from: NHS Cancer Screening Service referral	**90 %**	**95.97%** (YTD at Feb 2020, latest figures)	See page 74 for further information
Maximum 6-week wait for diagnostic procedures	**99 %**	**80.8%** March 2020 (reported now against 1% target for breaches, so: 19.2%)	The fall in diagnostic performance was due to the restrictions associated with the Covid19 pandemic. Routine diagnostic imaging was halted to ensure that urgent clinical activity could be met, along with reduced staff being available for both primary imaging and reporting. The department are currently working on a recovery plan and utilising third party providers where possible.

Data source: Monthly National Situation Report (unify)

3.3 Progress against seven day hospital services

It is important to ensure timely access to expertise and diagnostic test whenever patients may need them. In 2013 Sir Bruce Keogh developed a number of standards to support seven day service delivery. In 2016 NHS England further defined the recommendations and outlined the requirement for all acute hospitals to have four priority standards in place to maintain patient safety and ensure a quality experience regardless of the day of the week the person was admitted or their clinical condition dictated they needed it.

The four priority standards are;

- Standard 2 – Time to first consultant review
- Standard 5 – Access to diagnostic tests

- Standard 6 – Access to consultant-directed interventions
- Standard 8 – Ongoing review by consultant twice daily if high dependency patients, daily for others

These standards are audited nationally every year. Below is information on how we are doing at the Countess in relation to ensuring these standards are met based on the latest data available – November 2019

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.	For urgent care, on the working hours of the weekdays, patients are seen and assessed by a consultant on a rolling basis. This system is in place from 8:00 am to 9:00pm. The Acute medicine consultants are present on the admission unit/ GPU and within A&E till 6:45pm and the General Medical consultant is on the floor from 6:45pm to 9:30pm. Overnight admissions are reviewed at the morning ward rounds. On the Weekends, there is similar presence of General Medical Consultant for post take ward round from 8:00am to 9:00pm.	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Standard Met

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 5: Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: • Within 1 hour for critical patients • Within 12 hour for urgent patients	Q: Are the following diagnostic tests and reporting always or usually available on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs, in the appropriate timescales?	Microbiology	Yes available off site via formal arrangement	Yes available off site via formal arrangement	Standard Met
		Computerised Tomography (CT)	Yes available on site	Yes available on site	
		Ultrasound	Yes available on site	Yes available on site	
	We provide access to the diagnostic procedures listed opposite seven days per week. For some specific diagnostics, the procedure may occur off site for clinical or operational reasons, but these arrangements are formalised with healthcare system partners	Echocardiography	Yes available on site	Yes mix of on site and off site by formal arrangement	
		Magnetic Resonance Imaging (MRI)	Yes available on site	Yes mix of on site and off site by formal arrangement	
		Upper GI endoscopy	Yes available on site	Yes available on site	

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 6: Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.	Q: Do inpatients have 24-hour access to the following consultant directed interventions 7 days a week, either on site or via formal network arrangements?	Critical Care	Yes available on site	Yes available on site	Standard Met
		Interventional Radiology	Yes available off site via formal arrangement	Yes available on site	
		Interventional Endoscopy	Yes available on site	Yes available on site	
		Emergency Surgery	Yes available on site	Yes available on site	
	We provide access to the full range of consultant directed interventions listed opposite seven days per week	Emergency Renal Replacement Therapy	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
		Urgent Radiotherapy	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
		Stroke thrombolysis	Yes available on site	Yes available on site	
		Percutaneous Coronary Intervention	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
		Cardiac Pacing	Yes available on site	Yes available off site via formal arrangement	

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 8: All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.	Patients on the Care of Elderly Medicine wards have two comprehensive ward rounds a week and have access to daily consultant input on the weekdays. Over the weekend these patients (like all other medical inpatients) are cared for by the on-call medical team which is led by the on-call consultant. Within the activity of Geriatric Medicine there are various areas that require 7 day working and among them - Stroke Medicine has 7 day consultant cover as part of the established rota; The emergency Multidisciplinary unit functions from 9-5 on the weekdays but the weekend cover on A&E by geriarticians is patchy and depends upon colleagues taking on extra shifts.	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency	Standard Not Met
		Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	Twice Daily: No the standard is not met for over 90% of patients admitted in an emergency	

Since 2015, there have been several changes in the working of the Geriatric medicine department. There has been expansion of the bed base, initiation of the Frailty service in A&E and introduction of the surgical liaison service. There has been an improvement in Stroke Medicine and Orthogeriatrics which has been reflected in the national audit data. With regards to the 7 day services and availability of resources, the department is in the same situation as the rest of the Urgent Care division. For Stroke Medicine, there is 24/7 rota of senior medical cover which ensures timely decision making and reviews of patients as needed. The Emergency Multidisciplinary Unit (The Frailty service within A&E) works 9-5 on the weekdays but is not covered out of hours or on the weekends. Weekend frailty rounds by geriatricians is done on an ad-hoc basis but depends on colleagues willing to take on extra shifts. The recent NHS pension's fiasco has adversely affected the running of this service. There is no weekend cover for the liaison services to Orthopaedics or Surgical Teams.

We have worked closely with the NHS Improvement 7 Day Services Regional Team to ensure that compliance with the four Priority Clinical Standards for 7 Day Services is assured. This is now, as of November 2019, enacted by local Board Assurance to fulfil the changes to this process stipulated by NHS Improvement. We enjoy full compliance on all relevant sections of the four Priority Standards. Within the freedoms of the revised local Board Assurance mechanism, will be working with our clinical teams through 2020/21 to explore the opportunities available to us to use the remaining six Clinical Standards to drive forwards further improvements within their scope.

3.4 Staff Speak Up Opportunities

The continued focus on the Freedom to Speak Up (FTSU) agenda supports and compliments the work within the Trust to ensure we embed a culture that is open, honest and transparent.

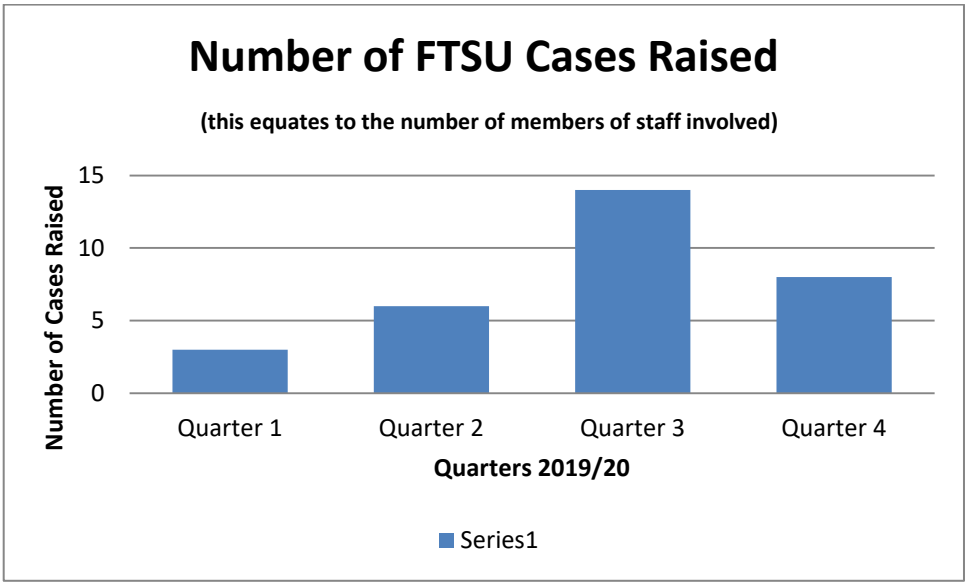
With the appointment of a substantive dedicated FTSU Guardian in May 2019 increased awareness of this important agenda throughout the Trust has continued as a major priority. The Guardian has ensured that there have been and will continue to be opportunities to meet with staff in order to increase knowledge about how concerns can be raised and support managers to increase their confidence in dealing with concerns when raised to them. The Trust has revised its FTSU policy in line with national recommendations and developed a strategy that highlights the aims of the service moving forwards. This ensures that every staff member understands the role they have to play in ensuring both patients and staff experiences are positive. A FTSU webpage on the Trust intranet has been launched providing information for staff that includes both local and national reports, learning tools, links to partner organisations and service updates. In addition every ward and department now has a FTSU Information Folder ensuring that those who do not have easy IT access are not disadvantaged.

Engagement sessions have continued with the Guardian present at induction days, forums and drop in sessions in order to further ensure that staff understand the importance of speaking up and feel confident to do so. Details of the confidential telephone line and designated email are widely publicised throughout the Trust with staff encouraged to make contact even if they are unsure if the concern that they have needs to be raised. Feedback

to those that do raise a concern is relayed verbally and through email or text. Staff are always thanked for raising their concern as it is recognised that for many this is not always easy. All contact between the Guardian and the staff member is confidentially recorded and data is stored in line with the Information Governance policy and good practice guidance from the National Guardians Office.

As predicted since the appointment of a dedicated Guardian the number of concerns raised has continued to increase from a range of staff groups however, they are in line with the number of concerns raised in other comparable trusts across England. The Trust ensures that individuals do not suffer detriment when they raise a concern but are supported throughout the process and have access to the Guardian throughout the process and on its conclusion.

