MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS' MEETING
(MEETING IN PUBLIC)

TO BE HELD ON MONDAY, 10th SEPTEMBER 2018
AT 2.00PM IN THE MAIN BOARDROOM

A G E N D A

1.	Apologies for Absence	
2.	Declarations of Interest	
3.	Patient Stories	*(DVD)*
4.	To Approve the Minutes of the Board of Directors' meeting held on 9th July 2018	*(Enclosed)*
5.	**Matters Arising**	
6.	**Chairman's Report**	*(Verbal Report of the Group Chairman)*
7.	**Chief Executive's Report**	*(Verbal Report of the Group Chief Executive)*
8.	**Operational Performance**	
	8.1 To Consider the Board Assurance Report	*(Summary Enclosed)*
	8.2 To Receive a Progress Report on the Single Hospital Service	*(Report of the Director of SHS Enclosed)*
	8.3 To Receive the Group Chief Finance Officer's Report	*(Report of the Group Chief Finance Officer Enclosed)*
9.	**Strategic Review**	
	9.1 To Receive an Update on Strategic Developments	*(Report of the Group Executive Director of Strategy Enclosed)*
	9.2 To Receive an Update Report on the Manchester Local Care Organisation	*(Report of the Chief Executive MLCO Enclosed)*
10.	**Governance**	
	10.1 To Receive an Update Report on the Regulatory Assessment Process 2018/19	*(Report of the Group Chief Nurse Enclosed)*
	10.2 To Receive the Q1 Complaints Report (2018/19)	*(Report of the Group Chief Nurse Enclosed)*
	10.3 To Receive an Update Report on 'Never Events' Action Plans to Mitigate Risk of Recurrence	*(Report of the Joint Group Medical Director Enclosed)*

10.4 To Receive an Update Report on the 'Freedom to Speak Up' Programme (2018) *(Report of the Group Executive Director of Workforce & OD Enclosed)*

10.5 To Receive a Report on the Patient Experience Annual Review (inc. Patient Surveys; Friends & Family Test, and, 'What Matters to Me') *(Report of the Group Chief Nurse Enclosed)*

10.6 To Receive a Report on the Gosport Inquiry Report *(Report of the Joint Group Medical Director Enclosed)*

10.7 To Receive a Report on Compliance with the Implementation of the Kirkup Recommendations *(Report of the Group Chief Nurse Enclosed)*

10.8 To Accept the Board Assurance Framework (September 2018) *(Report of the Group Executive Director of Workforce & OD Enclosed)*

10.9 To note the following Committees held meetings:

10.9.1 Group Risk Management Committee held on 2nd July, 2018

10.9.2 Audit Committee held on 23rd May, 2018 and Part 2 meeting held on 4th April 2018

10.9.3 Quality & Performance Scrutiny Committee held on 9th July and 6th August, 2018

10.9.4 HR Scrutiny Committee held on 7th August, 2018

10.9.5 EPR Task & Finish Group held on 6th August, 2018

10.9.6 Charitable Funds Committee held 9th July 2018

11. Date and Time of Next Meeting

The next meeting will be held on **Monday 12th November 2018** at **2pm** in the **Main Boardroom**

12. Any Other Business

NHS
Manchester University
NHS Foundation Trust

MINUTES OF THE BOARD OF DIRECTORS' MEETING

Meeting Date: 9th July 2018

(Held in Public)

96/18 Apologies for Absence

Apologies were received from Sir Mike Deegan, Professor Cheryl Lenney & Miss Toli Onon.

97/18 Declarations of Interest

There were no declarations of interest received for this meeting.

Decision:	Noted	**Action by:** n/a	**Date:** n/a

98/18 Patient Story – 'What Matters to Me'

The Group Deputy Chief Nurse introduced a patient story in the form of a DVD clip. The Board did not debate or discuss the clip, preferring to use the story and the imagery to keep the business of the Board focused on the patient experience.

Decision:	Patient Story Received and Noted	**Action by:** n/a	**Date:** n/a

99/18 Minutes of the Board of Directors Meeting held on 14th May 2018

The minutes of the meeting held on the 14th May 2018 were agreed as a correct record.

100/18 Matters Arising

The Board reviewed the actions from the Board of Directors meeting 14th May 2018 and noted progress. There was one matter arising from the last meeting as follows:

(i) MFT Values & Behaviours Framework - The Board received a re-submission of the report originally presented to the Board of Directors (Public) meeting on 14th May 2018 (Agenda Item 80/18) following the recommendation by the Board to amend the wording in the Framework from *'Behaviours we don't want',* to *'Behaviours we will not accept'.* With the exception of a further minor typographical error highlighted elsewhere in the report, the remainder of the paper remained unchanged.

