NHS
Countess of Chester Hospital
NHS Foundation Trust

2025/26

Quality Accounts

Countess of Chester Hospital NHS Foundation Trust

Content

Part 1: Foreword

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

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

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

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

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

1.1 Statement on Quality from the Chief Executive & Chair

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

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

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

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

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

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

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

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

Jane Tomkinson OBE

Chief Executive

Neil Large

Chairman

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Opening of The Wilson Blue Skies Balcony

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Countess of Chester Hospital leads England in faster cancer diagnosis

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

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

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

For patients, this means:

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

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

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

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

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

2.1 Priorities for improvement 2026/27

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

The Trust is committed to delivering the following priorities:

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

Delivering Safe Services

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

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

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

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

Delivering Safe Services

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

How progress will be monitored, measured, and reported:

Metrics:

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

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

Priority 2: Reduce the incidence of inpatient falls

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

How progress will be monitored, measured, and reported:

Metrics:

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

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

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

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

How progress will be monitored, measured, and reported:

Metrics:

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

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

Delivering Effective Services

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

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

Delivering Effective Services

How progress will be monitored, measured, and reported:

Metrics:

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

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

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

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

How progress will be monitored, measured, and reported:

Metrics:

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

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

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

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

How progress will be monitored, measured, and reported:

Metrics:

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

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

Delivering Kind and Compassionate Care

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

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

How progress will be monitored, measured, and reported:

Metrics:

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

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

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

2.2 Statements of assurance from the Board

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

Clinical Audit and Confidential Enquiries

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

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

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

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

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

Transition (Adolescents and Young Adults) and Young Type 2 Audit	Yes	Yes	Active
Gestational Diabetes Audit	Yes	Yes	Active
National Audit of Care at the End of Life (NACEL)	Yes	Yes	Active
National Audit of Metastatic Breast Cancer (NAoMe)[1]	Yes	Yes	Continuous monitoring
National Audit of Primary Breast Cancer (NAoPri)[1]	Yes	Yes	Continuous monitoring
National Bowel Cancer Audit (NBOCA)[1]	Yes	Yes	Active
National Lung Cancer Audit (NLCA)[1]	Yes	Yes	Active
National Oesophago-Gastric Cancer Audit (NOGCA)[1]	Yes	Yes	Active
National Prostate Cancer Audit (NPCA)[1]	Yes	Yes	Active
National Heart Failure Audit (NHFA)	Yes	Yes	Active
National Audit of Cardiac Rhythm Management (NACRM)	Yes	Yes	Active
Myocardial Ischaemia National Audit Project (MINAP)	Yes	Yes	Active
2025 Major Haemorrhage Audit	Yes	Yes	Completed
National Early Inflammatory Arthritis Audit (NEIAA)[1]	Yes	Yes	Continuous monitoring
National Emergency Laparotomy Audit (NELA)	Yes	Yes	Continuous monitoring
National Emergency Laparotomy Audit (NELA) No Laparotomy	Yes	Yes	Continuous monitoring
National Joint Registry	Yes	Yes	Continuous monitoring
National Major Trauma Registry	Yes	Yes	Continuous monitoring
National Maternity and Perinatal Audit (NMPA)[1]	Yes	Yes	Continuous monitoring
National Neonatal Audit Programme (NNAP)[1]	Yes	Yes	Continuous monitoring
National Obesity Audit (NOA)[1]	Yes	Yes	Not eligible
Age-related Macular Degeneration Audit	Yes	Yes	Active
Cataract Audit	Yes	Yes	Active
National Paediatric Diabetes Audit (NPDA)[1]	Yes	Yes	Continuous monitoring
National Perinatal Mortality Review Tool (PMRT)	Yes	Yes	Continuous monitoring
National Respiratory Audit programme-NRAP-COPD Secondary Care	Yes	Yes	Continuous monitoring
National Respiratory Audit programme-NRAP-Adult Asthma Secondary Care	Yes	Yes	Continuous monitoring
National Respiratory Audit programme-NRAP-Children and Young People's Asthma Secondary Care	Yes	Yes	Continuous monitoring
National Vascular Registry (NVR)[1]	Yes	Yes	Active
Paediatric Intensive Care Audit Network (PICANet)[1]	Yes	Yes	Active
Sentinel Stroke National Audit Programme (SSNAP)[1]	Yes	Yes	Active