The Trust is required to submit speaking up data to the National Guardians Office on a quarterly basis for national publication. The Trust's submissions for 2019/20 are as follows:



During 2019/20 a total of 31 cases were raised, compared to 10 cases the previous year we have seen a 210% increase.

3.5 NHS Doctors and Dentists in training

The Trust tracks medical staff vacancies of all types on a daily basis and deploys its resources mapped to demand across all specialties. Vacancies arise through regional school trainee allocation variances, maternity and paternity leave, sickness and planned leave. Where feasible, substantive fixed term contracts are enacted to back-fill required resource; in other instances, bank and agency staff are contracted. Our additional spend in relation to vacancy management is controlled at Divisional level with Medical Director oversight.

Current vacancy status 31st March 2020

Grade	Urgent Care		Planned Care		Diagnostic	
	Gaps	Filled /appt made	Gaps	Filled /appt made	Gaps	Filled /appt made
Consultant	4	0	1	0	5	4*
ST3+	1.8	0	3	1	0	0
ST1/2	2.4	2	8.6	1		
Specialty Doc	0.6	0	1	0		
F2	0	0	2	2		
GP Trainee			1	0		
TOTAL	8.8	2	16.6	4	5	4*

- **2 consultant posts filled on temp basis with specialty doctor**

Medical Staffing Managers within the Cheshire & Merseyside region have developed a set of terms and conditions for Locally Employed Doctors to enable equity across the footprint as to how we employed and pay our Locally Employed Doctors. Trusts are in negations with their own British Medical Association (BMA) representatives and Joint local negotiating Committees (JLNC) in agreeing to adopt the Terms and Conditions. It is hoped that this will improve the recruitment and retention of Locally Employed Doctors. The Cheshire & Mersey Medical Staffing Managers Group are also beginning to work with other Regions in adopting theses terms and conditions and also the rates paid for medical agency locums to enable consistency across the North West and beyond. The aim is to drive down the agency rates for all Trusts and all Trusts are paid the same rates for each grade of medical staff, to the point where it is not beneficial to the doctor to work via agency and encourage them to come back in to employed status by the Trusts. Work on this still continues.

All Junior Doctors Rotas are fully compliant with the 2016 junior doctor's contract, and junior doctors are completing exception reports when necessary.

In accordance with the 2016 Medical Terms and Conditions of Service for Junior Doctors the FT has appointed a Guardian of Safe Working Hours to oversee the FT's adherence to the terms and conditions. An Annual report and quarterly exception reports are reported to the Trust Board the reports provide assurance on the exception reporting processes and the actions being taken as a result of the exception reports that have been raised

ANNEX 1

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

Statement from the Trust's Council of Governors 2019/20

Despite another year of change and challenge, the Council of Governors acknowledges the commitment and effort of the executive team in pursuing the quality agenda across all aspects of the Trust's operations.

We welcome the significant progress that has been made in those areas previously deemed by the CQC to require improvement.

What is less satisfactory however is that of the Trust's 11 key quality priorities for 2019/2020 two have yet to be fully completed.

Despite this, we welcome the many improvements that have been achieved in quality processes, performance and compliance across the organisation, particularly in areas including sepsis reduction and in the introduction of e-observations, an innovation that will have a major impact on safety and efficiency going forward.

The Trust is continuously faced with different and varying pressures and challenges whether seasonal, financial or staffing. More recently we have been faced with a pandemic. What remains a constant, and has never before been so dramatically brought into focus, is the undiluted professionalism, selflessness and unswerving commitment of our front-line teams and individuals.

They exemplify quality. It is for the rest of us to match their standard in the development and delivery of our processes, procedures and operational environment.

Covid-19 appears to be here to stay. Uncertainty around its management and development as we approach the winter season will inevitably present ever more challenges to the way the Trust operates and manages its resources.

The Council of Governors accepts that these matters will inevitably impact on the broad spread of welcome plans and initiatives outlined in this document which are intended to further raise the bar on improving quality standards across the three main areas of Patient Safety, Clinical Effectiveness and Patient Experience.

That's not to say that Covid-19 will diminish in any way the Trust's focus on quality or ever be allowed to excuse any fall in standards. What it may mean, though, is that some of the planned improvements may be impacted in the timescales that have been set for them.

The Council of Governors will continue to monitor progress through its evolving collaborations with the NEDs, through its own continuing dialogue with the executive team and, when circumstances allow their reintroduction, through various initiatives including its valued 'GovRounds' observation visits to wards and support services.

Statement from West Cheshire Clinical Commissioning Group 2019/20

We are committed to commissioning high quality services from our providers and we make it clear in our contract, the standards of care we expect to be delivered. We manage

performance through regular progress reports that demonstrate levels of compliance or concerns. It is through these arrangements that the accuracy of this Quality Account has been validated.

The Quality Account illustrates the range of work that the Trust has undertaken over the past year. We would like to acknowledge your focussed response to the 2018 CQC overall rating of 'Requires Improvement' and recognise the programme of comprehensive actions across all areas, plus your organisations commitment to ensure that you move to a 'Good' CQC rating.

The Trust's Clinical Strategy and the Corporate Strategy, along with measures such as the Ward Accreditation System, taking a 'Think Family approach' and listening to patient feedback, will support your focus on fundamental care standards. Embedding new technological methods of record keeping, remote consultations and sharing medical results from investigations will also support you in achieving these goals.

Patient safety is a key theme throughout the account and we commend the approach of Patient Safety Summits. In particular we note the significant work to improve compliance with the sepsis quality measures and we are encouraged by the steps taken to review the governance processes. We look forward to seeing the impact of the '60 day Countess Sepsis Challenge'. However we remain concerned that since 2016/17 the Trust has reported that it was unable to consistently achieve best practice in the recognition and management of sepsis. We therefore support the need for this to remain a priority for 2020/21.

We recognise that the learning captured through the Covid-19 pandemic, as well as your comprehensive audit programme, clinical research and Falls Quality Improvement Programme will lead to improved patient care.

We are also cognisant that nationally all providers face huge staffing challenges and the Trust are to be congratulated on the additional efforts put in place to retain staff, in particular the offer of support to staff at all levels of your organisation. The steps you have described in this report to ensure your staff feel valued, to support wellbeing, improve morale and support the retention of clinical staff across your Trust are particularly positive.

Feedback from your Patient Experience Operational Group and the Lived Experience Panel will enhance your opportunities to respond to insight from patients. Working with Cheshire Care Communities, Cheshire and Mersey Health & Care Partnership and the Cheshire West Integrated Care Partnership will further add to this learning and we look forward to seeing what innovative improvements come of this.

We support the priorities that the Trust has identified for the forthcoming year and look forward to continuing our partnership approach to assuring the quality of commissioned services. Furthermore we look forward to supporting you to achieve your priorities for improvement across patient safety, clinical effectiveness and patient experience.

In closing, we are of the opinion that this account provides a balanced picture of the Trust's performance during 2019/2020 and would wish you every success for implementation of the planned quality improvements in 2020/21.

Statement from Healthwatch 2019/20

Healthwatch Cheshire West has worked in partnership with the Hospital over the period covered by this report forming close working relationships with staff at the hospital through a number of opportunities

- Regular Enter and View Visits – to a number of departments at the hospital
- Representation at Patient Quality and Experience meetings
- Engagement at the hospital on a regular basis
- 12 Hour A&E Watch

Healthwatch Cheshire West feels this quality account, broadly reflects the work undertaken at the Countess over the period and particularly would like to praise the organization for its work in the following areas:

- For setting high aims on targets
- Asking the question ***Why is*** something ***important***
- For being open and honest, and learning from experience.
- For setting priorities of improvement in regard to improving patient experience.

Specific comments on the report:
We felt the report was logically laid out and easy to read.

We were impressed by the continuation of the Sepsis Programme, which exceeded targets over 5%.

Healthwatch welcomed the knowledge of working with partner agencies supported the reduction of patient, family and advocacy complaints.

The table on page 62 shows the number of falls over the trajectory given by the hospital. However, we recognise the hospitals commitment to the Falls Prevention Programme and the actions taken to improve this.

We were impressed by the Community of Care Model and the positive work and results the programme is showing.

Statement from Overview and Scrutiny Committee 2019/20

Requested but not received

.

