Mid Cheshire Hospitals NHS Foundation Trust

AGENDA

Board of Directors
A meeting will be held in Public at
09.30am on Monday, 7 October 2019
in the Boardroom, Leighton Hospital, Crewe

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 meetings held in Public on Monday 2 September *(attached)* *(for approval)*	A	Chairman **09.52**	**4**
5.	**Matters Arising and Action Log** *(verbal) (to approve)*	A	Chairman **09.55**	**18**
6.	**Annual Work Programme 2019/20** *(attached)* *(to approve)*	I/A	Chairman **09.57**	**19**
7.	**Chairman's Announcements** (*to note a verbal report*) **7.1 NEDs/Governors Meeting – 9 September 2019** **7.2 Board Away Day – 30 September 2019**	I	Chairman **10.00**	-
8.	**Governor's Items** (*to note a verbal report*) **8.1 Nominations & Remuneration Committee** **8.2 Annual Members Meeting** **8.3 Governor Appointments & Resignations**	I	Chairman **10.10**	-

Item No		Title of Item	Action	Led By	Page No.
9.	**Chief Executive's Report** *(to note a verbal report)*				
	9.1	**System Update**	I	Chief Executive **10.15**	**-**
	9.2	**Executive Away Day**			
10.	**CARING**				
	10.1	**Quality, Safety & Experience Report** *(attached) (for discussion)*	I/D	Director of Nursing & Quality **10.30**	**20**
	10.2	**Nursing and Midwifery Staffing Comprehensive Report** *(attached) (for discussion)*	I/D	Director of Nursing & Quality **10.40**	**79**
11.	**SAFE**				
	11.1	**Draft Quality Governance Committee notes from the meeting held on 9 September 2019** *(attached) (to note)*	I	Committee Chair **10.50**	**98**
	11.2	**Serious Untoward Incidents and RIDDOR Events** *(verbal)* (*to note*)	I/D	Interim Medical Director **10.55**	**-**
12.	**RESPONSIVE**				
	12.1	**Performance Report** *(attached) (to note)*	I/D	Chief Operating Officer **11.00**	**114**
	12.2	**Draft Performance & Finance Committee notes from the meeting held on 26 September 2019** *(to follow) (to note)*	I	Committee Chair **11.10**	**-**
	12.3	**Legal Advice** *(verbal)* (*to note*)	I	Chief Executive **11.15**	**-**
	12.4	**DMEC Operational Management and Matron Restructure Business Case** *(attached) (to approve)*	A/D	Chief Operating Officer **11.20**	**137**
	12.5	**Acute Care Team Business Case** *(attached) (to approve)*	A/D	Interim Medical Director **11.35**	**160**
13.	**WELL-LED**				
	13.1	**Visits of Accreditation, Inspection or Investigation** *(verbal)* (*to note*)	I	Chief Executive **11.45**	**-**
	13.2	**Draft Audit Committee from the meeting held on 9 September 2019** *(attached) (to note)*	I/D	Committee Chair **11.50**	**195**

Item No	Title of Item	Action	Led By	Page No.
13.3	**Emergency Preparedness, Resilience and Response (EPPR)** *(attached) (to note)*	A/D	Chief Operating Officer **11.55**	**211**
13.4	**Workforce Race Equality Scheme** *(attached) (to note)*	A/D	Director of Workforce and OD **12.00**	**216**
13.5	**EU Exit Update Report** *(attached) (to note)*	I/D	Director of Workforce and OD **12.05**	**227**
13.6	**Replacement of Pharmacy Automation System Business Case** *(attached) (to approve)*	A/D	Chief Operating Officer **12.10**	**229**
13.7	**Cheshire East and Cheshire West and Chester Place Five Year Plans** *(attached) (to approve)*	A/D	Director of Strategic Partnerships **12.20**	**253**
14.	**EFFECTIVE**			
14.1	**Workforce Report** *(attached) (to note)*	I/D	Director of Workforce and OD **12.30**	**317**
14.2	**Transformation and People Committee notes from the meeting held on 5 September 2019** *(attached) (to note)*	I/D	Committee Chair **12.40**	**320**
14.3	**Consultant Appointments** *(verbal) (to note)*	I	Interim Medical Director **12.45**	**-**
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, Leighton Hospital at 9.30am on **Monday, 4 November 2019**	I	Chairman	

Board of Director Meeting held in Private (Action Log)

Minute Ref:	Date of Meeting	Action	Lead	Deadline Date	Comments	Date of Board meeting to be reviewed	Status
2/19/09/7.1.12	02/09/2019	100 day plan is ciruclated to the Board	J Sumber	30/09/2019		07/10/2019	Completed

Board of Directors Workplan 2019/20

Version: 3

Item	Board of Directors Meeting												Board Away Day				
	April	*May*	*June*	*July*	*August*	*Sept*	*Oct*	*Nov*	*Dec*	*Jan*	*Feb*	*March*	*Apr*	*Jun*	*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		
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 Preparedness, Resilience& Response (EPPR)							x										
Doctors Revalidation Report						x											
Effective																	
Workforce Report	x	x	x	x	x	x	x	x	x	x	x	x					
Equality Delivery System					x												
Workforce Race Equality Scheme						x											
Gender Pay Gap Report																	
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					

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

We Care Because You Matter

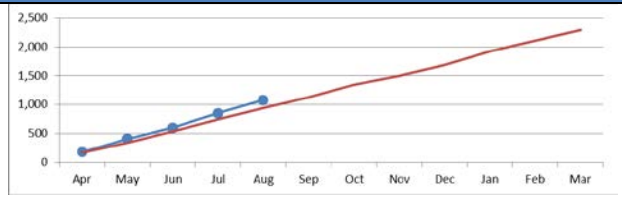
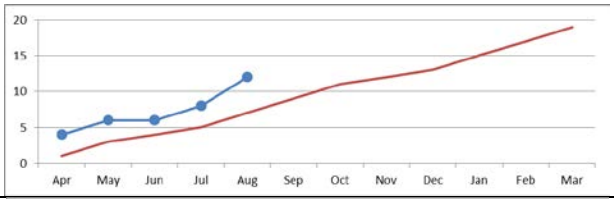
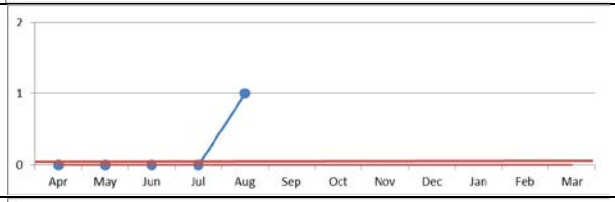
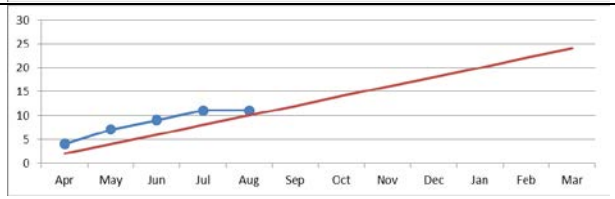
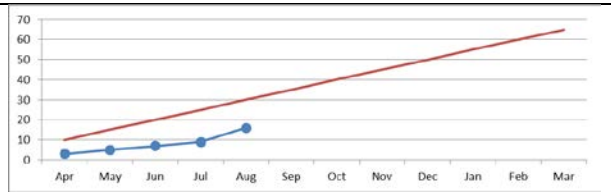
Quality, Safety and Experience Report

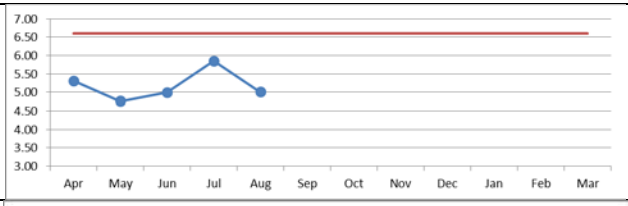
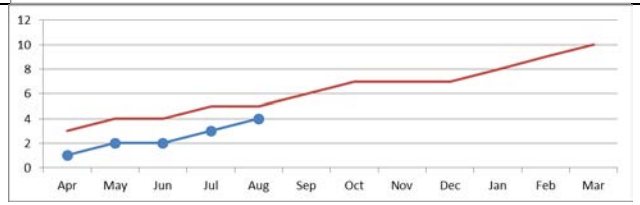
October 2019

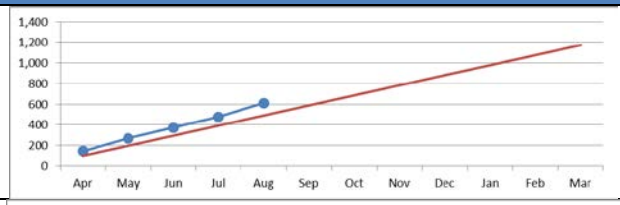
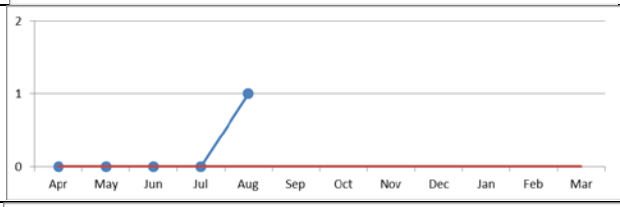
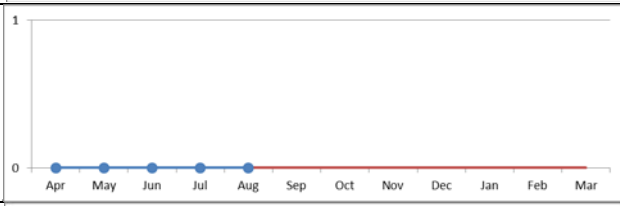
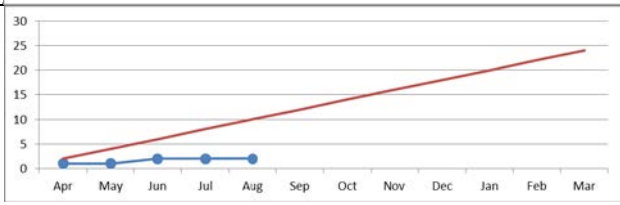
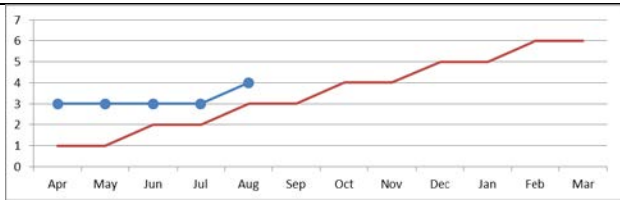
(August 2019 data)

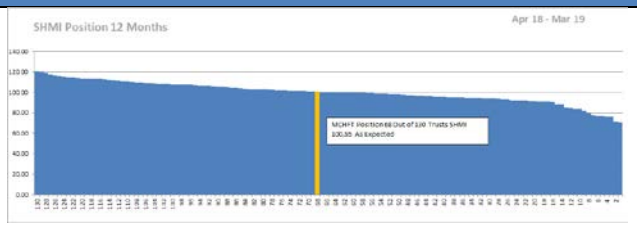
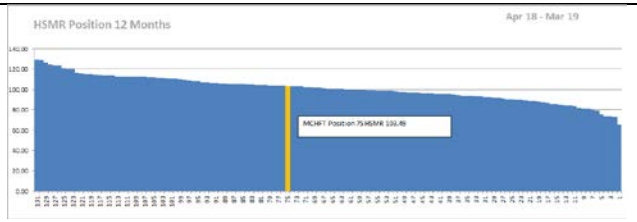
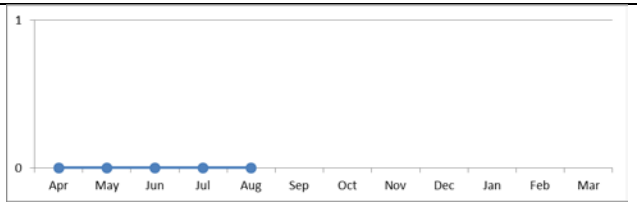
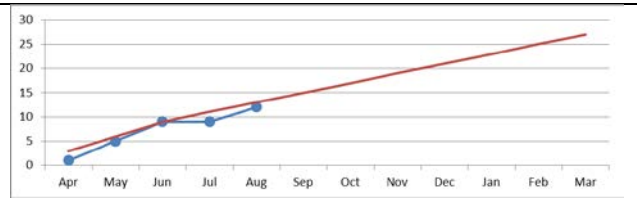
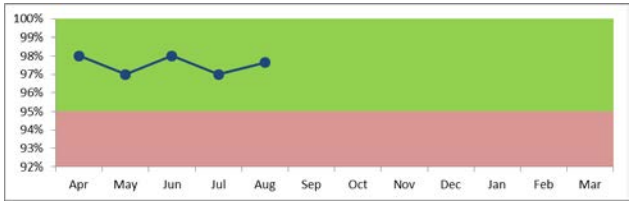
Contents

Contents (continued):

Indicators	Target	Trajectory 2019/20
Acute Trust		
Patient Safety Harm Incidents The target is to reduce the total number of patient safety harm incidents when compared to the previous financial year by the end of March 2020.	**Less than 2300 at end of March 2020**	
StEIS Reported Incidents The target is to reduce StEIS reported incidents when compared to the previous financial year by the end of March 2020.	**Less than 19 at end of March 2020**	
Never Events Zero tolerance of Never Events.	**Zero**	
Pressure Ulcers – Hospital Acquired The target is to have no more than two lapses in care (avoidable) pressure ulcers per month.	**Less than 24 lapses in care at end of March 2020**	
Medication Harm Incidents The target is to reduce the total number of medication incidents resulting in harm when compared to the previous financial year by the end of March 2020.	**Less than 66 at end of March 2020**	

Indicators	Target	Trajectory 2019/20
Acute Trust		
Inpatient Falls - Harm The target is to have a reduction in harm from patient falls when compared to the previous financial year.	**Less than 268 at end of March 2020**	
Inpatient Falls – Rate Per 1,000 Bed Days A reduction in the number of falls per 1,000 bed days when compared to the RCP National Audit 2015 (average number of patient falls per 1,000 bed days).	**Ratio less than 6.6**	
Inpatient Falls – Fractured NOF A reduction in the number of fractured NOF resulting from patient falls when compared to the previous financial year.	**Less than 10 at end of March 2020**	

Indicators	Target	Trajectory 2018/19
CCICP		
CCICP Patient Safety Harm Incidents The target is to reduce the total number of CCICP patient safety harm incidents when compared to the previous financial year by the end of March 2020.	**Less than 1238 at end of March 2020**	
CCICP Serious Incidents The target is to continue the trend of having zero CCICP patient safety serious incidents by the end of March 2020.	**Zero**	
CCICP Never Events Zero tolerance of CCICP Never Events.	**Zero**	
CCICP Pressure Ulcers – Community Acquired The target is to have no more than two lapses in care (avoidable) pressure ulcers per month.	**Less than 24 lapses in care at end of March 2020**	
CCICP Medication Harm Incidents The target is to reduce the total number of medication incidents resulting in harm when compared to the previous financial year by the end of March 2020.	**Less than 7 at end of March 2020**	

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 The target is less than 27 cases of Clostridium Difficile in 2019/20. The target includes cases who have been identified in the community but had a hospital admission in the previous 28 days.	**Less than 27 at end of March 2020**	
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 the total number of patient safety harm incidents when compared to the previous financial year by the end of March 2020.

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

For August 2019, there were a total of 234 patient safety harm incidents:

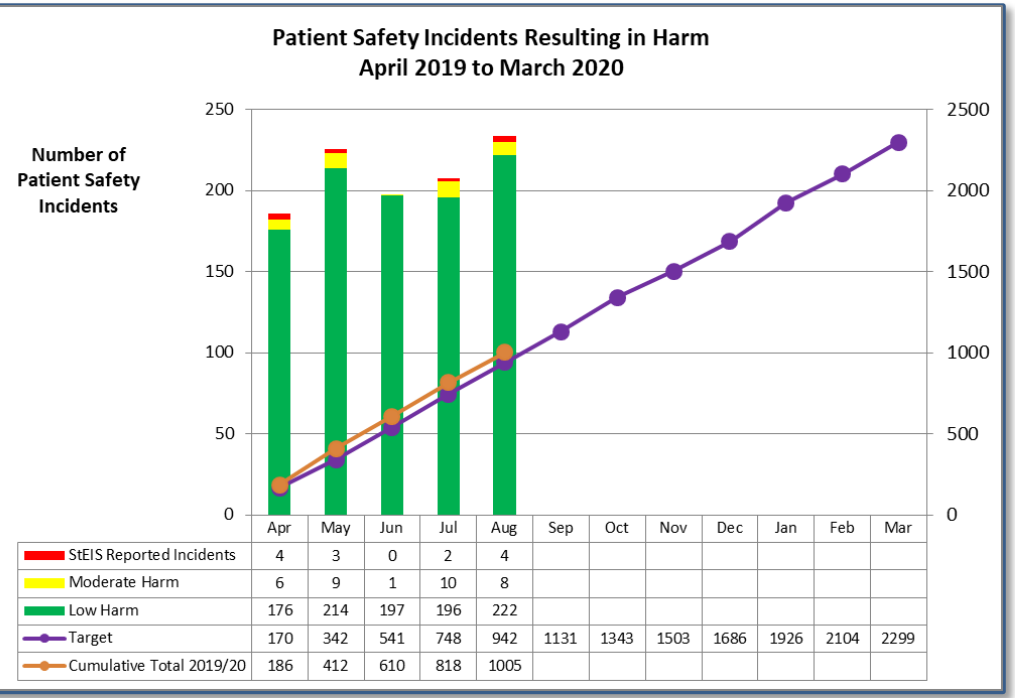
94.9% (222 incidents) have resulted in low harm

3.4% (8 incidents) have resulted in moderate harm

1.7% (4 incidents) have been reported to StEIS

Improvement actions include;

- Incident report training for all new staff to the Trust. This training ensures that all staff in the Trust know how to report a patient safety incident and they also understand the importance of incident reporting.
- Direct feedback to all staff on the outcome of the incidents they have reported to demonstrate the changes in practice that have been made as a result of the incident.
- Sharing of learning from reported incidents through safety alerts, lessons learned episodes of care, individual patient stories and Safety Matters.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
StEIS Reported Incidents	4	3	0	2	4							
Moderate Harm	6	9	1	10	8							
Low Harm	176	214	197	196	222							
Target	170	342	541	748	942	1131	1343	1503	1686	1926	2104	2299
Cumulative Total 2019/20	186	412	610	818	1005							

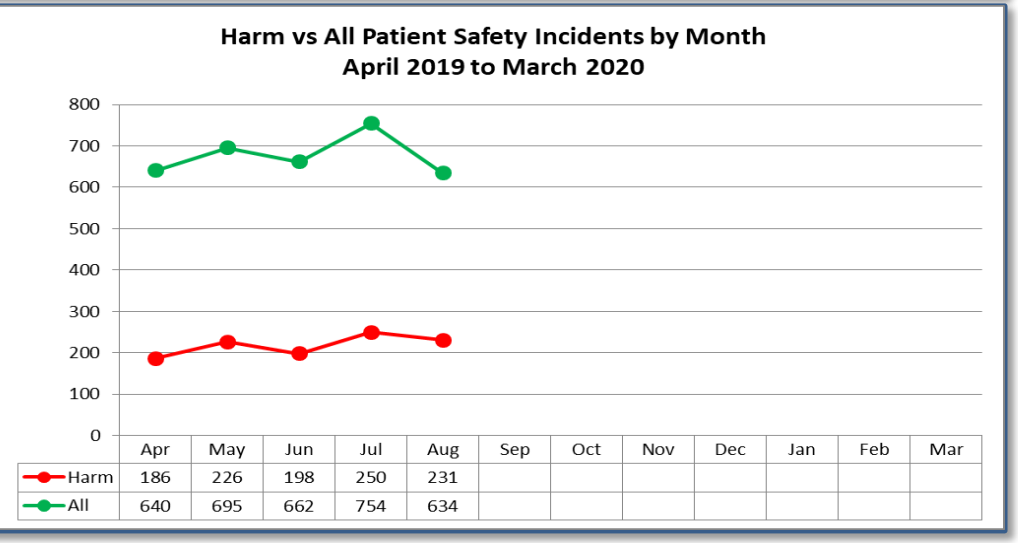
Harm vs All Patient Safety Incidents

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 2019, the gap between harm and all patient safety incidents was 403. The aim over the twelve month period is to see this gap widening.

A safety culture survey was undertaken in the Trust in December 2018 to January 2019. The results were shared at the EQGG in April 2019 and divisional improvement plans developed to take into account the feedback received during the survey.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Harm	186	226	198	250	231							
All	640	695	662	754	634							

Description	Aggregate Position	Trend

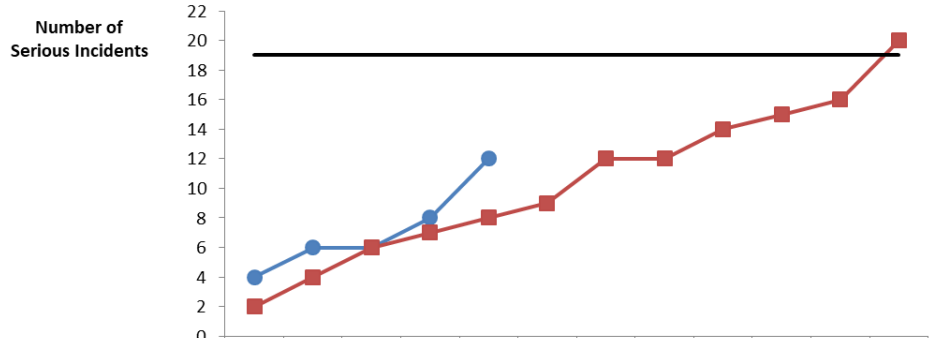
StEIS Reported Incidents

The target is to reduce the number of StEIS reported incidents when compared to the previous financial year by the end of March 2020.

This chart demonstrates the number of incidents that have been reported to StEIS.

For August 2019, there were 4 StEIS reported incidents;

- A patient with sepsis had debridement of a category 3 pressure ulcer and an unstageable pressure ulcer. Post-surgery the patient died.
- A patient fall resulting in a fractured neck of femur
- Potential patient treatment delay
- Retained stylet in a PICC line.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative 2019/20	4	6	6	8	12							
Cumulative 2018/19	2	4	6	7	8	9	12	12	14	15	16	20
Target	19	19	19	19	19	19	19	19	19	19	19	19

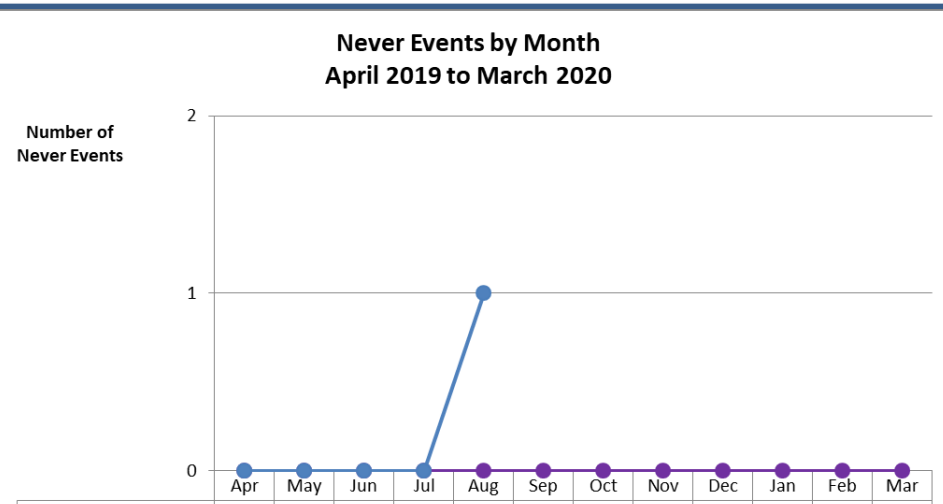
Never Events

The target is to have zero Never Events

This chart demonstrates the number of Never Events that have been reported.

For August 2019 there was one Never Event reported;

A patient attended theatre for the insertion of a double lumen peripherally inserted central catheter (PICC) line. The stylet was left insitu in error following the procedure.



	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	1							

Description	Aggregate Position	Trend

Pressure Ulcers (PU) – Hospital Acquired

The target is to have no more than 24 pressure ulcers resulting from lapses in care by the end of March 2020.

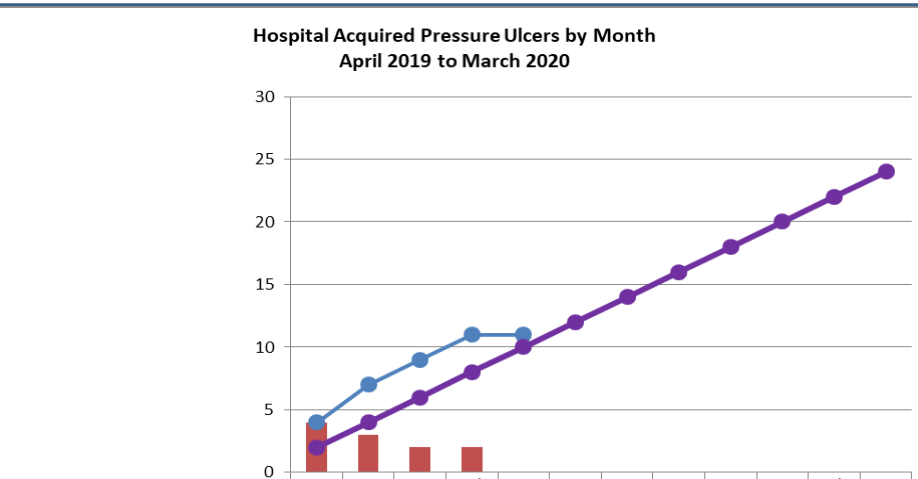
For August 2019, there were a total of 25 hospital acquired pressure ulcer incidents:

- 0% (0 PUs) occurred with lapses in care that did contribute to the PU.
- 0% (0 PUs) occurred with lapses in care that did not contribute to the PU.
- 8% (2 PUs) occurred with no lapses in care identified.
- 56% (14 PUs) confirmed but awaiting tool.
- 8% (2 PUs) are awaiting confirmation from PUP.
- 28% (7 PUs) are awaiting verification.

Improvement actions include;

The following guides have been ratified and shared with staff to support pressure ulcer prevention:

- The new Trust TVN commenced in post in September 2019.
- A Pressure Ulcer Summit is planned in October . The summit plans to deliver education and training from lessons learnt. A focus will be on the importance of documentation of the Registered General Nurse.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Lapses in Care Identified	4	3	2	2	0							
Cumulative Lapses in Care	4	7	9	11	11							
Lapses in Care Cumulative Target	2	4	6	8	10	12	14	16	18	20	22	24
% Lapses in Care PU	28.6%	20.0%	13.3%	11.1%	0.0%							

Medication Harm Incidents

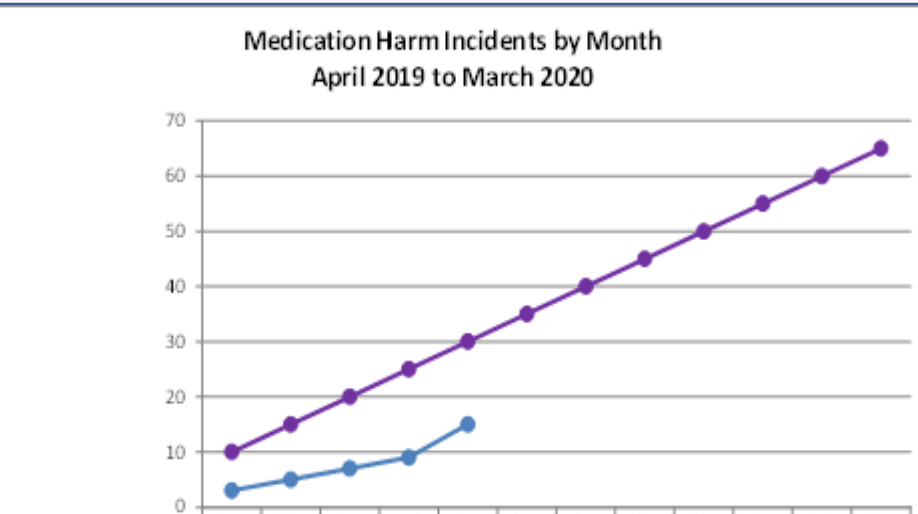
The target is to reduce the total number of medication incidents resulting in harm when compared to the previous financial year by the end of March 2020.

For August 2019, there were a total of 6 medication incidents resulting in harm reported:

- 100% (6 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:

- Further development of comprehensive medicines management induction and on-going training programs for all clinical staff.
- Introduced medicines management training for prescribers and developed a medical gasses training program (an online training module).
- Promotion and audit of the Trust Medicines Policies to ensure that all medicines are stored, prescribed, administered and where necessary disposed of in the safest and most appropriate manner with on going training for nursing, pharmacy and medical staff.
- Pharmacy technicians administer medicines on certain wards.

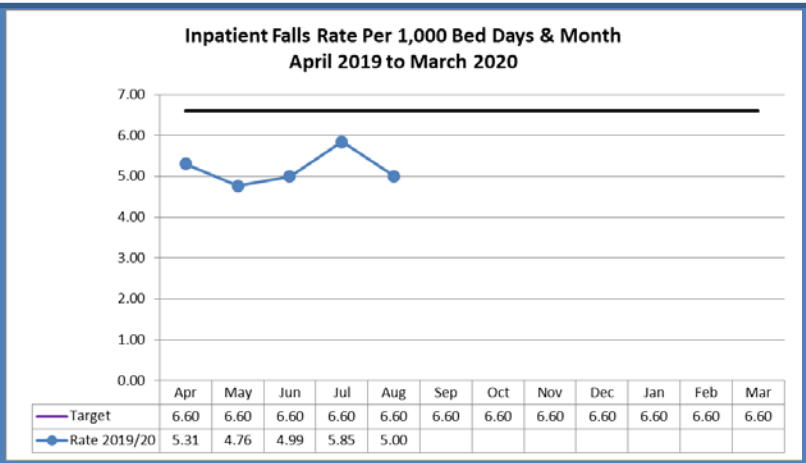


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative Total	3	5	7	9	15							
Cumulative Target	10	15	20	25	30	35	40	45	50	55	60	65

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

Inpatient Falls.

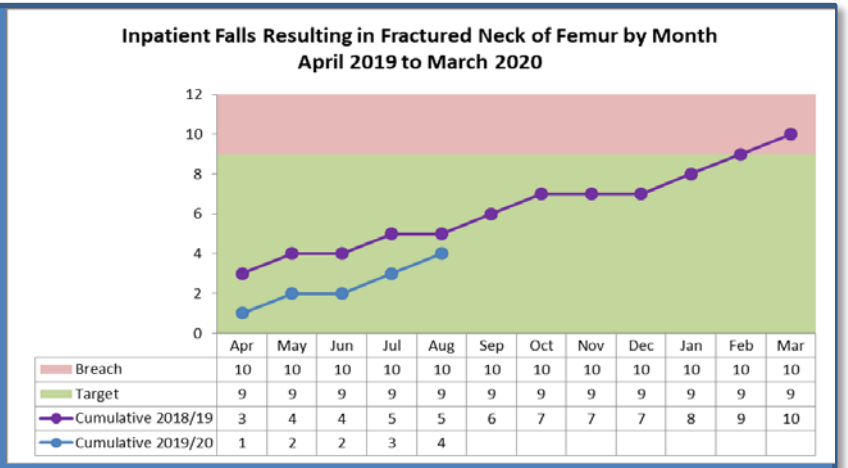
A reduction in the number of falls per 1,000 bed days when compared to the previous financial year (less than 6.6)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Target	6.60	6.60	6.60	6.60	6.60	6.60	6.60	6.60	6.60	6.60	6.60	6.60
Rate 2019/20	5.31	4.76	4.99	5.85	5.00							

For August 2019, the falls rate per 1,000 bed days was 5.00.

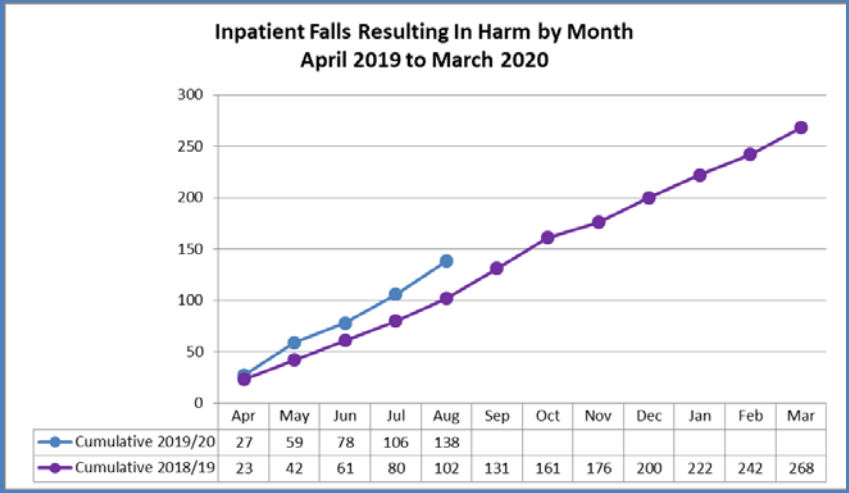
A reduction in the total number of fractured neck of femurs as a result of a fall (less than 10)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Breach	10	10	10	10	10	10	10	10	10	10	10	10
Target	9	9	9	9	9	9	9	9	9	9	9	9
Cumulative 2018/19	3	4	4	5	5	6	7	7	7	8	9	10
Cumulative 2019/20	1	2	2	3	4							

In August 2019, there was one fractured neck of femur reported.

A reduction in the total number of falls with harm compared to previous year (less than 268)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative 2019/20	27	59	78	106	138							
Cumulative 2018/19	23	42	61	80	102	131	161	176	200	222	242	268

In August 2019, there were a total of 32 falls with harm.

- 91% (29) resulting in low harm
- 6% (2) resulting in moderate harm
- 3% (1) resulting in major harm

Improvement actions include:

- The Trust is launching Falls Awareness week in September 2019. This will enable sharing of information / advice to patients, carers, relatives and staff on Falls prevention. This advice will include the 3 elements of the national CQUIN;
  - Lying & standing blood pressure
  - Hypnotics, antipsychotics or anxiolytics
  - Mobility assessment.

Central Cheshire Integrated Care Partnership (CCICP)

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

CCICP Patient Safety Harm Incidents

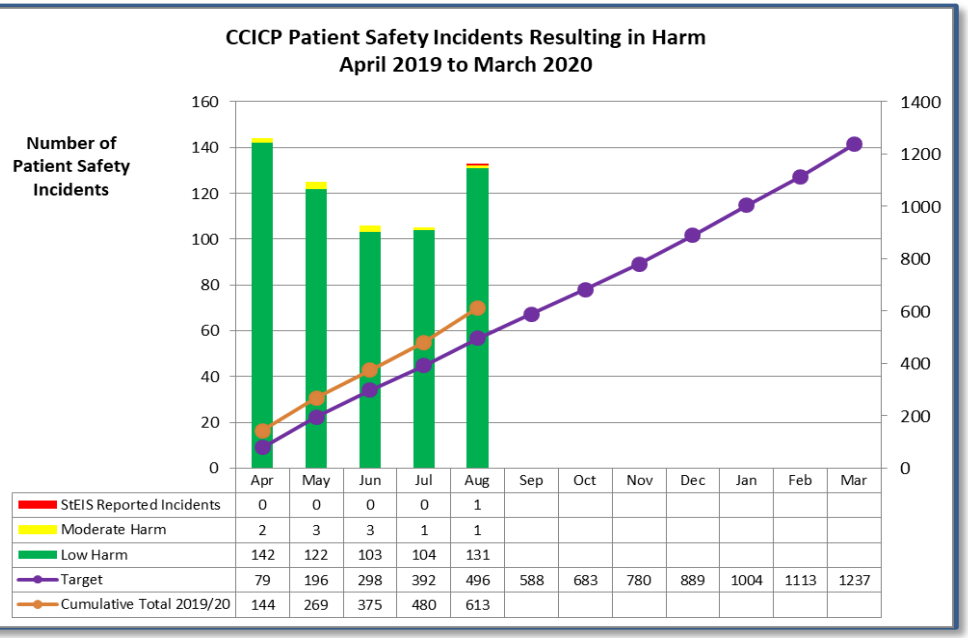
The target is to reduce the total number of CCICP patient safety harm incidents when compared to the previous financial year by the end of March 2020.

For August 2019, there were a total of 133 patient safety harm incidents:

- 98.5% (131 incidents) have resulted in low harm
- 0.75% (1 incidents) have resulted in moderate harm
- 0.75% (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:

- Every team leader Nursing and Therapy across CCICP has now received incident reporting training. This is being delivered to all front line staff. A record of staff trained is kept centrally.
- A proactive approach to managing incidents is being progressed with significant improvements for meeting CCICP's compliance of managing our incidents within the 10 day timeframe.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
StEIS Reported Incidents	0	0	0	0	1							
Moderate Harm	2	3	3	1	1							
Low Harm	142	122	103	104	131							
Target	79	196	298	392	496	588	683	780	889	1004	1113	1237
Cumulative Total 2019/20	144	269	375	480	613							

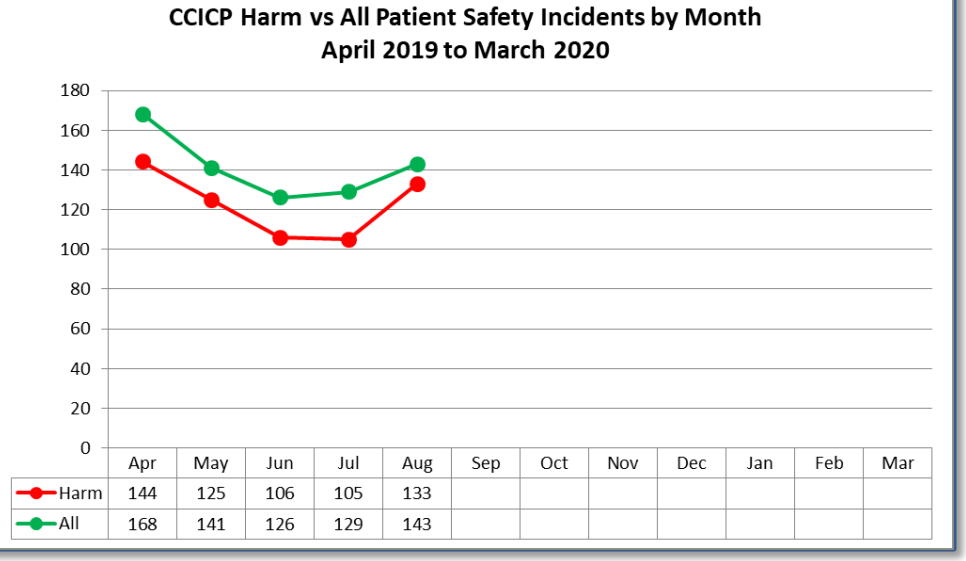
CCICP Harm vs All Patient Safety Incidents

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

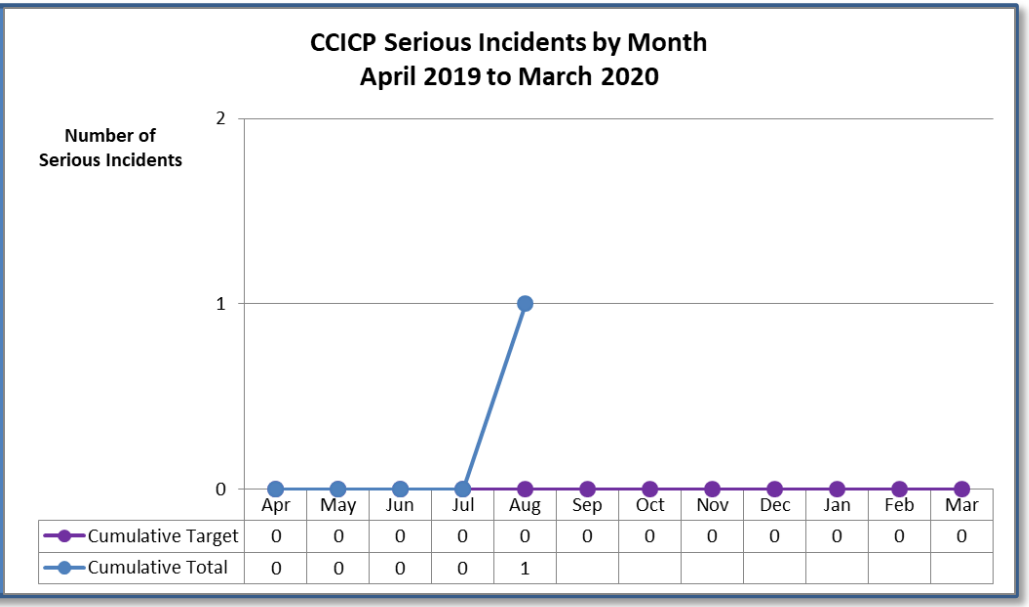
This chart demonstrates the number of incidents that have resulted in harm vs all patient safety incidents.

In August 2019, the gap between harm and all patient safety incidents was 10.

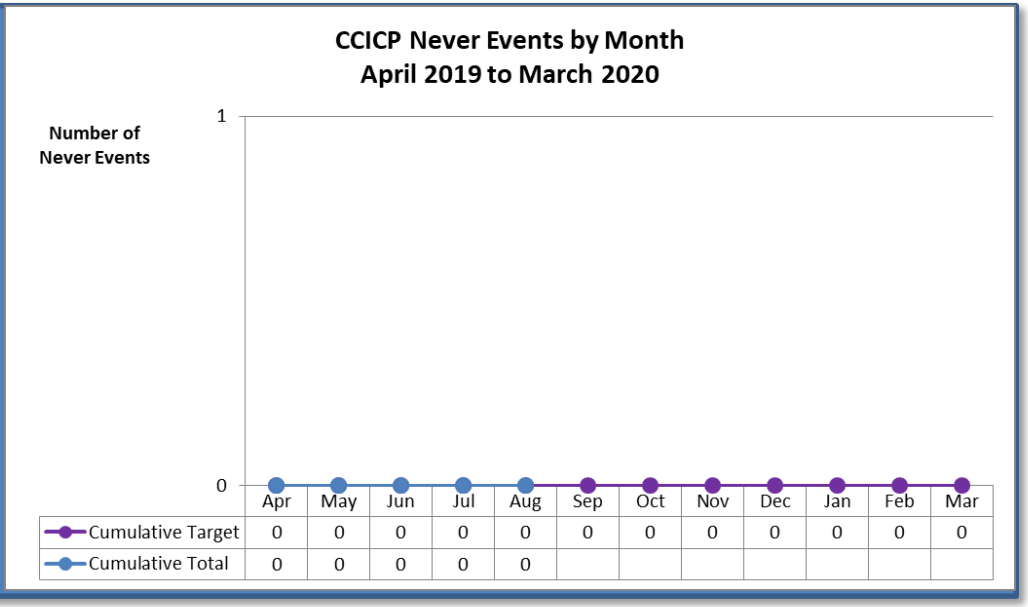
A safety culture survey was undertaken in the Trust in December 2018 to January 2019. The results were shared at the EQGG in April 2019 and divisional improvement plans developed to take into account the feedback received during the survey



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Harm	144	125	106	105	133							
All	168	141	126	129	143							

Description	Aggregate Position	Trend
CCICP Serious Incidents *The target is to continue the trend of having zero CCICP patient safety serious incidents by the end of March 2020.*	This chart demonstrates the number of incidents that have resulted in serious harm. For August 2019, there was one serious incident reported; • A patient with sepsis had debridement of a category 3 pressure ulcer and an unstageable pressure ulcer. Post-surgery the patient died.	

	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	1							

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 2019 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

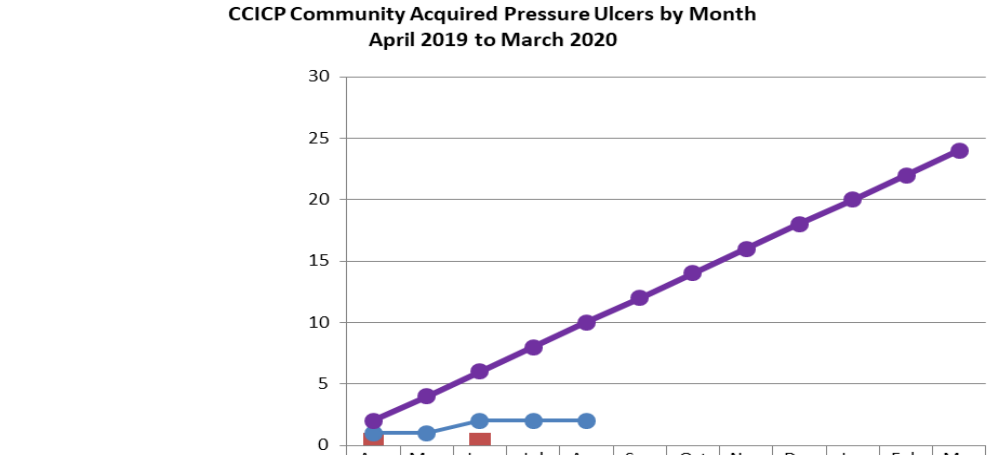
The target is to have no more than 24 pressure ulcers resulting from lapses in care by the end of March 2020.