UK Parkinson's Audit	Yes	Yes	Active

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

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

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

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

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

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

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

Local Clinical Audits

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

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

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

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

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

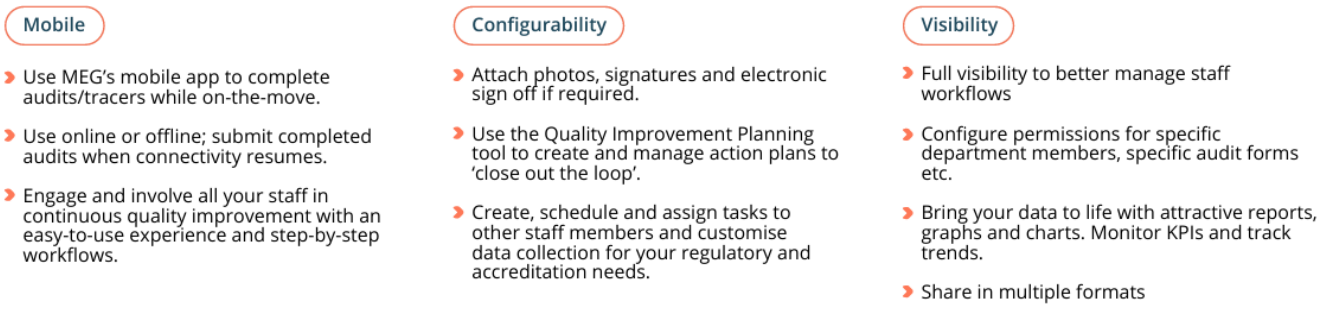
	Audit shows ***Significant Assurance*** for the Trust
Women and Children's	
High Risk Induction of Labour - Fetal Monitoring	**Audit Aim:** Following an ICB action this snapshot audit was commenced to examine if high risk inductions have a fetal monitoring plan and if the plan was followed appropriately.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

Local Audits

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

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

Key Benefits:



Local audit programmes in MEG:

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

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

Striving for Excellence Programme

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

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

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

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

Research

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

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

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

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

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

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

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

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

Care Quality Commission

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

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

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

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

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

Data Governance

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

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

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

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

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

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

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

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

Information Governance

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

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

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

Learning from deaths

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

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

each quarter was:

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

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

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

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

Review method

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

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

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

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

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

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

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

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

2.3 Reporting against Core Indicators

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

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

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

Please see table below.

Indicator	2025/26	2024/25	2023/24	2022/23	National Average	Where applicable – best performer	Where applicable – worst performer
SHMI value and banding (most recent February 2025 to January 2026 2025)	87.0 Within expected range	90.9 Within expected range	96.7 Within expected range	99.9 Within expected range	100.3	71.9	125.6
% Patient deaths coded for palliative care at diagnosis or specialty level; Source: NHS England (SHMI publication) February 2025 to January 2026	38%	39%	44%	41%	N/A		
Our Standard Hospital Mortality Indicator (SHMI) has improved significantly and falls within the expected range. There has been focus on improvement work on disease groups where the Trust was previously an outlier. This position has been sustained during the 12-month reporting period.							
Patient reported outcome scores for primary hip replacement surgery	Data not available	Data not available	Data not available	Data not available	N/A		
Patient reported outcome scores for Knee replacement surgery	Data not available	Data not available	Data not available	Data not available	N/A		
28-day readmission rate for patients aged 0-15 Source: HED Jan 2025 to December 2025	21.20%	19.00%	18.80%	17.10%	10.20%	3.70%	21.90%
28-day readmission rate for patients aged 16 or over Source: HED Jan 2025 to December 2025	7.60%	7.10%	7.30%	6.90%	8.10%	4.00%	13.10%
Paediatric readmission rates have increased and remain above the national average. This is likely due to the work undertaken in the department to avoid unnecessary hospital stays, where it is clear there is no intervention needed that cannot be provided in the community. Careful explanation of the signs to look out for that might require reattendance at the hospitals, along with written information, is given to families. This may be supported by a temporary 'open access' arrangement to the ward, by the Hospital at Home team.							
VTE (annualised) The percentage of patients who were admitted to hospital and who were at risk assessed for venous thromboembolism during the reporting period.	82.70%	78.10%	81.20%	78.20%	N/A		
The threshold for completion of a VTE risk assessment was within 24 hours of admission prior to 2024/25, this was changed to within 14 hours of admission from 2024/25.							
C. Difficile Rate per HES 100,000 bed days**	Total: 32.8 Hospital onset: 24.5 Community onset: 8.3	Total: 41.6 Hospital onset: 33.1 Community onset 8.5	Total: 40.7 Hospital onset: 31.7 Community onset: 9.0	Total: 51.4 Hospital onset: 40.4 Community onset: 10.9	N/A		
C. Difficile rates have decreased overall in this reporting period and this is the case for both Hospital onset and Communitgy onset c-diff. Each case has a multi-disciplinary investigation to establish if there is any learning.							
Number of Never Events	4	2	0	5	N/A		
Never Events are serious incidents that should not occur as there are strong systemic national policy and frameworks in place to prevent them from happening. Each of these incidents have been investigated under the NHS Serious Incident Framework and reported to the Strategic Executive Information System (StEIS).							
Rate of Never Events per HES 100,000 bed days	1.9	1.0	0	3.2	N/A		

