Mid Cheshire Hospitals NHS
NHS Foundation Trust

A G E N D A

Board of Directors
A meeting will be held in Public at
9.30am on Monday, 7 August 2017
In the Board Room, Leighton Hospital

Action Key	
A	Approval
I	Information
D	Discussion

Item No	Title of Item	Action	Led by	Page No
1.	**Welcome and Apologies** To welcome members of the public and attendees and to receive apologies for absence from Board Members. *(to note)*	I	Chairman 09.30	-
2.	**Patient or Staff Story** *(verbal)*	I/D	Director of Nursing & Quality 09.32	-
3.	**Board Members' Interests** *(to note)* To **consider** any • Changes to Directors' interests since the last meeting • Conflicts of interest deriving from this agenda	I	Chairman 09.45	-
4.	**Minutes of the Last Meeting** To **approve** the minutes of the Board of Directors meeting held in Public on Monday, 3 July 2017 *(attached) (to approve)*	A	Chairman 09.47	-
5.	**Matters Arising and Action Log** *(attached) (to approve)*	A	Chairman 09.50	-
6.	**Annual Work Programme 2017/18** *(attached) (to approve)*	I/A	Chairman 09.53	-
7.	**Chairman's Announcements** (*to note a verbal report*) **7.1 CCG Board to Board – 10 August 2017** **7.2 Charitable Trust Appointments** **7.3 Dementia Appeal** **7.4 Volunteer Presentation**	I	Chairman 09.55	-
8.	**Governors' Items** (*to note a verbal report*) **8.1 Council of Governors Meeting – 20 July 2017** **8.2 Change to the Constitution**	I	Chairman 10.05	-
9.	**Chief Executive's Report** (*to note a verbal report*) **9.1 Capped Expenditure Programme**	I	Chief Executive 10.10	-

Item No	Title of Item		Action	Led by	Page No
	9.2	**Connecting Care Board**			
	9.3	**Cheshire & Merseyside 5 Year Forward View**			
	9.4	**Cheshire & Wirral LDSP Meeting Workshop**			
	9.5	**Executive Away Day – 24 July 2017**			
10.	**CARING**				
	10.1	**Quality, Safety & Experience Report** *(attached)* (*to note*)	I/D	Director of Nursing & Quality 10.35	-
11.	**SAFE**				
	11.1	**Draft Quality Governance Committee notes from the meeting held on 10 July 2017** *(attached)* (*to note*)	I	Committee Chair 10.45	-
	11.2	**Serious Untoward Incidents and RIDDOR Events** *(verbal)* (*to note*)	I/D	Deputy Chief Executive/ Medical Director 10.50	-
12.	**RESPONSIVE**				
	12.1	**Performance Report** *(attached)* (*to note*)	I/D	Director of Finance 11.00	-
	12.2	**Draft Performance & Finance Committee notes from the meeting held on 27 July 2017** *(to follow)* (*to note*)	I	Committee Chair 11.10	-
	12.3	**Legal Advice** *(verbal)* (*to note*)	I	Chief Executive 11:15	-
	12.4	**Use of Trust Seal and Report** *(attached)* *(for approval)*		Chief Executive 11:20	-
	12.5	**Equality Delivery System Self-Assessment** *(attached) (to note)*		Director of OD and Workforce 11.25	-
13.	**WELL-LED**				
	13.1	**CCICP IT Business Case** *(attached) (to approve)*	A/D	Director of Strategic Partnerships 11.35	-
	13.2	**Draft Transformation and People Committee notes from the meeting held on 6 July 2017** *(attached)* *(to note)*	I	Committee Chair 11.45	-
	13.3	**Visits of Accreditation, Inspection or Investigation** (*verbal*) (*to note*)	I	Chief Executive 11.50	-

Item No	Title of Item	Action	Led by	Page No
14.	**EFFECTIVE**			
	14.1 **Workforce Report** *(attached) (to note)*	D/I	Director of Workforce and OD **11.55**	-
	14.2 **Consultant Appointments** *(verbal)* (*to note*)	I	Deputy Chief Executive/ Medical Director **12.05**	-
15.	**Any Other Business (verbal)**	I/A/D	Chairman **12.10**	-
16.	**Time, Date and Place of Next Meeting**			
	To confirm that the next meeting of the Board of Directors will take place in public, in the Board Room at Leighton Hospital, at 9.30am on Monday, 4 September 2017	I	Chairman	

Resolution: To exclude the press and public from the meeting at this point on the grounds that publicity of the matters being reviewed would be prejudicial to public interest, by reason of the confidential nature of business. The press and public are requested to leave at this point.

Board of Director Meeting held in Public (Action Log)

Action No	Date of Meeting	Action	Lead	Deadline Date	Comments	Date of Board meeting to be reviewed	Status
17/05/13.2.5	02/05/2017	Board to receive a 12 month review of CCICP in September	D Frodsham	04/09/2017		04/09/2017	

Board of Directors Workplan 2017 /18 Version: 2

Item	Board of Directors Meeting												Board Away Day				
	April	*May*	*June*	*July*	*August*	*Sept*	*Oct*	*Nov*	*Dec*	*Jan*	*Feb*	*March*	*Apr*	*Aug*	*Oct*	*Dec*	*Feb*
Patient/Staff Story	x	x	x	x	x	x	x	x	x	x	x	x					
Chief Executive Report	x	x	x	x	x	x	x	x	x	x	x	x					
Chairman's Report	x	x	x	x	x	x	x	x	x	x	x	x					
Governor Report	x	x	x	x	x	x	x	x	x	x	x	x					
Caring																	
CQC Registration biannual Report						x						x					
Nursing and midwifery staffing comprehensive report								x									
Patient Survey Results (National)						x											
Patient Quality Safety and Experience Report	x	x	x	x	x	x	x	x	x	x	x	x					
Staff Survey												x					
CQC Comprehensive Inspection Action Plan						x						x					
Safe																	
Health & Safety Update to Board													x				
SUI & RIDDOR	x	x	x	x	x	x	x	x	x	x	x	x					
Quality Governance Committee	x	x	x	x	x	x	x	x	x	x	x	x					
Guardian of Safe Working Hours Report			x			x			x			x					
Effective																	
Consultant Appointments	x	x	x	x	x	x	x	x	x	x	x	x					
Medical Staffing Update (Part II)	x	x	x	x	x	x	x	x	x	x	x	x					
Responsive																	
Annual Budget/Planning/ Budget Pack	x											x					x
Quality Account	x																
Legal Advice	x	x	x	x	x	x	x	x	x	x	x	x					
Performance & Finance Committee	x	x	x	x	x	x	x	x	x	x	x	x					
Performance Report	x	x	x	x	x	x	x	x	x	x	x	x					
Report on Use of Trust Seal	x			x			x			x							
Corporate Trustee															x		x
Well-Led																	
Annual Budget/Contract Discussions	x											x					
Annual Plan (Extraordinary BoD Meetings)	x	x										x					
Annual Report & Accounts		x															
Audit Committee		x	x			x		x		x		x					
Board Assurance Framework		x			x			x			x						
Top 5 Risks		x			x			x			x						
Trust Strategy	x							x						x	x		x
Trust Strategy Update		x															
Visits of Accreditation, Inspection or Investigation	x	x	x	x	x	x	x	x	x	x	x	x					
Well-Led Governance Framework Self Assessment													x				
Corporate Goverance Handbook	x																
Transformation and People Committee	x	x	x	x	x	x	x	x	x	x	x	x					
Board Sub-Committee Annual Review			x														
Workforce Race Equality Scheme							x										
Board Actions	x	x	x	x	x	x	x	x	x	x	x	x					

Board Report

Presented to Board in August 2017

Quality: Safety and Experience

(June 2017 data)

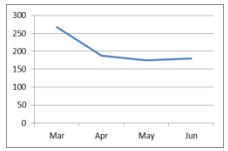
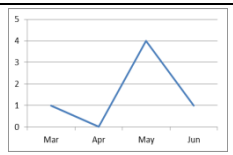
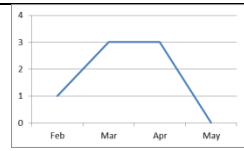
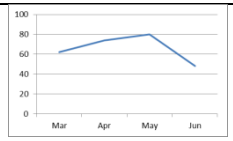
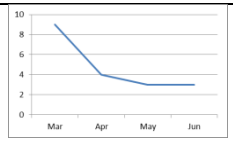
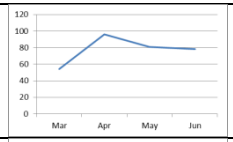
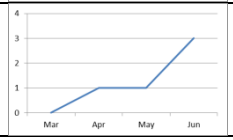
This report provides an overview of performance relating to quality, safety and experience in June 2017.

Board Papers – Quality, Safety & Experience Section: August 2017

Contents

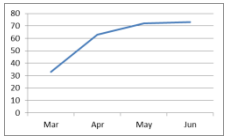
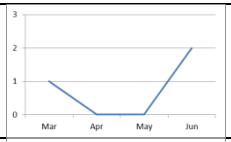
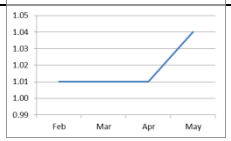
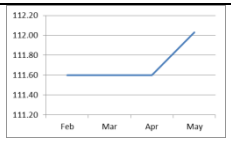
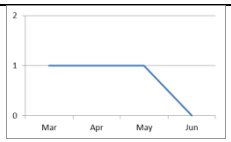
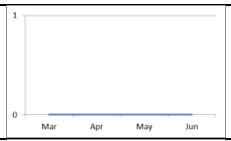
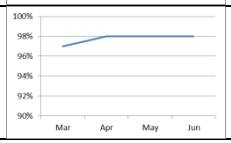
Contents (continued):

Board Papers – Quality, Safety & Experience Section: August 2017

Indicators	Position compared to previous month	Target	Last four months				YTD 17/18	Trajectory
			Mar-17	Apr-17	May-17	Jun-17		
Patient Safety Harm Incidents The aim is to reduce the number of harm incidents by the end of January 2018, measured by comparison to the previous financial year. In 2016/2017 2574 patient safety harm incidents were reported.	↑	**<2574 at end of January 2018**	**268**	**188**	**174**	**180**	**542**	
Serious Incidents (including Never Events) The aim is to have no serious incidents and a zero tolerance on Never Events by the end of January 2018	↓	**Zero at end of January 2018**	**1**	**0**	**4**	**1**	**5**	
Pressure Ulcers The aim is to reduce hospital acquired avoidable pressure ulcers by 5% quarter on quarter in 2017/2018	↓	**12 at end of quarter 1**	**1**	**3**	**3**	**0**	**QTD 17/18** **6**	
Inpatient Falls The aim is to reduce inpatient falls by 10% by January 2018	↓	**733 at end of January 2018**	**62**	**74**	**80**	**48**	**202**	
Medication Incidents The aim is to reduce medication incidents resulting in harm by 10% in comparison to the previous financial year	⇔	**59 at end of 2017/2018**	**9**	**4**	**3**	**3**	**10**	
CCICP Patient Safety Harm Incidents The aim is to reduce the number of harm incidents. A target will be set in quarter 3 once a full year's data is available.	↓		**54**	**96**	**81**	**78**	**255**	
CCICP Serious Incidents (including Never Events) The aim is to have no serious incidents and a zero tolerance on Never Events by the end of January 2018	↑	**Zero at end of January 2018**	**0**	**1**	**1**	**3**	**5**	

Key							
↑	Declined since last month	↓	Improved since last month	⇔	On track to deliver	⇔	Work in place to recover position

Board Papers – Quality, Safety & Experience Section: August 2017

Indicators	Position compared to previous month	Target	Last four months				YTD 17/18	Trajectory
			Mar-17	Apr-17	May-17	Jun-17		
CCICP Pressure Ulcers The aim in quarter 1 is to develop a process to enable pressure ulcers to be classified as avoidable or unavoidable. A baseline for a 5% improvement will be agreed at the end of quarter 1, which will then be measured quarterly.	**Process & measure to be agreed**		**33**	**63**	**72**	**73**	**208**	
CCICP Medication The aim is to reduce harm medication incidents. A target will be set in quarter 3 once a full year's data is available.	**Process & measure to be agreed**		**1**	**0**	**0**	**2**	**2**	
SHMI The Trust's aim within the Sign Up To Safety Campaign is to have a SHMI at or below 1.0 from April 2016	**1.04** ⬆	**Below 1.0**	**1.01**	**1.01**	**1.01**	**1.04**	**N/A**	
HSMR The Trust's aim is to have an HSMR <100	**112.03** ⬆	**<100**	**111.6**	**111.6**	**111.6**	**112.03**	**N/A**	
MRSA The target for MRSA Bacteraemia is zero in 2017/18	⬇	**Zero at end of 2017/2018**	**1**	**1**	**1**	**0**	**2**	
C-Diff Avoidable The target is less than 24 avoidable cases of Clostridium Difficile in 2017/18	⇔	**<24 at end of 2017/2018**	**0**	**0**	**0**	**0**	**0**	
Safety Thermometer The Trust aim is that >95% of patients receive harm free care as monitored by the Safety Thermometer.	⇔	**>95%**	**97%**	**98%**	**98%**	**98%**	**N/A**	

Key							
⬆	**Declined since last month**	⬇	**Improved since last month**	⇔	**On track to deliver**	⇔	**Work in place to recover position**

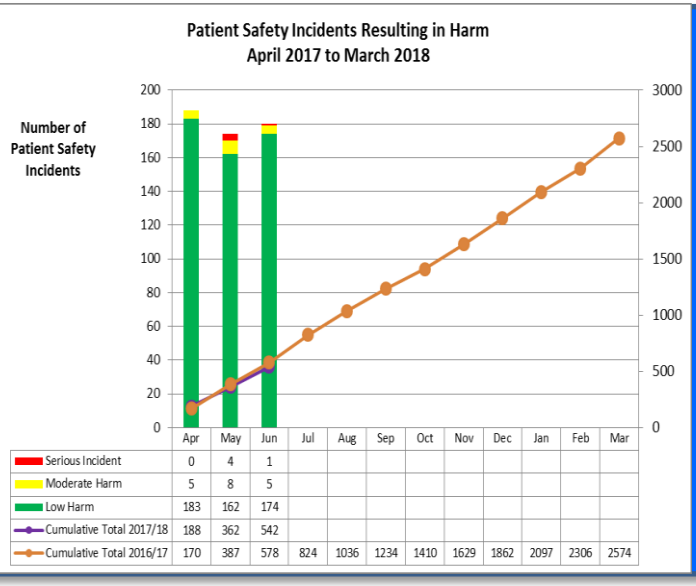
Quality & Safety Section:

Description	Aggregate Position	Trend	Performance against previous month

Patient Safety Incidents resulting in harm.

This chart demonstrates the total number of reported patient safety incidents which resulted in harm.

For this financial year to date:
95.8% (519 incidents) have resulted in low harm
3.3% (18 incidents) have resulted in moderate harm
0.9% (5 incidents) have resulted in serious harm



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Serious Incident	0	4	1									
Moderate Harm	5	8	5									
Low Harm	183	162	174									
Cumulative Total 2017/18	188	362	542									
Cumulative Total 2016/17	170	387	578	824	1036	1234	1410	1629	1862	2097	2306	2574

To reduce the number of patient safety harm incidents, a number of initiatives are being undertaken. These include:

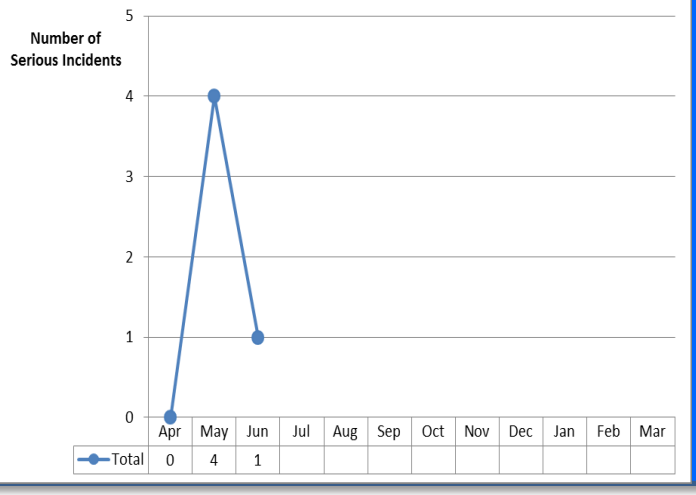
- Bi-weekly Patient Safety Summit Meetings with Executive & Senior Teams
- Participation in the Sign Up To Safety Campaign

Serious Incidents.

This chart demonstrates the number of incidents that have resulted in serious harm.

For this financial year to date, there have been five serious incidents reported.

- 5 x patient falls resulting in serious fractures



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total	0	4	1									

To reduce the number of serious incidents, the Trust has signed up to the Sign Up To Safety Campaign.

Board Papers – Quality, Safety & Experience Section: August 2017

Description	Aggregate Position	Trend	Performance against previous month

Description

Pressure Ulcer (PU) Incidents including both avoidable and unavoidable pressure ulcers based on EPUA Guidance

Aggregate Position

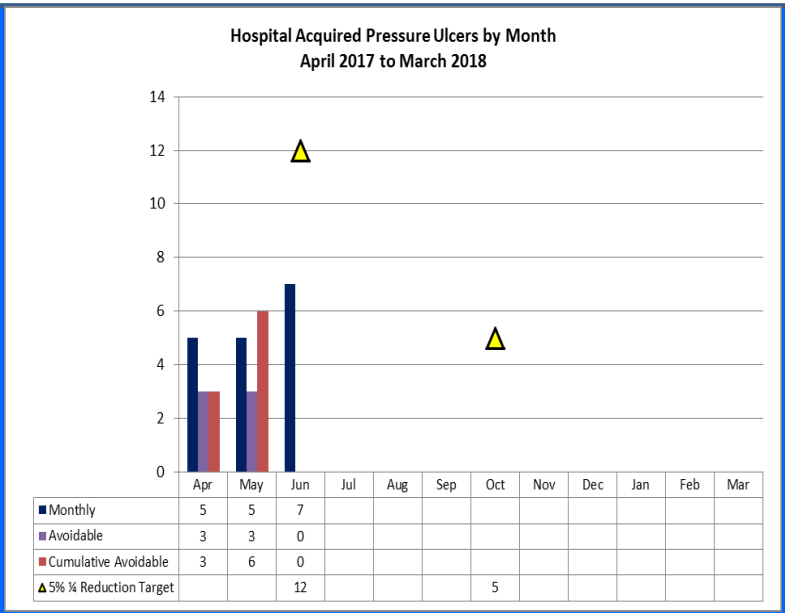
For this financial year to date:

- 100% (17 PU's) have resulted in low harm (defined as a patient that has developed a stage 2 or unstageable PU)
- 0% (0 PU's) have resulted in serious harm (defined as a patient that has developed a stage 3 or 4 PU)

The 5% reduction target to achieve by the end of quarter 1, was to have no more than 12 avoidable pressure ulcers reported. There have been a total of 6 avoidable pressure ulcers for this quarter; therefore the target has been achieved.

In June 2017, no avoidable PU's were reported, as shown by the purple bar on the chart.

Trend



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Monthly	5	5	7									
Avoidable	3	3	0									
Cumulative Avoidable	3	6	0									
5% ¼ Reduction Target			12				5					

Performance against previous month

Improvement actions include:

- Investment in additional funding on a permanent basis to recruit a Tissue Viability Nurse to specifically focus on the elimination of avoidable pressure ulcers.
- This nurse works closely with the skin care specialist nurse to provide education and support to staff in the skin care they provide to their patients.
- The team also provides enhanced support with weekly focus on a target ward, this has raised the awareness of pressure ulcer prevention with the organisation.
- A number of pressure relieving equipment trials are being undertaken within the Trust to support the patient's care journey. This includes the trials of a hybrid mattress, pressure relieving boots, cushions and sole protectors for the end of beds.

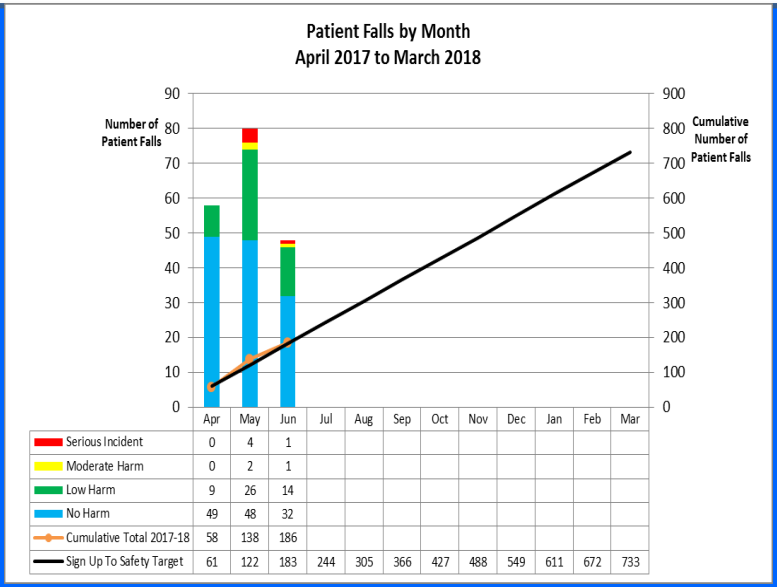
Board Papers – Quality, Safety & Experience Section: August 2017

Description	Aggregate Position	Trend	Performance against previous month

Patient Falls Incidents.

For this financial year to date:

- 69.4% (129 falls) have resulted in no harm
- 26.3% (49 falls) have resulted in low harm
- 1.6% (3 fall) has resulted in moderate harm
- 2.7% (5 falls) have resulted in serious harm



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Serious Incident	0	4	1									
Moderate Harm	0	2	1									
Low Harm	9	26	14									
No Harm	49	48	32									
Cumulative Total 2017-18	58	138	186									
Sign Up To Safety Target	61	122	183	244	305	366	427	488	549	611	672	733

Improvement actions include:

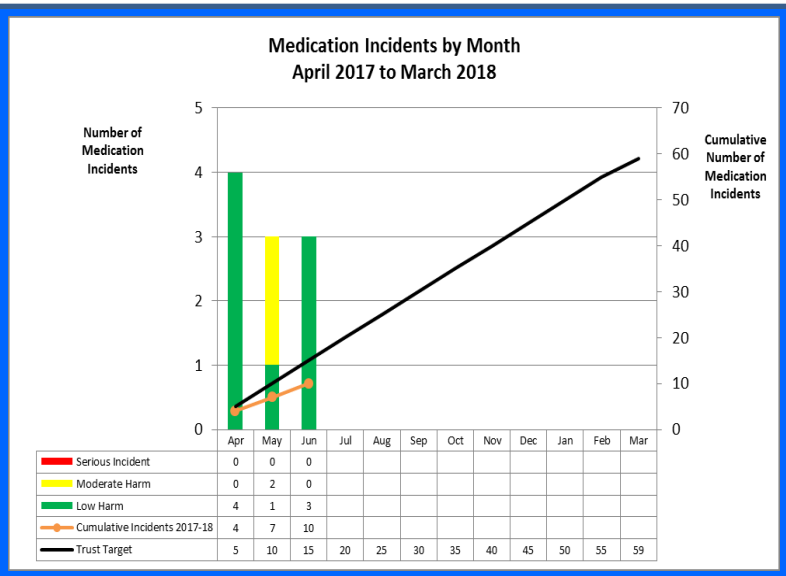
- Successful initiatives from the One Step Ahead collaborative commenced roll out across the organisation in October 2016 including:
  - Toilet/commode tagging
  - Cohort of higher risk patients to increase supervision
  - Staff placement in bays to increase supervision
  - Safety crosses in all ward areas

Description	Aggregate Position	Trend	Performance against previous month

Medication Incidents.

For this financial year to date:

- 80% (8 medication incidents) have resulted in low harm
- 20% (2 medication incidents) have resulted in moderate harm
- 0% (0 medication incidents) have resulted in serious harm



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Serious Incident	0	0	0									
Moderate Harm	0	2	0									
Low Harm	4	1	3									
Cumulative Incidents 2017-18	4	7	10									
Trust Target	5	10	15	20	25	30	35	40	45	50	55	59

Improvement actions include:

- Development of an action plan to improve prescribing errors across the Organisation. This will be monitored by the Safety Medicines Practice Group and Executive Quality Governance Group.

Board Papers – Quality, Safety & Experience Section: August 2017

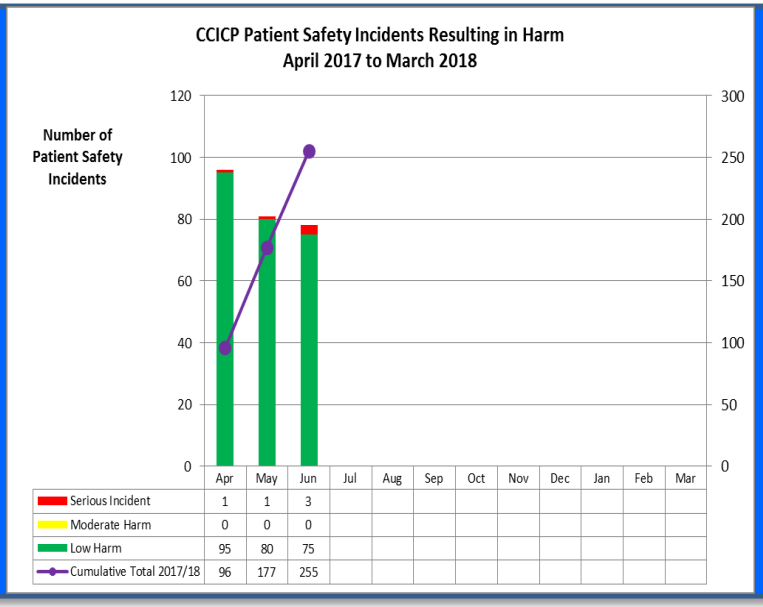
Description	Aggregate Position	Trend	Performance against previous month

CCICP Patient Safety Incidents resulting in harm.

This chart demonstrates the total number of reported patient safety incidents which resulted in harm.

For this financial year to date:

- 98% (250 incidents) have resulted in low harm
- 0% (0 incidents) have resulted in moderate harm
- 2% (5 incidents) have resulted in serious harm



To reduce the number of patient safety harm incidents, a number of initiatives are being undertaken. These include:

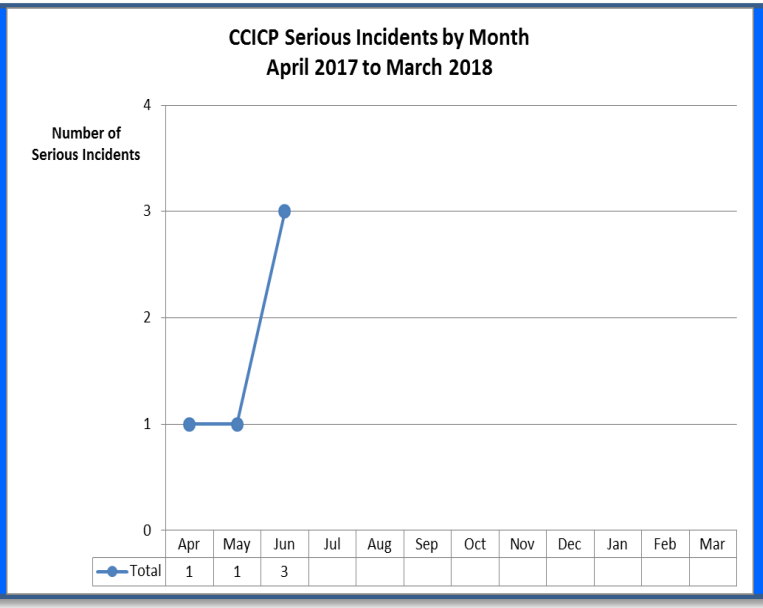
- Bi-weekly Patient Safety Summit Meetings with Executive & Senior Teams
- Participation in the Sign Up To Safety Campaign

CCICP Serious Incidents.

This chart demonstrates the number of incidents that have resulted in serious harm.

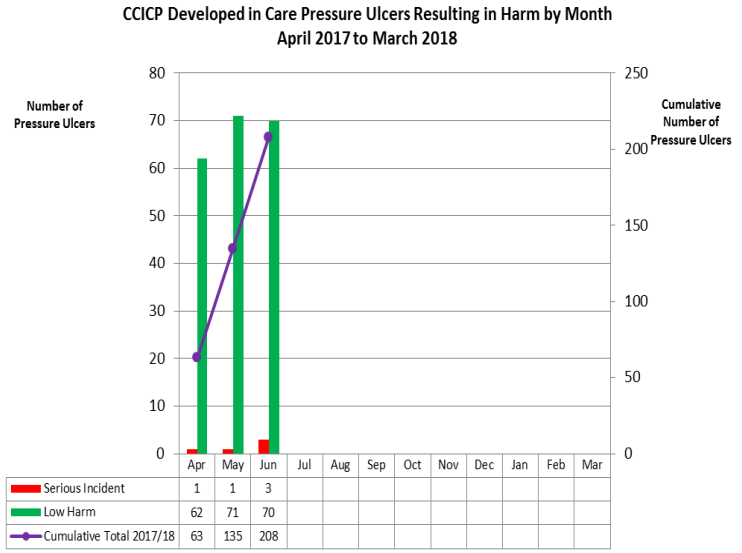
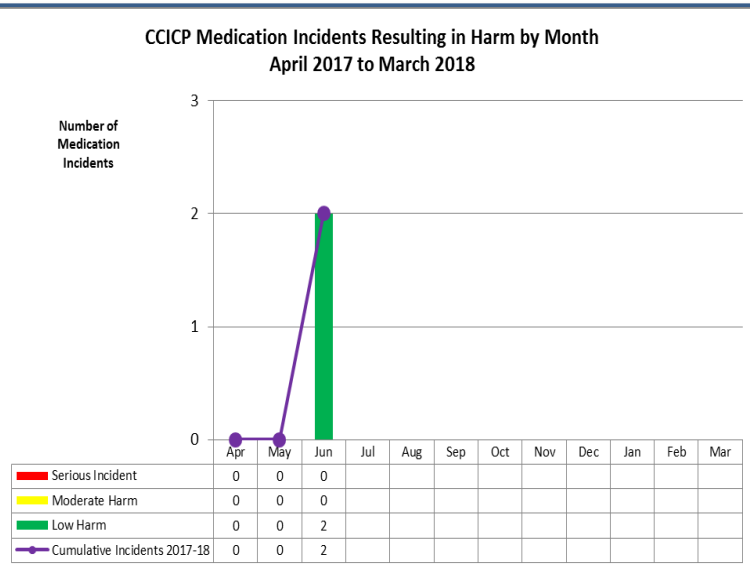
For this financial year to date:

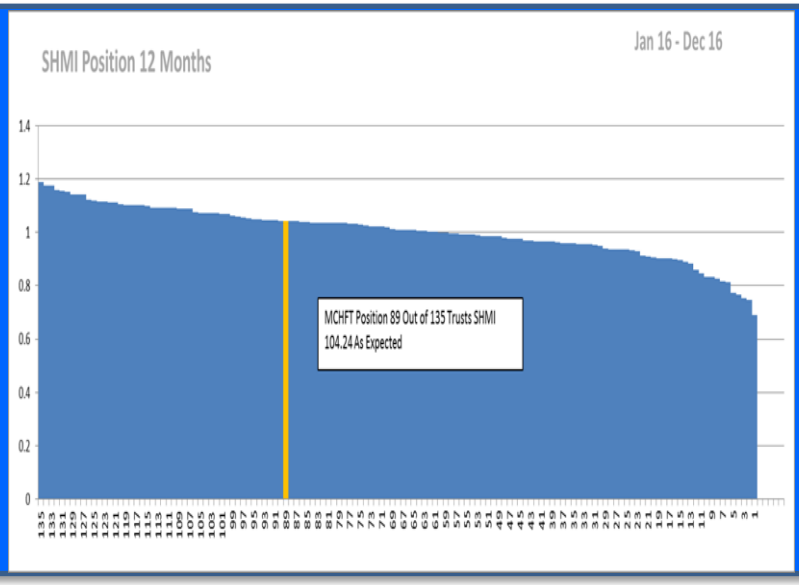
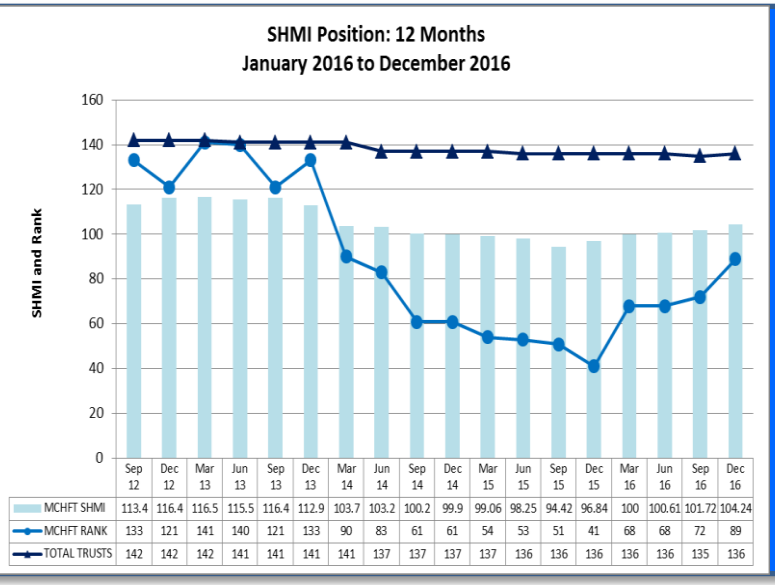
- 3 x Acquired on case load Pressure Ulcer – Stage 4
- 2 x Acquired on case load Pressure Ulcer – Stage 3



To reduce the number of serious incidents, the Trust has signed up to the Sign Up To Safety Campaign.

