NHS
Countess of Chester Hospital
NHS Foundation Trust

Annual Report & Accounts

2018/2019

Presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.

The Countess of Chester Hospital NHS Foundation Trust

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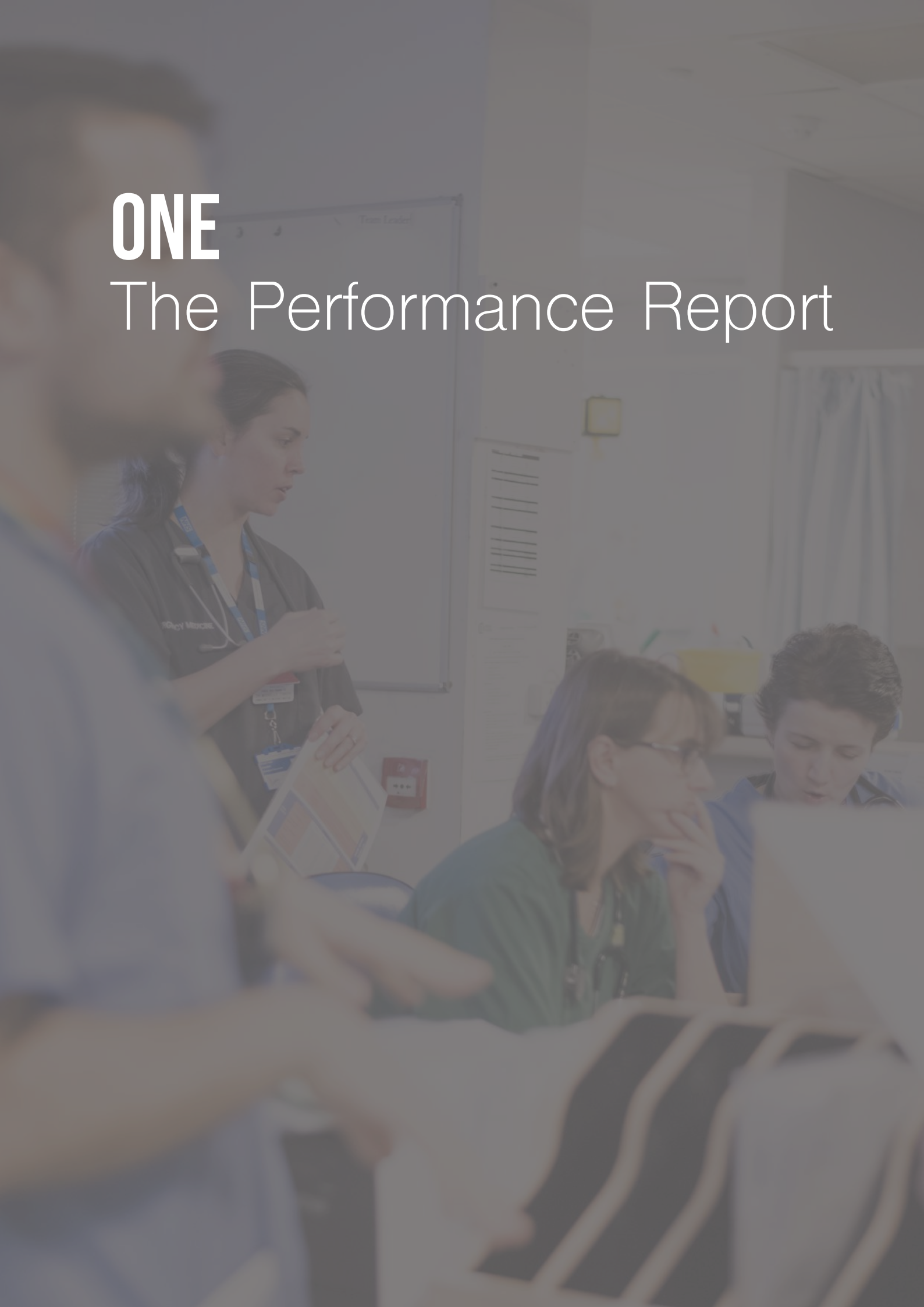


1. Performance Report

1.1 Performance Overview

Statement from the Chairman & Chief Executive

Welcome to the 2018/19 Annual Report of the Countess of Chester Hospital NHS Foundation Trust. This has been a year of change for the Trust and a year of challenge but also achievement.

In my new role as Chief Executive Officer of The Countess of Chester Hospital NHS Foundation Trust I look forward to working hard with staff and partners to deliver the consistently high standards of care to which we all aspire and which our patients deserve. I am delighted and extremely proud to be in this role.

Of key importance for 2019/20 will be the implementation of the Trust's new clinical strategy which will set out our priorities to clearly inform the decisions we make as an organisation for the next five years. It will define our objectives and provide the framework for improvement.
The clinical strategy will be closely followed by a new Trust-wide corporate strategy.

Over the last 12 months we have continued to experience rising levels of demand for all of our services. This is unlikely to change given the demography of our local population unless we work together with partners across the system in the transformation of services. We are therefore pleased to report increasing levels of engagement with the Integrated Care Partnership priorities for delivery of improved outcomes and experiences for our population. With this in mind it was especially pleasing last summer to see West Cheshire identified as one of the "most improved" areas for one-year cancer survival.

We delivered a significant improvement in the urgent care pathway in June, when we created a new 51 bedded Acute Medical Unit. With daily consultant review, the unit is designed to reduce the number of admissions to medical wards, reduce bed occupancy and length of stay, and improve patient flow overall. This is an important component of our plans to effectively respond to the levels of demand facing us.

In July, we opened our Older Persons' Assessment Unit, with a new multi-disciplinary team created to see older patients before a crisis point is reached, as well as those at risk of readmission. Where needed, the Emergency Geriatrician is on hand to give advice, and offer alternative management strategies to avoid the need for attendance at the Emergency Department.

The autumn provided us with an opportunity to highlight more good practice when we won a national Nursing Times Award for use of technology and data in nursing. Benefits provided by the Trust's Co-ordination Centre were at the heart of the nomination with the daily use of real-time patient flow and e-rostering software having a significant positive impact on the safe and effective treatment of patients and staff at the hospital.

In spite of the increasing demands on our teams, we continue to receive much positive feedback from our patients and their relatives, including a grandmother writing to the Queen herself to praise the care she received at The Countess last summer.

Our Countess midwives were also praised for the care they provide in the NHS Maternity Survey, with 97% of respondents saying they

were confident in the care provided to them and 98% of women felt they were treated with dignity and respect.

We continue to promote an open, honest and transparent culture and are pleased to have appointed a dedicated freedom to speak up guardian who joins us in June. We celebrate staff and recognise their achievements through initiatives such as our monthly "Countess Gems" recognition awards and have improved engagement with staff through the introduction of a weekly "What's Brewing" Executive drop-in session and quarterly senior leadership summits.

In February 2019 we honoured our staff at our yearly Celebration of Achievement Awards. This was a truly inspiring and uplifting occasion with many staff acknowledged for going above and beyond in the delivery of excellence.

The work we have undertaken to create an inclusive workplace was recognised in the autumn when we were ranked 24th in a list of the Inclusive Top 50 UK Employers List. We know we have more to do and we are committed to promoting all strands of diversity including age, disability, gender, LGBT, race, faith and religion.

Our staff survey results were disappointing as they have been for the past few years. We will be working hard together over the coming months to improve in the areas where we fall short of the standard to which we aspire. Of particular concern was staff did not feel that we have a strong safety culture. This is a basic fundamental of healthcare that we simply must get right. Results showed that there was a 3% drop in members of staff who said they would know what to do if they were concerned about unsafe clinical practice. Whilst our overall result for this question is in line with the national average, we are committed to the creation of a "patient safety first" culture throughout the organisation.

In December we were inspected by the Care Quality Commission as part of their Well Led review process, with their final report being published on 17th May 2019. Further detail is provided later in this report.

We recognise our civic responsibility, especially as one of the biggest employers in Chester and the Flintshire border, to help local partners address the wider determinants of health in the community for our population and I will ensure the Trust plays its part at both local and regional level to best serve the needs of our patients.

Sir Duncan Nichol CBE
Chairman

Dr **Susan Gilby**
Chief Executive Officer

21st May 2019

About the Countess of Chester Hospital NHS Foundation Trust

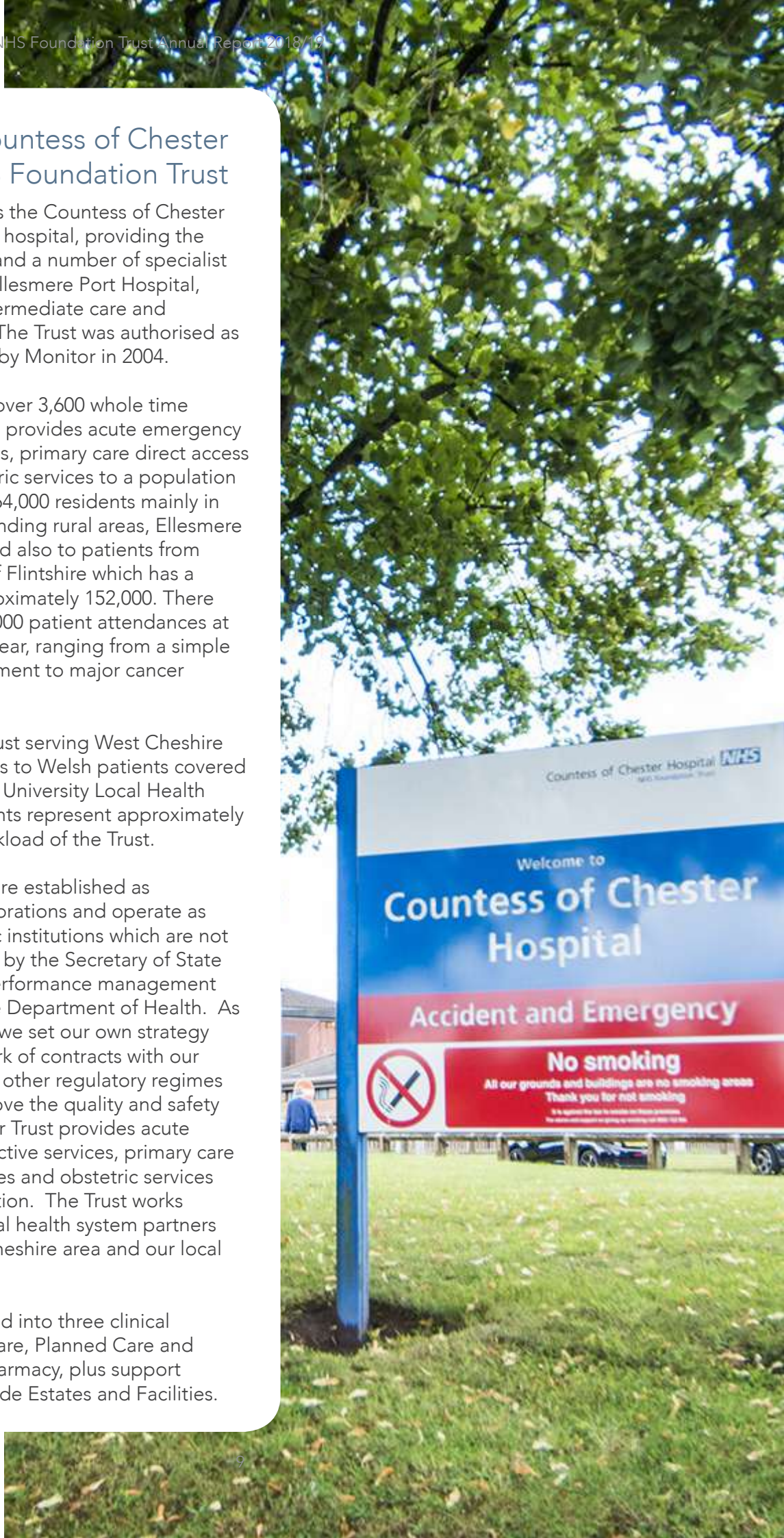
The Trust comprises the Countess of Chester Hospital, a 600 bed hospital, providing the full range of acute and a number of specialist services, and also Ellesmere Port Hospital, a rehabilitation, intermediate care and outpatient facility. The Trust was authorised as a Foundation Trust by Monitor in 2004.

The Trust employs over 3,600 whole time equivalent staff and provides acute emergency and elective services, primary care direct access services and obstetric services to a population of approximately 264,000 residents mainly in Chester and surrounding rural areas, Ellesmere Port and Neston and also to patients from the Deeside area of Flintshire which has a population of approximately 152,000. There are more than 500,000 patient attendances at the hospital every year, ranging from a simple outpatient appointment to major cancer surgery.

We are the main Trust serving West Cheshire and provide services to Welsh patients covered by Betsi Cadwaladr University Local Health Board. Welsh patients represent approximately one fifth of the workload of the Trust.

Foundation Trusts are established as public benefit corporations and operate as independent public institutions which are not subject to direction by the Secretary of State for Health or the performance management requirements of the Department of Health. As a Foundation Trust we set our own strategy within the framework of contracts with our commissioners and other regulatory regimes to continually improve the quality and safety of patient care. Our Trust provides acute emergency and elective services, primary care direct access services and obstetric services to our local population. The Trust works closely with our local health system partners in the Wirral and Cheshire area and our local communities.

The Trust is arranged into three clinical Divisions: Urgent Care, Planned Care and Diagnostics and Pharmacy, plus support services which include Estates and Facilities.



Strategic Context

Our vision at The Countess of Chester Hospital NHS Foundation Trust is to deliver NHS care locally that makes our staff and our community proud.

Over the next ten years the Trust is facing a significant challenge in West Cheshire because of the continued growth in our aged population. This is impacting currently on our emergency service delivery, and waiting times targets for our patients. Demographic analysis of our population projects another 7,000 people within our locality, with 6,000 of those living beyond the age of 80 years, an increase of 41%. Including Flintshire (our North Wales catchment) the total population will increase by over 13,000 people. This increase in demand, particularly with the elderly, will place significant additional pressure on all of our services, therefore we are exploring new ways of working, both locally and more widely.

Cheshire & Mersey Health & Care Partnership (STP)

In addition to the key objectives of the Long Term NHS Plan, the challenge of transforming a complex group of organisations and services across such a large and diverse footprint across Cheshire & Merseyside (C&M) is a real one. To transform our services and become sustainable, we need to mitigate demand, unwarranted variation, duplication, and cost. To achieve this we will be supporting the strategic work streams across Cheshire & Mersey. These are -

- Acute Sustainability
  Defining a single aggregated vision and model of care for C&M acute services
- Mental Health & LD Sustainability
  New pathways and models of crisis care, CAHMS, and integrated physical & MH services
- Carter at Scale
  Designing sustainable back office and clinical support services with reduced duplication and increased efficiencies
- Population Health
  Focus on reducing high blood pressure, alcohol related harm, and a reduction in prescribed antibiotics
- GP Networking
  To co-design new generic models for the future of Primary Care

The strategic workstreams are in addition to the locality 'Place Based' integrated care programmes across Cheshire & Merseyside, and a number of other cross cutting and enabling workstreams supporting overall delivery.

Cheshire West Integrated Care Partnership

We are working with our health and social care partners in West Cheshire to create a new Integrated Care Partnership (CW ICP), hosted by the Countess of Chester Hospital, to transform how services are delivered to our most complex and demanding patients. CW ICP will deliver a Transformation Plan and Programme for 2019/20 building on the work in 2018/19. Based on the Large Scale Change (NHSE) social system model for change methodology, the CW ICP Transformation Plan will include activities (test for change) that support realisation of the following six transformation goals -

1. Understand and actively mobilise the population
2. Actively promoting self-care, self-service and developing community assets
3. Actively divert people to the most effective and efficient access points
4. Support and encourage the flow of people to the right resources
5. Support and encourage people with multiple conditions and complex needs through multiagency teams
6. Support community professionals with resources from the acute

CW ICP will focus on the following programmes to deliver the vision, outcomes and deliverables of the CW ICP Transformation Plan. The programmes are clinically sponsored, have senior management programme leads, and involve representatives from all partner organisations –

- Care Communities
  We will develop nine Care Communities across Cheshire West to deliver our Model of Care.
- Intermediate Care
  We will develop Intermediate Care

services which take away services that don't need to be delivered in an acute setting into community.

- Long Term Care
  We will support people living with Long Term Care needs to receive the right services in their community.
- Healthy Lives
  We will support people to enjoy Healthy Lives in their communities.

We have a shared ambition for a more aligned strategic focus to support organisations to achieve strategic priorities and benefiting from the synergies that undoubtedly exist by bringing workforce and estate into a more collaborative operating model. Variations in our outcomes and efficiency will be reduced at a faster pace by working together under the new leadership model.

Finally, we are developing our Trust Clinical Strategy which, in the context of the pressures and developments above, will describe clinically the direction and shape of our services over the next five years. This will be supported by a five-year business plan, which will determine our operational plans which will be refreshed annually.

Principal Risks Faced by the Trust

The following table shows the Trust's 2018/19 strategic risks from our assurance framework-

Strategic Risk in 2018/19	Board Committee	Risk score at quarter 4*
Failure to maintain and enhance the quality and safety of the patient experience and ensure regulatory compliance	Quality, Safety and Patient Experience	4x3=12
Unable to meet demand for services within available resources	Finance and Integrated Governance	4x4=16
Failure to collaboratively innovate and transform the Trusts clinical services	Finance and Integrated Governance	4x3=12
Failure to deliver the Trusts culture, values and staff engagement plan	People and Organisational Development	4x3=12
Failure to deliver in year financial plan and manage consequences of delivering a deficit budget	Finance and Integrated Governance	4x5=20
Failure to comply with Compliance Framework	Finance and Integrated Governance	4x4=16
Failure to maintain robust corporate governance and overall assurance	Finance and Integrated Governance	3x4=12
Failure to maintain Information Governance standards	Finance and Integrated Governance	3x4=12
Failure to provide appropriate informatics infrastructure, systems and services that affect high quality patient care in-line with the business objectives of the Trust	Finance and Integrated Governance	3x4=12
Failure to recruit, train and retain professional staff.	People and Organisational Development	4x4=16

** The risk score is formed based on 'likelihood' and 'severity/impact rating' as follows -*

- *Severity/Impact: 5-Catastrophic, 4-Major, 3-Moderate, 2-Minor, 1-Insignificant*
- *Likelihood: 5-Almost certain, 4-Likely, 3-Possible, 2-Unlikely, 1-Rare*
- *The grading bands of risks are: 1-5 Very low, 6-8 Low, 9-15 Moderate, 16-25 High*

The Quarter 4 score is subject to agreement by the Board of Directors in May 2019. 2018/19 has been a demanding year for the Trust, as we have operated below the emergency standards access measure of four hours. Acute patient flow, with slow development of capacity outside the hospital with the exception of the Intermediate Care Partnership beds at Ellesmere Port, continues to be a risk and concern into 2019/20. This is having an impact on a number of strategic risks. Financial plan risks along with financial

and recovery plans have been a high risk in 2018/19 and will continue into 2019/20.

During the year, the Board has been updated in public session on the national expectations on Trusts related to the United Kingdom leaving the European Union. The Trust has complied with all relevant national requirements. The Board has reviewed the potential risks, and has concluded that this is not a significant strategic risk for the organisation given the matters being dealt with directly by NHS central bodies and HM Government.

1.2 Going Concern Overview

International Accounting Standard (IAS) 1 requires management to assess, as part of the accounts preparation process, the NHS Foundation Trust's ability to continue as a going concern.

In accordance with the Department of Health and Social Care Group Accounting Manual the financial statements have been prepared on a going concern basis as we do not either intend to apply to the Secretary of State for the dissolution of the NHS Foundation Trust without the transfer of the services to another entity, or consider that this course of action will be necessary.

The Trust's performance in-year showed a pre-impairment deficit of £8.1m after the receipt of £2.8m additional 'incentive' Provider Sustainability Funding, which is an adverse variance to the original plan submitted to NHS Improvement at the start of the year. During the year, the Trust required £6.7m interim revenue loans from the Department of Health and Social Care to support the revenue cash position.

The current 2019/20 forecasts show a (pre-impairments) planned break even position, including £8.0m of PSF funding. To achieve this, the Trust will need to deliver cost reductions of £9.4m (equivalent to 3.7% of turnover), which includes £5.9m that has currently been classified as high risk.

In addition, the Trust will apply for an interim capital loan to finance its 2019/20 capital program. The Trust finished the year with £7.4m cash balance to support the £4.4m of outstanding capital creditors and the ongoing revenue position. The latest operating and cash flow forecasts currently show that the Trust will require net additional interim revenue support of £1.3m to cover the cash lag in the timing of the incentive payments received, although this is dependent on the successful delivery of its financial plan and there will be a revenue cash requirement in the early part of the year due to phasing of cost reduction schemes. The Trust has drawn down £3.4m of interim revenue loans up to May 2019. Further capital financing will be required for 2020/21 and beyond. As with any Trust placing reliance on the DHSC for financial support, the directors acknowledge that there can be no certainty that this support will continue although, at the date of approval of these financial statements, they have no reason to believe that it will not do so.

Due to the significant reduction in capital funding available to the sector, NHS Improvement will review the interim capital loan application, to ensure that it meets its requirements of being 'urgent and necessary' only. It is possible that not all of the required capital loan will be approved, in which case the relevant capital expenditure would need to be deferred until a later date, when funding would be reapplied for.

Contracts for 2019/20 have been agreed with all major English commissioners, and the overarching funding issues with Flintshire have been resolved.

Based on these indications the directors believe that it remains appropriate to prepare the accounts on a going concern basis. However, the matters referred to above represent a material uncertainty that may cast significant doubt on the Trust's ability to continue as a going concern, that it may therefore be unable to realise its assets and discharge its liabilities in the normal course of business. The financial statements do not include any adjustments that would result from the basis of preparation being inappropriate.

1.3 Performance Analysis

The Board receives the Integrated Performance Report each month, structured round Safe, Kind and Effective care which include detailed exception reports, and performance against key quality indicators.

This includes actions being undertaken to address any risks and uncertainties. The Board receives quarterly updates on cancer performance, a winter resilience plan during quarter three and ad hoc reports pertaining to specific areas of operational risk.

Key Performance Indicators, by Quarter, 2018/19

	Target	Q1	Q2	Q3	Q4
Infection Control Targets					
Clostridium Difficile	23	9	7	4	10
MRSA	0	1	0	2	0
Waiting Times					
Total time in A&E	95%	81.2%	86.6%	82.2%	81.9%
Diagnostic 6 week target	99%	90.4%	91.0%	95.0%	95.3%
% RTT incomplete Pathway	92%	88.6%	87.8%	86.1%	83.9%
Cancer Targets					
14 days - all cancers	93%	98.5%	98.3%	97.7%	98.1%
14 days - breast symptomatic	93%	98.6%	99.7%	100%	100%
31 day - decision to treat to treatment	96%	100%	99.7%	99.0%	99.3%
31 days - subsequent surgical treatment	94%	98.0%	94.7%	94.6%	86.1%
31 days - subsequent non-surgical treatment	98%	100%	100%	100%	100%
62 days - first treatment from urgent GP referral	85%	88.5%	82.0%	81.9%	82.2%
62 days - first treatment from screening referral	90%	100%	98.2%	95.4%	96.2%

Infection Control

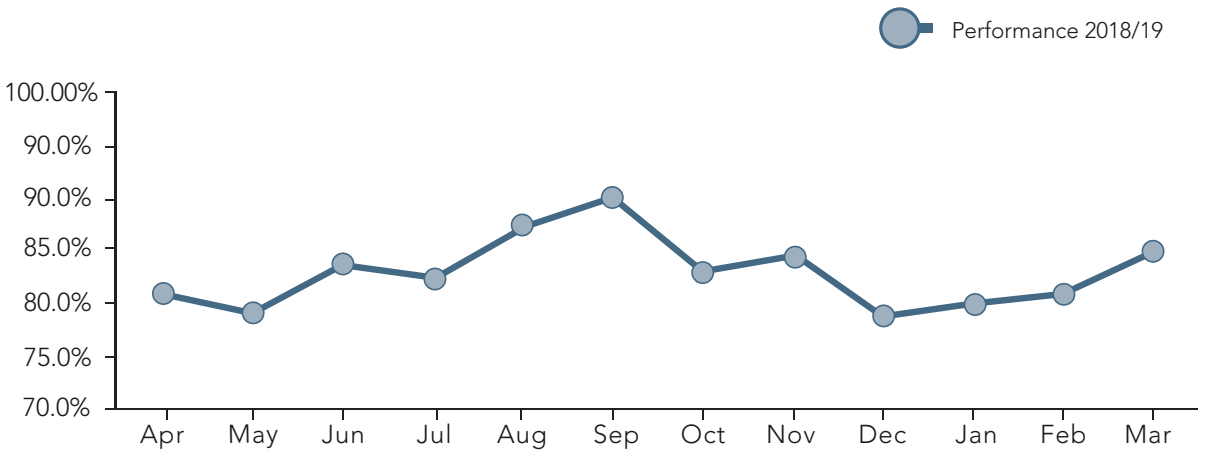
The Trust did not achieve the Clostridium difficile infection objective of no more than 23 cases within the year. 30 cases of Clostridium difficile infection were reported during 2018/19. There were three cases of avoidable MRSA bacteraemia infections last year also, an increase of two on the previous year.

Emergency Department / A&E Access Measure

This access measure is to achieve a maximum wait time of four hours in A&E from patient arrival to admission, transfer or discharge. Performance has remained below the 95% target all year. Along with other trusts nationally, we have found this a challenging time, due to increasing demand, higher patient acuity and an ageing population. The Trust has been working with the Emergency Care Improvement Programme, building on our own improvement work streams with the aim of improving performance against this measure.

The Trust has focused on developing an Urgent Treatment Centre and other ambulatory care streams to support alternatives to the use of a Type 1 A&E.

A&E 4 Hour Wait Performance

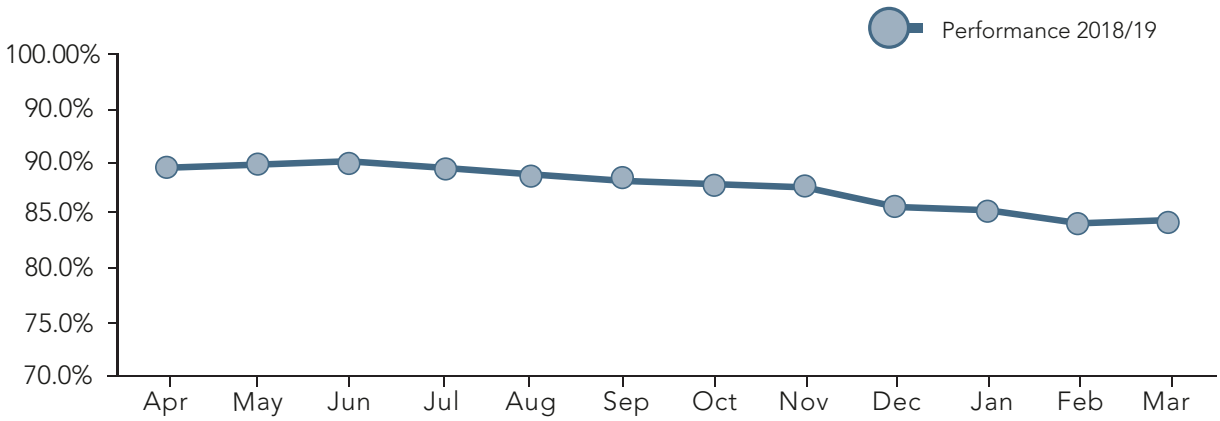


18 Weeks Referral to Treatment (RTT)

The threshold for this target is 92% and monitors the percentage of incomplete pathways for English patients within 18 weeks of referral to treatment. We did not achieve this threshold during 2018/19. Increases in demand, particularly for suspected cancer referrals, coupled with high bed occupancy from pressures in urgent and emergency pathways, have required close monitoring and intervention throughout the year. The Trust is working to reduce the number of cancelled or missed appointments, to improve utilisation and continue to improve the productivity in theatres through improved patient communication via text messaging services.

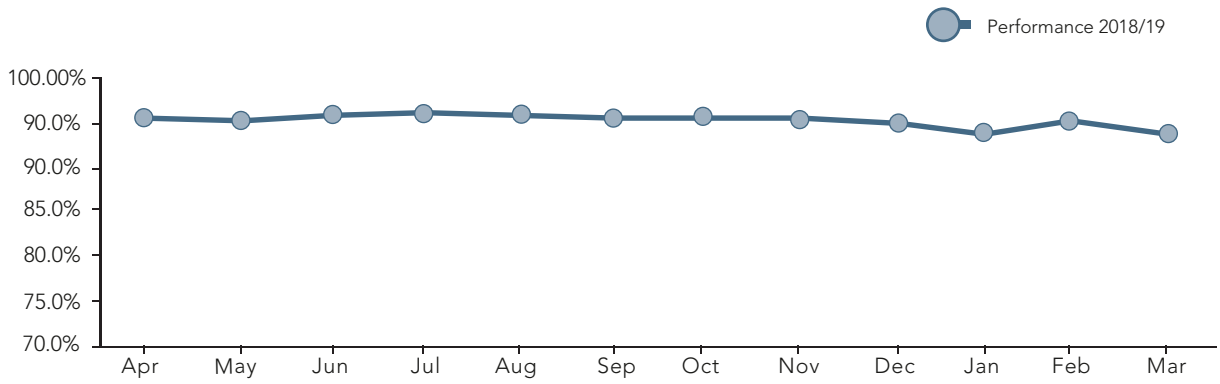
The following graph shows the English referral to treatment performance by month.

English 18 Weeks RTT - Incomplete



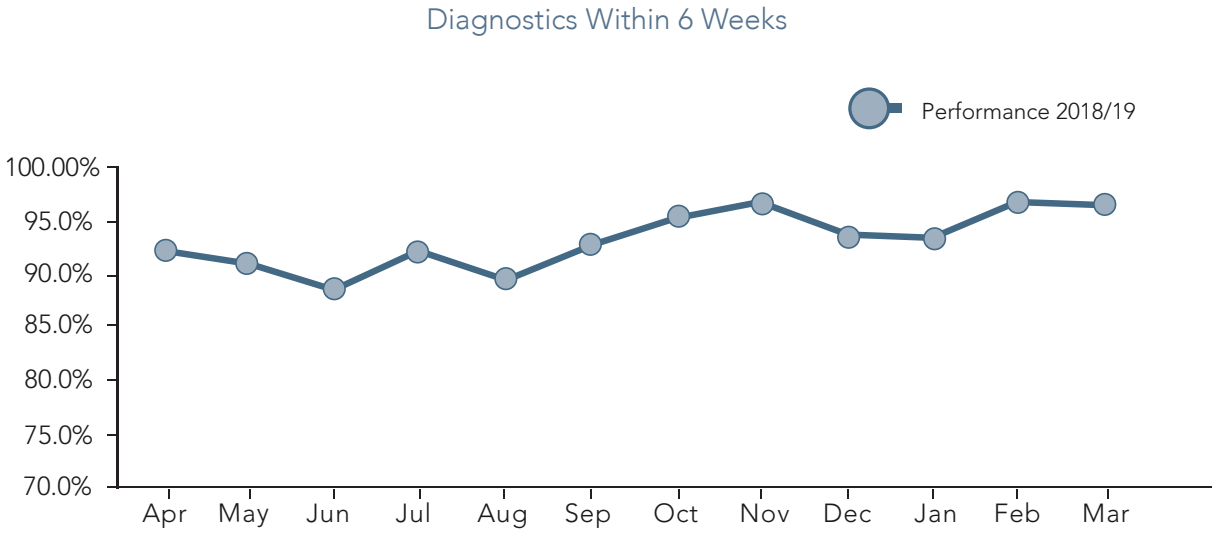
The RTT target in Wales of 26 weeks is different to the English target and Welsh patients are normally seen within the contractual target. The graphs showing the Welsh target performance for admitted and non-admitted patients, by month, can be seen as follows.

Welsh 26 Weeks RTT - Incomplete



Diagnostics Six Week Standard

This standard is for diagnostic tests to be carried out within six weeks of the request being received. We did not achieve the 99% threshold during 2018/19. Nationally there are workforce challenges for sonographers, which has resulted in capacity pressures for certain modalities. The Trust has prioritised those diagnostics related to cancer resulting in some challenges to delivering the 6 week standard for routine tests.



Cancer 62 Day Standard

The 62 Day Cancer standard continues to be a challenge, although the Trust is working collaboratively with primary care to improve patient pathways. Certain specialities have been prioritised and we are monitoring outcomes against agreed actions. The Trust has seen some in year improvements but further work is required to deliver performance on a quarterly basis.

Activity

2018/19 saw a further significant increase in A&E attendances, with a subsequent impact on increased non-elective admissions also. Outpatient activity continues to reduce in line with our commissioner's plans to move activity closer to home.

	2016/17	2017/18	2018/19	% change
Elective Inpatients	4,900	4,905	4,690	-4.4%
Elective day case patients (same day)	32,834	32,902	37,395	13.7%
Non-elective (urgent) inpatients	31,916	31,991	32,682	2.2%
Outpatients - first attendance	69,243	67,767	65,142	-3.9%
A&E	69,254	70,743	75,645	6.9%

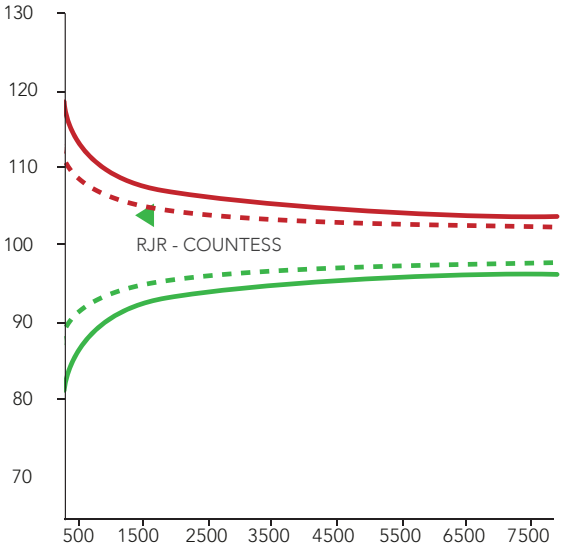
Summary Hospital Mortality Indicator (SHMI)

The SHMI quarterly values for 2018/19 were -

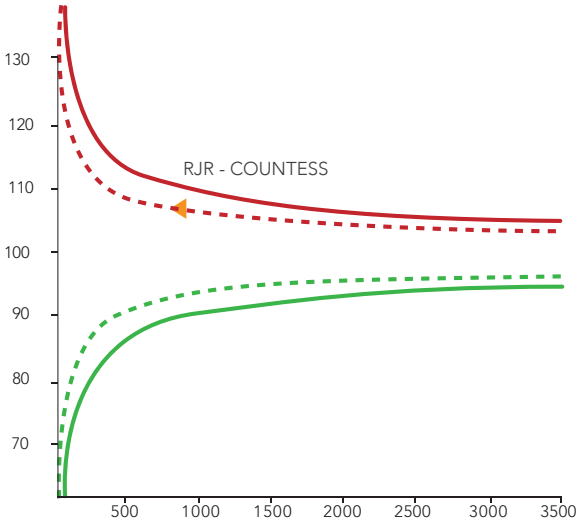
Year	COCH SHMI	Best Trust	Worst Trust	Outlier Alert Level
April 17 - March 18	1.04	0.70	1.23	Band 2 As expected
July 17 - June 18	1.04	0.70	1.25	Band 2 As expected
October 17 - September 18	1.07	0.70	1.27	Band 2 As expected
January 18 - December 18	1.07	0.70	1.23	Band 2 As expected

Both SHMI and the Hospital Standardised Mortality Ratios (HSMR) indicators are analysed and reviewed within the Trust on a monthly basis, via the Learning from Death's Group.

SHMI Ranking



HSMR Ranking



SHMI - The Trust is at Alert Level GREEN for SHMI relative to peers /
HSMR - The Trust is at Alert Level AMBER for HSMR relative to peers

Equality, Diversity and Human Rights

We have a well-developed and award winning equality governance framework, which includes patients and third sector organisations from across the full range of protected characteristics.

We undertake a significant number of inclusion and engagement activities with protected groups which are overseen by our Equality, Diversity and Human Rights Strategy Group, and the equality sub-groups that report into it.

The following achievements in 2018/19 are a consequence of our transparent, inclusive and engaging equality, diversity and human rights agenda and we are proud to have achieved the following -

- Delivered system changes and reasonable adjustments to meet the Accessible Information Standard for Health and Social Care (AIS).
- NHS Equality Delivery System 2 (EDS2) rating in 2018/19 scored the Trust at Achieving status across fourteen of the eighteen EDS2 outcomes, the remaining four being rated as Excelling following assessment by stakeholder groups from the protected characteristics and Health Watch.
- Published our fourth annual NHS Workforce Race Equality Standard (WRES) submission for the year 2018/19
- Facilitated forum and consultation events to for staff who are disabled or have a long term condition, in preparation for the NHS England Workforce Disability Equality Standard (WDES).
- Retained the Navajo Charter Mark in May 2017 for commitments to Staff and Patients who identify as Lesbian, Gay Bisexual, Trans and Intersexed, which stands for the period 2017-19.
- Attained Disability Confident Employer (Level 2) status accreditation in February 2019, for policies, support and development opportunities for disabled employees.
- Co-facilitated multi-agency health and wellbeing forums with stakeholder groups representing the protected characteristics, including an event for people with mental health problems and those who face economic and health inequalities.
- Continued to facilitate stakeholders from across the protected characteristics to be involved, and in some cases chair, the Trust's equality groups, the equality governance framework and joint working initiatives.
- Co-facilitated events in partnership with statutory and 3rd sector organisations e.g. One World Week and Chester LGBT Pride.
- Enhanced the governance and accessibility of the Health Passport and Reasonable Adjustments for disabled people and carers.
- Set in place preparations for the new NHS Sexual Orientation Monitoring Standard, as an NHS Employer pilot site, launched in July 2018.
- Came number 24 in UKs Top 50 Most Inclusive Employers Award.
- Joined Stonewall as a Stonewall Champion Employer.
- Undertook staff focus groups, and as a result set up virtual staff networks for LGBT+, BME, carers and staff with disabilities.

Looking ahead, the Trust will look to develop even further its engagement and collaboration with stakeholder groups within our community, and across our members of staff representing the protected characteristics.

Health & Safety

Health & Safety training and policies have continued to be developed throughout the year. In particular, there has been a focus on enhancing and embedding health and safety risk assessment processes across the Trust.

Modern Slavery Statement

The Trust is committed to ensuring there is no modern slavery or human trafficking in any part of our business activity. Our commitment to social and environmental responsibility is covered by our approach to modern slavery and human trafficking, which is part of our safeguarding strategy and arrangements.

Safeguarding

Our commitment to ensure no modern slavery or human trafficking is reflected in a number of our policies and procedures. These include our Safeguarding and Promoting the Welfare of Children, Safeguarding Adults Policy and Safeguarding Strategy, which have been developed and maintained within the national and local safeguarding children governance and accountabilities frameworks. It includes guidance on initial contact with a suspected human trafficking victim and the National Referral Mechanism.

Training and Promotion

Our safeguarding training includes role relevant modern slavery awareness and resources to promote understanding of the Department of Health's project around Provider Responses, Treatment and Care for Trafficked People (PROTECT).

1.4 Progress against our Sustainable Development Plan

Introduction

As an NHS organisation, and as a spender of public funds, we have an obligation to work in a way that has a positive effect on the communities we serve. Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. By making the most of social, environmental and economic assets we will continue to improve health both in the immediate and long term. We will do this even in the context of the rising cost of natural resources. The Trust ensured that the social and environmental impacts embedded in the legal requirements of the Public Services (Social Value) Act (2012) were met.

Our Sustainable Development Management Plan has been refined which will outline the Trust's vision for sustainability over the next 5 years. This will ensure that the Trust continues to meet all legislative, contractual and mandatory responsibilities relating to sustainable development. It will ensure that sustainable developments are aligned to the strategic objectives of the Trust.

Economic Contribution

The Trust employs over 3,600 whole time equivalent staff. Over the last four years the Trust has made a major contribution to the economic growth of the community and the prosperity of its people. Year on year the Trust makes a significant contribution to the training and development of doctors and nurses. It has strong links with Chester and Liverpool Universities. During 2018/19, the Trust has been heavily focused on its support for the Widening Participation and Apprenticeship agenda, with over 60 apprentices being recruited to the Trust during the year in a range of multi-disciplinary posts.

Good Corporate Citizenship (GCC)

One of the ways in which we measure our impact as an organisation on corporate social responsibility is through the use of the Good Corporate Citizenship (GCC) self-assessment tool. The last time we used the tool we scored 53%. In 2016 the Trust's reporting was graded as poor by the NHS's Sustainable Development Unit and we were placed in twenty first position in our peer group of 37 Small Acute Trusts. The Trust aims to improve on its poor rating and progress to excellent within the next five years; achieving, at least, a minimum rating this year.

Travel

In partnership with Cheshire West and Chester Council we introduced a more accessible direct bus route (20,000 passengers per year) and a 'park & ride' option to encourage more staff and patients to use public transport.

However, there has been little shift away from car use by patients and staff at the hospital. The travel action plan therefore includes the following objectives for the next three years -

1. To reduce the proportion of single occupancy car use by promoting car sharing
2. To increase the proportion of staff using public transport including the new Park & Ride
3. To increase levels of walking and cycling amongst staff
4. Cut staff travel to meetings by making greater use of teleconferencing, webinars and the like.

The Trust has installed a number of charging points for electric cars and is expanding the number of electric vehicles within the fleet. In line with Government policy on the reduction of both diesel and petrol vehicles over the coming year demand for electric vehicle charging points is predicted to continue

to increase. To meet this demand we are planning to install more car charging points at the Countess in the coming year.

Catering

The Trust buys as much fresh food as possible on a daily basis and all its main food items, such as fresh meat, bread, dairy products, fruit vegetables and frozen and chilled items are sourced locally. Tuna is responsibly fished and the Trust offers an excellent range of fair trade products. Craig Hough, head of catering, maintains: "We believe using high-quality local products offers our patients the best quality food. It also helps us to work with our suppliers to cut down on transport, saving cost and reducing air pollution. Our ingredients cost just under £3 per patient per day due to our waste being very low at around 3% - we monitor all our food and waste continually. The 3% waste is collected and converted to Bioenergy."

Procurement

The Trust has sustainability principles within the procurement process so that they have become an integral part of all relevant contracts, at pre-tender, tender and post-contract award stages (including monitoring and evaluation), through to the end of the life of the contract and including any disposal of equipment. The Supplies Team manage the recycling of toner cartridges used by Trust. All Procurement staff carry out Ethical and Sustainability training to ensure awareness of sustainability issues. Procurement Staff work with suppliers to reduce packaging and deliveries in addition to questioning the need for new items. In

addition Procurement staff encourage small and medium enterprises (SMEs) and local suppliers to bid for appropriate work through relevant frameworks. Lastly, Procurement works with the local University to provide work placements and where appropriate take on apprentices and provide a robust training plan.

Waste Management

We recycle 100% of refuse waste either through RDF (refuse derived fuel) or cardboard recycling. Batteries, mobile phones, computers and light fittings are all recycled as the Trust's drive to reduce land fill continues. Proactive management of clinical waste and appropriate waste streaming has also reduced the level of incineration by 27% over the last two years.

Energy Management

As a key component of our Environmental Strategy, the Trust has continued to promote responsible Energy Management. We are committed to operate in the most energy efficient manner possible in our use of buildings, plant and equipment wherever this is cost-effective. The Trust monitors energy and water consumption on a daily basis to ensure waste is minimised. We have a CHP (Combined Heat and Power plant) on site which supports the optimisation of energy consumption.

We have gained more control over energy consumption through review and improvement of purchasing, operating, motivation and training practices. We have invested in a rolling programme of energy saving measures to generate returns for reinvestment in further Eenergy management activities. We have commenced a lighting replacement programme to convert all lighting units to LED.

The Countess of Chester Country Park

The Countess of Chester Country Park is now a thriving 29 hectare public space having been transformed from a derelict brownfield site. The Trust continues to work with partners, led by the Land Trust, to sustain and enhance the Country Park though appropriate maintenance whilst maximising opportunities for community engagement through a range of health and wellbeing, educational and environmental initiatives.

Long Term Climate Change

The Trust has worked with partners to understand how climate change may impact on the hospital and has included appropriate provisions in contingency planning and major incident responses.

In the long term, summers may get hotter. The hospital has emergency plans to address the extremes of both summer and winter conditions. There may also be impacts from floods due to more extreme weather fluctuations. The hospital is built on relatively high ground. The risk of high water levels causing building damage is, therefore, low.

1.5 Financial Review for 2018/19

Overview

The Countess of Chester Hospital NHS Foundation Trust reported a deficit position of £8.1m (before impairment) at the end of the 2018/19 financial year, being £11.1m worse than the NHS Improvement (NHSI) agreed plan for the year, predominantly due to the net loss of Provider Sustainability Funding (£2.75m) and non-achievement of efficiency schemes (£5.8m).

Delivery of NHSI's compliance regime and associated financial metrics are summarised below -

	Q3 2018/19		Q4 2018/19	
Use of Resource Rating	Metric	Rating	Metric	Rating
Capital Service Cover	- 0.43	4	-0.37	4
Liquidity	-17.41	4	-15.64	4
I&E Margin	-3.70%	4	-3.40%	4
I&E Margin Variance from Plan	-2.90%	4	-4.70%	4
Agency	-0.57%	1	-0.83%	1
Overall weighted average		3		3

This will keep the Trust in NHS Improvement's Finance Segment 3: Providers Offered Targeted Support.

In accordance with the Department of Health and Social Care Group Accounting Manual the financial statements have been prepared on a going concern basis as we do not either intend to apply to the Secretary of State for the dissolution of the NHS Foundation Trust without the transfer of the services to another entity, or consider that this course of action will be necessary.

Income and Expenditure

The following summary table shows a pre-impairment deficit position of £8.1m.The Trust's total income for 2018/19 was £238.2m. The majority of income comes from our main commissioner NHS West Cheshire Clinical Commissioning Group (CCG) at £149.4m, with £24.9m received from Betsi Cadwaladr University Health Board (BCUHB), and £8.5m from NHS England.

In 2018/19 the Trust continued on a block contract arrangement with its main commissioner, Western Cheshire CCG, fixing our income to facilitate system wide working. It should be noted that under PbR rules (payment based on actual activity), our contract with West Cheshire CCG would have over-performed by £2.9m - this was driven by an increase in our outpatient activity and high cost drugs prescribed.

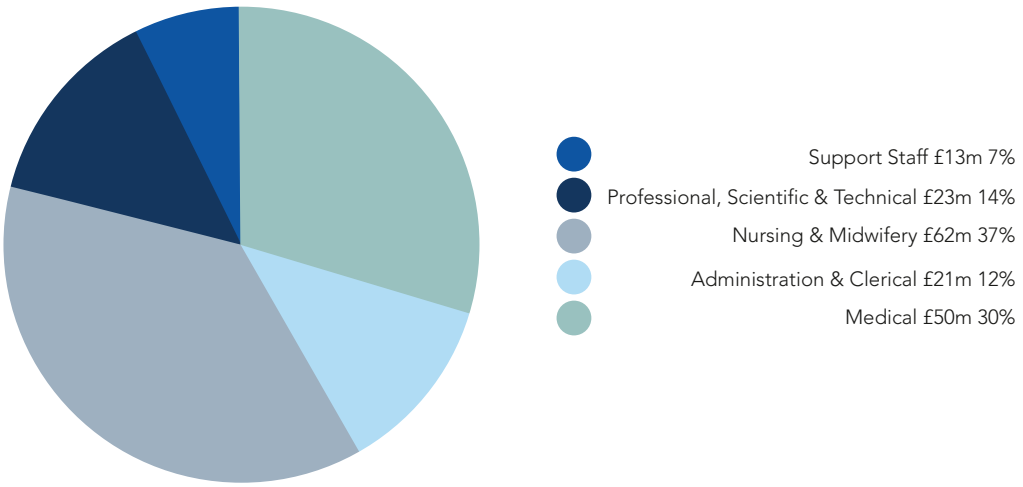
The Trust experienced a number of expenditure pressures on its budget during the year, with both medical and nursing pay spend exceeding planned levels. The consequent spend on medical agency was £3.3m for the year, however overall we were still below the agency cap set by NHS Improvement in 2018/19 (£4.843m). Consumable costs were generally in line with the increased demand.

Income & Expenditure	2016/17 £m	2017/18 £m	2018/19 £m
Income	230.2	238.2	238.2
Expenses (before net impairment & re-organisational costs)	(228.5)	(230.87)	(240.4)
EBITDA	*1.7*	*7.5*	*(2.2)*
Interest, depreciation & dividend	(5.3)	(5.7)	(5.9)
Surplus/(Deficit) prior to exceptional items	*(3.6)*	*1.8*	*(8.1)*
Impairments & re-organisation costs	3.9	12.1	(5.1)
Surplus/(Deficit) for the year	*0.3*	*13.9*	*(13.2)*

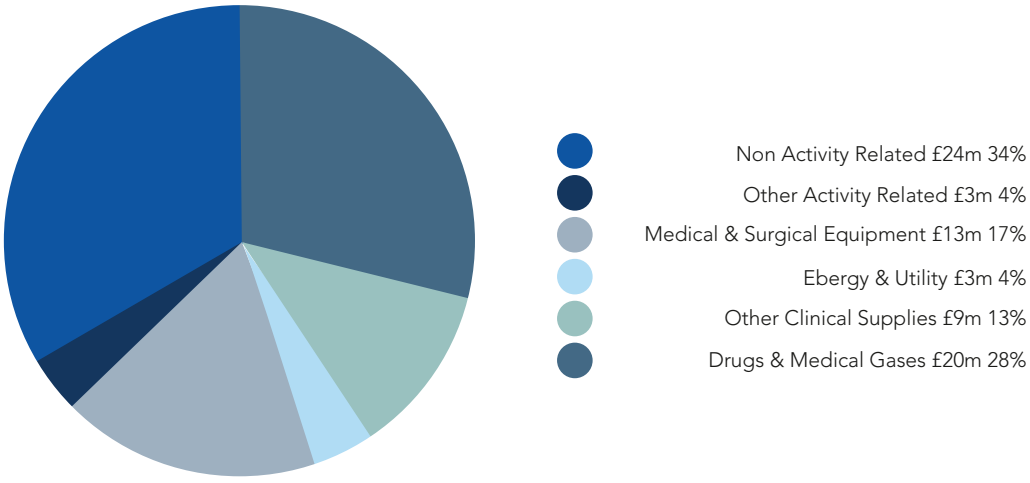
The majority of Trust expenditure is spent on clinical care, with our staff representing the largest proportion of spend at £168m.

The following charts summarise income and expenditure by category -

Breakdown of Pay Expenditure 2018/19



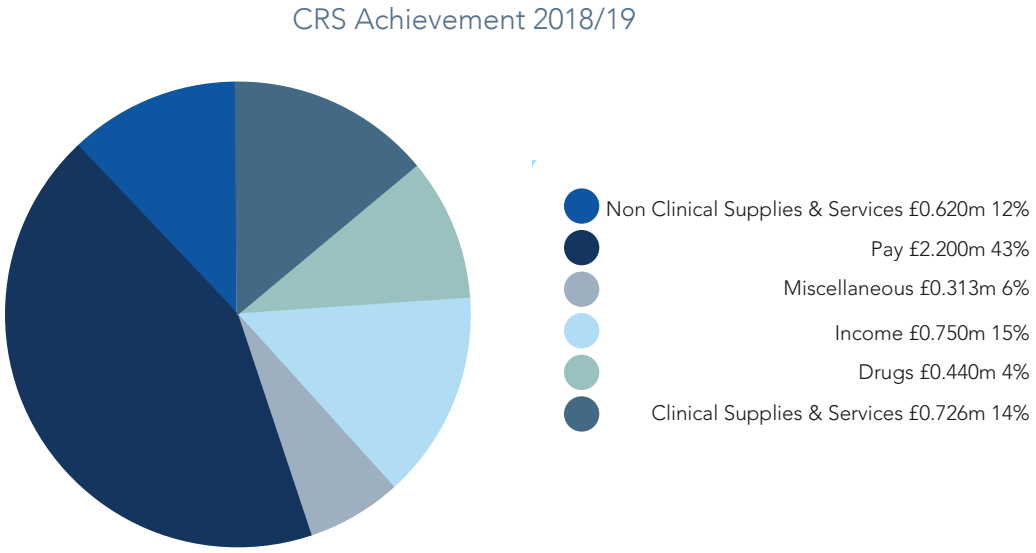
Breakdown of Non-Pay Expenditure 2018/19



Cost Reduction and Efficiency (CRS)

The Trust's efficiency target for 2018/19 year was £10.7m, however, only £5.1m savings (48%) were achieved (16% on a recurrent basis), resulting in a financial pressure of £9m being carried forward into 2019/20.

The following chart shows the breakdown of where the savings have been delivered during the year -

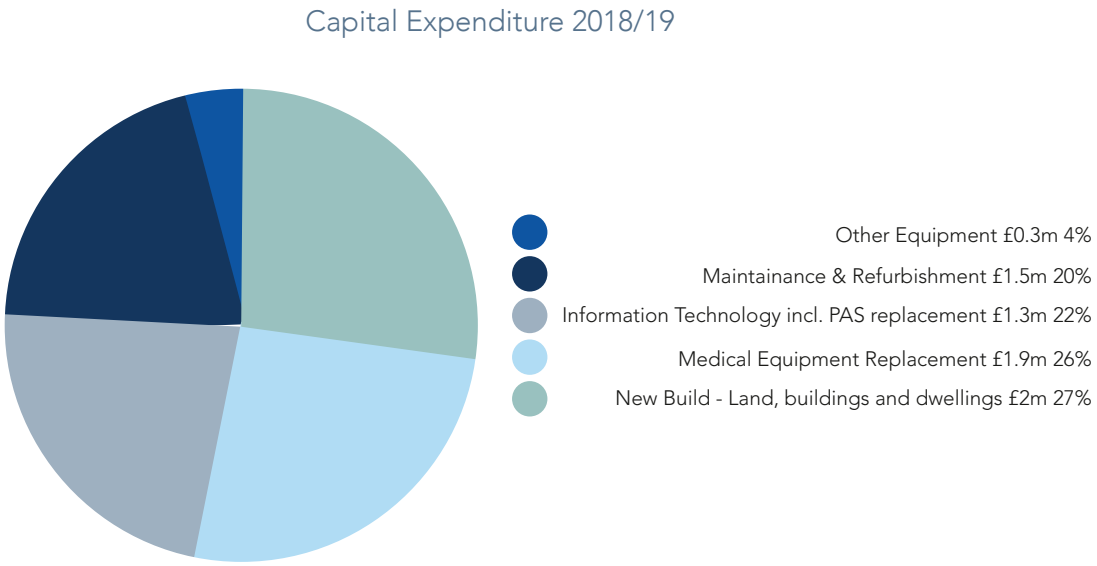


The Trust will be required to continue to deliver significant savings annually for the foreseeable future. This can no longer be achieved in isolation due to an ageing population with increased demands, yet less funding available. We will need the continued support of our commissioners, along with partnership working to continue to reconfigure and transform services within the local health system, so that we can continue to care for our patients on a timely basis, in the most appropriate setting.

Capital Investment

Being a Foundation Trust allows us to manage our finances so that we can invest in the infrastructure and estate of the hospital.

Capital resources amounting to £7.4m were spent during 2018/19 in the areas shown in the chart below -



The Trust will seek approval for additional capital spend during 2019/20 from NHS I & E.

Signature

Dr Susan Gilby
Chief Executive Officer

21st May 2019

TWO
The Accountability Report

2. The Accountability Report

2.1 Directors' Report 2018/19

Quality Governance and Governance Structures

The Trust has structures and processes in place at and below Trust Board level which enables the Board to assure the quality of care it provides. Maintaining an effective quality governance system supports the Trust's compliance against national standards. The Trust is committed to the continuous improvement of these systems and achieving compliance against NHS Improvement's Well Led Framework for governance.