ANNEX 2

Statements of directors' responsibilities for the quality report

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

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

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

- the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2019/20 and supporting guidance Detailed Requirements for Quality Reports 2019/20;
- the content of the Quality Report is not inconsistent with internal and external sources of information including;
    - Board minutes and papers for the period April 2019 to May 2020
    - papers relating to quality reported to the board over the period April 2019 to May 2020
    - feedback from commissioners, dated August 2020
    - feedback from governors, dated August 2020
    - feedback from local Healthwatch organisations, August 2020
    - feedback from Overview and Scrutiny Committee, requested – not received
    - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
    - the 2018 national patient survey, published in June 2019
    - the 2019 national staff survey, published in February 2020
    - the 2019/20 Head of Internal Audit's annual opinion over the trust's control environment, March 2020
    - Care Quality Commission Inspection, dated May 2019
- the quality report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the quality report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- the quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the board

Date: .....Chairman

Date: .....Chief Executive

Meeting	**1st December 2020**		**Board of Directors**					
Report	**Agenda item 17.e**		**Council of Governors Chair's Report**					
Purpose of the Report	Decision		Ratification		Assurance		Information	**x**
Accountable Executive	Chris Hannah				Chair			
Author(s)	Keith Haynes Debbie Bryce				Interim Governance Consultant, Lead for Governance Improvement			
Board Assurance Framework	-							
Strategic Aims	-							
CQC Domains	Well Led							
Previous Considerations	The previous Council of Governors Chair's report to Board of Directors was on 8 September 2020							
Summary	This report is intended to provide a summary update of business from the Council of Governors meeting held on 1 October 2020.							
Recommendation(s)	The Board is asked to note the report.							
Corporate Impact Assessment								
Statutory Requirements	The Council of Governors holds the non-executive directors individually and collectively to account for the performance of the Board of Directors, and represent the interests of the members of the Trust as a whole and the interests of the public.							
Quality & Safety								
NHS Constitution								
Patient Involvement								
Risk								
Financial impact								
Equality & Diversity								
Communication								

1.0 Key items of business discussed

1.1 The meeting of the Council of Governors was held via videoconference on 1 October, 2020. There was both a public and private session held. Items of business included:-

In public session:

- The Chief Executive Officer's (CEO) Update;
- Questions on the Board of Directors meetings, 21 July and 8 September, along with the July 2020 integrated performance report and the July finance report;
- Questions in relation to the Quality & Safety Committee Chair's report;
- Consideration of amendments to the Trust's Constitution;
- Governor elections update;
- An update on Covid-19 recovery; and
- Governors' feedback on intelligence received from members and the public on services provided by the Trust.

In private session:

- To consider and approve recommendations from the Chair of the Governor Nominations Committee in relation to:
    - Refreshed terms of reference;
    - Trust Chair's and Non-Executive Director's Objectives 2020/21 and Appraisal Process;
    - Non-Executive Director & Audit Chair Appointment; and
    - Interim Chair's Term of Office and Appointment of Trust Chair.

1.2 It was noted that the meeting was not quorate and that any outstanding decision required from an appointed partnership governor would be sought virtually following the meeting. This approval was subsequently sought and received in relation to the decisions within section 2.0, below.

1.3 The governors were updated by the CEO on the local position in relation to the Covid-19 pandemic and the resulting significant operational pressures. The update included the challenges with testing and the current number of positive Covid-19 cases within the Trust. In addition, the capital development funding available to complete the planned remodelling of the Emergency Department, as well as to introduce a same day emergency care unit to the site was raised, which will enable the Trust to deliver urgent care in line with best practice, to keep patients out of hospital. The Director of Finance informed the governors that the Trust's £11.1m capital programme funding related to 'business as usual' capital, and the £7m development Capital was in addition to this.

1.4 There were questions raised by governors on the July integrated performance report content in relation to hospital acquired Covid-19 cases, which were responded to by the CEO. The

governors were informed that the Trust had invited the regional Infection Prevention and Control (IPC) team to undertake a rapid review of cases, systems and processes and that significant progress had been made in this area.

1.5 The Non-Executive chair of the Quality & Safety Committee made the governors aware that the Emergency Planning Officer (EPO) is now in post, as of 3 August 2020; and that the Director of Nursing and Quality has met with the CQC in relation to the review of the Trust's Covid-19 response.

1.6 A proposed refreshed Trust Constitution, including Standing Orders, was pre-circulated to governors, who were informed that the purpose of the recent review was to bring the Trust in line with the Foundation Trust Code of Governance, best practice and the Model Constitution. It was acknowledged that having the proposed changes highlighted via tracked changes was helpful and that formal approval of the Constitution would be brought back to the December meeting of the Council of Governors.

1.7 An update was provided on the progress with governor elections including those who had been appointed as their positions were uncontested, and the ballot process to follow for those positions contested, operated by an independent election services provider.

1.8 The Chief Operating Officer provided a detailed update on Covid-19 recovery which included reference to the Trust's submitted trajectory response to the national Phase 3 letter and the associated challenges with this. The use of private sector endoscopy capacity was raised along with the dedicated area introduce for vulnerable elective care patients. There was good engagement on this issue, with a number of questions raised by governors, which were responded to.

1.9 In private session, the Chair of the Governor Nominations Committee, Deputy Lead Governor, Mr Russell Jackson, updated the governors on the recent work of the Committee, making a number of recommendations. The Senior Independent Director, Non-Executive Director, Ms Fallon, was in attendance and supported the discussions, having sought some prior opinions in relation to the timescale for appointing to the substantive chair position. The governors considered the agenda items and prior to deliberations on the appointment of a Trust Chair, the Interim Trust Chair absented herself from the meeting for the item.

2.0 Key agreements or decisions made

The Council of Governors:

2.1 Agreed to establish a small task & finish group to consider in detail the proposed amendments to the Trust's Constitution ahead of consideration and formal approval by the Council of Governors, and Board of Directors, in December 2020.

2.2 Approved the terms of reference of the Governor Nominations Committee.

2.3 Noted the Trust Chair's and Non-Executive Directors' Objectives 2020/21,

2.4 Noted the future arrangements for the appointment of the Non-Executive Director and Audit Committee Chair.

2.5 Approved the recommendation that arrangements be made to recruit to the position of Trust Chair on a substantive basis.

2.6 Noted that additional approval would be sought in order to ratify the above points, due to lack of a quorum during the meeting.

3.0 Recommendation

3.1 The Board is asked to note the report.

Meeting	**1st December 2020**		**Board of Directors**					
Report	**Agenda item 17.f**		**Updated Board Business Cycle**					
Purpose of the Report	Decision		Ratification		Assurance		Information	x
Accountable Lead	Keith Haynes		Interim Governance Consultant					
Author(s)	Debbie Bryce		Lead for Governance Improvement					
Board Assurance Framework								
Strategic Aims	-							
CQC Domains	Well Led							
Previous Considerations	-							
Summary/ Highlights	The report provides the updated cycle of business of the Board. The October public meeting of the Board of Directors was amended to an informal meeting, due to the proximity of the September meeting. As such, the business cycle has been updated to reflect any significant amendments for October and December. The following key items of business have been deferred on the Board business cycle, in October and December 2020: i. GMC National Trainee Survey results ii. Estates and Facilities annual report (as deferred for consideration by Quality & Safety Committee) iii. Radiology Services Trust Board Oversight Report (as deferred for consideration by Quality & Safety Committee) iv. Strategic objectives (corporate strategy due in January 2021) v. Gender pay gap report (to allow time for associated action plan to be produced) vi. Well Led Framework review and action plan (deferred via associated Committee to allow further consideration) vii. Finance & Performance Committee annual report (to align with year-end reports) viii. Charitable Funds Accounts (not yet finalised) ix. Health & Safety Annual Report (as deferred by Quality & Safety Committee to December 2020) x. Estates Strategy xi. Communications & Engagement Strategy.							

	In addition, the Board will receive updates on some business cycle items via the committee chair's reports, rather than stand-alone Board agenda items. The following item has been added to the business cycle in December: (a) Council of Governors Chair's report.
Recommendation(s)	The Board is asked to note the updated business cycle.
Corporate Impact Assessment	
Statutory Requirements	-
Quality & Safety	
NHS Constitution	
Patient Involvement	
Risk	
Financial impact	
Equality & Diversity	
Communication	

Countess of Chester Hospital NHS Foundation Trust - Board Business Cycle (Version 12 - for December 2020 Board)