For August 2019, there were a total of 92 community acquired pressure ulcer incidents:

- 0.0% (0 PUs) occurred with lapses in care that did contribute to the PU.
- 4.3% (4 PUs) occurred with lapses in care that did not contribute to the PU.
- 72.8% (67 PUs) occurred with no lapses in care identified.
- 0% (0 PUs) confirmed but awaiting tool.
- 14.1% (13 PUs) are awaiting confirmation from PUP.
- 8.7% (8 PUs) are awaiting verification.

Improvement actions include:

- Roll out of a 100 day challenge for days free from Category 3 and 4 pressure ulcers.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Lapses in Care Identified	1	0	1	0	0							
Cumulative Total	1	1	2	2	2							
Lapses in Care Cumulative Target	2	4	6	8	10	12	14	16	18	20	22	24
% Avoidable PU	1.2%	0.0%	1.6%	0.0%	0.0%							

CCICP Medication Harm Incidents.

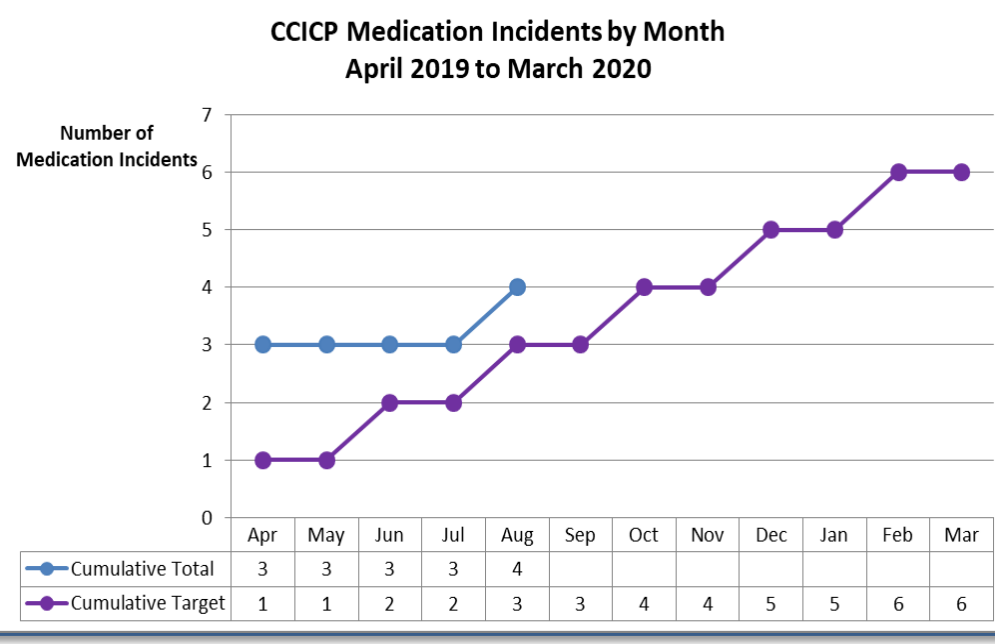
The target is to reduce the total number of medication incidents resulting in harm when compared to the previous financial year by the end of March 2020.

For August 2019, there were 1 medication incidents reported resulting in harm:

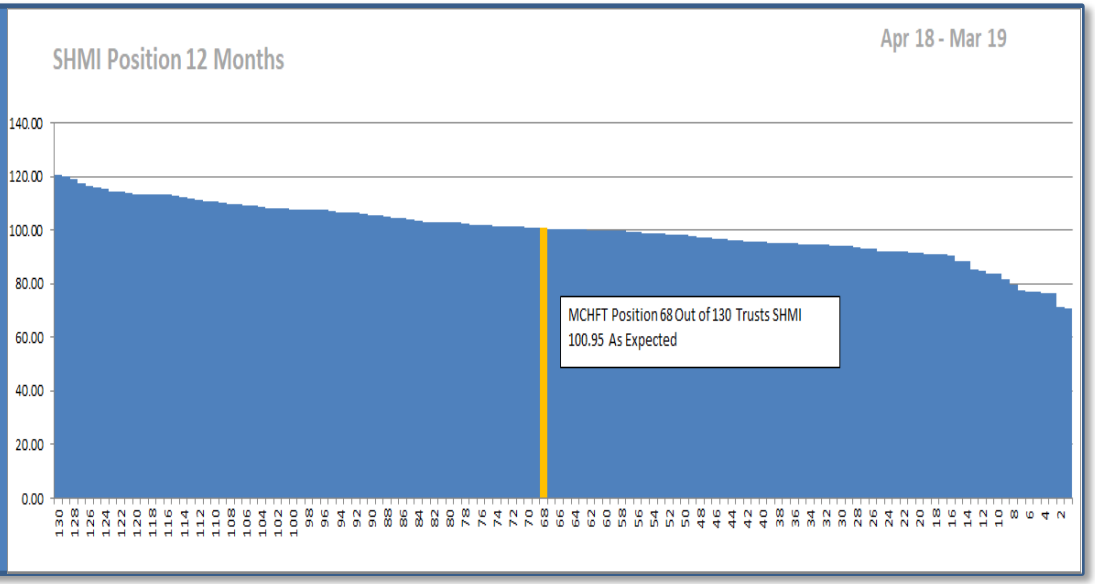
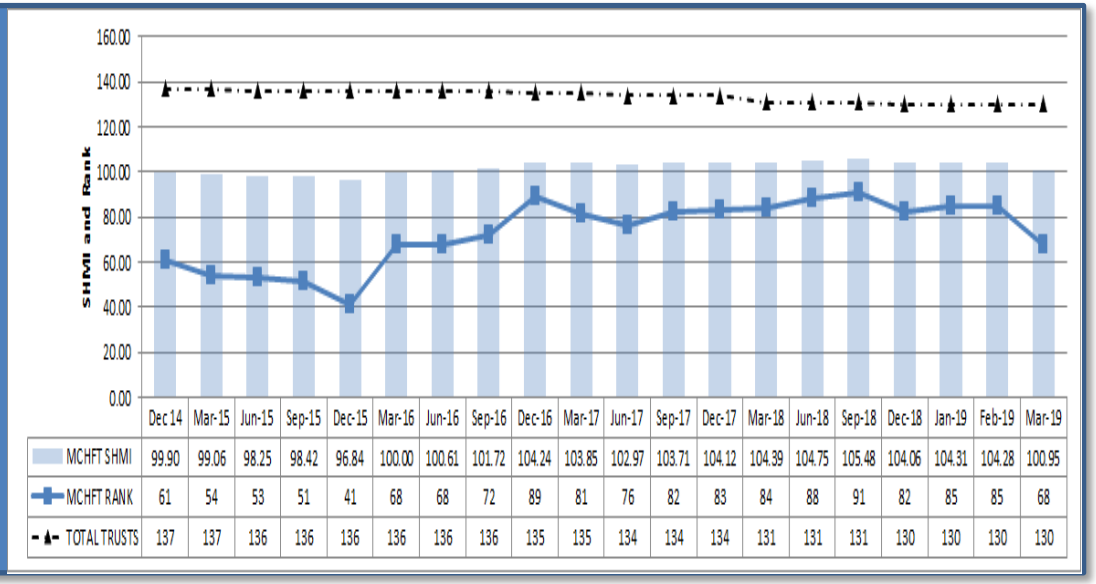
- 100% (1 medication incidents) resulted in low harm
- 0% (0 medication incidents) have resulted in moderate harm
- 0% (0 medication incidents) have resulted in serious harm

Improvement actions include;

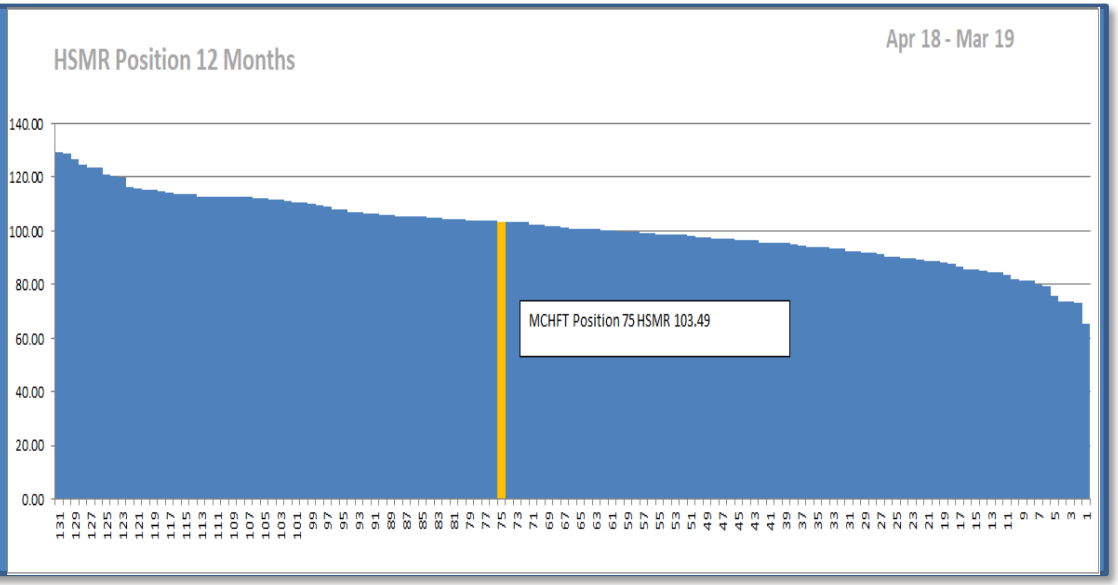
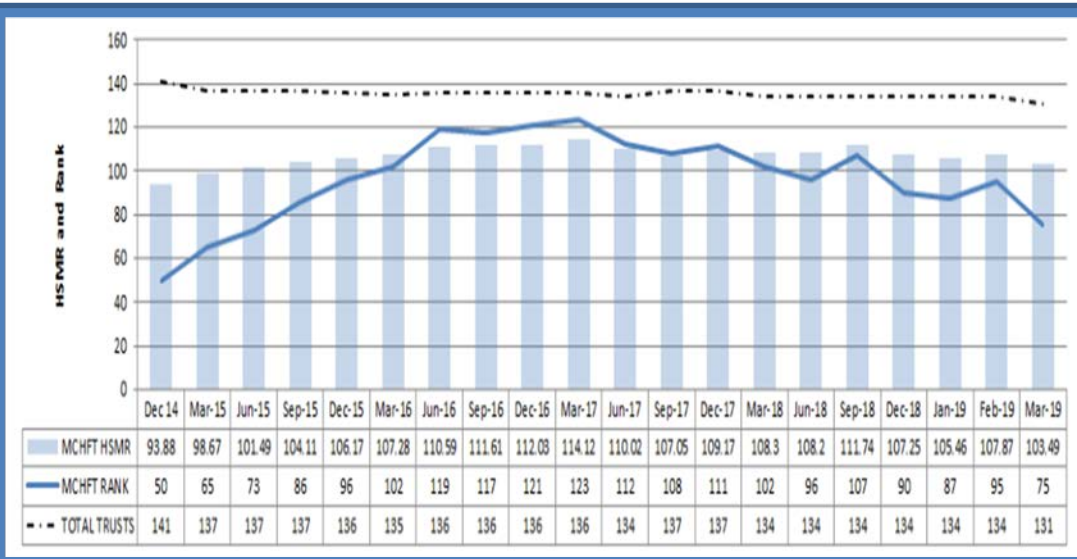
- All registered nursing staff undertake the medication competency annually and new staff undertake the competency as part of their induction programme.
- The CCG have been requested to support patients in Residential Care Homes whom are on Critical Medication such as Insulin by having a 'Red Bag'. This will support A&E and Community Services in safe care delivery.



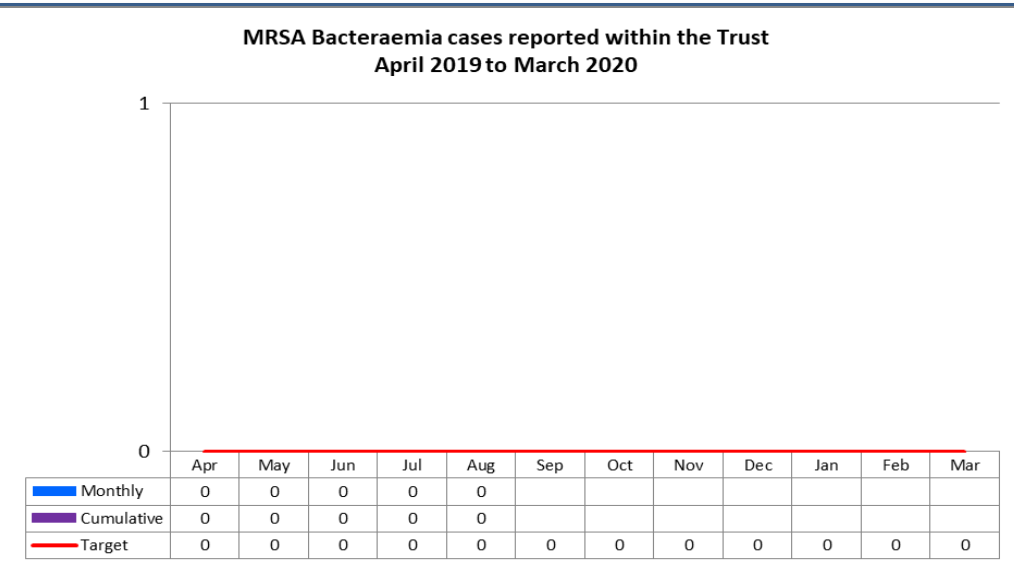
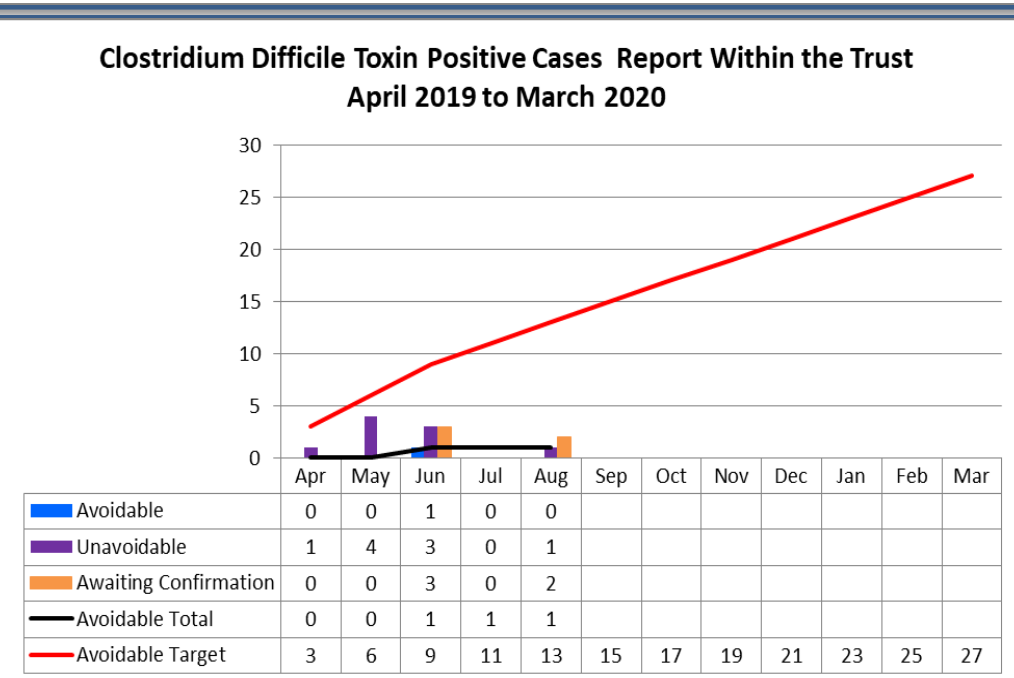
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative Total	3	3	3	3	4							
Cumulative Target	1	1	2	2	3	3	4	4	5	5	6	6

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 100.95 for the time period April 2018 to March 2019 and places the Trust 68 out of 130 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 April 2018 to March 2019 and is "as expected".	

	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	Mar-18	Jun-18	Sep-18	Dec-18	Jan-19	Feb-19	Mar-19
MCHFT SHMI	99.90	99.06	98.25	98.42	96.84	100.00	100.61	101.72	104.24	103.85	102.97	103.71	104.12	104.39	104.75	105.48	104.06	104.31	104.28	100.95
MCHFT RANK	61	54	53	51	41	68	68	72	89	81	76	82	83	84	88	91	82	85	85	68
TOTAL TRUSTS	137	137	136	136	136	136	136	136	135	135	134	134	134	131	131	131	130	130	130	130

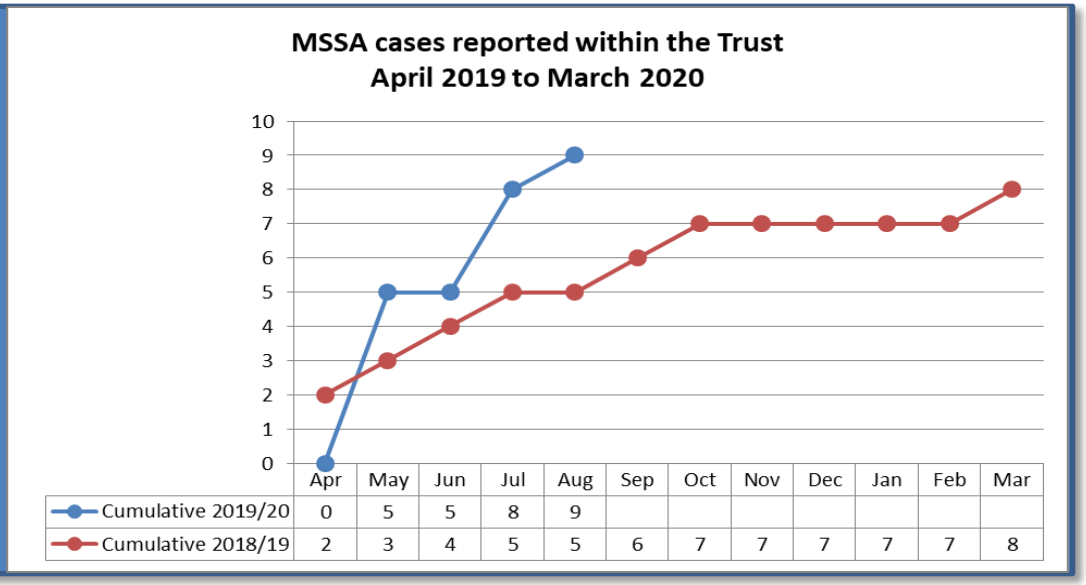
Description	Aggregate Position	Trend
Hospital Standardised Mortality Rate (HSMR) by Trust. *The Trust's target is to be at least within the "as expected" bracket.*	The chart benchmarks the Trust's HSMR against all NHS Trusts. MCHFT is shown by the amber bar. The Trust's HSMR is 103.49 (April 2018 to March 2019) and places the Trust 75 out of 131 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 April 2018 to March 2019 and is "as expected".	

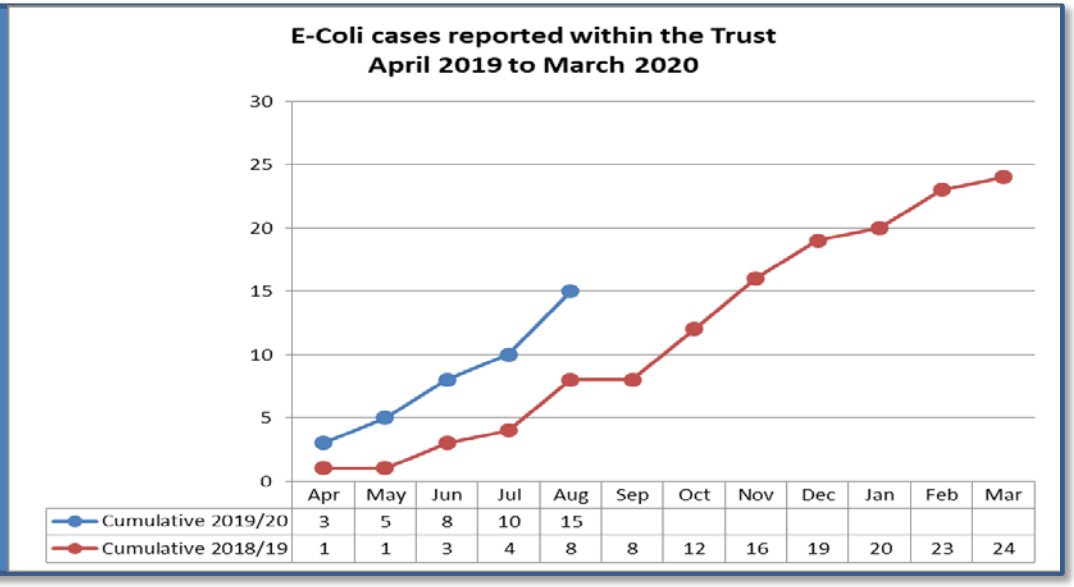
	Dec 14	Mar-15	Jun-15	Sep-15	Dec-15	Mar-16	Jun-16	Sep-16	Dec-16	Mar-17	Jun-17	Sep-17	Dec-17	Mar-18	Jun-18	Sep-18	Dec-18	Jan-19	Feb-19	Mar-19
MCHFT HSMR	93.88	98.67	101.49	104.11	106.17	107.28	110.59	111.61	112.03	114.12	110.02	107.05	109.17	108.3	108.2	111.74	107.25	105.46	107.87	103.49
MCHFT RANK	50	65	73	86	96	102	119	117	121	123	112	108	111	102	96	107	90	87	95	75
TOTAL TRUSTS	141	137	137	137	136	135	136	136	136	136	134	137	137	134	134	134	134	134	134	131

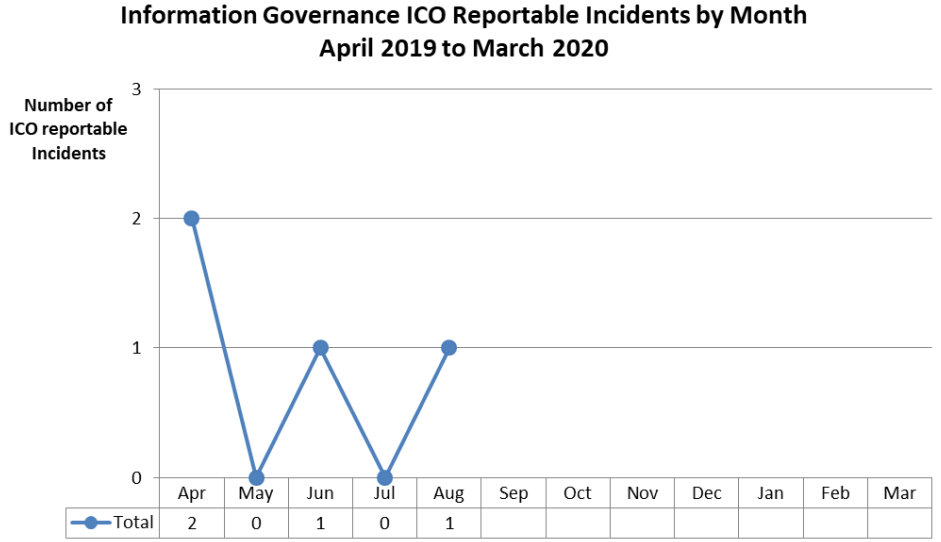
Description	Aggregate Position	Trend
MRSA Bacteraemia Cases. *Zero tolerance of MRSA cases.*	In August 2019, no MRSA bacteraemia cases were reported in the Trust. In this financial year there have been no confirmed MRSA bacteraemia cases to date.	
Clostridium Difficile toxin positive cases. *The target is less than 27 cases of Clostridium Difficile in 2019/20*	In August 2019, no avoidable cases were reported. The target is less than 27 cases of Clostridium Difficile in 2019/20. The target includes cases that have been identified in the community but had a hospital admission in the previous 28 days. Improvement actions include: • Continuing focus on inappropriate anti-microbial prescribing • All cases are subject to post infection reviews in accordance with NHS England requirements. Any lapses in care are addressed through this process • Share lapses in care with individual clinicians involved in patient pathway to ensure lessons learnt.	

	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

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Avoidable	0	0	1	0	0							
Unavoidable	1	4	3	0	1							
Awaiting Confirmation	0	0	3	0	2							
Avoidable Total	0	0	1	1	1							
Avoidable Target	3	6	9	11	13	15	17	19	21	23	25	27

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 2019, 1 MSSA case was reported in the Trust. This occurred on Ward 1. In this financial year there has been 9 confirmed MSSA cases reported.	

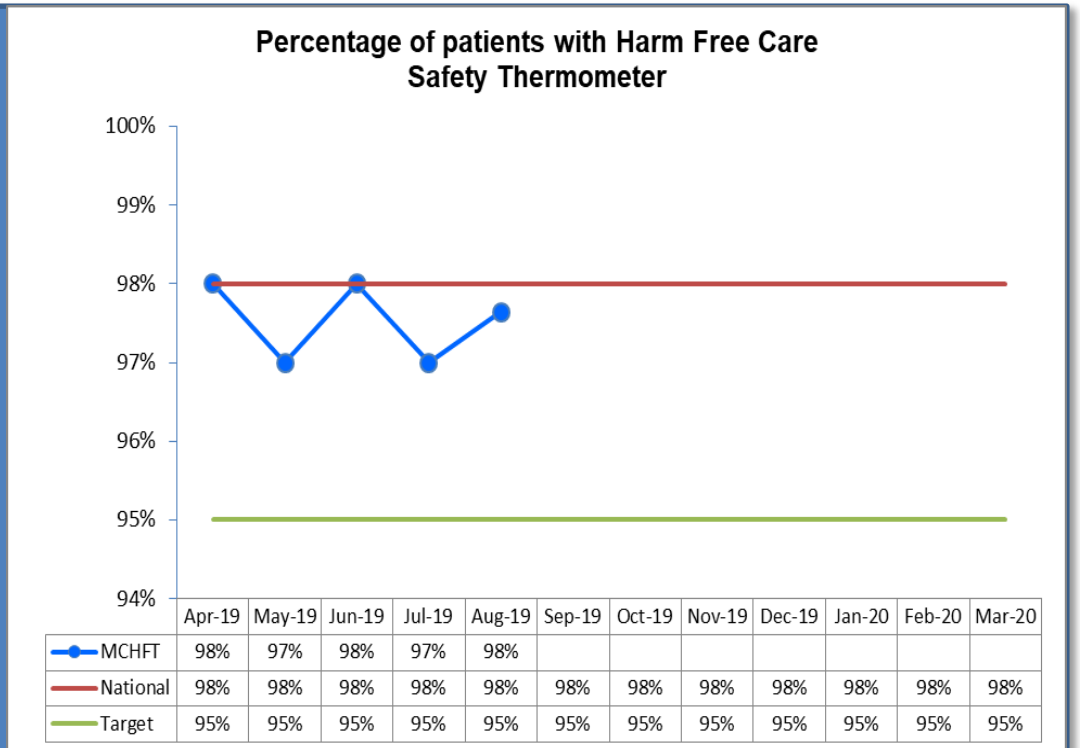
E-Coli Cases. *The aim is to have a reduction in E-Coli cases when compared to the previous financial year, to demonstrate an incremental improvement*	In August 2019, 5 E-Coli cases were reported. These occurred on Ward 10, Ward 5, Ward 13, Ward 18 and Critical Care In this financial year there have been 15 confirmed E-Coli cases reported. The Trust is working collaboratively as part of the Healthcare economy partnership working to reduce Gram negative BSI focusing on E-Coli.	

Description	Aggregate Position	Trend
Information Governance Information Commissioners Office (ICO) reportable incidents.	In August 2019, 1 information governance ICO reportable incident was 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 2019-20 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	**Prevention of Ill health** Achieving 90% of antibiotic prescriptions for lower UTI in older people meeting NICE guidance for lower UTI (NG109) and PHE Diagnosis of UTI guidance in terms of diagnosis and treatment.	✗	£55,879 **(£NIL)**		£55,879		£55,879		£55,879	**£223,517**
1b	**Prevention of Ill health** Achieving 90% of antibiotic surgical prophylaxis prescriptions for elective colorectal surgery being a single dose and prescribed in accordance to local antibiotic guidelines.	✓ **Partially**	£55,879 **(£31,665)**		£55,879		£55,879		£55,879	**£223,517**
2	**Prevention of Ill health** Achieving an 80% uptake of flu vaccinations by frontline clinical staff.	NOT REQUIRED	No Payment		No Payment		No Payment		**MCHFT £447,030** **CCICP £184,318**	**MCHFT £447,030** **CCICP £184,318**
3a	**Prevention of Ill health** Achieving 80% of inpatients admitted to an inpatient ward for at least one night who are screened for both smoking and alcohol use	✓	£37,253		£37,253		£37,253		£37,253	**£149,011**
3b	**Prevention of Ill health** Achieving 90% of identified smokers given brief advice.	✓ **Partially**	£37,253 **(£6,054)**		£37,253		£37,253		£37,253	**£149,011**
3c	**Prevention of Ill health** Achieving 90% of patients identified as drinking above low risk levels, given brief advice or offered a specialist referral.	✓ **Partially**	£37,253 **(£25,425)**		£37,253		£37,253		£37,253	**£149,011**

CQUIN Indicator	Indicator Name	Milestone Achieved								
		Q1	Financial Incentive Achieved	Q2	Financial Incentive Achieved	Q3	Financial Incentive Achieved	Q4	Financial Incentive Achieved	Maximum Value
7	**Patient Safety** Achieving 80% of older inpatients receiving key falls prevention actions are met and recorded	✓ **Partially**	£111,757 **(£19,101)**		£111,757		£111,757		£111,757	£447,030
9	**Best Practice Pathways** Achieving 55% of eligible stroke survivors receiving a six month follow up within 4-8 months of their stroke	✓	£46,079		£46,079		£46,079		£46,079	**£184,318**
11a	**Best Practice Pathways** Achieving 75% of patients with confirmed pulmonary embolus being managed in a same day setting where clinically appropriate.	✓ **Partially**	£37,253 **(£5,662)**		£37,253		£37,253		£37,253	**£149,011**
11b	**Best Practice Pathways** Achieving 75% of patients with confirmed atrial fibrillation being managed in a same day setting where clinically appropriate.	✓ **Partially**	£37,253 **(£14,156)**		£37,253		£37,253		£37,253	**£149,011**
11c	**Best Practice Pathways** Patients with or confirmed Community Acquired Pneumonia should be managed in a same day setting where clinically appropriate.	✗	£37,253 **(£NIL)**		£37,253		£37,253		£37,253	**£149,011**
SP1	**Hospital Pharmacy Transformation and Medicines Optimisation**	✓	**£9,670**		**£9,670**		**£9,670**		**£9,670**	**£38,680**

Description	Aggregate Position	Trend
Safety Thermometer - Harm Free Care.	In August 2019, 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.	

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
MCHFT	98%	97%	98%	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: October 2019

Description	Aggregate Position	Trend	
Registered Nurses monthly expected hours by shift versus actual monthly hours per shift. Day time shifts only	89.3% of expected Registered Nurse hours were achieved for day shifts. Any registered nurse numbers that fall below 85% within the current ward establishment 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 2019 89.3%** July 2019 88.3% June 2019 88.6%	The lowest staffing levels during the day were on CAU at 76.9%
Registered Nurses monthly expected hours by shift versus actual monthly hours per shift. Night time shifts only	91.9% of expected Registered Nurse hours were achieved for night shifts.	Trend **August 2019 91.9%** July 2019 93.0% June 2019 95%	The lowest staffing levels during the night were on Ward 5 at 68.8%
Healthcare Assistant monthly expected hours by shift versus actual monthly hours per shift. Day time shifts only	93.77% of expected HCA hours were achieved for day shifts.	Trend **August 2019 93.77%** July 2019 94.74% June 2019 99.6%	The lowest staffing levels during the day were on NICU at 71%
Healthcare Assistant monthly expected hours by shift versus actual monthly hours per shift. Night time shifts only	97.59% 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 2019 97.59%** July 2019 100.66% June 2019 109.9%	The lowest staffing levels during the night were on Ward 9 at 87.1%
Total number of wards that are lower than 85% RN fill days and nights is 4	Day – NICU (83.2%), CAU (76.9%), Ward 4 (79.9%), Ward 5 (81.2%) Night – NICU (78.7%), Ward 5 (68.8%),	• 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	

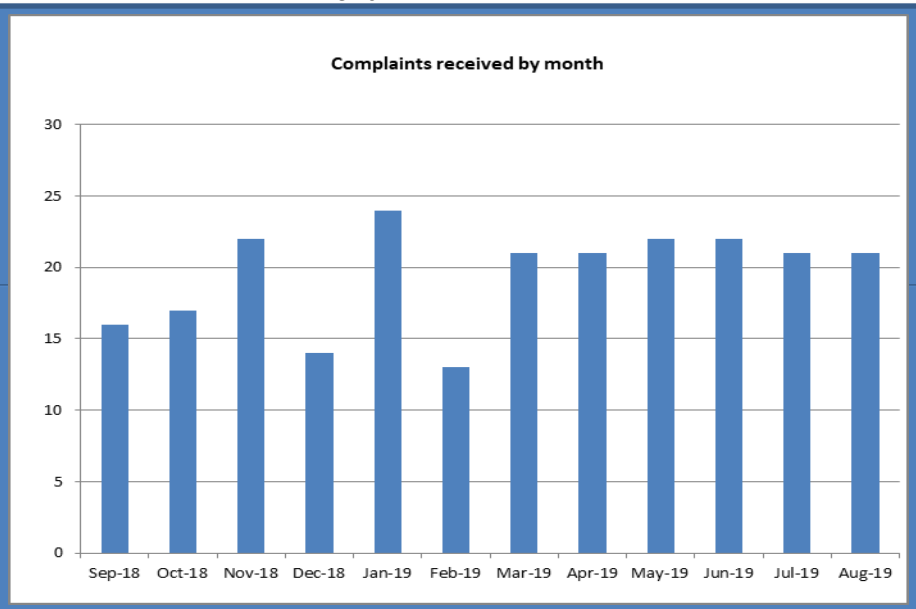
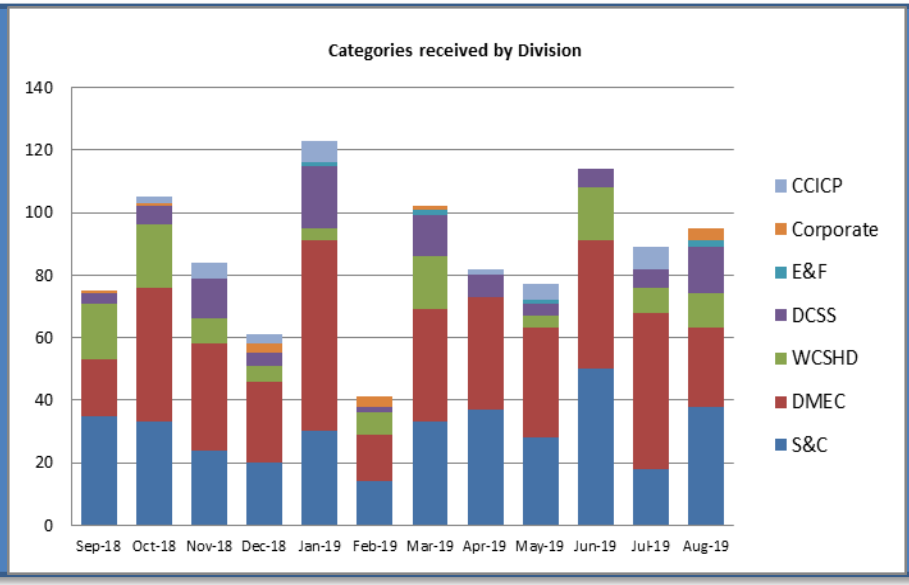
Board Papers – Quality, Safety & Experience Section: October 2019

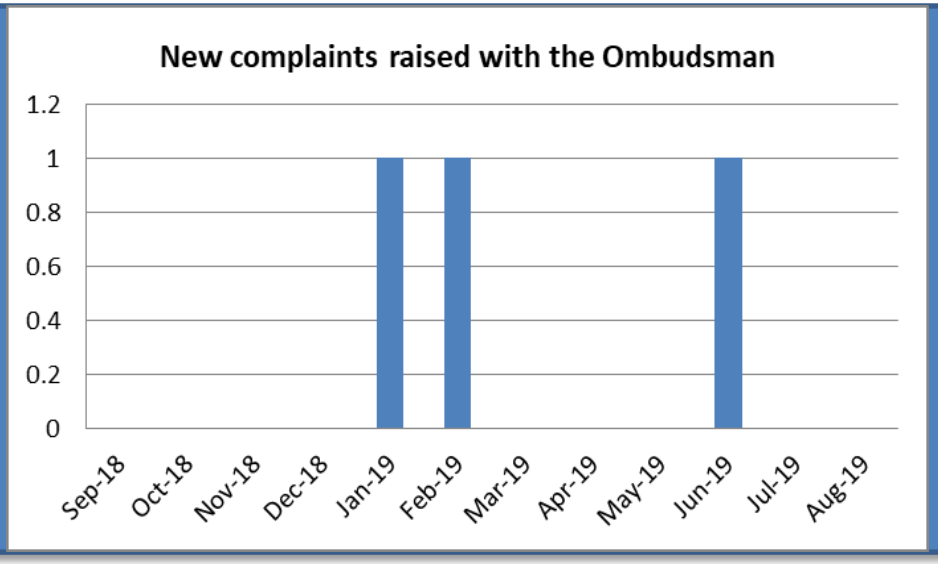
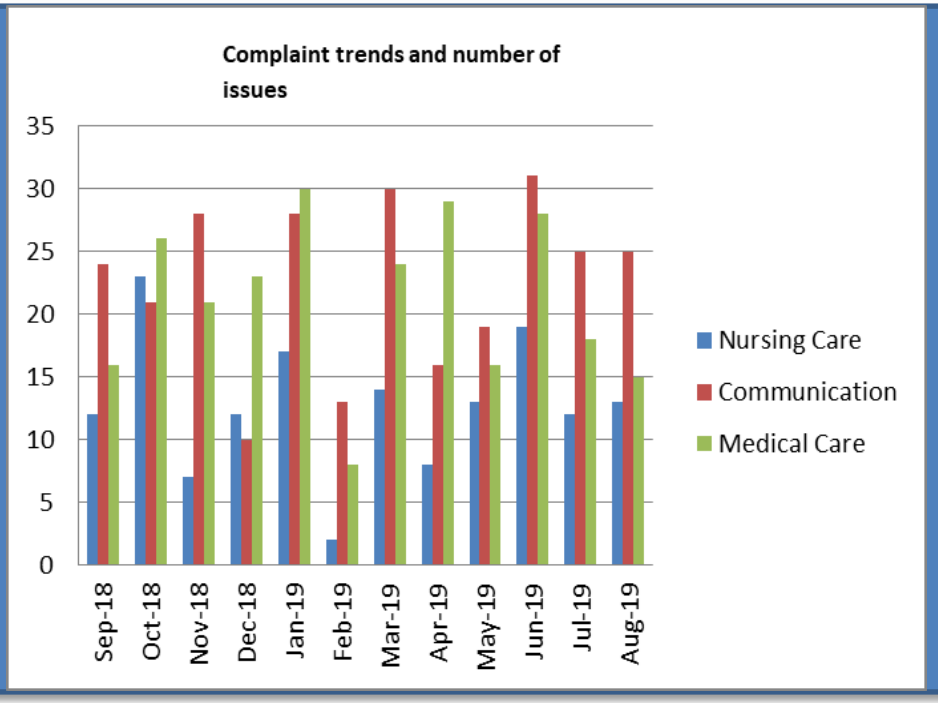
Ward Name	Day				Night				Day		Night		Care Hours Per Patient Day			
	Qualified		Unqualified		Qualified		Unqualified		Qualified	Unqualified	Qualified	Unqualified	Cumulative count over month of pts at 23:59 each day	Qualified	Unqualified	Overall
	Planned	Actual	Planned	Actual	Planned	Actual	Planned	Actual	Fill Rate	Fill Rate	Fill Rate	Fill Rate				
MCHFT	38181	34105	34474	32326	27775	25526	21317	20803	89.32%	93.77%	91.90%	97.59%	14981	161.6	77.8	239.4
Child & Adolescent Unit	2325	1788	775	775	1783	1599	357	334	76.9%	100.0%	89.7%	93.5%	300	11.3	3.7	15.0
Critical Care	3913	3913	606	606	2423	2423	10	10	100.0%	100.0%	100.0%	100.0%	246	25.8	2.5	28.3
Ward 23	1238	1200	785	785	765	765	765	765	96.9%	100.0%	100.0%	100.0%	525	3.7	3.0	6.7
NICU	1925	1601	183	130	1783	1403	0	0	83.2%	71.0%	78.7%	-	178	16.9	0.7	17.6
Ward 26 MLU	785	754	0	114	765	715	0	99	96.0%	-	93.5%	-	49	30.0	4.3	34.3
Ward 26 Labour	2635	2432	735	608	2294	2257	382	382	92.3%	82.8%	98.4%	100.0%	187	25.1	5.3	30.4
Acute Medical Unit	1683	1497	2270	2152	1884	1781	1584	1488	89.0%	94.8%	94.5%	93.9%	828	4.0	4.4	8.4
Elmhurst	743	739	2345	2308	744	744	1584	1560	99.5%	98.4%	100.0%	98.5%	916	1.6	4.2	5.8
Ward 1 Coronary Care	2094	1826	1440	1340	1536	1489	768	754	87.2%	93.1%	96.9%	98.1%	922	3.6	2.3	5.9
Ward 10 Ortho Trauma	2154	1879	3264	2976	1140	1107	1872	1787	87.2%	91.2%	97.1%	95.4%	1149	2.6	4.1	6.7
Ward 11 SAU	1794	1577	1623	1351	1296	1149	1200	1102	87.9%	83.3%	88.6%	91.8%	638	4.3	3.8	8.1
Ward 13 Vascular & Colorectal	1750	1532	1913	1823	1116	1040	1224	1127	87.5%	95.3%	93.2%	92.1%	960	2.7	3.1	5.8
Ward 14 Gastroenterology	1356	1338	1852	1774	1164	996	1476	1404	98.6%	95.8%	85.5%	95.1%	960	2.4	3.3	5.7
Ward 15 Female Ward	1745	1529	1614	1502	1140	972	1212	1171	87.6%	93.1%	85.3%	96.6%	944	2.6	2.8	5.5
Ward 18 Surgical Speciality	1368	1205	1116	1061	768	744	804	780	88.1%	95.1%	96.8%	97.0%	698	2.8	2.6	5.4
Ward 2 Short Stay	1771	1508	1839	1712	1128	1091	1319	1217	85.1%	93.1%	96.7%	92.3%	966	2.7	3.0	5.7
Ward 21b Rehabilitation	1005	920	2331	2270	744	744	1403	1296	91.5%	97.4%	99.9%	92.3%	723	2.3	4.9	7.2
Ward 4 Elderly	1676	1338	2071	1926	756	714	1496	1464	79.9%	93.0%	94.4%	97.7%	792	2.6	4.3	6.9
Ward 5 Respiratory	2230	1810	1854	1749	1548	1065	960	1283	81.2%	94.4%	68.8%	133.6%	956	3.0	3.2	6.2
Ward 6 Rehab	1770	1615	2472	2361	1500	1294	1080	1043	91.2%	95.5%	86.3%	96.6%	816	3.6	4.2	7.7
Ward 7	1390	1342	2586	2230	744	743	1451	1416	96.6%	86.3%	99.8%	97.6%	980	2.1	3.7	5.8
Ward 9 Ortho Elective	834	765	805	775	756	695	372	324	91.7%	96.3%	91.9%	87.1%	248	5.9	4.4	10.3

Experience Section:

Indicators	YTD 19/20	May-19	Jun-19	Jul-19	Aug-19
Complaints received by month	107	22	22	21	21
Complaints being reviewed by the Ombudsman	1	0	1	0	0
Closed complaints by month	109	20	19	26	29
Contacts raising informal concerns	418	103	75	92	62
Compliments received in month	1889	269	453	293	584
Number of new claims received in month	23	7	7	4	2
Number of claims closed	15	3	2	4	4
Number of inquests concluded	4	0	0	3	0
NHS Choices - Star Ratings (Leighton)		4.5	4.5	4	4
NHS Choices - Star Ratings (VIN)		5	5	5	5
NHS Choices - Number of new postings	32	1	7	12	8
F&FT Response Rate ED, MIU, UCC and Assessment Areas*		16%	17%	16%	17%
Proportion of positive responses ED, MIU, UCC and Assessment Areas		85%	85%	85%	89%
F&FT Response Rate Inpatients and Daycases		38%	39%	42%	35%
Proportion of positive responses Inpatients and Daycases		94%	93%	93%	94%
F&FT Response Rate Outpatients		2%	2%	2%	1%
Proportion of positive responses Outpatients		97%	96%	98%	97%
F&FT Response Rate Maternity - Birth		18%	12%	7%	7%
Proportion of positive responses Maternity - Birth		97%	96%	100%	100%
F&FT Response Rate Community (CCICP)		7%	11%	3%	6%
Proportion of positive responses Community (CCICP)		89%	89%	86%	91%

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

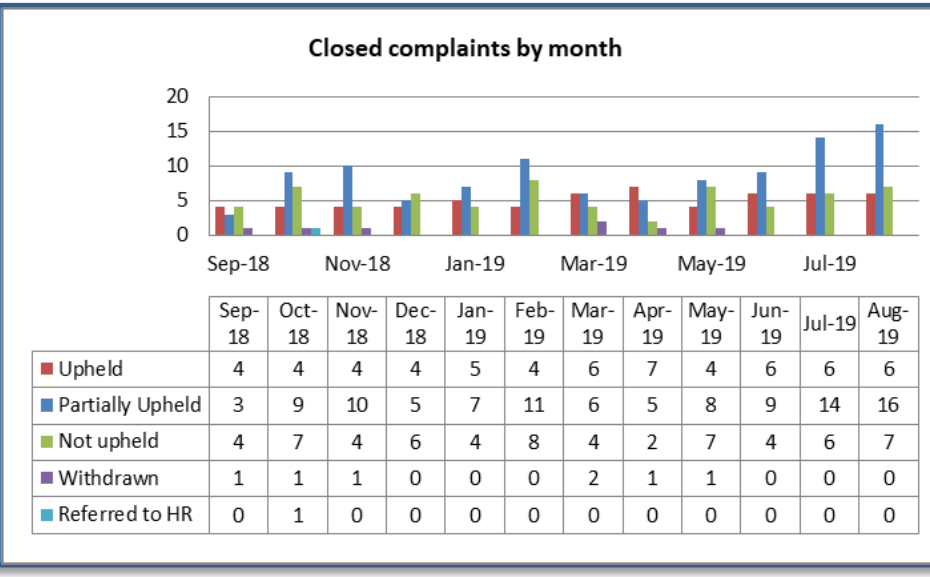
Description	Aggregate Position/Description	Trend
Monthly formal complaints received by the Trust.	21 complaints were received in August 2019 which covered 95 concerns. There was also one re-opened complaint. The highest categories were: • Communication with 25 concerns • Medical with 15 concerns • Nursing with 13 concerns 3 areas receiving the highest numbers of complaints/issues were: • Acute Medical Unit - 3 complaints with 8 concerns • Medical Imaging - with 3 complaints and 6 concerns • Emergency Department - with 3 complaints raising 4 concerns	 Formal Complaints
Number of formal complaint issues by division.	This graph shows the breakdown of concerns by month for each division. S&C: 38 DCSS: 15 W&CD: 11 DMEC: 25 CCICP: 0 E&F: 2 Corporate Services: 4	 Formal Complaint issues by division

Description	Aggregate Position/Description	Trend	
New complaints raised with the Public Health Service Ombudsman	In August 2019, there were no new complaints opened with the Parliamentary Health Service Ombudsmen (PHSO). There are 2 cases which are at the investigation stage. In the last rolling 12 months we have had 3 cases with the PHSO of which none to date have been upheld.		Ombudsman
Complaint trends and number of issues.	The main trends in August 2019 were:- Nursing Care - 13 concerns raised over 5 complaints. 4 of these were related to nutrition and 4 to 'other'. Communication - 25 concerns over 11 complaints. 9 of these concerns related to communication with patients face to face. Medical Care - 15 concerns over 11 complaints. 4 of these concerns related to diagnosis problems and 4 to medication error/delay.		Complaint Trends

Description	Aggregate Position/Description	Trend

Closed Complaints

In August 2019 29 complaints were closed, 5 of which were re-opened complaints.