The Trust governance structures ensure that the Trust Board has an overarching responsibility through its leadership and oversight, to ensure and also be assured that the organisation operates with openness, transparency and candour in relation to its patients, staff and the wider community. The Board holds itself to account through a wide range of stakeholders for the overall effectiveness and performance of the organisation.

Robust quality governance includes our values and structures in conjunction with the supporting processes that enable the Board to discharge its responsibilities for quality. Our responsibilities include ensuring essential CQC Key Lines of Enquiry based on their framework of Safe, Effective, Caring, Responsive and Well-led for quality and safety is met. We strive for continuous quality improvement and ensuring that the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture by ensuring that every member of staff that has contact with our patients is motivated and enabled to deliver safe, kind and effective care. We monitor key quality standards and receive assurance on them via the Quality, Safety and Patient Experience Committee and the line of accountability through the committees that feed into it. This key scrutiny committee requests assurance that high standards of care are provided by the Trust and ensures that there are adequate and appropriate governance structures, processes and controls in place across the organisation. We also report to our Commissioner on quality standards such as CQUINs and Clinical Audit. We seek and use feedback from patients via the Friends and Family Test, along with national surveys, and the outputs from our Patient Experience & Involvement Strategy. To support staff engagement, the Trust has a number of well embedded formal and informal systems including a programme of Executive 'walk-rounds', a weekly 'What's Brewing' question & answering briefing session.

In order to review and strengthen the Trusts' current governance systems and processes, an external Governance Review was undertaken which commenced in quarter 4 of 2018/19. The Trust will be implementing the recommendations to this review, in addition to those from the CQC 'Well Led' inspection during 2019/20.

By well-led, we mean that

Our quality of care is incorporated into the national Single Oversight Framework that the Trust is assessed against by NHS Improvement (NHSI). The framework looks at five themes -

The framework looks at five themes -

- Quality of care
- Finance and use of resources

- Operational performance
- Strategic change
- Leadership and improvement capability (well-led)

Our quality reporting also forms part of our Trust Board integrated performance report which triangulates quality and safety, workforce and operational and financial indicators and gives the Board visibility of all key areas of performance. This report is produced and reviewed monthly, with the metrics of the report structured across the headings Safe, Kind & Effective in 2018/19, with a plan to change the report to be structured around the CQC Domain headings of Safe, Effective, Caring, Responsive and Well Led, in 2019/20. The details of the quality and safety metrics are presented and discussed in more detail at the Trust's Quality, Safety and Patient Experience Committee.

The Board has continued to promote the development of its culture across the organisation which supports open dialogue and includes directors and senior managers personally listening to complaints, concerns and suggestions from partners, patients and staff.

The three sub-committees of the Board of Directors, which comprise the Finance and Integrated Governance Committee, the Quality, Safety and Patient Experience Committee, and the People and Organisational Development Committee, have continued to focus on the quality agenda. All three are chaired by a Non-Executive Director and clinical and managerial representatives make up the membership. The Audit Committee is a statutory committee of the Trust which reports to the Board, chaired by a Non-Executive Director and the composition includes two further Non-Executive Directors. The Board receives the minutes of each of the sub-committees. To further support the Board, each of the sub-committees receive regular updates and minutes from operational groups who are chaired by a named Executive Director. There is an opportunity at each meeting for the relevant group's minutes to be questioned and where needed, further details can be requested and clarified. In 2019/20 it is planned that governance will be strengthened by reviewing the overall structure of Board sub-committees and reporting arrangements into sub-committees.

The Board and its sub-committees have oversight of the Trust's performance through the integrated performance report. This enables challenge of the control systems in place and, where appropriate, seeking further intelligence on the current trend analysis with the Trust's performance indicators. Feedback is also received from the Council of Governors and their links with members of the public, patients and staff. The Trust has a Risk Management Strategy in place and supporting procedures set out the key responsibilities for managing risk within the organisation, including ways in which the risk is identified, evaluated and controlled. Leadership from managers at all levels is in place to ensure risk management is a part of an integrated approach to quality, corporate and clinical governance, performance management and assurance.

Further detailed information on the Trust's risk management system and risk training is detailed within the Annual Governance Statement section of this annual report. The Trust received feedback from its external governance review at the end of the year that further focus is required in the area of risk management and linking this to the Board Assurance Framework and this work will be undertaken during early 2019/20. Work will also be undertaken to better connect the governance framework of the organisation to its real risks, and reflect this in performance reporting and assurance.

The Trust self-assesses each year the validity of its Corporate Governance Statement that it is fully compliant with the requirements of the NHS Improvement Provider License. The Foundation Trust is registered with the Care Quality Commission (CQC) to provide care, treatment and support, without compliance conditions. Further information on the CQC *'Well Led'* inspections can be found within the Annual Governance Statement section of this Annual Report. In respect of quality, safety and patient experience, further details of aspects

focused upon during the year can be found in the Quality Report section of the Annual Report.

Focusing on Governance

The NHS Foundation Trust Code of Governance

The Board of Directors places emphasis on ensuring governance is effective and robust and is reflective of best practice. The NHS Foundation Trust Code of Governance provides the Trust with the structure to support the many aspects of an effective Board. The Code of Governance is adopted on a 'comply or explain' basis and any variation from the best practice within the Code is detailed within the Disclosures section of this Annual Report.

Council of Governors

The foundation for effective relationship building between directors and Governors is a clear understanding by both groups of the responsibilities and boundaries of their respective roles. The Board of Directors provide active leadership of the Trust within a governance framework of prudent and effective controls which enables risk to be assessed and managed. The Council of Governors has a duty to hold the non-executive directors individually and collectively to account for the performance of the Board of Directors and are also responsible for representing the interests of the Trust's members and the public and staff in the governance of the Trust. Governors are responsible for regularly feeding back information about the Trust, its vision and its performance to members and the public and the stakeholder organisations that either elected or appointed them.

The Council of Governors holds the Non-Executive Directors and Board of Directors to account by analysis of the integrated performance reports that they receive, challenging assumptions and raising questions as appropriate. In addition to the formal quarterly meetings of the Council of Governors and the Annual Members' meeting, the Governors hold a Governors' Quality Forum meeting every month, which the Chairman and Director of Corporate and Legal Services attend on every occasion. Non-Executive Directors and Executive Directors attend these meetings on a regular basis. At these meetings the Governors receive an update on Trust matters in relation to quality and operational information and have the opportunity to raise any issues on behalf of the Trust membership.

At the Council of Governors' meetings which are also attended by members of the Board of Directors, there are interactive sessions where Governors hold the Board to account and provide feedback from the membership on the quality of our services received by members.

The types of decision taken by each of the Boards together with any delegated powers are set out below. The Board of Directors may delegate any of its powers to a Committee of Directors or to an Executive Director. The Board has reserved the issues set out in its Scheme of Reservation and Delegation and further guidance on the operation of the Trust is set out in the Standing Orders and Standing Financial Instructions. The main decisions taken by the Board of Directors include those relating to -

- Strategic direction and policy determination.
- The quality agenda.
- Actions required to address significant performance issues.
- Governance and compliance arrangements.
- Major business cases for capital or revenue investment.
- The annual plan, financial strategy and Annual Report.
- The acquisition, disposal or change of land or buildings.
- Major contracts.
- Risk, clinical governance standards and policies.
- The constitution, terms of authorisation and working arrangements of its committees.
- Approval of Standing Orders, Standing Financial Instructions and Schemes of Reservation and Delegation.
- Arrangements for the Trust's responsibilities as a corporate trustee for its charitable funds.

The types of decisions taken by the Council of Governors include -

- Appoint and, if appropriate, remove the Chair.
- Appoint and, if appropriate, remove the other Non-Executive Directors.
- Decide the remuneration and allowances, and the other terms and conditions of office, of the chair and the other Non-Executive Directors.
- Approve the appointment of the Chief Executive.
- Appoint and, if appropriate, remove the NHS Foundation Trust's External Auditor.
- Decide on a quality of care issue to be reviewed for the Quality Account.
- Determine a local quality measure for auditing internally and externally for the Quality Account.
- To agree the Trust's membership strategy, and its policy for the composition of the Council of Governors.

Composition of Council of Governors

Area	Number of Governors
Chester & Rural Cheshire	8
Ellesmere Port & Neston	4
Flintshire	3
Out of area	1
Staff	5
Partnership Organisations	8
Total	*29*

There are two vacancies to be filled in respect of Partnership Organisations and Ellesmere Port and Neston Constituency.

The membership of the Council of Governors during 2018/19, for both elected and appointed, and their length of tenure, is as follows -

Governor	Term of Office
Public - Chester & Rural Cheshire	
Mr Thomas Bateman (Lead Governor)	Term of Office Expired October 2018
Mrs Helen Clifton (Deputy Lead Governor)	Term of Office Expired October 2018
Ms Caroline Stein	Re-elected for 2nd term of office for 3 years until October 2020
Ms Sue McClelland-Sheldon	Re-elected October 2016 for 3 years until October 2019
Mr Roger Howells	Elected October 2016 for 3 years until October 2019
Ms Karen Newbury	Elected October 2016 for 3 years until October 2019
Mr John Jones	Elected October 2017 for 3 years until October 2020
Mr Hems de Winter	Elected October 2018 for 3 years until October 2021
Ms Brenda Southward	Elected October 2018 for 3 years until October 2021
Ms Jennifer Gill	Elected October 2017 for 3 years until October 2020
Public - Ellesmere Port & Neston	
Ms Sue Bagby	Term of office expired October 2018
Cllr Brian Jones	Re-elected for a 2nd term of office for 3 years until October 2021
Mr Peter Folwell (Lead Governor)	Elected October 2016 for 3 years until October 2019
Public - Flintshire	
Ms Fran Parry	Elected October 2018 for 3 years until October 2021

Governor	Term of Office
Mr Russell Jackson	Re-elected for 2nd term of office for 3 years until October 2019
Ms Ruth Overington	Elected October 2016 for 3 years until October 2019
Partnership Organisations	
Mr Michael Hemmerdinger Voluntary Services	Appointed January 2018
Prof Dorothy Marriss University of Chester	Appointed February 2011
Mr Keiran Timmins Western Cheshire CCG	Appointed August 2016
Cllr Eleanor Johnson Cheshire West and Chester Council	Appointed June 2017
Mr Michael Boyle Flintshire Community Health Council	Appointed September 2016
Staff	
Dr Ian Benton	Re-elected October 2017 for 3 years until October 2020
Mrs Chris Price	Elected October 2016 for 3 years until October 2019
Ms AnneMarie Lawrence	Stood down January 2019
Ms Lisa Myers	Elected October 2016 for 3 years until October 2019
Mr Steve Bridge	Re-elected October 2017 for 3 years until October 2020

Election of Council of Governors

Notice of elections were published in July 2018 in the following public constituencies -

- Chester & Rural Cheshire
- Ellesmere Port & Neston
- Flintshire

An election was held in September 2018 in the Chester & Rural Cheshire, Ellesmere Port & Neston and Flintshire Constituencies.

The election turnout was as follows -

- Chester and Rural Cheshire – Uncontested
- Ellesmere Port & Neston – Uncontested
- Flintshire – Uncontested
- Chester & Rural Cheshire - 2 Governors elected
- Ellesmere Port & Neston - 1 Governor re-elected,
- Flintshire - 1 Governor elected

The Board confirm that elections are held in accordance with the election rules stated in the Trust Constitution and undertaken by Election Reform Services.

Attendance at Council of Governors' Meetings

There have been four Council of Governors' meetings held during 2018/19 and the attendance by Governors is shown below, along with expenses of Governors and Directors -

No of meetings held in 2018/19	4	Expenses 2018/19
Council of Governors attendance		
Mr Thomas Bateman	2/2	
Mrs Helen Clifton	1/3	
Mr Peter Folwell (Lead Governor)	3	£478.00
Ms Karen Newbury	4	£65.40
Mr John Jones	3	
Ms Jennifer Gill	4	
Cllr Brian Jones	1	
Ms Sue Bagby	1/2	
Mr Michael Hemmerdinger	1	
Prof Dorothy Marriss	4	
Ms Sue McClelland-Sheldon	1	
Ms Ruth Overington	3	£88.00
Ms Fran Parry	1/2	
Cllr Eleanor Johnson	3	
Mr Michael Boyle	0	
Mr Kieran Timmins	0	
Mr Russell Jackson	4	
Dr Caroline Stein	4	£211.20
Hems de Winter	0/2	
Dr Ian Benton	0	
Mr Steve Bridge	2	
Brenda Southward	2/2	
Roger Howells	3	
Chris Price	3	
AnneMarie Lawrence	0/3	
Lisa Myers	0	
Board of Directors attendance at Council of Governors' meetings		
Sir Duncan Nichol, Chairman	3	£294.74
Mr Tony Chambers, Chief Executive	2/2	-
Dr Susan Gilby, Chief Executive	1/2	
Mrs Alison Kelly, Director of Nursing and Quality	3	£191.58
Mr Ian Harvey, Medical Director	2/2	
Dr Darren Kilroy, Interim Medical Director	1/2	
Mrs Sue Hodkinson, Director of People & Organisational Development	2	-
Ms Lorraine Burnett, Chief Operating Officer	2	£452.02
Mr Stephen Cross, Director of Corporate and Legal Services	4	-
Mr Simon Holden, Director of Finance	3	£642.76
Ms Chris Hannah, Non-Executive Director	1	£1,433.08 *includes expenses claimed as ICP Chair

No of meetings held in 2018/19	4	Expenses 2018/19
Mrs Ros Fallon, Non-Executive Director	2	-
Mrs Rachel Hopwood, Non-Executive Director	2	-
Mr Andrew Higgins, Non-Executive Director	1	-
Mr Ed Oliver, Non-Executive Director	2	-

Summary of Declaration of Interests of Governors

The register of Declaration of Interests is held by the Director of Legal and Corporate Services and will be available on the Trust website in 2019/20. Anyone requiring a copy of the register should contact the Interim Trust Secretary at Debbie.bryce@nhs.net.

The Council of Governors have individually signed to confirm that they meet the 'Fit and Proper Persons Test'. The Board of Directors have received information on the views of the Governors and Members about the Trust and its services in the following ways -

- Regular attendance at the Council of Governors' meetings.
- Joint workshops of the Board and Council of Governors.
- Regular attendance at Governors' Quality Forum meetings and receipt of reports.
- Discussion at Annual Members' Meetings.
- Receipt of reports from the Director of Corporate and Legal Services at each of the Board of Directors' meetings.
- Joint presentations to and feedback from organisations in the local community.

Board of Directors

The composition of the Board of Directors during 2018/19 was as follows -

Non-Executive Directors (Independent)

Sir Duncan Nichol CBE
Chairman
Re-appointed 1st November 2018 for a further 3 year term of office.

Mr Andrew Higgins
Senior Independent Director
Re-appointed 1st November 2017 for a 2 year term of office.

Mrs Rachel Hopwood
Deputy Chairman
Re-appointed 1st December 2017 for a 3 year term of office.

Mr Ed Oliver
Re-appointed 1st September 2016 for a 3 year term of office.

Mrs Ros Fallon
Appointed 1st May 2016 for a 3 year term of office.

Mrs Chris Hannah
Appointed 1st April , 2018, for a 3 year term of office. Also appointed as Chair of Cheshire West Integrated Care Partnership, hosted by the Countess of Chester Hospital NHS Foundation Trust, for a two year term of office.

Executive Directors

Mr Tony Chambers
Chief Executive
(stood down September 2018).

Dr Susan Gilby
Medical Director (August 2018)
and Acting Chief Executive (September 2018 to March 2019).

Mr Ian Harvey
Medical Director/Deputy Chief Executive
(retired August 2018).

Mrs Alison Kelly
Director of Nursing & Quality (& Deputy Chief Executive during 2018/19).

Mr Simon Holden
Director of Finance.

Mrs Sue Hodkinson
Director of People and Organisational Development.

Ms Lorraine Burnett
Chief Operating Officer.

Mrs Alison Lee
Managing Director,
Cheshire West Integrated Care Partnership, of which the Countess of Chester is the host
(since September 2018).

Attendance at Board of Directors and Board Committee Meetings

	Board of Directors	Audit Committee	Finance & Integrated Governance Committee	Quality, Safety & Patient Experience Committee	People & Organisational Development Committee	Charitable Funds
No of Meetings held for 2018/19	*6*	*5*	*3*	*10*	*5*	*3*
Sir Duncan Nichol	6	-	3	4	-	2
Tony Chambers	2/2	-	2/3	-	-	1/1
Susan Gilby	3/3	-	-	1	-	-
Ian Harvey	2/2	-	2/2	3/4	2/2	1/1
Darren Kilroy	3/4	-	2/2	5/5	0	-
Alison Kelly	6	-	2	10	5	-
Sue Hodkinson	3	-	1	3	2	-
Lorraine Burnett	6	-	3	-	3	-
Simon Holden	6	-	3	-	-	3
Stephen Cross	5	-	2	-	-	2
Andrew Higgins	6	4	3	9	-	-
Rachel Hopwood	6	4	3	5	-	-
Ed Oliver	5	5	3	-	5	3
Ros Fallon	6	-	3	8	5	-
Chris Hannah	6	-	1	-	-	-

Background of the Board Members

Sir Duncan Nichol - Chairman
Sir Duncan was re-appointed as Chairman on 1st November 2018 for a third three year term of office. He spent most of his NHS managerial career in the North-West of England, becoming CEO of the NHS in 1989, before his appointment as Professorial Fellow at the University of Manchester. Since then he has divided his commitments between the public and private sectors, formerly as chairman of the Parole Board; HM Courts Service and deputy chairman of the Christie NHS FT and currently as Non-Executive Director of Steris, Deltex Medical Ltd and UKAS.

Tony Chambers - Chief Executive (stood down September 2018)
Since being appointed as Chief Executive in December 2012 his focus was to work with West Cheshire Health and Care partners to make the Countess of Chester Hospital one of the first High Reliability Organisations within the NHS, and an ambition to be fully transparent in providing care using live, real time information and therefore one of the best and safest organisations within the NHS.
He led the successful reorganisation of regional vascular services which saw the South Mersey Arterial Network operate at the Countess from April 2014 and was the Senior Responsible Officer for the Operational

Productivity work stream (Carter at Scale) for the Cheshire and Mersey Health and Care Partnership. From starting his career as a student nurse in Bolton in 1985 he has worked in a variety of clinical and management roles in a range of sectors and has been a Director in the NHS for several years; most recently as the Director of Planning in South Wales. Prior to this he held director roles in hospitals in Greater Manchester and West Yorkshire.

Dr Susan Gilby - Medical Director (August 2018 to September 2018) & Acting Chief Executive (September 2018 to March 2019)
Dr Susan Gilby joined The Countess on 1 August, 2018, as Medical Director before becoming Acting Chief Executive in September 2018 and then the substantive Chief Executive in April 2019.
Dr Gilby, who first had a spell at The Countess during her specialist training, has previously worked as Medical Director at Wirral University Teaching Hospital NHS Foundation Trust and Wye Valley NHS Trust and as Associate Medical Director at Mid Cheshire Hospitals NHS Foundation Trust.

Dr Ian Harvey - Medical Director/Deputy Chief Executive (retired August 2018)
Ian commenced his role as Medical Director on 1st July 2012. Ian qualified in Medicine in Liverpool and, after completing specialist training in Sheffield, Liverpool and Wrightington, took up a post as Consultant Trauma and Orthopaedic Surgeon with an interest in upper limb and hand surgery in the Trust in August 1994. Prior to becoming Medical Director, Ian was Divisional Medical Director for Planned Care and his other managerial roles in the Trust have included Lead Clinician for Orthopaedics and Clinical Director for Orthopaedic and Plastic Surgery and Rheumatology.

Dr Darren Kilroy - Interim Medical Director (from September 2018)
Darren trained in Emergency Medicine in the North West as well as Australia and, following an initial subspecialty interest in medical education, worked in several leadership roles in Greater Manchester alongside his consultant post. He holds a Masters in Healthcare Business Administration from Keele Business School, and his PhD thesis examined the sociological aspects of medical training in the UK. He sits on NHS Employers' Medical Workforce Forum and advises NHS Improvement in relation to bank and agency pay in healthcare. Darren joined The Countess full-time in April 2018 after working between The Countess of Chester and East Cheshire NHS Trust, where he was Deputy Medical Director.

Simon Holden - Director of Finance
Simon joined the Board in January 2016, and is an experienced senior NHS leader, having held both Chief Executive & Director of Finance posts, with a number of different NHS organisations. He is financially qualified with a successful track record of delivery and achievement. Simon is a Fellow Member of the Association of Chartered Certified Accountants (FCCA), and also a Fellow of the Royal Institution of Chartered Surveyors (FRICS) and has held a number of senior roles during his 36 years within the NHS. Simon has previously been the Chief Executive of NHS Property Services Limited (2012 to 2015), Director of Finance for Bedfordshire CCG (2015 to 2016),

and has previously been the Director of Finance for NHS Cheshire, Warrington and Wirral. He is also Treasurer of the Cheshire Centre for Independent Living (CCIL), a user led charitable organisation empowering disabled people to have independence, and also Chairman of the Pear Tree Primary School Academy Trust in Nantwich, Cheshire.

Alison Kelly - Director of Nursing and Quality (& Acting Deputy Chief Executive 2018/19)

Alison joined the Countess in March 2013 having previously been the Deputy Chief Nurse at the University Hospital of South Manchester since 2008. Alison has a background in critical care nursing and also has a wide range of experience as a senior nurse in managerial, educational and clinical positions in a number of Trusts in the North West, including Salford, Blackpool and East Cheshire. She is particularly interested and passionate about driving the patient experience agenda and identifying how patient feedback can enhance service development and improvement. Alison was appointed as the Governing Body Nurse at Salford CCG (up until March 2019), which gives an important wider view on the role of nursing across a health system and also contributes income for the Corporate Nursing budget at the Countess.

Sue Hodkinson - Director of People & Organisational Development

Sue joined the Countess in February 2011 and was appointed to the post of Director of People & Organisational Development in November 2014. Having worked in a number of senior HR posts in the NHS for over 10 years and as a Chartered Member of the Chartered Institute of Personnel Development (CIPD), she brings extensive healthcare and private sector HR experience & knowledge to the Executive Team.

Sue works very closely with other members of the executive team to focus on the staff experience and culture within our Trust and the links to improving the patient experience. Sue is executive lead for staff health & wellbeing, in addition to being the Chair of the collaborative HR & Wellbeing Business Service (www.hrwbs.com), which the Trust operates in conjunction with Wirral University Teaching Hospital NHS Foundation Trust. Sue has recently joined the Board of Governors at Upton Westlea Primary School, as the Local Community Governor.

Lorraine Burnett - Chief Operating Officer

Lorraine joined the Countess in March 2013 as the Divisional Director for Urgent Care and was substantively appointed as Director of Operations from May 2016. She started her career as a paediatric nurse at the Royal Manchester Children's Hospital in 1990 and later spent 8 years as a nurse specialist. She has since held senior management roles in community services before moving to hospital management in 2011.

Alison Lee - Managing Director, Cheshire West Integrated Care Partnership (from 1st September 2018)

Alison was previously the Chief Executive of NHS West Cheshire Clinical Commissioning Group. She now leads the Integrated Care Partnership (ICP), which means she is now an employee of The Countess but works across local NHS organisations and Cheshire West and Chester Council.

Alison started her working life in Marks and Spencer, in financial accounts and then the food division in their London HQ.

After graduating from the University of Kent with a degree in Industrial Relations and Human Resource Management she joined the NHS Graduate Management Training Scheme. She has worked in the NHS for over 25 years, with most time spent working with General Practice in both Merseyside and Cheshire.

Alison has also worked as part of a national "turnaround" team focusing on improving performance in NHS organisations including the ambulance service. Her personal ambition is to help everyone feel part of the NHS and for the 360,000 people in Cheshire West to live the best life possible.

Andrew Higgins - Non-Executive Director/Senior Independent Director

Andrew joined the Board in November 2011 and was re-appointed for a 3rd term of office with effect from November 2017 for 2 years. Andrew is a chartered accountant with a background in audit and advisory services. In 2010 he retired from KPMG, a major accounting and advisory firm, after a career spanning 33 years in the UK and overseas. Andrew has experience of working with a variety of commercial and not-for-profit organisations, with particular emphasis on the financial services and housing sectors. From 2008 to 2010 Andrew worked in Japan in an international liaison role and advised US and European multi-nationals with interests in the Far East. Now settled south of Tarporley, Andrew pursues a variety of interests including a Non-Executive Director post with a West Midlands building society.

Rachel Hopwood - Non-Executive Director/Deputy Chairman

Rachel joined the Board in December 2011 and was re-appointed for a 3rd term of office with effect from December 2017 for 3 years. Rachel was appointed as Deputy Chair at the Board of Directors meeting in July 2016. Rachel is a chartered accountant, qualifying with Ernst & Young, a major accounting and advisory firm. After a career in finance and investment banking in the City of London, latterly as an Executive Director at ABN AMRO, she relocated with her family back to Cheshire in 2008. Prior to joining the Board, Rachel was a Non-Executive Director of Western Cheshire PCT and Lay Advisor to West Cheshire Clinical Commissioning Group. She is also a Director in a company providing risk, management and financial consultancy services in the region.

Ed Oliver - Non-Executive Director

Ed joined the Trust in September 2013 and was re-appointed for a 2nd term office with effect from 1st September 2016. He is a graduate electrical engineer from the University of Strathclyde, Glasgow. Following this he had a 28 year career with Marks and Spencer before retiring in 2000 as the Regional Manager for Merseyside. He joined a family business in 2001 called Tops Estates who owned a number of Shopping Centres around the UK. This was to develop the operational side of the business, before finally retiring in 2009.
Ed has always during his business career been involved in outside agencies, such as: Prince's Trust on Merseyside - Vice Chairman 1991-2000; Liverpool Chamber of Commerce and Industry - Vice Chairman and Chairman 2001 – 2010; Ronald McDonald Family House, Alder Hey Children's Hospital, Liverpool - Board member and Chairman; 1994 – 2014 Liverpool Business Improvement District Co. He founded the business in 2003 and was Chairman of the Exec Board. Non-Executive Director, Alder Hey Children's Hospital NHS Foundation Trust. 2004 – 2013. Current Chairman of the CH1 Chester City BID Co.

Ros Fallon - Non-Executive Director

Ros joined the Trust in May 2016 and was appointed for a 3 year term of office with effect from 1st May 2016, which was recently extended for a further 12 months in early 2019/20. Ros Fallon was born in Liverpool and qualified there as a Registered Nurse in 1980. Ros then moved to Manchester to work in cardiothoracic surgery and subsequently qualified as a Registered Midwife. Ros practiced as a clinical midwife for 17 years in Manchester, Cheshire and Warrington before undertaking an MSc in Health Informatics and moving into strategic leadership roles. Ros has experience of whole system strategic planning, operational delivery and performance improvement. Ros has led transformational change programmes both locally and nationally and has held executive director positions in the NHS in Cumbria and Liverpool. Ros retired from permanent NHS employment in 2013, however, she still undertakes some ad hoc improvement assignments within the NHS.

Mrs Chris Hannah - Non-Executive Director

Chris joined the Trust on 1st April 2018 as Non-Executive Director and also as Chair of Cheshire West Integrated Care Partnership. Chris has over three decades of experience in NHS management, holding a number of chief executive positions. She was Chief Executive of Cheshire and Merseyside Strategic Health Authority from 2002 – 2006. Chris is also chair of Alternative Futures Group, a charity providing supported living and independent treatment/recovery services to people with learning disabilities and mental health issues. For 12 years, she chaired Skills for Health and Justice, a charity and company limited by guarantee which works with employers across the majority of public services in the U.K. focusing on improving workforce skills and productivity.

The Trust recognises that the Board of Directors has to provide a portfolio of skills and expertise to reflect the patient care and experience and the Trust's sustainable clinical services to ensure a high performing and effective organisation. The Board members provide a breadth of public and private sector expertise.

The Directors of the Board undergo an annual performance assessment, reviewing performance against agreed objectives, personal skills and competencies and progress with personal development plans. In year, the Board have held a number of workshops, as required, to aid Board development and progress the Trust's vision.

Summary of Declaration of Interests of Directors

The register of Declaration of Interests is held by the Director of Corporate and Legal Services and will be available on the Trust website in 2019/20. Anyone requiring a copy of the register should contact the Interim Trust Secretary at Debbie.bryce@nhs.net. The Board of Directors have individually signed to confirm that they meet the 'Fit and Proper Persons Test'.

The Chairman has the following other significant commitments -

- Non-Executive Director of Steris
- Non-Executive Director of Deltex Medical Ltd
- Non-Executive Director of UKAS

These three other significant commitments do not in any way impact on his role as Chairman of the Trust.

Audit Committee

The Audit Committee consists of three independent Non-Executive Directors, two of whom are qualified accountants, of whom one is the Audit Committee Chair (Mrs Rachel Hopwood). Executive Directors and senior staff are regularly invited to attend the Committee to answer questions and inform content. Internal and external auditors are also present at meetings. The overall purpose of the Trust's Audit Committee is to provide independent assurance to the Board in matters including monitoring the integrity of the financial statements, reviewing the internal financial controls and reviewing the Trust's system of internal control. Private meetings with either the internal or external auditors are held after each committee meeting, when required.

Audit Committee Attendance 2018/19 is included within the previous meeting table. During the year the Audit Committee undertook the following in discharging its responsibilities -

- Reviewed the Annual Governance Statement and supporting assurance processes in conjunction with the Head of Internal Audit opinion;
- Approved a risk based internal audit plan and actively reviewed the findings of all audits;
- Approved the plan and reviewed the work of the Trust's Local Counter Fraud Specialist;
- Reviewed the significant issues for the Trust;
- Reviewed and approved the updated Corporate Governance Manual covering standing orders, standing financial instructions and scheme of delegation;
- Agreed the nature and scope of the external audit plan and reviewed the reports, recommendations and management responses;
- Reviewed the Trust's annual financial statements and recommended their adoption to the Board of Directors;
- Reviewed the effectiveness of the Committee using an independent framework;
- Approved tender waivers;
- Reviewed the data quality of the Quality Account;
- Reviewed any significant issues that the Committee considered in relation to the financial statements, operations and compliance, and how these issues were addressed;
- Reviewed the effectiveness of the external audit process and the approach taken to the reappointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted;
- Reviewed the effectiveness of internal audit process; and
- Reviewed scope of external auditor providing non-audit services, the value of

the non-audit services provided and an explanation of how audit objectivity and independence are safeguarded.

The Audit Committee has considered significant issues in respect of the following -

- The Countess of Chester Hospital NHS Foundation Trust reported a deficit position of £8.1m (before the reversal of impairments) at the end of the 2018/19 financial year, being £11.1m worse than the NHS Improvement (NHSI) agreed plan for the year predominantly due to the net loss of Provider Sustainability Funding (£2.75m) and non-achievement of efficiency schemes (£5.8m);
- The areas of significant judgement in respect of the preparation of the annual accounts;
- The recognition and treatment of the PSF funding due;
- Principles and approach to valuation of the Trust property;
- Provisions for impairment of receivables; and
- Other Provisions, including Permanent Injury Benefits and legal claims.

The Audit Committee were satisfied that the significant issues considered were addressed by the evidence presented to them by the Directors of the Trust, and further assurance gained from MIAA internal audit reports. Any work agreed outside the audit plan is subject to approval by the Audit Committee in accordance with the non-audit services policy, and all additional work provided in year was undertaken in accordance with this policy.

There has been no change in-year to the internal audit provider which is MIAA.

There has been no change in-year to the external audit provider which is KPMG.

The Directors acknowledge their responsibility for preparing the annual accounts for the organisation.

Governors' Nominations Committee

Non-Executive Directors including the Chair are appointed by the Council of Governors for the specified terms subject to re-appointment thereafter at intervals of no more than three years, and are subject to the 2006 Act provisions relating to the removal of a director.

Expressions of interest from Governors to serve on the Nominations Committee were invited from Governors, and the Nominations Committee met twice during 2018/19.
The Nominations Committee met on 26th October 2018 to receive feedback and observations on the proposed re-appointment of Sir Duncan Nichol as Chairman of the Trust.

The Committee had the opportunity to review the Chair's recent 360 appraisal, and to discuss areas of challenge including his thoughts on the future direction of the Trust and the work with the Integrated Care Partnership.

The Committee received feedback from Mr Higgins, Senior Independent Director, Mr Cross, Director of Corporate and Legal Services on behalf of the Executive Team, and Mr Bateman, Lead Governor.
The Nominations Committee recommended to the Council of Governors that Sir Duncan Nichol should be re-appointed as Chair of the Countess of Chester Hospital NHS Foundation Trust with effect from 1st November 2018. At the Council of Governors meeting on 26th October 2018, Sir Duncan was unanimously approved as Chair of the Trust for a three year term of office with effect from 1st November 2018.
The Nominations Committee met on 22nd March 2019 to receive feedback and observations on the proposed re-appointment of Ros Fallon as Non-Executive Director of the Trust. Feedback was received from Sir Duncan Nichol, Chairman, and Stephen Cross, Director of Corporate Legal Services, and input was also received from Mr Folwell, Lead Governor.

The Nominations Committee recommended to the Council of Governors that Mrs R Fallon should be re-appointed as a Non-Executive Director at the Countess of Chester Hospital NHS Foundation Trust with effect from 1st May 2019. At the Council of Governors

meeting on 22nd March 2019, Mrs Fallon was unanimously approved as a Non-Executive Director at the Trust for a one year term of office with effect from 1st May 2019.

The attendance at the Governors' Nominations Committee meeting by its members was as follows in 2018/19 -

Date	26.10.18	22.03.19
Russell Jackson (Chester)	✓	✓
Peter Folwell	✓	✓
Karen Newbury	✓	✓
Caroline Stein	✓	×
Steve Bridge	✓	×
Michael Hemmerdinger	✓	×

Board of Directors' Nominations Committee

There was no requirement for the Board of Directors' Nomination Committee to meet during 2018/19.

Membership

The members of the Foundation Trust are those individuals whose names are entered in the register of members. Every member is either a member of one of the public constituencies or a member of one of the classes of staff constituency. Membership is open to any individual who is over sixteen years of age.

Public Membership

There are four public constituencies -

- Chester & Rural Cheshire
- Ellesmere Port & Neston
- Flintshire
- Out of Area

Membership of a public constituency is open to individuals -

- Who live in the relevant area of the Foundation Trust;
- Who are not a member of another public constituency; and
- Who are not eligible to be members of any of the classes of the staff constituency.

Staff Membership

The staff constituency is divided into four classes as follows –

- Doctors
- Nursing and midwifery
- Allied healthcare professionals and technical/scientific
- Other staff groups

Membership of one of the classes of the staff constituency is open to individuals -

- Who are employed under a contract of employment by the Foundation Trust and who either;
- employed by the Foundation Trust under a contract of employment which has no fixed term or a fixed term of at least 12 months, or
- who have been continuously employed by the Foundation Trust or the NHS Trust for at least 12 months; or
- who are not so employed but who nevertheless exercise functions for the purposes of the Foundation Trust and who have exercised the functions for the purposes of the Foundation Trust for at least 12 months. For the avoidance of doubt, this does not include those who assist or provide services to the Foundation Trust on a voluntary basis.

A person may not become a member of the Foundation Trust if within the last five years they have been involved as a perpetrator in a serious incident of violence at the hospital or its facilities, or against any of the Foundation Trust's employees or other persons who exercise functions for the purposes of the Foundation Trust, or against registered volunteers.

Membership Size and Movements

Membership changes in the previous year and those estimated for 2019/20 are shown in the following table –

Constituency	Last year (2018/19)	Next year (2019/20 estimated)
Public		
At year start	6,556	6,357
New Members	4	200
Members Leaving*	203	100
At year end	6,357	6,457
*The figures now include those members who are deceased or whom have moved away. It is the Trust's intention to maintain public membership at its current levels. The Trust will focus on developing a quality membership by diversity, age and gender for 2019/20		
Staff		
At year start	4,754	4,887
New Members	916	200
Members Leaving*	783	200
At year end	4,887	4,887

Membership Strategy

The 2018/19 target to maintain current levels of membership was achieved. The Trust is committed to ensuring the quality of data for the membership and therefore, a thorough data cleanse of membership information was undertaken during 2018/19. It is the Trust's intention to continue to maintain public membership at its current levels and review its strategy in 2019/20.

The Trust changed the provider of the membership database in 2017/18, which gives a greater oversight and interaction for Governors and members. This includes the ability for new members to register online and interact over social media, therefore, enhancing the engagement and communication with the wider membership.

Membership Review

The mechanism by which the Board reviews membership plans, growth and engagement during the year is by a report of the Director of Corporate & Legal Services as appropriate at a Board meeting. These reports are also provided to Council of Governors' meetings.

Current and Future Engagement with Members

The Trust has engaged with its members via the following -

- Countess Matters magazine
- Local newspaper articles
- Patient interest groups
- Surveys
- Trust website
- Participating in Governor elections
- Drop in sessions for potential candidates
- Data validation project with membership
- Increased awareness via social media

Contact for members to communicate with Governors and Directors is available on the website and contact details are also available in the Foundation Trust's 'Countess Matters' magazine circulated to all members three times per year.

Other Information

Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) requires that the income from the provision of goods and services for the purposes of the Health Service in England must be greater than its income from the provision of goods and services for any other purposes. The Trust met this requirement in 2018/19.

Accounting Information

As far as the Directors are aware all relevant audit information has been fully disclosed to the auditors and no relevant audit

information has been withheld or made unavailable nor have any undisclosed post balance sheet events occurred.

The management of risk is a key function of the Board; the Trust seeks to minimise all types of service, operational and financial risk through the Board Assurance Framework which is subject to regular review and audit.

Better Payment Practice Code

Revised Better Payment Practice Code		2017/18		2018/19	
		NHS	Non NHS	NHS	Non NHS
% Payment within 30 days of receipt of undisputed invoices - target 95%	Volume	91.30%	97.90%	95.90%	98.30%
	Value	96.70%	96.50%	99.70%	98.60%

No interest was paid to suppliers under the Late Payment of Commercial Debts (Interest) Act 1998.

Cost Allocation & Charging Requirements

The Trust can confirm that it has complied with the cost allocation and charging requirements set out in HM Treasury - Managing Public Money, July 2013.

Signature

Dr Susan Gilby
Chief Executive Officer

21st May 2019

2.2 Remuneration Report 2018/19

The Remuneration Committee is responsible for the appointment of the Chief Executive Officer (CEO) and, together with the CEO, Executive Directors who form part of the Board of Directors.

The Committee reviews and recommends the terms and conditions of service for Very Senior Managers (VSMs) who are not subject to Agenda for Change terms and conditions. It supports the review of performance of colleagues on an annual basis, conducted by the CEO, and has oversight of the Trust's senior management pay framework.

The Committee is chaired by the Chairman of the Trust and includes attendance from all Non-Executive Directors. The Chief Executive Officer, Director of People and Organisational Development and Director of Corporate and Legal Services attend by invitation to ensure the Committee is appraised of relevant internal or external advice, data or information. It is important to note that the CEO would not be present where discussions related to their appraisal, terms and conditions or appointment.
The Remuneration Committee is required to ensure levels of remuneration are sufficient to attract, retain and motivate directors of the quality required to run the organisation successfully, but to avoid paying more than is necessary.

The Committee meets as and when is required and is comprised of the following members -

- Sir Duncan Nichol, Chair
- Andrew Higgins, Non-Executive Director
- Rachel Hopwood, Non-Executive Director
- Ros Fallon, Non-Executive Director
- Ed Oliver, Non-Executive Director
- Chris Hannah, Non-Executive Director

The Remuneration Committee met once in year on 22nd May 2018 to consider the salary for the substantive Chief Finance Officer and the Medical Director. The Committee also discussed the updated "Guidance on pay for very senior managers in NHS trusts and foundation trusts" (NHS Improvement - March 2018) and considered the option of earn-back and its potential application.
In addition, the Committee met virtually in March 2019 following the communication that was issued to all Trusts by Ian Dalton, NHS Improvement Chief Executive, in December 2018, detailing a recommendation from ministers regarding the 2018/19 annual pay increase for very senior managers (VSMs). For VSM staff, providers were recommended to pay a flat rate uplift of £2,075 pa, backdated to 1st April 2018. This was commensurate with the cash value of the 2018/19 award applied to agenda for change staff at the top of pay bands 8c, 8d and 9. The Committee agreed to support this recommendation.

In considering the Executive Directors remuneration the Committee takes into account the national inflationary uplifts recommended for other NHS staff, any variation in or change to the responsibility of Executive Directors and relevant benchmarking with other NHS and public sector posts. The performance of Executive Directors and the Chief Executive is discussed at the Remuneration Committee. Executive Directors are subject to annual appraisal by the CEO who is in-turn appraised by the Chairman. Levels of remuneration should be sufficient to attract, retain and motivate directors of the quality and with the skills and experience required to the Countess of Chester Hospital NHS Foundation Trust successfully.

The contracts of employment of all Executive Directors, including the CEO, are permanent and are subject to six months' notice of termination. Earn-back is only in place with the CEO as per national guidelines

and no other performance-related pay scheme (e.g. pay progression or bonuses) is currently in operation within the Trust. There are no special provisions regarding early termination of employment.

All other senior managers are subject to Agenda for Change pay rates, terms and conditions of service, which are determined nationally.

There are two executives who were paid more than £150,000 in 2018/19, when the remuneration is considered on a pro-rata basis for the whole year. For the purposes of this disclosure, pay is defined as salary and fees, all taxable benefits and any annual or long term performance related bonuses, of which there were none during the year. The Trust is satisfied that the remuneration is reasonable, following scrutiny by the Remuneration Committee.

Council of Governors' Remuneration Committee

There was no requirement for the Council of Governors' Remuneration Committee to meet during 2018/19.

The remuneration tables are included on the following pages.

Signature

Chief Executive Officer

21st May 2019

Salary and Pension Entitlements of Senior Managers

Name and Title	Salary	Other taxable remuneration	Benefits in kind	Pension related benefits	Total	Normal retirement age	Salary	Other taxable remuneration	Benefits in kind	Pension related benefits	Total
	(bands of £5,000)	(to nearest £100)	(to nearest £100)	(bands of £2,500)	(bands of £5,000)		(bands of £5,000)	(to nearest £100)	(to nearest £100)	(bands of £2,500)	(bands of £5,000)
	2018/19						2017/18				
	£000	£	£	£000	£000		£000	£000	£	£000	£000
Mr Tony Chambers - Chief Executive (to 20.9.18)	75-80	-	-	-	75-80	67	155-160	-	900	75-77.5	235-240
Dr Susan Gilby - Medical Director (from 1.8.18 to 20.9.18)	25-30	-	-	-	25-30	na	-	-	-	-	-
Dr Susan Gilby - Acting Chief Executive (from 21.9.18)	100-105	-	-	-	100-105	na	-	-	-	-	-
Mr Simon Holden - Director of Finance	140-145	-	-	-	140-145	na	140-145	-	-	-	140-145
Mr Ian Harvey - Medical Director (to 21.8.18)	65-70	-	-	-	65-70	60	170-175	-	-	32.5-35	205-210
Dr Darren Kilroy - Acting Medical Director (from 25.9.18)	65-70	18,700	-	42.5-45	130-135	60	-	-	-	-	-
Mrs Susan Hodkinson - Director of People & Organisational Development	95-100	-	200	35-37.5	130-135	67	90-95	-	300	45-47.5	140-145
Mrs Alison Kelly - Director of Nursing & Quality	100-105	-	-	20-22.5	120-125	60	95-100	-	-	20-22.5	120-125
Ms Lorraine Burnett - Operations Director	105-110	-	-	32.5-35	135-140	67	100-105	-	-	52.5-55	155-160
Mr Stephen Cross - Director of Corporate and Legal Affairs	85-90	-	6,300	20-22.5	110-115	60	85-90	-	6,300	22.5-25	115-120
Alison Lee - Integrated Care Pathway Managing Director (from 1.9.18)	30-35	-	700	20-22.5	55-60	60	-	-	-	-	-
Sir Duncan Nichol - Chairman	45-50	-	-	-	45-50	-	45-50	-	-	-	45-50
Mr Andrew Higgins - Non-Executive Director	10-15	-	-	-	10-15	-	10-15	-	-	-	10-15
Mrs Rachel Hopwood - Non-Executive Director	10-15	-	-	-	10-15	-	10-15	-	-	-	10-15
Mr Ed Oliver - Non-Executive Director	10-15	-	-	-	10-15	-	10-15	-	-	-	10-15
Mrs Ros Fallon - Non-Executive Director	10-15	-	-	-	10-15	-	10-15	-	-	-	10-15
Mrs Chris Hannah - Non-Executive Director (from 1.4.18)	10-15	-	-	-	10-15	-	-	-	-	-	-
Total Directors Remuneration	*1040-1045*	*18,700*	*7,200*	*177.5-180*	*1225-1230*		*975-980*	-	*7,500*	*255-257.5*	*1235-1240*

- Reporting bodies are required to disclose the relationship between the remuneration of the highest paid Director in their organisation and the median remuneration of the organisation's workforce.
- Alison Lee and Chris Hannah are employed by this Trust but 55% of their salaries are recharged to other organisation. Alison Lee is Managing Director of the ICP and Chris Hannah is the Chair of the ICP, and therefore are funded on a cost sharing basis. The cost above is the element that is charged to the Countess of Chester Hospital.
- Alison Kelly currently works for Salford CCG as a Governing Body Nurse on a part time basis. Her salary is shown net of the recharge, the pension remains unchanged.
- Other taxable remuneration for Darren Kilroy relates to payments outside of his role as Medical Director.

	2019	2018
Band of Highest Paid Director's Remuneration	195-200	170-175
Median Total Remuneration	*26,619*	*25,023*
Ratio	7.40	6.99

- The total remuneration includes salary and benefits-in-kind, it does not include employer pension contributions and the cash equivalent transfer value of pensions.
- Pension related benefits figures show the amount of annual increase in the future pension entitlement at the normal retirement age, in accordance with the HRMC method. The source information is provided by the NHSBSA.

Name and Title	Real Increase in pension at age 60	Real Increase in pension lump sum at age 60	Total accrued pension at age 60 at 31 March 2019	Lump sum at age 60 related to accrued pension at 31 March 2019	Cash Equivalent Transfer Value at 31 March 2019	Cash Equivalent Transfer Value at 31 March 2018	Real Increase in Cash Equivalent Transfer Value
	(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	(to nearest £1,000)	(to nearest £1,000)	(to nearest £1,000)
Pension Benefits	2018/19					2017/18	2018/19
	£000	£000	£000	£000	£000	£000	£000
Mr Tony Chambers - Chief Executive (to 20.9.18)	-	-	35-40	75-80	662	1080	-
Dr Susan Gilby - Medical Director (from 1.8.18 to 20.9.18)	-	-	-	-	-	-	-
Dr Susan Gilby - Acting Chief Executive (from 21.9.18)	-	-	-	-	-	-	-
Mr Simon Holden - Director of Finance	-	-	-	-	-	-	-
Mr Ian Harvey - Medical Director (to 21.8.18)	-	-	-	-	-	1,802	-
Dr Darren Kilroy - Acting Medical Director (from 25.9.18)	0-2.5	-	45-50	105-110	840	700	119
Mrs Susan Hodkinson - Director of People & Organisational Development	0-2.5	-	15-20	35-40	290	227	56
Mrs Alison Kelly - Director of Nursing & Quality	0-2.5	2.5-5	40-45	125-130	867	734	111
Ms Lorraine Burnett - Operations Director	0-2.5	-	35-40	85-90	666	554	95
Mr Stephen Cross - Director of Corporate and Legal Affairs	0-2.5	2.5-5	10-15	35-40	-	-	-
Alison Lee - Integrated Care Pathway Managing Director (from 1.9.18)	0-2.5	-	40-45	105-110	860	720	119

Name and Title	Salary	Other Taxable Remuneration	Benefits in kind	Pension related benefits	Total
	(bands of £5,000)	(to nearest £100)	(to nearest £100)	(bands of £2,500)	(bands of £5,000)
Other Arrangements	2018/19				
	£000	£	£	£000	£000
Mr Tony Chambers - (from 20.9.18)	80-85	-	-	52.5-55	135-140
Mrs Dee Appleton Cairns- Acting Director of People & Organisational Development (from 1.8.18 to 31.10.18)	20-25	-	-	12.5-15	35-40
Mrs Alison Hall HR Solutions by Design - Acting Director of People & Organisational Development (from 5.11.18 to 28.2.19)	30-35	-	-	-	30-35

- Susan Hodkinson (Director of People and Organisational Development) had a period of sickness during the financial year. As the position is a key board member it was decided to provide interim cover for the period of absence. The disclosure above relates to two people who have provided interim cover for the role of Director of People and Organisational Development and the period to which they relate.
- Tony Chambers stood down as Chief Executive of the Trust on 20th September 2018. He continued to be employed by the Trust for a further 6 months.
- The benefit in kind is for a lease car scheme and a home technology scheme which is open to all members of staff. It is a scheme whereby the employer agrees to reduce their salary for the full cost of the benefit. If an employee withdraws from the scheme this will have an effect of increasing their pay as they are not then sacrificing it for a benefit.
- As Non-Executive members do not receive pensionable remuneration, there are no entries in respect of pensions for Non-Executive members.
- A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capitalised value to the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme.
- They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries. The NHS pension scheme will not make a cash equivalent transfer once a member reaches the age of 60 and is then therefore, not applicable.
- Real Increase in CETV - This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

2.3 Staff Report 2018/19

The Trust's key priorities for 2018/19 were based around our values of -

Safe
Delivering safe services by reducing clinical variation

Kind
Delivering kind and compassionate care by building on our high performance culture

Effective
Delivering effective services by reducing process variation

Delivering safe services by reducing clinical variation through the 'Model Ward' programme

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

Delivering kind and compassionate care by building on our high performance culture

We focused on creating a culture within the Countess that fosters the values and behaviours that patients, the public and staff expect, one where staff come to work, to do their work and improve their work and getting the right number of nursing staff, with the right skills, to the right patient at the right time.

Delivering effective services by reducing process variation

We focused on the way in which we work to ensure we improve the safety, quality and experience of our patients.

One of the key areas of focus has been around how we engage with our staff and develop a high performance culture, which requires collective leadership at every level and inspiring everyone to be the best they can be. The Trust's People & Organisational Development Strategy will be refreshed as a key enabling strategy in 2019/20.

The current strategy is illustrated in the diagram below, which supports the themes of Organisational Culture, Organisational Excellence, and Organisational Renewal, and is intended to address the workforce challenges the Trust is facing.

Patient

Our Vision

"Delivering NHS care locally that makes our staff and community proud"

Our Values and Behaviours

Safe Kind Effective

The Model Hospital

Organisational Culture

- Values & Behaviours
- Positive Staff Experience
- Leadership Framework
- Career Development Pathways
- Rewards & Recognition
- Compliance with Training
- Apprentices hips
- Performance Management Framework

Organisational Excellence

- Acuity
- E-Rostering
- Variable Pay
- Recruitment & Retention
- Talent Management
- Succession Planning
- Operational Blueprints
- Equality & Diversity

Integrated Care Partnership

Organisational Renewal

- Health & Wellbeing
- Attendance Management
- Stress Management
- Flu Campaign
- Smoking Cessation
- Fast Track Physio
- Payroll & Pensions
- Corporate Services
- ESR

Cheshire West Integrated Care Partnership

The Model System

Partnership & Collaboration

Meeting Regulatory Requirements

NHS Improvement

- Cost Improvement Programme
- Annual Plan & Report

Care Quality Commission

- Quality Report
- Staff Survey
- Staff Friends & Family

Health Education England North West

- HEE Workforce Plan
- Apprentice Development
- Widening Participation

Organisational Culture

We want to be one of the most clinically led and engaged organisation in the NHS, with our clinicians leading improvements and innovation activities. In looking at our values and behaviours, we re-energized what our values and behaviours mean for all of our staff as well as exploring personal accountability in delivering change. This has led to further embedding our Behavioural Standards and our staff shaping what each of those Behavioural Standards mean, supported through our Barometer Group.

We have strengthened our Leadership Framework to build on the successes of recent initiatives such as our Master Classes and a bespoke leadership programme that's helped us with the development of a new performance framework. The new framework is linked to our behavioural standards, and encourages supportive development conversations between line managers and the people they are responsible for, and will be piloted further into 2019/20.

Compliance with mandatory training and core skills has been made clearer for our staff but we still have more work to do on the quality of appraisal conversations, as our staff have described to us in the results of the most recent Staff Survey (2018). This will link with the pilot work we are undertaking in 2019/20. Partnering arrangements with the University of Chester and other educational providers remain a priority with new career development pathways established to prepare staff to take on promotion opportunities. This work

has included a growth in apprenticeships at all levels and increased utilisation of the apprenticeship levy.

Reward and recognition remains at the heart of how we work and value our people. There are award and celebration events, with an emphasis on increased frequency and support for more informal team-led recognition activities.

Our policies and procedures continue to be reviewed and developed, drawing on the feedback from our Staff Partnership Forum, and Local Negotiating Committee (LNC). During times of significant organisational change, we recognize the contribution from staff representatives to help us get the engagement and communication with our workforce right.

Organisational Excellence

We know there is more to do with the introduction of new systems or use of technology. We have delivered specific changes in the following areas -

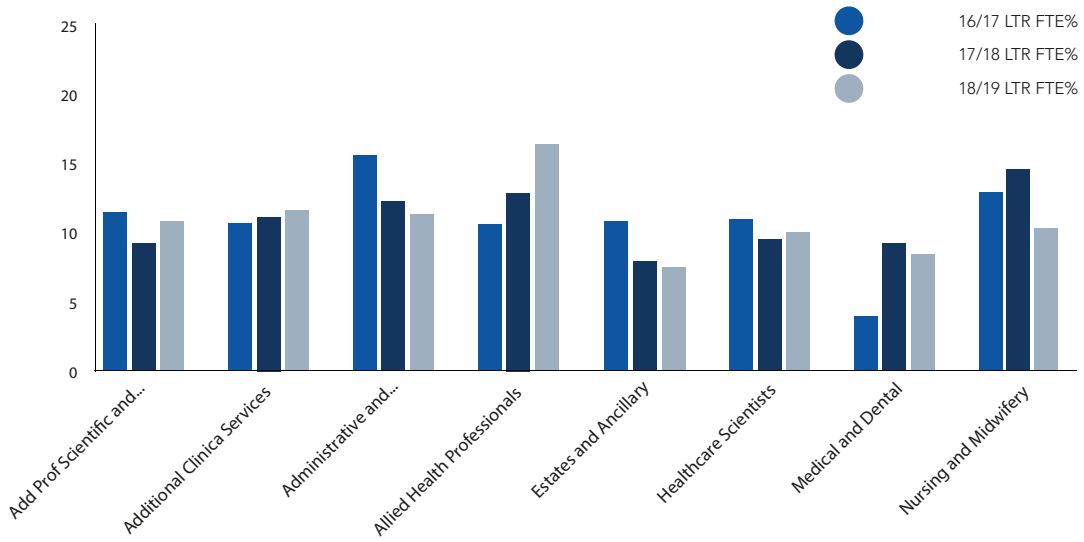
- Developing our acuity based workforce, which has enabled improved matching of staffing levels to meet patient need.
- Supporting the implementation of E-rostering for Nursing & Midwifery colleagues to enable a demand driven approach and a reduction in costs associated with temporary staff.
- A regional collaborative task group to address variable pay, with new controls, guidance and policies to help the Trust achieve its cost improvement plans in this area.
- Recruitment to values has revamped our recruitment processes to ensure the right behaviours are at the heart of how we attract, recruit and retain our staff.
- The implementation of a weekly payroll, to support our bank colleagues being paid more frequently, following their feedback.

The Countess approach to equality and diversity has been locally and nationally recognised, with a key achievement this year being our inclusion in the list of Top 50 Most Inclusive Employers, which was our first opportunity to apply for this national recognition. Alongside this we have refreshed our approach to Equality, Disability and Inclusion and whilst continuing our Disability Equality Group, Age Equality and Adult Safeguarding Group, Culture Faith and Belief Group and Gender and Sexual Equality Group, we have made some of our meetings virtual and established a Black and Ethnic Minority (BAEM) virtual group.