Patient Safety Response Framework (PSIRF)

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

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

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

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

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

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

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

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

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

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

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

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

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

Infection Prevention & Control

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

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

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

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

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

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

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

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

Responsiveness to Patients Needs

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

The platforms include:

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

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

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

There have been a variety of Patient Experience groups over the previous year to monitor progress and drive the patient and family experience agenda. It is recognised that improvements are required

regarding improve stakeholder and patient and family engagement inclusion in these forums.

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

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

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

Patient Surveys

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

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

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

Mealtime help and food availability outside of mealtimes has improved year on year since 2020

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

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

Key strengths include:

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

Key improvement priorities include:

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

Friends and Family Test

The Trust also asked patients and service users to rate their overall experience by completing the

Friends and Family Test (FFT). The purpose of these surveys is to understand what patients think of healthcare services provided by the Trust, and actions plans are developed to drive improvements.

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

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

Some of the feedback from FFT:

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

External partners

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

Healthwatch concluded that The Countess of Chester Hospital continues to receive mixed feedback

from patients. While staff are consistently praised for their kindness and professionalism, systemic issues (particularly communication failures, treatment delays, and inconsistent care coordination) remain significant barriers to patient satisfaction and safety. A renewed focus on timeliness, communication standards, and patient-centered planning will be key to improving experiences and rebuilding public confidence in the Trust.

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

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

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

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

Creating the Countess Culture

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

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

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

Our data and staff feedback show that we are a culture in transition. To sustain progress, we must move beyond surface-level interventions. We will take a structured and evidence-based

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

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

Equality Delivery System

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

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

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

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

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

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

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

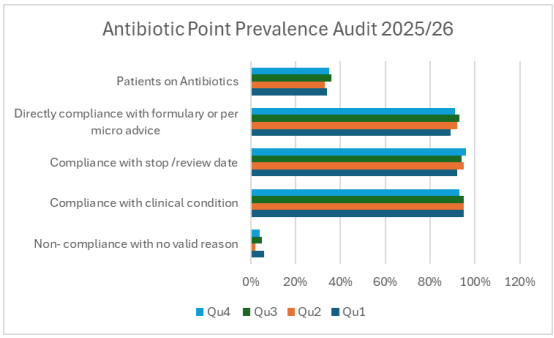
For patients the newly developed Patient Experience Improvement Framework will support the improvement required for the Trust to achieve an achieving activity score. There are clear governance and monitoring frameworks in place.

Part 3: Other information

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

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

Delivering Safe Services

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

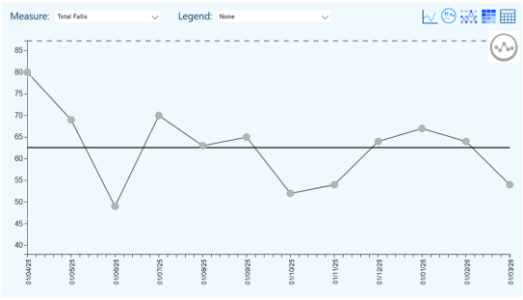
<table>
<tr><th>Priority</th><th>Measure of success</th><th>Achievement</th><th>Progress update</th></tr>
<tr>
<td>Priority 2:
Reduce the incidence of inpatient falls.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Delivering Effectiveness Services