The Board approved the amendments to the Framework as presented.

Decision:	Amendments to the V&B Framework Noted and Approved.	**Action by:** n/a	**Date:** n/a

101/18 Group Chairman's Welcome and Opening Remarks

i) The Group Chairman reported that the NHS celebrated its 70th anniversary on Thursday, 5th July 2018. She described a number of events which had been held across MFT. Particular attention was drawn to the focus on Trafford as the birthplace of the NHS and it was noted that a Blue Plaque was unveiled by Greater Manchester Mayor Andy Burnham. It was further noted that MFT had also been involved in a number of media activities leading up to the anniversary, including: 'Songs of Praise' featuring Trafford staff, a BBC documentary featuring Renal at MRI, and, BBC Radio 5 Live broadcasted from Trafford General Hospital on the 5th July. The Board was also advised that representative members of MFT staff attended a service at Westminster Abbey at noon on the 5th July and a choral concert at York Minster.

ii) The Group Chairman reported that MFT had marked the one year anniversary of the Arena Bomb Attack on 22nd May 2018. It was noted that a minute's silence was observed at 2.30pm throughout the organisation. The Group Chairman explained that the Multifaith Centre at MRI and the Hospital Chapel at Wythenshawe held a day of reflection and there was also a Service at Manchester Cathedral.

iii) The Group Chairman reported that the Great Manchester Run had taken place on 20th May 2018 and MFT had a large team of over 370 staff taking part in the event. The Board noted that over £19,000 had been raised for the MFT Charity on the day.

iv) The Group Chairman reported that the MFT Charity had launched its £4m iMRI Scanner Appeal at the end of June 2018 to revolutionise brain surgery at RMCH.

v) The Group Chairman was pleased to announce that a number of current and former MFT staff had received awards from the Queen in her Birthday Honours List. The Board congratulated Gilly Robinson (Consultant Nurse [Retired] who specialised in acquired brain injuries at RMCH) who received an MBE for services to Children's Nursing; Debbie Smith (Macmillan Information and Support Centre Manager, Wythenshawe) who received a BEM; and, Agimol Pradeep (a former CMFT member of staff who led important research into identifying methods to raise awareness of organ donation in the South Asian community) who received a BEM for her continued work in this area.

Decision:	Verbal Report Noted	**Action by:** n/a	**Date:** n/a

102/18 Group Chief Executive's Report

(i) The Group Deputy CEO reported that Phase 1 of the new Emergency Department expansion at Wythenshawe Hospital successfully opened its doors on Wednesday 16th May 2018. It was noted that improvements in this first phase of the development included 25 new majors cubicles, a new reception and waiting area with improved triage and ambulance bays.

(ii) The Group Deputy CEO reported that Mr Simon Stevens had visited RMCH on 14th June 2018 and during his time there, visited the Bone Marrow Transplant Unit and Paediatric Emergency Department.

(iii) The Group Deputy CEO confirmed that the Trust had now received the CQC's 'Provider Information Return' (PIR) request.

(iv) The Board noted that Clinical Leads had been appointed to each of the six Clinical Working Groups for *Wave One* of the Clinical Service Strategy programme.

(v) The Group Deputy CEO reported that over the last few months, the Greater Manchester Delivery Group (nursing and midwifery) had been leading a project, in collaboration with Greater Manchester Health and Social Care Partnership, the four Universities, NHS Providers, GP Practices and Social Care Providers, including the independent care sector, to develop a Greater Manchester nurse recruitment campaign. She explained that the campaign was launched as a 'call to action' on 29th June 2018.

(vi) The Board was pleased to note that four MFT clinicians had been promoted to MAHSC Honorary Clinical Chairs in the Faculty of Biology, Medicine and Health with effect from 1st August 2018. Congratulations were extended to Dr Jane Eddleston; Dr Sandip Mitra; Dr Akbar Vohra; and, Dr Titus Augustine

(vii) The Group Deputy CEO reported that the Trust would actively and positively support the ongoing investigation into the Neonatal Unit at the Countess of Chester Hospital if required.

(viii) The Board also noted that there had been a number of recent changes to the senior leadership team at Trafford Council.

Decision:	Verbal Report Noted	**Action by:** n/a	**Date:** n/a

103/18 Operational Performance

Board Assurance Report

The Joint Group Medical Director confirmed that the high level metrics for mortality remained positive with the Trust position better than the national average. He also confirmed that incident reporting remained strong across all sites (reflecting a strong reporting culture across the organisation). Particular attention was drawn to the recent outcome of a detailed investigation into devices (Syringe Drivers) used to administer drugs and painkillers at the Gosport War Memorial Hospital in Hampshire. The Joint Group Medical Director confirmed to the Board that following a national alert issued in 2011, both legacy organisations (CMFT & UHSM) had completely withdrawn all similar devices at that time and therefore none were in use in MFT.