Retention of Staff

Whilst the Trust recognises the need to retain staff and skills wherever possible, it acknowledges that circumstances and opportunities can arise that result in staff leaving. The Trust utilises an exit interview process where it captures the reasons for staff leaving. Where patterns indicate potential concerns, the Equality and Diversity Manager, with support from Human Resources and Staff Side, will investigate. We have also been working with NHS Improvement in Cohort Four of the Recruitment and Retention work stream, to assess and implement further actions to improve the retention of nursing and midwifery staff particularly. As such, our labour turnover is as follows -

Labour Turnover for Full Time Equivalents % by Year & Staff Group



Attendance Management

Supporting staff attendance remained high on our list of priorities in terms of close monitoring and effective processes to support and address any issues, as well as practical options to keep people fit and healthy –

- Stress management courses, mindfulness courses, resilience sessions and counselling services remain available to everyone working at the Countess.
- The 2018/19 staff flu campaign was another success with over 82% of frontline staff vaccinated, exceeding the national target of 75%, and with the Trust being recognised as was one of the top 20 achieving Trusts nationally.

Whilst we did not achieve our Trust target for sickness absence, we have instigated further actions to support staff attendance into 2019/20, including the implementation of an Employee Assistance Programme.

Trust Target	FTE-Days Lost to Sickness Absence	Average % Over 12 Months (Jan 2019 to Dec 2018)
3.65%	32,008	4.15%

Organisational Renewal

Staff Health and Wellbeing

Supporting the wellbeing of our staff to enable safe, kind and effective care is delivered by the Trust's Safe Effective Quality Occupational Health Service (SEQOHS) accredited Occupational Health & Wellbeing Department, enabled through the Health & Wellbeing Strategy. The Trust has a Health and Wellbeing Steering Group who meet quarterly to review this plan.

Staff physical and mental wellbeing is supported by offering opportunities for all of our staff to join physical exercise classes and a range of mental health initiatives particularly focusing on resilience and mindfulness. During 2018, two Occupational Health Nurses trained as Mental Health First Aid (MHFA England) instructors. We now deliver courses internally and externally to become qualified Mental Health First Aid Trainers, to understand the impact of supporting mental health and to develop the skills to look after our own, and others mental health and wellbeing.

Recognising the need for staff to be able to access counselling and health advice in a timelier manner, in early 2019, we will introduce an Employee Assistance Programme which provides a 24 hour confidential telephone helpline, face to face counselling within five working days, an online health portal, and mobile phone health e-Hub App.

Employee health and wellbeing influences whether staff are able to work at their peak, and are critical success factors for individual and organisational performance, and improved patient outcomes.

Equality & Diversity

We have built on our regionally and nationally recognised programme of work to support Equality and Diversity within the Trust and we are now recognised as an Equality and Diversity Alumni Partner by NHS Employers. We have also been successful in achieving number 24 in the Top 50 Most Inclusive Employers. This recognition is due to our delivery against six measurable criteria –

- improving patient access and experience
- empowered, engaged and well supported staff
- inclusive leadership at all levels
- better health outcomes for all
- demonstration of commitment to the partners programme and benefits the organisation will receive from taking part

We pride ourselves in communicating with stakeholders both internally and as part of our wider community in work around Equality and Diversity, our robust governance structure is headed up by the Equality Diversity and Human Rights Strategy Group, which reports into the People and Organisational Development Committee. Two key areas that the Strategy Group focus on relate to the assessing delivery against the Workforce Race Equality Standard (WRES), and the Equality Delivery System 2 (EDS2).

The Workforce Race Equality Standard (WRES) was implemented by NHS England in July 2015. The WRES is a set of key indicators outlining how the Trust can demonstrate data and engagement evidence on how Black and Minority Ethnic (BME) members of staff are represented in recruitment, HR formal procedures and leadership & development. It also sets standards to outline actions the Trust will undertake to improve ESR and training data capture and engagement with its BME staff. The Trust continues to meet all of its WRES objectives and has published a 2018 WRES report. It has introduced a BME staff network, and improvements in data analysis of the access to non-mandatory training and personal development.

The Equality Delivery System 2 (EDS2) is an equality performance assessment framework introduced in January 2012 by NHS England. It covers 18 outcomes around the patient care, quality, safety, workforce and leadership domains. The Countess has attained recurrent high grading from assessors, with 15 outcomes being rated as *'Achieving'* and the remaining three outcomes being rated as *'Excelling'* in 2018/19.

Equality and Diversity – Gender Breakdown

Gender - Employee	16/17	17/18	18/19
Female	3,224	3,219	3,312
Male	741	758	770
Total	*3,965*	*3,977*	*4,082*

Gender - Directors	16/17	17/18	18/19
Female	3	4	5
Male	3	3	3
Total	*6*	*7*	*8*

Staff Cost Analysis

	Total 2018/19	Permanently Employed	Other	Total 2017/18
	£000	£000	£000	£000
Employee Expenses				
Short term employee benefits - salaries and wages	135,680	120,579	15,101	130,086
Post employee benefits social security costs	12,103	10,951	1,152	11,483
Apprenticeship levy	638	576	62	605
Post employee benefits employer contributions to NHS Pensions Agency	15,239	13,788	1,451	14,433
Other Employment Benefits	-	-	0	3
Termination Benefits	-	-	0	-
Agency/contract staff	4,422	-	4,422	4,373
Total	*168,082*	*145,894*	*22,188*	*160,983*
Average number of persons employed				
Medical and dental	466	195	271	444
Ambulance Staff	1	1	-	-
Administration and estates	719	662	57	711
Healthcare assistants & other support staff	846	802	44	820
Nursing, midwifery & health visiting staff	981	906	75	1,004
Nursing, midwifery & health visiting learners	-	-	-	-
Scientific, therapeutic and technical staff	443	412	31	430
Healthcare Scientists	132	121	11	128
Bank Staff	207	-	207	159
Total	*3,795*	*3,099*	*696*	*3,696*

The Trust spent £75,000 on consultancy during 2018/19 (2017/18 - £140,000).

Staff Survey

One way that we monitor staff engagement is through the national NHS Staff Survey which is conducted each year by the Trust, the results of which are used by the Care Quality Commission, our regulators, our commissioners and others to assess our performance. In partnership with our trade union colleagues, operational and medical representatives, with governance from the People and Organisational Development (POD) Committee, we have developed an action plan to address areas of concern. Our results are published nationally on our website. In addition, to this we also monitor the views of our staff on a quarterly basis against key indicators via the national Staff Friends and Family Test.

This year, we changed our approach to the NHS Staff Survey by undertaking a sample survey, instead of a survey of all our staff. This was due to the feedback we had received from many of our staff that who wished us to adopt a different approach. As such, we surveyed a random sample of 1,250 of our staff (excluding bank & agency workers). The key headlines from the survey were as follows -

- The response rate for the Trust was 36%.
- Around 448 members of staff completed the survey.
- The Trust response rate was below the national average (40%)

The level of response rate was disappointing, and is recognised as a key area of improvement for future surveys. We also undertake other local surveys to test the temperature of the organisation, as well as

feedback being asked from staff to shape and inform our High Performance Culture Workstream.

The main change in the format of this year's survey is a reduced number of summary indicators, and instead the questions have been presented in the form of ten main themes -

- equality, diversity & inclusion
- health and wellbeing
- immediate managers (which includes providing support and feedback)
- morale (a new area for 2018)
- quality of appraisals
- quality of care
- safe environment - bullying and harassment
- safe environment - violence
- safety culture
- staff engagement.

The Trust performed better than the acute average in three indicators as follows (all scores are marked out of 10) -

Higher than the acute average in three indicators

- Equality Diversity & Inclusion - 9.2 v 9.1
- Health & Wellbeing – 6.1 v 5.9
- Safe Environment Bullying &Harassment 8.1 v 7.9

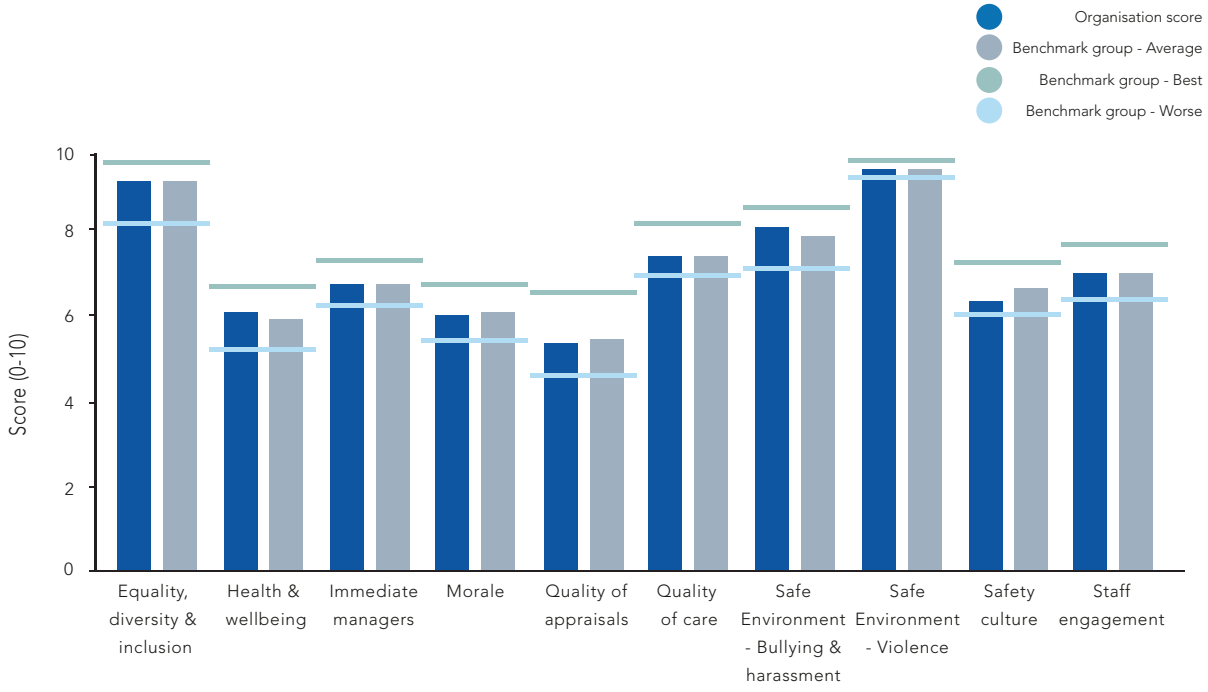
Equal to the acute average in three indicators

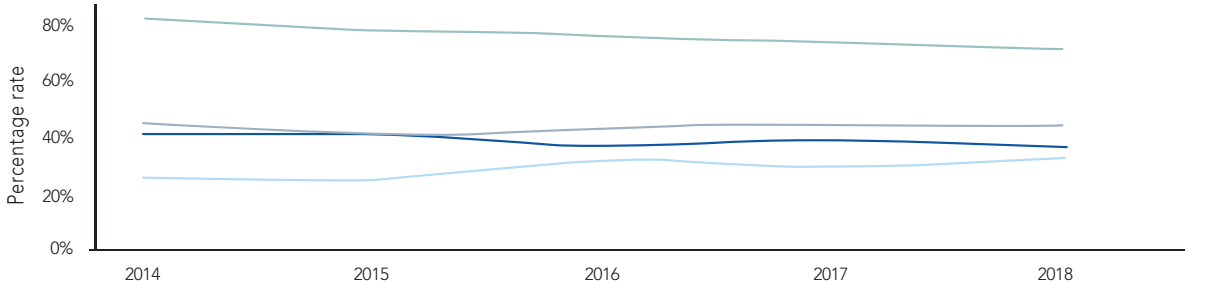
- Immediate managers – 6.7
- Quality of care – 7.4
- Safe environment violence – 9.4

Lower than the acute average in four indicators

- Morale – 6.0 v 6.1
- Quality of appraisals – 5.3 v 5.4
- Safety Culture – 6.3 v 6.6
- Staff engagement – 6.9 v 7.0.

The key domain showing a lower than acute average score which, whilst not statistically significant, showing the largest gap is: Safety Culture – 6.3 v 6.6.





	2018/19		2017/18		2016/17	
	Trust	Benchmarking Group	Trust	Benchmarking Group	Trust	Benchmarking Group
Equality, diversity & inclusion	9.20	9.06	na	na	na	na
Health and wellbeing	6.05	5.85	na	na	na	na
Immediate managers	6.70	6.72	3.75	3.74	3.67	3.73
Morale	5.98	6.06	na	na	na	na
Quality of appraisals	5.37	5.39	3.04	3.11	3.05	3.11
Quality of care	7.51	7.35	3.85	3.92	3.96	3.96
Safe environment - bullying and harassment	8.05	7.88	na	na	na	na
Safe environment - violence	9.37	9.44	20%	15%	15%	15%
Safety culture	6.32	6.53	3.57	3.65	3.63	3.65
Staff engagement	6.93	6.93	3.75	3.79	3.77	3.81

Overall Staff Engagement

Following additional effort on staff engagement, improvements were made in areas of Advocacy and Motivation; however there was a decline in Involvement -

	2018 score	2017 score	Diff	Sector score	Diff
Advocacy	6.95	6.74	+0.21 (not sig)	6.80	+0.15 (not sig)
Motivation	7.26	7.16	+0.10 (not sig)	7.26	-0.01 (not sig)
Involvement	6.59	6.70	-0.10 (not sig)	6.73	-0.14 (not sig)
Overall Staff Engagement	6.93	6.87	+0.05 (not sig)	6.93	-0.00 (not sig)

Bottom Five Ranking Scores 2018

1	11g	Have you put yourself under pressure to come to work?	95%
2	4g	There are enough staff at this organisation for me to do my job properly	25%
3	9d	Senior managers act of staff feedback	27%
4	9c	Senior managers here try to involve staff in important decisions	31%
5	5g	(How satisfied are you with) My level of pay	33%

The survey results have been shared with the Board, and the People and Organisational Development Committee (which is sub-committee of the Board), and have also been shared across the organisation. What our staff have told us as a result of the NHS Staff Survey in 2018 is that we need to improve in many aspects of the key themes, and particularly in the area of involving them in decisions around patient care, or those that may affect their area of work.

The NHS Staff Survey also shows that our staff are telling us that the Trust is struggling to provide the level of care they and we aspire to against the increasing levels of demand and activity, which is comparable with the national results. However, it is pleasing to note that some of the actions identified in the results of the 2017 survey, particularly in relation to the reporting in the numbers of staff experiencing violence and knowing how to report it, has improved due to our increased focus in this area. Looking

ahead, we have to do more to focus on our Safety Culture, particularly the reporting of near misses, staff engagement, the pressure colleagues put themselves under to attend work, the quality of our appraisals, the communication and involvement of colleagues across the Trust regarding decisions that affect their work, and to continue to create an environment free from discrimination, bullying and harassment.

An action plan is in place to address the areas of concern, and a communication plan has been developed to ensure that all members of staff are fully briefed on the results, and the actions required. Each section of the action plan has an executive lead and a service lead to ensure progress and monitoring against the planned actions - with regular reports to the People and OD Committee. Reports will also be made to the Staff Partnership, and the Culture and Engagement Steering Groups. Where we are able, we are also sharing the detailed results with individual areas to encourage ownership of the results, and to empower our front line colleagues.

Staff Consultations

	1	2	3	4	5	6	7	8
Reason/ name	Review of shift pattern for the Clinical Support Workers to introduce two shift patterns 4pm to 12am, and 8pm to 8am At this stage there are informal conversations to be arranged with the staff to discuss their thoughts and to decide whether formal consultation is required	Review of Porters Shift patterns – Moving to a mix of shift patterns including rotational shifts - to enable more efficient, cost effective service. Creating more substantive roles to avoid over reliance on bank workers.	Critical Care Outreach rotational post and 24:7 working The provision of Critical Care Outreach Services (CCOS) recommends each hospital should be able to provide a Critical Care Outreach or Rapid Response service that is available 24 hours per day 7 days per week. Currently at the Countess of Chester Hospital	Ward 40 closing as a result of SAU moving to Ward 40 and the decrease in service needs following the introduction of ESSU	Rotation of 1 x Radiology Support Worker between EPH and COCH who currently only works in one location	Trust On Call payments/ Senior Manager On Call and other departmental local arrangements (3)	Contract Refresh – Transition of the Band 1 into a Band 2 position in line with the national pay deal	Contract Refresh – Pay Progression as per national agreement
Staff Groups	Clinical Support Workers	Porters	Nursing	Nursing, HCAs, Care & Comfort and Housekeeper	Clinical Support Worker	All A4C	Band 1's across all Divisions	All A4C staff
Number of staff	3	38	5		1	Approx 10	360	
Start Date	April 2019	Jan 2019	April 2019	March 2019	April 2019	May 2019	January 2019	April 2019
End Date	TBC	March 2019	May 2019	April 2019	TBC	Sept 2019	May 2019	May 2019
Outcome		Formal consultation period completed. Final decisions and allocation to shift patterns about to be completed in order for new rotas to commence.	CCOT on rotational post with Critical Care Staff	Relocate staff to other areas within the Trust	Not started yet	Agreement of new harmonised pay for out of hours services	Band 1 staff will either transition to a Band 2 position or remain as a Band 1	New Trust policy / process for pay step change

Equal Opportunities Policy

The Trust has policies in place to facilitate fair and non-discriminatory consideration for employment applications from disabled people and with regard to access to training, career development and promotion. The Trust sets this out in the Equal Opportunities Policy and in the Disability Equality Policy. Reasonable adjustment options with regard to learning and development are identified within the Learning and Development Strategy. The Trust also publishes detailed data on its disabled employees and job applicants within its annual Workforce Equality Analysis Report, as per the specific duties of the Equality Act (2010).

Countering Fraud & Corruption Policy

The Countess of Chester Hospital NHS Foundation Trust does not tolerate fraud, corruption or bribery within the NHS. The Trust has an overarching Anti-Fraud, Corruption and Bribery Policy and Response Plan in place, produced by the Trust's Anti-Fraud Specialist, which has been reviewed in 2018/19. The aim is to eliminate all NHS fraud, corruption and bribery as far as possible, freeing up public resources for better patient care.

NHS Protect is a business unit of the NHS Business Services Authority. It has responsibility for all policy and operational matters relating to the prevention, detection and investigation of fraud, corruption and bribery and the management of security in the NHS. All instances where fraud, corruption and bribery is suspected are properly investigated until their conclusion, by staff trained by NHS Protect. Any investigations will be handled in accordance with the NHS Counter Fraud and Corruption Manual.

Ill Health Retirements

During 2018/19 (prior year 2017/18) there was 1 (4) early retirement from the Trust agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £40,000 (£203,000). The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division. This information was supplied by NHS Business Services Authority - Pensions Division.

Off Payroll Engagements

Off-payroll engagements are arrangements where an individual provides their services to the Trust, but, under HMRC rules, they are not paid through the Trust payroll. Typically, this is because the individual is working through a temporary staffing agency, or they are legitimately in business in their own right, and the legal nature of the arrangement between the Trust and the off-payroll individual is a commercial business arrangement, rather than one of employment.

The Trust makes use of off-payroll engagements in a number of circumstances -

- when there is a short term need that cannot be met from internal staffing resources, including bank staff
- when specialist expertise is required that is not available internally
- when there is difficulty recruiting to a post

Off-payroll engagements as of 31 March 2019, for more than £245 per day and that last for longer than six months

No. of existing engagements as of 31 March 2019	12
Of which, the number that have existed:	
for less than one year at time of reporting	11
for between one and two years at time of reporting	0
for between two and three years at time of reporting	0
for between three and four years at time of reporting	0
for four or more years at time of reporting	1

New off-payroll engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019, for more than £245 per day and that last for longer than six months

Number of new engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019	14
Of which,	
Number assessed as within the scope of IR35	14
Number assessed as not within the scope of IR35	0
Number engaged directly (via PSC contracted to trust) and are on the Trust's payroll (the rest are on the payroll of the temporary staffing agency)	1
Number of engagements reassessed for consistency/assurance purposes during the year	1
Number of engagements that saw a change to IR35 status following the consistency review	0

Off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2018 and 31 March 2019

No. of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
Total number of individuals that have been deemed "board members and/or senior officials with significant financial responsibility" during the financial year. This figure should include both off-payroll and on-payroll engagements.	16

A mutually agreed resignation scheme was open to all staff whereby they could apply to leave. These relate to actual departures during the financial year.

Exit Package cost band	Number of compulsory redundancies		Number of other departures agreed		Total number of exit packages by cost band	
	2018/19	2017/18	2018/19	2017/18	2018/19	2017/18
<£10,000	-	-	15	13	15	13
£10,000-25,000	-	-	1	6	1	6
£25,000-50,000	-	-	2	4	2	4
£50,000-100,000	-	-	1	2	1	2
£100,000-150,000	-	-	-	-	-	-
Total number of exit packages by type	-	-	*19*	*25*	*19*	*25*

Exit Packages: Non-Compulsory Departure	2018/19		2017/18	
	Agreements Number	Agreements Number £000	Agreements Number	Agreements Number £000
Mutually agreed resignations (MARS) contractual costs	4	161	15	374
Non-compulsory payments in lieu of notice	15	30	9	36
Exit payments following Employment Tribunals or court orders	-	-	1	25
Non-contractual payments requiring HMT approval	-	-	-	-
Total	*19*	*191*	*25*	*435*

Trade Union Facility Time

Relevant Union Officials – Total Number of Employees who were relevant union officials during the relevant period

Number of employees who were relevant union officials during reporting period	Full-time equivalent employee number
25	23.56

Percentage of Time Spent on Facility Time

Percentage of Time	Number of Employees
0%	0
1-50%	25
51-99%	0
100%	0

Percentage of Pay Bill Spent on Facility Time

Total Cost of Facility Time	£177,179
Total Pay Bill	£168,175,000
Percentage of the Total Pay Bill Spent on Facility Time (calculated as total cost of facility time/ total pay bill x 100)	0.11%

Paid Trade Union Activities

Time spent on paid trade union activities as a percentage of total paid facility time hours	100%

2.4 The Disclosures

The Countess of Chester Hospital NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a *'comply or explain'* basis. Disclosures are included within the 2018/19 Annual Report on the *'comply or explain'* basis.

The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code.

Code Provision	Disclosure
B.1.2	The Board intend to redress the balance between Executive Directors and Non-Executive Directors, since the 1st September, 2018. This is referenced within the Annual Governance Statement.
B.6.2	The Trust commissioned an external evaluation of its governance in December 2018. The external review was undertaken by Facere Melius Ltd. The Managing Director and employees of Facere Melius Ltd had no other connections to the Trust.
D.1.3	The Director of Nursing & Quality is released by the Trust to act as the Governing Body Nurse at Salford CCG, as outlined within the Director's Report. The Director of Nursing & Quality does not retain the earnings from this role and it is received as income to the Trust. This CCG appointment ceased on 31st March 2019.

The Accountability Report provides further disclosures including the composition of the Board and Council of Governors, members of Nominations, Audit and Remuneration Committees; the Chair's other significant commitments, the work of the Audit Committee, and the work of the Nomination Committee.

The Annual Governance Statement includes how the Board of Directors has conducted a review of the effectiveness of its system of internal controls.

2.5 NHS Improvement's Single Oversight Framework

NHS Improvement's Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs.

The framework looks at five themes -

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

The Trust is in NHS Improvement's Segment 2: Providers Offered Targeted Support – Support needs identified in finance, use of resources and operational performance.

This segmentation information is the Trust's position as at the 2nd May 2019.

Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

Finance and Use of Resources

The finance and use of resources theme is based on the scoring of five measures from '1' to '4', where '1' reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the single Oversight Framework, the segmentation of the Trust disclosed above might not be the same as the overall finance score here.

A table outlining the finance and use of resources scores for the Trust can be seen in the Financial Review section of the Performance Report.

2.6 Statement of Accounting Officer's Responsibilities

Statement of the chief executive's responsibilities as the Accounting Officer of the Countess of Chester Hospital NHS Foundation Trust.

The NHS Act 2006 states that the chief executive is the Accounting Officer of the NHS Foundation Trust. The relevant responsibilities of the Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require the Countess of Chester Hospital NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Countess of Chester Hospital NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care's Group Accounting Manual and in particular to -

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS Foundation Trust's performance, business model and strategy
- assess the Foundation Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern
- use the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Foundation Trust without the transfer of its services to another public sector entity.

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error, and for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The Accounting Officer is also responsible for ensuring that the use of public funds complies with the relevant legislation, delegated authorities and guidance.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.

Signed:

Dr Susan Gilby,
Chief Executive Officer
21st May 2019

2.7 Annual Governance Statement 2018/19

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the Countess of Chester Hospital NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in the Countess of Chester Hospital NHS Foundation Trust for the year ended 31 March 2019 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

As the Chief Executive, I am responsible for overseeing risk management across all organisational, financial and clinical activities. I have delegated the executive lead for risk management to the Director of Nursing & Quality who in turn is supported by an Associate Director of Risk & Safety who manages the Risk & Safety Team.

At the beginning of the year the Trust had a Risk & Performance Committee in place in which all risk matters were discussed. However, further to a change in leadership, and the acknowledgement that a more effective process was required, this was reviewed during the year. In light of this, a revised structure of how risks are discussed via an Executive Risk Review meeting has been put in place. This is chaired by the Director of Nursing & Quality, and provides an environment whereby the clinical Divisions and corporate teams are constructively challenged on their risks, as well as supported to take forward actions to mitigate these.

The Board draws assurance from the Quality, Safety and Patient Experience Committee (QSPEC), Finance and Integrated Governance Committee (FIGC), and the People and Organisational Committee (POD), which are all sub committees of the Board of Directors. There is purposeful interaction between the risk management function and the Trust's Audit Committee. The Audit Committee is a key statutory Committee through which a sub-set of the Trust's Non-Executive Directors bring independent judgement to bear on issues of risk management and performance. This interface supports the effectiveness of the Trusts systems of internal control.

The Trust has a Risk Management Strategy in place which outlines the Trust's approach to risk and provides a framework for managing risk across the organisation. The roles and responsibilities of all staff in relation to the identification and management of risk are identified in this and other related policies, e.g. Incident Reporting Policy. The Strategy sets out the role of the Board of Directors

and relevant committees. Risk management is supported in the following ways -

- A centralised Risk and Safety Team is led by the Trusts Associate Director of Risk & Safety; and
- A team of Risk & Safety Leads support the Divisions and corporate teams.

All Divisions manage their operational risks at a local level through their Divisional Governance Boards, and each Manager is responsible for overseeing the management of their risk registers. They can escalate or request to de-escalate risks accordingly through the regular Executive Risk Review, or Corporate Leaders Group if an issue is particularly urgent, to ensure a timely acknowledgment, discussion and planning regarding management of any new high scoring risks. The Divisional Governance Boards are chaired by the Divisional Medical Director; they have responsibility for providing leadership to, and provide oversight of, the achievement of the Division's objectives through the mitigation of risk and review of relevant assurance. Each Division is supported by a dedicated Risk and Safety Lead Manager (as articulated above), who facilitates relevant discussion and provides specific reports as required.

In addition to the risk training articulated below, bespoke risk management training has been provided in year to all Ward Managers; this was a workshop facilitated by Mersey Internal Audit (MIAA). An external facilitator also provided Root Cause Analysis training for approximately 15 senior clinical leaders (including consultants) to support serious incident investigation within the Trust. The Trust has further developed its processes for learning during the year with the 'Lessons Learned' weekly communication which is sent to all staff across the Trust. The 'Lessons Learned' communication recognises that we do not always get things right and shares the learning as part of our supportive learning culture development. This follows the Serious Incident Panel meeting each week.

The Serious Incident Panel is chaired by the Director of Nursing & Quality, with representatives from the Legal, Patient Experience and Risk teams. Relevant themes and trends are shared via reports and reviews at the Quality, Safety & Patient Experience Committee which is chaired by a Non-Executive Director. In addition to weekly 'Lessons Learned', a Quality Newsletter is shared monthly with key learning and topics communicated in respect of quality governance. Both these communications have had positive feedback from individuals and teams. Patient experiences and stories are shared in various forums across the Trust, including the Board of Directors meeting. The Trust encourages patients and families to become involved in sharing their stories directly with teams and in addition, being involved in quality improvements where appropriate.

The Trust Serious Incident Panel meets weekly and reviews all significant incidents, complaints, inquest learning and claims. When an event is deemed significant enough to be formally investigated, in line with the Serious Incident Framework; these are reported externally to StEIS (the National Framework for Reporting and Learning from Serious Incidents requiring Investigation). These incidents, the quality of the review and report, and its subsequent action plan, are monitored internally via a monthly report to the Quality, Safety & Patient Experience Committee, and via the monthly Clinical Commissioning Group (CCG) serious incident meeting. Externally we report via a six-monthly report of incidents, complaints, claims and HM Coroner's inquests.

All serious incidents are reported to our commissioners and to other bodies in line with current reporting requirements. Whilst we recognise there may always be human factors at play, we continue to revisit our systems and processes to ensure learning, and any necessary changes identified become business as usual. Serious incidents are reported through the Quality, Safety & Patient Experience Committee, and Divisional Governance boards. In addition, lessons learnt are fed back through to nursing teams at Ward Managers' meetings and safety briefs at a local level to ensure information reaches relevant staff groups. Medical staff have presented their findings at whole hospital rolling half days. Medicines related incidents and meetings to support monitoring have been refreshed during the

year. The Trust has a robust clinical audit programme which includes subsequent audit on selected incidents ensuring changes made as a result of an investigation have been effective.

The Trust underwent a Care Quality Commission (CQC) *'Well Led'* inspection in December 2018.The review findings were that we did not have fully effective systems for managing risk, that the risk management system did not connect to the Board Assurance Framework, that committee reporting accountabilities were not clear, and that some issues raised in the last inspection have not been addressed in a timely manner, with gaps in governance and safety issues. The Trust received a rating of *'Requires Improvement'* in the final report published on the 17th May 2019.

Prior to the inspection, it was identified by the then acting Chief Executive, that a robust external review was required of the Trust's governance processes, with the purpose of deepening the organisation's understanding of its leadership and governance arrangements and identifying key development actions. This was commissioned before the CQC *'Well Led'* inspection.

Key recommendations from the external governance review included -

- Developing a long-term strategy for the organisation;
- Making better use of the Board Assurance Framework (BAF) to drive the Board agenda and aligning the BAF to the Trust's risk management system;
- Implement a development programme for board members and senior operational leaders to improve knowledge around assurance and use of data;
- Review and refresh organisational structures;
- Improve systems and processes; and
- Embed leadership, culture and behaviours.

It is recognised going forward, a new model of integrated governance will be implemented in response to the recommendations of the external governance review. This will provide oversight and realignment of all governance and risk processes, including quality governance, clinical governance, financial governance, information governance and staffing/people governance, and will also provide an opportunity to review the current reporting mechanisms and committee structures.

Risk Training

All new members of staff receive an overview of the Trust's risk management processes as part of the corporate induction programme, supplemented by local induction organised by line managers. Further education is provided with cyclical mandatory training undertaken by both clinical and non-clinical staff; the risk content for this programme was updated in year and is continually reviewed in light of any changes. Any learning from incidents is integrated into training throughout the year. There is a robust appraisal process which facilitates the identification of individual staff training needs. These are reviewed as part of the member of staff's annual performance and development appraisal. All relevant risk policies are available to staff via the Trust's document management system including -

- Risk management policy
- Incident reporting including serious incidents; and
- Complaints policy.

The Trust aspires to be a learning organisation, using a range of mechanisms including clinical supervision, reflective practice, individual and peer reviews, performance management, continuing professional development, clinical audit and the application of evidence based practice. The revalidation process that a number of health professionals now have to do further supports learning and development.

Work continues to support the realisation of the Trust's vision, to further embrace the culture of embedding positive attitudes. Lessons learned and good practice is shared throughout the Trust via mechanisms such as the Quality, Safety & Patient Experience Committee, the Corporate Leadership Group, alongside the monthly 'Safe, Kind

and Effective' bulletins and Sharing our Learning from incidents in the weekly 'Lessons Learned' communication and the recent introduction of a monthly Quality Newsletter.

As above, in response to the external governance review, the Trust recognises that further work is required to strengthen risk training at all levels in the organisation in order to facilitate an improved risk management system.

The risk and control framework

The Foundation Trust has not published an up-to-date register of interests for decision-making staff within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance, however, this has been raised in a recent internal audit, and we are currently in the process of addressing this.

The Foundation Trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.
Risk management requires participation, commitment and collaboration from all staff. The process starts with the systematic identification of risks via structured risk assessments. Identified risks are documented on risk registers. These are held within the Trust's 'Datix' system; the Trust's electronic system of collating risks, incidents, complaints, clinical audit and claims.

All risks are assessed and scored using a Trust approved scoring matrix which takes into account the likelihood and severity of each risk. This results in each risk being awarded a score of between 1 (very low) to 25 (high). The potential consequence and likelihood of the risk occurring are scored along with the effectiveness of existing control measures. It is the sum of these scores which determine the level in the organisation at which the risk is reported and monitored to ensure effective mitigation. The risk scoring bandings will be reviewed in 2019/20, following the external governance review which found that they are not in line with industry norms.

Following a risk assessment, if the risk score is significant, the risk is entered onto the Datix Risk Register System and the owner of the risk (ward/department manager) is identified on the form. The Datix Risk Register System will then automatically generate a confirmation email to notify the identified risk owner of the added risk. Low scoring risks are managed by the area in which they are found whilst higher scoring risks are managed at progressively higher levels in the organisation. High scoring risks are presented at the Executive Risk Review meeting (see previous section) for confirm and challenge purposes.

The Trust seeks to reduce risk as far as possible, however, it is understood that delivering healthcare carries inherent risks that cannot be completely eradicated. The Countess of Chester Hospital NHS Foundation Trust, therefore, pursues assurance that controls continue to be implemented for risks that cannot be reduced any further.

The Trust's Board Assurance Framework (BAF) sets out the strategic risks that could impact on the delivery of the Trust's objectives. The BAF has ten strategic risks, which should be reviewed quarterly at the Board of Directors meeting. Each of these has an executive lead. The risks are as follows -

- Failure to maintain and enhance the quality and safety of the patient experience and ensure regulatory compliance
- Unable to meet the demand for services within available resources
- Failure to collaboratively innovate and transform the Trust's clinical services
- Failure to deliver the Trust's culture, values and staff engagement plan
- Failure to deliver in year financial plan and manage consequences of delivering a deficit budget
- Failure to comply with Compliance Framework
- Failure to maintain robust corporate governance and overall assurance
- Failure to maintain Information Governance standards

- Failure to provide appropriate Informatics infrastructure, systems and services that effect high quality patient care in-line with the business objectives of the Trust
- Failure to recruit, train and retain professional staff.

The work plan of committees should be aligned to the strategic risks where relevant so that the Trust is assured that there is an aligned independent and executive focus on strategic risk and assurance. It is recognised, however, that this requires further consideration following the findings of the external governance review. A review of the Board Assurance Framework was undertaken by the Trust independent auditors in March 2019 and was given a *'Moderate'* rating. Internal Audit found that the Board Assurance Framework had only been reviewed twice by the Board in 2018/19. The annual programme of internal audit aligns to the Trusts most significant risks.

At the time of this report the Foundation Trust remains fully compliant with the registration requirements of the Care Quality Commission. As described above the Trust had an unannounced inspection of three core services (urgent & emergency services, medical and surgical) during its *'Well Led'* inspection in November 2018. This was followed up by a formal *'Well Led'* inspection in December 2018, resulting in an overall *'Requires Improvement'* rating as described above.

Recommendations for action in relation to the final 2018/19 CQC report will be received by the Board, with future assurance being provided through the designated Board committee on quality and risk. A Trust-wide plan supported by the Trust's Quality Improvement Strategy will be implemented.

In respect of ensuring that quality and safety are considered in the context of the Cost Reduction Schemes (CRS), a robust Quality Impact Assessment (QIA) is undertaken for all schemes. The documentation is then reviewed and signed off accordingly by the Medical Director and Director of Nursing & Quality. The process of tracking the impact of schemes via metrics is monitored via the Divisional Governance Committees with oversight provided at the Risk & Performance Committee (with a detailed review taking place at the weekly CRS meeting).

Incident reporting continues to be encouraged at all levels of the organisation. 'Excellence Reporting' has continued throughout the year also as a method of recognition of quality – this promotes the reporting of positive events, such as excellent team work, individual performance or delivery of care as examples. This is proving a positive way for staff in gaining feedback on their contribution to services for patients. There is a process whereby these reports feed into the Trust's staff recognition awards and support staff groups that requires feedback as part of their professional revalidation.

Involving patients is vital in ensuring the Trust's services meet the needs of patients. Throughout the year, work has continued following the launch of a revised Patient Experience & Involvement Strategy supported by the Patient Experience Operational Group.

The Trust's Governors play an essential part in providing feedback about how services can improve; Governor Rounds are formally in place, facilitating Governors to undertake independent reviews of departments and clinical areas. Findings are shared in real time with the relevant leader at the time. A six-monthly report of findings is also collated which is shared at the Quality, Safety & Patient Experience Committee. Monthly 'Clinical Rounds' are also in place, whereby, clinical and non-clinical staff, Non-Executive Directors and Governors participate in auditing a department or clinical area. This audit is based on the CQC inspection model.

There are numerous ways in which patients provide feedback to the Trust so that improvements can be made, in particular when a significant clinical incident has occurred or a complaint is received, patients and/or their families are approached (if it is deemed appropriate at the time) to be involved in making improvements or sharing their experiences to support lessons learned. Some of these stories have been shared at the Board of Director's meeting during the year, including staff stories.

The Board receives the Integrated Performance Report each month centred round Safe, Kind and Effective care which includes detailed exception reports and performance against key quality indicators. This also includes actions being undertaken to address any risks and uncertainties. The Trust's compliance with the constitutional targets has been challenging throughout the year. Emergency Department performance has been compromised during 2018/19 due to continued increases in demand, complexity of patients and high bed occupancy levels.

The Foundation Trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

The Trust is fully compliant with Emergency Preparedness, Resilience & Response (EPRR) standards within the Civil Contingency requirements. An EPRR Committee is in place chaired by the Chief Operating Officer as Executive Board lead. This Committee provides oversight of Major Incident procedures and Business Continuity processes (including BREXIT). A Health and Safety Committee is in place which reports to the EPRR Committee.

Foundation Trust Governance

The Foundation Trust governance structures should ensure that the Board has an overarching responsibility through its leadership and oversight, to be assured that the organisation operates with openness, transparency and candour, particularly in relation to its patients, the wider community and staff. The Board holds itself to account through a wide range of stakeholders and the overall effectiveness and performance of the organisation.

In December 2018, an external governance review was commissioned by the acting Chief Executive to assist the Board of Directors to review the relationship and responsibilities of the Board sub-committees, and resilience across the organisation. The findings of which are articulated above within the 'Capacity to Handle Risk' section.

The CQC 'Well Led' review indicated that leadership and culture within the organisation needed to be improved, as Executive visibility was reported as low and staff morale on medical wards was poor. This will be a key area of focus in 2019/20 for the Board, along with the focus to address the gaps in governance and safety issues.

The Governors play a significant role in holding the Board, and in particular the Non-Executive Directors, to account in a challenging but constructive way. The Council of Governors meets quarterly and a meeting of the Governor's Quality Forum is held monthly. Governors are represented across a wide range of Trust organisational committees.

The Board is currently reviewing and recommissioning all of its sub-committees, with a view to redesigning the spread of assurance across each. The Audit Committee is a significant statutory committee of the Board and has a key role in ensuring the system of internal control, which is covered later in this statement.

The Board receives the minutes of each of the sub-committees to gain further assurance and it has been recognised that individual reports from Committees to Board are required moving forwards, following the external governance review. To further support the Board, each of the sub-committees receive regular updates and minutes from the operational groups which are chaired by the Executive Directors.

The Board and its sub-committees are responsible for leadership and oversight of the Trust's performance and aim to formulate an effective strategy for the organisation in 2019, following the publication of the NHS Long Term Plan, and whole system approaches to integrated care. Work has already begun on this in 2018/19 through the development of an overarching clinical strategy for the organisation, which is due to be issued in early 2019/20, following robust consultation during its development.

Work has progressed in 2018/19 in the development of the Cheshire West Integrated Care Partnership (ICP). As part of this development a governance programme is considering the governance challenges ahead and how these can be addressed. The Trust will host the ICP in 2019, with a number of strategic and enabling programmes in place to support it. An ICP Integration Agreement has recently been approved by provider Partner Boards, with an effective date of 1st April, 2019, and it is expected that governance arrangements will be agreed in Summer 2019 to establish an Integrated Care Partnership Board, which will function on an aligned decision making model with our provider partners.

The Audit Committee will consider the validity of the Corporate Governance Statement submission as required under NHS Foundation Trust condition 4(8)(b), prior to Board approval.

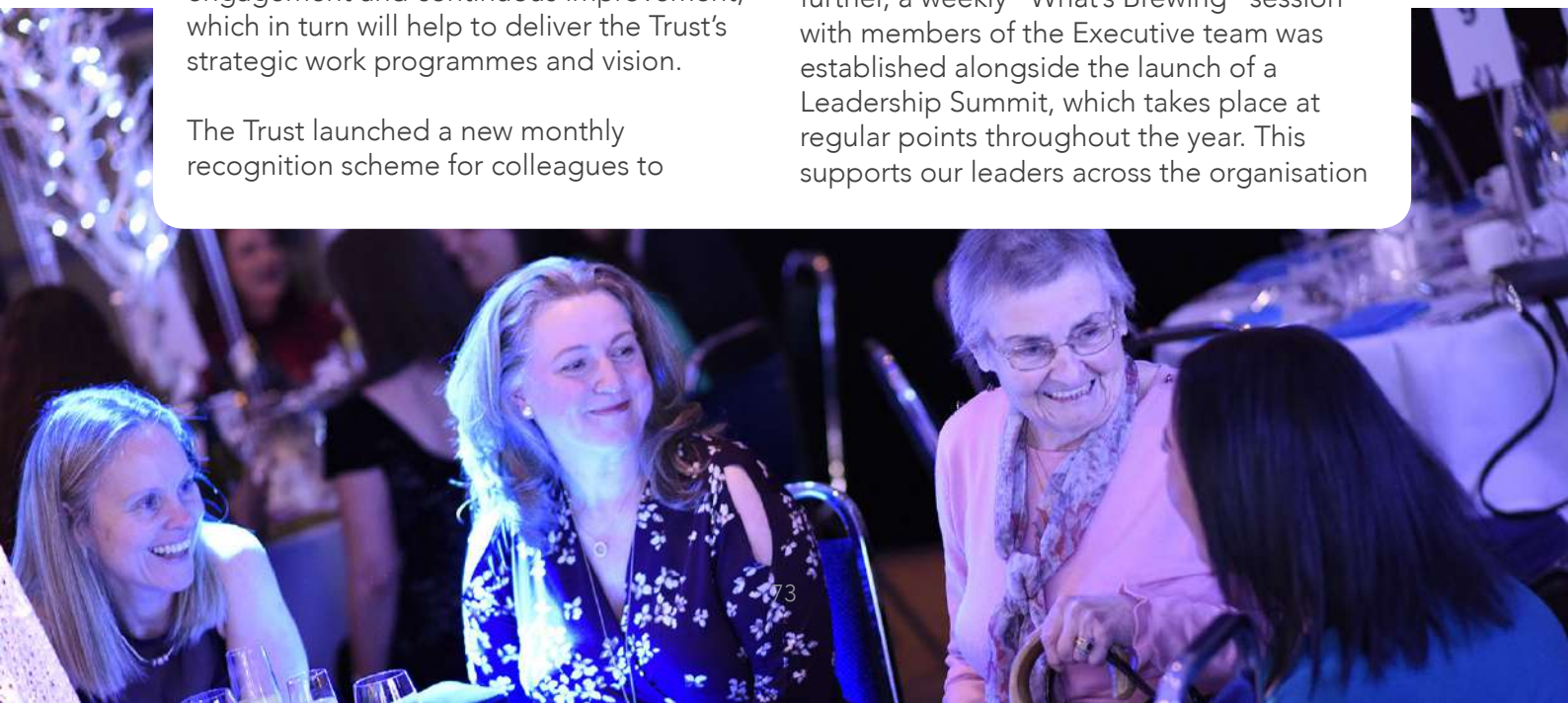
People, Organisational Development & Workforce Planning

The Trust continued its delivery of the 2016-18 People and Organisational Development Strategy & Delivery Plan, including embedding the Trust's behavioural standards. These standards, the learning from our 2018 staff survey, and the results of a cultural review that we will undertake during 2019, will be used to help create the right organisational culture for clinical engagement and continuous improvement, which in turn will help to deliver the Trust's strategic work programmes and vision.

The Trust launched a new monthly recognition scheme for colleagues to nominate a 'Countess Gem' and introduced an interactive 'Thank You Wall' on our intranet. Both of these activities complement the range of reward and recognition schemes the Trust has in place to recognise the outstanding work our members of staff undertake to support our patients and each other. These schemes include our annual Celebration of Achievement Awards, Apprenticeship Awards, Foundation Doctor Awards and Long Service Recognition.

The Trust further embedded the processes for junior doctors to transition over to the new contract, including the Guardian of Safe Working and the process for exception reporting. During 2018/19 the Trust reviewed its resources to support Freedom to Speak Up, and undertook a recruitment exercise to appoint a substantive Guardian who will take up post in late Spring 2019. A key objective going forward will be establishing a network of Freedom to Speak Up Champions across the Trust, as well as a revised policy to support any member of staff in knowing how to raise concerns on a timely basis.

The Trust has a number of well embedded formal and informal systems including a programme of Executive 'walk-rounds' that take place on the first day of the month, alongside other impromptu visits. The use of safety briefings, huddles and executive presence within the Trust induction process for all new starters are all important elements of keeping our teams informed, at the same time providing opportunity for feedback. To support this process further, a weekly "What's Brewing" session with members of the Executive team was established alongside the launch of a Leadership Summit, which takes place at regular points throughout the year. This supports our leaders across the organisation



to have further development and time out to discuss organisational challenges and opportunities for improvement. We also have a Staff Barometer Group which we use to gain feedback on new initiatives the Trust is considering, which complements our engagement with staff side and union colleagues.

Lastly, supporting the wellbeing of our staff to enable them to provide Safe, Kind and Effective care to our patients has been an area of key focus. We have introduced additional Occupational Health & Wellbeing clinical capacity, resilience awareness sessions, health and wellbeing events held at both the Countess and Ellesmere Port Hospitals. We have also promoted the awareness and reporting of incidents of violence that our members of staff are subject to. This was highlighted as a key concern in our NHS Staff Survey findings in 2017 and as such we have improved the methods of reporting incidents on Datix, seen improved levels of reporting of incidents, established the review of incidents by the Trust's Adult Safeguarding Strategy Board, and established additional support mechanisms for colleagues from our Occupational Health and Wellbeing Teams.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

With current work streams relating to E-Roster and Job Planning, Variable Pay and improvements in data quality, the Trust is compliant with the Developing Workforce Safeguards Document issued by NHS Improvement in October 2018 and a full analysis of the compliance was provided to the Divisional Board in April 2019. Additional information regarding this compliance will be provided to the relevant Board sub-committee in quarter one 2019.

A significant part of the guidance is about scheduling the "right staff, right skills, right place, right time" and NHS Improvement is promoting the agenda for rostering and job planning for all of the workforce and not just select groups. The Countess is ahead of this as E-Roster has already been implemented for all nursing and midwifery staff, and is about to be piloted for medical and dental staff. The latter is being done in conjunction with improvements in e-job planning.

The Countess workforce planning process is a joint task between Workforce and Finance colleagues. Year-end base line data is added to staffing developments and risks identified by Divisional senior managers and collated into a single plan. This plan then informs the establishment for staffing across the Trust. The Trust uses e-Roster to monitor safer staffing levels across most areas of the organisation. All safer staffing issues brought by the professional judgement of service leads, and the information generated from our e-Roster/job planning systems influence the Trust Risk Register and Board Assurance Framework so that any staffing risks are clearly escalated and monitored across the organisation. Safe Staffing reports are also provided to the Board and relevant sub-committees on the required timelines.

The medium and long-term workforce plans of the Trust are currently in development, however include the increased use of new roles, including Physicians Associates and the recruitment of the first cohort of Nursing Associates, as well as expanding the use of apprenticeships, particularly clinical apprenticeships. Continued development of the Integrated Care Partnership will see additional workforce developments and system wide workforce planning, particularly in intermediate care, and closer working with other partners across the local system and across the Cheshire & Merseyside Health Care Partnership.

Review of economy, efficiency and effectiveness of the use of resources

The Trust's resources are managed within a sound financial governance framework defined in the Corporate Governance Manual and Standing Financial Instructions. The Trust is committed to ensuring value for money and continued with a challenging Cost Reduction Strategy whilst implementing its long-term programme of service transformation. The Trust's Planning Team helps co-ordinate and facilitate the delivery of these schemes.

Overall performance is monitored by the Board of Directors, supported by the Finance and Integrated Governance Committee, QSPEC and the other sub-committees. The Board of Directors receive monthly integrated performance reports which provide data in respect of financial, quality, national and locally agreed contractual target performance. Any areas of risk are highlighted through the use of a Red, Amber, Green (RAG) rating.

The performance of individual divisions and wards is measured and monitored through budgetary control and service-line reporting systems, and a performance management framework which is linked to the delivery of operational plans. These plans incorporate financial as well as quality, efficiency and productivity targets. All plans are subject to scrutiny and monitoring on a monthly basis (via the Cost Releasing Savings meeting and Executive Directors Group).

The Trust had originally forecast a deficit, before Provider Sustainability Fund (PSF) monies, of £4.34m for 2018/19 (with PSF monies being allocated of £7.3m), giving a control total of £2.96m surplus if the Trust was successful in achieving 100% of its Provider Sustainability Fund metrics. This position being very much based upon the Trust delivering £10.7m of Cost Reduction Savings (CRS).

The Trust achieved an actual deficit of £8.1m, a deterioration of £9.9m against the previous year. This was predominantly due to the net loss of Provider Sustainability Funding monies of £2.75m and non-achievement of CRS £5.8m.

The Board approved the Board Assurance Statement regarding the in-year change to the financial forecast required by NHS Improvement following an updated forecast in September 2018. The change in forecast reflected changes to the strategic and national efficiency schemes identified in the plan and expenditure pressures relating to workforce shortages and increased non elective demand.

Following the deterioration of the Trust's financial forecast an internal turnaround programme was instructed, reporting to the Board that has mitigated further risks in 2018/19 and identified further opportunities for 2019/20.

During the year, the Trust applied for interim revenue support from the Department of Health and Social Care (DHSC) totalling £6.7m to support its revenue cash position - within this figure is also £1.9m to cover the current shortfall in capital payments pending the approval of the loan by DHSC, as advised by NHS Improvement. In 2019/20, the financial plan is to meet its control total of breakeven with a stretching efficiency target of £9.4m.

The Trust has continued to progress its own improvement programme which has seen the implementation of the Trust Coordination Centre, and the further roll out of our acuity based staff rostering system, which have provided greater operational transparency and a central location for managing the hospital.

We continue to work with our health and social care partners in West Cheshire to create a new Integrated Care Partnership (Cheshire West ICP), hosted by the Countess of Chester Hospital, to transform how services are delivered to patients in a collaborative way across the local health system. We have a responsibility to the local health and social care system, and are committed to working with our partners and playing into the West Cheshire transformation plans.

The Trust's internal and external auditors provide assurance in respect of the internal control environment and the use of the Foundation Trust's resources. Audit findings and recommendations are monitored and reported through the Audit Committee and the Foundation Trust's Audit Tracker.

Information Governance

The Trust is required to undertake a mandatory annual Data Security and Protection Toolkit (DSPT) self-assessment (Previously IG Toolkit). The Data Security and Protection Toolkit draws together legislation and relevant guidance and presents them in a single standard as a set of requirements. The assessment enables the Trust to measure its compliance against National Data Guardian data security standards to provide assurance to the organisation, patients and staff that information is handled correctly and protected from unauthorised access, loss, damage and destruction.

The Data Security and Protection Toolkit has increased the spectrum since last year and now assesses compliance against the following areas -

- Personal Confidential Data
- Staff Responsibilities
- Training
- Managing Data Access
- Process Reviews
- Responding to Incidents
- Continuity Planning
- Unsupported Systems
- IT Protection
- Accountable Suppliers.

The Data Security and Protection Toolkit assessment provides an overall compliance score with each standard measured requiring multiple evidence standards to be met. The Trust's most recent DSPT submission to NHS Digital in October 2018 returned a Moderate Assurance identifying two areas of concern: Supplier Assurance and IT Security. An action plan is in place to address these gaps and to ensure full ongoing compliance with the General Data Protection Regulations (GDPR). There is still further improvement required regarding Data Security even though NHS Digital has positively recognised the work undertaken to date. However, this is high on the informatics agenda and a key focus for the coming year. An improvement plan is in place which is monitored by the Information Governance Committee. The outcome for the Data Security and Protection Toolkit 2018/19 is still awaited from NHS Digital.

Information Governance Incident Report

Summary of serious incident(s) requiring investigations involving personal data as reported to the information commissioner's office in 2018/19				
Date of Incident (month)	Nature of Incident	Nature of Data Involved	Number of data subjects potentially affected	Notification Steps
March 2019	Laptop stolen from GPU	No data involved	None	Notified to ICO and police. ICO returned an answer on notification that, because all data was encrypted and the Trust was able to track a full audit trail of log-on attempts up until the theft and could prove the device was not logged on at the time, this was not notifiable to the ICO – we have retained this notice and the incident number. Cheshire police are still investigating the theft.
Further Action on information risk	No risk on this occurrence. IT team to add into A&E weekly checks that all laptops are physically checked to ensure bolts are not loose.			

Summary of other personal data related incidents in 2018/19		
Category	Breach Type	Total
A	Corruption or inability to recover electronic data	0
B	Disclosed in Error	86
C	Lost in Transit	33
D	Lost or stolen hardware	1
E	Non-secure Disposal – hardware	0
F	Non-secure Disposal – paperwork	22
G	Uploaded to website in error	1
H	Technical security failing (including hacking)	0
I	Unauthorised access/disclosure	28
J	Other	67

Regular communication is shared on themes and trends regarding incidents. Learning is fed into training and a programme of audit is in place to monitor compliance, this takes place across all areas of the Trust.

The Trust continues a resilient approach to GDPR. All existing sharing agreements are not required to be updated with GDPR details unless there is a significant change, but, as a matter of diligence, the Trust is updating them as and when required. All new agreements are validated with full reference to GDPR and Data Protection Act 2018 before being approved.

Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS Improvement (in exercise of the powers conferred on Monitor) has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

Steps which have been put in place to assure the board that the Quality Report presents a balanced view and that there are appropriate controls in place to ensure the accuracy of data is set out below -

- Lead roles for quality and the production of the Quality Accounts have been assigned. The Foundation Trust has an overarching Quality Improvement Strategy which articulates key priorities and links with the national quality and safety agenda.
- The Foundation Trust QSPEC is a sub-committee of the Board, chaired by a non-executive director, supported by the Director of Nursing and Quality. This Committee is charged with overseeing the production of the majority of the data and information relating to the Annual Quality Accounts and has non-executive board membership.
- The content of the quality report reflects both internal and external sources of information to ensure the consistency and accuracy of reported data. The priorities of safety, experience and effectiveness are derived from public and service users and from areas of concern that have been highlighted. Using Governors, social media and Healthwatch, the public has also been asked to give views of what the Trust should be prioritising.
- The Board of Directors review safety and quality performance indicators monthly as part of the monthly Integrated Performance Report. This report provides trend as well as cumulative performance information and exception reports are provided on metrics/ indicators requiring improvement. The metrics have been reviewed in year and will give further assurance that improvements are being made or areas for improvement are being monitored.
- The Board of Directors also receive more

detailed qualitative and quantitative information through specific reports in respect of quality related areas such as complaints, patient experience, infection, prevention and control, safeguarding, clinical audit, clinical benchmark and mortality reports.
- The report accurately reflects the position and performance of the quality performance using nationally agreed metrics and standards. Some of the standards and metrics are subject to external audit in year. Three of the national indicators are audited at year end, two of which are mandated and the third is chosen by the Governors.
- Views of the completed Quality Accounts come from the public by way of the Overview and Scrutiny group as well as our commissioners.