				Qtr			Qtr		Qtr		Qtr		Qtr		
Item	**Frequency**	**Lead**	**Nov'19**	**Jan'20**	**Mar'20**		**Apr'20**	**June**	**July**	**Sep'20**	**Oct'20 ***	**Dec'20**	**Jan'21**	**Mar'21**
General Business														
Welcome and apologies for absence	Monthly	N/A	x	x	x		x	x	x	x	x	x	x	x
Declarations of Interest	Monthly	N/A	x	x	x		x	x	x	x	x	x	x	x
Minutes of last meeting	Monthly	N/A	x	x	x		x	x	x	x	x	x	x	x
Action tracker and Matters Arising	Monthly	N/A	x	x	x		x	x	x	x	x	x	x	x
CEO report	Monthly	Chief Executive Officer	x	x	x		x verbal	x verbal	x	x	x	x	x	x
Infection Control BAF	Each meeting	Dir of Nursing & Quality						x	x	x	x	x	x	x
BAF and CRR mapped onto BAF	Quarterly	Dir of Comms & Corporate Affairs	x	x			x		x		x	x	x	
Quality of Care														
Patient Story	Monthly	Dir of Nursing&Quality		x	x		→	→	→	→	x	x	x	x
Clinical Presentation - Clinical Service Deep Dive (covered within Q&S Committee Chair's report from Dec 2020)	Quarterly	Dir of Nursing&Quality and Exec Medical Director						→		x		x		x
GMC National Trainee Survey Results	Annual	Exec Medical Director							→		→			x
Quality & Safety Committee Chair Update	Monthly	Non-Exec Director	x		x			x	x	x	x	x	x	x
Safeguarding Annual Report	Annual	Dir of Nursing&Quality			x 18-19				→	x				
Quality Impact Assessment Report	Annual	Dir of Nursing&Quality and Exec Medical Director						x	←					
Quality Accounts	Annual	Dir of Nursing&Quality						→		→	→	x		
Patient Experience Annual Report	Annual	Dir of Nursing&Quality			x 18-19				x	←				
Learning Disability Mortality Report (within Safeguarding report)	Annual	Exec Medical Director							→	x				
Guardian for Safer Working Report	Annual	Exec Medical Director						x		→				
Freedom to Speak Up Guardian Report	6 monthly	Dir of Nursing&Quality			x						→	x		
Learning from Incidents Qtr Report (covered within Q&S Committee Chair's report from Dec 2020)	Quarterly	Dir of Nursing&Quality			x				x		x		x	
Learning from Deaths Report	Bi-Annually	Exec Medical Director						→			x			
Mortality Indicators Report	Quarterly	Exec Medical Director	x	x	x		x		x		x		x	
CQC Inspection Report	Adhoc	Dir of Nursing&Quality		Adhoc									Adhoc	
Healthcare Acquired Infections Report	Annual	Dir of Nursing&Quality	x									x		
Director of Nursing Bi-annual Nurse Staffing Report	6 Monthly	Dir of Nursing&Quality			x					→	→	x		
Maternity Incentive Standards Submission	Annual	Dir of Nursing&Quality							x					
Updates on Clinical Services Strategy (covered within F&P Chair's report from Dec 2020)	Quarterly	Exec Medical Director						→		x		x		x
PLACE Report	Annual	Dir of Nursing&Quality						→	x					
Operational Performance														
Integrated Performance Report	Monthly	Executives	x	x	x		x	x short version	x short version	x	x	x	x	x
Winter Planning	Annual	Dir Clinical Operations									x	x		

Item	Frequency	Lead	Nov'19	Jan'20	Mar'20	Apr'20	June	July	Sep'20	Oct'20 *	Dec'20	Jan'21	Mar'21
Finance, Use of Resource and Performance													
Finance & UoR Indicators	Monthly	Director of Finance	x	x	x	x	x	x	x	x	x	x	x
Consultant and Honorary Consultant Appointments	Adhoc	Dir of HR & OD and Exec Medical Director											
National Cost Collection Pre-Submission Report	Annual	Director of Finance				→ defer 12 mths							
Update on Capital Budget	As required	Director of Finance						x					
Finance & Performance Committee Chair Update	Monthly	Non-Exec Director	x	x	x	x	→	x	→	x	x	x	x
Finance & Performance Committee Annual Report	Annual	Director of Finance and Dir Clinical Operations								→			x
Audit Committee Chair Update	Monthly	Non-Exec Director	x			x	x	x	x			x	x
Charitable Funds Committee Chair Report	Quarterly	Non-Exec Director				→		x	←		x	x	x
Procurement & Commercial Report	Annual	Director of Finance						x					
Remuneration Committee Annual Report	Annual	Dir of HR & OD and Chair						x					
Accounts and Annual Report	Annual	Director of Finance and Dir of Comms & Corporate Affairs					x						
Charitable Funds Accounts	Annual	Director of Finance		x							→	x	
Estates & Facilities Report	Annual	Dir Clinical Operations									→		x
Strategic Change													
Revenue Budget	Annual	Director of Finance			x								x
Capital Budget	Annual	Director of Finance			x								x
Trust Board Oversight Report - Radiology Services	Annual	Dir Clinical Operations						→		→		→	x
Emergency Planning & Resilience	Annual	Dir Clinical Operations	x							x			
Brexit Impact Assessment	As required	Dir Clinical Operations			x In F&P report								
Health & Safety Annual Report	Annual	Dir Clinical Operations						→		→		x	
Transformation and Quality Improvement Report (to be covered within Chair's report from Dec 2020)	Quarterly	Chief Executive Officer				→		→		→	x	→	x
Inclusion [Strategy or Report]	Annual	Director of HR & OD								→	x		
Well-led Framework Review and Action Plan	Annual	Director of Nursing & Quality					→			→			
Information Governance Annual Report	Annual	Dir of Comms & Corporate Affairs						x	←				
Operating Plan	Annual	Dir Clinical Operations and Director of Finance			x								**x**
Annual Plan (update against strategic objectives)	Quarterly	Chief Executive Officer						→		x		x	
Strategic Objectives	Adhoc	Chief Executive Officer				→					→	x	
IT Strategy and annual update on progress with strategy	Annual	Chief Digital Information Officer									x		
Update on cyber security progress	Bi-annual	Chief Digital Information Officer							→		**x**		**x**
Estates Strategy and annual update on progress with strategy	Annual	Dir Clinical Operations									→		**x**
Communications & Engagement Strategy and annual update on progress with strategy	Annual	Dir of Corporate Affairs								→			

Item	Frequency	Lead	Nov'19	Jan'20	Mar'20	Apr'20	June	July	Sep'20	Oct'20 *	Dec'20	Jan'21	Mar'21
People & OD Strategy and annual update on progress with strategy	Annual	Dir of HR & OD								x			
Electronic Patient Record update report	bi-monthly	Chief Digital Information Officer				x		→	→	x	x		x
Integrated Care Partnership Board Reports (within CEO report)	Six times per year	Chief Executive Officer			x	X ICPB post-poned		x	x		x	x	
Leadership & Improvement Capability													
Staff related CQUINs	Annual	Director of HR & OD				→				x			
Annual Review of Rules of Procedure/SFI's	Annual	Director of Finance & Dir of Comms & Corporate Affairs				→		x					
Annual Organisational Audit for Revalidation	Annual	Exec Medical Director							x				
Senior Independent Director Annual Report	Annual	Non-Exec Director/SID											x
Education & Development Annual Report (referenced within F&P Chair's report)	Annual	Exec Medical Director					→		→		x		x
Gender Pay Gap	Annual	Director of HR & OD		x							→	x	
Council of Governors Report/Update	Three times per year	Dir of Comms & Corporate Affairs		x		x (Mar COG post-poned)		→ meet 24th July	x		x	x	
Annual Provider License Self Certification	Annual	Dir of Comms & Corporate Affairs					x						
Annual Staff Survey	Annual	Director of HR & OD				→			x				
Fit and Proper Person Report	Annual	Dir of Comms & Corporate Affairs and Dir of HR & OD						x	←				
Variation to Standing Orders for Covid-19 and subsequent review	Ad-hoc	Dir of Comms & Corporate Affairs				x	x						
Proposed terms of reference Remuneration & Nominations Committee	Ad-hoc	Dir of Comms & Corporate Affairs						x					
Public Sector Equality Duty and Equality Delivery System (Workforce Equality Analysis Report - WEAR, WRES and WDES)	Annual	Director of HR & OD		x (WEAR)				x	x (WRES & WDES)				
Other Items													
Minutes from Quality & Safety Committee	Monthly	N/A	x	x	x	x	x	x	x	x	x	x	x
Minutes from Finance & Performance Committee	Monthly	N/A	x	x	x	x	x	x	x	x	x	x	x
Minutes from Audit Committee	Monthly	N/A		x	x		x	x	x		x	x	x
Minutes from Charitable Funds Committee	Quarterly	N/A		x		→		x		x		x	
Any Other Business	Monthly	N/A	x	x	x	x	x	x	x	x	x	x	x
Questions from the Public	Monthly	N/A				→	→	x	x	x	x	x	x
Review of the Meeting	Monthly	N/A	x	x	x	x	x	x	x	x	x	x	x

Note:

Updates since previous version shown in blue text.

→ indicates original position of item on business cycle and intention to move forward and reschedule or pick up at an original date scheduled

April and June 2020 Board were focused on essential business only due to the Covid-19 response and an agreed variation to Standing Orders

* October 2020 Board was amended to an informal Board, in private, due to the proximity to the previous meeting,

Continuous Improvement Strategy bi-annual update scheduling to be considered for 2021/22

Countess of Chester Hospital NHS Foundation Trust

Meeting	**1st December 2020**		**Board of Directors**					
Report	**Agenda item 17.g**		**Finance Report – Month 06**					
Purpose of the Report	Decision		Ratification		Assurance	X	Information	X
Accountable Executive	Simon Holden				Director of Finance			
Author(s)	Simon Holden				Director of Finance			
Board Assurance Framework	E1	Underlying Long Term Trust Financial Sustainability						
Strategic Aims								
CQC Domains	Safe, Caring, Responsive, Effective & Well Led.							
Previous Considerations	Finance and Performance Committee, 17th November 2020							

Summary Recommendation(s)

The purpose of this report is:

- To provide details of the Trust financing regime up to 30th September 2020; and
- To provide details of the Trust's financial position, as at 30th September 2020 (Month 06).