In response to a point of clarification from Mr Rees, the Joint Group Medical Director agreed to review Wythenshawe Hospital's Level 4/5 data highlighted in the Safety Report. In response to a question from Dr Benett regarding the continued positive level of performance around the three key Mortality metrics, the Joint Group Medical Director explained that this reflected the quality and standards of care that are provided across the organisation (and the former legacy organisations), rather than any single action.

The Group Deputy Chief Nurse highlighted the Trust's performance around 'Compliments' and work to improve the capturing and recoding of compliments going forward. It was agreed that Complaints would be discussed under Agenda Item 103/18 below (Governance). The Board also noted that the Trust was expecting 300 new starters within the Nursing & Midwifery Workforce in September/October 2018 and had also recently had a successful international recruitment campaign. It was also noted that whilst the Trust was reviewing how data is captured and reported for the Friends & Family Test, all Hospitals/MCS were reviewing their current performance and producing improvement plans.

The Group Chief Operating Officer provided an overview of performance under the main headings of Cancelled Operations (which demonstrated improvement); Diagnostics (which also demonstrated sustained improvement); Urgent & Emergency Care (A&E performance had deteriorated in May and therefore heightened levels of focus was now applied in all areas with emphasis on transformation and shared learning across all sites); Cancer Waiting Times (renewed focus on recovering performance trajectories by Q3); and, Referral to Treatment (RTT). Particular attention was drawn to the RTT performance within the Trust and it was reported that following a review of the organisation's longest waiting patients, and some subsequent investigation of the Trust's PAS system, approximately 250 patients had recently been identified as waiting over 52 weeks for treatment. She explained that the reasons for this were multi-factorial, around systems and processes. The Board was advised that following the identification of this recording issue, the Trust immediately launched an open and extensive investigation.

In response to questions from the Group Chairman and the Group Deputy Chairman (the latter specifically around capacity), the Group Chief Operating Officer explained that a clinical review for each patient case was immediately undertaken and to date, the Trust had not identified any patient harm as a result of this delay. She noted that patients had received apologies for the delay in treatment. It was also noted that agreed plans were now in place to treat all the patients by the end of September 2018 (overseen on a weekly basis by a Task Force chaired by the Chief Operating Officer and Chief Finance Officer). It was confirmed this was not expected to have an adverse impact on the organisation's ability to work towards meeting the ongoing RTT trajectories.

The Group Chairman confirmed that the Trust's RTT performance highlighted by the Group Chief Operating Officer would receive further (and ongoing) review at the Board's Quality & Performance Scrutiny Committee.

In response to question from Mr Rees regarding the possible impact of Flu and the adverse weather on attendances to A&E Departments, the Chief Operating Officer confirmed that further analysis was underway looking at the acuity of patients attending A&E facilities across the organisation.

The Group Director of Workforce & OD reported that the Trust had experienced a dip in Mandatory Training (Clinical & Corporate) performance in May 2018 and this was expected due to a 'switch' from one recoding platform to a new system. However, performance in three Hospitals/MCS continued to be below trajectory and each area had been requested to provide their recovery plans going forward. In response to a question around the lack of improvement in the 'Engagement Scores' since the last report, the Group Director of Workforce & OD explained that the last report focused on the Q3 (2017/18) survey and the Q4 (2017/18) Pulse Check was issued before the Q3 national survey results had been received. It was noted that whilst this meant Staff Engagement Plans to address the issues raised had not been formulated in time to have a positive impact on the performance highlighted in the May Report, the plans were now in place and Hospitals/MCS were now actively working on improving their engagement trajectories.

It was also noted that Staff Retention within the organisation was performing well and the thresholds for Nursing & BME retention target was set in keeping with national standards (the threshold is a 1% change on either side of the NHS norm). The Board also noted that that the HR Scrutiny Committee (HRSC) had undertaken a 'deep dive' into Appraisal Performance across the organisation. In response to a question from the Group Chairman, the Joint Group Medical Director provided further assurance on the quality of the Medical Workforce Appraisal Process. The Group Director of Workforce & OD advised that a similar question had been raised at the HRSC by the Group Deputy Chairman, in relation to non-medical appraisals which led to a discussion around how the quality of appraisals is assured.