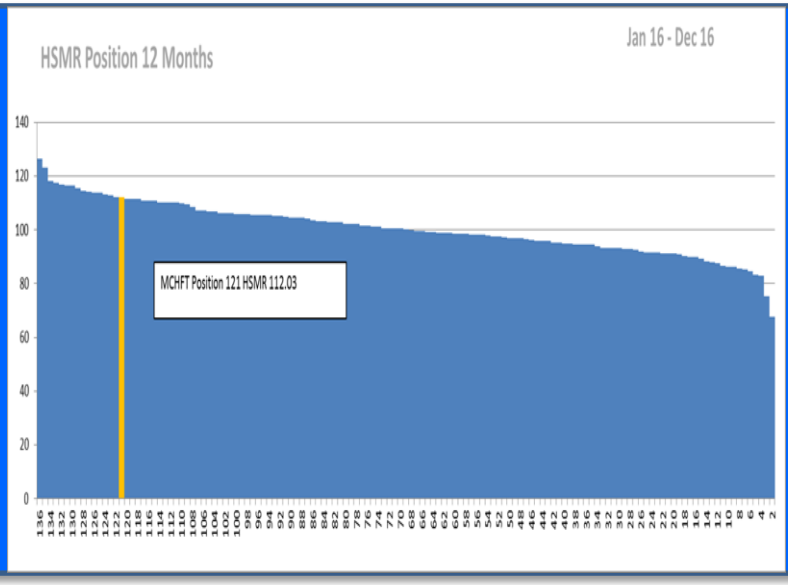
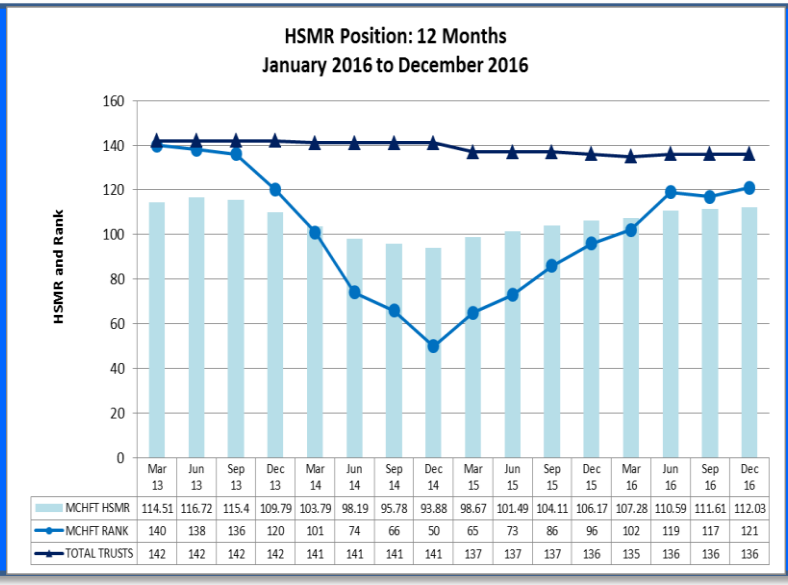
Board Papers – Quality, Safety & Experience Section: August 2017

Description	Aggregate Position	Trend	Performance against previous month
CCICP Pressure Ulcer (PU) Incidents.	For this financial year to date: • 97.6% (203 PU's) have resulted in low harm (defined as a patient that has developed a stage 2 or unstageable PU) • 2.4% (5 PU's) stage 3 or stage four PU's have been reported.		Membership at the Trust Skin Care Group has been expanded to include representatives from CCICP. This is to ensure that learning is shared across both Organisations. The aim during Q1 is to develop a process to enable PU's to be appropriately classified. We are on track to achieving this aim.
CCICP Medication Incidents.	For this financial year to date: • 100% (2 medication incidents) have resulted in low harm • 0% (0 medication incidents) have resulted in moderate harm • 0% (0 medication incidents) have resulted in serious harm		Membership at the Trust Safer Medicines Practice Group has been expanded to include representatives from CCICP. This is to ensure that learning is shared across both Organisations. Target will be set for achievement at Q3.

Description	Aggregate Position	Trend	Performance against previous quarter
Summary Hospital-Level Mortality Indicator (SHMI) by Trust.	The chart benchmarks the Trust's latest SHMI against all NHS Trusts. MCHFT is shown as the yellow bar. The Trust's SHMI is 1.04 for the time period January 2016 to December 2016 and places the Trust 89 out of 136 Trusts.		The Trust's aim within the Sign Up To Safety Campaign is to have a SHMI at or below 1.0 from April 2016.
MCHFT 12 Month Rolling Position Summary Hospital-Level Mortality Indicator (SHMI) by Trust.	The chart shows the SHMI and rank of MCHFT for each of the 12 month rolling position submissions from the period October 2011 to September 2012 to the latest submission January 2016 to December 2016.		The Trust's aim within the Sign Up To Safety Campaign is to have a SHMI at or below 1.0 from April 2016.

	Sep 12	Dec 12	Mar 13	Jun 13	Sep 13	Dec 13	Mar 14	Jun 14	Sep 14	Dec 14	Mar 15	Jun 15	Sep 15	Dec 15	Mar 16	Jun 16	Sep 16	Dec 16
MCHFT SHMI	113.4	116.4	116.5	115.5	116.4	112.9	103.7	103.2	100.2	99.9	99.06	98.25	94.42	96.84	100	100.61	101.72	104.24
MCHFT RANK	133	121	141	140	121	133	90	83	61	61	54	53	51	41	68	68	72	89
TOTAL TRUSTS	142	142	142	141	141	141	141	137	137	137	137	136	136	136	136	136	135	136

Board Papers – Quality, Safety & Experience Section: August 2017

Description	Aggregate Position	Trend	Performance against previous quarter
HSMR by Trust.	The chart benchmarks the Trust's HSMR against all NHS Trusts. MCHFT is shown by the amber bar. The Trust's HSMR is 112.03 (January 2016 to December 2016) and places the Trust 121 out of 136 Trusts.		The Trust's aim is to have an HSMR <100.
MCHFT 12 Month Rolling Position HSMR Position	The data in the chart shows the HSMR and rank of MCHFT for each of the 12 month rolling position submissions from the April 2012 to March 2013 to the latest submission January 2016 to December 2016.		The Trust's aim is to have an HSMR <100.

	Mar 13	Jun 13	Sep 13	Dec 13	Mar 14	Jun 14	Sep 14	Dec 14	Mar 15	Jun 15	Sep 15	Dec 15	Mar 16	Jun 16	Sep 16	Dec 16
MCHFT HSMR	114.51	116.72	115.4	109.79	103.79	98.19	95.78	93.88	98.67	101.49	104.11	106.17	107.28	110.59	111.61	112.03
MCHFT RANK	140	138	136	120	101	74	66	50	65	73	86	96	102	119	117	121
TOTAL TRUSTS	142	142	142	142	141	141	141	141	137	137	137	136	135	136	136	136

Board Papers – Quality, Safety & Experience Section: August 2017

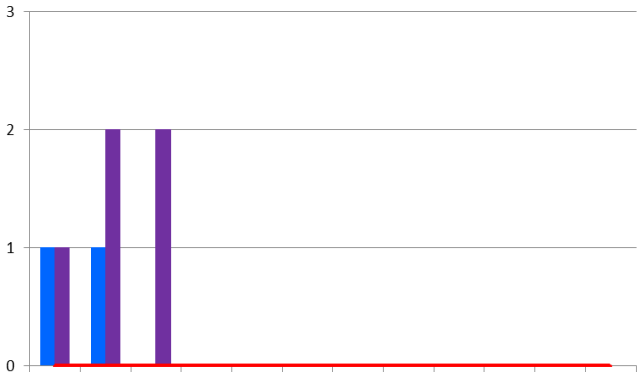
Description	Aggregate Position	Trend	Performance against previous month

MRSA Bacteraemia Cases.

In June 2017 no MRSA bacteraemia cases were reported in the Trust.

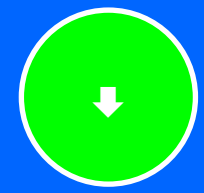
In this financial year there has been two confirmed MRSA bacteraemia cases reported.

MRSA Bacteraemia cases reported within the Trust
April 2017 to March 2018



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Monthly	1	1	0									
Cumulative	1	2	2									
Target	0	0	0	0	0	0	0	0	0	0	0	0

A post infection review is underway to determine the cause and identify any lapses in care.

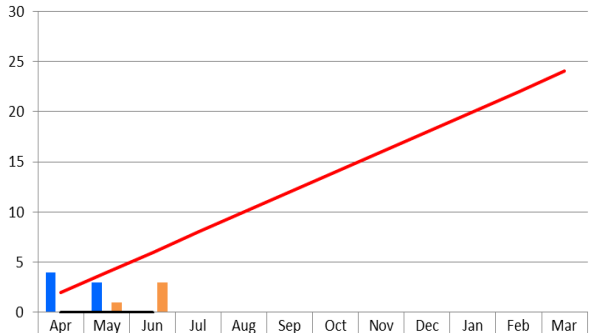


Clostridium Difficile toxin positive cases.

In June 2017, no avoidable case were reported at present, 3 cases are still awaiting confirmation following the SBAR meetings.

The total avoidable cases year to date is 0.

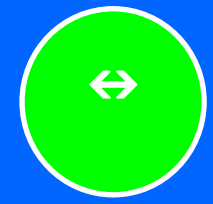
Clostridium Difficile toxin positive cases reported within the Trust
April 2017 to March 2018



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Unavoidable	4	3	0									
Avoidable	0	0	0									
Awaiting Confirmation	0	1	3									
Avoidable Total	0	0	0									
Avoidable Target	2	4	6	8	10	12	14	16	18	20	22	24

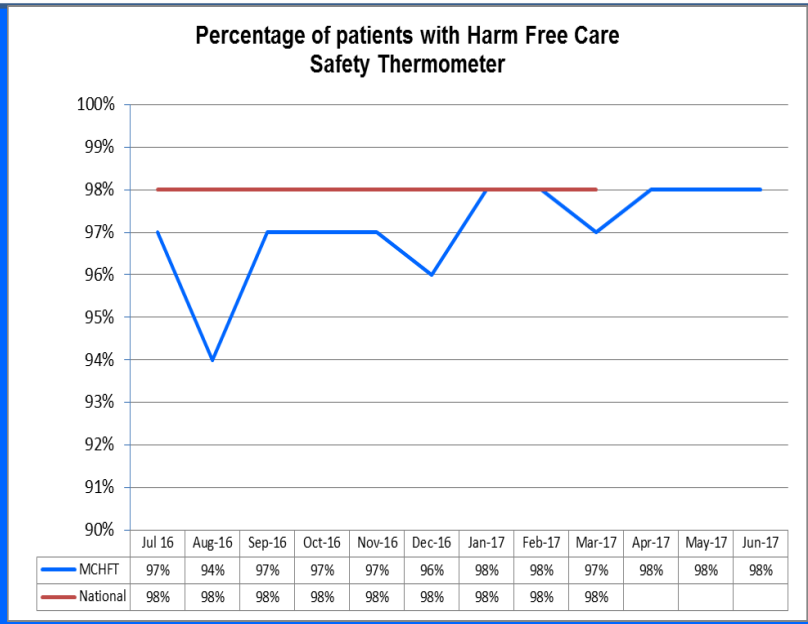
Improvement actions include:

- Ward Managers to reinforce the importance of accurate stool chart documentation
- Ward staff to attend the weekly Clostridium Difficile Infection meetings to support ownership at a ward level



Board Papers – Quality, Safety & Experience Section: August 2017

CQUIN Indicator	Indicator Name	Milestone Achieved								
		Q1	Financial Incentive Achieved	Q2	Financial Incentive Achieved	Q3	Financial Incentive Achieved	Q4	Financial Incentive Achieved	Maximum Value
1a	**Health & Wellbeing** 5% point improvement in two of the three questions on H&W, MSK & Stress.	Data available at the end of quarter one								£144,109
1b	**Health & Wellbeing** Maintain the four changes for improving healthy food for NHS staff, visitors and patients. Introduce three new changes to food and drink provision.									£144,109
1c	**Health & Wellbeing** Achieve an uptake of flu vaccinations of front line clinical staff of 70% by end of February 2018.									£144,109
2a	**Sepsis: Identification** Greater than 90% of eligible patients to have a timely identification of sepsis by the end of quarter four 2017/18.									£108,082
2b	**Sepsis: Treatment** Greater than 90% of eligible patients to have a timely treatment of sepsis by the end of quarter four 2017/18.									£108,082
2c	**Sepsis: Antibiotic Review** An empiric review for at least 90% cases in the sample should be performed by the end of quarter four 2017/18.									£108,082
2d Part 1	**Reduction in antibiotic consumption** Achieve a reduction of x% or more in total antibiotic consumption per 1,000 admissions.									£36,027
2d Part 2	**Reduction in carbapenem consumption** Achieve a reduction of x% or more in total carbapenem consumption per 1,000 admissions.									£36,027
2d Part 3	**Reduction in piperacillin tazabactam consumption** Achieve a reduction of x% or more in total piperacillin tazabactam consumption per 1,000 admissions.									£36,027
4	**Mental Health in Emergency Department** Achieve a 20% reduction in attendances to the Emergency Department for people with Mental Health needs.									£432,328
6	**Offering advice and guidance** Providers to set up and operate advice and guidance services for non-urgent GP referrals, allowing GPs to access consultant advice prior to referring patients into secondary care.									£432,328
7	**NHS e-Referrals** Availability of services and appointments for e-Referral service.									£432,328
8a	**Supporting proactive and safe discharge** Acute providers.									£432,328
9 Part a	**Tobacco screening** 90% of unique adult patients who are screened for smoking status and whose results are recorded.									Nil as applies to year 2 only

Description	Aggregate Position	Trend	Performance against previous month
Safety Thermometer - Harm Free Care.	In June 2016, 98% of patients received harm free care as measured by the Safety Thermometer. The Safety Thermometer data is collected during the morning of the first Wednesday of each month and is collected by the nursing staff on duty on the ward assisted by the Divisional Senior Nursing Teams. National figures are not yet available for April 2017, May 2017 and June 2017.		>95% of patients to receive harm free care as monitored by the Safety Thermometer.

	Jul 16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
MCHFT	97%	94%	97%	97%	97%	96%	98%	98%	97%	98%	98%	98%
National	98%	98%	98%	98%	98%	98%	98%	98%	98%			

Description	Aggregate Position	Trend	Performance against previous month
Registered Nurses monthly expected hours by shift versus actual monthly hours per shift. Day time shifts only	94.7% of expected Registered Nurse hours were achieved for day shifts. Any registered nurse numbers that fall below 85% are required to have a divisional review and an update of actions provided to the Director of Nursing & Quality and the Deputy Director of Nursing & Quality.	Trend **June 2017 94.7%** May 2017 94.5% April 2017 93.5%	The lowest staffing levels during the day were on Ward 9 at 79.6%.
Registered Nurses monthly expected hours by shift versus actual monthly hours per shift. Night time shifts only	95.3% of expected Registered Nurse hours were achieved for night shifts. During the month of June NICU was extremely and unusually quiet, both in terms of occupancy (32%) and acuity. As a result there were a number of shifts (day & night) when the staffing requirements were adjusted accordingly.	Trend **June 2017 95.3%** May 2017 97.2% April 2017 97%	The lowest staffing levels during the night were on NICU at 60.7%
Healthcare Assistant monthly expected hours by shift versus actual monthly hours per shift. Day time shifts only	102% of expected HCA hours were achieved for day shifts. The NICU staffing is low for unqualified staff, particularly on the day shift. This is predominantly due to sickness. However, assurance can be provided that clinical care has not been compromised during December 2016.	Trend **June 2017 102%** May 2017 98.7% April 2017 98.5%	The lowest staffing levels during the day were on NICU at 61%
Healthcare Assistant monthly expected hours by shift versus actual monthly hours per shift. Night time shifts only	113.7% of expected HCA hours were achieved for night shifts. For areas with over 100% staffing levels for HCA's this is reviewed and is predominately due to wards requiring 1 to 1 specials for patients following a risk assessment or to increase staffing numbers when there are registered nursing gaps that are not filled.	Trend **June 2017 113.7%** May 2017 107.4% April 2017 105.8%	The lowest staffing levels during the night were on 7 different wards at 100%

Board Papers – Quality, Safety & Experience Section: August 2017

Ward Name	Main Specialties	Day				Night				Day		Night		Care Hours Per Patient Day			
		Qualified		Unqualified		Qualified		Unqualified		Qualified	Unqualified	Qualified	Unqualified	Cumulative count over month of pts at 23:59 each day	Qualified	Unqualified	Overall
		Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Fill Rate	Fill Rate	Fill Rate	Fill Rate				
MCHT		41695.5	39475.6	29626.2	30212	24238	23103.6	15064.3	17134.9	94.7%	102.0%	95.3%	113.7%	14237	4.4	3.3	7.7
AMU	Gen. Medicine	1950	1833.8	1470	1476.3	1837.5	1800.8	1470	1470	94.0%	100.4%	98.0%	100.0%	761.0	4.8	3.9	8.6
CAU	Paeds	2484.5	2484.5	982.5	982.5	1380	1380	23	23	100.0%	100.0%	100.0%	100.0%	339.0	11.4	3.0	14.4
Critical Care	Gen. Surgery	3986.5	3986.5	535.5	535.5	2365.5	2365.5	0	0	100.0%	100.0%	100.0%	-	236.0	26.9	2.3	29.2
Elmhurst	Rehab	847.5	847.5	2160	2166	750	750	1500	1525	100.0%	100.3%	100.0%	101.7%	868.0	1.8	4.3	6.1
Ward 1	Gen. Medicine	2125	2131.3	1125	1106.3	1470	1433.3	735	759.5	100.3%	98.3%	97.5%	103.3%	804.0	4.4	2.3	6.8
Ward 10 SSW	Gen. Surgery	1661	1461	960	968	615	615	307.5	307.5	88.0%	100.8%	100.0%	100.0%	629.0	3.3	2.0	5.3
Ward 12	Gen. Surgery	2171	1995	1920	1872	922.5	809.8	615	697	91.9%	97.5%	87.8%	113.3%	863.0	3.3	3.0	6.2
Ward 13	Gen. Surgery	2216	2120	1920	1912	922.5	748.3	615	666.3	95.7%	99.6%	81.1%	108.3%	921.0	3.1	2.8	5.9
Ward 14	Gen. Medicine	1662	1554	1440	1512	720	720	1080	1140	93.5%	105.0%	100.0%	105.6%	919.0	2.5	2.9	5.4
Ward 15	Trauma & Ortho	2178.5	1898.5	2640	2640	922.5	850.8	922.5	984	87.1%	100.0%	92.2%	106.7%	867.0	3.2	4.2	7.4
Ward 18	Gen. Medicine	478.8	391.3	450	450	220.5	220.5	220.5	257.3	81.7%	100.0%	100.0%	116.7%	108.0	5.7	6.5	12.2
Ward 2	Gen. Medicine	1750	1768.8	1500	1612.5	735	1016.8	1102.5	1212.8	101.1%	107.5%	138.3%	110.0%	914.0	3.0	3.1	6.1
Ward 21b	Gen. Medicine	1271.5	1187	1755	1839.5	750	750	750	750	93.4%	104.8%	100.0%	100.0%	688.0	2.8	3.8	6.6
Ward 23	Obstetrics	1200	1200	760	760	740	740	740	740	100.0%	100.0%	100.0%	100.0%	635.0	3.1	2.4	5.4
Ward 26	Obstetrics	3222.7	3222.7	620.7	620.7	2590	2590	382.3	382.3	100.0%	100.0%	100.0%	100.0%	170.0	34.2	5.9	40.1
Ward 4	Gen. Medicine	1572	1386	1800	1782	720	696	1440	1440	88.2%	99.0%	96.7%	100.0%	952.0	2.2	3.4	5.6
Ward 5	Gen. Medicine	2377.5	2190	1500	1550	1470	1396.5	735	759.5	92.1%	103.3%	95.0%	103.3%	934.0	3.8	2.5	6.3
Ward 6	Gen. Medicine	1980	1917.5	1875	1843.8	1470	1274	735	771.8	96.8%	98.3%	86.7%	105.0%	795.0	4.0	3.3	7.3
Ward 7	Gen. Medicine	1702.5	1671.3	1500	2093.8	735	722.8	1102.5	1776.3	98.2%	139.6%	98.3%	161.1%	948.0	2.5	4.1	6.6
Ward 9	Trauma & Ortho	1646	1310	1440	1392	615	615	307.5	471.5	79.6%	96.7%	100.0%	153.3%	494.0	3.9	3.8	7.7
NICU	Paeds	1862.5	1531.4	372.5	227.1	1725	1046.5	0	448.5	82.2%	61.0%	60.7%	-	30.0	85.9	22.5	108.5
Ward 11 SAU	Gen. Surgery	1350	1387.5	900	870	562	562	281	552.6	102.8%	96.7%	100.0%	196.7%	362.0	5.4	3.9	9.3

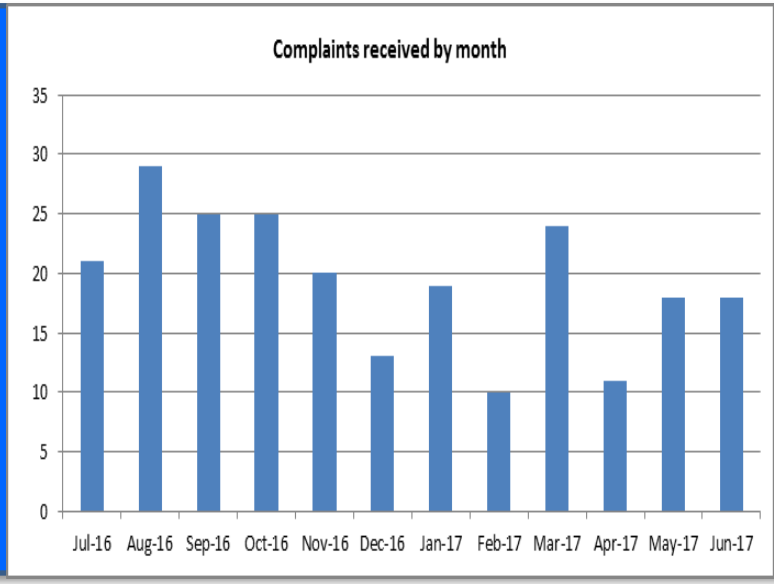
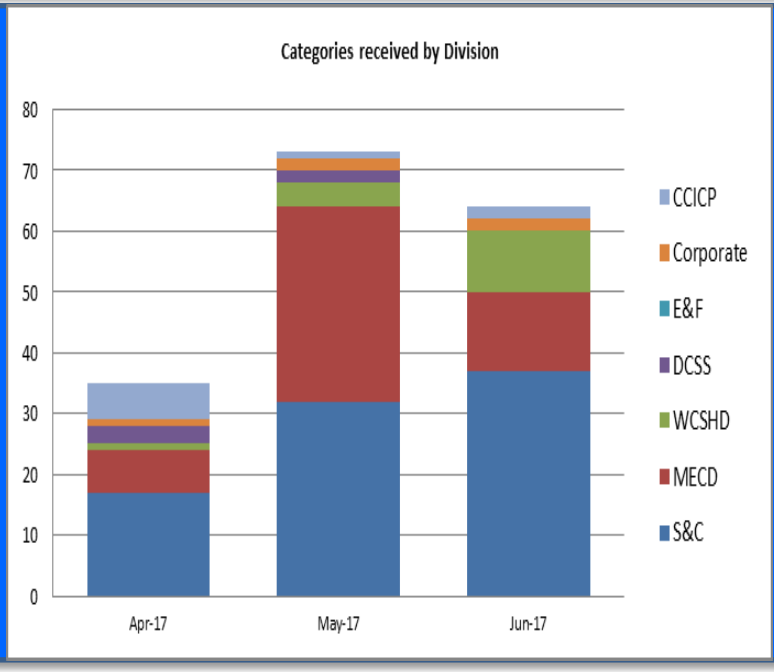
Board Papers – Quality, Safety & Experience Section: August 2017

Ward Name	Main Specialties	Safety Thermometer Results			
		Acquired Pressure Ulcers	Patient Falls resulting in harm	CAUTI	New VTE
MCHFT		1.08% (9)	0.84% (7)	0% (0)	0.24 % (2)
AMU	Gen. Medicine	0% (0)	13.04% (3)	0% (0)	0% (0)
CAU	Paeds	0% (0)	0% (0)	0% (0)	0% (0)
Critical Care	Gen. Medicine	28.57% (2)	0% (0)	0% (0)	0% (0)
Elmhurst	Rehab	0% (0)	0% (0)	0% (0)	0% (0)
Ward 1	Gen. Medicine	0% (0)	0% (0)	0% (0)	0% (0)
Ward 10 SAU	Gen. Surg	0% (0)	0% (0)	0% (0)	0% (0)
Ward 10 SSW	Gen. Surg & Urology	0% (0)	0% (0)	0% (0)	0% (0)
Ward 12	Gen. Surg & Gynae	0% (0)	0% (0)	0% (0)	0% (0)
Ward 13	Gen. Surg	0% (0)	0% (0)	0% (0)	0% (0)
Ward 14	Gen. Medicine	0% (0)	0% (0)	0% (0)	0% (0)
Ward 15	Trauma & Ortho	0% (0)	0% (0)	0% (0)	0% (0)
Ward 18	Gen. Medicine	0% (0)	10% (1)	0% (0)	0% (0)
Ward 2	Gen. Medicine	0% (0)	0% (0)	0% (0)	3.12% (1)
Ward 21B	Rehab	4.35% (1)	4.35% (1)	0% (0)	0% (0)
Ward 23	Obstetrics	0% (0)	0% (0)	0% (0)	0% (0)
Ward 26	Obstetrics	0% (0)	0% (0)	0% (0)	0% (0)
Ward 4	Gen. Medicine	0% (0)	0% (0)	0% (0)	0% (0)
Ward 5	Gen. Medicine	0% (0)	0% (0)	0% (0)	0% (0)
Ward 6	Gen. Medicine	0% (0)	0% (0)	0% (0)	0% (0)
Ward 7	Gen. Medicine	3.12% (1)	0% (0)	0% (0)	3.12% (1)
Ward 9	Trauma & Ortho	4.17% (1)	0% (0)	0% (0)	0% (0)
NICU	Paeds	0% (0)	0% (0)	0% (0)	0% (0)
DN – Alsager	District Nursing	0% (0)	0% (0)	0% (0)	0% (0)
DN - Ashfields	District Nursing	0% (0)	0% (0)	0% (0)	0% (0)
DN – Danebridge	District Nursing	0% (0)	0% (0)	0% (0)	0% (0)
DN – Eaglebridge	District Nursing	1.85% (1)	1.85% (1)	0% (0)	0% (0)
DN – Firdale	District Nursing	2% (1)	0% (0)	0% (0)	0% (0)
DN – Grosvenor & Hungerford	District Nursing	0% (0)	0% (0)	0% (0)	0% (0)
DN – Middlewich	District Nursing	0% (0)	9.09% (1)	0% (0)	0% (0)
DN – Rope Green	District Nursing	0% (0)	0% (0)	0% (0)	0% (0)
DN - Church View	District Nursing	4.55% (1)	0% (0)	0% (0)	0% (0)
DN – Winsford	District Nursing	2.38% (1)	0% (0)	0% (0)	0% (0)

Experience Section:

Indicators	YTD 17/18	Last four months			
		Mar-17	Apr-17	May-17	Jun-17
Complaints received by month	50	24	12	20	18
Complaints being reviewed by the Ombudsman		3	3	2	2
Closed complaints by month	51	16	19	17	15
Contacts raising informal concerns	236	91	79	81	76
Compliments received in month	445	190	119	143	183
Number of new claims received in month	18	2	1	12	5
Number of claims closed	8	4	3	3	2
Number of inquests concluded	4	0	0	3	1
NHS Choices - Star Ratings (Leighton)		4.5	4.5	4.5	4.5
NHS Choices - Star Ratings (VIN)		5	5	5	5
NHS Choices - Number of new postings	23	14	7	8	8
F&FT Response Rate ED, MIU, UCC and Assessment Areas*		5%	4%	3%	5%
Proportion of positive responses ED, MIU, UCC and Assessment Areas		97%	94%	93%	94%
F&FT Response Rate Inpatients and Daycases		25%	28%	21%	18%
Proportion of positive responses Inpatients and Daycases		99%	96%	98%	98%
F&FT Response Rate Outpatients		4%	4%	6%	5%
Proportion of positive responses Outpatients		97%	95%	95%	94%
F&FT Response Rate Maternity - Birth		12%	7%	11%	8%
Proportion of positive responses Maternity - Birth		96%	100%	100%	100%
F&FT Response Rate Community (CCICP)		21%	21%	14%	13%
Proportion of positive responses Community (CCICP)		91%	89%	90%	88%

*ED = Emergency Department; MIU = Minor Injuries Unit; UCC = Urgent Care Centre

Description	Aggregate Position/Description	Trend	
Monthly Trust complaints received by the Trust	18 complaints were received in June 2017 which covered 64 categories. The highest categories were: • Communication • Medical – Adverse Outcome • Attitude of staff Highest 3 areas receiving complaints/issues were: • Ward 15: 2 complaints/ 12 issues • Ward 13: 2 complaints/ 7 issues • Paediatric Medical Staff: 2 complaints/ 6 issues		Formal Complaints
Number of formal complaints by Division	This graph shows the breakdown of categories by month for each division. S&C: 37 DCSS: 0 W&CD: 10 MECD: 13 CCICP: 2 E&F: 0 Corporate Services: 2 Examples of complaints for June 2017 S&C – A clear care plan was not communicated W&CD – Medical staff spoke inappropriately during consultation MECD – Staff unaware that surgery had been carried out at another Trust CCICP – Poor communication regarding discharge Corporate Services – Poor communication		Formal Complaints by Division

Board Papers – Quality, Safety & Experience Section: August 2017

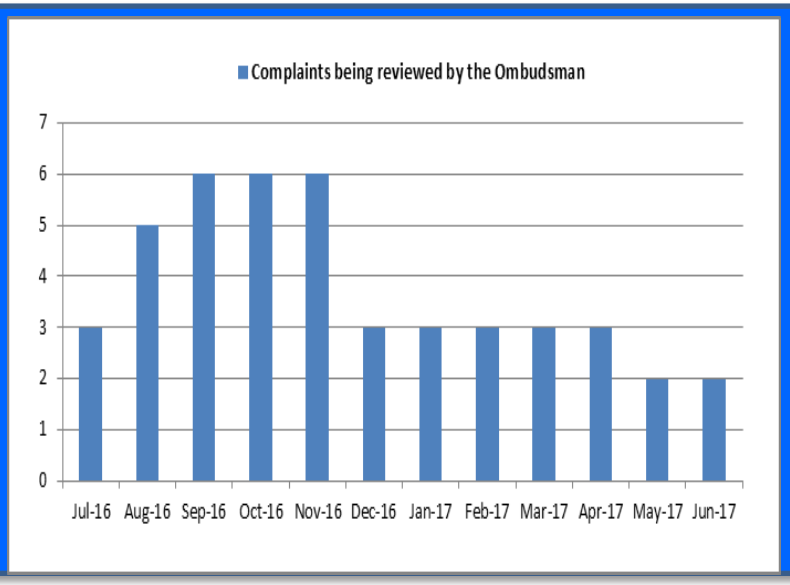
Description	Aggregate Position/Description	Trend

Complaints being reviewed by the Public Health Service Ombudsman

In June 2017 2 complaints were active with the PHSO

1 x awaiting final report and letter

1 x under further investigation via PHSO & NHS England

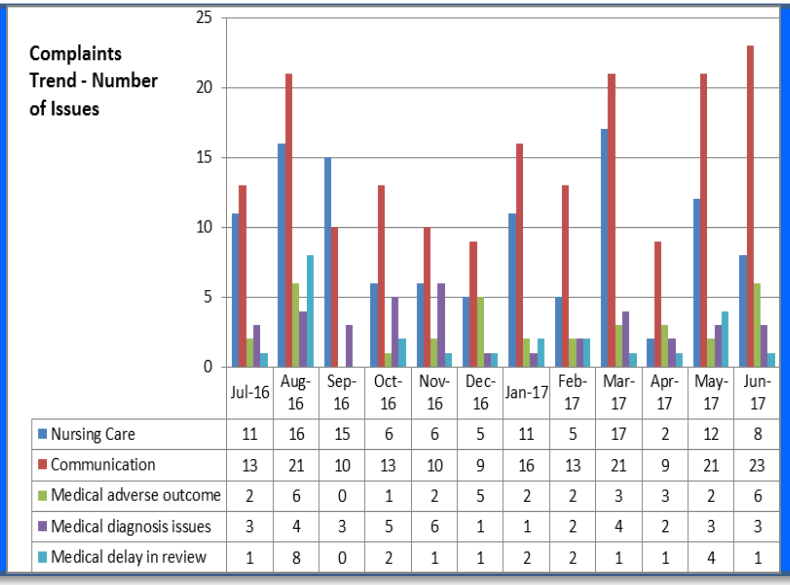


Ombudsman

Complaint Trends and number of issues

The main trends in June 2017 were:

- Communication: 12 complaints/ 23 issues
- Medical – Adverse Outcome: 6 complaints/ 6 issues
- Attitude of Staff: 5 complaints/ 5 issues



	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
Nursing Care	11	16	15	6	6	5	11	5	17	2	12	8
Communication	13	21	10	13	10	9	16	13	21	9	21	23
Medical adverse outcome	2	6	0	1	2	5	2	2	3	3	2	6
Medical diagnosis issues	3	4	3	5	6	1	1	2	4	2	3	3
Medical delay in review	1	8	0	2	1	1	2	2	1	1	4	1

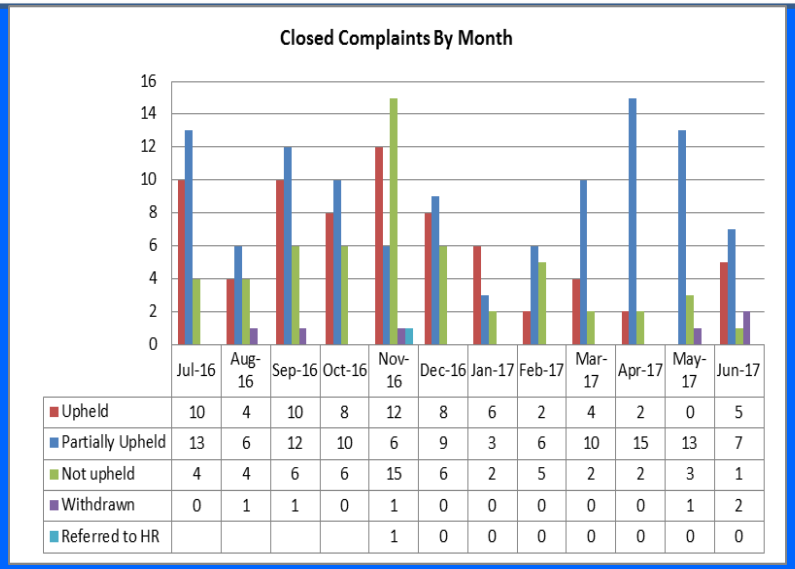
Complaint Trends

Board Papers – Quality, Safety & Experience Section: August 2017

Description	Aggregate Position/Description	Trend

Closed Complaints

15 complaints were closed in June 2017



	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
Upheld	10	4	10	8	12	8	6	2	4	2	0	5
Partially Upheld	13	6	12	10	6	9	3	6	10	15	13	7
Not upheld	4	4	6	6	15	6	2	5	2	2	3	1
Withdrawn	0	1	1	0	1	0	0	0	0	0	1	2
Referred to HR					1	0	0	0	0	0	0	0

Closed Complaints by Division

The Table provides a breakdown of closed complaints by division, demonstrating those complaints which were upheld, not upheld or partially upheld.

