Countess of Chester Hospital NHS Foundation Trust

Inspection report

Executive Suite, Countess Of Chester Health Park
Liverpool Road
Chester
CH2 1UL
Tel: 01244365000
www.coch.nhs.uk

Date of inspection visit: 17 October - 16 November 2023
Date of publication: 14/02/2024

Ratings

Overall trust quality rating	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

Our findings

- The trust had prioritised diagnostic activity and self-assessment since the last inspection to enable it to act to improve care and treatment. The trust welcomed external reviews in several key areas to stress test internal systems, identify weaknesses and formulate improvement plans. Leaders understood the priorities and issues the trust faced and needed to turn plans into action to embed and sustain improvements.
- Staff in most services and leaders at all levels told us that the trust was a better place to work than it was a year ago. The trust had relaunched Freedom to Speak Up processes with a refreshed policy and new champion roles to ensure all staff felt able to raise concerns. Leaders told us they were committed to acting the concerns raised by staff.
- The trust was due to launch a new strategy shortly after our inspection. The new strategy committed the trust to making significant improvements in the quality and safety, as well as rebuilding public trust and confidence in the trust's services.
- Staff consistently demonstrated resilience in the context of significant internal and external pressures on services. Staff continued to treat patients with compassion and kindness, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.

How we carried out the inspection

The inspections of the trust's core services were led by a CQC operations manager and supported by ten CQC inspectors, one CQC regulatory coordinator, a CQC inspection planner and 9 specialist professional advisors.

The inspection of the well-led key question (the trust's senior leadership and governance) was led by a CQC Deputy Director of Operations and supported by an operations manager, one CQC inspector, one CQC regulatory coordinator and an inspection planner. The team also received support from four specialist professional advisors and executive reviewers with a background and experience in NHS senior management.

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Outstanding practice

We found the following outstanding practice:

- The trust's maternity service had raised funds to publish a book in collaboration with a woman who had experienced baby loss. The book was published in October 2023 and raised awareness about stillbirth and gave support to bereaved families including support for siblings. The service had planned further fundraising to gift all UK NHS trusts with 10 copies of the book.
- The trust's services for children and young people had a strong visible person-centred culture with staff delivering exceptional and personalised care to babies, children, young people and their families. All staff demonstrated great resilience to continue their roles in providing excellent care under difficult circumstances. In October 2022 the service had introduced a pilot phlebotomy service on Saturdays for blood sample tests. This had this had been so successful it was made permanent. The service now completes approximately 500 appointments a month. Staff were very experienced with distraction techniques whilst taking blood samples which meant families avoided paying any parking charges. This also meant families who worked during the week could access the service for their child.
- The trust's neonatal unit had introduced new tools to communicate with women and birthing partners in real time and share videos and pictures using a secure communication system.

Our findings

However, the trust was seeking to recruit permanent leaders at the time of our inspection. Leaders, including those in interim positions, understood and managed the priorities and issues the trust faced. The board was actively seeking to increase the diversity in knowledge, skills and abilities to effectively lead the trust. They were visible and approachable in the trust for patients and staff.

The board was comprised of the executive and non-executive directors. There were six executive directors including the acting chief executive, the chief finance officer, the medical director, the acting director of nursing and quality and acting assistant chief executive officer, the chief operating officer and the chief people officer. There was an additional non-voting director post for a chief digital information officer which was vacant at the time of our inspection. The chief finance officer was also the deputy chief executive.

In the three years leading to the inspection, the trust had experienced a significant period of instability at board level. This had included three new chief executives and three new chairs in this period. Most of the trust's executive team had been appointed since March 2022, including the medical director and chief people officer. The acting chief executive and the acting director of nursing and quality were also both substantive executive directors of a nearby NHS trust. Both had acted in interim positions to support the trust's board since 2022.

