Mid Cheshire Hospitals NHS Foundation Trust

AGENDA

Board of Directors
A meeting will be held in Public at
09.30am on Monday, 1 October 2018
at Alsager Golf Club, ST7 2UR

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 Member's Interests** *(to note)* To **consider** any • Changes to Directors' interests since the last meeting • Conflicts of interest deriving from this agenda	I	Chairman **09.50**	-
4.	**Minutes of the Last Meeting** To **approve** the minutes of the Board of Directors meeting held in Public on Monday, 3 September 2018	A	Chairman **09.52**	-
5.	**Matters Arising and Action Log** *(verbal) (to note)*	A	Chairman **09.55**	-
6.	**Annual Work Programme 2018/19** *(attached)* *(to approve)*	I/A	Chairman **09.57**	**18**
7.	**Chairman's Announcements** (*to note a verbal report*)	I	Chairman **10.00**	-
8.	**Governor's Items** (*to note a verbal report*) **8.1 New Governor Induction** **8.2 NEDs and Governors – 11 September 2018** *(Deputy Chair)* **8.3 Annual Members Meeting – 2 October 2018**	I	Chairman **10.10**	-
9.	**Chief Executive's Report** *(to note a verbal report)* **9.1 CQC Report and Rating** **9.2 System Update**	I	Chief Executive **10.20**	-

Item No	Title of Item	Action	Led By	Page No.
9.3	**Executive Director Away Day**			
10.	**CARING**			
10.1	**Quality, Safety & Experience Report** *(attached) (for discussion)*	I/D	Director of Nursing & Quality **10.45**	**19**
10.2	**Nursing and Midwifery Staffing Comprehensive Report** *(attached) (for discussion*	I/D	Director of Nursing & Quality **10.55**	**64**
11.	**SAFE**			
11.1	**Draft Quality Governance Committee notes from the meeting held on 10 September 2018** *(attached) (to note)*	I	Committee Chair **11.05**	**-**
11.2	**Serious Untoward Incidents and RIDDOR Events** *(verbal)* (*to note*)	I/D	Deputy Chief Executive/ Medical Director **11.10**	**-**
11.3	**Guardian of Safe Working Hours Report Q1 2018-19** *(verbal) (to note)*	I/D	Interim Director of Workforce and OD **11.15**	**-**
12.	**RESPONSIVE**			
12.1	**Performance Report** *(attached) (to note)*	I/D	Chief Operating Officer **11.20**	**90**
12.2	**Draft Performance & Finance Committee notes from the meeting held on 20 September 2018** *(attached) (to note)*	I	Committee Chair **11.30**	**-**
12.3	**Legal Advice** *(verbal)* (*to note*)	I	Chief Executive **11.35**	**-**
12.4	**Equality Diversity System 2017/18**	I/D	Interim Director of Workforce and OD **11.40**	**130**
13.	**WELL-LED**			
13.1	**Visits of Accreditation, Inspection or Investigation** *(verbal)* (*to note*)	I	Chief Executive **11.55**	**-**

Item No	Title of Item	Action	Led By	Page No.
13.2	**Draft Audit Committee notes from the meeting held on 10 September 2018** *(attached) (to note)*	I	Committee Chair **12:00**	-
13.3	**Organisational Risk Register** *(attached) (to note)*	I	Deputy Chief Executive/ Medical Director **11.55**	**179**
13.4	**EPRR Core Standards** *(attached) (to approve)*	A/D	Chief Operating Officer **12:00**	**217**
13.5	**Workforce Race Equality Scheme Annual Report** *(attached) (to approve)*	A/D	Interim Director of Workforce and OD **12.05**	**221**
14.	**EFFECTIVE**			
14.1	**Workforce Report** *(attached) (to note)*	I/D	Interim Director of Workforce and OD **12.10**	**238**
14.2	**Transformation and People Committee notes from the meeting held on 6 September 2018** *(attached) (to note)*	I	Committee Chair **12.20**	-
14.3	**Consultant Appointments** *(verbal) (to note)*	I	Deputy Chief Executive/ Medical Director **12.25**	-
15.	**Any Other Business** *(verbal)*	A/I/D	Chairman	-
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 Boardroom at Leighton Hospital, at 9.30am on **Monday, 5 November 2018**	I	Chairman	

Board of Directors Workplan 2018/19

Version: 2

Item	Board of Directors Meeting												Board Away Day			
	April	*May*	*June*	*July*	*August*	*Sept*	*Oct*	*Nov*	*Dec*	*Jan*	*Feb*	*March*	*Apr*	*Oct*	*Dec*	*Feb*
Patient/Staff Story	x	x	x	x	x	x	x	x	x	x	x	x				
Minutes of the Last Meeting	x	x	x	x	x	x	x	x	x	x	x	x				
Board Actions	x	x	x	x	x	x	x	x	x	x	x	x				
Annual Work Programme	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 Items	x	x	x	x	x	x	x	x	x	x	x	x				
Chief Executive's Report	x	x	x	x	x	x	x	x	x	x	x	x				
Caring																
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				
Staff Survey		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				
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		x
Freedom to Speak up Guardian		x			x			x			x					
Well-Led																
Annual Budget/Contract Discussions	x											x				
Annual Plan	x	x										x				
Annual Report & Accounts (Extra Ordinary Board)		x														
Audit Committee		x	x				x		x		x					
Board Assurance Framework	x		x			x			x			x				
Quarterly Organisational Risk Register	x			x			x			x						
Learning from Deaths Quarterly Report			x			x			x			x				
Trust Strategy	x							x						x		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						
Board Sub-Committee Annual Review			x													
Emergency																
Doctors Revalidation Report						x										
Effective																
Workforce Report	x	x	x	x	x	x	x	x	x	x	x	x				
Transformation and People Committee	x	x	x	x	x	x	x	x	x	x	x	x				
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				

Mid Cheshire Hospitals NHS
NHS Foundation Trust

We Care Because You Matter

Board of Directors

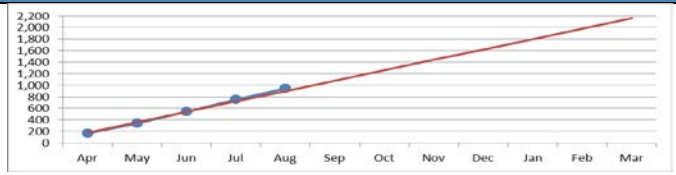
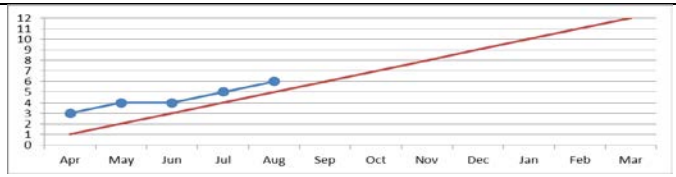
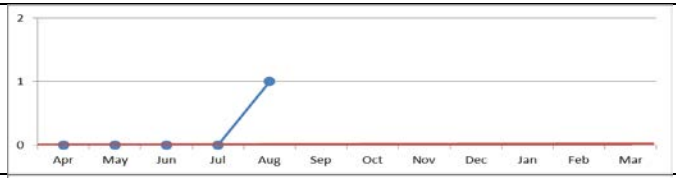
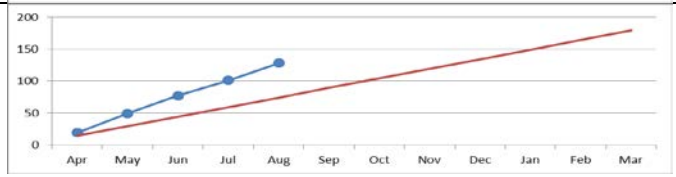
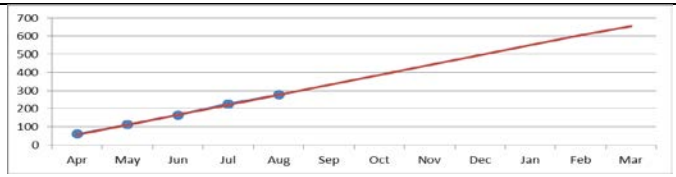
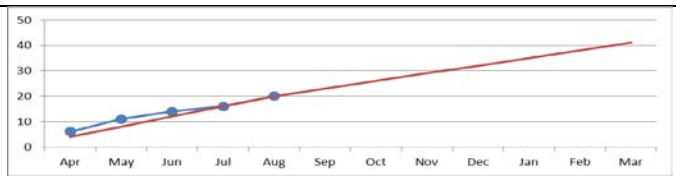
Quality, Safety and Experience Report

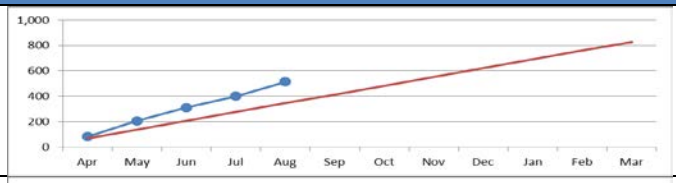
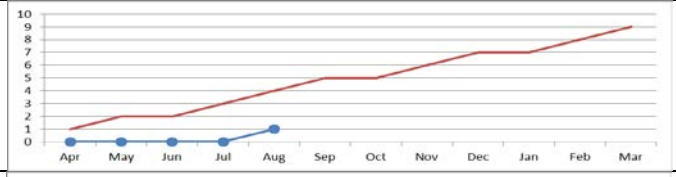
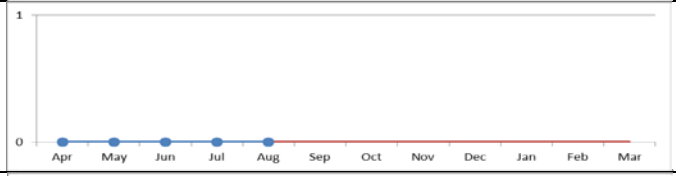
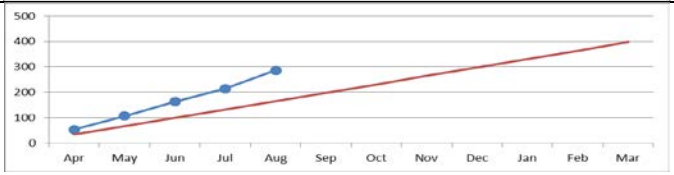
October 2018

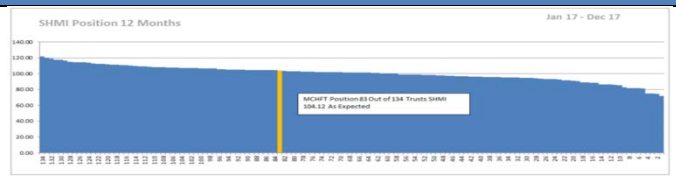
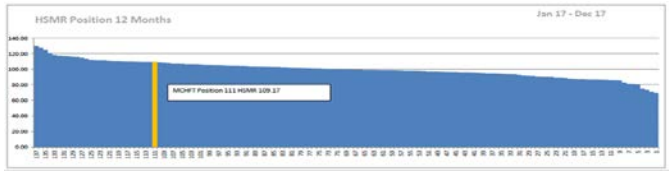
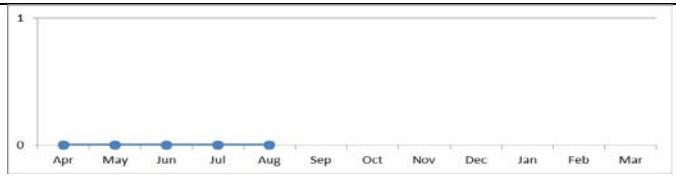
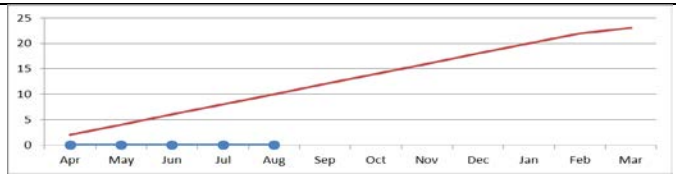
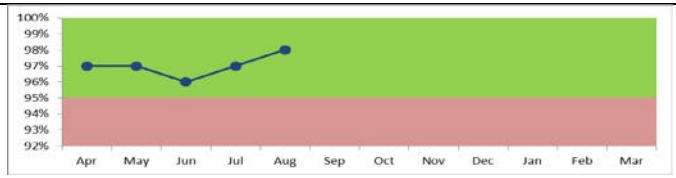
(August 2018 data)

Contents

Contents (continued):

Indicators	Target	Trajectory 2018/19
Acute Trust		
Patient Safety Harm Incidents The target is to reduce patient safety harm incidents by 5% when compared to the previous financial year by the end of March 2019.	**Less than 2161 at end of March 2019**	
Serious Incidents The target is to reduce patient safety serious incidents by 10% when compared to the previous financial year by the end of March 2019.	**Less than 12 at end of March 2019**	
Never Events Zero tolerance of Never Events.	**Zero**	
Pressure Ulcers – Hospital Acquired The target is to reduce hospital acquired pressure ulcers by 10% when compared to the previous financial year by the end of March 2019.	**Less than 150 at end of March 2019**	
Inpatient Falls The target is to reduce inpatient falls by 10% when compared to the previous financial year by the end of March 2019.	**Less than 656 at end of March 2019**	
Medication Harm Incidents The target is to reduce medication incidents resulting in harm by 10% when compared to the previous financial year by the end of March 2019.	**Less than 41 at end of March 2019**	

Indicators	Target	Trajectory 2018/19
CCICP		
CCICP Patient Safety Harm Incidents The target is to reduce CCICP patient safety harm incidents by 5% when compared to the previous financial year by the end of March 2019.	**Less than 828 at end of March 2019**	
CCICP Serious Incidents The target is to reduce CCICP patient safety serious incidents by 10% when compared to the previous financial year by the end of March 2019.	**Less than 9 at end of March 2019**	
CCICP Never Events Zero tolerance of CCICP Never Events.	**Zero**	
CCICP Pressure Ulcers – Community Acquired The target is to reduce community acquired pressure ulcers by 10% when compared to the previous financial year by the end of March 2019.	**Less than 398 at end of March 2019**	

Indicators	Target	Trajectory 2018/19
SHMI The Trust's target is to be at least within the "as expected" bracket. This has been achieved for the latest reporting period.	**As expected**	
HSMR The Trust's target is to be at least within the "as expected" bracket. This has been achieved for the latest reporting period.	**As expected**	
MRSA Zero tolerance of MRSA cases.	**Zero**	
C-Diff Avoidable The target is less than 23 avoidable cases of Clostridium Difficile in 2018/19.	**Less than 23 at end of March 2019**	
Safety Thermometer The Trust target is that >95% of patients receive harm free care as monitored by the Safety Thermometer.	**>95%**	

Quality & Safety Section:

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

Patient Safety Harm Incidents

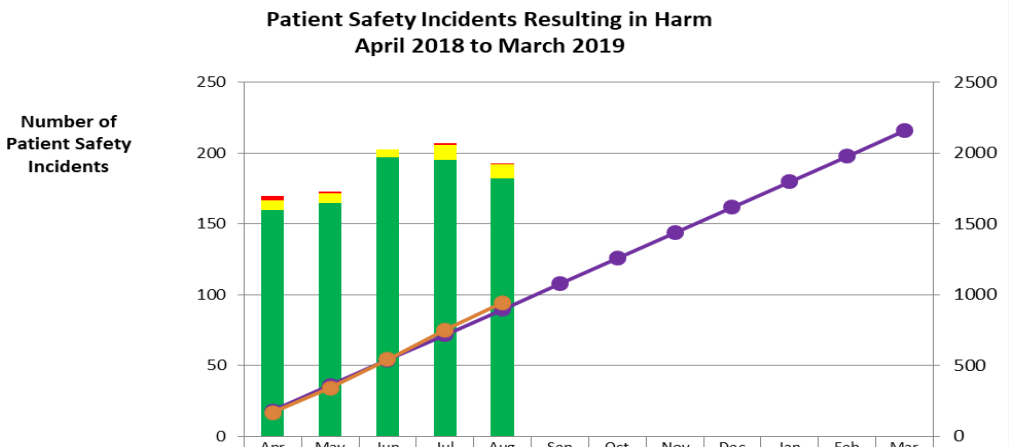
The target is to reduce patient safety harm incidents by 5% when compared to the previous financial year by the end of March 2019.

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

For August 2018, there were a total of 193 patient safety harm incidents:
95% (182 incidents) have resulted in low harm
4.4% (10 incidents) have resulted in moderate harm
0.6% (1 incident) resulted in serious harm

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

- Twice monthly Patient Safety Summit Meetings with Executive & Senior Teams
- Twice monthly Patient Safety Matters newsletter that is delivered Trust wide
- Deteriorating Patient Steering Group formed to implement NEWS2 on the 5 November 2018



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Serious Incident	3	1	0	1	1							
Moderate Harm	7	7	6	11	10							
Low Harm	160	165	197	195	182							
Target	180	360	540	720	900	1080	1260	1440	1620	1800	1980	2161
Cumulative Total 2018/19	170	343	546	753	946							

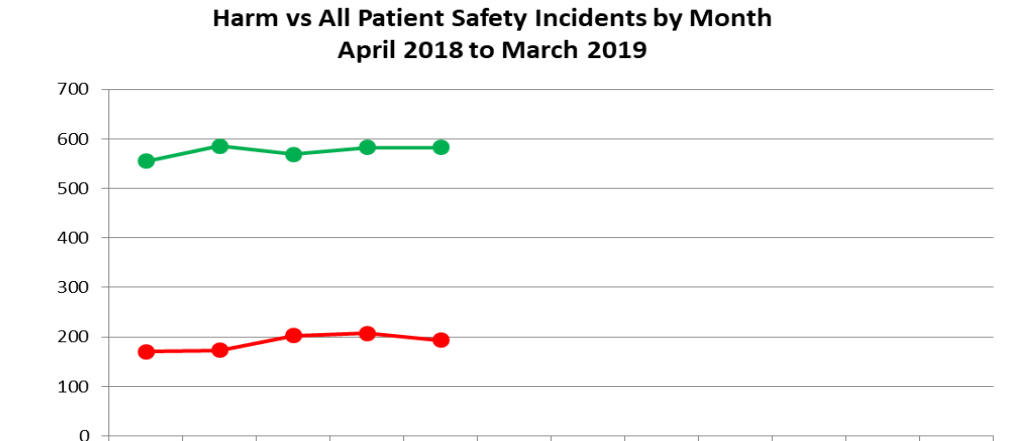
Harm vs All Patient Safety Incidents

The aim is to maintain / widen the gap between harm and all patient safety incidents reported

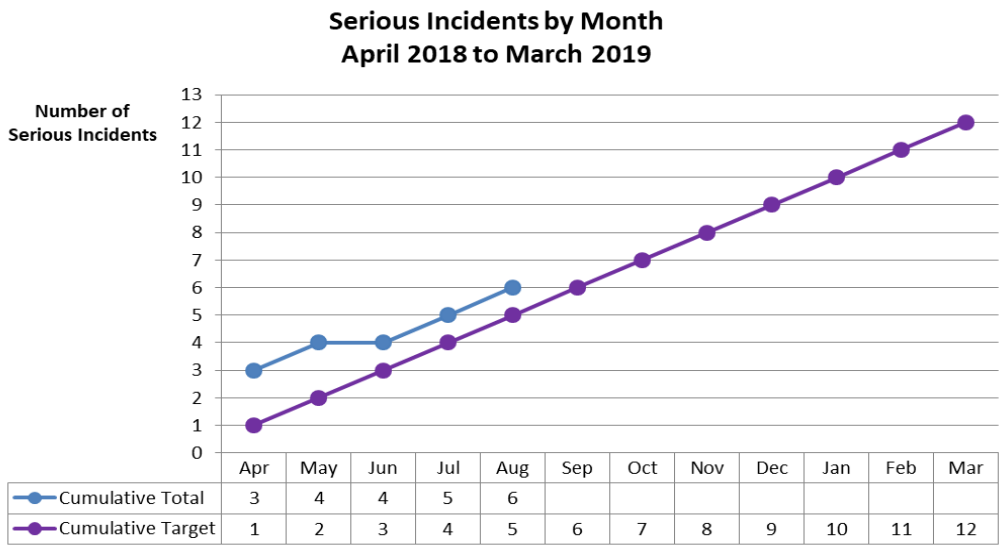
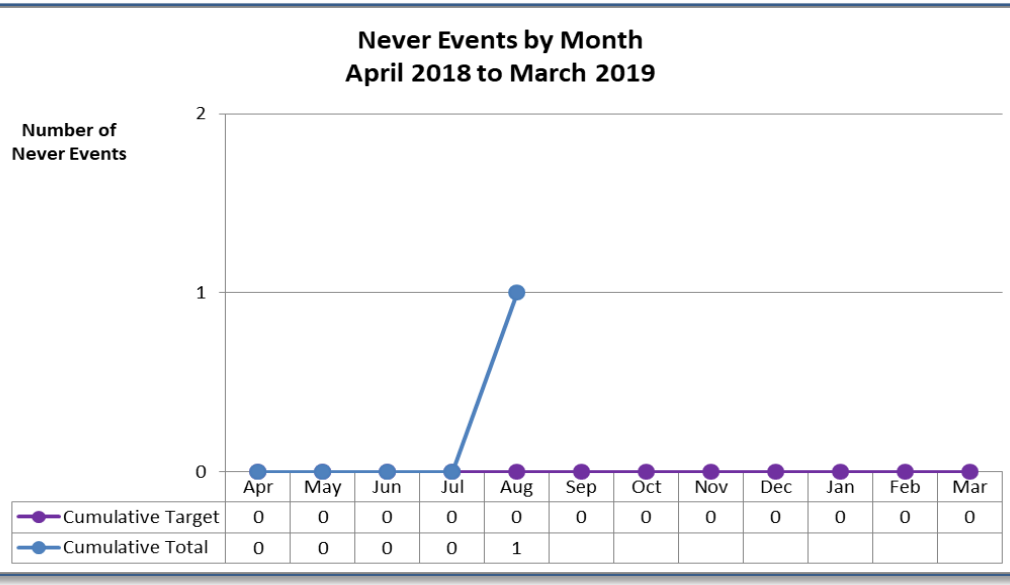
This chart demonstrates the number of incidents that have resulted in harm vs all patient safety incidents.

In August 2018, the gap between harm and all patient safety incidents was 390. The aim over the twelve month period is to see this gap widening.

Within healthcare, a safety culture is defined as a "culture where staff has a constant and active awareness of the potential for things to go wrong. It is also a culture that is open and fair and encourages people to speak up about mistakes." An important benefit in a safety culture in the NHS is "A potential reduction in the recurrence and in the severity of patient safety incidents through increased reporting and organisational learning" *Source: 7 steps to patient safety, NPSA, 2004.*



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Harm	170	173	203	207	193							
All	555	585	569	583	583							

Description	Aggregate Position	Trend
Serious Incidents *The target is to reduce patient safety serious incidents by 10% when compared to the previous financial year by the end of March 2019.*	This chart demonstrates the number of incidents that have resulted in serious harm. For August 2018, there was one serious incident reported. • Never Event (detailed below).	
Never Events *The target is to have zero Never Events*	This chart demonstrates the number of Never Events that have been reported. For August 2018 one Never Event was reported. **DETAIL REMOVED UNDER SECTION 40 OF THE FREEDOM OF INFORMATION ACT** No harm was caused to the patient. Duty of Candour was completed in a timely manner.	

Board Papers – Quality, Safety & Experience Section: August 2018

Description	Aggregate Position	Trend

Pressure Ulcers – Hospital Acquired

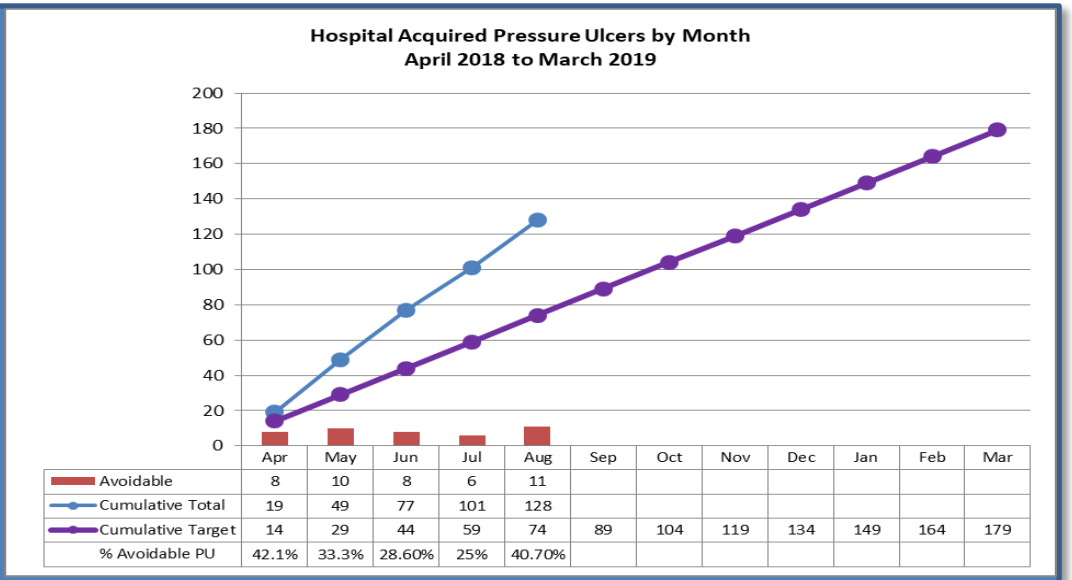
The target is to reduce hospital acquired pressure ulcers by 10% when compared to the previous financial year by the end of March 2019.

For August 2018, there were a total of 27 hospital acquired pressure ulcer incidents:

- 40.7% (11 PU's) have resulted in avoidable harm. Of these 7 were category 2 pressure ulcers and 4 were categorised as unstageable. All avoidable pressure ulcers are reviewed at the monthly pressure ulcer panel.
- 40.7% (11 PU's) have been classed as unavoidable following investigation. These were all category 2 pressure ulcers
- 18.6% (5) are currently undergoing investigation prior to confirmation.
-

Improvement actions include

- Implementation of a weekly ward support programme. Allocating daily divisional drop in sessions for all wards on pressure ulcer prevention
- Development of pressure ulcer champions to support 'master classes' in pressure ulcer prevention and support the Tissue Viability Specialist Nurse with 'back to basic' training.
- Implement Trust wide initiatives in pressure ulcer reduction including standardised approach to the location of repositioning charts at the end of each bed.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Avoidable	8	10	8	6	11							
Cumulative Total	19	49	77	101	128							
Cumulative Target	14	29	44	59	74	89	104	119	134	149	164	179
% Avoidable PU	42.1%	33.3%	28.60%	25%	40.70%							

Description	Aggregate Position	Trend

Inpatient Falls.

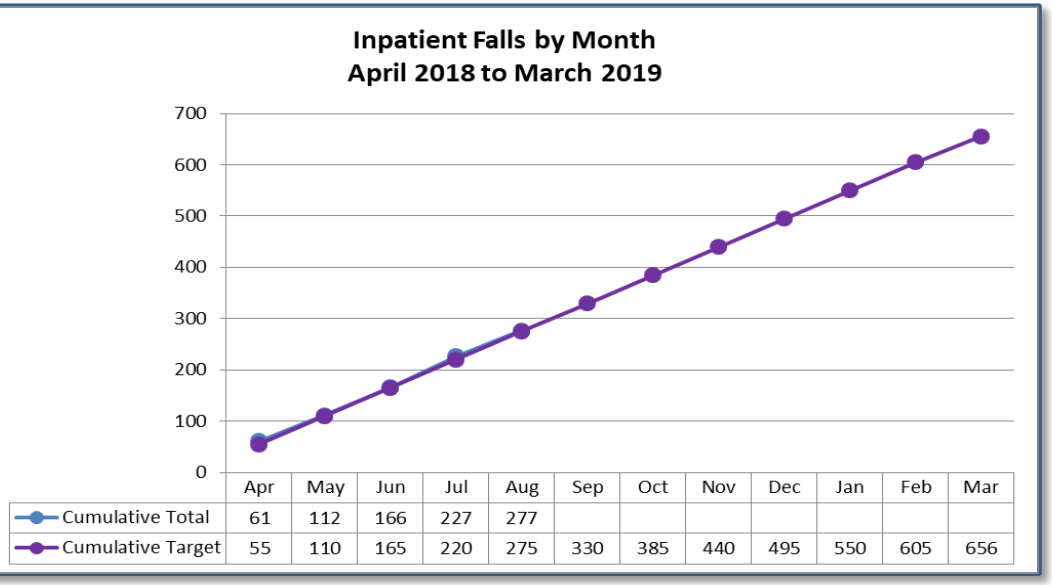
The target is to reduce inpatient falls by 10% when compared to the previous financial year by March 2019

For August 2018, there were a total of 50 inpatient falls

- 60% (30 falls) have resulted in no harm
- 32% (16 falls) have resulted in low harm
- 8% (4 falls) have resulted in moderate harm
- 0% (0 falls) have resulted in serious harm

Improvement actions include:

- Bespoke training where an increase in falls has been identified
- Continued review of practice during senior nurse walkabouts



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative Total	61	112	166	227	277							
Cumulative Target	55	110	165	220	275	330	385	440	495	550	605	656

Medication Harm Incidents

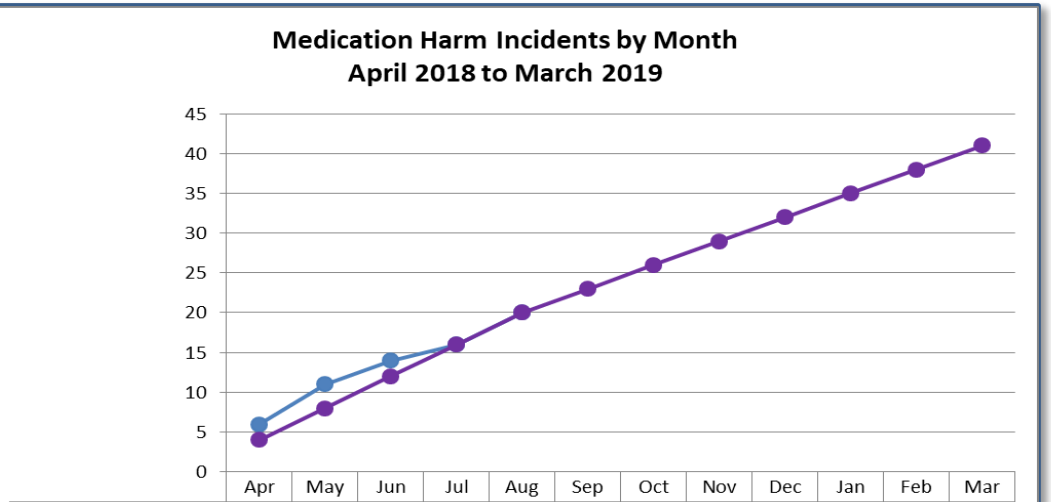
The target is to reduce medication incidents resulting in harm by 10% when compared to the previous financial year by the end of March 2019.

For August 2018, there were a total of 4 medication incidents resulting in harm reported:

- 100% (4 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

Improvement actions include:

- Junior medical staff training
- E-learning package in place
- Zero tolerance to prescription anomalies at ward level



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative Total	6	11	14	16	20							
Cumulative Target	4	8	12	16	20	23	26	29	32	35	38	41

Central Cheshire Integrated Care Partnership (CCICP)

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

CCICP Patient Safety Harm Incidents

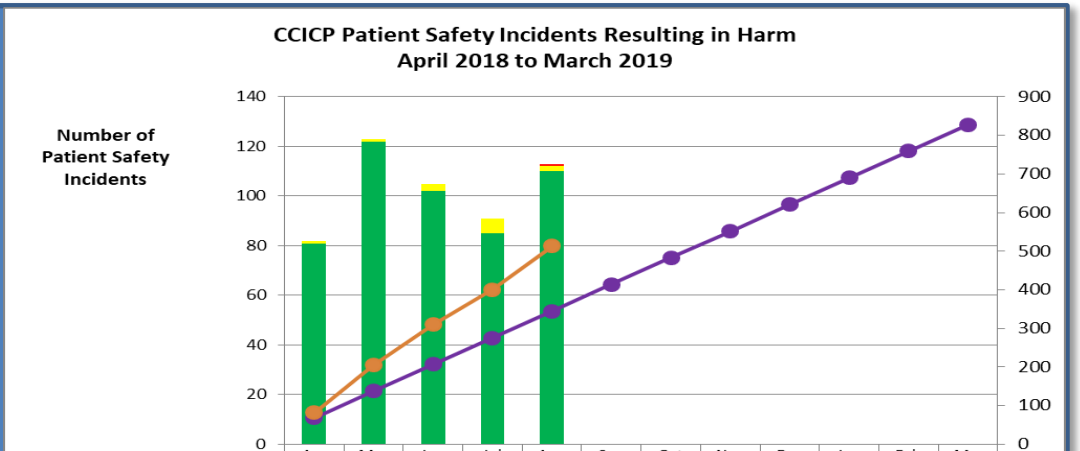
The target is to reduce CCICP patient safety harm incidents by 5% when compared to the previous financial year by the end of March 2019.

For August 2018, there were a total of 113 patient safety harm incidents:

- 97.3% (110 incidents) have resulted in low harm
- 1.8% (2 incidents) have resulted in moderate harm
- 0.9% (1 incidents) have resulted in serious harm

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

- Twice monthly Patient Safety Summit Meetings with Executive & Senior Teams
- Twice monthly Patient Safety Matters newsletter that is delivered Trust wide
- Local quality champions introduced



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Serious Incident	0	0	0	0	1							
Moderate Harm	1	1	3	6	2							
Low Harm	81	122	102	85	110							
Target	69	138	207	276	345	414	483	552	621	690	759	828
Cumulative Total 2018/19	82	205	310	401	514							

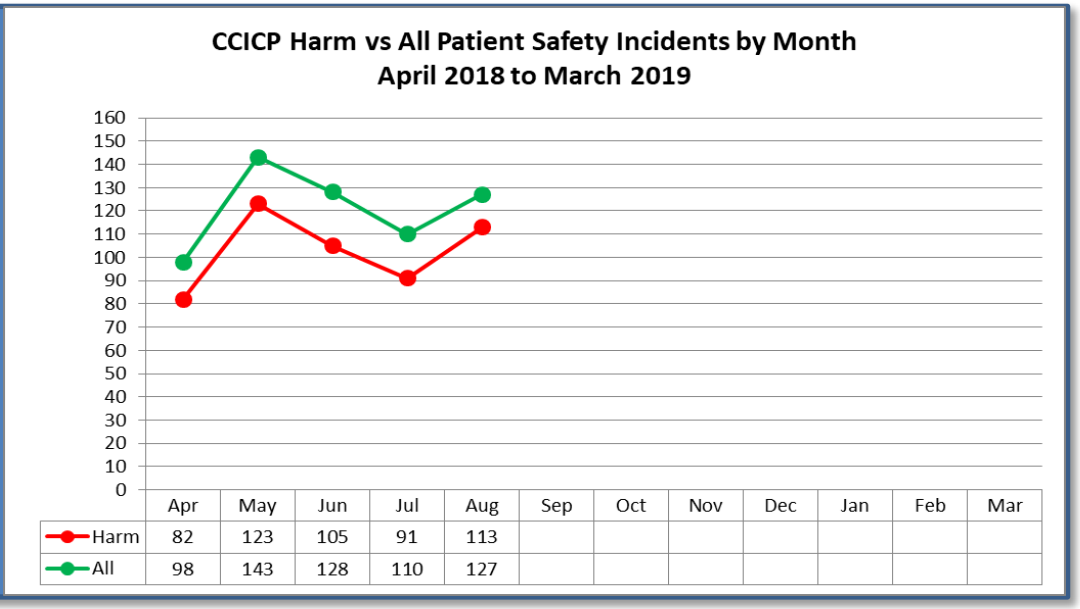
CCICP Harm vs All Patient Safety Incidents

The aim is to increase no harm reporting and eventually widen the gap between harm and all incidents.

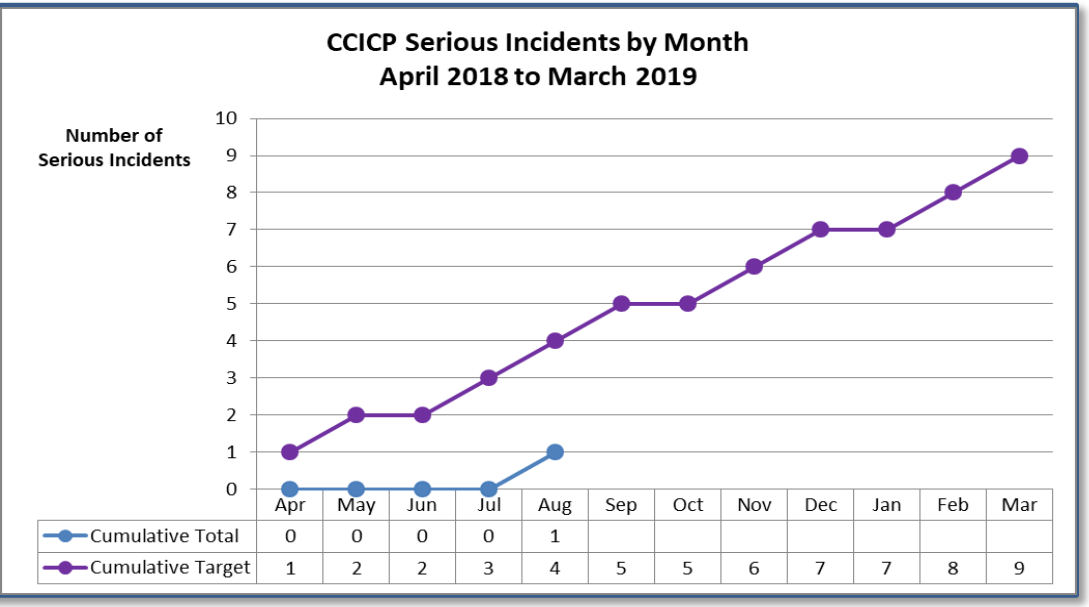
This chart demonstrates the number of incidents that have resulted in harm vs all patient safety incidents.

In August 2018, the gap between harm and all patient safety incidents was 12.

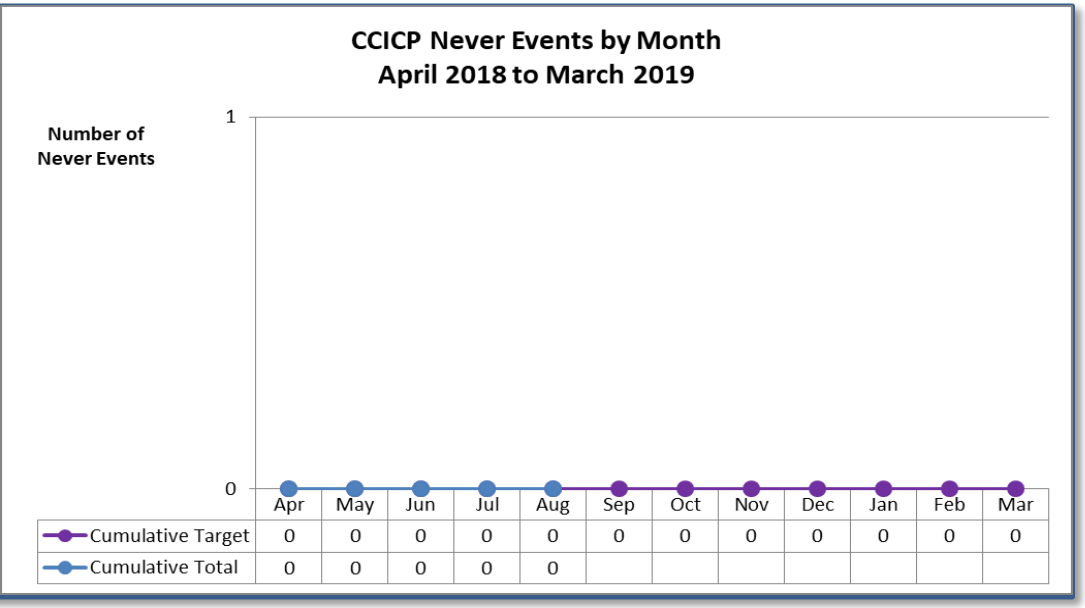
Within healthcare, a safety culture is defined as a "culture where staff have a constant and active awareness of the potential for things to go wrong. It is also a culture that is open and fair and encourages people to speak up about mistakes." An important benefit in a safety culture in the NHS is "A potential reduction in the recurrence and in the severity of patient safety incidents through increased reporting and organisational learning" *Source: 7 steps to patient safety, NPSA, 2004.*



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Harm	82	123	105	91	113							
All	98	143	128	110	127							

Description	Aggregate Position	Trend
CCICP Serious Incidents *The target is to reduce patient safety serious incidents by 10% when compared to the previous financial year by the end of March 2019.*	This chart demonstrates the number of incidents that have resulted in serious harm. For August 2018, there was one serious incident reported. This related to a developed in care category 4 pressure ulcer.	

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative Total	0	0	0	0	1							
Cumulative Target	1	2	2	3	4	5	5	6	7	7	8	9

	Description	Aggregate Position	Trend
CCICP Never Events *The target is to have zero Never Events*	This chart demonstrates the number of Never Events that have been reported. For August 2018 no Never Events were reported. No Never Events have been reported for CCICP since the merger of the Trust in October 2016.	

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative Target	0	0	0	0	0	0	0	0	0	0	0	0
Cumulative Total	0	0	0	0	0							

Description	Aggregate Position	Trend

Pressure Ulcers – Community Acquired

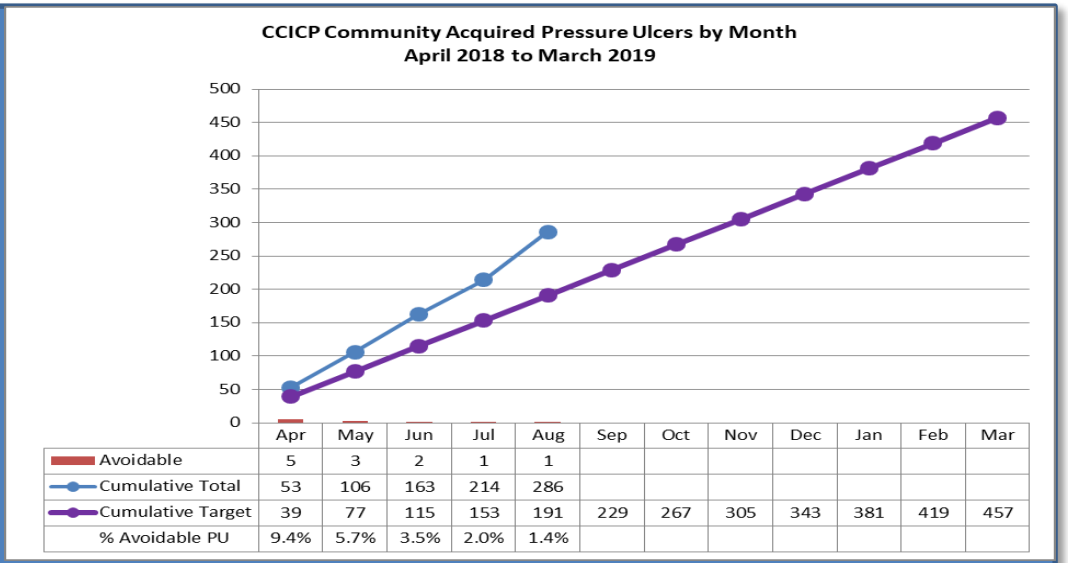
The target is to reduce community acquired pressure ulcers by 10% when compared to the previous financial year by the end of March 2019.

For August 2018, there were a total of 72 community acquired pressure ulcer incidents:

- 1.4% (1 PU's) has resulted in avoidable harm. This was an unstageable pressure ulcer.
- 44.4% (32 PU's) have been classed as unavoidable following investigation. Of these 24 were category 2 pressure ulcers and 15 were categorised as unstageable
- 54.2% (39) are currently undergoing investigation prior to confirmation

Improvement actions include:

- React 2 Red teaching sessions are now being delivered in Nursing Homes
- Training is being provided for community stroke rehab team.
- Workshops have been booked to launch new products on the wound formulary
- Posters / leaflets launched in GP surgeries to promote pressure ulcer prevention.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Avoidable	5	3	2	1	1							
Cumulative Total	53	106	163	214	286							
Cumulative Target	39	77	115	153	191	229	267	305	343	381	419	457
% Avoidable PU	9.4%	5.7%	3.5%	2.0%	1.4%							

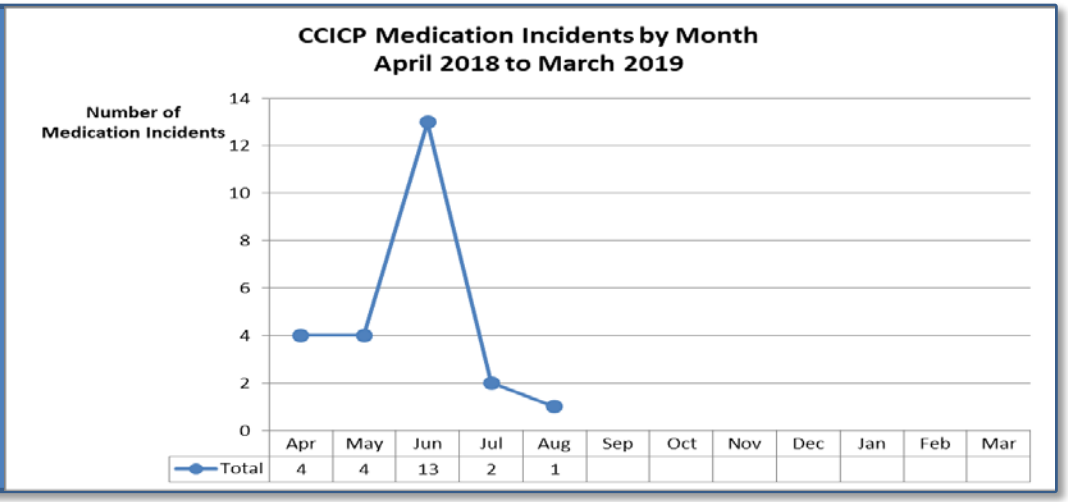
CCICP Medication Incidents.