Division	Upheld	Partially Upheld	Not Upheld	Withdrawn	Ref HR	Sub-Total
Medicine and Emergency Care	1	1	0	1	0	3
Surgery and Cancer	3	3	1	0	0	7
Diagnostics & Clinical Support Services	0	2	0	0	0	2
Women's and Children's	1	0	0	1	0	2
Estates & Facilities	0	1	0	0	0	1
CCICP	1	1	0	1	0	3
		Total closed				**15**

Complaints closed by Division

Division	Specialty	Department	Summary Of Complaint	Outcome Details	Lessons Learned	Incident Link ?
Surgery and Cancer Division						
Surgery & Cancer	General Surgery	Ward 12 (General Surgery)	EPISODE OF CARE: February 2017 The complainant raised issues relating to noise at night while an inpatient, medication issues and incorrect discharge information	UPHELD We found that the ward had been noisy at night and staff had not offered ear plugs or eye masks to the patients. Apologies were provided for the incorrect discharge information and medication issues.	• New process in place for TTO's on the ward • staff reminded of availability of ear plugs and eye masks • apologies given for the poor experience on the ward	N
Surgery & Cancer	General Surgery	Ward 13	EPISODE OF CARE: February 2017 The complainant raised issues of nursing care, staff attitude and communication during an inpatient stay.	PARTIALLY UPHELD We found that there were a number of areas for improvement regarding nutrition, hydration, medications and communication, however there were aspects of care which were appropriately delivered.	• Improved communication regarding NBM instructions • Improved communication regarding meal ordering and availability of drinks • Education of staff regarding availability of medications in the emergency drug cupboard • Staff to give full explanations prior to gaining consent for procedures	N

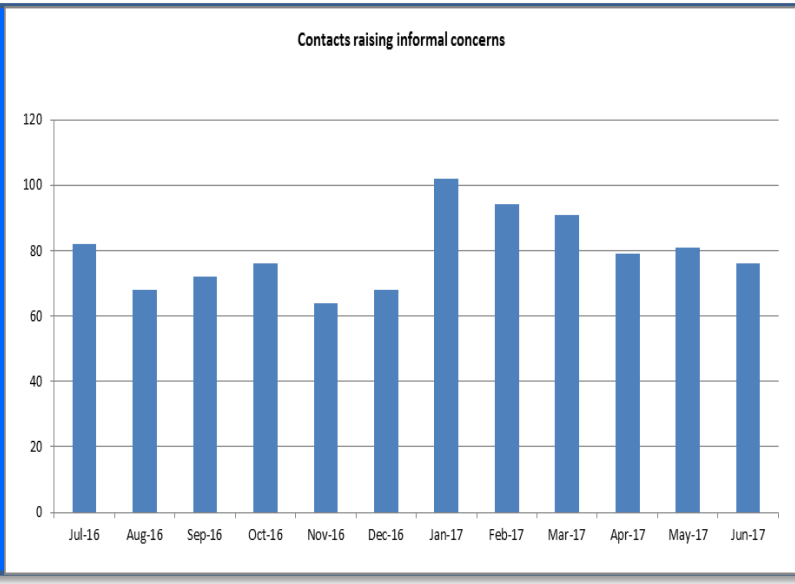
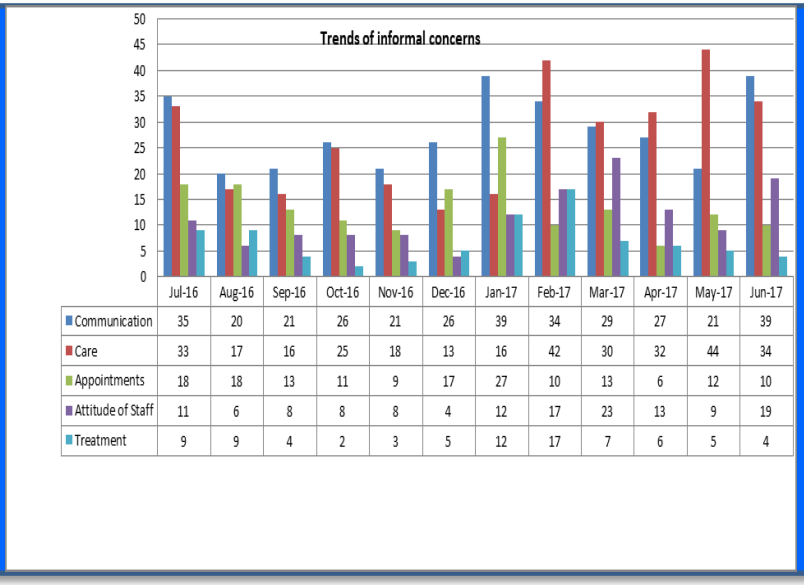
Division	Specialty	Department	Summary Of Complaint	Outcome Details	Lessons Learned	Incident Link ?
Surgery and Cancer Division						
Surgery & Cancer	Urology	Urology Medical Staff	EPISODE OF CARE: June 2014 The complainant has raised issues of care and communication from the urology service.	NOT UPHELD We found that all care and communication had been provided appropriately	None Required	N
Surgery & Cancer	Orthopaedics	Orthopaedic Medical Staff	EPISODE OF CARE: March 2017 The complainant raised concerns about a medication error leading to an overdose of medication	UPHELD We found that there had been a failure in communication regarding medications and ongoing care instructions on discharge	• Staff to ensure accurate medication advice is provided on discharge • Staff to ensure specific discharge care information is provided	Y
Surgery & Cancer	General Surgery	General Surgery Medical Staff	EPISODE OF CARE: March 2017 The complainant raised concerns regarding staff attitude during 2 clinic appointments.	PARTIALLY UPHELD We found that appropriate questions were asked by the clinician, however the delivery of the questions could have been improved.	• Staff to explain why difficult questions are asked • Staff reminded to be polite at all times during consultations	N
Surgery & Cancer	Orthopaedics	Orthopaedic Medical Staff	EPISODE OF CARE: April 2017 The complainant raised issues of care and attitude in an outpatient appointment.	PARTIALLY UPHELD We found that the appropriate care was provided however further referral to another speciality via the GP could have been considered.	• Patient to be referred to another speciality via the GP	N
Surgery & Cancer	General Surgery	SAU	EPISODE OF CARE: April 2017 The complainant raised concerns regarding an investigation into missing property while an inpatient.	UPHELD We found that the policy was not correctly followed by the ward staff	• Staff updated on the process of reporting missing property • Incident form completed retrospectively	Y

Division	Specialty	Department	Summary Of Complaint	Outcome Details	Lessons Learned	Incident Link ?
Division of Medicine and Emergency Care						
Division Of Medicine & Emergency Care	Cardiology	Ward 1	EPISODE OF CARE: July 2016 The complainant raised issues of nursing care during a night shift regarding delay in medication	WITHDRAWN The patient sadly passed away and their partner does not wish to progress with complaint	• The complaint has been shared with the team for lessons to be learned	N
Division Of Medicine & Emergency Care	Emergency Department	Emergency Department	EPISODE OF CARE: December 2016 The complainant raised concerns about care received by the patient in the Emergency Department following a 7 hour wait	UPHELD We found that there were failings in care however we were unable to confirm if the delay impacted on the patient's outcome.	• ED staff to consider previous admissions when patients attend • Staff to take action when families escalate concerns in the patient's condition • RCA carried out into the care provided and shared with the complainant	Y
Division Of Medicine & Emergency Care	Emergency Department	Emergency Department	EPISODE OF CARE: December 2016 The complainant raised concern regarding care received by the patient in ED after attending with a possible stroke	PARTIALLY UPHELD We found that the diagnosis was appropriate based upon presenting symptoms, however a further CT scan could have been performed. Communication with the family could have been improved.	• Consideration of further CT scan • Improved communication with relatives	Y

Board Papers – Quality, Safety & Experience Section: August 2017

Division	Specialty	Department	Summary Of Complaint	Outcome Details	Lessons Learned	Incident Link ?
Diagnostics and Clinical Support Services						
Diagnostic & Clinical Support Services	Respiratory	Cardio Respiratory	EPISODE OF CARE: November 2016 to January 2017 The complainant raised concern regarding care received by the patient while an inpatient and inappropriate discharge.	PARTIALLY UPHELD It was found that there were multiple instances of a breakdown in communication with the patient's family, however It was found that the discharges were appropriate.	• Communication to be improved	N
Diagnostic & Clinical Support Services	Medical Imaging	Medical Imaging	EPISODE OF CARE: April 2016 The complainant raised concern regarding the patient's attendance in the ED and subsequent scan following a fall	PARTIALLY UPHELD We found that there was a breakdown in the communication of the patient's care plan/passport, however all aspects of care were provided appropriately.	• Staff reminded to check if a care plan/passport is in place	N
Women's and Children's Division						
Women's & Children's	Maternity Services	Ward 26 (High Risk)	EPISODE OF CARE: October 2016 The complainant raised concern regarding care received during the birth of her child	UPHELD We found that the patient's requests regarding care were not carried out by staff causing trauma and upset to the patient	• Staff to take patients requests into consideration wherever possible • Review birth plans	Y
Women's & Children's	Paediatrics	Paediatrics Medical Staff	EPISODE OF CARE: June 2017 The complainant raised concerns regarding being unable to gain a specific prescription for the patient.	COMPLAINT WITHDRAWN	• Complaint shared with the division and relevant staff for future learning	N

Division	Specialty	Department	Summary Of Complaint	Outcome Details	Lessons Learned	Incident Link ?
Estates and Facilities Division						
Estates & Facilities	Security	Main Reception - Leighton	EPISODE OF COMPLAINT: October 2016 The complainant raised concerns regarding smoking on Trust premises, and interactions when raising the concern.	PARTIALLY UPHELD We found there were failings in cleanliness of the site due to cigarette waste, however interactions were carried out appropriately with the complainant.	• Increased domestic service introduced over weekends • Smoking Champions recruited • Staff to direct patients and visitors to the dedicated smoking shelters on site • Dedicated stop smoking advisor introduced	N
CCICP						
None						
Corporate Services						
None						

Description	Aggregate Position/Description	Trend	
Informal Concerns Numbers	The number of contacts raising informal concerns for June 2017 was 76 which is 5 less than the previous month. The Surgery and Cancer Division has received the largest number of individual concerns raised at 48 with 22 of these issues belong to General Surgery.		Informal Concerns Feedback
Informal Concerns Trends	Communication was the highest trend for informal concerns in June 2017, with 16 of the 39 issues raised belonging to the Division of Medicine and Emergency Care, 6 belonging to respiratory.		Informal Concerns Trends

	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
Communication	35	20	21	26	21	26	39	34	29	27	21	39
Care	33	17	16	25	18	13	16	42	30	32	44	34
Appointments	18	18	13	11	9	17	27	10	13	6	12	10
Attitude of Staff	11	6	8	8	8	4	12	17	23	13	9	19
Treatment	9	9	4	2	3	5	12	17	7	6	5	4

Board Papers – Quality, Safety & Experience Section: August 2017

Description	Aggregate Position/Description	Trend

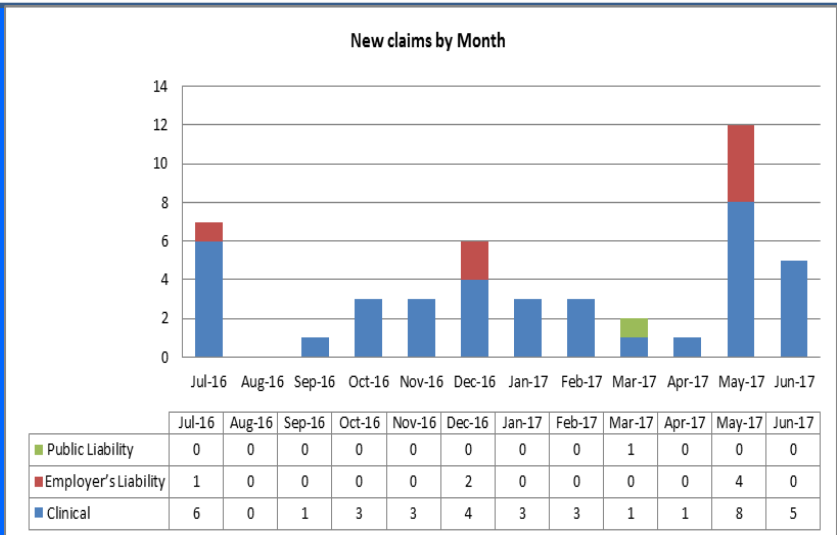
New claims received.

5 new clinical negligence claims were received in June 2017. These related to:

- General Surgery (1)
- Orthopaedics (1)
- General Medicine (1)
- Respiratory Medicine (1)
- General Surgery and Anaesthetics (1)

No new employer's liability claims were received. These related to:

No new public liability claims were received.



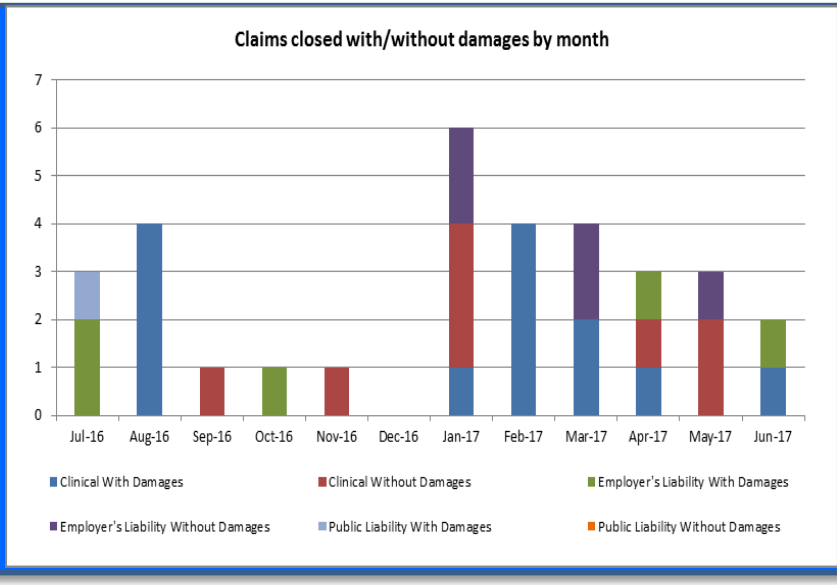
	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
Public Liability	0	0	0	0	0	0	0	0	1	0	0	0
Employer's Liability	1	0	0	0	0	2	0	0	0	0	4	0
Clinical	6	0	1	3	3	4	3	3	1	1	8	5

Claims

Claims closed with/without damages.

1 clinical negligence claim was closed in June 2017, which was upheld.

1 employer's liability claim was closed which was upheld.



Closed Claims

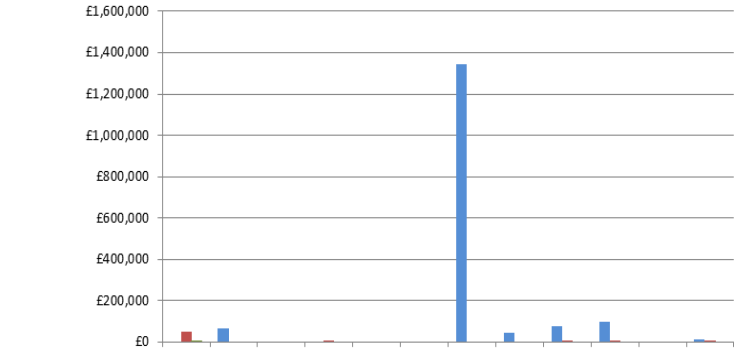
Board Papers – Quality, Safety & Experience Section: August 2017

Description	Aggregate Position/Description	Trend

Value of claims closed by month

Damages of £10,000 were paid out on the 1 clinical negligence claim closed in June 2017. This related to Histopathology.

Damages of £2,500 were paid out on the 1 employer's liability claim closed in June 2017. This related to General Medicine (Ward 5).



	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
Clinical Damages Paid £	0	67,099	0	0	0	0	1,341,544	44,750	76,000	95,689	0	10,000
Employer's Liability Paid £	47,780	0	0	1,400	0	0	0	0	1	7,000	0	2,500
Public Liability Paid £	4,500	0	0	0	0	0	0	0	0	0	0	0

Value of Claims

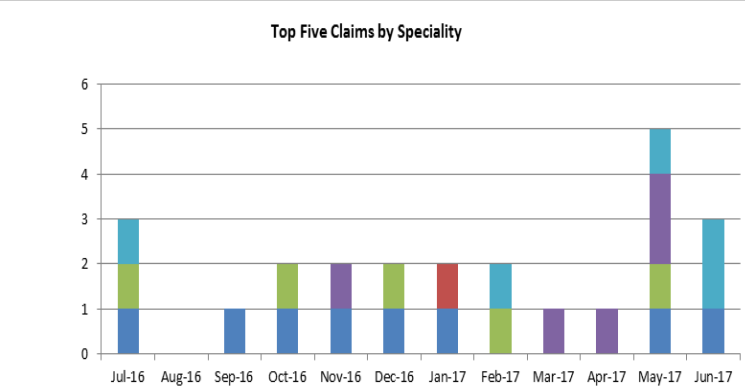
Top five claims by Specialty

3 new claims were received which relate to the Trust's top five specialties for claims:

Orthopaedics – Alleged failure to properly assess and treat injury to leg resulting in a below knee amputation.

General Surgery – Alleged 18 month delay in referring claimant to the Respiratory Team when a shadow on the lung was identified on a CT scan. Claimant was subsequently diagnosed with lung cancer.

General Surgery and Anaesthetics – But for failures in consent, alleged that deceased person would not have consented to bowel surgery and would not have died from resulting surgical complications.



	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
General Surgery	1	0	0	0	0	0	0	1	0	0	1	2
Obstetrics	0	0	0	0	1	0	0	0	1	1	2	0
Emergency Dept	1	0	0	1	0	1	0	1	0	0	1	0
Ophthalmology	0	0	0	0	0	0	1	0	0	0	0	0
Orthopaedics	1	0	1	1	1	1	1	0	0	0	1	1

Top 5 Claims by Specialty

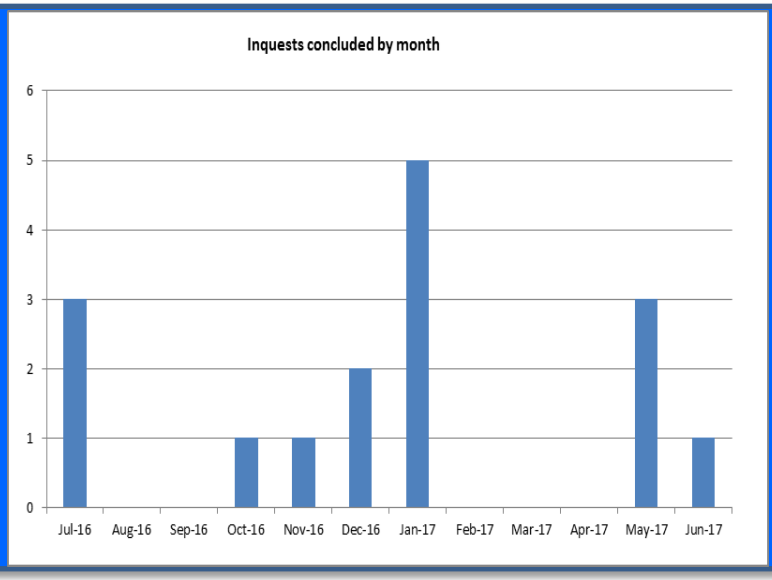
Board Papers – Quality, Safety & Experience Section: August 2017

Description	Aggregate Position/Description	Trend

Number of Inquests concluded by month

1 inquest was concluded in June 2017.

The conclusion was one of accidental death.

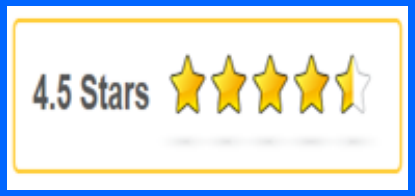


Inquests

NHS Choices Star Ratings

The above ratings are based on 260 postings received to date.

Leighton Hospital is rated at 4.5 stars.



Victoria Infirmary, Northwich is rated at 5 stars.

NHS Choices – Star Ratings

Board Papers – Quality, Safety & Experience Section: August 2017

Description	Aggregate Position /description	Trend

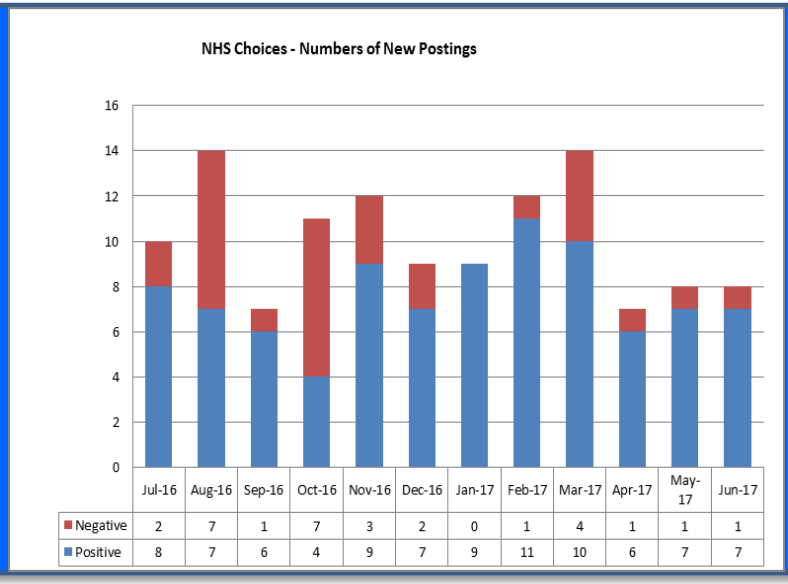
NHS Choices postings

There were 8 postings on NHS Choices in June 2017 of which were 1 negative and 7 were positive. Examples of feedback included:

Attended breast care clinic today with a male relative. We were treated with dignity, compassion, privacy and respect the kindness efficiency and care has been excellent. At no time were we classed as being any different than a female even the pre clinic questionnaire was designed for the men as well as the women (Breast Clinic)

The sister was warm, pleasant and professional when I phoned. Qualities that are so important for the patient on the end of a telephone. (Early Pregnancy Unit)

My grandad was admitted to the hospital for a chest drain and due to complications was placed on palliative care and passed away 6 days later. Throughout the whole week there were instances of poor practice, lack of compassion and reluctance to speak to us as family members



	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
Negative	2	7	1	7	3	2	0	1	4	1	1	1
Positive	8	7	6	4	9	7	9	11	10	6	7	7

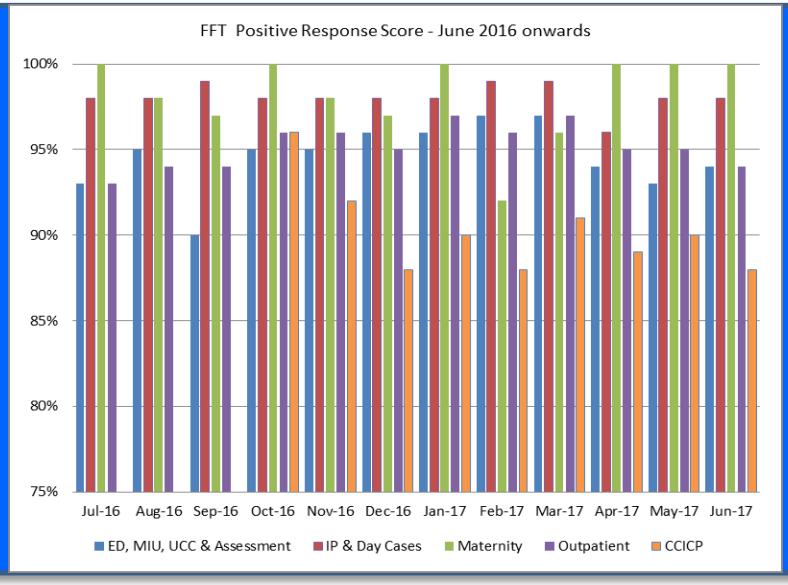
NHS Choices - Postings

The Family and Friends Test asks patients if this would recommend our hospital services to a friend or relative based on their treatment and experience

In June 2017 the Trust has scored the following positive response scores :

Inpatients and day cases	98%
Emergency care /Assessment areas	94%
Outpatients	94%
Maternity	100%
CCICP	88%

2323 responses were received and 95% of those patients would recommend our hospital services.



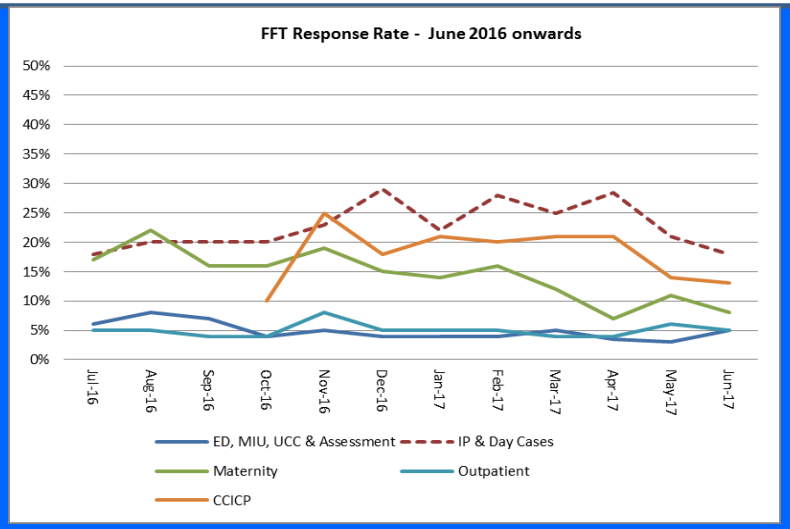
Family & Friends Test

Board Papers – Quality, Safety & Experience Section: August 2017

Description | **Aggregate Position** | **Trend**

Number of responses received for IP, Day Case, ED, maternity compared to eligible patients

June 2017 Ward/Dept	% Response	Total Responses received	How many would recommend
A&E , UCC & MIU	5%	302	284
Inpatients & Daycases	18%	780	767
Maternity	8%	17	17
Outpatients	5%	923	870
CCICP	13%	184	162



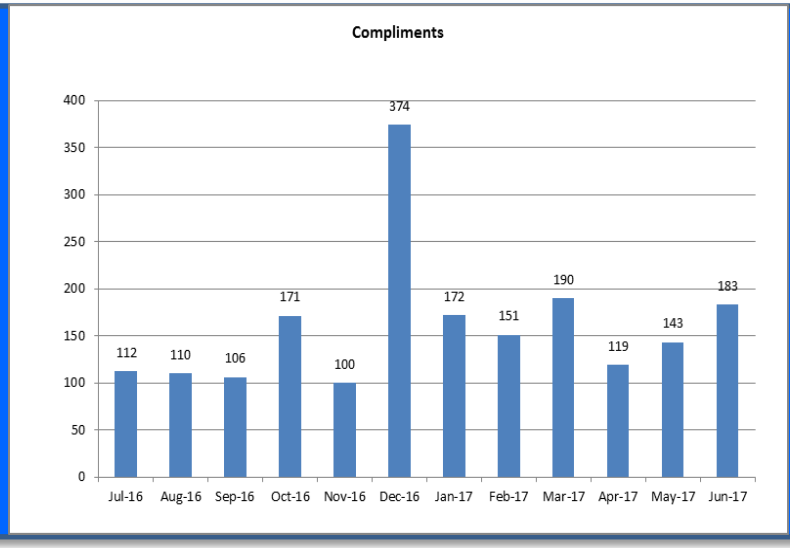
Family & Friends Test

Compliments received

There were 183 compliments/thank-you's received for June 2017:

'I recently had a colonoscopy in the treatment centre. I want to say how great everyone was that I came into contact with. Instructions were clear and easy to follow. The staff nurse and the consultant put me at ease and looked after me really well, explaining everything in full. I was very impressed with how I was managed, with dignity and respect. The tea and toast was lovely! Thank- you'

'I just want to say how wonderful all the staff were when I had to attend the emergency department. The doctors, nurses and student nurses were all very friendly and professional. Thank you.'



Compliments

Mid Cheshire Hospitals NHS
NHS Foundation Trust

Board of Directors Performance Report

June 2017

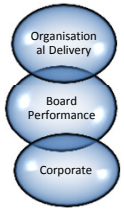
"To Deliver Excellence in Healthcare through Innovation & Collaboration"

Introduction

Performance Report

The MCHT Monthly Performance Report has been developed to integrate key domains of Quality and Safety, Performance and Corporate into one consistently presented report. It has been developed to provide an over arching view of performance against Trust priorities as set out in the NHS Improvement Compliance Framework, NHS Operating Framework, CCG CQuIN and Annual Plan.

The Monthly Performance Report will focus upon delivery of service improvements within 3 key domains:



The delivery of the service improvements within the 3 key domains are also reflected in the Board Assurance Framework which identifies where the organisation has insufficient assurance in delivering the strategic objectives of the organisation.
Within this Performance Report the indicators within each domain are presented on a summary page with the current month and year to date performance given. All indicators are measured against a NHS Improvement, national, peer or locally agreed target. A further analysis of all measures within each domain is then provided with supporting trend information and narrative. Performance against each indicator is rated as either red/green against the year to date or single month/quarter target as appropriate. Supporting narrative is provided on an exception basis.

This report is an evolving summary of overall Trust Performance, therefore measures, targets and reporting periods will be refined over time. A supporting and more detailed quality and safety report will be presented separately. This is also under further review.

Tracy Bullock
Chief Executive

Contents

Headline Measures

Organisational Delivery				
Indicator	**Standard**	**YTD**	**Jun-17**	
Cancer				
Rapid Access Referrals (%) *(seen in 2 wks)*	93.00%	97.39%	97.17%	
Total Patients Seen		*2,184*	*777*	
Patients seen >14 days		*57*	*22*	
62 day GP Classic (%)	85.00%	94.29%	92.77%	*
Accountable Patients Treated		*175*	*42*	
No. of Breached Pathways (adjusted)		*10*	*3*	
62 day Screening (%)	100.00%	100.00%	100.00%	*
Accountable Patients Treated		*39*	*15*	
No. of Breached Pathways (adjusted)		*0*	*0*	
Unplanned Activity				
A&E <4hrs Standard (%)	95.00%	92.72%	94.24%	
A&E Attendances LH & MIU (% to plan)		99.51%	99.42%	
A&E Attendances LH & MIU (Vol)		*22,628*	*7,593*	
Planned Activity				
Incomp Pathways <18wk (%)	92.00%	96.23%	96.41%	
>6wk Diagnostic Waits (%)	1.00%	0.21%	0.44%	
Total Patients Waiting for a First Outpatient Appointment			7,352	

** Provisional figures subject to change depending on further validation or treatment outcome*

Indicator	Standard	YTD
Workforce		
Sickness absence Rolling 12 Month		4.02%
Turnover Rolling 12 Month		10.14%

Exec Summary

In June 2017, the Trust delivered four of the five NHS Improvement Single Oversight Framework performance indicators. The indicator which was not achieved was the 4-hour A&E standard, with performance of 94.24% against the 95% standard. Comparatively, this is an improvement in performance against June 2016 (87.46%) and exceeds the required 91.72% STF performance trajectory for the month. This means that the STF performance trajectory for the 4-hour A&E standard has been met for Quarter 1 at an aggregate 92.72% perfomance.
The Trust has continued to achieve headline cancer access standards for June 2017 and consequently Quarter 1, with strong performance in terms of rapid access referrals and 62 day treatment pathways. Breast Screening was achieved at aggregate for Quarter 1.

The Trust continues to achieve the 92% standard for RTT 18 week incomplete pathways, with performance in June 2017 at 96.41%. The Trust is continuing to monitor this standard, with specific reference to managing the level of 'over performance' being delivered against 92%. The month also saw the Trust achieve the Non-Admitted and Admitted RTT elements.
Diagnostics waiting times continued to perform well June 2017, with just 0.44% of patients waiting longer than 6 weeks for their diagnostic test, against a regulatory threshold of 1%.