	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Upheld	4	4	4	4	5	4	6	7	4	6	6	6
Partially Upheld	3	9	10	5	7	11	6	5	8	9	14	16
Not upheld	4	7	4	6	4	8	4	2	7	4	6	7
Withdrawn	1	1	1	0	0	0	2	1	1	0	0	0
Referred to HR	0	1	0	0	0	0	0	0	0	0	0	0

Closed Complaints

Closed complaints by Division

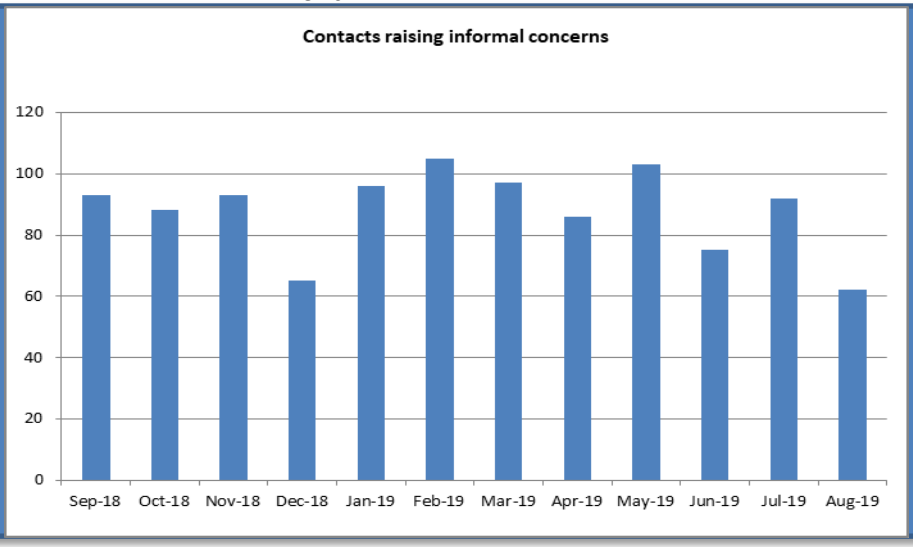
The table provides a breakdown of closed complaints for August 2019 by division.

The table also identifies the outcome of the complaint in terms of which complaints were upheld, not upheld, partially upheld or referred to Human Resources (HR)

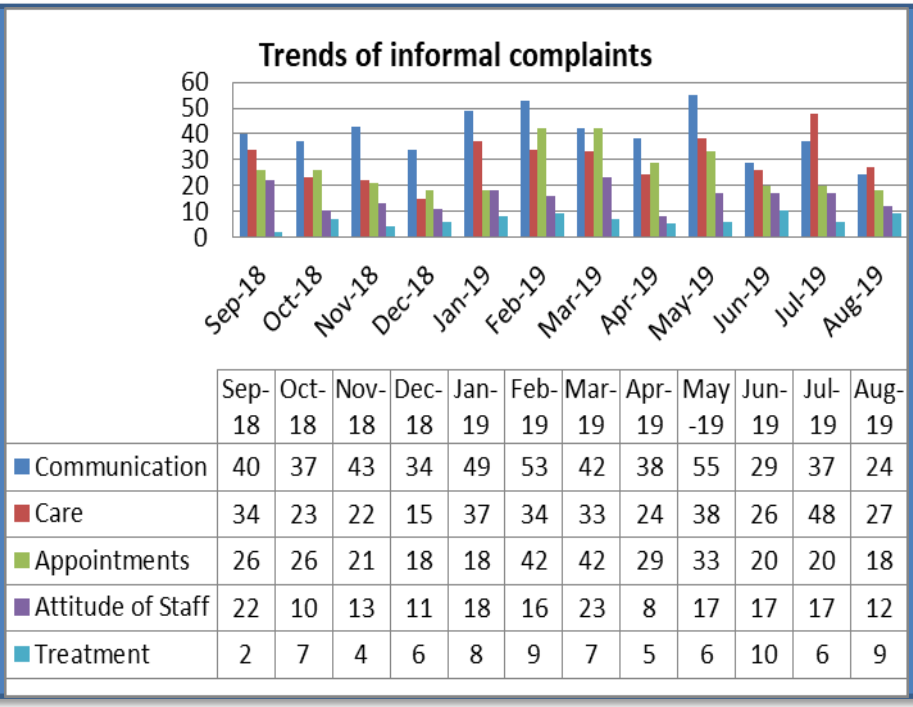
Division	Upheld	Partially Upheld	Not Upheld	Withdrawn	Ref HR	Sub-Total
DMEC	1	8	2	0	0	11
Corporate	0	0	0	0	0	0
Surgery & Cancer	3	2	4	0	0	9
Women & Children's	1	2	0	0	0	3
DCSS	1	2	1	0	0	4
CCICP	0	2	0	0	0	2
					Total closed =	**29**

Board Papers – Quality, Safety & Experience Section: October 2019

Closed Complaints August 2019 - 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 2019 was 62 raising 120 individual concerns. The Division of Medicine and Emergency Care received the highest number of overall concerns at 51, with the Surgery and Cancer Division receiving 34. The Emergency Department received the largest number of individual concerns at 18 which were raised from 7 contacts. Gynaecology received 7 concerns from 4 contacts. Ward 3 received 6 concerns from 5 contacts.	

Informal concerns numbers

Description	Aggregate Position/Description	Trend
Informal concerns trends.	Care and communication were the highest trends for informal concerns in August 2019. <u>27 care issues raised:</u> 16 related to medical care, of which 5 relate to the Emergency Department. 10 relate to nursing care, 2 of which relate to the Emergency Department and 2 to Ward 10 and Ward 14. <u>24 communication issues raised:</u> 6 related to communication with patients face to face and 5 to communication with relatives face to face and relatives on the phone. 9 relate to the Division of Medicine and Emergency Care and 6 to Surgery and Cancer Division.	

	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Communication	40	37	43	34	49	53	42	38	55	29	37	24
Care	34	23	22	15	37	34	33	24	38	26	48	27
Appointments	26	26	21	18	18	42	42	29	33	20	20	18
Attitude of Staff	22	10	13	11	18	16	23	8	17	17	17	12
Treatment	2	7	4	6	8	9	7	5	6	10	6	9

Informal concerns trends

Description	Aggregate Position/Description	Trend

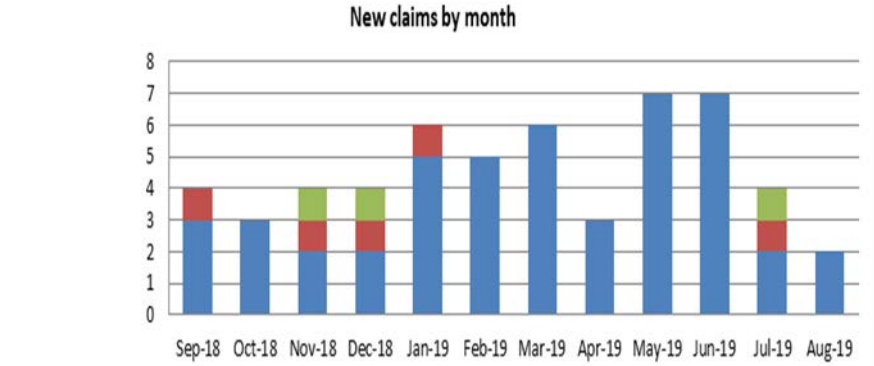
New claims received.

In August 2019, 2 new clinical negligence claims were received. These related to:

- Medicine and Emergency Care – Emergency Department (1)
- Jointly against Medicine and Emergency Care – Emergency Department and CCICP – Podiatry (1)

No new employer's liability claims were received.

No new public liability claims were received.



	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Public Liability	0	0	1	1	0	0	0	0	0	0	1	0
Employer's Liability	1	0	1	1	1	0	0	0	0	0	1	0
Clinical	3	3	2	2	5	5	6	3	7	7	2	2

Claims

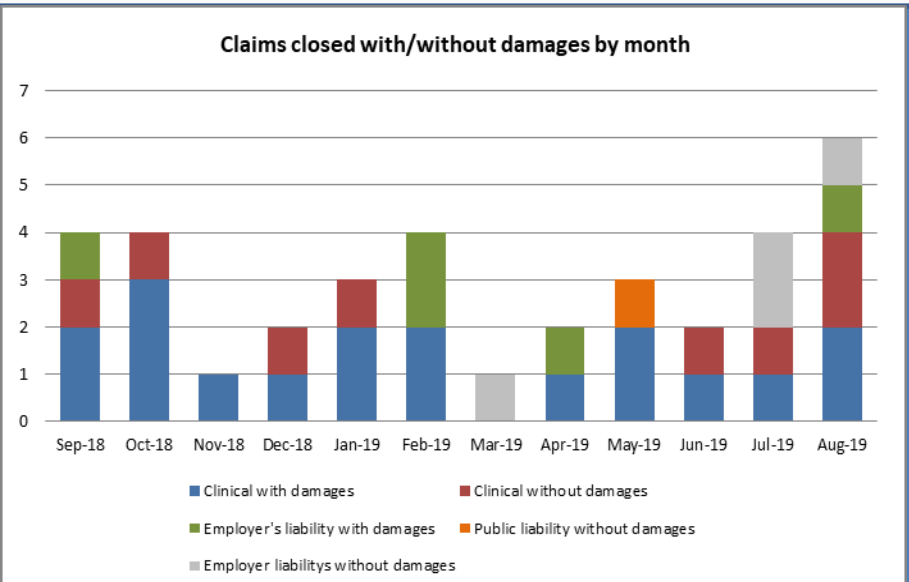
Claims closed with/without damages.

In August 2019 the following claims were closed with/without damages:-

4 clinical negligence claims were closed, 2 of which was upheld.

2 employer's liability claims were closed, 2 of which were upheld

No public liability claims were closed.



Closed Claims

Description	Aggregate Position/Description	Trend

Value of claims closed by month

In August 2019 damages of £315,153 were paid out on 2 clinical negligence claims.

Surgery and Cancer (Orthopaedics)

Narrative removed under Section 40 of the Freedom of Information Act. Lessons Learnt:

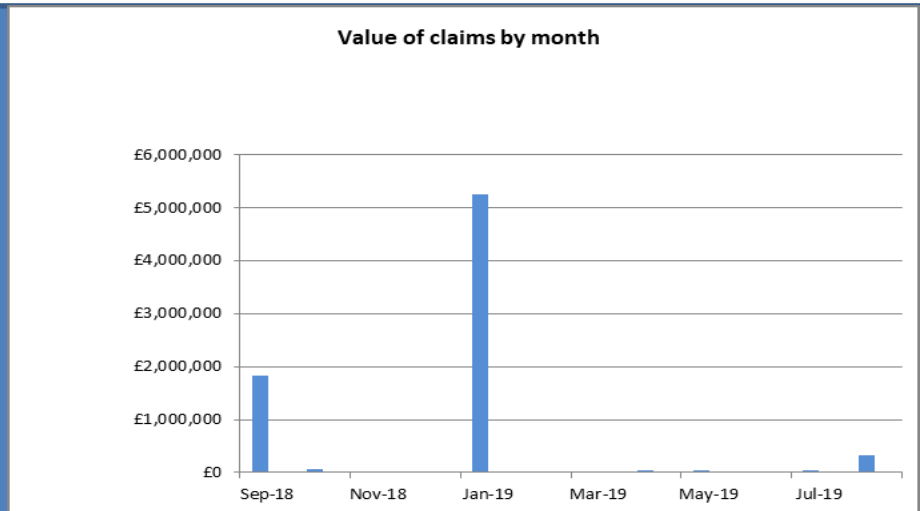
1. If an MRI scan is not of sufficient quality, it should be repeated.
2. Interval MRI scans at 3 months for continued symptoms should be arranged.

Surgery and Cancer (General Surgery)

Narrative removed under Section 40 of the Freedom of Information Act. Lessons Learnt: Claim discussed with consultant and learning points identified.

Damages of £2,000 were paid out on 1 employer's liability claim. Medicine and Emergency Care (General Medicine)

Narrative removed under Section 40 of the Freedom of Information Act. Lessons Learnt: Details of potentially aggressive patients are now given to ward staff at handover.



	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Clinical damages paid £	1,832,43	358,737	5,000	5,585	5,251,78	30,103	0	37,043	46,250	£16,288	50,000	315,153
Employer's liability paid £	5,397	0	0	0	0	0	0	1,500	0	0	0	2,000

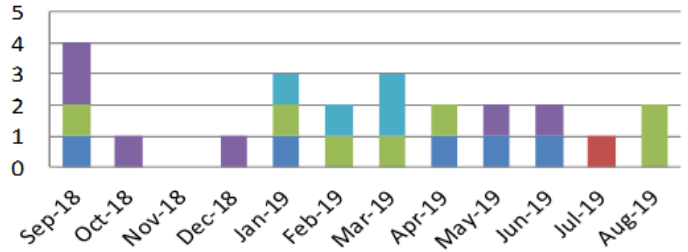
Value of claims

Top five claims by Specialty

In August 2019, 2 new claims were received which relate to the Trust's top five specialties for claims:

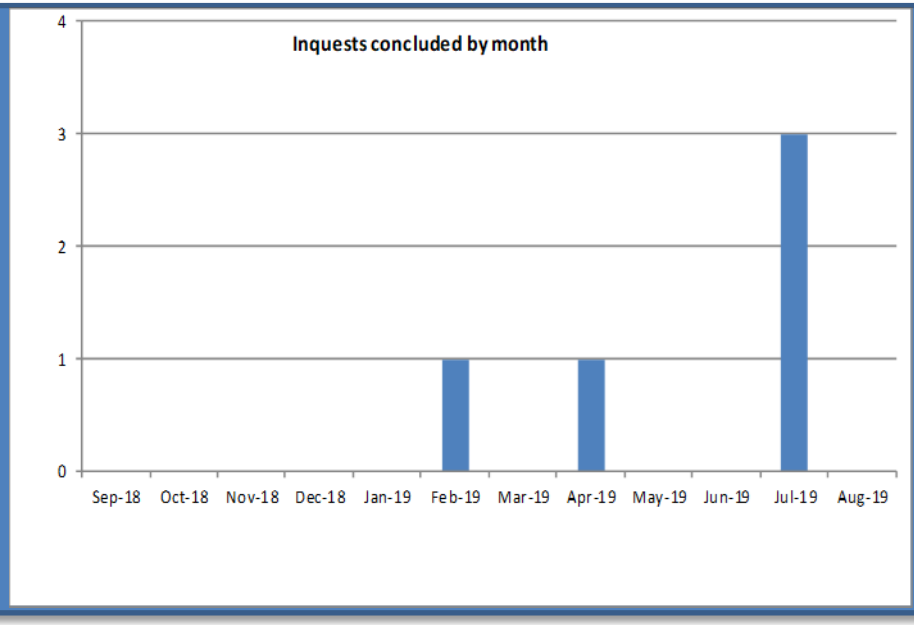
Emergency Department

Narrative removed under Section 40 of the Freedom of Information Act.

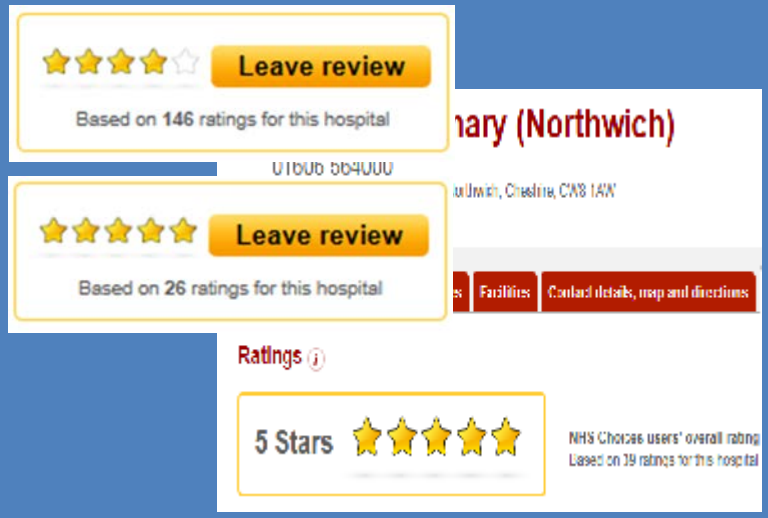


	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
General Surgery	0	0	0	0	1	1	2	0	0	0	0	0
Obstetrics	2	1	0	1	0	0	0	0	1	1	0	0
Emergency Dept	1	0	0	0	1	1	1	1	0	0	0	2
Ophthalmology	0	0	0	0	0	0	0	0	0	0	1	0
Orthopaedics	1	0	0	0	1	0	0	1	1	1	0	0

Top 5 claims by specialty

Description	Aggregate Position /Description	Trend
Number of Inquests concluded by month	No inquests were concluded in August 2019.	

Inquests

NHS Choices Star Ratings	In August 2019 Leighton Hospital is rated at 4 stars. Victoria Infirmary, Northwich is rated at 5 stars. The above ratings are based on 172 reviews	

NHS Choices – Star Ratings

Description	Aggregate Position /description	Trend

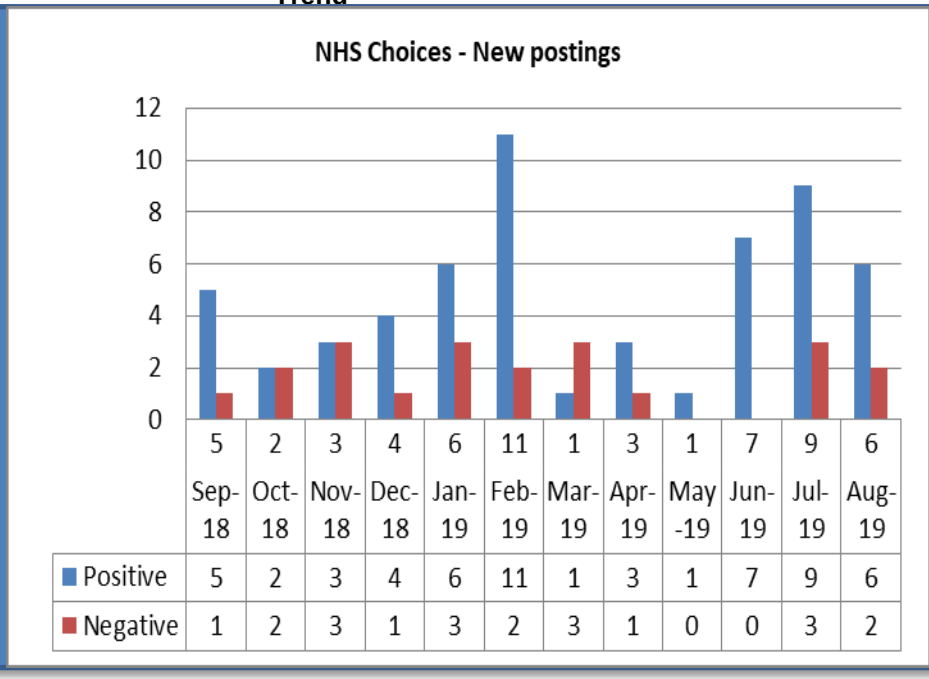
NHS Choices postings

There were 8 postings on NHS Choices in August 2019 of which 6 were positive, and 2 negative. Examples of comments:-

I really cannot fault this hospital or it's excellent staff. They made an inevitably stressful experience very simple and easy. I'm most grateful to everyone there. The NHS at its very best. (General Surgery)

My son was recently admitted to ward 17 for his asthma flare up. Staff on the ward waited patiently for his arrival as he was very anxious. On arrival they treated him with care knowing he was feeling anxious. They took their time caring for him and took the time for him to feel relaxed before treating him. The ward had older children which is amazing. I was impressed with the smaller bays and the entertainment rooms in between with Xbox 1, tv and sofas. Just what an 12 yr old needed. The staff were amazing and we could not ask for more, thank you (CAU)

My dentist was absolutely brilliant. I hardly felt the three injections and my tooth was removed literally within seconds.! So hats off to the "A Team" and thank you so much for making what was in my mind was going to be an horrendous experience, into a more than tolerable one. (Maxillofacial)



	5 Sep-18	2 Oct-18	3 Nov-18	4 Dec-18	6 Jan-19	11 Feb-19	1 Mar-19	3 Apr-19	1 May-19	7 Jun-19	9 Jul-19	6 Aug-19
Positive	5	2	3	4	6	11	1	3	1	7	9	6
Negative	1	2	3	1	3	2	3	1	0	0	3	2

NHS Choices – Postings

The Family and Friends Test.

In August 2019 the Trust has scored the following positive response scores:

Emergency care /assessment areas 89%;

Inpatients and day cases 94%;

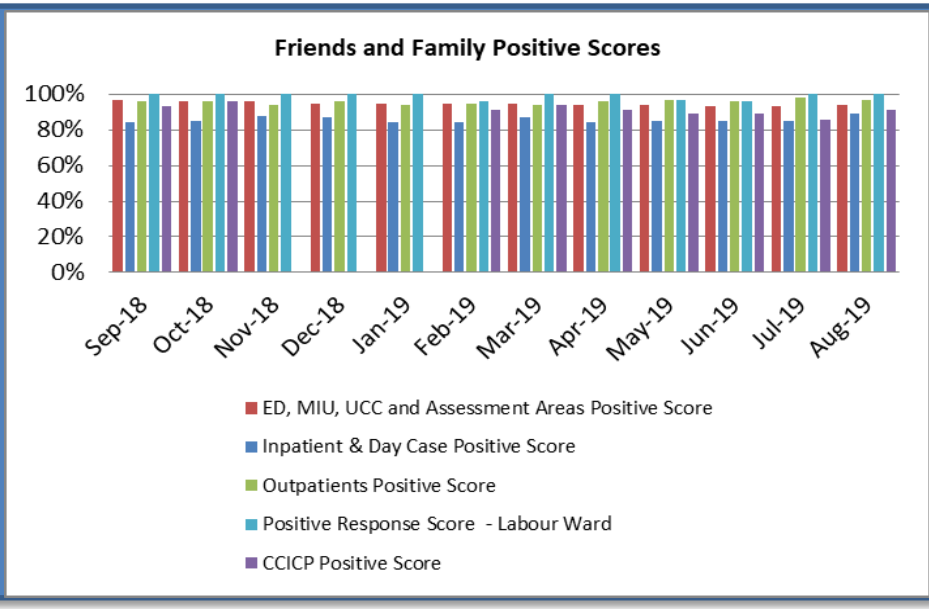
Outpatients 97%;

Maternity (Labour ward) 100%; CCICP 91%.

Text messaging is in place for inpatients with a slight improvement in response rate.

Outpatients are still using a paper based survey with text messaging delayed due to a technical issue with a plan to resolve by September.

CCICP text messaging is in place however response rates are relatively low as further work is required on the data extract

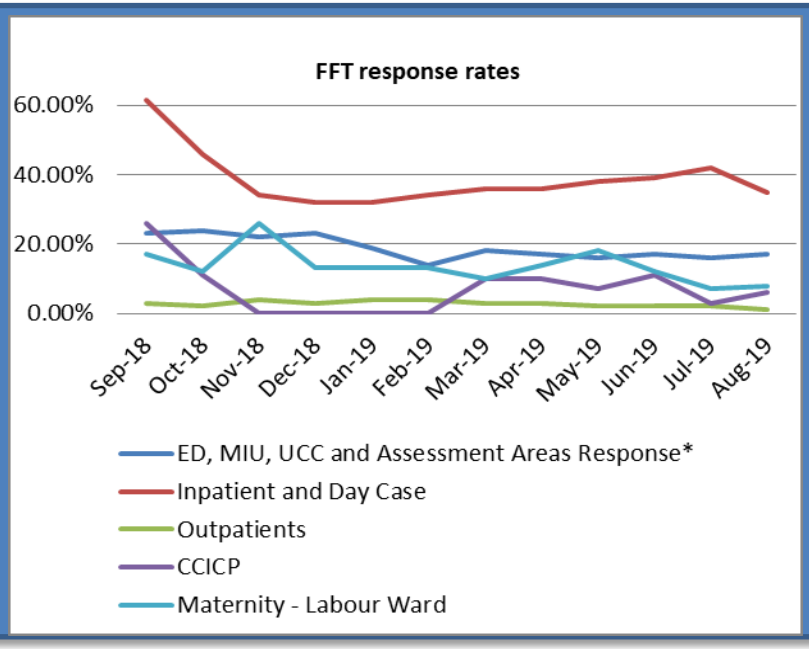


Family & Friends Test

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

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

August 2019 Ward/Dept.	% Response	Total responses received	How many would recommend
A&E , UCC & MIU	17%	1236	1055
CCICP	6%	47	43
Inpatients & Day cases	35%	1669	1566
Maternity	7%	39	38
Outpatients	1%	151	147



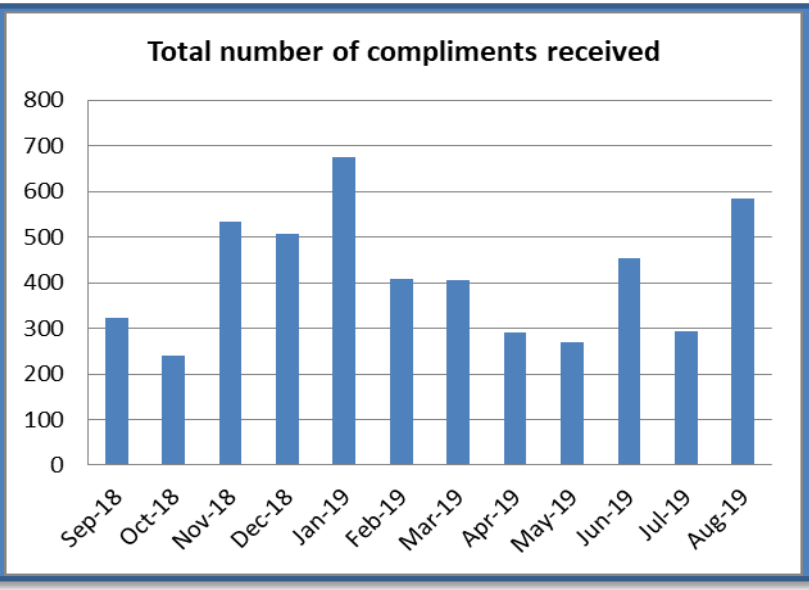
Family & Friends Test

Compliments received

There were 584 compliments received in August 2019.
84 of these were logged by the Customer Care Team and 214 received across the Trust.

'The staff on the children's ward were fantastic and knowledgeable. My son was treated so kindly and whatever he wanted they got for him in a timely manner. We were taken down to theatre by the play specialist nurse, she made my son feel at ease and was there to distract him from what was a scary procedure and she took his nerves away. Staff bent over backwards to provide him with food and drinks.'

'I gratefully accepted help from a lady in your Physio department, she got a porter for me who was most pleasant as he wheeled me down to reception. I am extremely thankful for the help of these kind,



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:	**7 October 2019**

1. Introduction

This paper provides the required assurance that Mid Cheshire Hospitals NHS 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 bi-annual patient acuity data from both January and June 2019.

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) triangulated to patient harms 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, bi-annual 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.

In October 2018 NHS Improvement (NHSI) produced further guidance within the Developing Workforce Safeguards document. This guidance reinforces that providers must formally ensure NQB's 2016 guidance is embedded, safe staffing processes are in place and ensure that the annual governance statement in relation to governance processes being safe and sustainable is confirmed. It also states that there should be a locally agreed quality dashboard that cross-checks of comparative data on staffing and skill mix with other efficiency and quality metrics.

In addition to this the NHS Long Term Plan (2019) outlines a number of specific workforce actions developed by NHS Improvement that could have a positive impact, two relevant actions are:

- Ensure that you have enough people with the right skills and experience, so that staff have the time they need to care for patients well.
- Ensure that people have rewarding jobs, work in a positive culture, with an opportunity to develop their skills and use state of the art equipment and have the support to manage complex and often stressful nature of delivering healthcare.

In this context, MCHFT completed staffing reviews that took into account the detailed requirements of the NQB guidance and NHSI Developing Workforce Safeguards document and were performed between February and July 2019 led by the Director of Nursing and Quality, Deputy Director of Nursing and Quality, Divisional Head of Nursing and Matrons.

In addition to this work the Emergency Department (ED) have completed its first acuity review in January 2019 using the Baseline Emergency Staffing Tool (BEST) (RCN 2013). This audit allows ED's to define the disparity between staffing numbers and patient acuity/workload.

For CCICP a review has taken place covering the 5 care communities with a focus on acuity within the district nurse services. This is the first acuity review for CCICP.

In line with the NQB (2016) recommendations, the template used took account of the following factors for the period of assessment and triangulated this information against the harm free care data:

- *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*
- *Sickness & Absence rates*
- *Vacancy rates*

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 21%- 25% to support training, annual leave and sickness. However it has been identified that there is some variances with this uplift across some areas which will be explored during 2020/21 budget setting to understand if this variance is justified.

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 2019 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, it also covers two seasons of the year. 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 BAPM (British Association of Perinatal Medicine) tool 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+ acuity tool measures the workload for midwives arising from the needs of women, from admission to the labour ward in real time.

In 2019 an external BR+ assessment was commissioned which will review the midwifery staffing, taking into account case mix and acuity levels.

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 2019 and June 2019.

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 (night)
June 2019	364.98	346.13	- 18.85	1:6-1:10 (1:10-1:16)
January 2019	341.01	356.01	- 15	1:6-1:10 (1:10-1:16)
June 2018	341.99	354.15	- 12.16	1:6-1:8
January 2018	341.00	362.63	- 21.63	1:6-1:8

The results of the reviews highlighted that there was a total of 4 wards identified as having an increase in acuity and dependency with a similar variance to the reviews undertaken in 2018. However it is important to consider that each review is completed within different seasons of the year which can have an impact on acuity/dependency. Following the review it is clear that ward 7 have a deficit relating to the third Registered Nurse on nights, leaving a 1:16 ratio.

The figures above do not include the Emergency Department or Critical Care. However, these areas have undergone a full Strategic Staffing Review and following last year's annual planning investment rounds both received investments to provide 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.

4.1.1 Emergency Department

Table 1.1 shows the funded establishment, staffing needs and the Registered Nurse ratio for the ED and the results from a BEST Tool Audit which were completed between September and November 2018. The BEST Tool allows Emergency Departments to define the disparity between staffing numbers and patient acuity/workload at that time.

Table 1.1 Emergency Department

	Funded Establishment (WTE staff providing clinical care)	BEST Tool (WTE) Acuity assessment Sept 2018	BEST Tool (WTE) Acuity assessment November 2018	Difference Acuity / Funded Establishment staff providing clinical care
Senior Emergency/Emergency Charge Nurses (Band 7)	4	9.5	8.84	- 4.84
Emergency Nurses (Band 6)	8.26	29.26	26.53	-18.27
Foundation Staff Nurse (Band 5)	32.91	39.01	35.37	- 2.46
Clinical support workers (Band 2)	14.52 (Band 2)	19.51	17.69	- 3.17

The results of the review highlight that there is a deficit within each banding of care staff. During the review and in addition there is also a number of other factors that have been taken into account including activity levels within the Emergency Department. For this reason the investments already agreed by the Trust Board in 2018 (year 1) were 2.7 band 7, 10.79 band 5 and 17.48 band 2 staff.

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 2019 and June 2019.

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 (night)**
June 2019	220.57	220.11	0.46 (no escalation beds open)	1:8 Mon – Fri 1:9 -1:13 Sat & Sun (1:10-1:13)
January 2019	223.45	262.09	-38.64 (12 escalation beds on SAU)	1:8 Mon – Fri 1:9 -1:13 Sat & Sun (1:10-1:13)
June 2018	237.15	257.46	- 20.31	11:8 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

The acuity data collected in January 2019 to June 2019 shows a deficit in staffing relating to acuity and dependency overall and in particular for 4 ward areas. It is important to note that from January 2019 and onwards there have been up to an additional twelve beds open on the Surgical Ambulatory Care Unit (SACU) and there have been between 15 and 27 medical outliers in surgical beds. However at the time of completing the June acuity review there were no escalation beds open, medical outliers were minimal and the orthopaedic elective ward had capacity. Following the acuity review it was clear that ward 13 continues to have a deficit relating to weekend cover on day shifts for Registered Nurses (1:13 ratio) and ward 10 a deficit relating to the total number of Healthcare Assistants on Night duty (1:13).

Actions 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 wards in the Division of Diagnostic and Clinical Support Services in January 2019 and June 2019.

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 2019	71.61	70.2	+1.41	1:8
January 2019	71.49	70.99	+0.5	1:8
June 2018	80.61	81.52	-0.91	1:8
January 2018	78.96	81.52	-2.56	1:8

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

The 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 2018. This gap has closed slightly due to the development of the Pharmacy Technician role who is included in the staffing numbers. 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.

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

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 2019 and June 2019.

Table 4 – Paediatric Acuity Data

	Funded Establishment (WTE staff providing clinical care)	**% of shifts filled described as negative or positive by STEAM tool**	**Registered nurse ratio (day and night)**
June 2019	44.64	52% of shifts positively staffed 48% of shifts negatively staffed	1:3 for under 2 years of age 1:4 for 2 years of age and over
January 2019	46.37	32% of shifts positively staffed 68% of shifts negatively staffed	1:3 for under 2 years of age 1:4 for 2 years of age and over
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 negatively staffed 57% 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 2019 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 are also currently reviewing the impact of establishing a four bedded High Dependency Unit and what the potential staffing implications are for this unit in the future.

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 2019	Midwifery staffing less than acuity 13% Midwifery staffing meets acuity 87%
January 2019	Staffing less than acuity 11% Staffing meets acuity 89%
June 2018	Staffing less than acuity 5% Staffing meets acuity 95%
January 2018	Staffing less than acuity 4% Staffing meets acuity 96%

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.

The current BR+ external review is in its preliminary stages with a final report being available end of October 2019. The divisional team have also been asked to factor in the acquisition of up to 350 women which have been transferred over to our service following the closure of 1 to 1 Midwifery Services. This will potentially impact the current workload and acuity score in the future.

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 2019 and June 2019.

Table 6 – NICU Acuity Data

	Funded Establishment (WTE staff providing clinical care)	**% of shifts filled described as negative, adequate or positive by BAPM tool**
June 2019	28.95	• 38.3% of shifts adequately staffed • 16.7% of shifts negatively staffed • 45% of shifts positively staffed
January 2019	27.93	• 8% of shifts adequately staffed • 3% of shifts negatively staffed • 89% of shifts positively staffed
June 2018	32.41	• 30% of shifts adequately staffed • 55% of shifts positively staffed • 15% of shifts negatively staffed
January 2018	32.53	• 16% of shifts adequately staffed • 7% of shifts positively staffed • 77% of shifts negatively staffed

The acuity and dependency on NICU varies significantly throughout the year and there is no real pattern to assist with prediction of acuity, as outlined above in 2019. 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.

4.4.4 Central Cheshire Integrated Care Partnership (CCICP)

Table 7 shows the establishment and acuity for each Care Community from March 2019 and July 2019. The below caseload figures have been obtained manually by team leaders and should be taken as a guide only, the implementation of Malinko (electronic case load tool) will enable CCICP to have an accurate reflection of caseload requirements in the future.

Table 7- CCICP data

	Northwich		Crewe		Nantwich		SMASH		Winsford	
Population	72.382		87.005		33.435		67.206		35.448	
Registered Budgeted Staffing WTE March 2019 Band 5, 6 and 7	23.13		26.18		12.95		22.14		11.00	
Registered Budgeted Staffing WTE July 2019 Band 5, 6 and 7	24.03		27.18		13.95		22.94		12.50	
Non-Registered Budgeted Staffing WTE March 2019	2.88		4.34		1.60		2.84		1.8	
Non-Registered Budget WTE July 2019	2.88		4.34		1.60		2.84		1.8	
Staffing in accordance with 1000 population March 2019	0.32		0.3		0.39		0.33		0.31	
Staffing in accordance with 1000 population July 2019	0.33		0.31		0.42		0.34		0.35	
Number on Caseload	633		938		531		457		294	
Caseload per 1000 population	8.75		10.78		15.88		6.8		8.29	
Caseload aligned to band 6 caseload manger	No		No		No		No		Yes	
Aligned Residential Beds	413		174		270		214		185	
Capacity and Demand	March 2019	July 2019	March 2019	July 2019	March 2019	July 2019	March 2019	July 2019	March 2019	July 2019
Rag Rating Red %	15%	5%	0%	0%	0%	0%	0.61%	0%	0%	0%
Rag Rating Amber %	69%	75%	50%	80%	10%	16%	34.4%	37%	44%	25%
Rag Rating Green %	30%	20%	50%	20%	90%	84%	64.9%	63%	56%	75%

The Rag Rating score in table 7 is based on assessment criteria to identify patients that sit in specific categories of priority/need. Priority 1 patients are identified as high-risk patients that cannot have visits deferred; Priority 2 patients are patients that would be impacted through deferring visits, but no harm would be caused; and Priority 3 patients are patients that can safely have their visits deferred to another day.

The rag rating scores are as follows:-

Green – There is capacity within the service to meet workload without deferring any visits.
Amber – The team can meet daily workload but will need to defer low priority visits
Red – Unable to meet daily workload even when low priority visits are deferred.

The acuity review has highlighted that only Winsford Care Community aligns its caseload management to band 6 managers. It is worth noting that Northwich has considerably more care home beds aligned to them. In relation to the capacity and demand tool both Northwich and Crewe Care Communities defer visits on a regular basis, however this is based on professional judgement and is open to interpretation, the introduction of the malinko system which will support work allocation and scheduling.

5. Strategic Staffing Reviews – agreed actions

The divisional nursing actions and recommended investments following the strategic staffing and establishment reviews undertaken in January 2019 to June 2019 are as follows:

5.1 Medicine and Emergency Care Division

Investments recommended:

- Ward 7 - To fund the third Registered Nurse on Night duty, seven days a week

Divisional actions agreed:

- Review supernumerary co-ordinator role across all ward areas
- ED continue with BEST acuity tool on a bi-annual basis
- Add sickness/vacancy to acuity template for future reviews
- Continue with rotation post between Critical Care and Ward 5 (respiratory)
- Consider funding security staff for ward 14 to reduce the use of outsourced security agency
- To continue to actively recruit into all vacancies
- Review the Pharmacy Technician role across the divisions

5.2 Surgery and Cancer Division

Investments recommended:

- Increase to 5 Registered Nurses on weekend shifts for ward 13 in line with all other ward areas and increase to 5 HCA on night duty on ward 10.

Divisional actions agreed:

- Continue to actively recruit to all Registered Nurse/Healthcare Assistant vacancies namely on wards 10, 12 & 13
- Engage in discussions with regards to unfunded ward attender clinics, namely on wards 9, 12, 13 & 18
- Review impact on high levels of medically boarded patients and potential bed modelling review.

5.3 Diagnostics and Support Services Division

Investments recommended:

- Nil.

Divisional actions agreed:

- Potential for an additional Healthcare Assistant on night duty to reduce 1:1 special requirements
- Deep dive into medication errors on 21b in relation to bank and agency staff
- Deep dive into falls at Elmhurst
- Scope out options for a rehabilitation acuity tool to identify requirements at Elmhurst
- Add Allied Health Professional column to acuity tool to support acuity reviews in the future

5.4 Women & Children's Division

Investment recommended:

- Awaiting outcome of BR+ external review

Divisional actions agreed:

- Review of Paediatric High Dependency Unit model and potential staffing options

5.5 Central Cheshire Integrated Care Partnership (CCICP)

Investments recommended:

- Await implementation of Malinko system to identify future establishment requirements.

Divisional actions agreed:

- Implement band 6 caseload management
- Review of ambulatory wound care provision
- Review Tissue Viability Service
- Review catheter care across all care communities
- Review of insulin administration across all care communities

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 assurance to the Trust Board of Directors, the Trust has a number of short, medium and long term actions in place. Table 8 outlines these actions in years of achievement and future plans.

Table 8

2019/20 Achievements	2020/21 Future Plans
Funding agreed for International Recruitment, 43 post offered. Introduction of a UK adaptation programme- 11 candidates recruited	Further International recruitment given the potential success of first cohort.
Return to practice programme with experienced nurses in post and in dedicated wards where they intend to practice on re-qualification – 11 candidates recruited.	Embed the Registered Nurse Apprenticeship degree programme.
Commencement of Registered Nurse Apprenticeship training – September 2019 – cohort of 20.	Continued recruitment of trainee Nursing Associates.
Implementation of non-traditional roles to provide support to wards, such as physiotherapists, pharmacy technicians and therapy assistance.	Further recruitment of alternative roles to complement the multi disciplinary team.
Implementation of full induction programme for newly appointed Registered Nurses.	Roll out of 'Reaching Your Potential' and Succession Planning across all disciplines.
Looking after staff - Health and Wellbeing strategy, self-roster & ESR self service. Building on our reputation - employer of choice, social media & staff survey feedback.	Continue roll out of the e-Roster system including benefits realisation and compliance with Attain (NHSI 2019).
Responding to generational choices - career development & talent management.	Development of new Workforce models at scale - Advanced Practice.
The implementation of an e-Rostering - Electronic Health Roster/Safe care. Flexible working arrangements where possible	Review of the current Retire & Return Policy.
Trust attendance at job fairs and school career fairs	Retention projects to focus on Staff Health and Wellbeing.