The Board noted the Board Assurance Report (May 2018)

Decision:	Report Noted	**Action by:** n/a	**Date:** n/a

Q1 (2018/19) Transformation Programme Report

The Chief Operating Officer presented the Quarter One (2018/19) Transformation Programme Report.

The Board was reminded of the 3-year road map within the Transformation Strategy with a focus on Year 2 delivering integration benefits and going from 'good' to 'great'. The Chief Operating Officer also reminded the Board that during 2018/19, the focus would be on delivering the patient and financial benefits from the merger business case, as well as continuing to embed and sustain the MFT standards for outpatients, elective and non-elective care across all Hospitals / Managed Clinical Services. She explained that the transformation resource would focus on the complex change work streams which would primarily be in the delivery of the integration benefits.

Attention was drawn to the timescales and commitments to deliver the integration programmes of work during 2018/19. The Chief Operating Officer highlighted some of the key objectives and progress made between April and June 2018 against the key headings of 'MFT Operational Excellence Standards'; 'Integrated Care and Pathways to deliver Clinical Benefits'; and, 'Creating the Culture and build capability for continuous improvement for Change'. The Board was also familiarised with the key objectives receiving additional focus in Quarter Two (2018/19).

In response to a question from Mr Rees regarding assurance that there was connectivity between the Transformation Programme and the Trust's Service Strategy and Integration Plans, the Chief Operating Officer confirmed that the MFT Transformation Team were active members of the Trust's Service Strategy Committee (and sub-Groups).

Decision:	Report Noted	**Action by:** n/a	**Date:** n/a

Progress Report on the Single Hospital Service (SHS)

The Deputy Director for the SHS provided an update on the Manchester SHS Programme including the NHS Improvement proposal for MFT to acquire North Manchester General Hospital.

The Board noted that the integration activity across MFT continued to progress as planned with the main focus of activity currently on implementing and planning for the more complex strategic programmes of work due to deliver in Years 1 and 2. The Deputy Director for the SHS explained that this work continued to be actively overseen by the Integration Steering Group (ISG) with cross referencing to the work underway to design an MFT Clinical Service Strategy and deliver a major transformation programme including a significant organisational development agenda.

The Deputy Director for the SHS confirmed that Programme Boards for the key clinical integration programmes had now been established and the Board noted updates on the main programmes of work underway, namely, Urology; Orthopaedics; implementation of Healthier Together plans and associated surgical services; implementation of new shared pathway for Acute Coronary Syndrome; improved hip fracture rehabilitation pathway for Trafford residents; primary focus of the newly established Managed Clinical Services on integration notably across the Oxford Road Campus, Wythenshawe and Trafford sites.

The Board was advised that integration planning for Year 2 and beyond was underway but a formal process to re-affirm plans and reflect on the progress made at one year post merger would be commenced in mid/late August 2018.

The Deputy Director for the SHS went on to describe the work progressing on the second phase of the SHS Programme: the acquisition of North Manchester General Hospital (NMGH) by MFT.

The Board was reminded of the background to the proposed acquisition and it was noted that the Manchester Health and Care Commissioning, and, the North East Sector Commissioners were leading separate processes to develop service model for acute services at NMGH and the other PAHT sites, respectively. It was noted that MFT was providing input into the MHCC process as required and that GMH&SCP would also support this process as necessary to ensure that the Commissioning plans were consistent.

The Deputy Director for the SHS also confirmed that work was continuing, within MFT, to develop the Strategic Case which was the first key submission required in the transaction process. He also explained that MFT was on track to deliver this objective within the planned timescale, and, that a process had started of understanding the profile of clinical services at NMGH and to undertake vendor due diligence. The Board also noted that a staff engagement plan for NMGH was currently being developed and staff engagement sessions open to all staff at NMGH were being planned, with the first one scheduled to take place on 11th July 2018.

In response to a question from Professor Georghiou, the Deputy Director for the SHS confirmed that there was a dynamic interaction between MFT and SRFT regarding the identified boundaries between services within North Manchester.

Mrs McLoughlin stated that there was an expectation and requirement for the same level of attention to detail and precision around the NMGH acquisition to that witnessed during the successful merger of the former UHSM & CMFT and subsequent creation of the new MFT.

In conclusion, the Board received the report and noted the work underway to progress the post-merger integration plans. The Board also noted the position of the proposed transfer of North Manchester General Hospital as part of NHS Improvement's plan for the dissolution of Pennine Acute NHS Trust.

Decision:	Update Report Noted	**Action by:** n/a	**Date:** n/a

Chief Finance Officer's Report

The Group Chief Finance Officer reported that the financial performance for the first two months of the year was a bottom line deficit (on a control total basis) of £2.4m (0.9% of operating income). He confirmed that this was just in-line with the plan submitted to NHS Improvement.