Quality and Accuracy of Elective Waiting Time Data Assurance

The Trust's Access Policy provides the operational framework for the management of patients who are waiting for elective treatment. The policy reflects national guidance and is reviewed annually and agreed by NHS West Cheshire CCG.

The Trust produces routine elective waiting time data (both inpatient and outpatient), which is subject to review and analysis in-line with good standards of corporate governance.

Individual staff who are involved with the collection and recording of this data are made aware of their responsibilities and receive annual mandatory training.

The Trust has developed an operational management tool using Qlikview software to better support the management and analysis of patients on an elective pathway.

The Operational Data Quality Group is established to oversee key aspects of data quality. Reporting bi-annually to the Trust Informatics Board, the group monitors, analyses and addresses issues in relation to data quality, escalating issues as appropriate.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Report attached to this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the Audit Committee, the Quality, Safety & Patient Experience Committee, Finance & Integrated Governance Committee, People and OD Committee, the external governance review, along with the Executive Risk Review Meeting, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board Assurance Framework has been subject to some review at Board and Executive Director level. The Board Assurance Framework provides the Board with assurances on the way it manages the organisation at a strategic level and high level potential risks have been documented and assurances identified. However, the external governance review has identified that further work is required on the Board Assurance Framework to link further with the risk management system and driving the Board agenda.

The Board has risk identification and risk management processes to deliver its annual plan, comply with its registration and compliance with the terms of its licence. The Corporate Directors Group reviews the significant risks as escalated by the divisions through this forum; these in turn inform the Executive Risk Register that is aligned to the Board Assurance Framework.

Following their independent assessment of the Trust Board Assurance Framework, our internal auditors concluded that – "The organisation's Assurance Framework is structured to meet the NHS requirements, could be more visibly used by the Board and clearly reflects the risks discussed by the Board'. The Board, in association with the findings of the external governance review, intend to consider in early 2019/20 how the Board Assurance Framework can be more visibly used and direct the agenda of the Board of Directors.

There have been some changes to the Board composition this year, which are outlined in the Annual Report, however, these include the appointment of an acting Chief Executive (since made substantive), an acting Medical Director, the replacement of one of the Non-Executive Directors who is also the Chair of the Cheshire West Integrated Care Partnership (since 1st April 2018) and the appointment of an Executive Director as the Managing Director of the Cheshire West Integrated Care Partnership. The Board intend to redress the number imbalance between Executive Directors and Non-Executive Directors, since 1st September, 2018.

The Audit Committee focus is to seek assurance that financial reporting and internal control principles are applied and to maintain an appropriate relationship with the Trust's auditors, both internal and external. Where risks are identified across the Board Assurance Framework and audit report outcomes to the Audit Committee, relevant executive directors and senior managers are called to account by attending the Audit Committee meetings.

The Audit Committee is positioned as an independent source of assurance to the Board and its independence is paramount, with a clearly defined challenge and scrutiny role. The Audit Committee have reviewed risks and gained assurance on the effectiveness of controls through the work of the internal and external auditors. This Committee has undertaken a review of its effectiveness, with facilitation from the internal audit.

The Director of Internal Audit (MIAA) provides me with an annual opinion, substantially derived from the conduct of risk based reviews within the internal audit plan, generated from and aligned to the risks identified in the Trust's Assurance Framework. The overall opinion for the period 1st April 2018 to 31st March 2019 provides, *"Moderate Assurance that there is an adequate system of internal control, however, in some areas weaknesses in design and/or inconsistent application of controls puts the achievement of some of the organisation's objectives at risk"*.

I have received **Substantial** internal audit assurance on the systems and processes operated for -

- Financial Systems, Integrity & Reporting
- Referral Management
- ESR/Payroll; and
- Take Home Medicines (TTO).

I have received **Moderate** internal audit assurance on the systems and processes operated for -

- Data Security & Protection Toolkit Assurance
- Locums and Variable Pay; and
- E-Rostering.

I have received **Limited** internal audit assurance on the systems and processes operated for -

- Quality Spot Checks; and
- Safeguarding.

Actions have been taken by my executive team to address the recommendations made in the **Moderate** and **Limited** opinion audit reports, to improve the control environment and these will be independently followed up in year by the Internal Audit team. In particular, the two high risk recommendations and two out of three of the moderate risk recommendations within the Adult Safeguarding review have been completed which included a review of resources within the team; and all of the recommendations from the Quality Spot Checks review have been completed during the year. All audit recommendations are tracked by the Trust and monitored by the Audit Committee to satisfactory completion and the Head of Internal Audit informs me that good progress has been

made with regards to implementation of recommendations.

Areas where internal audit have supported the organisation in strengthening arrangements in respect of governance, risk management and internal control include two Risk Management workshops sessions in Quarter 3, where a total of 92 members of staff within the Trust attended the sessions. The purpose of the sessions was to reinforce the roles and responsibilities of Risk Management and to provide greater understanding of risk, control and assurance. Audit advice and support has also been provided in-year in relation to the Model Hospital programme of work.

Conclusion

During the year, no significant internal control issues have been identified. It is recognised that moderate assurance was provided on the system of internal control and actions are in place or have been identified or completed to address the limited assurances received. There are a number of significant risks and challenges facing the Trust and these have been outlined within the content of this statement and are under consideration by the Board. In particular, the Board intend to fully review their governance structures and reporting arrangements in early 2019/20 following consideration of the findings of the external governance review, and the CQC report. A long-term strategy for the organisation will also be developed, and better use made of the Board Assurance Framework.

The Board of Directors remain committed to developing a supportive learning culture for quality governance, continuous improvement and enhancement of the system of internal control as and when issues are identified.

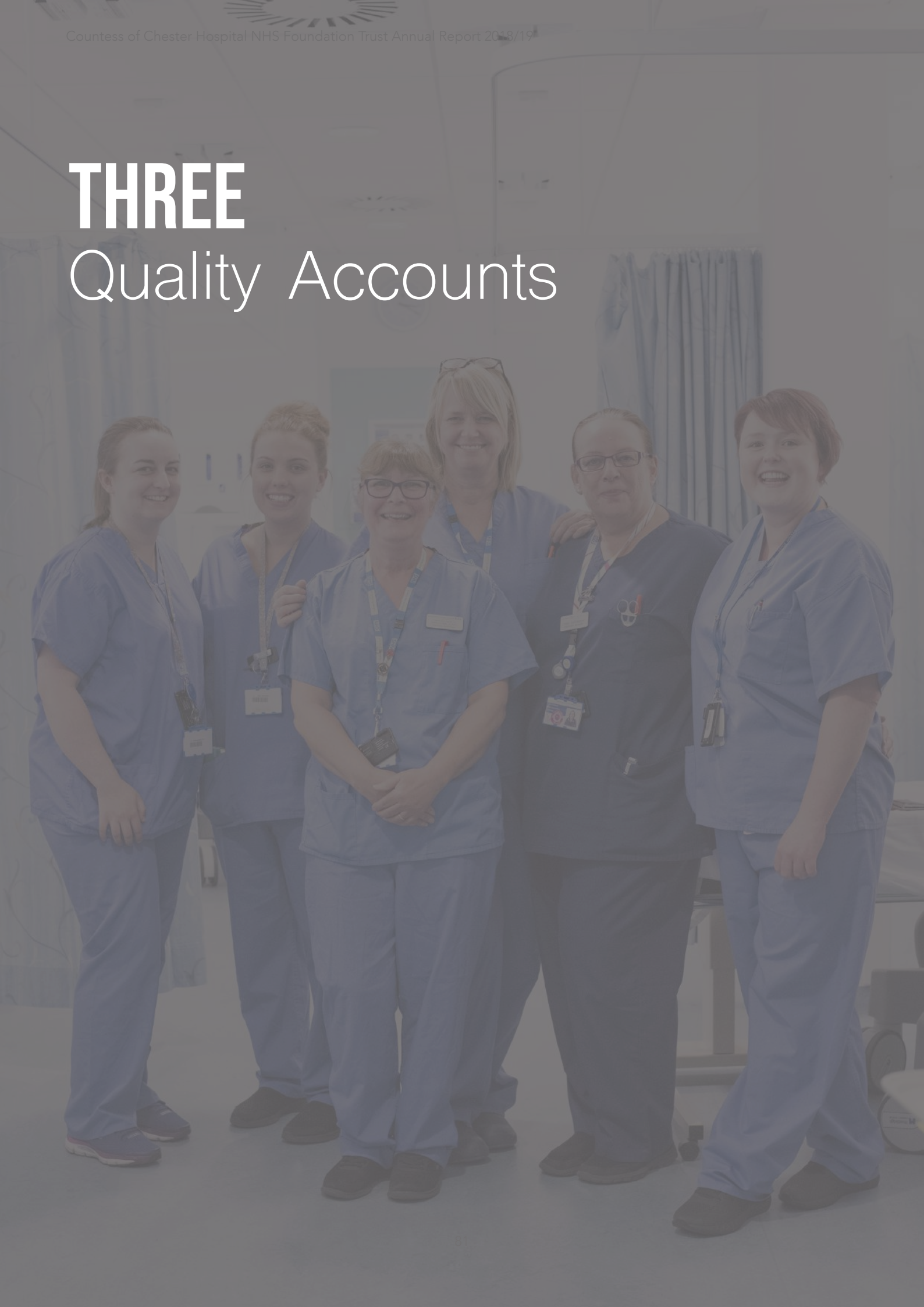
The Board, like other organisations across the NHS, is facing a number of challenging issues and wider organisational factors. The key challenges for Trust performance targets are in the area of 62 day cancer target, C-difficile cases, Referral to Treatment 18 weeks, 6 weeks diagnostics, A&E waiting times and rates of sickness absence, and these remain an area of Board focus. The Board recognises the deterioration in the financial position in 2018/19 and has also submitted a financial plan for 2019/20 that allows us to accept our NHS I control total and have access to the Financial Recovery Fund.

The Board takes account of how it can work with its health system partners to address the current challenges the organisation faces and this is a driving factor in the development of the Cheshire West Integrated Care Partnership.

Signed:

Dr Susan Gilby
Chief Executive Officer
21st May 2019

THREE
Quality Accounts



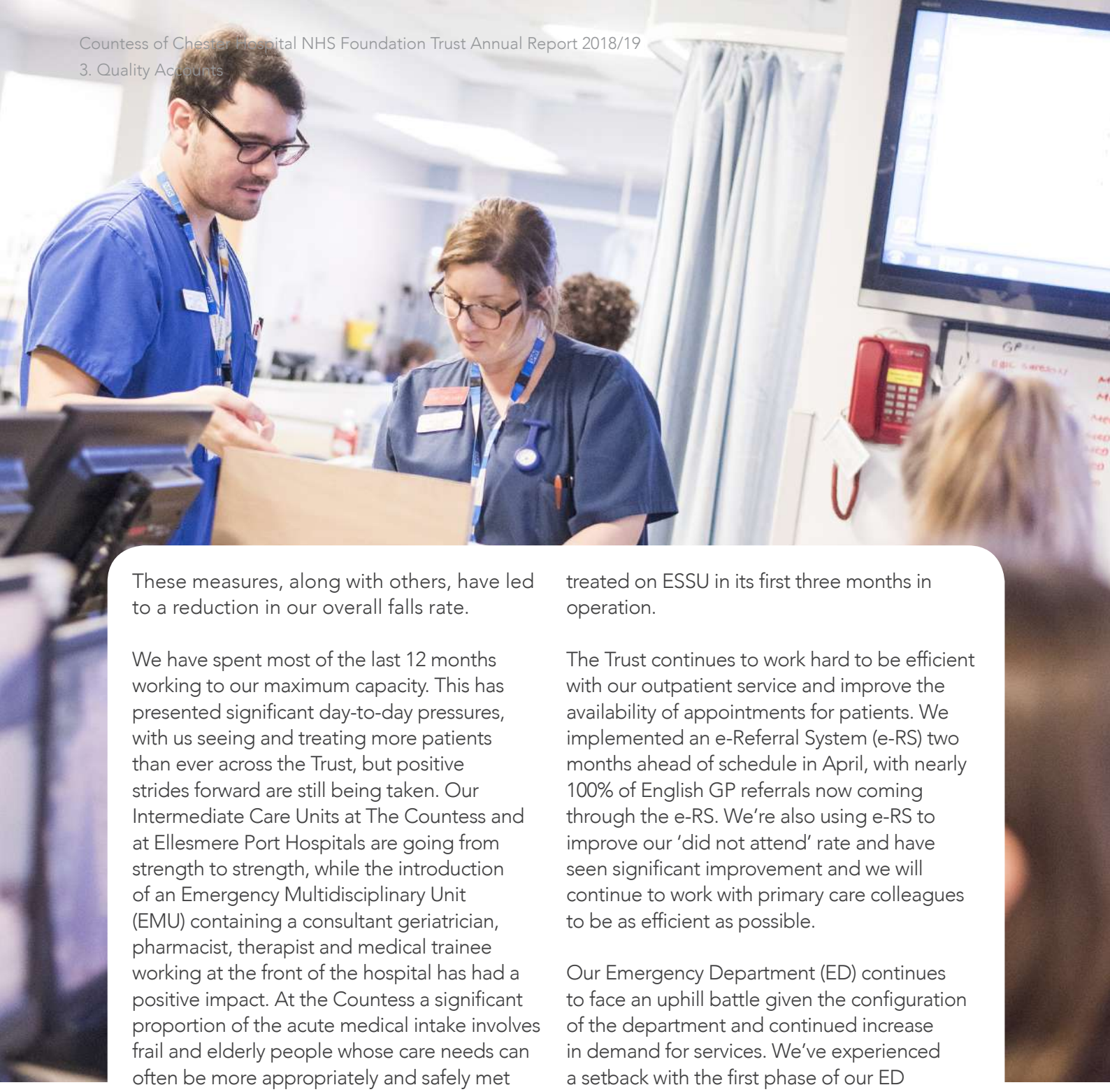
3. Quality Accounts

3.1 Summary Statement on Quality from the Chief Executive 2018/19

In my new role as Chief Executive Officer it is my pleasure to introduce you to the annual quality account. It's been a year of change for the Trust, but also achievement.

We continue to work more closely with our partners in the wider healthcare system both as host of the West Cheshire Integrated Care Partnership (ICP) and with Betsi Cadwaladr University Health Board to deliver good quality patient care to meet the needs of our population. Over 300 members of our allied health professional team transferred to the ICP in December, showing a real commitment to work more collaboratively for our patients. This partnership approach is already reaping rewards with West Cheshire last year identified as one of the "most improved" areas for one-year cancer survival.

I was delighted to see the Trust win a national Nursing Times Award in the technology and data in the nursing category. Benefits provided by the Trust's Co-ordination Centre were at the heart of the nomination with the daily use of real-time patient flow and e-rostering software having a huge impact on the safe and effective treatment of patients and staff at the hospital. Our next step is to embed the work we are doing on our Model Ward throughout the entire hospital, reducing clinical variation and getting it right first time in areas such as sepsis diagnosis/treatment and falls prevention. As part of that, standardised sepsis pathways have been launched in all adult inpatient areas and sepsis response kits are being made available. A lot of work is also being undertaken as part of the Falls Prevention Programme to ensure lying and standing blood pressures are taken, along with cognitive assessments to identify patients at risk of delirium or acute confusion.



These measures, along with others, have led to a reduction in our overall falls rate.

We have spent most of the last 12 months working to our maximum capacity. This has presented significant day-to-day pressures, with us seeing and treating more patients than ever across the Trust, but positive strides forward are still being taken. Our Intermediate Care Units at The Countess and at Ellesmere Port Hospitals are going from strength to strength, while the introduction of an Emergency Multidisciplinary Unit (EMU) containing a consultant geriatrician, pharmacist, therapist and medical trainee working at the front of the hospital has had a positive impact. At the Countess a significant proportion of the acute medical intake involves frail and elderly people whose care needs can often be more appropriately and safely met in the community. By working in this way we have been able to discharge 70.9% of patients seen in EMU back into the community for more appropriate care. Initiatives such as these and working in a more joined up way with health and social care system partners has seen a 50% reduction in the days spent in hospital by stranded patients waiting for discharge.

In December 2018 our Elective Short Stay Unit (ESSU) opened in our Jubilee Day Care Centre to reduce the number of on-the-day cancellations of surgery. The ESSU is a nine-bedded area where beds are protected for elective care activity. Over 350 patients were treated on ESSU in its first three months in operation.

The Trust continues to work hard to be efficient with our outpatient service and improve the availability of appointments for patients. We implemented an e-Referral System (e-RS) two months ahead of schedule in April, with nearly 100% of English GP referrals now coming through the e-RS. We're also using e-RS to improve our 'did not attend' rate and have seen significant improvement and we will continue to work with primary care colleagues to be as efficient as possible.

Our Emergency Department (ED) continues to face an uphill battle given the configuration of the department and continued increase in demand for services. We've experienced a setback with the first phase of our ED development project, but staff continue to work hard to meet ever increasing demand, evidenced with improved compliance with the NHS Improvement's Patient Safety Checklist.

Unfortunately the Trust reported two Never Events in 2018/19. In terms of lessons learnt, messages are sent Trust-wide in a timely manner following each weekly Serious Incident Panel. These messages are sent to all staff not just clinical. In respect of the Never Events, the Medical Director and Director of Nursing & Quality were keen to share the immediate lessons learnt with the relevant teams within 24 hours of the event. Training on human

factors and safety culture continues to be implemented, particularly in areas of the Trust where invasive procedures are undertaken. This will continue to be an area of focus during 2019/20 taking into account some observations fed back to us by our CQC Inspectors following our recent review.

Our staff survey results were disappointing as they have been for the past few years. We will be working hard together over the coming months to improve in the areas where we fall short of the standard to which we aspire. Of particular concern was staff did not feel that we have a strong safety culture. This is a basic fundamental of healthcare that we simply must get right. Results showed that there was a 3% drop in members of staff who said they would know what to do if they were concerned about unsafe clinical practice. Whilst our overall result for this question is in line with the national average, we are committed to the creation of a "patient safety first" culture throughout the organisation.

It was also disappointing that we reported three avoidable cases of MRSA bloodstream infection and 30 cases of C. difficile infections in 2018/19 and will be adopting a 'back to basics' approach to implement and embed best practice following a Healthcare Acquired Infection Review.

Much work is underway to improve the Freedom to Speak Up initiative at the Trust, with a dedicated Freedom to Speak Up Guardian set to join imminently.

Our research team continue to fly the flag for The Countess, with us regularly featuring among the top five for patient recruitment in clinical trials both regionally and nationally. We strive to embed a quality improvement approach in all areas with all F1 and F2 junior doctors now expected to participate in their own quality improvement projects during their time with us.

In December we were inspected again by the Care Quality Commission as part of their Well Led review process. We are disappointed to report that the CQC could not be assured that our current systems and processes were effective. They identified a number of areas for improvement including requirement notices against some regulations and gave us an overall rating of *'Requires Improvement'*.

We recognise we have not got it right for everyone we have cared for and we are determined to learn lessons to consider how we can change to be better. Internally, we issue a regular Lessons Learned email for staff highlighting areas to improve on. We will work with our Patient Advice and Liaison Service (PALS) to ensure the public feel listened to and involved in their care.

I commend this quality account to you, and I am, as always, grateful to the many people who have contributed to its content. I confirm that, to the best of my knowledge, the information in this document is accurate and has been complied with the requested requirements.

Dr Susan Gilby,
Chief Executive Officer
May 2019

3.2 Priorities for improvement and statements of assurance from the Board

The Planning, Partnerships and Development team (formally known as the Model Hospital team) are supporting the improvement of patient safety, quality and outcomes. Our choices and those of the local population we serve are reflected in our priorities going forward. The Patient Experience Operational Group (PEOG) gathers the views of patients, families and the public to support and where necessary direct improvements in clinical practice, service delivery and patient pathways. It provides a forum to engage with a range of hospital teams, patient representatives and Governors to review feedback and agree any actions needed in response.

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

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

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

The Trust was rated as *'Requires Improvement'* overall:

Overall rating for this trust	Requires improvement	
Are services safe?	Requires improvement	
Are services effective?	Requires improvement	
Are services caring?	Good	
Are services responsive?	Requires improvement	
Are services well-led?	Requires improvement	

This rating was given for the following reasons:

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

We accept these findings and have already started working on actions to address the requirement notices received against the regulations. Focus areas include management and treatment of sepsis, recognition and response to the deteriorating patient and falls prevention. The regulatory actions will be monitored in a CQC Task & Finish Group which will be jointly chaired by the Director of Nursing & Quality and the Medical Director. This will ensure all 'must do' actions are completed

with assurance provided that actions are audited and embedded in practice. This assurance will be fed into the newly formed Quality Committee (a Board reporting Committee) and will be reviewed on a regular basis.

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

- Implementing a ward accreditation framework;
- Communication and training for all staff in continuous improvement;
- Ensuring our improvements are aligned with the Trust strategies;
- Gaining clarity on existing Quality Champion roles;
- Building on staff capability so staff are empowered and confident to improve services;
- Designated Executive lead and engagement with senior leaders across the Trust; and
- Utilising contacts and resources from other NHS Trusts who have successfully undertaken transformational change utilising a continuous improvement methodology.

A key theme identified from the Well Led inspection was that the Trust did not have fully effective systems for managing risk, that the risk management system did not connect to the Board Assurance Framework (BAF), that Committee reporting accountabilities were not clear, and that some issues raised in the last inspection had not been addressed in a timely manner, with gaps in governance and safety issues. Prior to the inspection, it was identified by the then Acting Chief Executive, that a robust external review was required of the Trust's governance processes, with the purpose of deepening the organisation's understanding of its leadership and governance arrangements and identifying key development actions. This was commissioned before the CQC Well Led inspection.

Key recommendations from the external governance review include:

- Developing a long-term strategy for the organisation;
- Making better use of the BAF to drive the Board agenda and aligning the BAF to the Trust's risk management system;
- Implement a development programme for Board members and senior operational leaders to improve knowledge around assurance and use of data;
- Review and refresh organisational structures;
- Improve systems and processes; and
- Embed leadership, culture and behaviours.

A new model of integrated governance will be implemented in response to the above recommendations. This will provide oversight and realignment of all governance and risk processes, including quality governance, clinical governance, financial governance, information governance and staffing/people governance.

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

Safe; improving the safety of patients in our care

Improved compliance with NHS Improvement Patient Safety Checklist in the Emergency Department

This checklist provides assurance against the safety measures expected for patients being cared for within the Emergency Department and allows us to collect real time information to monitor patient safety. This has taken some time to gain effectvie compliance; a focus now is on sustaining this compliance going forward.

Ensuring clinical leaders are sharing identified trends with staff in their ward or department by triangulating clinical and non-clinical:

- Incident reports;
- Claims;
- Concerns and Complaints; and
- Local and National Survey findings.

'Safety Briefs' have been modified to ensure key messages are shared. A 'Lessons Learned' weekly communication is disseminated across the Trust following the Serious Incident Panel; this means learning is shared rapidly with teams and illustrates themes that have arisen from incidents, claims, complaints and coroners cases.

Implementing a Sepsis Quality Improvement programme

We recognise that despite significant work being undertaken regarding improving compliance against our Sepsis quality measures, further improvement is still required. In particular in relation to the recognition and management of Sepsis. Work has included the launch of a standardised pathway for adults in the Emergency Department and inpatient areas, meaning screening for Sepsis and administration of antibiotics is timelier.

Implementing the National Early Warning (NEWS2) track and trigger tool

This NHS England approved tool was introduced Trust wide in September 2018 to all adult inpatient wards and departments. The tool provides a score for physiological measurements already recorded in routine practice, when patients present to, or are being monitored in hospital. It supports staff to recognise if a patient's clinical condition is worsening and directs staff to respond quickly to any deterioration. Our recent CQC inspection identified that we did not consistently utilise the NEWS2 tool or escalate patients' clinical condition accordingly. Monthly audit is in place which has more recently demonstrated improvements in compliance.

Kind; improving the experience of patients

Falls Quality Improvement Programme

Significant work has been undertaken in respect of standardising falls prevention measures across all adult inpatient areas. A collection of risk assessments have been implemented including an initial screening tool, manual handling risk assessment, bed rails assessment, delirium screen and identifying if the patient has a diagnosis of dementia. The programme has focused on staff education and engaging the multi-professional teams to apply best practice measures, however these have not always been applied consistently but there will continue to be a focus on this important area of work as part of our Quality Improvement Strategy. There has been a reduction in the number of falls reported but not on severity of harm unfortunately. A focus going forward will continue to be on anticipating risk and learning from incidents. We have supported the wider Integrated Care Partnership by working closely with the Clinical Commissioning Group and 3rd sector providers to develop a post fall discharge pathway. Patients can be referred post discharge or from a clinic (all specialities) to increase strength and balance or to maintain it with a view to reducing the risk of falls.

Patient Flow

We have worked collaboratively with our local system to ensure patients do not stay in hospital longer than they need to. This work has resulted in a reduction in locally 'Stranded' patients. However, achieving compliance with the Emergency Department 4 hour standard has, and continues to be challenging.

Further development of the Integrated Care Partnership

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

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

Effective use of real time information to manage safe staffing against patient acuity and ward activity

We have improved our processes using an evidence based tool to support professional judgement when making real time staffing decisions. This means we have been able to deploy staff to ward and department areas in the most need; basing this assessment on the acuity (severity of illness) and dependency (nursing need) of patients. This work received national recognition during the year.

Outpatients

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

Learning from Deaths

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

The Countess of Chester Hospital NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is to provide care, treatment and support, without any conditions attached to registration. The Care Quality Commission has not taken any enforcement action against the Countess of Chester Hospital NHS Foundation Trust during 2018/19. The Countess of Chester Hospital NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

3.3 Progress made since publication of the 2017/18 quality report

Our key priorities for 2018/19 were chosen to reflect the three domains of quality defined as;

Safe
Delivering safe services by reducing clinical variation through the Model Ward Programme

Kind
Delivering kind and compassionate care by building our high performance culture

Effective
Delivering effective services by reducing process variation

Delivering safe services by reducing clinical variation through the 'Model Ward' programme

We focused on getting it right first time for all our patients to ensure the right care and treatment is started at the right time in the patient's journey. In particular we concentrated on how we recognise and treat patients with sepsis, how we protect time in the wards for medicine rounds to improve safety and how we prevent patients from falling whilst in our hospital.

Delivering kind and compassionate care by building on our high performance culture

We focused on creating a culture within the Countess that fosters the values and behaviours that patients, the public and staff expect, one where staff come to work, to do their work and improve their work and getting the right number of nursing staff, with the right skills, to the right patient at the right time.

Delivering effective services by reducing process variation

We focused on the way in which we work to ensure we improve the safety, quality and experience of our patients. In particular we concentrated on how we care for our elderly, preventing unnecessary time in hospital and reducing the number of avoidable cancellations for patients requiring surgery or outpatient appointments.

What did we achieve?

Out of the 20 key priorities chosen for 2018/19, eleven have been achieved in full, with a further five close to target, however four remain outstanding. For further details in relation to progress and delivery of each priority please refer to section 3.7 on page 133.

Key priorities 2018/19	On plan/ achieved	Close to target	Behind plan
Delivering safe services by reducing clinical variation			
Increase in the number of patient who are appropriately screened for sepsis			
Increase in the number of patients with sepsis who are given antibiotics within 1 hour of diagnosis			
Reduction in the number of medicine administration errors in the Model Ward areas			
Increase in the compliance against 'Fall Prevention Measures'			
Reduction in the number of falls that result in harm to patients in our care			
Delivering kind and compassionate care by building on our high performance culture			
Increase the number of staff trained in High Performance Culture Framework • 140 staff trained in the 2 day High Performance workshop during 2018/19 • 630 staff trained in the half day Trust Behavioural Standards session during 2018/19			
Reduction in the number of concerns raised by patients in relation to staff attitude and behaviour (using the Friends & Family feedback)			
Increase the number of staff trained in Quality Improvement tools and techniques • 30 staff trained in Quality Improvement Basics • 8 staff trained in Quality Improvement FUNdamentals & have delivered a quality improvement project • 15 F1/F2 (junior doctors) trained in Quality Improvement tools and techniques & have contributed to a quality improvement project			
Increase the number of Quality improvement projects completed			
Closing the gap between the actual nursing hours provided and the hours needed (using Care Hours Per Patient Day data)			
Delivering effective services by reducing process variation			
Reduce the number of hospital admissions for the elderly population			
A 40% reduction in the average monthly bed days due to delays for stranded patients			
Increase the number of patients returning to their own place of residence			
Reduce the number of avoidable cancellations on the day of surgery			
Reduce the number of patients who fail to attend on the day of surgery			
Improve start times within theatres to maximise utilisation			
Reduce the number of new outpatient appointments cancelled by the hospital			
Reduce the number of new outpatient appointments cancelled by patients (as a result of introducing more patient choice)			
Recude the number of 'do not attend' (DNAs) for both new and review outpatient appointments			
Reduce the number of inappropriate new outpatient appointments through electronic triage (Consultants at the hospital offering advice & guidance to GPs)			

3.4 Priorities for improvement in 2019/20

After taking this into account, our key priorities for 2019/20 have been chosen to reflect three areas:

- Delivering safe services by reducing clinical variation;
- Delivering kind and compassionate care to patients and our staff; and
- Delivering effective services by reducing process variation.

Delivering safe services by reducing clinical variation

We will be focusing on providing consistency in the care and treatment we deliver to our patients. Getting it right first time for all our patients to ensure the right care and treatment is started at the right time in the patient's journey. We will be using quality improvement tools and techniques to support any changes we need to make. This relates to our compliance with CQC standards and the recognition that during our last inspection, there was a lack of consistency in implementing some of our key quality and safety measures. However, our aim is to demonstrably improve on last year:

Our measure of success will be;

- Increased compliance with NEWS2 scoring (recognising and responding to the deteriorating patients)
- Implementation of e-observations
- Increase in the number of patient who are appropriately screened for sepsis (target 90%)
- Increase in the number of patients with sepsis who are given antibiotics within 1 hour of diagnosis (target 90%)
- Improved compliance to the Sepsis 6
- Sustained compliance against 'Fall Prevention Measures'
- Reduction in the number of falls that result in harm to patients in our care
- Reduction in the number of healthcare associated infections

Why is recognising and responding to deteriorating patients important?

It is important to have a standardised approach to the monitoring and recording of patient's physiological observations whilst they are in hospital, as these observations indicate how sick the patient is. Staff need to take observations at a frequency that is appropriate to the patients severity of illness and take action in response to the findings to ensure that the right level of care and treatment is provided in a timely manner. This is particularly important for patients who are experiencing atypical observations (deviation from the norm), those who have a worsening trend or those who suffer a sudden deterioration.

The NHS England approved early warning system (NEWS2) was implemented across all adult wards and departments in September 2018. This tool provides a score for each physiological observation taken and this is then aggregate into a total score which indicates the response needed. Six simple physiological parameters form the basis of the scoring system:

1. respiration rate
2. oxygen saturation
3. systolic blood pressure
4. pulse rate
5. level of consciousness or new confusion
6. temperature

Once the observations have been taken and the score allocated, there is a graded response system for staff to follow to ensure a responder with the right knowledge and skills attends to direct the care and treatment needed. Progress against our measures for success will be monitored through the Deteriorating Patient Group which reports to the Quality, Safety & Patient Experience Committee (QSPEC), a sub-committee of the Board of Directors.

Why is the implementation of e-observations important?

It is well recognised internationally that paper based observation scoring systems have a high error rate. This can happen for a variety of reasons and is complex and multi-factorial. Some of the reasons identified have been attributed to calculation errors when adding up the score, which in turn results in the score not leading to the appropriate clinical response. This puts acutely unwell patients at risk of delays in treatment and/or failure to rescue. Implementing an electronic solution (through e-observations) has demonstrated a significant reduction in the error rate in other hospitals and we have designed a roll out plan during 2019/20 to bring in equipment in a phased approach that will automatically add up the patients observation score and prompt the staff based on that score to take the most appropriate action. Progress against our measures for success will be monitored through the Deteriorating Patient Group which reports to the Quality, Safety & Patient Experience Committee (QSPEC), a sub-committee of the Board of Directors.

Why is Sepsis important?

Many people die from Sepsis and this in some cases can be avoided; if we are able to identify sepsis quickly and start the appropriate treatment it will help to save lives. This can happen for a variety of reasons, sepsis can be difficult to identify as there are so many signs and symptoms and it can be confusing as these signs and symptoms may also indicate other illnesses or disease. We have launched a standardised pathway for sepsis within the Emergency Department and adult inpatient areas to support staff to identify sepsis early so that appropriate treatment can be implemented. With using this pathway we have already started to see an improvement in our compliance to screening and timely administration of antibiotics.

However, this is just the first step in making sure our patients have access to the right care and treatment for sepsis and we are committed to making further improvements in compliance to reach the national target (90%), we will also be focusing on how we comply with other interventions listed within the Sepsis 6 care bundle. Progress against our measures for success will be monitored through the Sepsis Steering Group which reports to the Quality, Safety & Patient Experience Committee (QSPEC), a sub-committee of the Board of Directors.

Why is preventing the risk of falls important?

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

of nationally recognised interventions including:

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

We are committed to ensuring these practice changes are consistently applied and embedded into routine practice and our focus during 2019/20 will be on demonstrating that they are consistently achieved. Progress against our measures of success will be monitored by the Falls Steering Group which reports to the Quality, Safety & Patient Experience Committee (QSPEC), a sub-committee of the Board of Directors.

Why is reducing healthcare associated infections important?

Infection prevention and control is a fundamental aspect of care and ensures that we have the right systems and processes in place to protect patients, visitors and staff, by reducing risks associated with avoidable healthcare associated infections. Routinely following standard infection prevention and control precautions can help to prevent the transmission (spread) of infection, these precautions include:

- Hand hygiene;
- Personal protective equipment (PPE);
- Environmental cleaning;
- Decontamination of equipment;
- Preventing sharps injury; and
- Waste disposal and linen management.

There are also a range of additional precautions that are used when caring for patients with particular illnesses and/or infections. These standard precautions apply in all areas and situations across the hospital and it is important to remember that we are committed to reducing risks associated with all infections, not just those infections that have a national reduction objective applied.

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

Compliance with infection control measures and Healthcare Associated Infections rates was significantly lower than expected during this reporting period and in light of this; we requested to have our infection prevention and control systems and processes independently reviewed, with a focus on re-enforcing and developing existing infection prevention and control risk reduction measures including:

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

This quality improvement work programme aims to completely refresh our approach to the Infection Prevention & Control agenda. Progress against our measures of success will be monitored by the Infection Prevention

Committee which reports directly to the Quality, Safety and Patient Experience Committee, a sub-committee of the Board of Directors.

Delivering kind and compassionate care patients and our staff

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

Our measure of success will be

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

Why is introducing an Employee Assistance Program important?

Working in healthcare can be stressful to staff particularly in a hospital setting, with busy wards and departments, growing workloads to meet an increasing demand and the complexity of the patient case mix. We are committed to supporting our staff to improve morale, increase motivation and support them to remain in work. The Employee Assistance Programme will provide 24 hour access to a confidential helpline, on site face to face counselling and offers further benefits to staff and their families in relation to specific advice on debt, addictions and critical incident.

Managers will also be able to access coaching, consultancy and support. This will mean our staff will not have to wait for staff counselling and support which in turn will promote earlier returns to work and contribute to an overall reduction in sickness absence. Progress against our measures of success will be monitored by the People and Organisational Development Committee (POD), a sub-committee of the Board of Directors.

Delivering effective services by reducing process variation

We will focus on the way in which we work to ensure we improve the safety, quality and experience of our patients. In particular we will be concentrating on improving processes, governance and leadership with a focus on patient experience within our Emergency Department, Maternity Services and Cancer Services. We will continue to reduce avoidable cancellations in Outpatient and Theatres.

Our measure of success will be:

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

Why is improving the usage of the Urgent Treatment Centre (UTC) important?

Approximately 200 patients attend our Emergency Department each day; we aim to ensure patients are seen in the 'right place by the right person' to receive the care they need, quickly. To support this we are launching an Emergency Department

Improvement Programme which will have a focus on 5 key work streams. These workstreams have been designed to improve patient flow, patient experience and improve the 4 hour national standard. One of these workstreams aims to increase the usage of the UTC. The centre was opened in October 2017; its purpose is to provide quicker access to urgent care and treatment that can be safely provided outside of the Emergency Department, this helps to ease the workload for the emergency unit and ensures patients are seen in an appropriate location and helps to avoid long waits. We know that more of our Emergency Department patients could utilise the UTC and we are committed to improving their experience by maximising how we use the centre.

This will involve working with external partners to increase activity into the UTC and will contribute to improvement in achieving the 4 hour national standard and will support working to deliver the 'Same Day Emergency Care' over seven days. Progress against our measures of success will be monitored by the Corporate Leadership Group, a sub-committee of the Board of Directors.

Why is reducing the waiting times for patients on cancer pathways important?

We currently see around 98% of patients with suspected cancer for their first appointment within 14 days of referral from a GP but we want to improve this further, we aim to reduce the time to first outpatient appointment for patients on cancer pathways by increasing the number of patients seen within 7 days. To support the achievement of this objective we will be working with Primary Care colleagues to ensure that patients understand that they are on a suspected cancer pathway, and are available for appointments at short notice. We will also continue to implement different pathway models including telephone consultations with Clinical Nurse Specialists (where appropriate). Earlier contact with clinical professionals will provide patients with more timely access to diagnostics and will enable a faster outcome (diagnosis of cancer or ruling out of cancer). Progress against our measures of success will be monitored by the Cancer Committee which reports directly to the Corporate Leaders Group, and also the Quality and Patient Safety Committee (QSPEC), a sub-committee of the Board of Directors.

Why is the Continuity of Carer Model important?

Better Births (a report from the National Maternity Review) and the Five Year Forward View of the NHS Maternity Services in England, sets out a vision for maternity services to be safe and personalised. At the heart of this vision is the ambition that

women should have provision of care by a known midwife throughout their pregnancy, labour, birth and postnatal period. This continuity has shown to improve health outcomes and safety for ladies and their babies and has demonstrated greater satisfaction levels. We aim to offer 20% of women to book onto a Continuity of Carer model during this reporting period. Continuity of Carer is defined as; every woman having a midwife, who is part of a small team of 4 to 8 midwives who are based in the community and know the woman and family and can provide continuity throughout the pregnancy, birth and postnatally.

We have developed a model to meet the needs of our local population with a focus on offering this model to women who require low risk Midwifery led care. We will have a small team of midwives who will provide all aspects of low risk care for women and care for the woman in labour either at home or in the alongside Midwife led unit. Progress against our measures of success will be monitored by the Women's and Children's Board which reports directly to Quality, Safety & Patient Experience Committee (QSPEC), a sub-committee of the Board of Directors.

Why is introducing 'Partial Booking' important?

When a service user attends the outpatients department and they need a 'review' or 'follow up' appointment at a future date, we book the patient into the next available clinic slot within the relevant time scale (as advised by the clinician) but this can sometimes be 6 to 12 months in advance. If appointments are made too far in advance the chances that the patient cannot attend the appointment or the hospital may need to rearrange the appointment increases and as a result appointment slots may be lost and/or not utilised. Partial Booking offers a system where the patient will be sent a reminder text or letter 6 weeks before their appointment is due and they will be asked to phone the hospital to arrange a mutually convenient appointment date. It will be rolled out during 2019/20 across all specialties to reduce the number of 'review' outpatient appointment cancellations and DNAs.

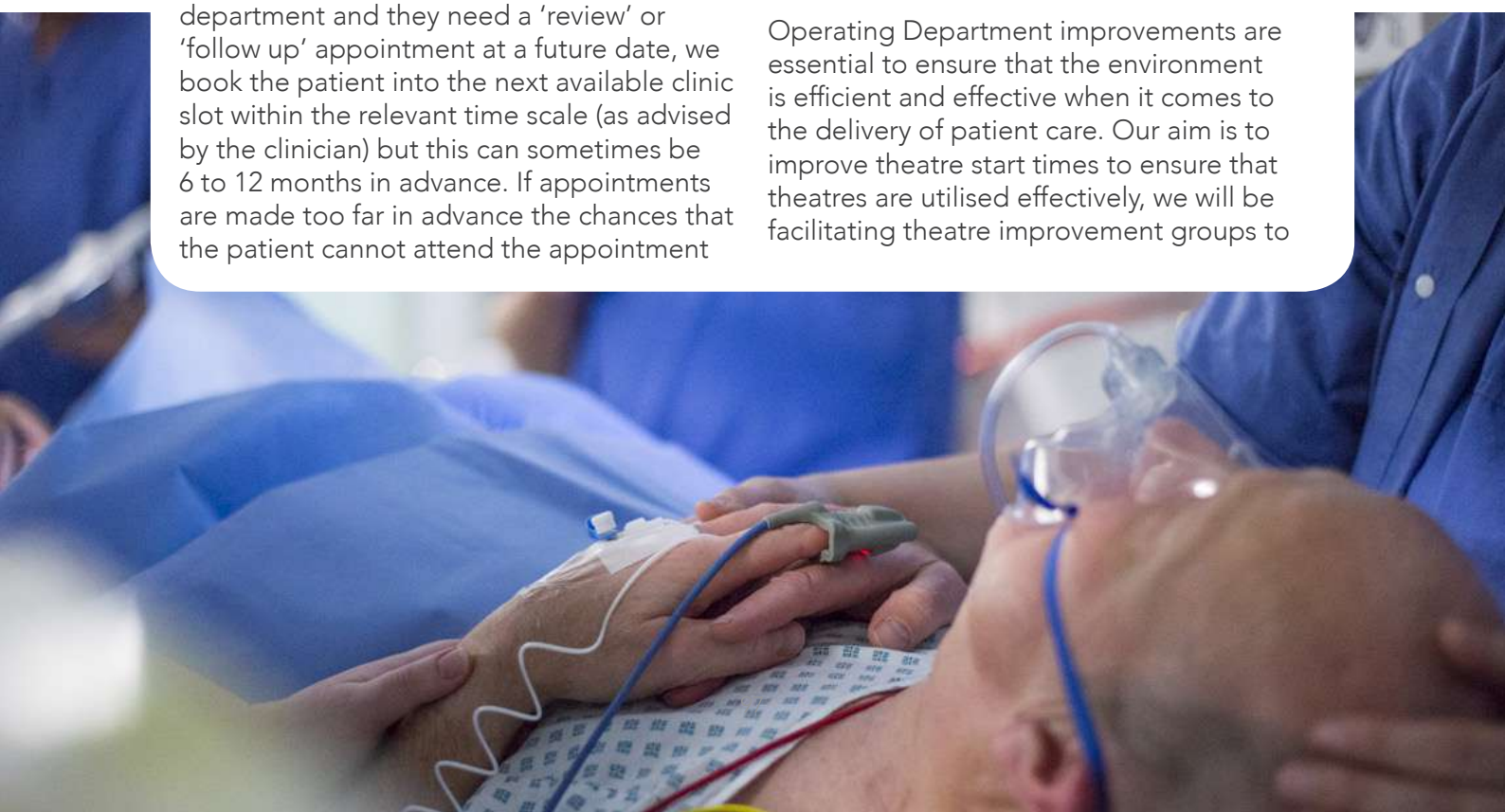
The benefits of using a 'Partial Booking' system include:

- We will be offering the patient more choice (appointment date and time)
- We will be reducing DNAs and cancellations
- We will be reducing rework for appointments staff
- We will be improving patient experience (reducing complaints)

Progress against our measures of success will be monitored by the Cerner Patient Admin Group which reports directly to Corporate Leadership Group, a sub-committee of the Board of Directors.

Why is improving our Operating Department important?

Operating Department improvements are essential to ensure that the environment is efficient and effective when it comes to the delivery of patient care. Our aim is to improve theatre start times to ensure that theatres are utilised effectively, we will be facilitating theatre improvement groups to



drive this improvement forward. There is ongoing work to reduce cancellations on the day, a text reminder service has been installed and we are already seeing benefits however we recognise that there is further work to be done to reduce cancellations on the day. Progress against our measures of success will be monitored through the Planned Care Governance Board and Divisional Management Board which reports to Quality, Safety & Patient Experience Committee (QSPEC), a sub-committee of the Board of Directors

These priorities reflect the Trust's vision and form part of the wider 2019/20 programme of work through the Cheshire & Mersey Health & Care Partnerships, Cheshire West Integrated Care Partnership and the design of the Trust Clinical strategy (under development).

Cheshire & Mersey Health & Care Partnership (STP)

Focusing on the transformation of our services to provide sustainability, we need to mitigate demand, unwarranted variation, duplication, and cost. To achieve this we will be supporting the strategic work streams identified across Cheshire & Mersey.

Cheshire West Integrated Care Partnership

We are continuing to work with our health and social care partners in West Cheshire to create a new Integrated Care Partnership, hosted by the Countess of Chester Hospital, to transform how services are delivered to our most complex and demanding patients.

Areas of focus include:

1. Understanding and actively mobilising the population
2. Actively promoting self-care, self-service and developing community assets
3. Actively diverting people to the most effective and efficient access points
4. Supporting and encouraging the flow of people to the right resources
5. Supporting and encouraging people with multiple conditions and complex needs through multiagency teams
6. Supporting community professionals with resources from the acute

Trust Clinical Strategy

This strategy is currently being developed to support the strategic direction of the Cheshire & Mersey Health & Care Partnerships and the Cheshire West Integrated Care Partnership and will describe clinically the direction and shape of our services over the next five years. This will be supported by a five-year business plan, which will determine our operational plans.

Quality Improvement Strategy

Our ambition is for the Countess of Chester Hospital to build a culture of continuous improvement. This means that we make improvement a routine daily activity and use Quality Improvement (QI) methodology to tackle the problems we are faced with. As the leading healthcare provider Jönköping in Sweden says, "everyone has two jobs; to do your work and to improve your work." A new Quality Improvement Strategy is currently in development and will outline our plans to create the capacity and capability that is needed across the Trust to enable staff to further the development of safe, kind and effective care. This will underpin the implementation of required actions from our CQC inspection.

Electronic Patient Record (EPR) Replacement

The Trust currently manages inpatient and outpatient activity on an EPR that has been in use since 1999. The technology behind this EPR is now outdated and will not be supported in the near future. A replacement EPR is required to meet the Trust's strategic objectives in providing a safe and caring environment for patients and staff.

The benefits from the Trust investment will:

- Improve clinical standardisation in all care pathways;
- Improve patient safety and reduce clinical risk by utilising modern EPR technology such as rules driven care pathway management and full electronic order acknowledgement;
- Provide an EPR system with comprehensive clinical data that is able to be accessed wherever and whenever it

is required: a fully mobile solution;
- Increase efficiency of clinical care by enabling the implementation of standardised processes;
- Reduce administrative burden of the Trust by enabling the efficient collection of data at the point of care; and
- Support the effective sharing of clinical data across organisational boundaries.

The intention is to have the replacement EPR operational by the end of 2020.

3.5 Statements of assurance from the board

During 2018/19 the Countess of Chester Hospital NHS Foundation Trust provided and/or sub-contracted 47 relevant health services. The Countess of Chester Hospital NHS Foundation Trust has reviewed all the data available to them on the quality of care in all of these relevant health services.

The income generated by the relevant health services reviewed in 2018/19 represents 100% of the total income generated from the provision of relevant health services by the Countess of Chester Hospital NHS Foundation Trust for 2018/19. A proportion of the Countess of Chester Hospital NHS Foundation Trusts income in 2018/19, at a value of £4.1m (2017/18 £3.95m), was conditional on achieving quality improvement and innovation goals agreed between us and any person or body we entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

The Countess of Chester Hospital NHS Foundation Trust received £4.1m associated payment in 2018/19 for achieving quality improvement and innovation goals. Further details of the agreed goals for 2018/19 and for the following 12 month period are available electronically at www.coch.nhs.uk

Our Services

Accident & Emergency
Audiology
Breast Surgery
Cardiology
Cardiothoracic Surgery
Chemical Pathology
Clinical Haematology
Colorectal Surgery
Critical Care
Dermatology
Diabetic Medicine
Diagnostic Imaging
Dietetics
Endocrinology
Endoscopy
ENT
Fertility
Gastroenterology
General Medicine
General Surgery
Geriatric Medicine
Gynaecology
Hepatology
Maxillo-Facial Surgery
Nephrology
Obstetrics
Occupational Therapy
Ophthalmology
Oral Surgery
Orthodontics
Orthoptics
Paediatrics
Pain Management
Palliative Care
Pathology Direct Access
Peadiatric Epilepsy
Physiotherapy
Plastic Surgery
Podiatry
Respiratory Medicine
Rheumatology
Neonatal
Trauma & Orthopaedics
Upper Gastrointestinal Surgery
Upper GI Surgery
Urology
Vascular Surgery

Clinical Audit

During 2018/19, 47 national clinical audits and 7 national confidential enquiries into patient outcome and death (NCEPOD) covered relevant health services that the Countess of Chester Hospital NHS Foundation Trust provides. During that period the Countess of Chester Hospital NHS Foundation Trust participated in 94% national clinical audits and 100% of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in. The national clinical audits and national confidential enquiries that the Countess of Chester Hospital NHS Foundation Trust was eligible to participate in during 2018/19 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Audits 2018/19	Eligible	Participated	% Submitted
Trauma Audit & Research Network	Yes	Yes	84-100%
Head and Neck Cancer Audit	Yes	Yes	Review 1/1/20
Cardiac Rhythm Management	Yes	Yes	99.5-100%
Acute Myocardial Infarction (MINAP)	Yes	Yes	Review 31/3/20
Audit of Critical Care (ICNARC)	Yes	Yes	Review 31/1/20
National Core Diabetes Audit	Yes	Yes	100%
National Diabetes Inpatients Audit	Yes	Yes	100%
National Diabetes Foot Care Audit	Yes	Yes	Review 31/3/20
National Pregnancy in Diabetes Audit	Yes	Yes	100%
National Diabetes Transition	Yes	Yes	100%
National Heart Failure Audit	Yes	Yes	81%
National Joint Registry	Yes	Yes	Review 30/9/20
National Lung Cancer Audit	Yes	Yes	100%
National Neonatal Audit Programme	Yes	Yes	Review 31/3/20
National Ophthalmology Audit	Yes	No	NA
National Prostate Cancer Audit	Yes	Yes	60%
National Vascular Registry	Yes	Yes	>70%
National Oesophago-gastric Cancer Audit	Yes	Rolling	>90%
BTS Paediatric Pneumonia	No	No	NA
National Elective Surgery Patient Reported Outcome Measures (PROMs)	Yes	Yes	Variable across two conditions
National Emergency Laparotomy Audit	Yes	Yes	100%
College of Emergency Medicine	Yes	Yes	100%
Feverish Children			
College of Emergency Medicine: VTE Risk in Lower Limb Amputation	Yes	Yes	100%
BTS Adult Asthma	Yes	Yes	100%
BAUS Urology Audits: Female Stress Urinary Incontinence Audit	Yes	Yes	100%
BAUS Urology Audit: Nephrectomy Audit	Yes	Yes	Review 31/12/20
BAUS Urology Audits: PCNL	Yes	Yes	Review 31/12/20
Bowel Cancer	Yes	Yes	Review 31/12/20
National Paediatric Diabetes Audit	Yes	Yes	Review 1/4/19
Inpatient Falls	Yes	Yes	100%

National Audits 2018/19	Eligible	Participated	% Submitted
National Hip Fracture Database	Yes	Yes	Review 1/4/20
Inflammatory Bowel Disease Programme	Yes	No	NA
Learning Disability Mortality Review Programme	Yes	Yes	Review 31/1/20
National Audit of Dementia	Yes	Yes	100%
National Cardiac Arrest Audit	Yes	Yes	Review 31/3/20
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis	Yes	Yes	Review 31/5/19
National Asthma and COPD Audit Programme	Yes	Yes	Review 31/3/20
National Comparative Audit of Blood Transfusion Programme	Yes	Yes	Review 31/3/20
Renal Registry	Yes	Yes	Review 31/3/20
Sentinel Stroke National Audit Programme	Yes	Yes	Review 31/3/20
MBRRACE	Yes	Yes	Review 31/3/20
BTS Community Acquired Pneumonia	Yes	Yes	Review 28/6/19

The national confidential enquiries the Countess of Chester NHS Hospital Foundation Trust participated in during 2018/19 are as follows:

NCEPOD 2018/19	Eligible	Participated	% Submitted
NCEPOD: Long Term Ventilation	Yes	Yes	100%
NCEPOD: Acute Bowel Obstruction	Yes	Yes	100%
NCEPOD: Pulmonary Embolism	Yes	Yes	100%
NCEPOD: Young People's Mental Health	Yes	Yes	100%
NCEPOD: Peri-operative Diabetes	Yes	Yes	100%
NCEPOD: Acute Heart Failure	Yes	Yes	100%
NCEPOD: Children & Young People with Cancer	Yes	Yes	100%

The reports of 3 national clinical audits were reviewed by the provider in 2018/19 and the Countess of Chester Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided in relation to:

- National Emergency Laparotomy Audit (NELA)
- National Joint Register (NJR) Report 2018
- Avoiding Term Admissions & Reducing Separation of Mother and Baby

National Emergency Laparotomy Audit (NELA)

Laparotomy is a procedure where a patient needs an operation within their abdomen usually due to a problem with their bowel or abdominal organs, (such as liver or spleen). It is frequently an urgent or emergency procedure due to bowel blockage, perforation, failing blood supply, trauma or abscess. It is a procedure that can be needed in all age groups and because of the urgent nature of the surgery the seriousness of the conditions that necessitate the operation it is a relatively high risk procedure with approximately 10% of all patients needing this procedure unfortunately not surviving to hospital discharge at 30 days post procedure.

It has been nationally recognised that certain key elements of care are associated with improved outcomes for this group of patients and for the last 5 years this hospital has been collecting and contributing data to the NELA, (National Emergency Laparotomy Audit). This data includes hospital infrastructure, risk profile of patients, access to CT scanning, seniority of surgeons

and anaesthetists in theatre, access to critical care post operatively for the highest risk patients and general adherence to standards of care that have been associated with better overall outcomes across this patient group.

The number of patients in the national audit was 23,929. The number of patients contributed by the Countess of Chester Hospital NHS Foundation Trust was 106. The Audit was completed between 1st December 2016 and 30th November 2017. We present 14 key performance indicators with comparison of our performance against national and regional average performances. This data was collected in the 12 months December 2016-December 2017 and was published nationally in October 2018. This is a rolling national audit that is published every October. As with any audit we would aspire for 100% achievement in these areas but accept that clinical presentation or urgency may sometimes make this impossible, (for example a patient who has abdominal injuries that need immediate surgery but they are too unstable to have a CT scan and are therefore transferred immediately to theatre as to not do so would be worse for them).

We have always been proud at the Countess of our performance in this area and this year's data supports that with our mortality and length of stay data. One area that has nationally been slow to change is the provision of specialist input into the care of the patients over the age of 70 by a care of the elderly physician with an interest in perioperative medicine. We have appointed a consultant to address this and we expect this to be reflected in next year's data.

The six key NELA themes are:

1. Improving outcomes and reducing complications
2. Ensuring all patients receive an assessment of their risk of death
3. Delivering care within agreed timeframes for all patients
4. Enabling consultant input in the perioperative period for all high risk patients
5. Effective multidisciplinary working
6. Supporting quality improvement

	Key quality measured audited Nationally include:	COCH	National	Regional
1	Case ascertainment	100%		
2	CT reported prior to surgery	69%	65	64
3	Risk documented prior to surgery	80%	74	75
4	Arrival in theatre appropriate for surgery	77%	83	74
5	*Both* Consultant Anaesthetist and Consultant Surgeon in theatre if risk >5%	77%	77	77
6	Consultant Surgeon in theatre if risk >5%	95%	93	85
7	Consultant Anaesthetist in theatre if risk >5%	82%	88	90
8	Admitted Critical Care where risk >5%	78%	80	83
9	Admitted Critical Care where risk >10%	84%	88	88
10	Post-op review by Care of Elderly Specialist i.e. age >70 years	6%	18	21
11	Unplanned return to theatre	3%	6	4
12	Unplanned admission to Critical Care	2%	4	1
13	Post-op length of stay	10 days	11	13
14	Risk adjusted mortality	10%	10	

Points 5, 6 & 7; we consistently have consultant surgeon presence in theatre in the highest risk cases, the lower presence of consultant anaesthetist presence could be attributable to senior non consultant anaesthetists with appropriate skill level for the patient, data capture error or an area for improvement. This will be audited prospectively.