:

7. E-Rostering position

The e-Rostering project was launched in the Trust in November 2018 with scope to implement across the Nursing and Midwifery workforce. The project plan was an initial roll out across 5 inpatient wards, with a full roll out to 20 wards to date with a total of 825 staff rostered as of September 2019.

To date the project has seen the following benefits:-

- Improved rostering practices with rosters 6 weeks in advance that improved opportunity to securing bank and agency workers to fill gaps.
- Standardisation of shift times.
- Compliance with WTD as substantive and bank hours now combined.
- Pro-active management of annual leave to ensure that every shift has an experienced, substantive staff member who could take charge of the ward.
- Increased use of substantive staff contracted hours leading to better productivity.
- Increased visibility of staffing issues and redeployment across wards to fill gaps.
- e-Rostering system is linked to the bank system so bank shifts match the demand template to prevent overbooking.
- Roster managers trained to use the auto-roster option in the software to reduce administration time and release time to care.
- Through education, roster managers have improved knowledge and understanding of headroom, demand and CHPPD and KPIs.
- Simplified electronic payroll processes and improved payroll accuracy.
- Review of demand templates with divisional finance teams to align budgets.

Safe Care Live - The e-Rostering team have taken a bespoke approach by implementing the attendance element as part of e-Rostering roll out. This facilitates the move towards a 'Live Daily Staffing Status' across the organisation. In order to achieve the full operational benefits the second phase 'Acuity Driven Staffing', which calculates required staffing numbers from patient acuity 3 times a day requires further investment.

8. Conclusion

The Trust has seen a growth in patient acuity and dependency year on year across a number of adult wards with a number of areas having agreed investment in 2019.

In addition to this, there are 3 ward areas that are not at the nationally recommended care staff ratios, as outlined within the 2019 acuity reviews. The 3 areas have been reviewed against their current budgetary spend and mitigations in place. In terms of patient safety, the executive team have acknowledged the areas not at the recommended levels and have no risk appetite to wait 6 months for the 2020-21 budget to resolve. The establishment staffing ratios in the 3 areas will be increased with immediate effect and managed within the overall financial position for 2019/20, with the recurring funding incorporated into the assessment of the total nursing budget requirements as part of 2020/21 financial plan.

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 inclusion of the acuity reviews in both the Emergency Department and Community District Nursing services has given invaluable information into the requirements of both services and the potential drivers for improvement. The results of the BR+ report will be reviewed in Quarter 3 (2019).

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 eighteen 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 required investments on wards 7, 10 and 13 prior to the annual plan 2020-2021 following the bi-annual Staffing Reviews in January and June 2019.
- Note and support the divisional actions being undertaken following the bi-annual Staffing Reviews 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 now includes a review of staffing across the Emergency Department and the District Nurse Community Services as agreed in 2018.

Mid Cheshire Hospital
NHS Foundation Tru

Board of Directors Performance Report

August 2019

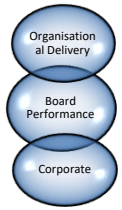
"To Deliver Excellence in Healthcare through Innovation & Collaboration"

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.

James Sumner
Chief Executive

Contents

Headline Measures

Organisational Delivery				
Indicator	**Standard**	**YTD**	**Aug-19**	
Cancer				
Rapid Access Referrals (%) *(seen in 2 wks)*	93.00%	97.01%	98.20%	
Total Patients Seen		*5,185*	*1,000*	
Patients seen >14 days		*155*	*18*	
62 day GP Classic (%)	85.00%	85.52%	87.60%	*
Accountable Patients Treated		*350*	*61*	
No. of Breached Pathways (adjusted)		*47*	*8*	
62 day Screening (%)	90.00%	93.33%	90.48%	*
Accountable Patients Treated		*56*	*11*	
No. of Breached Pathways (adjusted)		*8*	*1*	
Unplanned Activity				
4 Hour Access Standard (%)	95.00%	79.13%	78.03%	
A&E Attendances (LH/MIU/UUC) (% to plan)		100.09%	105.77%	
A&E Attendances LH & MIU (Vol)		*42,150*	*8,626*	
Planned Activity				
Incomp Pathways <18wk (%)	92.00%	91.78%	92.00%	
>6wk Diagnostic Waits (%)	1.00%	5.91%	3.05%	
Total Patients Waiting for a First Outpatient Appointment			9,523	

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

Indicator	**Standard**	**YTD**
Workforce		
Sickness absence Rolling 12 Month		4.55%
Turnover Rolling 12 Month		8.80%

Corporate					
	YTD Rating		**YE Rating**	**YE Metric**	
Indicator	**Plan**	**Actual**	**Forecast**	**Plan**	**Forecast**
Finance					
Use of Resource Rating	3	3	3		
Capital Service Capacity	4	3	4	0.61	0.64
Liquidity	3	3	3	-13	-13
I&E Margin	3	4	3	-0.70%	-0.70%
Distance from Financial Plan	1	1	1	0.00%	0.00%
Agency Spend	1	2	3	-15.00%	-25.00%

	YTD Target	**YTD Actual**	**YTD Variance**	**FY Target**	**FY Forecast**	**FY Variance**
Cost Improvement Schemes Total (£000's)	1,571	1,057	-514	5,342	5,342	0
Commission Contact Income SC & VR (£000's)	56,298	56,298	0			
Contract Income (£'000)	79,266	79,646	380			
Pay to Budget (£000's)	-61,580	-61,464	116			
Non Pay to Budget (£000's)	-24,265	-24,782	-517			
Agency Trajectory (£000's)	-1,900	-2,310	-410			

Exec Summary

In August 2019, the Trust delivered three of the five NHS Improvement Single Oversight Framework performance indicators (Rapid Access Referral, Cancer 62 day, RTT). The indicators not achieved were the 4 hour Access and the Diagnostic Waiting time standards.

The RTT Incomplete Pathway standard in August achieved 92.00% against the 92% performance standard.

The 4 hour Access Standard in August achieved 78.03% against the 95% performance standard. There has been a 15% increase in the number of patients attending A&E when compared to August 2018.

The Trust has achieved all three headline cancer access standards for August.

Diagnostics waiting times for August is 3.05% against a 1.00% threshold. This is an improvement on the previous month following the issues surrounding the Imaging server upgrade.

The UoRR metric is 3. If any of the UoRR metrics are 4, then the maximum rating that the trust can achieve is a 3.

The Trusts' I&E performance against the control total is £92k worse than the plan. The UoRR for I&E margin has decreased to a 4 in month 5, to reflect the variance against control total.

This position includes the Provider Sustainability Fund (PSF) earned to date, which is dependant on meeting the financial control total and also the Marginal Rate Emergency Threshold (MRET).

There is a variation in the CIP scheme, with challenges around delivering NHS Supply Chain savings, improvements to sickness rates within nursing and delays to other programmes of work.

The rate of agency use remains above the ceiling rate set by NHS, which increases the likelihood of this Use of Resource Rating deteriorating.

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 Access Standard).

The Trust has achieved a Use of Resource rating of 3, which is expected to maintain at this level throughout 2019/20.

Operational Performance

	Current YTD														Monthly Trend
	Target	Actual	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	
Maximum 6 week wait for Diagnostic procedures	1%	5.91%	0.31%	0.44%	0.48%	0.17%	0.54%	0.47%	0.42%	0.76%	0.64%	9.34%	7.76%	4.04%	3.05%	
All Cancers: 62 day GP Classic (%) *	85%	85.52%	91.78%	86.11%	86.50%	93.40%	86.90%	85.83%	85.84%	85.60%	86.62%	86.09%	85.95%	87.25%	87.60%	
All Cancers: 62 day Screening (%) *	90%	93.33%	91.84%	100.00%	100.00%	100.00%	81.80%	87.50%	100.00%	95.45%	90.00%	90.00%	61.11%	90.63%	90.48%	
18 weeks from point of referral to treatment - patients on an incomplete pathway (%)	92%	91.78%	93.05%	92.43%	92.82%	92.28%	92.01%	91.30%	91.63%	90.67%	91.05%	91.67%	92.07%	92.09%	92.00%	
A&E - maximum waiting time of 4 hours from arrival to admission/transfer/discharge (%)	95%	79.13%	87.14%	84.61%	85.51%	88.13%	83.57%	78.89%	81.12%	80.41%	79.90%	78.26%	80.60%	78.99%	78.03%	
STF Trajectory			93.92%	93.92%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	0.00%	0.00%				
Provider Submitted Trajectory													86.10%	86.10%	88.10%	

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

Financial & Resource

		Unit	YE Plan	YE Forecast	YE Rating	YTD Plan	YTD Actual	YTD Rating
Financial Sustainability	Capital Service Capacity	0.0x	0.61	0.64	4	1.02	1.27	3
	Liquidity	days	-13	-13	3	-11	-10	3
Financial Efficiency	I&E Margin	%	-0.70%	-0.70%	3	-1.30%	-1.20%	4
Financial Controls	Distance from Financial Plan	%	0.00%	0.00%	1	0.00%	0.10%	1
	Agency Spend	%	-15.00%	-25.00%	3	-14.00%	22.00%	2
Overall UOR Rating					3			3

Operational Delivery: *Cancer Pathway*

Headline Measures

	Current YTD		Rolling 13 months											
	Target	Actual	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Monthly Trend
Rapid Access Referrals (%) (seen in 2 wks)	93%	97.01%	96.73%	96.50%	96.87%	98.36%	97.78%	96.91%	97.66%	97.69%	95.83%	97.66%	96.89%	96.60%	98.20%	
Total Patients Seen		*5185*	*887*	*771*	*989*	*917*	*855*	*842*	*940*	*996*	*1031*	*982*	*965*	*1207*	*1000*	
Patients seen >14 days		*155*	*29*	*27*	*31*	*15*	*19*	*26*	*22*	*23*	*43*	*23*	*30*	*41*	*18*	
% seen within 7 days		*30.3%*	*35.2%*	*51.4%*	*41.5%*	*34.0%*	*35.4%*	*38.6%*	*38.1%*	*30.5%*	*30.3%*	*39.3%*	*37.5%*	*38.2%*	*43.3%*	
62 day GP Classic (%) *	85%	85.52%	91.78%	86.11%	86.50%	93.40%	86.90%	85.83%	85.84%	85.60%	86.62%	86.09%	85.95%	87.25%	87.60%	

** Provisional figures subject to change depending*

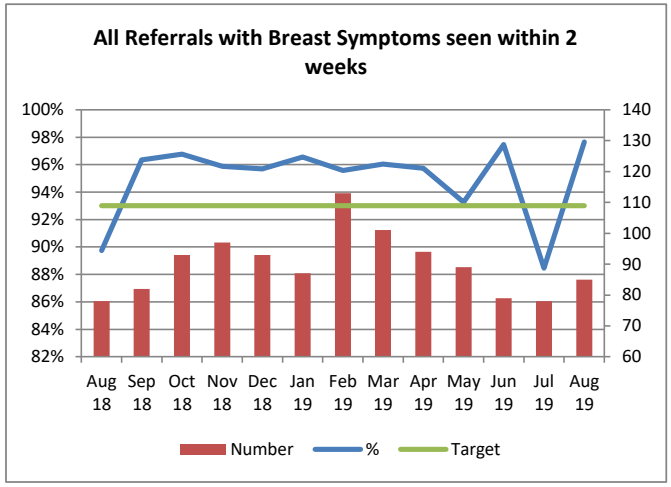
104+ day waits - (Cancer patients treated)	0	4	0	0	3	0	1	3	3	5	4	4	4

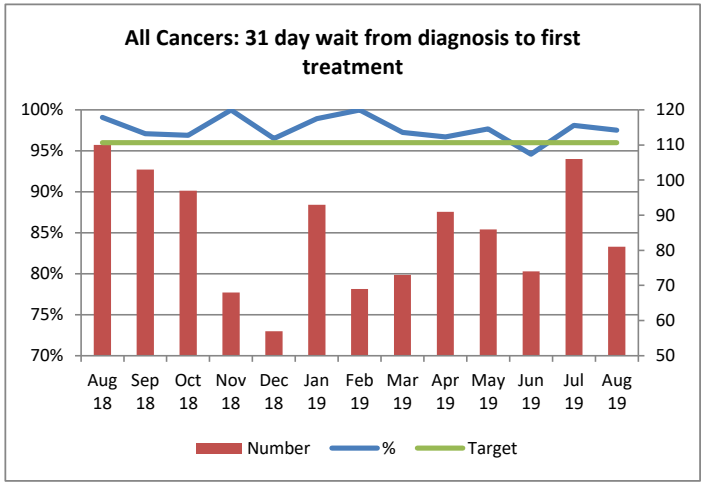
Commentary

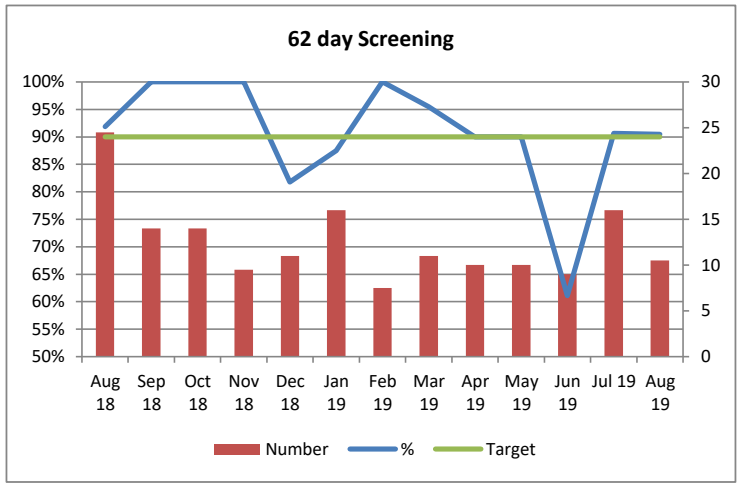
The Trust has achieved all three headline cancer standards during the month of August 2019. The figures presented in this paper reflect the Trust's regulatory performance measures adjusted figures that take into account breach reallocation between providers. From October 2018 the new cancer repatriation policy is in use.
The Trust has continued it's strong performance against the Rapid Access referrals standard, achieving 98.20% for August. This is inspite of a growth in demand of 13% more patients being seen compared to August 2018.
The 62 Day GP Classic standard has achieved 87.60% against an 85% target.

The 62 day screening standard has maintained it's performance at 90.48% for the second month, since the drop in performance in June 2019.

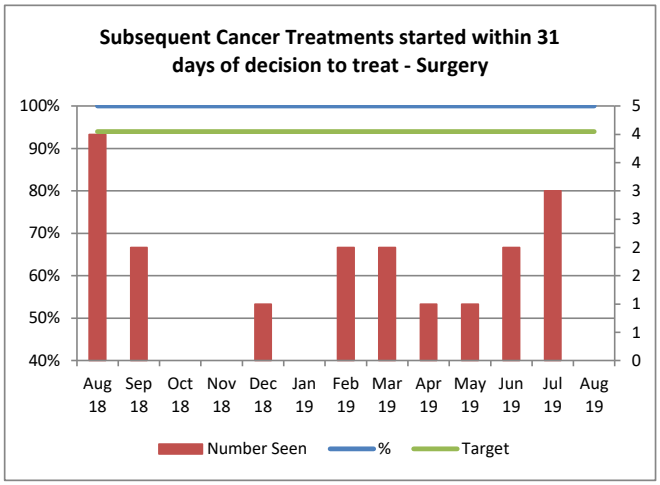
Primary Measures

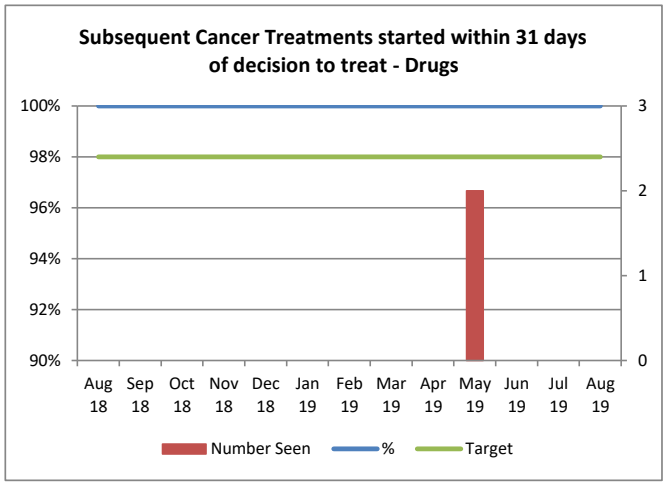


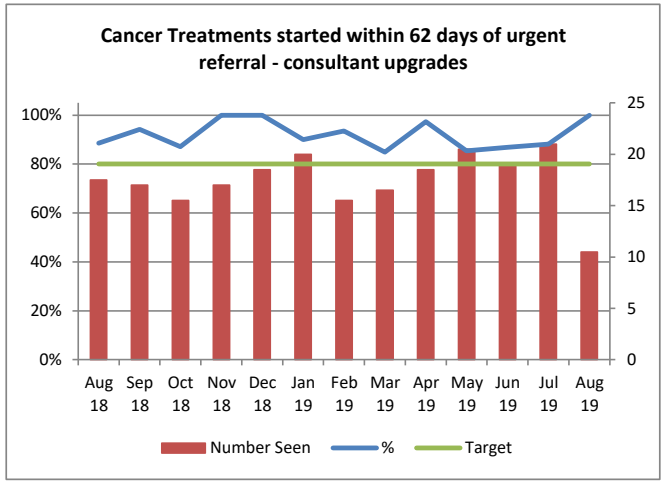




Operational Delivery: *Cancer Pathway*







Operational Delivery: *Unplanned Activity - A&E*

Headline Measures

	Current YTD Target	Current YTD Actual	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Monthly Trend
			Rolling 13 months													
A&E - >4 hr wait time from arrival to admission/ transfer/ discharge (% to Target)	95%	79.13%	87.14%	84.61%	85.51%	88.13%	83.57%	78.89%	81.12%	80.41%	79.90%	78.26%	80.60%	78.99%	78.03%	
No. of 4hr breaches		*8,796*	*967*	*1,158*	*1,167*	*884*	*1,209*	*1,621*	*1,349*	*1,574*	*1,642*	*1,822*	*1,559*	*1,878*	*1,895*	

	Plan	Actual	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Monthly Trend
A&E Attendances (LH/MIU/UUC) (% to Plan)		*100.09%*	97.7%	94.9%	100.0%	98.4%	95.8%	99.3%	97.0%	95.4%	100.4%	95.2%	96.3%	103.3%	105.8%	
A&E Attendances (LH/MIU/UUC) (No.)	*39,961*	*42,150*	7,517	7,524	8,056	7,445	7,358	7,679	7,147	8,034	8,169	8,382	8,036	8,937	8,626	
A&E Attendance Case Mix (based on acuity score) — *Major*		*11,801*	*2,380*	*2,228*	*2,455*	*2,269*	*2,235*	*2,392*	*2,170*	*2,341*	*2,351*	*2,540*	*2,235*	2,407	2,268	
Minor		*16,409*	*2,990*	*2,810*	*2,768*	*2,560*	*2,605*	*2,782*	*2,489*	*2,855*	*3,166*	*3,040*	*3,045*	3,559	3,599	
Paediatrics		*8,060*	*1,181*	*1,516*	*1,709*	*1,562*	*1,422*	*1,372*	*1,556*	*1,702*	*1,587*	*1,680*	*1,686*	1,739	1,368	
Resus		*5,873*	*966*	*969*	*1,120*	*1,048*	*1,095*	*1,128*	*928*	*1,126*	*1,063*	*1,121*	*1,070*	1,231	1,388	
A&E Attendance Location (based on Discharge) — *Major*		*16,394*	*3,225*	*3,090*	*3,413*	*3,187*	*3,176*	*3,354*	*2,983*	*3,317*	*3,245*	*3,405*	*3,142*	*3,320*	*3,282*	
Minor		*16,747*	*2,977*	*2,775*	*2,791*	*2,560*	*2,573*	*2,738*	*2,454*	*2,801*	*3,123*	*3,111*	*3,039*	*3,677*	*3,797*	
Paediatrics		*8,060*	*1,181*	*1,516*	*1,709*	*1,562*	*1,422*	*1,372*	*1,556*	*1,702*	*1,587*	*1,680*	*1,686*	*1,739*	*1,368*	
Resus		*942*	*134*	*142*	*139*	*130*	*186*	*210*	*150*	*204*	*212*	*185*	*169*	*200*	*176*	

Commentary

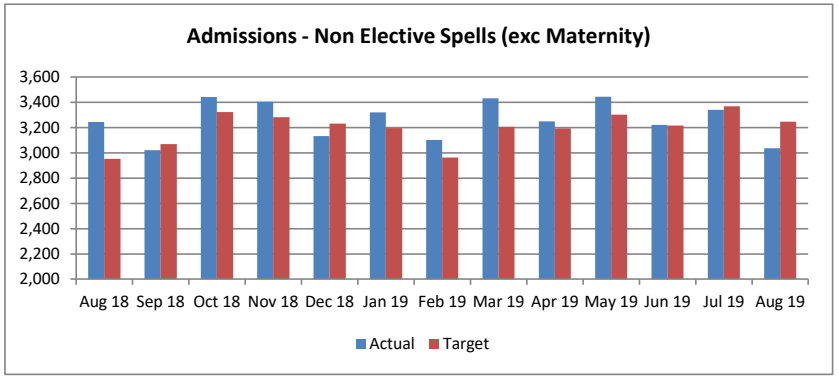
The Trust has achieved 78.03% against the 4-hour access standard in August 2019, with 15% more patients attending A&E compared the same period last year. In addition August 2019 has seen a 9% increase in the higher acuity patients coming into A&E compared to August 2018.

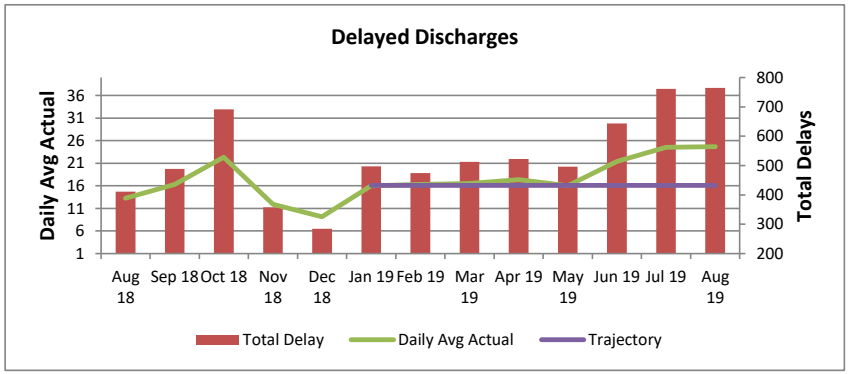
Medical outliers remain above the set threshold at 26, however have decreased since last month.

Patients medically optimised for discharge in August is similar to previous month at 25 against a threshold of 16. This has been an increasing trend since December 2018 and is the third consecutive month the system has failed this standard.

A&E Attendance to Non Elective Admission conversion has dropped for the third consecutive month, now at 35.54%, which is the lowest conversation rate for over 12 months.

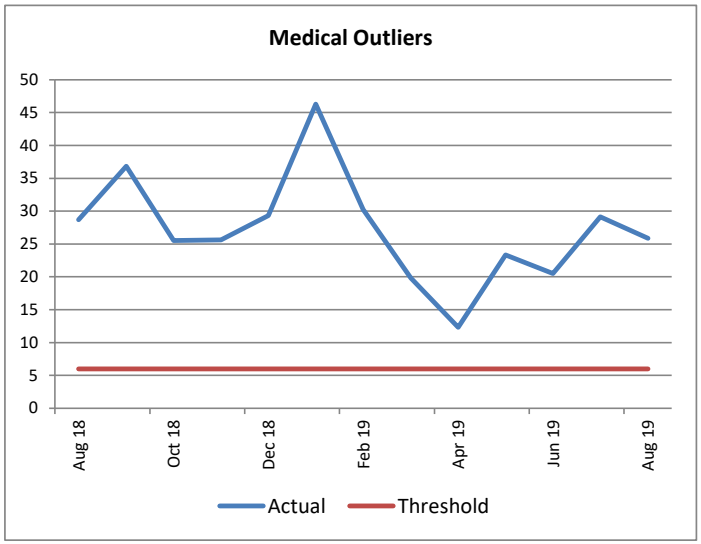
Primary Drivers

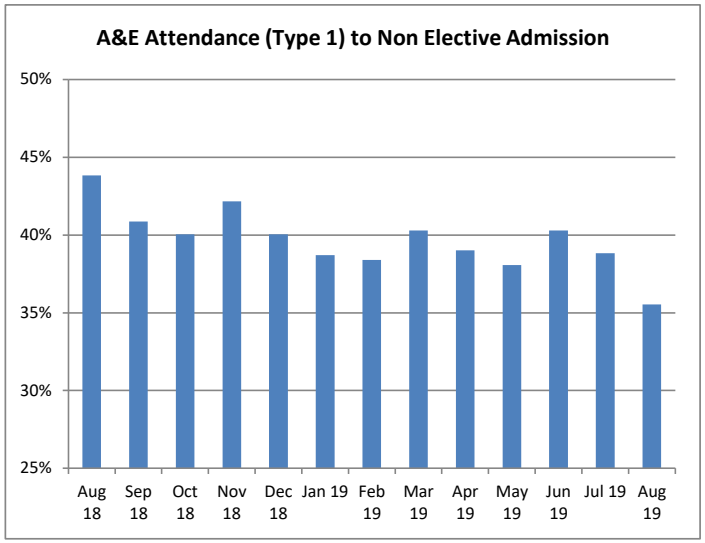


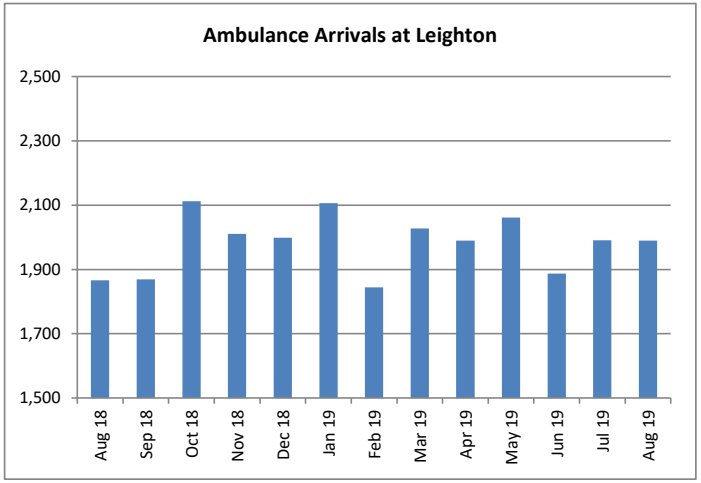


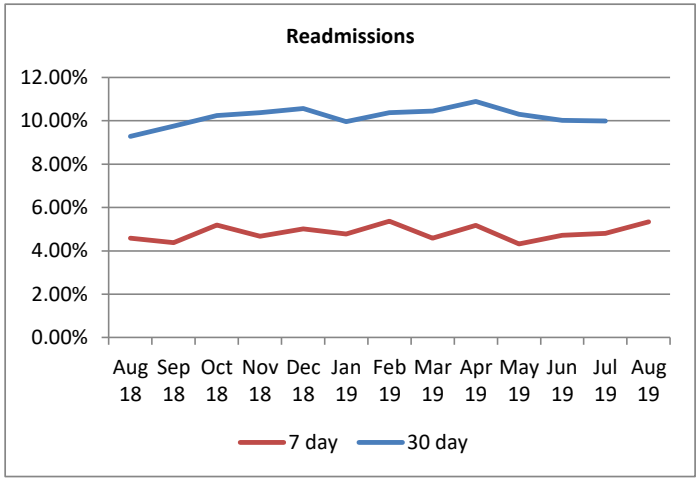
Operational Delivery: *Unplanned Activity A&E*

Secondary Drivers



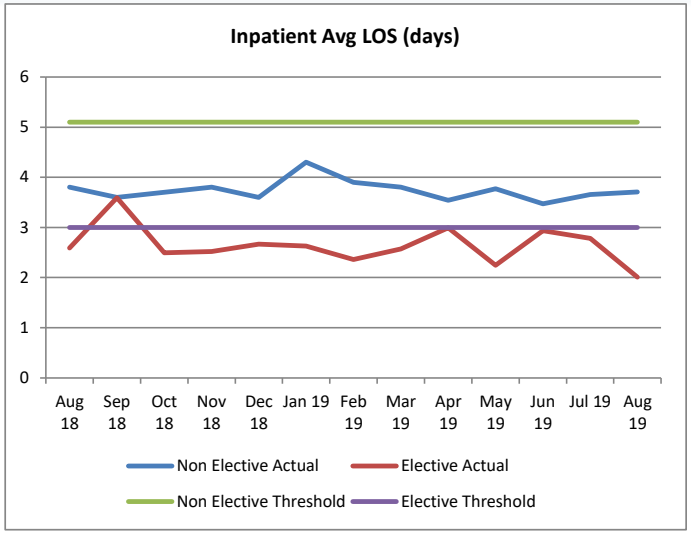


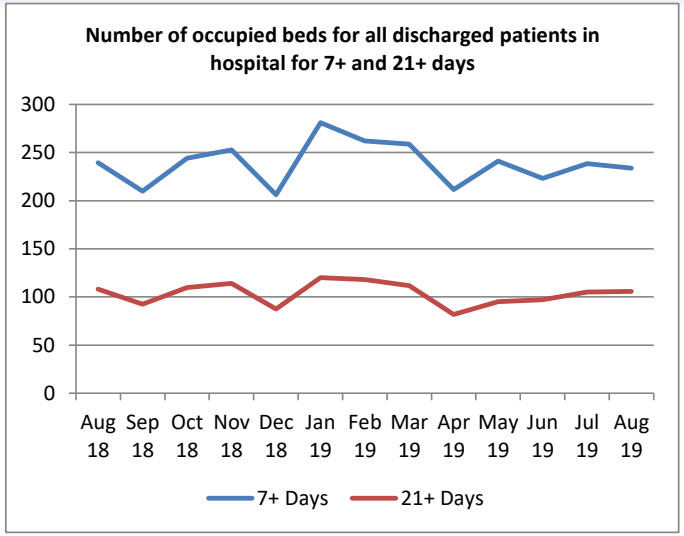


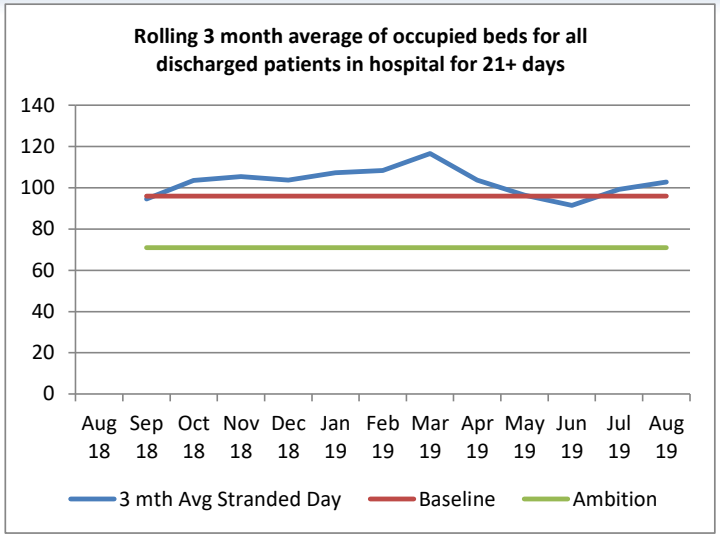


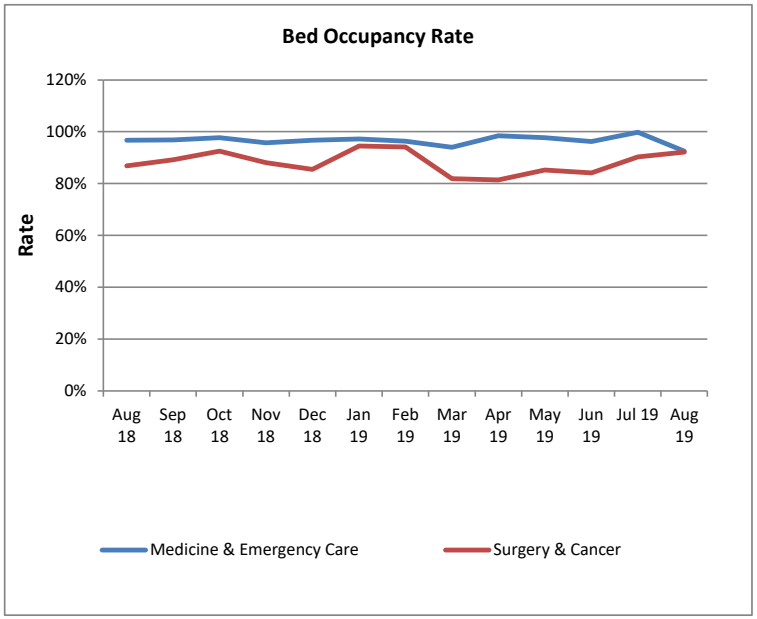
** Readmissions brought in line with national definition*

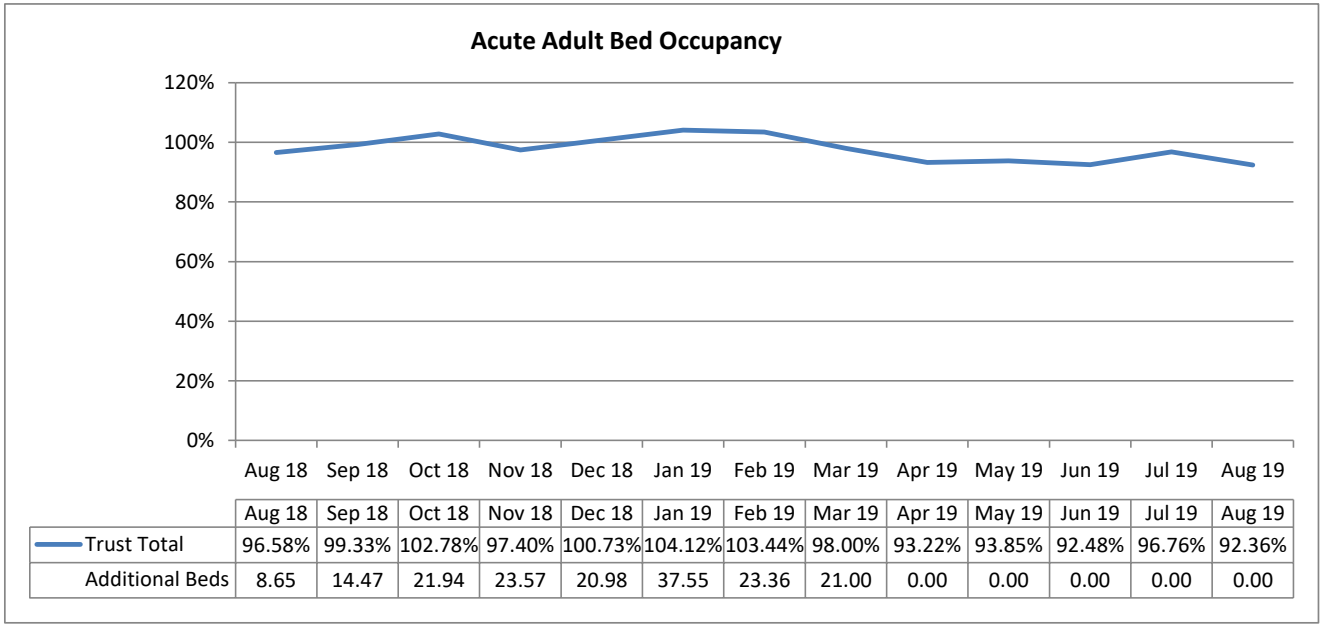
Operational Delivery: *Length of Stay*











	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19
Trust Total	96.58%	99.33%	102.78%	97.40%	100.73%	104.12%	103.44%	98.00%	93.22%	93.85%	92.48%	96.76%	92.36%
Additional Beds	8.65	14.47	21.94	23.57	20.98	37.55	23.36	21.00	0.00	0.00	0.00	0.00	0.00

Operational Delivery: *Planned Activity*

Headline Measures

	Current YTD		Rolling 13 months											
	Target	Actual	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Monthly Trend
18 weeks from Referral to Treatment in Aggregate - Incomplete	92%	91.78%	93.05%	92.43%	92.82%	92.28%	92.01%	91.30%	91.63%	90.67%	91.05%	91.67%	92.07%	92.09%	92.00%	
Total 18 Weeks		*76,581*	15,373	14,988	14,284	14,331	14,232	14,427	14,505	14,197	14,944	15,219	15,560	15,426	15,432	
No. > 18 Weeks		*6,289*	*1,069*	*1,135*	*1,025*	*1,106*	*1,137*	*1,255*	*1,214*	*1,324*	*1,338*	*1,267*	*1,234*	*1,216*	*1,234*	
Open Pathways >39 Weeks Waiting											*10*	*15*	*15*	*14*	*12*	
Diagnostic Waiting Time	1%	5.91%	0.31%	0.44%	0.48%	0.17%	0.54%	0.47%	0.42%	0.76%	0.64%	9.34%	7.76%	4.04%	3.05%	
Total Number of Waiters		*19,618*	*3,814*	*4,105*	*4,168*	*4,017*	*3,870*	*4,029*	*4,785*	*4,749*	*1,091*	*4,809*	*5,065*	*4,750*	*3,903*	
Waiters of 6 Weeks +		*1,160*	*12*	*18*	*20*	*7*	*21*	*19*	*20*	*36*	*7*	*449*	*393*	*192*	*119*	
Total Patients Waiting for a First Outpatient Appointment			9,851	9,654	9,496	9,430	8,948	9,428	9,823	9,682	9,800	9,981	9,603	9,659	9,523	
Longest Wait Time (weeks)											*48*	*44*	*46*	*48*	*46*	

Commentary

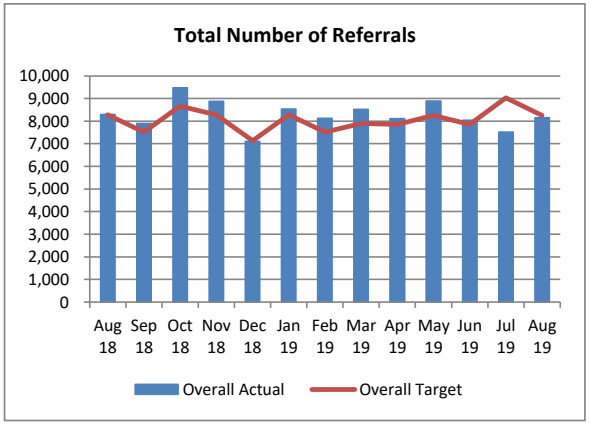
The Trust's RTT Incomplete Pathway position is 92.00% for August. Eight specialties have failed to meet the 92% target, these are General Surgery, Urology, Gastroenterology, Cardiology, Dermatology, Thoracic Medicine, Gynaecology and Trauma and Orthopaedics. Detailed improvement plans and trajectories are in place and continue to be reviewed weekly by the Chief Operating Officer and Director of Operations.

Mid Cheshire do not currently have any 52 week breaches for August, there are 12 patients waiting over 39 weeks; (1 in General Surgery, 1 in Ophthalmology, 1 in Cardiology, 3 in Urology, 5 in Gynae, 1 in Dermatology). All long wait patients are monitored and reviewed weekly at director led performance meetings.

In August 2019, 3.05% of patients waited longer than 6 weeks for their diagnostic tests. The failure of the Diagnostic six week standard is expected as a result of the failed server upgrade and the impact on the soliton system. Improvement from previous month has been seen.

Referral volumes have increased in August by 8% overall when compared to July 2019, the biggest increase is in GP referrals, up by 10% compared to July 2019.