Corporate					
	YTD Rating		YE Rating	YE Metric	
Indicator	**Plan**	**Actual**	**Forecast**	**Plan**	**Forecast**
Finance					
Use of Resource Rating		3	3		
Capital Service Capacity	4	4	4	0.76	0.48
Liquidity	4	2	4	-23	-20
I&E Margin	4	3	2	0.40%	0.40%
Distance from Financial Plan	0	1	1	0.00%	0.00%
Agency Spend	1	1	1	-10.20%	-10.20%

	YTD Target	YTD Actual	YTD Variance	FY Target	FY Forecast	FY Variance
Cost Improvement Scheme Total (£000's)	975	1,122	152	4,663	4,116	-517
Revenue Generation Scheme total (£000's)	329	159	-170	1,490	1,037	-453
Commission Contact Income SC & VR (£000's)	45,963	45,962	-1			
Contract Income (£'000) Net of Drugs	51,731	51,942	211			
Pay to Budget (£000's)	-41,479	-41,333	146			
Non Pay to Budget (£000's) Net of Drugs	-14,907	-14,886	21			
Agency Trajectory (£000's)	-1,472	-1,093	379			

The UoRR metric is 3, primarily a consequence of the override resulting from the deficit position year to date and the impact of the Trust's ability to service DH loans. The forecast position is to improve the I&E position to a surplus although it is expected liquidity will reduce as loans become repayable.

The Trust's I&E position is a deficit of £0.5M which is £0.3M better than plan as at Month 3.

The SC & VR commissioning contracts represent the revised contract value in line with the agreed Capped Expenditure Process (CEP).

There is a favourable variation in the CIP in month 3 but Revenue Generation Targets are behind plan as a result of slippage on annualised hours and best practice tariff and worse than planned performance in theatres efficiency.

The Trust is currently £0.4M better than its Agency spend trajectory which for the full year is £6.2M.

Single Oversight Framework

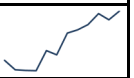
Triggers

Operational	For providers with Sustainability and Transformation Fund (STF) trajectories in any metric: failure to met the trajectory for this metric for at least two consecutive months (quarterly for quarterly metrics), except where the provider is meeting the NHS Constitution standard.
Finance & Resource	Poor levels of overall financial performance (avg score of 3 or 4). Very poor performance (score of 4) in any individual metric. Potential value for money concerns.

The Trust operational trigger rating continues as RED as a result of failure of a primary target during the year (A&E 95% 4-hour waiting time),despite the STF trajectory being achieved.

The Trust has a Use of Resource rating of 3 cumulative and is forecasting a rating of 3 for the full year. This results in a 'trigger' on the Finance & Resource theme. This is primarily driven by the deficit I&E position and loans required to support liquidity . The Trust is better than plan for its I&E margin ytd but is expected to meet its control total plan by year end. The Agency trajectory target is currently better than plan.

Operational Performance

	Current YTD													
	Target	Actual	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Monthly Trend
Maximum 6 week wait for Diagnostic procedures	1%	0.21%	0.16%	0.21%	0.11%	0.63%	0.13%	0.24%	0.18%	0.07%	0.09%	0.04%	0.17%	0.44%	
All Cancers: 62 day GP Classic (%) *	85%	94.29%	90.91%	86.47%	95.24%	95.37%	92.00%	90.24%	90.43%	86.41%	96.46%	96.88%	92.81%	92.77%	
All Cancers: 62 day Screening (%) *	90%	100.00%	85.71%	90.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	
18 weeks from point of referral to treatment - patients on an incomplete pathway (%)	92%	96.23%	93.99%	93.52%	93.50%	93.49%	94.47%	94.26%	95.32%	95.49%	95.73%	96.27%	95.98%	96.41%	
A&E - maximum waiting time of 4 hours from arrival to admission/transfer/discharge (%)	95%	92.72%	88.86%	93.12%	92.18%	89.21%	93.33%	89.25%	84.47%	93.33%	97.21%	93.37%	90.66%	94.24%	
A&E STF Trajectory			95.00%	95.01%	95.00%	92.01%	92.00%	92.00%	93.50%	92.01%	92.81%	91.72%	91.72%	91.72%	

** Provisional figures subject to change depending on further validation or treatment outcome*

Financial & Resource

		Unit	YE Plan	YE Forecast	YE Rating	YTD Plan	YTD Actual	YTD Rating
Financial Sustainability	Capital Service Capacity	0.0x	0.76	0.48	4	0.22	0.54	4
	Liquidity	days	-23	-20	4	-17	-0.12	2
Financial Efficiency	I&E Margin	%	0.40%	0.40%	2	-1.50%	-0.70%	3
Financial Controls	Distance from Financial Plan	%	0.00%	0.00%	1	0.00%	0.80%	1
	Agency Spend	%	-10.20%	-10.20%	1	-14.40%	-36.50%	1
Overall UOR Rating					3			3

Operational Delivery: *Cancer Pathway*

Headline Measures

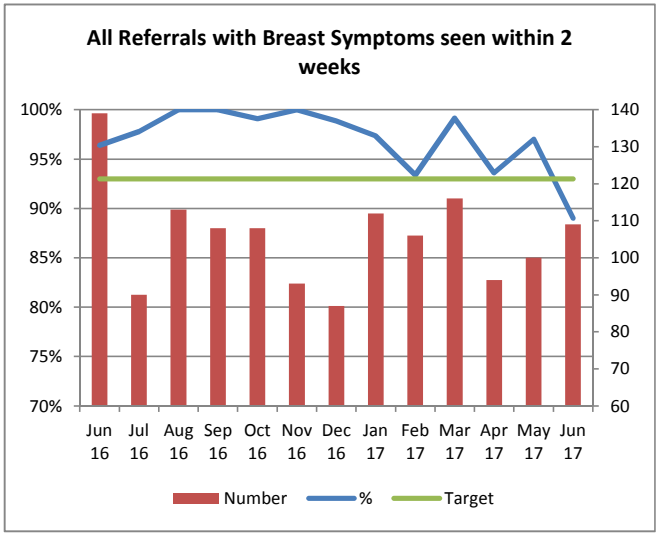
	Current YTD		Rolling 13 months											
	Target	Actual	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Monthly Trend
Rapid Access Referrals (%) (seen in 2 wks)	93%	97.39%	96.86%	98.20%	98.55%	98.25%	98.60%	98.79%	98.93%	97.66%	99.15%	98.10%	97.14%	97.84%	97.17%	
Total Patients Seen		*2184*	*795*	*666*	*685*	*687*	*713*	*743*	*652*	*641*	*706*	*842*	*665*	*742*	*777*	
Patients seen >14 days		*57*	*25*	*12*	*10*	*12*	*10*	*9*	*7*	*15*	*6*	*16*	*19*	*16*	*22*	
% seen within 7 days		*64.5%*	*48.6%*	*65.6%*	*63.8%*	*58.7%*	*64.5%*	*62.0%*	*51.1%*	*69.1%*	*54.3%*	*63.1%*	*55.5%*	*53.5%*	*0.0%*	
62 day GP Classic (%) *	85%	94.29%	83.61%	90.91%	86.47%	95.24%	95.37%	92.00%	90.24%	90.43%	86.41%	96.46%	96.88%	92.81%	92.77%	

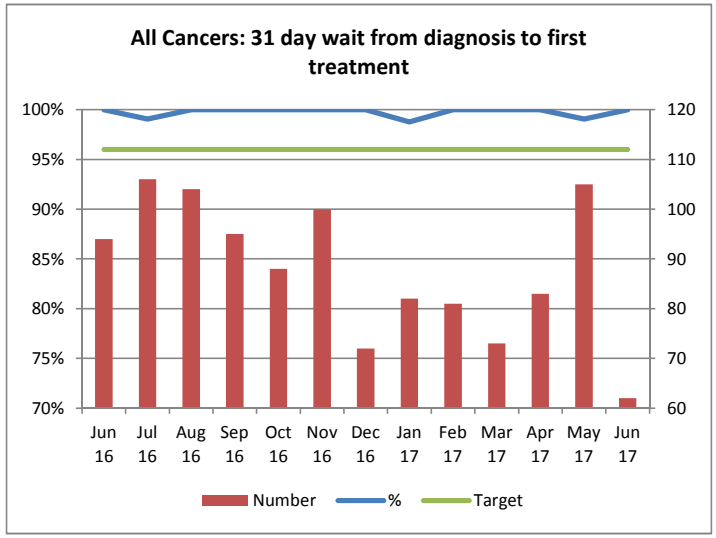
** Provisional figures subject to change depending on*

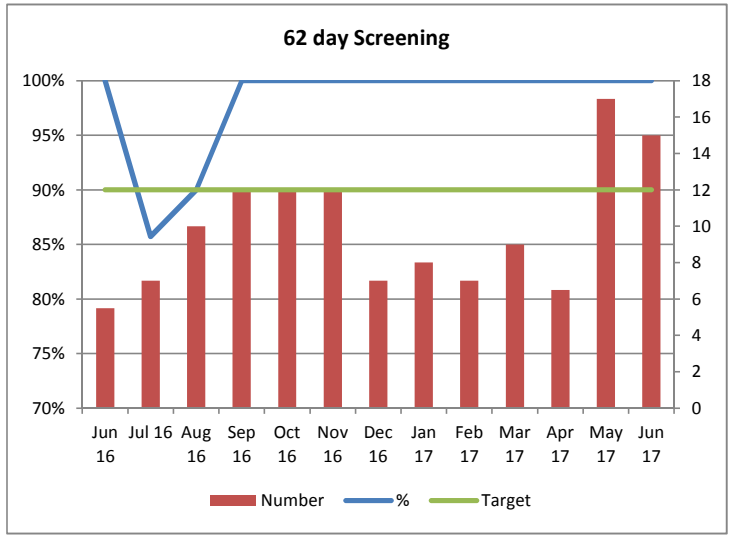
Commentary

The Trust has achieved all headline cancer standards during the month of June 2017 . The figures above reflect the Trust's regulatory performance measures (adjusted figures that take into account breach reallocation between providers).
The standard that has not been achieved in month is the Breast Symptomatic 2 week target of 93%. Delivery against this was 89%. This reflects the recent significant pressures in the area of Breast Radiology. Breast rapid access (2 week wait) achieved the 93% standard. Work continues at an operational level to manage the delivery and risks associated with Breast Radiology at the present time. Breast Screening was achieved at aggregate for Quarter 1

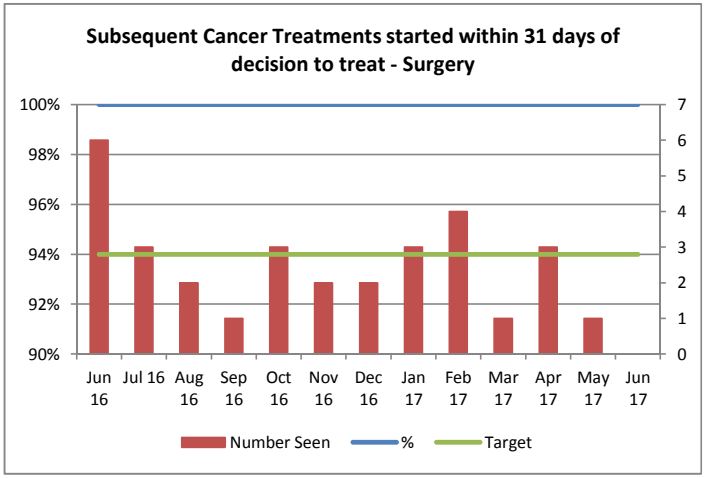
Primary Measures

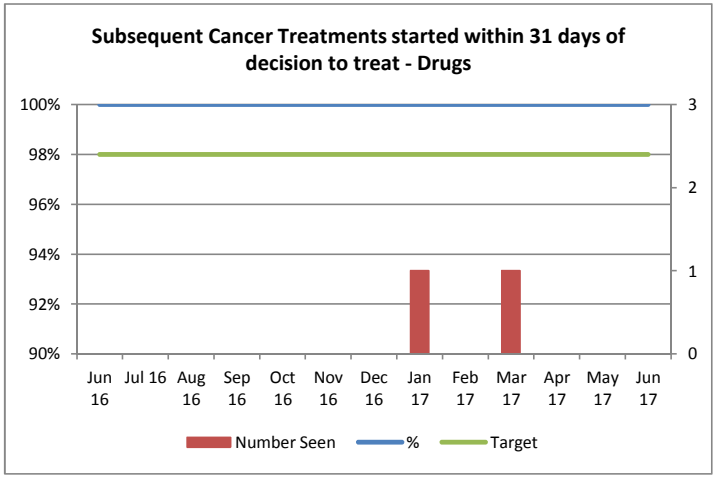


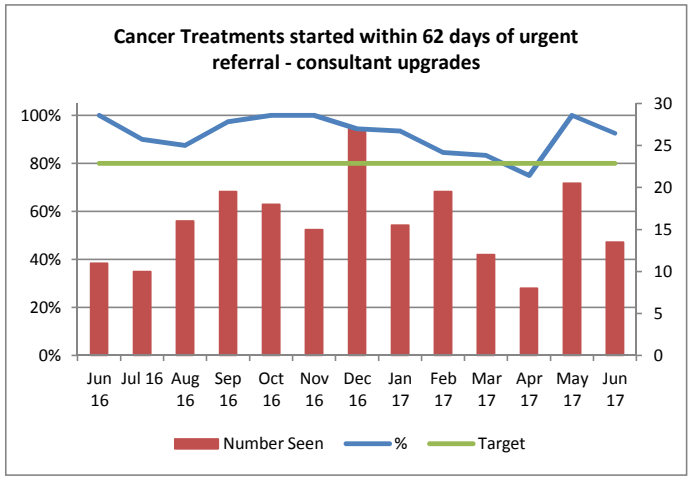




Operational Delivery: *Cancer Pathway*







Operational Delivery: *Unplanned Activity - A&E*

Headline Measures

	Current YTD		Rolling 13 months											
	Target	Actual	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Monthly Trend
A&E - >4 hr wait time from arrival to admission/ transfer/ discharge (% to Target)	95%	92.72%	87.46%	88.86%	93.12%	92.18%	89.21%	93.33%	89.25%	84.47%	93.33%	97.21%	93.37%	90.66%	94.24%	
No. of 4hr breaches		*1,648*	*934*	*854*	*503*	*570*	*813*	*443*	*753*	*1,082*	*411*	*205*	*474*	*737*	*437*	

	Plan	Actual	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Monthly Trend
A&E Attendances Leighton & MIU (% to Plan)		*99.51%*	*101.1%*	*99.3%*	*100.1%*	*103.6%*	*104.1%*	*97.2%*	*100.5%*	*103.7%*	*95.1%*	*98.5%*	*97.7%*	*101.3%*	*99.4%*	
A&E Attendances Leighton & MIU (No.)	*22,738*	*22,628*	*7,447*	*7,663*	*7,307*	*7,288*	*7,533*	*6,643*	*7,005*	*6,965*	*6,166*	*7,357*	*7,144*	*7,890*	*7,593*	

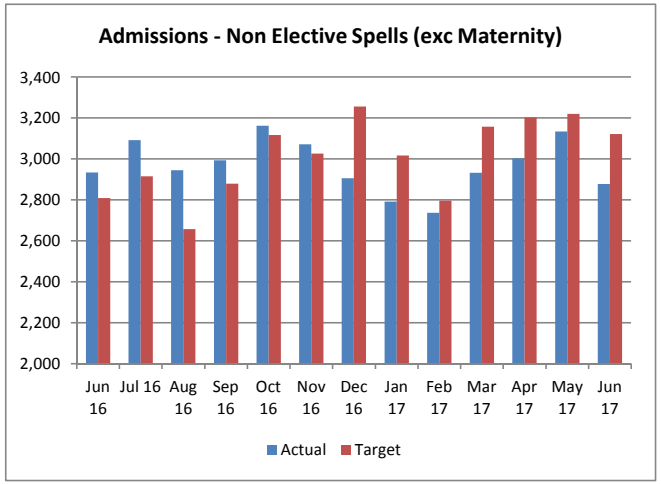
A&E Attendance Case Mix (Leighton)	*Major*		*53.35%*	*56.6%*	*58.0%*	*59.6%*	*57.6%*	*59.0%*	*60.4%*	*59.3%*	*56.2%*	*56.1%*	*55.8%*	*55.1%*	*51.6%*	*53.6%*	
	Minor		*34.08%*	*37.9%*	*36.6%*	*35.6%*	*37.7%*	*35.0%*	*33.8%*	*32.7%*	*32.1%*	*32.4%*	*32.0%*	*33.0%*	*34.9%*	*34.2%*	
	Resus		*3.18%*	*3.5%*	*3.4%*	*2.5%*	*2.3%*	*3.1%*	*2.8%*	*4.2%*	*4.1%*	*2.9%*	*2.3%*	*3.1%*	*3.3%*	*3.1%*	
	Unknown/UCC		*9.39%*	*2.0%*	*2.0%*	*2.3%*	*2.3%*	*2.9%*	*3.1%*	*3.8%*	*7.6%*	*8.6%*	*9.9%*	*8.8%*	*10.3%*	*9.1%*	

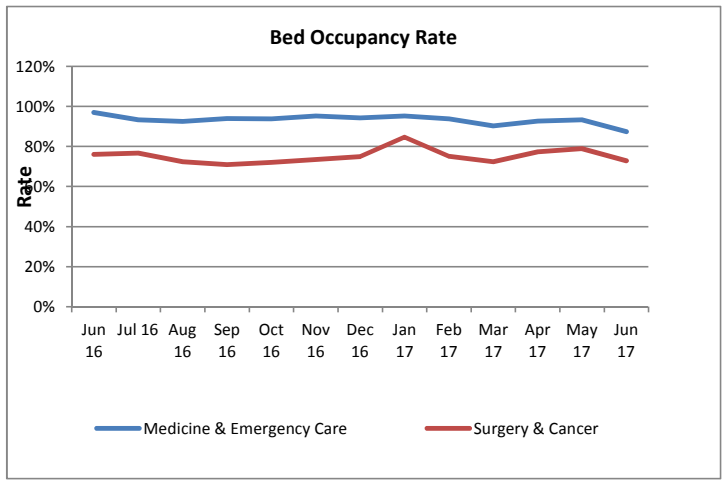
Commentary

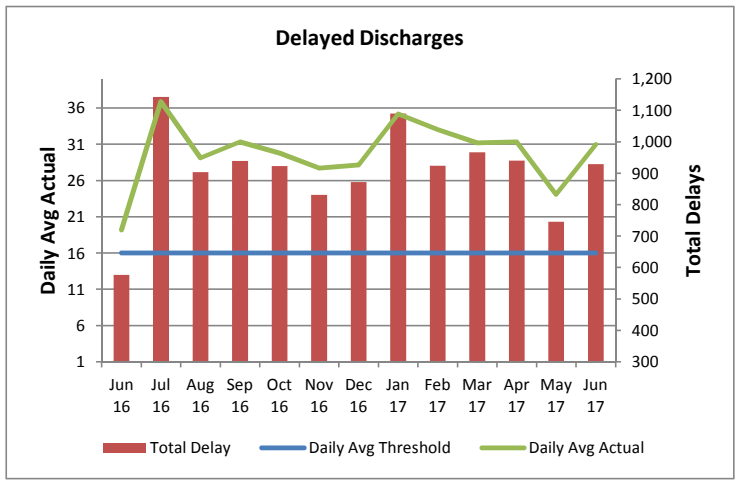
There was an increase in total ED attendances in June 2017 (7,593) compared to June 2016 (7,447). The Trust achieved 94.24% against the 95% 4-hour access standard.,an improvement against June 2016 which was 87.46%. This was also an improvement in performance against May 2017, which was 90.66%. The STF trajectory of 91.72% for Quarter 1 has been achieved.The STF trajectory for Quarter 2 is 91.34% both on a monthly basis and at aggregate level.
The Board are advised that the Trust delivered June 2017 performance with 25 fewer acute beds open than in June 2016, due toimplementation of the efficiencies associated with the Trust's Access & Flow Transformation Programme. In recent months, aggregate monthly performance against the 4 hour 95% standard at Mid Cheshire is in the top quartile nationally.

Non-elective admissions were below target levels, with June seeing the Type 1 conversion rate continue a downward trend to reach 31.2%. Bed occupancy fell compared to May 2017, even after taking into account 25 fewer medical beds being available in the Trust. Delayed transfers of care increased compared to May 2017, with 31 SITREP reportable delays on averageper day throughout the month and this continues to be an area of significant work for the health economy and internal Access & Flow programme. Medical outliers remained within target threshold in June at an average 2 per day.

Primary Drivers

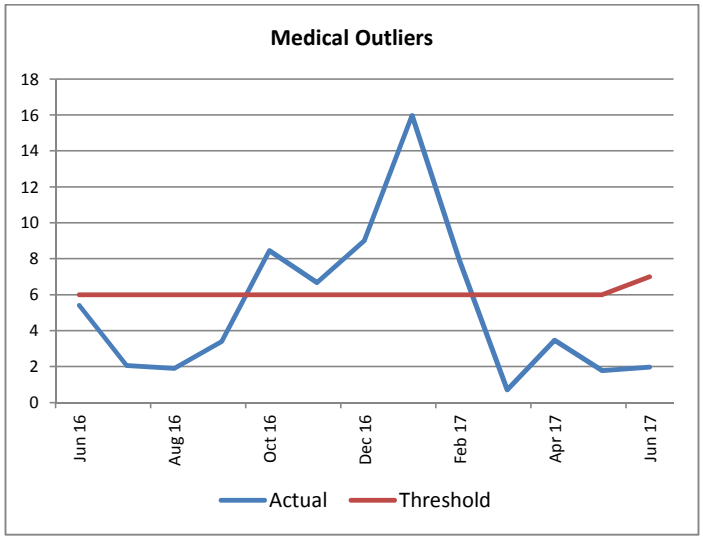


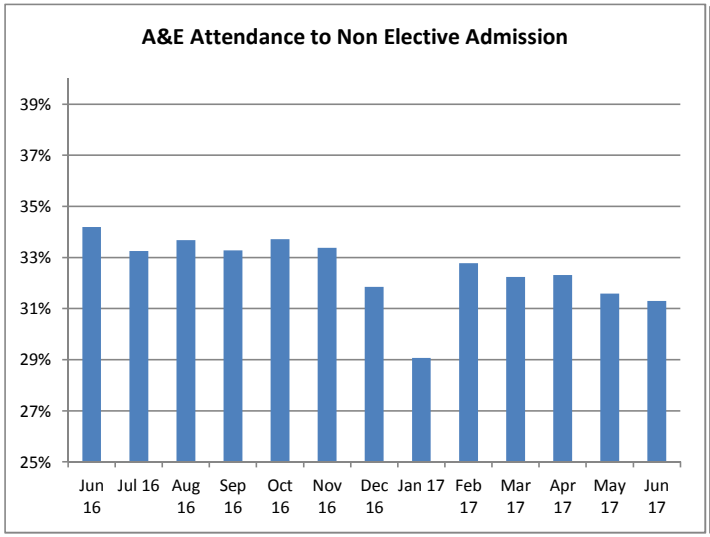


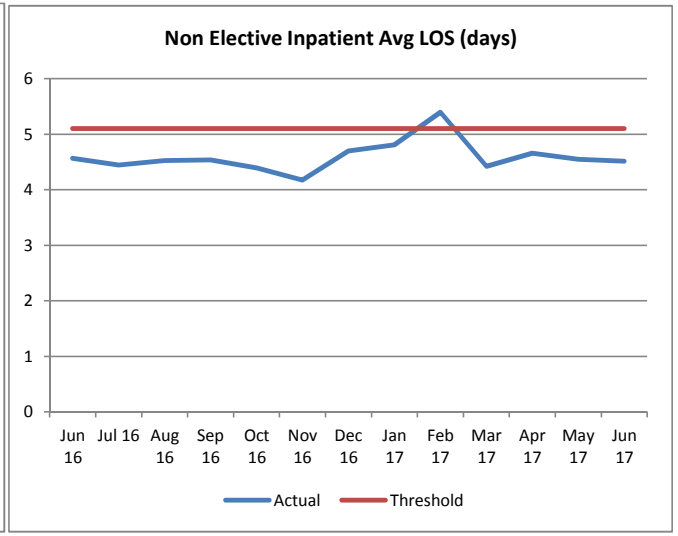


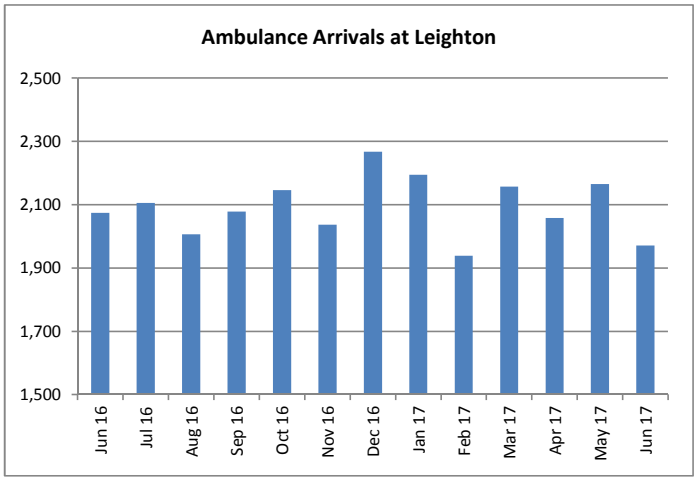
Operational Delivery: *Unplanned Activity A&E*

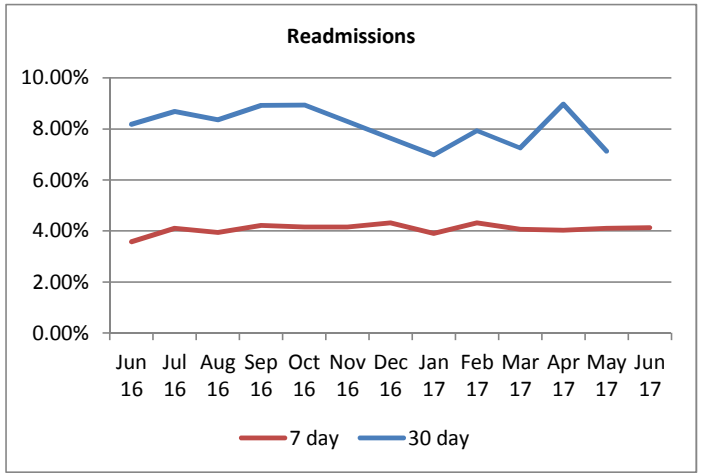
Secondary Drivers

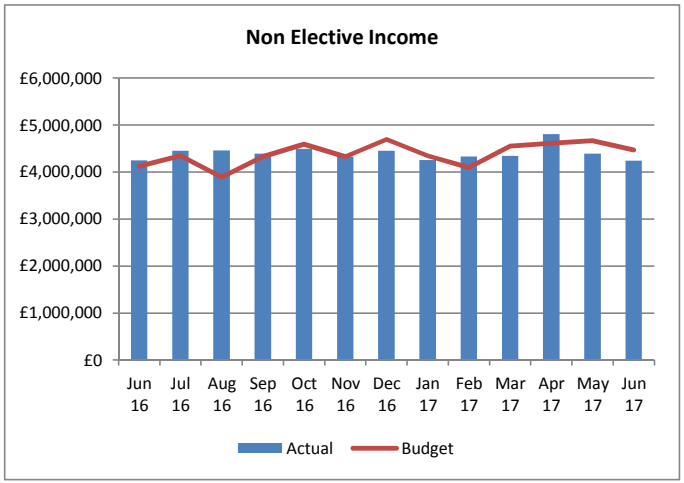












Operational Delivery: *Planned Activity*

Headline Measures

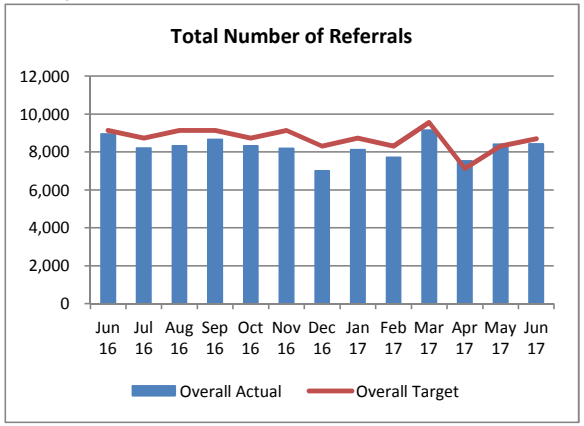
	Current YTD		Rolling 13 months											
	Target	Actual	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Monthly Trend
18 weeks from Referral to Treatment in Aggregate - Incomplete	92%	96.23%	93.95%	93.99%	93.52%	93.50%	93.49%	94.47%	94.26%	95.32%	95.49%	95.73%	96.27%	95.98%	96.41%	
Total 18 Weeks		*37,405*	*17,358*	*17,158*	*16,688*	*15,923*	*14,876*	*14,191*	*13,780*	*12,696*	*12,570*	*13,004*	*12,587*	*12,325*	*12,493*	
No. > 18 Weeks		*1,412*	*1,050*	*1,032*	*1,081*	*1,035*	*969*	*785*	*791*	*594*	*567*	*555*	*469*	*495*	*448*	
Diagnostic Waiting Time	1%	0.21%	0.18%	0.16%	0.21%	0.11%	0.63%	0.13%	0.24%	0.18%	0.07%	0.09%	0.04%	0.17%	0.44%	
Total Number of Waiters		*12,864*	*6,149*	*4,358*	*3,806*	*3,767*	*3,630*	*3,149*	*3,826*	*3,786*	*4,305*	*4,561*	*4,582*	*4,192*	*4,090*	
Waiters of 6 Weeks +		*27*	*11*	*7*	*8*	*4*	*23*	*4*	*9*	*7*	*3*	*4*	*2*	*7*	*18*	
Total Patients Waiting for a First Outpatient Appointment			10,937	10,967	10,746	10,155	9,544	8,359	7,842	7,205	7,812	7,057	7,223	7,172	7,352	
Longest Wait Time (weeks) - under development																

Commentary

The Trust reported 96.41% against the 92% incomplete pathways standard for RTT. One specialty (Community Paediatrics)was failing the 92% target at the end of the month, with performance at 90.21%. The Trust is now actively managing the level of over performance against this standard in light of the Capped Expenditure Programme with the aim of the over performance reducing over the coming months.
Referrals from GPs in June 2017 were 4.7% below plan. There were over 8,427 total referrals into the Trust, which is consistent with the level in May 2017.

The Trust has delivered the diagnostic wait time consistently since May 2016. In June 2017, 0.44% of patients waited longer than 6 weeks for their diagnostic tests. All modalities delivered the standard, however significant outsourcing continued in medical imaging to support this position.