The Board noted that the 'underlying' deficit of £6.9m in just 2 months (excluding Provider Sustainability Funding) represented £3.5m per month, compared to an aggregate monthly deficit around £1m per month over the final 5 months of 2017/18. The Board was reminded that the Hospitals/MCS' had aggregate Trading Gap targets of £66m.

The Group Chief Finance Officer explained that the primary cause of this worsened run-rate performance was the position across the Turnaround programmes. He highlighted that insufficient delivery plans had been developed, with a gap of £22m. It was noted that to date, delivery plans totalling £41m had been identified, and further plans continued to be developed by the Hospitals/MCS'.

In addition to that shortfall in overall plans, the Board was advised that delivery across the identified plans was also itself over £4m lower than plan profiles to the end of May.

In response to a question from Mr Gower, the Group Chief Finance Officer confirmed that the dynamics of the income performance against plans for this year was significantly different to the previous year, with risk-sharing agreements in place for 2018/19 with Manchester Health & Care Commissioning and with NHS England Specialised Commissioning. Income was performing steadily in line with plans overall. The focus for overcoming the unsustainable month-by-month run-rate was therefore on ensuring the energy and focus throughout the organisation continued to be on driving the delivery plans for improved efficiency and reducing costs in line with the plans across Hospitals & MCS' with timely QIA reviews continuing in place on any material new plans as these were identified.

The Group Chairman confirmed that the Finance Scrutiny Committee would continue to examine the detail of delivery progress for further assurance on the identified key areas of risk to overall financial performance across the Trust.

The Group Chief Finance Officer's Report was noted.

Decision:	Report Noted	**Action by:** n/a	**Date:** n/a

104/18 Strategic Review

Update on Key Strategic Developments

The Group Executive Director of Strategy provided an update on a range of key strategic issues which were currently being progressed. Particular attention was drawn to the North West bid to host a national genomics laboratory which was completed and submitted on 30th April 2018 with the contract initially due to be awarded on 1st June. However, it was noted that NHS England had continued to review the specialist testing envelope during this time and the contract award had been delayed as a result. It was confirmed that service commencement was still currently scheduled for 1st October 2018.

The Group Executive Director of Strategy reported that in order to support *Sustainability & Transformation Plans* (STPs) better, NHS England (NHSE) and NHS Improvement (NHS I) had published plans to work more closely together. He confirmed that work was underway to align the work of the two national bodies, refocusing their priorities away from regulation and towards improvement. The Board noted the new governance arrangements and it was further noted that a significant change would be the introduction of seven new Regional Directors, who would report to both CEOs (of NHSE & NHS I) and carry out the work of NHSE and NHS I on a regional level.

The Board received an update on several key activities within the GM Health & Social Care Partnership including the development of the new GM Target Operating Model; work with NHSE & NHS I on establishing a national financial framework to apply to Integrated Care Systems; the development of GM metrics; the updating of the GM estates strategy; work around the GM Digital programme; and, the Transformation Programme (inc. Theme 3 transformation, and, updates on MFT-led transformation projects - Vascular, Breast Cancer, Paediatrics, Respiratory, Cardiac and Critical Care & Anaesthetics).

The Group Executive Director of Strategy also provided a brief update on the overarching Group Service Strategy (inc. the development of the Clinical Service Strategies).

The Board of Directors noted the report and in particular the potential impact of changes in East Cheshire on MFT patient flows; updates on the GM Theme 3 transformation programme and constituent projects; and, progress on the development of an overarching group service strategy and underpinning clinical service strategies for the organisation.

Decision:	Update Report Noted	**Action by:** n/a	**Date:** n/a

Update on Annual Planning (2018/19) and the MFT Operational Plan (2018/19)

The Group Executive Director of Strategy presented the MFT Operational Plan (2018/19) for approval, and, provided an update on planning for 2019/20.

The Board was reminded that an overarching MFT Operational Plan had been developed for 2018/19 and was based on the format of the operational plans that had historically been required to submit to NHS Improvement and Monitor. It was noted that Corporate directors had contributed to the overarching plan, describing their departmental priorities and anticipated challenges for 2018/19.

The Group Executive Director of Strategy explained that the draft plan had been reviewed by the Council of Governors with comments received being considered and reflected in further versions of the document. The Board noted that the document had been signed-off by the Group Executive Director Team collectively as well as by the Group Management Board (GMB), and approval was now sought from the Board of Directors. Following a brief discussion, the Board of Directors approved the MFT MFT Operational Plan (2018/19).