Primary Drivers

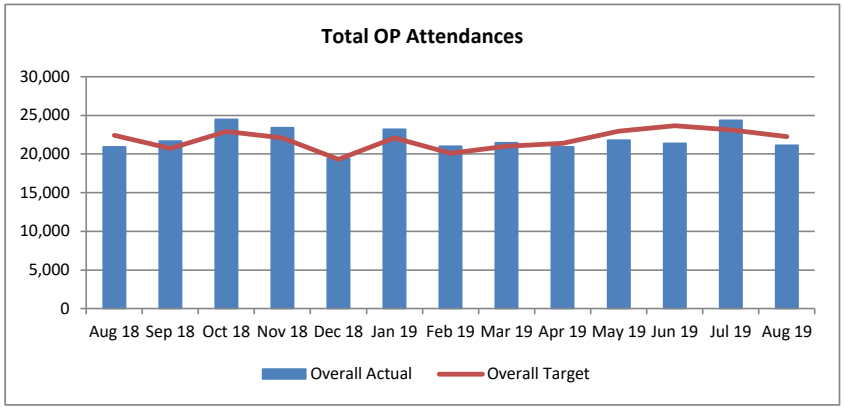


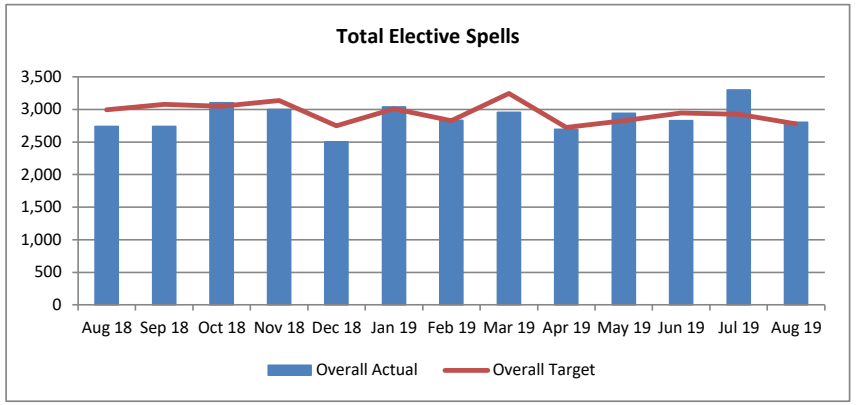
Referral Breakdown

	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Monthly Trend
GP Actual	5,184	4,925	5,755	5,684	4,412	5,424	4,915	5,270	4,587	5,231	4,583	4,103	4,497	
GP Target	5,157	4,683	5,394	5,157	4,446	5,157	4,683	4,920	4,374	4,593	4,374	5,030	4,593	
% to Target	100.5%	105.2%	106.7%	110.2%	99.2%	105.2%	105.0%	107.1%	104.9%	113.9%	104.8%	81.6%	97.9%	
Other Actual	3,107	2,968	3,714	3,189	2,696	3,118	3,204	3,250	3,524	3,655	3,453	3,411	3,654	
Other Target	3,120	2,833	3,263	3,120	2,689	3,120	2,833	2,976	3,483	3,657	3,483	4,006	3,657	
% to Target	99.6%	104.8%	113.8%	102.2%	100.3%	100.0%	113.1%	109.2%	101.2%	99.9%	99.1%	85.2%	99.9%	
Total Actual	8,291	7,893	9,469	8,873	7,108	8,542	8,119	8,520	8,111	8,886	8,036	7,514	8,151	
Total Target	8,276	7,515	8,657	8,276	7,135	8,276	7,515	7,896	7,857	8,250	7,857	9,036	8,250	
% to Target	100.2%	105.0%	109.4%	107.2%	99.6%	103.2%	108.0%	107.9%	103.2%	107.7%	102.3%	83.2%	98.8%	
GP % of Total	62.5%	62.4%	60.8%	64.1%	62.1%	63.5%	60.5%	61.9%	56.6%	58.9%	57.0%	54.6%	55.2%	

Operational Delivery: *Planned Activity*

Primary Drivers



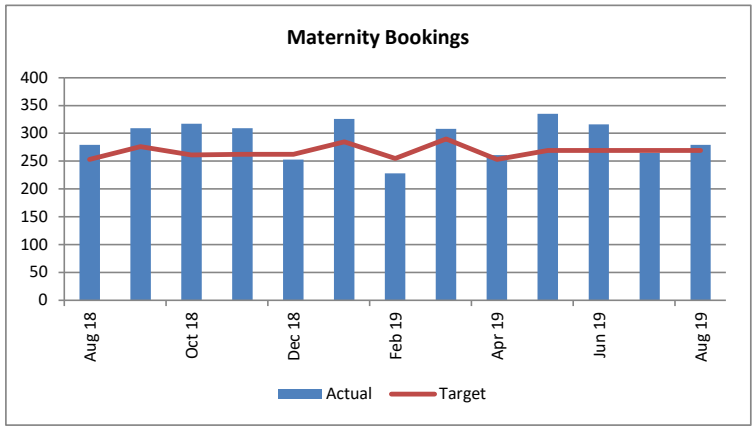


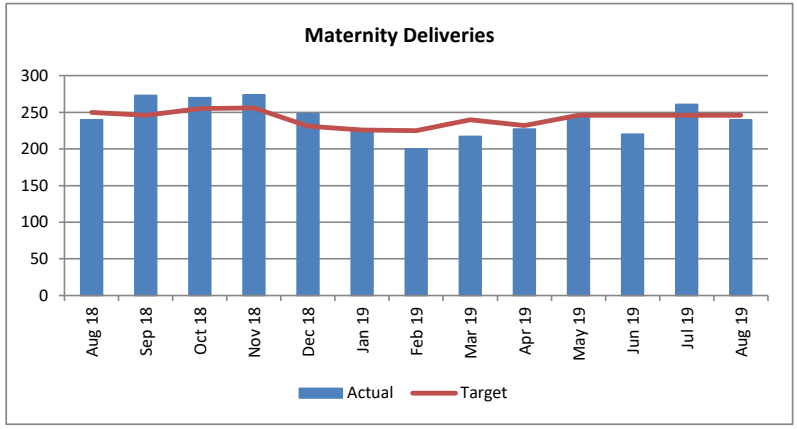
OP Attendance Breakdown	YTD 18 19	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Monthly Trend
New Actual	81,335	6,211	6,648	7,713	7,203	5,946	6,861	6,397	6,877	6,584	6,956	6,725	7,865	6,651	
New Target	74,744	6,502	5,934	6,778	6,496	5,625	6,496	5,901	6,189	6,416	6,848	7,173	6,817	6,588	
% to Target	108.8%	95.5%	112.0%	113.8%	110.9%	105.7%	105.6%	108.4%	111.1%	102.6%	101.6%	93.8%	115.4%	101.0%	
F U Actual	182,101	14,737	15,014	16,778	16,207	13,493	16,352	14,629	14,583	14,343	14,830	14,642	16,508	14,464	
F U Target	181,624	15,912	14,774	16,157	15,600	13,701	15,604	14,194	14,803	14,988	16,096	16,491	16,286	15,659	
% to Target	100.3%	92.6%	101.6%	103.8%	103.9%	98.5%	104.8%	103.1%	98.5%	95.7%	92.1%	88.8%	101.4%	92.4%	
Total Actual	263,436	20,948	21,662	24,491	23,410	19,439	23,213	21,026	21,460	20,927	21,786	21,367	24,373	21,115	
Total Target	256,368	22,414	20,708	22,935	22,095	19,326	22,100	20,095	20,992	21,403	22,944	23,663	23,102	22,247	
% to Target	102.8%	93.5%	104.6%	106.8%	105.9%	100.6%	105.0%	104.6%	102.2%	97.8%	95.0%	90.3%	105.5%	94.9%	
New % of Total	30.9%	29.6%	30.7%	31.5%	30.8%	30.6%	29.6%	30.4%	32.0%	31.5%	31.9%	31.5%	32.3%	31.5%	

Elective Spells Breakdown	YTD 18 19	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Monthly Trend
I P Actual	3,055	226	259	284	280	241	157	288	272	225	228	266	267	287	
I P Target	3,341	288	281	308	308	241	181	264	304	263	277	280	277	249	
% to Target	91.4%	78.6%	92.2%	92.3%	91.0%	100.1%	86.9%	109.0%	89.4%	85.6%	82.3%	94.9%	96.4%	115.1%	
Daycase Actual	31,155	2,513	2,479	2,817	2,717	2,262	2,882	2,543	2,685	2,467	2,714	2,560	3,033	2,517	
Daycase Target	32,775	2,709	2,795	2,740	2,827	2,507	2,826	2,565	2,942	2,462	2,548	2,666	2,650	2,530	
% to Target	95.1%	92.8%	88.7%	102.8%	96.1%	90.2%	102.0%	99.1%	91.3%	100.2%	106.5%	96.0%	114.4%	99.5%	
Total Actual	34,210	2,739	2,738	3,101	2,997	2,503	3,039	2,831	2,957	2,692	2,942	2,826	3,300	2,804	
Total Target	36,116	2,996	3,076	3,048	3,135	2,748	3,007	2,829	3,247	2,724	2,825	2,946	2,927	2,779	
% to Target	94.7%	91.4%	89.0%	101.8%	95.6%	91.1%	101.1%	100.1%	91.1%	98.8%	104.1%	95.9%	112.7%	100.9%	
I P % of Total	8.9%	8.3%	9.5%	9.2%	9.3%	9.6%	5.2%	10.2%	9.2%	8.4%	7.7%	9.4%	8.1%	10.2%	

Operational Delivery: *Planned Activity*

Primary Drivers





Operational Delivery: *Planned Activity*

Secondary Drivers

			Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Monthly Trend
Bed Occupancy Rate	Medicine & Emergency Care		96.7%	96.9%	97.7%	95.8%	96.7%	97.3%	96.3%	94.0%	98.4%	97.7%	96.2%	99.8%	92.5%	
	Surgery & Cancer		86.9%	89.2%	92.5%	88.1%	85.5%	94.5%	94.2%	81.9%	81.4%	85.2%	84.1%	90.3%	92.1%	
Elective Inpatient Avg LOS (Days)			2.6	3.6	2.5	2.5	2.7	2.6	2.4	2.6	3.0	2.2	2.9	2.8	2.0	
Delayed Transfers of Care (MFFD)		16.00	13	16	22	12	9	16	17	17	17	16	21	25	25	
Delayed Transfers of Care (% of Acute Beds)			2.8%	3.3%	4.5%	2.4%	1.8%	3.1%	3.3%	3.3%	3.5%	3.2%	4.3%	5.2%	5.1%	
Medical Outliers			29	37	26	26	29	46	31	20	12	23	20	29	26	
Readmission (Emergency Re-admissions after Planned Surgery)																
	30 Day Rate		2.73%	3.01%	3.28%	2.96%	2.87%	2.66%	3.86%	3.29%	3.38%	3.38%	3.10%	2.78%		
	7 Day Rate		1.27%	1.28%	1.16%	1.15%	1.09%	1.06%	1.45%	1.05%	1.41%	1.37%	1.00%	1.05%	1.28%	
Cancelled Operations - Non Clinical - Cancellation Rate			0.95%	0.73%	1.86%	0.63%	1.40%	0.58%	0.60%	0.65%	0.67%	1.17%	0.85%	1.30%	1.30%	
Theatre Efficiency																
	Main Theatres		78.4%	78.4%	77.9%	77.2%	73.9%	74.5%	76.2%	78.5%	76.7%	75.0%	77.4%	78.7%	78.3%	
	TC Theatres		73.2%	73.4%	76.6%	73.5%	72.0%	69.4%	73.0%	73.5%	72.4%	68.2%	74.8%	70.7%	71.9%	
DNA (OP Efficiency)			5.74%	5.55%	5.72%	5.62%	5.95%	5.75%	5.42%	5.41%	6.00%	6.02%	6.56%	5.87%	5.57%	
Hospital Cancellation Rate (OP Efficiency)			7.27%	7.57%	7.65%	7.63%	8.27%	7.65%	7.83%	8.12%	7.90%	7.48%	7.36%	8.10%	7.62%	

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

Performance and Finance - Headlines August 2019

Current Position | Analysis | Forward View

The reported position is cumulatively £92k worse than the control total.

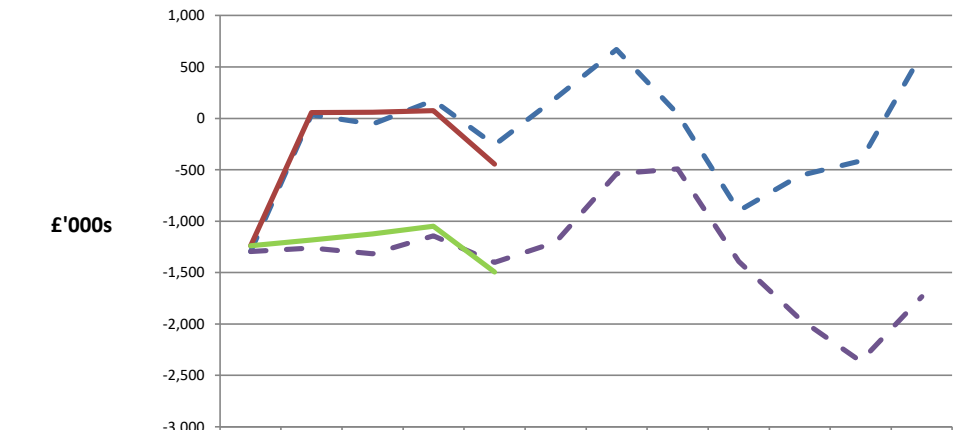
CCICP is underspent by £141k, and MCHFT overspent by £233k cumulatively to date

In month 5 (August) there is a deterioriation of £186k with MCHFT being £24k overspent and CCICP £162k overspent.

£200k capital to revenue adjustment in month between MCHFT and CCICP distorts the underlying in-month run rates for the segments

The overall use of resources rating for the Trust is currently 3 in line with expectations.

Financial Performance 2019/20



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
In Month Plan	-1,294	34	-56	173	-258	195	669	44	-900	-556	-413	628
In Month Actual	-1,238	56	58	76	-445							
In Month Variance	56	22	114	-97	-187							
Cumulative Plan	-1,294	-1,260	-1,316	-1,143	-1,401	-1,206	-537	-493	-1,393	-1,949	-2,362	-1,734
Cumulative Actual	-1,238	-1,182	-1,124	-1,048	-1,493							
Cumulative Variance	56	78	192	95	-92							

	YTD Rating		YE Rating	
Indicator	Plan	Actual	Forecast	Status
Finance				
Use of Resource Rating	3	3	3	
Capital Service Capacity	4	4	4	The planned deficit does not meet the financial commitments
Liquidity	3	3	3	The Trust has enough cash to meet it's obligations
I&E Margin	4	4	3	The current deficit as a percentage of turnover is greater than -2%
Distance from Financial Plan	1	2	1	The trust is currently off plan by £92k
Agency Spend	1	2	3	The current leve of spend on agency is greater than the cap.

The expectation is that the Trust will meet the annual plan, and receive both the PSF (£4.216m) and MRET (£3.215m).

Main risks around delivering the control total relate to delivering the CIP targets, delivering the associate contracted activity and managing unscheduled care pressures within the approved budgets and business cases.

Emerging concerns around increasing dependency on premium costs to deliver core activity

The Cheshire Health economy is currently developing a financial recovery plan to mitigate the risks in the systems. This may have implications for MCHFT either directly or indirectly through commissioner actions.

The Trust is expected to maintain the use of resources rating at a 3.

Performance and Finance - Contract Income August 2019

Current Position

Contract income is £28k above plan year to date with an improvement of £10k in month.

Associate contracts continue to underperform against plan pre-dominantly with Stoke/North Staffs and West Cheshire CCGs (£0.82m to date).

South Cheshire CCG is overperforming on contract compared to the contract value by £425k, and Vale Royal CCG is under performing by £127k. however no total variance is shown due to the block arrangements.

Unplanned activity is above plan by £95k ytd. Planned activity £31k is under plan, with a deterioration of £51k in month. Diagnostics is £528k over plan, relating to growth in both Radiology and Pathology. Maternity activity is now on plan with an in month improvement of £100k, relating to supporting the additional activity associated with an independent provider ceasing trading.

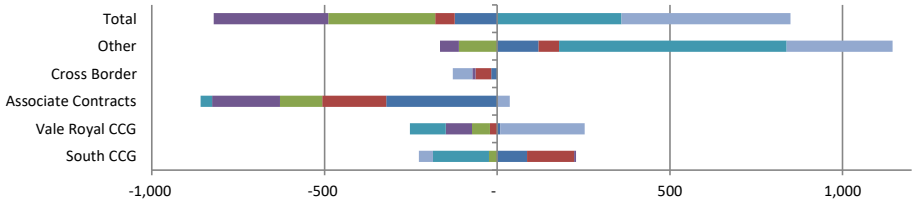
Within the 'other' column over-performance on high cost drugs within Specialised Commissioning (£0.66m) offsets against drugs spend within non-pay. There is also an element of anticpated income for Winter and additional costs for midwifery from the CCG.

Analysis

Contract Income Performance 2019/20 £'m

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative budget	19.3	39.0	59.1	79.3	98.9	119.2	139.9	159.9	179.5	199.3	218.5	239.6
Cumulative actual	19.0	39.0	59.0	79.3	98.9							
In month budget	19.3	19.7	20.1	20.2	19.6	20.3	20.7	20.0	19.6	19.8	19.2	21.1
In month actual	19.0	20.0	20.0	20.3	19.6							

Cumulative Variance to Contract Income plan £'000s



	South CCG	Vale Royal CCG	Associate Contracts	Cross Border	Other	Total
Unplanned Care	86	9	-321	-17	120	-123
Day case	137	-21	-186	-46	59	-57
Elective	-24	-52	-122	-	-111	-309
Outpatients	5	-76	-197	-9	-55	-332
High cost drugs	-162	-104	-33	-	659	360
Other	-41	244	36	-57	307	489
Total	1	-	-823	-129	979	28

Forward View

There is a risk that if the current level of underperformance on associate contracts continues, then this could impact the Trust by between £2m-2.5m.

The Trust has seen an increase in referrals for the first 5 months particularly around the surgical specialties, which the Trust is discussing with the CCG.

Whilst the block contract arrangement is currently overperforming the current assessment around CQUIN would negate this position.

Increase in the growth around diagnostics and cost of delivering the activity needs to be carefully managed.

The over performance on high cost drugs will remain at the current levels until the aseptic unit is re-opened, this is however funded by Specialised commissioners.

The additional activity and costs associated with the independent provider ceasing trading has now been agreed with the CCG.

Performance and Finance - Pay Expenditure August 2019

Current Position

Cumulatively Pay is better than plan by £27k, with CCICP being £47k better in month (£275k ytd), and MCHFT £136k worse in month (£248k ytd).

Whilst Medical pay is underspent, there are £727k of non pay costs ytd (excluding impacts of Soliton/scanner delays) in relation to externally sourced costs. This impacts DMEC (£133k ytd) and CSSD (£594k ytd). Including these would mean Medical Staff is overspent

Nursing pay has worsened in month by £249k (£349k ytd), partially as a result of escalation beds opened (£75k) and an increased use of agency in the month (£75k).

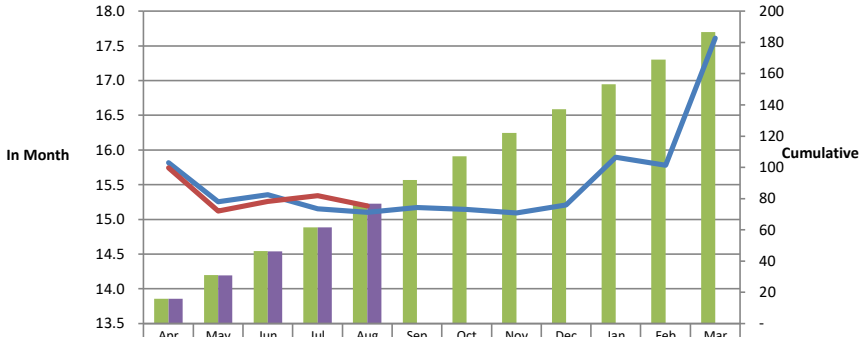
The cost of opening unfunded escalation beds has increased in the month and impact DMEC (£15k in month, £26k ytd) and S&C (£60k in month, £75k ytd).

In addition there are pressures within DMEC, Paediatrics and CSSD associated with patients who require intensive/specialist support.

There is also an underlying underperformance on pay CIPs, and the CCICP vacancy factor is reflected on the infrastucture support line.

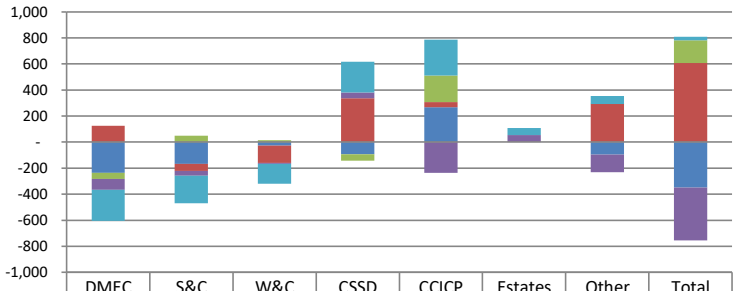
Analysis

Pay Expenditure 2019/20 £'m



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative budget	15.8	31.1	46.4	61.6	76.7	91.9	107.0	122.1	137.3	153.2	169.0	186.6
Cumulative actual	15.7	30.9	46.1	61.5	76.7							
In month budget	15.8	15.3	15.4	15.2	15.1	15.2	15.1	15.1	15.2	15.9	15.8	17.6
in month actual	15.7	15.1	15.3	15.3	15.2							

Pay Variances by Staff Group and Division £'000s



	DMEC	S&C	W&C	CSSD	CCICP	Estates	Other	Total
Total	-240	-210	-151	238	275	54	61	27
Infrastructure Support Staff	-83	-38	-8	43	-237	54	-137	-406
Non Clinical Staff	-46	48	16	-48	205	-	0	175
Medical Staff	125	-54	-132	337	39	-	293	607
Nursing Staff	-237	-166	-27	-93	269	-	-95	-349

Forward View

CCICP plan to make investments into the service, which is likely to result in the current level of underspend not continuing in future months.

There are expected to be some pay pressures in the coming months in relation to the following areas:-

a) Continued opening of unfunded escalation areas. This is being monitored on a weekly basis by the executive team.

b) Continued dependency on premium costs to deliver core activity. Further analysis at a detailed level is being undertaken to fully understand the premium costs associated with delivering core activity, and whether there are alternative options available, which also support the sustainability of the services.

c) Continued premium costs associated with intensive/specialist support for patients.

Premium costs will be challenging to manage within nursing until substantive appointments to vacancies are made.

Performance and Finance - Non-Pay Expenditure August 2019

Current Position

Non Pay is above plan by £781k. For CCICP the overspend of £281k in month is due to the one off capital transfer (£200k) and an increase in accommodation costs (£41k).

Within MCHFT, there is a cumulative £511k adverse variation and an in month improvement of £18k. Adjusting for the £200k CCICP capital transfer is £218k underlying worse than budget performance in month.

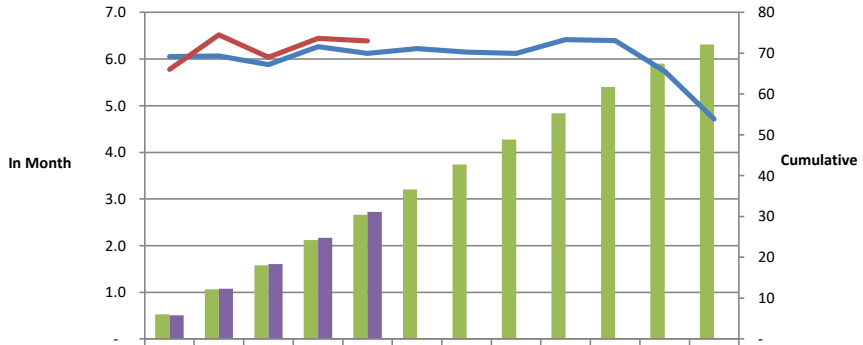
Where medical vacancies are procured as a service from external companies, they are included as other non pay, and offset by medical pay underspends. This affects CSSD (£204k in month, £594k ytd) DMEC (£40k in month, £133k ytd).

In addition to outsourcing costs relating to vacancies, there have been additional outsourcing costs incurred by the Trust in realtion to the soliton service upgrade, and delays in the commencement of the new CT/MRI scanners (£272k ytd).

Whilst drugs are overspent, this is within onology drugs which are offset by charge to other organisations. The in tariff drugs and home care are both below budget - giving the net overperformance of £187k cumulatively.

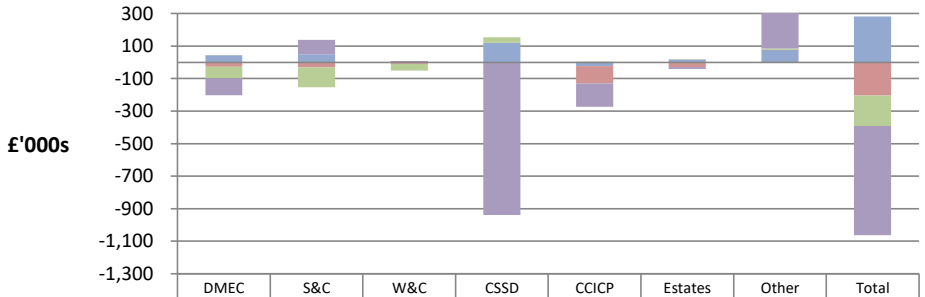
Analysis

Non Pay 2019/20 £'m



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative budget	6.1	12.1	18.0	24.3	30.4	36.6	42.8	48.9	55.3	61.7	67.4	72.1
Cumulative actual	5.8	12.3	18.3	24.8	31.2							
In month budget	6.1	6.1	5.9	6.3	6.1	6.2	6.1	6.1	6.4	6.4	5.7	4.7
In month actual	5.8	6.5	6.0	6.4	6.4							

Non Pay Variance by Division



	DMEC	S&C	W&C	CSSD	CCICP	Estates	Other	Total
Total	-159	-15	-41	-786	-270	-22	512	-781
Other Non Pay	-105	88	9	-937	-144	-11	427	-672
Drugs	-70	-122	-40	33	3	0	8	-188
Non Clinical Supplies	-28	-31	-9	-2	-106	-30	1	-204
Clinical Supplies	43	50	-1	120	-24	19	76	282

Forward View

The growing reliance on external companies to provide services to cover activity at the Trust comes at a premium rate, which year to date the Trust has spent £0.4m more than in 18/19.

The Diagnostics division has outsourced circa £1.8m of work year to-date which has incurred a premium cost of circa £200k.

There is active engagement with the N8 pathology collaborative with UHNM/ECT which should provide a long term clinical and financially sustainable service for pathology.

Radiology has become increasing reliant on external companies with an increase of £500k on the first five months of 18/19 (£1.1m ytd). A detailed review to generate options needs to be considered.

Within the medical specialties, the net impact of increasing medical vacancies being offset by external companies is not going to be financially sustainable going forward and other clinical options need to be considered.

Performance and Finance - Cost Improvement Programme August 2019

Current Position

The CIP programme is behind plan by £0.7m, although this is within the reported postiion to-date.

This relates to the following schemes

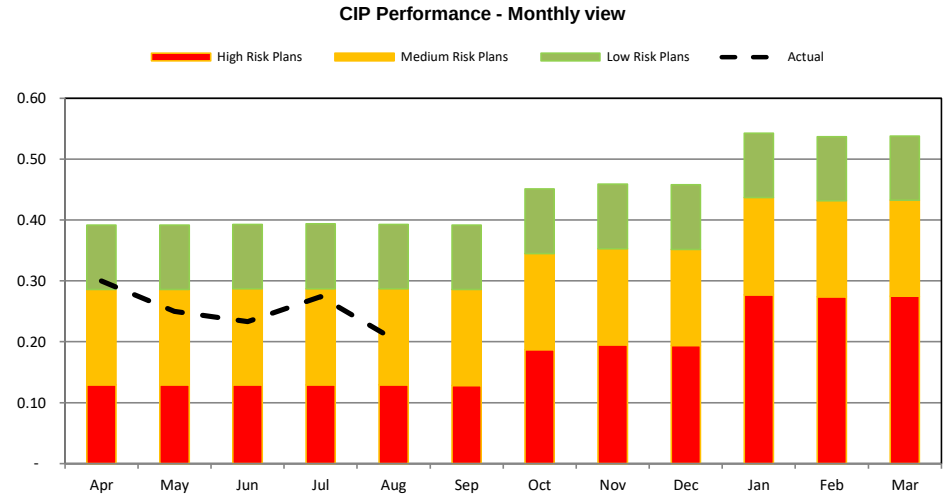
- Nurse savings on sickness/turnover (£103k)
- NHS Supply Chain (£257k)
- Unallocated Capital to Revenue scheme (£125k)
- Unallocated CIP Plans (£80k) in DMEC

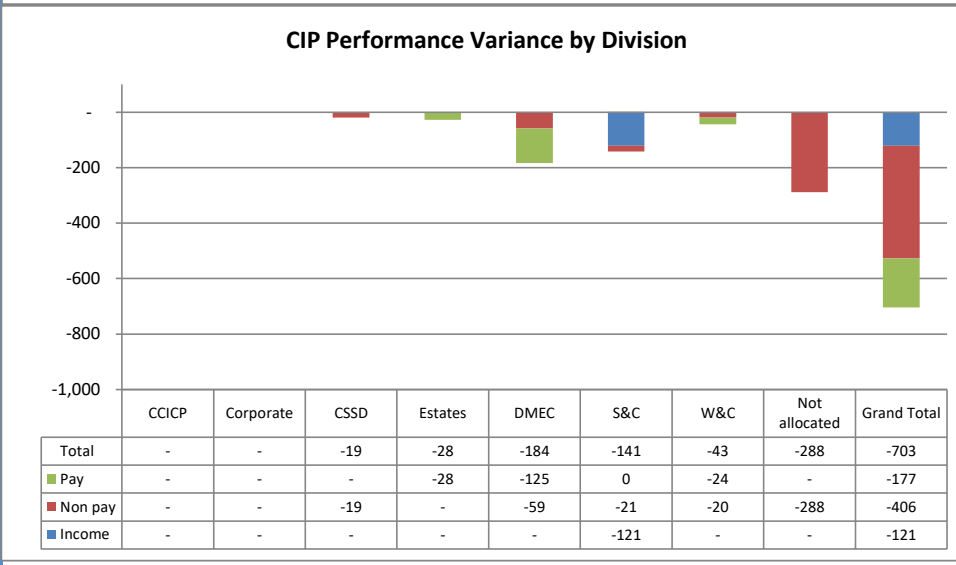
The NHS Supply Chain and Capital to Revenue schemes have not been allocated to Divisions.

Whilst Surgery and Cancer are currently behind, their 2 key schemes have had delays - which are expected to catch up in the third quarter.

The Division of Medicine and Emergency Care have challenges with identifying and delivering their CIP schemes around drugs, nursing savings and the additional CIP allocated to all divisions. This is causing them a pressure in overspend to-date and they have identified or delivered little of their £663k CIP target (with exception of NHS supply chain savings).

Analysis





	CCICP	Corporate	CSSD	Estates	DMEC	S&C	W&C	Not allocated	Grand Total
Total	-	-	-19	-28	-184	-141	-43	-288	-703
Pay	-	-	-	-28	-125	0	-24	-	-177
Non pay	-	-	-19	-	-59	-21	-20	-288	-406
Income	-	-	-	-	-	-121	-	-	-121

Forward View

There is a risk profile to the CIP plan which increases in Q3 (Pay schemes £0.4m).

There is a £0.3m risk associated with the capital to revenue transfer scheme although this is included in the current run rate.

Due to national issues with reporting by NHSI Supply chain it has not been possible to reconcile the anticipated Clinical/Non-Clinical supplies savings against the actual divisional position to ascertain the level of NHSI supply chain savings having been met. However we are currently show a net underspend on these lines and thus the £257k will be overstated.

Performance and Finance - Agency Spend August 2019

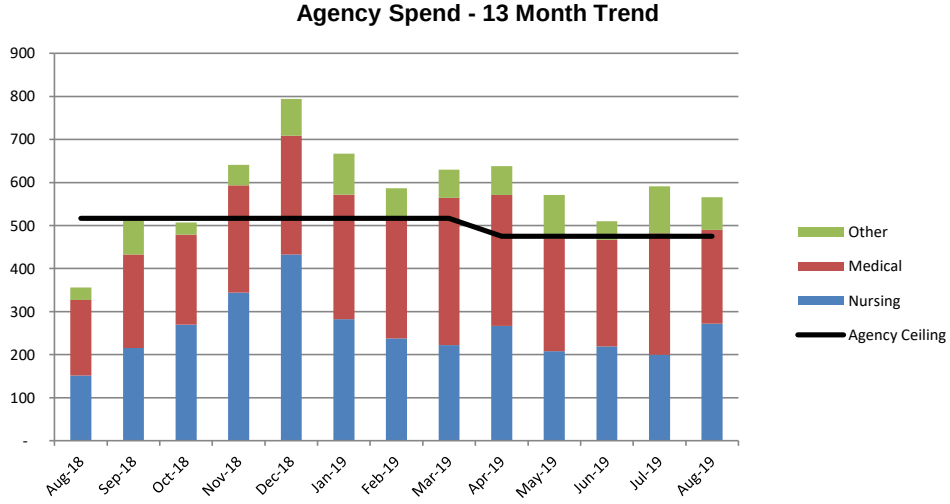
Current Position

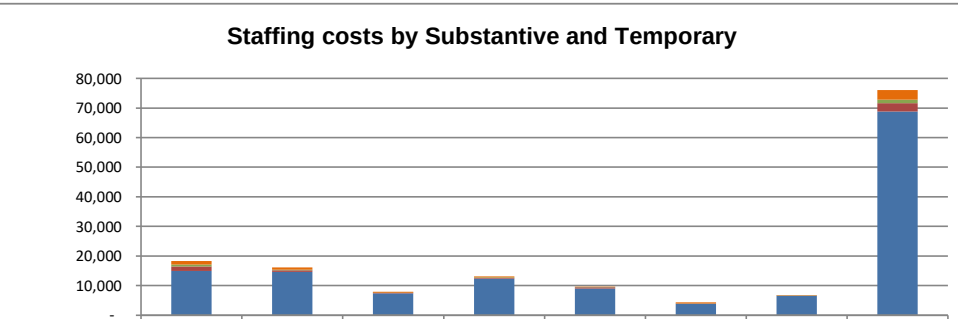
When the element of cost that is associated with non pay is included, the Trust reliance on non-substantive arrangements comes to 12%, with DMEC 22% and CSSD 18%

In Month, Nursing agency costs were £272k which is the highest level this financial year. This has been driven by escalation beds on SACU, and the need to cover vacancies and sickness to deliver core services.

This increase was offset by Medical agency costs that reduced to £218k which are the lowest this financial year and Other agency costs that totalled £76k in August which is £32k lower than July.

Analysis





	DMEC	S&C	W&C	CSSD	CCICP	Estates	Other	Total
Total	18,538	16,358	7,867	13,240	9,695	4,331	6,632	76,662
Waiting Lists	223	256	1	167	-	-	-	647
Bank	1,218	675	273	333	184	384	110	3,177
Locum	594	277	7	199	95	-	13	1,185
Agency	1,555	532	191	224	366	-	9	2,876
Substantive	14,948	14,619	7,396	12,317	9,050	3,947	6,500	68,777

Forward View

Agency Spend as a run rate is projected to exceed the contract ceiling of £5.7m, which is a lower level than the £6.2m 2018/19 level.

The Trust has developed some metrics to examine spend against budget in relation to registered and unregistered nursing, incorporating sickness/turnover and bank/agency shift data by reason code which are being used by the COO/DoN and DoF with the divisions.

Medical staff above cap and use of Thornbury agency use are reviewed by execs weekly.

Performance and Finance - Divisional Performance August 2019

Current Position

DMEC is the most challenged division being £0.45m overspent against plan to-date, with challenges in relation to achieving the activity targets set within the plan and pay pressure, in part due to non delivery of their CIP schemes.

Surgery has seen a £85k deteriration in month pre-dominently as a result of escalation beds.

Women's and Children's has seen an improvement in month in Maternity activity, however this has been partially offset by increased pay costs in Paediatrics through agency and high dependency patients.

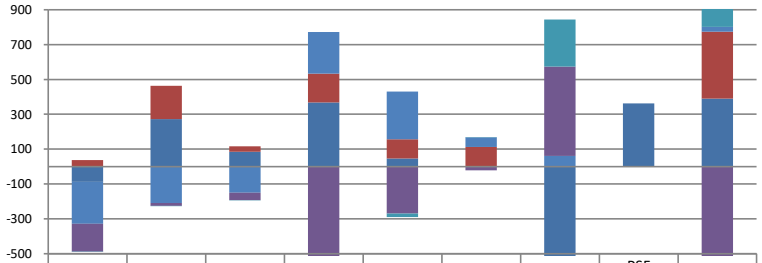
Clinical Support Services and Diagnostics has worsened in month by £99k.

CCICP continues currently to be better than budget, principally around pay.

Estates are better than plan as a result of an increase in the income received from car parking income and catering.

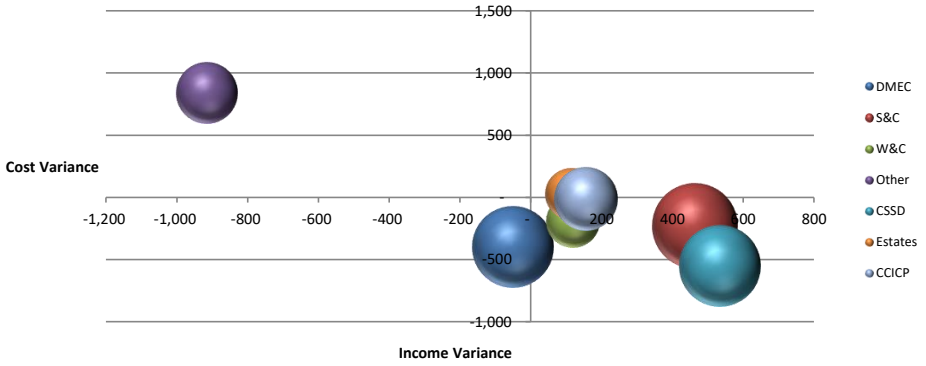
Analysis

Cumulative Variance by category



	DMEC	S&C	W&C	CSSD	CCICP	Estates	Other	PSF 1819	Total
Total	-451	237	-76	-14	141	145	-73	362	270
Other Costs	-0	-0	-0	-0	-20	0	271	-	251
Non Pay	-159	-15	-41	-786	-270	-22	512	-	-781
Pay	-240	-210	-151	238	275	54	61	-	27
Other Income	37	191	32	165	109	113	-263	-	384
Commissioning Income	-89	272	84	368	46	-	-654	362	390

Divisional Performance 2019/20



The bubble chart shows the financial performance of each division, in terms of income and cost variance – with the size of the bubble reflecting the overall budget
- Top right represents a positive performance that is better than plan for both costs and income
- The bottom left represents a performance that is worse than plan for both income and costs

Forward View

The Trust is currently expecting to meet the plan, however there are some emerging financial risks that are not within the plan:-

- Additional Escalation costs over and above the plans.

- Premium costs being required to deliver core services, materialising in non pay.

- Challenges for some Trust wide and individual Divisions CIP programmes, specifically around pay and supplies.

- Greater unscheduled care demand being experienced in the system than was originally planned for when setting the financial plan.

- Increasing GP referrals from host contracts (block contract), contrasting with a reduction from associate contracts (PbR contract).

- Financial risk within the wider Cheshire system which requires a Cheshire system financial recovery plan involving all NHS organisations.

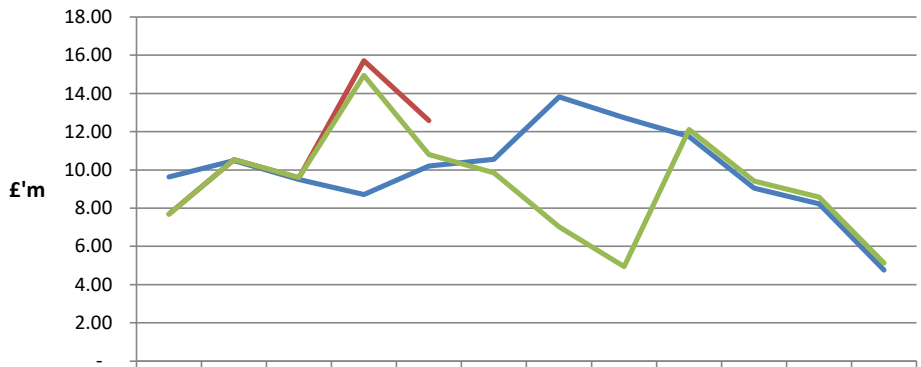
Performance and Finance - Cash August 2019

Current Position

Cash Position
Cash is better than plan by £2.4m.
This is mainly due to lower finance lease payments due to delays in the CT Scanner and a delay in the purchase of South Cheshire Private Hospital.

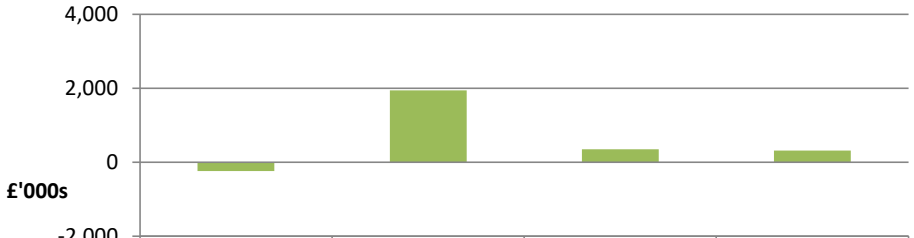
Analysis

Cash Position



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Plan	9.64	10.49	9.50	8.72	10.21	10.55	13.81	12.73	11.75	9.05	8.22	4.76
Actual	7.68	10.54	9.58	15.72	12.58							
Forecast	7.68	10.54	9.60	14.94	10.80	9.85	7.01	4.95	12.11	9.41	8.58	5.12

Cash Flow Movements



	Operating Surplus / (Deficit)	Increase / (Decrease) in Working Capital	Net Cash Inflow / (Outflow) from Capital Expenditure	Net Cash Inflow / (Outflow) from Borrowings
Variance	-240	1,939	355	321

Forward View

Cash is forecasted to be above target at the year end due to the £0.4m extra 2018/19 PSF. However there is a risk due to the capital loan of £4.2m still to be approved by DOH

Performance and Finance - Capital Expenditure August 2019

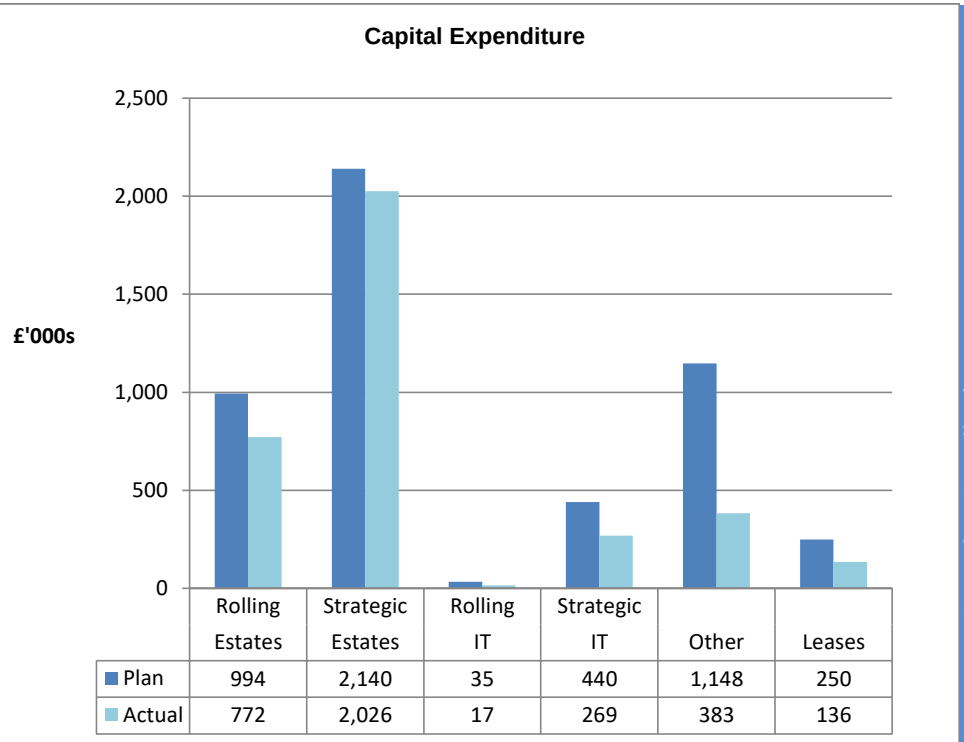
Current Position

The capital programme is £1.4m less than anticipated which is mainly due to:

(£1.1m) Purchase and updating of South Cheshire Private Hospital
(£0.3m) Third CT Enabling
(£0.1m) Backlog Maintenance
(£0.1m) High Impact Stand Alone IT Systems
(£0.1m) EPR Project
(£0.1m) Equipment Leases
£0.5m Third MRI Scanner build

The underspend is mainly due to a delay in the purchase of South Cheshire Private Hospital, which was originally expected to complete in July 2019. The main overspend is the Third MRI Scanner where the spend profile in the NHSI return has the scheme completing in December 2019. Whereas the Third MRI Scanner has completed in July 2019.

Analysis



		Year to Date £'000s			Year End £'000s		
		Plan	Actual	Variance	Plan	Forecast	Variance
Estates	Rolling	994	772	-222	2,490	2,490	0
Estates	Strategic	2,140	2,026	-114	6,551	6,031	-520
IT	Rolling	35	17	-18	90	90	0
IT	Strategic	440	269	-171	3,968	3,894	-74
Other		1,148	383	-765	1,742	2,007	265
Leases		250	136	-114	347	347	0
		5,007	**3,603**	**-1,404**	**15,188**	**14,859**	**-329**

Forward View

The Trust is forecasting an underspend of £0.3m to plan due to slippage in the schemes for EPR Project Accomodation of £0.3m and ICU Conversion of £0.2m.

The Trust had been asked by DOH to reduce it's capital programme by £3.0m. Although this request has now been retracted by the DOH, the forecast has still been reduced by £3m in anticipation of an underspend against capital.

Performance and Finance - Statement of Financial Position August 2019

Current Position | Analysis | Forward View

Assets Non-Current
The capital programme expenditure is £1.4m less than anticipated mainly due to a delay in the purchase of South Cheshire Private Hospital. In addition to this, there has been a delay in Finance Lease purchases.

Assets Current
NHS Receivables is £2.6m higher than plan. This is mainly due to outstanding debts with Christies £1.3m, £0.5m from East Cheshire Council and Chester and West Cheshire Council. In addition, prepayments for operating leases are higher than anticipated due to a switch from finance lease to operating leases.

Current Liabilities
These are higher than anticipated as the two main CCG's contract payments are £2.6m more than the plan. In addition, accruals are £1.1m higher than plan.

Non-Current Liabilities
This is due to the CT Scanner & MRI Scanner in the plan was assumed to be a finance lease and has now been assessed as an operating lease. Also there are some delays in finance leases.

	Plan Apr to August (£'000)	Actual Apr to August (£'000)	Variance (£'000)	Forecast 2019/20 (£'000)
Assets				
Assets, Non-Current	97,457	94,376	-3,081	101,849
Assets, Current	23,500	28,828	5,328	20,112
ASSETS, TOTAL	**120,957**	**123,204**	**2,247**	**121,961**
Liabilities				
Liabilities, Current	-28,580	-32,561	-3,980	-24,508
Liabilities, Non Current	-14,813	-12,899	1,914	-20,058
TOTAL ASSETS EMPLOYED	**77,564**	**77,744**	**180**	**77,395**
Taxpayers' and Others' Equity				
Taxpayers Equity	77,564	77,744	180	77,395
TOTAL FUNDS EMPLOYED	**77,564**	**77,744**	**180**	**77,395**

The Statement of Financial position is forecast mainly on plan.

The Trust had been asked by DOH to reduce it's capital programme by £3.0m. Although this request has now been retracted by the DOH, the forecast has still been reduced by £3m in anticipation of an underspend against capital. This has reduced the value of the Asset, Non-Current forecast.

In addition Asset, Current has improve by £0.4m due to the extra 2018/19 PSF. However there is a risk on the current assets due to the capital loan of £4.2m still to be approved by DOH.

Title of Paper :	Emergency Preparedness, Resilience and Response (EPRR) annual assurance process for 2019/20	
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:	Mid Cheshire NHS Foundation Trust has a statutory requirement to formally assure both itself and NHS England that it has policies, plans, arrangements and trained staff to have emergency preparedness, resilience and response readiness. 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:	**7 October 2019**

Cheshire & Merseyside Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) assurance 2019-2020

STATEMENT OF COMPLIANCE v2

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

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.