Primary Drivers

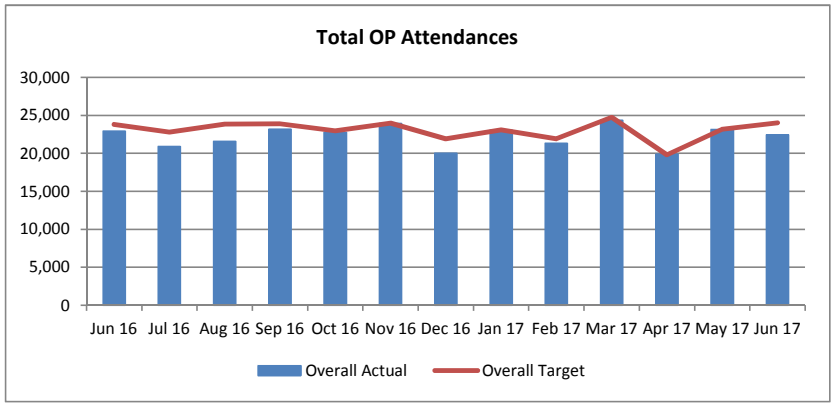


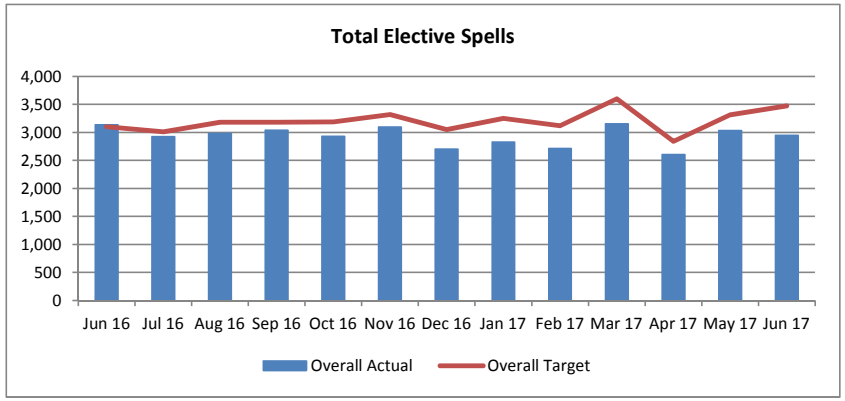
Referral Breakdown

	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Monthly Trend
GP Actual	5,586	5,055	5,035	5,383	5,063	5,061	4,192	4,930	4,592	5,534	4,427	4,779	5,248	
GP Target	5,767	5,505	5,767	5,767	5,505	5,767	5,243	5,505	5,243	6,029	4,507	5,259	5,509	
% to Target	96.9%	91.8%	87.3%	93.3%	92.0%	87.8%	80.0%	89.6%	87.6%	91.8%	98.2%	90.9%	95.3%	
Other Actual	3,370	3,151	3,298	3,277	3,263	3,135	2,821	3,200	3,126	3,621	3,100	3,631	3,179	
Other Target	3,376	3,222	3,376	3,376	3,222	3,376	3,069	3,222	3,069	3,529	2,614	3,050	3,195	
% to Target	99.8%	97.8%	97.7%	97.1%	101.3%	92.9%	91.9%	99.3%	101.9%	102.6%	118.6%	119.1%	99.5%	
Total Actual	8,956	8,206	8,333	8,660	8,326	8,196	7,013	8,130	7,718	9,155	7,527	8,410	8,427	
Total Target	9,143	8,728	9,143	9,143	8,728	9,143	8,312	8,728	8,312	9,559	7,121	8,308	8,704	
% to Target	98.0%	94.0%	91.1%	94.7%	95.4%	89.6%	84.4%	93.2%	92.9%	95.8%	105.7%	101.2%	96.8%	
GP % of Total	62.4%	61.6%	60.4%	62.2%	60.8%	61.7%	59.8%	60.6%	59.5%	60.4%	58.8%	56.8%	62.3%	

Operational Delivery: *Planned Activity*

Primary Drivers



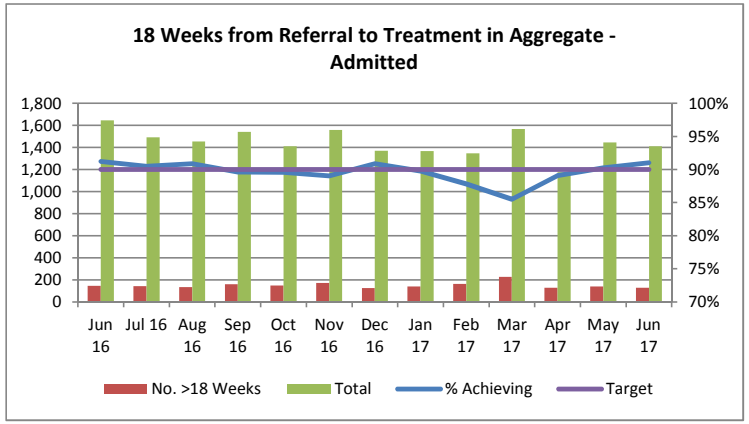


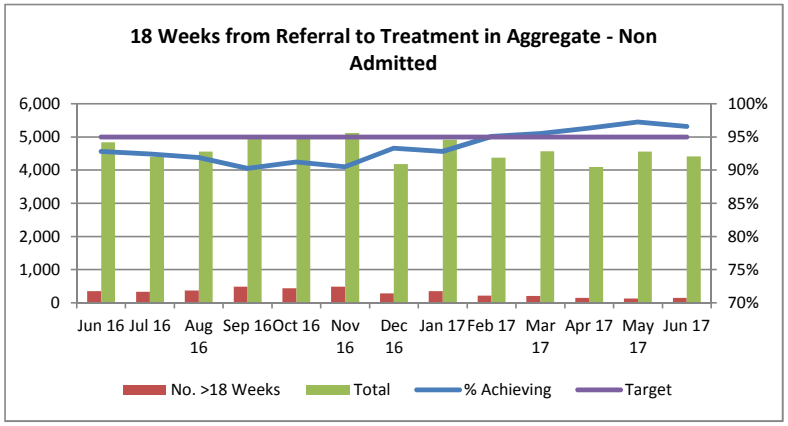
OP Attendance Breakdown	YTD	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Monthly Trend
New Actual	88,827	7,533	6,530	6,851	7,565	7,421	7,305	6,202	6,811	6,243	7,110	5,727	6,787	6,742	
New Target	92,448	7,329	7,002	7,333	7,337	7,081	7,408	6,747	7,138	6,791	7,764	6,059	7,075	7,385	
% to Target	96.1%	102.8%	93.3%	93.4%	103.1%	104.8%	98.6%	91.9%	95.4%	91.9%	91.6%	94.5%	95.9%	91.3%	
F U Actual	200,518	15,363	14,368	14,715	15,599	15,346	16,631	13,820	16,223	15,063	17,229	14,147	16,325	15,689	
F U Target	207,441	16,457	15,807	16,498	16,540	15,894	16,549	15,170	15,958	15,098	16,983	13,759	16,112	16,617	
% to Target	96.7%	93.4%	90.9%	89.2%	94.3%	96.6%	100.5%	91.1%	101.7%	99.8%	101.4%	102.8%	101.3%	94.4%	
Total Actual	289,345	22,896	20,898	21,566	23,164	22,767	23,936	20,022	23,034	21,306	24,339	19,874	23,112	22,431	
Total Target	299,889	23,786	22,809	23,831	23,876	22,975	23,957	21,917	23,096	21,889	24,747	19,818	23,187	24,002	
% to Target	96.5%	96.3%	91.6%	90.5%	97.0%	99.1%	99.9%	91.4%	99.7%	97.3%	98.4%	100.3%	99.7%	93.5%	
New % of Total	30.7%	32.9%	31.2%	31.8%	32.7%	32.6%	30.5%	31.0%	29.6%	29.3%	29.2%	28.8%	29.4%	30.1%	

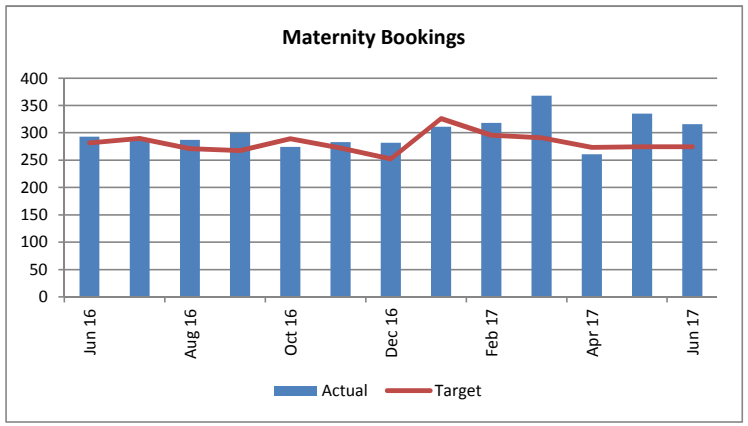
Elective Spells Breakdown	YTD	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Monthly Trend
I P Actual	3,832	313	294	298	302	332	324	258	210	304	342	260	307	288	
I P Target	4,611	365	348	365	365	352	369	335	359	342	393	300	350	367	
% to Target	83.1%	85.7%	84.4%	81.6%	82.7%	94.4%	87.9%	77.0%	58.5%	88.8%	87.1%	86.5%	87.6%	78.5%	
Daycase Actual	34,262	2,825	2,630	2,684	2,739	2,598	2,773	2,442	2,618	2,411	2,809	2,343	2,728	2,662	
Daycase Target	37,023	2,738	2,660	2,818	2,818	2,834	2,952	2,717	2,892	2,775	3,208	2,541	2,965	3,106	
% to Target	92.5%	103.2%	98.9%	95.3%	97.2%	91.7%	93.9%	89.9%	90.5%	86.9%	87.6%	92.2%	92.0%	85.7%	
Total Actual	38,094	3,138	2,924	2,982	3,041	2,930	3,097	2,700	2,828	2,715	3,151	2,603	3,035	2,950	
Total Target	41,635	3,103	3,008	3,183	3,183	3,186	3,321	3,052	3,252	3,117	3,601	2,842	3,315	3,473	
% to Target	91.5%	101.1%	97.2%	93.7%	95.5%	92.0%	93.3%	88.5%	87.0%	87.1%	87.5%	91.6%	91.6%	84.9%	
I P % of Total	10.1%	10.0%	10.1%	10.0%	9.9%	11.3%	10.5%	9.6%	7.4%	11.2%	10.9%	10.0%	10.1%	9.8%	

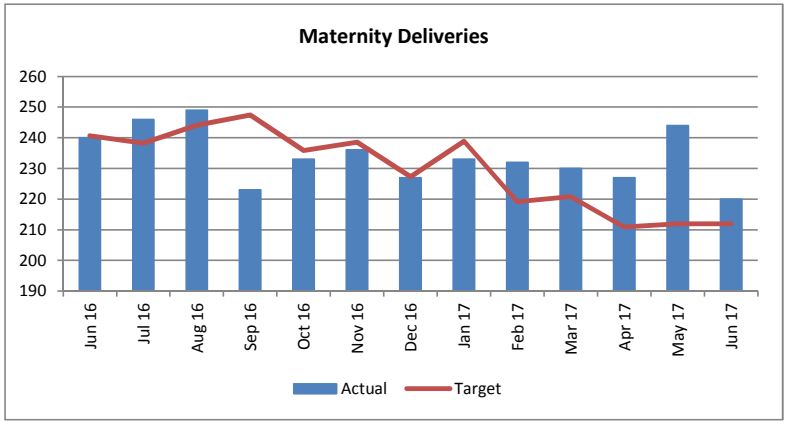
Operational Delivery: *Planned Activity*

Primary Drivers





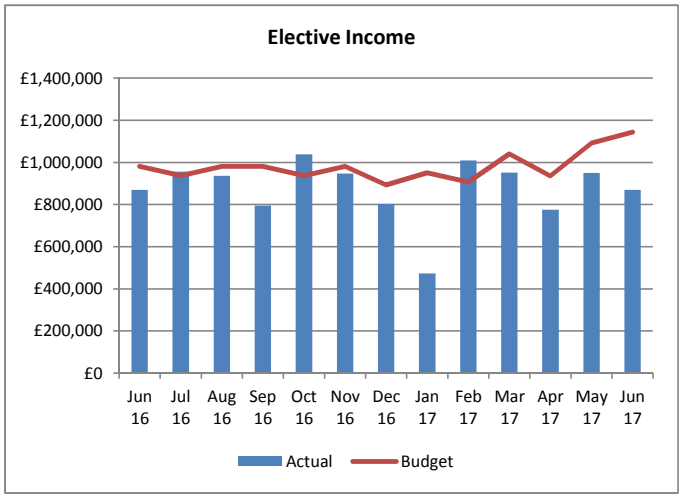


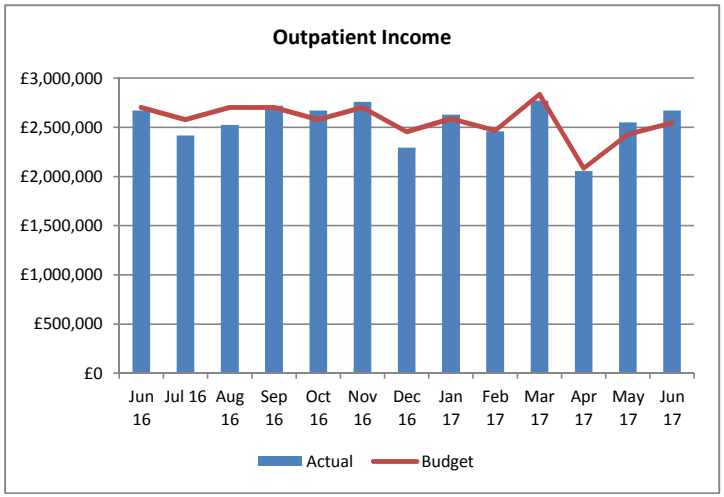


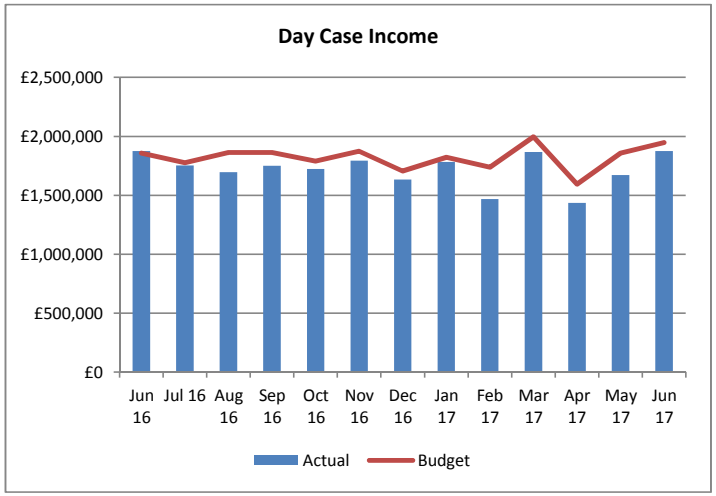
Operational Delivery: *Planned Activity*

Secondary Drivers

			Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Monthly Trend
Bed Occupancy Rate	Medicine & Emergency Care		97.0%	93.2%	92.5%	94.0%	93.7%	95.2%	94.2%	95.2%	93.8%	90.3%	92.6%	93.3%	87.4%	
	Surgery & Cancer		76.0%	76.7%	72.4%	71.0%	72.0%	73.4%	74.9%	84.6%	75.1%	72.3%	77.3%	78.9%	72.9%	
Elective Inpatient Avg LOS (Days)			2.6	3.2	3.2	2.7	3.3	2.3	3.3	2.1	2.8	2.4	3.4	2.9	3.1	
Delayed Transfers of Care (MFFD)		16.00	19	37	29	31	30	28	28	35	33	31	31	24	31	
Medical Outliers			5	2	2	3	8	7	9	16	8	1	3	2	2	
Readmission (Emergency Re-admissions after Planned Surgery)																
** reported from 16/17. One month delay*	30 Day Rate		3.24%	2.77%	2.91%	3.15%	3.29%	3.14%	3.46%	3.27%	2.95%	0.27%	4.00%	3.05%	0.00%	
	7 Day Rate		1.33%	1.65%	1.01%	1.16%	1.29%	1.37%	1.24%	1.75%	1.67%	1.40%	1.73%	1.56%	1.49%	
Cancelled Operations - Non Clinical - Cancellation Rate			1.09%	1.40%	0.98%	1.48%	1.16%	0.61%	2.12%	0.85%	1.25%	1.07%	1.30%	1.06%	0.81%	
Theatre Efficiency																
	Main Theatres		77.3%	74.9%	79.6%	76.6%	77.6%	75.7%	75.5%	71.4%	76.3%	76.2%	77.5%	79.5%	78.4%	
	TC Theatres		71.7%	72.3%	74.4%	74.6%	77.2%	73.9%	72.6%	72.1%	76.0%	75.3%	75.6%	79.6%	72.7%	
DNA (OP Efficiency)			6.39%	6.34%	6.47%	6.72%	5.92%	6.15%	6.28%	6.13%	5.44%	5.35%	5.86%	5.94%	6.63%	
Hospital Cancellation Rate (OP Efficiency)			4.87%	5.19%	5.99%	5.01%	5.36%	5.34%	5.56%	5.40%	5.73%	6.03%	6.57%	7.63%	7.51%	







Financial Performance: Income & Expenditure Position - Aggregated

	Month			Year to Date			Forecast	Base Budget 17/18 £'000
	Plan Jun (£'000)	Actual Jun (£'000)	Variance Jun (£'000)	Plan Apr to Jun (£'000)	Actual Apr to Jun (£'000)	Variance Apr to Jun (£'000)	17/18 (£'000)	
Operating								
Operating Income								
NHS Acute Activity Income								
Elective	1,120	1,028	-92	3,184	2,757	-427	13,056	13,056
Non-Elective	4,470	4,724	254	13,847	14,583	736	57,516	57,516
Maternity	1,130	1,140	10	3,300	3,439	140	13,208	13,208
Day cases	1,949	1,778	-171	5,448	4,976	-472	22,214	22,214
Outpatients	2,499	2,340	-159	7,056	6,788	-268	29,032	29,032
A&E	802	966	164	2,387	2,519	131	9,309	9,309
Other NHS	6,479	6,556	77	19,147	19,215	67	75,858	83,071
Total NHS Clinical Revenue	**18,448**	**18,530**	**82**	**54,369**	**54,276**	**-92**	**220,193**	**227,406**
Other Operating Income	1,907	1,873	-34	5,732	5,592	-140	22,934	22,934
TOTAL OPERATING INCOME	**20,355**	**20,403**	**48**	**60,101**	**59,868**	**-232**	**243,127**	**250,340**
Operating Expenses								
Employee Benefits Expenses (Pay)	-13,837	-13,715	122	-41,479	-41,333	146	-165,181	-168,053
Drugs	-1,276	-1,294	-18	-4,138	-3,829	309	-16,526	-17,178
Clinical Supplies	-1,575	-1,558	17	-4,876	-4,444	432	-19,493	-20,366
Non Clinical Supplies	-219	-317	-98	-850	-877	-27	-3,338	-3,764
Other operating expenses	-2,710	-2,758	-48	-7,682	-8,071	-389	-30,177	-32,468
TOTAL OPERATING EXPENSES	**-19,617**	**-19,642**	**-25**	**-59,025**	**-58,554**	**471**	**-234,715**	**-241,829**
EBITDA	**738**	**761**	**23**	**1,076**	**1,314**	**239**	**8,412**	**8,511**
Non Operating								
Non Operating Income								
Interest & Asset disposal	3	2	-1	9	2	-7	36	36
Non-Operating Expenses								
Depreciation & Finance Leases	-511	-422	89	-1,427	-1,296	131	-5,850	-5,950
PDC Dividend Expense	-158	-158	0	-476	-476	0	-1,900	-1,900
Net Surplus/(deficit) before Exceptional Items	**72**	**183**	**111**	**-818**	**-456**	**363**	**698**	**697**
Prior Period Adjustment	-27	0	27	0	0	0	0	0
	0	0	0	0	0	0	0	
	0	0	0	0	0	0	0	0
Net Surplus/(deficit) after Exceptional Items	**45**	**183**	**138**	**-818**	**-456**	**363**	**698**	**697**

The Trust delivered a £0.5M deficit cumulative against a planned deficit of £0.8M.

Contract income is £0.1M worse than plan in cumulative. Key variances include planned income and drugs and the impact of the CEP.

Other income is 0.1M worse cumulative as a result of RTA income and nhs recharge variances.

Pay is £0.1M better than plan cumulative as a result of underspends in medical pay from unfilled vacancies and community services. The Pay budget has been reduced in line with the CEP.

Non-Pay is £0.3M better than plan in month as a result of high cost drugs (income offset) , reduced spend on clinical supplies and community services. The non-pay budget has been reduced in line with the CEP.

The forecast is to acheive the agreed control total and deliver the cost savings under the CEP, recognising the reduced income flows from South Cheshire & Vale Royal CCGs.

Financial Performance: Income & Expenditure Position - MCHFT

	Month			Year to Date			Base Budget 2017/18 £'000
	Plan Jun (£'000)	Actual Jun (£'000)	Variance Jun (£'000)	Plan Apr to Jun (£'000)	Actual Apr to Jun (£'000)	Variance Apr to Jun (£'000)	
Operating							
Operating Income							
NHS Acute Activity Income							
Elective	1,120	1,028	-92	3,184	2,757	-427	13,056
Non-Elective	4,470	4,724	254	13,847	14,583	736	57,516
Maternity	1,130	1,140	10	3,300	3,439	140	13,208
Day cases	1,949	1,778	-171	5,448	4,976	-472	22,214
Outpatients	2,499	2,340	-159	7,056	6,788	-268	29,032
A&E	802	966	164	2,387	2,519	131	9,309
Other NHS	4,300	4,249	-51	12,609	12,562	-48	55,266
Total NHS Clinical Revenue	**16,269**	**16,223**	**-46**	**47,831**	**47,623**	**-207**	**199,601**
Other Operating Income	1,832	1,793	-39	5,507	5,353	-154	22,035
Inter-Trust Income	48	48	0	143	143	0	571
TOTAL OPERATING INCOME	**18,149**	**18,064**	**-85**	**53,480**	**53,119**	**-361**	**222,207**
Operating Expenses							
Employee Benefits Expenses (Pay)	-12,092	-12,017	75	-36,249	-36,311	-62	-146,616
Drugs	-1,274	-1,294	-20	-4,131	-3,829	302	-17,149
Clinical Supplies	-1,472	-1,431	41	-4,610	-4,187	423	-19,799
Non Clinical Supplies	-211	-224	-13	-646	-675	-29	-2,589
Other operating expenses	-2,285	-2,305	-20	-6,519	-6,751	-232	-26,565
Inter-Trust Charges	-82	-82	0	-245	-245	0	-979
TOTAL OPERATING EXPENSES	**-17,416**	**-17,353**	**63**	**-52,400**	**-51,998**	**402**	**-213,697**
EBITDA	**733**	**711**	**-22**	**1,081**	**1,121**	**41**	**8,510**
Non Operating							
Non Operating Income							
Interest & Asset disposal	3	2	-1	9	2	-7	36
Non-Operating Expenses							
Depreciation & Finance Leases	-511	-422	89	-1,427	-1,296	131	-5,950
PDC Dividend Expense	-158	-158	0	-476	-476	0	-1,900
Net Surplus/(deficit) before Exceptional Items	**67**	**133**	**66**	**-813**	**-649**	**165**	**696**

The Trust excluding Community Services, delivered a £0.9M deficit cumulative against a planned deficit of £1.2M.

Contract income is £0.1M worse than plan cumulative. Key variances include planned income and drugs. An adjustment to PbR of £0.2M has been made against the CEP. The impact of the CEP has been reflected in contract income targets in Month 3.

Other is £0.2M worse in month as a result of RTA income and nhs recharge variances.

Pay is £0.1M worse than plan cumulative as a result of underspends in Medical pay from unfilled vacancies offset by higher spend on Nursing and corporate vacancy targets.

Non-Pay is £0.4M better than plan cumulative as a result of high cost drugs (income offset) and clinical supplies.

The impact of the CEP has been reflected in pay and non-pay budgets in Month 3.

Financial Performance: Income & Expenditure Position - CCICP

	Month			Year to Date			Base Budget 2017/18 £'000
	Plan Jun (£'000)	Actual Jun (£'000)	Variance Jun (£'000)	Plan Apr to Jun (£'000)	Actual Apr to Jun (£'000)	Variance Apr to Jun (£'000)	
Operating							
Operating Income							
NHS Acute Activity Income							
Elective	0	0	0	0	0	0	
Non-Elective	0	0	0	0	0	0	
Maternity	0	0	0	0	0	0	
Day cases	0	0	0	0	0	0	
Outpatients	0	0	0	0	0	0	
A&E	0	0	0	0	0	0	
Other NHS	2,179	2,307	128	6,538	6,653	115	27,805
Total NHS Clinical Revenue	**2,179**	**2,307**	**128**	**6,538**	**6,653**	**115**	**27,805**
Other Operating Income	75	80	5	225	239	14	899
Inter-Trust Income	82	82	0	245	245	0	979
TOTAL OPERATING INCOME	**2,336**	**2,469**	**133**	**7,008**	**7,137**	**129**	**29,683**
Operating Expenses							
Employee Benefits Expenses (Pay)	-1,745	-1,698	47	-5,230	-5,022	208	-21,437
Drugs	-2	0	2	-7	0	7	-29
Clinical Supplies	-103	-127	-24	-266	-257	9	-567
Non Clinical Supplies	-8	-93	-85	-204	-202	2	-1,175
Other operating expenses	-425	-453	-28	-1,163	-1,320	-157	-5,903
Inter-Trust Charges	-48	-48	0	-143	-143	0	-571
TOTAL OPERATING EXPENSES	**-2,331**	**-2,419**	**-88**	**-7,013**	**-6,944**	**69**	**-29,682**
EBITDA	**5**	**50**	**45**	**-5**	**193**	**198**	**0**
Non Operating							
Non Operating Income							
Interest & Asset disposal	0	0	0	0	0	0	
Non-Operating Expenses							
Depreciation & Finance Leases	0	0	0	0	0	0	
PDC Dividend Expense	0	0	0	0	0	0	
Net Surplus/(deficit) before Exceptional Items	**5**	**50**	**45**	**-5**	**193**	**198**	**0**

Community Services delivered a £0.2M surplus cumulative against a planned break even position.

Contract income is £0.2M better than plan cumulative as a result of property income accrued to offset costs..

Pay is £0.2M better than plan cumulative as a result of unfilled vacancies partly clinical and partly corporate.

Non-Pay is £0.2M worse than plan cumulative due to property costs.

The impact of the CEP has been reflected in budgets.

Financial Performance: Income & Expenditure Position

		Income			Expenditure				NET TOTAL	
		Contract	Variable	Better/ (Worse) than Budget	Pay	Better/ (Worse) than Budget	Non-Pay	Better/ (Worse) than Budget	Total	Better/ (Worse) than Budget
Surgical & Cancer Div Mgt	Divisional Management S&C	0	0	(30)	(214)	(212)	(9)	(5)	(223)	(247)
Endoscopy	Endoscopy	1,623	1	(139)	(600)	13	(284)	67	741	(59)
General Surgery Directorate	General Surgery	4,329	17	102	(2,145)	108	(456)	1	1,745	211
Head & Neck Directorate	Head & Neck	1,381	95	(43)	(643)	15	(193)	10	640	(18)
Macmillan Cancer Centre	Macmillan Cancer Centre	165	367	68	(226)	(12)	(336)	(12)	(30)	44
Ophthalmology	Ophthalmology	2,869	14	(180)	(986)	90	(771)	190	1,126	100
Orthopaedic Directorate	Orthopaedics	4,731	53	(546)	(1,540)	83	(867)	(12)	2,376	(475)
Theatres & TC	Theatres & TC	0	85	(4)	(1,805)	24	(652)	(3)	(2,372)	18
Urology Directorate	Urology	1,395	24	(39)	(661)	21	(117)	(31)	641	(50)
Surgical and Cancer Division	**Surgery & Cancer**	**16,493**	**655**	**(812)**	**(8,820)**	**129**	**(3,685)**	**205**	**4,643**	**(477)**

The Surgical Division is £0.5M worse than plan cumulative. The key variances are Income in the Orthopaedics specialty below planas a result of elective activity and Ophthalmology income as a result of high cost drugs. Both pay and non-pay are better than plan with no significant variances.

		Income			Expenditure				NET TOTAL	
		Contract	Variable	Better/ (Worse) than Budget	Pay	Better/ (Worse) than Budget	Non-Pay	Better/ (Worse) than Budget	Total	Better/ (Worse) than Budget
Emergency Care Divisional Mgmn	Divisional Mangement M&EC	0	72	72	(599)	(61)	(42)	(89)	(569)	(78)
Accident & Emergency Dir	Emergency Department	3,837	184	279	(1,391)	103	(185)	(25)	2,446	357
Anaesthetics & Critical Care	Anaesthetics & Critical Care	1,515	9	(24)	(2,059)	(37)	(252)	51	(787)	(10)
Medical Directorate	General Medicine	10,508	85	(149)	(5,615)	(178)	(1,022)	131	3,956	(197)
Urgent Care Centre	Urgent Care Centre	0	0	0	(175)	5	0	17	(175)	21
Emergency Services Division	**Medicine & Emergency Care**	**15,861**	**350**	**178**	**(9,839)**	**(169)**	**(1,501)**	**84**	**4,871**	**93**

The Medicine and Emergency Care Division are £0.1M better than plan. The key variances are Pay in the medical directorate as a result of higher nursing and medical costs than budget.There are a high number of temporary medical resources in post against the CIP profile and high use of bank HCA over establishment.

		Income			Expenditure				NET TOTAL	
		Contract	Variable	Better/ (Worse) than Budget	Pay	Better/ (Worse) than Budget	Non-Pay	Better/ (Worse) than Budget	Total	Better/ (Worse) than Budget
Wom Chil & sexl hlth Div Magmn	Divisional Mangement W&C	0	4	2	(337)	(45)	(36)	(2)	(369)	(46)
Gum clinic	GUM clinic	0	0	0	0	0	(0)	(0)	(0)	(0)
Obstetric & Gynaecology Dir	Obstetrics & Gynaecology	4,609	16	150	(2,178)	(11)	(359)	(36)	2,088	102
Paediatric Directorate	Paediatrics	2,847	24	(95)	(1,845)	85	(268)	(5)	758	(14)
Women and Childrens Division	**Women and Children**	**7,455**	**44**	**57**	**(4,360)**	**29**	**(663)**	**(43)**	**2,477**	**42**

The Womens and Childrens Division is meeting plan cumulative. Maternity income is higher than plan and there are no other significant variances to report.

Financial Performance: Income & Expenditure Position

		Income			Expenditure				NET TOTAL	
		Contract	Variable	Better/ (Worse) than Budget	Pay	Better/ (Worse) than Budget	Non-Pay	Better/ (Worse) than Budget	Total	Better/ (Worse) than Budget
Diag & Clinc Spt Sv Div Mgmnt	Divisional Management D&S	0	0	0	(70)	11	(7)	(26)	(76)	(15)
Dermatology	Dermatology	413	6	(112)	(239)	21	(105)	(19)	75	(111)
ECG department	ECG	91	7	(8)	(247)	25	(18)	2	(166)	19
Elmhurst	Elmhurst	499	48	4	(384)	(9)	(48)	(1)	115	(6)
Integrated Discharge	Integrated Discharge	0	4	4	(73)	(5)	(2)	(1)	(70)	(2)
Medical Records Department	Medical Records Department	0	0	(1)	(426)	21	(54)	0	(480)	21
Outpatients	Outpatients	0	44	2	(138)	(1)	(13)	1	(107)	2
Pathology Directorate	Pathology	3,005	967	92	(2,449)	(11)	(2,174)	(11)	(650)	71
Pharmacy Departments	Pharmacy	746	58	48	(754)	38	(720)	(53)	(671)	33
Radiology Directorate	Radiology	837	172	(83)	(1,461)	74	(534)	(40)	(987)	(49)
Therapeutic Departments	Therapies	0	1	1	(470)	21	(12)	13	(481)	35
Victoria Infirmary Northwich	Victoria Infirmary Northwich	491	5	(49)	(428)	(18)	(65)	10	4	(57)
Diagnostics and Support Divisi	**Diagnostics and Support**	**6,081**	**1,313**	**(102)**	**(7,139)**	**168**	**(3,750)**	**(124)**	**(3,495)**	**(58)**

The Diagnostics Division is £0.1M worse than plan cumulative. The key variances include better than plan on Direct Access income offset by less activity in Dermatology as a result of medical gaps.

		Income			Expenditure				NET TOTAL	
		Contract	Variable	Better/ (Worse) than Budget	Pay	Better/ (Worse) than Budget	Non-Pay	Better/ (Worse) than Budget	Total	Better/ (Worse) than Budget
Estates & Facilities Div Mgnt	Divisional Management E&F	0	0	0	(118)	3	(32)	0	(150)	3
Catering Directorate	Catering	0	331	5	(399)	(13)	(320)	(5)	(388)	(12)
Estates Departments	Estates Departments	0	110	(9)	(417)	(27)	(1,508)	114	(1,815)	77
Hotel Services	Domestics	0	0	0	(331)	(9)	(3)	(0)	(335)	(9)
Laundry Services Departments	Laundry	0	301	(1)	(283)	(33)	(204)	(10)	(186)	(44)
Security	Security	0	406	(2)	(185)	3	(123)	(9)	98	(8)
Site Services	Porters	0	0	0	(687)	11	(22)	(3)	(709)	8
Estates & Facilities Division	**Estates & Facilities Division**	**0**	**1,148**	**(7)**	**(2,421)**	**(64)**	**(2,212)**	**87**	**(3,485)**	**16**

The Estates and Facilities Division is on plan cumulative with no significant variances to report.

		Income			Expenditure				NET TOTAL	
		Contract	Variable	Better/ (Worse) than Budget	Pay	Better/ (Worse) than Budget	Non-Pay	Better/ (Worse) than Budget	Total	Better/ (Worse) than Budget
Executive Management	Executive Management	0	0	0	(357)	10	(31)	24	(388)	33
Computer Services	Computer Services	0	34	30	(342)	35	(548)	(39)	(856)	26
Finance & Information	Finance & Information	0	7	(1)	(796)	(41)	(171)	(9)	(960)	(51)
Human Resources	Human Resources	0	106	(13)	(573)	26	(101)	54	(568)	66
Risk Manangement & R&D	Risk Management & R&D	0	111	(24)	(378)	20	0	24	(267)	20
Quality Assurance Departments	Nurse Management	0	86	51	(673)	(65)	(2,296)	6	(2,883)	(9)
Trust Central Expenditure	Trust Central Expenditure	1,428	1,434	357	(550)	(142)	(424)	177	1,888	392
Other Departments	Other Departments	5	64	35	(63)	2	(62)	17	(57)	53
	Corporate	**1,433**	**1,843**	**434**	**(3,732)**	**(156)**	**(3,633)**	**254**	**(4,089)**	**532**

The Corporate Division is £0.5M better in month and relates to contingency and investment monies held in Trust Central pending drawdown or decision.

	Community Services	**6,951**	**240**	**15**	**(5,022)**	**208**	**(1,779)**	**(139)**	**390**	**84**
	EBITDA	**54,274**	**5,592**	**(236)**	**(41,333)**	**145**	**(17,222)**	**324**	**1,312**	**232**

Financial Performance: Commissioner Income Analysis

Commissioner	FY Target (£'000)	YTD Target (£'000)	CEP Adjustmt	Final Actual (£'000)	Final Variance (£'000)
NHS Eastern Cheshire CCG	8,212	2,001	0	1,984	-17
NHS Eastern Cheshire CCG Community	401	100	0	100	0
NHS South Cheshire CCG Community	15,802	3,963	-256	3,963	-0
NHS South Cheshire CCG	99,576	25,701	-436	25,701	-0
NHS Vale Royal CCG	54,424	13,870	-252	13,870	-0
NHS Vale Royal CCG Community	9,685	2,429	-157	2,429	-0
NHS Warrington CCG	248	61	0	79	18
NHS West Cheshire CCG	3,347	820	0	920	100
NHS West Cheshire CCG Community	186	46	0	46	0
NHS North Staffordshire CCG	1,900	463	0	556	93
NHS Shropshire CCG	624	152	0	250	98
NHS Stoke on Trent CCG	1,407	342	0	412	70
Local Authority	0	0	0	0	0
NHS Commissioning Board	1,511	376	0	376	0
Specialist Commissioning Group	8,449	2,095	0	2,121	26
Non Contract Activity	1,932	476	0	500	24
Overseas Visitors Chargeable	0	0	0	0	0
Non-Commissioner Specific	12,489	1,473	260	970	-503
TOTAL	**220,193**	**54,369**	**-841**	**54,276**	**-93**

The South Cheshire and Vale Royal contracts are in line with the agreed CEP value. Against PbR , the Trust is underperforming by £0.4M primarily associated with high cost drugs and elective activity.