The Group Executive Director of Strategy went on to describe the development of the Hospitals/MCS Business Plans and the involvement of the Council of Governors. It was noted that feedback from Governors had been passed-on to the Hospitals / MCS leadership teams for consideration. It was also noted that the Group Executive Director Team had collectively signed-off the Hospital/MCS plans and GMB had given approval.

The Board noted the approach to the first year of annual planning for MFT and it was always intended that the process would be further developed and refined for 2019/20 and subsequent years. The Group Executive Director of Strategy described some of the lessons learned in 2018/19 and the development of a revised process for next year. It was noted that the proposals for the 2019/20 planning process would be brought to GMB in early Autumn 2018.

The Board of Directors noted the report and approved MFT Operational Plan (2018/19).

Decision:	Report Noted and the MFT Operational Plan (2018/19) Approved	**Action by:** n/a	**Date:** n/a

Update on the Manchester Local Care Organisation (MLCO)

Ms Calvin-Thomas (MLCO) provided an update on progress regarding the development of the MLCO since April 2018 with a particular focus on New Care Models (NCMs); Development of Integrated Neighbourhood Team Leads; MLCO 2018/19 key deliverables; North Manchester Community Services transfer; and MLCO internal governance.

In conclusion, the Board noted that there continued to be good progress made in developing the NCMs and establishing 12 Integrated Neighbourhood Team hubs across the City of Manchester; the development of the 12 Integrated Neighbourhood Team Leads positions, with the intention to recruit to these posts by Quarter 3 2018; the establishment of a monitoring and reporting mechanism of the 2018/19 key deliverables associated with the MLCO, through the Programme Board and into MLCO Partnership Board; the progress made in regards to the TUPE transfer of staff in North Manchester Community Services from PAHT to MFT from July 2018 following the contract transfer in April 2018; and, the establishment of the MLCO's internal governance structures and associated processes (as described in the report presented).

In response to a question from Mr Rees, the Group Chairman explained that the inaugural meeting of the LCO Scrutiny Committee would be arranged in early September 2018 and performance metrics for the new MLCO would be developed and monitored at the new Committee. Professor Bailey welcomed the opportunity for Systems Leadership Learning across the system.

The Board noted the contents of the update report.

Decision:	Update Report Noted	**Action by:** n/a	**Date:** n/a

105/18 Governance

Update Report on the Regulatory Assessment Process 2018/19 (inc. PIR)

The Deputy Chief Nurse provided an update on the Regulatory Assessment Process (2018/19). The Board was reminded that statute required all NHS Trusts to be appropriately registered with the CQC, and, that the CQC inspected all core services of any new NHS Trust.

The Deputy Chief Nurse described the revised registration details of MFT along with details of the CQC inspection notification process. It was noted that following the merger, the Trust proposed a revised registration arrangement with the CQC and this had been approved by the CQC Registration Team. It was also noted that the application was made and the new registration details were now reflected on the CQC website (www.cqc.org.uk). It was confirmed that each MFT registered site would receive its own CQC rating, and, the Group as a whole would also receive a rating.

The Board was also reminded that the CQC had indicated their intention to undertake an inspection of all core services across all sites within one year of the formation of the new organisation; this was as set out in their regulatory guidance. The Deputy Chief Nurse confirmed that the CQC had issued a request for information; Provider Information Return (PIR) on Friday, 15th June 2018 (and it was noted that these were usually issued 9 weeks before the Regulatory Planning Meeting. It was also noted that the Well-Led inspection would be completed within 12 weeks of the regulatory planning meeting and the inspection of the core services would take place in between the regulatory planning meeting and the Well-Led inspection.

The Deputy Chief Nurse explained that the CQC target was to publish reports within 12 weeks of the Well-Led inspection and it was expected that component parts of managed clinical services would be published within a report on the host geographical site.

The Board noted the revised registration arrangements and the process for notification of inspection.

Decision:	Update Report Noted	**Action by:** n/a	**Date:** n/a

Approve the MFT Quality & Safety Strategy

The Deputy Chief Nurse presented the MFT Quality & Safety Strategy to the Board for approval following endorsement and recommendation by the Group Quality and Safety Committee.

The Deputy Chief Nurse reminded the Board that 'Quality' and 'Safety' were fundamental aspects of the Trust's vision and informed the strategic and operational priorities of the organisation. She explained that the Quality and Safety Strategy was central to the work of the Trust and aligned closely with other core strategies such as the Leadership and Culture Strategy and the Trust Values and Behaviours. It was noted that the accountability structure for delivery of the Strategy would be through the Quality and Performance Scrutiny Committee to the Board of Directors.