Points 8 & 9; we know that there were data entry errors for admission to Critical Care when responsibility for data capture in this metric changed hands. We believe this figure to be inaccurate and the error corrected. We will be monitoring this closely.

Point 10; we have now appointed a care of the elderly consultant with a responsibility for review of post op emergency surgical patients.

Action Required	Action Lead	Timescale for Action	Where Reported
Audit seniority of Anaesthetic input in laparotomy patients	Consultant in Critical Care	6 months	Locally
Audit accuracy of critical care admission recording post laparotomy with correlated risk	Consultant in Critical Care	6 months	Locally
Local education of Surgical, a] Anaesthetic, Radiology, Critical Care and Audit Departments	Consultant in Critical Care/Consultant in General Surgery	Ongoing	RHD attendance

NELA is an ongoing national audit that has improved year on year. Any patient undergoing a laparotomy in our hospital is reported each week to the Clinical Lead which has support us in achieving 100% case ascertainment.

National Joint Register (NJR) Report 2018

The NJR has expanded in recent years to include all joint replacements, as well as hips and knees, and since 2003 we have submitted over 4000 records. Overall, the hospitals results are good. We perform better than average for all of the hospital categories (including consent rates, revision rates, and mortality), with the exception of 'compliance', which is a measure of cases submitted compared with Hospital Episode Statistic data. This is worst for the newer sub-specialities entering data (which include Foot & Ankle and Elbow). There is also a negative trend in the consenting of patients, for collection of data for NJR, however our rate is far better than national comparisons.

The surgical outcome of the patients is better than average, particularly for hip revision, and all consultants would appear to perform better than average from the data provided. However the dashboard does suggest one surgeon has a worse than expected revision rate, we have requested further information from NJR in relation to this, so we are able to take forward improvement actions. The remainder of data demonstrates that revision and mortality for knees is within the standard range (of 2 standards deviations).

Further data is provided about the type and cost of implant; however it is important to note this is incomplete. On analysis it does demonstrate good compliance with national guidance, but there is a slight tendency to use more expensive implants, such as ceramic or uncemented cups in the elderly, where there is no evidence of any benefit.

Action Required	Action Lead	Timescale for Action	Where Reported
Confirm whether there is an outlying Surgeon	Clinical Lead	Completed	Follow-up email
Ensure compliance remains high	Management Lead	31/3/20	Next report
Reinforce compliance with advice regarding choice of implants	Clinical Lead	31/3/20	Next report

Avoiding Term Admissions & Reducing Separation of Mother and Baby

The number of unexpected admissions to neonatal units is seen as a proxy indicator that preventable harm may have been caused at some point along the maternity or neonatal pathway: Collaborative work between the midwifery, obstetric and neonatal team continues. As part of the work, we also aim to reduce the number of babies separated from their mothers and promote quality and efficiency of care. Areas of development include (but are not limited to):

Severe brain injury diagnosed in first 7 days of life (term)	Cooling will be investigated by Healthcare Safety Investigation Branch (maternity). Final report will be fed back to Each Baby Counts and MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries). Action plans to be developed following any recommendations in the reports. Cases must also be reported to NHS Resolution.
Quality Improvement project: Facilitating IV cannulation and antibiotics on Labour Suite	Medical students are collecting data regarding time taken between identification of risk factors for sepsis and administration of neonatal antibiotics. Process mapping planned.
Review transitional care admission criteria	Consider changing 'transitional care' admission criteria to include babies requiring saturation monitoring e.g. the 'grunting' baby. Discussions ongoing – presence of Band 5 NNU nurse needed.
Maternal request for elective C-section	Demonstrate to women the increased risk of respiratory problems secondary to elective C-section (using local data collected via the term admissions audit).

Action plans for each work stream have been developed, with lead clinicians identified, it is anticipated that all projects will be implemented by December 2019.

The reports of approximately 200 local and regional clinical audits were reviewed by the Trust in 2018/19. The Trust intends to take the following actions to improve the quality of healthcare, this includes:

Audit ID 23467 - Syringe Driver Audit

An audit of syringe pump use was carried out for 3 months starting on the 1st October 2019 to assess compliance against Trust Policy and the Merseyside and Cheshire Palliative Care Network guidance. A Continuous Subcutaneous Syringe Driver (T34) delivers drugs over a 24hour period and is the syringe driver in use within our hospital for palliative care. The audit was completed under the direction of the Supportive and End of Life Group. This is a re-audit following on from the previous audit that was carried out between July and October 2018.

Results and Discussion

40 records were reviewed during the audit period, with time on the syringe driver varying from 2 hours 27 minutes to 8 days. The results were audited against the Syringe Driver Policy and the syringe driver chart. It was disappointing that there was poor compliance across a number of elements as follows:

- Only 60% of the charts had the allergy section completed;
- Patient identifiers recorded (name, dob, cc no, NHS no) 100% compliant;
- Prescription signed and dated 93% compliant (on 3 charts date omitted);
- Time when prescribed 47.5% compliant;
- Time started 99 % compliant;
- 5 minute check 38% compliant;
- 60 minute check 18% compliant;
- Initial 4 hourly check 35% compliant; and
- 40% of charts had no documentation of checks overnight.

Results show compliance with the Trusts policy and Merseyside and Cheshire Palliative Care Network guidance requires improvement.

Action	Action Lead	Timescale
Following feedback to Supportive and End of Life meeting. It was suggested to complete next Audit for every patient with a syringe driver during time frame rather than the sample of on from each ward.	Palliative Care Nurse Specialist	1/10/18 - 1/1/19 completed
Disseminate findings to Link Nurse meeting	Palliative Care Nurse Specialist	6/11/18 meeting cancelled new date to be arranged
Share findings with Supportive and End of Life Care Group	Palliative Care Nurse Specialist	2/4/19 completed
Ongoing ward teaching and Datix individual cases	All SPC Team	Ongoing
Attend the Learning from Deaths meeting	Palliative Care Nurse Specialist	15/3/19 completed

Once these actions have been completed, this audit will continue as a rolling audit every 3 - 6 months to ensure improvement in compliance is sustained. This audit will be monitored through the End of Life Care Group and the Clinical Audit Group.

Audit ID 23435-Febrile Neutropenia Audit

The Nice Guideline Neutropenic Sepsis: prevention and management in people with cancer (CG151), was published in September 2012 with the aim of reducing the number of unnecessary deaths and improving outcomes for patients with a common complication of cancer treatment. The guideline recommends that neutropenic sepsis should be treated as an acute medical emergency and intravenous antibiotics should be offered immediately. The aim on the Children's Unit is to treat all children admitted with suspected febrile neutropenia with intravenous antibiotics within one hour of admission.

Results & Discussions

14 patients were admitted to the Children's Unit and treated for suspected sepsis during the audit period. All patients received intravenous antibiotics within 60 minutes of arrival. The Children's Unit achieved 100% compliance with the recommendation that all oncology patients admitted with suspected febrile neutropenia should receive their first dose of intravenous antibiotics within 60 minutes. There are no recommendations for change in practice following the 2018 audit.

Outcome:

- No re-audit recommended;
- No actions necessary as 100% compliance with Nice guideline was achieved;
- No recommendations for a change in practice; and
- Ward staff in liaison with medical staff will always strive to ensure that Oncology patient admitted with suspected Febrile Neutropenia are seen and treated as a priority on arrival at the Children's' Unit.

Participation in Clinical Research

The number of patients receiving relevant health services provided or sub-contracted by the Countess of Chester Hospital NHS Foundation Trust in 2018/19 that were recruited during that period to participate in research approved by a research ethics committee was 925.

Clinical coding & data quality

Good quality information underpins the effective delivery of services, patients' pathways and supports staff to delivery safe care that meets the expectations of patients and the wider public. Reliable data of high quality is essential to ensuring decisions are made appropriately about service design and priority improvements. The Countess of Chester Hospital NHS Foundation Trust submitted records during 2018/19 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. It is important when submitting this data to ensure the information is accurate, clear and completed. The following measures provide information on our compliance against the standards required; which includes data from April 2018 to February 2019:

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

- 99.8 % for admitted patient care
- 99.9 % for outpatient care
- 98.6 % for accident and emergency care

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

- 96.2 % for admitted patient care
- 99.8 % for outpatient care
- 98.6 % for accident and emergency care

The reduction in percentage of valid General Medical Practice code is due to the transmission of this data field into the Data Warehouse and then on to the Secondary Uses Service, and does not reflect the compliance of General Practice details held on the hospitals system for patients. Work continues to resolve this issue. A fix has been identified which mitigates any technical interfacing problems of this field between the two systems. It is expected this fix will uplift the percentage by 3.5%.

The Countess of Chester Hospital NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2018/19 by the Audit Commission. During the course of 2018/19 the Trust commissioned an external audit of 200 finished consultant episodes (FCEs) and the following accuracy rates were reported:

	% Correct	Mandatory
Primary Diagnosis	92.00%	>=90%
Secondary Diagnosis	85.91%	>=80%
Primary Procedure	96.15%	>=90%
Secondary Procedure	94.59%	>=80%

The assurance level given in respect of clinical coding and underlying processes was *'Substantial Assurance'*.

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

All administrative and clerical staff involved in the operational management of patients waiting to be seen, are mandated to take an annual detailed programme of training relating to the key aspects of operational patient administration, helping to improve knowledge and data quality. This is reviewed and updated on an annual basis.

The Healthcare Evaluation Data (HED) clinical benchmarking tool is being utilised to identify variation in clinical performance. Identified variations can sometimes relate to issues of data quality, when identified these are addressed accordingly.

A weekly process for the updating of deceased patients on the Trust electronic patient record system using the national Demographic Batch Service (DBS) continues to be used. This has enabled weekly updates to all patients on the Master Patient Index (MPI) improving the quality of the indices. The Performance Information System continues to be developed for a number of operational areas and is used to assist in the real-time identification and rectification of some aspects of poor data quality, including specific data quality pages for Accident & Emergency, theatres and Referral to Treatment (RTT) modules.

A review of our current Data quality governance processes is underway to ensure effective management of data quality, at the same time working towards implementation of a new Electronic Patient Record system and any potential data issues. Data quality is monitored as part of the Data Protection and Security Toolkit and for the standards relating to data quality The Countess of Chester Hospital NHS Foundation Trust met the standards. Data quality is monitored as part of the Information Governance toolkit and for the seven standards relating to data quality The Countess of Chester Hospital NHS Foundation Trust met all standards. These standards are monitored by the Data Quality group.

The Countess of Chester Hospital NHS Foundation Trust Information Governance Assessment Report overall score for 2018/19 was graded Green (satisfactory).

Learning from Deaths

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

During 2018/19 1,211 of the Countess of Chester Hospital NHS Foundation Trust patients died. The number of deaths in each quarter was:

- 293 in the first quarter
- 265 in the second quarter
- 303 in the third quarter
- 350 in the fourth quarter

By 31st March 126 case record reviews and 8 investigations had been carried out in relation to 134 of the deaths included above. In one case following a case record review an investigation was carried out prior to coroner's court. The number of deaths in each quarter for which a case record review or investigation was carried out was:

- 13 in the first quarter (4.4%)
- 31 in the second quarter (11.7%)
- 10 in the third quarter (3.3%)
- 80 in the fourth quarter (22.9%)

There was an issue in quarter three in relation to the dissemination of notes for Structured Judgement Review (SJR) hence the low figure of reviews for this quarter. This issue has now been resolved. A number of

notes relating to deaths in quarter 4 have been distributed for SJR but they have not been completed prior to this report being finalised. They will be included in the next reporting period account (2019/20). Following review, 2 cases representing 0.17% of the total deaths during the reporting period were judged to be more likely than not to have been due to problems in the care provided to the patient at our hospital. In relation to each quarter, this consisted of:

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

Review Method

Deaths are currently reviewed using 3 different methods:

- If questions arise in relation to the care of someone who has died then this maybe raised as a clinical incident and a 72 hour review will be undertaken using an SBAR (Situation, Background, Assessment & recommendation tool). These cases are reviewed at the Serious Incident Panel and if appropriate a formal Serious Incident (SI) investigation will be initiated which is carried out using Root Cause Analysis (RCA) methodology,
- Approximately 10-15% of deaths are reviewed using the Royal College of Physicians SJR methodology. A structured judgement review blends traditional, clinical-judgement based review methods with a standard format. The objective of this review method is to look for strengths and weaknesses in care process, to provide information about what can be learnt about the hospital systems where care goes well, and to identify points where there may be gaps, problems or difficulty in the care process. The quality of care is assessed against a scale of excellent, good, adequate, poor and very poor. Where the first review deems the care to have been poor or very poor the case is sent for a second review; and
- A short mortality review form was introduced on 1st February 2019 to review the majority of deaths not reviewed as an SI or a SJR. This process complement's the current SJR and SI processes. These reviews are undertaken by senior clinicians alongside members of the coding team. Any cases identified using this tool where care is deemed to be suboptimal are put forward for a formal structured judgement review.

Lessons Learnt

Any lessons learned are discussed at the Learning from Deaths Group and a quarterly report is fed back to the Divisions through the hospital governance process and also to individual departmental clinical leads at departmental meetings. Any immediate concerns/lessons learned are fed back to the departments immediately following the review. They are also included in a recently developed Quality Newsletter which is disseminated across all staff in the Trust. It is clear; however, from the SJR's reviews and the short mortality review form that in the majority of cases the quality of care being provided is of a very high standard.

Areas of excellence identified & shared

Awareness of patients entering "end of life" with the involvement of palliative care (End of Life Care team) is testament to the quality of clinical care being provided:

- Early identification that patient was likely in last days of life and good involvement of patient and family in ongoing care and end of life care;
- Specialist input was obtained appropriately which ensured that treatment was correct and reactive to the emerging results of investigations. Regular discussions held with the patient and relatives to update them of the clinical picture, and this was documented clearly within the case-notes;
- Patient referred to critical care for his renal failure. There was comprehensive documentation in the notes from Intensive Care Consultant with regular reviews/documentation. There was a comprehensive documentation by Care of Elderly Consultant including ceilings of care;
- Had a patient centered approach and

patients holistic needs considered. There were appropriate discussions with family and palliative care involvement; and
- There was a phased transition from "active" to "palliative" care which was appropriate given the degree of uncertainty; there was also appropriate ongoing family involvement. Documented achieved outcome of dying peacefully with family.

Specific learning

The two areas of practice below have been variable and inconsistencies have been identified over this reporting period, however there will continue to be a key focus on improving each element during 2019/20 to ensure patients are treated in a safe and timely way.

Escalation of elevated NEWS2; in September 2018 the Trust implemented the NHS England approved National Early Warning Score (NEWS). NEWS2 provides a unified language to describe and communicate the physiological risk of sick patients across the NHS. It is a validated early warning tool for detecting and monitoring deteriorating adult patients. The score is based on commonly measured observations: respiration rate, oxygen saturations, blood pressure, heart rate, temperature and level of consciousness. Each measurement is scored 0-3 depending on the degree they vary from normal so the higher the NEWS2 score the sicker the patient and the higher their risk of deterioration. The scoring tool is built in to the observation chart, the score from each parameter is added to gain a total NEWS2 score and a clinical response is initiated.

Recognition and management of Sepsis; during 2018/19 the Sepsis improvement programme has continued to deliver benefits to patients to support earlier identification of Sepsis and more timely interventions in response, achievements during this reporting period include:
- Standardised Sepsis pathways has been launched in all adult inpatient areas;
- Nurse training resource/competency pack designed and rolled out;
- Education Strategy implemented (Level 1 and 2 training underway, Level 3 training to be launched using the UK Sepsis Trust train the trainer package);
- Sepsis response kits to be made available to all areas (unique design allows for the response kit to act as a teaching aid and is a focal point for sepsis awareness training);
- Sepsis awareness provided on induction for registered nurses and nursing assistants;
- Sepsis awareness provided on Skills Update for Nurses and contained within ALERT course; and
- Sepsis champions identified in adult inpatient areas to support compliance, training and to identify staff who wish to undertake extended roles such as cannulation and venepuncture to aid process of sepsis.

Four investigations were completed during this reporting period that related to deaths during the previous reporting period which were not included in the 2018/19 reported figures on page 108. Two of these deaths are judged to be more likely than not to have been due to problems in care provided to the patient. This judgement is based on the findings of the Serious Incident Report's which were undertaken using formal RCA methodology. Taking this into account a revised estimate of the number of deaths during the previous reporting period judged to be more likely than not to have been due to problems in the care provided to the patient at our hospital has increased from two to four.

3.6 Performance against core indicators

The Countess of Chester Hospital NHS Foundation Trust considers that this data is as described for the following reasons; information has been taken from Meditech (our electronic patient record) and where available from the Healthcare Evaluation Data (HED), our data quality process including clinical validation has been followed.

Indicator	2018/19	National Average	Best performer (where applicable)	Worst performer (where applicable)	2017/18	2016/17	2015/16
SHMI value and banding (most recent Jan-Dec 2017)	107 As expected	98.4	68.9	120.6	104 As expected	113 Above expected	108 Above expected
% patient deaths coded for palliative care at diagnosis or speciality level; ;atest comparative information for period Oct 16-Sep 17	33.7%	NA			36.3%	39.6%	34.6%
Patient reported outcome scores for groin hernia surgery (Combined health gain - 2017/18 amd 2018/19 provisional data) Source: HED	Data not yet available	NA			6.21 Provisional	0.23	0.67
Patient reported outcome scores for varicose vein surgery (Combined health gain - 2017/18 and 2018/19 provisional data) Source: HED	Data not yet available	NA			-13.87 Provisional	-1.23	-2.97
Patient reported outcome scorses for primary hip replacement surgery (Combined health gain - 2017/18 and 2018/19 provisional data) Source: HED	Data not yet available	NA			11.34 Provisioanl	12.24	12.19
Patient reported oucome scores for primary knee replacement surgery (Combined health gain - 2017/18 amd 2018/19 provisional data) Source: HED	Data not yet available	NA			8.15 Provisioanl	7.79	7.92
28 day readmission rate for patients aged 0-15 Source: HED 2018/19 Data to Feb 2019	13.3%	9.6%	2.9%	16.3%	11.9%	10.8%	11.7%
28 day readmission rate for patients aged 16 or over Source: HED 2018/19 Data to Feb 2019	5.8%	8.1%	4.1%	11.7%	5.8%	5.9%	5.5%
Staff friends and family (care) Latest national data Q4 2018/19	80.5% (Q4)	82% (Q2)	100% (Q2)	39% (Q2)	79% (Q2)	78% (Q4)	77% (Q4)
VTE (annualised)	94.7%	95.6% (Q3 18/19)	NA		96.1%	96.8%	97.8%
C.Diff Rate per HES 100,000 bed days Source: HED 2018/19 Data to Feb 2019	16.4	11.9	1.4	28.9	15.3	12.5	13.2

Indicator	2018/19	National Average	Best performer (where applicable)	Worst performer (where applicable)	2017/18	2016/17	2015/16
Number of Serious Incidents at L1	50	NA			78	48	30
Number of Serious Incidents at L2	14	NA			15	16	43
Number of Never Events	2	NA			1	4	2
Rate of Serious Incidents at L1 Per HED 100,000 bed days	25.5	NA			41.3	25.7	15.9
Rate of Serious Incidents at L2 per HES 100,000 bed days	7.1	NA			8.0	8.0	22.8
Rate of Never Events per HES 100,000 bed days	1.0	NA			0.5	2.1	1.1
Responsiveness to Patient Needs	Please refer to page 118						

***28 day readmission rates will differ in value from previous quality reports due to a change in data source and methodology, data has been taken from the Healthcare Evaluation Data (HED) to allow for national comparison*

The Countess of Chester Hospital NHS Foundation Trust has taken the following actions to improve its performance in 28 day readmission in 0 – 15 year olds, risk & patient safety and infection prevention & control and so the quality of its services.

28 Day Readmission Rate for patients aged 0-15

The Health Evaluation data (HED) has shown that the 28 day readmission rate for patients aged 0-15 is 13.3% for 2018/19, which is slightly higher than the national average of 9.6%. While readmission within 28 days of adult patients and paediatric surgery is considered a useful marker of quality, it is a much more complex in paediatric medicine and should not be viewed as an isolated measure.

Most paediatric medical admissions are short, with an average length of stay around 24 hours. Many admissions are with viral infections, which may have a natural history of worsening before resolving. Paediatricians will try to avoid unnecessary hospital stays for these conditions, where it is clear at that time there is no intervention that would be needed that could not be provided in the community. Careful explanation of the signs to look out for that might necessitate re-attendance at the hospital along with written information is given to families. This may be supported by a temporary 'open access' arrangement to the ward, by hospital at home team support and/or advice as to when to seek review in primary care. It is however inevitable that a proportion of these children will deteriorate as part of the natural progression of their illness and need readmission. In paediatrics, a higher readmission rate might therefore reflect a high standard of patient-centred care, by reducing unnecessary admissions and so reducing the overall bed occupancy on the ward at any one time. This means that available beds can be utilised immediately for children who need hospital-based care and treatment. Previous audit of 28 day readmissions in our department found that this group also included oncology patients with anticipated repeated admissions and children with second conditions unrelated to the original admission.

The paediatric department is working alongside our commissioners to reduce short stay admissions to the ward by managing these children in primary care. This group will include children who may later need admission as the natural history of their illness progresses. These strategies include the development of paediatric hubs, where children with acute illness will be seen by clinicians with a higher level of paediatric

expertise with the facility for a short period of observation in the community, a consultant-led phone advice service and electronic triage of primary care referrals.

Risk & Patient Safety

Serious Incidents

During 2018/19 in line with the NHS England Serious Incidents Framework the Trust reported 64 incidents to our Commissioners and NHS England which equates to 0.8% of the 12,023 incidents reported; of which 7,972 met the National Reporting & Learning System (NRLS) reportable criteria. Each incident has a comprehensive investigation with recommendations to address any lessons learnt. In the reporting period 2018/19 the Trust trained over 40 staff in Root Cause Analysis (RCA) to support a robust investigation process.

The top three categories of serious incidents reported in 2018/19 were:

- Slip/trips/falls
- HCAI/Infection Prevention & Control
- Treatment delay

Incident Category	StEIS Incident Type	Total Number of Incidents
Infection Control	HCA/Infection control Incident	8
Infection Control total		*8*
Serious Incidents	Diagnostic Incident	2
	Maternity/Obstetric Incident: Baby Only	4
	Maternity/Obstetric Incident: Mother & Baby	4
	Maternity/Obstetric Incident: Mother Only	2
	Medication Incident	4
	Slips/trips/falls	26
	Sub-optimal care of the deteriorating patient	4
	Surgical/invasive procedure incident	3
	Treatment delay	7
Serious Incidents total		*56*
Grand total		*64*

Data source: Datix Risk Management System.
Definition: NHS Serious Incident Framework found at: https://improvement.nhs.uk/documents/920/serious-incidnt-framwrk.pdf

In 2018/19 there were 22 Serious Incidents with severe harm or death:

	2018/19	Total
Severe (permanent or long term harm caused)	12	12
Death	10	10
Total	*22*	*22*

Data source: Datix Risk Management System.
Definition: NHS Serious Incident Framework found at: https://improvement.nhs.uk/documents/920/serious-incidnt-framwrk.pdf

Never Events

During this quality account year (2018/19) unfortunately the Trust reported two never events, as follows:

- A wrong side block in theatre; and
- An exit from a ground floor window.

These incidents were subjected to a robust investigation which includes an action plan to address the issues identified. The incidents were reported to Strategic Executive Information System (StEIS) who collate preventable incidents from all NHS providers to monitor trends and support wider learning, in both these cases there was no harm to the patient and our 'duty of candour' was delivered in an acceptable timescale.

Lessons Learnt

In year, the delivery of lessons learnt messages across our hospital has remained a key focus. A 'Lessons Learned' weekly communication is shared through email to all staff groups following the Serious Incident Review panel. This illustrates themes for learning from incidents, claims, complaints coroner's cases, audit and national safety alerts/learning. This email is then used to facilitate safety briefings at a ward, department or speciality level in addition to being fed back through various team meetings, mandatory training and other learning opportunities.
We have continued to share key messages with staff through 'Screen savers' and this information is accessible on the Risk & Safety team intranet pages which all our staff have access to. To complement the various methods of ensuring staff are well informed we have also introduced a monthly Quality & Safety newsletter.

Duty of Candour

Whilst we had previously implemented the Duty of Candour legislation; work has continued in 2018/19 to ensure that Duty of Candour supported by a standalone policy is fully embedded into routine practice. Compliance for serious incidents is reported monthly to the Quality, Safety & Patient Experience Committee (a sub-committee of the Board of Directors).

All staff receive information on Duty of Candour at induction and this is further supported by a leaflet which staff members can keep and refer back to, it is also discussed during the welcome event and all mandatory training sessions to reinforce the importance and our requirements as a hospital. There is an information section dedicated to duty of candour guidance on the Trust's intranet pages.

Risk Management System

The Trust utilises Datix as its risk management system. Work has continued during 2018/19 to ensure that it supports productive risk management processes, all evidence in the form of reports; action plans and duty of candour are an example of some of the elements stored within this system. During 2018/19 several dashboards were built based on incident data to help drive improvements and dashboards developed the previous year were used as part of risk management. This has allowed for easy analysis of themes and trends and shows at a glance how we are doing. Improved capability within Datix will remain a focus in the coming year to support our governance processes and clinical teams with the change to reporting categories from 'clinical' and 'none clinical' to 'who was affected'. Whilst positive changes have been made we recognise that further work is required to fully embed the use of triangulation of data so this will be a focus in 2019/20. Any changes and/or improvements made to our risk and quality governance arrangements will be aligned to the recommendations being implemented following the external governance review.

Risk Assessment Training

Risk assessments help keep our patients, staff and visitors safe. In 2018/19 a well evaluated training session on 'risk assessment completion' to help improve the overall quality of risk related activities was delivered to over 300 key staff.

NatSSIPSs

We have continued to develop outputs that contribute to the National Safety Standards

for Invasive Procedures (NatSSIPs) and will continue to work on the standards until fully achieved and embedded.

Comparing Incident Categories over the last three years

The information in the table below outlines the categories of patient safety incidents that we declared in 2018/19 relating to the National Serious Incident Framework. These are adverse events where either 'unintended' or 'unexpected' incidents that lead to harm for those receiving NHS healthcare and therefore are reported externally to our regulators. An open, transparent culture is important to readily identify trends and take timely, preventative action. The categories are broad subjects however each incident is reviewed against set criteria to ensure a thorough investigation, identification of root causes, contributory factors, lessons learnt & recommendations. Our falls prevention programme which is made up of a number of nationally recognised interventions to identify our patients most at risk of falling, will continue to support staff to consistently apply preventative interventions that are known to reduce these risks, this is already demonstrating improvement with a reduction of the number of reportable incidents with

	2016/17	2017/18	2018/19
Pressure Ulcers	1	2	0
HCAI	3	5	8
Falls with harm	15	31	26

Data source: Datix Risk Management System.
Definition: NHS Serious Incident Framework found at: https://improvement.nhs.uk/documents/920/serious-incidnt-framwrk.pdf

Infection Prevention and Control

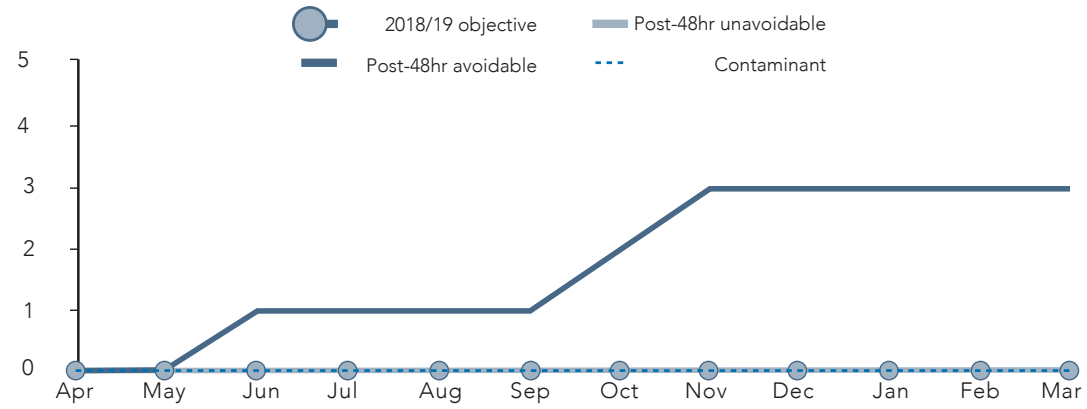
The Trust plans to maintain the intensity of both infection prevention and control and antimicrobial stewardship throughout 2019/20, sustaining our 'zero tolerance' approach to avoidable infection. Focus will be on 'going back to basics' to ensure we are implementing and embedding best practice

For 2018/19, it is disappointing that we reported:

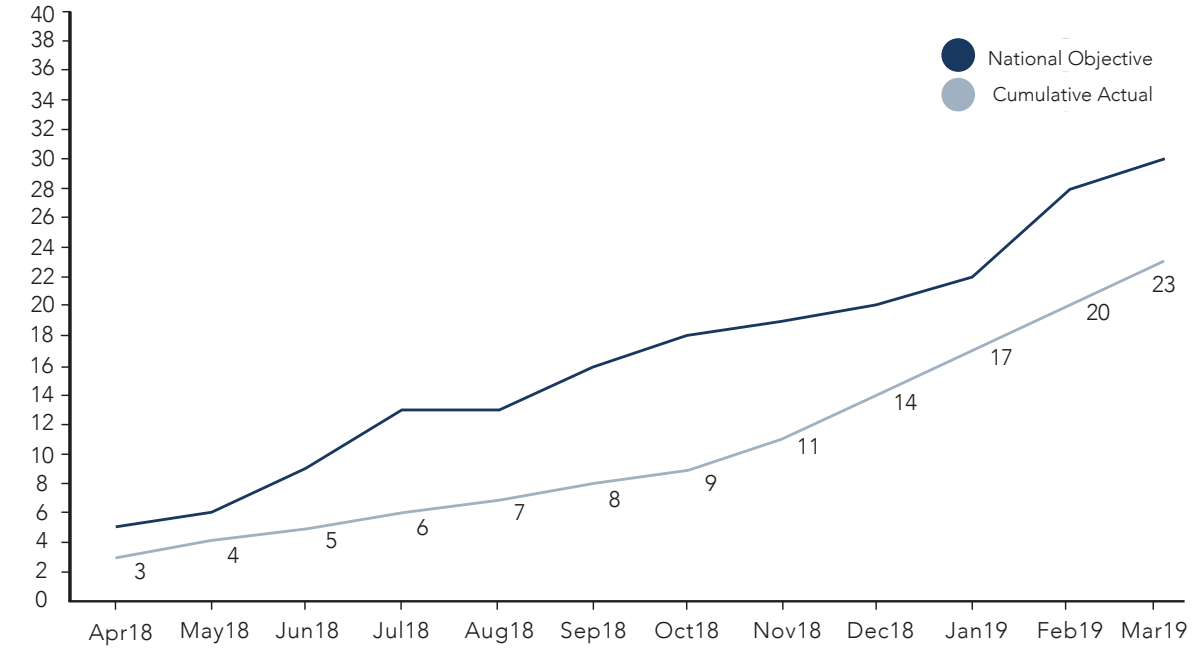
- 3 avoidable cases of MRSA bloodstream infections against an objective of zero avoidable cases of infection within year;
- 30 cases of Clostridium difficile infection, against an objective of less than 23 cases within year; and
- An overall average hand hygiene compliance of 96%, with compliance falling below the 95% threshold on two occasions.

We supported the Clinical Commissioning Group (CCG) with whole health economy improvements to reduce risks associated with Gram-negative bloodstream infections, as part of the national improvement programme for these infections.

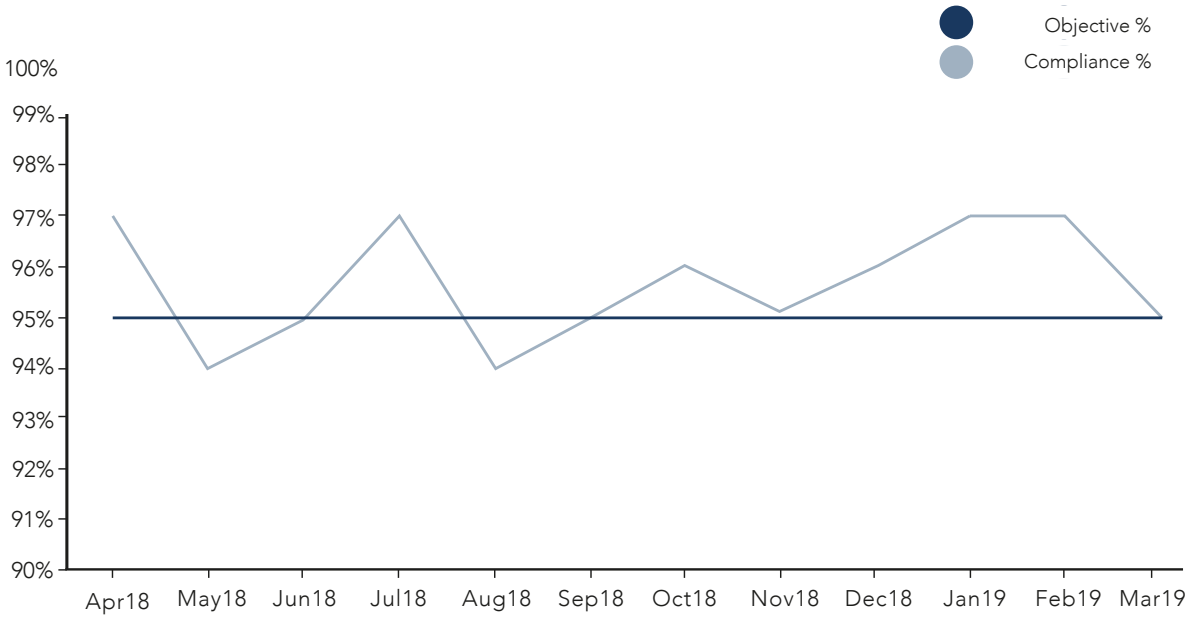
MRSA Bacteraemia 2018/19 (cumulative)



Total C.difficile cases 2018/19 (cumulative)



Hand Hygiene Compliance April 2018-March 2019



In support of this continuous improvement programme, it is essential that we have robust infection prevention and control systems and processes in place for staff, patients and visitors and that these include methods of monitoring staff compliance with risk reduction activities. Timely communication of monitoring outcomes is an important part of this process. Maintaining compliance with the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections provides the framework for all infection prevention and control activity within the organisation. Hand hygiene, having a suitable and clean environment and equipment to deliver healthcare, good antimicrobial stewardship, audit/surveillance and rolling programmes of training and education to support compliance with evidence-based infection prevention and control policy and procedure, are all central to this.

In addition, investigation for certain infections helps the organisation to identify when improvement may be required, or when things could be done differently and continuing to share this learning with our staff and partners in healthcare delivery will contribute towards reducing risks associated with infection, including activities such as improvement programmes for MRSA screening and insertion and management of invasive devices.

For 2019/20, the way in which national Clostridium difficile infection surveillance is undertaken has changed, with broader definitions for how cases of infection are assigned to acute Trusts. It is known that this will increase the number of infections assigned to acute Trusts for future surveillance, investigation and learning. This has been reflected within the Clostridium difficile infection objectives for acute Trusts for 2019/20, with the Trust's objective set at less than 36 cases of infection within year. The objective for MRSA bloodstream infections remains unchanged at zero avoidable infections within year and the quality premium for Clinical Commissioning Groups to demonstrate a reduction in Gram-negative bloodstream infections remains unchanged, although the national timescales for achieving this aim have been extended.

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

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

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

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

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

PEOG Objectives include;

- Ensuring that clear strategies are in place to demonstrate effective patient centred care (e.g. Patient Experience Strategy, Service User Involvement Strategy, Carer Involvement Strategy, Community Involvement Strategy and Equality, Diversity & Human Rights Strategy);
- Monitoring and improving service user experience based on feedback from patients, carers and relatives, using a range of internal and external sources of feedback;
- Receiving reports on progress from patient survey(s);
- Supporting clinical teams and specialties to develop improvement plans that reflect patients' feedback and respond to issues or concerns raised;
- Ensure that specialty action plans are being implemented and evidence of improvement in the service user experience is achieved;
- Sharing lessons learnt from patient feedback across the organisation; and
- Work in collaboration with partner agencies (e.g. Health Watch and PLACE) to improve patient experience, receive and note reports and monitor action plans developed in response.

During 2018/19 PEOG have strengthened assurance processes to include information in the Integrated Board Report on the number of complaints open, number open past 40 days (expected response time) and the number of cases with interest from the Parliamentary and Health Service Ombudsman (PHSO). Improvement work in relation to these measures have delivered a sustained reduction in the number of complaints open past the 40 days (consistently under target) and the number of cases with interest from the PHSO (also consistently under target). This would suggest that complainants (from patients, families or advocates) are receiving a resolution to the complaint they have raised in a timely and meaningful way.

Activities & Deliverables

Learning from patient feedback & sharing lessons learnt

There are several mechanisms available for patients and the public to share their feedback with us, these include

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

Each Division receives a report on patient experience feedback monthly, which identifies themes and trends to support improvement. Learning from complaints and concerns raised are triangulated at the Serious Incident Review panel and cascaded out to staff and teams through the mechanisms described in the risk and patient safety section on page 114.

GovRounds

GovRounds were developed and implemented in May 2018. This initiative has been designed by our Governors and is centred on gaining 'an impression' of a ward or department through the eyes of the patient and public. It uses the 15 Step methodology, which has been tailored to sit within our trust values of Safe, Kind and Effective. We have received positive feedback in relation to the rounds by both the teams of Governors undertaking them and the wards and departments that have been visited. 7 areas have been visited during this reporting period and they include:

- Ward 50 (Elderly care)
- Ward 45 (Surgery)
- Ward 54 (Escalation)
- Ward 43 (Haematology & Oncology)
- Ward 41 (Orthopaedic and Trauma)
- Ward 32 (Antenatal and Postnatal)
- Radiology Department

A report following each visit is completed by the Governors and shared with the ward or department and the relevant Divisional leads, PEOG hold a GovRound tracker so that the areas visited and any actions in response can be monitored. Teams are asked to share their experience of the round and Ward 32 staff recently feedback; "we are always up for an outside critical eye, to ensure we are providing an excellent service to our women and babies".

Patient Engagement

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

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

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

National Survey Programme

We take part in a series of annual patient surveys as required by the Care Quality Commission (CQC) and NHS England for all NHS Acute Trusts in England. During this reporting period we have received 2 published CQC reports, 1 published NHS England report and we have participated in the following surveys:

Survey	Status	Publication Date
2017 Adult Inpatient	Completed	June 2018
2017 Cancer	Completed	September 2018
2017 Maternity	Completed	November 2018
2018 Maternity	In progress	tbc
2018 Adult Inpatient	Completed	tbc
2018 Children and Young People	In progress	tbc
2018 Emergency and Urgent Care	In progress	tbc

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

2017 Adult Inpatient (published by the CQC June 2018)

This survey looked at the experiences of 72,778 people who were discharged from an NHS acute hospital in July 2017. Data was collected on 1,250 recent inpatients at the Countess of Chester Hospital NHS Foundation Trust and the questionnaire was sent out to 1,230 patients who were eligible for inclusion. Responses were received from 460 patients (reduction from 470 in 2016) in total giving a 37.4% response rate and accounts for 0.63% of the overall CQC responses reviewed.

About our respondents; key facts about the 460 inpatients who responded to the survey:

- 26% of patients were on a waiting list/ planned in advance
- 71% came in as an emergency or urgent case
- 54% had an operation or procedure during their stay
- 50% were male and 50% were female
- 4% were aged 16-39; 14% were aged 40-59; 19% were aged 60-69 and 64% were aged 70+

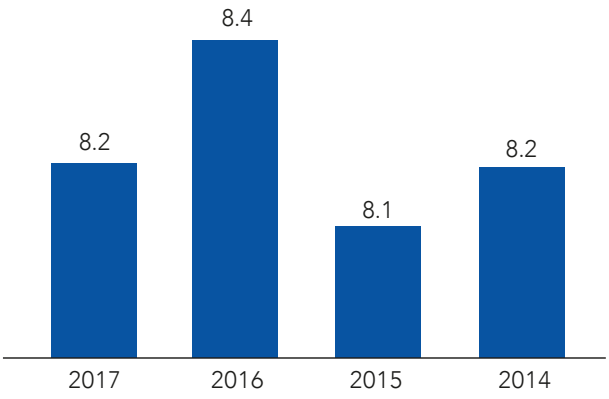
These facts are important when the CQC undertake their analysis, as Trusts may have differing profiles of people who use their services. As this can potentially affect the results because people tend to answer questions in different ways, depending on certain characteristics, the CQC apply a standardised analysis tool which enables a more accurate comparison of results from Trusts with different population profiles, making comparisons between Trusts as fair as possible.

Our results

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

The findings largely reflect the national position, showing that overall patient experience has remained consistent, with improvement noted in some areas, whilst others have shown some decline. The graph overleaf demonstrates consistency in the rating of positive patient experience since 2014 at our hospital.

Overall Experience



Patients' overall views about 'care and services' scored 4.3 which is within the expected national range, however this is a decline locally from 5.6 in 2016 and has highlighted 2 areas in particular that require attention. A rating of 1.7 was given to the question "were you ever asked to give your views on the quality of care" and 2.2 to the question "did you see, or were you given, any information explaining how to complain to the hospital about the care you received".

Question	2017	2016	2015	2014	Comment
Overall, did you feel you were treated with respect and dignity?	9.1	9.2	9.0	8.9	Consistently high
During your hospital stay were you ever asked to give your views on the quality of care?	1.7	1.8	1.6	1.9	Consistently low; requires improvement
Did you see, or were you given any information explaining how to complain to the hospital about the care you received?	2.2	2.4	2.3	3.0	Consistently low; requires improvement
Overall rating for section	*4.3*	*About the same*			

Have we improved?

Analysis from the CQC shows that the 2017 findings demonstrate gradual improvement in a number of areas. This includes patients' perceptions of:

- the quality of communication between themselves and medical professionals (doctors and nurses);
- the quality of information about operations or procedures;
- privacy when discussing their condition;
- quality of food; and
- cleanliness of their room or ward.

However, the results also indicate that responses to some questions are less positive or have not improved over time. This includes patients' perceptions of:

- noise at night from other patients;
- emotional support from staff during their hospital stay;
- information on new medications prescribed while in hospital; and
- the quality of preparation and information for leaving hospital.

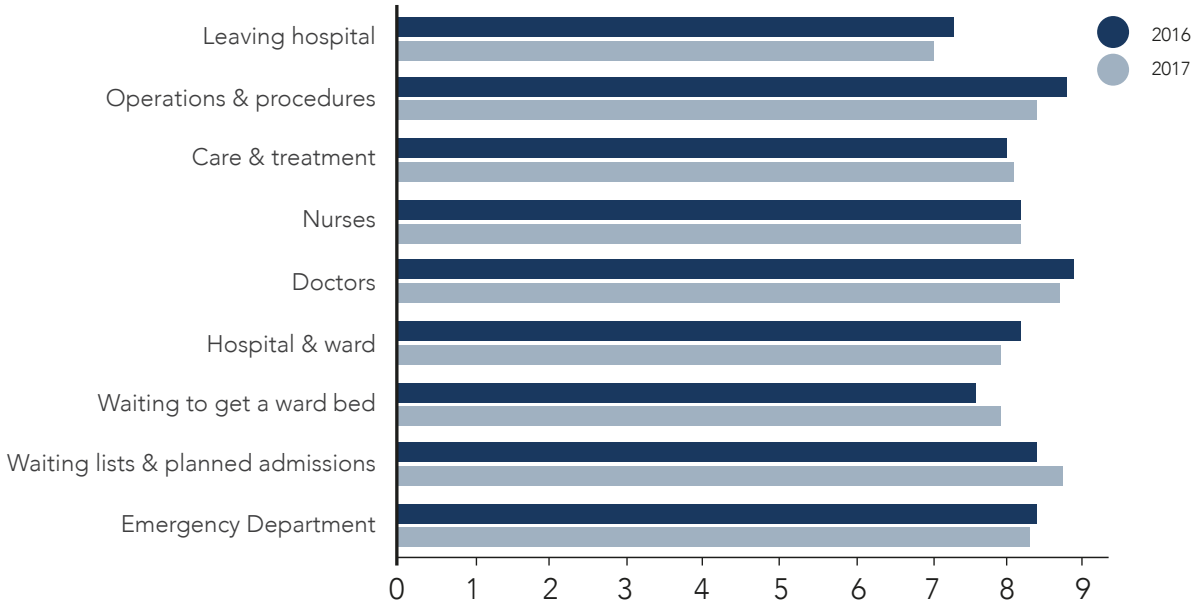
CQC comparison by survey category

S1	The Accident & Emergency Department (answered by emergency patients only)	
S2	Waiting list or planned admissions (answered by those referred to hospital)	
S3	Waiting to get to a bed on a ward	
S4	The hospital and ward	
S5	Doctors	
S6	Nurses	
S7	Your care & treatment	
S8	Operations & procedures (answered by patients who had an operation or procedure)	
S9	Leaving hospital	
S10	Overall views of care and services	
S11	Overall experience	

The black diamond represents the Trust's position and the grey area reflects that performance is within the expected range.

The findings reflect the national statistics and show that improvements have been made in the 'waiting lists & planned admissions' category across all questions (an area identified from the 2016 findings as requiring improvement), as well as the 'care and treatment' and 'waiting to get a ward bed' categories. Improvements have also been noted in other responses but these have not impacted the overall category rating as it is accompanied by a decline in experience in some associated questions. Only one area has scored 'worse' than the national comparison, this relates to being given 'enough privacy' when being examined or treated in the Emergency Department, which is likely to be a direct result of the facilities and space available for the growing demand and complexity of patients seen within this area.

Overall rating by category



2017 Cancer Patient Experience (published by NHS England in September 2018)

The National Cancer Survey has been designed to monitor national progress on cancer care; to provide information to drive local quality improvements; to assist commissioners and providers of cancer care; and to inform the work of the various charities and stakeholder groups supporting cancer patients. 321 of our patients responded to the survey giving a 60% response rate (slightly below the national rate of 63%).

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

- Above the national average in 37
- Below the national average in 7
- Within the expected range in 4

Highest scoring questions

	Question	This Trust %	Nat. average score %
14	Patient given practical advice and support in dealing with side effects of treatment	76 (59-74)	67
18	Patient found it easy to contact their CNS	94 (80-74)	86
38	Given clear written information about what should/should not do post discharge	95 (79-94)	86
55	Patient given a care plan	44 (26-44)	35

When asked 'was there anything good about your NHS cancer care?' Our patients said:

"There is no box to say the treatment was even quicker than expected"

"I cannot fault the care I received. It was all planned out and I know what to expect in the future"

"Having a designated cancer nurse"

"I was treated well with sensitivity"

"There has been excellent dialogue between Doctors treating my cancer and cardiologists"

Lowest scoring questions

	Question	This Trust %	Nat. average score %
22	Hospital staff gave information on getting financial help	51	58
36	Hospital staff definitely did everything to help control pain	78	84
42	Doctor had the right notes and other documents with them	94	96
44	Beforehand, patients had all the information needed about radiotherapy treatment	84	87
50	Patient definitely given enough support from health or social services during treatment	45	53
51	Patient definitely given enough support from health or social services after treatment	41	45
58	Taking part in cancer research discussed with patient	25	31

When asked 'was there anything that could be improved?' Our patients said:

"They need to listen to the patient more"

"I do feel that the waiting time for results of scans is too long, I do understand how busy the hospital is, very anxious awaiting appointments regarding important results"

"Having to sit and wait for your appointment - it was far too long on most days, which made me very uncomfortable!"

Following this feedback the Lead Nurse for Cancer has designed an action plan to progress improvements in relation to what our patients have fed back. This plan has been shared with the PEOG group and forms part of a wider action plan for Cheshire & Merseyside Cancer Alliance. One of the main areas for improvement being implemented across the alliance is the recovery package.

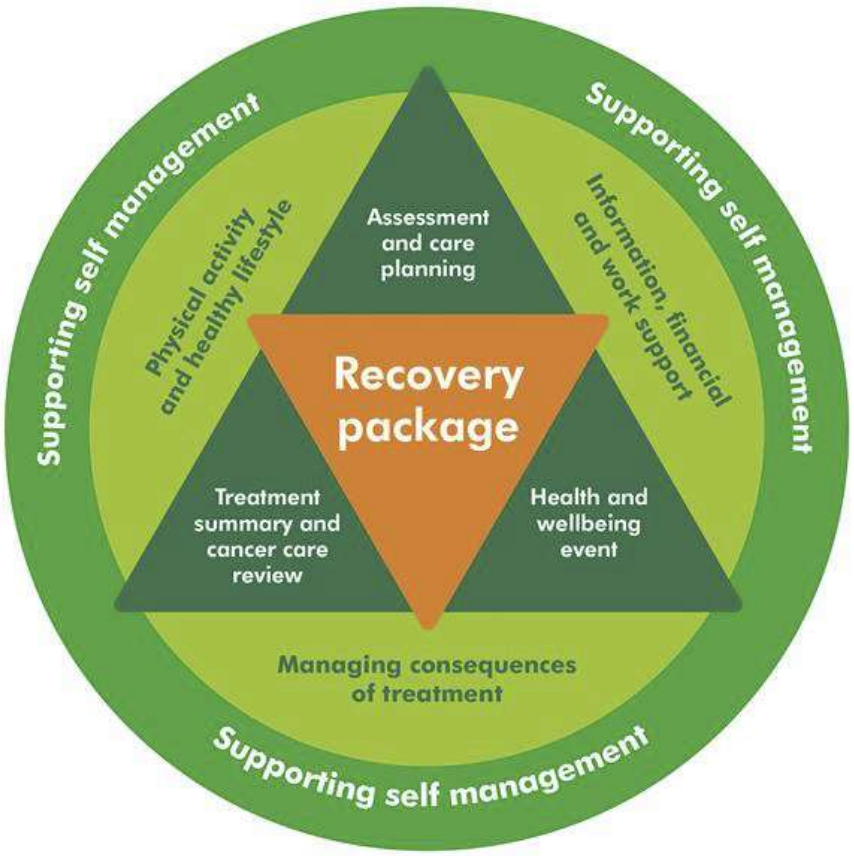
The Recovery Package

The Recovery Package is part of an initiative for improving the experience of those living with and beyond cancer (LWBC) The Cheshire and Merseyside Cancer Alliance has identified improved access to aspects of the Recovery Package (illustrated) together with the implementation of risk stratified follow up pathways as 2 areas for development within one of their named priorities of LWBC. We have a LWBC steering group to take this work forward with Cancer Nurse Specialists being instrumental in developing this aspect of patient experience.

Holistic Needs Assessment (HNA) allows a patient to highlight the most important issues to them, physical, practical, emotional, spiritual or social and this can inform the development of a care and support plan with their nurse or key worker. Currently all but one site specific team are delivering Holistic Needs Assessment (HNA) at points within the patient pathway that is appropriate for the individual patient.

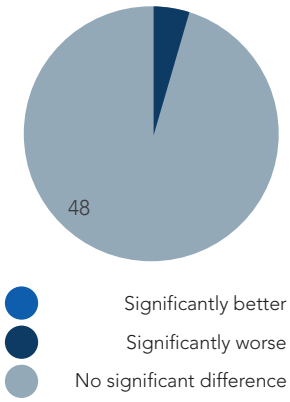
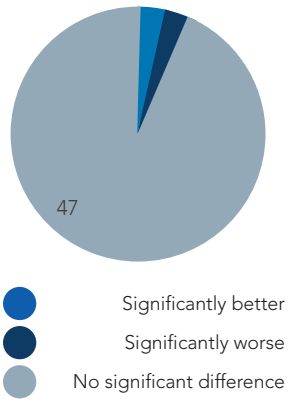
The team from the Macmillan Support and Information Centre at the Countess of Chester Hospital together with colleagues from Wirral University Trust Hospital ran a successful joint Health and Wellbeing Event in Ellesmere Port Civic Hall comprising of short talks and a stands. A further event is planned for 9th May 2019. In addition Health and Wellbeing clinics are run as part of the development of Risk Stratified Remote Surveillance being implemented for Breast and Prostate Cancer patients as part of LWBC.

There is a plan to develop Treatment Summaries further as part of the LWBC Steering group actions, together with plans to build on existing achievements.



2017 Maternity Survey (published by NHS England in November 2018)

Sample and response rates				
300	296	32%	36%	43%
Invited to complete the survey	Eligible at the end of survey	Completed the survey (94)	Average response rate for similar trusts	Your previous response rate

		Historical Comparison*	Comparisons with average*
98%	C19+ Treated with respect and dignity		
97%	C20+ Had confidence and trust in staff		
91%	C18+ Involved enough in decisions about their care		

Key Improvements since 2017

- Given a choice about where to have check-ups
- Saw the midwife as much as they wanted
- Offered a choice of where to have baby
- Given enough information about where to have baby
- Felt midwives aware of medical history

Our views

98% C19+. Treated with respect and dignity

97% C20+. Had confidence and trust in staff

91% C18+. Involved enough in decisions about their care

Our core strengths

- Given a choice about where to have check-ups
- Saw the midwife as much as they wanted
- Discharged without delay
- Found midwives asked how mother was feeling emotionally
- Felt concerns were taken seriously

Issues to address

- Found partner was able to stay with them as long as they wanted
- Felt they they were given appropriate advice and support at the start of labour
- Felt length of stay in hospital was about right
- Told to arrange a postnatal check-up of own health with GP
- Had skin to skin contact with baby shortly after birth

Picker

Achievements to celebrate

- 98% of women felt they were treated with dignity and respect
- 97% had confidence in staff
- Women felt they saw the midwife as much as they wanted

Next steps

- Review availability for partners staying overnight
- Ensure women are asked about emotional well being
- Improve skin to skin at birth

Trust's responsiveness to Staff Feedback

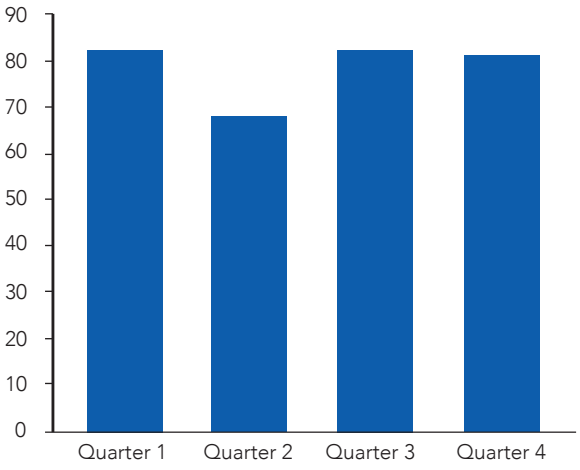
We are committed to listening to the views of our staff as well as the patients and public from across our community. Staff have a first-hand experience of what our services are like and valuable information relating to the care and treatment provided by the hospital can be sort by exploring the views of our people working within the organisation. A simple way to gather intelligence in relation to this, is the staff Friends & Family test, this is a short quarterly survey were staff are asked if they would recommend our hospital to their family and friends for care or treatment. The survey is sent out every quarter and the feedback for 2018/19 can be found in the graph opposite.

This gives a mean average of 78% of staff who responded and said they were either 'likely' or 'extremely likely' to recommend our hospital to friends and family for care or treatment. For 3 of the reporting quarters the finding demonstrate a high percentage of staff making this recommendation (greater than 80%) however, in quarter 2 there was a lower than expected percentage, it is not clear why this may have happened but it correlates with a significant change in Executive Leadership which may have caused feeling of uncertainty amongst workers. This position has now stabilised and recommendations have returned to consistently greater than 80%.