Non Commissioner Specific includes Public Health who commission Bowel Screening, STF and a target for Hep C very high cost drugs which will vary as associated with a small number of patients. (cost budget offset)

Other commissioners are not showing any significant variances.

Other Contract Income	FY Target (£'000)	YTD Target (£'000)	YTD Actual (£'000)	Final Variance (£'000)
Bed Based Services	5,951	1,488	1,467	-21
Adult & Neonatal Critical Care	7,884	1,971	1,956	-14
Urgent Care Centre	0	0	0	0
Community Paediatrics	1,300	325	325	1
Direct Access Services	10,245	2,490	2,402	-88
Unbundled Radiology	3,613	903	876	-27
High Cost Drugs	10,554	2,639	2,335	-304
Screening Programmes	1,474	368	368	0
Audiology	1,057	264	311	47
IVF	321	80	58	-23
CQUIN	4,438	860	635	-225
STF	5,993	899	764	-135
Community Services	26,075	6,538	7,068	530
Other	-2,100	322	649	327
TOTAL	**76,806**	**19,147**	**19,215**	**67**

Other contract income is showing £0.1M better than plan.

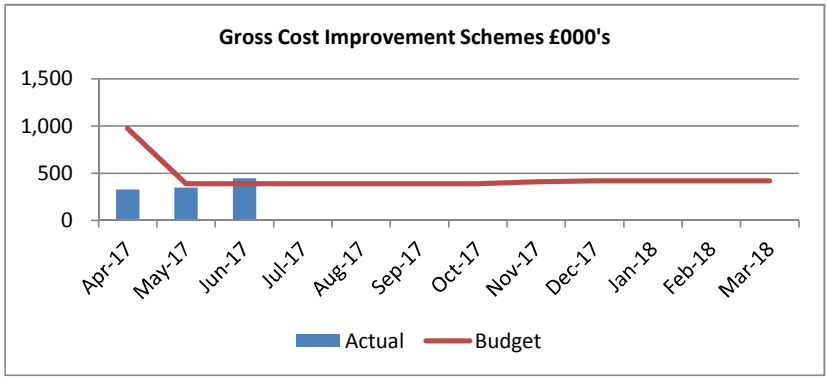
An analysis of the key service lines identifies that this is primarily the result of High Cost Drugs where expenditure (and therefore recovery) predictions are not yet realised.

STF has been assumed at 15% under-recovery of the trajectory as the finanical plan has been met in months but the A&E criteria recently communicated was not achieved. this is subject to appeal.

Other includes the impact of the CEP (£0.8 favourable) and there is also a provision against CQUIN performance.

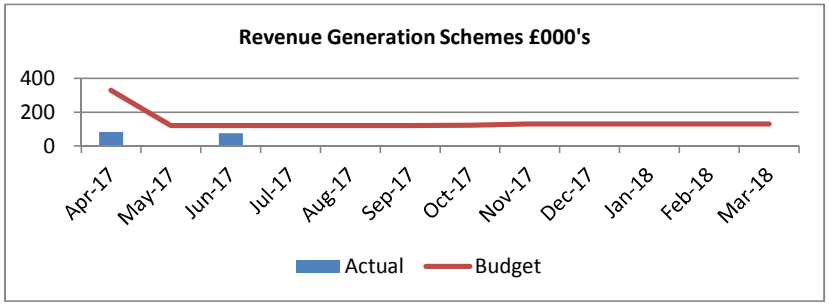
Financial Performance: Cost Improvement Programme

Cost Improvement Schemes						
Scheme Category	**YTD Target**	**YTD Actual**	**YTD**	**FY Target**	**FY Forecast**	**FY Variance**
Access & Flow	0	17	21	600	570	0
Back Office	143	143	0	570	570	0
Drugs	80	75	-5	320	300	-20
Medical Workforce	312	606	294	1,383	1,494	111
Non-Pay Efficiency	78	7	-71	340	82	-258
Nursing Workforce	75	0	-75	300	0	-300
Procurement	188	188	0	750	750	0
Service redesign	100	88	-13	400	350	-50
Total (£'000)	**975**	**1,122**	**152**	**4,663**	**4,116**	**-517**



The Cost Improvement Programme is underperforming on Nursing (use of temporary staffing and e-rostering) and Non-pay efficiency (infusion pump consumables). Medical workforce savings are delivering in excess of the target related to the CEP schemes on managing elective activity.

Revenue Generation Schemes						
Scheme Category	**YTD Target**	**YTD Actual**	**YTD**	**FY Target**	**FY Forecast**	**FY Variance**
Back Office	6	0	-6	25	0	-25
Commercial	29	38	9	140	55	-85
Drugs	44	7	-37	175	29	-146
Medical Workforce	125	41	-84	500	416	-84
Outpatient Efficiency	50	50	0	200	200	0
Theatres Efficiency	50	23	-27	300	273	-27
Service redesign	25	0	-25	150	65	-86
TOTAL (£'000)	**329**	**159**	**-170**	**1,490**	**1,037**	**-453**



Revenue Generation schemes are £0.2M worse than plan as a result of not achieving the efficiency related to consultand annualised hourse and Theatres efficiency improvement and in addition the negotiation in respect of aseptics drug recharges to NHSE is less than anticipated.
Service redesign includes EBUS and best practice tariff which are schemes yet to be signed off.

Financial Performance: Capital Report

SCHEME	BOARD APPROVED	FUNDING SOURCE	FUNDING APPROVED	EXPENDITURE BROUGHT FORWARD	2017/18 ANNUAL BUDGET	2017/18 CUMULATIVE BUDGET TO DATE	CUMULATIVE ACTUAL	BETTER/WORSE THAN BUDGET	2017/18 FORECAST	2018/19 + FORECAST	WHOLE PROJECT PROPOSED PLAN	TOTAL FORECAST
ROLLING ALLOCATIONS (Approved Delegated Budgets)												
ESTATES												
ASBESTOS REMOVAL	Yes	Internal	Yes		150	38	0	38	150	600	750	750
DESIGN TEAM	Yes	Internal	Yes		280	70	69	1	280	1120	1,400	1,400
CT / VT - HEATING INFRASTRUCTURE	Yes	Internal	Yes		175	0	9	-9	175	525	700	700
BACKLOG GENERAL PROVISION	Yes	Internal/Loan	Yes		1604	547	-26	573	1,604	6750	8,354	8,354
TOTAL				**0**	**2,209**	**655**	**52**	**602**	**2,209**	**8,995**	**11,204**	**11,204**
IT												
STORAGE - DATA ARCHIVING	Yes	Internal	Yes		27	0	0	0	27		27	27
INTERSITE CONNECTIVITY	Yes	Internal	Yes		31	31	0	31	31	25	56	56
INTERFACING	Yes	Internal	Yes		85	20	12	8	85	110	195	195
IT APPLICATIONS	Yes	Internal	Yes		100	25	3	22	100	400	500	500
IBM HARDWARE	Yes	Internal	Yes		144	144	0	144	144	0	144	144
TOTAL				**0**	**387**	**220**	**16**	**204**	**387**	**535**	**922**	**922**
TOTAL ROLLING ALLOCATIONS				**0**	**2,596**	**875**	**68**	**807**	**2,596**	**9,530**	**12,126**	**12,126**

SCHEME	BOARD APPROVED	FUNDING SOURCE	FUNDING APPROVED	EXPENDITURE BROUGHT FORWARD	2017/18 ANNUAL BUDGET	2017/18 CUMULATIVE BUDGET TO DATE	CUMULATIVE ACTUAL	BETTER/WORSE THAN BUDGET	2017/18 FORECAST	2018/19 + FORECAST	WHOLE PROJECT PROPOSED PLAN	TOTAL FORECAST
STRATEGIC INVESTMENTS (Requires individual signoff)												
ESTATES												
DR'S MESS INTO RMO'S	Yes	Internal	Yes		42	0	0	0	42	0	42	42
WARD 11 REFURBISHMENT	Yes	Internal	Yes	1500		0	-2	2	0	0	1,500	1,500
WARD 16 REFURBISHMENT	Yes	Internal	Yes	854	283	283	494	-211	283	0	1,137	1,137
CAR PARK BARRIERS	Yes	Internal	Yes		60	0	0	0	60	0	60	60
CENTRALISED POAC	Yes	Internal	Yes		122	0	0	0	122	0	122	122
BISTRO & 2 OFFICES	Yes	Internal	Yes		178	0	0	0	178	0	178	178
OPHTHALMOLOGY OUTPATIENTS - PHASE 2	Yes	Internal	Yes	86	249	0	92	-92	249	0	335	335
UNDER / OVERS CAPITAL SCHEMES 16/17	Yes	Internal	Yes			0	3	-3	0	0	0	0
WARD REFURBISHMENT	Yes	Loan	Not yet approved		4200	100	0	100	2100	8100	12,300	10,200
MRI SCANNER 3RD BUILD	Yes	Internal/Loan	Not yet approved	109	1540	400	-11	411	1540	0	1,649	1,649
WASTE COMPOUND AND SEGREGATION	No	Internal	Not yet approved		250	0	0	0	250	0	250	250
BARIATRIC SIDE ROOM	No	Internal	Not yet approved		100	0	0	0	100	0	100	100
3RD CT SCANNER BUILD	No	Loan	Not yet approved		850	142	0	142	850	0	850	850
TOTAL				**2549**	**7874**	**925**	**576**	**349**	**5774**	**8100**	**18523**	**16423**
IT												
VOICE OVER IP	Yes	Internal	Yes	171	295	295	229	66	295	200	666	666
RADIOLOGY INFORMATION SYSTEM	Yes	Internal	Yes	96	132	0	9	-9	132	0	228	228
WIRELESS UPGRADE	Yes	Internal	Yes	6	24	0	0	0	24	0	30	30
PCTI	Yes	Internal	Yes	18	12	0	5	-5	12	0	30	30
E-HANDOVER	No	Internal	Not yet approved		244	0	0	0	244	0	244	244
UNDER / OVERS CAPITAL SCHEMES 16/17	Yes	Internal	Yes			0	0	0	0	0	0	0
PATIENT ADMIN SYS / CORE ELECTRONIC PATIENT RECORDS	No	Loan	Not yet approved		1500	0	0	0	1500	3000	4,500	4,500
EDMS & E NOTES	No	Loan	Not yet approved		1956	0	0	0	1956	0	1,956	1,956
UPS	Yes	Internal	Yes		150	150	0	150	150	0	150	150
CLINICAL PORTAL	No	Loan	Not yet approved		1260	0	0	0	1260	0	1,260	1,260
Q PULSE	Yes	Internal	Yes		30	30	0	30	30	0	30	30
NET CALL / CALL CENTRE	Yes	Internal	Yes	12	13	13	0	13	13	0	25	25
HIGH IMPACT STAND ALONE IT SYSTEMS	Yes	Internal	Yes		100	30	0	30	100	400	500	500
PACS REPLACEMENT	No	Loan	Not yet approved		1590	0	0	0	1590	0	1,590	1,590
E-PRESCRIBING	No	Loan	Not yet approved		900	0	0	0	900	460	1,360	1,360
VENDOR NEUTRAL ARCHIVE	No	Loan	Not yet approved		605	605	0	605	605	0	605	605
CREDITS FOR CLEANING SOFTWARE	Yes	Internal	Yes		11	11	0	11	11	0	11	11
REPLACEMENT BUSINESS INTELLIGANCE SYSTEM	No	Internal	Not yet approved		80	80	0	80	80	0	80	80
TOTAL				**303**	**8902**	**1214**	**243**	**971**	**8902**	**4060**	**13265**	**13265**
TOTAL STRATEGIC INVESTMENTS				**2852**	**16776**	**2139**	**819**	**1320**	**14676**	**12160**	**31788**	**29688**
ADDITIONAL												
EQUIPMENT	Yes	Internal	Yes		0	0	7	-7	10	0	0	10
GP STREAMING ESTATES	Yes	Internal	Yes				0	0	500	0	0	500
GP STREAMING IT	Yes	Internal	Yes				0	0	250	0	0	250
COMMUNITY SERVICES	Yes	Internal	Yes				0	0	1000	0	0	1,000
LEASING INVESTMENTS												
EQUIPMENT	Yes	Internal	Yes		648	0	0	0	648		648	648
3RD CT SCANNER	No	Internal	Not yet approved		480	0	0	0	480		480	480
REPLACEMENT CT SCANNER	No	Internal	Not yet approved		480	0	0	0	480		480	480
3RD MRI SCANNER	No	Internal	Not yet approved		640	0	0	0	640		640	640
ACCESS CONTROL	No	Internal	Not yet approved		100	0	0	0	100		100	100
LAUNDRY FINISHING	No	Internal	Not yet approved		56	0	0	0	56		56	56
OPHTHALMOLOGY EQUIPMENT	No	Internal	Not yet approved		150	0	0	0	150		150	150
CCTV	No	Internal	Not yet approved		157	0	0	0	157		157	157
CATERING TROLLIES	Yes	Internal	Yes		180	180	137	43	180		180	180
TOTAL LEASING INVESTMENTS				**0**	**2891**	**180**	**137**	**43**	**2891**	**0**	**2891**	**2891**
TOTAL CAPITAL PROGRAMME (EXCLUDING LEASES)				**2,852**	**19,372**	**3,013**	**894**	**2,120**	**19,032**	**21,690**	**43,914**	**43,574**
TOTAL CAPTIAL PROGRAMME				**2,852**	**22,263**	**3,193**	**1,031**	**2,163**	**21,923**	**21,690**	**46,805**	**46,465**

The capital programme is less than anticipated which is mainly due to a delay in Vendor Neutral Archive £605K and the Third MRI Scanner build £400K, Third CT Scanner build £142K, Backlog Maintenance £172K and Ward 17 Refurbishment. All of these are reliant on capital loan funding which has not been secured. In addition there are delays in the UPS £150K and IBM Hardware £144K and £160k of other minor schemes, however these were both funded internally.

Accruals have been made for Theatres £49K, Ward 16 refurbishment £109K , 2nd MRI £292K, Ward 11 £61K Ophthalmology 112K

Financial Performance: Statement of Financial Position

	Plan Apr to Jun (£'000)	Actual Apr to Jun (£'000)	Variance (£'000)	Forecast 2016/17 (£'000)
Assets				
Assets, Non-Current	**82,050**	**81,480**	**-569**	**97,350**
Assets, Current				
Trade and other Receivables	3,988	13,721	9,733	4,650
Other Assets (including Inventories & Prepayments)	4,987	5,282	295	5,385
Cash and Cash Equivalents	5,852	6,915	1,063	2,839
Total Assets, Current	**14,827**	**25,918**	**11,091**	**12,874**
ASSETS, TOTAL	**96,877**	**107,399**	**10,522**	**110,224**
Liabilities				
Liabilities, Current				
Finance Lease, Current	-559	-1,141	-582	-1,136
Loans Commercial Current	-327	-326	1	-1,686
Trade and Other Payables, Current	-13,735	-12,734	1,000	-13,032
Provisions, Current	-231	-159	72	-235
Other Financial Liabilities	-8,136	-8,250	-114	-8,647
Total Liabilities, Current	**-22,988**	**-22,610**	**378**	**-24,735**
Net Current Assets/(Liabilities)	**-8,161**	**3,309**	**11,469**	**-11,861**
Liabilities, Non Current				
Finance Lease, Non Current	-3,588	-4,713	-1,125	-4,490
Loans Commercial Non-Current	-11,142	-17,792	-6,650	-19,487
Provisions, Non-Current	-1,625	-1,650	-25	-1,548
Trade and Other Payables, Non-Current	0	0	0	**0**
Total Liabilities Non-Current	**-16,355**	**-24,155**	**-7,800**	**-25,525**
TOTAL ASSETS EMPLOYED	**57,534**	**60,634**	**3,100**	**59,964**
Taxpayers' and Others' Equity				
Taxpayers Equity				
Public dividend capital	75,157	75,157	0	75,907
Retained Earnings	-27,843	-24,685	3,158	-26,163
Donated asset reserve	0	0	0	0
Revaluation Reserve	10,220	10,162	-58	10,220
TOTAL TAXPAYERS EQUITY	**57,534**	**60,634**	**3,100**	**59,964**
TOTAL FUNDS EMPLOYED	**57,534**	**60,634**	**3,100**	**59,964**

Non Current assets - The main reason for the variance is that the plan was produced before the final position for 2016/17 was established which meant the opening balance was £1,704K in the plan less than the actual position which is mainly due to the to the addition of an endoscopy Finance lease of £1,800K at the end of the financial year which was anticipated later in the 2017/18 plan.

This is offset by the capital programme expenditure being £1,873K less than anticipated which is mainly due to a delay in Vendor Neutral Archive £605K and the Third MRI Scanner build £400K, Third CT Scanner build £142K, Backlog Maintenance £172K and Ward 17 Refurbishment. All of these are reliant on capital loan funding which has not been secured. In addition there are delays in the UPS £150K and IBM Hardware £144K and £160k of other minor schemes, however these were both funded internally. The remaining underspend is due to some Finance leases which were anticipated to start in Q1 but as yet have not been completed.

NHS Trade Receivables are higher than anticipated due to £2,257K STF Incentive and Bonus funding for 2017/18 still outstanding. In addition Trade receivables are worse than anticipated due to the contract with the two main commissioners remaining unsigned. Therefore the Trust is receiving a monthly contract value for April to June less than was anticipated in the plan. In addition there are a number of other outstanding debts. These are Eastern Cheshire CCG £940K (£718K paid early July), East Cheshire NHS Trust £700K Christies £228K, Shrewsbury NHS Trust £153K (£153K paid in early July) and Property Services £224K. Also there is an accrual for outstanding contract payments compared to activity of over £8,050K which includes £4,558K of STF funding.
Non NHS Receivables is more than anticipated relating to some outstanding invoices for Cheshire and Cheshire West Council £97K and South Cheshire Private Hospital £126K.

Trade and Other Payables - Trade and Other Payables - Trade Creditors are lower than anticipated partly due to lower than anticipated expenditure..

Finance Leases for both current and non current are higher than anticipated partly due to the large endoscopy lease received at the end of 2016/17

Provisions mainly relates to the actual opening balance being lower than the plan due to a lower than anticipated increase in provision at the end of 2016/17.

Loans are due to capital loans not been taken out £1,347K and working capital loans of £6,446K being received whilst the Trust sorts out its contract with its two main CCG's.

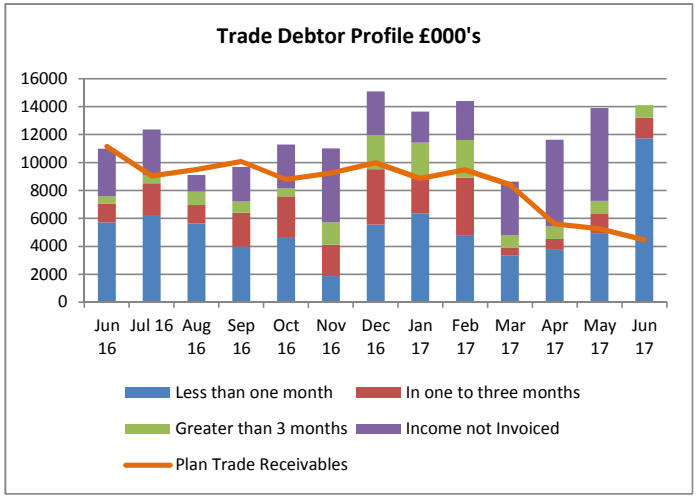
Financial Performance: Cash Position and Working Capital

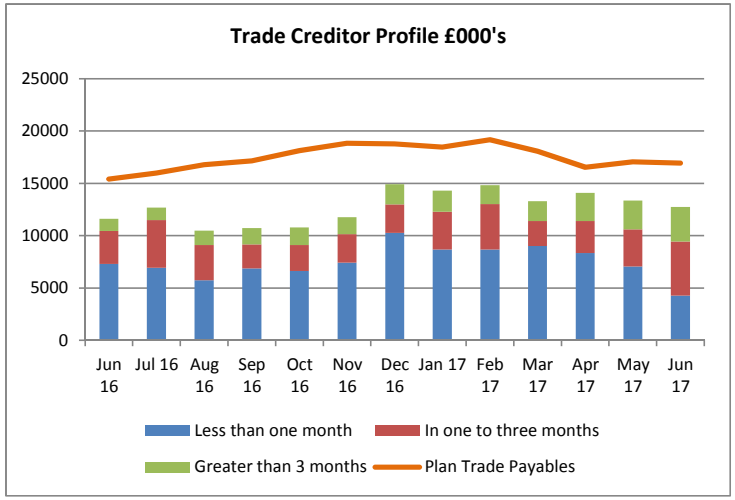
	Plan Apr to Jun (£'000)	Actual Apr to Jun (£'000)	Variance
Surplus/(deficit) after tax	**-982**	**-456**	**526**
Non-cash flows in operating Surplus/(deficit) total	1,418	1,294	-124
Operating cash flows before movements in working capital	**436**	**838**	**402**
Increase/(Decrease) in working capital Total	4,335	-2,612	-6,947
Net cash inflow/(outflow) from operating activities	**4,771**	**-1,774**	**-6,545**
Net cash inflow/(outflow) from investing activities total	-2,423	-1,459	964
Net Cash inflow/(outflow) before financing	**2,348**	**-3,233**	**-5,581**
Net cash inflow/(outflow) from financing activities Total	-2,346	4,501	6,847
Net increase/(decrease) in cash and cash equivalents	**2**	**1,268**	**1,266**
Opening cash balance	**5,850**	**5,647**	**-203**
Closing cash balance	**5,852**	**6,915**	**1,063**

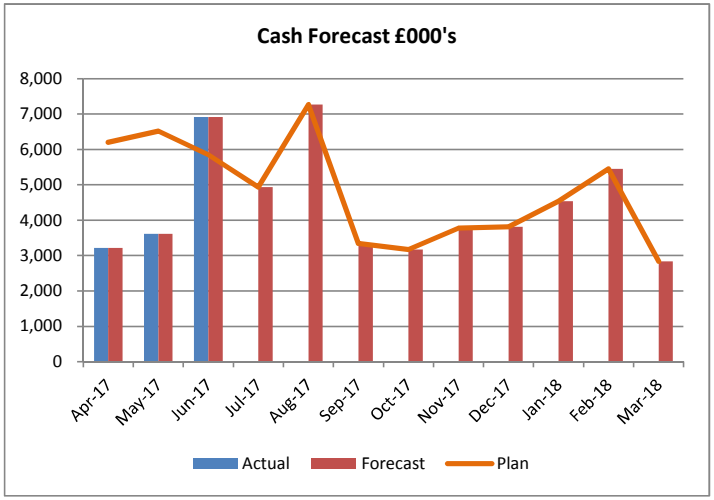
Cash is £1,063K better than anticipated. This is mainly due to the financial position being £749K better than planned and the capital programme being £1,873K less than expected. However this is offset by £1,347K capital loans which have not been approved to fund some of this capital programme.

In addition Trade receivables are worse than anticipated due to the contract with the two main commissioners remaining unsigned. Therefore the Trust is receiving a monthly contract value for April to June less than was anticipated in the plan. In addition there are a number of other outstanding debts. These are Eastern Cheshire CCG £940K (£718K paid early July), East Cheshire NHS Trust £700K Christies £228K, Shrewsbury NHS Trust £153K (£153K paid in early July) and Property Services £224K. Also there is an accrual for outstanding contract payments compared to activity of over £8050K which includes £4,558K of STF funding. Also Trade Creditors are lower than anticipated partly due to lower than anticipated expenditure.

Due to the reduced payment by the CCG's the Trust has accessed some distress funding from the Department of Health for £6,446K to support the cash position.







Finance: *Staff Costs*

Headline Measures

	YTD £000's	Rolling 13 months £000's													
		Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Monthly Trend
Pay Budget	41,486	12,055	11,964	12,056	12,024	12,019	12,166	12,131	12,385	12,345	12,385	13,777	14,031	13,678	
Pay Actual	41,339	11,934	11,783	11,689	11,925	11,892	12,241	11,825	12,102	11,997	12,331	13,549	14,075	13,715	
Variance	147	121	181	367	99	127	-75	306	283	348	55	228	-44	-37	
% to Budget	*99.6%*	*99.0%*	*98.5%*	*97.0%*	*99.2%*	*98.9%*	*100.6%*	*97.5%*	*97.7%*	*97.2%*	*99.6%*	*98.3%*	*100.3%*	*100.3%*	
Nursing Staff % to Budget	102.0%	99.6%	99.2%	98.1%	98.9%	98.6%	101.6%	98.4%	97.0%	100.5%	98.7%	101.8%	104.4%	99.8%	
Medical Staff % to Budget	97.0%	94.4%	94.3%	90.1%	98.4%	100.6%	94.9%	90.7%	94.4%	90.4%	99.5%	90.5%	101.9%	98.8%	
Other Staff % to Budget	98.9%	102.0%	101.1%	101.2%	100.2%	98.0%	104.2%	101.9%	101.2%	98.7%	109.3%	99.9%	95.2%	101.7%	

Figures exclude Community Services for 2016/17

Commentary

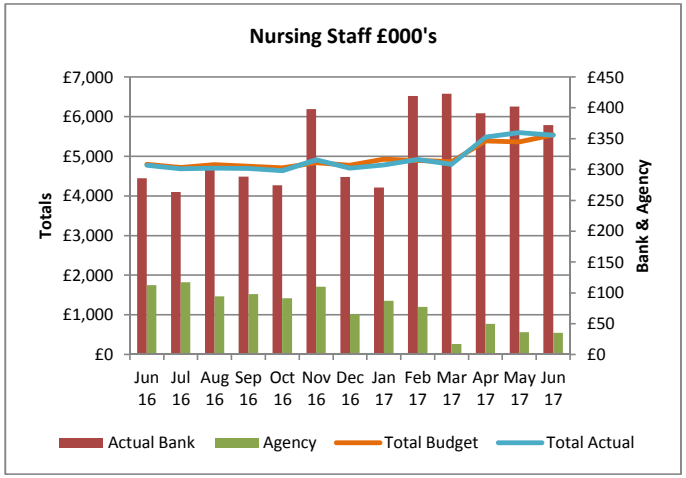
Pay is better than budget by £0.1M as at Mth 3.

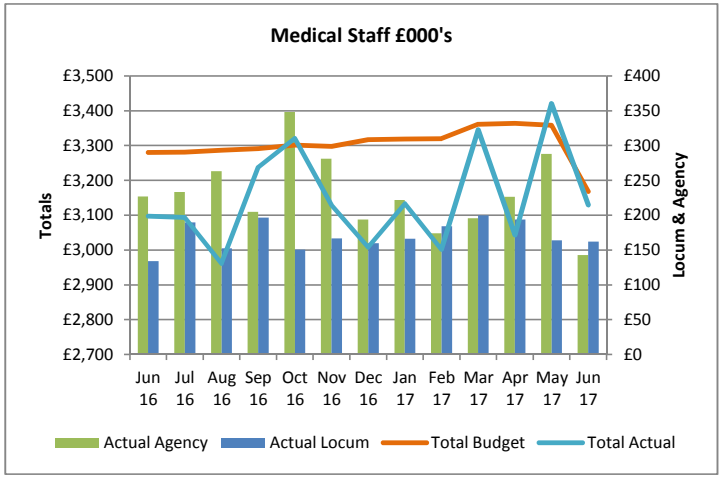
Nursing costs are higher than plan in Emergency Care as a result of Acuity. Nursing vacancies have started to reduce and Nursing Agency spend continues to be controlled, however, bank use over establishment for HCAs continues to support one to one patient supervision and is a financial pressure.

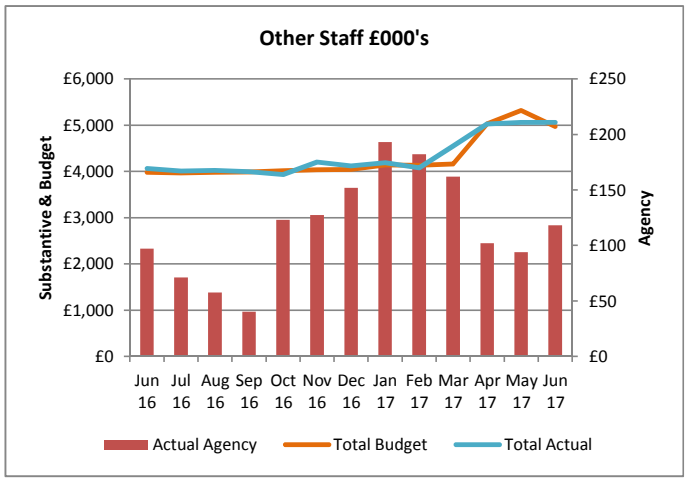
Medical pay is underspent against budget cumulative as a result of consultant and junior doctor vacancies being unable to be filled with substantive or acceptable locum arrangements .

The Agency trajectory is better in month by £0.2M and cumulative by £0.4M mainly as a result of the reclassification of locum costs in 2017/18.

Primary Drivers

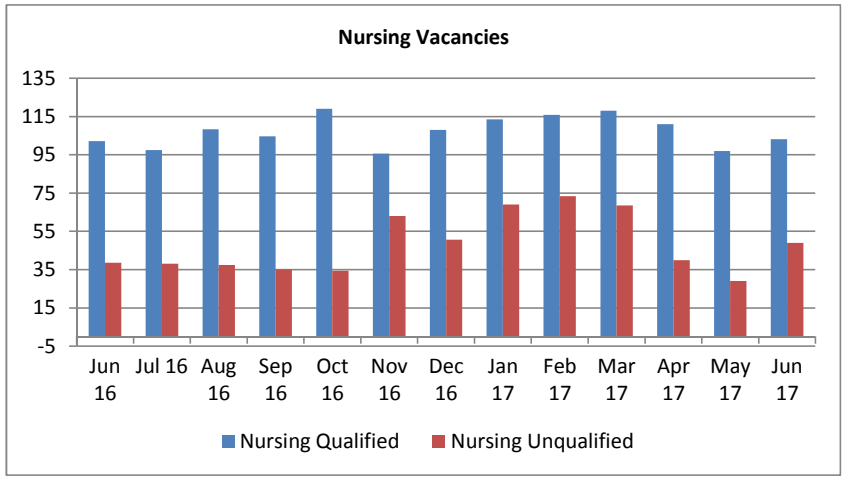


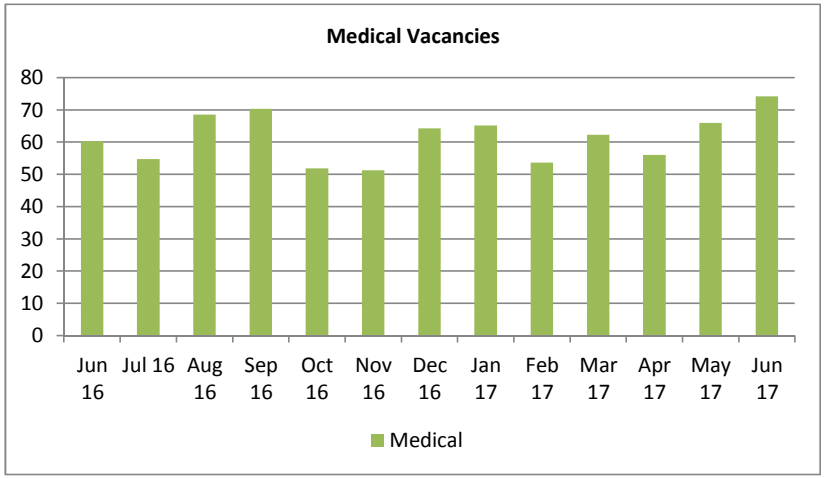




Finance: *Staff Costs*

Secondary Drivers





Agency Trajectory

	YTD	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Monthly Trend
Plan	-1,472	-561	-515	-563	-525	-495	-477	-506	-495	-470	-484	-482	-518	-472	
Actual	-1,093	-570	-611	-568	-540	-699	-721	-572	-668	-618	-574	-378	-418	-296	
Variance	379	-9	-96	-5	-15	-204	-244	-66	-173	-148	-90	104	100	176	
CCICP Actual	0	0	0	0	0	0	-69	-77	-152	-210	4	-77			

From 17/18, CCICP are included in the main figures above.

	Rolling 13 Months													
	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Monthly Trend
Sickness Rate (Rolling 12 mths)	3.95%	3.92%	3.85%	3.78%	3.80%	3.81%	3.86%	3.94%	3.95%	3.92%	3.96%	3.99%	4.02%	
Total Leavers	41	36	31	39	35	37	36	44	27	42	31	38	38	
Turnover (Rolling 12 mths)	11.63%	11.48%	11.12%	10.65%	8.97%	9.10%	9.27%	9.17%	9.09%	9.27%	10.00%	10.21%	10.14%	

Mid Cheshire Hospitals NHS
NHS Foundation Trust

Title of Paper :	Request to Affix Trust Seal and Trust Seal Report	
Author:	Katharine Dowson	
Executive Lead:	Tracy Bullock	
Type of Report:	Concept Paper	
	Strategic Options Paper	
	Business Case	
	Information	x
	Review/Benefits/Audit	

Link to Strategic Domains:		***Link to Domain:***	
Delivering Outstanding Clinical Quality, Safety & Experience		Safe	
Being a Leading partner in a Progressive Health Economy		Effective	
Striving for Outstanding Organisational Effectiveness	x	Caring	
Aspiring to Excellence in Practice Through Our Workforce		Responsive	
Creating a 21st Century Infrastructure for Transformative Health and Social Care		Well-Led	x

Link to Board Responsibility:	Performance	
	Accountability	x
	Strategy	
	Implementation	
Action Required:	Decide	
	Approve	x
	Note	
	Recommend	
	Delegate	

Positive Benefit:	Board approval required to affix Trust seal to a lease
Risk:	Lease cannot be completed without approval

To be published on Trust Website –complete version	***Y*** *(delete as appropriate)*
If no, to be published on Trust Website – redacted	***N*** *(delete as appropriate)*
If not to be published complete or redacted, please detail the reason why	
Presented at Board Meeting of:	7 August 2017

Mid Cheshire Hospitals NHS
NHS Foundation Trust

Estates & Facilities Division

Capital Procedures

Form CF13 – Request to affix Trust Seal
(Version 1.0 – February 2013)

In line with the provisions Trust Standing Order Section 17 (Sealing of Documents), we request approval to affix the Trust Seal to the following document –

Type of Documents – Property Lease

Title of Document – Lease between Mid Cheshire Hospitals Foundation Trust and Cheshire and Wirral Partnership NHS Foundation Trust relating to premises at Leighton Hospital

Reason for Trust Seal – Engrossment of a 5 year lease renewal to an area located within the A & E Department at Leighton Hospital. Each party may terminate the lease on giving not less than 12 months prior notice. The accommodation has a GIA of 80.3sqm

Please note - this document is a request to affix the Trust Seal, the content of the Lease has been agreed and authorised.