The aim is to increase no harm reporting of Medication Incidents.

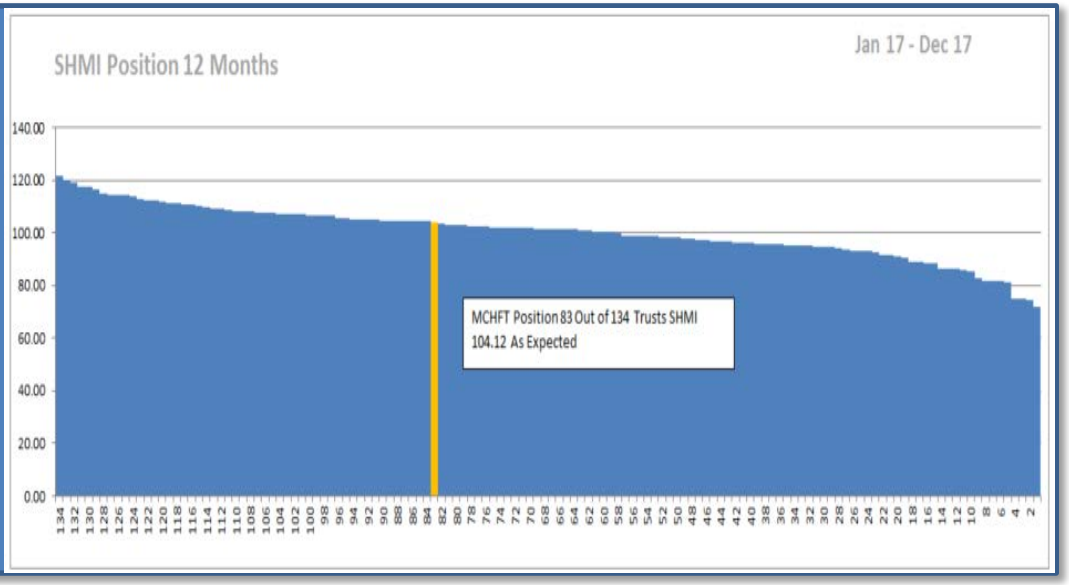
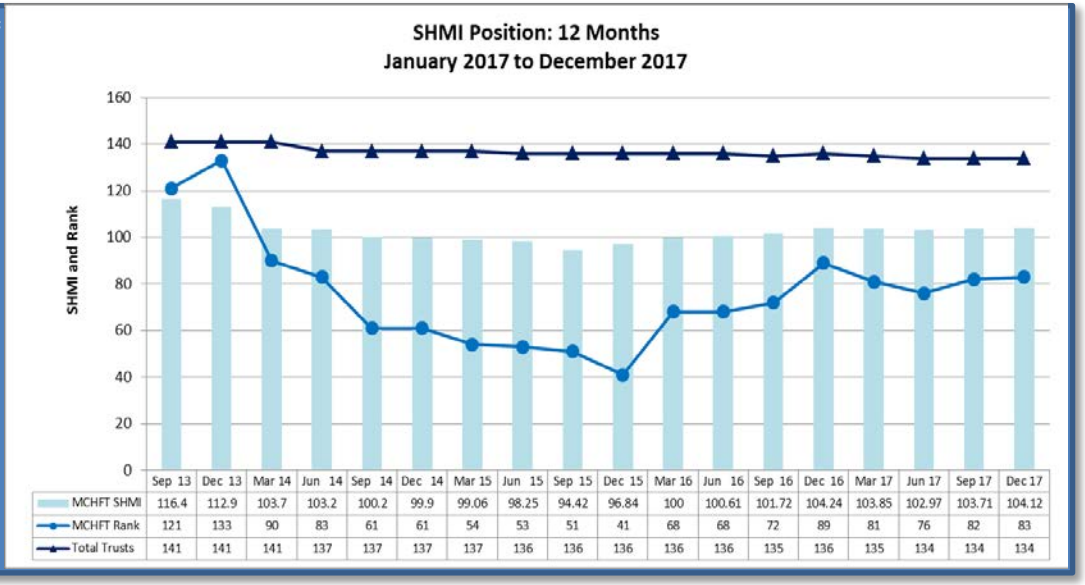
For August 2018, there was a total of 1 medication incident reported:

- 100% (1 medication incident) resulted in no harm
- 0% (0 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

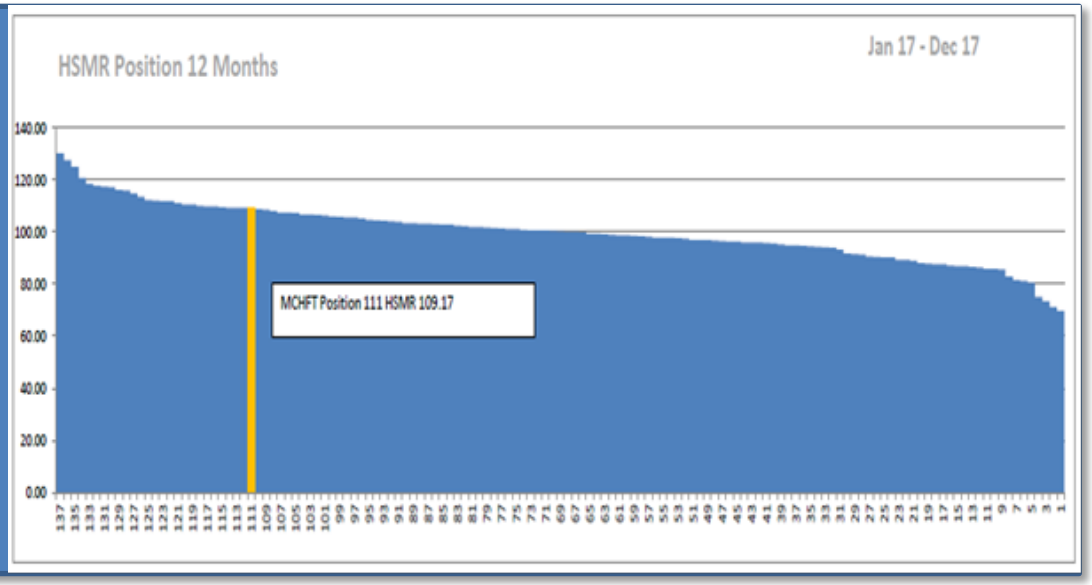
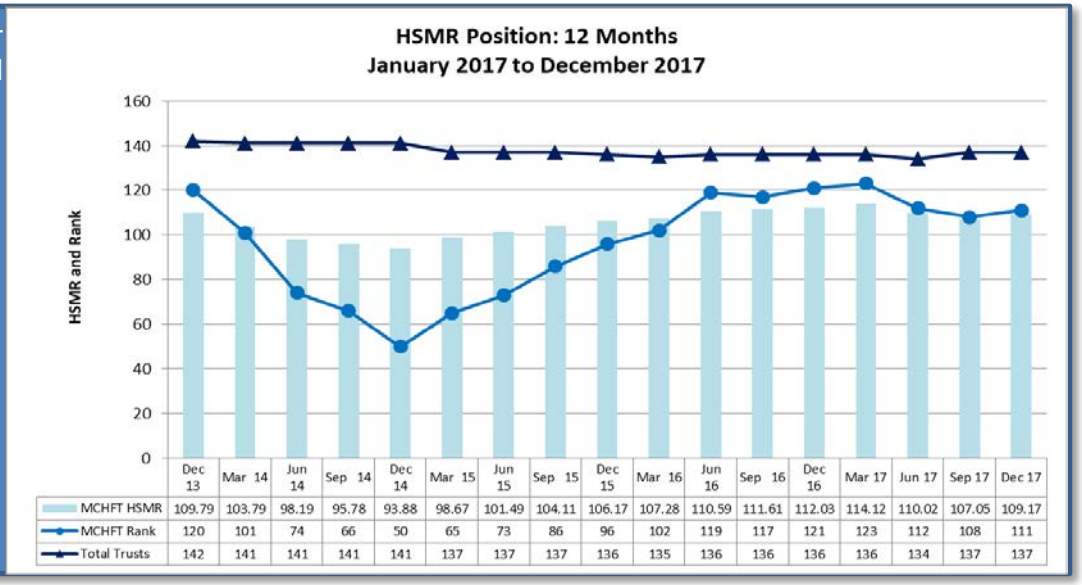
CCICP has a dedicated pharmacy lead who is actively encouraging the reporting of all grades of incidents across all services.



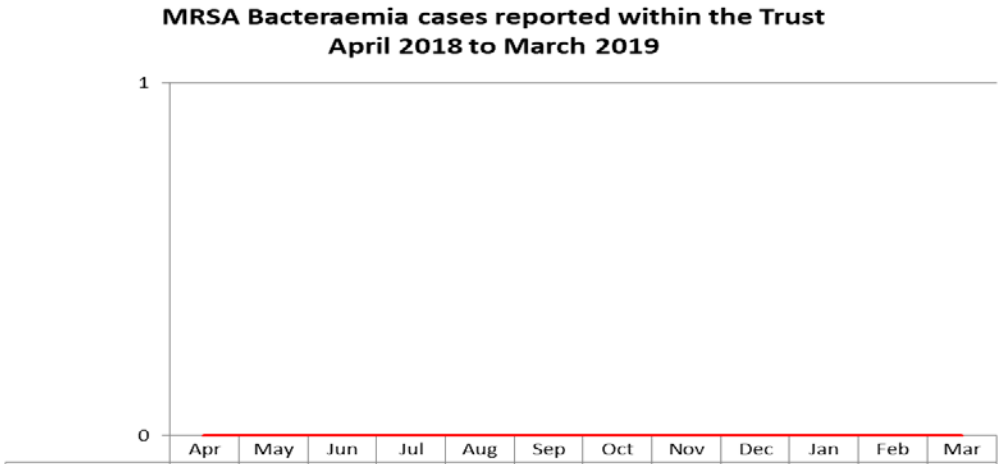
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total	4	4	13	2	1							

Description	Aggregate Position	Trend
SHMI *The Trust's target is to be at least within the "as expected" bracket.*	The chart benchmarks the Trust's latest SHMI against all NHS Trusts. MCHFT is shown as the yellow bar. The Trust's SHMI is 104.12 for the time period January 2017 to December 2017 and places the Trust 83 out of 134 Trusts and is "as expected".	
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 for the period January 2017 to December 2017 and is "as expected".	

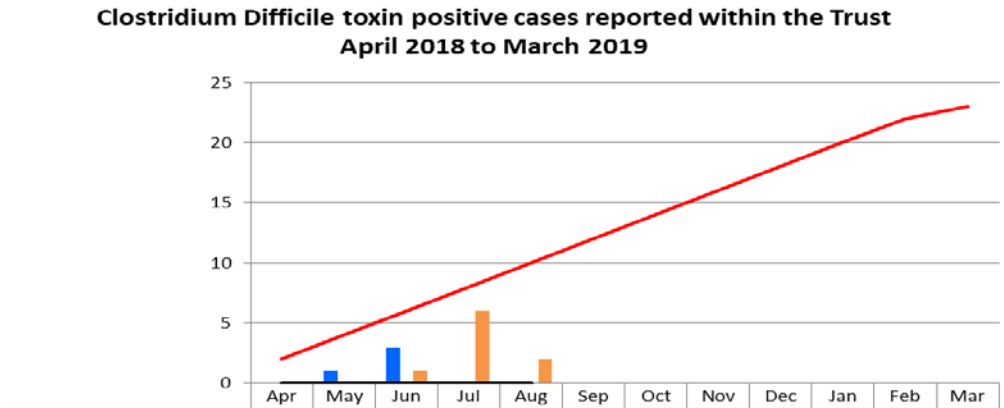
	Sep 13	Dec 13	Mar 14	Jun 14	Sep 14	Dec 14	Mar 15	Jun 15	Sep 15	Dec 15	Mar 16	Jun 16	Sep 16	Dec 16	Mar 17	Jun 17	Sep 17	Dec 17
MCHFT SHMI	116.4	112.9	103.7	103.2	100.2	99.9	99.06	98.25	94.42	96.84	100	100.61	101.72	104.24	103.85	102.97	103.71	104.12
MCHFT Rank	121	133	90	83	61	61	54	53	51	41	68	68	72	89	81	76	82	83
Total Trusts	141	141	141	137	137	137	137	136	136	136	136	136	135	136	135	134	134	134

Description	Aggregate Position	Trend
Hospital Standardised Mortality Rate (HSMR) by Trust. *The Trust's target is to be at least within the "as expected" bracket.*	The chart benchmarks the Trust's HSMR against all NHS Trusts. MCHFT is shown by the amber bar. The Trust's HSMR is 109.17 (January 2017 to December 2017) and places the Trust 111 out of 137 Trusts and is "as expected".	
MCHFT *12 month rolling position for HSMR*	The data in the chart shows the HSMR and rank of MCHFT for each of the 12 month rolling position submissions for the period January 2017 to December 2017 and is "as expected".	

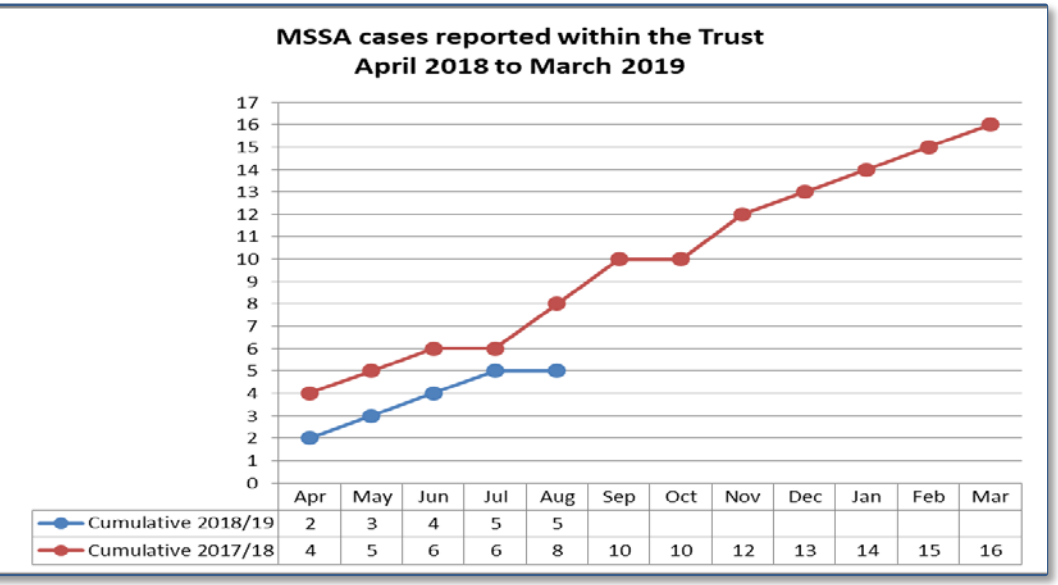
	Dec 13	Mar 14	Jun 14	Sep 14	Dec 14	Mar 15	Jun 15	Sep 15	Dec 15	Mar 16	Jun 16	Sep 16	Dec 16	Mar 17	Jun 17	Sep 17	Dec 17
MCHFT HSMR	109.79	103.79	98.19	95.78	93.88	98.67	101.49	104.11	106.17	107.28	110.59	111.61	112.03	114.12	110.02	107.05	109.17
MCHFT Rank	120	101	74	66	50	65	73	86	96	102	119	117	121	123	112	108	111
Total Trusts	142	141	141	141	141	137	137	137	136	135	136	136	136	136	134	137	137

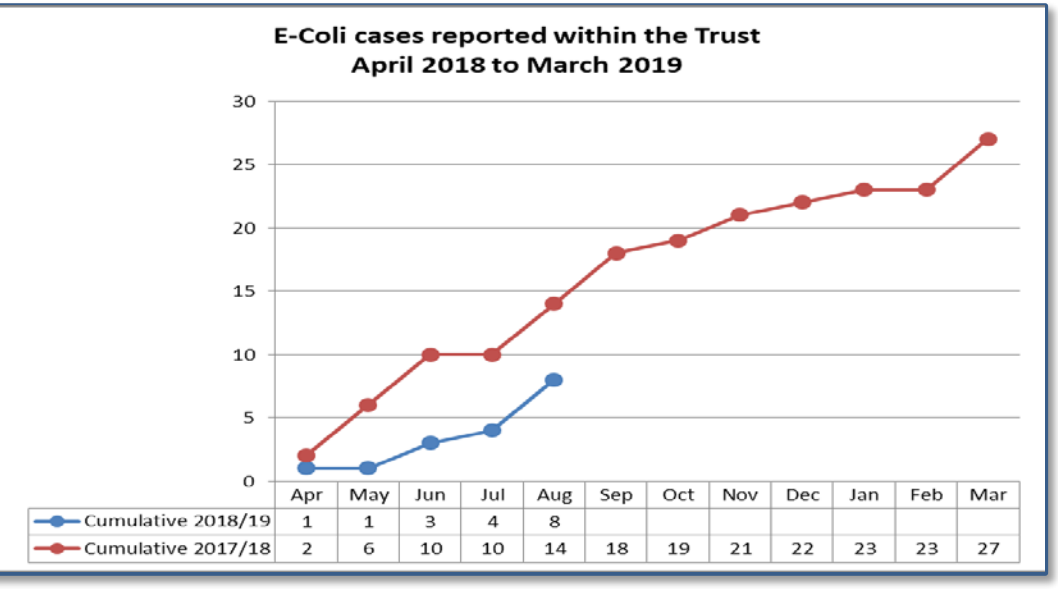
Description	Aggregate Position	Trend
MRSA Bacteraemia Cases. *Zero tolerance of MRSA cases.*	In August 2018, no MRSA bacteraemia cases were reported in the Trust. In this financial year there has been no confirmed MRSA bacteraemia cases reported.	

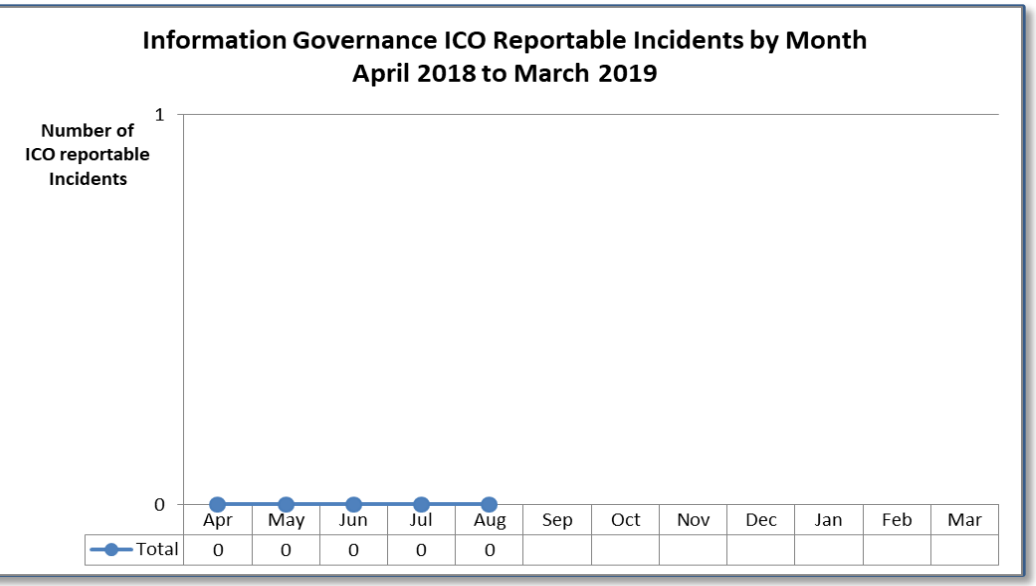
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Monthly	0	0	0	0	0							
Cumulative	0	0	0	0	0							
Target	0	0	0	0	0	0	0	0	0	0	0	0

Description	Aggregate Position	Trend
Clostridium Difficile toxin positive cases. *The target is less than 23 avoidable cases of Clostridium Difficile in 2018/19*	In August 2018, no avoidable cases were reported. The total avoidable cases year to date is zero. The total unavoidable is four. Improvement actions include: • Bed side reviews are in place on the identification of infection • Consultant level engagement in C-difficile root cause analysis and lessons learnt	

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Unavoidable	0	1	3	0	0							
Avoidable	0	0	0	0	0							
Awaiting Confirmation	0	0	1	6	2							
Avoidable Total	0	0	0	0	0							
Avoidable Target	2	4	6	8	10	12	14	16	18	20	22	23

Description	Aggregate Position	Trend
MSSA Cases. *The aim is to have a reduction in MSSA cases when compared to the previous financial year, to demonstrate an incremental improvement*	In August 2018, no MSSA cases were reported in the Trust. In this financial year there has been five confirmed MSSA cases reported.	

E-Coli Cases. *The aim is to have a reduction in E-Coli cases when compared to the previous financial year, to demonstrate an incremental improvement*	In August 2018, four E-Coli cases were reported. The cases occurred on Ward 2, Ward 10, Ward 13 and Ward 14.	

Description	Aggregate Position	Trend
Information Governance Information Commissioners Office (ICO) reportable incidents.	In August 2018, no information governance ICO reportable incidents were reported in the Trust. The Trust has detailed plans in place to address the requirements of the General Data Protection Regulations (GDPR) which is overseen by the Information Governance Group.	

CQUIN 2018-19 Performance

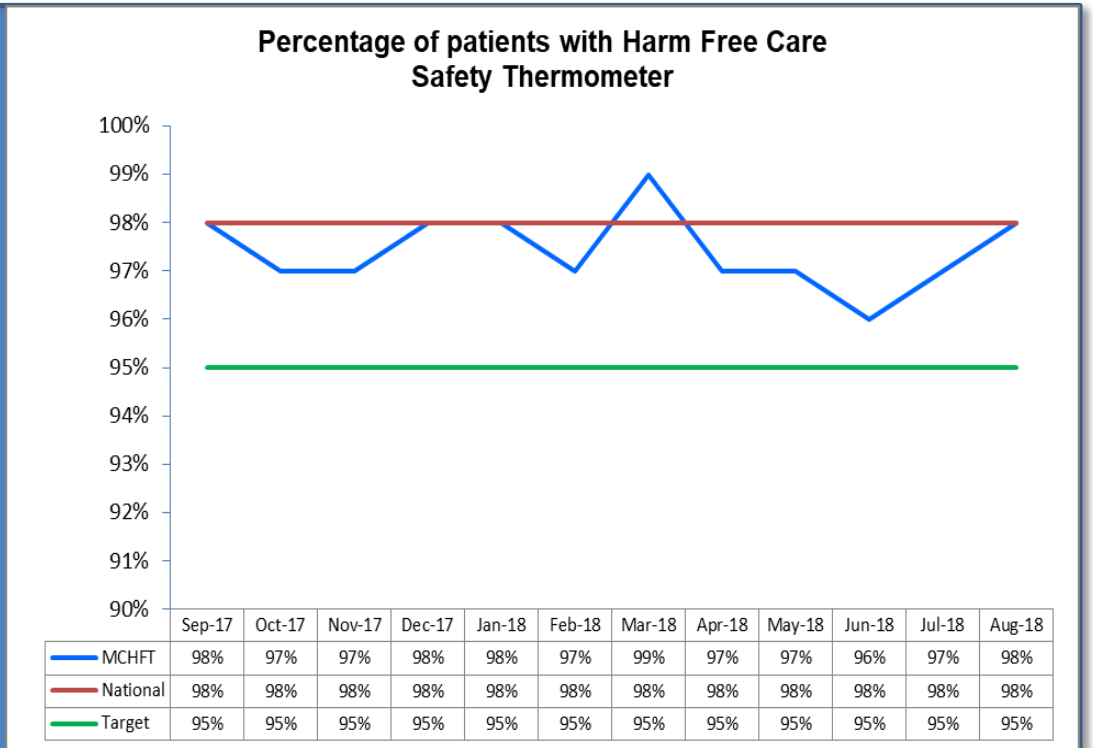
CQUIN Indicator	Indicator Name	Milestone Achieved								
		Q1	Financial Incentive Achieved	Q2	Financial Incentive Achieved	Q3	Financial Incentive Achieved	Q4	Financial Incentive Achieved	Maximum Value
1a	**Health & Wellbeing** 5% point improvement in two of the three questions on H&W, MSK & Stress		No payment		No payment		No payment		£137,574	**£137,574**
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.		No payment		No payment		No payment		£137,574	**£137,574**
1c	**Health & Wellbeing** Achieve an uptake of flu vaccinations of front line clinical staff of 75% by end of February 2019.		No payment		No payment		No payment		£137,574 £137,180	**£137,574** **CCICP £137,180**
2a	**Sepsis: Identification** The percentage of patients who met the criteria for sepsis screening and were screened for sepsis.	 **Partially**	£25,795		£25,795		£25,795		£25,795	**£103,181**
2b	**Sepsis: Treatment** The percentage of patients who were found to have sepsis and received IV antibiotics within1 hour.	 **Partially**	£25,795		£25,795		£25,795		£25,795	**£103,181**
2c	**Sepsis: Antibiotic Review** Percentage of antibiotic prescriptions documented and reviewed by a competent clinician within 72 hours		£25,795		£25,795		£25,795		£25,795	**£103,181**
2d Part 1	**Reduction in antibiotic consumption** Achieve a reduction of x% or more in total antibiotic consumption per 1,000 admissions.		No payment		No payment		No payment		£34,393	**£34,393**
2d Part 2	**Reduction in carbapenem consumption** Achieve a reduction of x% or more in total carbapenem consumption per 1,000 admissions.		No payment		No payment		No payment		£34,393	**£34,393**
2d Part 3	**Reduction in piperacillin tazabactam consumption** Achieve a reduction of x% or more in total piperacillin tazabactam consumption per 1,000 admissions.		No payment		No payment		No payment		£34,393	**£34,393**

CQUIN 2018-19 Performance

CQUIN Indicator	Indicator Name	Milestone Achieved								
		Q1	Financial Incentive Achieved	Q2	Financial Incentive Achieved	Q3	Financial Incentive Achieved	Q4	Financial Incentive Achieved	Maximum Value
4	**Mental Health in Emergency Department** Maintain 20% reduction in attendances to the Emergency Department for people with Mental Health needs.	✓	No Payment				£41,272		£371,451	**£412,723**
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.	✓	£65,908		£65,908		£65,908		£226,998	**£412,723**
9a	**Tobacco screening** Percentage of unique adult patients who are screened for smoking status AND whose results are recorded..	✓	£5,159		£5,159		£5,159		£5,159	**£20,636**
9b	**Tobacco brief advice** Percentage of unique patients who smoke AND are given very brief advice	✓	£20,636		£20,636		£20,636		£20,636	**£82,545**
9c	**Tobacco referral and medication offer** Percentage of unique patients who are smokers AND are offered referral to stop smoking services AND offered stop smoking medication.	✓	£25,795		£25,795		£25,795		£25,795	**£103,181**
9d	**Alcohol brief advice or referral** Percentage of unique adult patients who are screened for drinking risk levels AND whose results are recorded in local data systems	✓	£25,795		£25,795		£25,795		£25,795	**£103,181**
9e	**Alcohol brief advice or referral** Percentage of unique patients who drink alcohol above lower-risk levels AND are given brief advice OR offered a specialist referral if the patient is potentially alcohol dependent	✓	£25,795		£25,795		£25,795		£25,795	**£103,181**

CQUIN 2018-19 Performance

CQUIN Indicator	Indicator Name	Milestone Achieved								
		Q1	Financial Incentive Achieved	Q2	Financial Incentive Achieved	Q3	Financial Incentive Achieved	Q4	Financial Incentive Achieved	Maximum Value
10	**Improving the assessment of wounds** **(Community Only)** The indicator aims to increase the number of wounds which have failed to heal after 4 weeks that receive a full wound assessment.	✓	No payment		£68,590		No payment		£68,590	**£137,180**
11	**Personalised Care and Support Planning** **(Community Only)** This CQUIN is to be delivered over two years with an aim of embedding personalised care and support planning for people with long-term conditions	✓	No payment		No payment		No payment		£137,180	**£137,180**
PHE1	**Breast Screening Programme Clerical Staff Development (Health Promotion role)** Update and improve the clerical teams knowledge of health promotion to support clients who access The Breast Screening Unit and key partners involved in the Breast Screening Programme	✓	£3,742.50		£3,742.50		£3,742.50		£3,742.50	**£14,969**
PHE2	**Cancer Screening Programme – reducing professional stress and building resilience** Holistic mapping review of health & wellbeing services and support available to staff within the bowel and breast screening programmes for the management of professional stress and building resilience	✓	£5,822		£5,822		£5,822		£5,822	**£23,288**
SP 1	**Nationally Standardised Dose Banding for Adult Intravenous Systemic Anticancer Therapy (SACT) 38** A tool kit has been developed to support CQUIN. Targets will be set for each of the SACT drugs.	✓	£10,292		£10,292		£10,292		£10,292	**£41,167**
SP 2	**Hospital Pharmacy Transformation and Medicines Optimisation**	✓	£15,437		£15,437		£15,437		£15,437	**£61,749**

Description	Aggregate Position	Trend
Safety Thermometer - Harm Free Care.	In August 2018, 98% of patients received harm free care as measured by the point prevalence 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/DN caseload assisted by the Senior Nursing Teams. This is applicable to inpatient areas and district nursing caseloads only. The target is for >95% of patients to receive harm free care as monitored by the Safety Thermometer. The Patient Safety Thermometer process is currently under review nationally.	

	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
MCHFT	98%	97%	97%	98%	98%	97%	99%	97%	97%	96%	97%	98%
National	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

Board Papers – Quality, Safety & Experience Section: August 2018

Ward Name	Main Specialties	Safety Thermometer Results August 2018			
		Acquired Pressure Ulcers	Patient Falls resulting in harm	CAUTI	New VTE
MCHFT		**0.24% (2)**	**0.83% (7)**	**0.12% (1)**	**0% (0)**
AMU	Gen. Medicine	0% (0)	0% (0)	0% (0)	0% (0)
CAU	Paediatrics	0% (0)	0% (0)	0% (0)	0% (0)
Critical Care	Gen. Medicine	0% (0)	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)
SAU	Gen. Surgery	0% (0)	3.45% (1)	0% (0)	0% (0)
SSW	Gen. Surgery & Urology	0% (0)	0% (0)	0% (0)	0% (0)
Ward 15	Gen. Surgery & Gynae	0% (0)	3.7% (1)	0% (0)	0% (0)
Ward 13	Gen. Surgery	0% (0)	0% (0)	0% (0)	0% (0)
Ward 14	Gen. Medicine	0% (0)	0% (0)	0% (0)	0% (0)
Ward 10	Trauma & Ortho	0% (0)	0% (0)	0% (0)	0% (0)
Ward 2	Gen. Medicine	0% (0)	0% (0)	0% (0)	0% (0)
Ward 21B	Rehab	0% (0)	4.17% (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)	3.12% (1)	0% (0)	0% (0)
Ward 9	Trauma & Ortho	0% (0)	0% (0)	0% (0)	0% (0)
NICU	Paediatrics	0% (0)	0% (0)	0% (0)	0% (0)
DN – Alsager	District Nursing	0% (0)	0% (0)	0% (0)	0% (0)
DN – Ashfields and Haslington	District Nursing	0% (0)	0% (0)	2.7% (1)	0% (0)
DN – Dane Bridge	District Nursing	0% (0)	0% (0)	0% (0)	0% (0)
DN – Eagle Bridge	District Nursing	0% (0)	2.0% (1)	0% (0)	0% (0)
DN – Firdale	District Nursing	0% (0)	0% (0)	0% (0)	0% (0)
DN – Middlewich	District Nursing	0% (0)	3.45 (1)	0% (0)	0% (0)
DN - Church View	District Nursing	0% (0)	2.63% (1)	0% (0)	0% (0)
DN – Winsford	District Nursing	2.94% (1)	0% (0)	0% (0)	0% (0)
DN OOH	District Nursing	0% (0)	0% (0)	0% (0)	0% (0)
AMU	Gen. Medicine	0% (0)	0% (0)	0% (0)	0% (0)

Board Papers – Quality, Safety & Experience Section: August 2018

Description	Aggregate Position		Trend
Registered Nurses monthly expected hours by shift versus actual monthly hours per shift. Day time shifts only	90.4% 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 August 2018 90.4% July 2018 90.3% June 2018 88.9%	The lowest staffing levels during the day were on Ward 4 at 76.6%
Registered Nurses monthly expected hours by shift versus actual monthly hours per shift. Night time shifts only	96.8% of expected Registered Nurse hours were achieved for night shifts.	Trend August 2018 96.8% July 2018 94.8% June 2018 99.3%	The lowest staffing levels during the night were on Ward 12 at 73.1%
Healthcare Assistant monthly expected hours by shift versus actual monthly hours per shift. Day time shifts only	98.6% of expected HCA hours were achieved for day shifts.	Trend August 2018 98.6% July 2018 99.3% June 2018 95.1%	The lowest staffing levels during the day were on Ward 9 at 51.6%
Healthcare Assistant monthly expected hours by shift versus actual monthly hours per shift. Night time shifts only	101.5% 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 August 2018 101.5% July 2018 116.9% June 2018 101.8%	The lowest staffing levels during the night were on Ward 9 at 35.5%
Total number of wards that are lower than 85% RN fill days and nights is 7.	Ward 10 – 84.1% (day), Ward 12 – 80.4% (day), Ward 21b 82% (day), Ward 4 – 76.6% (day), Ward 5 – 79.6% (day), Ward 9 – 79.4% (day), Ward 12 – 73.1% (night), Ward 5 – 73.4% (night), Ward 6 – 79.8% (night).	• Actions taken: Staffing reviewed on daily basis by Matrons/HoN following Escalation process • Risk assessments taken place to review bed occupancy and patient acuity before transferring staff	

Board Papers – Quality, Safety & Experience Section: August 2018

Ward Name	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				
MCHFT	40968.4	37132.6	29885.4	29630.7	24929.1	23654.0	16707.8	18983.0	90.4%	98.6%	96.8%	101.5%	15236	134.5	66.0	200.5
AMU	2011.3	1748.3	1519	1476.3	1898.8	1666	1519	1519	86.9%	97.2%	87.7%	100.0%	841	4.1	3.6	7.6
CAU (Winter)	1569.5	1569.5	744	744	1345.5	1345.5	368	368	100.0%	100.0%	100.0%	100.0%	292	10.0	3.8	13.8
Critical Care	3905	3905	575	575	2413	2413	0	0	100.0%	100.0%	100.0%	-	217	29.1	2.6	31.8
Elmhurst	871.5	871.5	2232	2202	775	775	1550	1912.5	100.0%	98.7%	100.0%	123.4%	907	1.8	4.5	6.4
Ward 1	2193.8	2100	1162.5	1068.8	1519	1494.5	759.5	747.3	95.7%	91.9%	98.4%	98.4%	960	3.7	1.9	5.6
Ward 12	2243	1803	1984	2168	953.3	697	635.5	1035.3	80.4%	109.3%	73.1%	162.9%	920	2.7	3.5	6.2
Ward 13	2288	1992	1984	1928	953.3	820	635.5	645.8	87.1%	97.2%	86.0%	101.6%	930	3.0	2.8	5.8
Ward 14	1716	1488	1488	1428	744	744	1116	1236	86.7%	96.0%	100.0%	110.8%	968	2.3	2.8	5.1
Ward 2	1806.3	1587.5	1550	1468.8	759.5	857.5	1139.3	1212.8	87.9%	94.8%	112.9%	106.5%	941	2.6	2.8	5.4
Ward 21b	1336.5	1096	1813.5	1859	775	775	775	862.5	82.0%	102.5%	100.0%	111.3%	744	2.5	3.7	6.2
Ward 23	1238	1212.7	785.3	722	764.7	764.7	764.7	752.3	98.0%	91.9%	100.0%	98.4%	693	2.9	2.1	5.0
Ward 26	3406.3	3406.3	658.7	658.7	2775	2775	370	370	100.0%	100.0%	100.0%	100.0%	217	28.5	4.7	33.2
Ward 4	1716	1314	1860	1752	744	732	1488	1488	76.6%	94.2%	98.4%	100.0%	986	2.1	3.3	5.4
Ward 5	2325	1850	1550	1525	1519	1114.8	759.5	1139.3	79.6%	98.4%	73.4%	150.0%	965	3.1	2.8	5.8
Ward 6	1937.5	1737.5	1937.5	2056.3	1519	1212.8	759.5	1261.8	89.7%	106.1%	79.8%	166.1%	843	3.5	3.9	7.4
Ward 7	1758.8	1527.5	1550	1781.3	759.5	759.5	1139.3	1433.3	86.8%	114.9%	100.0%	125.8%	981	2.3	3.3	5.6
Ward 9	1206	958	992	512	635.5	615	317.8	112.8	79.4%	51.6%	96.8%	35.5%	219	7.2	2.9	10.0
NICU	1924.6	1793.3	183.4	184	1782.5	1610	0	0	93.2%	100.3%	90.3%	-	264	12.9	0.7	13.6
Ward 11 SAU	1500	1725	930	1237.5	580.7	814.9	580.7	796.2	115.0%	133.1%	140.3%	137.1%	589	4.3	3.5	7.8
Ward 18 SSW	1351.3	1207.5	1162.5	1100	759.5	735	759.5	747.3	89.4%	94.6%	96.8%	98.4%	627	3.1	2.9	6.0
Ward 10 Ortho	2664	2240	3224	3184	953.3	932.8	1271	1342.8	84.1%	98.8%	97.8%	105.6%	1132	2.8	4.0	6.8

Experience Section:

Indicators	Last four months			
	May-18	Jun-18	Jul-18	Aug-18
Complaints received by month	21	9	10	21
Complaints being reviewed by the Ombudsman	0	0	0	0
Closed complaints by month	14	38	14	18
Contacts raising informal concerns	100	106	120	96
Compliments received in month	326	400	257	330
Number of new claims received in month	4	1	7	5
Number of claims closed	4	0	2	6
Number of inquests concluded	0	0	1	0
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	7	9	6	10
F&FT Response Rate ED, MIU, UCC and Assessment Areas*	26%	26%	25%	25%
Proportion of positive responses ED, MIU, UCC and Assessment Areas	85%	82%	83%	85%
F&FT Response Rate Inpatients and day cases	12%	28%	34%	46%
Proportion of positive responses Inpatients and day cases	98%	96%	97%	96%
F&FT Response Rate Outpatients	5%	4%	4%	4%
Proportion of positive responses Outpatients	96%	96%	96%	96%
F&FT Response Rate Maternity - Birth	2%	5%	18%	11%
Proportion of positive responses Maternity - Birth	100%	100%	100%	100%
F&FT Response Rate Community (CCICP)	23%	21%	19%	22%
Proportion of positive responses Community (CCICP)	89%	91%	93%	92%

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

Description	Aggregate Position/Description	Trend

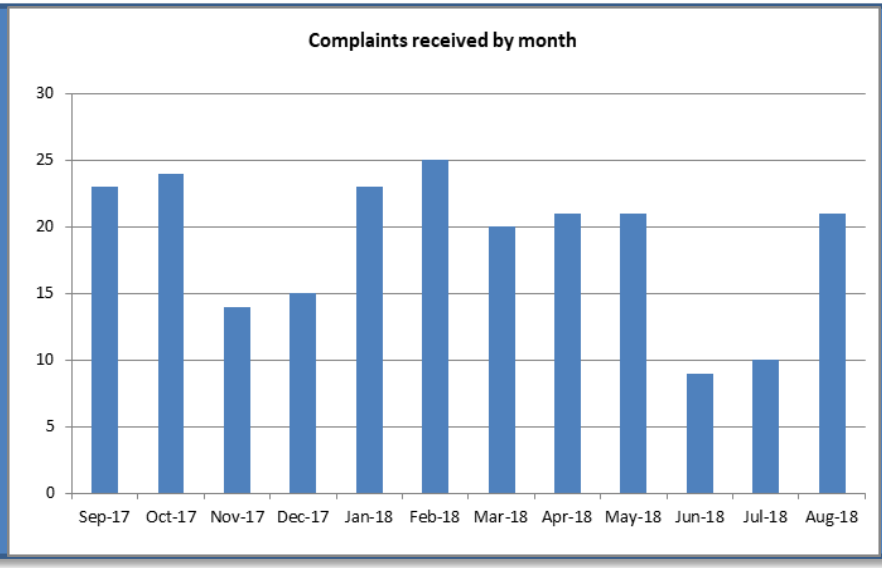
Monthly complaints received by the Trust.

21 complaints were received in August 2018 which covered 109 concerns. The highest categories were:

- Attitude of Staff
- Communication - with patients
- Medical Care - adverse outcome and diagnosis problems

The areas receiving the highest number of complaints/issues were:

- Emergency Department with 7 complaints /12 issues
- General Surgery with 3 complaints / 12 issues
- Orthopaedics with 4 complaints / 10 issues



Formal Complaints

Number of formal complaint issues by division.

This graph shows the breakdown of issues by month for e ach division.

S&C: 59

DCSS: 7

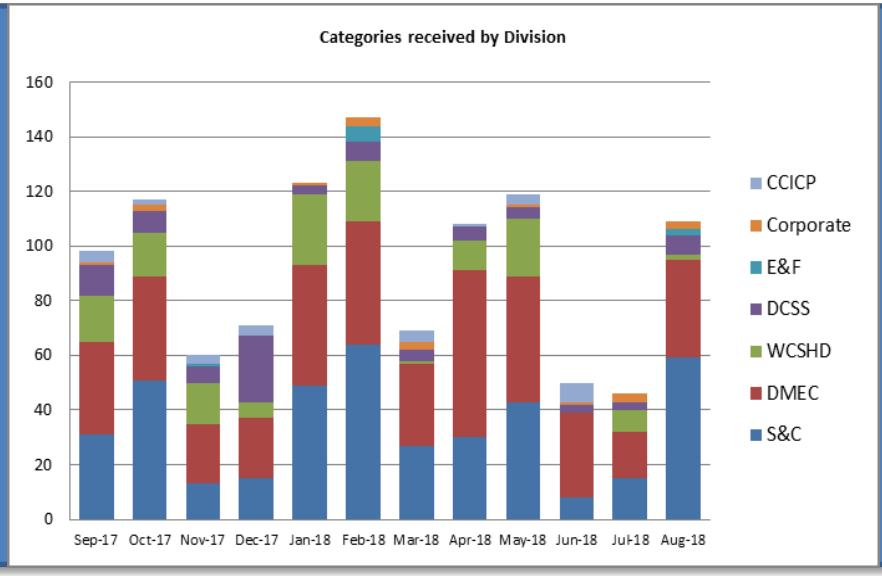
W&CD: 2

DMEC: 36

CCICP: 0

E&F: 2

Corporate Services: 3



Formal Complaint issues by division

Board Papers – Quality, Safety & Experience Section: August 2018

Description	Aggregate Position/Description	Trend

Complaints being reviewed by the Public Health Service Ombudsman

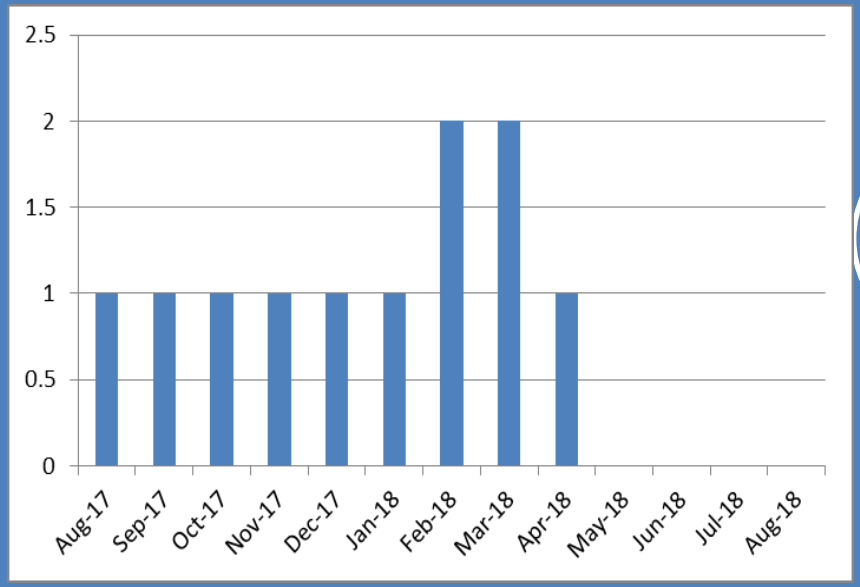
In August 2018, there were no new complaints and 4 complaints which remain active with the PHSO. In addition there is 1 complaint which has been closed in June, with the Trust waiting for written confirmation from the PHSO.