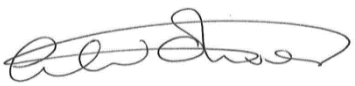
Compliance Level	Evaluation and Testing Conclusion
Full	Arrangements are in place and the organisation is fully compliant with all core standards that the organisation is expected to achieve. The Board has agreed with this position statement.
Substantial	Arrangements are in place however the organisation 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**
65	0	4	61
Acute providers: **65** Specialist providers: **55** Community providers: **54** Mental health providers:**54** CCGs: **43**			

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.



Chris Oliver, Chief Operating Officer and the
organisation's Accountable Emergency Officer

07/10/2019
Date of board / governing body meeting

24/09/2019
Date signed

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	13	1	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	4	0	0
Business Continuity	9	9	0	0
CBRN	14	11	3	0
Total	64	60	4	0

Deep Dive	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Severe Weather response	15	14	1	0
Long Term adaptation planning	5	2	3	0
Ambulance Resilience	0	0	0	0
Total	20	16	4	0

Publishing Approval Reference: 000719

Overall assessment:	Substantially compliant

Instructions:
Step 1: Select the type of organisation from the drop-down at the top of this page
Step 2: Complete the Self-Assessment RAG in the 'EPRR Core Standards' tab
Step 3: Complete the Self-Assessment RAG in the 'Deep dive' tab
Step 4: Ambulance providers only: Complete the Self-Assessment in the 'Interoperable capabilities' tab
Step 5: Click the 'Produce Action Plan' button below

Overall assessment:										
Ref	Domain	Standard	Detail	Evidence - examples listed below	Organisation Evidence	Self assessment RAG **Red (not compliant)** = Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. **Amber (partially compliant)** = Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. **Green (fully compliant)** = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
15	Duty to maintain plan	Pandemic influenza	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to pandemic influenza.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The Trust's Pandemic Plan was reviewed in February 2017 and a review has been scheduled for November 2019.	Partially compliant	The Trust's Pandemic Plan was reviewed in February 2017 and a review has been scheduled for December 2019.	Site Ops & Emergency Preparedness Manager	Nov-19	
59	CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week.	Rotas of appropriately trained staff availability 24 /7	A programme of review between ED and the Site Ops & Emergency Preparedness Manager is underway including a recruitment campaign and training dates to be arranged for 2019 and into 2020. NHS E EPRR team are supporting where appropriate.	Partially compliant	There is currently a small number of staff trained on PRPR and HazMat / CBRN. The trust has commenced a recuitment process and are looking at arranging regular training events. NHS England and NHS Improvement have offerred to support the training.	Site Ops & Emergency Preparedness Manager	Mar-20	
66	CBRN	Training programme	Internal training is based upon current good practice and uses material that has been supplied as appropriate. Training programmes should include training for PPE and decontamination.	Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • A range of staff roles are trained in decontamination techniques • Lead identified for training • Established system for refresher training	The Trust has started a training programme for staff including recruiting additional persons to train. ED are currently looking to set up training dates for 2019 and into 2020.	Partially compliant	The Trust has started a training programme for staff including recruiting additional persons to train. ED are currently looking to set up training dates for 2019 and into 2020.	Site Ops & Emergency Preparedness Manager	Mar-20	
67	CBRN	HAZMAT / CBRN trained trainers	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.	Maintenance of CPD records	Training records in place with details of who has been trained in 2018 and 2019.	Partially compliant	There is currently a small number of staff trained on PRPR and HazMat / CBRN. The trust has commenced a recuitment process and are looking at arranging regular training events. NHS England and NHS Improvement have offerred to support the training.	ED Consultant	Dec-19	
2	Severe Weather response	Overheating	The organisation has contingency arrangements in place to reduce temperatures (for example MOUs or SLAs for cooling units) and provide welfare support to inpatients and staff in high risk areas (For community and MH inpatient area may include patients own home, or nursing/care home facility)	Arrangements are in place to ensure that areas that have been identified as overheating can be cooled to within reasonable temperature ranges, this may include use of cooling units or other methods identified in national heatwave plan.	Discussions have taken place at Estates and Facilities senior team meeting with reference to temporary cooling units being hired for summer months.	Partially compliant	Matter to be discussed at EPG meeting for potential further action.	Amanda Cartmill, Facilities Manager	Oct-19	
16	Long term adaptation planning	Risk assess	Are all relevant organisations risks highlighted in the Climate Change Risk Assessment are incorporated into the organisations risk register.	Evidence that the there is an entry in the organiations risk register detailing climate change risk and any mitigating actions	Matter to be discussed at the EPG and Sustainability Meetings in October.	Partially compliant	Matter to be discussed at the EPG and Sustainability Meetings in October.	Site Ops & Emergency Preparedness Manager	Dec-19	
17	Long term adaptation planning	Overheating risk	The organisation has identified and recorded those parts of their buildings that regularly overheat (exceed 27 degrees Celsius) on their risk register. The register identifies the long term mitigation required to address this taking into account the sustainable development commitments in the long term plan. Such as avoiding mechanical cooling and use of cooling higherachy.	The organisation has records that identifies areas exceeding 27 degrees and risk register entries for these areas with action to reduce risk	All climate change risks are monitored by the MCHFT Sustainability Group which meets bi-annually and relevant risks are reviewed. Estates are aware of certain areas across the Trust which are liable to overheat. Thermometers arein plac ein some areas and will be placed in all key areas. A temperature monitoring process to be commenced by Estates.	Partially compliant	Matter to be discussed at the EPG and Sustainability Meetings in October. Additionally, a review group consisting of Estates, Service level reps and Emergency Planning to be set up to meetin March 2020.	Rob Few, Head of Estates	Mar-20	
18	Long term adaptation planning	Building adaptations	The organisation has in place an adaptation plan which includes necessary modifications to buildings and infrastructure to maintain normal business during extreme temperatures or other extreme weather events.	The organisation has an adaptation plan that includes suggested building modifications or infrastructure changes in future	All climate change risks are monitored by the MCHFT Sustainability Group which meets bi-annually and relevant risks are reviewed.	Partially compliant	Matter to be discussed at the EPG and Sustainability Meetings in October. This is also part of the Estates Strategy to review.	Rob Few, Head of Estates	Dec-19	

Title of Paper:	Workforce Race Equality Standard (WRES)	
Author:	Natalie Wallace, HR Manager	
Executive Lead:	Heather Barnett, Director of Workforce and OD	
Type of Report:	Concept Paper	
	Strategic Options Paper	
	Business Case	
	Information	
	Review/Benefits/Audit	x

Link to Strategic Domains:		***Link to Domain:***	
Delivering Outstanding Clinical Quality, Safety & Experience	x	Safe	
Being a Leading partner in a Progressive Health Economy		Effective	
Striving for Outstanding Organisational Effectiveness	x	Caring	x
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	x
	Accountability	x
	Strategy	x
	Implementation	
Action Required:	Decide	
	Approve	x
	Note	
	Recommend	
	Delegate	

Positive Benefit:	The report allows us to compare the experiences of Black and Minority Ethnic (BAME) and white staff and enables us to develop local action plans and demonstrate progress against the indicators of race equality.
Risk:	National evidence shows that BAME staff have a poorer experience in a number of areas when attending work compared to white staff which could led to poor morale, increased absence, an impact on patient care and an increased risk in discrimination claims.

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:	**7 October 2019**

Mid Cheshire Hospitals
NHS Foundation Trust

Workforce Race Equality Standard (WRES) 2018/2019

Summary:

The Workforce Race Equality Standard (WRES) is a set of nine specific measures (metrics) that enable NHS organisations to compare the experiences of white and black and minority (BAME) staff. This information will then be used to develop local action plans, and enable the Trust to demonstrate progress against the indicators of race equality.

The main purpose of the WRES is:

- to help local, and national, NHS organisations (and other organisations providing NHS services) to review their data against the nine WRES indicators,
- to produce action plans to close the gaps in workplace experience between white and Black and Ethnic Minority (BAME) staff, and,
- to improve BAME representation at the Board level of the organisation.

The WRES Metrics

The 9 Metrics are confirmed as follows:

Metric Number	Data source	Metrics
1	ESR data	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 disaggregated by: • Non-Clinical staff • Clinical staff - of which - Non-Medical staff - Medical and Dental staff
2	NHS Jobs data	Relative likelihood of staff being appointed from shortlisting across all posts
3	HR database	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation (based on data from a two year rolling average)
4	Local training data	Relative likelihood of staff accessing non-mandatory training and CPD
5	Staff survey	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
6	Staff	Percentage of staff experiencing harassment, bullying or abuse from

	survey	staff in last 12 months
7	Staff survey	Percentage believing that trust provides equal opportunities for career progression or promotion
8	Staff survey	In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues
9	ESR	Percentage difference between the organisations' Board membership and its overall workforce disaggregated: • By voting membership of the Board • By executive membership of the Board

WRES Findings against the metrics

Metric 1- Percentage of staff in each of the AfC Bands 1-9 or Medical and Dental subgroups and VSM

The largest proportion of the non- clinical workforce for white staff are in Band 2 and Band 3 posts which is a trend seen in previous years.

The largest proportion of BAME non-clinical staff are in Band 2 posts with the same number in these Band 2 posts as across all other banded posts combined.

For clinical staff, the largest proportion of staff are in Bands 2 and 5 across all ethnicities.

BAME staff at Band 7 or above make us less than 1% of the overall workforce (those on Agenda for Change terms and conditions) however account for approximately a third of all medical staff.

Metric 2 - Relative likelihood of staff being appointed from shortlisting across all posts

The findings show that white staff are 1.32 times more likely to be appointed from shortlisting compared to BME staff. This is an improvement on the previous year where white staff were 1.46 times more likely to be appointed.

21.5% of all applications for posts during the 2018/19 period were from BAME applicants. BME applicants who were short listed accounted for 11.90% of the total for the period 2018/19.

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 & Inclusion Group.

Metric 3 - Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation

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

Based on a 2 year period April 2017- March 2019 BME staff were 1.01 times more likely than white staff to enter the formal disciplinary process. This metric has seen year on year improvements decreasing from 1.70 in 2017 and 1.65 in 2018.

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

Work is also underway to review the overall disciplinary process in response to the letter dated May 2019 from Baroness Harding in relation to 'learning lessons to improve our people practices'. This work and associated action plan will be monitored and reviewed by the Executive Workforce Assurance Group.

Metric 4 - Relative likelihood of staff accessing non-mandatory training and CPD

It is noted that each staff member may have attended more than one training session and have several training sessions attributed to them however the figures have been calculated to ensure that only one period of training/CPD is taken into account.

White staff are 0.86 times more likely to access non-mandatory training than their BME counterparts. This is a slightly worsening position when compared to 2017/18 when white staff were 0.44 times more likely to access non-mandatory training.

The Trust will continue to monitor attendance at training and CPD events to ensure that such courses and opportunities for learning are accessible to all.

Metric 5 - Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

White staff report a poorer experience for this metric when compared to BAME staff with 25.70% of staff reporting that they have experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months, compared to 17.90% of BAME staff.

This metric has seen a significant improvement for BAME staff compared to the previous year whereby 33.33% of BAME staff reported harassment, bullying or abuse; however this has increased slightly this year for white staff (24.39% in the previous reporting period).

The Trust will continue to review all incidents relating to harassment, bullying or abuse from patients in line with the zero tolerance guidance.

Metric 6 - Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

This metric has remained fairly static when comparing the current and previous years findings. 20.20% of white staff reported that they experienced harassment, bullying or abuse from staff compared to 32.26% of BAME staff. The previous year's results were 21.19% (white) and 32.10% (BAME).

The Trust have recently approved a standalone bullying and harassment policy for which a series of refreshed communication and training sessions in relation to expected behaviours of staff will be circulated.

Metric 7 - Percentage believing that the trust provides equal opportunities for career progression or promotion

BAME staff report a poorer experience for this metric with 86.40% believing equal opportunities are provided compared to 91.20% of white staff. This is a slight improvement on the previous year for BAME staff (84.21%) however a slightly worsening position for white staff (92.87%)

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

Metric 8 - In the last 12 months have you personally experienced discrimination at work from any of the following?
b) Manager/team leader or other colleagues

Significant improvements have been seen for this metric since the previous year although it is recognised that further work is required in this area, with 10.30% of BAME staff experiencing discrimination compared to 20.00% in the previous year. This is compared to 4.90% for white staff compared to 6.75% in the previous year.

Metric 9 - Percentage difference between the organisations' Board membership and its overall workforce disaggregated

There has been no change to this indicator since the previous years with the Board voting profile 100% white.

Conclusion

An improvement has been seen in the WRES results for 2018/19 particularly in respect of BAME staff being appointed from shortlisting, the likelihood of being subjected to formal disciplinary action or discrimination and experiencing harassment, bullying or abuse from patients/service users. Whilst it is positive that improvements are being seen, the findings still evidence that even in these areas BAME Staff still experience a poorer experience at work in some areas than white staff.

An action plan will be drafted to address the concerns identified which will be regularly monitored and reviewed by the Equality, Diversity and Inclusion Group.

Natalie Wallace
HR Manager
July 2019

Mid Cheshire Hospitals
NHS Foundation Trust

Equality, Diversity & Inclusion Action Plan
Workforce Race Equality July 2019

The Trust is committed to:

- Creating an environment in which people can feel valued; treating people fairly and with dignity and respect
- Embedding Trust values and behaviours that highlight treating others as we would wish to be treated ourselves

The Trust aims to ensure that principles of equality, diversity and inclusion are embedded throughout every part of the organisation and improve its status as an organisation that leads the promotion of equality, diversity and inclusion, challenges discrimination wherever it happens, and promotes equality in service delivery and employment.

To achieve our aims the Trust is committed to:

- Promoting equality of opportunity for all
- Promoting an inclusive environment in which all persons are treated with respect
- Fulfilling all of our legal obligations under the equality legislation
- Regarding all breaches of equal opportunities as misconduct which could lead to disciplinary proceedings
-

This document outlines the identified risks/key focus areas from the 2019 Workforce Race Equality Standard (WRES) and the areas where further action is required.

The actions will be included on the overall Equality, Diversity and Inclusion action plan which records the outcomes of several equality schemes. The action plan reports on the progress against actions and is monitored by the Equality, Diversity and Inclusion Group which review on a quarterly basis, escalating any issues to the Transformation and People Committee.

Item	Evidence	Action(s)	Lead responsibility	Timescale for delivery	Updates/Progress
Lack of BAME representation across all levels	**WRES Indicator 1** **WRES Indicator 9** BAME staff at Band 7 or above make us less than 1% of the overall workforce	Encourage participation of BAME staff in leadership development programmes e.g. Stepping Up, Ready Now programmes	HR Manager – Employment Relations and E&D Learning & Development department	June 2020	
		Explore establishing a BAME staff network/other staff networks	HR Manager – Employment Relations and E&D	March 2020	Survey Monkey undertaken to collate staff views and results analysed. Staff networks focus groups on-going throughout March – June 2019.
	Board voting profile white 100% BAME 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 External Agencies	Where identified vacancies	

Lack of BAME staff being appointed from shortlisting	**WRES Indicator 2 ED&I objective - To encourage the recruitment conversion and progression rates of BAME staff.** White staff are 1.32 times more likely to be appointed from shortlisting compared to BAME staff	Make better use of technology and social media to reach and attract potential candidates to encourage applicants from underrepresented groups to apply. Make links with local community groups Monitoring of detailed analysis of ethnicity patterns in recruitment Review applications to determine reasons why BAME candidates were not appointed following interview	Recruitment Manager HR Manager - Employment Relations and E&D Recruitment Manager Recruitment Manager	March 2020 October 2019 March 2020	Due to ED&I group in September 2019
BAME staff more likely to be subjected to formal procedures under the disciplinary process	**WRES Indicator 3** BME staff are 1.01 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 in relation to race. 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 2020 On-going	

BAME staff, experiencing harassment, bullying or abuse from staff in last 12 months	**WRES Indicator 5** 32.26% of BAME staff experienced harassment, bullying or abuse from staff in last 12 months	Promotion of expected behaviours of staff		March 2020	Stand-alone policy produced and ratified. Promotion to commence in September 2019.
High number of staff, in particular BAME staff, experiencing discrimination at work from the following - Manager/team leader or other colleagues	**WRES Indicator 8** 10.30% of BAME staff experiencing discrimination	Undertake a communication campaign to staff regarding discrimination and unacceptable behaviours. Message to be reinforced via E&D training and promotion of new B&H policy. Ensure reported cases of discrimination are dealt with in an effective and timely manner	HR Manager - Employment Relations and E&D Deputy HR Manager Human Resources Department	March 2020 On-going via E&D training	To be included in the promotion of the new B&H policy. Policy launch event taking place in September 2019.

Title of Paper:	EU Exit Planning	
Author:	Neil Furness, Site Operations and Emergency Preparedness Manager and Emma McGuigan Director of Operations	
Executive Lead:	Heather Barnett	
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	x	Safe	x
Being a Leading partner in a Progressive Health Economy		Effective	
Striving for Outstanding Organisational Effectiveness	x	Caring	
Aspiring to Excellence in Practice Through Our Workforce		Responsive	x
Creating a 21st Century Infrastructure for Transformative Health and Social Care		Well-Led	x

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

Positive Benefit:	To ensure the Trust is prepared for EU Exit on October 31 2019.
Risk:	None

To be published on Trust Website –complete version	**Y**
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:	**7 October 2019**

Title	EU Exit and Mid Cheshire Hospitals NHS Foundation Trust's Planning
Authors	Neil Furness, Site Ops & Emergency Preparedness Manager Emma McGuigan, Director of Operations
Date	17th September 2019

1. Introduction

This paper summarises the actions taken so far in relation to the planning that has been undertaken by Mid Cheshire Hospitals NHS Foundation Trust (MCHFT) for the UK leaving the European Union (EU) in 2019. An initial paper was presented in January and April 2019 to the Performance and Finance Committee, this is a further update for the Committee.

Background

The UK was on course to leave the EU on 29th March 2019. Further extensions of 14th April or 22nd May were subsequently agreed and with a current position announced on 12th April of a formal extension of the Article 50 period being agreed until 31st October 2019. As we approach this deadline without a formal deal in place for the EU exit, NHS organisations have been asked to reinstate their EU exit preparedness.

Briefings

An EU Exit briefing was delivered to the Executive on 25th March.
Briefings held by NHS England in Manchester and Liverpool in September 2019

Situation Reporting

An assurance template requested by NHS England was completed and returned by 18th September 2019 to provide overview and assurance regarding the organisation's EU exit plans. NHS England has confirmed that daily sit rep reporting will re-commence in October 2019 and will be extended to cover a 7 day reporting period.

EU Exit Working Group

The MCHFT EU Working Group, chaired by Heather Barnett, Director of Workforce has been reinstated from August 2019 and will continue to meet. NHS organisations have been asked to ensure Adult Social Care colleagues are include in the EU exit preparations, this has been enacted by MCHFT.

2. Conclusion

MCHFT have reinstated the EU exit working group to oversee preparedness and will coordinate the sit rep and assurance responses as required.

3. Recommendation:

The Group is asked to note the reinstatement of the EU Exit Working Group and the content of this paper.

Title of Paper:	The Cheshire East and Cheshire West Place Partnerships' Five Year Plans	
Author:	**Guy Kilminster** Corporate Manager (Cheshire East) **Professor Helen Bromley** Consultant in Public Health (Cheshire West and Chester)	
Executive Lead:	Denise Frodsham, Director of Strategic Partnerships Chief Executive	
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:	Successful implementation of this Plan will enable residents of Cheshire East and Cheshire West and Chester to take a more proactive role in their health care, receive care closer to home, attend hospitals less often, and live well for longer. If the transformation occurs as intended, a financially and clinically sustainable system will be established.
Risk:	The financial pressures upon the system may worsen, undermining the Plan's implementation.

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:	**7 October 2019**

1. Introduction

The purpose of this report is to seek the Mid Cheshire Hospitals NHS Foundation Trust's Board of Directors endorsement of the Cheshire East Place Partnership Five Year Plan and the Cheshire West Place Partnership Five Year Plan.

The creation of a Five Year Plan was a requirement upon each 'place' within the Cheshire and Merseyside Health and Care Partnership. The Place Five Year Plans for Cheshire East and Cheshire West are required to be endorsed by all partner governing bodies prior to submission to the Cheshire and Merseyside Health and Care Partnership.

The Five Year Plans set out the visions and aspirations of the two Partnerships, to transform the health and care systems across their respective local authority areas. If delivered, the residents of Cheshire will benefit from a focus on prevention and early intervention, helping them live well for longer, and see improved services, closer to home, that are both clinically and financially sustainable. There will be a greater emphasis upon community based care, through the Care Communities, with an emphasis on encouraging residents to seek hospital based care and treatment only when necessary.

The Plans and associated appendices are attached:

Cheshire East Place Partnership Five Year Plan
Cheshire East Place Partnership Five Year Plan Technical Appendix (e-copy only)
Cheshire East Five Year Plan Summary of Engagement Feedback (e-copy only)

Cheshire West Place Partnership Five Year Plan
Cheshire West Place Partnership Five Year Plan Technical Appendix (e-copy only)
Cheshire West Five Year Plan Summary of Engagement Feedback (e-copy only)

1. The Cheshire East and Cheshire West Place Partnerships' Five Year Plans

The Cheshire East and Cheshire West Place Partnerships' Five Year Plans are high level statements of intent, setting out the vision and aspirations of the Partnerships, to transform the health and care system across their respective local authority areas. The Plans will feed into the Cheshire and Merseyside Health and Care Partnership Five Year Strategy – which will help to determine whether or not the Partnership achieves Integrated Care System status.

Although there are separate Plans for each borough, they have been developed alongside each other and aligned wherever possible. Cheshire West's Plan will also replace the Health and Wellbeing Strategy for Cheshire West and Chester, with the current version due to expire in 2020.

The Plans aim to improve the health and wellbeing of local communities, enabling people to live longer and healthier lives. This will be achieved by creating and delivering safe, integrated and sustainable services that meet people's needs, making best use of all the assets and resources we have available to us.

As Mid Cheshire Hospitals NHS Foundation Trust is a key partner of both Partnerships, the Five Year Plans are presented to the Board of Directors for endorsement. The Plans are being taken to the governing bodies of all partner organisations prior to their submission to the Cheshire and Merseyside Health and Care Partnership.

2. Recommendation:

The Board of Directors of the Mid Cheshire Hospitals NHS Foundation Trust is asked to endorse the Cheshire East and Cheshire West Place Partnerships' Five Year Plans.

3. Reason for recommendation:

To ensure that the Cheshire East and Cheshire West Place Partnerships' Five Year Plans can be submitted to the Cheshire and Merseyside Health and Care Partnership as required, on time and with the endorsement of all partner organisations.

4. Population affected

The Five Year Plans cover the whole population, with emphasis on those that are more at risk or vulnerable.

5. Context

The Sustainability and Transformation Partnerships were formed in 2015/16 as a result of the NHS England 'Five Year Plan's' aspirations to see closer working across health and care and progress being made towards integrated provision. There was also an imperative to make more effective use of resources across the system. The Cheshire and Merseyside STP was formed in January 2016, a partnership of the twelve clinical commissioning groups, twenty NHS provider organisations (hospitals, community and mental health trusts) and the nine local authorities. The STP was re-branded as the Cheshire & Merseyside Health & Care Partnership in 2017.

The publication of the NHS Long Term Plan in January 2019 has re-emphasised the importance of these partnerships in the NHS future plans, with the transition to Integrated Care Systems (ICS) being the aspiration for each regional partnership by 2021. Achieving ICS status will bring additional resources and a level of autonomy for the Partnership in its decision making. The Five Year Strategy will be a key element of this, demonstrating that the C&MH&CP has the maturity and ambition to deliver what NHS England expects from the ICS. Similarly, the place-based Five Year Plans need to show that there is a common vision for the provision of health and care services within that area, with a good understanding of the local challenges and a commitment from local partners to work together and deliver transformed health and care.

The Cheshire and Merseyside Health and Care Partnership (and its equivalents elsewhere in the country) and local place-based health and care partnerships, are seen by NHS England as a pragmatic way to unify planning and service delivery across primary and specialist care, physical and mental health and health and social care.

6. Finance

The Cheshire and Merseyside health and care system is financially challenged and within both the Cheshire West and Cheshire East Places there are significant financial pressures. Over the next five years addressing these and ensuring the financial sustainability of the system is a priority.

7. Consultation and Engagement

Both the Cheshire East and Cheshire West Five Year Plans have been out to a period of public engagement during July and August. Some changes have already been made in response to this feedback and as implementation plans are developed, they will be further informed by the responses (and by future engagement and conversation that takes place). If any service changes are proposed, then these will be subject to the usual formal consultation requirements.

8. Access to further information

For further information relating to this report contact:

Name	Guy Kilminster
Title	Corporate Manager Health Improvement (Cheshire East Council)
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Name	Professor Helen Bromley
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#BecauseWeCare
Cheshire East Partnership

Cheshire East Partnership

Five Year Plan

2019-2024

NHS

Cheshire East Council


"Our vision is to enable people to live well for longer; to live independently and to enjoy the place where they live."

Contents

01 Foreword

The vision of our five-year plan is to improve the health and wellbeing of local communities, enabling people to live longer and healthier lives. We will do this by creating and delivering safe, integrated and sustainable services that meet people's needs by the best use of all the assets and resources we have available to us. Wellbeing comes from everyone taking ownership of what they can do for themselves and their community, with support available and focussed when and where it's needed.

The Cheshire East Partnership is an alliance of partners working together to improve the health and wellbeing of the residents of the Cheshire East local authority area. The Five Year Plan sets out what we want to do, why we want to do it and the difference we believe we can make to the health and wellbeing of local residents.

We want this document to start a community wide conversation about our health and wellbeing and what we can all do to enhance it. Good health and wellbeing are not just about NHS and care services nor are they just about treating illness and accidents. Good health and wellbeing come from every aspect of our lives, environment, wealth and society. The quality of our education, employment, housing, neighbourhoods, friendships, relationships, families, jobs, safety, food and air are among the many things that influence our health, happiness and wellbeing, for better or worse.

We want children and young people to get the best start in life and be ready for school; we want people to live well and independently for longer; and we want older people to be able to maintain their independence for as long as possible, through more dementia friendly communities and active ageing initiatives, as well as by reducing social isolation. We also want to encourage people to take responsibility for looking after themselves, their families and neighbours, and to enable more care to be delivered in the community.

Across our communities there are differences in the levels of ill health and wellbeing, often linked to big differences in other aspects of the quality of life. Our approach is to focus on reducing these inequalities and use the wealth of our community's, knowledge, power and resources to achieve this. This is not so much about what we can do directly as public bodies, though that is hugely important, but about what we can support people, families and communities to do for themselves and with us. That is something we need to talk about and it's a conversation we want everyone to be involved in.

In summary, our vision is to enable people to live well for longer; to live independently and to enjoy the place where they live. We want to keep people well and healthy rather than just try to fix things when they go wrong.

Mark Palethorpe
Acting Executive Director of People
Cheshire East Council and
Senior Responsible Officer
Cheshire East Partnership Board

Steven Michael
Independent Chair
Cheshire East
Partnership Board

Clare Watson
Chief Officer of the four
Cheshire Clinical
Commissioning Groups

John Wilbraham
Chief Executive
East Cheshire NHS
Trust

Denise Frodsham
Director of Strategic
Partnerships
Mid Cheshire Hospitals
NHS Foundation Trust

Sheena Cumiskey
Chief Executive
Cheshire and Wirral Partnership
NHS Foundation Trust

Tina Cookson
Nurse Director
South Cheshire and Vale Royal
GP Alliance

Justin Johnson
Chief Executive
Vernova Healthcare
Community Interest Company

02 The *Cheshire East* Place

The term place-based health is becoming more commonly used across the country. Cheshire East Place covers the area of Cheshire East Local Authority. It brings together the leadership, planning and delivery of health and local authority care services, working together without barriers and bureaucracy getting in the way. Additionally taking a place-based approach requires working effectively with other local authority departments, for example, Children and Families, Housing, Planning, Revenues and Benefits, and Culture and Leisure; with other public sector organisations, for example the Police, Fire and Rescue, Department for Work and Pensions; and with the many community, voluntary and faith sector organisations that add significant value through their delivery of services in Cheshire East.

The core Cheshire East Place Partnership is made up of the following organisations working together:

- Cheshire East Council
- Cheshire and Wirral Partnership NHS Foundation Trust (CWP)
- East Cheshire NHS Trust (ECT)
- NHS Eastern Cheshire Clinical Commissioning Group (ECCCG)
- Mid Cheshire Hospitals NHS Foundation Trust (MCHFT)
- NHS South Cheshire Clinical Commissioning Group (SCCCG)
- South Cheshire and Vale Royal GP Alliance
- Vernova Healthcare CIC
- Healthwatch.

Others working closely with us, through the Health and Wellbeing Board and other partnerships include the Cheshire Constabulary and Cheshire Fire and Rescue service, the University Hospital of South Manchester NHS Foundation Trust, Stockport NHS Foundation Trust, University Hospitals of North Midlands NHS Trust, health and care commissioners and providers across Cheshire, Merseyside, Wirral, Greater Manchester, North Midlands and Wales.

As a Place we sit within the Cheshire and Merseyside Health and Care Partnership (C&MH&CP), one of nine Places, all based upon the local authority geographies of Cheshire and Merseyside. This Partnership was established to confront the health and care challenges of population health, the quality of care, and increasing financial pressures. By 2021 the Partnership has the ambition of becoming an Integrated Care System: NHS organisations in partnership with the local councils in Cheshire and Merseyside taking collective responsibility for managing resources, delivering NHS standards and improving the health and wellbeing of the population they serve.

As its name suggests, the Partnership is not a single entity but a collection of organisations responsible for providing health and care services that have come together, to plan how best to deliver these services in future so that they meet the needs of local people, are high quality and are affordable. Their priorities feature in our local Plan and our interaction with the Cheshire and Merseyside work-streams will influence our on the ground delivery.

We shall also contribute to the ambitions of the C&MH&CP in relation to Social Value and have committed to the Social Value Charter that the Partnership has recently published.

A vibrant and diverse economy and community

Cheshire East is an area of contrasts. It is a place of agriculture and industry, countryside, villages, market towns and urban centres with distinct needs, assets and characters. We are preparing to capitalise on the anticipated arrival of high speed rail (HS2) as a catalyst for growth, development of business and enterprise in Cheshire East. This will create new opportunities for regeneration and employment within the borough and new demands on public services.

Cheshire East is a great place for people who want to balance work and life because we are located between the North and the Midlands and we are close to Wales and Merseyside.

We are ideally located to capitalise on both the quick links to these centres and to be a haven from them.

Our plans will recognise the value of our communities and respond to the needs of our communities, delivering integrated health and care designed with and for local care communities. We plan to deliver continuous improvements in productivity in the private and public sectors, harnessing local world class businesses and our rich research and development infrastructure. Business development, housing growth and education and training opportunities are key elements of wider strategies designed to complement and benefit from health and care developments.

Consequently businesses, housing providers and developers and the education sector will also be key partners in the delivery of the Plan.

We have been laying the foundations of integration and transformation over the past year. Some examples of partnership working to date include:

- Establishing a robust governance structure for the partnership
- Strengthening our eight Care Communities and introducing changes to the way the teams work to improve the joined up working between health and social care
- Securing external funding to test new ways of working in the Care Communities
- Introducing our Primary Care Networks and initiating the implementation of social prescribing across Cheshire East
- Continuing to support and promote the Cheshire Care Record to facilitate the secure sharing of patient data, ensuring that residents need only tell their story once
- Initiating the testing of a patient held record to provide easier access for people to see their own health records through an app
- Testing the use of Skype for Business between care Homes and A&E across six care homes to help reduce admissions
- Establishing the Cheshire East Carers' Hub as a one stop shop for carer support, advice and information

Main hospital sites

Care Communities

SMASH Sandbach, Middlewich, Alsager, Scholar Green and Haslington

BDP Bollington, Disley and Poynton

CHAW Chelford, Handforth, Alderley Edge and Wilmslow

CHOC Congleton and Holmes Chapel

03 Our Local Vision

Health and wellbeing go hand in hand with economic growth and prosperity. Good health is also about good housing, good education, good employment and good infrastructure and services. They are all interlinked and need to complement each other.

Our vision is to improve the health and wellbeing of local communities, enabling people to live longer and healthier lives. We will do this by creating and delivering safe, integrated and sustainable services that meet people's needs by the best use of all the assets and resources we have available to us. Wellbeing comes from everyone taking ownership of what they can do for themselves and their community, with support available and focussed when and where it's needed.

Our focus will be upon:

- Tackling inequalities, the wider causes of ill-health and the need for social care support through an integrated approach to reducing poverty, isolation, housing problems and debt
- Prevention of ill health, early intervention, health improvement and creating environments that support and enable people to live healthily
- Ensuring our actions are centred on the individual, their goals, and the communities in which they live and supporting people to help themselves
- Having shared planning and decision making with our residents

This means we need our services to be as integrated as our lives are. To improve the health and wellbeing of communities and reduce the demand for health and social care, a focus on preventing ill health needs to be at the heart of our strategic plans, actions, services and programmes. This also means that we need to think of health and care in a new way and understand that workplaces, housing, schools, leisure and communities are a vital part of promoting wellbeing and preventing, or delaying a need for care arising.

We want to make it as easy as possible to stay healthy, supporting people where it makes a difference, intervening where it's necessary but also promoting a shared understanding of individual responsibility to lead a healthy life, reducing people's need for help and keeping them independent.

The Five Year Plan provides our high level vision and aspirations for transformation. More detail on the different elements will be found in recently published strategies such as the Cheshire East All Age Mental Health Strategy 2019 – 2022 and the Children's Mental Health Transformation Plan, or in forthcoming strategies and plans that are currently being drafted.

Our Strategic Goals for the Cheshire East Place over the next five years are:

- To develop and deliver a sustainable, integrated health and care system
- To create a financially balanced system
- To create a sustainable workforce
- To significantly reduce the health inequalities

Source: *Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute 2015.*

Contributions to Health Outcomes

30% Health Behaviour	40% Socioeconomic Factors	20% Clinical Care	10% Built Environment
10% Smoking	10% Education	10% Access to Care	5% Environmental Quality
10% Diet and Exercise	10% Employment	10% Quality of Care	5% Built Environment and Housing
5% Alcohol use	10% Income		
5% Poor Sexual Health	5% Family Social Support		
	5% Community Safety		

It is clear from this table that there are many factors that impact our quality of health. And those factors need to influence potential solutions. We tend to focus on hospitals and GPs when we think about our health and how the NHS serves us. Whilst it is essential that our NHS clinical services are excellent, they only make up a fifth of what contributes to the quality of our health. Our plans will look at involving all aspects of our health and wellbeing needs, and especially on preventing ill health and avoiding harm so that we can enhance wellbeing and reduce the unsustainable pressure on overstretched services.

The Five Year Plan complements the Cheshire East Health and Wellbeing Strategy and sits alongside the Cheshire East Connected Communities Strategy, Industrial Strategy and developing Environment Strategy. Collectively these strategies will help to guide our approach and lead to better health and social care outcomes across Cheshire East.

04 Why do we need to change?

Many of us are living much longer, in better homes and communities, but we are experiencing increasing fragility and vulnerability in older age. This has placed increased demand and financial pressures upon the health and care system requiring innovative change in order to ensure financial viability going forward.

Our lives are more connected digitally, creating new ways of living and working and new ways of accessing services and taking part in activities and it is increasingly clear that health and care services need to be shaped around individuals to make their lives better and easier.

People's health and wellbeing is not simply about taking a pill, seeing a doctor or waiting for a service. It involves helping people to take greater responsibility for their own self-care, being more proactive in their own health and wellbeing. As a system we will enhance the provision of and signposting to information, facilitating people to better help themselves, their families and communities. We also need to be using information more effectively to identify vulnerable people who may be at risk and addressing the wider determinants of health such as housing, poverty, employment and education.

The main causes of death and illness in Cheshire East are cancer, heart disease and respiratory illness.

Overall, risk factors (for example smoking) for cancer in Cheshire East are lower than the England average, but there are areas, particularly in the south of the borough, where risk factors are much higher. There are stark differences in cancer outcomes across Cheshire East and such outcomes are particularly poor in Crewe.

The mortality rates for heart disease in Cheshire East are lower than the England and Northwest averages but heart disease still accounts for around a quarter of premature deaths in this area and people who live in Crewe have a significantly higher risk of early death from heart disease.

Respiratory disease accounts for a tenth of premature deaths in Cheshire East. This is better than the national average but worse when compared to similar local authorities. Outcomes are generally poorer for those from the most deprived communities.

Against this backdrop the demand for health and care services continues to grow, for at least five reasons. The first three are either desirable or unavoidable:

- Our growing and ageing population means more people need health and care support
- Growing concern about areas of unmet health need, for example, young people's mental health needs
- Expanding frontiers of medical science and innovation, introducing new treatment possibilities that a modern health service should rightly be providing, for example, gene therapy

But the other reasons we can collectively do something about:

- Improving the early prevention of avoidable illness or need for care by making the most of local assets in the community or services that support behaviour change. Examples include smoking cessation to reduce the risk of cancer and heart disease; diabetes prevention and reducing the risk of cancer through reducing obesity; and reducing respiratory hospital admissions from lower levels of air pollution.
- Getting the right service in the right place for someone who is unwell or in need of care is often difficult. This is because many current services were created for a different era with different needs.

This document represents a commitment by all the partners across Cheshire East to collaborate to tackle the complex, difficult and inequitable health and wellbeing issues together.

In general, the health and wellbeing of the residents of Cheshire East is good, but there are clear inequalities within the area.

We recognise that services should be designed for local needs and that, for instance, what is needed and what works for people in Nantwich will be different to what's needed and what works in Macclesfield. Working with our different communities, local networks and using the individual strengths of our towns and villages we want to ensure people have the best health and wellbeing from services arranged for their local circumstances.

Meaningful engagement with our communities, patients and carers continues to inform all that we do, and we will provide services to improve health and social care for our local populations.

Public engagement

Healthwatch Cheshire East have recently undertaken engagement on the NHS Long Term Plan and the first draft of the Cheshire East Partnership Five Year Plan.

Through surveys, engagement events and focus groups we have heard local peoples views and ideas that will help shape our local plans. The key messages that have come out of this include:

- In order to live a healthy life people felt that access to the help and treatment they need when they want it was most important.
- People were facing challenges in getting through to GP Practices to make appointments and were concerned at the number of days wait to see a GP. Similarly there were concerns regarding the time it took to see a consultant or to receive information back after such an appointment.
- The challenge in rural areas to access health services was an issue for many, with limited public transport hampering their ability to get to appointments. Use of technology to mitigate against this was suggested (acknowledging that for some this would not help).
- In terms of maintaining their health and independence in later life, people surveyed overwhelmingly felt the most important factor was being able to stay in their own home for as long as it was safe.
- When considering managing and using support and treatment, people felt that the right treatment should be a joint decision between them and healthcare professionals and they should be consulted throughout the process.
- People in Cheshire East told us that being able to talk to their doctor or other health care professional wherever they are was the most important factor in being engaged in health service delivery.
- People with, or caring for people with autism felt that the time they had to wait to receive their initial assessment, diagnosis or treatment was too long. Waiting times ranged from eight months to three years. Members of our focus group also felt that there was a lack of understanding by front line staff of the autism spectrum. Funding and access to services was a serious issue for the parents of people with autism spectrum conditions.
- People with, or people caring for those with, dementia gave mixed responses to the initial support they received; most felt that it either met their needs or somewhat met their needs. Most reported that ongoing care and support was easy to access.
- 94% of people who responded with a Mental Health condition felt that their overall experience of getting help was either average, negative, or very negative.

To address these challenges, the issues raised by local people and the needs evidenced through the changing population demographics, we will commission services that work seamlessly and wrap around the needs of people. "Together", our guide to co-production and collaboration with residents, the community,voluntary and faith sector will be key to improving health and wellbeing.

Our intention is to:

- help people to live healthier lives for longer
- enable people to stay out of hospital when they do not need to be there
- deliver more services at home or closer to home
- reduce the demand on all hospital services

We will continue to involve and engage our communities, staff and partners and we will draw on expertise and best practice from across the NHS, social care and beyond. We will formally consult where that is necessary, but only after we have engaged and listened to our communities in a process of co-creation. This will include activities like focus groups, co-production events and really effective communication.

We will ensure that the partnership of health and social care organisations in Cheshire East Place is integrated in its approach and outlook and that our plans are made in Cheshire East for the people of Cheshire East.

05 Outcomes

We want to develop clear plans that complement each other and deliver measurable outcomes for our communities. We want these outcomes to be straightforward and understandable. We want to build support and agreement for them.

The chances of success will be greater if we are clear about what we want to achieve and why. The priorities we have selected (as part of the Health and Wellbeing Strategy) are focussed on supporting everyone in Cheshire East, from childhood through to older age.

This document is about how we all can work towards, and benefit from, achieving these outcomes. We believe these outcomes are achievable and we believe they can only be achieved through the combined strengths and qualities of every part of our community, from the individual through to the public service. We all have a part to play and we will all benefit from the achievement. This will also help to ensure we have a long-term financially sustainable health and care system in Cheshire East.

Our key outcomes are that we should:

1. Create a place that supports health and wellbeing for everyone living in Cheshire East
2. Improve the mental health and wellbeing of people living and working in Cheshire East
3. Enable more people to Live Well for Longer in Cheshire East
4. Ensure that children and young people are happy and experience good physical and mental health and wellbeing

Wealth and Wellbeing

The wealth of any community directly contributes to its health and wellbeing. That is why we are making jobs, skills and opportunities a key part of our health and wellbeing work. Being healthy for and at work, goes hand in hand with having the jobs necessary for everyone's happiness and prosperity.

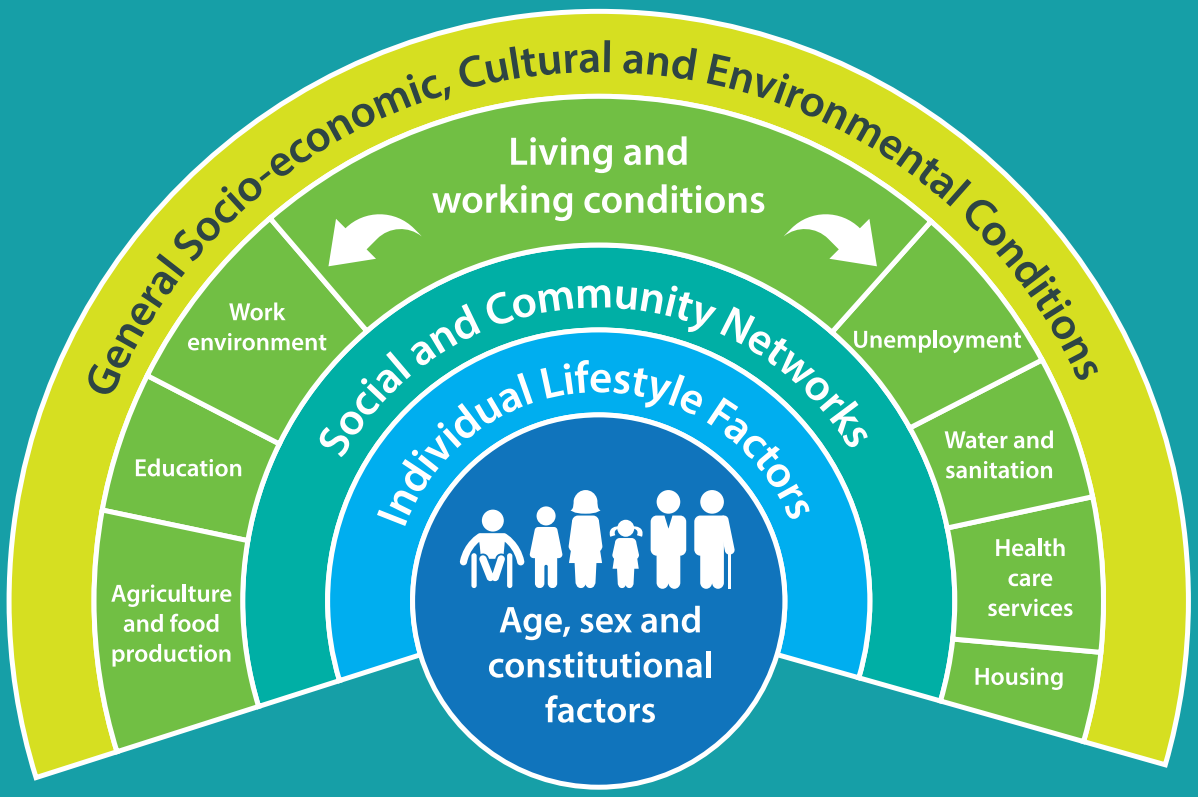
One of the things we can do to improve local prosperity is to invest in our own community, whenever this gives us the best outcomes and provides best value. We want to maximise the additional benefits that can be created by delivering, procuring or commissioning goods and services in Cheshire East. We don't just want to buy a product or service; we want that money to also support the income and wealth of our residents and businesses. We want our local economy to benefit from the funds we have to spend, and we want our workplaces to benefit our residents. So, when we spend money, we do so in a way that achieves as many of the following objectives as possible:

- Enabling people to be well in work by directly supporting their mental wellbeing
- Removing complex barriers to employment and financial independence through our 'In To Work' support programmes
- Ensuring that the skills strategy opportunities extend to people who are currently not in work and face the greatest challenges
- Promoting employment and economic sustainability
- Raising the living standards of local residents
- Ensuring that individuals and families have housing suitable for their needs
- Promoting participation and citizen engagement
- Building the capacity and sustainability of the voluntary and community sector
- Promoting equity and fairness
- Promoting environmental sustainability

The diagram below shows how health, happiness, jobs, services, neighbourhoods, communities and our economy are interconnected. Health inequalities are underpinned by the conditions in which people are born, grow, live, work and age. The broad social and economic circumstances which together influence the quality of the health of the population are known as the 'social determinants of health'. The ways in which these social determinants impact on both mental and physical health are complex and inter-related, often acting over a long period of time.