The trust had reviewed leadership capacity and capability and had recognised there was more to do to ensure there was stable leadership with an appropriate range of skills, knowledge and experience to effectively lead the trust. At the time of our inspection, the trust was finishing recruitment processes for a new permanent chief executive and had active recruitment processes ongoing for a permanent chief nurse and director of finance. The recruitment processes had been intentionally staggered to ensure the new chief executive would have a role in building the new permanent executive team. The trust had engaged specialist agencies to recruit new non-executive directors with a focus on increasing both clinical and human resources knowledge and expertise on the board.

The trust board and senior leadership team displayed integrity on an ongoing basis. Leaders were clear that whilst the trust had made improvements since the last inspection, there was still a need for further significant improvements.

Succession planning was not in place throughout the trust although leaders had recognised this was an area for improvement. The chief executive told us that the trust faced significant challenges recruiting experienced directors with diverse skills and backgrounds. The trust planned to implement a succession planning process after the board-level recruitment processes had been completed. There was a draft plan to implement succession planning which included improvements to appraisal systems which would allow the trust to identify aspiring leaders.

The trust did not have a board level lead director for mental health. The director of nursing was the board level lead director for learning disability and autism.

There was a programme of visits to services and staff fed back that leaders were approachable. Governors and non-executive directors were involved in visits to services.

The trust leadership team had a comprehensive knowledge of current priorities and challenges across all services. Since our last inspection, the trust has prioritised diagnostic activity and self-assessment to identify risks. The trust had welcomed external reviews in several key areas to stress test internal systems, identify weaknesses and formulate improvement plans. This meant leaders were sighted on the priorities and challenges faced by the trust and plans to make improvements.

Our findings

The trust applied Duty of Candour appropriately. The trust's serious incident reports included explicit reference to Duty of Candour and details for how this had been carried out. The reports showed patients received an apology without delay after an incident had occurred. The trust monitored compliance with a requirement to complete the Duty of Candour within 10 days of an incident occurring. The trust's compliance had varied since March 2023 although low numbers of incidents resulted in significant changes to compliance data. The trust's data showed there were 23 incidents requiring the Duty of Candour, and staff had completed the Duty of Candour within the required timeline for 18 incidents.

Staff did not always have the opportunity to discuss their learning and career development needs at appraisal. At the time of our inspection 76% of all staff had received an appraisal which equated to 2836 of 3734 eligible staff. The trust did not provide data which evidenced whether volunteers, locum staff or agency staff received an appraisal.

Staff had access to support for their own physical and emotional health needs through occupational health. The trust had appointed a workforce well-being lead and was shortly launching a workforce well-being hub. The trust's disciplinary records showed staff were encouraged to use the workforce well-being lead for support through specific processes including disciplinary processes. The trust had a wellbeing strategy for 2023-26 which established set milestones for how the trust would improve the staff wellbeing offer each year.

The trust's sickness and absence figures were not outliers and were within expected ranges. As of August 2023, the trust's sickness rate was 5% and the top sickness reason was anxiety, stress, depression or other psychiatric illness. The trust's turnover rate was 10% and was consistently below the sector average which looks at comparable acute trusts.

Vacancy rates had fallen although still exceeded the trust's target. As of June 2023, the trust's overall vacancy rate was 9% which was a reduction from 12% in June 2022. The vacancy rate for nursing and midwifery staff had fallen from 10.5% in June 2022 to 7.5% in June 2023. The vacancy rate for medical staff had increased from 6% in June 2022 to 10% in June 2023 although this was primarily due to increases in the number of medical roles available.

The trust had a Guardian of Safe Working Hours who produced an annual report for the People and Organisational Development committee. The next report was due to be presented to the board in January 2024. The report for 2022 showed a significant increase in exception reports which are reports from junior doctors submitted when there is a planned or unplanned variation in work schedules. Most reports were submitted by junior doctors working in planned care. There were 25 exception reports about loss of teaching and training opportunities.