Number of copies to be sealed – One copy of Lease Renewal

The seal is to be applied to – Page 8

Parties to Agreement - The parties are Mid Cheshire Hospitals NHS Foundation Trust and Cheshire and Wirral Partnership NHS Foundation Trust

Value – Rental income of £14,152 per annum with rent review date of 4th July 2020

Mike Babb
Divisional Director of Estates & Facilities

Date: 6th July 2017

To be completed by Trust Secretary

Approval minuted at Board meeting of *(date)*_____

Seal Applied *(date)*_____

Seal Number _____

HILL DICKINSON

Dated 2017

RENEWAL LEASE BY REFERENCE TO AN EXISTING LEASE

between

(1) Mid Cheshire Hospitals NHS Foundation Trust

and

(2) Cheshire and Wirral Partnership NHS Foundation Trust

Relating to
Ground Floor Office Premises
Leighton Hospital
Leighton Crewe
Cheshire
CW1 4QJ

CONTENTS

LAND REGISTRY PRESCRIBED CLAUSES

LR1. Date of lease **2017**

LR2. Title number(s)

LR2.1 Landlord's title number(s)

CH346590 and CH347597

LR2.2 Other title numbers

None

LR3. Parties to this lease

Landlord

MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST of Leighton Hospital, Leighton Crewe, Cheshire CW1 4QJ

Tenant

CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST of Trust Board Offices, Upton Lea, Countess of Chester Health Park, Liverpool Road, Chester CH2 1BQ

LR4. Property

In the case of a conflict between this clause and the remainder of this lease then, for the purposes of registration, this clause shall prevail.

See the definition of **Property** in clause 1.1 of this lease and Schedule 1 of the Existing Lease.

LR5. Prescribed statements etc.

LR5.1 Statements prescribed under rules 179 (dispositions in favour of a charity), 180 (dispositions by a charity) or 196 (leases under the Leasehold Reform, Housing and Urban Development Act 1993) of the Land Registration Rules 2003.

None.

LR5.2 This lease is made under, or by reference to, provisions of:

None.

LR6. Term for which the Property is leased

The term as specified in this lease at clause 1.1 in the definition of **Contractual Term**.

LR7. Premium

None.

LR8. Prohibitions or restrictions on disposing of this lease

This lease contains a provision that prohibits or restricts dispositions.

LR9. Rights of acquisition etc.

LR9.1 Tenant's contractual rights to renew this lease, to acquire the reversion or another lease of the Property, or to acquire an interest in other land

None.

LR9.2 Tenant's covenant to (or offer to) surrender this lease

None.

LR9.3 Landlord's contractual rights to acquire this lease

None.

LR10. Restrictive covenants given in this lease by the Landlord in respect of land other than the Property

None.

LR11. Easements

LR11.1 Easements granted by this lease for the benefit of the Property

The easements included in clause 1.1 of this lease in the definition of **Incorporated Terms** and specified in schedule 3 of the Existing Lease.

LR11.2 Easements granted or reserved by this lease over the Property for the benefit of other property

The easements included in clause 1.1 of this lease in the definition of **Incorporated**

Terms and specified in Schedule 3 of the Existing Lease.

LR12. Estate rentcharge burdening the Property

None.

LR13. Application for standard form of restriction

None

LR14. Declaration of trust where there is more than one person comprising the Tenant

None

THIS LEASE is dated 2017

BETWEEN

(1) **MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST** of Leighton Hospital, Leighton Crewe, Cheshire CW1 4QJ (**Landlord**)

(2) **CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST** of Trust Board Offices, Upton Lea, Countess of Chester Health Park, Liverpool Road, Chester CH2 1BQ (**Tenant**)

BACKGROUND

(A) The Landlord is the freehold owner of the Property.

(B) The residue of the term of the Existing Lease is vested in the Tenant.

(C) The Landlord has agreed to grant a new lease of the Property to the Tenant on the terms set out in this lease.

AGREED TERMS

1 **INTERPRETATION**

The following definitions and rules of interpretation apply in this lease.

1.1 **Definitions:**

Annual Rent: rent at rate of fourteen thousand one hundred and fifty two pounds (£14,152) per annum.

Contractual Term: a term of years beginning on, and including 4 July 2017 and ending on, and including 3 July 2022.

Excluded Terms: any terms, requirements, covenants or conditions contained in the Existing Lease to the extent that they are inconsistent with, specifically excluded or substituted by, the terms of this lease.

Existing Lease: the lease by virtue of which the Tenant holds the Property, which is dated 16 December 2013 and made between (1) Mid Cheshire Hospitals NHS Foundation Trust and (2) Cheshire and Wirral Partnership NHS Foundation Trust (a copy of which is annexed to this lease).

Incorporated Terms: with the exception of the Excluded Terms, all of the terms, requirements, covenants and conditions contained in the Existing Lease with such modifications as are necessary to make them applicable to this lease and the parties to this lease including:

(a) the definitions and rules of interpretation in the Existing Lease;

(b) the agreements and declarations contained in the Existing Lease;

(c) the rights granted and reserved by the Existing Lease (including the right of re-entry and forfeiture);

Landlord's Covenants: the obligations in this lease, which include the obligations contained in the Incorporated Terms, to be observed by the Landlord.

LTA 1954: Landlord and Tenant Act 1954.

Plan: the plan attached to the Existing Lease.

Property: the property known as part of the ground floor of Leighton Hospital, Leighton Crewe, Cheshire CW1 4QJ shown edged red on the Plan and more particularly as described in Schedule 1 of the Existing Lease.

Rent Payment Dates: on the third day of every calendar month or (if the Rent for a particular month is invoiced later than the first of relevant month to which it relates) then within fourteen (14) days of receipt by the Tenant of such invoice.

Review Date: 4 July 2020

Tenant's Covenants: the obligations in this lease, which include the obligations contained in the Incorporated Terms, to be observed by the Tenant.

VAT: value added tax chargeable under the Value Added Tax Act 1994 and any similar replacement and any similar additional tax.

1.2 References to the landlord and tenant in the Existing Lease shall be read as references to the Landlord and Tenant in this lease.

2 GRANT

2.1 Landlord lets the Property to the Tenant for the Contractual Term at the rents reserved.

2.2 This grant is made on the terms of this lease which include the Incorporated Terms as if they were set out in full in this lease.

2.3 The Tenant covenants with the Landlord that it will comply with the Tenant's Covenants.

2.4 The Landlord covenants with the Tenant that it will comply with the Landlord's Covenants.

2.5 The grant is made with the Tenant paying the following as rent to the Landlord:

2.5.1 the Annual Rent and all VAT in respect of it;

2.5.2 the Additional Service Charge;

2.5.3 all interest payable under this lease and the Existing Lease; and

2.5.4 any other sums due under this lease.

3 THE RENT

The Tenant shall pay the Rent and any VAT in respect of it will be pay on the Rent Payment Dates.

4 REVIEW OF THE RENT

On the Review Date the Rent shall be reviewed in accordance with the Incorporated Terms.

5 EXCLUSION OF SECTIONS 24-28 OF THE LTA 1954

5.1 The parties confirm that:

5.1.1 the Landlord served a notice on the Tenant, as required by section 38A(3)(a) of the LTA 1954, applying to the tenancy created by this lease, not less than fourteen (14) days before this lease was entered into a certified copy of which statutory declaration is annexed to this lease;

5.1.2 [ ] who was duly authorised by the Tenant to do so made a statutory declaration dated [ ] in accordance with the requirements of section 38A(3)(b) of the LTA 1954 a certified copy of which statutory declaration is annexed to this lease; and

5.1.3 there is no agreement for lease to which this lease gives effect.

6 ENTIRE AGREEMENT

6.1 This lease and the documents annexed to it constitute the whole agreement between the parties and supersede all previous discussions, correspondence, negotiations, arrangements, understandings and

agreements between them relating to their subject matter.

6.2 Each party acknowledges that in entering into this lease and any documents annexed to it it does not rely on any representation or warranty (whether made innocently or negligently).

6.3 Nothing in this lease constitutes or shall constitute a representation or warranty that the Property or any common parts over which the Tenant has rights under this lease may lawfully be used for any purpose allowed by this lease.

7 CONTRACTS (RIGHTS OF THIRD PARTIES) ACT 1999

A person who is not a party to this lease shall not have any rights under the Contracts (Rights of Third Parties) Act 1999 to enforce any term of this lease.

8 GOVERNING LAW

This lease and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims) shall be governed by and construed in accordance with the law of England and Wales.

9 JURISDICTION

Each party irrevocably agrees that the courts of England and Wales shall have exclusive jurisdiction to settle any dispute or claim arising out of or in connection with this lease or its subject matter or formation (including non-contractual disputes or claims).

This document has been executed as a deed and is delivered and takes effect on the date stated at the beginning of it.

Executed as a deed by affixing the)
common seal of **MID CHESHIRE**)
HOSPITAL NHS FOUNDATION TRUST)
in the presence of:)

_____

Authorised Signatory

_____

Authorised Signatory

Recommendation

The Board of Directors are asked to note the sealings that have taken place since the last Board report in May 2017.

Quarterly Report of Sealings for the period 1 May 2017 to 31 July 2017

Seal Number	***Description***	***Date of Board Approval***	***Date of Sealing***
92	Deed of Settlement and release between Abbott Laboratories Ltd and MCHFT, East Cheshire Trust, NHS Eastern Cheshire CCG, NHS South Cheshire CCG and NHS Vale Royal CCG	Chairman's Action Reported to Board of Directors 3 July 2017	29 June 2017

Mid Cheshire Hospitals NHS
NHS Foundation Trust

Title of Paper :	Equality Delivery System Self-Assessment	
Author:	Natalie Wallace	
Executive Lead:	Estelle Carmichael	
Type of Report:	Concept Paper	
	Strategic Options Paper	
	Business Case	
	Information	
	Review/Benefits/Audit	x

Link to Strategic Objectives:		***Link to Domain:***	
Delivering Outstanding Clinical Quality, Safety & Experience		Safe	
Being a Leading partner in a Progressive Health Economy	x	Effective	
Striving for Outstanding Organisational Effectiveness	x	Caring	x
Aspiring to Excellence in Practice Through Our Workforce	x	Responsive	x
Creating a 21st Century Infrastructure for Transformative Health and Social Care		Well-Led	x

Link to Board Responsibility:	Performance	
	Accountability	x
	Strategy	
	Implementation	
Action Required:	Decide	
	Approve	
	Note	x
	Recommend	
	Delegate	

Positive Benefit:	Evidences Trust progress to ensure equality of opportunity.
Risk:	Non-compliance with Equality Legislation

To be published on Trust Website –complete version	***Y*** *(delete as appropriate)*
If no, to be published on Trust Website – redacted	***N*** *(delete as appropriate)*
If not to be published complete or redacted, please detail the reason why	
Presented at Board Meeting of:	August 7 2017

Mid Cheshire Hospitals NHS
NHS Foundation Trust

EQUALITY DELIVERY SYSTEM (EDS2) 2016-17

EXECUTIVE SUMMARY

The Equality Delivery System (EDS) was formally launched in November 2011. In November 2014 NHS England launched EDS2 which was developed as a streamlined and simpler to use approach than the original EDS.

EDS2 is the framework by which all NHS organisations implement the Equality Act 2010. Its main purpose is to help NHS organisations review and improve their performance for people with characteristics protected by the Equality Act 2010 and to help them deliver on the Public Sector Equality Duty (PSED). It aims to improve performance in relation to equality at work and to embed equality into mainstream NHS organisations.

EDS2 contains 18 outcomes against which NHS organisations assess and grade themselves. They are grouped into 4 goals which are detailed on the following pages. These outcomes relate to issues that matter to people who use, and work in the NHS. They also support the themes and deliver on the NHS Outcomes Framework and the NHS Constitution.

Mid Cheshire Hospitals NHS Foundation Trust services are committed to ensuring that everyone has an equal chance to live a long and healthy life, regardless of age, disability, gender identity, marital / civil partnership status, pregnancy / maternity, race, religion or belief, sex, or sexual orientation.

The Trust see's the Equality Delivery System as an opportunity to look at how well we are doing to eliminate discrimination and make plans to improve equality in Mid Cheshire.

LEGISLATIVE CONTEXT

The Equality Act 2010, which received royal assent on 8 April 2010, was implemented on 1st October 2010. It replaced several pieces of previous legislation relating to discrimination (for example, the race relations Act of 1976 and the Sex Discrimination Act of 1975) with the intention of updating, strengthening and simplifying equality law.

The Equality Act 2010 cover the same protected characteristics that were covered by existing equality legislation but it also extends protections to some groups not previously covered. The list of protected characteristics now covered reads as follows: - sex; race; disability; pregnancy & maternity; age; religion or belief; sexual orientation; marriage & civil partnership and gender reassignment.

The act also created the Public Sector Equality Duty (PSED), which requires all publicly funded organisations to take further steps towards ensuring equality in the workplace. The public sector equality duty contains two parts: - the general duty and the specific duty. Public sector organisations must meet both.

The general duty requires that organisations have due regard to the need to:-

- Eliminate unlawful discrimination, harassment & victimisation
- Advance equality of opportunity between different groups
- Foster good relations between different groups

The specific duty requires the publication of: -

- Equality objectives, at least every four years
- Information to demonstrate compliance with the equality duty, at least annually

The use of EDS2 and the use of evidence and insight to assess and grade their equality performance, helps NHS organisations respond to but the general and the specific duties of the PSED.

INTRODUCTION

At the heart of the EDS is a set of 18 outcomes, as detailed in the following pages. The outcomes cover the issues of most concern to patients, communities, NHS staff and NHS Boards. Using these, NHS performance is analysed and graded by NHS organisations working with local patients, community groups, staff, staff-side and voluntary organisations.

These outcomes are grouped into four goals as follows:-

EDS2 GOALS	Better Health Outcomes
	Improved patient access and experience
	A representative and supported workforce
	Inclusive leadership

These four goals encapsulate a set of 18 outcomes that lie at the heart of the EDS. These outcomes focus on the issues that are the most pertinent to patients, carers, communities, NHS staff and Boards. Performance is analysed and graded against these outcomes, the results of which are fed into action plans. Patients and communities have an important role to play in grading performance against those outcomes. For each outcome, there are four grades:-

EDS2 GRADING OF OUTCOMES	Undeveloped	staff members or people from all protected groups fare poorly compared staff members or people overall
	Developing	staff members or people from only some protected groups fare as well as staff members or people overall
	Achieving	staff members or people from most protected groups fare as well as staff members or people overall
	Excelling	staff members or people from all protected groups fare as well as staff members or people overall

The following sections show how we believe we have performed against each of the outcomes.

MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST SUBMISSION 2016-17

The goals and outcomes of EDS2				
Goal	No	Description of Outcome	2015/16 Level	2016/17 Level
Better Health Outcomes	1.1	Services are commissioned, procured, designed and delivered to meet the health needs of local communities	Achieving	Achieving
	1.2	Individual people's health needs are assessed and met in appropriate and effective ways	Achieving	Achieving
	1.3	Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed	Achieving	Achieving
	1.4	When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse	Achieving	Achieving
	1.5	Screening, vaccination and other health promotion services reach and benefit all local communities	Achieving	Achieving
Improved patient access and experience	2.1	People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds	Achieving	Achieving
	2.2	People are informed and supported to be as involved as they wish to be in decisions about their care	Achieving	Achieving
	2.3	People report positive experiences of the NHS	Achieving	Achieving
	2.4	People's complaints about services are handed respectfully and efficiently	Achieving	Achieving
A representative and supported workforce	3.1	Fair NHS recruitment and selection processes lead to a more representative workforce at all levels	Achieving	Achieving
	3.2	The NHS is committed to equal value and expects employers to use equal pay audits to fulfil their legal obligations	Achieving	Achieving
	3.3	Training and development opportunities are taken up and positively evaluated by all staff	Excelling	Excelling
	3.4	When at work, staff are free from abuse, harassment, bullying and violence from any source	Achieving	Achieving
	3.5	Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives	Excelling	Excelling
	3.6	Staff report positive experiences of their membership of the workforce	Excelling	Excelling
Inclusive Leadership	4.1	Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations	Achieving	Achieving
	4.2	Papers that come before the Board and other major committees identify equality-related impacts including risks, and say how these risks are to be managed.	Achieving	Achieving
	4.3	Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free of discrimination	Achieving	Achieving

Reference No.	1.1 – Better Health Outcomes
Outcome	Services are commissioned, procured, designed and delivered to meet the health needs of local communities

The Trust ensures its obligations in relation to commissioning of services are met in the following ways:-

• Services are commissioned by the CCGs with consideration to health needs related to cultural issues, beliefs, race, gender, disability, sexual orientation, pregnancy and maternity. Compliance with Equality and Diversity requirements was also an explicit part of discussions with Commissioners for the current contract
• The Trust links equality issues to its public consultation on its Quality accounts.
• Where the Trust consults with the local population it services, it does so in ways that maximise access (physically and geographically) for local communities
• The Trust has an action plan for health and well-being. This considers healthy eating, physical health and wellbeing and psychological well-being.
• Services, business cases and tender specifications are subject to equality impact assessment. Assessments consider all protected characteristics and low income
• The Trust's membership is routinely reported and monitored to the Governors' Membership and Communications Committee. Membership is broadly comparable with the local population based on gender and ethnicity.

Evidence
• Action plan for health and well being
• Living well, working well and dying well in Cheshire East
• Living well in Cheshire East statement
• Public engagement event locations
• Equality Impact Assessment Policy & Procedure
• Patient Placement Policy
• Equality & Diversity Strategy
• E & D annual report
• Trust performance reports
• Cheshire East health and well-being board minutes

The Trust is a signatory to living well, working well and dying well in Cheshire East. This commits the Trust to working with others to address health inequalities in the area. That commitment has been progressed through the health and well-being board whose purpose is to make a positive difference to the health and well-being of the residents of East Cheshire through reducing health inequalities. The Trust's Chief Executive is a member of this board, which meets on alternate months.

We encourage the use of patient/staff and carer feedback for all service changes. Every patient and carer has one of these to complete or is given help to complete it where required. The feedback is used as part of continual improvement to ensure the service meets the needs of the patients and carers in the community.

The health needs of the community are assessed through the Joint Strategic Needs Assessment and in the Director of public health's annual report.

The organisation continues to work with diverse groups to create patient passports which help to inform carers and professionals of the normal range for patients that may use the service in an attempt to make the experience as seamless as possible for the patients and the carers.

Each division has a patient and public involvement programme which is monitored by the Action Group for Patient Experience and the Executive Patient Experience Group. These are reviewed in the quality account and audited by the Trust's external auditors.

The Trust maintains a list of stakeholder groups which cover a wide range of interests and many of the protected groups. The stakeholder list is used for communication and consultation and the Trust has increased its range of communication media. It now regularly makes use of social media and regularly tweets and makes use of the Trust's Facebook page. The maternity unit has also developed their own Facebook page. This can increase awareness for those with differing access needs and from differing demographic segments.

The Trust holds Public Board meetings each month.

The commissioners review progress against health and well-being targets at contract meetings and the joint quality and safety meeting.

Medicine and emergency care division are currently engaged in the frailty pathway development. Part of the work looks to facilitate the frailty project steering group which is working very closely with the community teams, including GP, matrons, service managers from the CCG's and patient representation. The division are collectively completing a review of the systems and processes with the aim to provide collaborative working which ensure that together as a health community, a provision of a holistic, timely and fully integrated system of services that delivers early proactive specialist interventions to optimise the medical, psychological and functional outcomes.

Grading	**Achieving**

Reference No.	1.2 – Better Health Outcomes
Outcome	Individual people's health needs are assessed and met in appropriate and effective ways.

The Trust ensures its obligations in relation to assessing people's health needs in the following ways:-

- Undertake individual care assessments and implement individualised treatment plans.
- As far as possible, assess patients in their own environment.
- Implement the principles of the Mental Capacity Act.
- Undertake best interests meetings where appropriate.
- Ensure the right patient is in the right place at the right time.

Evidence

- Translation Policy
- Electronic guidelines on the Intranet
  - Long Term Conditions
  - Learning Disability
  - Dementia
  - End of Life Care (e-paige)
- Unified DNAR policy and lilac form
- Patient Placement Policy
- Producing and providing patient information policy
- Agenda and minutes from the Learning Disability Meeting
- Care Indicator Results

- Advancing Quality Report
- Privacy & Dignity Policy
- Adult Safeguarding Policy
- Dementia Care Bundle
- Patient Passports
- Changing Places
- Training records for MCA and DOLS
- Easy Read Patient Information and appointment letters e.g. Breast Screening Services
- Internet Site – Patient Information
- Carers Survey (Dementia)

All patients are assessed as they are admitted to hospital and many pathways now exist to help ensure patients receive the correct care at the appropriate time.

A variety of guidelines are available electronically for staff to ensure they follow the correct pathway for the patient's condition, such as learning disability or dementia. The unified do not resuscitate policy and lilac form has been implemented in the Trust.

The patient placement policy guides staff to ensure inpatients are cared for in the right location according to their needs. The Trust has a range of patient information literature which is available on the intranet and internet. Easy read patient information leaflets have also been developed which track patient journeys through the hospital. All information is approved by the Patient Information Group and there is also a reader's panel with patient representatives who approve all patient information before it is printed.

Trust staff receive training on induction and mandatory training about safeguarding; the Mental Capacity Act, and deprivation of liberty. An e-learning programme about MCA has been implemented.

The Trust holds best interest meetings for patients who lack capacity and involves carers. These can take place at a patient's home, although they mostly take place on the ward where the patient is an inpatient.

The translation / interpreter service is well utilised to ensure staff can communicate effectively with patients and their carers. The same principle applies to use of the deafness support network. Patient passports are used to help staff to get to know patients, their carers and are helpful in communicating with patients and ensuring they are treated as individuals.

Grading	**Achieving**

Reference No.	1.3 – Better Health Outcomes
Outcome	Transitions from one service to another, for people on care pathways, are made smoothly with everyone well informed.

The Trust's intention is to:

- Ensure consistent approach to the transition between services internal and external to the Trust.
- Ensure patients' experiences in the Trust reflect fair and equal access to services.
- Undertake individual care assessments and implement individualised treatment plans in collaboration with patients and / or carers.
- Undertake best interests meetings where appropriate for protected groups.
- Ensure fair and equal access to patient support mechanisms including the customer

care team, key workers and appropriate agencies.

Evidence

- Access management policy
- Interpreting and translation policy
- Patient placement policy
- Eliminating mixed sex accommodation policy
- Easy read version of the quality account
- Travel and associated expenses policy
- Procedure for identifying, recording and managing equality, diversity and human rights actions
- Patient Passports
- Advancing Quality Report
- Easy read patient information leaflets
- Terms of reference for learning disability development group
- Guidance on religions
- Changing places facility
- Electronic guidelines on the Intranet
  - Long Term Conditions
  - Learning Disability
  - Dementia
  - End of Life Care (e-page)
- Unified DNAR policy and lilac form
- Privacy & Dignity Policy
- Adult Safeguarding Policy
- Dementia Care Bundle
- Training records for MCA and DOLS
- Internet Site – Patient Information including comprehensive Easy Read information)
- Equality Impact Assessments for Services within the Trust (for e.g. Cancer services)

All policies have equality impact assessments undertaken prior to approval. No issues have been identified in relation to the protected groups as a result of these policies.

All patients are assessed as they are admitted to hospital and many pathways now exist to help ensure patients receive the correct care at the appropriate time. This can be seen through the advancing quality report.

A variety of guidelines are available electronically for staff to ensure they follow the correct pathway for the patient's condition, such as learning disability or dementia.

The patient placement policy guides staff to ensure inpatients are cared for in the right location according to their needs.

The Trust has a range of patient information literature which is available on the intranet and internet.

All information is approved by the Patient Information Forum and there is also a reader's panel with patient representatives who approve all patient information before it is printed.

The Trust has a contract with EIDO who provide the majority of treatment information, so this is always clinically up to date.

Easy read patient information leaflets have also been developed which track patient journeys through the hospital.

Trust staff receive training on induction and mandatory training about safeguarding; the Mental Capacity Act, and deprivation of liberty. An e-learning programme about MCA has been implemented.

The Trust holds best interest meetings for patients who lack capacity and involves carers. These can take place at a patient's home, although they mostly take place on the ward where the patient is an inpatient.

The unified "Do Not Resuscitate" policy and lilac form has been embedded in the Trust.

The translation / interpreter service is well utilised to ensure staff can communicate effectively with patients and their carers. The same principle applies to use of the deafness support network.

Patient passports are used to help staff to get to know patients, their carers and are helpful in communicating with patients and ensuring they are treated as individuals.

There are operational policies for each tumour group within the Trust (Cancer Peer Review), which details specific care pathways.

Grading	**Achieving**

Reference No.	1.4 – Better Health Outcomes
Outcome	When people use NHS Services their safety is prioritised and they are free from mistakes, mistreatment and abuse

The Trusts intention is to:

• Manage and store all incidents via the electronic Ulysses system
• Identify key objectives for the Integrated Governance team to improve patient safety and lessons learned which are used to improve practice
• Monitor and action relevant safety alerts issued from the DH Central Alert System
• Provide assurance against published NICE and National guidance
• Ensure a robust process for the Safeguarding of Adults and Children.

Evidence:

• Incident Investigation, Learning and Improving Procedure
• Incident Reporting Procedure
• Central Alerting System Procedure and Management
• Policy for the Management of National Clinical and Health and Safety Guidance
• Integrated Governance Monthly Exception Report
• No Secrets' Adult Protection – Flowchart
• Sign up to Safety Driver diagram programme aims
• Quality Account 2015 / 2016
• Quality & Safety Improvement Strategy 2016 / 2018
• Patient and Public Involvement Strategy 2016 – 2019

The Trust has an Incident reporting and an Incident Investigation, Learning and Improving Policy. These policies outline to staff how and when they should report any type of incident. These processes enable Trust staff to put controls in place to prevent a recurrence of

incidents and share lessons learnt. The National Reporting and Learning System recognises the Trust as having a 'risk aware and positive safety culture' as the Trust is a timely reporter of patient safety incidents, with the type and level of severity of incidents in line with other NHS Acute Hospital Trusts.

The Trust uses Safeguard (Ulysses) risk management software to store all incidents. This system allows staff to report incidents electronically. The patient demographics are automatically updated from the Patient Administration System (PAS) and contain the patient's age, religion and ethnic group; although it must be pointed out that the latter two fields are hidden from staff due to information governance restrictions. The Ulysses system allows reports to be generated on any selected field; these reports are then presented to the relevant committees for monitoring.

The Trust has a Quality & Improvement Strategy which is monitored by the Quality Governance Committee and its reporting groups and includes safety priorities as defined by the national "Sign up to Safety" campaigns. These review sepsis, falls, pressure ulcers, mortality, Acute Kidney Injury and Never Events.

The Trust has a Patient and Public Involvement Strategy which is monitored by the Executive Patient Experience Group. The strategy focuses its key areas of improvement on the NICE Quality Standard 15 for Patient Experience. The NICE quality standard for patient experience in adult NHS services sets out how a high-quality service should be organised, so that the best care can be offered to people using NHS services.

The Board of Directors hold monthly meetings to discuss, among other things, patient safety within a safety board report which reviews performance on key issues of safety. In addition to this the Medical Director and Deputy Chief Executive delivers a verbal account of any serious incidents that have occurred since the last meeting. Ensuring Board level engagement in patient safety is a priority for the Trust to ensure that initiatives are in place and monitored to prevent avoidable harm to patients.

The Trust receives safety alerts via the Department of Health's Central Alert System (CAS). This alerts the trust to any safety issues in relation to medicines and medical equipment. The Trust has a robust policy in place to ensure that there is a system in place to ensure that the necessary actions are carried out and completed to ensure the safety of patients. The Trust uses Safeguard (Ulysses) Risk Management software to manage the CAS alerts.

The Trust receives NICE guidance on a monthly basis. These are managed on the Safeguard (Ulysses) Risk Management Alert software and are monitored on a monthly basis in the Integrated Governance Monthly Exception report. In addition to this the Trust also has a system in place for ensuring that high level reports or other national guidance is reviewed and actioned to ensure patients safety and that best practice and guidance is being adhered to. Part of the process for NICE and national guidance requires the identified leads for the guidance to carry out a gap analysis to demonstrate assurance. The gap analyses that are required to provide evidence for any NICE and external guidance, address those specific issues that are highlighted in the reports. These are monitored via the Trust governance structures.

Additionally, all Incidents, CAS Alerts, and NICE / National Guidance are monitored in the Integrated Governance Monthly Exception Report via the Risk Management Strategy Alert System.

The Trust has robust safeguarding vulnerable adults' procedures in place, underpinned by the Safeguarding Vulnerable Adults Policy. The Policy guides staff in relation to the definition of a vulnerable adult, the types of abuse they may be exposed to and how to raise a

concern. The Policy also reflects The Care Act 2014, and its recommendations to “make safeguarding personal”, whilst informing staff about the principles of safeguarding and that safeguarding adults is ‘everybody’s business’. As part of the Trust process for Safeguarding Adults, staffs when completing a Safeguarding Adults Trigger also complete an electronic incident report via the Ulysses system.

The Director of Nursing attends the Adult Safeguarding Board for Cheshire East and Cheshire West. This is to ensure that the needs of our client group are represented at a strategic level and that the Trust is represented when future developments and key objectives are set.

The Trust has a Domestic Abuse Policy and has an Independent Domestic Abuse Advisor (IDVA) who works for MCHFT on a full time basis at Leighton Hospital. The Trust is signed up to East Cheshire (Crewe) and West Cheshire (Vale Royal) Multi Agency Risk Assessment Conference (MARAC) protocols. The IDVA at Leighton Hospital is the dedicated MARAC representative for the Trust and attends and contributes to the monthly meetings. The focus of MARAC is preventing repeat victimisation, risk reduction and enhancing the safety of domestic abuse victims and their children.
An alert is placed against a patient record on the Trust computer system (ICS) for all victims of domestic abuse and their children who are discussed at MARAC. The alert remains in place for 12 months and highlights to staff the patient is or has been a high risk domestic abuse victim or child of a high risk domestic abuse victim in the last 12 months to ensure that their safety issues are considered and addressed prior to discharge. Staff are advised to refer all domestic abuse cases or suspected domestic abuse cases to the Hospital IDVA who will assess and attempt safe contact with the victim to offer advice and support.

The IDVA for MCHFT works on a multi-agency basis and as such works collaboratively with the Domestic Abuse Family Safety Units in Cheshire East and Cheshire West. Victims identified as requiring specialist support can be signposted to domestic abuse agencies that specialise in supporting LGBT victims, Polish victims (including Polish speaking workers), male victims, clients experiencing honour based violence or victims of forced marriage. Using translation services it is possible for the Hospital IDVA to complete safety planning and risk assessments for patients whose first language is not English. The Hospital IDVA provides domestic abuse training to key departments as part of their mandatory safeguarding training.

The Trust uses patient passports for adults and children where they may have a learning disability or for older adults who may have dementia. Patients with a learning disability or dementia are flagged on the patient admission system, which enables staff to make the necessary reasonable adjustments to their care in a timely manner.

The Trust complies with the Accessible Information Standard and has produced a guide for staff to raise awareness of how to provide information to patients in suitable formats and promote services and facilities available including e-learning.

All Trust employees working in Wards and Departments with direct patient or patient relative contact receive conflict resolution and prevent training. A key measure to protect NHS staff and those who deliver NHS services is conflict resolution training. This preventative tool in tackling violence against staff forms part of a range of measures to make NHS healthcare environments safer. Conflict resolution training provides staff with important de-escalation, communication and calming skills to help them prevent and manage potentially violent situations.

Prevent training, which is part of the national counter terrorism strategy, focuses on working with vulnerable individuals who may be at risk of being exploited by radicalisers and drawn in

to terrorist related activity. It provides processes by which employees who are concerned for vulnerable individuals, being potentially exploited, can raise and share their concerns through the Trusts internal policies and procedures

Grading	**Achieving**

Reference No.	1.5 – Better Health Outcomes
Outcome	Screening, vaccination and other health promotion services reach and benefit all local communities

The Trust's provides or supports national screening programmes including:

- Breast Cancer
- Bowel Cancer
- Sexual Health Screening Blood Borne Virus Screening
-

Since 1st October 2015 the HIV treatment and care service has been provided by the Royal Liverpool and Broadgreen University Hospitals NHS Trust (RLBUHT) in collaboration with Mid-Cheshire Hospitals NHS Foundation Trust (MCHFT). HIV Clinics continue to be provided on a local weekly basis at Leighton Hospital in Crewe.