1 has been active since 2012/2013 and is undergoing a review external to the PHSO

1 case agreed for investigation in February 2018. All information has been shared with the PHSO. The concern was with regard to care leading up to the patient's death.

1 case relating to treatment required following caesarean section which resulted in critical care stay. Opened 23/03/18, all information sent to PHSO and the case is at assessment stage.

1 case relating to concerns with the referral for vascular review and nursing issues. Opened 14/04/2018 and the case is at assessment stage.



Ombudsman

Complaint trends and number of issues.

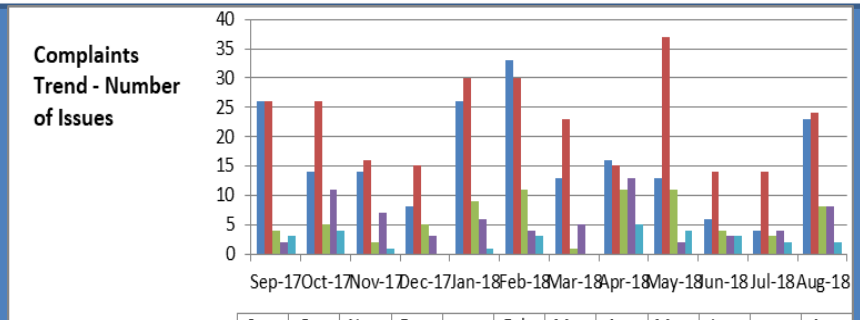
The main trends in August 2018 were:

Communication with 12 complaints raising 24 issues

Nursing Care with 8 complaints raising 23 issues.

Medical adverse outcome with 8 complaints raising 8 issues

Medical diagnosis issues with 8 complaints raising 8 issues



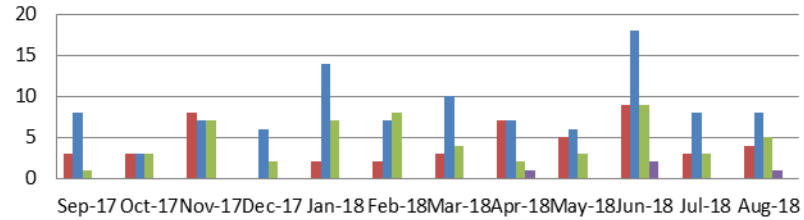
	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Nursing Care	26	14	14	8	26	33	13	16	13	6	4	23
Communication	26	26	16	15	30	30	23	15	37	14	14	24
Medical adverse outcome	4	5	2	5	9	11	1	11	11	4	3	8
Medical diagnosis issues	2	11	7	3	6	4	5	13	2	3	4	8
Medical delay in review	3	4	1	0	1	3	0	5	4	3	2	2

Complaint Trends

Description	Aggregate Position/Description	Trend

Closed Complaints

18 complaints were closed in August 2018.



	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Upheld	3	3	8	0	2	2	3	7	5	9	3	4
Partially Upheld	8	3	7	6	14	7	10	7	6	18	8	8
Not upheld	1	3	7	2	7	8	4	2	3	9	3	5
Withdrawn	0	0	0	0	0	0	0	1	0	2	0	1
Referred to HR	0	0	0	0	0	0	0	0	0	0	0	0

Closed Complaints

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
DMEC	4	2	1	1	0	8
Corporate	0	1	0	0	0	1
Surgery and Cancer	0	3	3	0	0	6
Women & Children's	0	1	1	0	0	2
DCSS	0	1	0	0	0	1
CCICP	0	0	0	0	0	0
Totals:	**4**	**8**	**5**	**1**	**0**	**18**

Complaints closed by division for August 2018

TABLES REMOVED UNDER SECTION 40 OF THE FREEDOM OF INFORMATION ACT.

Description	Aggregate Position/Description	Trend

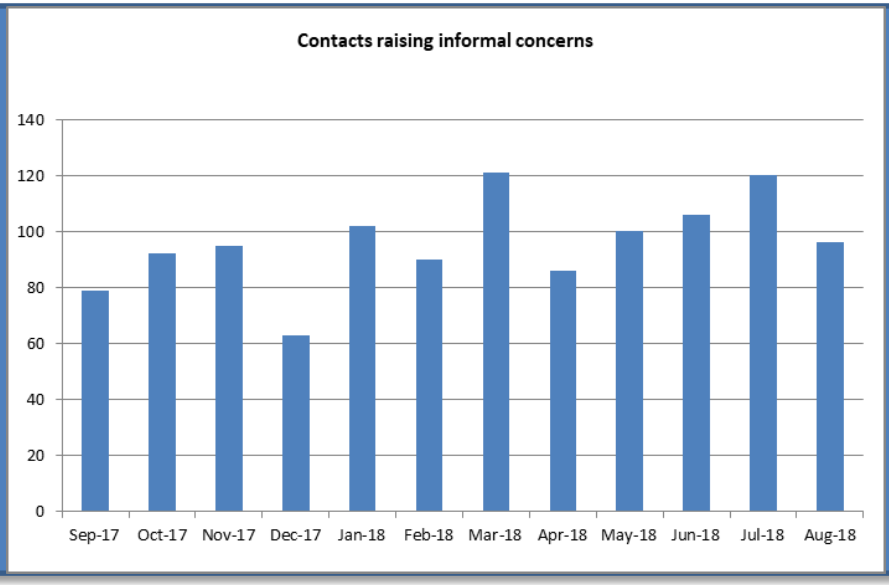
Informal Concerns Numbers.

The number of contacts raising informal concerns for August 2018 is 96 which is 24 less than the previous month. The 96 contacts raised 151 individual concerns

The Divisions of Medicine and Emergency Care and Surgery and Cancer received the largest number of individual concerns raised at 55 and 53 respectively.

Of the 55 concerns raised for the Division of Medicine and Emergency Care, 18 relate to the Emergency Department and 14 to Cardiology.

Of the 53 concerns raised for Surgery and Cancer, 23 relate to General Surgery.



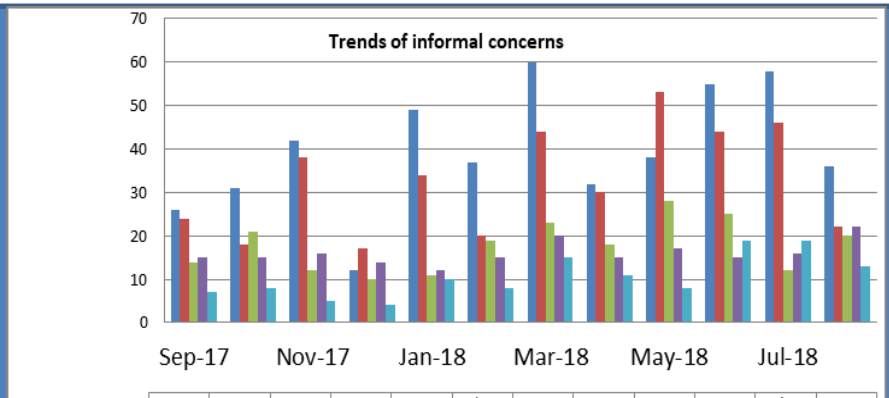
Informal Concerns Feedback

Informal Concerns Trends.

Communication was the highest trend for informal concerns in August 2018, with 13 issues for the Division of Medicine and Emergency Care and 12 for Surgery and Cancer Division. Of these, 4 of the issues raised relate to Medical Records, 3 relate to ward 7 and ward 18 respectively and 3 relate to the eye care centre.

Of the 22 issues relating to care, 6 were relating to care of the elderly specifically. 16 related to the Division of Surgery and Cancer with 5 of the 16 pertaining to Ward 15.

Of the 22 issues relating to attitude of staff, 5 are attributed to the Emergency Department.



	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Communication	26	31	42	12	49	37	60	32	38	55	58	36
Care	24	18	38	17	34	20	44	30	53	44	46	22
Appointments	14	21	12	10	11	19	23	18	28	25	12	20
Attitude of Staff	15	15	16	14	12	15	20	15	17	15	16	22
Treatment	7	8	5	4	10	8	15	11	8	19	19	13

Informal Concerns Trends

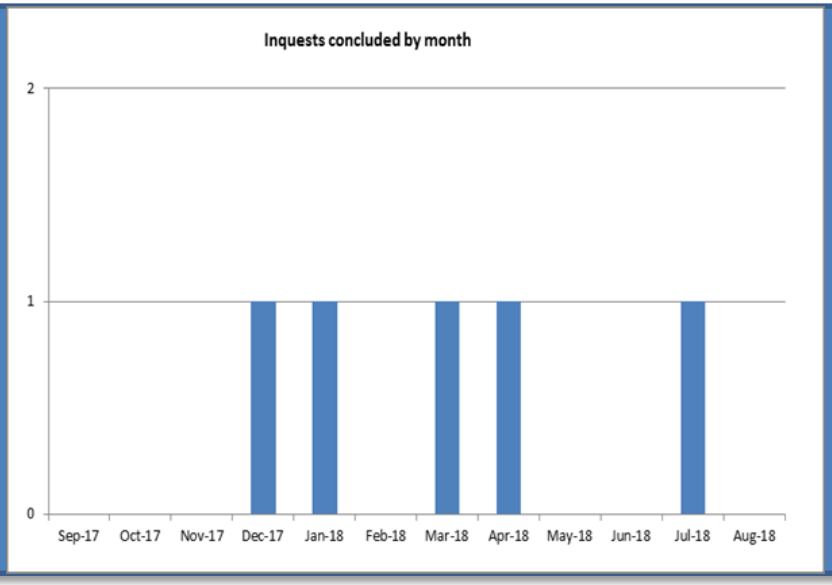
Description	Aggregate Position/Description	Trend
New claims received.	Narrative and Chart removed under Section 43 of the Freedom of Information Act.	Claims
Claims closed with/without damages.	Narrative and Chart removed under Section 43 of the Freedom of Information Act.	Closed Claims

Description	Aggregate Position/Description	Trend
Value of claims closed by month	Narrative and Chart removed under Section 43 of the Freedom of Information Act.	
Top five claims by Specialty	Narrative and Chart removed under Section 43 of the Freedom of Information Act.	

Description	Aggregate Position /Description	Trend

Number of Inquests concluded by month

No inquests were concluded in August 2018



Inquests

NHS Choices Star Ratings

Leighton Hospital is rated at 4.5 stars.

Victoria Infirmary, Northwich is rated at 5 stars.

The above ratings are based on 225 postings received to date.

NHS Choices – Star Ratings

Board Papers – Quality, Safety & Experience Section: August 2018

Description	Aggregate Position /description	Trend

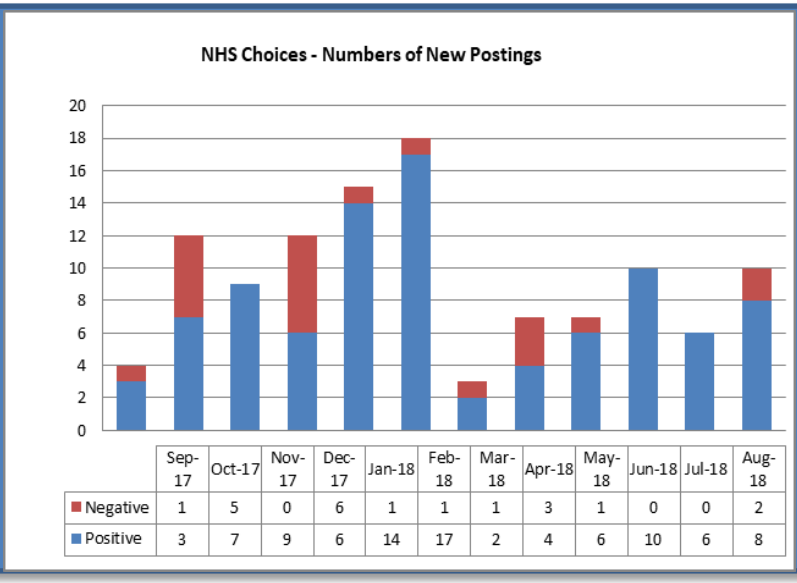
NHS Choices postings

There were 10 postings on NHS Choices in August 2018 of which 2 were negative and 8 were positive. Examples of feedback included:
My 2 year old son was seen very swiftly on an extremely busy day. All the staff we encountered were extremely helpful and courteous, their professionalism and care was much appreciated (ED)

The staff listened to what both my elderly and disabled mother and I were saying, she was treated with gentleness and professionalism (ED)

Having just encountered a 4 night stay on ward 19 with my 5 year old daughter, I have nothing but praise and thanks for the wonderful staff on the ward. Although very busy at times, nothing was too much trouble for any member of staff (CAU)

I was seen within 6 days (this included a bank holiday) which was excellent. I can only say that the Consultant exceeded my expectations, her professionalism, manner, knowledge and confidence was the best. (ENT)



	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Negative	1	5	0	6	1	1	1	3	1	0	0	2
Positive	3	7	9	6	14	17	2	4	6	10	6	8

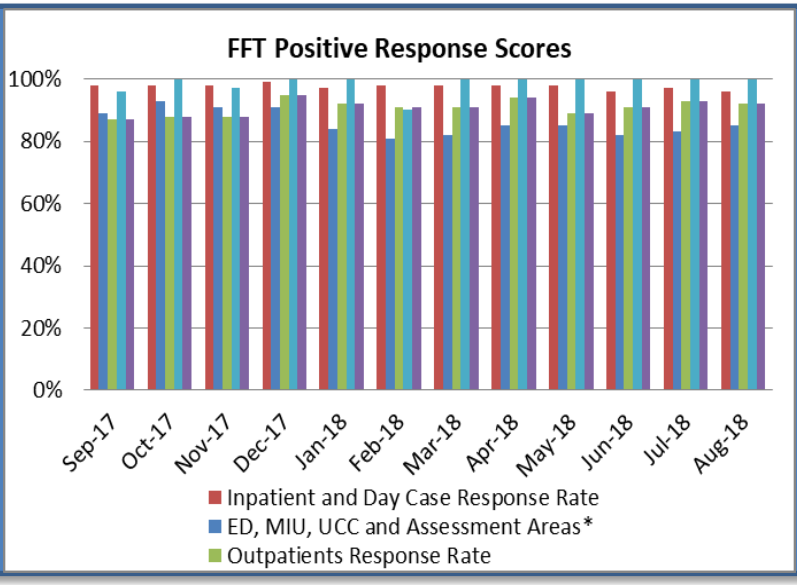
NHS Choices – Postings

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 August 2018 the Trust has scored the following positive response scores:

Inpatients and day cases	96%
Emergency care /Assessment areas	85%
Outpatients	96%
Maternity	99%
CCICP	92%

4782 responses were received and 92% of those patients would recommend our hospital services.



Family & Friends Test

Description | **Aggregate Position /description** | **Trend**

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

August 2018 Ward/Dept.	% Response	Total responses received	How many would recommend
A&E , UCC & MIU	25%	1618	85%
Inpatients & Day cases	49%	1827	96%
Maternity	11%	70	99%
Outpatients	4%	1005	96%
CCICP	22%	262	92%

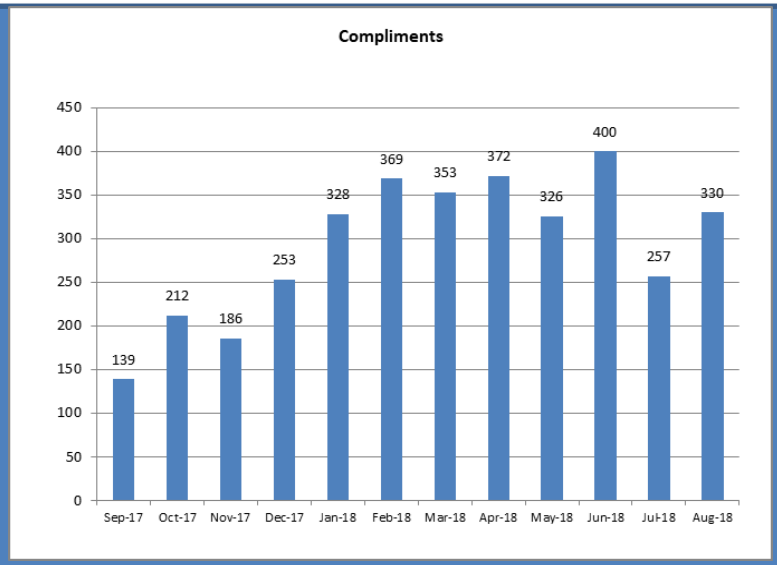
Family & Friends Test

Compliments received

There were 330 compliments/thankyou's received in August 2018. 117 of these were logged by the Customer Care Team and 213 received across the Trust.

'My daughter was admitted to A&E with a suspected miscarriage and the doctors and staff were very caring and helpful. She was later transferred to Ward 12 and again the staff and doctors were very caring in what was a very traumatic experience. Thank you.'

'I am writing to express my thanks for the faultless care I had through my pregnancy and labour at Leighton hospital in May. My community midwife was always available to contact whenever I needed her and I was never made to feel like all my questions were stupid. I felt reassured throughout my pregnancy with her, as well as in the post-natal period.'



Compliments Compliments

Title of Paper:	Nursing and Midwifery Comprehensive Staffing Report	
Author:	Julie Tunney – Director of Nursing & Quality	
Executive Lead:	Julie Tunney - Director of Nursing & Quality	
Type of Report:	Concept Paper	
	Strategic Options Paper	
	Business Case	
	Information	✓
	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	✓	Caring	✓
Aspiring to Excellence in Practice Through Our Workforce	✓	Responsive	✓
Creating a 21st Century Infrastructure for Transformative Health and Social Care		Well-Led	✓

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

Positive Benefit:	Assurance of safe staffing levels across Nursing and Midwifery
Risk:	-

To be published on Trust Website –complete version	**Y**
If no, to be published on Trust Website – redacted	**n/a**
If not to be published complete or redacted, please detail the reason why	
Presented at Board Meeting of:	**1 October 2018**

1. Introduction

This paper provides the required assurance that Mid Cheshire Hospital Foundation Trust (MCHFT) plans safe nursing, midwifery and care staffing levels across all in-patient ward areas and that there are appropriate systems in place to manage the demand for nursing, midwifery and care staffing.

In order to provide transparency, the paper provides detail of the strategic staffing reviews undertaken in line with the National Quality Boards (NQB) requirements (2013 & 2016) to review nursing and midwifery staffing as a quality and performance measure and details the biannual patient acuity data from January and June 2018.

The NQB expectations set out in their guide to nursing midwifery and care staffing capacity and capability (2016) that boards take full responsibility for the quality and care provided to patients and as a key determinant of quality take full and collective responsibility for nursing midwifery and care staffing capability and capacity. As part of the Trust's standard requirements of the NHS contract, workforce reviews must be undertaken bi-annually and the results and recommendations taken through the public Trust Board.

In addition to this, MCHFT Trust Board reviews safe staffing levels every month via the Patient Quality, Safety and Experience Report, which includes monthly fill rates for registered and unregistered staff, Care Hours per Patient Day (CHPPD) and actions taken to address shortfalls.

2. Background

In 2013 the NQB set safe staffing guidance, in which there is a framework of ten expectations that organisations and staff should use to make decisions about staffing that puts patients first. Expectation seven relates to monthly staffing data checks, biannual reviews and annual reporting.

In 2016 the NQB built on this guidance and provided an updated safe staffing resource that is underpinned by three principles -

- Right care
- Minimising avoidable harm
- Maximising the value of available resource

This revised resource explains that the key to high quality care for all is held within the ability to deliver services that are well led and sustainable. It describes as set out in the Five Year Forward View (2014) that it is vital that we have a single shared goal to maintain and improve quality to improve health outcome and to do this within the financial resources entrusted to MCHFT.

This revised resource outlines that staffing reviews are required to be based on numbers of staff and skill mix within establishments, levels of patient harm and hours of staff available each shift, this information is all contained within the CHPPD.

To cover each of these three principles a template was used for each ward and clinical area for the staffing reviews that took into account the detailed requirements of the NQB guidance and was used to provide a 360 degree review. Between February and July 2018, **10 separate 3 hour reviews** took place with the Divisional Head of Nursing and Matrons for each area presenting their ward information. The reviews were led by the Director of Nursing & Quality and the Deputy Director of Nursing & Quality.

In line with the NQB (2016) recommendations, the template used took account of the following factors for the period of assessment:

- *Bed occupancy rates*
- *Total budgeted establishment*
- *WTE based on January and June 2018 acuity and dependency*
- *Ward based Registered Nurses*
- *Ward based Health Care Assistants*
- *Skill mix*
- *WTE per bed*
- *Registered Nurse ratio per bed Mon-Fri*
- *Registered Nurse ratio per bed Sat/Sun*
- *Registered Nurse ratio per bed nights*
- *Allied Health Professionals*
- *Pressure ulcers*
- *Falls*
- *Medication incidents*
- *Complaints*
- *Friends and Family scores*
- *Ward attenders*

3. Methodology

In 2001 the Audit Commission recommended that establishment setting, regardless of the method, must be simple, transparent, integrated, benchmarked and linked to ward outcomes.

NICE Guidance in July 2014 (NICE Guidance: Safe Staffing for nurses in adult in-patient wards SG1) described that there is no single nursing staff-to-patient ratio that can be applied across the whole range of wards to safely meet patients' nursing needs. Each ward has to determine its nursing staff requirements to ensure safe patient care.

The guideline made recommendations about the factors that should be systematically assessed at ward level to determine the nursing staff establishment. It recommends on-the-day assessments of nursing staff requirements to ensure that the nursing needs of individual patients are met throughout a 24-hour period.

Further guidance published by the Shelford Group of Hospitals the Safer Nursing Care Tool (SNCT) (2015) described an evidence based tool that enables nurses to assess patient acuity and dependency, incorporating a staffing multiplier to ensure that nursing establishments reflect patient needs in acuity/dependency terms. At MCHFT we have utilised this model since 2007 when it was then named the Association of UK University Hospitals (AUKUH) Tool. The tool measures patient dependency and is then supported by the professional judgement of the ward leader. The Trust was an early adopter of this tool and our preference for using this tool was and remains in recognition of its' sensitivity and ability to provide information based on actual patient needs as opposed to averages and bed ratios and that this information could be aligned to Patient Safety and Experience data.

In addition, each ward establishment meets the need to have built within it uplifts that enable the compliment of staff to absorb annual leave, short term sickness and study leave without the need

to use temporary staff. The Trust's ward budgets are uplifted by 23%- 25% to support training, annual leave and sickness.

The SNCT was used for adult areas, whereas other tools were used for paediatrics and maternity. The tools used are described in the sections below;

3.1 Adults

The results of the acuity data undertaken in January and June 2018 have been examined and triangulated as previously described using the SNCT. The SNCT is an evidenced based tool that enables nurse to assess acuity and dependency incorporating a staffing multiplier to ensure that nursing establishments reflect patients' needs in acuity/dependency terms. The tool is used in conjunction with nurse sensitive indicators such as patient falls and pressure ulcers as indicated in section 2. In addition to this the tool can also be used to benchmark across other trusts.

Within the SNCT the level of care is then equated to the required number (WTE, whole time equivalent) of staff at the time. This can then be calculated to provide a final staffing requirement for each ward as follows:

Level of care	WTE
0	0.99
1a	1.39
1b	1.72
2	1.97

3.2 Paediatrics

3.2.1 Children's in patient ward -The System to Escalate and Monitor (STEAM) is a paediatric approved tool designed to measure the clinical intensity of patients on a paediatric ward. The tool is completed electronically every four hours. Once the tool is completed it provides the following staffing assessments;

- Positive staffing: where there was a higher staff to patient ratio based on the acuity of the patient
- Negative staffing: where there was lower staff to patient ratio based on the acuity of the patient

3.2.2 Neonatal Intensive Care Unit (NICU)- Acuity on the NICU is measured using the STEAM tool against BAPM (British Association of Perinatal Medicine) Standards and recorded on the Badgernet system. This tool shows the neonatal nursing numbers against actual cot occupancy figures and the level of dependency of the neonate. The data is inputted twice daily highlighting both day and night staffing numbers.

3.3 Maternity

The Birthrate Plus (BR+) intrapartum acuity tool has been used at MCHFT for several years. It is based on an understanding of the total midwifery time required to care for women based on a minimum standard of providing one-to-one midwifery care throughout established labour.

The principles underpinning the BR+ methodology are consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings, and have been endorsed by the Royal College of Midwives (RCM) and the Royal College of Obstetricians and Gynaecologists (RCOG).

BR+ measures the workload for midwives arising from the needs of women, from admission to the labour ward.

4. Acuity results by division

4.1 Medicine and Emergency Care Division

Table 1 shows the funded establishment, staffing needs and the Registered Nurse ratio for the wards in the division of medicine and emergency care between January 2018 and June 2018.

Table 1 Medicine & Emergency Care Division Acuity Data

	Funded Establishment (WTE staff providing clinical care)	Safer Nursing Care Tool (WTE) Acuity assessment	Difference Acuity / Funded Establishment staff providing clinical care	Registered nurse ratio (day)
June 2018	341.99	354.15	-12.16	1:6-1:8
January 2018	341.00	362.63	-21.63	1:6-1:8
June 2017	287.92	300.37	-12.45	1:6-1:8
January 2017	320.57	341.64	-21.07	1:6-1:8

The results of the reviews highlighted that there was a total of 6 wards identified as having an increase in acuity and dependency with a similar variance to the reviews undertaken in 2017.

The figures above do not include the Emergency Department or Critical Care. However, these areas have undergone a full Strategic Staffing Review and it was noted that neither departments had in place a supernumerary Registered Nurse Shift Coordinator as recommended by the Care Quality Commission (CQC) and Cheshire & Merseyside Critical Care Network and Royal College of Nursing Standards (2003).

Actions to be progressed within the division are included within section five of this report.

4.2. Surgery & Cancer Division

Table 2 shows the funded establishment, staffing needs and the Registered Nurse ratio for the wards in the division of surgery and cancer between January 2018 and June 2018.

Table 2 – Surgery & Cancer Division Acuity Data

	Funded Establishment (WTE staff providing clinical care)	Safer Nursing Care Tool assessment (WTE) Acuity	Difference Acuity / Funded Establishment staff providing clinical care	Registered nurse ratio (day)
June 2018	237.15	257.46	-20.31	1:8 Mon – Fri 1:9 -1:10 Sat & Sun
January 2018	234.97	277.69	-42.72 (12 escalation beds)	1:8 Mon – Fri 1:9 -1:10 Sat & Sun
June 2017	210	216.74	-6.74	11:8 Mon – Fri 1:9 -1:10 Sat & Sun
January 2017	210	231.12	-21.12	1:8 Mon – Fri 1:9 -1:10 Sat & Sun

The acuity data collected in January 2018 to June 2018 shows a deficit in staffing relating to acuity and dependency overall. In total there are 5 wards that were highlighted with a higher variance than the reviews undertaken in 2017. It is important to note that from January 2018 and onwards there have been up to an additional twelve beds open on SACU and there have been between 15 and 27 medical outliers in Surgical beds. The data post June 2018 outlines that this has risen over the summer months. This has had an impact on the acuity on the Surgical wards.

Actions related to be progressed within the division are included within section five of this report.

4.3 Diagnostic and Clinical Support Services Division

Table 3 shows the funded establishment, staffing needs and the Registered Nurse ratio for the ward in the division of diagnostic and clinical support services in January 2018 and June 2018.

Table 3 – Diagnostic and Clinical Support Services Division Acuity Data

	Funded Establishment (WTE staff providing clinical care)	Safer Nursing Care Tool assessment (WTE) Acuity	Difference Acuity / Funded Establishment staff providing clinical care	Registered nurse ratio (day)
June 2018	80.61	81.52	-0.91	1:8
January 2018	78.96	81.52	-2.56	1:8
June 2017	32.05	34.61	-2.56	1:8
January 2017	32.05	34.61	-2.56	1:8

Both ward 21b and Elmhurst Intermediate Care Centre have been included in this review.

There results of the review highlighted that ward 21b was identified as having an increase in acuity and dependency, however, with a lower variance to the reviews undertaken in 2017. This gap has closed slightly due to the development of the Pharmacy Technician role. The ward is, however, seeing a changing cohort of patients with an increase in length of stay whilst patient wait for packages of care. Whilst such patients have low acuity in terms of medical needs there are often significant care needs to ensure that patient safety is maintained.

4.4 Women & Children's Division

4.4.1 Paediatric Acuity

Table 4 shows the funded establishment, percentage of shifts filled and the Registered Nurse ratio for the Children's in patient area in the division of Women's and Children's services in January 2018 and June 2018.

Table 4 – Paediatric Acuity Data

	Funded Establishment (WTE staff providing clinical care)	**% of shifts filled described as negative, adequate or positive by STEAM tool**	**Registered nurse ratio (day and night)**
June 2018	45.93	75% of shifts positively staffed 25% of shifts negatively staffed	1:3 for under 2 years of age 1:4 for 2 years of age and over
January 2018	42.66	43% of shifts positively staffed 57% of shifts negatively staffed	1:3 for under 2 years of age 1:4 for 2 years of age and over
June 2017	44.40	87% of shifts positively staffed 13% of shifts negatively staffed	1:3 for under 2 years of age 1:4 for 2 years of age and over
January 2017	46.53	70% % of shifts negatively staffed 30% of shifts positively staffed	1:3 for under 2 years of age 1:4 for 2 years of age and over

The acuity and dependency on the Children's inpatient area varies significantly throughout the year and there is no pattern to assist with prediction of acuity, as outlined above in the 2018 reviews. The division reviews this data every 4 hours and alters the staffing requirements accordingly. They also present a quarterly staffing report to its Divisional Board and Paediatric Governance Group. The paediatric inpatient ward although not positively staffed on all occasions was deemed to be safe using the skill mix of staff available at the time.

The division plan to triangulate the data from STEAM with the RCN defining staffing levels for Children and Young People's services (2013).

4.4.2 Maternity

The Birth Rate Plus (BR+) Intrapartum Acuity Tool provides an objective assessment of the complexity and risk of women during intrapartum care, in order to calculate the number of midwives required to achieve the agreed staffing standard of one midwife to one woman during labour and delivery.

Labour Ward calculate the acuity for the High Risk (HR Acuity) area alone and for the Labour Ward Suite (Escalation Acuity) every 2 hrs, using the escalation guideline to manage risk in real time.

High Risk Acuity (Includes High risk labour rooms, theatre, Induction of Labour suite and Triage)

Escalation Acuity - Includes all above and Midwifery Led Unit

The aim is to pro-actively manage the workload and staffing to achieve a positive acuity, which equals a safe standard of care.

Table 5 – Midwifery Acuity Data

Date	Acuity Results
June 2018	Midwifery staffing less than acuity 5% Midwifery staffing meets acuity 95%
January 2018	Staffing less than acuity 4% Staffing meets acuity 96%
June 2017	Staffing less than acuity 6% Staffing meets acuity 94%
January 2017	Staffing less than acuity 6% Staffing meets acuity 94%

By proactively managing the workload these figures show that adequate measures were put in place to maintain safe staffing on the labour ward areas for both low and high risk women.

4.4.3 Neonatal Intensive Care Unit (NICU)

Table 6 shows the funded establishment, percentage of shifts filled and the Registered Nurse ratio for NICU in the division of Women's and Children's services in January 2018 and June 2018.

Table 6 – NICU Acuity Data

	Funded Establishment (WTE staff providing clinical care)	**% of shifts filled described as negative, adequate or positive by STEAM tool**
June 2018	32.41	• 30% of shifts adequately staffed • 55% of shifts negatively staffed • 15% of shifts positively staffed
January 2018	32.53	• 16% of shifts adequately staffed • 7% of shifts negatively staffed • 77% of shifts positively staffed
June 2017	33.06	• 83% of shifts adequately staffed • 13% of shifts positively staffed • 6% of shifts negatively staffed
January 2017	34.05	• 36% of shifts adequately staffed • 12% of shifts positively staffed • 32% of shifts negatively staffed

The acuity and dependency on NICU varies significantly throughout the year and there is no pattern to assist with prediction of acuity, as outlined above in 2018 reviews. The division reviews this data every 12 hours and alters the staffing requirements accordingly. They also present a quarterly staffing report to its Divisional Board and Paediatric Governance Group. Although NICU was not positively staffed on all occasions it was deemed to be safe using the skill mix of staff available at the time.

5. Strategic Staffing Reviews – agreed actions

The nursing actions and investments following the strategic staffing and establishment reviews undertaken in January 2018 to June 2018 are as follows:

5.1. Medicine and Emergency Care Division

Investments agreed:

- **Ward 2** - To fund the third Registered Nurse on Night duty, seven days a week

- **Emergency Department** - To fund the supernumerary Registered Nurse Coordinator, 24 hours a day, seven days a week
- **Critical Care** - To fund the supernumerary Registered Nurse Coordinator, 24 hours a day, seven days a week.

Divisional actions agreed:

- To review ward 1 establishment and split out Coronary Care Unit to review staffing requirements for 2019
- To review ward 3 rota's and use of band 4 technicians to release additional support for wards 2 and 3
- Wards 4,6,7 and 14 to review all supernumerary roles within daytime hours, add to the establishment to support staffing out of hours
- To review current admission criteria for ward 2 short-stay unit to support clinical safety
- To commence the acuity review in the Emergency Department using the BEST national acuity tool
- To continue to actively recruit to all vacancies.

5.2 Surgery and Cancer Division

Investments agreed:

- The phased introduction of 12 hour shifts in **wards 13, 18 and 10** to close the current gap between ward establishments and patient acuity.

Divisional actions agreed:

- To undertake a review of unfunded ward attender activity and plans to address actions on wards 9,12,13 and18
- To review options for a higher dependency area within ward 13
- To continue to actively recruit to all vacancies.

5.3 Diagnostics and Support Services Division

Investments agreed:

- **Ward 21b** - To fund the Health Care Assistant Twilight shift seven days a week

Divisional actions agreed:

- To review the Advanced Care Practitioner Role within Elmhurst and add into workforce plans
- To review options for a discharge facilitator on both 21B and Elmhurst.

5.4 Women & Children's Division

Investment agreed:

- **Labour ward** - To fund 0.78 WTE Midwife to ensure compliance with intrapartum care

Divisional actions agreed:

- Staff to continue to work across all areas where possible to ensure required cover
- To scope the possibility of the Nursing Associate Role within children's services.

6. Workforce Plans

It is acknowledged that there is a national shortage of Registered Nurses and that the majority of Care Provider organisations are facing the same challenges in filling registered nursing vacancies.

To actively address this, and to provide reassurance to the Trust Board of Directors, the Trust has a number of ongoing long and short term initiatives in place that include,

- Building on our reputation- employer of choice, social media & staff survey feedback
- Growing our own- linking with student cohort, apprenticeships & Trainee Nurse Associate
- Responding to generational choices- career development & talent management
- Return to practice programme with experienced nurses in post and in dedicated wards where they intend to practice on re-qualification
- Looking after staff- Health and Well Being strategy, self -roster & ESR self service
- The introduction of an E Rostering- Electronic Health Roster/Safe care
- Flexible working arrangements where possible
- Trust attendance at job fairs and school career fairs
- The launch of internal Career Clinics in September 2018
- Development of new Workforce models at scale- Advanced Practice
- Review of alternative and non-traditional roles to provide support to wards, such as physiotherapists and pharmacists.

There are 10 key task and finish groups that have been set up to support the achievement of the above they include:

1. Ongoing recruitment
2. STAR Programme
3. Return to Practice Programme
4. UK Adaptation Programme
5. International Recruitment
6. Rotational Nurse – Pilot posts in Respiratory & Community
7. New roles – Nurse Associates, Pharmacy Technicians, Nursing Apprenticeships
8. Allied Health Professionals
9. Advanced Practice
10. Retention Group
11. After Action Review resulting in 'You Said, We Did' sessions

7. Conclusion

The trust has seen a growth in patient acuity and dependency across a number of adult and children's wards, with a number of areas having agreed investment in 2018.

To continue our ambition for consistency across all wards the assessment of acuity and dependency will continue to be the driver to ensure safe and sustained staffing levels. The recent purchase of eRoster and Safe Care (a live electronic acuity tool) will allow an in-depth completion of staffing levels and skill mix to the actual patient demand. It will provide visibility across wards and areas and will transform rostering into an acuity based daily (and more frequently) staffing process that unlocks productively and safeguards patient care.

The priority area of focus remains the recruitment and retention of Registered Nurses, Midwives, and care staff. Having such staff in post to the agreed funded ward establishments is the key to having the greatest impact on our ability to provide safe, high quality, cost effective care. Over the previous twelve months there has been a focused investment in new and innovative approaches to recruitment and retention as described. This focus will continue to be a high priority within the trust.

Recommendations

The Board of Directors is asked to:

- Note the work undertaken in relation to assurance of safe staffing across the wards as identified in the bi-annual reviews and the strategic staffing review
- Note and support the actions being undertaken following the biannual staffing reviews in January and June 2018
- To recognise that the investment in April 2018 has not yet resulted in all Registered Nurses in post and has subsequently not had an impact. However, this will in 2019.
- Support the recommendations that registered and unregistered nurse staffing levels need to be a continued area of incremental investment in line with evidenced based Reviews
- Note that the report does not include a review of staffing across community care and the Emergency Department, however, this work is underway and will be included in the next annual Trust Board report for 2019.

Mid Cheshire Hospital
NHS Foundation Tru

Board of Directors Performance Report

August 2018

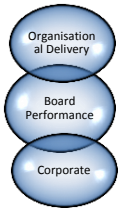
"To Deliver Excellence in Healthcare through Innovation & Collaboration"

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**	**Aug-18**	
Cancer				
Rapid Access Referrals (%) *(seen in 2 wks)*	93.00%	96.71%	96.73%	
Total Patients Seen		*4,320*	*888*	
Patients seen >14 days		*142*	*29*	
62 day GP Classic (%)	85.00%	91.07%	90.77%	*
Accountable Patients Treated		*342*	*65*	
No. of Breached Pathways (adjusted)		*31*	*6*	
62 day Screening (%)	90.00%	94.29%	91.49%	*
Accountable Patients Treated		*70*	*24*	
No. of Breached Pathways (adjusted)		*4*	*2*	
Unplanned Activity				
A&E <4hrs Standard (%)	95.00%	84.25%	87.14%	
A&E Attendances (LH/MIU/UUC) (% to plan)		96.93%	97.67%	
A&E Attendances LH & MIU (Vol)		*39,038*	*7,517*	
Planned Activity				
Incomp Pathways <18wk (%)	92.00%	92.72%	92.63%	
>6wk Diagnostic Waits (%)	1.00%	0.33%	0.31%	
Total Patients Waiting for a First Outpatient Appointment			9,851	

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

Indicator	Standard	YTD
Workforce		
Sickness absence Rolling 12 Month		4.27%
Turnover Rolling 12 Month		11.67%

Exec Summary

In August 2018, the Trust delivered four of the five NHS Improvement Single Oversight Framework performance indicators (three cancer standards, A&E and RTT). The indicator not achieved was the 4hour A&E waiting time target.

The 4-hour A&E standard in August achieved 87.14% against the 95% performance standard. This is the highest performing month since November 17 however is still a deterioration in performance compared to the same month in 2017 (95.26%).

The Trust has achieved all three headline cancer access standards for August. Rapid access referrals and 62 day treatment pathways have continuously achieved above target for over 12 months. All three cancer standards passed quarter 1 and are achieving year to date.

The Trust continues to achieve the 92% standard for RTT 18 week incomplete pathways, with performance in August 2018 at 92.63%. The Trust is continuing to monitor this standard, with specific reference to managing the level of 'over performance' previously being delivered against 92%.

Diagnostics waiting times continue to perform well, with just 0.31% 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	3	4	4	2.39	-3,839.63
Liquidity	2	2	1	-1	0
I&E Margin	3	4	4	2.10%	-871.20%
Distance from Financial Plan	0	4	4	0.00%	-873.30%
Agency Spend	1	1	1	-23.27%	-23.27%

The UoRR metric is 3, primarily a consequence of the override resulting from the impact of the Trust's ability to service DH loans from revenues and depreciation.

The Trusts's I&E position is a deficit of £2.3M which is £1.9M worse than the planned deficit of £0.4M. Part of this is a provision of £0.8M against the provider sustainability fund, for the failure to achieve the A&E target.

There is a variation in the CIP scheme against, with planned bed closures no longer being progressed.

The Trust is currently £24k better than its Agency spend trajectory which includes costs associated with keeping escalation beds open in April.

	YTD Target	YTD Actual	YTD Variance	FY Target	FY Forecast	FY Variance
Cost Improvement Schemes Total (£000's)	3,075	2,381	-693	6,772	5,881	-872
Commission Contact Income SC & VR (£000's)	76,458	76,458	0			
Contract Income (£'000)	92,083	91,747	-336			
Pay to Budget (£000's)	-71,178	-71,624	-446			
Non Pay to Budget (£000's)	-28,771	-29,799	-1,028			
Agency Trajectory (£000's)	-1,825	-1,801	24			

Single Oversight Framework

Triggers

Operational	For providers with Sustainability and Transformation Fund (STF) trajectories in any metric: failure to meet 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's 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).

The Trust has acheived a Use of Resource rating of 3, which is expected to improved during 2018/19, although is at risk due to the deterioriating financial position.This results in a 'trigger' on the Finance & Resource theme. This is primarily driven by the capital service capacity metric which will improve when short term loans required to support liquidity are repaid in the year. The trust is currently above planned agency spend, however it was still below the control total at the end of August.