The Board is asked to note:

1. The current financial regime in place from 1st April 2020 (Month 01), till 30th September 2020 (Month 06);
2. That a new financial model beyond this point has been identified with no return to Payment by Results, but block contracts with 3 pots of block money available and 1 variable source of funding:
   - Block deficit funding;
   - Block Covid funding;
   - Block growth funding (Including Winter & Restoration; and
   - A withdrawal, or increase, of funding at a marginal rate depending of the level of Elective activity delivered (However, at the time of writing the allocation of the block funding to the Trust for the period 1st October 2020 to 31st March has not been finalised).
3. The Trust's funding currently being based upon its expenditure in November & December 2019, and January 2020 (i.e. Months 08,09 &10);
4. The resultant pressure to limit expenditure which mirrors that which was incurred during this *reference period* (of Months 08,09 & 10), unless specifically "related to Covid";
5. The September 2020 (Month 06) position resulting in a required "True Up" of £2.3m (previously £1m Month 05, although noting exceptional items of Medical Pay Award £0.5m & Medical & Surgical activity £0.5m, with a resultant underlying of circa £1.3m)

	6. The cumulative year to date "True Up" of £7.1m (for month 1-6); 7. The Financial Bridge analysis showing the constituent parts behind the financial position, resulting in the requirement for a £7.1m True Up (& noting circa £12.5m of identified Covid expenditure); 8. The narrative performance information, showing a underperformance on activity of circa 85,000 units, equating to an income shortfall of £24.8m (but not reflected in this position, as not applicable in the current financial regime) as at end of August; 9. The activity trend graphs showing an upward trend for all points of delivery over the last five months, with local trajectories lower than the national expected trajectory; 10. The variance analysis, whereby: • Departmentally these variations are to be expected (with Planned Care underspent, and Urgent Care over spent, reflecting the changed working patterns in the hospital); & • Subjectively, whereby the month on month position has increased by c£1m driven by: i. Payment of the Medical pay award in September relating to April-September (£0.420) and ii. an increase in medical & surgical consumable expenditure reflecting further progress of the restoration the trust elective programme (£0.667m). 11. Cumulative Covid expenditure, separately identified, totalling £12.5m (previously £10.5m at Month 05), as reported to NHS E/I, and subject to separate scrutiny, and including £0.9m relation to Cerner; 12. The additional separate Trust Board paper regarding the current Capital position; 13. The Cash funding, & Cash balances held of £34.6m as at 31st September 2020; and 14. The Risks currently being managed and the mitigations in place.
Corporate Impact Assessment	
Statutory Requirements	Meets the Trust compliance with Foundation Trust Status
Quality & Safety	Seeks to address Quality & Safety issues across the Trust.
NHS Constitution	n/a
Patient Involvement	n/a
Risk	There is an overarching risk that the Trust may lose financial control if governance standards are reduced.
Financial impact	£7.1m True Up YTD at Month 06
Equality & Diversity	n/a
Communication	This report can be communicated publically.

Countess of Chester Hospital NHS Foundation Trust

Finance Report
September 2020 (Month 06)

1.1 Background

In response to the global pandemic of Covid 19 (and as described previously), the Operational Planning and Contracting Process for 2020/21 and Payment by Results (PbR) mechanism has been formally suspended nationally.

To recapitulate, the interim arrangements were put in place to initially cover the period 1st April to 31st July 2020, but have been extended till at least the 30th September 2020, and are described below.

This new financial regime was introduced to support a change in focus to facilitate tackling Covid 19, but introduced a number of new revenue and capital constraints (whilst this new regime is in place), including:

- No new investments revenue Business Cases, unless Covid related;
- No requirement to deliver Cash Releasing Savings (CRS);
- Expected costs based upon Month 08, 09 & 10 2019/20 the "reference period";
- The concept of "proportionate and reasonable"; and
- Reimbursable Covid Capital related costs (now subject to prior approval).

NHS England & Improvement (NHS E/I) has issued national guidance to support the interim financial arrangements namely:

- All providers will move to block contract payments for an initial period of 1st April to 30th September 2020, with suspension of the usual PBR national tariff payment architecture and associated administrative/ transactional processes.

- A national top-up payment ('projected top-up') will be issued to providers to reflect the difference between the expected baseline net costs and block contract and other income, where modelling of the expected cost base is higher;

- A national true-up ('retrospective top-up') will be provided to adjust provider positions for additional costs and/or loss of revenue where the block and top-up payments do not equal the actual costs of genuine and reasonable additional marginal costs due to COVID-19; and

- These funding streams should provide sufficient funds for providers to deliver a break-even position through the period and will provide the basis against financial performance will be monitored.

The simplified financial arrangements from October 2020 (Month 7) to March 2020 (Month 12) have been released and are based upon the principles of system allocations, performance and management of risk. There is no return to Payment by Results.

For the Trust this means that block NHS funding has been allocated to the Cheshire & Merseyside Health & Care partnership (HCP) with three pots of block money available and one variable source of funding:

- Block deficit funding;

- Block Covid funding;
- Block growth funding (Including Winter & Restoration); and
- The withdrawal or increase of funding at a marginal rate (25% underperformance & 75% over performance) depending of the level of Elective activity delivered (Elective Incentive Scheme).

At the time of writing, the allocation of the block funding to the Trust for the period 1st October 2020 to 31st March has not been finalised

2.0 Financial Summary

The table below shows the September 2020 (Month 06) cumulative financial position under the current interim arrangements as per reported to NHSE/I:

Financial Plan as per NHSI/E Template	September NHSI/E Plan £k	September Actual Expenditure £k
Clinical Income	119,976	118,424
Non Clinical Income	10,056	6,580
Total Income	**130,032**	**125,004**
Pay Expenditure	94,800	99,305
Non Pay Expenditure	43,632	41,206
Total Expenditure	**138,432**	**140,511**
Operating Surplus / (Deficit)	**(8,400)**	**(15,507)**
Finance Income	**60**	**10**
Finance Expense	**(318)**	**(407)**
PDC	**(1,002)**	**(743)**
Total Finance Costs	**(1,260)**	**(1,140)**
Deficit Prior to Top Up	**(9,660)**	**(16,697)**
Projected Top Up	9,660	9,660
Projected True Up / Retrospective Top Up	0	7,059
Net monthly surplus / (deficit)	**0**	**22**
Remove capital donations/grants I&E impact		**(22)**
Adjusted Financial Performance including Top-up	**0**	**0**

***Please note the above table may contain roundings.*

The table above demonstrates how the Trust has requested a cumulative "True Up" of £7,059k, for costs incurred over, and above, those expected.

3.1 Financial Bridge

As can be seen from the Financial Bridge, the negative costs related to:

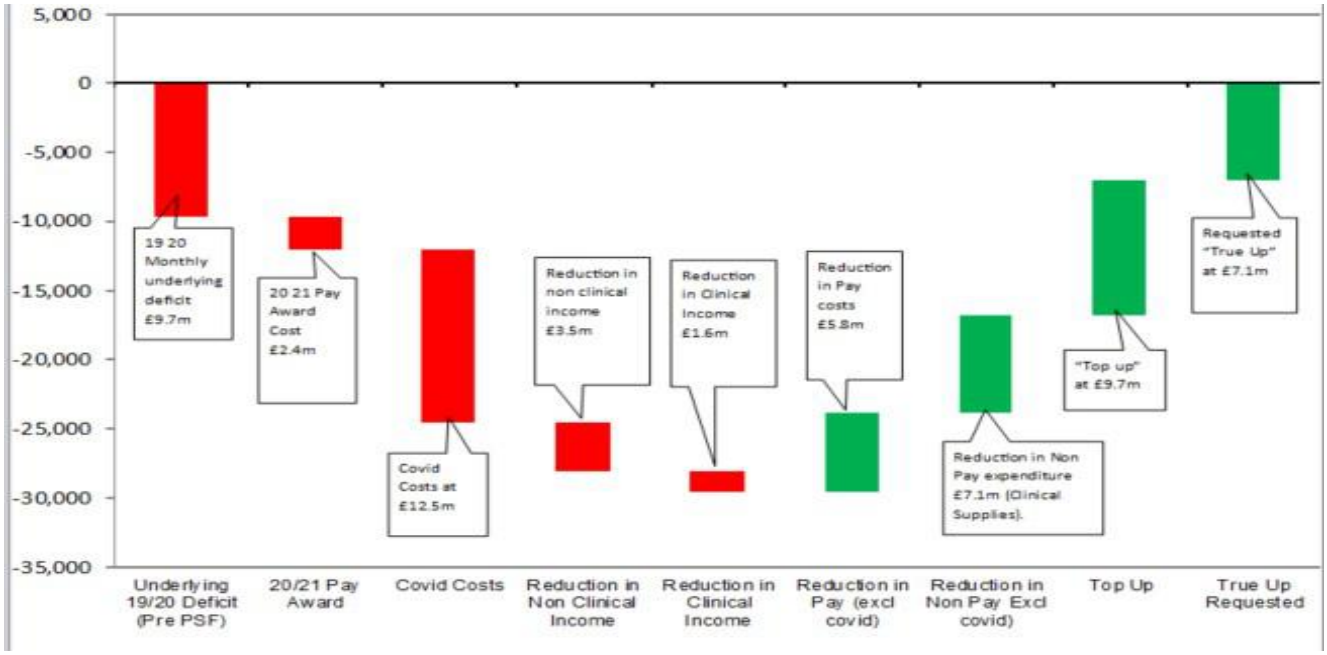
- The Trust's underlying deficit (using the 2019/20 £9.7m Provider Sustainability Funding);
- The additional costs of the 2020/21 Pay Awards (£2.4m), including the Consultant pay award awarded in September and backdated from April (circa £0.4m);

- The additional Covid Costs incurred by the Trust (circa £12.5m); and
- A reduction in both clinical income (circa £1.6m) and Non Clinical Income (circa £3.5m)

The positive aspects arising on the Financial Bridge are:

- A reduction in Pay costs (circa £5.8m);
- A reduction in Non Pay costs (circa £7.1m); and
- An allocated "Top Up" (circa £9.7m), from NHS E/I.