Evidence

- The Trust Breast Screening programme forms part of the national programme and is externally accredited
- The Breast Care Unit have developed a picture pathways to support those patients coming for screening who have learning disabilities
- The Trusts Bowel Screening Programme forms part of the national programme and is externally accredited.
- The bowel screening team are working with Cheshire and Mersey Fire and Rescue Services, Public Health England (PHE) and Cancer Research UK (CRUK) to develop and implement safe and well checks around key identified health interventions across Cheshire and Merseyside. One of which aims to raise awareness and uptake of screening whom are eligible for routine screening (ages 60 years to 74 years) and those who are 75 years+ whom can opt in to perform the screening test.
- The bowel screening team are working with PHE and the local Clinical Commissioning Group (CCG) to address cancer survivorship across Cheshire by raising awareness of the screening programme amongst GP's, practice nurses and non-clinical practice staff.
- The bowel screening team are providing targeted health promotion to GP's surgeries in Cheshire which are identified to have low uptake rates for bowel screening.
- The bowel screening team have developed a GP resource leaflet to support the roll out of bowel scope across Cheshire and provide signposting to resources that practices can utilise to advertise the screening programme to their patients.
- The bowel screening team have developed close partnership working with the local area team supporting patients with learning disabilities and are able to offer easily accessible information to aid with decision making.
- The bowel screening team are working in partnership with Crewe Town Council to address health inequalities within the local community as set out in the Community Plan – A vision for Crewe.
- The bowel screening team have reviewed all patient information in-line with the 2016-17 health CQUIN to ensure all information is fit for purpose and have made alterations to those identified with a positive outcome for their participants.

- Admission to hospital is arranged for frail people undergoing Bowel Screening
- Patient undergoing Bowel screening who have special needs are supported utilising visual tools, picture/ story books, Braille and foreign language support

The trust offers free flu vaccinations to all employees. This is delivered by a number of trained peer to peer vaccinators and supported by Occupational Health. During 2016/17, the trust vaccinated over 76% of front line healthcare workers.

Where appropriate, staff who access Occupational Health are provided with advice on stopping smoking and nicotine replacement therapy.

The trust also has a Staff Health & Wellbeing Strategy that is managed by the Health & Wellbeing Steering Group. The Group aims to help staff maintain or improve their levels of physical and psychological wellbeing. The trust has re-launched the Green Walking Route around the Trust. This is a 1K walk around the trust premises. Staff are encouraged to walk the route during their breaks. The trust also took part in the Cheshire & Warrington Team games held at Chester Racecourse in September. The event saw 6 teams from MCHFT take part in a variety of sporting challenges

The Trust caters for special dietary requirements and offers healthy options.

Grading	**Achieving**

Reference No.	2.1 – Improved Patient Access and Experience
Outcome	People, carers and communities can readily access hospital services and should not be denied access on unreasonable grounds.

The Trust's intention is to:

• Ensure consistent and equitable access to services by patients referred to hospital
• Ensure that patients on elective, outpatient and diagnostic waiting lists are treated in chronological order taking account of their clinical priority.
• Establish a consistent approach in the management of referral to treatment pathways and service specific waiting lists across the Trust.
• Ensure national and local waiting time standards are met

Evidence
• Access management policy
• Interpreting and translation policy
• Patient placement policy
• Eliminating mixed sex accommodation policy
• Easy read version of the quality account
• Travel and associated expenses policy
• Procedure for identifying, recording and managing equality, diversity and human rights actions
• Patient Passports
• Easy read patient information leaflets
• Map of accessible car parking spaces
• Easy read quality account
• Agenda from Long Term Conditions event
• Training plan for dementia
• Terms of reference for learning disability development group
• Guidance on religions
• Changing places facility

All policies have equality impact assessments undertaken prior to approval. No issues have been identified in relation to the protected groups as a result of these policies.

All services, business cases and tender specifications are also subject to equality impact assessments.

The equality impact assessments consider all protected groups.

The Trust has interpreting and translation services provided by the Big Word and the Deafness Support Network.

The Trust has patient passports (Information about ME to Help YOU), and easy read patient information leaflets to help improve patients' experiences.

The Trust will reimburse car parking fees for those on defined benefits.

A map of accessible car parking spaces is available.

To ensure all patients are aware of Trust's quality priorities and achievements, an easy read quality account is available. This can be used to help patients and carers decide that they want to be treated at Mid Cheshire Hospitals NHS Foundation Trust.

A mandatory training plan is in place to ensure staff are able to care appropriately for patients with dementia and their carers.

The Dignity Matron supports patients with learning disabilities and making reasonable adjustments. The Dignity Matron is supported by the learning disability team from Cheshire and Wirral Partnership NHS Foundation Trust. Both Trusts meet at the learning disability development group which is chaired by the Deputy Director of Nursing & Quality from Mid Cheshire Hospitals NHS Foundation Trust.

The Trust now has a changing places facility which is ideally located to allow access to patients who require such a facility. It is near the outpatients department and the hospital's main entrance.

The Trust has undertaken a disability access audit of all its sites. Disability access risks have been added to other estate related risks so that all risk may be managed in a comprehensive way. This is managed by the Trust's infrastructure committee.

The Trust provides appropriate food choices, support and religious facilities.

Grading	**Achieving**

Reference No.	2.2 - Improved Patient Access and Experience
Outcome	People are informed and supported to be as involved as they wish to be in decisions about their care.

The Trust's intention is to:

• Provide information through a range of literature, including easy read and large print.
• Provide information electronically or paper based.
• Involve people who lack capacity and their carers in their treatment / care through the use of best interest meetings and IMCAS (Independent Mental Capacity Advocate).
• Train our staff to understand the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS).
• Ensure staff understand individual patient's needs and involve them and their carers in their care.

Evidence
• Bedside Folders
• Privacy & Dignity Policy
• Translation Service Policy
• Adult Safeguarding Policy
• Dementia Care Bundle
• Dementia Strategy
• Patient Passports
• Quality Account (Easy Read)
• Changing Places
• Easy Read Patient Information
• Training records for MCA and DOLS
• Easy Read appointment letters, e.g. Breast Screening Services
• Internet Site – Patient Information
• Reasonable Adjustment Care Plan

• Patient Stories
• Independent Domestic Violence Advocate Posters
• Minutes from Patient Information Group
• National Inpatient Survey Results
• Carers Survey (Dementia)
• Best Interests Meeting Pro forma
• Unified DNAR Policy and lilac form
• Minutes from the learning disability group
• Minutes from the dementia group
• Electronic identifier for patients with an LPA for health and welfare / finance

The Trust has a range of patient information literature which is available on the intranet and internet. All information is approved by the Patient Information Group and there is also a reader's panel with patient representative who approve all patient information before it is printed. Easy read patient information leaflets have also been developed which track patient journeys through the hospital.
Patient passports are used to help staff to get to know patients, their carers and are helpful in communicating with patients and ensuring they are treated as individuals. More detailed care plans for individual patients are also in use across the organisation. Patients with these care plans in place are identified electronically on admission to the Trust. Staff will then implement the care plans and help to promote seamless transition between wards and departments.

The Trust has a contract with EIDO who provide the majority of treatment information, so this is always clinically up to date.

Trust staff receive training on induction and mandatory training about safeguarding; the Mental Capacity Act, and Deprivation of Liberty. E-learning programmes in relation to the Mental Capacity Act, Deprivation of Liberty Safeguards, Adult Safeguarding and Dementia have all been implemented and the Trust is currently working with the Community Learning Disability (LD) Team to devise an e-learning package in relation to LD.

The Trust holds best interest meetings for patients who lack capacity and involves carers. These can take place at a patient's home, although they mostly take place on the ward where the patient is an inpatient.

The translation / interpreter service is well utilised to ensure staff can communicate effectively with patients and their carers. The same principle applies to use of the deafness support network.

A carer's survey is undertaken each month with carers of patients with dementia to ensure they are involved as much as they wish with the care of the patient.

Grading	**Achieving**

Reference No.	2.3 - Improved Patient Access and Experience
Outcome	People report positive experiences of the NHS.

The Trust's intention is to:

• Complete national and local surveys and produce action plans to improve services
• Produce a programme of patient satisfaction surveys and use different methods to involve staff, patients and customers.
• Organise working groups with patient representatives to develop action plans and check progress
• Compare our results with other hospitals.

Evidence:-
• Equality and diversity annual report
• National inpatient survey 2016 results (overview)
• Annual 2015/2016 complaints, comments, compliments report
• Quality Account 2016-2017
• Agenda and minutes from executive patient experience group
• Agenda and minutes from complaints review group
• Agenda and minutes from the patient experience action group
• Agenda for patient register group
• Board quality and patient experience report
• Feedback from NHS Choices
• Friends and Family Test results
• Local outpatient survey programme
• Divisional patient and public involvement programme
• Open and honest care reports
• Posters developed to promote examples of 'You Said, We Did' actions

The Trust is currently achieving a 4.5 out of five star rating on NHS Choices for Northwich Victoria Infirmary and a four out of five star rating for Leighton Hospital.

The Board of Directors receives patient stories and the quality and patient experience report at each Board meeting, which are all public meetings.

Each division develops a patient and public involvement programme each year which is monitored at the patient experience action group.

Examples of actions taken as a result of feedback are shared with staff and the public. This is also made available on the Trust's website.

The complaints review group is chaired by the Director of Nursing and Quality and has medical, patient and governor representation.

The executive patient experience group is chaired by the Director of Nursing and Quality and has representation from Healthwatch. The executive patient experience group oversees public and patient feedback.

The executive patient experience group receives reports from a range of sub-committees including the learning disability development group; patient information forum; complaints review group, bereavement and end of life group and patient experience action group.

The Trust provides customer care training to promote values and behaviours within the Trust

and includes examples of patient feedback.

Hospital passports for patients are now established.

The open and honest care project has been progressed by the Trust. The results are published on the internet site and shared with nurses and the divisions.

A new mosque is available on site.

Feedback from patients has been reviewed in relation to equality and diversity. All local surveys are evaluated and this is referenced in the equality and diversity annual report.

Trust staff have attended local interest groups, such as University of the Third Age (U3A), and local community venues to promote the Customer Care Team.

The Trust has patient representation on divisional boards, the organ donation group, patient information group and the dementia operational group.

The Friends and Family Test has been extended in the Trust to Community Services utilising text messaging. In 2016/2017, the Trust received over 32,000 responses, with 94% of the public responding that they would be extremely likely or likely to recommend the Trust. More information is included in the Quality Account.

Following the national inpatient survey results, all wards have continued to promote the quiet protocol to reduce unnecessary noise at night so that patients have plenty of sleep. The wards are now improving information sharing with patients in preparation for their discharge. A guide to discharge has been revised and is now communicated with patients and relatives to help prepare for a safe discharge.

Pets as therapy have become regular weekly visitors to the Trust. Visits are made to a wide variety of wards and patients who enjoy chatting with the volunteers and stroking dogs.

Grading	**Achieving**

Reference No.	2.4 - Improved Patient Access and Experience
Outcome	People's complaints about services are handled respectfully and efficiently.

The Trust's intention is to:

- Acknowledge and respond to complaints in a timely manner
- Offer all complainants a meeting to discuss their concerns
- Resolve all complaints as early as possible
- Train its staff to respond appropriately to complainants, with respect and compassion
- Review all complaint responses to ensure they are compassionate and all issues are addressed.
-

Evidence:-

- Complaints policy
- Complaint survey pro forma
- Board patient experience report
- Quality Account 2016/17
- Annual 2016/17 complaints, comments, compliments report

- Complaints review group agenda and minutes
- Customer care and complaints training
- Tell us what you think poster
- Customer care team leaflet
- Complaint response checklist
- You said we did poster

All complaints are acknowledged by a phone call wherever possible, or alternatively via email or in writing and complainants are encouraged to meet to discuss their concerns; however written reports are produced were complainants do not want a meeting. A written acknowledgement is then sent with a response deadline, a customer care leaflet and a Healthwatch leaflet.

The customer care leaflets are available in other languages, easy read and large print. The leaflet advises that nobody will be treated any differently as a result of a complaint. It also contains a sample letter to help people frame their complaint. The leaflets are held on all wards and departments.
All complaint responses are quality checked prior to sending out to ensure all issues are addressed, and receive.

Complaints are then managed within the divisions and responses generated by clinicians/nurses/senior managers. All complaint meetings are recorded and a copy of the recording is given to the complainant. All complainants are offered the support of an advocate.

In October 2016 a continual process for feedback was commenced with questionnaires sent to complainants following closure of their case. The questionnaire seeks information regarding the handling of the complaint and the complaint process rather than the outcome of the complaint, and enables the team to initiate changes sooner than using an annual survey.

The complaints review group undertakes a detailed review of complaints at each meeting using the complaint response checklist, where the aim is to review a complaint that has been upheld, one that has not been upheld and a case that has been reopened at the request of the complainant.

Where cases have been reopened and the complainant feels their concerns remain unaddressed, information is provided regarding escalation to the Parliamentary Health Service Ombudsman for independent review.

The Trust has no upheld complaints to report that relate to discrimination in the 2015/16 time period.

Complainants are always offered the opportunity to re-raise ongoing concerns with the Trust and some complainants have been involved with ongoing Trust activities.

The Trust is committed to developing learning from complaints and has used complainants in patient stories and developed “You said we did” posters.

Training on how to manage complaints is delivered to staff.

Grading	**Achieving**

Reference No.	3.1 – A Representative and Supported Workforce
Outcome	Fair NHS recruitment and selection processes lead to a more representative workforce at all levels.

The Trust's intention is to:
• Ensure access to vacancies at all levels is fair and inclusive
• Ensure Trust recruitment and selection methods are fair, inclusive and without bias or discrimination
• Ensure staff who undertake selection are trained to design and execute selection methods which reduce bias and are non-discriminatory
• Ensure recruitment and selection practices are fair and legal and meet NHS Employers Recruitment Check Standards
• Monitor recruitment at all levels to assess that Trust policies and procedures are being adhered to.

Evidence
• Recruitment policy
• Initial and Ongoing Registration Policy
• Guidance for Recruiting Managers
• Reference and Employment History Check Policy
• Disclosure and Barring Policy
• Recruitment Conversion reporting and Analysis 2015/16
• Workforce Race Equality Standard 2016

Policies and guidance are available for all aspects of the recruitment and selection process providing comprehensive information and guidance for those undertaking recruitment and selection at the Trust.

Over the past 10 years the Trust has monitored how successfully it converts protected groups from applicant to employee and has consistently identified two strong themes: a tendency in some staff groups to convert more women than men into successful applicants; a tendency to convert less BME applicants into successful candidates. However, since introducing a Trust-wide training programme in 2015 the Trust has seen a significant year on year improvement in the rates of conversion for these particular groups. The Training focuses on ensuring anyone taking part in recruitment and selection activity understands the role of bias in making decisions, what recruitment discrimination looks like and how to recruit for values and behaviours.

The Trust monitors and responds to all candidate feedback. This allows us a good perspective on how candidates view our recruitment practices (some forums are anonymous) and how they felt about their recruitment experience. We then incorporate this feedback into the development of our practices. Additionally, we always give candidates the chance to discuss their comments with us in more detail.

The Trust continues to develop and promote routes into employment for people who may have taken career breaks and local people who have left NHS professions. It has had 2 (soon to be 3) successful cohorts of Nurses Returning to Practice (a scheme which has been commended nationally for its innovation) and is endeavouring to develop a similar route for Radiographers, with one Radiographer returning to practice with the Trust in 2016. Additionally the Trust is adopting extended roles across its professional and non-professional workforce allowing for more internal progression across the board.

The Trust continues to offer work placement schemes and pre-employment support to people via Jobcentreplus, schools and colleges to support people who have barriers to entering the workforce, whether this be long term unemployment, a disability or a lack of

qualification and work experience.

The Trust uses a multi-media approach to the advertising of vacancies; all vacancies are advertised on online, many via social media and we also utilise local radio and press. By using different mediums we hope to engage a diverse audience in our vacancies and encourage them to apply for roles at the Trust. An alternative means of applying for our vacancies is available to any candidate who is unable to apply for the normal route.

The Trust attends local jobs and careers fairs on a regular basis, again promoting vacancies to a diverse range of our local population including school children, older people, people with disabilities and those who may have been out of the workforce for a significant period of time.

Grading	**Achieving**

Reference No.	3.2 – A Representative and Supported Workforce
Outcome	The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations

The Trust's intention is to:-
• Continue to adopt national terms and conditions with Agenda for Change job matching in accordance with national guidance.
• Conduct equal pay audits/gender pay gap reports every year in accordance with the public sector equality duty
• Discuss the results of the equal pay audit/gender pay gap report with staff representative groups.
• Continue to monitor staff satisfaction in relation to pay equality via the staff survey
• Review policies for maternity and paternity pay in line with usual trust timescales

Evidence
• Agenda for Change job matching policy
• Training materials used for job matchers
• Staff survey results
• Equal pay audit
• Minutes of meetings with E & D group
• Trust policies

Only board directors are not on national pay scales. Executive pay arrangements are discussed and agreed at remuneration committee.

The terms of reference for the clinical excellence awards panel calls for representation from the patients' forum, and a gender and ethnicity mix in consultant representation.

The Trust uses national terms and conditions of employment for medical and non-medical. For non-medical staff, these have been subject to review by the NHS Staff Council's Equality Group.

An equal pay audit exploring gender and race was completed in both 2015 and 2016 and concluded that the differences in average pay by gender and ethnicity were linked to distribution across the pay bands due to length of service. The audit will be completed again

in 2017 and will incorporate the requirements as determined under the Gender Pay Gap reporting regulations in 2018.

In the last 10 years, there have been no successful or settled equal pay or discrimination claims against the Trust from employees or former employees.

Plans for improvement include:-

• Consider monitoring incremental non-progression by protected characteristics
• Ensure job matching panels are diverse

Grading	**Achieving**

Reference No.	3.3 – A Representative and Supported Workforce
Outcome	Training and Development opportunities are taken up and positively evaluated by all staff

The Trust's intention is to:

• Anticipate and validate the learning and development needs of all staff and teams using the formal appraisal cycle, team development events and informal discussion annually to ensure all staff members and groups have every opportunity to develop and refine the necessary knowledge and skills sets required to successfully carry out their role
• Broaden participation in the Learning and Development forum by encouraging participation from staff members and groups across the workforce
• Identify and operationalise divisional training needs analyses to produce an organisational landscape of developmental requirements that can be resourced delivered.
• Deliver a portfolio of learning opportunities including formal courses, eLearning, forums and coaching to closely match organisational learning requirements
• Create bespoke opportunities for staff groups to develop their leadership skills and become advocates for Trust values and behaviours
• Support a culture of equality and diversity by celebrating openness and inclusivity and by supporting leaders to role-model positive behaviours and values
• Maintain accurate training records for each member of staff

Evidence

• Statutory and Mandatory Training Policy (updated in 2016)
• Vocational Training (including Apprenticeships) Policy and Procedure
• Appraisal Policy and Documentation (review scheduled for 2017)
• Guidance Document for Managers to Approve Study Leave
• Onboarding training on Equality, Diversity and Human Rights
• Periodic update training and ad hoc key concept refresher training
• Good practice training on Management Development Programme
• Level 1 Course Evaluation, level 2 follow up with participants and line managers to assess training impact, and level 3 assessment of behavioural change related to training participation
• International Induction – Language, culture and lifestyle training, and mentor support
• Learning and Development Training Bulletin
• Screenshot – Learning Zone Intranet
• Training Needs Analysis
• Training participation and evaluation data 2016/17

• Induction participation and evaluation data 2016/17
• Local induction pack (updated in 2017)
• On-line learning packages, onboarding and induction materials

All staff participate in equality and diversity training as part of their onboarding programme. The Trust has a 90% compliance target, and revised on-boarding and induction procedures were implemented in June 2016 to ensure compliance improves year on year. Compliance is regularly monitored at board level and is achieved. All new staff also complete local induction with their manager, which creates an additional opportunity to identify and discuss training needs on commencement in post. This dialogue continues at milestone meeting throughout the new hire probation period.

All staff participate in an annual appraisal process consisting of regular 1 to 1 meetings throughout the year. Emerging development requirements are identified and discussed in a timely fashion and a range of professional development options and support can be accessed throughout the year. A formal annual appraisal meeting takes place once a year, and a personal development plan is one of the key outcomes. Compliance with this element of the appraisal process is tracked and monitored at board level.

The outputs of appraisal conversations, team meetings and departmental planning activities combine to inform the divisional training needs analysis which identifies requirements and indicates possible solutions such as training programmes, coaching and shadowing. The Learning and Development department supports and advises throughout the TNA process to ensure that a wide range of options are considered and return on investment is measured.

The Trust's intranet site has an area called the Learning Zone, which can be accessed by all staff. There is a wealth of information on it about development opportunities and support available. Staff are encouraged to contact the L&D team with professional development queries and for advice and guidance on development pathways and opportunities. Including documentation and research resources available through the JET Library. 1 to1 consultations with learning and development specialists are also available to every staff member who wishes to explore ways to develop skills or increase proactivity and awareness.

We have a range of training rooms and facilities in the Trust. All are located on the ground floor and have easy access. Staff can also access e-learning programmes, MOOCs and support materials by using PCs situated in learning and development, computer services and the JET Library. Facilitated support sessions for e-learning users are also available bi-monthly.

The Trust has agreed to support the development of two staff members as Dyslexia champions, and they will engage in training to better signpost support for staff members. Access-to-Work applications are encouraged as a mechanism to provide specialist support and advice and to recommend solutions that will better support staff members with disabilities.

Grading	**Excelling**

Reference No.	3.4 – A Representative and Supported Workforce
Outcome	When at work, staff are free from abuse, harassment, bullying and violence from any source

The Trust's intention is to:
• Continue to promote mediation as a means of early resolution of disputes between staff members
• Continue to work with the team of Employee Support Advisers to develop and promote their understanding

Evidence

- Mediation Leaflet
- Staff survey results
- Exit interview forms
- Mediation report
- ESA poster
- Staff Voicemail poster
- Minutes from the Violence and Aggression Group

The Trust acknowledges that front-line staff are at increased risk of abuse, harassment, bullying and violence from patients and relatives compared to back office colleagues. The Trust has a policy for the management of aggressive behaviour.

The Employee Support Adviser Service is available to all members of staff wanting to have initial discussions relating to dignity at work issues. The service was refreshed late 2016 and new Employee Support Advisors were appointed and trained with representatives from across all divisions.

In addition, a Staff Voicemail Service is available whereby staff can leave a message raising their concerns confidentially. This service was also refreshed late 2016.

Any complaints of harassment, bullying or general bad behaviour from others are addressed through the Trust's procedures. The emphasis is placed upon resolving the problem and mediation is used to resolve conflict wherever possible. The Trust has a team of trained mediators.

The progress of the employee support adviser and mediation services is monitored by the Workforce Assurance Group.

Occupational Health services, the Employee Assistance Programme (via Insight counselling services) are available for all staff to access.

The staff survey results for 2016 place the Trust in an average position in terms of the percentage of staff reporting bullying, harassment tor abuse from other staff. Focus groups take place following the results of the staff survey to further explore the findings.

Equality and diversity and Dignity at Work briefing sessions are being developed to take place during 2017/18, following on from ad-hoc sessions held in 2016 and the Freedom to Speak Up campaign will be re-launched across the Trust in 2017.

Conflict management training is provided and mandatory for specific front line staff groups. The Trust has a Violence and Aggression Forum which met on a quarterly basis.

Grading	**Achieving**

Reference No.	3.5 – A Representative and Supported Workforce
Outcome	Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives

The Trust's intention is to:-

• Ensure staff are able to achieve an optimum work lift balance throughout their career at the Trust
• Ensure that an appropriate balance between meeting staff requirements for flexibility of working and the Trust requirement for safe staffing levels is achieved

Policies and procedures exist to ensure that provision is made for all staff to enjoy a balance between work and home life.

Evidence

- Mutually Agreed Flexibility Scheme
- Flexible Working Policy
- Career Break and Secondment policy
- Supporting Working Parents Policy
- Special Leave Policy
- Retirement and Long Service Guidelines

Flexible working arrangements are available to all staff and in addition are also considered for staff returning to work after long term absence. The mutually agreed flexibility scheme applies to all staff. Where agreed this allows staff to purchase additional annual leave whilst spreading the cost over the year.

The Trust employs staff across all working ages. The retirement and long service guidelines detail the various ways in which individuals can opt for retirement and return to work if this is desired.

The career break policy allows individuals to take time out of the workplace to carry out caring duties whilst preserving employment. The supporting working parents' policy, the special leave policy and the flexible working policy all allow for individuals to plan their working lives around their home lives as much as possible.

The staff survey contains a question asking whether staff are satisfied with the opportunities for flexible working patterns. In 2016, the Trust result of 52% was slightly better than the national average across other acute Trusts of 51% and an improvement on last year's Trust result of 48%.

Grading	**Excelling**

Reference No.	3.6 – A Representative and Supported Workforce
Outcome	Staff report positive experiences of their membership of the workforce

The Trust is mindful of the need to collect and consider the perspectives and opinions of all members of its workforce, and uses a range of methods to ensure an accurate picture is gathered and acted on in a timely way.

Every year, the national staff survey data is shared across all divisions of the organisation with supporting analysis including breakdowns of results and key themes. The Trust then

develops an action plan to address areas for further development or where there are concerns. The 2016 plan included a broad action around bullying, harassment, violence, aggression and dignity at work which incorporates discrimination. The action plans are monitored through the executive Workforce Assurance Group. The 2016/17 staff survey placed MCHFT as number 1 for staff satisfaction in an Acute Trust.

In the 2015 staff survey the results for Mid Cheshire Hospital Trust showed a high level of engagement of staff. The score for 2016 was 3.90 (out of 5) this is above (better than) average when compared with Trusts of a similar type and an improvement on last year's score of 3.87. The national average for acute trusts was 3.81. Our score compares well against Trusts in our region which show a range from 3.73 to 3.86.

Some other examples of staff reporting positive experiences of their membership of the workforce through the national staff survey include:

• Frequent opportunities for me to show initiative in my role - 76%
• Does your organisation take positive action on health and well-being – 93%
• My training, learning or development has helped me to do my job more effectively from - 83%
• My training, learning or development has helped me to stay up to date with professional requirements – 89%
• My training, learning or development has helped me to deliver a better patient/service user experience - 82%
• My manager supported me to receive training, learning or development – 88%
• If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation - 75%
• Care of patients/service users is my organisation's top priority – 82%

The Trust's staff engagement policy is in place to ensure the Trust's vision to "Deliver excellence in healthcare through Innovation and collaboration". The policy actively encourages a two-way dialogue on improving organisational performance with clearly set goals, targets and current challenges; engages staff in organisational, service and individual changes which may affect them; provides effective management support and personal development to support staff performance; and supports staff so they remain healthy and safe.

Staff focus groups take place regularly throughout the year, and the CEO invites all staff to speak with her directly through her weekly Wednesday afternoon drop in sessions.

E&D is one of the e-learning modules available to staff on induction and as part of the statutory and mandatory update training.

Staff on internally and externally facilitated leadership programmes review and discuss staff survey and focus group data.

Evidence
- Staff Survey data set (in the public domain)
- Board of Governors staff survey review presentation
- Vocational Training (including Apprenticeships) Policy and Procedure
- Focus group feedback assessments (anonymised)
- CEO drop-in schedule
- Leadership development programme schedule

Grading	**Excelling**

Reference No.	4.1 - Inclusive Leadership
Outcome	Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations.

A range of opportunities are used where Trust Board and senior leaders champion engagement with all our communities, patients and staff.

• The Chief Executive regularly holds engagement sessions with staff allowing her to give personal briefings on current issues facing the Trust and the wider health economy, as well as listening to staff concerns.

• The Trust holds engagement events with the general public

• A patient/staff story is presented at the start of every monthly board meeting. These have included stories/feedback from vulnerable service users, those with disabilities and those from ethnic minorities to ensure a rounded view

• The Trust has an on-going programme of recruitment monitoring (including that for board executive and non-executive members)

• Equality and Diversity training is included on the developing manager programmes offered by the Trust to aspiring managers

• Equality & diversity training is included on mandatory training updates and on induction to the trust, in addition to bespoke, ad-hoc sessions where required.

• The Chief Executive engagement events include some focus on the Trust's non-tolerance of bullying and the welcoming of diversity in the workforce.

Grading	**Achieving**

Reference No.	4.2 – Inclusive Leadership
Outcome	Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed

The Trust ensures its obligations in relation to ensuring that committee and board papers identify equality related impacts in the following ways:-

• All new and revised trust policies and procedures are accompanied by a bespoke equality impact assessment which is presented to the relevant committee at the time when it is received.

• Equality impact assessments for all of the Trusts services were reviewed in October 2014 and are published on the Trust's website. These will be reviewed again in late 2017, and each new or changed service will be assessed for the equality impact upon the revision. Assessments consider all protected characteristics and low income.

• All Trust project initiation documents (PID), business case templates and cost improvement plan (CIP) proposal documents require an equality impact assessment to be carried out prior to submission. In this way the Trust is assured that the impact upon all protected groups is

taken into consideration when any significant change to service provision is proposed or enacted. In addition, by the end of 2016/17 all business cases going to the Board will require an Equality Impact Assessment to be included to ensure that the Board can assess any equality-related impacts and risks.

Grading	**Achieving**

Reference No.	4.3 – Inclusive Leadership
Outcome	Middle Managers and other line managers support their staff to work in culturally competent ways within a work environment free of discrimination

Evidence
• Statutory and Mandatory Training Policy (updated in 2016)
• Appraisal Policy and Documentation (review scheduled for 2017)
• Onboarding training on Equality, Diversity and Human Rights
• Good practice training on Management Development Programme (schedule)
• Training participation and evaluation data 2016/17
• Induction participation and evaluation data 2016/17
• Local induction pack (updated in 2017)
• On-line learning packages, onboarding and induction materials

The Trust ensures line managers proactively support their staff to work in culturally competent ways within an environment free of discrimination in the following ways:

• All staff must successfully complete the Trust online onboarding package on equality and diversity. The package includes a graded assessment which has an 80% pass rate. All staff who struggle to complete the assessment successfully are offered additional coaching and support to ensure they fully understand their rights and responsibilities as Trust employees.

• Equality and Diversity forms part of the Trust's statutory training component and refresher training must be completed at least once every three years in line with Skills for Health recommendations. Refresher training is offered online and trained facilitation and support is offered to all participants.

• All leadership and professional development programmes include both explicit and implicit training on Equality and Diversity rights and responsibilities, including reference to Trust values and behaviours and their role in supporting the evolution of a culture that is free of discrimination.

• Bespoke Divisional and Team-based sessions are designed and delivered to meet location specific requirements, and to ensure the training is accessible and relevant to all team members.

• All people management skills training, including the management of sickness absence; recruitment and selection and managing performance include comprehensive reviews of employer obligations relating to the Equality Act 2010.

• Supervision and line-manager workshops are offered frequently to support newly promoted managers and new hires who identify training support in their local induction conversations.

• The Trust has supported the creation of an in house cohort of coaches who are qualified to

support line managers individually in developing their cultural competence. A return on investment study on these coaches is scheduled for 2017.	
Grading	**Achieving**

Performance Report Workforce Chapter
Month: Jun-17

Measure	Target	Performance	Description	Narrative	Rolling Trend
Sickness Absence	3.60%	**4.02%**	Rolling 12m average Sickness Absence described as a Percentage	The top reasons for absence continues to be Anxiety/ Stress and Depression and Musculo-skeletal Injuries. Evidence from divisional reports suggest tha tthe majority of long-term absence is related to personal stress and acute illness which is being managed according to our Trust procedures. Considerations is also be given to further developing MSK and Stress support services in Occupational Health to support sustained reductions in absence in these areas.	
Appraisal Rate	90.00%	**81.84%**	Percentage of Staff who have received an appraisal in the last 12 months. Excludes New Staff with less than 12m service. ***Includes CCICP staff****	Significant improvement in month that is related to the inclusion of the CCICP appraisal data. In addition it has been identified that staff with more than one position have been recorded as requiring more than one appraisal and this data has been cleansed by the HR team. Wards and departments with low appraisal rates continue to be targeted for rapid improvement.	
Mandatory Training	90.00%	**81.65%**	Mandatory Training Monthly Rate ***Includes CCICP staff****	A review of the data heald within the Oracle Learning management system has been completed and again some data cleansing has been necessary for staff with more than one role in the Trust. The review has identified that workforce training in the following areas requires significant imporvement and a joint piece of work between the L&D team and Divisional HRMs in underway to identify and target specific staff to bring thir training up to date.	
Staff Turnover	10.00%	**10.14%**	Number of Leavers expressed as a percentage of the workforce over a 12m rolling period.	Turnover has increased by 0.07% during June 2016. The level of leavers is not of signifcant concern at this time, although the data is currently skewed by CCICP because all staff leaving CCICP are considered to be leaving within 12m of commencing with the Trust.	

Measure	Target	Performance	Description	Narrative	Rolling Trend
Agency Spend	(472)	**(296)**	In month and cumulative total spend for the Trust.	The Trust continues to perform well against our intenal agency spend targets and for the third month running we have spent less that we have budgeted for. In June we spend some £123k less than in May. The areas of highest spend (amounting to circa 30% each) are: CCICP Diagnostics and Clinical Support Services and Medicine & Emergency Care. Upon further analysis almost 80% of our June 2017 agency spend was for medical staff and allied health professionals. A recent review of CCICP agency spend demonstrated that a medical agency spend has increased substantially in the months since the new IR35 regulations came into affect. Further recruitment into AHP roles, whilst slow, will support a sustained reduction in spend in this area.	
NHSI Ceiling	less than 100%	**62.7%**	Trust Agency Spend as a percentage of the Ceiling Set by NHS Improvement		
Over Cap Rates	To be benchmarked after Q2	40.78%	Number of Agency shifts filled by agency staff that are over the nationally determined capped rates	A total of 230/564 shifts that were filled during June by agency staff were paid at rates above the NHSI Capped rates. All rates above these caps are scrutinsed and approved by the DoF and DoW&OD before they are booked. In many cases the rates are less than £10 about the capped rates. The posts of greatest concern in relation to this metric are Clinical Coders, GPs (in GPOoH), AHPs and Shortage Medical Professions (I.e. Breast Radiologists)