Operational Performance

	Current YTD														Monthly Trend
	Target	Actual	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	
Maximum 6 week wait for Diagnostic procedures	1%	0.33%	0.34%	0.21%	0.24%	0.25%	0.39%	0.53%	0.08%	0.33%	0.26%	0.17%	0.32%	0.56%	0.31%	
All Cancers: 62 day GP Classic (%) *	85%	91.07%	95.08%	91.67%	95.74%	94.50%	96.77%	87.30%	92.06%	94.06%	87.13%	92.91%	92.00%	91.40%	90.77%	
All Cancers: 62 day Screening (%) *	90%	94.29%	100.00%	91.67%	83.33%	94.12%	100.00%	100.00%	100.00%	100.00%	100.00%	89.47%	91.67%	100.00%	91.49%	
18 weeks from point of referral to treatment - patients on an incomplete pathway (%)	92%	92.72%	96.78%	97.10%	96.79%	96.36%	95.15%	94.46%	94.02%	92.54%	92.73%	92.98%	92.73%	92.55%	92.63%	
A&E - maximum waiting time of 4 hours from arrival to admission/transfer/discharge (%)	95%	84.25%	95.26%	93.99%	88.28%	88.05%	74.22%	78.38%	77.91%	77.90%	82.65%	85.14%	81.78%	84.57%	87.14%	
STF Trajectory			91.34%	91.34%	90.52%	90.52%	90.52%	90.52%	90.52%	95.00%	92.72%	92.72%	92.72%	93.92%	93.92%	
Provider Submitted Trajectory														87.18%	89.20%	

** 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	2.39	-3,839.63	4	1.34	-72.10	4
	Liquidity	days	-1	0	1	-3	-3	2
Financial Efficiency	I&E Margin	%	2.10%	-871.20%	4	-0.90%	-869.30%	4
Financial Controls	Distance from Financial Plan	%	0.00%	-873.30%	4	0.00%	-868.40%	4
	Agency Spend	%	-23.27%	-23.27%	1	-7.36%	-8.32%	1
Overall UOR Rating					3			3

Operational Delivery: *Cancer Pathway*

Headline Measures

	Current YTD		Rolling 13 months											
	Target	Actual	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Monthly Trend
Rapid Access Referrals (%) (seen in 2 wks)	93%	96.71%	97.35%	96.81%	97.60%	98.23%	95.85%	94.83%	93.05%	98.64%	96.08%	96.76%	97.54%	96.37%	96.73%	
Total Patients Seen		*4320*	*793*	*722*	*750*	*736*	*626*	*715*	*806*	*811*	*766*	*956*	*855*	*855*	*888*	
Patients seen >14 days		*142*	*21*	*23*	*18*	*13*	*26*	*37*	*56*	*11*	*30*	*31*	*21*	*31*	*29*	
% seen within 7 days		*41.5%*	*46.2%*	*64.8%*	*54.8%*	*51.4%*	*52.9%*	*54.6%*	*53.1%*	*61.2%*	*45.2%*	*39.6%*	*43.7%*	*44.4%*	*35.1%*	
62 day GP Classic (%) *	85%	91.07%	95.08%	91.67%	95.74%	94.50%	96.77%	87.30%	92.06%	94.06%	87.13%	92.91%	92.00%	91.40%	90.77%	

** Provisional figures subject to change depending*

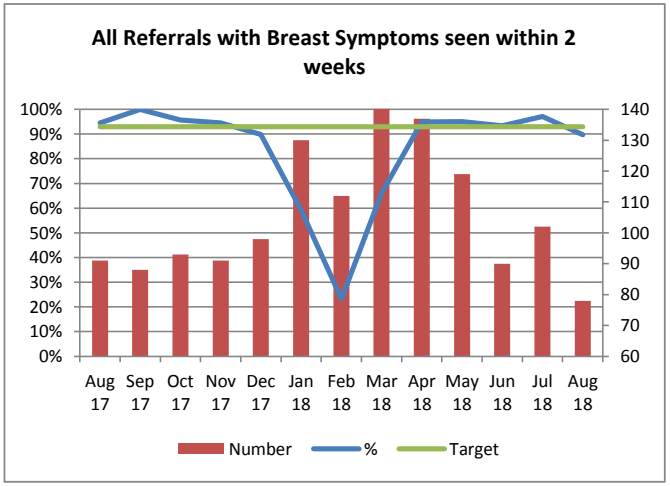
104+ day waits - (Cancer patients treated)			1	0	1	1	0	1	2	3	1	1	0	1	1

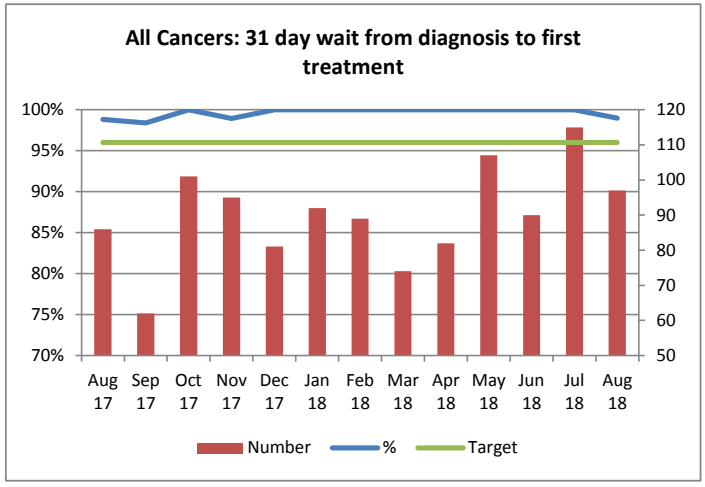
Commentary

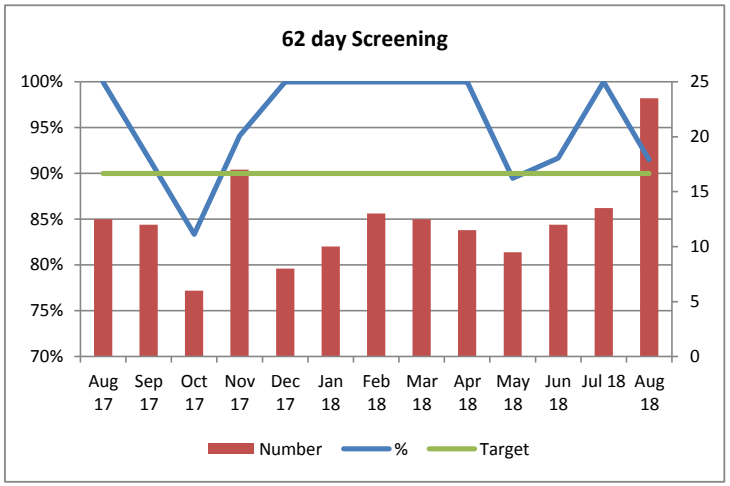
The Trust has achieved all three headline cancer standards during the month of August 2018. The figures presented in this p aper reflect the Trust's regulatory performance measures (adjusted figures that take into account breach reallocation between providers).
The Trust has continued it's strong performance against the Rapid Access referrals standard achieving 96.73% in August. Thi s is in spite of an increase in demand of 12% on the same month last year.
Performance for the 2 week Breast Symptomatic standard has dropped in August to 90% against the 93% target. This was primarily due to reduced capacity throughout the August period, robust plans are in place to ensure compliance with the quarter standard.
The screening 62 day standard performed well in August at 91% against a 90% target despite seeing the highest volume ever in a month at Mid Cheshire.

There was one recorded long wait (104 days and over) for patients on a 62 day cancer pathway in August. The wait was down to patient choice and therefore deemed unavoidable. All patients treated over 104 days will have a harm review undertaken.
All Trusts now identify and report those patients who have waited 104+ days to be treated, the next page shows an overview of the Greater Manchester position.

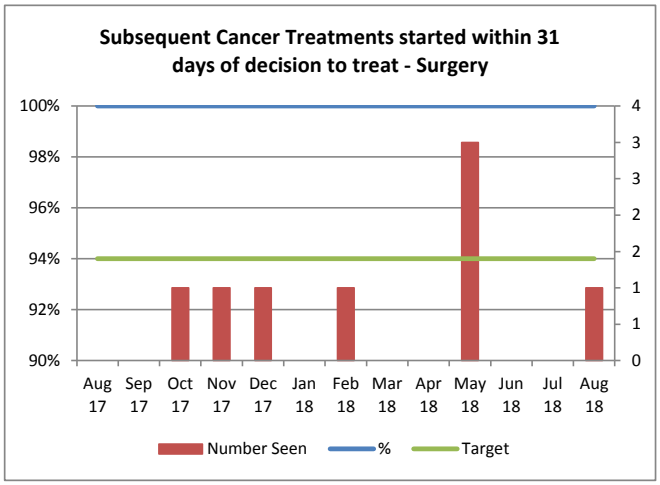
Primary Measures

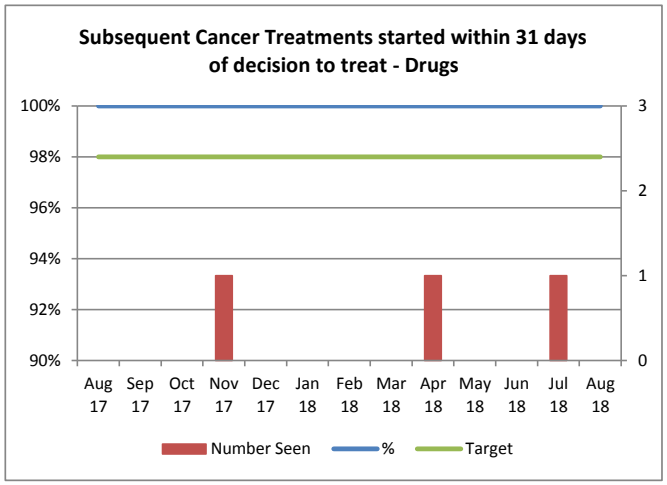


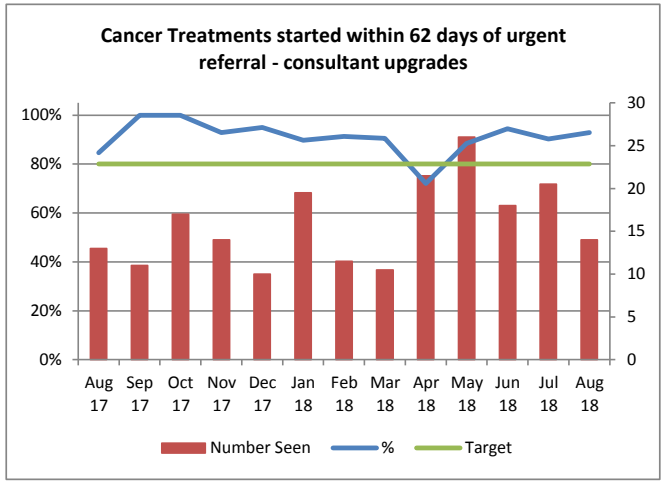




Operational Delivery: *Cancer Pathway*







ACCOUNTABLE PROVIDER - All Care 62 day Q1 2018/19	Accountable Treats TOTAL	WITHIN 62 DAYS	AFTER 62 DAYS	TREATED WITHIN 62 DAYS	Over Day 104
BOLTON NHS FOUNDATION TRUST	171	159	12	92.98%	0
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	182.5	170.5	12	93.42%	1
TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	146	131	15	89.73%	2
EAST CHESHIRE NHS TRUST	108.5	87.5	21	80.65%	2
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	196	175.5	20.5	89.54%	2.5
SALFORD ROYAL NHS FOUNDATION TRUST	204	180.5	23.5	88.48%	4
STOCKPORT NHS FOUNDATION TRUST	178	143.5	34.5	80.62%	8.5
THE CHRISTIE NHS FOUNDATION TRUST	245	150	95	61.22%	16.5
PENNINE ACUTE HOSPITALS NHS TRUST	376	277.5	98.5	73.80%	21.5
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	446.5	362.5	84	81.19%	27

Operational Delivery: *Unplanned Activity - A&E*

Headline Measures

	Current YTD		Rolling 13 months												
	Target	Actual	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Monthly Trend
A&E - >4 hr wait time from arrival to admission/ transfer/ discharge (% to Target)	95%	84.25%	95.26%	93.99%	88.28%	88.05%	74.22%	78.38%	77.91%	77.90%	82.65%	85.14%	81.78%	84.57%	87.14%	
No. of 4hr breaches		*6,148*	*332*	*422*	*872*	*851*	*1,920*	*1,543*	*1,469*	*1,679*	*1,244*	*1,179*	*1,472*	*1,286*	*967*	

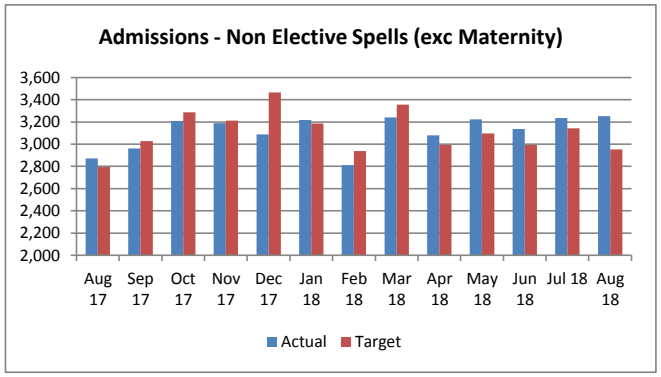
	Plan	Actual	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Monthly Trend
A&E Attendances (LH/MIU/UUC) (% to Plan)		*96.93%*	93.1%	97.1%	99.8%	92.9%	99.3%	97.1%	94.4%	93.6%	93.2%	95.3%	98.9%	99.5%	97.7%	
A&E Attendances (LH/MIU/UUC) (No.)	*88,209*	*39,038*	7,011	7,023	7,439	7,119	7,447	7,138	6,649	7,598	7,170	7,933	8,081	8,337	7,517	
A&E Attendance Case Mix (based on acuity score)	*Major*	*11,682*	*1,769*	*1,724*	*1,688*	*1,605*	*1,815*	*2,191*	*2,173*	*2,422*	*2,288*	*2,460*	*2,386*	*2,168*	*2,380*	
	Minor	*15,749*	*3,152*	*2,939*	*3,198*	*2,936*	*3,324*	*2,940*	*2,474*	*2,886*	*2,799*	*2,992*	*3,325*	*3,643*	*2,990*	
	Paediatrics	*7,615*	*1,182*	*1,416*	*1,588*	*1,557*	*1,379*	*1,304*	*1,305*	*1,544*	*1,419*	*1,676*	*1,648*	*1,691*	*1,181*	
	Resus	*3,992*	*908*	*944*	*965*	*1,021*	*929*	*703*	*697*	*746*	*664*	*805*	*722*	*835*	*966*	
A&E Attendance Location (based on Discharge)	*Major*	*15,609*	*2,898*	*2,899*	*3,011*	*2,776*	*3,201*	*3,038*	*2,761*	*3,204*	*2,957*	*3,170*	*3,136*	*3,121*	*3,225*	
	Minor	*15,069*	*2,815*	*2,600*	*2,731*	*2,659*	*2,661*	*2,617*	*2,403*	*2,650*	*2,623*	*2,948*	*3,157*	*3,364*	*2,977*	
	Paediatrics	*7,615*	*1,182*	*1,416*	*1,588*	*1,557*	*1,379*	*1,304*	*1,305*	*1,544*	*1,419*	*1,676*	*1,648*	*1,691*	*1,181*	
	Resus	*745*	*116*	*108*	*109*	*127*	*206*	*179*	*180*	*200*	*171*	*139*	*140*	*161*	*134*	

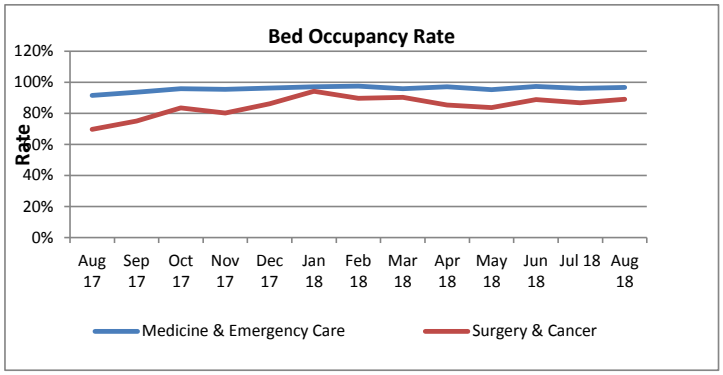
Commentary

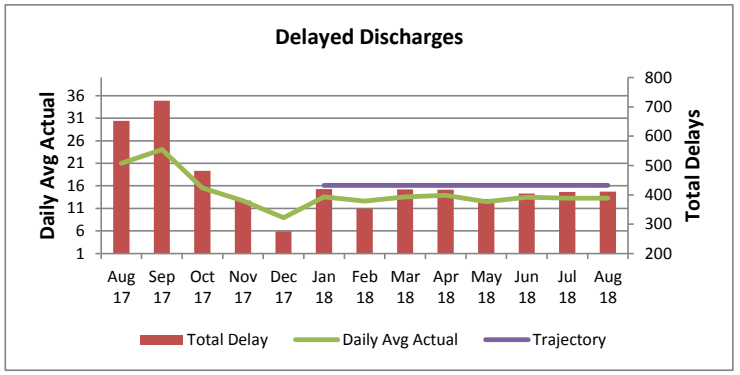
The Trust has achieved 87.14% against the 4-hour access standard in August 2018 . Following last month where the Trust saw the highest number of ED attendances recorded ever, volumes have reduced in August, however still remain 7% higher than the same month last year. Similar to July, in August we have seen a higher acuity of patients arriving in A&E , the case mix of Majors and Resus combined equate to a 25% increase on the same month last year. As a result, there has also been an increase in emergency admissions of 13% compared to August 2017.

The Type 1 conversion rate has seen an all time high in August with 44%. of Type 1 attendances requiring admission. Medical outliers is also the highest in the last 12 months, at 29 for August.

Primary Drivers

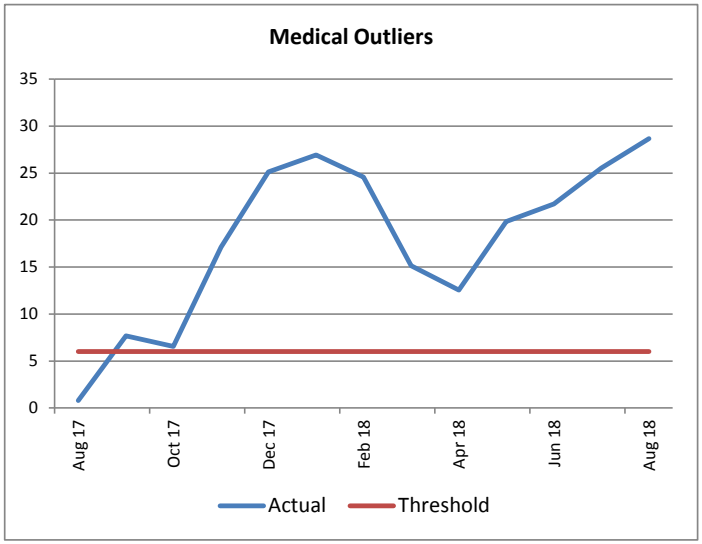


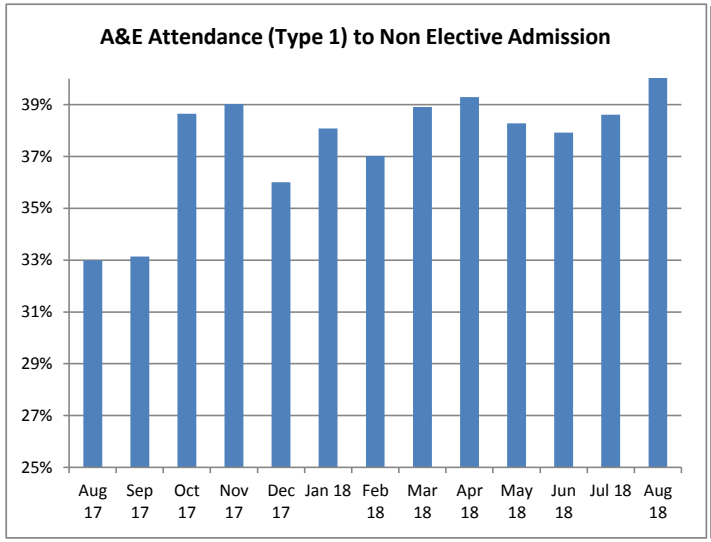


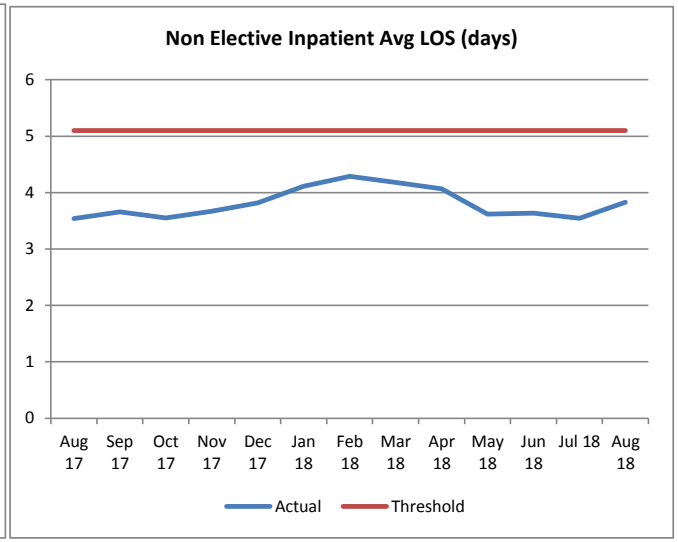


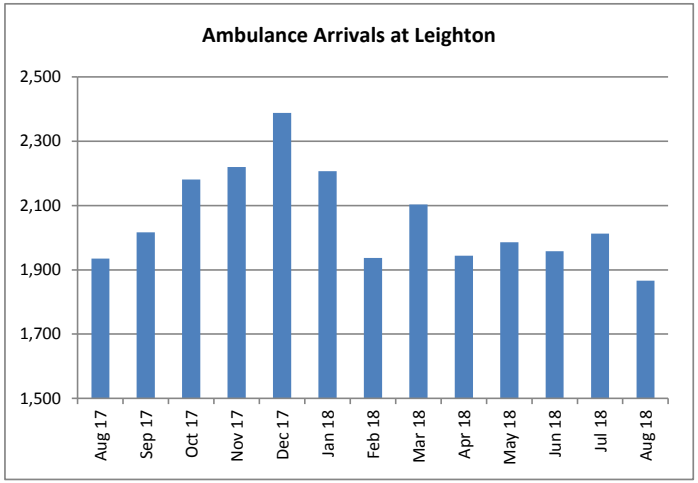
Operational Delivery: *Unplanned Activity A&E*

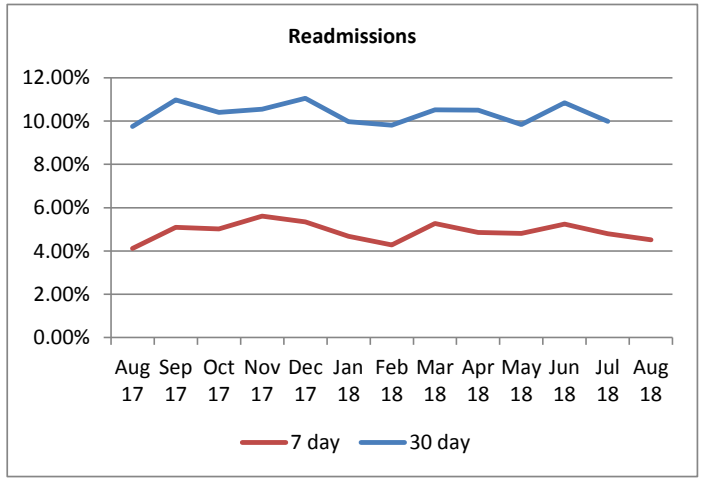
Secondary Drivers

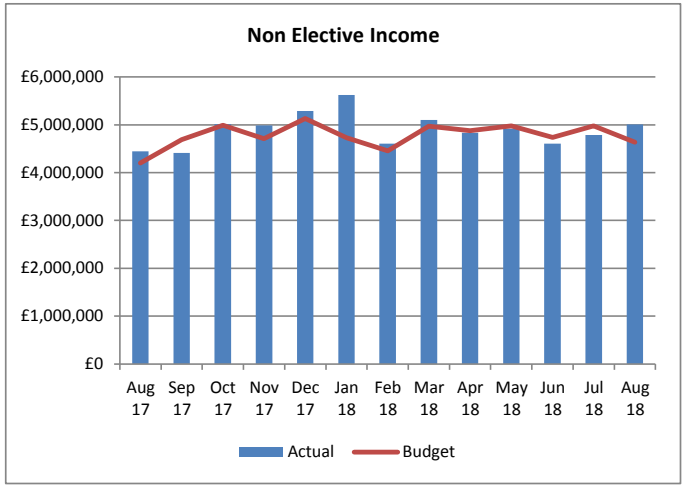












** Readmissions and LOS metrics brought in line with national definitions*

Operational Delivery: *Planned Activity*

Headline Measures

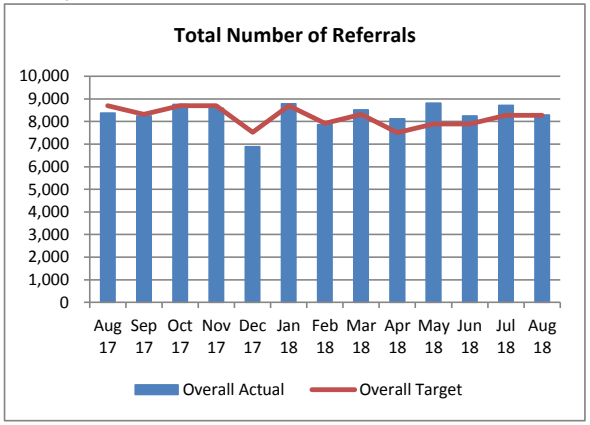
	Current YTD		Rolling 13 months											
	Target	Actual	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Monthly Trend
18 weeks from Referral to Treatment in Aggregate - Incomplete	92%	92.72%	96.78%	97.10%	96.79%	96.36%	95.15%	94.46%	94.02%	92.54%	92.73%	92.98%	92.73%	92.55%	92.63%	
Total 18 Weeks		*69,598*	*12,431*	*12,297*	*12,054*	*12,258*	*12,158*	*12,845*	*13,105*	*13,771*	*13,729*	*13,801*	*13,893*	*13,818*	*14,357*	
No. > 18 Weeks		*5,064*	*400*	*356*	*387*	*446*	*590*	*711*	*784*	*1,028*	*998*	*969*	*1,010*	*1,029*	*1,058*	
Open Pathways >39 Weeks Waiting															*9*	
Diagnostic Waiting Time	1%	0.33%	0.34%	0.21%	0.24%	0.25%	0.39%	0.53%	0.08%	0.33%	0.26%	0.17%	0.32%	0.56%	0.31%	
Total Number of Waiters		*21,041*	*3,189*	*3,380*	*3,306*	*3,191*	*3,614*	*3,587*	*3,548*	*4,293*	*4,224*	*4,127*	*4,619*	*4,257*	*3,814*	
Waiters of 6 Weeks +		*69*	*11*	*7*	*8*	*8*	*14*	*19*	*3*	*14*	*11*	*7*	*15*	*24*	*12*	
Total Patients Waiting for a First Outpatient Appointment			8,029	7,809	7,731	7,916	8,085	8,342	8,501	8,866	9,243	9,579	9,354	9,496	9,851	
Longest Wait Time (weeks)											*45*	*49*	*43*	*43*	*44*	

Commentary

In August the Trust reported 92.63% against the 92% incomplete pathways standard for RTT. Three specialties have failed to meet the 92% target, these are General Surgery, Cardiology and Trauma and Orthopaedics. All failing specialities have developed a trajectory and plan for RTT compliance which will be monitored via the Trust performance systems.
Mid Cheshire have not reported any 52 week breaches for August however there are 9 patients waiting over 39 weeks; (3 at 40 weeks, 2 at 41 weeks, 3 at43 weeks and 1 at 44 weeks). All long wait patients are monitored and reviewed weekly at director lead performace meetings.

The Trust has delivered the diagnostic wait time consistently since July 2016. In August 2018, 0.31% 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

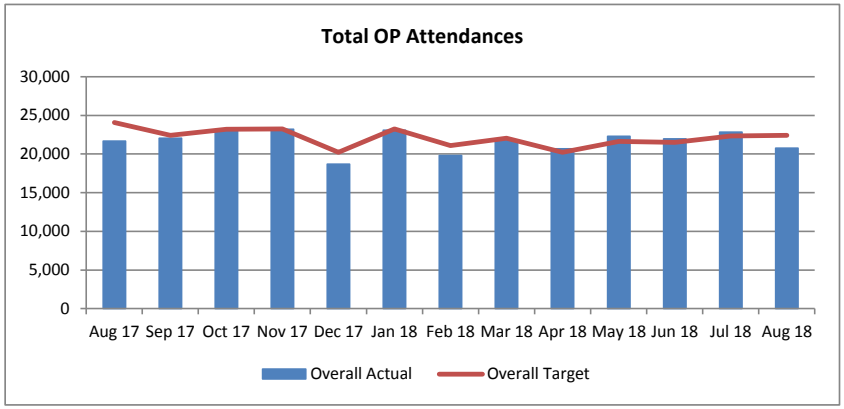


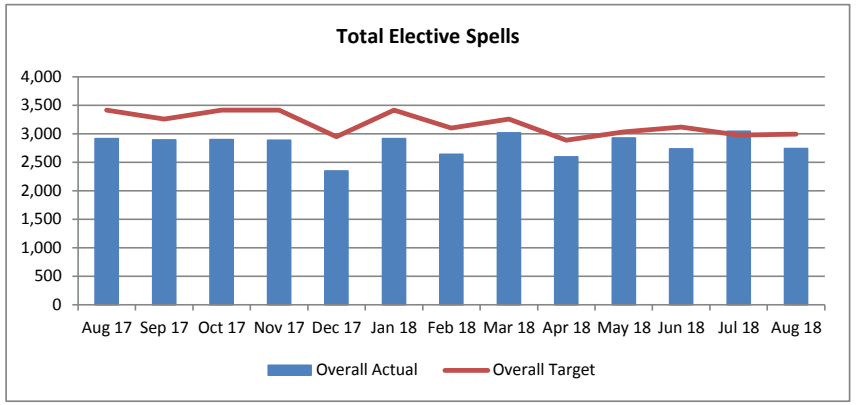
Referral Breakdown

	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Monthly Trend
GP Actual	5,211	5,277	5,506	5,424	4,157	5,573	4,928	5,388	4,858	5,400	5,065	5,355	5,184	
GP Target	5,509	5,259	5,509	5,509	4,758	5,509	5,008	5,259	4,683	4,920	4,920	5,157	5,157	
% to Target	94.6%	100.3%	99.9%	98.5%	87.4%	101.2%	98.4%	102.5%	103.7%	109.8%	103.0%	103.8%	100.5%	
Other Actual	3,156	2,969	3,252	3,166	2,731	3,205	2,931	3,119	3,253	3,407	3,186	3,352	3,107	
Other Target	3,195	3,050	3,195	3,195	2,759	3,195	2,904	3,050	2,833	2,976	2,976	3,120	3,120	
% to Target	98.8%	97.4%	101.8%	99.1%	99.0%	100.3%	100.9%	102.3%	114.8%	114.5%	107.1%	107.5%	99.6%	
Total Actual	8,367	8,246	8,758	8,590	6,888	8,778	7,859	8,507	8,111	8,807	8,251	8,707	8,291	
Total Target	8,704	8,308	8,704	8,704	7,517	8,704	7,913	8,308	7,515	7,896	7,896	8,276	8,276	
% to Target	96.1%	99.3%	100.6%	98.7%	91.6%	100.9%	99.3%	102.4%	107.9%	111.5%	104.5%	105.2%	100.2%	
GP % of Total	62.3%	64.0%	62.9%	63.1%	60.4%	63.5%	62.7%	63.3%	59.9%	61.3%	61.4%	61.5%	62.5%	

Operational Delivery: *Planned Activity*

Primary Drivers



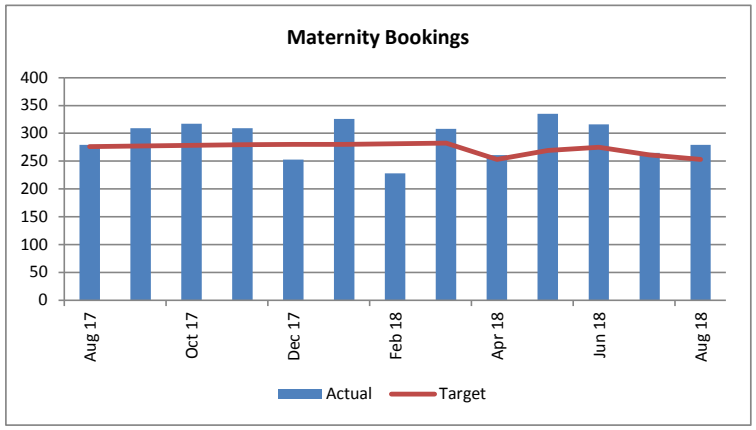


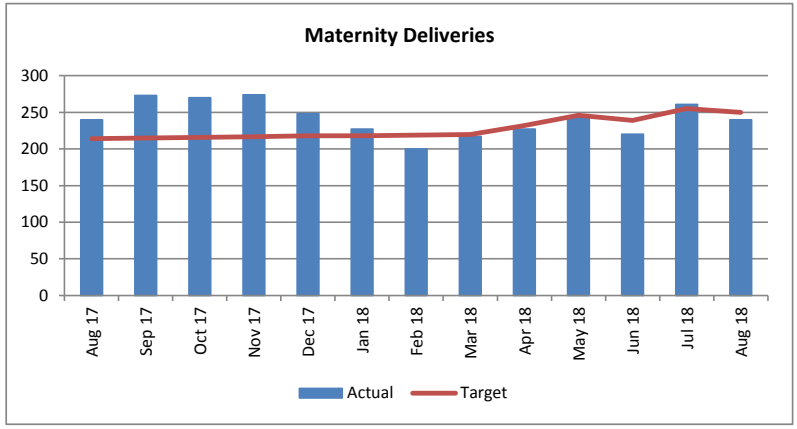
OP Attendance Breakdown	YTD 18 19	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Monthly Trend
New Actual	33,592	6,421	6,821	6,988	6,910	5,805	6,862	6,217	6,855	6,472	7,137	6,867	6,987	6,129	
New Target	31,325	7,427	6,941	7,250	7,253	6,272	7,253	6,585	6,909	5,892	6,224	6,212	6,495	6,502	
% to Target	107.2%	86.5%	98.3%	96.4%	95.3%	92.6%	94.6%	94.4%	99.2%	109.9%	114.7%	110.5%	107.6%	94.3%	
F U Actual	74,937	15,236	15,239	16,176	16,304	12,892	16,215	13,583	14,927	14,214	15,172	15,087	15,825	14,639	
F U Target	76,791	16,663	15,462	15,955	15,987	13,971	15,991	14,504	15,152	14,346	15,407	15,283	15,844	15,912	
% to Target	97.6%	91.4%	98.6%	101.4%	102.0%	92.3%	101.4%	93.7%	98.5%	99.1%	98.5%	98.7%	99.9%	92.0%	
Total Actual	108,529	21,657	22,060	23,164	23,214	18,697	23,077	19,800	21,782	20,686	22,309	21,954	22,812	20,768	
Total Target	108,116	24,090	22,403	23,205	23,240	20,243	23,244	21,089	22,061	20,237	21,631	21,495	22,339	22,414	
% to Target	100.4%	89.9%	98.5%	99.8%	99.9%	92.4%	99.3%	93.9%	98.7%	102.2%	103.1%	102.1%	102.1%	92.7%	
New % of Total	31.0%	29.6%	30.9%	30.2%	29.8%	31.0%	29.7%	31.4%	31.5%	31.3%	32.0%	31.3%	30.6%	29.5%	

Elective Spells Breakdown	YTD 18 19	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Monthly Trend
I P Actual	1,277	298	279	299	308	234	164	240	273	216	293	263	276	229	
I P Target	1,455	346	330	346	346	298	346	314	330	301	301	294	271	288	
% to Target	87.8%	86.2%	84.6%	86.5%	89.1%	78.6%	47.4%	76.5%	82.8%	71.8%	97.4%	89.4%	101.9%	79.6%	
Daycase Actual	12,770	2,619	2,616	2,603	2,578	2,115	2,753	2,404	2,745	2,378	2,637	2,476	2,768	2,511	
Daycase Target	13,558	3,071	2,931	3,071	3,071	2,650	3,071	2,790	2,931	2,590	2,735	2,822	2,706	2,706	
% to Target	94.2%	85.3%	89.3%	84.8%	83.9%	79.8%	89.6%	86.2%	93.7%	91.8%	96.4%	87.7%	102.3%	92.8%	
Total Actual	14,047	2,917	2,895	2,902	2,886	2,349	2,917	2,644	3,018	2,594	2,930	2,739	3,044	2,740	
Total Target	15,013	3,417	3,260	3,417	3,417	2,947	3,417	3,104	3,260	2,891	3,036	3,116	2,977	2,993	
% to Target	93.6%	85.4%	88.8%	84.9%	84.5%	79.7%	85.4%	85.2%	92.6%	89.7%	96.5%	87.9%	102.3%	91.5%	
I P % of Total	9.1%	10.2%	9.6%	10.3%	10.7%	10.0%	5.6%	9.1%	9.0%	8.3%	10.0%	9.6%	9.1%	8.4%	

Operational Delivery: *Planned Activity*

Primary Drivers



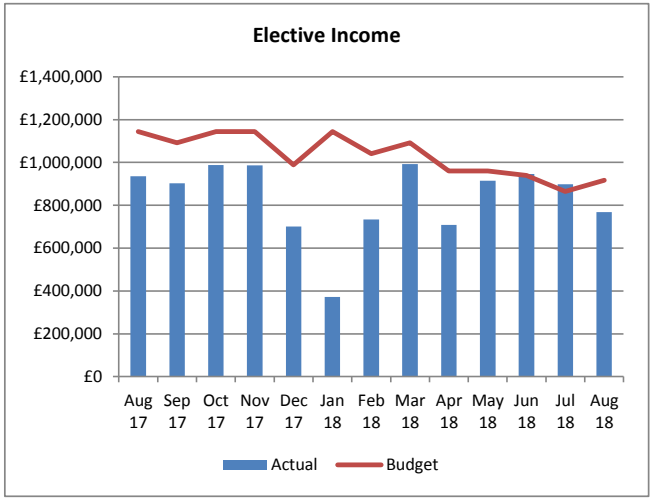


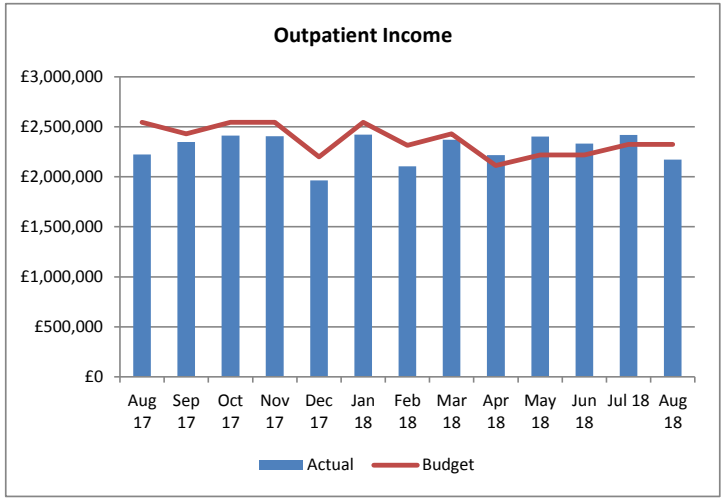
Operational Delivery: *Planned Activity*

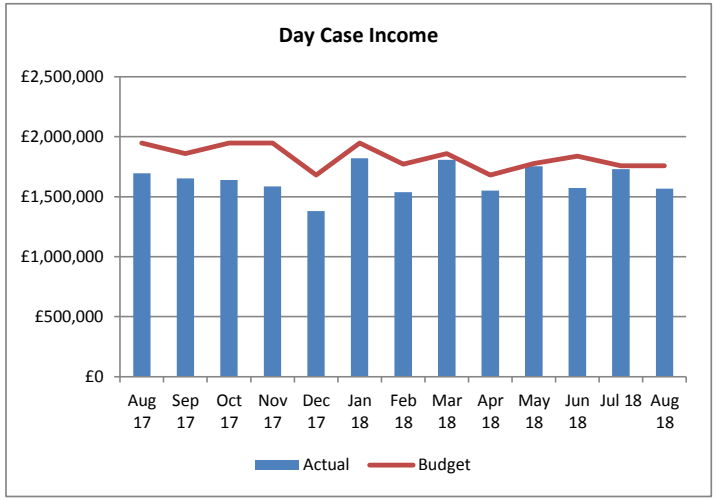
Secondary Drivers

			Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Monthly Trend
Bed Occupancy Rate	Medicine & Emergency Care		91.5%	93.7%	96.0%	95.5%	96.4%	97.2%	97.5%	96.0%	97.1%	95.4%	97.3%	96.1%	96.7%	
	Surgery & Cancer		69.7%	75.1%	83.5%	80.3%	86.2%	94.4%	89.6%	90.4%	85.4%	83.8%	88.9%	86.7%	89.1%	
Elective Inpatient Avg LOS (Days)			2.6	2.3	2.4	2.7	2.4	2.3	2.4	2.5	3.1	2.6	2.5	2.4	2.6	
Delayed Transfers of Care (MFFD)		16.00	21	24	16	13	9	14	13	14	14	12	13	13	13	
Delayed Transfers of Care (% of Acute Beds)			4.6%	5.2%	3.4%	2.7%	1.9%	2.6%	2.5%	2.7%	2.8%	2.7%	2.9%	2.8%	2.8%	
Medical Outliers			1	8	7	17	25	27	25	15	13	20	22	26	29	
Readmission (Emergency Re-admissions after Planned Surgery)																
	30 Day Rate		3.40%	3.84%	3.48%	3.44%	3.15%	3.01%	2.56%	3.28%	3.37%	3.35%	2.99%	3.12%		
	7 Day Rate		1.02%	1.32%	1.59%	1.20%	0.88%	1.27%	0.88%	1.41%	1.00%	1.27%	1.03%	1.42%	1.32%	
Cancelled Operations - Non Clinical - Cancellation Rate			0.40%	0.57%	1.27%	0.75%	2.24%	1.01%	1.23%	1.48%	1.40%	1.07%	0.95%	0.95%	0.96%	
Theatre Efficiency																
	Main Theatres		78.6%	80.5%	78.8%	77.0%	74.4%	74.9%	74.2%	76.8%	79.5%	78.9%	78.9%	76.7%	78.4%	
	TC Theatres		76.0%	71.5%	78.1%	75.5%	77.5%	74.5%	71.5%	71.8%	69.0%	74.2%	72.6%	75.6%	73.2%	
DNA (OP Efficiency)			5.71%	5.83%	5.51%	5.27%	6.21%	5.46%	5.17%	5.41%	5.25%	6.02%	5.91%	6.13%	5.84%	
Hospital Cancellation Rate (OP Efficiency)			7.58%	6.11%	6.27%	6.19%	7.18%	7.34%	6.88%	6.43%	6.72%	6.80%	6.80%	7.05%	7.27%	

** Readmissions, DNA Rate and LOS metrics brought in line with national definitions*







Financial Performance: Income & Expenditure Position - Aggregated

	Month			Year to Date			Forecast	
	Plan Aug (£'000)	Actual Aug (£'000)	Variance Aug (£'000)	Plan April to Aug (£'000)	Actual April to Aug (£'000)	Variance April to Aug (£'000)	2018/19 (£'000)	Budget 2018/19 £'000
Operating								
Operating Income								
NHS Acute Activity Income								
Elective	918	766	-152	4,642	4,235	-406	10,659	10,659
Non-Elective	4,638	4,842	204	24,207	24,158	-49	59,628	59,628
Maternity	1,183	1,120	-63	5,859	5,588	-272	14,000	14,000
Day cases	1,758	1,566	-192	8,810	8,175	-635	21,139	21,139
Outpatients	2,323	2,205	-118	11,192	11,542	350	26,672	26,672
A&E	825	909	84	4,302	4,417	115	10,139	10,139
Other NHS	6,184	6,623	439	30,682	31,964	1,282	78,037	78,037
Total NHS Clinical Revenue	**17,829**	**18,031**	**202**	**89,695**	**90,080**	**385**	**220,274**	**220,274**
Other Operating Income	2,838	2,828	-10	10,660	10,635	-25	22,502	22,502
Inter-Trust Income	0	0	0	0	0	0	0	0
TOTAL OPERATING INCOME	**20,667**	**20,859**	**192**	**100,355**	**100,715**	**360**	**242,776**	**242,776**
Operating Expenses								
Employee Benefits Expenses (Pay)	-14,900	-14,960	-60	-71,178	-71,624	-446	-168,313	-168,313
Drugs	-1,545	-1,504	41	-6,892	-6,827	65	-15,868	-15,868
Clinical Supplies	-1,528	-1,645	-117	-7,792	-7,624	168	-18,370	-18,370
Non Clinical Supplies	-297	-350	-53	-1,491	-1,585	-94	-3,537	-3,537
Other operating expenses	-2,514	-2,794	-280	-12,596	-13,763	-1,167	-31,419	-31,419
TOTAL OPERATING EXPENSES	**-20,784**	**-21,253**	**-469**	**-99,949**	**-101,423**	**-1,474**	**-237,507**	**-237,507**
EBITDA	**-117**	**-394**	**-277**	**406**	**-708**	**-1,114**	**5,269**	**5,269**
Non Operating								
Non Operating Income								
Interest & Asset disposal	3	8	5	15	31	16	36	36
Non-Operating Expenses								
Depreciation & Finance Leases	-446	-437	9	-2,230	-2,222	8	-6,190	-6,190
PDC Dividend Expense	-192	-192	0	-960	-960	0	-2,300	-2,300
Adjusted Financial Performance surplus/(deficit)	**-752**	**-1,015**	**-263**	**-2,769**	**-3,860**	**-1,090**	**-3,185**	**-3,185**
Provider Sustainability Fund	562	393	-169	2,387	1,671	-717	8,428	8,428
Net Surplus/(deficit) before Exceptional Items	**-190**	**-622**	**-432**	**-382**	**-2,189**	**-1,807**	**5,243**	**5,243**
Donations for purchase of assets	24	6	-18	120	56	-64	288	288
Depreciation on Donated Assets	-23	-23	0	-115	-115	0	-278	-278
Prior Period Adjustments	0	0	0	0	0	0	0	0
Net Surplus/(deficit) after Exceptional Items	**-189**	**-639**	**-450**	**-377**	**-2,248**	**-1,871**	**5,253**	**5,253**

The Trust delivered a cumulative £1.6m deficit (before exceptional items) against a budget deficit of £0.2m.

Contract income is above plan, due to additional funding for escalation beds in April. Planned income has improved in May/June in surgical specialties.

Other income is below plan with some variances as a result of Training income, RTA income, CCICP contract variations and NHS recharges.

Pay is £0.4M worse than plan. The key impacts are a higher spend on nursing and HCAs than plan offset by vacancies and unfilled posts within the community. Medical vacancies continue to contribute to an underspend, however there have been some backdated pay costs which are expected to be one off occur in May.

Non-Pay is £1.0M worse than plan. Clinical supplies spend is lower than budget reflecting the elective performance.