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

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

Delivering Kind and Compassionate Services

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

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

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

3.2 Performance against the relevant indicators and performance thresholds

Indicator	Target	Performance	Explanation
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	**60% March 2026** **<1% March 2026**	**63.8%*** March 2026 1.2%* March 2026 *unvalidated figures; March RTT submission will be made 28/04/26	The Trust delivered improvements on its RTT 18-week compliance (starting the year on 48.5%) and delivered end of year performance above target. Similarly, the Trust significantly reduced its RTT long wait pathways; reducing the >52 week % from 6.6% at the start of the year to 1.2% by year end.
A&E: maximum waiting time of four hours from arrival to admission/ transfer/ discharge ED: higher number of patients admitted, discharged or transferred from ED within 12 hours across 25/26 compared to 24/25	**78% March 2026** **12 hours breaches <25.84%**	**61.2% March 2026** **22.33% Average for 25/26**	Whilst small improvements in 4-hour performance have been made within 25/26 compared to 24/25 (average performance over 25/26 was 2.1% higher than previous year), the Trust still finished the year well below the national standard of 78%. The Trust did reduce the average number of 12 hour breaches by 3.51%. However, it remained an outlier in performance compared with peers. In 25/26 attendances to ED were 7% above previous year. In addition, No Criteria To Reside (NCTR) averaged 21.7%. Both these factors significantly contributed to increased congestion within the ED.
All cancers: 62-day wait for first treatment	**75 %**	**76.6%** (February 2026, latest figures)	Whilst the Trust has not delivered against the 75% target, consistently during 2025/26, we are working to improve this and continue to improve performance. We have continued to perform significantly better than the national provider's average e.g. Feb 26: COCH- 76.6%, national average- 67%. Whilst all cancer tumour sites have ongoing improvement plans to support improved access to treatment, specific focus continues to be paid to supporting access to Urology and Gynaecology cancer services.
Maximum 6-week wait for diagnostic procedures		83.7%	

3.3 Progress against seven-day hospital service

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

The four key standards are:

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

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

The current position at the Trust is as follows:

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

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

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

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

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

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

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

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

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

3.4 Freedom to Speak Up (FTSU)

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

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

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

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

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

FTSU Activity: April 2025 – December 2025

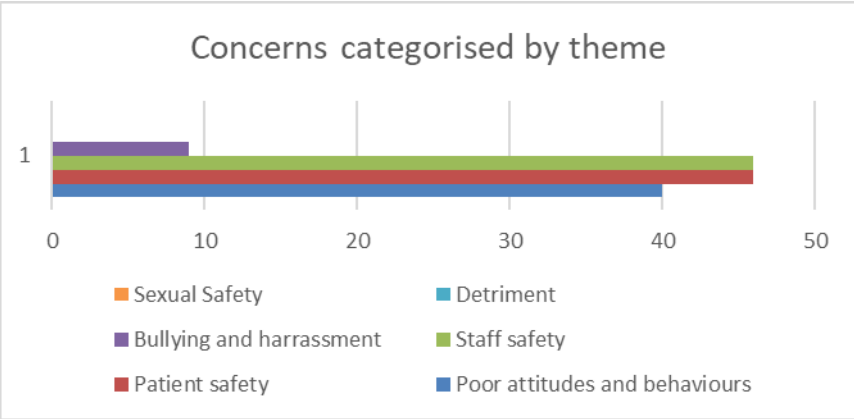
The Trust has several safety reporting channels such as speaking directly to line managers, incident reporting and team and Trust safety huddles. Issues raised in other channels are not logged as FTSU unless referred to or raised directly to the FTSU Guardian.

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

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

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

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



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

Other Key Observations:

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

FTSU Mandatory Training

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

FTSU Champions

The network of over sixty champions continues to provide an alternative for colleagues wanting to either raise a concern or just understand more about Freedom to Speak. In addition, champions are a voice within their own teams, taking time to share information at local meetings and during new staff inductions. Champions training is held three times a year and facilitated by the FTSU Guardian.

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

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

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

3.5 NHS doctors and dentists in training

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

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

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

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

NHS Cheshire and Merseyside Integrated Care Board welcomes the opportunity to review and comment on the Countess of Chester Hospital NHS Foundation Trust Quality Account for 2025/26.

The Quality Account provides a clear, balanced and transparent reflection of the Trust's performance during a year of continued system challenge and increased demand. It demonstrates a sustained commitment to delivering safe, effective and compassionate care, with patients and families at the centre of improvement activity.

NHS Cheshire and Merseyside recognise the strong progress made by the Trust in achieving eight of its nine quality priorities for 2025/26. Significant achievements include measurable improvements in infection prevention, inpatient falls, suspected sepsis assessment, and the experience of maternity and children's services. The new facilities provide a comfortable and welcoming environment for patients and their families, and it is particularly positive to see the implementation of Sophie's Legacy within the department. We will work with the Trust to support the implementation of the remaining areas of improvement.