During the 2018/19 reporting period we undertook a national staff survey to gain feedback from our workforce on a range

Social Media Infographic

% of staff recommending our Hospital

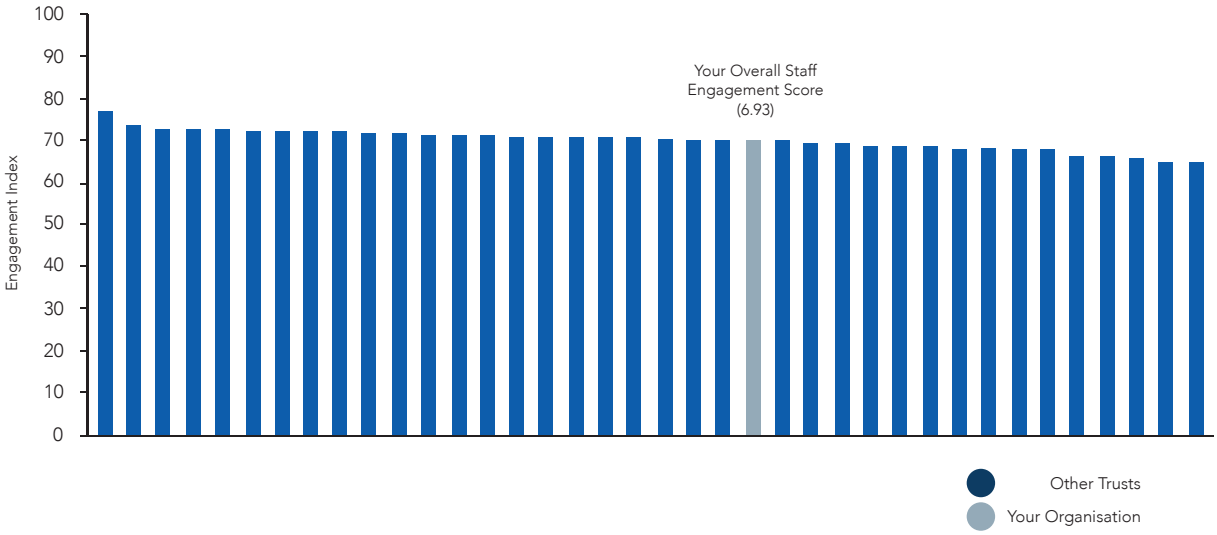


of different measures. We asked a random sample of our staff to participate (1,250 of our people), 448 questionnaires were returned giving a response rate of 35.8%. This was a reduction from the previous year (40%). When staff were asked if they would recommend our hospital as a place to work, 19% strongly agreed and 44% agreed (total 63%). This was a slight increase from the 2017 survey which reported 61% across those categories.

National Staff 2018		63%

Staff Engagement

Measured across 3 themes; advocacy, motivation and involvement, our hospital score for this was 6.93 (out of a maximum of 10). This was a slight improvement over all but remains lower than other acute provider trusts as demonstrated in the graph below.



When reviewing our feedback it is important to look at the questions in which we score well, this helps us to replicate and spread this consistently across all staff groups and in all wards and departments.

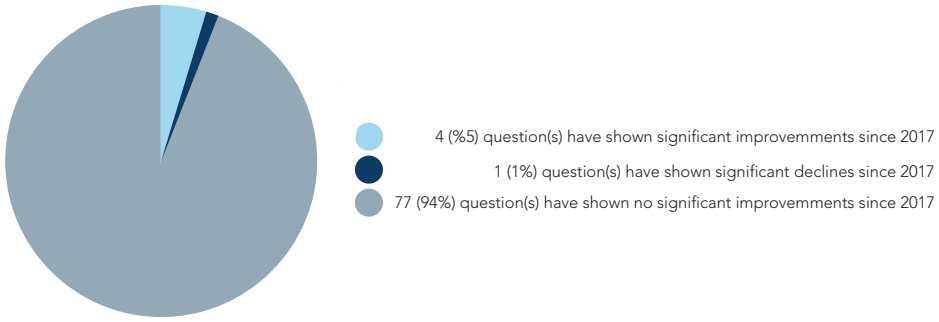
Top Ten Scores			
1	12b	Experienced physical violence at work from manager in the last 12 months	0%
2	12c	Experienced physical violence at work from other colleagues in the last 12 months	2%
3	15a	Experienced discrimination at work from patients/service users, their relatives or other members of the public in the last 12 months	4%
4	16c	The last time you saw an error, near miss of incident that could have hurt staff or patients/service users, did you or a colleague report it?	96%
5	18a	If you were concerned about unsafe clinical practice, would you know how to report it?	94%
6	3b	I am trusted to do my job	94%
7	15b	Experienced discrimination at work from a manger/team leader or other colleagues in the last 12 months	8%
8	3a	I always know what my work responsibilities are	91%
9	19g	Did you manager support you to receive this training, learning or development?	91%
10	11a	Does your organisation take positive action on health and well-being?	90%

It is also important to look at the areas we need to improve, these may be identified because they have the lowest scores reported, or it can be as they have significantly changed since our previous survey feedback.

Bottom Ten Scores			
1	11g	Have you put yourself under pressure to come to work?	95%
2	4g	There are enough staff for me to do my job properly	25%
3	9d	Senior managers act of staff feedback	27%
4	9c	Senior managers here try to involve staff in important decisions	31%
5	5g	(How satisfied are you) My level of pay	33%
6	9b	Communication between senior management and staff is effective	40%
7	22c	Feedback from patients/service users is used to make informed decisions within my directorate/ department	42%
8	5f	(How satisfied are you with) The extent to which my organisation values my work	44%
9	11d	In the last three months have you ever come to work despite not feeling well enough to perform your duties?	56%
10	22b	I receive regular updates on patient/service user experience feedback in my directorate/department (e.g. via line managers or communication teams)	46%

Comparisons to 2017 Survey

The information below shows that we have significantly improved on 4 questions within the survey but significantly declined in 1.

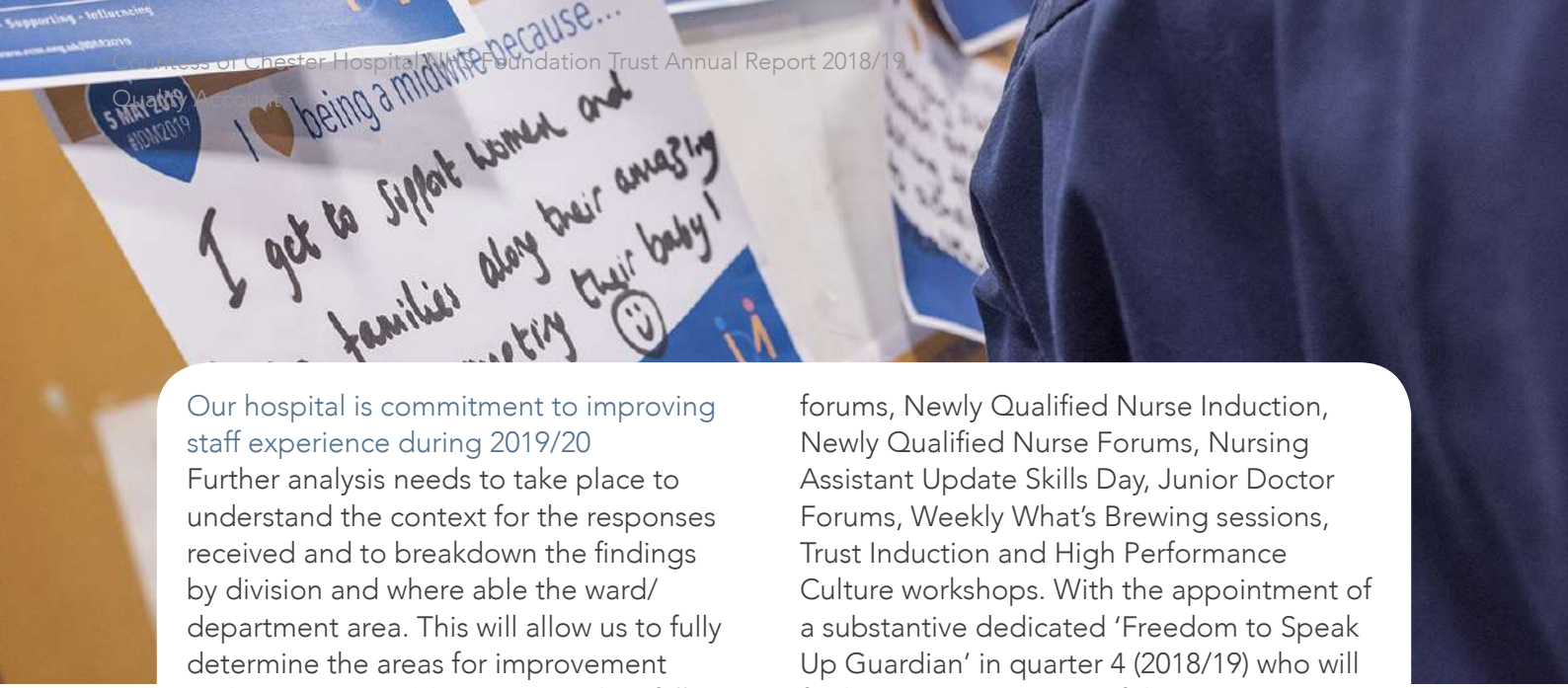


Things we have significantly improved on since last year

	Question	2017	2018	Difference
2a	I look forward to going to work	55%	60%	+5.80%
5g	(How satisfied are you) My level of pay	28%	33%	+4.96%
12b	Experienced physical violence at work from managers in the last 12 months	1%	0%	-0.63%
12d	The last time you experienced physical violence at work,, did you or a colleague report it?	65%	78%	+12.79%

Things we have significantly declined on since last year

	Question	2017	2018	Difference
18a	If you were concerned about unsafe clinical practice, would you know how to report it?	97%	94%	-2.74%



Our hospital is commitment to improving staff experience during 2019/20

Further analysis needs to take place to understand the context for the responses received and to breakdown the findings by division and where able the ward/department area. This will allow us to fully determine the areas for improvement and assist us in addressing any shortfalls as quickly as possible, this is particularly important for the measures which rank lower than expected and/or have worsened from the previous score. The actions identified will be monitored through the People & Organisational Development Committee, a subcommittee of the Board of Directors. Where the analysis identifies themes and trends by professional group, these actions will be designed and implemented through the Nursing & Midwifery Workforce Board and the Medical Workforce Board both of which report directly to the People & Organisational Development Committee. We will be involving our Staff Governors and our Staff-side and Union partners to design actions that will deliver sustainable improvements and ones that are supported by our staff and focus on their priorities.

Freedom to Speak Up (FTSU)

The continued focus on the Freedom to Speak Up agenda supports and compliments the work already underway within our hospital in ensuring we have a culture that is open and transparent to reflect our values of being Safe, Kind and Effective. The engagement of our teams is very important and the current mechanism for staff to raise a concern/s under Freedom to Speak Up is through a FTSU Guardian, confidential telephone line and/or a designated email address.

FTSU continues to be a key topic for discussion with members of staff at every opportunity, for example on executive walkabouts, clinical area reviews, student forums, Newly Qualified Nurse Induction, Newly Qualified Nurse Forums, Nursing Assistant Update Skills Day, Junior Doctor Forums, Weekly What's Brewing sessions, Trust Induction and High Performance Culture workshops. With the appointment of a substantive dedicated 'Freedom to Speak Up Guardian' in quarter 4 (2018/19) who will further raise awareness of this important agenda, we would expect to see an increase in cases going forward which can only be seen as positive. The appointment of the new dedicated Guardian will culminate in the revision of the current model of how Freedom to Speak Up is managed across the organisation.

It is important to note that whilst a review of the Trust's policy is being undertaken in the context of the national agenda, the current Speak Out Safety Policy continues to remain available and visible to staff. A national Policy template is now available including key sections to include which the Trust is utilising.

We have dealt with a number of cases across different staff groups, all of which have been managed on an individual basis, ensuring regular communication continue with the individual/s, with outcomes also being shared. We ensure that the individual does not suffer any detriment when they raise a concern. Based on some of the work we have undertaken in the past year, it is encouraging to note that the results of our staff survey results on raising concerns have improved against the following two questions:

- I would feel secure raising concerns about unsafe clinical practice: 69% against an acute sector average of 69.2%. This is an improvement on the 2017 (67.3%) survey of 1.7%; and
- I would feel secure raising concerns about unsafe clinical practice: 69% which is an improvement of 1.7% on 2017 (67.3%). This is against a sector average of 69.2%.

Quality of Care Indicators

3.7 An overview of the quality of care offered based on 2018/19 performance

Delivering safe services by reducing clinical variation through the 'Model Ward' programme

We set out to make improvements to both care and operational processes through the 'Model Ward' programme, focusing on getting it right first time for all our patients to ensure the right care and treatment is started at the right time in the patient's journey.

Our measures of success included;

- Increasing the number of patient who are appropriately screened for sepsis
- Increasing in the number of patients with sepsis who are given antibiotics within 1 hour of diagnosis
- Reducing the number of medicine administration errors in the Model Ward areas
- Increasing the compliance against 'Fall Prevention Measures'
- Reducing in the number of falls that result in harm to patients in our care

Sepsis

A large programme of work has been undertaken during 2018/19 to improve compliance against the national 'screening' and 'timely treatment' measures for sepsis. These measures are important to track and maintain as they provide an indication of how well we recognise and respond to sepsis. This was an area we chose to focus on as we recognised our compliance rates against these measures were lower than expected and below the national comparatives. This could imply that patients with sepsis at our hospital were not being recognised early and as a result immediate treatment was being delayed. The programme of work needed was designed following a workshop held in September 2017 which brought together stakeholders from across the Trust, Commissioners, PHE & public representatives. As a result the following areas were focused on (and will continue to be during 2019/20) as part of the improvement plan:

- CQUIN data sampling & collection;
- Pathway development;
- Gap analysis against NICE & NCEPOD Standards;
- Developing & implementing an Education & Training Strategy; and
- Exploring innovative products & models to support improvements.

Work has progressed during 2018/19 against all key focus areas; however this has been at a slower pace than initially anticipated. This has been largely a result of the majority of improvement actions being dependent on the implementation of the standard pathways which was delayed until quarter 4 due to the implementation of the NEWS2 track and trigger tool in quarter 3.

What we have achieved:

- Standardised Sepsis pathways have been launched in all adult inpatient areas;
- Nurse training resource/competency pack designed and rolled out;
- Education Strategy implemented (Level 1 and 2 training underway, Level 3 training to be launched using the UK Sepsis Trust train the trainer package in 2019/20).
- Sepsis response kits to be made available to all areas (unique design allows for the response kit to act as a teaching aid and is focal point for sepsis awareness training);

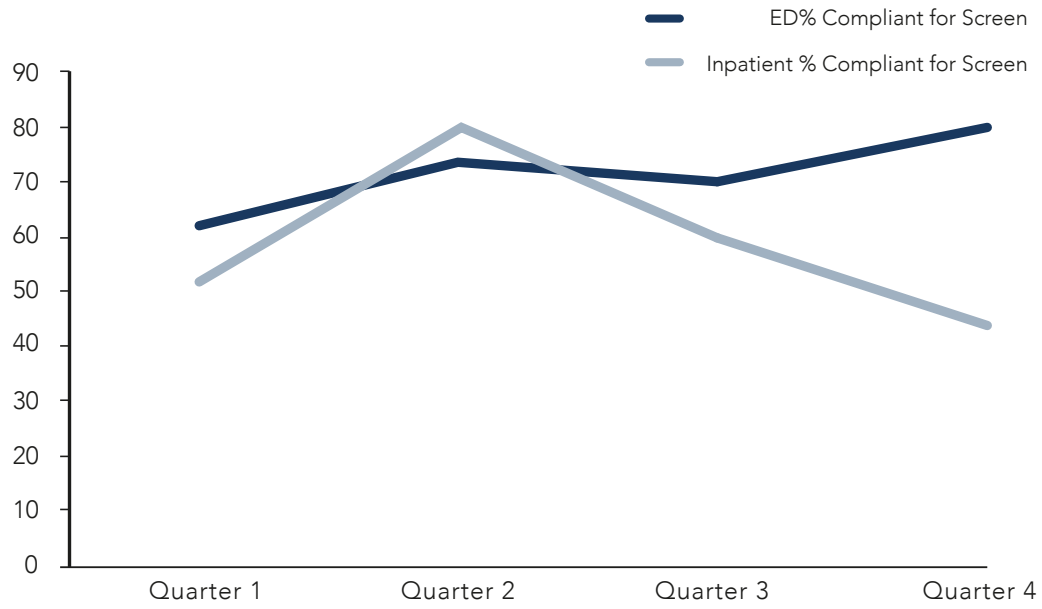
- Sepsis awareness provided on induction for registered nurses and nursing assistants;
- Sepsis awareness provided on Skills Update for Nurses and contained within ALERT course; and
- Sepsis champions identified in adult inpatient areas to support compliance, training and to identify staff who wish to undertake extended roles such as cannulation and venepuncture to aid process of sepsis.

As these improvements have not been implemented until quarter 4 of the reporting period, we have not been able to demonstrate an overall improvement against the following measures and there remains inconsistency depending on patient location:

- Increasing the number of patient who are appropriately screened for sepsis; and
- Increasing the number of patients with sepsis who are given antibiotics within 1 hour of diagnosis.

Increasing the number of patients who are appropriately screened for sepsis

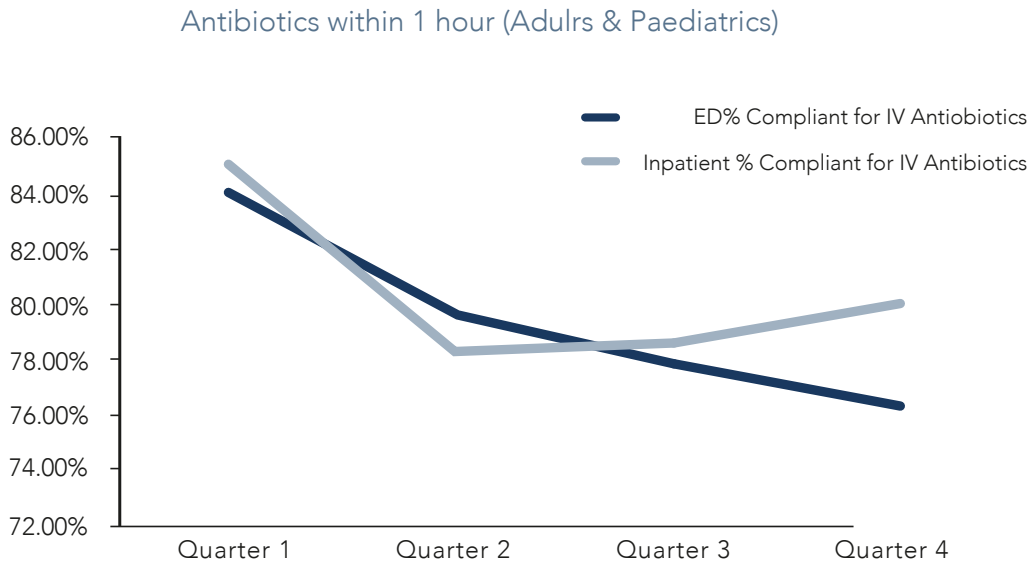
Antibiotics within 1 hour (Adults & Paediatrics)



Data Source: Monthly National Situation Report (unify) Definitions can be found at https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2015/10/mnth-Sitreps-def-dtoc-v1.09.pdf

Screening compliance in the Emergency Department has improved during the reporting period from 61.9% to 79.6% but remains below the national standard. In inpatient areas there has been no improvement seen overall to screening compliance which correlates with the pathway not being rolled out in the adult inpatient wards and departments until quarter 4 of the reporting period.

Increasing the number of patients with sepsis who are given antibiotics within 1 hour of diagnosis



Data Source: Monthly National Situation Report (unify) Definitions can be found at https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2015/10/mnth-Sitreps-def-dtoc-v1.09.pdf

Across both the Emergency Department and the inpatient areas there has been a reduction in compliance to the timely treatment of sepsis. This may be a result of the workload pressures currently seen across the hospital, with increasing demand on services and the complexity and dependency of the patients in our care.

It is important when considering these measures to also review the outcomes and survival rates for patients with sepsis as these also give details on the quality of sepsis care and treatment provided at our hospital. Data analysed by the National NHSi Suspicion of Sepsis Dashboard demonstrates that the Countess of Chester Hospital NHS Foundation Trust has a 17.16% 30 day re-admission rate (better than national comparator of 19.52%) and a 91.55% survival rate (in line with national comparator 92.1%).

However, despite this we recognise there is much work to do and that by improving our screening and implementation of early interventions we will improve the outcomes and survival for our population further. The Medical Director and Director of Nursing & Quality will be providing close oversight of these measures in order to achieve improvements.

Medicine administration

Protected medicine rounds were introduced to the four model wards in June 2018 with the primary goal to reduce administration errors in these clinical areas as well as reducing medication delays and releasing nursing time for patient care.

What did we achieve?

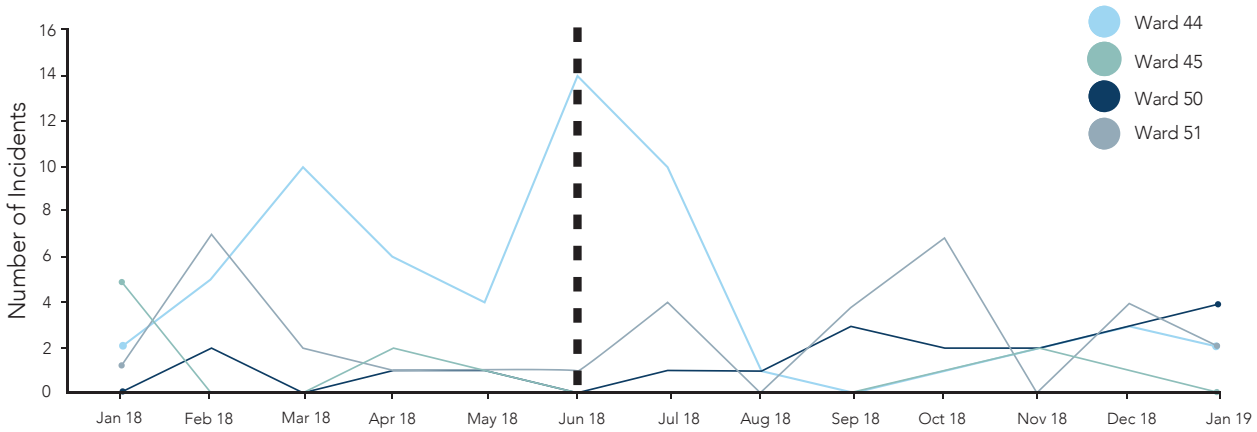
Protected medicine rounds have been implemented across two care of the elderly and two surgical wards. With the use of red tabards, visual ward signs and the ward clerks' support for filtering messages to reduce interruptions.

Reducing the number of medicine administration errors in the Model Ward areas

Reviewing the pre and post implementation data, from January to May 2018 there were 13 incidents due to administration errors compared to an increase to 17 incidents from June to October 2018. The main causative factor for this increase is likely workforce issues with ongoing gaps in the registered nursing establishment. This has been further compounded by an increase in the number of care hours needed to support the complexity and acuity of patients within these wards. As such, it has resulted in protected medicine rounds not being carried out consistently.

The below graph shows the overall number of medication errors throughout 2018. Since June, there appears to be an overall downward trend in medication errors. This has correlated with improved staffing levels as gaps have been addressed through the wider nursing recruitment and retention programme and ward establishment review. Although this project has not delivered the full benefits intended, it has proof of concept and work will continue through 2019/20 to implement and spread this learning.

Number of Medication Incidents - January 2018 to January 2019



Data Source: Datix Risk Management System

Falls Prevention Programme

We set out to implement a falls prevention programme, this involved implementing a number of nationally recognised interventions to identify patients at risk and support staff to consistently applying a number of interventions known to reduce the risk of a fall. Whilst we have reduced the number of falls, we will build upon the work already undertaken to further reduce the number of falls reported with moderate or above harm.

What did we achieve?

Increasing the compliance against 'Fall Prevention Measures'

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

Ensuring patients call bells are within reach and ensuring patients have appropriate footwear whilst in hospital

A review of the pre-existing care and comfort chart has been completed and the routine completion of this now ensures that standard fall's prevention measures are met on a 2 hourly basis for all patients. Once standard falls prevention measures are met as routine, when completing the new fall's risk assessment , staff can begin to focus on what additional measures are required to reduce the risk further. Identifying at risk patients quickly is essential and the guidance supplied by the Royal College of Physicians and NICE has been adopted into our new comfort check chart.

Undertaking a cognitive assessment (to identify confusion)

The falls lead has been working closely with the dementia specialist team to identify improvements to the admission and assessment process in relation to cognitive assessment. It is planned that a new assessment screen will include clearer guidance to staff on when to initiate cognitive screening or when it may be suitable to request an assessment from a expert healthcare professional. Changes in cognition, in the absence of dementia, can contribute to postural instability.

Identifying patients at risk of delirium

The dementia specialist team have reviewed and updated the delirium pathway allowing for staff to quickly consider if a person is presenting with acute confusion. The prevention, recognition and treatment of delirium is now in line with best practice guidelines and staff can access, through the policy, a list of do's and don'ts to help manage the person in the safest possible way. Ensuring a falls risk assessment is completed forms part of the same pathway.

Undertaking a simple visual assessment (non-diagnostic)

Ward areas have been provided with distance and near vision non-diagnostic checking tool to allow staff to quickly identify concerns with a patients eye sight. The tool is from the Royal College of Physicians (RCP) and enables ward staff to quickly assess a patient's eyesight in order to help prevent them falling or tripping whilst in hospital.

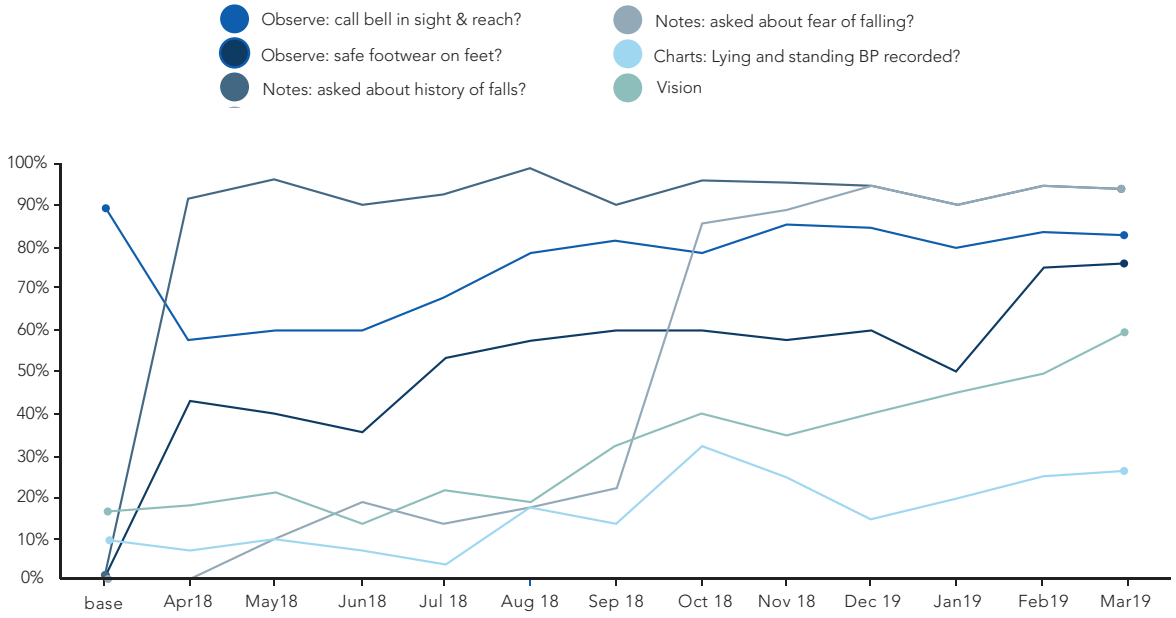
Ensuring a lying and standing blood pressure is taken

A drop in blood pressure (BP) on standing (orthostatic hypotension) is a common occurrence in acutely unwell hospitalised patients and is a risk factor for falls. All ward areas are now able to input the results from a lying and standing blood pressure into the falls risk assessment. Staff can now also record findings onto the newly revised adult inpatient observation chart.

Ensuring patient medications are reviewed

Inpatients taking medicines known to contribute to falls, medication review can play an important part in falls prevention. The aim of the review should be to modify or withdraw the drug, if this is not possible, close monitoring is required.

Ensuring Patient Medications are reviewed



Data Source: Meditech (Electronic Patient Record). Definition: Royal College of Physicians FallSafe Bundle

There has been an increasing trend in improved compliance to all standard and enhanced falls prevention measures during the reporting period.

Reducing in the number of falls that result in harm to patients in our care

	All Falls	Bed Days	Falls per 1000 Bed Days
April 2018	93	16,130	5.76
May 2018	93	16,498	5.64
June 2018	105	15,625	6.72
July 2018	89	16,108	5.52
August 2018	86	15,649	5.50
September 2018	83	15,887	5.22
October 2018	113	16,747	6.74
November 2018	104	16,275	6.2
December 2018	89	16,286	5.46
January 2019	100	17,372	5.76
February 2019	81	15,569	5.20
March 2019	106	17,752	5.97

Data Source: Datix Risk Management System
Definitions: NHS Serious Incident Framework found at: https://improvement.nhs.uk/documents/920/serious-incidnt-framwrk.pdf

In 2015/16 our mean falls rate per 1,000 bed days was 7.7 above the mean published for England and Wales (6.6). Following implementation of the falls prevention programme by the end of quarter 4 our overall falls rate has reduced to 5.7. This is a 35% reduction and is in spite of the increase in bed day. Our average number of falls resulting in moderate/severe harm is 0.19 per 1,000 bed days; this is in line with national comparatives. Focus will continue on this programme during 2019/20, with the intention to demonstrate a further reduction in falls and sustained compliance to falls prevention measures.

Delivering kind and compassionate care by building on our high performance culture

We set out to build on the work undertaken in the previous reporting period by creating a culture within the Countess that fosters the values and behaviours that patients, the public and staff expect and one where staff come to work, to do their work and improve their work. With a focus on ensuring we get the right number of nursing staff, with the right skills, to the right patient at the right time.

Our measure of success included;

- Increasing the number of staff trained in High Performance Culture Framework
  - 140 staff trained in the 2 day High Performance workshop during 2018/19
  - 630 staff trained in the ½ day Trust Behavioural Standards session during 2018/19
- Reducing the number of concerns raised by patients in relation to staff attitude and behaviour (using the Friends & Family feedback)
- Increasing the number of staff trained in Quality Improvement tools and techniques
  - 30 staff trained in Quality Improvement Basics
  - 8 staff trained in Quality Improvement FUNdamentals & have delivered a quality improvement project
  - 15 F1/F2 (junior doctors) trained in Quality Improvement tools and techniques & have contributed to a quality improvement project
- Increasing the number of Quality Improvement projects completed
- Closing the gap between the actual nursing hours provided and the hours needed (using Care Hours Per Patient Day data)

High Performance Culture

Feedback from our patients is important to us, along with other safety, quality and outcome measures the 'lived experience' of our patients and visitors is used to direct improvements in clinical practice, service delivery and patient pathways. We gather and make sense of a range of different patient experiences and patients tell us at times that their experience has been affected by the way in which staff have spoken to them or made them feel. We have focused on improving this for our patients by delivering 'high performance culture' workshops to all our staff and sharing the experiences of patients and their families.

What we achieved?

Increasing the number of staff trained in High Performance Culture Framework
We set out to train 140 staff in the 2 day High Performance workshop during 2018/19; we exceeded this target and trained 158 in total (18 more than expected).

Professional Group	Number Trained
Add Prof Scientific and Technic	7
Additional Clinical Services	1
Administrative and Clerical	38
Allied Health Professionals	15
Estates and Ancillary	7
Healthcare Scientists	13
Medical and Dental	12
Nursing and Midwifery Registered	65
Total	*158*

We set out to train 630 staff in the ½ day Trust Behavioural Standards session during 2018/19; we exceeded this target and trained 1,151 in total (521 more than expected).

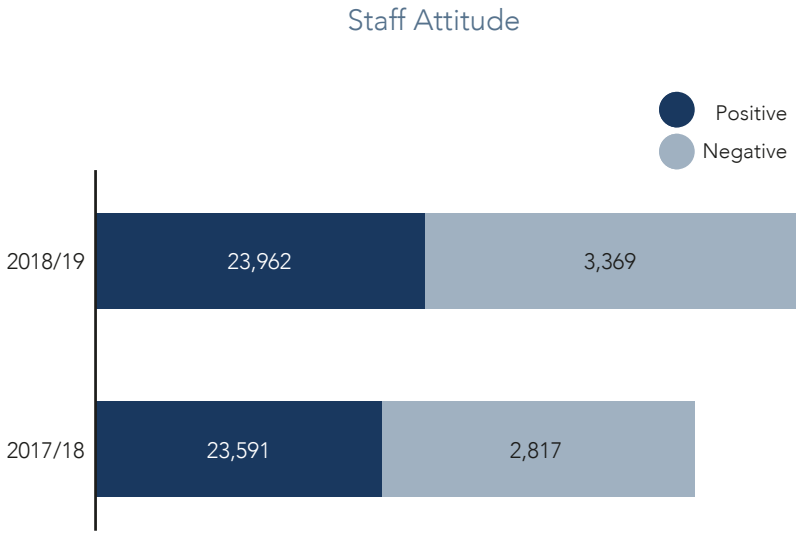
Professional Group	Number Trained
Add Prof Scientific and Technic	87
Additional Clinical Services	262
Administrative and Clerical	285
Allied Health Professionals	73
Estates and Ancillary	152
Healthcare Scientists	43
Medical and Dental	23
Nursing and Midwifery Registered	226
Total	*1,151*

Data Source: ESP (Electronic Staff Record)

What we have done 2018/19	What we will do 2019/20
Roll out of three hour Trust Behavioural Standards (TBS) Workshops (aimed at non-managers/leaders	• Review TBS session stats, content and evaluation • Redesign TBS Workshop as appropriate • Introduction of full TBS content onto Welcome Event for all new starters • Continuation of delivery of redesigned workshop
Continuation of delivery of 2 day High Performance Culture Workshops (HPW) (Cohort 3)	• Review HPW session stats, content and evaluation • Redesign content of HPW as appropriate with a focus on tangible outcomes in the workplace
Creation of a multi-disciplinary Trust wide High Performance Culture Barometer Group	• Schedule meetings for 2019 on a bi-monthly basis • Utilise forum for ongoing discussion regarding staff survey results and targets
Redesign and branding of existing Trust Behavioural Standards	• Introduction of icons and development of a design toolkit to further embed the standards visually • Create stronger intranet presence for the Trust Behavioural Standards
Development and filming of TBS Video Podcast as an additional learning route/aid	• Finalise podcast as a learning tool to be viewed as six standalone films or one continual film • Launch podcast and monitor uptake
Creation of Countess GEMs (Going the Extra Mile) recognition scheme in response to staff feedback regarding regular recognition	• Continuation of monthly Countess GEMs activity • Development of Thank You Wall
Embedding High Performance Culture with leaders and managers	• Development and roll out of Phase 1 of new Trust Leadership Development Framework • Development of intranet page with supporting resources

Reducing the number of concerns raised by patients in relation to staff attitude and behaviour (using the Friends & Family feedback)

When comparing the data from the Friends & Family Test with the previous year's data it is disappointing to see that we have had a 3% increase in the number of negative comments received about staff attitude, as shown the graph overleaf.



Data source: Friends and Family Test
Definitions: Friends and Family Test found at https://www.england.nhs.uk/fft/friends-and-family-test-data/

However, formal complaints relating to staff attitude remain stable. Staff attitude was the 4th most used theme in both the last two financial years. Nationally this theme is consistently ranked in the top three most complained about themes. Whilst our position is better than the national average we have still seen a slight increase in the number of formal complaints raised against staff attitude meaning that as an organisation we need to place more focus on staff attitude during 2019/20.The ground work completed through the High Performance Workshop has laid the foundations for future improvement. We recognise the importance of getting this right for our patients and work during 2019/20 aims to improve the perception of staff attitude.

Theme	2016/17	2017/18	2018/19
Attitude	31	45	43
Percentage of the number of complaints received	14.5	20.5	21

Data Source: Datix Risk Management System

Quality Improvement

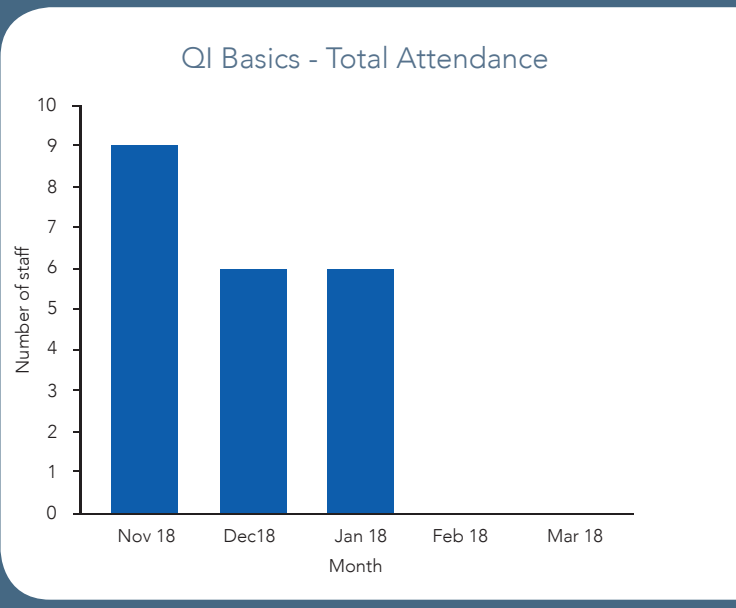
Improving the care and treatment delivered to patients is the responsibility of all staff at every level in the hospital. Often the best ideas for improvement and those with the greatest impact for patients are from the staff on the ground delivering services. During 2018/19 we have focused on strengthening our 'Quality Improvement Strategy' to build a network of quality champions to take forward improvements in operational processes, care delivery and service development. These projects have been chosen by the staff and are relevant to their areas of work and expertise. They have used quality improvement tools and techniques and outlined clear, measurable aims and outcomes to demonstrate the benefits to patients, families and the wider public.

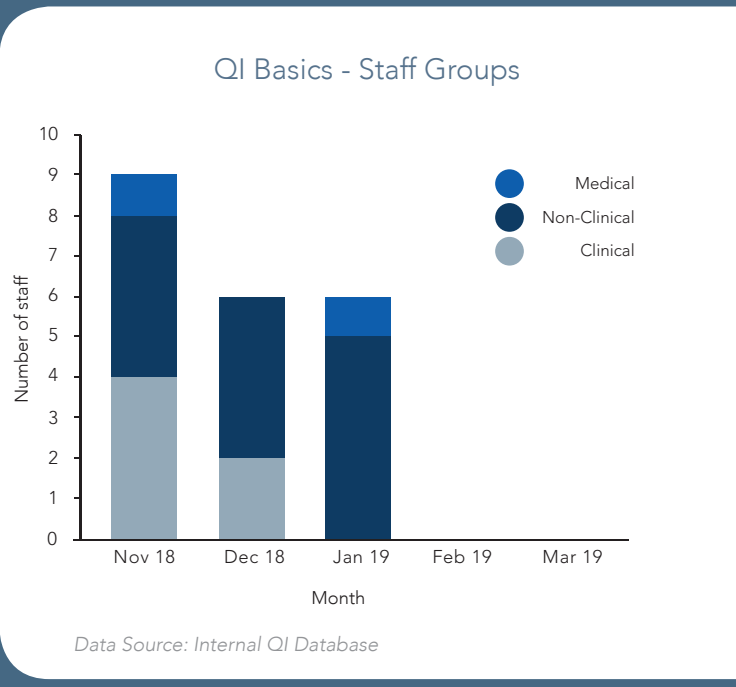
What we achieved?

Increasing the number of staff trained in Quality Improvement (QI) tools and techniques

The Basics day course is designed to provide individuals with an introduction to the basic concepts, tools and techniques of quality improvement which can be transferred back into the place of work. This entry level training covers a broad spectrum of foundation knowledge, from introduction to the concepts of quality improvement and the Model for Improvement, to understanding the application of the tools covered. The aim of the day is to build knowledge, insight, enthusiasm, reassurance and confidence amongst the staff to support the introduction and spread of systematic Quality Improvement using proven Improvement Science methodology.

We set ourselves a target to train 30 members of staff from across the Trust within 2018/19. We unfortunately did not meet this target, despite efforts to encourage staff to attend. The QI team have offered monthly training for up to 15 people but often would have to cancel due to low booking numbers.

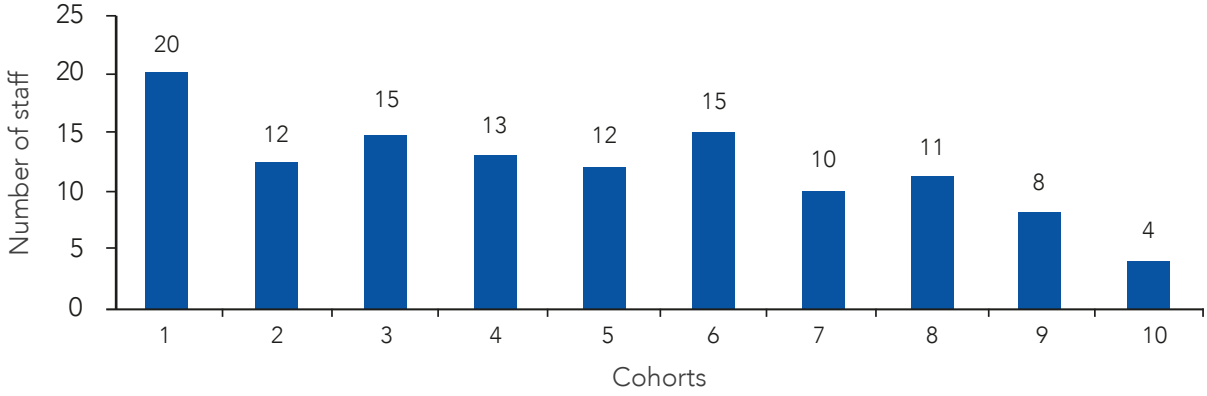




Data Source: Internal QI Database

"QI Fundamentals" also known as "Introduction to Improvement" is a 6 ½ day training programme that has been delivered at the Countess of Chester Hospital since 2014. In 2018/19 we set out to train 8 staff on this programme and exceeded the target, we trained a total of 10 staff (2 more than expected) in cohorts 9 and 10. The staff members, from a wide range of departments if successfully submit a project will become "Quality Champions" for the organisation. Currently, no projects have been submitted following completion of QI Fundamentals in 2018/19, as the candidates have up to twelve months to complete and submit. The Quality Improvement team have regular sessions with the candidates to offer support and coaching with their projects, and gain assurance they are well underway. Although we exceeded our target our numbers of attendees are decreasing. It will be an aim within the QI Strategy to increase the number of staff who are QI trained.

Introduction to Improvement
Total Registered (Attended <50% & >50% sessions 2014-19)



Data Source: Internal QI Database

All F1/F2 (Junior Doctors) are expected to participate in a Quality Improvement Project during their time with us. It is now mandatory that all F2's complete an improvement project as part of their Annual Review of Competency Progression (ARCP). QI training is delivered as part of the Medical Education programme by the Service Improvement Team using approaches embraced by multiple agencies including NHS Improvement, Advancing Quality Alliance and the Royal College of Physicians. Additional to QI training sessions, Doctors are able to access QI clinics for one to one coaching and practical support.

We set out to train 15 F1/F2 doctors in Quality Improvement tools and techniques; we exceeded this target and the following projects have been implemented as a result:

- Skin Lesion Op Note
- Simulated On-call Teaching
- EAU Admission checklist
- Hydration in the end of life patient
- Laxative Prescribing with Oramorph
- Implementing an Acute Pancreatitis Proforma
- Cardiac Monitoring "Can this patients have a monitored bed? "
- Review of patients with newly diagnosed depression and adherence to QOF

standard follow-up and review
- Improving the Quality and Efficiency of Internal Phone to Phone Communication in the Clinical Setting
- "Duty Doctor" Northgate Medical Practice

Working to improve the learning experience in 2019/20 there will be 3 half day teaching sessions and the continued QI clinics sessions.

We set out to increase the number of Quality Improvement projects completed, we achieved this as we had 6 poster projects submitted following the successful completion of the I2I Programme in 2017/18 and for 2018/19 candidates have up 12 months to submit following attendance on the course (10 expected submissions).

Right number of nursing staff, with the right skills, to the right patient at the right time

To keep our patient safe and well cared for whilst in hospital a flexible approach to nurse staffing is needed to be able to move staff to support the actual acuity (level of sickness) and dependency (level of care needs) of patients. As there is no single nurse to patient ratio that can be applied across all wards and departments, largely due to the varying types of inpatient areas, the complexity of patient needs and the geographical layout of wards & departments, it is important to be able to assess the nursing and care needs of individual patients.

At the Countess we use a tool called 'SafeCare' which allows staff to measure patients' needs 3 times a day, SafeCare links to the electronic staff roster and provides visibility and transparency of nurse staffing and patient acuity across the Trust. Senior nursing teams are then able to identify if there is a shortage or excess of nursing hours in real-time and can use this information alongside professional judgement to redeploy staff accordingly. Traditional methodologies for assessing the number of staff needed are now recognised to be out dated. Care Hours Per Patient Day (CHPPD) was introduced as part of Lord Carters review of operational productivity and performance in English acute hospitals in 2015, and is a way of presenting staffing data that can better summarise the complexity of the constant change in staff and patient numbers. It measures how many hours of care are provided collectively by registered nurses/midwives, healthcare assistants and therapists (if included in the ward model) per patient in a 24 hour period. During 2018/19 we set out to use CHPPD more intelligently to ensure the right number of nursing staff with the right skills are available to meet the needs and expectations of patients, families and the wider public.

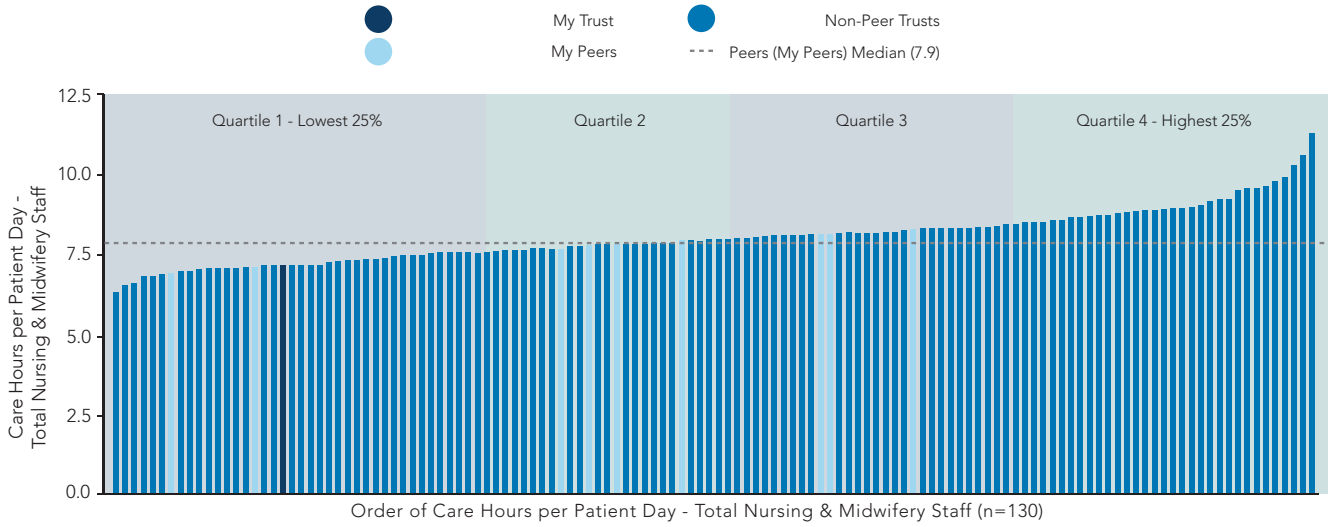
What we achieved?

We set out to close the gap between the actual nursing hours provided and the hours needed (using Care Hours per Patient Day data) in adult inpatient wards and departments. To be able to complete this work a Nurse Establishment Review has been undertaken to understand the requirement of nursing need in those areas and assess if the current availability of registered and unregistered nurses meets this. The review used the Safe Nursing Care Tool (also known as the Shelford tool). This tool has been validated and is endorsed by NICE and the National Quality Board and is recognised by regulators as the most accurate way to assess nursing requirement within adult inpatient wards and departments.

Data collection spanned a 10 month period for those wards or departments included, with acuity assessments completed up to 3 times daily per patient (including nights and weekends). This standard exceeds the national requirement for establishment reviews and data collection has been quality assured through spot check audits. Quantitative analysis has been undertaken using descriptive statistics and each ward and department findings are presented as care hours needed vs the establishment currently available, identifying any variance. Further quantitative measures were correlated to the findings using safety, quality

and patient experience metrics and additional qualitative analysis was undertaken by the Associate Directors of Nursing to apply professional judgement to the number and skill mix of nursing staff needed by ward or department as indicated by the SafeCare data collected.

Care Hours per Patient Day - Total Nursing & Midwifery Staff, National Distribution



Data Source: NHS Model Hospital Portal

Cost per Care Hour - Total Nursing and Midwifery	Aug 2018	£20.18	£24.62	£25.41	

Data Source: NHS Model Hospital Portal

The findings demonstrated that there was a variance in the care hours needed to support the patient acuity and dependency most frequently seen within the included adult inpatient wards and this generally fell short of those required. This was further supported on analysis of the NHS Model Hospital Portal data. The identified short fall was converted into the numbers needed and skill mix required using the Shelford tool methodology and those wards with the biggest variance and the highest areas of risk have received additional establishment which is currently being recruited to.

Work will continue during 2019/20 to monitor the care hours required to meet patient acuity and this information will be used to direct establishment figures.

Delivering effective services by reducing process variation

We know that by changing the way we work (our processes) we can improve the safety, quality and experience of our patients. If we are not working together across our local health system and joining services in a seamless way, it creates delays and bottle necks in the patient journey. This is

frustrating for patients as they often feel lost and/or stranded between services which creates additional anxiety and distress. It can be particularly difficult for our elderly population who may have a number of complex needs for both health and social care and find it challenging to access the appointment and services they need. We set out in 2018/19 to launch an older person's assessment unit, reduce unnecessary time spent in hospital and reduce the number of avoidable cancellations for patients requiring surgery or outpatient appointments.

Our measure of success included;

- Reducing the number of hospital admissions for the elderly population
- 40 % reduction in the average monthly bed days due to delays for stranded patients
- Increasing the number of patients returning to their own place of residence
- Reducing the number of avoidable cancellations on the day of surgery
- Reducing the number of patients who fail to attend on the day of surgery
- Improving start times within theatres to maximise utilisation
- Reducing the number of new outpatient appointments cancelled by the hospital
- Reducing the number of new outpatient appointments cancelled by patients (as a result of introducing more patient choice)
- Reducing the number of 'do not attend' (DNAs) for both new and review outpatient appointments
- Reducing the number of inappropriate new outpatient appointments through electronic triage (Consultants at the hospital offering advice & guidance to GPs)

Older Person Assessment Unit

When older people with complex health and social care needs arrive in the Emergency Department (ED) it is important they have access to the expertise of Elderly Care Consultants so their individual needs are assessed in full. At the Countess we changed the way in which we work a couple of years ago to ensure there was a geriatrician in ED at the point of need but we recognised there was further improvements to be made. During 2018/19 we set out to develop the service to deliver an older persons assessment unit to provide an in-reach into ED and also take direct referrals from General Practice.

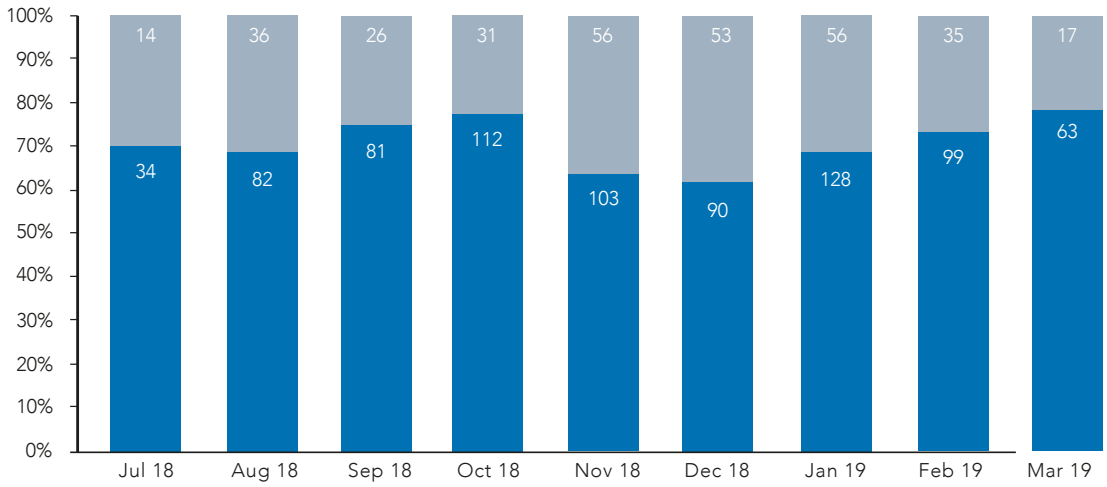
What have we achieved?

A significant proportion of the acute medical intake in our hospital involves frail older people whose care needs can often be more appropriately and safely met in the community. Trailing a multidisciplinary approach of a Consultant Geriatrician, Pharmacist, Therapist and Medical trainee working at the 'front door' of the hospital, the results demonstrated this to be an effective model which we have developed into an older persons assessment unit within the ED footprint.

The Emergency Multidisciplinary Unit (EMU) opened its doors at the Countess in June 2018. Since its opening the unit has had a positive impact on the way that frail, elderly patients are managed at presentation to the 'front door' of the hospital. The multi-disciplinary team approach provides rapid access to a Comprehensive Geriatric Assessment, reducing inappropriate hospital admissions and significantly improving patient experience. Since opening, the development and progression of EMU and the Community Geriatric service is now within the NHS Operational Planning Guidance and has been highlighted as a key benefit in reducing acute non-elective admissions for older frail patients. This type of service has now been recognised nationally and is forming part of the Same Day Emergency Care plans with the aim of delivering 7 day services for the extended 12 hour daily period which in turn is part of the revised NHS Access Standard for Urgent and Emergency Care.

- Since opening, 1,116 patients have been admitted to EMU
  - 792 (70.9%) were discharged back to the community
  - 159 (14.3%) were admitted to an intermediate care facility
- 165 (14.8%) were admitted to an acute medical ward (amongst the admitted

patients, 55 (33.3%) were then treated by Geriatricians, 95 (57.6%) by other medical specialities and 15 (9.1%) in an outlying ward).