Other operating costs are overspent by £1.2M which have had someone off costs associated with the refurbishment and 1718 costs within estates , along with the continued pressure of outsourcing diagnostic tests within radiology/pathology.

The Provider Sustainability Fund is off plan due to the failure of the A&E target. The full year impact of not reaching the A&E target is £2.4m.

* EBITDA Total excludes Charitable Income

Financial Performance: Income & Expenditure Position - MCHFT

	Month			Year to Date			Forecast	Budget
	Plan Aug (£'000)	Actual Aug (£'000)	Variance Aug (£'000)	Plan April to Aug (£'000)	Actual April to Aug (£'000)	Variance April to Aug (£'000)	2018/19 (£'000)	2018/19 £'000
Operating								
Operating Income								
NHS Acute Activity Income								
Elective	918	766	-152	4,642	4,235	-406	10,659	10,659
Non-Elective	4,638	4,842	204	24,207	24,158	-49	59,628	59,628
Maternity	1,183	1,120	-63	5,859	5,588	-272	14,000	14,000
Day cases	1,758	1,566	-192	8,810	8,175	-635	21,139	21,139
Outpatients	2,323	2,205	-118	11,192	11,542	350	26,672	26,672
A&E	825	909	84	4,302	4,417	115	10,139	10,139
Other NHS	3,814	4,253	439	18,832	20,114	1,282	49,574	49,574
Total NHS Clinical Revenue	**15,459**	**15,661**	**202**	**77,845**	**78,230**	**385**	**191,811**	**191,811**
Other Operating Income	2,747	2,737	-10	10,200	10,101	-99	21,500	21,500
Inter-Trust Income	0	0	0	0	0	0	0	0
TOTAL OPERATING INCOME	**18,206**	**18,398**	**192**	**88,045**	**88,331**	**286**	**213,311**	**213,311**
Operating Expenses								
Employee Benefits Expenses (Pay)	-13,004	-13,135	-131	-62,058	-62,816	-758	-146,930	-146,930
Drugs	-1,543	-1,502	41	-6,882	-6,818	64	-15,844	-15,844
Clinical Supplies	-1,442	-1,551	-109	-7,365	-7,159	206	-17,353	-17,353
Non Clinical Supplies	-216	-230	-14	-1,086	-1,178	-92	-2,568	-2,568
Other operating expenses	-2,107	-2,411	-304	-10,555	-11,874	-1,319	-26,706	-26,706
Inter-Trust Charges	114	366	252	569	821	252	1,364	1,364
TOTAL OPERATING EXPENSES	**-18,198**	**-18,463**	**-265**	**-87,377**	**-89,024**	**-1,647**	**-208,037**	**-208,037**
EBITDA	**8**	**-65**	**-73**	**668**	**-693**	**-1,361**	**5,274**	**5,274**
Non Operating								
Non Operating Income								
Interest & Asset disposal	3	8	5	15	31	16	36	36
Non-Operating Expenses								
Depreciation & Finance Leases	-446	-437	9	-2,230	-2,222	8	-6,190	-6,190
PDC Dividend Expense	-192	-192	0	-960	-960	0	-2,300	-2,300
Net Surplus/(deficit) before STF/Exceptional Items	**-627**	**-686**	**-59**	**-2,507**	**-3,845**	**-1,337**	**-3,180**	**-3,180**
Provider Sustainability Fund	562	393	-169	2,387	1,671	-717	8,428	**8,428**
Net Surplus/(deficit) before Exceptional Items	**-65**	**-293**	**-228**	**-120**	**-2,174**	**-2,054**	**5,248**	**5,248**
Donations for purchase of assets	24	6	-18	120	56	-64	288	288
Depreciation on Donated Assets	-23	-23	0	-115	-115	0	-278	-278
Prior Period Adjustments	0	0	0	0	0	0	0	0
Net Surplus/(deficit) after Exceptional Items	**-64**	**-310**	**-246**	**-115**	**-2,233**	**-2,118**	**5,258**	**5,258**

The Trust excluding Community Services, delivered a £2.1M deficit against a planned deficit of £0.1M in the month - giving a £2.0M variance against plan cumulatively.

Contract income and other operating income are £0.3M better than plan - largely as a result of funding for escalation beds kept open in April.

Pay is £0.8M worse than plan cumulative as a result of higher spend on Nursing & HCAs, which has increased n the month, notably within Medicine & Emergency Care and Surgery & Cancer - where there are a number of medical outliers.

Clinical supplies is overspent in the month, but below plan cumulatively, reflecting an overall underperformance in planned activity.

Other Operating Expenses is £1.4M worse as a result of continuing outsourcing pressures in diagnostics (£513K) and pathology (3135k) and pressures within estates (1718 costs (£173K), one of costs (£30k) and in year issues (£277k).

There is a cumulative reflection of the A&E performance provided for within the provider sustainability fund.

Financial Performance: Income & Expenditure Position - CCICP

	Month			Year to Date			Forecast	
	Plan Aug (£'000)	Actual Aug (£'000)	Variance Aug (£'000)	Plan April to Aug (£'000)	Actual April to Aug (£'000)	Variance April to Aug (£'000)	2018/19 (£'000)	Budget 2018/19 £'000
Operating								
Operating Income								
NHS Acute Activity Income								
Elective	0	0	0	0	0	0	0	
Non-Elective	0	0	0	0	0	0	0	
Maternity	0	0	0	0	0	0	0	
Day cases	0	0	0	0	0	0	0	
Outpatients	0	0	0	0	0	0	0	
A&E	0	0	0	0	0	0	0	
Other NHS	2,370	2,370	0	11,850	11,850	0	28,463	28,463
Total NHS Clinical Revenue	**2,370**	**2,370**	**0**	**11,850**	**11,850**	**0**	**28,463**	**28,463**
Other Operating Income	91	91	0	460	534	74	1,002	1,002
Inter-Trust Income	0	0	0	0	0	0	0	0
TOTAL OPERATING INCOME	**2,461**	**2,461**	**0**	**12,310**	**12,384**	**74**	**29,465**	**29,465**
Operating Expenses								
Employee Benefits Expenses (Pay)	-1,896	-1,825	71	-9,120	-8,808	312	-21,383	-21,383
Drugs	-2	-2	0	-10	-9	1	-24	-24
Clinical Supplies	-86	-94	-8	-427	-465	-38	-1,017	-1,017
Non Clinical Supplies	-81	-120	-39	-405	-407	-2	-969	-969
Other operating expenses	-407	-383	24	-2,041	-1,889	152	-4,713	-4,713
Inter-Trust Charges	-114	-366	-252	-569	-821	-252	-1,364	-1,364
TOTAL OPERATING EXPENSES	**-2,586**	**-2,790**	**-204**	**-12,572**	**-12,399**	**173**	**-29,470**	**-29,470**
EBITDA	**-125**	**-329**	**-204**	**-262**	**-15**	**247**	**-5**	**-5**
Non Operating								
Non Operating Income								
Interest & Asset disposal	0	0	0	0	0	0	0	
Non-Operating Expenses								
Depreciation & Finance Leases	0	0	0	0	0	0	0	
PDC Dividend Expense	0	0	0	0	0	0	0	
Adjusted Financial Performance surplus/(deficit)	**-125**	**-329**	**-204**	**-262**	**-15**	**247**	**-5**	**-5**
Provider Sustainability Fund	0	0	0	0	0	0	0	**0**
Net Surplus/(deficit) before Exceptional Items	**-125**	**-329**	**-204**	**-262**	**-15**	**247**	**-5**	**-5**
Donations for purchase of assets	0	0	0	0	0	0	0	0
Depreciation on Donated Assets	0	0	0	0	0	0	0	0
Prior Period Adjustments	0	0	0	0	0	0	0	0
Net Surplus/(deficit) after Exceptional Items	**-125**	**-329**	**-204**	**-262**	**-15**	**247**	**-5**	**-5**

Community Services delivered a £247k surplus cumulative against a planned deficit position.

Contract income is on plan, with expected variations in progress with the CCG around Stoma care, Pain and MCATS.

Other Operating income is better than budget as a result of an increase in charges within estates, which is offset by an increase in cost in non-pay, and some non-recurrent gains on 1718 income.

Pay is £312k better than plan cumulative as a result of unfilled vacancies partly clinical and partly corporate, continuing the trend from 2017/18.

The only area of pay that raises a concern continues to be GP out of hours, where recruitment is underway for permanent staff, under new terms, which is planned to reduce the agency cost ultimately.

Non pay is largely better than budget, however there are overspends for NHS rents, and continence costs.

Inter-trust recharges reflect a review of vacancies which is subject to review with CCICP.

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	(21)	(432)	(411)	(38)	(40)	(471)	(472)
Endoscopy	Endoscopy	2,596	1	(256)	(1,014)	83	(495)	161	1,088	(12)
General Surgery Directorate	General Surgery	7,080	49	150	(3,780)	47	(777)	(62)	2,572	135
Head & Neck Directorate	Head & Neck	2,200	170	(178)	(1,047)	72	(276)	54	1,047	(52)
Macmillan Cancer Centre	Macmillan Cancer Centre	282	749	144	(421)	(35)	(720)	(119)	(111)	(9)
Ophthalmology	Ophthalmology	5,085	25	216	(1,811)	(10)	(1,537)	(137)	1,762	70
Orthopaedic Directorate	Orthopaedics	7,611	116	(62)	(2,704)	83	(1,425)	(40)	3,599	(18)
Theatres & TC	Theatres & TC	0	144	(2)	(3,125)	(9)	(1,160)	(121)	(4,141)	(132)
Urology Directorate	Urology	2,400	21	66	(1,216)	(78)	(241)	(45)	965	(57)
Surgical and Cancer Division	**Surgery & Cancer**	**27,254**	**1,275**	**59**	**(15,551)**	**(257)**	**(6,669)**	**(349)**	**6,310**	**(547)**

The Surgical Division is £547k worse than plan year to date. Pay is £257kk worse than budget, with overspends on HCA bank and agency nursing costs high as a result of medical outliers - and also the failure to close the ward during the Summer months as part of the CIP programme, and acuity on ward 18 requiring additional HCA support. Whilst non pay is overspent £120k of this is offset by increased charges to the Christie as part of their SLA.

		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	0	0	(941)	(230)	(41)	(13)	(982)	(244)
Accident & Emergency Dir	Emergency Department	6,598	345	3	(2,688)	(104)	(320)	(42)	3,935	(143)
Anaesthetics & Critical Care	Anaesthetics & Critical Care	2,670	26	(16)	(3,195)	215	(467)	47	(966)	246
Medical Directorate	General Medicine	17,599	58	10	(9,614)	(204)	(1,831)	141	6,211	(54)
Urgent Care Centre	Urgent Care Centre	0	0	0	(277)	22	0	34	(277)	56
Emergency Services Division	**Medicine & Emergency Care**	**26,867**	**429**	**(3)**	**(16,715)**	**(302)**	**(2,658)**	**166**	**7,922**	**(139)**

The Medicine and Emergency Care Division are £139k worse than plan. The variances on income relate to un-coded A&E attendances, and an underperformance on non-elective activity/pass through drugs offset by an over performance within outpatients. Pay costs, which have been under pressure particularly around nursing/HCA costs have worsened in the month - with increases in bank usage in both areas, and also an increase in bedwatch charges.

		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	0	0	(551)	19	(51)	18	(602)	36
Gum clinic	Gum clinic	0	0	0	0	0	0	0	0	0
Obstetric & Gynaecology Dir	Obstetrics & Gynaecology	7,298	56	(442)	(3,663)	(21)	(568)	(6)	3,123	(469)
Paediatric Directorate	Paediatrics	4,706	39	(272)	(3,311)	(126)	(423)	28	1,011	(369)
Women and Childrens Division	**Women and Children**	**12,005**	**95**	**(714)**	**(7,526)**	**(128)**	**(1,043)**	**39**	**3,531**	**(802)**

The Women's and Children's Division is £802k worse than plan. Contract income continues to be below plan for Gynaecology and Obstetrics - both as a result of lower than plan activity. Pay pressures are a result of midwifery over establishment, which is expected to reduce as vacancies have started to arise.

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	(115)	20	(13)	(49)	(128)	(29)
Dermatology	Dermatology	755	9	2	(409)	32	(143)	(8)	211	25
ECG department	ECG	168	8	(1)	(436)	31	(33)	0	(293)	30
Elmhurst	Elmhurst	832	68	(4)	(675)	(38)	(66)	15	160	(28)
Integrated Discharge	Integrated Discharge	0	0	0	(132)	(12)	(3)	(2)	(135)	(14)
Medical Records Department	Medical Records Department	0	0	(1)	(754)	(25)	(94)	(1)	(848)	(28)
Outpatients	Outpatients	0	58	(12)	(237)	2	(23)	0	(202)	(10)
Pathology Directorate	Pathology	4,827	1,667	140	(3,996)	219	(3,632)	(279)	(1,133)	80
Pharmacy Departments	Pharmacy	1,487	82	(54)	(1,422)	(37)	(1,479)	(23)	(1,332)	(113)
Radiology Directorate	Radiology	1,207	343	(97)	(2,682)	16	(1,036)	(237)	(2,167)	(318)
Therapeutic Departments	Therapies	0	0	0	(891)	6	(24)	16	(915)	22
Victoria Infirmary Northwich	Victoria Infirmary Northwich	858	1	(32)	(738)	(17)	(119)	4	2	(45)
Diagnostics and Support Divisi	**Diagnostics and Support**	**10,135**	**2,238**	**(60)**	**(12,486)**	**196**	**(6,666)**	**(564)**	**(6,780)**	**(427)**

The Diagnostics Division is £427k worse than plan year to date,which is an improvement on previous month as as result of reviewing the SLA with UHNM in relation to ClinicalHaematology. Radiology has seen a deterioration in income, relating to activity as well as an increase in outsource costs within non pay leading to the £237k adverse variance,

		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	(219)	10	(74)	15	(293)	25
Catering Directorate	Catering	0	560	(6)	(729)	(48)	(591)	(42)	(760)	(96)
Estates Departments	Estates Departments	0	194	(5)	(667)	(1)	(3,014)	(386)	(3,487)	(392)
Hotel Services	Domestics	0	0	0	(579)	(5)	(7)	(2)	(586)	(7)
Laundry Services Departments	Laundry	0	482	(29)	(480)	(27)	(372)	(43)	(370)	(100)
Security	Security	0	706	1	(307)	13	(302)	(54)	97	(40)
Site Services	Porters	0	0	0	(1,226)	(11)	(34)	(1)	(1,260)	(11)
Estates & Facilities Division	**Estates & Facilities Division**	**0**	**1,942**	**(40)**	**(4,208)**	**(69)**	**(4,393)**	**(513)**	**(6,659)**	**(622)**

The Estates and Facilities Division is £622k worse than plan. Within non pay there are some 1718 costs (Carbon Credits £160k, Gritting £13k) and some one off costs a (£16k fixture and fitting, £14k overspend on barrier repairs). Utilities are £124k over as a result of problems with the combined heat and power - which have been resolved in July, and the issues around waste contamination (£26k YTD) have been resolved at the end of June.

		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	6	6	(634)	3	(256)	5	(883)	13
Computer Services	Computer Services	0	12	8	(645)	11	(1,195)	(244)	(1,828)	(226)
Finance & Information	Finance & Information	0	19	6	(1,262)	38	(288)	31	(1,532)	75
Human Resources	Human Resources	0	208	9	(1,021)	37	(177)	76	(991)	122
Risk Manangement & R&D	Risk Management & R&D	0	179	(46)	(639)	29	(47)	(6)	(507)	(23)
Quality Assurance Departments	Nurse Management	0	103	58	(1,163)	(101)	(3,429)	34	(4,489)	(9)
Trust Central Expenditure	Trust Central Expenditure	3,561	3,578	130	(858)	(184)	(119)	158	6,165	105
Other Departments	Other Departments	8	74	25	(108)	(31)	(89)	28	(116)	22
	Corporate	**3,570**	**4,179**	**195**	**(6,331)**	**(198)**	**(5,601)**	**82**	**(4,181)**	**79**

The Corporate Division is £79k better than budget, the pay award is no longer held centrally. Computer Services require budget to be transferred from Trust Central.

Community Services		**11,921**	**533**	**144**	**(8,808)**	**312**	**(2,770)**	**110**	**876**	**566**
EBITDA		**91,751**	**10,691**	**(418)**	**(71,624)**	**(446)**	**(29,800)**	**(1,028)**	**1,020**	**(1,892)**

Financial Performance: Commissioner Income Analysis

Commissioner	FY Target (£'000)	YTD Target (£'000)	CEP Adjustmt	Final Actual (£'000)	Final Variance (£'000)
NHS Eastern Cheshire CCG	8,088	3,352	0	3,240	-112
NHS Eastern Cheshire CCG Community	412	172	0	172	0
NHS South Cheshire CCG Community	17,254	7,163	0	7,163	0
NHS South Cheshire CCG	101,698	42,118	683	42,118	0
NHS Vale Royal CCG	55,052	22,827	-496	22,827	0
NHS Vale Royal CCG Community	10,482	4,350	0	4,350	0
NHS Warrington CCG	284	120	0	143	23
NHS West Cheshire CCG	3,537	1,464	0	1,489	25
NHS West Cheshire CCG Community	191	80	0	80	0
NHS North Staffordshire CCG	2,307	966	0	1,098	132
NHS Shropshire CCG	892	371	0	327	-44
NHS Stoke on Trent CCG	1,609	675	0	722	47
Public Health England	1,541	556	0	542	-14
NHS Commissioning Board	1,569	654	0	654	0
Specialist Commissioning Group	8,645	3,611	0	3,165	-446
Non Contract Activity	2,007	827	0	868	42
Cross Border Flows (non Betsi)	149	62	0	58	-3
Betsi	229	95	0	476	382
Non-Commissioner Specific	12,861	2,621	0	2,253	-367
TOTAL	**228,805**	**92,083**	**187**	**91,747**	**-336**

Other Contract Income	FY Target (£'000)	YTD Target (£'000)	YTD Actual (£'000)	Final Variance (£'000)
Bed Based Services	5,962	2,484	2,405	-79
Adult & Neonatal Critical Care	7,896	3,301	3,360	58
Community Paediatrics	1,303	543	543	0
Direct Access Services	9,509	3,984	3,982	-3
Unbundled Radiology	3,505	1,469	1,479	10
High Cost Drugs	9,762	4,216	4,099	-117
Screening Programmes	1,530	638	638	0
Audiology	1,167	486	431	-55
IVF	258	108	78	-29
CQUIN	4,312	1,327	1,182	-145
PSV	8,428	2,387	1,671	-716
Community Services	28,426	11,759	11,759	0
CEP	-2,817	-1,174	186	1,360
WINTER FUNDING	750	312	345	33
Other	6,726	1,232	1,480	248
TOTAL	**86,717**	**33,072**	**33,638**	**565**

South Cheshire CCG is currently performing below the contract value set , and Vale Royal above - if the contract were set on PbR tariffs - which is continuing the trend of the first quarter.

Other commissioners, except East Cheshire CCG are in the main over performing against plan. East Cheshire underperformance is in unplanned care (£67k), and within surgical specialties for planned care (£84k).

Specialist Commissioning has a negative variance being the result of a high cost drug rebate of £442k in July.

Cross border flows includes Welsh commissioners where the Trust is continuing to the North Welsh Health board, pre-dominantly in orthopaedic surgery, and ophthalmology.

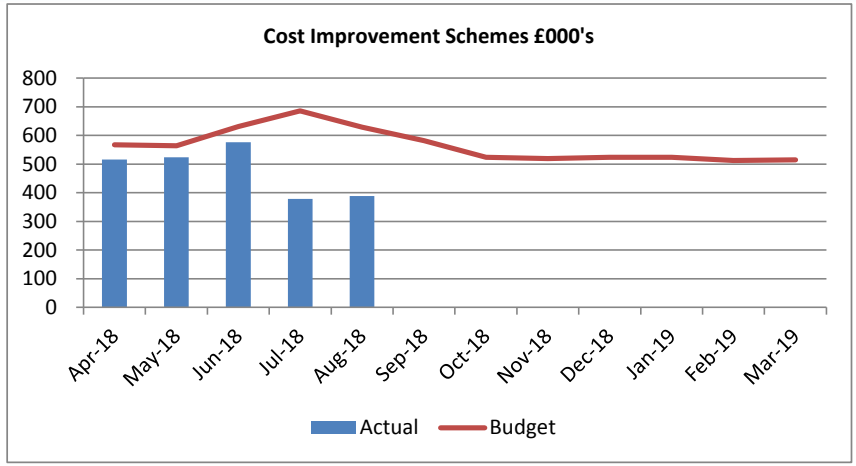
Other contract income is showing £0.6M better than plan.

An analysis of the key service lines identifies that, aside the CEP adjustment there were gains against the un-coded prior year spells valuation (£120k), CQUIN is £145k behind plan based on most recent forecasts of achievement, High cost drug income excluding the rebate is £587k above plan, non-performance of the A&E target has been recognised year to date.

The impact of the CEP is less than expected year to date by £1.4m, although there is marked difference between the 2 CCGs in under and over performance of A&E and NEL admissions.

Financial Performance: Efficiencies

Cost Improvement Schemes (£'000's)						
Scheme Category	**YTD Target**	**YTD Actual**	**YTD**	**FY Target**	**FY Forecast**	**FY Variance**
Access & Flow	478	189	-289	524	189	-335
Commercial	81	94	13	195	249	54
Drugs	125	125	0	657	657	0
Medical Workforce	646	643	-2	1,550	1,269	-282
Non-Pay Efficiency	512	658	146	1,228	1,687	459
Nursing Workforce	505	286	-219	974	688	-286
Procurement	289	192	-97	684	459	-205
Theatres Efficiency	42	0	-42	100	0	-100
Service redesign	253	194	-59	540	463	-77
Market Share	144	0	-144	320	220	-100
Total (£'000)	**3,075**	**2,381**	**-693**	**6,772**	**5,881**	**-872**



The CIP achievement year to date is £693kk worse than budget with key schemes around the failure to close a ward during the Summer period (£335k) , improvement of nurse/HCA sickness (£104k), reduction in WLIs either not currently delivering/partially delivering(£70k).

There is also a further risk associated with drugs scheme due to the potential delays for release of new bio-similars (£357k).

Capped Expenditure Schemes (£'000's)						
Scheme Category	**YTD Target**	**YTD Actual**	**YTD**	**FY Target**	**FY Forecast**	**FY Variance**
TeleDerm	29	0	-29	70	70	0
Non-Pay Efficiency	42	42	0	100	100	0
Drugs	21	21	0	50	50	0
Commercial	83	0	-83	200	200	0
Procurement	42	0	-42	100	100	0
Elective	465	356	-109	1,116	1,116	0
Total (£'000)	**682**	**419**	**-263**	**1,636**	**1,636**	**0**

The CEP schemes rolled over from 1718 are under achieving by £263k, with key issues around delivering planned cost savings in IVF, and work with East Cheshire in relation to births /out of hours contracts, as these are legacy CEP schemes these are being discussed with commissioners .

A review of the potential for further out of area work is underway in order to achieve the elective CIP, which maybe at further risk due to Winter pressures and the requirement to maintain RTT waiting lists at March 2018 levels.

Financial Performance: Capital Report

SCHEME	BOARD APPROVED	FUNDING SOURCE	FUNDING APPROVED	EXPENDITURE	2018/19	2018/19	2018/19 CUMULATIVE ACTUAL	2018/19 BETTER/WORSE THAN BUDGET	2018/19 FORECAST	2019/20 + FORECAST	WHOLE PROJECT ACTUAL TO DATE	WHOLE PROJECT PROPOSED PLAN	TOTAL FORECAST
STRATEGIC INVESTMENTS (Requires individual signoff)													
ESTATES													
CAR PARK BARRIERS	Yes	Internal	Yes	44	16	16	41	-25	16		85	60	60
BISTRO & 2 OFFICES	Yes	Internal	Yes	120	58	58	58	0	58		178	178	178
UNDER / OVERS CAPITAL SCHEMES 17/18	Yes	Internal	Yes		0	0	18	-18	0		18	0	0
WARD REFURBISHMENT	Yes	Loan	Yes	224	1864	1679	1419	260	1864	8600	1643	10,688	10,688
MRI SCANNER 3RD BUILD	Yes	Internal/Loan	Yes	174	1475	800	0	800	1475	0	174	1,649	1,649
WASTE COMPOUND AND SEGREGATION	Yes	Internal	Yes		350	0	0	0	350		0	350	350
TURNKEY FOR REPLACEMENT CT SCANNERS	No	Internal	Yes		165	0	0	0	165	135	0	300	300
BARRIER ACCESS CONTROL	Yes	Internal	Yes		100	0	0	0	100		0	100	100
CAR PARK LAND *	Yes	Loan	Not yet approved		400	60	10	50	400	1500	10	1,900	1,900
EPR PROJECT ACCOMODATION *	Yes	Loan	Not yet approved		350	0	0	0	0		0	350	0
ENDOSCOPY WASHER BUILD *	No	Loan	Not yet approved		250	0	0	0	0	500	0	750	500
PATHOLOGY RISKS	Yes	Internal	Yes		100	100	0	100	100		0	100	100
SSD ENABLING *	Yes	Loan	Not yet approved		668	0	0	0	668		0	668	668
WARD REFURBUISHMENT *	No	Loan	Not yet approved		1600	0	0	0	1400	200	0	1,800	1,600
DEMENTIA APPEAL	No	Donated	Not yet approved							1500		1,500	1,500
3RD CT ENABLING	No	Internal	Not yet approved							935		935	935
TOTAL				**562**	**7396**	**2713**	**1545**	**1168**	**6596**	**13370**	**2107**	**21328**	**20528**
IT													
UNDER / OVERS CAPITAL SCHEMES 17/18	Yes	Internal	Yes		0	0	1	-1	0		1	0	0
UPS	Yes	Internal	Yes		250	0	0	0	250		0	250	250
Q PULSE	Yes	Internal	Yes	25	37	37	0	37	37		25	62	62
HIGH IMPACT STAND ALONE IT SYSTEMS	Yes	Internal	Yes	88	112	62	2	60	112	400	90	600	600
REPLACEMENT BUSINESS INTELLIGANCE SYSTEM	Yes	Internal	Yes		80	80	35	45	80		35	80	80
CONFIGURATION MANAGEMENT SYSTEM	Yes	Internal	Yes		35	0	0	0	0		0	35	0
CORE INFRASTRUCTURE UPGRADE	yes	PDC	Yes		538	188	90	98	538	180	90	718	718
CYBER SECURITY	Yes	PDC	Yes	17	291	291	291	0	291		308	308	308
X-RAY MACHINE STORAGE	Yes	Internal	Yes		100	0	52	-52	100		52	100	100
SEQUEL / WINDOWS LICENCES	Yes	Internal	Yes		80	0	0	0	80		0	80	80
VIRTUAL DESKTOP	No	Internal	Yes		400	0	0	0	200		0	400	200
VIRTUAL CLINICS	No	Internal	Yes		50	50	0	50	50		0	50	50
VPN	Yes	PDC	Yes		70	35	0	35	70		0	70	70
VOICE OVER IP	Yes	Internal	Yes	466	100	41	1	40	75	100	467	666	641
SYSTEM REFRESH / REPLACEMENT													
LAB CENTRE PATHOLOGY	No	Internal	Yes		800	0	0	0	0	1600	0	2,400	1,600
CHEMOCARE	yes	Internal	Yes		85	0	0	0	0		0	85	0
DIGITAL DICTATION	Yes	Internal	Yes		60	0	0	0	60	73	0	133	133
DOCMAN	Yes	Internal	Yes		52	0	0	0	52		0	52	52
WIRELESS UPGRADE /N3 UPGRADE	Yes	Internal	Yes							65	0	65	65
PHARMACY ASCRIBE	No	Internal	Yes							200	0	200	200
STAFF WIFI	No	Internal	Yes							80	0	80	80
SOLITON MEDICAL IMAGING	No	Internal	Yes							250	0	250	250
BADGERNET	Yes	Internal	Yes							45	0	45	45
BLOOD TRACKING SYSTEM	No	Internal	Yes							200	0	200	200
CARDIO RESPIRATORY SYSTEM	No	Internal	Yes							350	0	350	350
TOTAL				**596**	**3140**	**784**	**472**	**312**	**1995**	**3543**	1068	**7279**	**6,134**
TOTAL STRATEGIC INVESTMENTS				**1158**	**10536**	**3497**	**2017**	**1480**	**8591**	**16913**	**3175**	**28,607**	**26,662**

The Estates strategic investments capital spend is £1,169K underspent mainy due to the and Third MRI Scanner £800K where Estates, a supplier has now been choosen and design work has started. In addition Ward 17 is £260K underspent and Pathology risks £100L. The IT Strategic investments projects are £312K which is mainly due to Core Infrastructure upgrad e £98K and High Impact Standalone £60K.

Financial Performance: Capital Report

SCHEME	BOARD APPROVED	FUNDING SOURCE	FUNDING APPROVED	EXPENDITURE	2018/19	2018/19	2018/19 CUMULATIVE ACTUAL	2018/19 BETTER/WORSE THAN BUDGET	2018/19 FORECAST	2019/20 + FORECAST	WHOLE PROJECT ACTUAL TO DATE	WHOLE PROJECT PROPOSED PLAN	TOTAL FORECAST
ROLLING ALLOCATIONS (Approved Delegated Budgets)													
ESTATES													
ASBESTOS REMOVAL	Yes	Internal	Yes		271	68	7	61	135	736	7	1,007	871
DESIGN TEAM	Yes	Internal	Yes		313	120	111	9	313	1252	111	1,565	1,565
CT / VT - HEATING INFRASTRUCTURE	Yes	Internal	Yes		459	125	13	112	150	1009	13	1,468	1,159
BACKLOG GENERAL PROVISION	Yes	Internal/Loan	Yes		2650	1197	1002	195	1,600	7799	1002	10,449	9,399
TOTAL				**0**	**3,693**	**1,510**	**1,134**	**376**	**2,198**	**10,796**	**1134**	**14,489**	**12,994**
IT													
INTERSITE CONNECTIVITY	Yes	Internal	Yes		50	25	16	9	50		16	50	50
INTERFACING	Yes	Internal	Yes		151	21	70	-49	151	340	70	491	491
IT APPLICATIONS	Yes	Internal	Yes		193	37	17	20	193	400	17	593	593
STORAGE & BACKUP	No	Internal	Yes							250		250	250
TOTAL				**0**	**394**	**83**	**102**	**-19**	**394**	**990**	**102**	**1,384**	**1,384**
TOTAL ROLLING ALLOCATIONS				**0**	**4,087**	**1,593**	**1,236**	**357**	**2,592**	**11,786**	**1,236**	**15,873**	**14,378**
ADDITIONAL													
EQUIPMENT	Yes	Internal	Yes		0	0	59	-59	59		59	0	59
MEDICAL RECORDS RACKING	Yes	Internal	Yes		43	43	0	43	43		0	43	43
CANCER MDT	Yes	PDC	Yes		30	30	0	30	30		0	30	30
GP STREAMING ESTATES	Yes	PDC	Yes	12	488	488	328	160	488		340	500	500
GP STREAMING IT FRONT OF HOUSE	Yes	PDC	Yes	108	142	0	0	0	142		108	250	250
COMMUNITY SERVICES	Yes	Internal	Yes	105	630	330	303	27	630		408	735	735
LEASING INVESTMENTS													
EQUIPMENT	Yes	Internal	Yes		600	273	273	0	600		273	600	600
3RD CT SCANNER	No	Internal	Not yet approved		531	0	0	0	0		0	531	0
REPLACEMENT CT SCANNER	No	Internal	Not yet approved		532	0	0	0	532		0	532	532
3RD MRI SCANNER	Yes	Internal	Yes		600	0	0	0	600		0	600	600
ROOM 2 X-RAY	No	Internal	Not yet approved		250	0	0	0	250		0	250	250
SSD WASHERS	No	Internal	Not yet approved		320	0	0	0	320		0	320	320
TOTAL LEASING INVESTMENTS				**0**	**2833**	**273**	**273**	**0**	**2302**	**0**	273	**2833**	**2302**
TOTAL CAPITAL PROGRAMME (EXCLUDING LEASES)				**1,383**	**15,956**	**5,981**	**3,944**	**2,037**	**12,575**	**28,699**	**5,327**	**46,038**	**42,657**
TOTAL CAPTIAL PROGRAMME				**1,383**	**18,789**	**6,254**	**4,217**	**2,037**	**14,877**	**28,699**	**5,600**	**48,871**	**44,959**

The rolling allocation is £357K underspent due to the delay in some of the backlog maintenance and CTVT replacement

The forecast spend has been reduced by the following: Asbestos £136K, Backlog Maintenance £1,050K, Ward Efurbishment £200K , Endoscopy Washer Build £250K. EPR Project office £350K and Virtual Desktop £200K. This cost have been moved to 2019/20. In respect of the Ward Refurbishment and the Endoscopy Build these are funded via loans and therefore the loans will be drawn down accordingly.

Financial Performance: Statement of Financial Position

	Plan Apr to Aug (£'000)	Actual Apr to Aug (£'000)	Variance (£'000)	Forecast 2018/19 (£'000)
Assets				
Assets, Non-Current	**101,403**	**98,963**	**-2,440**	**109,674**
Assets, Current				
Trade and other Receivables	7,678	5,923	-1,755	9,055
Other Assets (including Inventories & Prepayments)	6,174	6,758	584	6,600
Cash and Cash Equivalents	10,939	13,344	2,405	11,700
Total Assets, Current	**24,791**	**26,025**	**1,234**	**27,355**
ASSETS, TOTAL	**126,194**	**124,988**	**-1,206**	**137,029**
Liabilities				
Liabilities, Current				
Finance Lease, Current	-1,063	-683	380	-2,147
Loans Commercial Current	-256	-204	52	-667
Trade and Other Payables, Current	-13,256	-16,587	-3,331	-14,107
Provisions, Current	-179	-184	-5	-225
Other Financial Liabilities	-8,628	-6,736	1,892	-6,552
Total Liabilities, Current	**-23,382**	**-24,395**	**-1,013**	**-23,698**
Net Current Assets/(Liabilities)	**1,409**	**1,630**	**221**	**3,657**
Liabilities, Non Current				
Finance Lease, Non Current	-4,969	-4,428	541	-5,840
Loans Commercial Non-Current	-12,340	-12,040	300	-16,854
Provisions, Non-Current	-1,604	-1,586	18	-1,489
Trade and Other Payables, Non-Current	0	0	0	**0**
Total Liabilities Non-Current	**-18,913**	**-18,054**	**859**	**-24,183**
TOTAL ASSETS EMPLOYED	**83,899**	**82,539**	**-1,360**	**89,148**
Taxpayers' and Others' Equity				
Taxpayers Equity				
Public dividend capital	76,791	76,791	0	76,791
Retained Earnings	-8,485	-9,845	-1,360	-3,236
Donated asset reserve	0	0	0	0
Revaluation Reserve	15,592	15,592	0	15,592
TOTAL TAXPAYERS EQUITY	**83,898**	**82,538**	**-1,360**	**89,147**
TOTAL FUNDS EMPLOYED	**83,898**	**82,538**	**-1,360**	**89,147**

Assets Non-Current
The main reason for the variance is that the plan is the capital programme expenditure being £2,673K less than which is mainly due to a delay in the GP Streaming Project £160K, third MRI Scanner build £800K, Backlog maintenance £159K , Ward 17 Refurbishment £260K and a delay in the renewal of some finance leases £641K.

Trade and other Receivables
NHS Trade Receivables are lower than anticipated due to the A&E PSF to August 2018 was assumed to be still outstanding. The PSF for A&E to the end of August has not been accrued as the A&E target has not been achieved. Also it was assumed in the plan that all the PSF was paid in equal twelfths. Therefore the impact of the incorrect phasing and failure of the A&E target is £1,839K

Other Assets
This higher than anticipated due to higher than expected Drug Stocks £249K and IT Maintenance and Radiology Maintenance contract.

Finance Lease Current
This mainly due to a finance lease being paid earlier than anticipated.

Trade and other Payables
Trade Creditors is higher due to the payment run being made early September instead of late August. Also the Trust has paid back less than anticipated of the advance contract payment in August. This will be as anticipated in September.

Other Financial Liabilities
This is mainly due to Accruals being less than expected mainly due to the plan being based on last years accruals. There are fewer accruals in 2018/19 for CCICP expected expenditure in particular CCICP rental invoices which are now sitting in Trade and other Payables.

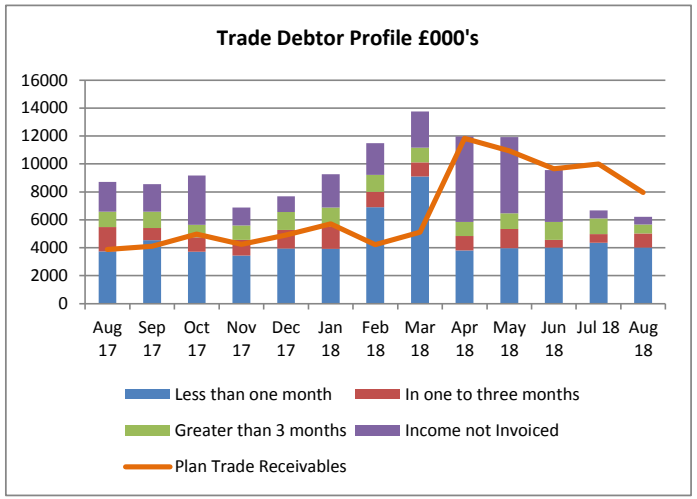
Finance Lease Non- Current
This due to the delay in the replacement of finance leases.

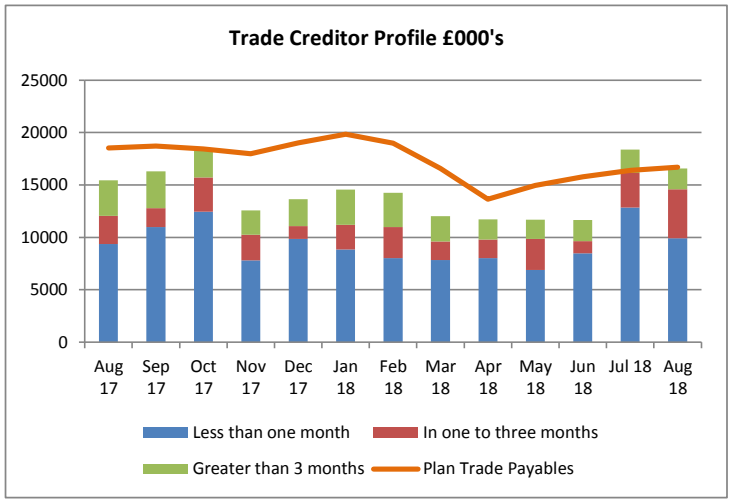
Loans Commercial Non-Current
This is due to the delay in the drawing down of an approved loan for the ward refurbishment and the third MRI scanner.

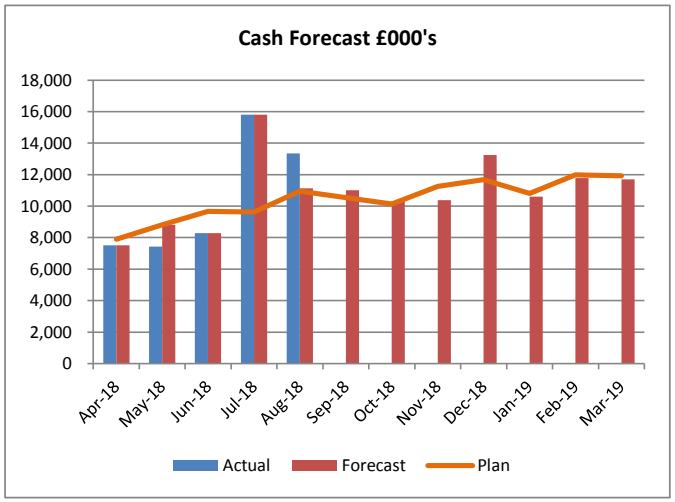
Financial Performance: Cash Position and Working Capital

	Plan Apr to Aug (£'000)	Actual Apr to Aug (£'000)	Variance
Surplus/(deficit) after tax	**-881**	**-2,248**	**-1,367**
Non-cash flows in operating Surplus/(deficit) total	2,542	2,314	-228
Operating cash flows before movements in working capital	**1,661**	**66**	**-1,595**
Increase/(Decrease) in working capital Total	7,123	10,334	3,211
Net cash inflow/(outflow) from operating activities	**8,784**	**10,400**	**1,616**
Net cash inflow/(outflow) from investing activities total	-4,997	-3,590	1,407
Net Cash inflow/(outflow) before financing	**3,787**	**6,810**	**3,023**
Net cash inflow/(outflow) from financing activities Total	-610	-1,227	-617
Net increase/(decrease) in cash and cash equivalents	**3,177**	**5,583**	**2,406**
Opening cash balance	**7,761**	**7,761**	**0**
Closing cash balance	**10,938**	**13,344**	**2,406**

Cash is £2,406K more than anticipated, this mainly due to the cash advance returned to the CCG being less than anticipated £1,171K. In addition the delay in the capital payment is improving the cash position but this is offset by £300K of a capital loan for the ward refurbishment which has not been drawn down. Also there is a negative impact on the cash flow due to a worse than anticipated operating surplus position.







Finance: *Staff Costs*

Headline Measures

	YTD £000's	Rolling 13 months £000's													
		Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Monthly Trend
Pay Budget	71,179	13,688	13,730	13,774	13,799	13,721	13,916	13,817	13,785	14,001	14,112	14,008	14,158	14,900	
Pay Actual	71,743	13,843	13,875	13,947	13,826	13,692	14,278	14,017	14,133	14,094	14,152	14,237	14,183	15,077	
Variance	-564	-155	-145	-173	-27	29	-362	-200	-348	-93	-40	-229	-25	-177	
% to Budget	*100.8%*	*101.1%*	*101.1%*	*101.3%*	*100.2%*	*99.8%*	*102.6%*	*101.4%*	*102.5%*	*100.7%*	*100.3%*	*101.6%*	*100.2%*	*101.2%*	
Nursing Staff % to Budget	101.6%	97.5%	99.3%	101.6%	102.9%	102.4%	105.9%	104.7%	105.0%	101.7%	99.9%	102.1%	100.5%	103.5%	
Medical Staff % to Budget	97.6%	108.2%	103.5%	102.6%	97.4%	95.3%	98.5%	97.1%	103.2%	95.4%	100.5%	99.2%	97.3%	95.6%	
Other Staff % to Budget	101.9%	100.9%	101.4%	100.1%	99.1%	99.8%	101.6%	100.7%	99.5%	102.9%	100.6%	102.7%	101.6%	102.0%	

Commentary

Figures exclude Community Services for 2016/17

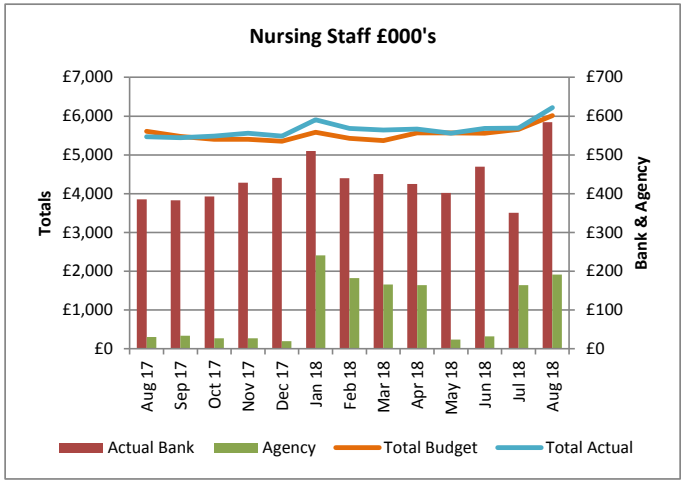
Pay is worse than budget by £0.5M year to date.

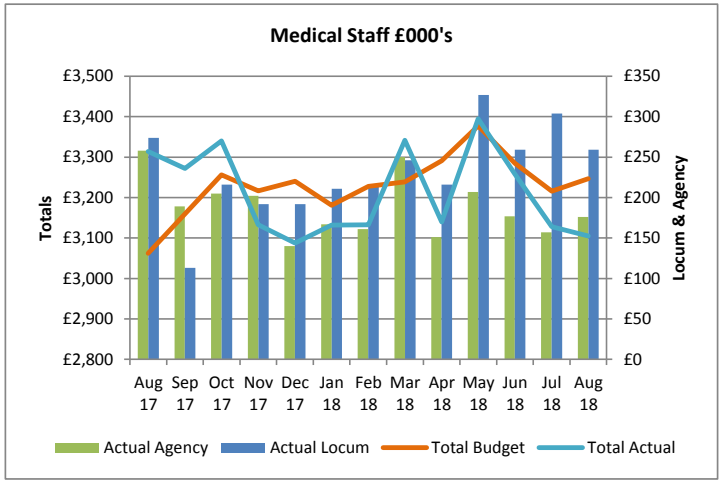
Nursing costs associated with keeping escalation beds/CAU assessment area open in April have been offset against agreed additional Winter money funding within contract income,however the recent escalation are unfunded. Bank use over establishment for HCAs continues to support one to one patient supervision and is a financial pressure. Nursing vacancies and sickness levels have remained static in the month.