The Social Determinants of Health

Source: Dahlgren and Whitehead (1991)



This shows:

- Personal characteristics occupy the core of the model and include gender, age, ethnic group, and hereditary factors
- Individual 'lifestyle' factors include behaviours such as smoking, alcohol use, and physical activity
- Social and community networks include family and wider social circles
- Living and working conditions include access and opportunities in relation to good jobs, housing, education and welfare services
- General socioeconomic, cultural and environmental conditions include factors such as disposable income, taxation, and availability of work

We will ensure that health and wellbeing considerations are taken into account in relation to the many different elements of the Cheshire East Place including for example spatial planning, transport, housing, skills and employment.

Tackling inequalities

Public Health England says, "Health inequalities are avoidable and unfair differences in health status between groups of people or communities."

There are some stark differences across Cheshire East that we have identified and must deal with. There is a difference in life expectancy of around 13 years between the lowest rates in Crewe Central and the highest in Gawsworth for women. For men, there is an 11-year gap between the lowest rate, again in Crewe Central, and the highest in Wilmslow East.

In general, there is more ill health in parts of Crewe and Macclesfield than in other areas. We know that this also coincides with areas of deprivation, poorer housing, education achievement and employment. Smoking, alcohol consumption and obesity are all also correspondingly higher.

We have identified common health issues in Cheshire East which have a significant impact across a person's lifetime if left unaddressed and are key factors in health inequalities. To make a difference in these areas we need to focus on avoiding inequalities from entirely preventable conditions. The focus will be on:

- Giving children the best start in life and ensuring they are ready for school
- Supporting children's emotional health and wellbeing and tackling adverse childhood events
- Reducing alcohol related harms
- Helping people better manage long term conditions and disability affecting day to day activity
- Reducing heart disease and high blood pressure
- Preventing the risks from frailty and falls and improving mental health and wellbeing as we get older

The human and community costs of preventable conditions

Alcohol misuse

The harmful effects of alcohol are a major cause of ill health in Cheshire East. Nearly three quarters of 15-year-olds have tried an alcoholic drink. This is significantly higher than the national average.

Drinking at levels that can harm health is far too common. Across Cheshire and Wirral, 27% of the adult population (270,045 people) consume alcohol at levels above the UK Chief Medical Officers lower-risk guidelines increasing their risk of alcohol-related ill health.

We estimate the direct, measurable impact of alcohol harm costs Cheshire and Merseyside many millions of pounds a year including:

- £86 million as direct costs to the NHS (hospital admissions due to alcohol, A&E attendances, Ambulance journeys, GP and outpatient appointments)
- £32 million in social services cost (children's and adults social service provision)
- £100 million related to crime and licensing (alcohol specific and alcohol related crimes, costs of licensing)
- £185 million in the workplace (absenteeism, presenteeism, unemployment, premature mortality)

Behind these numbers are individual stories of harm and misery. There is an immeasurable cost to people, their families and their children from alcohol misuse. It can generate violence and abuse causing a terrible impact on other people's safety and physical and mental well-being.

High blood pressure

We have identified high blood pressure as a major issue affecting about a quarter of people but most of them are either undiagnosed or untreated. We have an ageing population who are increasingly at risk of high blood pressure due to age, obesity and excessive drinking. If we do not start to address this disease right across every community, we will have increasing cases of stroke, heart attacks and vascular dementia that will require long term care and give people a poorer quality of life.

There are many ways of dealing with high blood pressure. On a personal responsibility level, reducing weight and taking more exercise will have a major impact on reducing blood pressure and the health risks it creates.

At a community level we are training volunteers in local charities, community groups and across the public sector to take blood pressure measurements and providing them with the equipment to do it. This is aimed at identifying people with high blood pressure who do not yet know they have it and so can't be supported.

At the NHS level we will make sure that everyone with a diagnosis is supported or treated to reduce and manage their blood pressure.

The impact of smoking

Smoking is the single most important driver of health inequalities and is more common among unskilled and low-income workers than among professional high earners. It has a disproportionate impact on children and young people from deprived areas, and its uptake in children is heavily influenced by adult smokers, perpetuating the cycle of inequalities to the next generation. There is also a strong association between deprivation and smoking in pregnancy and negative impacts of smoking on children with asthma.

Data suggests that Cheshire East has relatively low levels of smoking among adults compared with the rest of the North West, but rates vary considerably across Cheshire East with higher rates in Crewe.

New services for new needs as our population changes

Our population will change in the coming years as we expect HS2 to bring significant movement of working age families to the Place and at the same time we expect the population of older people to grow substantially.

In the next ten years, in Cheshire East, we will see significant increases in the number of people aged over 65 and dramatic increases (38%) in the number of people aged over 85. Our over 85s are most likely to experience the risks associated with increasing frailty and to have three or more medical conditions that require support and care. We therefore need to shift our resources accordingly to better manage this demand.

We are also experiencing and anticipating a significant rise in people with dementia and we need to plan to provide appropriate environments, supportive communities as well as care for them. Too many people with dementia end up unnecessarily in hospital when other community located options would be better for them.

Our assumptions and planning for our eight Care Communities (see below) will therefore be tailored to supporting people to live with and manage frailty and several health conditions more effectively at home and in their communities. Local teams of health and social care professionals, working in partnership with families and carers, community and voluntary services will enable the delivery of better co-ordinated care. We will work to decrease and, where possible, eliminate or reduce, that deterioration to crisis level which frequently requires emergency hospital admission.

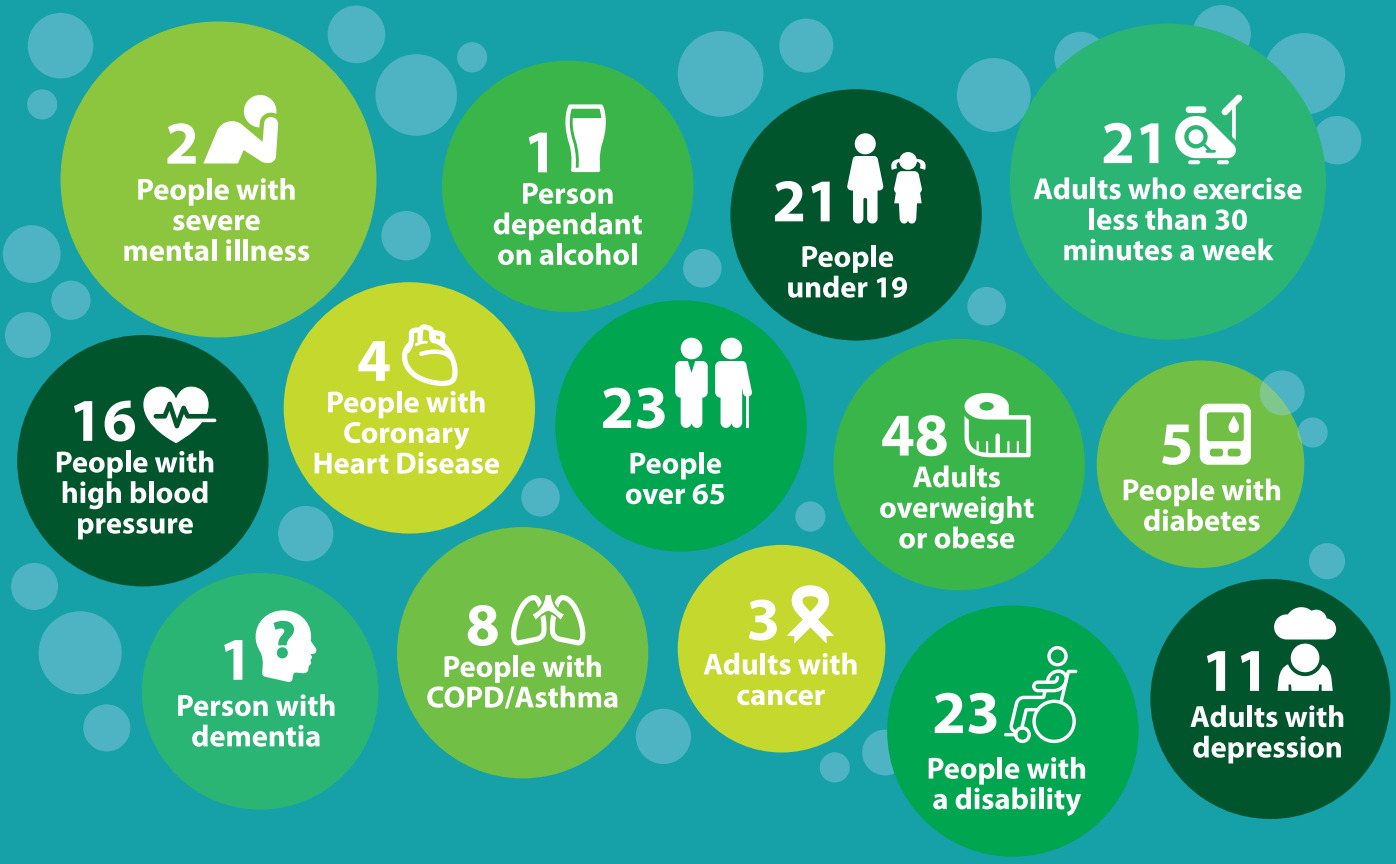
This requires different workforce skills and different ways of providing care and support locally, but it means our two hospitals will see fewer people with avoidable conditions because they will have been identified early on and managed more effectively in the their communities.

Alongside changing demographics, Cheshire East has some profound health and social care needs and some unacceptable health differences as outlined above. We are focussed on reducing these differences in the causes of illness, the age at which ill-health happens and patient outcomes.

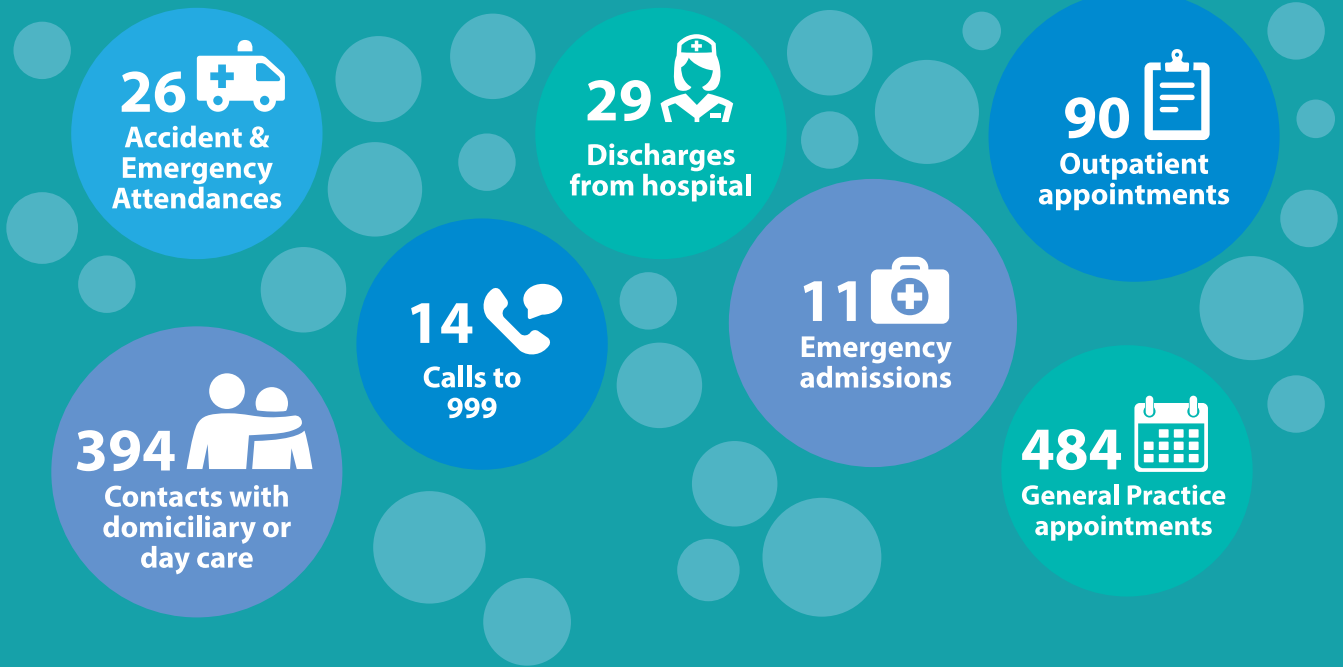
Diabetes, dementia and mental health difficulties are all increasing in Cheshire and we do not currently have the right resources in the right place at the right time to tackle them effectively. We need to get better at preventing these conditions developing, spot them rapidly if they do, provide treatment where it works best and help people to become better at supporting their own health over a long period. In addition to our aging population, due to advances in medicine and care, more young people are living longer with complex disabilities; therefore we need to ensure that our services can accommodate this change in demand. The Cheshire East Partnership will work to deliver the recently published *'My Life, My Choice'* strategy for people with learning disabilities.

If Cheshire East was a village of 100 people, their health needs would look like the picture below. Cheshire East's population is 378,000 so multiply each of the numbers below by 3780 to understand the true scale of what our community's needs look like.

If Cheshire East was a village of 100...



And in a year there would be...



A strong start for our children

Giving our children the best start in life will give them the best chances for their future lives. Health and care services are involved in supporting mothers to have a healthy pregnancy and a safe and healthy delivery. Reducing stillbirths and mother and child deaths during birth by 50% is a key national priority backed up by ensuring most women can benefit from continuity of carer through and beyond their pregnancy. We will work to ensure that we provide extra support for expectant mothers at risk of premature birth. Mothers' mental health during and after their pregnancy will also get much more focus.

We will support mothers to breastfeed recognising the benefits that this has for both mother and baby.

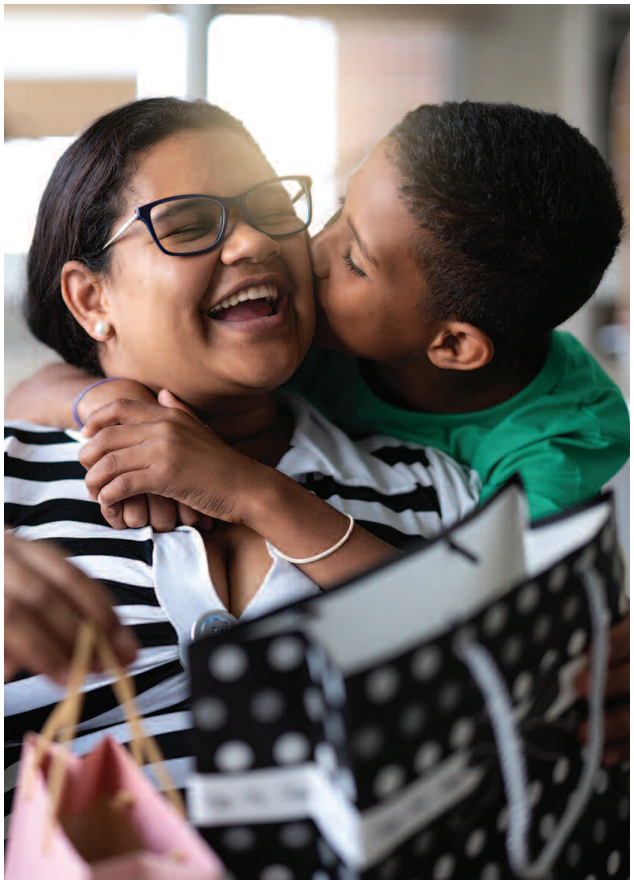
We will support children to be healthy by focussing on avoiding childhood obesity and increasing mental health support for children and young people who need it. School readiness for all children will be a priority and we will be supporting children who have had adverse childhood experiences so they can thrive as adults. We will provide the right care for children with a learning disability and reduce waiting times for autism assessment. We will also ensure that the best treatments are available for children with cancer.

The high level of children 0-4 years visiting A&E and high levels of childhood asthma are two concerns we are making a priority.

We will also focus on the health and wellbeing of our most vulnerable children and young people. In particular we will be:

- Improving Services for Looked After Children as required by Promoting the Health and Wellbeing of Looked after Children: Statutory Guidance for Local Authorities, Clinical Commissioning Groups and NHS England (2015): The performance and quality of health input for children in care and care leavers has been constantly monitored by reviewing the timeliness and quality of all health assessments, and by close partnership working with LA colleagues. An area for particular focus will be around the use of the electronic information systems within both the LA and NHS organisations and ways to improve timeliness, functionality and accuracy will be explored.
- Reviewing the Strengths and Difficulties Questionnaire strategy to ensure the completed scores inform the annual health assessment and care planning
- Completion of a Self-Audit by the Cared For Children's Nursing Team in line with commissioning standards. This will be used to benchmark current services provided against commissioning standards and identify areas where improvement/development is required.
- Strengthening of training arrangements: Undertake a training need analysis of the multi-agency workforce to identify existing gaps in knowledge to promote delivery of statutory responsibilities and role as corporate parents.
- Develop a training strategy to deliver interagency training across the health economy to improve the workforce knowledge and understanding of the Looked After Children and Care Leaver population.

New ways of working



New ways of working will be key to meeting the rising demand and achieving better outcomes for our population. They will also be needed to make the most of the new technology, medicines and treatments that will have an impact on improving health and wellbeing and making it easier to access health and care services when this becomes necessary.

Supporting people in the community to maintain their health and wellbeing will the number one priority, with increased numbers of staff working closely with the community and voluntary services to address the wider determinants of health. All health and care staff will take responsibility for positively promoting lifestyle and behaviour change, helping people to understand what they can do to proactively improve their health and wellbeing.

Our Care Communities

We have created eight Care Communities across Cheshire East, with staff from GP practices, community and acute services, social care, other public sector organisations and the community voluntary and faith sector beginning to work together much more effectively. The Care Communities all have a common 'core offer' but they can add to that to reflect specific, local priorities, needs and differences. Care Communities will work closely with the newly established Primary Care Networks.

Our intention is to offer a truly tailored, local service which means:

- We can proactively identify people at high risk of needing services and we can then intervene early and quickly to prevent their situation worsening
- We can help people through self-care and better support their families and carers
- We can make better use of the different professionals working in therapies, pharmacies, social and primary care
- We can recognise the existing strong local relationships, skills and connections and support them to grow and flourish

Our plans show that once our Care Communities are up to full strength, they will be providing services that will release significant numbers of hospital bed days – fewer people needing to be in hospital and their hospital stays being shorter. This will lead to less people having to go to hospital with more services being provided more locally. Hospitals will be able to focus on those with the most serious health issues and those needing urgent emergency treatment. These changes will also generate savings that can be used for investing in new services and ensuring a more sustainable health and care system going forward.

Our Care Communities model will allow services to focus on individuals, supported by families and friends within their local communities. We will be able to link in more closely and in partnership with other community resources and assets that impact health and wellbeing such as housing, jobs and education and to work more collaboratively with all partners including the voluntary, community and faith sector.

We will increase our support to communities by providing information, infrastructure, networks and skills to help local groups and social enterprises grow and overcome any hurdles they identify. This will enable our communities to become more enterprising, reducing dependency and enabling more deprived areas to address the inequalities which impact on their lives.

We know that a one-size fits all approach will not work. Instead we will develop evidence-based, community-led activities, which are designed to involve and connect people. We hope to encourage social connections between people with similar experiences to provide peer support, helping residents to confront and cope with life's challenges and benefit from its pleasures and opportunities.

Integration – health and care service working together for you

Too often people are passed around the health and care system before they get what they need. Increasingly people have more than one problem and need different specialists and teams working together to help them. And too often there are practical and organisational barriers that get in the way.

Our integrated approach in the Care Communities will bring teams together for the local population. We will match the right care for a patient's needs and use integrated case management when its right for the patient, such as for individuals with complex needs. Therefore, people who are older with longer term conditions, complex families and those with mental illness will access services through a single point and benefit from their needs being managed and co-ordinated through a multi-agency team of professionals working to a single assessment, a single care plan and a single key worker.

We will use this integrated approach in all aspects of our service and planning. As Cheshire East Place we will create an Integrated Care Partnership (ICP) bringing together the partner organisations that provide health and care services. This will allow the right combined care to be provided regardless of traditional organisational boundaries and barriers.

In Cheshire this has also led to the four Clinical Commissioning Groups (CCGs) proposing to merge so that they can plan and budget for services that we know are needed on a large scale. Local variations will be looked after through the ICP and our Care Communities.

When services are viewed from the patient and client's individual situation it becomes much clearer what care and support will make the most difference to them. For some it will be a mix of hospital and care at home. For others it will be about supporting their independence with community-based back up. Integrated care planning and commissioning means we can create the right mix of services to match the needs of patients.

Getting older is not a disease or illness, and we will each do it on our own way. Our aim is to keep people living happily, healthily and independently whilst providing different levels of support and care as needed.

This extends to the end of life care provided in Cheshire East by communities, hospices and hospitals. This should be planned and personalised for people with life limiting conditions, to live well, before dying with peace and dignity in the place of their choice.

Promoting wellbeing and preventing ill health

The NHS has understandably been seen as there for us when we need it, when we are unwell or injured. But we would like it to be as well known for keeping us healthy and well, independent and able. Similarly, social care supports people in need. We would rather people keep well so that they don't need our services, don't suffer from avoidable illness and harm. Our approach is to enable more people to Live Well for Longer.

The evidence shows that we need to focus on the root causes of a lot of ill health such as alcohol, obesity, smoking, poverty, poor housing and poor education. The NHS and care system recognises that it is currently more focussed on managing diseases from diagnosis, rather than helping to avoid them and slow down their impact.

We want to act across the life-course, from childhood to older age, focussing on prevention and early intervention. So, we will be working to reduce alcohol and substance misuse, smoking, and obesity. We want to create opportunities to make physical activity and eating well, easily understood and easy for everyone to do.

We will support people to take responsibility for their own wellbeing throughout their lives, to keep our communities healthy and independent. We also know there's a close link between health and wellbeing and basic prosperity. A healthy population is a healthy workforce.

As a health and care system we will make a difference across our communities. We won't assume it is for someone else or another service to be responsible but rather recognise and take responsibility for the contribution we can make too. We want the result of our work to ensure:

- Our local communities are supportive with a strong sense of neighbourliness
- People have the life skills and education they need in order to thrive
- Everyone is equipped to live independently
- People have access to good cultural, leisure and recreational facilities
- Everyone has a home
- We support key employment sectors and local supply chains
- We value and support the rural economy

Going digital

Achieving the step-change in prevention and early intervention and the delivery of services will require effective use of new technology. We will harness data and digital technology to extend the range and reach of our services. We will use technology to support people in taking responsibility for their own health. We will equip our teams and services with digital information, equipment and systems so that no one should have to tell their story more than once, unless there is a clinical need to do so. Everyone should be able to access their health and care services in the way in which they access other services in their day-to-day lives.

New ways of assessing health risks, early diagnosis and providing preventative care are being created by new digital technology and information analysis. We want to make those benefits available to people in Cheshire East. Our aim is to use technology to support population health management. This is the identification of people at risk of illness and those who would benefit from early intervention to help reduce illness and premature death. The money saved can be used for other health and care services.

We will connect all health and care services and invest in modernising systems and equipment so that all services are linked, and information is not lost between different parts of the system. This will improve the quality of care and reduce time lost by our staff chasing or missing information. We will also significantly reduce paper processes and records that cause inefficiency and delays in care.

We are already collaborating across Cheshire with the Cheshire Integrated Care Record, and across the wider Cheshire and Merseyside region to ensure a single set of digital standards that are reliable, cost effective and consistent for all patients and professionals using them.

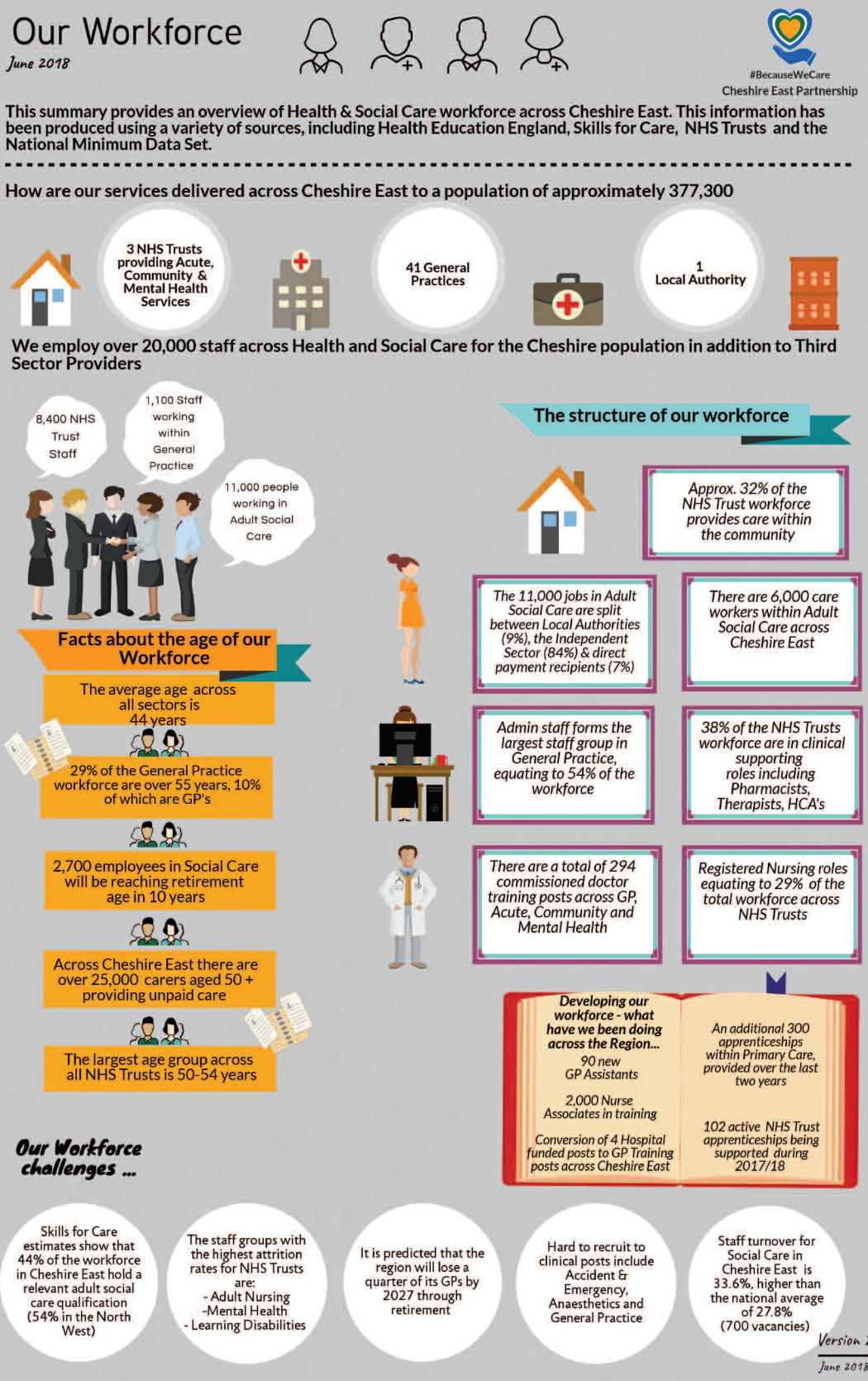
In our Connected Care Communities, we will explore how we can use telemedicine and assistive technology to keep people safe and give them rapid access to support. We will work to tailor this support to the needs of individuals. We will also provide more convenient access to services and health information for patients, with the new NHS App as a digital 'front door', better access to digital tools and patient records for staff, and improvements to the planning and delivery of services based on the analysis of patient and population data. 'Live Well' will continue to be developed as the one-stop online portal and directory to useful information, guidance and advice.

Building the right health and care workforce

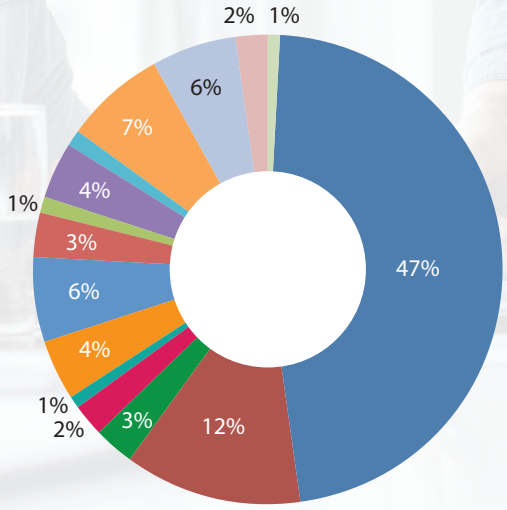
Our workforce in health and social care in Cheshire East totals over 20,000 people; just over 11,000 in social care and 9,000 in our NHS organisations but recruitment and retention remains a significant challenge.

Our Workforce and Organisational Development strategy is being further developed as our changing clinical models evolve with the aspiration to have a single workforce strategy and plan for health and care services across the Cheshire East Place. We already know we will have great difficulty recruiting care workers, GPs, nurses and consultants, so our strategy will include the development of services that can be delivered by other health and social care professionals. We are placing a special focus upon future workforce supply, recruitment and retention across Cheshire East and ensuring system-wide leadership.

We are concerned about being able to provide safe and recommended levels of staffing both now and in the era of seven-day services. We will consider how we develop services, so they are both safely staffed, rewarding places to work and accessible to local people.


Our Workforce
June 2018
#BecauseWeCare
Cheshire East Partnership
This summary provides an overview of Health & Social Care workforce across Cheshire East. This information has been produced using a variety of sources, including Health Education England, Skills for Care, NHS Trusts and the National Minimum Data Set.
How are our services delivered across Cheshire East to a population of approximately 377,300
3 NHS Trusts providing Acute, Community & Mental Health Services
41 General Practices
1 Local Authority
We employ over 20,000 staff across Health and Social Care for the Cheshire population in addition to Third Sector Providers
8,400 NHS Trust Staff
1,100 Staff working within General Practice
11,000 people working in Adult Social Care
Facts about the age of our Workforce
The average age across all sectors is 44 years
29% of the General Practice workforce are over 55 years, 10% of which are GP's
2,700 employees in Social Care will be reaching retirement age in 10 years
Across Cheshire East there are over 25,000 carers aged 50 + providing unpaid care
The largest age group across all NHS Trusts is 50-54 years
The structure of our workforce
Approx. 32% of the NHS Trust workforce provides care within the community
The 11,000 jobs in Adult Social Care are split between Local Authorities (9%), the Independent Sector (84%) & direct payment recipients (7%)
There are 6,000 care workers within Adult Social Care across Cheshire East
Admin staff forms the largest staff group in General Practice, equating to 54% of the workforce
38% of the NHS Trusts workforce are in clinical supporting roles including Pharmacists, Therapists, HCA's
There are a total of 294 commissioned doctor training posts across GP, Acute, Community and Mental Health
Registered Nursing roles equating to 29% of the total workforce across NHS Trusts
Developing our workforce - what have we been doing across the Region...
90 new GP Assistants
2,000 Nurse Associates in training
Conversion of 4 Hospital funded posts to GP Training posts across Cheshire East
An additional 300 apprenticeships within Primary Care, provided over the last two years
102 active NHS Trust apprenticeships being supported during 2017/18
Our Workforce challenges ...
Skills for Care estimates show that 44% of the workforce in Cheshire East hold a relevant adult social care qualification (54% in the North West)
The staff groups with the highest attrition rates for NHS Trusts are:
- Adult Nursing
-Mental Health
- Learning Disabilities
It is predicted that the region will lose a quarter of its GPs by 2027 through retirement
Hard to recruit to clinical posts include Accident & Emergency, Anaesthetics and General Practice
Staff turnover for Social Care in Cheshire East is 33.6%, higher than the national average of 27.8% (700 vacancies)
Version 2
June 2018

What the money is spent on:



Expenditure (£000)

- Acute Hospitals - 446,000
- Adult Social Care Commissioning - 116,108
- Adult Social Care Operations - 30,865
- Ambulance and patient transport - 15,000
- CCG running costs - 8,000
- Children's Social Care - 40,724
- Community - 60,000
- Continuing healthcare - 31,000
- Funded nursing care - 11,000
- Mental health - 42,000
- Other - 6,000
- Prescribing - 62,000
- Primary care - 58,000
- Public Health and communities - 19,714
- Social care - 7,000

Using taxpayers' money wisely

The NHS in Cheshire East spends almost £750million a year but its income is just under £700m a year. This deficit has arisen, in part, because of the huge increases in demand for services that have outpaced budgets. Similarly, all local authority services have faced very considerable financial challenges in recent years and increasing demand in both adults and children's social care. Cheshire East Council spends some £207 million on adults and children's social care, public health and community services. With delays in the publication of the Social Care Green paper, national changes to local government and school funding and uncertainty over the future of the Public health grant, the financial resources of the Cheshire East Place will continue to be fragile We recognise, however, that by focussing on keeping people healthy and supported in their own communities and by reducing duplication we can save money.

Our plans will change the balance between care in our acute hospitals and care in the community. We will need to increase the range and choice of care provided in people's homes and in local clinics and primary care centres. By reducing the pressure on our hospitals and keeping people well enough not to use them, we will be ensuring that you only need to go into hospital when care cannot be provided in your community. Our strategy is clear in that we will focus our future investment on keeping people as well and as independent as possible.

Where there are administrative barriers, we will remove them and where there is duplication of effort, or benefits of closer partnership and collaboration being missed we will change. We will also make existing commissioning structures more efficient by consolidating our local CCGs.

Getting the most out of taxpayers' investment in the NHS means we will continue working with doctors and other health professionals to identify ways to reduce duplication in how clinical services are delivered. We will make better use of the NHS' combined buying power to get commonly-used products cheaper and reduce spend on administration. We will make sure the Cheshire pound is invested in the health and care of the people of Cheshire East effectively, efficiently and accountably.

06 Conclusion

We want to use the strengths of our community in every meaning of the word to improve wellbeing and avoid illness and prevent death.

We have four clear outcomes that we believe we can achieve and will make the most difference to everybody's health and wellbeing:

1. Create a place that supports health and wellbeing for everyone living in Cheshire East
2. Improve the mental health and wellbeing of people living and working in Cheshire East
3. Enable more people to Live Well for Longer in Cheshire East
4. Ensure children and young people are happy and experience good physical and mental health and wellbeing

Cheshire East thrives where people have the confidence and pride to stand on their own two feet, to compete and to fully participate in community life. We will support people to do that and remove the barriers that get in the way.

Helping people to help themselves, understanding their own risks and what they can do about them is our priority. We would rather never have to help, than treat an avoidable need. We would rather spend public resources enhancing lives than fixing them.

We recognise that our community health and wealth are linked and that our community and personal wellbeing are intertwined. We have relied on the NHS to respond to problems that will keep happening if we don't fix their causes. That is not something the NHS can do alone, nor should it. Prevention and wellbeing come from personal responsibility, community action and combined public services working together to provide the right care and support, where it will make a difference, when it will make a difference.

We have many resources and abilities to achieve this and we need to make sure we can make them all count, but we will also work in new and more effective ways and make sure the benefits that technology and digital offer are available for everyone.

There are unmet needs and inequalities in Cheshire East that we know about and will focus on responding to. Cheshire East has so much to offer and is a wonderful place to live. Our duty is to make sure we make that a healthy and well-lived reality for all our residents.

This document is designed to stimulate debate and conversation. We present here information and issues about our health and wellbeing as we know them. We share our optimism about what we think can be achieved and our concerns about inequalities that are unacceptable and avoidable. We also offer our commitment to work on our community's behalf. If we work together, we can deliver a better quality of life and health for all of us.

07 Appendix One

How we will know we have been successful?

We set out below some measures of success. The most important measures being how we impact people's lives and wellbeing for the better. Other measures will include financial responsibility and balance for our budgets, good quality ratings from regulators such as the CQC and meeting NHS performance targets.

Outcome One - Create a place that supports health and wellbeing for everyone living in Cheshire East

Indicators for Success

We want to:

- Maintain the low numbers of 16-17-year olds not in education, employment or training (NEET) or whose activity is not known
- Increase the percentage of people aged 16-64 in employment
- Reduce the number of people who are killed or seriously injured on the roads
- Increase the number of people who use outdoor space for exercise/health reasons
- Further reduce the number of households that experience fuel poverty

Key Deliverables

- Ensure that health and wellbeing considerations are at the heart of all work related to spatial planning, transport, housing, skills and employment
- Develop a Supplementary Planning Document for Health and Wellbeing

Outcome Two - Improve the mental health and wellbeing of people living and working in Cheshire East

Indicators for Success

We want to:

- Increase the numbers of adults who report good wellbeing
- Reduce the recorded prevalence of depression in adults
- Reduce the proportion of school pupils with social, emotional and mental health needs
- Increase the proportion of adult social care users who have as much social contact as they would like
- Increase the proportion of adult social carers who have as much social contact as they would like
- Increase the proportion of adults in contact with secondary mental health services living independently
- Increase the proportion of adults in contact with secondary mental health services in employment
- Reduce the suicide rate

Key Deliverables

- Deliver our responsibilities in ensuring that Cheshire and Merseyside achieve Suicide Safer Status – demonstrating work to reduce rates of suicide.
- Assess the levels of isolation across the borough

Outcome Three - Enable more people to Live Well for Longer in Cheshire East

Indicators for Success

- Increase the breastfeeding initiation rates
- Increase the prevalence of breastfeeding at 6-8 weeks after birth
- Reduce the numbers of children with tooth decay
- Reduce the numbers of 4-5- and 10-11-year olds who are overweight or obese
- Reduce the number of adults that smoke
- Reduce the number of adults who are overweight or obese
- Increase the number of adults that are physically active
- Reduce the number of alcohol related admissions to hospital
- Increase the number of people who successfully complete alcohol or drug treatment
- Increase the numbers of people meeting the recommended '5-a-day' on a 'usual day'
- Increase the number of people who are offered and accept a NHS Health Check
- Reduce the numbers of older people who fall and need to be admitted to hospital

Key Deliverables

- Deliver four collaborative health and wellbeing campaigns across all partners per year
- Deliver a physical activity programme in schools not currently participating in a programme
- Develop a falls prevention strategy

07 Appendix Two

The NHS Long Term Plan

NHS England published the NHS Long Term Plan in January this year which set out the challenges the NHS faces today and the pressures that it will face in the next decade. It made commitments on how the NHS would respond to the opportunities that new ways of working, additional funding and technology advances can provide everyone. It set out for the whole NHS the plan for new services and better experience and outcomes for patients:

1. Doing things differently: we will give people more control over their own health and the care they receive, encourage more collaboration between GPs, their teams and community services, as 'primary care networks', to increase the services they can provide jointly, and increase the focus on NHS organisations working with their local partners, as 'Integrated Care Systems', to plan and deliver services which meet the needs of their communities.

2. Preventing illness and tackling health inequalities: the NHS will increase its contribution to tackling some of the most significant causes of ill health, including new action to help people stop smoking, overcome drinking problems and avoid Type 2 diabetes, with a particular focus on the communities and groups of people most affected by these problems.

3. Backing our workforce: we will continue to increase the NHS workforce, training and recruiting more professionals – including thousands more clinical placements for undergraduate nurses, hundreds more medical school places, and more routes into the NHS such as apprenticeships. We will also make the NHS a better place to work, so more staff stay in the NHS and feel able to make better use of their skills and experience for patients.

4. Making better use of data and digital technology: we will provide more convenient access to services and health information for patients, with the new NHS App as a digital 'front door', better access to digital tools and patient records for staff, and improvements to the planning and delivery of services based on the analysis of patient and population data.

5. Getting the most out of taxpayers' investment in the NHS: we will continue working with doctors and other health professionals to identify ways to reduce duplication in how clinical services are delivered, make better use of the NHS' combined buying power to get commonly- used products for cheaper, and reduce spend on administration.

Our plans in Cheshire East will reflect the national plan's direction of travel but also our local priorities. We will involve and engage local people and communities in making plans and developing services that reflect their views and needs.

National plan, local impact

As we have shown, cancer, heart disease, stroke, diabetes and mental health are the dominant health conditions that will affect most of us. The NHS Long Term Plan aims to prevent 150,000 heart attacks, strokes and dementia cases and provide education and exercise programmes to tens of thousands more patients with heart problems, preventing up to 14,000 premature deaths over the next ten years. In Cheshire East we will ensure that residents benefit from these plans getting the right specialist care quickly from the best NHS centre for their needs.

Diagnosing and treating cancer early is crucial to saving lives. The NHS aims to save 55,000 more lives a year by diagnosing more cancers early and invest in spotting and treating lung conditions early to prevent 80,000 stays in hospital.

Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood.

We will ensure that our children, young people and adults have improved emotional wellbeing and mental health thanks to a focus on prevention and early support. Avoiding loneliness and isolation is a key objective and our Care Communities model of services will mean health and care professionals are closer to the ground to both anticipate needs and respond to them quickly and more personally.

As a society we are reducing the stigma of mental health that has meant many people in the past were reluctant to seek help. We must now be able to anticipate and provide the support to all that need it.

07 Appendix Three

Healthwatch Cheshire East engagement report

On production of the NHS Long Term Plan, NHS England commissioned Healthwatch England to gain the views of the public. In turn, Healthwatch England asked the 152 local Healthwatch throughout the country to work with their Sustainable Transformation Partnerships (STP) or Health and Care Partnerships (HCP), to engage with people to find out what was important in regard to the way services will be delivered in the NHS under the Long Term Plan.

As the coordinating local Healthwatch for the nine within Cheshire and Merseyside who conducted the research, Healthwatch Cheshire (consisting of East and West) oversaw the research across Cheshire and Merseyside and brought the information together to produce final reports. Healthwatch Cheshire were also responsible for liaising with the Cheshire and Merseyside HCP regarding the work.

Research in Cheshire East was conducted through two surveys and three specific focus groups, and took place following the publication of the Long Term Plan from mid-March to the end of May 2019. The surveys were designed nationally by Healthwatch England, with the first entitled 'People's general experiences of health and care services', and the second survey looking at 'NHS support for specific conditions'. The surveys were available online and also in hard copy which were available at Healthwatch engagement events at venues across Cheshire East.

In Cheshire East, Healthwatch Cheshire East received 270 survey responses, consisting of 202 general surveys and 68 specific condition surveys. There were also 33 attendees across three specific focus group events focusing on what is important in regards to health and care for students and people with autism. These groups were conducted with students from the Crewe Campus of South and West Cheshire College, and two sessions with Space4Autism in Macclesfield.

Feedback Healthwatch Cheshire East received included:

- In order to live a healthy life people felt that access to the help and treatment they need when they want it was most important.
- In terms of maintaining their health and independence in later life, people surveyed overwhelming felt the most important factor was being able to stay in their own home for as long as it was safe.
- When considering managing and using support and treatment, people felt that the right treatment should be a joint decision between them and healthcare professionals and they should be consulted throughout the process.
- People in Cheshire East told us that being able to talk to their doctor or other health care professional wherever they are was the most important factor in being engaged in health service delivery.
- People with, or caring for people with autism felt that the time they had to wait to receive their initial assessment, diagnosis or treatment was too long. Waiting times ranged from eight months to three years. Members of our focus group also felt that there was a lack of understanding by front line staff of the autism spectrum. Funding and access to services was a serious issue for the parents of people with autism spectrum conditions.
- People with, or people caring for those with, dementia gave mixed responses to the initial support they received; most felt that it either met their needs or somewhat met their needs. Most reported that ongoing care and support was easy to access.
- 94% of people who responded with a Mental Health condition felt that their overall experience of getting help was either average, negative, or very negative.