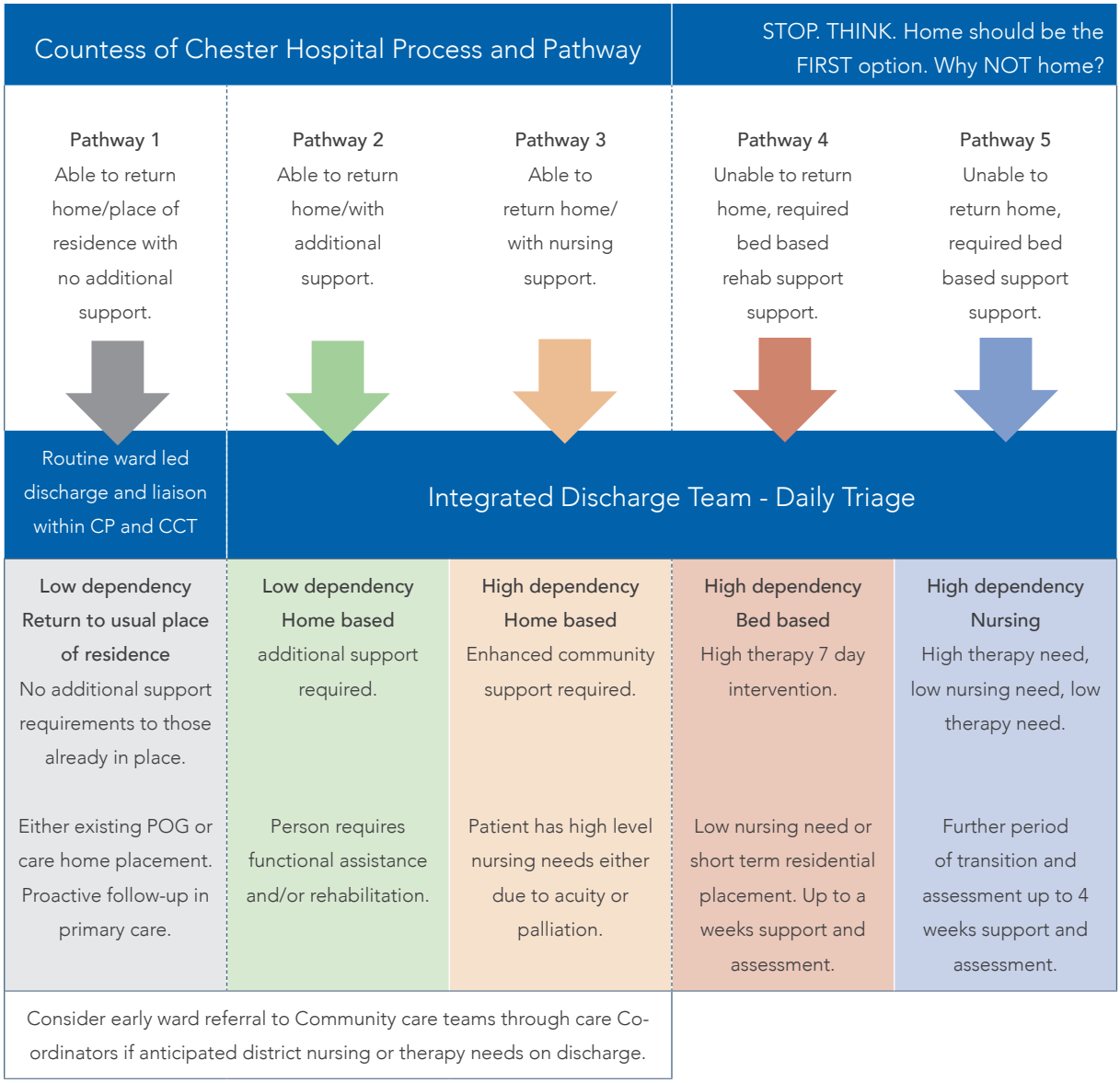


Data Source: Meditech (Electronic Patient Record)

Why is reducing unnecessary time in hospital important?

Patients who are ready to be discharged from hospital can sometimes be stranded whilst they are waiting on the next step of their discharge. This can happen for a variety of reasons, delays in the assessment of care needs, delays in the appropriate funding being allocated and the number of beds or care packages available outside of the hospital. Patients who remain in hospital longer than they require are likely to have a poorer experience and are more likely to lose their independence and confidence.

Working with our local health and social care system partners, we have worked to reduce the number of patients stranded by implementing five new pathways for patients requiring a supported discharge and improving our joint working.

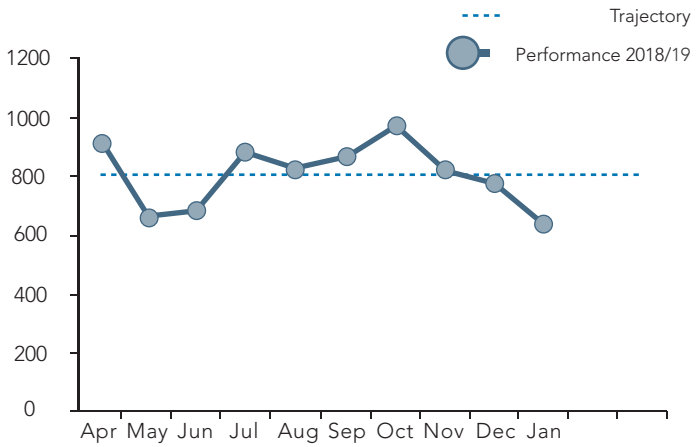


What have we achieved?

We set out to reduce the average monthly bed days due to delays for stranded patients by 40%. From April 2018 to the latest figures available in February 2019 we have achieved a 50% reduction in days delayed. We have monitored:

- The number of days that patients have been delayed in their discharge; and
- The percentage number of patients that have been discharged to their own home after an admission through our Intermediate Care Units to ensure that earlier discharges from hospital are not detrimental.

Delayed days (all reasons)

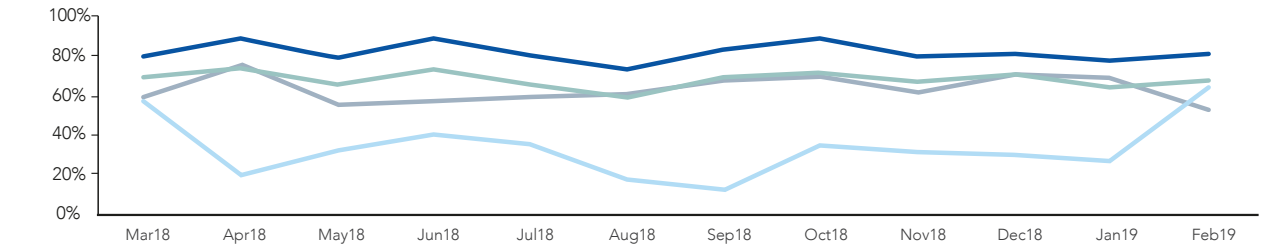


Data Source: NHSI Delayed transfer of care improvement tool dashboard

Increasing the number of patients returning to their own place of residence

Pathways were introduced in April 2018 with extensive training and an emphasis on patients returning to their own place of residence. As the pathways and changes in working practice have been embedded we have now achieved a sustained reduction in days that patients are delayed even during our busier winter months, where we have seen in previous years a pattern of dramatic increases in delays. During this period the number of patients that have returned to their own home has remained stable ensuring that we are still rehabilitating patients appropriately so they regain their independence and functional ability.

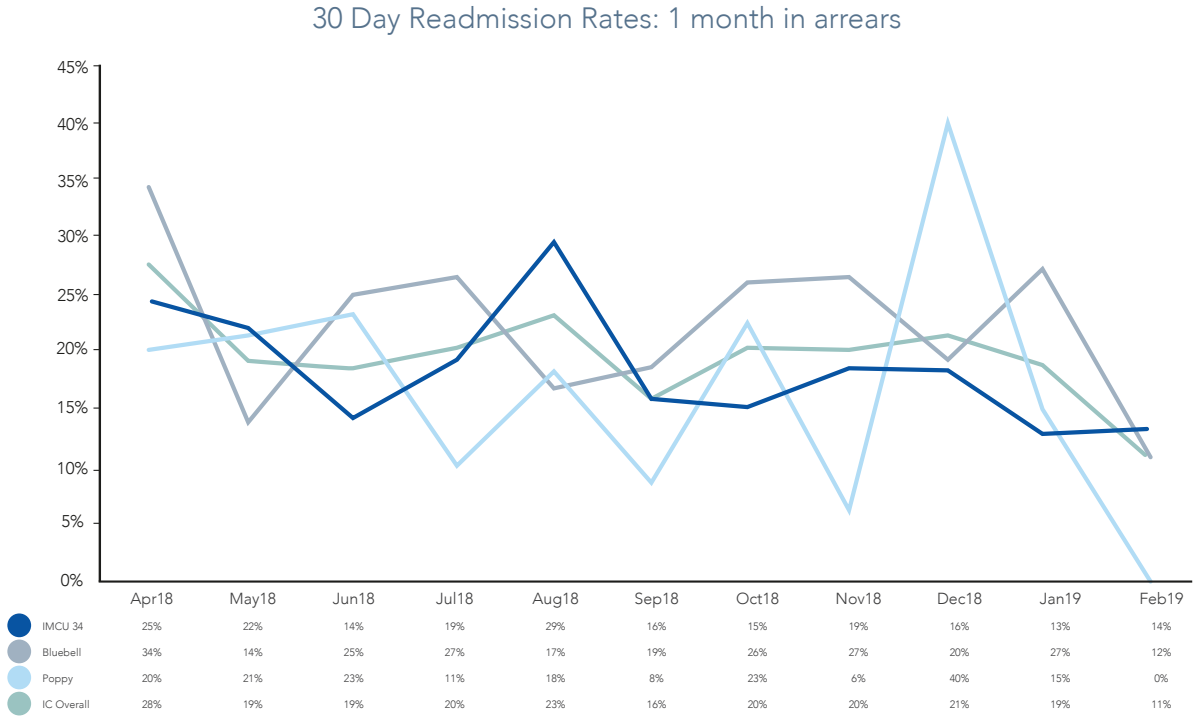
Percentage of Patients Discharged Home directly from Intermediate Care



	Mar18	Apr18	May18	Jun18	Jul18	Aug18	Sep18	Oct18	Nov18	Dec18	Jan19	Feb19
IMCU 34	78%	88%	79%	90%	79%	73%	83%	88%	80%	81%	78%	80%
Bluebell	58%	76%	56%	58%	60%	60%	69%	69%	62%	69%	68%	53%
Poppy	56%	20%	33%	41%	36%	19%	13%	35%	32%	30%	28%	64%
IC Overall	68%	74%	66%	73%	65%	61%	70%	72%	67%	70%	66%	67%

Data Source: Internal Intermediate care dashboard

Due to an integrated approach to local Intermediate Care provision, readmission rates across all three units demonstrate a downward trajectory over a 12 month period. This supports a progression in integrated working and is a clear indication of improved quality of care.



Data Source: Internal Intermediate care dashboard

Operating Department Improvements

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

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

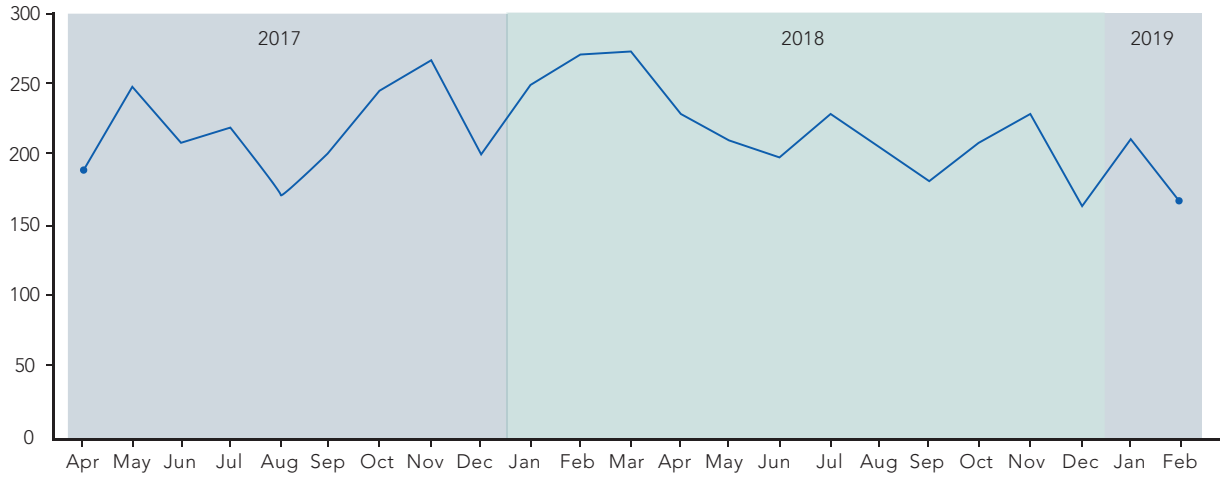
Theatre's Perfect Week

In July 2018 a 'Theatre's Perfect Week" was run to scrutinise the way in which we schedule, run and monitor our theatres on a daily basis. We looked to significantly reduce patient delays by improving any of our existing daily approaches that are considered contributing factors. For instance, we knew that operating lists can start late and that there are many factors that can contribute to this. We spoke to our staff and patients to help us understand what they thought goes wrong, to support what improvements needed to be made.

We set out to reduce the number of avoidable cancellations on the day of surgery, on average through 2017/18 we had 229 cancellations per month across Theatres (excluding Endoscopy), this has reduced further in 2018/19 to an average of 203 per month. To help we have reinforced the messages given to patients at each point of delivery (including Gatekeeper, Pre-Assessment as well as through the reminder service) regarding illness, eating/drinking

and when to stop (or start) their regular drugs. Comparing January and February over the two years we can see that in 2017/18 there were 523 cancellations on the day compared to 378 this year, a reduction of 27.7%.

Overall Cancellations



Data Source: Qlikview (Internal Operational Dashboard)

We set out to reduce the number of patients who fail to attend on the day of surgery Our Failed to Attend rate (FTA) has stayed reasonably static, climbing by 0.6 people per month on average over this period compared to the previous year. We have put a reminder service in place, however the service hasn't had the desired outcomes. Changes are being made to this, including not sending reminders in the current format to specific cohorts of patients such as the over 75's, as a more tailored approach will be required for these patients.

	Overall Cancellations	Fail to Attend's	Average Start Time (am)	Average Start Time (pm)
April 2017	87	6	09:22	14:19
May 2017	248	11	09:24	14:22
June 2017	208	15	09:19	14:18
July 2017	220	11	09:20	14:13
August 2017	173	8	09:15	14:14
September 2017	203	15	09:20	14:13
October 2017	248	10	09:22	14:13
November 2017	269	9	09:23	14:21
December 2017	200	4	09:23	14:17
January 2018	251	12	09:27	14:15
February 2018	272	8	09:25	14:22
March 2018	274	7	09:25	14:19
April 2018	231	7	09:27	14:17
May 2018	210	9	09:18	14:08
June 2018	199	14	09:12	14:18
July 2018	230	13	09:19	14:08
August 2018	206	17	09:21	14:16
September 2018	182	10	09:18	14:14
October 2018	210	8	09:18	14:17
November 2018	229	8	09:23	14:18
December 2018	164	7	09:18	14:20
January 2019	212	10	09:19	14:15
February 2019	166	11	09:16	14:04

Data Source: Qlikview (Internal Operational Dashboard)

We set out to improve start times within theatres to maximise utilisation, start times in Theatres have improved year on year on average from 09:22/14:17 in 2017/18 to 09:19/14:13 in 2018/19.

Elective Short Stay Unit (ESSU)

In December 2018 our ESSU was opened to further improve the number of operations that are cancelled on the day of surgery (due to no beds being available). The ESSU is a 9 bedded area within our Jubilee Day Surgery Centre where beds are protected for elective activity. 365 patients were treated in ESSU between 10th December 2018 and 31st March 2019.

Outpatients appointment improvements

Outpatient appointment cancellations happen frequently; this may be a result of the hospital changing the date or the patient not attending. There are a variety of reasons why this may happen but commonly identified themes include;

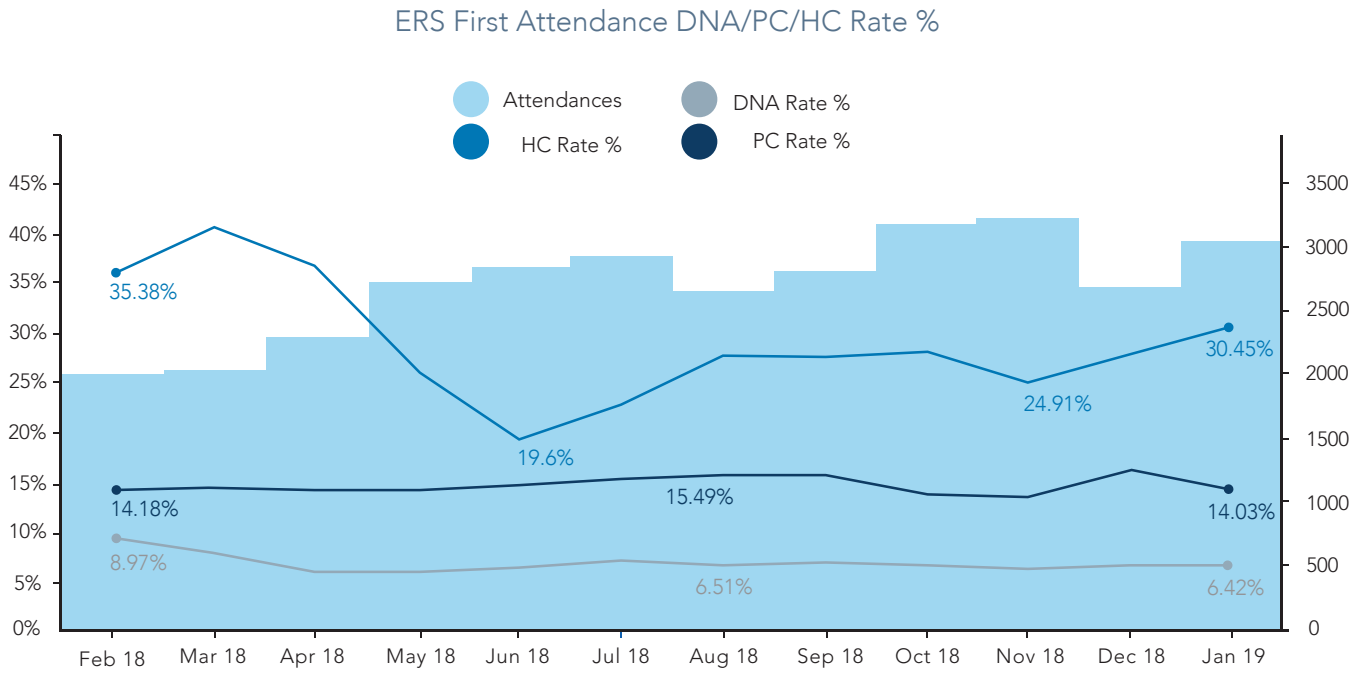
- Appointments made too far in advance (patient plans may change, life events occur)
- Appointment no longer needed
- Appointment made unnecessarily
- Letter not sent or received

Since the introduction of the Referral Assessment Service and Advice and Guidance functionality on the e-Referral System (e-RS), along with the appointment reminding system , there has been successful reduction in process variation resulting in improvements in outpatient appointments and bookings for our patients.

Reduction in the number of new outpatient appointment cancellations by the hospital and patients

The graph below shows the rate of new outpatient appointments booked via e-RS that have resulted in Patient cancellation, Hospital cancellation and DNAs. The overall trend is a reduction in all of these metrics in the last rolling 12 months, however after a stepped change in the reduction of hospital cancellation rate from March 2018, disappointingly there has been a definite increase in the rate of hospital cancellations since June 2018 which will continue to be monitored and the reason for this increase identified.

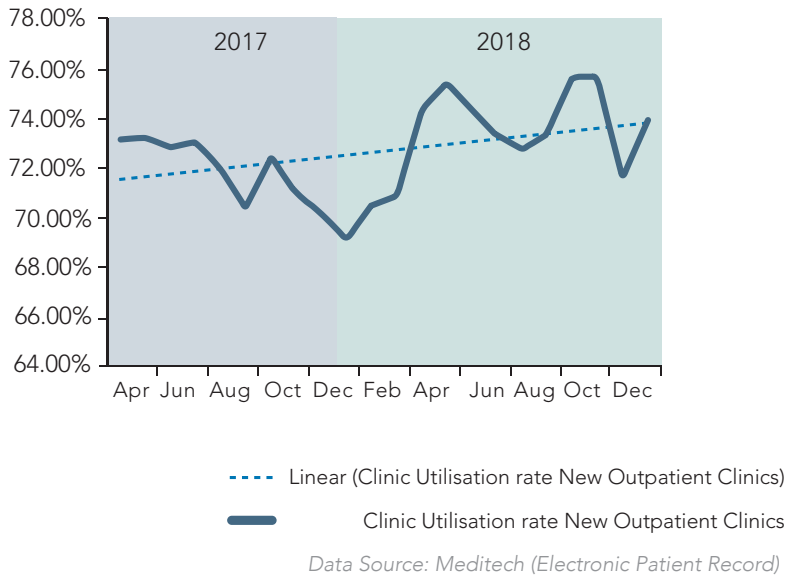
The patient cancellation rate has remained steady with a reduction from September to November 2018, where it peaked in December 2018 and then reduced to its lowest level in January 2019.



Data Source: Meditech (Electronic Patient Record)

These measures can also be looked at in conjunction with the Clinic utilisation rate for new appointments. As can be seen the average clinic utilisation has improved from 71.58%, April 2017 to March 2018 to 74.06% for April 2018 to January 2019 for new outpatient clinics.

Clinic Utilisation Rate New Outpatient Clinics



Data Source: Meditech (Electronic Patient Record)

Reduction of inappropriate referrals

With effect from 1st October 2018, the NHS Standard Contract stipulated that all English General Practice (GP) referrals for new consultant led outpatient appointments needed to be made through the e-Referral System (e-RS). We had a soft deadline of the end of May 2018 to implement this initiative. This was actually implemented on 1st April 2018, two months ahead of schedule. As can be seen from the chart below nearly 100% of English GP referrals are received through e-RS. Referral Assessment functionality was set up on e-RS to allow GPs to refer into the various specialties and gain advice from Consultants rather than book an outpatient appointment. This has reduced the number of unnecessary appointments and freed up appointment slots for those patients that need to be seen in the hospital. The chart below shows that from February 2018 to January 2019, 2,365 referrals were returned to GP referrers with advice, approximately 7% of total referrals received. These referrals would normally have had appointments booked in advance of Consultant triage. The Referral Assessment functionality provides GPs with helpful information and advice from Consultants as well helping to manage patient expectations.

Triage Outcome

Count of UBRN	Income Record												
Display	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Total
Accept and refer/ book later	5	349	2,182	2,538	2,764	3,185	2,792	2,655	3,073	2,716	2,398	3,006	27,663
Refer/book now	9	207	353	367	213	157	296	449	375	620	425	439	3,910
Return to referrer with advice	3	35	195	298	218	197	230	176	278	242	208	285	2,365
Total	*17*	*591*	*2,710*	*3,203*	*3,195*	*3,539*	*3,318*	*3,280*	*3,726*	*3,578*	*3,031*	*3,730*	*33,938*

Advice and Guidance functionality has also been implemented for a number of specialties on e-RS. This allows the GP to raise a query with Consultants prior to a referral being sent if necessary. As can be seen from the chart below, 6 specialties have Advice and Guidance set up on e-RS. In addition to these, Clinical Haematology went live in March 2019 with Paediatrics and Diabetes are going live from 1st April 2019. Further specialties are planned to roll out during 2019. A total of 352 advice requests have been received and responded to since September 2018 to January 2019. This has prevented referrals being sent and inappropriate appointments being made and allowed GPs to manage patients appropriately.

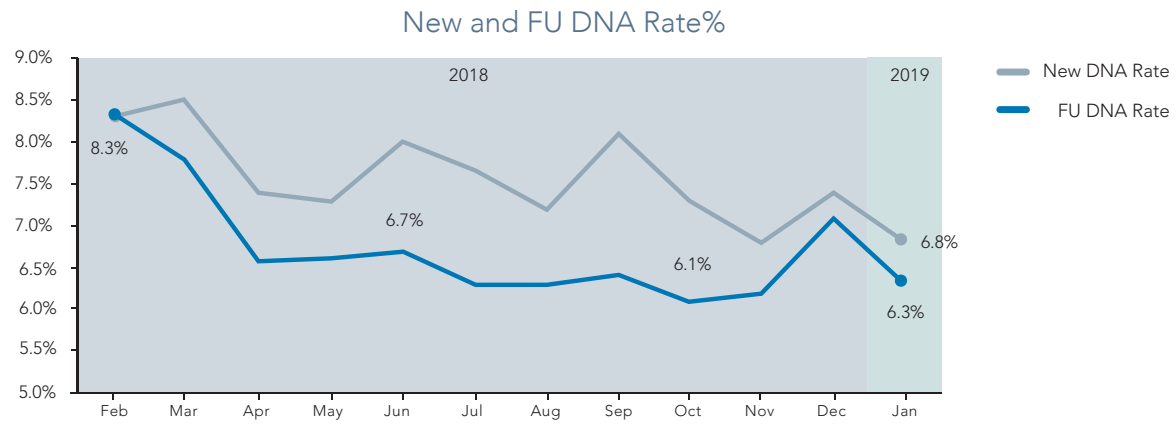
Advice and Guidance Requests and Responses

Action	Advice					
Count of UBRN	Action Date					
Service Name	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Total
Breast Surgery - Advice and Guidance - Countess of Chester			1	1	5	7
Chemical Pathology - Advice and Guidance - Countess of Chester - RJR		3	2	4	2	11
Dermatology - Advice and Guidance - Countess of Chester			7	15	12	34
Endocrinology - Advice and Guidance - Countess of Chester - RJR	20	58	46	40	32	196
Microbiology - Advice and Guidance - Countess of Chester Hospital - RJR				2	3	5
Rheumatology - Advice and Guidance - Countess of Chester - RJR		14	30	22	32	98
(blank)					1	1
Grand Total	*20*	*75*	*86*	*84*	*87*	*352*

Data Source: Electronic Referral System (e-RS)

Reduction in the amount of "Did not attends" (DNAs) for both new and review outpatient appointments

In conjunction with the roll out of e-RS Referral Assessment Services and Advice and Guidance, a new electronic reminder service was also implemented in March 2018, via 2-way text messaging and interactive voice messaging to landlines. This gives patients the opportunity to confirm, cancel or rebook their appointment if required. The graph below shows the stepped changed in the reduction of DNA rate for both new and follow up outpatient appointments from 8.3% in February 2018 to 6.5% for both new and review appointments.



Data Source: Meditech (Electronic Patient Record)

3.8 Performance against the relevant indicators and performance thresholds

Indicators

Indicator	Target	Performance	Explanation
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate - patients on an incomplete pathway	92%	86.56%	The Trust has seen an overall growth in referrals that led to a lack of available capacity. This has been most evident in our medical specialties that whilst achieving 92% performance are no longer able to positively contribute to the overall Trust position. The performance is indicative of a significant growth in cancer referrals and the agreed priority to improve against our 2017/18 cancer performance.
A&E: maximum waiting time of four hours from arrival to admission/ transfer/ discharge	95%	82.9%	The trust sees the majority of attendances through a type 1 stream and does not have significant numbers of type 3 attendances to enable an improvement in the combined performance. The type 1 performance is consistent with other trusts in Cheshire and Merseyside. The Trust has undertaken a gap analysis against national best practice and will be re-engaging with the emergency intensive support team to enable improvement for 2019/20.
All cancers: 62-day wait for first treatment from: Urgent GP referral for suspected cancer	85%	83.52%	There has been an 11% growth in suspected cancer referrals in 2018/19. However the year end performance is an improved position from 2017/18 and reflects the prioritisation of this standard by the Trust. The intensive support team worked with the trust with a focus on Urology pathways which account for a significant number of the breaches. An issue with data reporting was identified in Q3 due to not including reallocated breaches to the Countess position, details on the resolution and actions taken can be found in the box below.
All cancers: 62-day wait for first treatment from: NHS Cancer Screening Service referral	90%	97.24%	In Q3 the cancer manager had a period of long term absence, on NHS Cancer Screening Service referral returning to work she noted a mistake in the reporting of Q3 figures due to not including reallocated breaches to the Countess position. This was immediately escalated to the Trust Board and NHS Improvement through the Cancer Alliance. The performance was updated internally but required liaison with NHS Digital to adjust the nationally reported figures. To mitigate any reoccurrence, all standard operating procedures for the cancer tracking team have been reviewed and updated to ensure they are fully compliant, as well as further training for the team to enable them to cross cover for any absence. The Trust is assured that whilst the error was made, it was subsequently identified, escalated appropriately and rectified. The completed action plan in relation to this issue has been completed and will be taken through the Cancer Committee for completeness.
Maximum 6-week wait for diagnostic procedures	99%	95.8%	Due to the focus on cancer pathways there was a significant impact on the routine referrals to Endoscopy which required an insourcing solution to improve the position. The Trust has improved over quarter 4 and plans to sustain this through 2019/20. There is an ongoing pressure in ultrasonography, impacting on a number of points of delivery, due to increasing demands at individual speciality level and a national workforce shortage. Unless increasing demands can be controlled this is likely to remain a significant issue for the Trust to manage.

Data source: Monthly National Situation Report (unify). Definitions can be found at https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2015/10/mnth-Sitreps-def-dtoc-v1.09.pdf. Cancer performance is as at February 2019 (March's data not yet available). RTT position at year end. Link to NHSE guidance; https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-guidance/DM01 position at year end; https://data.england.nhs.uk/dataset/monthly-diagnostic-waiting-times-and-activity-guidance-and-documentation/resource/08ba1833-44e6-42b0-8b6f-b07e2535249d

3.9 Progress against seven day hospital services

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

The four priority standards are;

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

These standards are audited nationally every year. Below is information on how we are doing at the Countess in relation to ensuring these standards are met.

September 2017 audit:

Only required audit against Standard 2 'time to first consultant review' and we achieved 71%

March 2017 audit:

Required audit against the four priority standards

Standard	Descriptor	% achieved
Standard 2	Time to first consultant review	73%
Standard 5	Access to diagnostic tests	94%
Standard 6	Access to consultant directed interventions	89%

March 2018 audit:

CS2 Revalidated	CS5 Revalidated	CS6 Revalidated	CS8 Revalidated	Number of Standards Met (Revalidated)
95%	97%	100%	98%	4

We have worked closely with the NHS Improvement 7 Day Services Regional Team to ensure that compliance with the four Priority Clinical Standards for 7 Day Services is assured. This is now, as of November 2018, enacted by local Board Assurance to fulfil the changes to this process stipulated by NHS Improvement. We enjoy full compliance on all relevant sections of the four Priority Standards. Within the freedoms of the revised local Board Assurance mechanism, will be working with our clinical teams through 2019/20 to explore the opportunities available to us to use the remaining six Clinical Standards to drive forward further improvements within their scope.

3.10 NHS Doctors and Dentists in training

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

Currant vacancy status 31st March 2019

Grade	Urgent Care		Planned Care		Diagnostic	
	Gaps	Filled/appt made	Gaps	Filled/appt made	Gaps	Filled/appt made
Consultant	8	3	6	2	4	2
ST3+	4	1	6	3	0.4	0
ST1/2	3		8	0		
Speciality Doc	2		1			
F2			1			
GP Trainee						
Total	17	4	22	5	4.4	

Currant vacancy status 30th April 2019

Grade	Urgent Care		Planned Care		Diagnostic	
	Gaps	Filled/appt made	Gaps	Filled/appt made	Gaps	Filled/appt made
Consultant	7	5	6	2	2	
ST3+	3.2	0.5	4	1	0.4	
ST1/2	2.4	1.6	7			
Speciality Doc			1	1		
F2			1			
GP Trainee						
Total						

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

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

In accordance with the 2016 Medical Terms and Conditions of Service for Junior Doctors the FT has appointed a Guardian of Safe Working Hours to oversee the FT's adherence to the terms and conditions.

An annual report and quarterly exception reports are reported to the Trust Board. The reports provide assurance on the exception reporting processes and the actions being taken as a result of the exception reports that have been raised.

3.11 ANNEX 1

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

Statement from the Trust's Council of Governors 2018/19

This year's Governor's Statement reports on a period of instability during which we have seen the sudden departure of the Chief Executive Officer, the resultant executive changes and subsequent appointment of a new CEO. Despite this upheaval the Trust has continued to operate in what are still extremely testing circumstances within the NHS.

The Trust has unfortunately failed to meet the nationally mandated targets despite strenuous efforts. However, the 62-day cancer target is virtually at the 85% target level. Outpatient Did Not Attend (DNA) rates have fallen from 8.97% to 6.42% due in part to the e-Referral system enabling GPs to contact consultants before referring their patients. Following last year's improvement in infection control the Governors are disappointed to see increases in both MRSA and Clostridium Difficile. Also, following an initial improvement in falls during 2017/18, the position has remained static during the past year despite the number of falls measures in place.

The Governors receive regular feedback through the Quality Forum from senior members of staff that assist with performing the statutory functions of the Council of Governors. The Council of Governors meets 4 times a year where there is a more formal occasion for them to discuss and delve into a number of the current topics. The Governors are continuously seeking to improve how they hold Non-Executive Directors to account, particularly against the NED responsibility for challenging and supporting the performance of Executive Directors. There is an on-going review of how this is best achieved.

In the past year the Governors have conducted 7 ward observation visits or GovRounds. Recent visits have included Radiology and Maternity where the Governors received highly positive responses about the staff and their work. The feedback from these visits has been very positive and both staff and patients welcome the opportunity to meet the Governors and to discuss their work or visit to the Trust. Among the improvements seen by Governors is the introduction of "Drug Round" tabards to minimise disruptions and thereby help to reduce potential errors. The GovRound report has recently been modified to include a section where the ward can respond to Governor's comments. The reports are presented to the Patient Experience Operating Group where an action plan of previous visits is monitored.

The Governors are disappointed to note that the Care Hours Per Patient Day falls within the lowest 25% of Trusts and is also below the median of 7.9. Achieving the right staffing levels for varying degrees of acuity is clearly an issue despite the introduction of e-Rostering. It is hoped that measures are put in place to improve this situation.

The confidence of the community who use the hospital remains high and the Governors look forward to 2019/20 where the CoCH continues to serve its established constituency.

Statement from West Cheshire Clinical Commissioning Group 2018/19

We are committed to commissioning high quality services from our providers and we make it clear in our contract what standards of care we expect them to deliver. We manage their performance through regular progress reports that demonstrate levels of compliance or areas of concern. It is through these arrangements that the accuracy of this Quality Account has been validated.

The Trust is commended for improving the compliance levels in the use of the NHS Improvement Patient Safety Checklist in the Emergency Department.

Your progress in the use of real time information to manage safe staffing against patient acuity is positive. We note that those wards with the biggest variance and the highest areas of risk have received additional establishment which is currently being recruited to. We look forward to seeing the impact of this investment through your staff and patient experience surveys and quality monitoring metrics.

The Trust has performed less well this year in delivering a reduction on the number of health care associated infections. This trend is in contrast to the positive progress that has been made in preceding years. We are encouraged by the steps taken already to review practice, along with your plans for reinforcing and developing existing infection prevention and control risk reduction measures.

We are pleased to note the continued progress in reducing the length of time patients have stayed in hospital and recognise your commitment to partnership working to enhance out of hospital care options.

It is of concern that, in both the 2016/17 and 2017/18 Quality Accounts, the Trust reports that it was unable to consistently achieve best practice in the recognition and management of sepsis. We support the need for this to be one of your priorities for 2019/20 and expect this focus to drive rapid progress towards the national standards.

Your programme of work on the use of a weekly 'Lessons Learned' communication, which allows learning to be shared rapidly with teams from incidents, claims, complaints and coroners is welcome and supports your culture of continuous quality improvement.

The Trust has reported a small reduction in the number of patients who sustain serious harm as a result of a fall whilst in hospital. Given the investment in the falls quality improvement project there is scope for this to have a greater impact and deliver improvements more swiftly.

We share your view that some progress has been made in Learning from Deaths processes. There is a need for sustained effort and resources for this important programme of work and look forward to seeing progress reports against this.

We note that there were two Never Events and have seen evidence of an open and honest approach to learning as a consequence of this.

We support the priorities that the Trust has identified for the forthcoming year and look forward to continuing to work in partnership with you to assure the quality of services commissioned in 2019/20.

Statement from Healthwatch

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

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

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

- For setting high aims on targets
- Asking the question Why is something important
- For being open and honest with a high level of reporting incidents
- For setting deliberate aims in regard to improving patient experience

Specific comments on the report:

We felt the report was logically laid out and easy to read.

2.1 Progress made since the last publication of the 2017/18 Quality Report was welcomed at the beginning of the report.

Healthwatch welcomed the introduction of the Sepsis Plan.

The layout of the tables on pages 34 and 35 was difficult to interpret as the indicators were at the bottom of page 34.

We were impressed by the Falls Prevention Programme and the positive work and results the programme is showing.

The indicators on page 157 relating to relevant indicators and performance thresholds are in four out of the five indicators below the target requirements. We felt these are disappointing as two of the indicators are nearly 10% below the required level.

3.12 ANNEX 2

Statements of directors' responsibilities for the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year. NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

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

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2018/19 and supporting guidance Detailed Requirements for Quality Reports 2018/19;
- 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 2018 to May 2019
    - papers relating to quality reported to the Board over the period April 2018 to May 2019
    - feedback from commissioners, dated 20th May 2019
    - feedback from governors, dated 13th May 2019
    - feedback from local Healthwatch organisations, dated 10th May 2019
    - feedback from Overview and Scrutiny Committee, requested on 30th April 2019 but not received
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
    - the 2017 national patient survey, published in June 2018
    - the 2018 national staff survey, published in February 2019
    - the 2018/19 Head of Internal Audit's annual opinion over the Trust's control environment, dated March 2019
    - Care Quality Commission Inspection, dated 17th May 2019
- the Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the Board

Chairman
21st May 2019

Chief Executive Officer
21st May 2019

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST ON THE QUALITY REPORT

We have been engaged by the Council of Governors of Countess of Chester Hospital NHS Foundation Trust to perform an independent assurance engagement in respect of Countess of Chester Hospital NHS Foundation Trust's Quality Report for the year ended 31 March 2019 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to limited assurance consist of the following two national priority indicators:

- A&E: maximum waiting time of four hours from arrival to admission, transfer or discharge; and
- maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.

We refer to these national priority indicators collectively as the 'indicators'.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the *Detailed requirements for quality reports for foundation trusts 2018/19* ('the Guidance'); and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes and papers for the period April 2018 to May 2019;
- papers relating to quality reported to the board over the period April 2018 to May 2019;
- feedback from commissioners, dated 20 May 2019;
- feedback from governors, dated 13 May 2019;
- feedback from local Healthwatch organisations, dated 10 May 2019;
- feedback from Overview and Scrutiny Committee, requested on 30 April 2019 but not received;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the latest national patient survey, dated June 2018;

- the latest national staff survey, dated February 2019;
- Care Quality Commission Inspection, dated 17 May 2019;
- the 2018/19 Head of Internal Audit's annual opinion over the trust's control environment, dated 16 April 2019; and
- any other information included in our review.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Countess of Chester Hospital NHS Foundation Trust as a body, to assist the Council of Governors in reporting the NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2019, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Countess of Chester Hospital NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information', issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicator;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change

over time. It is important to read the quality report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* and supporting guidance.

The scope of our assurance work has not included governance over quality or the non-mandated indicator, which was determined locally by Countess of Chester Hospital NHS Foundation Trust.

Conclusion

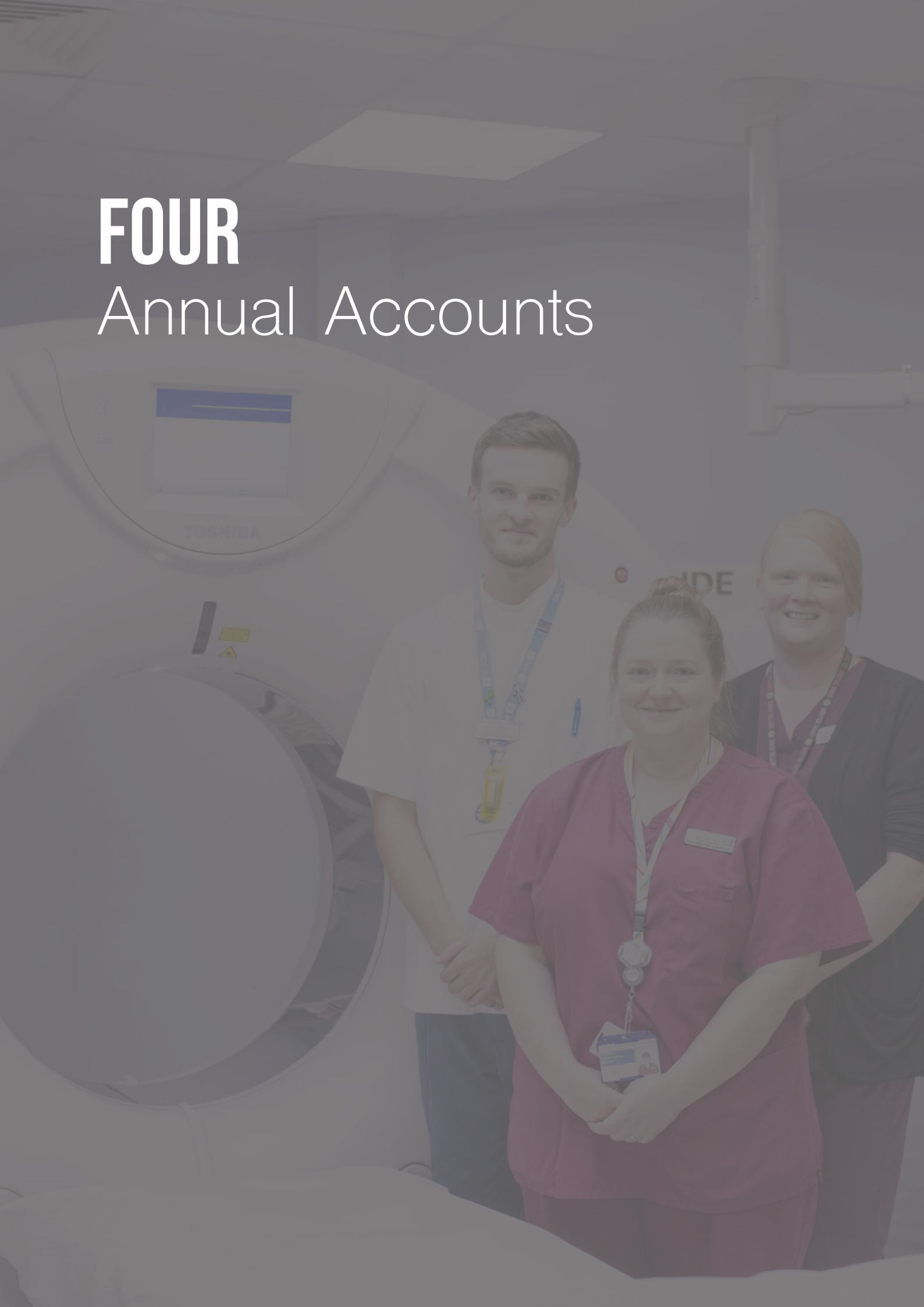
Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

KPMG LLP
Chartered Accountants
1 St Peter's Square
Manchester
M2 3AE

24 May 2019

FOUR
Annual Accounts



KPMG

Independent auditor's report

to the Council of Governors of Countess of Chester Hospital NHS Foundation Trust

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

1. Our opinion is unmodified

We have audited the financial statements of Countess of Chester Hospital NHS Foundation Trust ("the Trust") for the year ended 31 March 2019 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Taxpayers' Equity, Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion:

— the financial statements give a true and fair view of the state of the Trust's affairs as at 31 March 2019 and of its income and expenditure for the year then ended; and

— the Trust's financial statements have been properly prepared in accordance with the Accounts Direction issued under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006, the NHS Foundation Trust Annual Reporting Manual 2018/19 and the Department of Health and Social Care Group Accounting Manual 2018/19.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Trust in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Overview	
Materiality: financial statements as a whole	£4.0m (2018:£3.9m) 1.75% (2017: 1.75%) of total revenue

Risks of material misstatement		vs 2018
Event driven	**New:** Material uncertainty related to going concern	▲
	New: Accrued expenditure recognition	▲
Recurring risks	Valuation of land and buildings	◀▶
	Recognition of income from patient care activities	◀▶

2. Material uncertainty related to going concern

	The risk	Our response
We draw attention to note 1.1a to the financial statements which indicates that The Trust's outturn position for 2018/19 was a deficit of £13.2 million after impairments of £5.1 million against a planned surplus of £2.9 million. During the year, the Trust received £6.7 million of interim revenue support from the Department of Health and Social Care (DHSC). The Trust's financial plans for 2019/20 show a forecast breakeven position. This includes cost savings of £9.4 million, £3.7 million of which are currently unidentified and £5.9 million are high risk. This also includes an assumption of further DHSC revenue support of £7.1 million in the financial year (net £1.3 million after repayments scheduled in Q4) and £9.5 million of capital support. Without this cash support, the Trust would not be able to continue to operate. At present, there are no viable means for the Trust to repay its existing DHSC support loans of £38.7 million, or any new ones which are received during 2019/20. These events and conditions, along with the other matters explained in note 1.1a, constitute a material uncertainty that may cast significant doubt on the Trust's ability to continue as a going concern. Our opinion is not modified in respect of this matter.	**Disclosure quality** There is little judgement involved in the Accounting Officer's conclusion that the risks and circumstances described in note 1.1a to the financial statements represent a material uncertainty over the ability of the Trust to continue as a going concern for a period of at least a year from the date of approval of the financial statements. However, clear and full disclosure of the facts and the Accounting Officer's rationale for the use of the going concern basis of preparation, including that there is a related material uncertainty, is a key financial statement disclosure and so was the focus of our audit in this area. Auditing standards require that to be reported as a key audit matter.	Our procedures included: — **Assessing transparency:** we assessed the completeness and accuracy of the matters covered in the going concern disclosure by: — Using our professional judgement to determine whether the basis of preparation note adequately describes the challenges facing the Trust; — Agreeing the financial balances disclosed back to the Trust's financial statements for 2018/19 and their financial plan for 2019/20; — Agreeing the extent to which recurrent cost improvement schemes were achieved in 2018/19 and identified for 2019/20 to Board reporting and to the financial plan for 2019/20; — Inspecting the number of material contracts with commissioners which have been agreed for 2019/20; — Inspecting the Trust's cash flow forecasts and the requirement of additional distress funding, including agreeing the balances drawn down in April 2019 and May 2019; — Inspecting the terms of the loans and considering the timing of future repayments and the availability of funding; and — Considering long-term forecasts to assess the cash and loan position in the Trust.

3. Key audit matters: our assessment of risks of material misstatement

Key audit matters are those matters that, in our professional judgment, were of most significance in the audit of the financial statements and include the most significant assessed risks of material misstatement (whether or not due to fraud) identified by us, including those which had the greatest effect on:the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters. Going concern is a significant key audit matter and is described in section 2 of our report. In arriving at our audit opinion above, the other key audit matters, in decreasing order of audit significance, were as follows:

	The risk	Our response
Valuation of land and buildings Land and buildings (£69.3 million; 2017/18: £74.7 million) *Refer to page 45 (Audit Committee Report), note 1.6 , 1.20 (accounting policy) and note 8 (financial disclosures – Annual Accounts).*	**Subjective valuation:** Land and buildings are required to be maintained at up to date estimates of year-end market value in existing use (EUV) for non-specialised property assets in operational use, and, for specialised assets where no market value is readily ascertainable, the depreciated replacement cost (DRC).of a modern equivalent asset that has the same service potential as the existing property (MEA) The Trust's accounting policy requires an annual review for impairment, a periodic desk top valuation (usually every three years) and a full valuation (usually in five yearly intervals). When considering the cost to build a replacement asset the Trust may consider whether the asset would be built to the same specification or in the same location. Assumptions about changes to the asset must be realistic. The valuation is undertaken by an external expert engaged by the Trust, using construction indices and so accurate records of the current estate are required. Valuations are inherently judgmental. There is a risk that the methodology, assumptions and underlying data, are not appropriate or correctly applied. The Trust last had a full valuation at 1 April 2016. An interim desktop valuation was performed at 31 March 2019 resulting in a £5 million decrease in the value of the land and buildings. **Accounting Treatment** There is a risk that the valuation is not applied to the financial statement balances appropriately to recognise the valuation gains and impairment losses in line with the requirements of the Department of Health Group Accounting Manual 2018/19. The effect of these matters is that, as part of our risk assessment, we determined that the valuation of land and buildings has a high degree of estimation uncertainty, with a potential range of reasonable outcomes greater than our materiality for the financial statements as a whole, and possibly many times that amount.	Our procedures included: — **Assessing valuer's credentials**: We assessed the competence, capability, objectivity and independence of the Trust's external valuer and considered the information provided to the Trust in 2018/19 for consistency with the requirements of the DHSC Group Accounting Manual; — **Test of detail:** We critically assessed the Trust's formal consideration of indications of impairment and surplus assets within its estate, including the process undertaken. — **Test of detail:** We tested the accuracy of the estate base data provided to the valuer to complete the desktop valuation to ensure it accurately reflected the Trust's estate. — **Methodology choice:** We critically assessed the assumptions used in preparing the desktop valuation of the Trust's land and buildings to ensure they were appropriate. — **Accounting analysis:** We undertook work to understand the basis upon which any movements in the valuation of land and buildings had been classified and treated in the financial statements and determined whether they had complied with the requirements of the DHSC Group Accounting Manual 2018/19.

3. Key audit matters: our assessment of risks of material misstatement (continued)

	The risk	Our response
Recognition of income from patient care activities Income from activities (£217.0 million; 2017/18: £211.4 million) *Refer to page 45 (Audit Committee Report), note 1.3 (accounting policy) and note 2.2 and 2.4 (financial disclosures – Annual Accounts)*	**Effects of irregularities** The main source of income for the Trust is the provision of healthcare services to the public under contracts with NHS commissioners. The Trust participates in the national Agreement of Balances (AoB) exercise for the purpose of ensuring that intra-NHS balances are eliminated on the consolidation of the Department of Health's resource accounts. The AoB exercise identifies mismatches between income and expenditure and receivable and payable balances recognised by the Trust and its commissioners, which will be resolved after the date of approval of these financial statements. Mis-matches can occur for a number of reasons, but the most significant arise were: — the Trust and Commissioners record different accruals for completed periods of healthcare which have not yet been invoiced; or — income relating to partially completed period of healthcare is apportioned across the financial years and the Commissioners and the Trust make different apportionment assumptions. Where there is a lack of agreement, mis-matches can also be classified as formal disputes as set out in the relevant contract.	Our procedures included: — **Test of detail:** We compared the actual income for the Trust's most significant commissioners against the block contracts agreed at the start of the year and checked the validity of any significant variations between the actual income and the contract via agreement to appropriate third party confirmations; — **Test of detail:** We inspected confirmations of balances provided by the Department of Health as part of the AoB exercise and compared the relevant income recorded in the Trust's financial statements to the expenditure balances recorded within the accounts of Commissioners. Where applicable we investigated variances and reviewed relevant correspondence to assess the reasonableness of the Trust's approach to recognising income from Commissioners; — **Test of detail:** We considered the impact of any identified audit adjustments on the delivery of the Trust's control total and reconciled the year-end performance to the original plan to understand any deviations.

3. Key audit matters: our assessment of risks of material misstatement (continued)

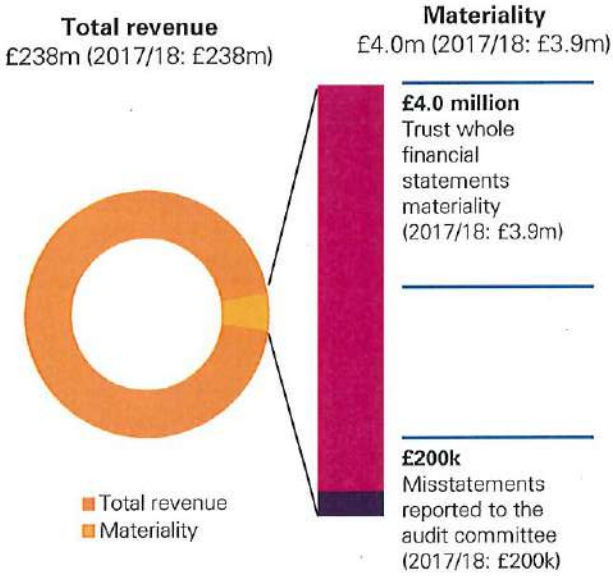
	The risk	Our response
Accrued expenditure recognition Trade and other payables (£20.2 million; 2017/18: £19.2 million) Other liabilities deferred income (£2.49 million; 2017/18: £1.74 million) Provisions (£1.8 million; 2017/18: £2.6 million) *Refer to page 45 (Audit Committee Report), note 1.5, 1.9, 1.11 (accounting policy) and note 12 and 14 (financial disclosures – Annual Accounts)*	**Effects of irregularities** As most public bodies are net spending bodies, then the risk of material misstatement due to fraud related to expenditure recognition may be greater than the risk of fraud related to revenue recognition. There is a risk that the Trust may manipulate expenditure to meet externally set targets and we had regard to this when planning and performing our audit procedures. This risk does not apply to all expenditure in the period. The incentives for fraudulent expenditure recognition relate to achieving financial targets and the key risks relate to the manipulation of creditors and accrued non-pay expenditure at year-end, as well as the completeness of the recognition of provisions or the inappropriate release of existing provisions.	Our procedures included: – **Test of detail:** We inspected all material items of expenditure in the March and April 2019 cashbooks and evaluated whether these had been accounted for correctly by reference to when the service had been delivered; – **Test of detail:** We inspected all material items of expenditure in the April 2019 bank statements to identify if there were any unrecorded liabilities that should have been accounted for in the 2018/19 financial statements; – **Test of detail:** We vouched a sample of individual accruals to supporting documentation to confirm the method of calculation and to confirm inclusion in the correct period; – **Test of detail:** We considered the completeness of provisions based on our cumulative knowledge of the Trust, inquiries with Directors, and inspection of legal correspondence. We considered whether there were events that would require a contingent liability disclosure in the accounts. We also considered the appropriateness of releases of provisions made in year by critically assessing the justification for the release against the relevant accounting standards; – **Test of detail:** We vouched a sample of journals posted before and after the year end to supporting documentation to confirm inclusion in the correct period and to critically assess whether any manual adjustments to expenditure were appropriate; – **Test of detail:** We vouched a sample of creditor balances to supporting documentation and post year-end cash payments to agree the correct treatment as a payable at year-end; and — **Test of detail:** We inspected confirmations of balances provided by the Department of Health as part of the AoB exercise and compared the relevant payables recorded in the Trust's financial statements to the receivables balances recorded within the accounts of other providers and other bodies within the AoB boundary. Where applicable we investigated variances and reviewed relevant correspondence to assess the reasonableness of the Trust's approach to recognising expenditure to other providers and other bodies within the AoB boundary.

4. Our application of materiality

Materiality for the Trust financial statements as a whole was set at £4.0 million (2017/18: £3.9 million), determined with reference to a benchmark of total revenue (of which it represents approximately 1.75% (2017/18: 1.75%). We consider operating income to be more stable than a surplus- or deficit-related benchmark.

We agreed to report to the Audit Committee any corrected and uncorrected identified misstatements exceeding £200 thousand (2017/18:£200 thousand), in addition to other identified misstatements that warranted reporting on qualitative grounds.

Our audit of the Trust was undertaken to the materiality level specified above and was all performed at the Trust's headquarters in Chester.



5. We have nothing to report on the other information in the Annual Report

The directors are responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work we have not identified material misstatements in the other information.

In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements

Remuneration report

In our opinion the part of the remuneration report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2018/19.

Corporate governance disclosures

We are required to report to you if:

— we have identified material inconsistencies between the knowledge we acquired during our financial statements audit and the directors' statement that they consider that the annual report and financial statements taken as a whole is fair, balanced and understandable and provides the information necessary for stakeholders to assess the Trust's position and performance, business model and strategy; or

— the section of the annual report describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee; or

— the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2018/19, is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements.

We have nothing to report in these respects.

6 Respective responsibilities

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 73, the Accounting Officer is responsible for: the preparation of financial statements that give a true and fair view; such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

We have nothing to report on the statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if:

- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006.
- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit.

We have nothing to report in these respects.

Our conclusion in respect of our work on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources is qualified

Under the Code of Audit Practice we are required to report to you if the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in the use of resources.

Qualified conclusion

Subject to the matters outlined in the basis for qualified conclusion paragraph below we are satisfied that in all significant respects Countess of Chester Hospital NHS Foundation Trust put in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources for the year ended 31 March 2019.

Basis for qualified conclusion

The Trust's outturn position for 2018/19 was a deficit of £13.2 million after impairments of £5.1 million against a planned surplus of £2.9 million. During the year, the Trust received £6.7 million of interim revenue funding from the Department of Health and Social Care (DHSC).