The trust's staff survey results showed staff did not always feel equality and diversity were promoted in their day-to-day work and when looking at opportunities for career progression. The trust showed multiple areas of high inequality in the Workforce Race Equality Standard (WRES) 2021/22 report, particularly in career progression, equal opportunity for promotion and harassment, bullying or abuse from staff. The 2022 staff survey indicated 4 measures where results from all other ethnic groups were notably worse than for White staff at the trust. The staff survey indicated 6 measures, under the Workforce Disability Equality Standard (WDES), showing poorer experiences from disabled staff non-disabled staff..

The Workforce Race Equality Standard showed that the majority of staff from ethnic minority groups were employed in lower bands with little or no representation after band 5, and zero after band 7. This had remained constant for the previous three years. For clinical staff, the data showed that there was increased representation from band 5 to 8a over the last 3 years. The trust noted that for medical and dental staff, representation of staff from ethnic minority groups

across the grades and at higher levels was significantly more than the local population and staff demographics and the figures showed a year-on-year increase of staff from ethnic minority groups at each grade. The trust had high numbers of staff who did not declare their disability status with between 7%-33% of staff across the pay scales choosing not to disclose their status.

The trust had a WRES and WDES action plan for 2023/24. The action plans identified specific indicators requiring improvement, alongside details for how the actions would be made sustainable and embedded.

Staff networks were in place although some networks were less embedded than others. The trust had seven networks which were the Women's Network, the BAME Network, the LGBTQ+ Network, the Disability and Wellbeing Network, the Carers' Network, the Faith and Belief Network and the Neurodiversity Network. The Faith and Belief Network was relaunched during our inspection of the trust's senior leadership team. Network chairs did not have protected time for their roles which limited their capacity to lead and develop staff networks. Only one of the staff networks had an executive sponsor.

Freedom to Speak Up

The trust had appointed a Freedom to Speak Up Guardian and provided them with sufficient resources and support to help staff to raise concerns. In 2023, the trust had invited an external review of Freedom to Speak processes.

Following the review, the trust refreshed the policy and relaunched Freedom to Speak Up across the trust. The relaunch included the recruitment and training of new Freedom to Speak Up champions and the implementation of a new Freedom to Speak Up network. At the time of our inspection, the trust had over thirty trained champions and a waiting list for staff to become champions. The network comprised of the Freedom to Speak Up Executive Director, Non-Executive Director Lead, the Freedom to Speak Up Guardian and the champions.

Staff knew how to use the whistle-blowing process and about the role of the Speak Up Guardian. Staff received training in Freedom to Speak Up and compliance with this training was 85% at the time of our inspection. The relaunch of Freedom to Speak Up in the trust had resulted in significant increases in staff feeling able to raise concerns. The Freedom to Speak Up Guardian told us that following the relaunch, the trust had since received more concerns and feedback from staff in three months than it had received in the previous year. The data to support this was not available at the time of our inspection as the most recent report to the board for Freedom to Speak which was presented in September 2023 included data up until the end of June 2023. This report showed consistent numbers of speaking up in most quarters between March 2022 and June 2023, with between 10-16 concerns raised, with the exception of a spike of 22 concerns raised in July-September 2022.

Governance

Governance processes were improving although there was more to do to ensure there was good governance throughout the trust. The trust had identified weaknesses in governance systems and plans to make improvements.

However, leaders at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. The board had refreshed the board assurance framework and implemented measures to ensure there was an organisation-wide ownership of risk.

The trust did not have effective structures, systems and processes in place to support the delivery of its strategy including sub-board committees, divisional committees, team meetings and senior managers. This was an area of

Services for children and young people

The unit had been designed with a focus on family integrated care. There were rooms to support infant feeding. Parents and carers had access to their own fridge to store breast milk. There was also another dedicated locked milk fridge. There was a 'Comfort Zone' where parents and carers could access hot drinks and meet with other parents and staff. There were two further ensuite rooms for families away from the clinical area with a lounge and kitchen.

On the neonatal unit there was there was outdoor access to a large secure garden leading out to a retreat which was a private area for families to use for peace and quietness.