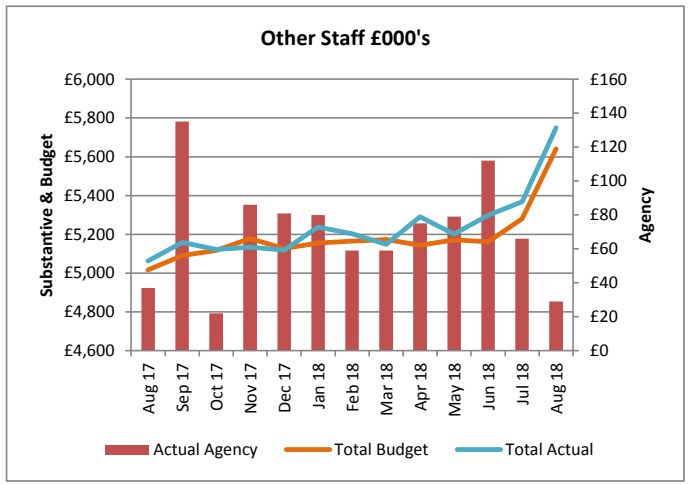
Medical pay is better than budget in month, and year to date due to vacancies most notably in Medicine & Emergency Care.

The Agency trajectory has improved as a result of the closure of the escalation beds, however there has been a significant increase in nursing agency spend during July. August Total agency spend remains below planned level, but is ikely to breach the target as a result of responding to unplanned care pressures. For every 1% of nursing staff where the shift cannot be covered, without premium

Primary Drivers

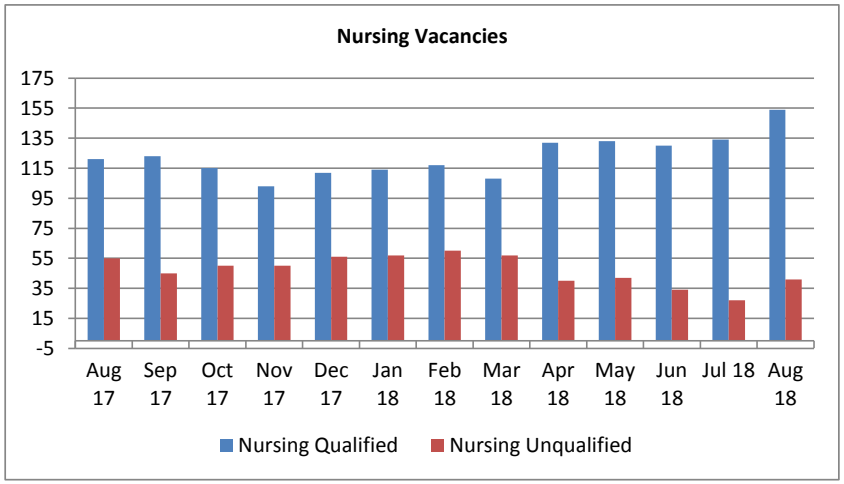






Finance: *Staff Costs*

Secondary Drivers



Medical vacancies under review

Agency Trajectory

	YTD	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Monthly Trend
Plan	-1,825	-563	-525	-495	-477	-506	-495	-470	-484	-365	-365	-365	-365	-365	
Actual	-1,801	-568	-540	-699	-721	-572	-668	-618	-574	-389	-310	-320	-387	-395	
Variance	24	-5	-15	-204	-244	-66	-173	-148	-90	-24	55	45	-22	-30	
CCICP Actual	0	0	0	-69	-77	-152	-210	4	-77	0	0	0	0	0	

	Rolling 13 Months													
	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Monthly Trend
Sickness Rate (Rolling 12 mths)	4.14%	4.20%	4.21%	4.23%	4.25%	4.28%	4.28%	4.38%	4.38%	4.37%	4.30%	4.29%	4.27%	
Total Leavers	48	54	45	39	33	46	37	59	39	41	38	40	63	
Turnover (Rolling 12 mths)	10.57%	11.10%	11.08%	10.93%	10.71%	10.70%	10.66%	11.18%	11.33%	11.28%	11.33%	11.17%	11.67%	

Mid Cheshire Hospitals
NHS Foundation Trust

Title of Paper:	Equality Delivery System (EDS2)	
Author:	Natalie Wallace, HR Manager	
Executive Lead:	Linda Holland, Interim Director of Workforce and OD	
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	x	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***
If no, to be published on Trust Website – redacted	***N***
If not to be published complete or redacted, please detail the reason why	
Presented at Board Meeting of:	1 October 2018

Mid Cheshire Hospitals
NHS Foundation Trust

EQUALITY DELIVERY SYSTEM (EDS2) 2017/18

EXECUTIVE SUMMARY

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.

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.

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 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 Public Sector Equality Duty.

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

Grading for each of the goals was done at an EDS2 Stakeholder Grading workshop held on 25th April 2018. The event was attended by:

- Body Positive Cheshire and North Wales

- Deafness Support Network
- Staff Side representative (Unison)

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

MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST SUBMISSION 2017/18

The goals and outcomes of EDS2				
Goal	No	Description of Outcome	2016/17 Level	2017/18 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	Developing
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	Achieving
	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	Achieving
	3.6	Staff report positive experiences of their membership of the workforce	Excelling	Achieving

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

Whilst the above grades appear to show a worsening position in 2017/18 compared to the previous reporting period, this is not strictly the case.

A more robust grading event has taken place this year in comparison to previous years with external stakeholders where the outcomes have been open to more scrutiny and challenge.

Grading evidence

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

Evidence drawn upon for the grading

• 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
• Patient Placement Policy
• 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. 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.

Grading	**Achieving**

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

Evidence drawn upon for the grading

- Translation Policy
- Electronic guidelines on the Intranet
  - Long Term Conditions
  - Learning Disability
  - Dementia
  - End of Life Care
- Unified DNAR policy
- 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
- 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 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 the Mental Capacity Act 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.

Evidence drawn upon for the grading

- 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
- 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
- Privacy & Dignity Policy
- Adult Safeguarding Policy
- Dementia Care Bundle
- Training records for Mental Capacity Act (MCA) and Deprivation of Liberty (DOLS)
- Internet Site – Patient Information including comprehensive Easy Read information
- Equality Impact Assessments for Services within the Trust

All policies have equality impact assessments undertaken prior to approval.

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

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.

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

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

Evidence drawn upon for the grading

- 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 campaigns
- Quality Account 2016/17
- Quality & Safety Improvement Strategy
- Patient and Public Involvement Strategy 2016 – 2019

The Trust has an Incident reporting system 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 are currently in the process of looking into implementing the Sexual Orientation Standard.

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 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 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 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 at Leighton Hospital. 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 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 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. The trust vaccinated over 76% of front line healthcare workers during the last campaign.

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 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 group have also devised a cookbook with healthy recipes to support the Trust Charity.

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

Grading	**Developing**

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.

Evidence drawn upon for the grading

- 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
- Patient Passports
- Easy read patient information leaflets
- Map of accessible car parking spaces
- Easy read quality account
- Training plan for dementia
- Changing places facility

All policies have equality impact assessments undertaken prior to approval which consider all protected characteristics. All services, business cases and tender specifications are also subject to equality impact assessments.

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.

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

The Trust provides appropriate food choices, support and religious facilities such as the chapel and the mosque.

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.

The Trust undertakes 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.

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.

Evidence drawn upon for the grading

- 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.

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.

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 drawn upon for the grading

• National inpatient survey 2016 results (overview)
• Annual complaints, comments, compliments report
• Quality Account
• 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 5 out of five star rating on NHS Choices for Northwich Victoria Infirmary and a 4.5 out of five star rating for Leighton Hospital. Some of the comments received include '*overall a very speedy and first class experience'* and *'I felt completely involved in the decisions made'.*

As a Trust we welcome feedback from a range of sources and use it to identify those areas where we are performing positively, as well as those where improvements may be made.
On average we receive around 20 complaints a month. Each one is taken seriously and thoroughly reviewed so that we can establish any changes that need to be made. We receive around 200 compliments a month and this does not include feedback such as reviews or posts on our social media pages.

"Everything about this hospital [Leighton] was wonderful and how you hope every NHS hospital should be run. Walking in, staff appear happy and welcoming. Volunteers on the reception are available to help you and a well-run café with reasonable prices helps guests enjoy either waiting or meeting experiences. Hospital staff are so helpful and friendly and appear to genuinely care and appreciate the standard of their work. A clean, modern hospital and a credit to the staff." (NHS Choices review)

"Words can never express my gratitude towards you all in Critical Care at Leighton Hospital. You do a wonder and very difficult and emotional job which deserves so much more than can ever be returned in words" (Email to the Customer Care Team)

"I cannot thank the staff in A&E, Resus and the Major ward enough. The staff, without exception, were just incredible. (Facebook review)

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.

Both a mosque and chapel are available on site.

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. 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 drawn upon for the grading

- Complaints policy
- Complaint survey pro forma
- Board patient experience report
- Quality Account 2017/18
- Annual 2017/18 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.

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.

The Trust allows for a continual process for feedback 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.

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

Training on how to manage complaints is delivered to staff.

The Trust is committed to developing learning from complaints. Lessons learned are shared on a monthly basis via “You said we did” posters which are displayed in all ward and outpatient areas and shared a staff team meetings, one to one direct feedback meetings and patient stories at Trust Board meetings.

Themes	Actions taken
It was felt that nursing staff needed some training around assisting bereaved families on the wards	The Bereavement Manager now provides training for ward areas on the bereavement process
Although bed rails are raised when necessary, some patients do try to get out of the bed themselves which could result in the patient falling	High risk patients are highlighted in the nurse handover sheet and further sensor pads have been purchased. A falls focus board has been placed in the staff room to familiarise staff with documentation and prevention strategies
No staff visible in the changing and waiting areas of the treatment centre when patients were waiting for a procedure resulting in poor communication	We have increased staff in these areas and will be allocating a nursing assistant to be based in this area to provide support and communication to patients waiting for procedures
Some patients felt that staff could have better explained procedures and the benefits of sedation	Information leaflets and letters sent to patients undergoing procedures are being reviewed. A questionnaire relating to choosing sedation will now be present in future surveys

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 drawn upon for the grading

• Recruitment policy
• Initial and On-going Registration Policy
• Guidance for Recruiting Managers

• Reference and Employment History Check Policy
• Disclosure and Barring Policy
• Recruitment Conversion reporting and Analysis 2016/17
• Workforce Race Equality Standard 2017

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.

The Trust monitors how successfully it converts protected groups from applicant to employee. Increased training appears to be decreasing inequality seen in most staff groups and the Trust continues to invest in this area. A more comprehensive programme to develop and execute values based recruitment is in progress and more gains should be seen on the back of this.

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 feel 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. Additionally the Trust is embracing extended roles across its professional and non-professional workforce e.g. TNAs allowing for more internal progression across the board.

The Trust continues to offer work placement schemes and pre-employment support via the inspiring futures team and some of this work focuses specifically on protected characteristics.

The Trust continues to use a multi-media approach to the advertising of vacancies assisting with accessibility.

The Trust continues to attend 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
• 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

Evidence drawn upon for the grading

- Agenda for Change job matching policy
- Staff survey results
- Equal pay audits
- Gender pay gap report
- Minutes of meetings with E & D group
- Trust policies

All new posts and post updates are subjected to job evaluation panels by trained panellists. Panels consist of appropriately trained members including staff side representatives and undergo a consistency checking process.

Equal pay audits exploring gender and race were 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. Further equal pay audits will be completed to continue monitoring.

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

The Trust's first Gender Pay Gap report was completed in March 2018 and is available on the Trust website and on a government website. The report showed a gender pay gap and further analysis will be undertaken to explore the detail and action plans will be devised to address the gap.

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.

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

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 continues to:

• Identify learning and development opportunities aligned with the requirements and wishes of all staff and teams using the formal appraisal cycle, team development events and informal discussions as drivers for conversation and reflection.
• 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, using a range of methods including shadowing, formal training, coaching, eLearning and mentorship.

• Nurture Learning and Development Forum membership and engagement by widening the terms of reference to include key external stakeholders who can advise, inform and introduce an additional dimension to discussion and debate.
• Think beyond the divisional training needs analyses to offer a portfolio of developmental opportunities that meet the needs of service users.
• 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 challenge where appropriate.
• Maintain accurate training records for each member of staff.

Evidence drawn upon for the grading

• Staff Survey results 2017
• Statutory and Mandatory Training Policy (updated in 2016)
• Vocational Training and Apprenticeships Policy (updated in 2018)
• Appraisal Policy and Documentation (review took place in 2017 and new processes implemented)
• Guidance Document for Managers to Approve Study Leave
• On boarding training on Equality, Diversity and Human Rights
• Bespoke training and coaching in support of staff members and volunteers
• 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
• Participation and evaluation data 2017/18
• Local induction pack (updated in 2017)
• On-line learning packages, on boarding and induction materials

The staff survey results from 2017 reviewed staff opinion on the quality of non-mandatory training, learning and development. The Trust score was 4.01% out of 5 which was slightly below the national average which was 4.06 out of 5.

All staff complete equality and diversity training as part of their on boarding programme, they then participate in a face to face induction programme and complete place-based 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 (such as workforce planning) combine to inform the divisional training needs analysis. The Education department supports and advises throughout the training needs analysis process to ensure that a wide range of options are considered and return on investment is measured.

1 to1 consultations with learning and development specialists are available to every staff member who wishes to explore ways to develop skills or increase proactivity and awareness. Career coaching is available and documentation and research resources are available through the JET Library.

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 and support materials by using PCs situated in learning and development, computer services and the JET Library. Staff can also access the Massive Open Online Course (MOOC). These are open learning training programmes that are developed mainly by higher education institutes and are open and free to anyone. See Future Learn for further information https://www.futurelearn.com. Facilitated support sessions for e-learning users are also available bi-monthly.

The Trust has named Dyslexia champions, who are able to 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.

The 2017 Workforce Race Equality Standard (WRES) showed that there has been an increase in the likelihood of Black and Minority Ethnic (BME) staff accessing non mandatory training during 2016/17 compared to the previous reporting period.

Grading	Achieving

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 drawn upon for the grading

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

The staff survey results for 2017 reported that the Trust were slightly better than an average position for staff who have experienced harassment, bullying or abuse from staff or patients and the public and also report better than the national average for staff who report experience of harassment, bullying or abuse. Focus groups take place following the results of the staff survey to further explore the findings and develop action plans. The NHS staff survey is undertaken on an annual basis.

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. 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.

Any complaints of harassment, bullying or general bad behaviour from others are addressed through the Trust's HR 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 Employee Support Adviser (ESA) 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/early 2017 and new Employee Support Advisors were appointed and trained with representatives from across all divisions. Regular networking sessions are being arranged for the advisers to share learning. A review of service access is undertaken on an annual basis to review effectiveness and utilisation by staff.

A Staff Voicemail Service is available whereby staff can leave a message raising their concerns confidentially.

The Freedom to Speak Up campaign was relaunched early 2018 following the appointment of a new Freedom to Speak Up guardian. This allows staff to raise whistleblowing concerns in a confidential and secure manner. A dedicated email address has been set up to receive concerns and staff are able to access other routes to raise concerns, such as via the Employee Support Advisors and the staff voicemail.

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

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

Equality and Diversity /Dignity at Work for Manager sessions are scheduled to take place in 2018

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 life 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 drawn upon for the grading

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

The staff survey explores whether staff are satisfied with the opportunities for flexible working patterns. In 2017, the Trust result of 51% was in line with the national average across similar Trusts.

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.

Grading	**Achieving**

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

Evidence drawn upon for the grading

- Staff Survey
- Staff friends and family test
- Vocational Training (including Apprenticeships) Policy and Procedure
- Focus groups
- CEO drop-in schedule
- Leadership development programme schedule
- Workforce Race Equality Standard (WRES)

The Trust collects and considers the perspectives and opinions of all members of its workforce using a range of methods to ensure an accurate picture is gathered.

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.

In the 2017 staff survey the results for Mid Cheshire Hospital Trust showed a high level of engagement of staff. The score for 2017 was 3.85 (out of 5) which is above (better than) average when compared with Trusts of a similar type. The national average for combined acute and community trusts was 3.78.

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

• Staff satisfaction with level of responsibility and involvement 3.99 out of 5
• Staff believing that the organisation provides equal opportunities for career progression or promotion 92%
• Organisation and management interest in and action on health and wellbeing 3.73 out of 5
• Staff recommendation of the organisation as a place to work or receive treatment 3.87 out of 5
• Percentage of staff able to contribute towards improvements at work 72%
• Staff satisfaction with the quality of work and care they are able to deliver 4.03 out of 5
• Percentage of staff agreeing that their role makes a difference to patients/service users 91%

The staff friends and family test is undertaken each year whereby all staff have the opportunity to feedback their views on their organisation. This ensures staff have further opportunity and confidence to speak up, and the views of staff are increasingly heard and are acted upon. 82% of staff would recommend the trust as a provider of care to their family or friends. Some comments from the staff friends and family test include 'My colleagues work incredible hard and efficiently and have the wellbeing of the patient at the forefront of their minds always' and 'I feel that there is a positive culture in my division and in many areas of the trust'

Staff focus groups take place regularly throughout the year, and the CEO invites all staff to speak with her directly through her CEO briefing sessions which are held on a regular basis throughout the year.

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

Grading	**Achieving**

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. In 2018, equality and diversity training for managers is included on the training programme and includes unconscious bias awareness.

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 are reviewed on a 3 yearly basis. These were reviewed again in late 2017. 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.

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 drawn upon for the grading

- Statutory and Mandatory Training Policy
- Appraisal Policy and Documentation

- Onboarding training on Equality, Diversity and Human Rights
- Training participation and evaluation data
- Induction participation and evaluation data
- Local induction pack (updated in 2017)
- On-line learning packages, onboarding and induction materials
- Provision of a Coaching and Mentoring Service at MCHFT Policy (New policy in 2018)

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. In addition a new equality and diversity for managers training session has been developed for 2018 which explores equality and diversity in further detail and address unconscious bias.

- 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 training on Equality and Diversity rights and responsibilities, including reference to Trust values and behaviours and their role in supporting a culture that is free of discrimination. The Trust values and behaviours were refreshed in early 2018.

- 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 and include unconscious bias awareness.

- 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 an in house cohort of coaches and mentors who are qualified to support line managers individually in developing their cultural competence and a new policy has been developed to support this.

- The 2017 staff survey reported that 10% of staff experienced discrimination at work in the last 12 months, which is in line with the national average for similar trusts. All trust are encouraged to report such incidents and a range of reporting mechanisms are available to staff such as the incident reporting system, staff voicemail and the Freedom to Speak Up Guardian, in addition to the relevant HR policies.

Grading	**Achieving**

Equality Delivery System for the NHS

EDS2 Summary Report

Implementation of the Equality Delivery System – EDS2 is a requirement on both NHS commissioners and NHS providers. Organisations are encouraged to follow the implementation of EDS2 in accordance with the '9 Steps for EDS2 Implementation' as outlined in the 2013 EDS2 guidance document. The document can be found at: **http://www.england.nhs.uk/wp-content/uploads/2013/11/eds-nov131.pdf**

This *EDS2 Summary Report* is designed to give an overview of the organisation's most recent EDS2 implementation. It is recommended that once completed, this Summary Report is published on the organisation's website.

NHS organisation name:

Mid Cheshire Hospitals NHS Foundation Trust

Organisation's Board lead for EDS2:

Estelle Carmichael, Director of Workforce ad Organisational Development

Organisation's EDS2 lead (name/email):

Natalie Wallace, HR Manager Natalie.wallace@mcht.nhs.uk

Level of stakeholder involvement in EDS2 grading and subsequent actions:

The equality and diversity group drive forward the EDS2 agenda

A stakeholder event took place on 25th April 2018 with the following representatives:
Body Positive Cheshire and North Wales
Deafness Support Network
Staff Side representative (Unison)

The completed EDS2 information was discussed with HealthWatch at a meeting on 15th August 2018 and shared with NHS South Cheshire CCG and NHS Vale Royal CCG on the same date

Organisation's Equality Objectives (including duration period):

Equality objectives 2016-2020

1. To make our information and services accessible to the people we serve.

2. To increase support for LGBT staff.

3. To encourage the recruitment conversion and progression rates of black, Asian and minority ethnic (BME) staff.

Headline good practice examples of EDS2 outcomes (for patients/community/workforce):

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.

The Trust holds best interest meetings for patients who lack capacity and involves carers.

The translation / interpreter service is well utilised to ensure staff can communicate

Publication Gateway Reference Number: 03247

Date of EDS2 grading	May	2018	Date of next EDS2 grading	May	2019

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
Better health outcomes	1.1	**Services are commissioned, procured, designed and delivered to meet the health needs of local communities** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ✓ Disability; ✓ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ☐ Sexual orientation Evidence drawn upon for rating: The Trust is a signatory to living well, working well and dying well in Cheshire East. 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	✓
	1.2	**Individual people's health needs are assessed and met in appropriate and effective ways** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ✓ Disability; ✓ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ☐ Sexual orientation Evidence drawn upon for rating: 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.	☐
	1.3	**Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ✓ Disability; ✓ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ☐ Sexual orientation Evidence drawn upon for rating: All policies have equality impact assessments undertaken prior to approval. 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	✓

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
Better health outcomes, continued	1.4	**When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ☑ Age; ☑ Disability; ☑ Gender reassignment; ☑ Marriage and civil partnership; ☑ Pregnancy and maternity; ☑ Race; ☑ Religion or belief; ☑ Sex; ☐ Sexual orientation **Evidence drawn upon for rating:** The Trust has an Incident reporting system and an Incident Investigation, Learning and Improving Policy. These policies outline to staff how and when they should report any type of incident. The Trust uses Safeguard (Ulysses) risk management software to store all incidents. This system allows staff to report incidents electronically.	☐
	1.5	**Screening, vaccination and other health promotion services reach and benefit all local communities** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ☑ Age; ☐ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ☑ Pregnancy and maternity; ☐ Race; ☐ Religion or belief; ☑ Sex; ☐ Sexual orientation **Evidence drawn upon for rating:** The Trust's provides or supports national screening programmes including: • Breast Cancer • Bowel Cancer • Sexual Health Screening Blood Borne Virus Screening The trust offers free flu vaccinations to all employees. Where	☑
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** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ☑ Age; ☑ Disability; ☑ Gender reassignment; ☑ Marriage and civil partnership; ☑ Pregnancy and maternity; ☑ Race; ☑ Religion or belief; ☑ Sex; ☐ Sexual orientation **Evidence drawn upon for rating:** All policies have equality impact assessments undertaken prior to approval which consider all protected characteristics. All services, business cases and tender specifications are also subject to equality impact assessments. The Trust has interpreting and translation services provided by the Big Word and the Deafness Support Network.	☑

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
Improved patient access and experience	2.2	**People are informed and supported to be as involved as they wish to be in decisions about their care** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ☑ Age; ☑ Disability; ☑ Gender reassignment; ☑ Marriage and civil partnership; ☑ Pregnancy and maternity; ☑ Race; ☑ Religion or belief; ☑ Sex; ☐ Sexual orientation **Evidence drawn upon for rating:** 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.	☐
	2.3	**People report positive experiences of the NHS** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ☑ Age; ☑ Disability; ☑ Gender reassignment; ☑ Marriage and civil partnership; ☑ Pregnancy and maternity; ☑ Race; ☑ Religion or belief; ☑ Sex; ☐ Sexual orientation **Evidence drawn upon for rating:** The Trust is currently achieving a 5 out of five star rating on NHS Choices for Northwich Victoria Infirmary and a 4.5 out of five star rating for Leighton Hospital. As a Trust we welcome feedback from a range of sources and use it to identify those areas where we are performing positively, as well as those where improvements may be made.	☐
	2.4	**People's complaints about services are handled respectfully and efficiently** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ☑ Age; ☑ Disability; ☑ Gender reassignment; ☑ Marriage and civil partnership; ☑ Pregnancy and maternity; ☑ Race; ☑ Religion or belief; ☑ Sex; ☐ Sexual orientation **Evidence drawn upon for rating:** 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. A written acknowledgement is then sent with a response deadline, a customer care leaflet and a Health Watch leaflet. The customer care leaflets are available in other languages, easy	☐

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
A representative and supported workforce	3.1	**Fair NHS recruitment and selection processes lead to a more representative workforce at all levels** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ☑ Age; ☑ Pregnancy and maternity; ☐ Disability; ☐ Race; ☑ Gender reassignment; ☑ Religion or belief; ☑ Marriage and civil partnership; ☐ Sex; ☑ Sexual orientation **Evidence drawn upon for rating:** 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. The Trust monitors how successfully it converts protected groups from applicant to employee.	☑
	3.2	**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** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ☑ Age; ☑ Pregnancy and maternity; ☑ Disability; ☑ Race; ☑ Gender reassignment; ☑ Religion or belief; ☑ Marriage and civil partnership; ☑ Sex; ☑ Sexual orientation **Evidence drawn upon for rating:** All new posts and post updates are subjected to job evaluation panels by trained panellists. Panels consist of appropriately trained members including staff side representatives and undergo a consistency checking process. Equal pay audits exploring gender and race were completed in both 2015 and 2016 and concluded that the differences in average pay	☐
	3.3	**Training and development opportunities are taken up and positively evaluated by all staff** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ☑ Age; ☑ Pregnancy and maternity; ☐ Disability; ☐ Race; ☑ Gender reassignment; ☑ Religion or belief; ☑ Marriage and civil partnership; ☑ Sex; ☑ Sexual orientation **Evidence drawn upon for rating:** The staff survey results from 2017 reviewed staff opinion on the quality of non-mandatory training, learning and development. The Trust score was 4.01% out of 5 which was slightly below the national average which was 4.06 out of 5. All staff participate in an annual appraisal process consisting of regular 1 to 1 meetings throughout the year. Emerging	☐

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
A representative and supported workforce	3.4	**When at work, staff are free from abuse, harassment, bullying and violence from any source** **Grade:** Undeveloped; Developing; Achieving; Excelling **Which protected characteristics fare well:** ☑ Age; ☐ Disability; ☐ Gender reassignment; ☑ Marriage and civil partnership; ☑ Pregnancy and maternity; ☐ Race; ☑ Religion or belief; ☑ Sex; ☐ Sexual orientation **Evidence drawn upon for rating:** The staff survey results for 2017 reported that the Trust were slightly better than an average position for staff who have experienced harassment, bullying or abuse from staff or patients and the public and also report better than the national average for staff who report experience of harassment, bullying or abuse. Focus groups take place following the results of the staff survey to further explore the findings and develop action plans. The NHS	☐
	3.5	**Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives** **Grade:** Undeveloped; Developing; Achieving; Excelling **Which protected characteristics fare well:** ☑ Age; ☐ Disability; ☑ Gender reassignment; ☑ Marriage and civil partnership; ☐ Pregnancy and maternity; ☐ Race; ☐ Religion or belief; ☑ Sex; ☑ Sexual orientation **Evidence drawn upon for rating:** Policies and procedures exist to ensure that provision is made for all staff to enjoy a balance between work and home life. • Mutually Agreed Flexibility Scheme • Flexible Working Policy • Career Break and Secondment policy • Supporting Working Parents Policy	☐
	3.6	**Staff report positive experiences of their membership of the workforce** **Grade:** Undeveloped; Developing; Achieving; Excelling **Which protected characteristics fare well:** ☑ Age; ☐ Disability; ☐ Gender reassignment; ☑ Marriage and civil partnership; ☑ Pregnancy and maternity; ☐ Race; ☑ Religion or belief; ☑ Sex; ☐ Sexual orientation **Evidence drawn upon for rating:** In the 2017 staff survey the results for Mid Cheshire Hospital Trust showed a high level of engagement of staff. The score for 2017 was 3.85 (out of 5) which is above (better than) average when compared with Trusts of a similar type. The national average for combined acute and community trusts was 3.78. Some other examples of staff reporting positive experiences of their	☐

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
Inclusive leadership	4.1	**Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ✓ Age; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Religion or belief; ✓ Sex **Evidence drawn upon for rating:** 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	
	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** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ✓ Age; ✓ Disability; ✓ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ✓ Sexual orientation **Evidence drawn upon for rating:** • 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 are reviewed on a 3 yearly basis.	
	4.3	**Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ✓ Age; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Religion or belief; ✓ Sex **Evidence drawn upon for rating:** • All staff must successfully complete the Trust online onboarding package on equality and diversity. The package includes a graded assessment. In addition a new equality and diversity for managers training session has been developed for 2018 which explores equality and diversity in further detail and address unconscious bias.	

Quarterly Organisational Risk Register Report 2018/19

Quarter 1

'Delivering Excellence in Healthcare through Innovation and Collaboration'

Contents

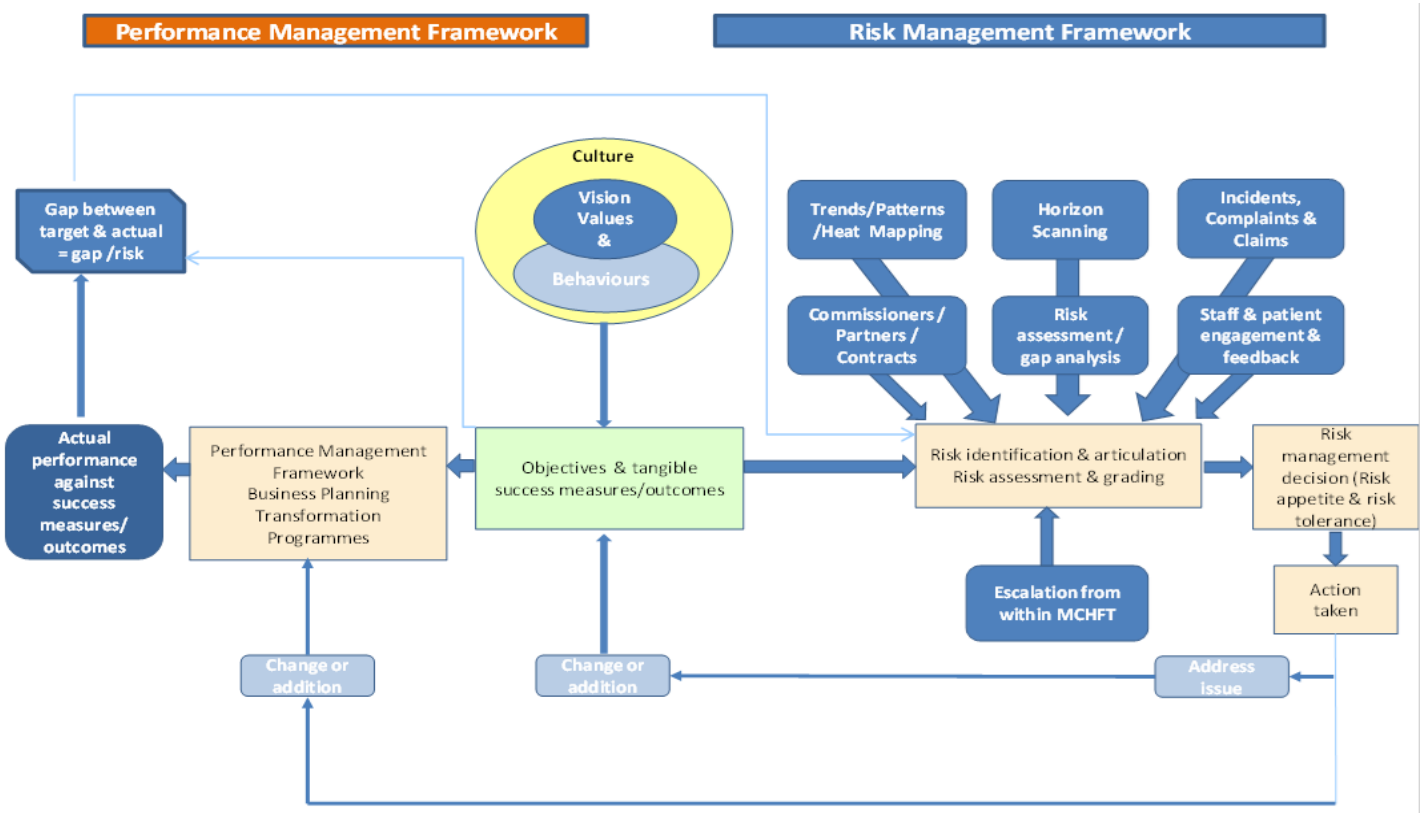
1. Purpose

The *Risk Management Strategy & Framework 2017/20* was approved in August 2017 and forms part of the Trust's wider internal control and governance arrangements. Work on the Trust's risk management processes will be iterative over the lifetime of the strategy & framework. This report provides an overview of organisational risks rated 15 and above (guide) and a summary of progress, with detailed risks rated 20 and above included in Appendix A. Appendix B provides a progress update against the six key priorities detailed in the *Risk Management Strategy & Framework 2017/20* and Appendix C provides the summary risk matrices.

2. Current position & next steps

This is the fourth version of the revised quarterly organisational risk register report. In parallel divisional/CCICP level reports are being developed and presented at Divisional/CCICP Boards as iterative documents for discussion and feedback. Work on revising the current approach to defining risk statements to a *"There is a risk that <risk event> as a result of <cause> which may lead to <effect/impact>"* is progressing with a focus on risks rated 15 and above. A programme of work is underway to develop risk management systems, including the introduction of web based risk reporting. The Estates & facilities Department has commenced as a pilot site within the programme and CCICP will become a second pilot site at the end of August 2018. Roll out of risk web is planned by March 2019.

The diagram below details the relationship between the performance and planning and risk management frameworks and the linkages across. Future versions of the divisional/CCICP reports will map the risks to the local objectives (*Trust Strategy 2017 with 2020 Horizon*: Plans on a Page).



3. Top five organisational risks

The top five organisational risks mapped to the Board Assurance Framework are detailed below.

	Risk Title	Mitigated (With controls) Risk Rating	Key Links to BAF 2018/19	Comments
1	Workforce Capacity and Skill Mix to Consistently Deliver High Quality Care, Seven Days a Week.	5(C)x4(L)=20	Q1,Q2,P1,P2, E2,W1,W2,W3 T2a,T2b	This is a new risk which replaces CS0275 "Delivering high quality clinical care 7 days a week" and CS0328 "Sustainability of vulnerable clinical services."
2	Delivery of Key Local And National Targets and Standards, In Particular the 4 Hour Standard in A&E.	5(C)x4(L)=20	Q1,Q2,E1,E2, P1,P2	This is a refresh of risk CS0325 "Operational sustainability of MCHFT."
3	A Lack of Funding to Implement the Information Management and Technology Strategy.	5(C)x4(L)=20	Q1,Q2,E1,E2, T2a,T2b	This is a refresh of risk CS0326 "Risk to the Trust of not delivering the IM&T Strategy."
4	Lack of Pace in the Significant Transformational Change Required to Deliver The Cheshire East Place Strategy and Consequently the Health and Care Partnership (HCP) For Cheshire & Mersey.	4(C)x4(L)=16	Q1,Q2,P1,P2, E1,E2,W2,T1	This is a new risk.
5	The Long Term Financial Sustainability of the Trust.	5(C)x4(L)=20	E1,E2,P1,P2, T1,T2a,T2b	This is a refresh of risk CS0327 "Financial sustainability of MCHFT."

4. New risks in the quarter 1 rated 15 & above

4.1 Corporate Services

- None for this period

4.2 CCICP

- None for this period

4.3 Diagnostics & Clinical Support Services

- None for this period

4.4 Medicine & Emergency Care

- None in this period

4.5 Estates & Facilities

- None for this period

4.6 Surgery & Cancer

- None for this period

4.7 Women & Children's

- None for this period

5. Risks past the review date rated 15 & above

- Influenza Type Disease Pandemic causing disruption to service

6. Closed / de-escalated risks previously rated 15 & above

There are no closed or de-escalated risks previously rated 15 & above for this reporting period.

7. Potential new risks awaiting assessment / horizon scanning

7.1 Corporate Services

- Counter Fraud
- Cyber Security.

7.2 CCICP

- None.

7.3 Diagnostics & Clinical Support Services

- Use of Modular Van Scanner during Replacement Scanner Works
- Anterior Cruciate Ligament Reconstruction
- Therapy Services for Neurology Patients
- Failure of the DAWN Anticoagulation System
- Lack of a Point of Care Co-ordinator
- East Cheshire Dermatology Services

7.4 Division of Medicine & Emergency Care

- Delivering of Resus training
- Saving 250k through Reducing HCA and Nursing sickness
- Corridor closure by Ward 6 restricting access to ICU.

7.5 Estates & Facilities

- None.

7.6 Surgery & Cancer

- Bowel Screening and gFOBt programme
- The decanting of SACU to allow for escalation of bedded areas
- Potential risks identified from the review of NICE Guidance, Quality Standards and Royal College/National Guidance.

7.7 Women & Children's

- Recording of Paediatric Transfers – high 9 – awaiting input
- Non-compliance with NICE guideline NG80 Asthma: diagnosis, monitoring and chronic asthma management
- On call Community Midwives staffing awaiting input
- Labour ward coordinator cover
- Clinical risk from external provider assessment with DGM for agreement
- CTG Training awaiting approval at Governance meeting
- Saving Babies Lives (scanning capacity) awaiting approval at Governance meeting
- Non-compliance with National guidelines ATP role in maternity theatre risk has been escalated to Divisional board.

8. Organisational Risk Register - Summary on a page

The total number of risks on the risk register currently is **334**. The scores of the mitigated assessed risks are depicted in the total column on the matrix below. Detailed risks rated 20 and above are presented in Appendix A. As work on the risk register progresses to apply a more consistent approach to both the articulation of the risk, the grading and centralisation of improvement actions, it is expected a shift will be seen in the overall risk profile of the organisation.

Total number of risks – Organisational	334

Risk Matrix	Likelihood														
Impact	1			2			3			4			5		
	Rare			Unlikely			Possible			Likely			Almost certain		
	Score	Total	%	Score	Total	%	Score	Total	%	Score	Total	%	Score	Total	%
5 Catastrophic	5	19	5.6%	10	69	20.4%	15	13	3.9%	20	7	2.1%	25	-	-
4 Major	4	6	1.8%	8	45	13.3%	12	64	18.9%	16	14	4.2%	20	7	2.1%
3 Moderate	3	6	1.8%	6	20	5.9%	9	33	9.8%	12	14	4.2%	15	3	0.9%
2 Minor	2	-	-	4	7	2.1%	6	1	0.3%	8	4	1.2%	10	3	0.9%
1 Negligible	1	-	-	2	-	-	3	1	0.3%	4	1	0.3%	5	-	-

9. Risks by Division, by mitigated risk score

Division	Risks rated 20 & above	Risks rated 16	Risks rated 15	Risks rated 12	Risks rated 10 & below	Total
Corporate Services	5	3	5	10	50	73
CCICP	0	2	0	10	10	22
Diagnostics & Clinical Support Services	0	2	2	12	14	30
Division of Medicine & Emergency Care	8	3	3	16	32	62
Estates & Facilities	0	1	3	3	18	25
Surgery & Cancer	0	1	1	14	35	51
Women & Children's	1	0	1	13	56	71
Totals:	14	12	15	78	215	334

10. Summary of the Organisational Risk Register by mitigated risk score (Rated 15 & above)

Reference	Lead	Divisional Objective*	Risk Title	Date of Initial Assessment	Rating with existing control measures (CxL)						Position Statement
					Controls Assurance Rating*	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Target Rating	
CS0302	**Head of Information Governance** Cora Suckley		Information Governance Overarching Risk Assessment	08/08/2014		5x4 = 20	5x4 = 20				5x2 = 10	*The risk is under review and will be split across cyber security and GDPR. The risks are currently in draft and will be finalised by the end of August 18*
CS0326	**Medical Director** Dr Paul Dodds		A Lack of Funding to Implement the Information Management and Technology Strategy.	07/09/2015		4x5 = 20	5x4 = 20				5x2 = 10	*This is a refresh of risk CS0326 "Risk to the Trust of not delivering the IM&T Strategy." The revised grading is provided under Q1and target columns*
CS0327	**Director of Finance** Mark Oldham		Long Term Financial Sustainability of the Trust	02/09/2015		5x5 = 25	5x4 = 20				5x2 = 10	*This is a refresh of risk CS0327 "Financial sustainability of MCHFT." The revised grading is provided under Q1and target columns*
CS0328	**Medical Director** Dr Dodds		Workforce Capacity and Skill Mix to Consistently Deliver High Quality Care, Seven Days a Week.	24/09/2015		5x4 = 20	5x4 = 20				5x2 = 10	*This is a new risk which replaces CS0275 "Delivering high quality clinical care 7 days a week" and CS0328 "Sustainability of vulnerable clinical services." The revised grading is provided under Q1and target columns*

Reference	Lead	Divisional Objective*	Risk Title	Date of Initial Assessment	Rating with existing control measures (CxL)							Position Statement
					Controls Assurance Rating*	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Target Rating	
CS0315	**Night Nurse Practitioner** Nigel Billington		Warding of members of the Out of hours Advanced Nurse Practitioner team (NNP) Team (or reduced cover due to other reasons)	16/02/2007		**Under Review**						*Risk assessment is currently under review.*
CS0325	**Chief Operating Officer** Chris Oliver		Delivery of Key Local And National Targets and Standards, In Particular the 4 Hour Standard in A&E.	29/09/2016		**4x4 = 16**	**5x4 = 20**				**5x2 = 10**	*This is a refresh of risk CS0325 "Operational sustainability of MCHFT" The revised grading is provided under Q1and target columns*
EF0260	**Director of E&F** Mike Babb		Loss of Mechanical Infrastructure and Associated Resources: Leighton Hospital	25/05/2010		**4x4 = 16**	**4x4 = 16**				**4x1 = 4**	*No change – Awaiting Asbestos removal.*
CS0284	**Director of Nursing & Quality** Julie Tunney		Registered nurse staff shortages	02/01/2013		**4x5 = 20**	**4x4 = 16**				**4x2 = 8**	*This is a refresh of risk CS0284 "Recruitment to the number of Nursing Vacancies across MCHFT" The revised grading is provided under Q1and target columns*
CS0314	**H&S Lead** Wendy Astle-Rowe		Trust Wide Fire Risk Assessment	28/04/2015		**5x3 = 15**	**5x3 = 15**				**5x2 = 10**	*This relates to the over-arching rating for the Trust relating to infrastructure and fire safety provisions. This is rated as a 15 mainly due to the infrastructure status in non-refurbished wards.*

Reference	Lead	Divisional Objective*	Risk Title	Date of Initial Assessment	Rating with existing control measures (CxL)						Position Statement
					Controls Assurance Rating*	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Target Rating	
CS0023	**Emergency Planning Officer** Neil Furness		Influenza Type Disease Pandemic Causing Disruption to Services			5x3 = 15	5x3 = 15				5x3 = 15	*Review overdue – meeting to be arranged with Head of Quality Governance.*
CS0233	**Patient Safety Manager** Sheila Townsend		Medical devices Training in MCHFT	02/02/2011		5x3 = 15	5x3 = 15				5x1 = 5	*Risk is currently scored as a 5x3. This is because the Medical Equipment Group agree that there is a risk of medical equipment being incorrectly used by staff within the Trust as there is no robust method of providing medical equipment training. An SOP for Self-assessment of medical equipment has been developed and rolled out following a successful pilot in the Critical Care Unit. The use of this SOP is not yet fully embedded into practice and until it is the risk of staff using medical equipment incorrectly and potentially causing a catastrophic event remains. The development of this SOP has not removed the need for a Medical devices trainer/coordinator within the Trust.*
CS0268	**Telecommunications Manager** Debbie Walton		Loss/unavailability of Switchboard telecommunications equipment	19/01/2013		5x3 = 15	5x3 = 15				5x2 = 10	*We are in the process of installing a new telephone system, until this is completed, the risk and scores will remain. Once completed, we will reassess the risk assessment.*

Reference	Lead	Divisional Objective*	Risk Title	Date of Initial Assessment	Rating with existing control measures (CxL)							Position Statement
					Controls Assurance Rating*	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Target Rating	
EF0101	**Head of Estates** Paul Dyche		Legionella- Water Distribution / Temperature at Leighton Hospital	09/12/2010		**5x3 = 15**	**5x3 = 15**				**5x1 = 5**	*No change - Work continuing as part of ward / street / dept. refurbishment programme.*
EF0393	**Head of Estates & Facilities** Mike Babb		Risks to the Continuity of MCHFT Critical Functions identified by the Estates and Facilities Division	14/03/2016		**5x3 = 15**	**5x3 = 15**				**5x1 = 5**	*Risk reviewed. No change at this time.*
EF0351	**Head of Estates** Paul Dyche		Strategic Backlog Maintenance	01/01/2013		**5x3 = 15**	**5x3 = 15**				**5x1 = 5**	*Risk reviewed. No change at this time.*
CP0057	Collette Barker		Moving & Handling training	05/10/2017		**4x4 = 16**	**4x4 = 16**				**4x2 = 8**	0.5wte Moving and Handling trainer will commence in post from 6th August 2018. It has been agreed that face to face Moving and Handling training will be delivered at a location at MCHFT and prioritised to at risk staff groups. First training sessions will commence 19th August 2018. There will be two sessions per week.