The Trust's financial plans for 2019/20 show a forecast breakeven position. This includes cost savings of £9.4 million, £3.7 million of which are currently unidentified and £5.9 million of which are high risk. This also includes an assumption of further DHSC revenue support of £7.1 million in the financial year (net £1.3 million after repayments scheduled for Q4) and £9.5 million of capital support. The Trust has already drawn down £3.45 million of interim revenue funding in 2019/20. Without this support, the Trust would not be able to continue to operate.

Whilst the Trust has identified efficiency schemes that will support the achievement of the Trust's short-term financial plans, its long-term plans are not yet sufficiently progressed to achieve a break-even position in the foreseeable future or an ability to repay the loans from the DHSC.

These issues are evidence of weaknesses in proper arrangements for planning finances effectively to support the sustainable delivery of the Trust's strategic priorities.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

The Trust is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources

Under Section 62(1) and Schedule 10 paragraph 1(d), of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in the use of resources .

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in November 2017, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

Report on our review of the adequacy of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required by guidance issued by the C&AG under Paragraph 9 of Schedule 6 to the Local Audit and Accountability Act 2014 to report on how our work addressed any identified significant risks to our conclusion on the adequacy of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources. The 'risk' in this case is the risk that we could come to an incorrect conclusion in respect of the Trust's arrangements, rather than the risk of the arrangements themselves being inadequate.

We carry out a risk assessment to determine the nature and extent of further work that may be required. Our risk assessment includes consideration of the significance of business and operational risks facing the Trust, insofar as they relate to 'proper arrangements'. This includes sector and organisation level risks and draws on relevant cost and performance information as appropriate, as well as the results of reviews by inspectorates, review agencies and other relevant bodies.

The significant risks identified during our risk assessment are set out overleaf together with the findings from the work we carried out on each area.

Significant Risk	Description	Work carried out and judgements
Overall financial performance	Due to a combination of regulatory scrutiny and significant financial challenge in the sector and locally across the health economy, we undertook a detailed review of the Trust's arrangements for planning its finances effectively to support the sustainable delivery of strategic priorities and the maintenance of its statutory functions.	Our work included: — Performing an analysis of the Trust's forecast position against plan; — Considering the core assumptions in the Trust's 2019/20 Annual Plan submission; — Considering the extent to which recurrent cost improvement schemes were achieved in 2018/19 and identified for 2019/20; and — Reviewing the number of material contracts with commissioners which had been agreed for 2019/20 and the supporting risk analysis as reported to the Board. **Our findings on this risk area:** The Trust reported a deficit of £13.2 million after impairments of £5.1 million in 2018/19. The Trust achieved £5.1 million of cost savings in 2018/19 of which £1.76 million was recurrent, against a target of £10.739 million in year. The target for 2019/20 is £9.4 million with £3.7 million currently unidentified and profiled for month 12. The current 2019/20 forecasts show a (pre-impairments) planned breakeven position. This has been agreed with NHSI. Contracts with the Trust's main English Commissioner, West Cheshire CCG, have been agreed for 2019/20, though the Trust is yet to agree the contract with its second largest commissioner. Whilst the Trust has identified efficiency schemes that will support the achievement of the Trust's short-term financial plans, its long-term plans are not yet sufficiently progressed to achieve an underlying break-even position in the foreseeable future or an ability to repay the loans from the DHSC. These issues are evidence of weaknesses in proper arrangements for planning finances effectively to support the sustainable delivery of the Trust's strategic priorities.

Significant Risk	Description	Work carried out and judgements
Borrowing and cash levels	As at March 2018 the Trust had £36.6 million of loans from the Department of Health, including £6.7 million of interim revenue funding drawn down in 17/18. The Trust has drawn down an additional £6.7 million of interim revenue funding in 18/19, and has drawn down £1.58 million of interim revenue funding in April 2019, with a further £1.87 million drawn down in May 2019. The Trust is also in the process of applying for a capital loan of £6.8 million though this is still yet to be approved. Cash balances are monitored on a daily basis to inform the Trust's quarterly cash-flow forecasts. The current level of borrowing increases pressure on financial performance with increased debt servicing costs.	Our work included: – Reviewing the Trust's cash flow forecasts and the use of distress funding; – Reviewing correspondence with NHS Improvement around the Trust's current financial health, financial risk ratings and requirements for further distress funding; – Confirming the terms of the loans to consider the timing of future repayments and the availability of funding; – Considering the overall level of debt within the Trust and impact on cash flow forecasts for debt servicing costs; and – Reviewing long-term forecasts to assess the cash and loan position in the Trust to support the going concern assessment. **Our findings on this risk area:** We are satisfied that the Trust has appropriate arrangements in place to: - Manage working capital, including forecasting cash flow requirements on a quarterly basis; - Monitor cash flow against forecasts to identify any unexpected variances; - Forecast and communicate the level of required cash flow, such that DHSC cash can be accessed in a way that enables the Trust to continue to meet its obligations as they fall due; and - Produce accurate and complete monthly finance reports for Trust Board and Finance and Integrated Governance Committee. However, the Trust's financial plans for 2019/20 show a forecast breakeven position after the receipt of £8 million of additional funding. This also includes an assumption of further DHSC revenue support of £7.1 million in the financial year (net £1.3 million after repayments scheduled for Q4) and £9.5 million of capital support. Without this revenue and capital support, the Trust would not be able to continue to operate. At present, there are no viable means for the Trust to repay its existing DHSC support loans of £38.7 million, or any new loans which are received during 2019/20. The Trust has already drawn down £3.4 million of interim revenue funding in 2019/20. These issues are evidence of weaknesses in proper arrangements for planning finances effectively to support the sustainable delivery of the Trust's strategic priorities.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006 and the terms of our engagement by the Trust. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report, and the further matters we are required to state to them in accordance with the terms agreed with the Trust, and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of Countess of Chester Hospital NHS Foundation Trust in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice issued by the National Audit Office.

Robert Jones
for and on behalf of KPMG LLP (Statutory Auditor)

Chartered Accountants
1 St Peter's Square, Manchester, M2 3AE
24 May 2019

KPMG

4.2 Foreword to the Accounts
Countess of Chester Hospital NHS Foundation Trust

These accounts for the year ended 31 March 2019 have been prepared by the Countess of Chester Hospital NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006 and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.

Dr Susan Gilby,
Chief Executive Officer
21 May 2019

4.3 Statement of comprehensive income for the year ended 31 March 2019

	Note	2018/19 £000	2017/18 £000
Operating Income from Patient Care Activities	2	216,966	211,400
Other Operating Income		21,280	26,756
Operating Expenses of Continuing Operations: including Impairment/ (Reversal of Impairment) of £5,056,000, 2017/18 £(12,054,000)	3	(249,846)	(222,912)
Operating (Deficit)/Surplus		(11,600)	15,244
Net Finance Costs:			
Finance Income	7.1	102	41
Finance Expense - Financial Liabilities	7.2	(678)	(609)
PDC Dividends payable	1.14	(1,018)	(778)
Net Finance Costs		(1,594)	(1,346)
Gains/(Losses) of disposal of assets		33	(61)
(DEFICIT)/SURPLUS FOR THE YEAR		(13,161)	13,837
Other comprehensive income:			
Impairment losses/(revaluation gains) property, plant and equipment	1.6	(586)	1,067
TOTAL COMPREHENSIVE INCOME AND EXPENSE FOR THE YEAR		(13,747)	14,904

The notes of pages 183 to 215 form part of these financial statements

4.4 Statement of Financial Position at 31 March 2019

	Note	March 31 2019 £000	March 31 2018 £000
NON-CURRENT ASSETS:			
Property plant and equipment	8	95,232	97,880
Total Non-Current Assets		**95,232**	**97,880**
CURRENT ASSETS:			
Inventories	10	1,687	1,437
Trade and other receivables	11	11,209	14,478
Other investments	15.1	2,591	2,591
Cash and cash equivalents	15.2	7,434	9,112
Total Current Assets		22,921	27,618
CURRENT LIABILITIES:			
Trade and other payables	12	(20,212)	(19,225)
Borrowings	13	(4,788)	(4,723)
Provisions	14	(530)	(1,232)
Tax payables		(3,458)	(3,022)
Other liabilities	12.1	(2,552)	(1,803)
Total Current Liabilities		(31,540)	(30,005)
Total Assets less Current Liabilities		86,613	95,493
NON-CURRENT LIABILITIES:			
Borrowings	13	(36,001)	(34,002)
Provisions	14	(1,272)	(1,350)
Other liabilities	12.1	(1,592)	(1,658)
Total Non-Current Liabilities		(38,865)	(37,010)
TOTAL ASSETS EMPLOYED		47,748	58,483
FINANCED BY:			
Public dividend capital		66,612	63,600
Revaluation reserve		5,039	5,625
Income and expenditure reserve		(23,903)	(10,742)
TOTAL TAXPAYERS' EQUITY		47,748	58,483

The notes on pages 183 to 215 form part of these financial statements

Dr Susan Gilby,
Chief Executive Officer
21 May 2019

4.5 Statement of Changes in Taxpayers' Equity 31 March 2019

	Total £000	Public Dividend Capital £000	Revaluation Reserve £000	Income and Expenditure Reserve £000
Taxpayers' Equity at 1 April 2018	58,483	63,600	5,625	(10,742)
Changes in Taxpayers' Equity for 2018/19				
Public Dividend Capital received	3,012	3,012	-	-
Public Dividend Capital repaid	-	-	-	-
Deficit for the year	(13,161)	-	-	(13,161)
Revaluation losses and impairment losses property, plant and equipment	(586)	-	(586)	
Taxpayers' Equity at 31 March 2019	47,748	66,612	5,039	(23,903)

	Total £000	Public Dividend Capital £000	Revaluation Reserve £000	Income and Expenditure Reserve £000
Taxpayers' Equity at 1 April 2017	43,313	63,334	4,558	(24,579)
Changes in Taxpayers' Equity for 2017/18				
Public Dividend Capital received	266	266		
Public Dividend Capital repaid	-	-	-	-
Surplus for the year	13,837	-	-	13,837
Revaluation gains and impairment losses property, plant and equipment	1,067	-	1,067	-
Taxpayers' Equity at 31 March 2018	58,483	63,600	5,625	(10,742)

The notes on pages 183 to 215 form part of these financial statements.

4.6 Statement of Cash Flows for the Year Ended 31 March 2019

	2018/19 £000	2017/18 £000
Cash flows from operating activities:		
Operating surplus from continuing operations	(11,600)	15,244
Operating surplus	(11,600)	15,244
Non-cash income and expense:		
Depreciation and amortisation	4,293	4,324
Income recognised in respect of capital donations	(223)	(183)
Impairments	5,056	-
Reversals of impairments	-	(12,054)
Amortisation of PPP credit	(65)	(67)
Decrease/(Increase) in Trade and Other receivables	3,081	(4,093)
(Increase)/Decrease in Inventories	(250)	217
Increase in Trade and Other payables	958	179
Increase/(Decrease) in Other liabilities	748	(352)
(Decrease) in provisions	(780)	(2,893)
Net cash generated from operations	1,218	322
Cash flows from investing activities:		
Interest received	102	41
Purchase of investments	-	(2,591)
Purchase of property, plant and equipment	(6,824)	(4,249)
Sales of property, plant and equipment	96	12
Receipt of cash donations to purchase capital assets	223	183
Net cash used in investing activities	(6,403)	(6,704)
Cash flows from financing activities:		
Public dividend capital received	3,012	266
Movement in loans from the Department of Health and Social Care	2,036	9,710
Capital element of Public Private Partnership obligations	(37)	(55)
Interest paid	(495)	(406)
Interest element of Public Private Partnership obligations	(179)	(184)
PDC Dividend paid	(830)	(930)
Net cash generated from financing activities	3,507	8,401
(Decrease)/Increase in cash and cash equivalents	(1,678)	2,019
Cash and Cash equivalents at 1 April	9,112	7,093
Cash and Cash equivalents at 31 March	7,434	9,112

The notes on pages 183 to 215 form part of these financial statements.

4.7 Notes to the Accounts

1. Accounting Policies

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2018/19 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to accounts.

1.1 Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.1a Going Concern

These accounts have been prepared on a going concern basis. International Accounting Standard (IAS) 1 requires management to assess, as part of the accounts preparation process, the NHS Foundation Trust's ability to continue as a going concern. In accordance with the Department of Health and Social Care (DHSC) Group Accounting Manual the financial statements have been prepared on a going concern basis as we do not either intend to apply to the Secretary of State for the dissolution of the NHS Foundation Trust without the transfer of the services to another entity, or consider that this course of action will be necessary for at least 12 months from the date of the accounts approval.

The Trust's performance in-year showed a pre-impairment deficit of £8.1m which is worse than the original plan submitted to NHS Improvement at the start of the year by £11.1m. This includes Provider Sustainability Fund (PSF) payments (a performance related incentive payment linked primarily to achievement of a pre-determined 'control total' surplus or deficit) of £4.5m, £2.7m less than plan.

During the year, the Trust required £6.7m interim revenue loans from the Department of Health and Social Care to support it's revenue cash position.

The current 2019/20 forecasts show a (pre-impairments) planned breakeven position, including £8m of incentive funding. To achieve this the Trust will need to meet it's performance targets and deliver cost reductions of £9.4m (equivalent to 3.5% of expenditure), which includes £5.9m which has been classified as high risk.

Contracts for 2019/20 have been agreed with all English Commissioners, securing almost 90% of our clinical income. Our contract with Betsi Cadwaladr LHB remains outstanding and negotiations are continuing.

The Trust finished the year with £7.4m cash balance to support the £4.4m of outstanding capital creditors and the ongoing revenue position. The latest operating and cash flow forecasts currently show that the Trust will require net additional interim revenue support of £1.3m to cover the cash lag in the timing of the incentive payments received,

although this is dependent on the successful delivery of it's financial plan and there will be a revenue cash requirement in the early part of the year due to phasing of cost reduction schemes. The Trust has drawn down £3.4m of interim revenue loans up to May 2019. Further capital financing will be required for 2020/21 and beyond. As with any Trust placing reliance on the DHSC for financial support, the directors acknowledge that there can be no certainty that this support will continue although, at the date of approval of these financial statements, they have no reason to believe that it will not do so.

Due to the significant reduction in capital funding available to the sector, the Trust has not had it's 2018/19 interim capital loan approved by DHSC, despite the approval of NHS Improvement, and will need to apply for additional interim capital loans to finance its 2019/20 capital program. NHS Improvement will, as in previous years, review the 2019/20 interim capital loan application, to ensure that it meets its requirements of being 'emergency' only. It is possible that the required capital loan will not be approved, in which case the relevant capital expenditure would need to reviewed by the Trust to take a view on whether to commit to the capital spend or not, based primarily on a consideration of the risk to patient safety. This would put additional pressure on the cash position,and in this case the Trust would be required to utilise its working balances in the first instance, and then apply for interim working balance support from DHSC.

Based on these indications the directors believe that it remains appropriate to prepare the accounts on a going concern basis. However, the matters referred to above represent a material uncertainty and may cast significant doubt on the Trust's ability to continue as a going concern and it may therefore be unable to realise its assets and discharge its liabilities in the normal course of business. The financial statements do not include any adjustments that would result from the basis of preparation being inappropriate.

1.2 Consolidation

These accounts are for The Countess of Chester Hospital NHS Foundation Trust alone.

The NHS Foundation Trust is the Corporate Trusteee for The Countess Charity.
The Foundation Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the Foundation Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the Charitable Funds and has the ability to affect those returns and other benefits through its power over the fund. However the transactions are immaterial in the context of the group and the transactions have not been consolidated. Details of the transactions with the charity are included in the related parties note.

1.3 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a

contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts
The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Revenue is recognised to the extent that collection of consideration is probable. Where contract challenges from commissioners are expected to be upheld, the Trust reflects this in the transaction price and derecognises the relevant portion of income.

Where the Trust is aware of a penalty based on contractual performance, the Trust reflects this in the transaction price for its recognition of revenue. Revenue is reduced by the value of the penalty.

In the event that the Trust does not receive income where a patient is readmitted within 30 days of discharge from a previous planned stay. This is considered an additional performance obligation to be satisfied under the original transaction price. An estimate of readmissions is made at the year end and this portion of revenue is deferred as a contract liability.

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioner but they affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

Revenue from the Provider Sustainability Fund and Other Central Funding
The funding regime for 2018/19 included distributions from a Provider Sustainability Fund, intended to incentivise performance. Distributions were made once a Trust had achieved certain targets, including the achievement of financial 'Control Totals'. Additional awards could be made from the fund for performing better than the allocated control total, and at the end of the year any remaining funds are distributed based on the overall performance of the Trust during the year. Income is recognised when the award is achieved during the year, and the year end allocation of surplus funds is recognised based on amounts notified by NHS Improvement. Note 3.3 includes details of amounts receivable.

Other central funding is recognised on the basis of the particular award, following notification from the relevant body. In 2018/19, this included additional funding for the Agenda for Change pay award which was actioned during the year, as shown in Note 3.2.

NHS Injury Cost Recovery Scheme
The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured

at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Revenue grants and other contributions to expenditure
Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Other income
Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

1.4 Expenditure on Employee Benefits Short-Term Employee Benefits
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees.

Termination Benefits
Termination benefits are recognised as an expense when the Trust is committed demonstrably, without realistic possibility of withdrawal, to a formal detailed plan to either terminate employment before the normal retirement age, or to provide termination benefits as a result of an offer made to encourage voluntary resignations in accordance with IAS 37. Termination benefits for voluntary resignations are recognised as an expense if the Trust has made an offer of voluntary resignation, it is probable that the offer will be accepted, and the number of acceptances can be estimated reliably. If the benefits are payable more than twelve months after the reporting period, then they are discounted to their present value.

Pension costs
Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they are defined contribution schemes.

Employers pension costs contributions are charged to operating expenses as and when they become due. Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

1.5 Expenditure on other goods and services
Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.6 Property, Plant and Equipment
1.6.1 Recognition
Property, plant and equipment is capitalised where;

- it is held for use in delivering services or for an administrative purposes;
- it is probable that future economic benefits will flow to, or service potential be provided to the Trust;
- it is expected to be used for more than one financial year;

- the cost of the item can be measured reliably; and
- the item has a cost of at least £5,000,or
- collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.
- form part of the initial equipping and setting up cost of a new building, or refurbishment of a ward or unit irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives eg. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

1.6.2 Measurement - Valuation
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. Thereafter they are stated at cost less accumulated depreciation and any recognised impairment loss. All assets are measured subsequently at fair value.

Subsequent to their initial recognition, property, plant and equipment are carried at revalued amounts. Valuations are carried out by Cushman & Wakefield, professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Valuation Standards. These valuations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. In practice this is usually achieved by a full valuation exercise at least every five years, and an interim valuation in the intervening years if required.

Fair values are determined as follows:

Land and non specialised operational property - market value for existing use
The depreciated replacement cost of specialised buildings has been valued on a modern equivalent asset basis and, where it would meet the location requirements of the service being provided, an alternative site has been used. For the current year, an interim valuation was carried out, based on market indices provided by Cushman & Wakefield. The last full asset valuation was undertaken as at 1 April 2016.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

Subsequent expenditure
Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits

or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Depreciation is charged using the straight- line method. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use.

Useful economic lives of property, plant and equipment
Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

Plant and Equipment are depreciated evenly over the estimated life of the asset, as follows:	
Buildings, excluding dwellings	5 to 79 years
Dwellings	60 years
Plant and Equipment	5 to 15 years
Transport Equipment	5 to 7 years
Information Technology	5 to 10 years
Furniture & Fittings	5 to 10 years

Disposals
The gain or loss arising on the disposal or retirement of an asset is determined as the difference between the sale proceeds and the carrying amount of the asset and is recognised in the Statement of Comprehensive Income.

Revaluation Gains and Losses
Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments
In accordance with the GAM, impairments that arise from a clear consumption of economic benefit or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised in the revaluation reserve. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised. Other impairments are treated as revaluation losses . Reversals of 'other impairments' are treated as revaluation gains.

1.6.3 De-recognition

Assets intended for disposal are reclassified as 'Held for Sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable i.e.;
- management are committed to a plan to sell the asset;
- an active programme has begun to find a buyer and complete the sale; - the asset is being actively marketed at a reasonable price;
- the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'; and
- the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

1.6.4 Donated, Government Grant and Other Grant Funded Assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

1.6.5 Public Private Partnership (PPP) Transactions

PPP transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM are accounted for as 'on-Statement of Financial Position' by the Trust. In accordance with IAS 17 the underlying assets are recognised as property, plant and equipment at their fair value together with an equivalent finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment.

Where a significant part of the operators income derives from charges to users rather than payments from the Trust a deferred income credit is established and released to the Statement of Comprehensive Income over the life of the agreement.

The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services. The finance cost is calculated using the implicit interest rate for the scheme.

The service charge is recognised in operating expenses and the finance cost is charged to Finance Costs in the Statement of Comprehensive Income.

1.7 Revenue grants and other contributions to expenditure

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also

recognised at the point of recognition for the benefit.

1.8 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the weighted average method.

1.9 Financial Assets and Financial Liabilities

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, i.e., when receipt or delivery of the goods or services is made.

Derecognition

All financial assets are de-recognised when the rights to receive cashflows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership. Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets are classified as subsequently measured at amortised cost, fair value through income and expenditure or fair value through other comprehensive income as appropriate.

Financial liabilities are classified as subsequently measured at amortised cost, fair value through income and expenditure or fair value through other comprehensive income as appropriate.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income as a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Cash and Cash Equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Impairment of Financial Assets
For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

1.10 Leases
Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

1.10.1 The Trust as Lessee
Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases
Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings
Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

1.10.2 The Trust as Lessor
Finance leases
Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases
Rental income from operating leases is recognised on a straight-line basis over the

term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

1.11 Provisions

The NHS Foundation Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical Negligence Costs

NHS Resolution operates a risk pooling scheme under which the NHS Foundation Trust pays an annual contribution to NHS Resolution which in return settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases the legal liability remains with the NHS Foundation Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 14.1, but is not recognised in the NHS Foundation Trust's accounts.

1.12 Non-Clinical Risk Pooling

The NHS Foundation Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

1.13 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.14 Public Dividend Capital (PDC)

Public Dividend Capital (PDC) is a type of public sector equity finance based on the excesses of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the NHS Foundation Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS Foundation Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets (including lottery funded assets) (ii) average daily cash balances held with the Government Banking Service (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility (iii) any PDC dividend balance receivable or payable. In accordance

with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

1.15 Value Added Tax

Most of the activities of the NHS Foundation Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.16 Corporation Tax

The Countess of Chester Hospital NHS Foundation Trust is a Health Service body within the meaning of s519A ICTA 1988 and accordingly is exempt from taxation in respect of income and capital gains within categories covered by this. There is a power for the Treasury to disapply the exemption in relation to the specified activities of a Foundation Trust (s519A (3) to (8) ICTA 1988). Accordingly, the Trust is potentially within the scope of Corporation Tax but there is no tax liability arising in respect of the current financial year.

1.17 Foreign Exchange

The functional and presentational currencies of the Trust are sterling. A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items (other than financial instruments measured at 'fair value through income and expenditure') are translated at the spot exchange rate on 31 March;
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

1.18 Third Party Assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS Foundation Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

1.19 Critical Judgements in Applying Accounting Policies

In the application of the Trust accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates. The estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods. The main area which requires the exercise of judgement is the calculation of provisions in note 14.1.

1.20 Key Sources of Estimation Uncertainty

The following are the key assumptions concerning the future, and other key sources

of estimation uncertainty at the Statement of financial Position date, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

Asset valuation and impairments: the valuation of the Trust's Land and Buildings Excluding Dwellings is subject to significant estimation uncertainty, since it derives from estimates provided by the Trust's external valuers who base their estimates on local market data as well as other calculations to reflect the age and condition of the Trust's estate.

It is impracticable to disclose the extent of the possible effects of an assumption or another source of estimation uncertainty at the end of the reporting period. On the basis of existing knowledge, outcomes within the next financial year that are different from the assumption around the valuation of our Land and Buildings Excluding Dwellings could require a material adjustment to the carrying amount of the asset recorded in note 8.

1.21 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that the individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the NHS Trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

1.22 Standards, amendments and interpretations in issue but not yet effective or adopted

The DHSC GAM does not require the following Standards and Interpretations to be applied in 2018/19. The DHSC GAM for 2018/19 was published in December 18. This contains the final guidance on the implementation of new accounting standards for NHS Group bodies. The following table presents a list of recently issued IFRS Standards and amendments that have not yet been adopted within the FReM and are therefore not applicable to DHSC group accounts in 2018/19

IFRS 14 Regulatory Deferral Accounts	Not EU-endorsed Applies to first time adopters of IFRS after 1 January 2019. Therefore not applicable to DHSC group bodies.
IFRS 16 Leases	Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM; early adoption is not therefore permitted.
IFRS17 Insurance Contracts	Application required from 2020/21, but not yet adopted by the FReM; early adoption is not therefore permitted.
IFRIC 23 Uncertainty over Income Tax Treatments	Application required for accounting periods beginning on or after 1 January 2019.

The Trust has considered the above new standards, interpretations and amendments to published standards that are not yet effective and concluded that they are either not relevant to the Trust or that they would not have a material impact on the Trust's financial statements, apart from some additional disclosures.

In the case of IFRS 16, there will be a requirement for the Trust to recognise the underlying assets (represented by the present value of the lease payments) and corresponding liabilities inherent in all of it's lease agreements (and contracts containing leases). In addition, the income statement will be charged with depreciation and interest instead of the lease payments, which is expected to 'front load' the expense to the earlier part of the agreement, but at this stage it is not expected that this will represent a material adjustment.

1.23 Accounting standards, amendments and interpretations issued that have been adopted early

No new accounting standards or revisions to existing standards have been early adopted in 2018/19.

2. Income

2.1 Segmental Reporting

All of the Countess of Chester Hospital NHS Foundation Trust's activities are in the provision of healthcare, which is an aggregate of all the individual speciality components included therein, and the very large majority of the healthcare services provided occur at the one geographical main site.

Similarly, the large majority of the Countess of Chester Hospital NHS Foundation Trust's revenue originates with the UK Government. The majority of expenses incurred are payroll expenditure on staff involved in the production or support of healthcare activities generally across the Trust together with the related supplies and overheads needed to establish this production. The business activities which earn revenue and incur expenses are of one broad combined nature and therefore on this basis one segment of 'Healthcare' is deemed appropriate.

The operating results of the Countess of Chester Hospital NHS Foundation Trust are regularly reviewed by the Trust's chief operating decision maker which is the overall Foundation Trust Board and which includes senior professional non-executive directors. The Trust Board review the financial position of the Countess of Chester Hospital NHS Foundation Trust as a whole in their decision making process, rather than individual components included in the totals, in terms of allocating resources. This process again implies a single operating segment under IFRS 8.

The finance report considered monthly by the Trust Board contains summary figures for the whole Trust together with graphical line and bar charts relating to different total income activity levels, and directorate expense budgets with their cost improvement positions.

Likewise only total balance sheet positions and cashflow forecasts are considered for the whole of the Countess of Chester Hospital NHS Foundation Trust. The Board as chief operating decision maker therefore only considers one segment of healthcare in its decision-making process.

The single segment of 'Healthcare' has therefore been identified consistent with the core principle of IFRS 8 which is to enable users of the financial statements to evaluate the nature and financial effects of business activities and economic environments

2.2 Total Income from Activities

	NOTE	2018/19 £000	2017/18 £000
Income from activities	2.2	216,966	211,036
Other operating income	2.4	21,280	26,756
Operating Income from Continuing Operations		238,246	238,156
Operating Income from Patient Care Activities:		2018/19 £000	2017/18 £000
Elective income		35,665	31,944
Non elective income		67,424	65.310
Outpatient income		12,393	11,213
Follow up outpatient income		32,522	30,522
Other type of activity income		44,581	49,601
A&E income		9,080	8,491
High cost drugs income from commissioners		12,169	13,955
Agenda for Change pay award central funding		2,875	-
Total Income		216,709	211,036
Income from activities - Commissioner Requested Services		216,709	211,036
Private patient income		257	364
Income from activities		216,966	211,400

As an NHS Foundation Trust, the majority of income in respect of patient care is received under a block contract with our host Clinical Commissioning Group with the remainder under Payment by Results (PBR).

The Terms of Authorisation set out the goods and services that the Trust is required to provide (Commissioner Requested Services). All of the income from activities before private patient income shown above is derived from the provision of Commissioner Requested Services.

All other income arises from non-mandatory services.

2.3 Income from Patient Care Activities (by source)

	2018/19 £000	2017/18 £000
Income from patient care activities received from:		
NHS England	11,336	14,288
Clinical commissioning groups	166,330	159,488
NHS Foundation Trusts	8,796	8,805
NHS Trusts	150	247
Local authorities	452	240
Department of Health and Social Care	2,875	-
NHS other (including Public Health England)	25,059	25,448
Non NHS: private patients	257	358
Non NHS: overseas patients (non-reciprocal, chargeable to patient)	92	117
Injury cost recovery scheme	1,382	776
Non NHS: other	237	1,693
	216,966	211,400

2.4 Other Operating Income

	2018/19 £000	2017/18 £000
Research and development	634	636
Education and training	7,771	7,688
Charitable contributions to expenditure	636	2,299
Non-patient care services to other bodies	1,999	1,630
Provider Sustainability Fund Income	4,547	8,670
Car parking	1,512	1,318
Catering	1,259	1,234
Other income	2,857	3,214
Amortisation of PPP deferred credits	65	67
	21,280	26,756

2.5 Directly Invoiced Overseas Visitors

	2018/19 £000	2017/18 £000
Income recognised this year	92	117
Cash payments received in-year (relating to invoices raised in current and previous years)	(44)	(51)
Amounts added to provision for impairment of receivables	37	53
Amounts written off in-year	95	57

2.6 Additional information on revenue from contracts with customers recognised in the period

Material Related Party transactions with Other NHS Bodies are further detailed below:

	Total	Revenue recognised from NHS providers Accounts	Revenue recognised from other DHSC group bodies Accounts	Revenue recognised from non DHSC group bodies Accounts
	2018/19 £000	2018/19 £000	2018/19 £000	2018/19 £000
Revenue recognised in the reporting period that was included in contract liabilities at the previous period end	1,737	206	70	1,461

3. Operating Expenses

	2018/19 £000	2017/18 £000
Operating expenses comprise:		
Purchase of healthcare from non-NHS and non-DH bodies	447	146
Staff and executive directors costs	168,052	160,922
Remuneration of non-executive directors	120	118
Drug Costs	20,083	20,660
Supplies and services (excluding drug costs)		
- clinical	26,281	23,001
- general	3,264	3,375
Establishment	2,097	2,177
Transport	159	178
Premises	10,704	8,857
Depreciation & Amortisation	4,293	4,324
(Decrease)/Increase in bad debt provision	(112)	1,301
Provisions / released in year	(555)	(2,277)
Audit fees - statutory audit	55	53
Other services: audit related assurance services	13	12
Other services: other	-	-
Contribution to clinical negligence scheme	8,315	9,661
Consultancy	75	140
Internal audit costs	93	89
Training courses	544	598
Notional training funded from apprenticeship fund	185	47
Insurance	39	37
Impairment/(Reversal of impairment) of property, plant and equipment	5,056	(12,054)
Other	638	1,547
	249,846	222,912

4. Arrangements containing an operating lease

	2018/19 £000	2017/18 £000
Minimum lease payments	2,360	1,815
	2,360	1,815

4.1 Total future minimum operating lease payments

	2018/19 £000	2017/18 £000
Payable:		
not later than one year;	1,656	1,566
later than one year and not later than five years;	6,648	6,521
later than five years.	325	2,003
	8,629	10,090

The Trust has short term operating leases for various types of equipment usually on a short term basis and the payments for these are included in the minimum lease payments for the financial year.

The Trust is also committed under contract for five managed service contracts which provide equipment as part of the contract. These contracts have between 1 and 5 years left before expiry, with an opportunity to extend to 10 years. Also included are a number of lease cars and vans. These leases are for a period of three years.

5. Employee Expenses and Numbers

5.1 Employee expenses

	Total 2018/19 £000	Total 2017/18 £000
Short term employee benefits - salaries and wages	135,680	130,086
Social security costs	12,103	11,483
Apprenticeship levy	638	605
Employer's contributions to NHS pensions	15,239	14,433
Other Employment Benefits	-	3
Temporary staff (including agency)	4,422	4,373
	168,082	160, 983

5.2 Retirements due to Ill-health

During 2018/19 (prior year 2017/18) there was 1 (4) early retirement from the Trust agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £40,000 (£203,000). The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division. This information was supplied by NHS Business Services Authority - Pensions Division.

5.3 Directors' Remuneration

	Total 2018/19 £000	Total 2017/18 £000
Executive Directors Remuneration	956	776
Employer's contributions for national insurance	119	101
Employer's contributions to the pension scheme	90	91

There are a total of 8 Executive Directors in total at the end of the financial year, 6 to whom benefits are accruing under defined benefit pension schemes. For further information please see the remuneration report on page 48 of the annual report.

5.4 Losses and Special Payments

NHS Foundation Trusts are required to record cash payments and other adjustments that arise as a result of losses and special payments. In the year the Trust had 186 (2017/18 131) separate losses and special payments, totalling £551,000 (2017/18 £154,000). These losses were mainly due to bad debts and damage/loss of property, and are reported on an accruals basis.

During the year the Trust paid an out-of-court special payment of £375k to a contractor based on legal advice. This was disclosed as a contingent liability in the Trust's 2017/18 Annual Accounts.

6. Pension Costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department)

as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes.

The valuation of scheme liability as at 31 March 2019, is based on valuation data as at 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account its recent demographic experience), and to recommend the contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgement from the Court of Appeal in December 2018, Government announced a pause to that part of the valuation process pending consultation of the continuing legal process.

6.1 Auto-Enrolement
The Pensions Act 2008 introduced automatic enrolment of eligible workers into a qualifying workplace pension scheme. The NHSPS is such a scheme and the legislation took effect from 2013. This took effect for the Countess of Chester NHS Foundation Trust from July 2013. The Trust has a duty to automatically enrol eligible workers, between the ages of 22 and State Pension age subject to certain pay criteria. For the Countess of Chester Hospital NHS Foundation Trust the number of enrolments and contributions are immaterial.

7. Net Finance Costs

7.1 Finance Income

	2018/19 £000	2017/18 £000
Interest on loans and receivables	102	41

7.2 Finance Costs

	2018/19 £000	2017/18 £000
Interest on Loans from the Department of Health and Social Care	499	425
Interest on obligations under PPP contracts:		
- finance cost	109	112
- contingent finance cost	70	72
	678	609

8. Property, Plant and Equipment Fixed Asset Movement 2018/19

	Land	Buildings Excluding Dwellings	Dwellings	Assets Under Construction	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings	Total 31 March 2019
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation									
At 1 April 2018	4,092	70,621	2,591	2,735	33,130	20	8,853	4,506	126,548
Additions - purchased	-	1,008	-	3,643	1,958	-	474	44	7,127
Additions - donated and grant funded	-	80	-	-	143	-	-	-	223
Reclassifications	-	306	-	(518)	-	-	123	89	-
Impairments	(1,006)	(5,830)	-	-	-	-	-	-	(6,836)
Other in year revaluation	-	-	-	-	-	-	-	-	-
Disposals	-	-	-	-	(971)	-	-	-	(971)
At 31 March 2019	3,086	66,185	2,591	5,860	34,260	20	9,450	4,639	126,091
Accumulated depreciation									
At 1 April 2018	-	-	620	-	19,220	20	5,319	3,489	28,668
Impairments	-	(1,194)	-	-	-	-	-	-	(1,194)
Other in year revaluation	-	-	-	-	-	-	-	-	-
Disposals	-	-	-	-	(908)	-	-	-	(908)
Provided during the year	-	1,194	62	-	1,786	-	987	264	4,293
At 31 March 2019	-	-	682	-	20,098	20	6,306	3,753	30,859
Net book value									
Purchased at 1 April 2018	2,982	69,193	-	2,735	13,309	-	3,534	1,017	92,770
PPP Obligations at 1 April 2018	1,110	-	1,971	-	-	-	-	-	3,081
Donated at 1 April 2018	-	1,428	-	-	601	-	-	-	2,029
Total at 1 April 2018	4,092	70,621	1,971	2,735	13,910	-	3,534	1,017	97,880
Net book value									
Purchased at 31 March 2019	1,976	64,756	1,909	5,860	13,520	-	3,144	886	92,051
PPP Obligations at 31 March 2019	1,110	-	-	-	-	-	-	-	1,110
Donated at 31 March 2019	-	1,429	-	-	642	-	-	-	2,071
Total at 31 March 2019	3,086	66,185	1,909	5,860	14,162	-	3,144	886	95,232

8.1 Net Book Value of Assets held under PPP Obligations

	2018/19 £000	2017/18 £000
PPP Arrangements		
Cost of valuation at 1 April	4,033	4,033
Cost or valuation at 31 March	4,033	4,033

	2018/19 £000	2017/18 £000
Depreciation at 1 April as previously stated	952	890
Accumulated depreciation at 1 April as restated	952	890
Provided during the year	62	62
Accumulated depreciation at 31 March	1,014	952
Net Book Value under PPP obligations at 31 March	3,019	3,081

In 2005/06, the Trust entered into a Public Private Partnership with Frontis Homes Limited, a registered social landlord, to provide our staff accommodation and on-call facilities. The £5.9m scheme has significantly improved the quality of the previous accommodation, and increased the ability of the Trust to continue to attract the best staff. The Trust will contribute annually toward the cost of the rent and services to be provided for the on-call facility. The term of the agreement is 40 years.

9. PPP Obligations

9.1 Gross PPP Obligations

	31 March 2019 £000	31 March 2018 £000
Gross PPP Liabilities	3,274	3,420
of which liabilities are due:		
Not later than one year	149	146
Between one and five years	743	751
After five years	2,382	2,523
Finance charges allocated to future periods	(1,196)	(1,305)
Net PPP Liabilities	2,078	2,115
Not later than one year	41	37
Between one and five years	353	343
After five years	1,684	1,735
	2,078	2,115

9.2 Total Future Payments in respect of PPP Arrangements

	31 March 2019 £000	31 March 2018 £000
of which due:		
Not later than one year;	430	420
later than one year and not later than five years;	1,832	1,787
later than five years.	9,074	9,549
Total future payments committed	11,336	11,756

9.3 Analysis of Amounts Payable to Service Concession Operator

	31 March 2019 £000	31 March 2018 £000
Unitary payment payable to service concession operator		
Consisting of:		
Interest Charge	109	112
Repayment of finance lease liability	37	55
Service element	204	171
Contingent rent	70	72
	420	410

10. Inventories

	31 March 2019 £000	31 March 2018 £000
Drugs	1,161	993
Consumables	526	444
	1,687	1,437

10.1 Inventories Recognised in Expenses

	31 March 2019 £000	31 March 2018 £000
Inventories recognised in expenses	21,765	21,934
Write-down of inventories recognised as an expense	50	70
Total Inventories recognised in expenses	21,815	22,004

11. Trade and Other Receivables

	31 March 2019 £000	31 March 2018 £000
Current		
Trade receivables	-	7,382
Contract receivables	6,610	-
Contract assets	-	-
Allowance for impaired contract receivables/assets	(509)	(2,703)
Amounts due in respect of NHS Improvement Provider Sustainability Fund (PSF)	2,759	6,191
PDC Dividend Receivable	169	357
VAT recoverable	164	244
Other receivables	382	342
Accrued Income	-	717
Prepayments	1,634	1,948
Total Current Trade and Other Receivables	11,209	14,478
Of which receivables from NHS and DHSC group bodies:		
Current	7,334	11,298

There are no non-current contract receivables. The majority of trade is with other NHS organisations, which are funded by government, therefore no credit scoring of them is considered necessary.

Following the application of IFRS 15 from 1 April 2018, the Trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

11.1 Allowance for Credit losses 2018/19

IFRS 9 and IFRS 15 are adopted without restatement therefore this analysis is prepared in line with the requirements of IFRS 7 prior to IFRS 9 adoption. As a result it differs in format to the current period disclosure.

	Receivables and Contract Assets £000
Allowances as at 1 Apr 2018 - brought forward	2,703
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	(1,857)
New allowances arising	264
Changes in existing allowances	-
Reversals of allowances	(376)
Utilisation of allowances (write offs)	(225)
At 31 March 2019	509

11.2 Provision for Impairment of Receivables - 2017/18

IFRS 9 and IFRS 15 are adopted without restatement therefore this analysis is prepared in line with the requirements of IFRS 7 prior to IFRS 9 adoption. As a result it differs in format to the current period disclosure.

	All Receivables 31 March 2018 £000
Balance at 1 April	1,716
Increase in allowance	2,061
Amount written off during the year	(314)
Amount recovered during the year	(760)
At 31 March 2018	2,703

12. Trade and Other Payables

	Current		Non-current	
	31 March 2019 £000	31 March 2018 £000	31 March 2019 £000	31 March 2018 £000
Trade payables	12,716	12,846	-	-
NHS Pension Scheme	2,183	2,018	-	-
Other payables	1,563	2,355	-	-
Accrued interest on DHSC loans	-	61	-	-
Accruals	3,750	1,945	-	-
Total	20,212	19,225	-	-
Of which payable to NHS and DHSC group bodies:				
Current	3,714	3,209	-	-

Following the adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within note 13. IFRS 9 is applied without restatement, therefore comparatives have not been restated.

12.1 Other Liabilities

	Current		Non-current	
	31 March 2019 £000	31 March 2018 £000	31 March 2019 £000	31 March 2018 £000
Deferred Income	2,486	1,737	-	-
Deferred PPP Credits	66	66	1,592	1,658
Total	2,552	1,803	1,592	1,658

13. Borrowings

	Current		Non-current	
	31 March 2019 £000	31 March 2018 £000	31 March 2019 £000	31 March 2018 £000
Loans from the Department of Health and Social Care	4,747	4,686	33,964	31,924
Obligations under PPP Contracts	41	37	2,037	2,078
	4,788	4,723	36,001	34,002

Schedule of Borrowing	Date Started	Date to be completed	Interest Rate	Loan Amount	Amount outstanding (excluding interest accrued) £000
Loan 1 - Normal course of business capital loan	Mar 10	Mar 20	3.09%	6,000	662
Loan 2 - Normal course of business capital loan	Mar 12	Sep 21	2.46%	5,000	1,318
Loan 3 - Normal course of business capital loan	Mar 13	Mar 18	0.48%	4,500	-
Loan 4 - Normal course of business capital loan	Mar 13	Sep 27	1.39%	16,800	10,584
Loan 5 - Normal course of business capital loan	Oct 14	Nov 21	1.36%	11,000	5,079
Loan 6 - Normal course of business capital loan	Sep 17	Aug 32	1.03%	8,090	7,532
Loan 7 - Interim revenue loan	Jan 18	Jan 21	1.50%	1,724	1,724
Loan 8 - Interim revenue loan	Feb 18	Feb 21	1.50%	1,305	1,305
Loan 9 - Interim revenue loan	Mar 18	Mar 21	1.50%	3,720	3,720
Loan 10 - Interim revenue loan	Dec 18	Dec 21	1.50%	1,638	1,638
Loan 11 - Interim revenue loan	Jan 19	Jan 22	1.50%	1,578	1,578
Loan 12 - Interim revenue loan	Mar 19	Mar 22	1.50%	3,506	3,506

13.1 Reconciliation of liabilities arising from financial activities

	Loans from DHSC £000	PPP schemes £000	Total £000
Carrying value at 1 April 2018	36,610	2,115	38,725
Cash movements:			
Financing cash flows - payments and receipts of principal	2,036	(37)	1,999
Financing cash flows - payments of interest	(495)	(109)	(604)
Impact of implementing IFRS 9 on 1 April 2018	61	-	61
Application of effective interest rate	499	109	608
Carrying value at 31 March 2019	38,711	2,078	40,789

14. Provisions

	Current	Non-Current	Current	Non-Current
	31 March 2019 £000	31 March 2019 £000	31 March 2018 £000	31 March 2018 £000
Pensions - Early Departure Costs	15	162	15	173
Pensions - Injury Benefit	37	1,110	36	1,177
Legal Claims	250	-	566	-
Other	150	-	447	-
Restructuring	78	-	168	-
	530	1,272	1,232	1,350

	Pensions - Early Departure Costs £000	Pensions - Injury Benefit £000	Legal Claims £000	Other £000	Restructuring £000	Total £000
At 1 April 2018	188	1,213	566	447	168	2,582
Arising during the year	4	1	132	-	-	137
Utilised during the year	(15)	(37)	(54)	-	(90)	(196)
Change in Discount Rate	-	(30)	-	-	-	(30)
Reversed unused	-	-	(394)	(297)	-	(691)
At 31 March 2019	177	1,147	250	150	78	1,802
Expected timing of cashflows:						
- not later than one year	15	37	250	150	78	530
- later than one year and not later than five years	60	158	-	-	-	218
- later than five years	102	952	-	-	-	1,054
	177	1,147	250	150	78	1,802

14.1 Provisions

Pensions relating to other staff

Provisions for capitalised pension benefits are based on tables provided by the Office for National Statistics, reflecting years to normal retirement age and the additional pension costs associated with early retirement. No further capitalisations of pension benefits have been applied during the financial year. This provision relates to two former employees.

Legal claims

Legal claims consist of amounts due as a result of third party and employee liability claims. The values are based on information provided by the Trust's solicitors and NHS Resolution.

Other

The other provision relates to outstanding pay reform assimilations and changes in legislation.

Permanent Injury Benefits
Permanent Injury Benefits are payable to eligible individuals, and are calculated in the same way as capitalised pension benefits. The calculations are based on current payments in relation to expected life tables as issued by the Office for National Statistics. These are discounted using the Treasury published discount rate.

Restructuring
The restructuring provision is for those staff that have applied for the Mutually Agreed Resignation Scheme but which have not yet been paid out.

£130,234,000 is included in the provisions of NHS Resolution at 31/3/19 in respect of clinical negligence liabilities for the Trust (31/3/2018 £153,892,000)

The provisions for legal claims are calculated by reference to expected cash flows discounted back at the relevant current Treasury discount rate.

15. Other Investments and Cash and Cash Equivalents

15.1 Other Investments

	31 March 2019 £000	31 March 2018 £000
Balances at 1 April	2,591	-
Net change in year	-	2,591
Other Investments	2,591	2,591

Other investments at 31 March 2019 represent amounts held in a designated deposit account set up as part of a funding agreement to deliver a new Neonatal Unit. Release of the funds is dependent on successful delivery of each phase of the construction, which is expected to last for around 18 months and commenced in April 2019. The account is denominated in sterling. The account attracts interest at rates based on LIBOR or equivalent market rates. The carrying amounts are equivalent to their fair values.

15.2 Cash and Cash Equivalents

	31 March 2019 £000	31 March 2018 £000
Bank balances at 1 April	9,112	7,093
Net change in year	(1,678)	2,019
Cash and cash equivalents in the statement of cash flows at 31 March	7,434	9,112
Broken down into:		
Cash at commercial banks and in hand	237	220
Cash with the Government Banking Service	7,197	8,892
Total cash and cash equivalents as in SoFP	7,434	9,112

Cash and cash equivalents at 31 March 2019 are held in instant access bank accounts, short-term money market investments and other deposit accounts denominated in sterling. They attract interest at rates based on LIBOR or equivalent market or public sector rates. The carrying amounts are equivalent to their fair values.

16. Capital Commitments and Events After the Reporting Date

16.1 Capital Commitments

	31 March 2019 £000	31 March 2018 £000
Contractual Capital Commitments at 31 March not otherwise included in these financial statements:		
Property, Plant and Equipment	1,863	76

16.2 Events After the Reporting Date

There are no disclosable events after the reporting date.

17. Third Party Assets

The Trust held £0k In the Bank (2017/18 £0) which relates to monies held by the NHS Foundation Trust on behalf of patients.

18. Related Party Transactions

The Countess of Chester Hospital NHS Foundation Trust is a public interest body authorised by NHS Improvement the Independent Regulator for NHS Foundation Trusts.
The Trust has received £595,000 (2017/18 £2,284,000 total) payments from a number of charitable funds for which the Trust acts as Corporate Trustee.

Other NHS entities that interact with the Countess of Chester Hospital NHS Foundation Trust are regarded as related parties. The transactions are in the normal course of business and are on an arms length basis. During the year the Countess of Chester Hospital NHS Foundation Trust had a number of material transactions with other NHS entities which are listed below. The amounts outstanding are unsecured and will be settled in cash. No guarantees have been given or received.

	2018/19		2018/19	
	Income £000	Expenditure £000	Current Receivables £000	Current Payables £000
Value of transactions with:				
Department of Health	2,931	-	13	-
Other NHS Bodies	201,694	17,126	7,131	3,881
Charitable Funds	595	-	43	-
Other WGA Bodies	25,963	29,215	459	5,852

Material Related Party transactions with Other NHS Bodies are further detailed below:

	2018/19		2018/19	
	Income £000	Expenditure £000	Current receivables £000	Current payables £000
Alder Hey Children's NHS Foundation Trust	182	161	4	80
Bridgewater Community Healthcare NHS Foundation Trust	159	7	78	7
Cheshire and Wirral Partnership NHS Foundation Trust	1,461	765	261	404
Liverpool Women's NHS Foundation Trust	19	225	1	35
Mid Cheshire NHS Foundation Trust	291	5	16	1
The Clatterbridge Cancer Centre NHS Foundation Trust	451	(4)	-	-
The Walton Centre NHS Foundation Trust	148	41	44	6
Warrington and Halton Hospitals NHS Foundation Trust	504	810	136	528
Wirral Community NHS Foundation Trust	135	-	15	-
Wirral University Teaching Hospital NHS Foundation Trust	6,607	3,818	1,534	1,539
East Cheshire NHS Trust	379	58	39	78
Royal Liverpool & Broadgreen University Hospitals NHS Trust	572	527	165	248
St Helens and Knowsley Hospitals NHS Trust	4	(18)	1	22
NHS Eastern Cheshire CCG	81	-	-	7
NHS Halton CCG	1,350	-	-	42
NHS Liverpool CCG	229	-	3	-
NHS Shropshire CCG	580	-	-	11
NHS South Cheshire CCG	541	-	7	-
NHS St Helens CCG	287	-	-	21
NHS Vale Royal CCG	1,558	-	3	-
NHS Warrington CCG	1,997	-	4	-
NHS West Cheshire CCG	152,511	84	673	235
NHS Wirral CCG	5,779	-	-	148
NHS England	4,549	55	2,759	9
Public Health England	53	456	9	18
Health Education England	7,603	3	79	-
NHS Resolution	-	8,314	-	13
Care Quality Commission	-	161	-	-
NHS Property Services	121	944	99	-
NHS England - Cheshire and Merseyside Local Office	2,296	-	98	-
NHS England - North West Specialised Commissioning Hub	8,851	-	-	106
HM Revenue & Customs - VAT	-	-	164	-
HM Revenue & Customs - Other	8	12,749	-	3,458
National Heath Service Pension Scheme	-	15,239	-	2,182
Welsh Health Bodies - Betsi Cadwaladr University Local Health Board	24,891	6	-	206
NHS Blood and Transplant	20	1,052	21	-
Cheshire East Unitary Authority	120	-	-	-
Cheshire West and Chester Unitary Authority	483	72	240	1
Flintshire County Council	242	2	-	-

19. Financial Instruments

Disclosure is required under International Accounting Standards of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. The Countess of Chester Hospital NHS Foundation Trust actively seeks to minimise its financial risks. In line with this policy, the Trust neither buys nor sells financial instruments. Financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

Market Risk

Interest-Rate Risk

All of the Trust's financial liabilities carry nil or fixed rates of interest. In addition, the only element of the Trust's assets that are subject to a variable rate are short term cash investments. The Trust is not, therefore, exposed to significant interest-rate risk. Interest rate profiles of the Trust's relevant financial assets and liabilities are shown in notes 12 and 15.

Foreign Currency Risk

The Trust has negligible foreign currency income or expenditure.

Credit Risk

The Trust operates primarily within the NHS market and receives the majority of its income from other NHS organisations, as disclosed in note 18. There is therefore little risk that one party will fail to discharge its obligation with the other. Disputes can arise, however, around how the amounts owed are calculated, particularly due to the complex nature of the Payment by Results regime. For this reason the Trust makes a provision for irrecoverable amounts based on historic patterns and the best information available at the time the accounts are prepared. The Trust does not hold any collateral as security.

Liquidity Risk

The Trust's net operating costs are incurred under annual agency purchase contracts with local Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. The Trust receives such contract income in accordance with Payment by Results (PBR), which is intended to match the income received in year to the activity delivered in that year by reference to the National Tariff procedure cost. The Trust received cash each month based on an annually agreed level of contract activity and there are quarterly payments made to adjust for the actual income due under PBR. This means that in periods of significant variance against contracts there can be a significant cash-flow impact. The Trust has adequate liquidity to deal with these variances.

The Trust finances its capital expenditure from internally generated funds or funds made available from Government, in the form of additional Public Dividend Capital, under an agreed limit. In addition, the Trust has borrowed from the Department of Health Financing Facility and may also borrow commercially in order to finance capital schemes. Financing is drawn down to match the capital spend profile of the scheme concerned and the Trust is not, therefore exposed to significant liquidity risks in this area.

20. Auditors Liability Limitation Agreements

As determined in the engagement letter with KPMG, external auditors to the Trust, the liability of either party under or in connection with the contract, whether arising in contract, tort, negligence, breach of statutory duty or otherwise, shall not exceed the sum of £2 million in any one year.

	2018/2019 £000	2017/2018 £000
Limitation on Auditors Liability	2,000	2,000

21. Carrying Values of Financial Assets

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total book value £000
Carrying values of financial assets as at 31 March 2019 under IFRS 9				
Trade and other receivables excluding non financial assets	9,019	-	-	9,019
Other investments / financial assets	2,591	-	-	2,591
Cash and cash equivalents at bank and in hand	7,434	-	-	7,434
Total at 31 March 2019	19,044	-	-	19,044

	Loans and receivables £000	Assets at fair value through I&E £000	Held to maturity £000	Total book value £000
Carrying values of financial assets as at 31 March 2018 under IAS 39				
Trade and other receivables excluding non financial assets	11,211	-	-	11,211
Other investments / financial assets	2,591	-	-	2,591
Cash and cash equivalents at bank and in hand	9,112	-	-	9,112
Total at 31 March 2018	22,914	-	-	22,914

Carrying value of financial liabilities

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost £000	Held at fair through the I&E £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9			
Loans from the Department of Health and Social Care	38,711	-	38,711
Obligations under finance leases	-	-	-
Obligations under PFI, LIFT and other service concession contracts	2,078	-	2,078
Other borrowings	-	-	-
Trade and other payables excluding non financial liabilities	18,029	-	18,029
Other financial liabilities	-	-	-
Provisions under contract	-	-	-
Total at 31 March 2019	58,818	-	58,818

	Other financial liabilities £000	Held at fair through the I&E £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2018 under IAS 39			
Loans from the Department of Health and Social Care	36,610	-	36,610
Obligations under finance leases	-	-	-
Obligations under PFI, LIFT and other service concession contracts	2,115	-	2,115
Other borrowings	-	-	-
Trade and other payables excluding non financial liabilities	17,097	-	17,097
Other financial liabilities	-	-	-
Provisions under contract	-	-	-
Total at 31 March 2018	55,822	-	55,822

	31 March 2019 £000	31 March 2018 £000
Maturity of Financial Liabilities		
In one year or less	22,817	21,819
In more than one year but not more than two years	10,871	4,723
In more than two years but not more than five years	16,139	16,634
In more than five years	8,991	12,646
	58,818	55,822

Initial application of IFRS 9

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £61k, and trade payables correspondingly reduced.

Reassessment of allowances for credit losses under the expected loss model resulted in a £0k decrease in the carrying value of receivables.

The GAM expands the definition of a contract in the context of financial instruments to include legislation and regulations, except where this gives rise to a tax. Implementation of this adaptation on 1 April 2018 has led to the classification of receivables relating to Injury Cost Recovery as a financial asset measured at amortised cost. The carrying value of these receivables at 1 April 2018 was £872,000.

Initial application of IFRS 15

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).