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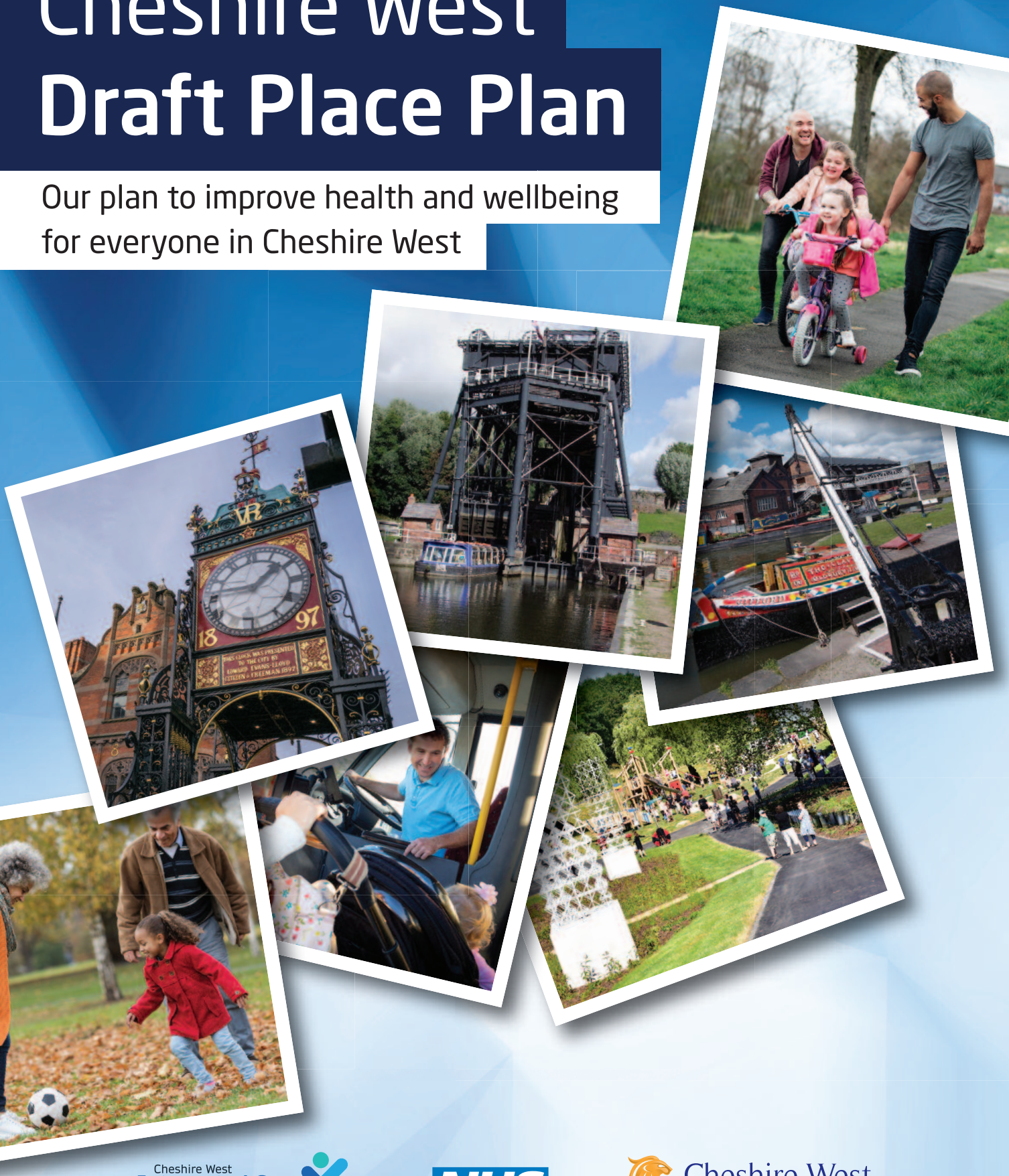
2019-2024

Cheshire West
Draft Place Plan

Our plan to improve health and wellbeing for everyone in Cheshire West



Cheshire West Integrated Care Partnership

Cheshire West and Chester Council and the NHS working together

NHS

Cheshire West and Chester

Contents

Foreword

We are delighted to present the first Place Plan for Cheshire West. Using insights from our current Health and Wellbeing Strategy and the Joint Strategic Needs Assessment, the Plan represents our vision for the next five years, highlighting areas where we can do more together to benefit the people of Cheshire West. The Plan will replace the Health and Wellbeing Strategy, but does not replace partners' individual plans; rather it builds upon them. It also takes account of other key relevant documents, which can be found listed at the back of this document in Appendix 1.

We want to transform our health and care services to achieve excellence and sustainability in the future. For this reason key leaders from across health and social care in Cheshire West have come together to develop the Place Plan. Our vision is "**To reduce inequalities, increase years of healthy life and promote improved mental and physical health and wellbeing for everyone in Cheshire West**".

Our aim is to make Cheshire West the best place to grow up, live, work and enjoy life to the full.

Councillor Louise Gittins
Chair of Health and Wellbeing Board/Leader of Cheshire West and Chester Council

Clare Watson
Accountable Officer for Cheshire Clinical Commissioning Groups

Del Curtis
Place Lead for Cheshire West

Plan on a page

Our vision

To reduce inequalities, increase years of healthy life and promote mental and physical health and wellbeing for everyone in Cheshire West

Our priorities

- Prevention and early detection
- Reducing inequalities
- Promoting wellbeing and self-care
- Making it easier to navigate health, social care and community based services
- Anticipating the future needs of our population
- Integrating our health and care services
- Keeping people safe

Key areas for action

- Best start
- Education and learning
- A healthy place to live
- Healthy homes
- Healthy lifestyles and preventing ill-health
- Preventing social isolation and loneliness
- A healthy place to work
- Creating an age-friendly place
- Health and care services
- The health and care workforce

Our values

- Shared accountability
- Promoting engagement and involvement
- Mental health is valued equally with physical health
- We are inclusive and value diversity
- Honest and open to feedback
- Evidence-based

One Place, One Plan

Working together to achieve the best for Cheshire West

Our place - Cheshire West

For most, Cheshire West is a great place to live, work and play. Many of our villages, towns and neighbourhoods are among the most attractive and dynamic communities in the country.

We have a thriving economy and cultural sector and our parks and green spaces are second to none. Compared to England, quality of life is generally good for many people across the borough, with lower levels of deprivation, higher incomes and generally, good health. However, there are pockets of significant disadvantage, where residents experience poorer living conditions, educational attainment, economic prospects and more years of poor health.

Against this background, our population is set to increase by about 10% by 2035, (to 367,000). Numbers of children will increase by 8% and most of this increase will have happened by 2027. By 2035, there will be 3,000 more children aged 11-15. The Ellesmere Port area (council locality) will see the largest increase in children. Older age groups will see the biggest increase, with the number of residents aged 65 plus expected to increase by 46%, and the numbers of people aged 85 and over forecast to more than double.

This presents real opportunities for the borough, but also some challenges. We are committed to working more closely with communities and partners to deliver high quality, efficient and effective public services through new and improved ways of working.

This will contribute to improving the quality of life and wellbeing of local people. Where local people get involved in shaping and deciding what happens in their neighbourhood, not only do they get the services that they want, but it helps to create a much greater sense of community and personal responsibility.

This Plan builds on the rich diversity of the people, communities and assets that make Cheshire West such a great place. Together we can maximise the quality of life and opportunity for all our residents. The Plan requires us to be brave and work in ways that are different to how we have worked in the past. Public services need to build on the strengths, assets and expertise of individuals and communities, letting you, our residents, teach us. Only by doing this together can we develop and make things better.

Our vision

To reduce inequalities, increase years of healthy life and promote mental and physical health and wellbeing for everyone in Cheshire West.

What does good look like?

- Prevention is the basis of everything we do
- A place that is taking practical and innovative action on climate change and environmental issues
- A modern and productive economy that draws investment, visitors and talent
- A place that people are proud to live in, with decent homes and sustainable and fulfilling jobs
- Social mobility and tackling inequalities are prioritised, to ensure all our residents can reach their full potential
- Older people are valued, making positive contributions to their communities and the economy
- We embrace and maximise the use of data and digital technology
- Everyone, regardless of sex, race, sexual orientation, gender identity or any other characteristic, sees an increase in years of healthy life
- Children get the best start in life
- Young people are supported to reach their potential and ambitions
- People live healthy lives and are supported to be in control of their own health
- Mental and physical wellbeing of all residents is maximised
- Resources are transferred out of hospitals and into the community
- A partnership provides effective, joined up and personalised care for the community
- Residents' voices are heard and can shape our future
- There is democratic oversight of our emerging integrated care system

Our values

1. Shared accountability across the public sector and with our population
2. Promoting engagement and involvement
3. Mental health is valued equally with physical health
4. We are inclusive and value diversity
5. Honest and open to feedback
6. Evidence-based

Our priorities

1. Prevention - and early detection
2. Reducing inequalities
3. Promoting wellbeing and self-care
4. Making it easier to navigate health, social care and community based services
5. Anticipating the future needs of our population - providing housing, schools and services to meet changing demand
6. Integrating our health and care services
7. Keeping people safe

Why do we need a Place Plan?

Dramatic improvements in living standards in the last 100 years mean we are living longer and healthier lives, but as a society, we still face persistent and growing challenges. One of these is the changing pattern of ill health. In general, we no longer die young from infectious disease; nowadays we tend to live longer, but with one or more long-term conditions - sometimes for years. Much of this is preventable, but where ill health does happen, a great deal can be improved by effective self-care.

The origins of our health and wellbeing are not health services, but the social and economic conditions we are born into and in which we live our lives. These determinants are known as the wider determinants, or the social determinants of health. They are a diverse range of social, economic and environmental factors, including the built and natural environment; housing; employment; income; education; and access to leisure opportunities. These factors determine the extent to which people have the physical, social and personal resources to deal with life. They also influence our health behaviours such as whether or not we smoke or get enough exercise.

As a health and care system, Cheshire West faces considerable financial uncertainty and unprecedented challenges. Uncertainties include the outcome of the Comprehensive Spending Review which will determine future years funding of public services and the forthcoming publication of the Green Paper on the future funding of social care for adults. In 2019-20, we face a combined (health and care) funding gap of £66m due to a combination of reductions in government funding, inflation and increased demand for services. This is a conservative estimate and we are working as a system to rectify this. Reductions in spending are coming at a time when many indicators of population health are worsening. If people's health gets worse, this is likely to prove far more expensive than the cost of supporting people to stay healthy.

We also know that demand for health and care support and services is increasing rapidly, as the population ages and our local health challenges increase. It can be difficult for people to know which service to access; our health and social care services can be disjointed and they are not designed to serve our residents' needs as described above. That, and a large projected financial gap by 2021 means that significant changes are required to maintain the quality and standards of care that we want our population to experience. In short, we need to deliver care that offers increased value by enabling more people to achieve better outcomes.

The NHS has a critical role to play but the challenges we face cannot be met by the health and care system alone. The crucial influence of the wider determinants means a much broader approach is needed: one that takes a comprehensive approach to keeping us well, pays close attention to the impact of the wider determinants of health; focuses on prevention and the role that people and communities can play.

This Plan outlines our approach to tackling these issues and what you can do to stay well. In due course, we will develop and publish a more detailed five-year action plan, with joint leadership from health and care, that sets out more precisely what we will do. We will develop the action plan based on local data and intelligence but, as importantly, by listening and taking into account your views.

Our approach to population health

A population health approach aims to improve the health of an entire population, in a defined area, whilst reducing health inequalities. It includes actions to reduce the occurrence of ill health; delivers appropriate health and care services; and seeks to influence the wider determinants of health. It requires working closely with individuals, communities and wider partner agencies.

Population health management is about bringing together health and care data to identify groups within the population to prioritise for support. It also helps us understand changes to care delivery including skill mix. In Cheshire West, we are using data to identify people who are at rising risk of being admitted to hospital, so that local services can make plans for individuals to prevent this.

As a system, we support the following:

- The proposal for a single NHS Clinical Commissioning Group across Cheshire. This organisation will buy (commission) health services on behalf of Cheshire West's population
- More joint commissioning of services by the NHS and the Council
- A much greater shift of resources from hospitals into the community, helping keep people well and out of hospital wherever possible
- One Integrated Care Partnership (an alliance of providers) for Cheshire West which will focus on prevention and pro-active care, improve health and wellbeing, better service quality and sustainable finances under a long-term, outcomes-based contract

In Cheshire West, we want to reduce inequalities and achieve better health outcomes for all our residents. Our aim is to improve our residents' physical and mental health, promote wellbeing and reduce health inequalities. Crucially, our approach focuses on prevention, influencing the wider determinants of health and the role of people and communities. Our approach is based on the King's Fund four pillars of population health:

1 The wider determinants of health

- The most important foundation for health
- Includes income, employment, education, housing, transport and leisure

2 Our health behaviours and lifestyle

- The second most important basis for good health
- Smoking, alcohol, diet and exercise

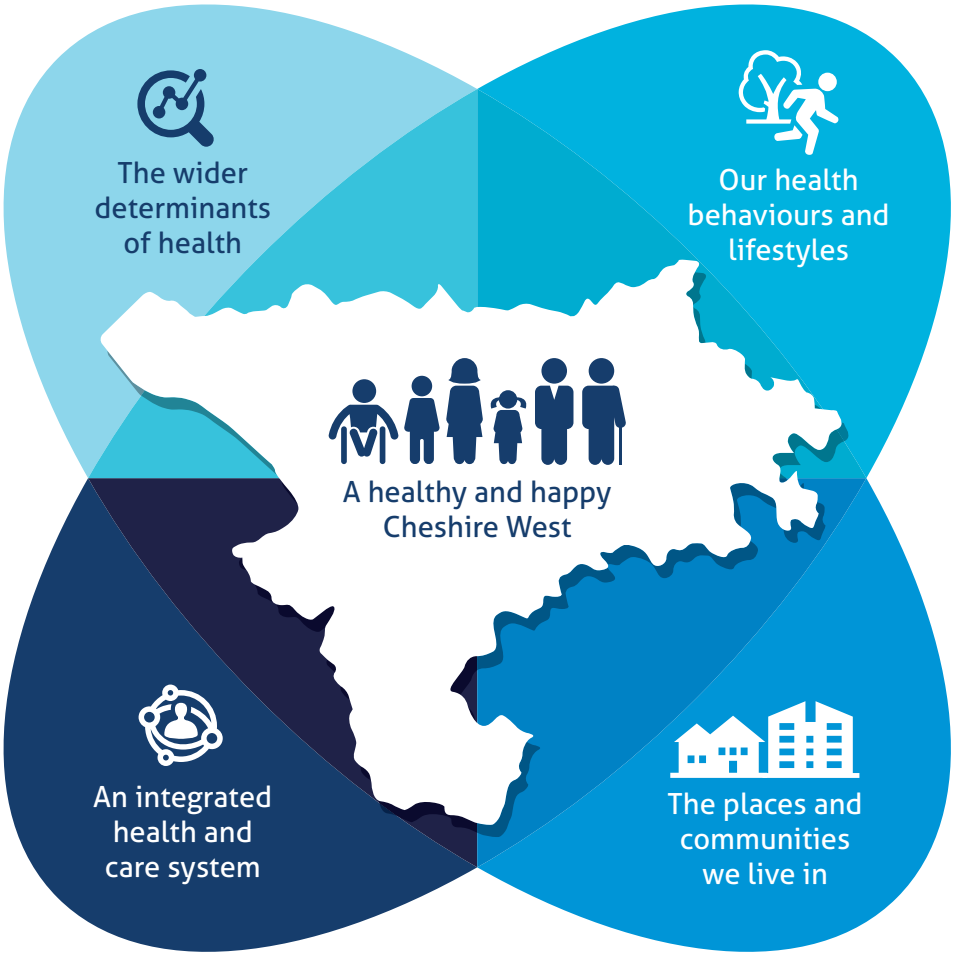
3 The places and communities we live in

- Our local environment is an important influence on our health behaviours
- There is strong evidence for the positive impact social relationships and community networks have, especially on mental health and wellbeing

4 An integrated health and care system

- We need to develop a more integrated health and care system to reflect the needs of our residents, particularly the growing number of people with complex long-term conditions

Components of a healthy Cheshire West



Source: Kings Fund (2018)

Individuals and communities are at the heart of everything we do and your views and perspectives are instrumental in shaping our Place Plan. Earlier this year, we rolled out a large programme of 'Community Conversations' where you told us how long-term conditions affected you, your experiences of health and social care, and what you wanted from local services in the future. The full report will be available in the summer of 2019.

At the same time, we are reviewing our health and social care community services. Emerging themes include our community health teams have a strong values base and strive to deliver excellent person-centred care, and that the care co-ordinator role (available in some parts of the borough) is a valuable asset. However, there is inconsistency in how services are delivered; communications within and between organisations could be better; and information and technology systems are sometimes a barrier to us working well together. There is also limited understanding and joined up working between health and social care, which sometimes leads to duplication of work. The review also identifies opportunities, especially where different services can work together more closely, wrapping the whole team around the individual; better joined up referral pathways; and the need for all teams to have mental health resources within them.

What makes a healthy Cheshire West?

The main cause of health inequality is social inequality, that is the variation across our population in income, employment, education and access to healthcare. Health inequalities will continue as long as social inequalities remain. Altering policies, environments and social norms can reduce inequalities across the lifecourse and doing this will benefit all our residents, as well as future generations.

Long-term investment in a lifecourse approach can limit ill health and the accumulation of risk throughout life. Therefore it can provide high returns for health and contribute to social and economic development. A holistic approach to investment is required, focusing on preventing health risks and reducing their cumulative effect throughout life and across generations to mitigate the economic burden of health costs. In order to address inequalities, investment should be targeted to where need is greatest.

Our Place Plan recognises the importance of both the wider determinants and an all-age, lifecourse approach. The Plan outlines the steps we will take to reduce social inequalities in Cheshire West. Key areas of focus are outlined on the following pages.

Best start

Giving every child the best start in life is crucial to reducing health inequalities across the lifecourse. The best start in life begins with a loving and secure relationship with parents, carers and family. This underpins a child's brain and language development, their ability to learn, their emotional wellbeing, and their capacity to form and maintain positive relationships with others.

Achieving the best start for children also means reducing childhood poverty, providing access to affordable housing, good education, jobs and sustainable transport. This is key to reducing inequalities. We want to create a safe environment that ensures children and young people have the best foundations, are ready to start school, and can thrive and develop skills enabling them to achieve their full potential.

A focus on early years will help improve our breastfeeding rates, support a reduction in childhood excess weight and maintain the uptake of childhood immunisation. It will also help reduce the risk and the impact of adverse childhood experiences, enabling people of Cheshire West to have longer happier lives.

In addition, improving children and young people's mental wellbeing will have a positive effect on their cognitive development, learning, physical and mental health, and social and economic prospects in adulthood.

We recognise the key role the Community Safety Partnership plays. We want to tackle hate crime and promote tolerance across the borough. We also want to join-up further early help services based on a clear understanding of local needs, including emerging national challenges such as child exploitation. Risks to positive emotional health and wellbeing must also be addressed, including parental substance misuse, the impact of parental conflict and domestic violence. Mental health services need to be more available and accessible with open access and a preventative approach.

We will:

- Work with partners to implement the recommendations of the National Maternity Review: Better Births - Improving outcomes of maternity services in England (NHS England, 2016)
- Take a 'Think Family'/'Team Around the Family' approach
- Encourage healthy weight in pregnancy and exclusive breastfeeding for the first six months of life
- Support high uptake of childhood immunisations
- Promote the importance of good dental health in children and young people
- Promote and improve the emotional health and wellbeing of children and young people
- Work to ensure health and care services for children and young people are age-appropriate, close to home and bring together physical and mental health
- Support 16-24 year olds who are, or are at risk of becoming isolated
- Engage and empower children and young people
- Build on previous work to ensure young carers are not negatively impacted by their caring role
- Support children in care and care leavers to achieve their full potential
- Ensure the needs of children and young people with special educational needs and disability are met
- Ensure the needs of children and young people who have parents with mental health or substance misuse problems are met
- Take action locally to reduce child poverty
- Tackle vulnerabilities and adverse childhood experiences (including safeguarding)
- Expand and increase access to parenting programmes
- Intervene at the earliest stage possible to prevent problems for children, young people and their families escalating
- Make sure that the crucial role of the community sector (voluntary, charitable and faith sector) is maximised fully

Education and learning

Children's education and skills development are important for their own wellbeing and for that of Cheshire West as a whole. Good quality early childhood education has lasting positive effects on health and other outcomes and these outcomes are particularly strong for those from disadvantaged backgrounds.

Learning ensures that children develop the knowledge and understanding, skills, capabilities and attributes that they need for mental, emotional, social and physical wellbeing now and in the future. Educational qualifications affect a person's ability to get a decent job, which in turn influences income, housing and other material resources.

In Cheshire West, we know that children and young people facing disadvantage do less well in school than their peers. They are at risk of becoming adults living in poverty unless they catch up with their peers. Those who grow up in poverty are less likely to be able to afford educational activities and resources; have parents who are more stressed and less well placed to help them with schoolwork; are more likely to leave school early and without a qualification; and less likely to have positive aspirations for their future.

Support and services available should include early help and prevention services; education; and special educational needs and disability services; support for children, families and schools.

It's not just children's education that matters – an approach to learning that covers adulthood is also needed. Improving skill levels and qualifications can have a positive economic impact – it has been estimated that the lifetime return on investment of level 1 courses for those aged 19-24 is £21.60 for every £1 invested.

Education in adulthood can have a positive impact on the health and wellbeing of participants and often, their families and the wider community. Adult learning can improve social capital and connectedness, health behaviour, skills, and employment opportunities, each of which affects health and wellbeing. Non-formal and informal learning for older people can decrease social isolation, whereas family learning for parents and children can help to tackle the intergenerational transfer of disadvantage.

Many adults face specific barriers to participating, such as time and financial constraints. This must be addressed if learning is to benefit all. To increase the likelihood of positive outcomes, many individuals will need support to manage this transition.

We will:

- Take a lifelong approach to learning
- Support children's transition between home and school, with a particular focus on interventions to reduce inequalities in health
- Enhance our school readiness programmes with a particular focus on closing the gap between our most vulnerable children and their peers
- Work with local schools (including pre-schools) to give children a healthy start in life, including promoting increased levels of physical activity
- Extend the role of schools in supporting families and communities and taking a 'whole child' approach to education
- Develop the school-based workforce to build their skills in working across school–home boundaries and addressing social and emotional development, physical and mental health and well-being
- Reduce the educational attainment gap between disadvantaged and non-disadvantaged children
- Ensure a consistent application of the 'Team Around the Family' assessment process
- Help children and young people to build their aspirations
- Support students from a wide range of backgrounds into further and higher education
- Use our local community assets including libraries and universities to support our approach to lifelong learning
- Make sure that access to adult learning is available to all but targeted and tailored to those with most need
- Design programmes that recognise 'softer' outcomes such as improvements in self confidence, as well as academic and vocational progression
- Work with employers to support workplace learning
- Encourage employers to increase the number of apprenticeships they offer, and ensure that these are reaching those most in need
- Be role model employers ourselves

A healthy place to live

Healthy environments

The quality of the built and natural environment including neighbourhood design, housing, the food environment, green spaces, transport, air quality and natural environments also affects our health. These factors are shaped significantly by the development and implementation of planning and design decisions, both nationally and locally.
In Cheshire West, we already have three overarching place-based programmes, led by the Council:

- Winsford Whole Place
- Enabling Lache
- Building Futures Ellesmere Port

Developments such as Weaver Square and Baron's Quay in Northwich also provide the opportunity to plan public services jointly together, creating vibrant and healthy communities for all.

Environmental disadvantages are not evenly spread. The more disadvantaged a community, the more likely it is to lack good quality open spaces, easy walking and cycling routes and well located services. They are also more likely to experience environmental burdens such as pollution and crime. All of these factors contribute to clear inequalities in society.

As a borough, we are committed to mitigating the effects of and adapting to climate change. Earlier this year, Cheshire West and Chester Councillors declared a climate emergency locally. Key areas for action include making the borough carbon neutral as soon as possible before 2045 and improving air quality locally.

In Cheshire West, we want to make the best of clear strategies and principles of healthy design to improve the health and well-being of our residents and tackle health inequalities.

Building on the success of the Council's strategic "whole place approach", we want to strengthen our joint approach to planning and developing communities and localities, promoting good health for all residents of Cheshire West.

We will:

- Jointly plan and develop environmental and other planning decisions, ensuring that they take account of all aspects of wellbeing
- Support infrastructure developments that support healthy lifestyle choices
- Embed active design principles within all new developments
- Explore opportunities for further developing our programme of work around 'one public estate'
- Work together in partnership across Cheshire West to promote shared - and committed - responsibility towards sustainability
- Sign up to the Cheshire and Merseyside Health and Care Partnership Social Value Charter
- Purchase sustainably - selecting and promoting goods and services using purchasing criteria which balance economic, social and environmental factors and require suppliers to do the same
- Encourage sustainable travel amongst our residents, visitors and key employers, including the Council and the NHS
- Work towards reducing road traffic injuries and deaths
- Ensure that natural environments and green spaces are accessible, functional and provide maximum benefit to the local community in terms of both recreation and biodiversity
- Monitor air quality and work across the area to reduce carbon emissions
- Work to reduce crime and disorder
- Help people feel safe in their homes and on the streets
- Encourage residents, visitors and businesses to minimise waste - reduce, re-use, recycle
- Support plastic-free initiatives across the borough

Healthy homes

Housing conditions influence our mental and physical wellbeing. For adults, inadequate or insecure housing causes or contributes to many preventable conditions, including respiratory, nervous system and heart diseases, cancer and falls. Children are particularly affected by poor quality or insecure housing. They are more likely to be stressed, anxious and depressed, have poorer physical health and do less well at school. Fuel poverty and homelessness have important consequences for health. Around ten per cent of excess winter deaths are caused by fuel poverty. The number of homeless people is rising. People who are homeless are more likely to experience physical and mental health problems.

High-quality housing can support health and care services locally in delivering better population health. A well-housed population helps to reduce and delay demand for NHS services and allows patients to go home when they are clinically fit to do so. In the short term, housing can support local areas in enabling timely discharge from hospital. Longer-term strategic use of NHS estates could potentially free up land to provide housing. For people with mental health problems, good-quality supported housing can support independent living in the community. Technology and telecare can help people remain independent in their own homes for longer.

We will:

- Work with the Local Enterprise Partnership, council planners and wider partners such as Housing Associations to ensure there is a range of good quality, affordable housing available that matches demand and meets our residents' needs
- Apply the learning from NHS England's Healthy New Towns programme
- Continue to develop age friendly and dementia friendly communities
- Work across the borough to prevent, reduce and address homelessness
- Work to ensure sustainable, high quality and low carbon housing/energy supplies thereby reducing fuel poverty
- Maximise the use of technology and telecare as appropriate for individuals' needs
- Focus on the strategic use of NHS buildings, making health and care service building fit for purpose
- Strengthen the role of our Integrated Care Partnership in housing, by
  - implementing the new memorandum of understanding on improving health and care through the home (Public Health England 2018)
  - Identify a named person in the Partnership to work on housing-related issues with wider partners

Healthy lifestyles and preventing ill-health

Emphasis on the wider determinants and a good start in life does not mean that actions at later stages of the lifecourse are unimportant. Adulthood is an important time for building assets, reducing risks and intervening early. Prevention is as much about the kind of communities we live in, the lifestyle choices we make, and the quality of care we receive, as it is the contents of our medicine cabinets. It is also about early detection, intervention and access to services and activities that can help maintain and sustain our good health.

What helps improve health?

- Stopping smoking - or never starting
- Drinking alcohol sensibly
- Exercising more
- Eating healthy foods

We will:

- Promote healthy behaviours in children, young people and adults to prevent them developing harmful habits
- Provide services to those most at risk from these behaviours to help them move towards healthier lifestyles
- Help all people keep themselves well and independent in their homes for longer
- Promote free or low cost wellbeing opportunities in the borough, for example Brio Leisure, including the Cheshire Change Hub, the annual Cheshire West Walking Festival, Mersey Forest, arts, leisure and cultural events
- Implement 'Making Every Contact Count' where every contact with a service (not just a health service or professional) is an opportunity for a conversation about ways to live a healthier life
- Produce an accessible and well-publicised 'Directory of Services' so that residents can:
  - Find information, advice and services easily
  - Make informed choices
  - Take personal responsibility for their health and wellbeing

Preventing social isolation and loneliness

Anyone can experience social isolation and loneliness. Groups particularly at risk include:

- 16 to 24-year-olds
- People with one or more long-term conditions
- People who need support for their mental health
- People who are unemployed
- Carers
- Those with complex social needs which affect their wellbeing
- Older people

The health impact of loneliness is equivalent to smoking 15 cigarettes a day. The community sector plays a key role in supporting our residents' wellbeing, signposting and providing a number of services, for example befriending schemes and projects such as 'Men in Sheds'. A strategic approach is needed to ensure that we tackle social isolation and loneliness across Cheshire West and that our interventions are successful.

The aim of social prescribing is to connect individuals with non-clinical or social needs to opportunities for social interaction, support, learning and healthy living. This will relieve some of the pressure on health services, but more importantly, it will improve the quality of life and wellbeing for our residents.

We will:

- Use the assets available in our community, mobilising individuals, associations and organisations to come together to realise and develop their strengths
- Provide individuals, associations and organisations with information and support to help address social isolation
- Support our community sector with their wide-ranging wellbeing work
- Work with the emerging Primary Care Networks and the Cheshire West Social Prescribing Network to enable a coordinated, system-wide approach to social prescribing (basing our model on the NHS England model of social prescribing)
- Train a number of people to become social prescribing link workers
- Monitor and evaluate the impact and outcomes of our approach to social prescribing
- Work with partners across the area to create a well publicised network of opportunities and support for residents of all ages to alleviate social isolation

A healthy place to work

We know that work is good for health and unemployment is bad for it. Good quality work is beneficial for our health and wellbeing and protects against social exclusion through the provision of income, social interaction, identity and purpose. Good quality work also needs to be sustainable and offer a minimum level of quality, including a decent living wage, opportunities for in-work development, flexibility to enable a balanced work and family life, and protection from adverse working conditions that can damage health.

On the other hand, unemployment is associated with increased sickness and early death including:

- Limiting long-term illness
- Heart disease and associated conditions
- Health-harming behaviours
- Poor mental health
- Suicide

Just as unemployment can be a risk factor for various health conditions, long-term health conditions such as poor mental health and musculoskeletal conditions (including back pain) can also be the cause of unemployment.

Work and health is central to our story of people and place. In Cheshire West, the top conditions for which people claim benefits due to inability to work are mental health and behavioural disorders and musculoskeletal problems. This is about 6,000 people, however there are many more people struggling to work or hold down jobs due to ill-health.

Helping people obtain or retain work, and be happy and productive in the workplace is a crucial part of the success and wellbeing of every community and employer. Our ambition is to enable all residents to take advantage of local opportunities for prosperity.

We will support residents in Cheshire West to meet their full potential by collectively addressing and removing health-related barriers to work. This will require collaboration between partners from across the private, public and community sector at sub-regional and local levels.

We will:

- Remove significant barriers to employment and financial independence through our local support programmes, including for those with severe mental health issues
- Collaborate with partners from across the private, public and community sectors to create pathways to good jobs and jobs that are more flexible to accommodate individuals' needs
- Work with the community sector to promote volunteering to support people into employment
- Promote a local living wage and support progress to higher paid work
- Enable people to be well in work by working with employers to support their mental and physical well being
- Support employers to be age- and carer-friendly employers
- Maximise opportunities to better use the skills and knowledge of our older residents

Creating an age-friendly place

Good health is the foundation of ageing well. Getting older is not a process of inevitable decline and many people stay fit and well long into their later years. Age brings with it a host of opportunities and advantages but it can also be a time of illness, dependence and loneliness.

We want older people in Cheshire West to enjoy their later years, and live life to the full. To that end we have joined the World Health Organization's Global Network of Age-friendly Communities, signifying our commitment to learning from and sharing best practice with other areas. We recognise that older people are a very diverse group, covering a wide range of ages, ethnicities, social and economic backgrounds and life experiences. As such, they will experience life in many different ways. Some may work past retirement age; many will have caring responsibilities for a parent, partner and/or grandchildren; a number will do voluntary work or mentoring in the workplace; and some may take up new educational and leisure opportunities. Older people will have at least as diverse a range of lifestyles as the adult population of working age.

We want our older population to live well, be independent and be part of their community.

We will:

- Tackle ageism
- Progress our Age-friendly Communities work
- Support and promote independence
- Promote opportunities to get involved in the local community, including volunteering
- Promote intergenerational programmes and activities
- Support keeping well and self-care
- Strengthen our health and care services to be more older-person centred
- Improve our dementia diagnosis rates

Health and care services

The Cheshire West health and care system is currently struggling to adapt to the main health issues experienced by our population. The system was not designed for people with multiple conditions using multiple services. The complexity of people's health issues today means services need to be designed and integrated around an individual's needs rather than around separate organisations. We want to work with people locally to jointly shape services, improve the quality of care, decrease health inequalities and make sure that services are financially sustainable for the future.

Our newly formed Cheshire West Integrated Care Partnership is an alliance of NHS providers and the Council, collaborating to meet the needs of our population. The overall vision of the Integrated Care Partnership is to help people to stay well, and where needed, provide more care closer to home. In this way, local people will benefit from services which are easier to access, better organised, more joined-up and, most importantly, targeted to their needs. The aims are to:

- Improve population health
- Improve healthy life expectancy so that, by 2035, we are enjoying at least five extra years of healthy, independent life, whilst closing the gap between the richest and poorest
- Reduce health inequalities
- Transform the experience and quality of care
- Ensure the sustainable delivery of health and social care

Sometimes, people access health care, particularly their GP surgery, for social needs rather than medical needs. These needs are a symptom of how the wider determinants of health influence our health and wellbeing. It is why integrated services need to focus on social models of health, not just medical ones.

The focus of the Integrated Care Partnership is therefore on prevention, supported self-care and delivering personalised care closer to home. To achieve this we will help more people take control of their own health and wellbeing and provide more care and support in our communities. Together with you, our residents, we want to actively manage health and wellbeing, reduce key risk factors such as smoking, and where needed, deliver tailored, personalised care. Only by working together, can we tackle our challenges and make sure our health and care system is fit for the future.

We will integrate services and further develop our teams, working together to improve population health, both physical and mental. This includes individual care management, building on the strengths that exist in our communities, committing to joined up care and 'Making Every Contact Count' across our borough.

Health and care services continued

We will:

- Support population level interventions like access to employment and workplace health and education
- Transfer resources out of hospital and into the community
- Improve access to GP and community health care
- Establish democratic oversight of our integrated care system
- Mobilise community assets, not solely buildings, but social networks and people to build stronger networks of support for wellbeing
- Promote and support collaboration between organisations
- Support the crucial role and work of the community (third) sector
- Develop services and foster community resilience to better support people and families, provide services closer to home and reduce demand for hospital services
- Support people to keep well and self-care where appropriate
- Improve end of life care and further develop the concept of compassionate communities
- Integrate health and social care services so that individuals experience care that is joined up and holistic
- Strengthen our multidisciplinary, multi-agency teams, particularly to include mental health on a par with physical health for people of all ages
- Implement a strong programme of 'Making Every Contact Count'
- Maximise the potential of digital technology to improve services and your experience of them

The health and care workforce

Our joint health and care workforce is one of our biggest assets. However, across Cheshire West, and indeed the whole country, workforce shortages are currently the biggest challenge facing health and care services. This poses a threat to the delivery and quality of care. Current workforce shortages are taking a significant toll on the health and wellbeing of staff.

People's rapidly changing health and care needs, alongside medical and technological advances, requires all frontline staff to acquire new skills and adopt new ways of working over the next decade. We want to make sure our health and care workforce supports a strong, safe and sustainable health and care system that is fit for the future.

We will:

- Support the implementation of the Local Industrial Strategy around its ambitions for People Inclusive Growth
- Align our health and care workforce strategies to support our approach to joined up care for individuals
- Address any local inequalities in recruitment, pay and career progression by gender, ethnicity and occupation
- Grow and develop our local health and care workforce, regardless of which organisation they work for
- Attract, recruit and retain people within Cheshire – 'keeping our Cheshire workforce in Cheshire'
- Maximise the potential of staff through better use of existing skills, enhancing those skills and redesigning roles, including use of the Apprentice Levy
- Develop staff so that they are equipped with the necessary digital skills to make the most of new technologies
- Offer development opportunities for staff to progress in their career
- Work with local further and higher education providers to ensure the supply and skills of our future health and care workforce is assured

Conclusion

We all have a role to play: individuals, families, communities and the public, private and community (third) sectors. Only by working together can we make this vision a reality. We want you to be part of the journey to ensure better health and wellbeing for you, your children and future generations.

What will we do?

We will:

- Ensure the priorities of mental health, reducing poverty and inequality and addressing the climate emergency are at the heart of everything we do
- Ensure there is a wide range of high quality facilities in our communities including good quality affordable housing, parks, leisure and safe cycling routes
- Help those who are unemployed into work or training and help those who are on low pay progress into better paid jobs
- Be model employers (including age-and carer-friendly) and encourage other local employers to be the same
- Invest in children, young people and adults as part of our lifecourse approach supporting pre-birth, early years, families, education, and building and supporting aspiration
- Help more residents stay independent through taking responsibility for maintaining their own health
- Help people as they grow older by keeping them healthy and connected to their communities for as long as possible in their own home
- Integrate health and care services to provide a better service for our residents
- Strengthen the emerging Primary Care Networks and the nine Care Communities, ensuring timely access to good quality primary care and community services

How you can play your part

- Be a good role model – don't smoke, drink alcohol sensibly and eat healthily
- Be supportive parents or guardians, encouraging children to be the best and the happiest they can be
- Take advantage of training and job opportunities, set high aspirations for yourself and your family
- Look after your own health and wellbeing - attend free health checks, screening, immunisations and seek advice about ways to make healthier choices, for example through your local pharmacy
- Seek support if feeling anxious, stressed or lacking confidence: look after your mental wellbeing at least as much as your physical wellbeing **https://www.mind.org.uk/information-support/tips-for-everyday-living/**
- Think about which service you need for your particular health care issue – there is lots of information on your GP practice website or on **www.nhs.uk**
- Only use A&E for emergencies and ring NHS 111 for non-emergencies
- Keep an eye out for your neighbours, especially older people in your neighbourhood and help them to be independent at home for as long as possible
- Keep as active as you can, whatever your stage in life – try walking, cycling or just getting outdoors
- Look after our place and the wider environment – reduce, reuse, recycle
- Get involved or volunteer in your local community
- Have your say and tell us how we are doing

Monitoring and evaluating the Place Plan

We set out below some measures of success. The most important measures being how we impact people's lives and wellbeing for the better. Other measures will include financial responsibility and balance for our budgets, good quality ratings from regulators such as the CQC and meeting NHS performance targets. These are outlined further in the Technical Appendix accompanying this document.

Population health

- Increase healthy life expectancy at birth

Best Start

- Reduce the numbers of children in low income families
- Increase breastfeeding rates
- Reduce the numbers of 4-5- and 10-11-year olds who are overweight or obese
- Increase the numbers of children and young people who report good wellbeing

Education and Learning

- Maintain the low numbers of 16-17-year olds not in education, employment or training (NEET) or whose activity is not known
- Maintain or improve the Average Attainment 8 score

A healthy place to live

- Reduce the number of people who are killed or seriously injured on the roads
- Increase the number of people who use outdoor space for exercise/health reasons
- Increase the proportion of adults in contact with secondary mental health services living independently

Healthy homes

- Further reduce the number of households that experience fuel poverty
- Reduce the number of rough sleepers
- Reduce the number of adults in contact with secondary mental health services who live in stable and appropriate accommodation

Lifestyle behaviours and preventing ill-health

- Reduce the number of adults that smoke
- Reduce the number of adults who are overweight or obese
- Increase the number of adults that are physically active
- Reduce the levels of depression in adults

Preventing social isolation and loneliness

- Increase the numbers of adults who report good wellbeing
- Decrease loneliness
- Increase the proportion of adult social care users who have as much social contact as they would like

A healthy place to work

- Increase the percentage of people aged 16-64 in employment
- Increase the proportion of adults in contact with secondary mental health services in employment
- Reduce the gap in employment rate between those with a learning disability and the overall employment rate

Creating an age-friendly place

- Improve health related quality of life for older people
- Reduce the numbers of older people who fall and need to be admitted to hospital

Health and care services

- Reduce the number of alcohol related admissions to hospital
- Increase the number of people who successfully complete alcohol or drug treatment
- Increase the number of people who are offered and accept a NHS Health Check

The health and care workforce

- Increased levels of staff retention

Appendix 1:

Key relevant documents that have informed the draft Place Plan

- Draft Cheshire and Warrington Local Industrial Strategy
- Cheshire West and Chester Council Plan
- Cheshire West and Chester Local Plan
- Cheshire West and Chester Housing and Homelessness Strategies
- West Cheshire Children and Young People's Plan
- Healthwatch Long Term Plan survey and findings
- The NHS Long Term Plan
- NHS Long Term Plan Implementation Framework
- The Five Year Forward View
- Delivering the Five Year Forward View
- The Five Year Forward View for Mental Health
- Next Steps on the Five Year Forward View
- General Practice Forward View
- Cheshire and Merseyside Population Health Framework
- Health and Care Partnership for Cheshire and Merseyside Business Plan 2018-19
- Joining up Care in Cheshire West
- Cheshire Clinical Commissioning Groups Operational Plans 2019

Accessing Cheshire West and Chester Council information and services

Council information is also available in audio, Braille, large print or other formats. If you would like information in another format or language, including British Sign Language, please email us at:
equalities@cheshirewestandchester.gov.uk

Tel: 0300 123 8 123 **Textphone:** 18001 01606 275757
Email: equalities@cheshirewestandchester.gov.uk
Web: www.cheshirewestandchester.gov.uk

We Care Because You Matter

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

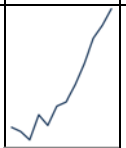
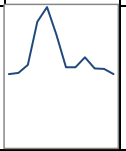
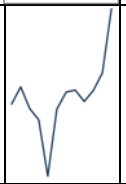
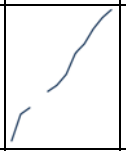
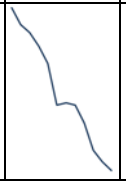
Board of Directors

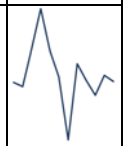
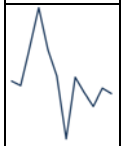
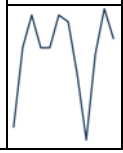
Workforce Report

October 2019

(August 2019 data)

Performance Report Workforce Chapter
Month: Aug-19

Measure	Target	Performance	Previous Month	Description	Narrative	Rolling Trend	Trend	C&W Average
SICKNESS ABSENCE	3.90%	4.55%	4.51%	Rolling 12m average Sickness Absence described as a Percentage	Rolling sickness absence increased slightly in month (+0.43%) from the previous month and remains in an Amber position. MEC and WC improved their rolling position.		↑	5.04%
IN MONTH SICKNESS ABSENCE	N/A	4.29%	4.38%	In-month 12m average Sickness Absence described as a Percentage	In-month sickness absence slightly decreased from the previous month (-0.09%). 4 of the 7 divisions experienced reduced sickness absence levels: DCSS, MEC, WC and CCICP.		↓	4.99%
APPRAISAL RATES	90.00%	86.51%	83.23%	Percentage of Staff who have received an appraisal in the last 12 months. Excludes New Staff with less than 12m service and Bank Staff	Overall, there was a 3.28% improvement in the appraisal rates across the Trust. All divisions experienced an improvement in compliance with the esceptions of Corporate and SC. The most significant improvement was in CCICP (10.31%). Corporate and EF are Green and the remaining divisions are Amber with the exception of WC (79.40%) who are Red but improved by 3.22% in month.		↑	86.44%
MANDATORY TRAINING	90.00%	83.59%	82.66%	Mandatory Training Monthly Rate Excludes Bank Staff, Staff on long term sick & mat. leave.	Training compliance increased by 0.93% in month and all divisions secured an improvement, the most significant improvement was in EF (4.23%). All divisions are Amber with the exceptions of Corporate and MEC.		↑	90.15%
STAFF TURNOVER	10.00%	8.80%	8.95%	Number of Leavers expressed as a percentage of the workforce over a 12m rolling period. Exclude Junior Doctors, Temporary and Fixed term.	The rolling position for turnover improved slightly in month (0.15%). Turnover reduced in all divisions with the exceptions of Corporate, DCSS and CCICP. All divisions are Green against target with the exception of CCICP (11.09%)		↓	10.50%

Measure	Target	Performance	Previous Month	Description	Narrative	Rolling Trend		
AGENCY SPEND	(404)	(566)	(591)	In month total spend for the Trust against plan	Agency spend decreased in month (£25k less than the previous month) and the agency spend target was not met. Medical and Dental agency spend decreased (£65k). N&M agency spend increased by £72k. All divisions had a lower spend than in the previous month with the exception of S&C and Corporate		↓	N/A
NHSI AGENCY CEILING	less than 100%	140.10%	146.29%	Trust Agency Spend as a percentage of the Planned Agency Spend			↓	N/A
OVER CAP RATES	N/A	63.40%	68%	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 ↑↓=