The Quality Account effectively showcases services that are leading the way in quality, innovation and patient experience, including the Chester Milk Bank, Sterile Services and Endoscopy. We also welcome the significant investment in facilities and infrastructure to improve patient care and experience, including the Blue Skies Balcony, the new Women and Children's Building, investment in modern equipment, and the establishment of research hubs, which collectively demonstrate the Trust's commitment to delivering high-quality, future-focused care. We particularly acknowledge the Trust's nationally leading performance in faster bowel cancer diagnosis and its continued improvement in Referral to Treatment pathways.

We note that the Quality Account appropriately recognises areas requiring further improvement, particularly in urgent and emergency care performance, discharge processes and aspects of timeliness and communication. We are reassured that these challenges are clearly articulated and supported by robust recovery and improvement plans with appropriate Board oversight. NHS Cheshire and Merseyside recognise the Trust's commitment to developing a positive culture and welcomes progress in leadership visibility and staff engagement, alongside an honest acknowledgement of ongoing challenges in consistency and psychological safety.

The Trust's audit programme has been described within the account and assures oversight of clinical effectiveness with 100% participation and many audits providing significant assurance for the Trust. The findings described around NACRM, MINAP and excisional margins for skin cancer lesions sound positive, we will work closely with the Trust to understand more about the clinical audit findings requiring action during 2026/27 and support this delivery to allow further improvement journeys to be presented in the next quality account.

The Trust's open learning culture is clearly demonstrated within the Account, with particular emphasis on learning from mortality reviews. We welcome the identification of key learning themes, robust governance arrangements, and improvements in family engagement and learning from inquests. We also support the Trust's plans to strengthen thematic analysis and cross-divisional learning to ensure measurable improvements in patient safety and care quality. The priorities identified by the Trust for 2026/27 are appropriate, patient-centred and aligned with system objectives, with a continued focus on safety, effectiveness and personalised, compassionate care. NHS Cheshire and Merseyside will continue to work closely with the Trust

to provide support and constructive challenge, to ensure sustained improvement and better outcomes for the populations we serve.
Overall, NHS Cheshire and Merseyside endorse the 2025/26 Quality Account and would like to thank the Trust's staff, patients and partners for their continued commitment to improving quality and safety.

Yours sincerely
Fiona Lemmens
Executive Clinical Director
NHS Cheshire and Merseyside ICB

Statement from Healthwatch Cheshire

Healthwatch Cheshire welcomes the clear focus within the Quality Accounts on improving patient safety, patient experience and access to care across the Countess of Chester Hospital NHS Foundation Trust. The report demonstrates a strong commitment to partnership working across hospital, community and care home settings, with a continued emphasis on supporting people to receive care closer to home wherever possible. Initiatives such as care home staff training, the introduction of local diagnostic services, improved respiratory support for children locally, and developments in virtual access for autistic patients and people with additional needs are particularly positive from a patient and community perspective. Healthwatch Cheshire has heard directly through Enter and View activity and patient feedback how valuable joined-up services, compassionate staff support and improved local access to care are for patients, families and carers.
The report also highlights a number of significant achievements around patient safety, cancer diagnosis times, infection prevention, falls reduction and personalised care. The Trust should be commended for recognising the importance of involving patients and families more directly in safety investigations and care planning, alongside the development of the Patient Engagement Framework and Patient Wellness Questionnaire linked to Martha's Rule. The strong emphasis on kindness, dignity and compassionate care reflected within patient survey results is encouraging, particularly given the ongoing pressures facing acute services nationally.
Healthwatch Cheshire also welcomes the Trust's acknowledgement of the areas where further improvement is required. Feedback received from patients continues to identify concerns around communication, discharge planning, waiting times, care coordination and administrative processes. It is positive that the Trust recognises these themes and has identified them within future priorities and improvement plans. From a patient perspective, maintaining clear communication, involving patients and families in decisions, and ensuring people feel informed and supported throughout their care journey will remain essential in improving confidence and overall experience. Continued engagement with patients, carers, community organisations and external partners will be important to ensure that improvement work remains focused on what matters most to local people.

Diane Brown 14/05/26

Statement from Health Scrutiny Committee, Cheshire West and Chester Council

The Health Overview and Scrutiny Committee welcomes the opportunity to comment on the Trust's Quality Accounts for 2025/26.

The Committee would like to place on record its thanks to staff across the Trust for their continued openness and engagement with scrutiny. Members value opportunities to visit services and speak directly with staff, which helps provide important context to the information presented.