There was a large play area on the children's ward area for children and siblings. There were games and activities suitable for all ages. There was a poster on the door which reminded everyone the room was a "child safe zone" which meant no medical assessments were allowed such as observations, medications, or examinations. The playroom had an adjoining outside area for children to play outside; however, staff told us this was temporarily closed due to ongoing safety works. There was a sensory room which had different light simulations and was used by all children, not just those with sensory loss.

All the wards and units were colourfully decorated and were child friendly. For example, there were suitable toilets, and every door hinge had a slam protection in place.

The service had enough suitable equipment to help them to safely care for children and young people. There was a fully stocked equipment trolley next to each cot. We checked a range of consumables items, and all were within their expiry date.

Staff informed us that storage was an issue on the children's ward however, we observed all equipment to be appropriately stored.

Staff disposed of clinical waste safely. There were arrangements in place for the handling, storage, and disposal of clinical waste. including sharps. All sharp boxes that we looked at were signed, dated, and stored appropriately.

A recent audit for the neonatal and children's outpatient unit which showed high compliance for managing waste and the safe handling and disposal of sharps.

Assessing and responding to patient risk

Neonatal unit

Staff completed and updated most risk assessments and removed or minimised risks and acted quickly acted upon risks of deterioration.

Staff completed risk assessments for each baby on admission. They used a newborn early warning scores (NEWS) nationally recognised tool to identify risks of deterioration and escalated them appropriately.

Staff provided care and support to neonatal babies, who had a gestational age of 32 weeks.

The service delivered a bespoke model of care which sat between the models of level one special care unit (SCU) and level 2 local neonatal unit (LNU).

There were restrictions on the service operating as a full level 2 unit because they only accepted babies who had a gestational age of 32 weeks or more.

The trust told us they could provide high-dependency care to babies for their full admission. The service assessed babies who required intensive care to check whether they could meet the baby's needs or whether it would be safer to transfer the baby to a tertiary unit. This meant the service continued to provide care at a higher level than a level one unit but did not fully deliver care at the level of a level two unit.

Staff knew about and dealt with any specific risk issues and would escalate any concerns to the medical team. They shared necessary information at shift changes and when handing over their care to others to keep children, young people, and their families safe.

There were multiple handover meetings, safety huddles and ward rounds where staff could escalate any concerns to relevant staff. They were scheduled to be at set times each day. They were well attended by all relevant staff. Staff held discussions about treatment management plans as well as staffing concerns, planned and unplanned admissions from Maternity referrals and discharges to transitional ward. All meetings were organised and structured in line with national guidance and good practice.

All staff were fully compliant with paediatric sepsis training. Risk assessments reviewed on inspection had been completed appropriately and this included the sepsis pathway.

There was on call medical cover with an allocated neonatal consultant who provided cover during the week and a neonatal / paediatric consultant who covered the weekend.

The neonatal unit was designed so that the emergency bell on the unit would sound and alert staff anywhere in the unit and staff responding quickly and effectively an alarm.

Staff could arrange urgent transfers to a level 2 local neonatal unit or level 3 neonatal intensive care unit for neonatal babies born under the age of 32 weeks or who required longer intensive care. There was a standard operating procedure to facilitate timely and safe transfers of babies from this trust to other trusts. The trust confirmed post inspection that any intensive care provided was always discussed with the tertiary neonatal unit as part of collaborative working. These transfers were completed by the Cheshire and Merseyside neonatal network transport service.

The neonatal service had a discharge checklist to ensure safe discharge. All babies under the age of 6 weeks of age were reviewed by a paediatrician, or by a year 3 specialist trainee (ST3) or above, prior to discharge in line with the discharge policy.

The transitional care handover also included information about the woman, and birthing person, as well as the baby.

The recent maternity inspection in 2023 highlighted a safety concern for when newborn babies were transferred from the Maternity theatres to the neonatal unit. Senior leaders explained this had been risk assessed and safety measures were in place to mitigate any clinical risks. For example, they used a warming “bear” to keep women warm during the transfer which meant the skin to skin contact could be maintained with the newborn baby.

Children’s ward