Reference	Lead	Divisional Objective*	Risk Title	Date of Initial Assessment	Rating with existing control measures (CxL)							Position Statement
					Controls Assurance Rating*	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Target Rating	
CP0061	Marie Buckley		Controlled drugs management	14/02/2018		4x4 = 16	4x4 = 16				4x2 = 8	The Pharmacist is in the process of reviewing MCHFTs and CCICPs procedural documents. Due to unforeseen circumstances the completion date planned for 30th June has had to be revised. It is anticipated that completion will be 31st August 2018
CS0370	**Director of Finance**		Potential Claims relating to Reportable Occupational Disease - including Mesothelioma & Noise induced Hearing Loss	13/11/2014		4x4 = 16	4x4 = 16				4x4 = 16	Reviewed no change
CS0371	**Head of L&D**		Lack of in-house trainer resources to deliver Conflict Resolution Training	31/01/2018		4x4 = 16	4x4 = 16				4x2 = 8	Reviewed no change
CS0294	**Head of Health & Safety**		Non-compliance with the Health & Safety (Sharp Instruments in Healthcare) Regulations 2013	21/11/2013		5x3 = 15	5x3 = 15				5x1 = 5	Reviewed no change

Reference	Lead	Divisional Objective*	Risk Title	Date of Initial Assessment	Rating with existing control measures (CxL)							Position Statement
					Controls Assurance Rating*	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Target Rating	
PG0057	**DGM**		Inadequate Availability of Medical Staff within Paediatrics	22/04/2009		**5x3 = 15**	**5x4 = 20**				**5x1 = 5**	*Risk rating increased 23.5* *One Consultant had already handed notice in - leaving end of July. A further Consultant has also resigned and will be leaving effectively the same time.* *The Paediatric Clinical Lead has escalated this within the Division and also up to the Medical Director. One job advert is out and one good applicant for a locum to cover first Consultant but no other applicants so far and it is believed the applicant will only want the locum not a substantive post. The absolute earliest they could possibly start is September.*

Reference	Lead	Divisional Objective*	Risk Title	Date of Initial Assessment	Rating with existing control measures (CxL)							Position Statement
					Controls Assurance Rating*	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Target Rating	
PG0272	**Obs and Gynae Clinical Lead**		Inadequate availability of medical staff to cover rotas - Obs and Gynae	08/06/2016		**5x3 = 15**	**5x3 = 15**				**5x2 = 10**	*Continues to be discussed at Obs and Gynae Governance meetings.* *18.6.18 update* *LAS ST1/2 Post - no further along with the candidate still awaiting visa from the Home Office. This post was only to cover until August 2018 so likely this will need to be re-advertised if still gaps from August.* *Contract extension to LAS ST3+ post for a further 12 months until August 2019 which will cover one gap on the middle grade rota.* *There is also an additional LAS ST3+ post out to advert for 12 months August 2018 - August 2019*
SC0558	Divisional General Manager	D1	Risks associated with reduced numbers of Middle / Junior grade medical staff	08/09/2017		**4x4 = 16**	**4x4 = 16**				**4x3 = 12**	Workforce planning reviews include the development of alternative roles Following the August 2018 allocation from the Deanery the current gaps are; 1 – Orthopaedics 1.4 F1 –General Surgery Other gaps have been filled with the use of LAS medical staff.

Reference	Lead	Divisional Objective*	Risk Title	Date of Initial Assessment	Rating with existing control measures (CxL)							Position Statement
					Controls Assurance Rating*	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Target Rating	
SC0614	Divisional General Manager	D1	Delivering high quality clinical care 7 days per week	29/03/2018		5x3 = 15	5x3 = 15				5x2 = 10	The Division has developed a concept paper to support seven day services in response to the NHS England 10 Clinical Standards (Standard 2 – time to first Consultant review, Standard 3 – MDT review, Standard 4 – shift handovers, Standard 6 – intervention/key services and Standard 8 – on going review). Each sub-division is developing a seven day services concept paper underpinned by the divisional paper The business vase for SACU / 7 day service has been submitted prior to Executive Review 09/2018.
DC1010	David Stokes		Breast Care Unit & Screening Programme	01/02/2018		4x4 = 16	4x4 = 16				4x1 = 4	*Risk reviewed 12/06/2018:* *There is no change to the risk rating for this assessment, as no substantive staff have been recruited to date. A substantive Consultant Breast Radiologist post is going to advert in August 2018.*
DC0887	David Butterworth		Consultant Histopathologist Capacity	24/03/2015		4x4 = 16	4x4 = 16				4x2 = 8	*Risk reviewed 14/05/2018:* *External reporting is now in place, for when required and an external Consultant Histopathologist performs Post Mortems one day per week.* *Specialty and LAS doctors attend MDT meetings.* *Joint recruitment with UHNM is being explored.*

Reference	Lead	Divisional Objective*	Risk Title	Date of Initial Assessment	Rating with existing control measures (CxL)							Position Statement
					Controls Assurance Rating*	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Target Rating	
DC0615	Karen Thomas		Use of Midazolam Injection against NPSA Rapid Response Report 11	22/03/2018			5x3 = 15				5x2 = 10	*Risk reviewed 14/06/2018: Whilst several elements of the risk assessment are acceptable, a training package is still awaited – therefore risk remains open.*
DC1025	David Stokes		CT Scanning Equipment	16/11/2017		5x3 = 15	5x3 = 15				5x1 = 5	*Risk reviewed 14/05/2018: the CT business case for replacement has now been agreed and a project group is to be established to install the replacement and then close the risk.*
EC0379	Matron Rachel Wilkinson		Risks associated with inadequate staffing levels - Ward 2	10/11/2016		4x5 = 20	4x5 = 20				4x2 = 8	*Active recruitment has taken place on Ward 2 with 2.0wte staff nurses starting in September 2018. A temporary summer overseas nurse who previously was a substantive trust member will be working on Ward 2 for approximately 2 months. A qualified nurse has also been moved from AMU on a rotational 3 month basis to assist with vacancies. Work is currently taking place regarding temporarily moving a qualified nurse from 2 other core wards to help with the vacancy gap. However 3 qualified nurses are leaving ward 2 and therefore the current risk rating remains unchanged.*

Reference	Lead	Divisional Objective*	Risk Title	Date of Initial Assessment	Rating with existing control measures (CxL)							Position Statement
					Controls Assurance Rating*	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Target Rating	
EC0327	Consultant Anaesthetist Michelle Green		Lack of secondary Anaesthetic on-call cover	31/07/2010		4x5 = 20	4x5 = 20				4x2 = 8	*ACCP's have been recruited and start in September 18 (2 years training programme). Speciality Doctors will support over the 2 year training period.*
EC0397	Matron Naomi Jenkins		Risks associated with inadequate staffing levels on Ward 5	19/06/2017		4x5 = 20	4x5 = 20				4x2 = 8	*A band 5 is being appointed in July 18. A rotation post is in the process of having the advert developed. Consideration of a pharmacy tech is also taking place.*
EC0287	Associate Medical Director Doug Robertson		Risks associated with insufficient numbers of junior doctors across the ECD Division	01/03/2013		5x4 = 20	5x4 = 20				5x2 = 10	*For this rotation there are only 2 vacancies across the Division (both due to Visa issues after filing them) whereas when the previous scoring was due to their being 5 /6 vacancies. Therefore the Likelihood was revised to Possible rather than Likely so is now 5 x 3 rather than the previous 5 x4. A quarterly review date has been set so that the position we are at for filling Junior Doctor posts in the next rotation(in December) can be established.*

Reference	Lead	Divisional Objective*	Risk Title	Date of Initial Assessment	Rating with existing control measures (CxL)							Position Statement
					Controls Assurance Rating*	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Target Rating	
EC0388	Matron Naomi Jenkins		Cardiac Monitoring System	13/06/2017		5x4 = 20	5x4 = 20				5x2 = 10	*To be reviewed in August 18.Delayed due to leave.*
EC0387	Divisional General Manager Zoe Harris		Lack of service provision within Respiratory	23/03/2017		4x5 = 20	4x5 = 20				4x2 = 8	*Substantive post was recruited to in Q1 for the 3rd respiratory consultant vacancy. AAC date in October 18 for the 4th substantive post.*
EC0384	Divisional General Manager Zoe Harris		Lack of service provision within Cardiology	29/11/2016		4x5 = 20	4x5 = 20				4x3 = 12	*There is currently 2.7wte Consultant vacancy within Cardiology. There is NHS Locum position currently being advertised. There are two shared Partnership working with UHNM positions, which are currently undergoing the recruitment process*
EC0399	Matron Naomi Jenkins		Non-Invasive Ventilation and Tracheostomy patients on Ward 5	12/09/2017		4x5 = 20	4x5 = 20				4x3 = 12	*There remains concern within the Division regarding the sustainability of the NIV service given the current high vacancies on Ward 5.Vacancies on RR (EC0397).*

Reference	Lead	Divisional Objective*	Risk Title	Date of Initial Assessment	Rating with existing control measures (CxL)							Position Statement
					Controls Assurance Rating*	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Target Rating	
EC0329	Divisional General Manager Zoe Harris		Failure to deliver National Access Targets within ED and the increasing level of delays impacting upon patient flow and quality of care / patient experience.	03/06/2015		4x4 = 16	4x4 = 16				4x3 = 12	*There has been a continued unprecedented demand within the Trust since the Christmas period which has impacted upon the delivery of the 4 hour standard.*
EC0402	Divisional General Manager Zoe Harris		Lack of Service Provision within Diabetes	23/03/2017		4x4 = 16	4x4 = 16				4x2 = 8	*1 substantive Diabetologist/Endocrinologist at the moment. An additional post went out to advert, however, no one was shortlisted form the applicants so the post has been re-advertised. The alternate ward cover hasn't been implemented, however there has been an increase in the outpatient provision available with the Associate Medical director running three clinics per week.*
EC0403	Divisional General Manager Zoe Harris		Lack of service provision within Endocrinology	09/01/2018		4x4 = 16	4x4 = 16				4x2 = 8	*1 substantive Diabetologist/Endocrinologist at the moment. An additional post went out to advert, however, no one was shortlisted form the applicants so the post has been re-advertised. The alternate ward cover hasn't been implemented, however there has been an increase in the outpatient provision available with the Associate Medical director running three clinics per week.*

Reference	Lead	Divisional Objective*	Risk Title	Date of Initial Assessment	Rating with existing control measures (CxL)							Position Statement
					Controls Assurance Rating*	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Target Rating	
EC0410	Clinical Service Manager Julie Love		No Supernumerary Critical Care Nurse in Charge	05/03/2018		5x3 = 15	5x3 = 15				5x2 = 10	*Band 5 posts are in the process of being appointed to. This will enable the Band 7 to be the Supernumerary Nurse.*
EC0317	Clinical Service Manager Julie Love		Delayed discharge from Critical Care	01/02/2010		3x5 = 15	3x5 = 15				5x2 = 10	*Due to the unprecedented demand within the Trust this has impacted on the number of delayed discharges from Critical Care. Additional measures have been added to the handover to support.*
EC0381	Matron Naomi Jenkins		Risks associated with insufficient advanced life support (ALS) covered registered nurses in the coronary care unit (CCU)	21/11/2016		5x3 = 15	5x3 = 15				5x2 = 10	*There continues to be 1.92wte band 5 vacancies in addition to a 1.0wte band 6 being seconded into a ANP role. A number of registered nurses have completed the ALS training and are now being supported to become CCU covered.*

11. Risks with partner organisations (Governance / partnerships between organisations)

As part of the Risk Management Strategy & Framework 2017/20 work across partner organisations will be undertaken to understand shared risks which may impact on the quality / performance of services provided at the Trust these include:

- University Hospitals of North Midlands NHS Trust
- CCICP Partners
- East Cheshire NHS Trust
- Local Authorities
- 'One to One' Midwifery

As part of the internal NHSI Well Led Developmental Review process governance between organisations was highlighted as a key area for review by the external review team.

Appendix A: Detailed Risks Rated 20 & above

CS0284 – Registered Nurse staff shortages	Very Low Risk			Low Risk			Moderate Risk			High Risk		Extreme Risk	
	1	2	3	4	5	6	8	10	12	15	16	20	25
							T (4x2)				C (4x4)	I (4x5)	

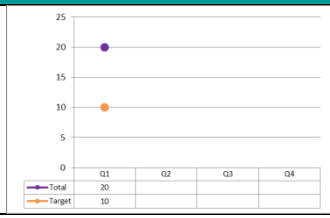
Potential Risk "There is a risk that <risk event> as a result of <cause> which may lead to <effect/impact>"	Lead	Control Measures	Controls Assurance Rating*	Position Statement	Original Date
Risk: There is a risk that patients may not receive timely interventions to address their clinical needs **Cause:** As a result of a reduced staffing capacity of registered nurses **Effect/Impact:** Which may lead to adverse clinical outcomes for patients Which may lead to regulatory sanctions Which may to an increase in complaints Which may lead to litigation Which may negatively impact on Trust reputation Which may lead to an adverse financial impact Which may lead to low staff morale	**Director of Nursing & Quality** Julie Tunney	1.Trust Escalation Policy with revised staff escalation matrix, includes: Delivery of a daily staffing meeting with the aim of identifying staff to address gaps Consideration given to the use of agency staff following executive authorisation. 2.The Trust has the following 24/7 support services available: Senior Manager On-Call proving advice Clinical site managers Executive on-call 3. Launch of a multi-disciplinary clinical workforce group (Consisting of task and finish groups to recruit RN roles and roles outside of the traditional RN recruitment.) This group reports progress to the Executive Workforce Group. 4. Revised and active recruitment of newly qualified nurses, as part of a multi-disciplinary clinical workforce group 5.Fast tracking of ECF's to reduce delays in the recruitment process. 6.Use of exit interview data to inform retention strategies. 7.Trust promotional information added to job descriptions on NHS Jobs. 8.Adverts revised to include set interview days. 9.Temporary staffing efficiencies programme, specifically targeted at: Robust recruitment plan in place Efficient rota management, with the implementation of an electronic roster and KPI's to monitor performance Improved ways of working for hospital bank SBAR tool in place to provide rationale for usage of off-framework agencies Awareness of agency cap and internal trajectory. Transgressions authorised by the executive team are reported to the Transformation and People Committee 10.Set of monthly arranged recruitment days across quarter 2. Those offered posts are then invited to 'Keep in Touch Days' 11. Revision of hospital bank service, including ways of recruitment, registered and unregistered fill rate.		*This is a refresh of risk CS0284 "Recruitment to the number of Nursing Vacancies across MCHFT" The revised grading is provided under Q1and target columns*	02/01/2013 **Review Frequency** Monthly **Monitoring Group** Executive Quality Governance Group **Risk Source** Risk Assessment **Version** 9 **BAF Links** Q1, Q2, E1, E2, W1, W2, W3 **Shift** **2017-18** Q1 20 ► Q2 20 ► Q3 20 ► Q4 20 ► **2018-19** Q1 16 Q2 Q3 Q4 **Shift Position** 

Key: I = Initial Risk Rating ▲ = Risk rating has increased since previous quarter

C = Current Risk Rating ► = No change from previous quarter

T = Target Risk Rating ▼ = Risk rating has decreased since previous quarter

Summary: CS0302 – Information Governance Overarching Risk Assessment (Under review)	Very Low Risk			Low Risk			Moderate Risk			High Risk		Extreme Risk	
	1	2	3	4	5	6	8	10	12	15	16	20	25
								T (5x2)				C (5x4)	I (5x5)

Potential Risk "There is a risk that <risk event> as a result of <cause> which may lead to <effect/impact>"	Lead	Control Measures	Controls Assurance Rating	Position Statement	Original Date
Risk: Risk of a breach of the obligation to process information fairly and lawfully in line with the principles of the Data Protection Act 1998 and other associated regulations. **Cause:** Failure to adequately protect data/information in line with regulations. **Effect/Impact:** • Unsatisfactory Information Governance Toolkit rating • Reporting required to Information Commissioners Office • Financial penalties • Reputational risks	**Head of Information Governance** Cora Suckley	1. Privacy Impact Assessment Procedure 2. Information Governance Training 3. Confidentiality and Data Protection Policy 4. Information Governance Handbook 5. Information Governance and Clinical Audit Guidance leaflet for staff 6. Bedside Folder (containing relevant paragraphs) relating to the management of personal information 7. Information sharing agreements signed off by Caldecott Guardian for all sharing of information. 8. Health Records Management Policy 9. Corporate Records Management Policy 10. Access to Health Records Policy 11. Confidentiality and Data Protection Policy 12. ICT Policies 13. Audits can be run on Patient Administration System if concerns are raised. 14. Websense software implemented 15. Review of IG Toolkit. Toolkit Action Plan drawn up and leads identified. Toolkit progress is monitored at Information Governance Group.		*The risk is under review and will be split across cyber security and GDPR. The risks are currently in draft and will be finalised by the end of August 18*	08/08/2014 **Review Frequency** Monthly **Monitoring Group** Executive Quality Governance Group **Risk Source** Risk Assessment **Version** 2 **BAF Links** T2 a & b **Shift** **2016-17** Q1 20 ► Q2 20 ► Q3 20 ► Q4 20 ► **2017-18** Q1 20 ► Q2 Q3 Q4 **Shift Position** 

Key:

I = Initial Risk Rating
▲ = Risk rating has increased since previous quarter

C = Current Risk Rating
► = No change from previous quarter

T = Target Risk Rating
▼ = Risk rating has decreased since previous quarter

CS0326 – A Lack of Funding to Implement the IIM&T Strategy.	Very Low Risk			Low Risk			Moderate Risk			High Risk		Extreme Risk	
	1	2	3	4	5	6	8	10	12	15	16	20	25
							T (4x2)					C (4x5)	I (5x5)

Potential Risk "There is a risk that <risk event> as a result of <cause> which may lead to <effect/impact>"	Lead	Control Measures	Controls Assurance Rating	Position Statement	Original Date
There is a risk that Trust IM&T systems will fail to function efficiently and effectively, as a result of a failure to invest in the necessary improvements to the IM&T infrastructure, which may lead to an adverse impact on patients' safety and quality of care. Causes: In 2012, the Trust Board approved the 5 year IM&T Strategy. The aim of the document was to provide a strategic direction to develop and replace an aging IM&T infrastructure which was becoming unfit for purpose. The Strategy also provided the opportunity to modernise services. In subsequent years progress has stalled and a lack of capital funds in 2017/18 meant that the Trust was unable to make significant further progress towards implementing its IM&T Strategy. Consequences: Without development to a clinical IT system which includes electronic noting there is potential for data errors and loss of personal data, resulting in poor patient experience, and potent complaints, claims and regulatory sanctions. There is also the potential impact of a loss of Trust reputation, and an adverse impact on recruitment and potential loss of external funding streams if the Trust is not perceived to be progressive	**Medical Director** Dr Paul Dodds	1. Clinical letters are sent directly to the GP patient record electronically (via Docman system) 2. Trust is contributing data to integrated digital care record the Cheshire Integrated Digital Care Record system and in the near future the eXchange Share2Care programme. 3. Case notes are tracked using the Trust's Patient Administration System 4. Case notes are 'weeded' by the Medical Records Library for easier access and management. 5. Some of the Trust's main IT systems are linked through a series of standard messages (HL7). This ensures duplication of information is minimised. 6. The largest repository of clinical information is the case notes and the Trust are able to provide these to patients on request. 7. Major investments in IT infrastructure, including; Trust-Wide Wi-Fi, new core network and virtualised server infrastructure. 8. Funding has been allocated in the Trust's Capital Programme to replace Telecommunications systems. 9. The Trust's Single-Sign On system enables fast, secure access for clinicians. 10. The IT Department are engaged with suppliers through User Groups and Requests for Change to ensure systems remain compliant. 11. Stand-alone and desktop based video-conferencing facilities for MDT meetings and in theatres. 12. Radiology System, Single Sign On and Virtual Desktop Infrastructure enable faster access to patient records		*This is a refresh of risk CS0326 "Risk to the Trust of not delivering the IM&T Strategy." The revised grading is provided under Q1and target columns*	07/09/2015 **Review Frequency** Monthly **Monitoring Group** Executive Quality Governance Group **Risk Source** Risk Assessment **Version** 1 **BAF Links** T2a, T2b & E2

Shift		
2016-17		
Q1	20	►
Q2	20	►
Q3	20	►
Q4	20	►
2017-18		
Q1	20	►
Q2		
Q3		
Q4		

Shift Position

Key: I = Initial Risk Rating; C = Current Risk Rating; T = Target Risk Rating

▲ = Risk rating has increased since previous quarter

► = No change from previous quarter

▼ = Risk rating has decreased since previous quarter

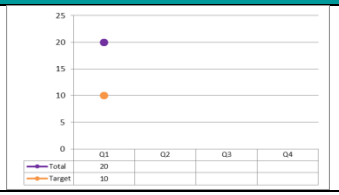
CS0327 – Long Term Financial Sustainability of MCHFT	Very Low Risk			Low Risk			Moderate Risk			High Risk		Extreme Risk	
	1	2	3	4	5	6	8	10	12	15	16	20	25
								T (5x2)				C (5x4)	I (5x5)

Potential Risk "There is a risk that <risk event> as a result of <cause> which may lead to <effect/impact>"	Lead	Control Measures	Controls Assurance Rating	Position Statement	Original Date
There is a risk that the Trust may incur increased costs and a loss of income, as a result of inefficiencies in financial management, which may lead to the loss of long term financial sustainability. Causes: There is historical evidence to indicate that demand is exceeding capacity and that this is increasing year on year. The Trust has delivered its financial control total for 2017/18 and agreed a contract for 2018/19 which supports the delivery of the 2018/19 financial target, however; in the current climate this will remain challenging. Consequences: There are a number of factors adversely impacting on financial efficiency and effectiveness, including; the potential for non-delivery of CIP targets, underperformance on elective activity, increasing premium costs of bank and agency staff, non-elective demand outstripping bed capacity, loss of contracts due to competition, increasing efficiency requirements in the National tariff, cash flow implications of deteriorating trading position. Financial inefficiencies may also impact on clinical services, resulting in adverse impacts on patient safety, clinical effectiveness and outcomes. Staff welfare may be adversely impacted. There is potential for an adverse impact on Trust reputation	**Director of Finance** Mark Oldham	1. Recruitment initiatives (foreign and domestic) and Premia incentives 2. Tendering for services 3. Weekly performance meetings re: activity delivery 4. Winter Funding schemes through SRG 5. Implementation of Integrated Community Teams 6. Annual Plan 7. Clinical Services Strategy 8. Borrowings in place for key schemes 9. Successful Expert Determination 10. Robust Cash Flow processes in place 11. Agreed Distress funding in place with Department of Health 12. Integrated Community Teams delivering controls on non-elective activity 13. Recruitment initiatives (foreign and domestic) and Premia incentives 14. Tendering for services (new and existing) 15. Weekly performance meetings re: activity delivery 16. Winter Funding schemes through SRG 17. Implementation of Integrated Community Teams 18. Annual Plan 19. Clinical Services Strategy 20. Borrowings in place for key schemes 21. Successful Expert Determination 22. Robust Cash Flow processes in place 23. Agreed Distress funding in place with Department of Health 24. Integrated Community Teams delivering controls on non-elective activity		*This is a refresh of risk CS0327 "Financial sustainability of MCHFT." The revised grading is provided under Q1and target columns*	29/05/2012 **Review Frequency** Monthly **Monitoring Group** Executive Quality Governance Group **Risk Source** Risk Assessment **Version** 2 **BAF Links** Q1, Q2, P1, P2, E1, E2, W1, T1, T2a, T2b

Shift

2016-17		
Q1	25	►
Q2	20	▼
Q3	20	►
Q4	20	►
2017-18		
Q1	20	►
Q2		
Q3		
Q4		

Shift Position



Key: I = Initial Risk Rating ▲ = Risk rating has increased since previous quarter | C = Current Risk Rating ► = No change from previous quarter | T = Target Risk Rating ▼ = Risk rating has decreased since previous quarter

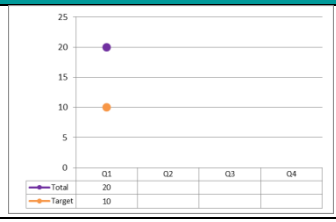
CS0328 – Workforce Capacity and Skill Mix to Consistently Deliver High Quality Care, Seven Days a Week.	Very Low Risk			Low Risk			Moderate Risk			High Risk		Extreme Risk	
	1	2	3	4	5	6	8	10	12	15	16	20	25
								T (5x2)				C (5x4)	I (5x5)

Potential Risk "There is a risk that <risk event> as a result of <cause> which may lead to <effect/impact>"	Lead	Control Measures	Controls Assurance Rating	Position Statement	Original Date
There is a risk that patients may not receive timely, high quality care, as a result of a failure to provide adequate numbers of staff with the appropriate skills seven days a week, which may lead to an adverse impact on patient safety, patient experience and clinical outcomes. Causes: The primary influencing factors for this risk assessment were the following reports and guidance: • Adult Emergency Services: Acute Medicine and Emergency General Surgery - NHS London • Inside Your Hospital Guide – Dr Foster • High Quality Care For All – Lord Darzi • Seven Day Services Clinical Standards – NHS England • Seven day hospital services: challenges and solutions – NHS Improvement These reports and guidance focus on the effects on patient care of a lack of clinical staff with the appropriate skills in the evening, at a weekend and on Bank Holidays. Consequences: There are a number of potential clinical consequences including: • delays in investigation, diagnosis and treatment • an Increase in the number of clinical incidents causing harm • adverse clinical outcomes • an increase in complaints due to poor patient experience	**Medical Director** Dr Paul Dodds	1. Recruitment to additional Consultant posts in the major acute specialties. 2. Divisional business cases in development to support the expansion of Consultant numbers to deliver the Seven Day Services Clinical Standards 3. Annual review of Consultant job plans to increase on site "out of hours" Consultant presence. 4. Recruitment to additional roles (e.g. Advanced Nurse Practitioners) to supplement the "out of hours" clinical / medical workforce. 5. Critical Care Outreach Service available 24/7 6. Prompt access to diagnostic services, including medical imaging and pathology. 7. Policy for Adult Inpatient Vital Signs and Early Warning Score Monitoring 8. Advancing Quality programme. 9. Development of clinical pathways with external partners to ensure that patients receive appropriate, high quality care "out of hours" (e.g. stroke thrombolysis with the University Hospitals of North Midlands). 10. Engagement in the Getting It Right First Time (GIRFT) national programme 11. Quality governance infrastructure, systems and processes. 12. Patient Safety Summit 13. Seven Day Services Steering Group 14. Deteriorating Patient Steering Group 15. Implementation of the Structured Judgement Review process to review in-patient deaths 16. Quality and Safety Improvement Strategy 2018/19 17. On-call rotas for executives and clinical specialties (e.g. Pharmacist) 18. Bank and agency staffing arrangements 19. Education and development programmes		*This is a new risk which replaces CS0275 "Delivering high quality clinical care 7 days a week" and CS0328 "Sustainability of vulnerable clinical services." The revised grading is provided under Q1and target columns*	24/09/2015 **Review Frequency** Monthly **Monitoring Group** Executive Quality Governance Group **Risk Source** Risk Assessment **Version** 3 **BAF Links** Q1, Q2, P1, P2, E1, E2, W1, W2, W3

Shift

2016-17		
Q1	20	►
Q2	20	►
Q3	20	►
Q4	20	►
2017-18		
Q1	20	►
Q2		
Q3		
Q4		

Shift Position

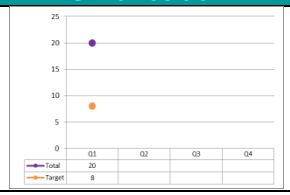


Key: I = Initial Risk Rating ▲ = Risk rating has increased since previous quarter

C = Current Risk Rating ► = No change from previous quarter

T = Target Risk Rating ▼ = Risk rating has decreased since previous quarter

EC0379 – Risks associated with inadequate staffing levels – Ward 2	Very Low Risk			Low Risk			Moderate Risk			High Risk		Extreme Risk	
	1	2	3	4	5	6	8	10	12	15	16	20	25
							T (4x2)					I & C (4x5)	

Potential Risk "There is a risk that <risk event> as a result of <cause> which may lead to <impact>"	Lead	Control Measures	Confidence in Controls	Position Statement	Original Date
Risk: Inadequate staffing ratio on Ward 2. **Cause:** Due to the impact of long/short term sick leave. **Effect/impact:** • Potential impact on service provision, quality of care and patient experience. • Potential patient safety harm due to delays in nursing review/intervention. • Reduced quality of care. • Increased work related stress. • Higher incident reporting. • Increased length of stay. • Financial implications with increased use of agency staff. • Potential delays in the completion of training and staff appraisals. • Potential for inappropriate skill mix.	**Matron** Rachel Wilkinson	1. Daily staffing review undertaken by the Matrons within the Division. 2. Ward escalation to Matrons when gaps present in rota. 3. Ward Managers within the Division review off duty to review the skill mix. 4. Ward 2 co-ordinator/Band 6 will attend AMU to review patients prior to transfer to assess the suitability. 5. Use of Nurse Bank and Agency staff. 6. Pharmacy technician utilised on ward 2. 7. Ward Manager can refer staff to Occupational Health following episodes of sickness. 8. Return to work interviews completed. 9. Safety huddles.		*Active recruitment has taken place on Ward 2 with 2.0wte staff nurses starting in September 2018. A temporary summer overseas nurse who previously was a substantive trust member will be working on Ward 2 for approximately 2 months. A qualified nurse has also been moved from AMU on a rotational 3 month basis to assist with vacancies. Work is currently taking place regarding temporarily moving a qualified nurse from 2 other core wards to help with the vacancy gap. However 3 qualified nurses are leaving ward 2 and therefore the current risk rating remains unchanged.*	10/11/2016 **Review Frequency** Monthly **Monitoring Group** Divisional Board **Risk Source** Risk Assessment **Version** 5 **BAF Links** **Shift** **2017-18** Q1 20 ► Q2 20 ► Q3 20 ► Q4 20 ► **2018-19** Q1 20 ► Q2 Q3 Q4 **Shift Position** 

Key: I = Initial Risk Rating ▲ = Risk rating has increased since previous quarter

C = Current Risk Rating ► = No change from previous quarter

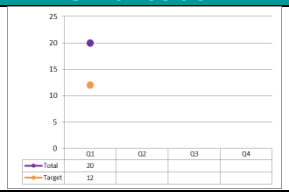
T = Target Risk Rating ▼ = Risk rating has decreased since previous quarter

EC0327 – Lack of secondary Anaesthetic on-call cover	Very Low Risk			Low Risk			Moderate Risk			High Risk		Extreme Risk	
	1	2	3	4	5	6	8	10	12	15	16	20	25
							T (4x2)					I & C (4x5)	

Potential Risk "There is a risk that <risk event> as a result of <cause> which may lead to <impact>"	Lead	Control Measures	Confidence in Controls	Position Statement	Original Date
Risk: Insufficient secondary on call cover for anaesthetics out of hours (Monday - Thursday 18:00-08:00). **Cause:** Critical Care & Maternity share 'second on' rota provision. **Effect/impact:** • Anaesthetic service unable to meet demand. • Reduced quality of care. • Potential patient safety harm due to delays in treatment • Unable to support off site transfers • None compliance with National Guidelines. • Failure to achieve Anaesthetic Clinical Service Accreditation. • Increased cost due to utilisation of Consultant cover. • Increase in work related stress. • Non-compliance with Deanery regulations regarding breaks.	**Clinical Lead** Michelle Green	1. First on rota (lower ST's doctor) anaesthetist provision. However don't always have Critical Care or Obstetric competencies. 2. Consultant Anaesthetist available 24/7 & general and Intensivist Consultant Anaesthetist split rota 3. Specialty/ Hospital Grades and Higher ST doctor rota on as second -on; 4. Specialty doctor & Higher ST 1:12 combined rota which is split at the weekends 5. Access to Consultant on-call- Out of hours. 6. Access to Critical Care Outreach Service- Nurses are not supernumerary which does not guarantee support. 7. Trainee Doctor bank provision. 8. Rota planning sent to Medical Staffing to support with any vacancy shifts. 9. Business case approved within MCHFT for splitting of the rota which is to be presented to the commissioners.		*ACCP's have been recruited and start in September 18 (2 years training programme). Speciality Doctors will support over the 2 year training period.*	31/07/2010 **Review Frequency** Quarterly **Monitoring Group** EQGG **Risk Source** Risk Assessment **Version** 6 **BAF Links** **Q1** **Shift**

2017-18		
Q1	15	►
Q2	15	►
Q3	20	▲
Q4	20	►
2018-19		
Q1	20	►
Q2		
Q3		
Q4		

Shift Position



Key: I = Initial Risk Rating; C = Current Risk Rating; T = Target Risk Rating

▲ = Risk rating has increased since previous quarter

► = No change from previous quarter

▼ = Risk rating has decreased since previous quarter

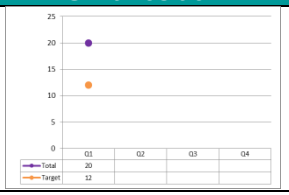
EC0397 – Risks associated with inadequate staffing levels on Ward 5	Very Low Risk			Low Risk			Moderate Risk			High Risk		Extreme Risk	
	1	2	3	4	5	6	8	10	12	15	16	20	25
									T (4x3)			I & C (4x5)	

Potential Risk "There is a risk that <risk event> as a result of <cause> which may lead to <impact>"	Lead	Control Measures	Confidence in Controls	Position Statement	Original Date
Risk: Inadequate staffing ratio on Ward 5. **Cause:** Due to the budgeted establishment not being achieved. **Effect/impact:** • Potential impact on service provision, quality of care and patient experience. • Potential patient safety harm due to delays in nursing review/intervention. • Reduced quality of care. • Increased work related stress. • Higher incident reporting. • Increased length of stay. • Financial implications with increased use of agency staff. • Potential delays in the completion of training and staff appraisals. • Potential for inappropriate skill mix. • Unable to facilitate NIV treatment.	**Matron** Naomi Jenkins	1. On-going recruitment. 2. Daily staffing review undertaken by the Matrons within the Division. 3. Ward escalation to Matrons when gaps present in rota. 4. Ward Managers within the Division review off duty to review the skill mix. 5. Use of Nurse Bank and Agency staff. 6. Planned implementation for a Pharmacy technician to be utilised on ward 5. 7. Safety huddles. 8. Involvement of Critical Care to facilitate NIV where appropriate. 9. ANP business case approval.		*A band 5 is being appointed in July 18. A rotation post is in the process of having the advert developed. Consideration of a pharmacy tech is also taking place.*	19/06/2017 **Review Frequency** Monthly **Monitoring Group** EQGG **Risk Source** Risk Assessment **Version** 1 **BAF Links** Q1 **Shift**

2017-18		
Q1	20	►
Q2	20	►
Q3	20	►
Q4	20	►

2018-19		
Q1	20	►
Q2		
Q3		
Q4		

Shift Position



Key: I = Initial Risk Rating ▲ = Risk rating has increased since previous quarter

C = Current Risk Rating ► = No change from previous quarter

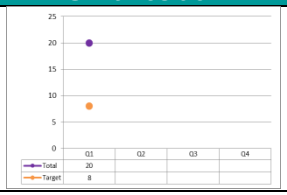
T = Target Risk Rating ▼ = Risk rating has decreased since previous quarter

EC0287 – Risks associated with insufficient numbers of junior doctors across the ECD Division	Very Low Risk			Low Risk			Moderate Risk			High Risk		Extreme Risk	
	1	2	3	4	5	6	8	10	12	15	16	20	25
							T (4x2)					C (5x4)	I (5x5)

Potential Risk "There is a risk that <risk event> as a result of <cause> which may lead to <impact>"	Lead	Control Measures	Confidence in Controls	Position Statement	Original Date
Risk: Insufficient numbers of junior Doctors across the Division. **Cause:** Lack of sufficient medical workforce due to vacancies. **Effect/impact:** • Potential patient safety harm due to delays in medical review/treatment • Non-compliance with National Guidance and Best Practice Standards for patient care. • Reduced quality of care. • Reduction in access and flow targets. • Potential breaches within European Working Time directives. • Potential breaches with RTT. • Potential lack of on call cover. • Potential impact on service provision, quality of care and patient experience. • Financial implications due to increased use of locum agency.	**AMD** Doug Robertson	1. Use of locum agencies. 2. Ongoing recruitment. 3. Ongoing job planning within the Division. 4. Forward planning of on call rota. 5. Consultant to cover when no Medical Registrar available. 6. Access and flow meetings and length of stay monitored. 7. RTT monitored within the Division.		*Vacancies in Medicine will all be filled in August 2018. Appointments have also been made for the ED vacancies. Risk rating to be reviewed at Divisional Board in July 2018.*	01/03/2013 **Review Frequency** Monthly **Monitoring Group** EQGG **Risk Source** Risk Assessment **Version** 9 **BAF Links** Q1

Shift		
2017-18		
Q1	20	►
Q2	20	►
Q3	20	►
Q4	20	►
2018-19		
Q1	20	►
Q2		
Q3		
Q4		

Shift Position



Key: I = Initial Risk Rating | C = Current Risk Rating | T = Target Risk Rating

▲ = Risk rating has increased since previous quarter | ► = No change from previous quarter | ▼ = Risk rating has decreased since previous quarter

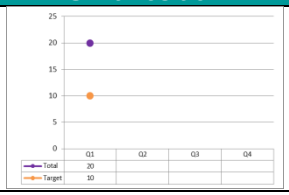
EC0388 - The risks associated with the loss of the cardiac monitoring system	Very Low Risk			Low Risk			Moderate Risk			High Risk		Extreme Risk	
	1	2	3	4	5	6	8	10	12	15	16	20	25
								T (5x2)				I&C (5x4)	

Potential Risk "There is a risk that <risk event> as a result of <cause> which may lead to <impact>"	Lead	Control Measures	Confidence in Controls	Position Statement	Original Date
Risk: Inability to motor cardiac patients via the telemetry system. **Cause:** The loss of the central cardiac monitoring system (Philips). **Effect/impact:** • Potential patient safety harm due to loss of monitoring. • Undetected arrhythmia resulting in delays in treatment/management. • Reduced quality of care. • Higher incident reporting. • Increased length of stay. • Potential impact on service provision, quality of care and patient experience. • Increased work related stress.	**Matron** Naomi Jenkins	1. Inclusion within the BCP regarding actions which are to be taken in the event of a loss of cardiac monitoring. 2. To alert senior cardiology doctors regarding the loss of cardiac monitoring. 3. Out of hours to inform the Clinical Site Manager & senior medical doctors regarding the loss of cardiac monitoring. 4. Issues identified with the cardiac monitoring system is to be escalated to EBME who will contact Philips.		*To be reviewed in August 18.Delayed due to leave.*	13/06/2017

Review Frequency
Quarterly
Monitoring Group
EQGG
Risk Source
Risk Assessment
Version
3
BAF Links
Q1

Shift		
2017-18		
Q1	15	►
Q2	15	►
Q3	20	▲
Q4	20	►
2018-19		
Q1	20	►
Q2		
Q3		
Q4		

Shift Position



Key: I = Initial Risk Rating | C = Current Risk Rating | T = Target Risk Rating

▲ = Risk rating has increased since previous quarter

► = No change from previous quarter

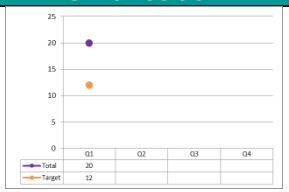
▼ = Risk rating has decreased since previous quarter

EC0387 - Lack of service provision within Respiratory	Very Low Risk			Low Risk			Moderate Risk			High Risk		Extreme Risk	
	1	2	3	4	5	6	8	10	12	15	16	20	25
									T (4x3)			I & C (4x5)	

Potential Risk "There is a risk that <risk event> as a result of <cause> which may lead to <impact>"	Lead	Control Measures	Confidence in Controls	Position Statement	Original Date
Risk: Insufficient numbers of Consultant Respiratory Physicians within the Division. **Cause:** Inability to recruit Consultant Respiratory Physicians. **Effect/impact:** • Potential patient safety harm due to delays in medical review/treatment • Non-compliance with National Guidance and Best Practice Standards for patient care. • Reduced quality of care. • Inability to comply with the proposed 7 day working. • Reduction in access and flow targets. • Potential breaches within European Working Time directives. • Potential breaches with RTT. • Potential impact on service provision, quality of care and patient experience. • Financial implications due to increased use of locum agency. • Increase in work related stress. • Potential reduction in deanery allocation. • Failure to achieve cancer targets. • Implementation of EBUS locally at MCHFT • Implementation of the sleep service • Implementation of medical thoracoscopy • Delivery of the pleural service	**DGM** Zoe Harris	1. On-going recruitment. 2. Use of Locum Consultants. 3. To explore Partnership agreements with external Trusts. 4. On-going job planning within the Division. 5. Forward planning of on call rota. 6. Access and flow meetings and length of stay monitored. 7. RTT monitored within the Division. 8. Task & finish group initiated. 9. ANP business case approved at Divisional Board.		*Substantive post was recruited to in Q1 for the 3rd respiratory consultant vacancy. AAC date in October 18 for the 4th substantive post.*	23/03/2017 **Review Frequency** Quarterly **Monitoring Group** EQGG **Risk Source** Risk Assessment **Version** 3 **BAF Links** Q1 **Shift**

2017-18		
Q1	20	►
Q2	20	►
Q3	16	▼
Q4	20	▲
2018-19		
Q1	20	►
Q2		
Q3		
Q4		

Shift Position



Key: I = Initial Risk Rating; C = Current Risk Rating; T = Target Risk Rating

▲ = Risk rating has increased since previous quarter

► = No change from previous quarter

▼ = Risk rating has decreased since previous quarter

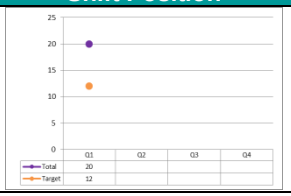
EC0399 - Increased patient dependency when caring for 4 dependent Respiratory patients, which may be a combination of Non-Invasive Ventilation and Tracheostomy patients	Very Low Risk			Low Risk			Moderate Risk			High Risk		Extreme Risk	
	1	2	3	4	5	6	8	10	12	15	16	20	25
									T (4x3)			I & C (4x5)	

Potential Risk "There is a risk that <risk event> as a result of <cause> which may lead to <impact>"	Lead	Control Measures	Confidence in Controls	Position Statement	Original Date
Risk: Increased patient acuity for NIV & tracheostomy patients in a clinical area which already has significant nursing vacancies. **Cause:** • Complex intervention. • Vacancies within Ward 5. **Effect/impact:** • Potential impact on service provision, quality of care and patient experience. • Potential patient safety harm due to delays in nursing review/intervention. • Reduced quality of care. • Increased work related stress. • Higher incident reporting. • Increased length of stay. • Financial implications with increased use of agency staff. • Potential for inappropriate skill mix. • Unable to facilitate NIV treatment.	**Matron** Naomi Jenkins	1. On-going recruitment. 2. Daily staffing review undertaken by the Matrons within the Division. 3. Ward escalation to Matrons when gaps present in rota. 4. Ward Managers within the Division review off duty to review the skill mix. 5. Use of Nurse Bank and Agency staff. 6. Planned implementation for a Pharmacy technician to be utilised on Ward 5. 7. Safety huddles. 8. Involvement of Critical Care to facilitate NIV where appropriate. 9. ANP business case approval. 10. Daily assessment of the ward acuity. 11. Selected location for NIV and tracheostomy patients to be nursed. 12. CCOS referrals. 13. Trust EWS Escalation Guidelines.		*There remains concern within the Division regarding the sustainability of the NIV service given the current high vacancies on Ward 5.Vacancies on RR (EC0397).*	12/09/2017

Review Frequency
Quarterly
Monitoring Group
EQGG
Risk Source
Risk Assessment
Version
2
BAF Links
Q1

Shift		
2017-18		
Q1		
Q2	16	►
Q3	16	►
Q4	20	▲
2018-19		
Q1	20	►
Q2		
Q3		
Q4		

Shift Position



Key: I = Initial Risk Rating; C = Current Risk Rating; T = Target Risk Rating

▲ = Risk rating has increased since previous quarter

► = No change from previous quarter

▼ = Risk rating has decreased since previous quarter

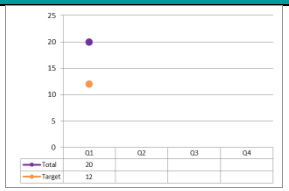
EC0384 – Lack of service provision within Cardiology	Very Low Risk			Low Risk			Moderate Risk			High Risk		Extreme Risk	
	1	2	3	4	5	6	8	10	12	15	16	20	25
									T (4x3)			I&C (4x5)	

Potential Risk "There is a risk that <risk event> as a result of <cause> which may lead to <impact>"	Lead	Control Measures	Confidence in Controls	Position Statement	Original Date
Risk: Insufficient numbers of Consultant Cardiologists within the Division. **Cause:** Inability to recruit Consultant Cardiologists. **Effect/impact:** • Potential patient safety harm due to delays in medical review/treatment • Non-compliance with National Guidance and Best Practice Standards for patient care. • Reduced quality of care. • Inability to comply with the proposed 7 day working. • Reduction in access and flow targets. • Potential breaches within European Working Time directives. • Potential breaches with RTT. • Potential lack of on call Cardiology cover. • Potential impact on service provision, quality of care and patient experience. • Financial implications due to increased use of locum agency. • Increase in work related stress. • Potential reduction in deanery allocation. • Failure to comply with the 6 week diagnostic wait time for DSE & TOE. • Unable to provide emergency inpatient TOE service. • Reduction within the service provision for heart failure.	**DGM** Zoe Harris	1. On-going recruitment. 2. Use of Locum Consultants. 3. Partnership agreements with UHNM. 4. On-going job planning within the Division. 5. Forward planning of on call rota. 6. Access and flow meetings and length of stay monitored. 7. RTT monitored within the Division. 8. Weekly DSE sessions being delivered.		*There is currently 2.7wte Consultant vacancy within Cardiology. There is NHS Locum position currently being advertised. There are two shared Partnership working with UHNM positions, which are currently undergoing the recruitment process*	29/11/2016 **Review Frequency** Monthly **Monitoring Group** EQGG **Risk Source** Risk Assessment **Version** 5 **BAF Links** Q1, Q2, E2, W1, W2

Shift

	2017-18	
Q1	20	►
Q2	20	►
Q3	16	▼
Q4	20	▲
2018-19		
Q1	20	►
Q2		
Q3		
Q4		

Shift Position



Key: I = Initial Risk Rating C = Current Risk Rating T = Target Risk Rating

▲ = Risk rating has increased since previous quarter ► = No change from previous quarter ▼ = Risk rating has decreased since previous quarter

PG00057 – Inadequate Availability of Medical Staff within Paediatrics	Very Low Risk			Low Risk			Moderate Risk			High Risk		Extreme Risk	
	1	2	3	4	5	6	8	10	12	15	16	20	25
					T (5x1)							I & C (5x4)	

Potential Risk "There is a risk that <risk event> as a result of <cause> which may lead to <effect/impact>"	Risk Owner	Existing Control Measures	Controls Assurance Rating	Position Statement	Original Date
1. Risk of delayed treatment, inappropriate/incorrect delivery of care due to insufficient availability of medical cover resulting from national shortfall of doctors. 2. Risk of nursing staff having to make clinical decisions due to insufficient availability of medical cover resulting in possible incorrect delivery of care and subsequent loss of NMC registration. 3. Risk of loss of services relating to paediatrics and neonatal services due to insufficient availability of medical cover leading to breach of 13 week outpatient target and/or 18week RFTT. Potential risk of closure of inpatient services. 4. Risk of statutory duty to maintain patient safety and possible prompt for CQC review	**Clinical Lead**	1. Locum cover provided where available. Existing consultants and medical staff working over and above expected shifts to alleviate some of the shortfall. This is not sustainable. Medical staffing continue to attempt to recruit to vacancies. Clinics reduced or cancelled if no middle grades available, priority given to ward and emergency work. Neonatal and Paediatric ANPs placed on medical rota Sept 17 to address gaps. 2. Nursing staff aware of requirement to work to NMC Code of Conduct. Locum cover provided where available. Existing consultants and medical staff working over and above expected shifts to alleviate some of the short all. This is not sustainable. Medical staffing continue to attempt to recruit to vacancies. Clinics reduced or cancelled if no middle grades available, priority given to ward and emergency work. 3. Locum cover provided where available. Existing consultants and medical staff working over and above expected shifts to alleviate some of the short all. This is not sustainable. Medical staffing continue to attempt to recruit to vacancies Clinics reduced or cancelled if no middle grades available, priority given to ward and emergency work. 4. Quality review meetings focusing on CQC domains. Staffing issues discussed monthly at divisional governance meetings and Labour Ward forum. Staffing incidents also discussed at the fortnightly Patient Safety Summit. Gaps in rotas examined on daily basis and issues escalated. Senior Management team aware of staffing situation.		*One Consultant had already handed notice in - leaving end of July. A further Consultant has also resigned and will be leaving effectively the same time.* *The Paediatric Clinical Lead has escalated this within the Division and also up to the Medical Director. One job advert is out and one good applicant for a locum to cover first Consultant but no other applicants so far and it is believed the applicant will only want the locum not a substantive post. The absolute earliest they could possibly start is September.*	22/04/2009 **Review Frequency** Monthly **Monitoring Group** Executive Quality Governance Group **Risk Source** Risk Assessment **Version** 4 **Links to Divisional Objectives**

Shift		
2017-18		
Q1	15	►
Q2	15	►
Q3	15	►
Q4	15	►
2018-19		
Q1	20	▲
Q2		
Q3		
Q4		

Shift Position

Key: I = Initial Risk Rating ▲ = Risk rating has increased since previous quarter | C = Current Risk Rating ► = No change from previous quarter | T = Target Risk Rating ▼ = Risk rating has decreased since previous quarter

Appendix B - Progress against the Risk Management Strategy & Framework (2017/20) Priorities

Progress against the key priorities for 2017/18 is detailed below, with the classification of progress included in Table 1 above.