The Board noted the content of the Strategy and especially the six principles identified to inform its delivery, namely, patient-focused services that deliver the Best Outcomes every time; 'Right Care First Time' and every time for every patient; accountability and outstanding leadership at every level; commitment to continuous learning and improvement; develop and share best practice at scale and pace and reduce inappropriate variation; and, being open and transparent and learning when things go wrong.

The Board was also advised that the Strategy set out a model for measuring and monitoring safety alongside established patient experience metrics. It was confirmed that this provided an overall framework within which each Hospital/MCS/LCO would be able to identify, monitor and report relevant metrics. The Deputy Chief Nurse explained that the Strategy stated a commitment to effective communication and hearing the voice of patients, carers, staff and stakeholders and offered a selection of mechanisms that were available to each Hospital/MCS/LCO to support engagement.

In response to an observation by the Group Chairman, the Deputy Chief Nurse explained that following the launch of the Strategy, each Hospital/MCS/LCO would develop a local Implementation Plan, setting out specific annual targets and trajectories to deliver the quality and safety priorities and objectives set out in the Strategy. She went on to explain that the plan would be informed by Hospital/Managed Clinical Service/LCO-specific metrics, some of which would be incorporated into Hospital/MCS/LCO performance dashboards to enable local monitoring, as well as enabling Group level monitoring through the Accountability Oversight Framework; thereby ensuring that performance and progress can be tracked from "ward to Board".

Following a brief discussion, the Board approved the Quality & Safety Strategy and supported implementation across the Group.

Decision:	Quality & Safety Strategy Approved	**Action by:** n/a	**Date:** n/a

Greater Manchester Clinical Research Network Annual Delivery Report (2017/18)

The Joint Group Medical Director presented the GM Clinical Research Network Annual Delivery Report (2017/18). Particular attention was drawn to the highlights of performance against the Annual Delivery Plan and it was recognised that Greater Manchester had experienced a successful year with the one Network approach motivating Partner Organisations to work flexibly and collaboratively offering research opportunities across specialties to all patients.

It was noted that the LCRN had brokered relationships between the Mental Health Trusts, Acute trusts and academic units in order to facilitate commercial clinical trials within dementia and mental health. It was also noted that in 2017/18, Greater Manchester had maintained a consistently strong performance across all of the clinical specialties, demonstrated by over 80% ranking in the top 10 nationally.

The Joint Group Medical Director described the Communications and PPI activities during the previous 12 months and key highlights were noted (as presented) with particular attention drawn to the 5th Annual GM Clinical Research Awards which recognised the continued success of research across the footprint of Greater Manchester.

The Board was advised that finances throughout 2017/18 were delivered on time and balanced at the year-end (March 2018). It was also noted that the Local Portfolio Management System (LPMS) R-Peak was fully operational with all Trusts now using the system (the LPMS was providing vital study information so that the organisation could keep up to date with performance). The Joint Group Medical Director also confirmed that the CRNGM had continued to work closely with the Northern Health Science Alliance and the other 3 Northern LCRN's over the past 12 months. It was also noted that the NHSA initiatives echoed the one NIHR approach and sought to strengthen collaborations across Northern Trusts and Universities.

The Board received and approve the CRNGM Annual Delivery Report (2017/18) and noted MFT's strong performance within CRNGM.

Decision:	Delivery Report Received and Approved	**Action by:** n/a	**Date:** n/a

Complaints Annual Report (2017/18)

The Deputy Chief Nurse presented the Complaints Annual Report for 2017/18 in keeping with Statutory Instruments No. 309, which requires NHS bodies to provide an annual report on the Trust's complaints handling, which must be made available to the public under the NHS Complaint Regulations (2009). It was noted that the Annual Report presented reflected all complaints and concerns made by (or on behalf of) patients of the current and legacy Trusts (CMFT & UHSM), received between 1st April 2017 and 31st March 2018.

The Deputy Chief Nurse explained that extensive work had been undertaken during 2017/18 to develop the complaints systems and processes for the newly formed MFT and the report served to celebrate some of those achievements and improvements, whilst acknowledging there were further improvements still to be realised in the newly established Trust.

The Board noted the comparative data provided within the report which was compared to the previous year's performance and that during 2017/18, the quality of complaints data reporting had continued to improve. However, the Deputy Chief Nurse explained that caution should be applied to attempting direct comparison of the data from the two former Trusts, as the data collection was extracted from different versions of the Ulysses Safeguard Complaints Management System for each legacy Trust.