The Committee also recognises the ongoing pressures facing NHS services and the increasing demand across the Trust's three sites. Members extend their thanks and appreciation to all staff for their continued commitment to delivering care to residents across Cheshire West and Chester, and welcome the opportunity to see first-hand the improvements being made for local people.

OVERALL VIEW

The Quality Account provide a comprehensive overview of the Trust's work and the Committee were pleased to read about the improvements they have made. However, the accounts remain lengthy and, at times, difficult to follow. The Committee would welcome a more accessible format in future, with clearer summaries and stronger links between narrative, data and outcomes and perhaps some case studies or examples of positive lived experiences.

PROGRESS AND IMPROVEMENT

The Committee welcomes the progress made across a number of areas, including the achievement of most quality priorities and improvements in patient safety and infection prevention. Members also recognise a number of positive developments during the year, including national recognition for patient safety, the award-winning Milk Bank, the development of new facilities such as the Blue Skies Balcony, improvements in diagnostic provision, and the opening of the net zero Women and Children's Building.

PERFORMANCE AND PATIENT SAFETY

While improvements have been made, a number of performance challenges remain, particularly in urgent and emergency care and infection-related indicators. Sepsis care was discussed in detail during the meeting. The Committee has been advised that a structured improvement programme is in place, supported by a specialist team with real-time monitoring. In one recent snapshot, 24 patients were treated for suspected sepsis, with 8 confirmed cases. Members recognised the complexity of sepsis diagnosis and the need to balance timely treatment with appropriate use of antibiotics but would welcome continued reporting on performance and outcomes. The Committee noted that patient deterioration was an important safety issue requiring continued focus.

USE OF DATA

Members highlighted the importance of ensuring data is accurate, consistent and meaningful. Concerns were noted around potential duplication where patients move wards and reliance on staff reporting.The Committee was advised that working groups review data and trends, but would welcome clearer explanation of validation processes.

PATIENT EXPERIENCE

The Committee welcomes strong patient feedback around dignity, compassion and trust, but notes response rates remain slightly below average. More clarity is needed on how feedback leads to measurable improvements.

CQC AND GOVERNANCE

The Committee notes the previous CQC inspection findings and the improvement work undertaken. The outcome of the latest inspection is awaited. The Committee would welcome future accounts to demonstrate progress against inspection findings.

SYSTEM PRESSURES AND URGENT CARE

Urgent and emergency care remains a key area of concern for the Scrutiny Committee. Members discussed increasing demand, limited access to GP services and the lack of a walk-in centre in Chester. These factors are contributing to more patients attending hospital, including those who may not require emergency care but have limited alternatives. The Committee noted that the Trusts cares and treats patients from Wales and this puts additional pressures on the Hospital. The Scrutiny Committee requested further information on the non-urgent attendances, repeat visits and the availability of community services.

PATIENT FLOW AND DISCHARGE

The Committee welcomes work to improve discharge processes but notes patient flow continues to be affected by delays and wider system pressures.

CONCLUSION

The Committee recognises progress and innovation made across the Trust but notes there remains some ongoing challenges, particularly in urgent care, patient flow, discharge, Sepsis and wider system demand, including access to primary care.

RECOMMENDATIONS

With regards to the Quality Accounts, the Health Overview and Scrutiny Committee recommends that the Trust:

1. Provide clearer links between narrative statements and performance data
2. Include examples of improved patient outcomes in the Quality Accounts
3. Strengthen reporting on progress against CQC action plans
4. Sets out clear targets, timescales and measures of success for priorities
5. Provides further details on pressures and any potential impact on
    - Health inequalities
    - How patient feedback leads to change

The Scrutiny Committee requested to be continually updated on further improvements on:

- Urgent and emergency care performance
- Patient flow and discharge
- Infection control improvements and Sepsis

Recommendations from the Health Scrutiny Committee meeting held on 22 June 2026:

1. The Committee requests that the Trust provides data for 2025/26 on the number of patients attending the Emergency Department who may not have required emergency care, including any analysis of the reasons for attendance.

2. The Committee would welcome further information on patients who repeatedly attend or re-present services, including any identified trends and actions being taken to address this.

3. The Committee also asks the Trust to work with system partners to identify gaps in community-based services that may be contributing to hospital attendances, and to provide an update to the Committee on this within the next six months.

4. The Committee would welcome the Trusts input into the Scrutiny Review of Discharge.

24 June 2026

Health Overview and Scrutiny Committee

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

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

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

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

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

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

Jane Tomkinson OBE

Chief Executive

Neil Large

Chairman