This results in a retrospective "True Up" being required of £7.1m cumulatively.

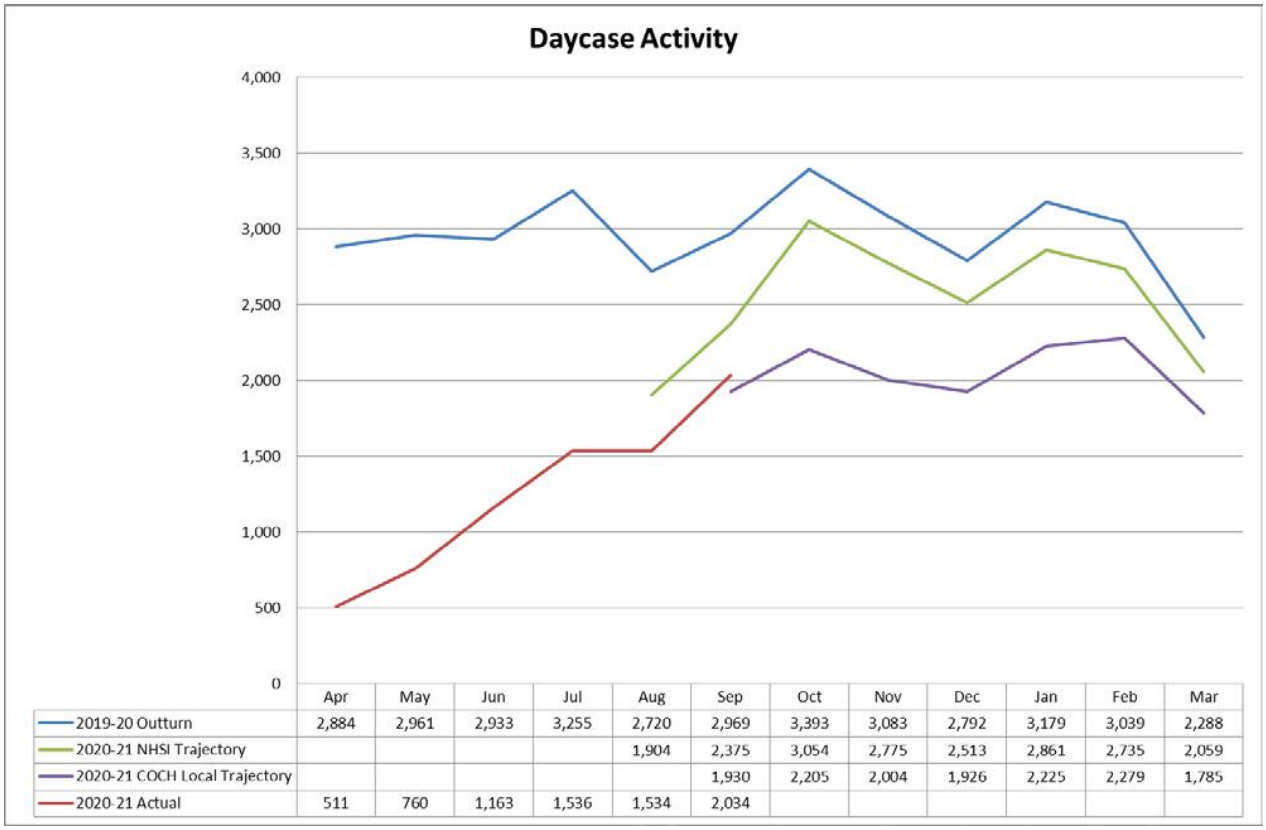


4.0 Activity Monitoring

The table below is provided for information only and compares the cumulative activity for April to September 2020, to April to September 2019 and associated income. It is provided to enable the reader to understand the impact Covid 19 has had on Trust activity levels. Please note the block contract arrangements, described in section one, mitigate the financial loss described in the table below:

Point of Delivery	September 2019 YTD Activity	September 2020 YTD Activity	Activity Variance	September 2019 YTD Value at 19/20 Tariffs	September 2020 YTD Value at 19/20 Tariffs	Value Variance
Daycases	17,715	7,538	(10,177)	£11,307,455	£4,783,449	(£6,524,006)
Elective Inpatients	2,094	964	(1,130)	£6,029,094	£2,544,358	(£3,484,737)
Non-Elective Inpatients (exc Maternity)	15,164	11,993	(3,171)	£32,362,088	£27,337,240	(£5,024,847)
Non-Elective Inpatients - Maternity	1,265	1,257	(8)	£3,341,513	£3,299,876	(£41,637)
First Outpatients	38,691	19,408	(19,283)	£6,059,305	£3,161,845	(£2,897,460)
Follow Up Outpatients	95,560	68,721	(26,839)	£7,415,770	£5,552,606	(£1,863,164)
Outpatient Unbundled & Procedures	39,389	19,403	(19,986)	£4,654,953	£1,945,268	(£2,709,685)
Maternity	4,923	4,407	(516)	£2,885,684	£2,831,982	(£53,701)
A&E Attendances	37,362	30,810	(6,552)	£4,236,766	£3,962,051	(£274,716)
Best Practice Adj'ts	0	0	0	£376,478	£255,718	(£120,761)
AMD	3,382	177	(3,205)	£2,964,514	£174,723	(£2,789,791)
Adult Critical Care	2,174	2,252	78	£3,314,492	£3,723,003	£408,511
Neonatal Critical Care	1,239	1,453	214	£801,173	£858,456	£57,283
Other Non PBR & CQUIN	0	0	0	£23,176,502	£21,874,127	(£1,302,375)
PBR & Non PBR Variance	**258,958**	**168,383**	**(90,575)**	**£108,925,788**	**£82,304,704**	**(£26,621,084)**

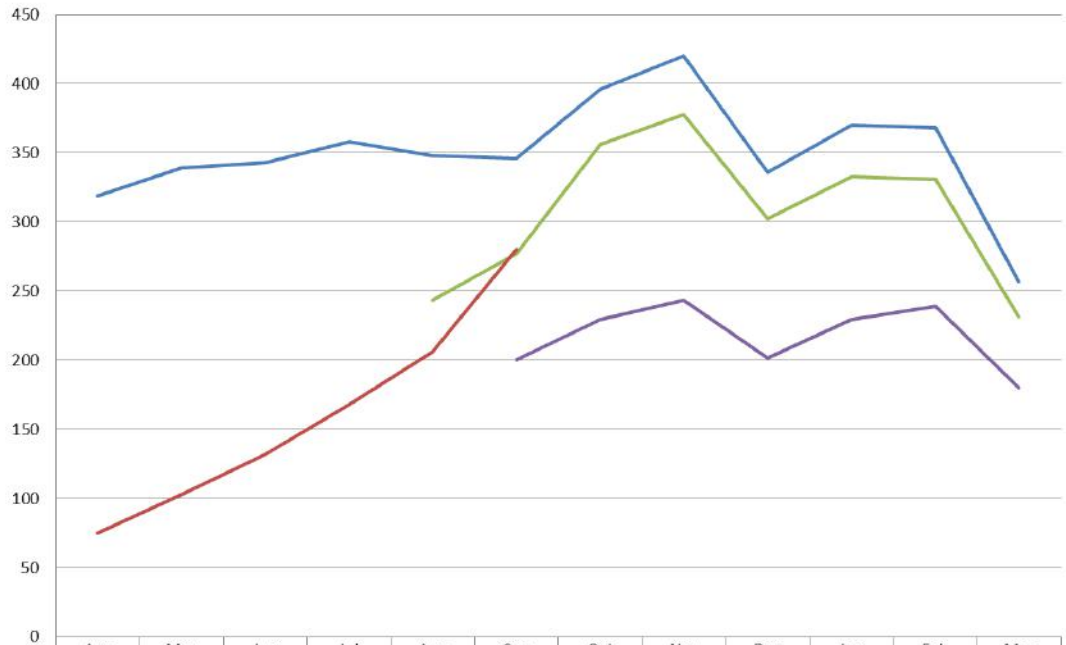
In addition to the above monitoring information, the table below shows the month on month trend in activity delivered by point of delivery, compared to performance for the same period in 2019/20, the COCH trajectory and the national target for the covid recovery phase by Point of Delivery:



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2019-20 Outturn	2,884	2,961	2,933	3,255	2,720	2,969	3,393	3,083	2,792	3,179	3,039	2,288
2020-21 NHSI Trajectory					1,904	2,375	3,054	2,775	2,513	2,861	2,735	2,059
2020-21 COCH Local Trajectory						1,930	2,205	2,004	1,926	2,225	2,279	1,785
2020-21 Actual	511	760	1,163	1,536	1,534	2,034						