Priority	Key areas 2017/19	Position	Commentary
1. New Risk Management Strategy & Framework 2017/20	• Categorisation matrix review (Part of the Incident Report & Management Policy)	Completed	• Executive Quality Governance Group (EQGG) December 2017
	• Revise Risk Assessment Procedure	On track: Not yet completed	• Planned March 2019
	• Review governance between organisations	On track: Not yet completed	• Part of NHSI Well Led Developmental Review
	• Revise organisational quarterly risk register report	Completed	• First iteration to EQGG November 2017 • Quality Governance Committee (QGC)December 2017 • Board of Directors January 2018
	• Implement quarterly divisional / CCICP risk register reports	Completed	• First iterations to Boards in November / December 2017
	• Implement risk approval process for risk rated 15 & above	Completed	• Standing agenda item on EQGG. Gate keeper system in place for approval at Divisional Boards/CCICP
	• Develop training needs analysis and risk based approach	On track: Not yet completed	• Roll out with web based by March 2019
	• Review the Risk Management Early Warning System	On track: Not yet started	• Planned May 2018
2. New Board Assurance Framework (BAF)	• Development of a new dynamic BAF aligned to the 'Three Lines of Defence' model and mapping process	On track: Not yet completed	• First iteration to Board of Directors – November 2017 • Sub-committee review in detail • Summary version to Board of Directors from Q3 2017/18 • Quarterly assurance mapping process commenced
3. Review of Risk Registers	• Apply new approach to risk descriptors: "There is a risk that <risk event> as a result of <cause> which may lead to <effect/impact>"	Completed	• Risks rated 15 & above prioritised and all new risks described as per strategy & framework. All risks to be re written through review process. Web based solution will aid this.
	• Link to organisational or divisional objectives	On track: Not yet completed	• Risk rated 12 & above prioritised – part of web based solution March 2019
	• Initial review of divisional risk registers	Completed	• Initial reviews undertaken with plans in place
	• Review process for high impact risks with low likelihood	On track: Not yet started	• Planned May 2018
	• Develop a register of risk registers	On track: Not yet started	• Web based solution by March 2019
	• Develop a risk profiling process	On track: Not yet started	• Web based solution by March 2019
	• Triangulate risk information in quality reports / mortality reports	On track: Not yet completed	• Initial reports to be developed for February 2018 Quality Assurance reviews

Appendix B - Progress against the Risk Management Strategy & Framework (2017/20) priorities

Priority	Key areas 2017/19	Position	Commentary
3. Review of Risk Registers	• Develop sources on web based system	On track: Not yet started	• By March 2019
	• Undertake TNA for risk management	On track: Not yet started	• Training to dovetail with web based system by March 2019
4. Governance Structure Group Reporting	• Review the information flows and functions of the groups reporting into the Executive Quality Governance Group.	On track: Not yet completed	• To include as part of the Well –Led Developmental Review in February 2018 with Board oversight in April 2018 by May 2018.
	• Review annually	On track: Not yet started	• Review March 2019
5. Safety Culture Assessment	• Undertake initial assessment	On track: Not yet started	• Initial assessments as part of the Well –Led Developmental Review in February 2018 with Board oversight in April 2018. • Trust rolling programme from July 2018
6. Ulysses – Web Based Solution for risk management and improvement planning	• Review of all fields to include controls assurance rating, cost benefit analysis, risk proximity and risk profiling • Education & training programme • Cleansing of all grades of risks • Quality improvement, audit and national guidance gap analysis system to be developed	Delivery remains feasible but potential risk to delivery within original timescales (Now by March 2019)	• Potential delays due to resourcing issues • Delay in Ulysses provision of improvement / action module • CCICP services will need reconfiguring on the system post change to care groups • Dependency on recruitment process to new Quality Governance Team (Quality Governance Analyst) • This action is included in the risk management internal audit report for completion by March 2018 – **moved to by March 2019**

Appendix C – Risk Matrices

Consequence / Likelihood	1	2	3	4	5
1	1	2	3	4	5
2	2	4	6	8	10
3	3	6	9	12	15
4	4	8	12	16	20
5	5	10	15	20	25

Likelihood	Definition	Estimated Probability	Lessons Learned
Almost certain	This event may be imminent or there are strong indications it will occur in the future. Not confident risk can be managed at this level and contingency is required	More than 80% chance of occurring	A regular occurrence. Circumstances found frequently
Likely	This event is likely to occur in most circumstances. Requires additional mitigation/contingency. Little confidence risk can be managed at this level.	51% to 80% chance of occurring	Has occurred from time to time and may do so again in the future
Possible	This event is likely to occur at some time even if controls operate normally. Confident risk can be managed at this level	21% to 50% chance of occurring	Has occurred previously but not often, and may have been in a limited way
Unlikely	Not expected, this event has a small chance of occurring at some time	6% to 20% chance of occurring	Has not happened, or happened in a very limited way
Rare	Highly unlikely, will occur only in very exceptional circumstances. Very confident risk can be managed at this level. Controls operate normally	Less than a 5% chance of occurring	Has rarely happened

Appendix D – Risk Management Systems Review

Verbal update at EQGG

Title of Paper :	Emergency Preparedness, Resilience and Response (EPRR) annual assurance process for 2018/19	
Author:	Neil Furness, Site Operations & Emergency Preparedness Manager	
Executive Lead:	Chris Oliver, Chief Operating Officer	
Type of Report:	Concept Paper	
	Strategic Options Paper	
	Business Case	
	Information	Yes
	Review/Benefits/Audit	Yes

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

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

Positive Benefit:	This submission demonstrates that MCHT has substantial level of compliance against the core standards and a work plan in place for the remaining standards to reach full compliance.
Risk:	There is a risk that in the event of an incident appropriate actions may not be taken as a result of a lack of currency or testing of emergency planning and / or business continuity plans which may lead to an adverse impact on patient safety and care.

To be published on Trust Website –complete version	***Yes***
If no, to be published on Trust Website – redacted	***-***
If not to be published complete or redacted, please detail the reason why	***-***
Presented at Board Meeting of:	**1 October 2018**

Cheshire & Merseyside Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) assurance 2018-2019

STATEMENT OF COMPLIANCE

Mid Cheshire Hospitals NHS Foundation Trust has undertaken a self-assessment against required areas of the NHS England Core Standards for EPRR v5.0.

Following assessment, the organisation has been self-assessed as demonstrating the **Substantial** compliance level (from the four options in the table below) against the core standards.

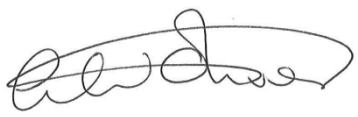
Compliance Level	Evaluation and Testing Conclusion
Full	Arrangements are in place and the organisation is fully compliant with all core standards that the organisation is expected to achieve. The Board has agreed with this position statement.
Substantial	Arrangements are in place however the organisation is not fully compliant with one to five of the core standards that the organisation is expected to achieve. A work plan is in place that the Board or Governing Body has agreed.
Partial	Arrangements are in place however the organisation is not fully compliant with six to ten of the core standards that the organisation is expected to achieve. A work plan is in place that the Board or Governing Body has agreed.
Non-compliant	Arrangements in place do not appropriately address 11 or more core standards that the organisation is expected to achieve. A work plan has been agreed by the Board or Governing Body and will be monitored on a quarterly basis in order to demonstrate future compliance.

The results of the self-assessment were as follows:

Number of applicable standards	Standards rated as **Red**	Standards rated as **Amber**	Standards rated as **Green**
64	0	4	60

Where areas require further action, this is detailed in the attached core standards improvement plan and will be reviewed in line with the organisation's EPRR governance arrangements.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan and governance deep dive responses.



Signed by the organisation's Accountable Emergency Officer

18/09/2018
Date signed

01/10/2018
Date of board / governing body meeting

Please select type of organisation: **Acute Providers**

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	14	14	0	0
Command and control	2	2	0	0
Training and exercising	3	3	0	0
Response	7	7	0	0
Warning and informing	3	3	0	0
Cooperation	4	3	1	0
Business Continuity	9	6	3	0
CBRN	14	14	0	0
Total	64	60	4	0

Deep Dive	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Incident Coordination Centres	4	4	0	0
Command structures	4	4	0	0
Total	8	8	0	0

Overall assessment:	Substantially Compliant

Ref	Domain	Standard	Detail	Evidence - examples listed below	Self assessment RAG Red = Not compliant with core standard. In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months. Amber = Not compliant with core standard. The organisation's EPRR work programme demonstrates an action plan to achieve full compliance within the next 12 months. Green = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
42	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, co-ordinating and maintaining resource eg staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA)	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Signed mutual aid agreements where appropriate	Partially compliant	All Mutual Agreements require a review with the relavnt partner Agencies. Meetings to be arranged to ensure arrangeents are still valid and that Memorandums' of Undertanding are complete and appropriate.	Site Operations & Emergency Preparedness Manager	Jan-19	In place where relevant but further work and review existing arrangements such as with the Red Cross, NW 4 x 4, Elmhurst etc.
49	Business Contin	Business Impact Assessment	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(s).	Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support	Partially compliant	A organisational review of the organisation's individual services Business Impact Assessement is required in order to ensure our business continuity plans and arrangements are in line with overall restoration and recovery priorities. Following its completion, a strategic review is required of MCHT's BIA.	Site Operations & Emergency Preparedness Manager	Jan-19	The Business Impact Assessment process is intergral to the Business Continuity plans and a review of each services BIA will be undertaken.
50	Business Contin	Data Protection and Security Toolkit	Organisation's IT department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Statement of compliance	Partially compliant	A working group is to be established between Emergency Planning. IG Governance, IT and represenatives from operational areas to ensure the revised data requirements for Governace Data Protection Regulations (GDPR) and for best practice against Cyber threats are in place and our business continuity plans are aligned accordingly.	Site Operations & Emergency Preparedness Manager and IG Governance Manager	Jan-19	We will not be compliant at this post as the standards are year end submission. The revised toolkit have a number of currently non-compliant EPRR standards. The previous was the IG toolkit. MCHFT will submit its position by March 2019. The IT team have some standards. We are currently compliant with the previous IG toolkit.
51	Business Contin	Business Continuity Plans	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure These plans will be updated regularly (at a minimum annually), or following organisational change	• Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation	Partially compliant	MCHT has a comprehensive range of Business Continuity Plans (BCPs) for both a Divisonal response as well as for individual services. Although all Divisioonal Plans have been reviewed in 2017 /18 there a number of service level plans that require reviewing and updating.	Site Operations & Emergency Preparedness Manager	Nov-18	MCHFT has a comprehensive set of Business Continuity Plans (BCP) at Divisional and service level. There are a number of plans that have not been reviewed since 2017 or earlier. A programme is in place to review each BCP and have updated.

Mid Cheshire Hospitals
NHS Foundation Trust

Title of Paper:	Workforce Race Equality Scheme Annual Report	
Author:	Natalie Wallace	
Executive Lead:	Linda Holland	
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	x	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	
	Note	x
	Recommend	
	Delegate	

Positive Benefit:	Understanding of the diversity in the Trust workforce and compliance with the Equality Delivery System requirements.
Risk:	Equality and Diversity standards are not met

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:	1 October 2018

Name of organisation

Mid Cheshire Hospitals NHS Foundation Trust

2. Date of report

July 2018

3. Name and title of Board lead for the Workforce Race Equality Standard

Linda Holland, Interim Director of Workforce and Organisation Development

4. Name and contact details of lead manager compiling this report

Natalie Wallace

HR Manager

Leighton Hospital

Middlewich Road

Crewe

CW1 4QJ

5. Names of commissioners this report has been sent to

NHS South Cheshire CCG and NHS Vale Royal CCG

6. Name and contact details of co-ordinating commissioner this report has been sent to

Jacqueline Goodall, Quality Improvement Manager, NHS South Cheshire CCG and NHS Vale Royal CCG

Qurban Hussain, Equality and Inclusion Business Partner, Midlands and Lancashire CSU

7. Unique URL link on which this report and associated Action Plan will be found

TBC

8. This report has been signed off by on behalf of the board on

Name: Transformation and People Committee

Date: 9th August 2018

9. Any issues of completeness of data

The time range for reporting in the WRES data report is ESR data as captured as at 31st March 2018.

There is little variance between the pre-populated data received from NHS England and the Trust verified data. We have re-checked our data and are confident in the figures produced.

10. Any matters relating to reliability of comparisons with previous years

Due to the Trust moving from Acute only in the 2017 staff survey to Combined Acute and Community in 2018, the 2017 findings are not reported for comparison for indicators 5-8.

11. Total number of staff employed within this organisation at the date of the report:

The head count as at 31st March 2018 is 4576

12. Proportion of BME staff employed within this organisation at the date of the report?

Total percentage for BME staff is 5.2% of the total workforce

13. The proportion of total staff who have self-reporting their ethnicity?

97.9% of staff have self-reported their ethnicity

14. Have any steps been taken in the last reporting period to improve the level of self-reporting by ethnicity?

The Trust reports a high level of self-reporting by ethnicity and will continue to collate equality monitoring information during the recruitment process.

15. Are any steps planned during the current reporting period to improve the level of self-reporting by ethnicity?

Promotional campaign to launch, to request that staff complete and update their monitoring information as part of the Employee Self Service implementation.

16. What period does the organisation's workforce data refer to?

ESR data as at 1st April 2017 to 31st March 2018

17. Percentage of staff in each band compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.

Data for reporting year

Non Clinical Band	White	BME	Not Known
Band 1	1.60%	0.13%	0.00%
Band 2	11.32%	0.26%	0.26%
Band 3	7.04%	0.07%	0.09%
Band 4	4.15%	0.09%	0.11%
Band 5	1.64%	0.02%	0.02%

Band 6	1.20%	0.00%	0.02%
Band 7	0.81%	0.02%	0.02%
Band 8a	0.90%	0.00%	0.00%
Band 8b	0.31%	0.02%	0.00%
Band 8c	0.09%	0.00%	0.00%
Band 8d	0.17%	0.00%	0.00%
VSM	0.13%	0.00%	0.00%

Clinical Band	**White**	**BME**	**Not Known**
Band 1	0.15%	0.00%	0.00%
Band 2	14.23%	0.70%	0.15%
Band 3	5.59%	0.13%	0.15%
Band 4	2.05%	0.07%	0.02%
Band 5	13.90%	1.18%	0.26%
Band 6	14.31%	0.52%	0.31%
Band 7	7.47%	0.15%	0.13%
Band 8a	2.25%	0.04%	0.02%
Band 8b	0.26%	0.00%	0.00%
Band 8c	0.08%	0.00%	0.00%
Band 8d	0.07%	0.00%	0.00%
VSM	0.00%	0.00%	0.00%

Consultants/NCCG/	**White**	**BME**	**Not Known**
Trainees/other	3.00%	1.75%	57.00%

Data for previous year

Non clinical band

Band 1 White 1.6% BME 0.06%

Band 2 White 11.9% BME 0.2%

Band 3 White 7.2% BME 0.1%

Band 4 White 4.5% BME 0.04%

Band 5 White 1.6% BME 0%

Band 6 White 1.3% BME 0%

Band 7 White 0.6% BME 0.02%

Band 8a White 0.6% BME 0.02%

Band 8b White 0.3% BME 0.02%

Band 8c White 0.04% BME 0%

Band 8d White 0.02% BME 0%

VSM White 0.11% BME 0%

Clinical band

Band 1 White 0.2% BME 0%

Band 2 White 15.3% BME 0.7%

Band 3 White 6.1% BME 0.2%

Band 4 White 2% BME 0.04%

Band 5 White 14.6% BME 1.1%

Band 6 White 15.3% BME 0.5%

Band 7 White 8.3% BME 0.1%

Band 8a White 2.1% BME 0.04%

Band 8b White 0.04% BME 0%

Band 8c White 0.4% BME 0%

Band 8d White 0.06 BME 0%

The implications of the data and any additional background explanatory narrative Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective

The majority of the workforce are white staff in clinical roles in bands 2, 5 and 6 (each accounts for 14% of the total workforce) which is the same as previous years. The highest proportion of BME employees are Consultants which account for 1.03% of the total workforce.

The report highlights that MCHFT has few BME people in senior positions (band 8 and above) working in the Trust, the same position as the previous year.

The Trust will look to engage with diverse communities and ensure that recruitment practices follow best practice. In addition the Trust will continue to seek training and development opportunities for BME staff via specific opportunities offered by the NHS Leadership Academy**.**

18. Relative likelihood of staff being appointed from shortlisting across all posts.

Data for reporting year - White staff are 1.46 times more likely to be appointed from shortlisting compared to BME staff (2017/18 data)

Data for previous year - White staff are 1.22 times more likely to be appointed from shortlisting compared to BME staff (2016/17 data)

The most recent findings show a slightly worsening position compared to the previous year.

From all BME applicants who were shortlisted, 18% were appointed. BME applicants who were short listed accounted for 13% of the total for the period 2017/18. BME applicants accounted for 8% of successful starters during this time period.

Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective

EDS2 Goal 3 Objective 3.1 Fair NHS recruitment and selection processes lead to a more representative workforce at all levels

One of the Trust's objectives for 2016-2020 is to encourage the recruitment conversion and progression rates of black, Asian and minority ethnic (BME) staff

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. Recruitment and Selection training for managers covers unconscious bias and all recruiting managers are to attend training prior to undertaking the recruitment and selection process.

The Trust will continue to monitor detailed analysis of ethnicity patterns in recruitment at the Equality & Diversity Group and explore the use of focused sessions/surgeries to support BME applicantants.

19. Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. This indicator will be based on data from a two year rolling average of the current year and the previous year.

Data for reporting year - Based on a 2 year period April 2016- March 2018, BME staff were 1.65 times more likely than White staff to enter the formal disciplinary process

Data for previous year - Based on a 2 year period April 2015- March 2017 BME staff were 1.70 times more likely than white staff to enter the formal disciplinary process

This indicator is measured over a 2 year period as defined in the WRES contract.

The data demonstrates that a disproportionate number of BME staff are being processed though the disciplinary system in relation to white members of staff, although there has been a slight improvement compared to the previous year.

The Trust will continue to monitor staff who enter into the disciplinary process and will provide an annual disciplinary by ethnicity profile report to equality and diversity group to determine any outlying trends, in addition to ensuring managers provide rationale for decision making.

20. Relative likelihood of staff accessing non-mandatory training and CPD.

Data for reporting year - White staff are 0.44 times more likely to access non mandatory training than their BME counterparts

Data for previous year - White staff are 0.72 times more likely to access non mandatory training than their BME colleagues

It is noted that one staff member may have attended more than one training session and have several training sessions attributed to them.

There has been an improvement in the likelihood of BME staff accessing non mandatory training during 2017/18 compared to the previous reporting period.

Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective

EDS2 Goal 3 Objective 3.3 Training and development opportunities are taken up and positively evaluated by all staff

The Trust continues to promote equal access to career progression opportunities. Analysis of ethnicity patterns in training reports will be monitored at the Trust Equality & Diversity Group.

21. KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.

Data for reporting year: White 24.39% BME 33.33%

Data for previous year: N/A

It has not been possible to compare the most recent 2017 staff survey to the previous year due to the Trust type changing from Acute only to Combined Acute and Community. A third of BME staff who completed the survey reported that they had experienced harassment, bullying or abuse from patients.

Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective

EDS2 Goal 3 Objective 3.4 When at work, staff are free from abuse, harassment, bullying and violence from any source

Further promotion is required on the 'zero tolerance' campaign so that all who use services are aware of expectations and consequences and to enable to Trust to be more proactive where members of the public are violent and aggressive towards our staff.

The Trust is to explore the equality monitoring of staff reporting violence and aggression by members of the public to enable more robust monitoring to identify trends.

22. KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.

Data for reporting year: White 21.49% BME 32.26%

Data for previous year: N/A

Again, it has not been possible to compare the 2017 staff survey results to the previous year however the reporting year shows a difference of over 10% in the experiences between white and BME staff.

Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective

EDS2 Goal 3 Objective 3.4 When at work, staff are free from abuse, harassment, bullying and violence from any source

EDS2 Goal 4 Objective 4.3 Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free of discrimination

The Trust has a number of actions planned to focus on our staff values and behaviours and tackling bullying such as the introduction of new equality and diversity training for managers and a revised , bullying and harassment policy with training to support, which link in with the values of the Trust to reinforce these amongst Trust employees.

23. KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion.

Data for reporting year: White 92.87% BME 84.21%

Data for previous year: N/A

Again, it has not been possible to compare the 2017 staff survey results to the previous year due to the change in Trust sector however less BME staff than white staff feel the Trust provides equal opportunities. The Trust will continue to support equal access to career development for existing staff providing opportunity to move into higher banded roles.

The Trust will continue in robust equality monitoring of staff accessing career progression opportunities.

24. Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues.

Data for reporting year: White 6.75% BME 20%

Data for previous year: N/A

One fifth of BME staff have reported that they have experienced discrimination at work from other staff members.

Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective

EDS2 Goal 4 Objective 4.3 Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free of discrimination

The Trust has a number of actions planned to focus on our staff values and behaviours such as the introduction of new equality and diversity training which will also link in with the values and expected behaviours of the Trust.

25. Percentage difference between the organisations' Board voting membership and its overall workforce.

Data for reporting year:

White: Board voting profile White 100% - Total workforce White 92.68%

BME: Board voting profile BME 0%- Total workforce BME 5.16%

Data for previous year:

Board voting profile White 100%

Board voting profile BME 0%

There has been no change to this indicator since the previous year

A WRES action plan will be produced to address any areas of concern identified in the findings.

Workforce Race Equality Standard (WRES) Action Plan 2018

WRES Indicator	What the WRES data tells us	Action(s)	Lead responsibility	Timescale for delivery
1 Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce.	42% of the workforce are white staff in clinical roles in bands 2, 5 and 6. BME staff account for 5.2% of the total workforce with little representation at senior level	Encourage participation of BME staff in leadership development programmes Explore establishing a BME staff network	HR Manager – Employment Relations and E&D Learning & Development department HR Manager – Employment Relations and E&D	March 2019 March 2019
2 Relative likelihood of staff being appointed from shortlisting across all posts	White staff are 1.46 times more likely to be appointed from shortlisting compared to BME staff	Make better use of technology and social media to reach and attract potential candidates to encourage applicants from underrepresented groups to apply Monitoring of detailed analysis of ethnicity patterns in recruitment Review applications to determine reasons why BME candidates were not appointed following interview	Recruitment Manager Recruitment Manager Recruitment Manager	On-going Annually December 2018

		Explore holding focused sessions/surgeries to support BME applicants		
3 Relative likelihood of staff entering the disciplinary process, measured by entry into a formal disciplinary investigation	BME staff are 1.65 times more likely than white staff to come under the disciplinary process	Undertake annual analysis of all disciplinary data to identify any trends or issues Regularly review all cases of potential disciplinary matters with managers providing rationale for decision making	HR Manager – Employment Relations and E&D HR Managers	May/June 2019 On-going monthly
4 Relative likelihood of staff accessing non-mandatory training and CPD	White staff are 0.44 times more likely to access non-mandatory training than BME staff.	Encourage participation of BME staff in leadership development programmes Explore ways in which the Trust can increase participation by BME staff in the available programmes/training events via staff network once established and staff focus groups.	Learning & Development department	On-going 2019/20 on-going
5 KF25 Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White 24.39% BME 33.33%	Undertake a refreshed communications campaign to all service users and visitors to the Trust regarding the Trust's zero	Communications department	March 2019

		tolerance approach to bullying, harassment, abuse and violence		
6 KF26 Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White 21.49% BME 32.26%	Full review of the Trust bullying and harassment provisions to include policy redraft and training and include link to Trust values and behaviours to reinforce across the Trust Continue to develop and deliver a wide range of health and wellbeing support initiatives to those who experience bullying and harassment	HR Manager – Employment Relations and E&D Head of Occupational Health Services/Health and Wellbeing Group	March 2019 On-going
7 KF21 Percentage believing that Trust provides equal opportunities for career progression or promotion	White 92.87% BME 84.21%	Encourage participation of BME staff in leadership development programmes and participation in coaching and mentoring	Learning & Development/OD	On-going
8 Q17 In the last 12 months have you personally experienced discrimination at work from any of the following? Manager/team leader or other colleagues	White 6.75% BME 20.00%	Undertake a communication campaign to staff regarding discrimination and unacceptable behaviours. Message to be reinforced via E&D training Ensure reported cases of discrimination are dealt with in an effective and timely manners	Communications department HR Manager - Employment Relations and E&D Human Resources	March 2019 On-going

9 Percentage difference between the organisation's Board voting membership and its overall workforce	BME -5.2% Board voting profile white 100% BME 0%	Ensure that the process for appointment of Executive and Non-Executive Director posts encourages applications from as diverse a pool of talent as possible to demonstrate the Trust's commitment to diversity and inclusion	Board	On-going

Workforce Race Equality Standards annual collection

as at March-2017

For any techincal queries or additional clarification relating to the collection please contact:

For any queries or additional clarification relating to submissions please contact: data.collections@nhs.net

Workforce Race Equality Standards

Validations
Please correct all issues listed within the table below. If the issues are not corrected then the pro forma will fail the validation stage in SDCS.

Trust - Frontsheet

SubmissionTemplate
Workforce Race Equality Standards 2017/18 template

Answer Required
Auto Populated
N/A

INDICATOR		DATA ITEM		MEASURE	31st MARCH 2017						31st MARCH 2018						Notes
					WHITE		BME		ETHNICITY UNKNOWN/NULL		WHITE		BME		ETHNICITY UNKNOWN/NULL		
			1a) Non Clinical workforce		Prepopulated figures	Verified figures	Prepopulated figures	Verified figures	Prepopulated figures	Verified figures	Prepopulated figures	Verified figures	Prepopulated figures	Verified figures	Prepopulated figures	Verified figures	
		1	Under Band 1	Headcount	0	0	0	0	0	0	0	0	0	0	0	0	
		2	Band 1	Headcount	72	72	3	3	1	1	73	73	6	6	0	0	
		3	Band 2	Headcount	528	528	10	10	11	11	515	518	14	12	12	12	
		4	Band 3	Headcount	320	320	6	6	4	4	319	322	3	3	4	4	
		5	Band 4	Headcount	199	199	2	2	1	1	190	190	5	4	5	5	
		6	Band 5	Headcount	71	71	0	0	2	2	73	75	2	1	1	1	
		7	Band 6	Headcount	56	56	0	0	0	0	55	55	0	0	1	1	
		8	Band 7	Headcount	28	28	1	1	0	0	36	37	1	1	1	1	
		9	Band 8A	Headcount	28	28	1	1	0	0	41	41	0	0	0	0	
		10	Band 8B	Headcount	28	12	1	1	0	0	14	14	1	1	0	0	
		11	Band 8C	Headcount	2	2	0	0	0	0	4	4	0	0	0	0	
		12	Band 8D	Headcount	8	8	0	0	0	0	7	8	0	0	0	0	
		13	Band 9	Headcount	0	0	0	0	0	0	0	0	0	0	0	0	
		14	VSM	Headcount	5	5	0	0	0	0	6	6	0	0	0	0	
1	Percentage of staff in each of the AfC Bands 1-9 OR Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce		**1b) Clinical workforce** of which Non Medical														
		15	Under Band 1	Headcount	0	0	0	0	0	0	0	0	0	0	0	0	
		16	Band 1	Headcount	8	8	0	0	0	0	7	7	0	0	0	0	
		17	Band 2	Headcount	682	682	30	30	7	7	643	651	39	32	6	7	
		18	Band 3	Headcount	272	272	8	8	9	9	252	256	8	6	6	7	
		19	Band 4	Headcount	90	90	2	2	1	1	94	94	3	3	1	1	
		20	Band 5	Headcount	650	650	49	49	24	24	633	636	60	54	13	12	
		21	Band 6	Headcount	681	681	23	23	21	21	649	655	28	24	14	14	
		22	Band 7	Headcount	370	370	6	6	11	11	341	342	8	7	6	6	
		23	Band 8A	Headcount	95	95	2	2	2	2	104	103	2	2	1	1	
		24	Band 8B	Headcount	17	17	0	0	0	0	12	12	0	0	0	0	
		25	Band 8C	Headcount	2	2	0	0	0	0	2	2	0	0	0	0	
		26	Band 8D	Headcount	3	3	0	0	0	0	3	3	0	0	0	0	
		27	Band 9	Headcount	0	0	0	0	0	0	0	0	0	0	0	0	
		28	VSM	Headcount	0	0	0	0	0	0	0	0	0	0	0	0	
			Of which Medical & Dental														
		29	Consultants	Headcount	90	90	45	45	6	6	93	95	49	47	4	4	
		30	*of which Senior medical manager*	Headcount		0		0		0		0		0		0	
		31	Non-consultant career grade	Headcount	22	22	18	18	6	5	17	18	20	19	3	3	
		32	Trainee grades	Headcount	10	10	7	7	0	0	3	3	7	7	4	4	
		33	Other	Headcount	0	0	0	0	25	25	21	21	7	7	16	16	
2	Relative likelihood of staff being appointed from shortlisting across all posts	34	Number of shortlisted applicants	Headcount								3807		563		88	
		35	Number appointed from shortlisting	Headcount								1006		102		37	
		36	Relative likelihood of shortlisting/appointed	Auto calculated		0.2144786602		0.1754032258		#VALUE!		0.2642500657		0.1811722913		0.4204545455	
		37	Relative likelihood of White staff being appointed from shortlisting compared to BME staff	Auto calculated		1.22						1.46					
3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation Note: This indicator will be based on data from a two year rolling average of the current year and the previous year	38	Number of staff in workforce	Auto calculated							4207	4241	263	236	98	99	
		39	Number of staff entering the formal disciplinary process	Headcount								120		11		4	
		40	Likelihood of staff entering the formal disciplinary process	Auto calculated		0.0163817664		0.0277777778				0.0282952134		0.0466101695		0.0404040404	
		41	Relative likelihood of BME staff entering the formal disciplinary process compared to White staff	Auto calculated				1.70						1.65			
4	Relative likelihood of staff accessing non-mandatory training and CPD	42	Number of staff in workforce (White)	Auto calculated								4241		236		99	
		43	Number of staff accessing non-mandatory training and CPD (White):	Headcount								1651		209		96	
		44	Likelihood of staff accessing non-mandatory training and CPD	Auto calculated		0.4287749288		0.5972222222		#VALUE!		0.3892949776		0.8855932203		0.9696969697	
		45	Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff	Auto calculated		0.72						0.44					
5	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	46	% of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	Percentage	#N/A		#N/A				24.39%		33.33%				
6	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	47	% of staff experiencing harassment, bullying or abuse from staff in last 12 months	Percentage	#N/A		#N/A				21.49%		32.26%				
7	KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion	48	% staff believing that trust provides equal opportunities for career progression or promotion	Percentage	#N/A		#N/A				92.87%		84.21%				
8	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues	49	% staff personally experienced discrimination at work from Manager/team leader or other colleague	Percentage	#N/A		#N/A				6.75%		20.00%				
9	Percentage difference between the organisations' Board voting membership and its overall workforce Note: Only voting members of the Board should be included when considering this indicator	50	Total Board members	Headcount		13		0		0		13		0		0	
		51	*of which: Voting Board members*	Headcount		13		0		0		13		0		0	
		52	*: Non Voting Board members*	Auto calculated		0		0		0		0		0		0	
		53	Total Board members	Auto calculated		13		0		0		13		0		0	
		54	*of which: Exec Board members*	Headcount		6		0		0		6		0		0	
		55	*: Non Executive Board members*	Auto calculated		7		0		0		7		0		0	
		56	Number of staff in overall workforce	Auto calculated		4321		214		130		4241		236		99	
		57	Total Board members - % by Ethnicity	Auto calculated		100.0%		0.0%		0.0%		100.0%		0.0%		0.0%	
		58	Voting Board Member - % by Ethnicity	Auto calculated		100.0%		0.0%		0.0%		100.0%		0.0%		0.0%	
		59	Non Voting Board Member - % by Ethnicity	Auto calculated													
		60	Executive Board Member - % by Ethnicity	Auto calculated		100.0%		0.0%		0.0%		100.0%		0.0%		0.0%	
		61	Non Executive Board Member - % by Ethnicity	Auto calculated		100.0%		0.0%		0.0%		100.0%		0.0%		0.0%	
		62	Overall workforce - % by Ethnicity	Auto calculated	0.00%	92.6%	0.00%	4.6%	0.00%	2.8%	0.00%	92.7%		5.2%		2.2%	
		63	Difference (Total Board -Overall workforce)	Auto calculated		7.4%		-4.6%		-2.8%		7.3%		-5.2%		-2.2%	

SubmissionTemplate
Workforce Race Equality Standards 2017/18 template

INDICATOR		DATA ITEM		MEASURE	31st MARCH 2017						31st MARCH 2018						Notes
					WHITE		BME		ETHNICITY UNKNOWN/NULL		WHITE		BME		ETHNICITY UNKNOWN/NULL		
			1a) Non Clinical workforce		Prepopulated figures	Verified figures	Prepopulated figures	Verified figures	Prepopulated figures	Verified figures		Verified figures	Prepopulated figures	Verified figures	Prepopulated figures	Verified figures	
		1	Under Band 1	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		2	Band 1	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		3	Band 2	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		4	Band 3	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		5	Band 4	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		6	Band 5	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		7	Band 6	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		8	Band 7	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		9	Band 8A	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		10	Band 8B	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		11	Band 8C	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		12	Band 8D	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		13	Band 9	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		14	VSM	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
1	Percentage of staff in each of the AfC Bands 1-9 OR Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce		**1b) Clinical workforce** of which Non Medical														
		15	Under Band 1	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		16	Band 1	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		17	Band 2	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		18	Band 3	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		19	Band 4	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		20	Band 5	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		21	Band 6	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		22	Band 7	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		23	Band 8A	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		24	Band 8B	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		25	Band 8C	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		26	Band 8D	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		27	Band 9	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		28	VSM	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
			Of which Medical & Dental														
		29	Consultants	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		30	*of which Senior medical manager*	Headcount		OK		OK		OK		OK		OK		OK	
		31	Non-consultant career grade	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		32	Trainee grades	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		33	Other	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
2	Relative likelihood of staff being appointed from shortlisting across all posts	34	Number of shortlisted applicants	Headcount				OK		OK		Good		Good		OK	
		35	Number appointed from shortlisting	Headcount				OK		OK		Good		Good		OK	
		36	Relative likelihood of shortlisting/appointed	Auto calculated													
		37	Relative likelihood of White staff being appointed from shortlisting compared to BME staff	Auto calculated													
3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation Note: This indicator will be based on data from a two year rolling average of the current year and the previous year	38	Number of staff in workforce	Auto calculated													
		39	Number of staff entering the formal disciplinary process	Headcount								Good		Good		Good	
		40	Likelihood of staff entering the formal disciplinary process	Auto calculated													
		41	Relative likelihood of BME staff entering the formal disciplinary process compared to White staff	Auto calculated													
4	Relative likelihood of staff accessing non-mandatory training and CPD	42	Number of staff in workforce (White)	Auto calculated													
		43	Number of staff accessing non-mandatory training and CPD (White):	Headcount								Good		Good		Good	
		44	Likelihood of staff accessing non-mandatory training and CPD	Auto calculated													
		45	Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff	Auto calculated													
5	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	46	% of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	Percentage													
6	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	47	% of staff experiencing harassment, bullying or abuse from staff in last 12 months	Percentage													
7	KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion	48	% staff believing that trust provides equal opportunities for career progression or promotion	Percentage													
8	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues	49	% staff personally experienced discrimination at work from Manager/team leader or other colleague	Percentage													
9	Percentage difference between the organisations' Board voting membership and its overall workforce Note: Only voting members of the Board should be included when considering this indicator	50	Total Board members	Headcount		Good		Good		Good		Good		Good		Good	
		51	*of which: Voting Board members*	Headcount		Good		Good		Good		Good		Good		Good	
		52	*: Non Voting Board members*	Auto calculated													
		53	Total Board members	Auto calculated													
		54	*of which: Exec Board members*	Headcount		Good		Good		Good		Good		Good		Good	
		55	*: Non Executive Board members*	Auto calculated													
		56	Number of staff in overall workforce	Auto calculated													
		57	Total Board members - % by Ethnicity	Auto calculated													
		58	Voting Board Member - % by Ethnicity	Auto calculated													
		59	Non Voting Board Member - % by Ethnicity	Auto calculated													
		60	Executive Board Member - % by Ethnicity	Auto calculated													
		61	Non Executive Board Member - % by Ethnicity	Auto calculated													
		62	Overall workforce - % by Ethnicity	Auto calculated													
		63	Difference (Total Board -Overall workforce)	Auto calculated													

We Care Because You Matter

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

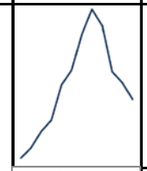
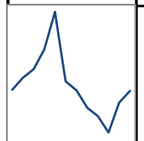
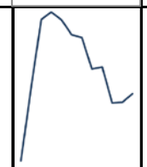
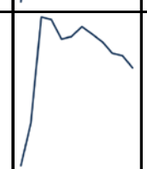
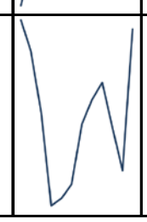
Board of Directors

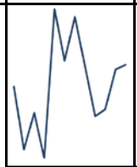
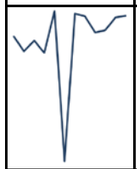
Workforce Report

October 2018

(Aug 2018 data)

Performance Report Workforce Chapter
Month: Aug-18

Measure	Target	Performance	Description	Narrative	Rolling Trend	Trend	C&W Average (July 2018)
Sickness Absence	3.40%	4.27%	Rolling 12m average Sickness Absence described as a Percentage	Rolling sickness absence has shown a small improvement from the July 2018 postion. 4 of the 7 divisions experienced a reduction in their rolling sickness absence. The in-month sickness absence rate is 4.18% which is a increase of 0.18% from the July in-month position.		↓	4.82%
In-Month Sickness Absence	N/A	4.18%	In-month 12m average Sickness Absence described as a Percentage			↑	4.67%
Appraisal Rate	90.00%	83.91%	Percentage of Staff who have received an appraisal in the last 12 months. Excludes New Staff with less than 12m service and Bank Staff	Appraisal rates have remained fairly static during July 2018 (+0.49%). Corporate and WC are currently achieving the targe. CCICP delivered a 6% improvement in-month.		↑	86.43%
Mandatory Training	90.00%	80.38%	Mandatory Training Monthly Rate Excludes Bank Staff, Staff on long term sick & mat. leave.	Mandatory training compliance rates have remained fairly static during August 2018 (-0.62%). DCSS remain above the 90% target. The Trust's dashboard has been updated to ensure that it is reflective of changes to training requirements and communications have been shared		↓	86.16%
Staff Turnover	10.00%	11.67%	Number of Leavers expressed as a percentage of the workforce over a 12m rolling period. Exclude Junior Doctors, Temporary and Fixed term.	Staff turnover has increased from 11.17% in July 2018. The Trust is actively involved in an NHS Employers sponsored project aimed at reducing turnover in the nursing staff group		↑	11.45%

Measure	Target	Performance	Description	Narrative	Rolling Trend		
Agency Spend	(365)	(395)	In month and cumulative total spend for the Trust.	The agency target was exceeded in August 2018.		↑	N/A
NHSI Ceiling	less than 100%	108.2%	Trust Agency Spend as a percentage of the Ceiling Set by NHS Improvement			↑	N/A
Over Cap Rates	N/A	47%	Number of Agency shifts filled by agency staff that are over the nationally determined capped rates			↑	N/A

Key

Adverse Increase	↑
Positive Increase	↑
Adverse Reduction	↓
Positive Reduction	↓
Neutral Change/ No Change	↑↓=