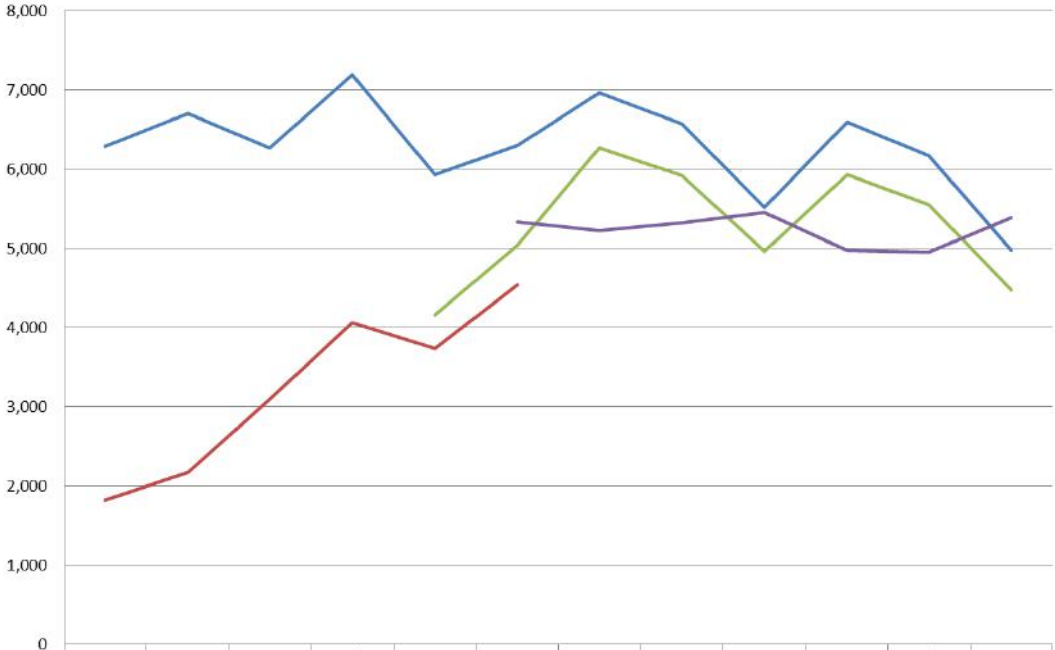
NHS
Countess of Chester Hospital
NHS Foundation Trust

Elective Inpatient Activity



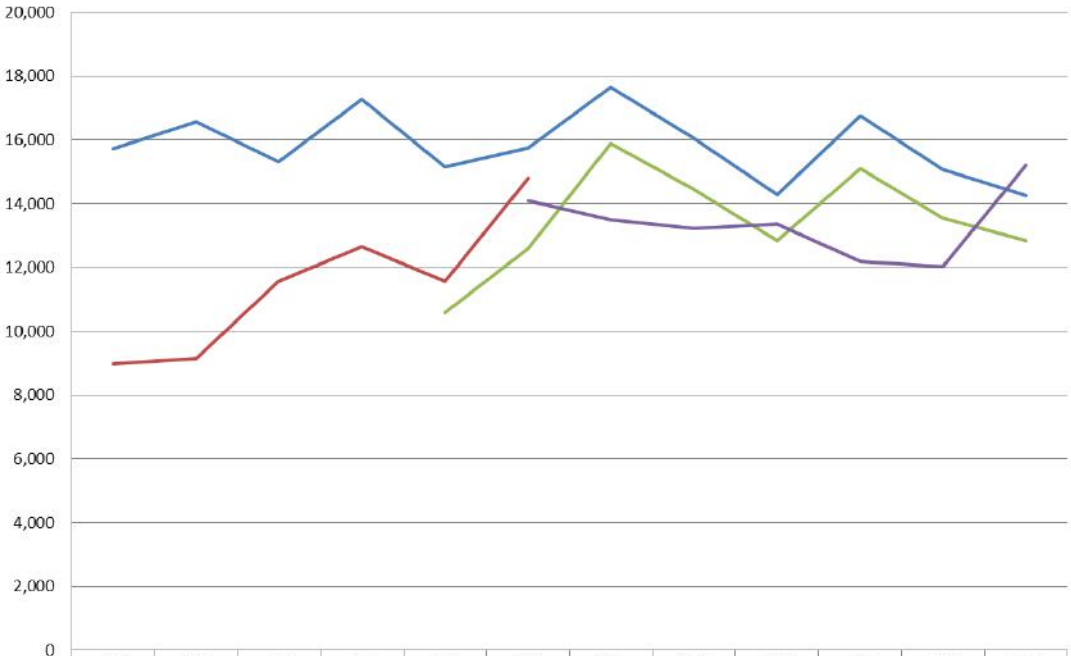
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2019-20 Outturn	319	339	343	358	348	346	396	420	336	370	368	257
2020-21 NHSI Trajectory					244	277	356	378	302	333	331	231
2020-21 COCH Local Trajectory						201	230	244	202	229	239	180
2020-21 Actual	75	103	132	168	206	280						

Consultant & Non-Consultant Led Outpatient First Attendance Activity



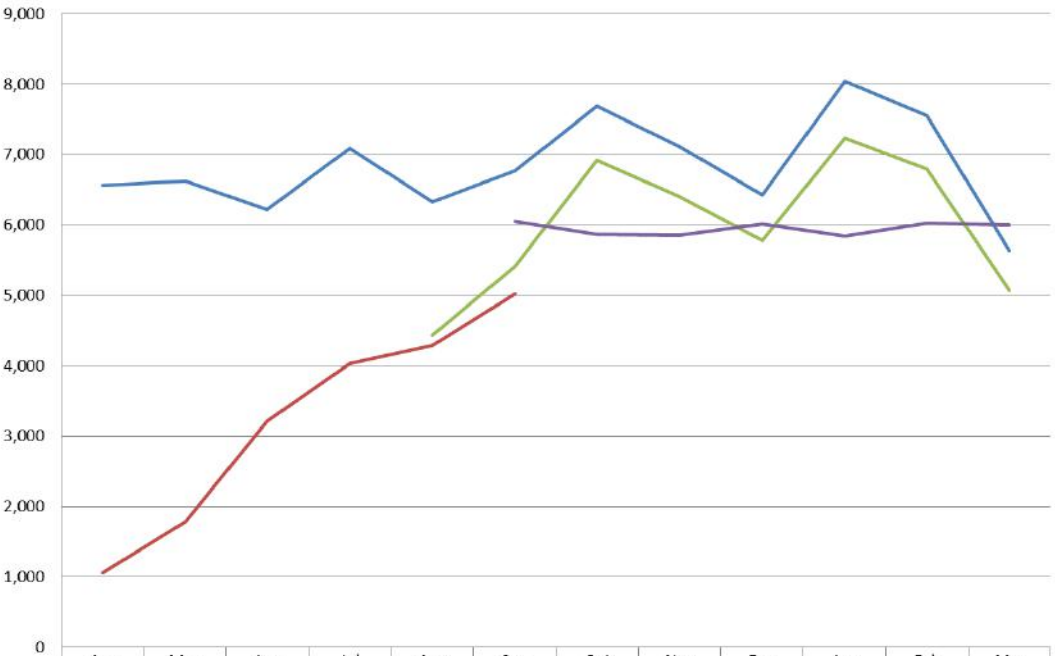
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2019-20 Outturn	6,286	6,708	6,269	7,191	5,934	6,306	6,959	6,576	5,518	6,593	6,173	4,974
2020-21 NHSI Trajectory					4,154	5,045	6,263	5,918	4,966	5,934	5,556	4,477
2020-21 COCH Local Trajectory						5,331	5,230	5,324	5,448	4,978	4,952	5,391
2020-21 Actual	1,824	2,165	3,092	4,056	3,730	4,542						

Consultant & Non-Consultant Led Outpatient Follow Up Attendance Activity



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2019-20 Outturn	15,726	16,571	15,325	17,269	15,145	15,754	17,664	16,047	14,274	16,766	15,062	14,270
2020-21 NHSI Trajectory					10,602	12,603	15,898	14,442	12,847	15,089	13,556	12,843
2020-21 COCH Local Trajectory						14,087	13,490	13,215	13,370	12,189	12,019	15,201
2020-21 Actual	8,973	9,155	11,572	12,659	11,558	14,803						

Consultant & Non-Consultant Led Outpatient Procedures Activity



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2019-20 Outturn	6,568	6,620	6,215	7,092	6,332	6,771	7,685	7,113	6,423	8,037	7,556	5,629
2020-21 NHSI Trajectory					4,432	5,417	6,917	6,402	5,781	7,233	6,800	5,066
2020-21 COCH Local Trajectory						6,054	5,869	5,858	6,016	5,843	6,030	5,996
2020-21 Actual	1,060	1,787	3,210	4,034	4,291	5,021						

As can be seen in the graphs above, all points of delivery show an upward trend over the last five months, with local trajectories lower than the national expected trajectory.

5.1 Variance Analysis

5.2 Divisional / Departmental Variances (to budget)

In the absence of the completion of the 2020/21 financial planning process, the Trust has adopted the NHS E/I Financial Plan as shown in section two of this report. The table below shows the Divisional / Departmental performance comparing actual expenditure to the 2019/20 recurrent budget inflated, for the pay award, and is provided as a comparator only. It does not currently include any adjustments for activity over, or under, performance:

Divisional Variances		Sep YTD Var	CRS YTD Var	Pressure YTD exc CRS & PBR
		£000s	£000s	£000s
Planned Care	Favourable	(1,854)	1,280	(3,134)
Urgent Care	Adverse	2,697	595	2,102
ICP	Favourable	(65)	213	(278)
D&I	Adverse	923	518	405
Nurse Management	Adverse	272	46	226
Corporate Services	Adverse	1,191	202	989
Central Services	Adverse	1,043	(799)	1,842
Covid	Adverse	12,496		12,496
Exclude Donated Asset Transactions	Adverse	15		15
Total		**16,718**	**2,055**	**14,663**
Top Up		(9,659)		
True Up		(7,059)		
Revised Total		0		

***Please note the above table may contain roundings.*

The data above is line with expectation:

- Planned Care underspend due to the elective programme being largely paused;
- Urgent Care overspend due to the operational pressures felt largely within this division;
- Diagnostic and Infrastrusture overspend due to loss of car parking, and Staff Restaurant income;
- Additional £12.5m costs incurred due to Covid 19 to date, further details can be found in section 6.0; and
- A True Up requirement of £7.1m, year to date.

5.3 Subjective variances (comparison of Month 05 to Month 06 expenditure)

The table below, whilst not intended to be an exhaustive list, is intended to highlight a number of the material movements in actual expenditure between August (Month 5) and September (Month 6). As can be seen, the largest areas relate to:

- Adverse movement in medical expenditure (£0.463m), this variance is due to the previously notified award of the non-training Medical staff pay inflation (backdated to April 2020);
- Adverse movement in drug expenditure reflecting the increase in the delivery of the elective care programme (£0.192m)
- Adverse movement in Medical and Surgical purchase (£0.667m) reflecting the increase in delivery of the elective care programme and additional testing & equipment costs in relation to Covid.

Variance Analysis - selected significant movements between August 2020 and September 2020

Code	Description	M1 Actual	M2 Actual	M3 Actual	M4 Actual	M5 Actual	M6 Actual	Movement M5-M6	Rationale	M1-6 YTD
		£	£	£	£	£	£	£		£
BE025	Medical Staff	4,564,995	4,733,488	4,522,987	4,215,367	4,385,245	4,847,935	462,690	CEAs (full annual amount) paid in M2. Medical pay award for consultant & middles grades paid in M6 relating to M1-6 £420k	27,270,016
BE060	Nursing/ Midwifery Staff	6,019,370	6,319,197	6,317,959	5,998,595	6,065,176	6,013,656	(51,520)		36,733,953
BE110	Admin & Clerical Staff	1,948,242	1,992,494	2,172,335	2,039,508	2,021,952	2,033,459	11,507		12,207,990
BE150	Medical (Non Nhs)	145,579	220,310	163,204	137,264	201,455	111,711	(89,744)		979,524
BE154	Nursing & Midwifery (Non Nhs)	87,494	116,300	186,066	141,079	199,227	234,568	35,341	High nursing agency usage	964,735
Total Salaries & Wages		**16,225,684**	**16,876,487**	**16,912,363**	**16,115,921**	**16,387,328**	**16,787,042**	**399,714**		**99,304,825**
CE302	Drugs (Including Gases)	1,438,007	1,514,434	1,621,076	1,647,069	1,472,290	1,664,985	192,695	Activity related overspend	9,357,862
CE305	Med & Surg Equip - Purchases	693,910	672,917	776,107	672,255	720,664	1,388,044	667,380	Activity related overspend	4,923,897
CE312	Lab Equipment - Purchases	443,465	506,735	424,780	445,989	472,553	421,407	(51,146)		2,714,928
CE322	Contract Hotel Services	41,882	41,143	80,160	52,393	39,539	49,299	9,760		304,416
CE324	Uniforms & Clothing	409,616	98,746	142,139	377,139	(16,814)	100,859	117,673	PPE purchases	1,111,685
CE362	Furniture, Office & Computers	551,727	726,525	546,316	540,779	910,424	518,695	(391,729)	Cerner hibernation costs charged to Covid	3,794,466
CE366	Building & Eng Materials	90,672	60,300	62,061	105,584	98,922	43,621	(55,301)		461,160
CE367	Building & Eng Contractors	123,772	75,382	65,668	159,207	109,063	99,956	(9,107)		633,049
CE368	Estates - Maint Contracts	23,764	46,798	16,992	26,443	70,612	31,869	(38,743)	Fire alarm maintenance contract payment in M5	216,478
CE390	Ext Staffing/ Consultancy Fees	161,654	139,397	253,181	173,949	103,697	285,532	181,835	Estates Consultancy Fees	1,117,409
CE396	Services Received	154,759	129,951	107,172	511,664	413,914	253,218	(160,696)	Fertility costs, offset by income received	1,570,680
Total Non Pay Expenditure		**6,440,220**	**6,509,542**	**6,558,647**	**7,207,171**	**6,953,132**	**7,587,150**	**634,018**		**41,255,862**
TOTAL TRUE UP & TOP UP		**(1,896,000)**	**(2,528,000)**	**(2,953,000)**	**(2,944,000)**	**(2,515,000)**	**(3,883,000)**			**(16,719,000)**

6.0 Covid Revenue Costs

The Trust is required, where possible, to identify the costs incurred as a result of Covid 19 and report it to NHS E/I. The costs identified must be “proportionate and reasonable”, and each Trust will be subject to external scrutiny. To aid this process the Trust has set up a Covid 19 specific cost centre, and by the end of September had identified £12.5m cumulative year to date expenditure as detailed in the table below:

Description		Non Pay	Pay	Grand Total
COVID-19 virus testing (NHS laboratories)	£	400,107		£ 400,107
Decontamination	£	133,146		£ 133,146
Enhanced PTS	£	492		£ 492
Existing workforce additional shifts			£6,678,715	£ 6,678,715
Expanding medical / nursing / other workforce	£	76,129	£ 869,479	£ 945,608
Increase ITU capacity (incl Increase hospital assisted respiratory support capacity, particularly mechanical ventilation)	£	1,016,784		£ 1,016,784
National procurement areas	£	1,003,192		£ 1,003,192
Other	£	853,384	£ 330,763	£ 1,184,147
Plans to release bed capacity	£	683,268		£ 683,268
Remote management of patients	£	183,235		£ 183,235
Remote working for non patient activites	£	273,819		£ 273,819
Segregation of patient pathways	£	17,864		£ 17,864
Grand Total	**£**	**4,641,420**	**£7,878,957**	**£ 12,520,377**

** *Please note the above table may contain roundings*

7.0 Capital Expenditure

Due to the increasing complexity of capital funding this year, a separate paper has been written to accompany the board report outlining the current position.

8.0 Cash

In response to the Covid 19 pandemic and the interim financing arrangements, Trusts were paid one twelfth of the block income on 1st April 2020, and a further one twelfth on the 15th April thus securing Trust balances to eliminate potential cash flow issues and enable swift payments to be made to suppliers. A further one twelfth has been received monthly with a cash balance of £34.6m as at the 30th September 2020. There is no clarity yet for the second half of the year, but NHSEI have confirmed that Trusts will be given at least two months' notice of any proposed change.

9.1 Key Risks and Mitigation

The key risks and mitigation identified last month remain under the current finance regime remain, namely:

- The potential failure to secure reimbursement for capital expenditure – the Trust is fully compliant with the processes in place to secure capital despite guidance changing frequently;
- The potential failure to secure reimbursement for revenue expenditure up to September 2020 - the Trust is fully compliant with the processes in place to secure revenue expenditure with clear auditable information for costs identified;

- The potential failure to secure sufficient block funding for the period October 2020 to March 2021 to cover the ongoing costs of Covid, and the delivery of the required restoration of the Trusts Elective activity programme;
- The potential costs incurred should there be a significant second surge, and the resultant pressure on maintaining elective activity.
- The Trust holds a significant contract circa £27m with Betsi Cadwaladr NHS Trust. Contracting rules continue to be different in Wales to England, however currently there is a commitment from Wales to apply the "spirit" of the national English approach for cross border commissioning during this unprecedented time. There is a risk that this could change with discussions taking place between Welsh Government and NHSE/I
- Given the urgency of some of the spending, and also given the resources available to the Trust, there is a heightened risk of fraud. – The Trusts Counter Fraud Service has been kept informed throughout the Covid process, with proactive pieces of work undertaken (including raising awareness with the staff, and also targeted investigations); and
- The NHS as a whole is mindful of the urge to "bend rules" during this reimbursement phase, and hence costs need to be proportionate and reasonable (in accordance with the new rules) – The NHS centrally has stated that there will be an Audit of Trust expenditure and returns, to ensure that rules have been applied consistently across all providers.
- The impact on the Trust's underlying recurring revenue position as a resultant of some significant capital investments (to support expansion), namely:
    - Additional CT Scanner, Ellesmere Port Hospital (£1,000,000)
    - Additional Endoscopy Suite, Countess of Chester Hospital (£300,000)
    - Expansion Critical Care 7 beds, Countess of Chester Hospital (£500,000)