The Board was advised that the number of PALS concerns received in 2017/18 by the former Trusts and MFT was 5,831 and this represented a decrease of 207 compared with 6,038 received in 2016/17 (a decrease of 3.4%). The Board also noted that there had been an overall decrease in the number of formal complaints in 2017/18, with a total of 1,572, which was 54 less than the 1,626 formal complaints received in 2016/17 (a 3.3% reduction).

The Deputy Chief Nurse drew attention to a number of other Complaints performance indicators including the average age of formal complaint cases; % of unresolved cases over 41 days old; the average response rate for patients and carers; the acknowledgement of complaints within 3 working days; and, Parliamentary and Health Service Ombudsman (PHSO) activity.

It was particularly noted that all cases over 41 working days old continued to be escalated within the relevant Hospitals/Managed Clinical Services and assurance was provided via the organisation's Accountability Outcomes Framework (AOF).

The Deputy Chief Nurse described the work of the Complaints Scrutiny Group and the focus of the 'Complaints Improvement Programme' (citing several examples of improvements delivered in 2017/18). The Board noted that the report detailed examples of learning and change as a direct result of feedback received through complaints and concerns. It was particularly noted that the Trust was grateful to those patients and families who had taken the time to raise concerns and acknowledged their contribution to improving services, patient experience and patient safety.

The Board noted the content of the report and in line with statutory requirements, approved it to be published on the Trust's website.

Decision:	Annual Report Noted and Approved for publication of the Trust's Website.	**Action by:** n/a	**Date:** n/a

Safeguarding Annual Report (2017/18)

The Deputy Chief Nurse presented the Safeguarding Annual Report (2017/18). She explained that in response to the merger of the former UHSM and CMFT in October 2017, there were two separate reports presented for each legacy Trust from 1st April to 30th September 2017 (Quarters 1 and 2) followed by a single MFT report for the period 1st October to 31st March 2017/18.

The Board noted that the Annual Safeguarding Report for Children, Adults and Looked After Children (LAC) informed and provided information regarding internal and external safeguarding activity undertaken by the Safeguarding Team in 2017/18 and outlined key priority areas for 2018/19.

The Deputy Chief Nurse reported that 2017/18 had been an extremely busy year for safeguarding citing examples of challenges, changes and opportunities presented during the previous 12 months. It was noted that the development of the SHS and the Manchester Local Care Organisation (MLCO) had enabled safeguarding to be considered at a whole system level across the organisation and beyond.

The Deputy Chief Nurse confirmed that throughout these changes, the underpinning safeguarding principle had remained unchanged: *'We listen, We believe, We act'*

The Board received assurance, as described in the report, that the Trust was fulfilling its statutory safeguarding responsibilities as outlined in Section 11 of the Children Act 2004 and in the Care Act 2014.

The Deputy Chief Nurse also confirmed that Safeguarding activity was underpinned by the standard and statutory guidance as outlined in the report.

The Board received and approved the Safeguarding Annual Report (2017/18)

Decision:	Annual Report Received and Approved	**Action by:** n/a	**Date:** n/a

To Note Committee meetings which had taken place:

- Group Risk Management Committee held on 9th May 2018
- Quality & Performance Scrutiny Committee held on 4th June 2018
- HR Scrutiny Committee held on 19th June 2017
- It was noted that the Audit Committee minutes held on 23rd May 2018, and, Part 2 minutes of the meeting held on 4th April 2018 would be received and noted at the next Board of Directors meeting held in September 2018

106/18 Date and Time of Next Meeting

The next meeting of the Board of Directors held in public will be on **Monday 10th September 2018** at **2pm** in the **Main Boardroom**

107/18 Any Other Business

There was no other business.

Present:	Mr J Amaechi	- Group Non-Executive Director
	Mr D Banks	- Group Director of Strategy
	Professor Dame S Bailey	- Group Non-Executive Director
	Dr I Benett	- Group Non-Executive Director
	Mrs J Bridgewater	- Group Chief Operating Officer
	Mr B Clare	- Group Deputy Chairman
	Mrs K Cowell	- Group Chairman
	Professor L Georghiou	- Group Non-Executive Director
	Mr N Gower	- Group Non-Executive Director
	Mrs G Heaton	- Group Deputy CEO
	Mrs M Johnson	- Group Director of Workforce & OD
	Mrs C McLoughlin	- Group Non-Executive Director
	Professor R Pearson	- Joint Group Medical Director
	Mr T Rees	- Group Non-Executive Director
	Mr A Roberts	- Group Chief Finance Officer
In attendance:	Mr D Cain	- Deputy Chairman Fundraising Board
	Mr S Gardner	- Deputy Director Single Hospital Service
	Mr A W Hughes	- Director of Corporate Services/Trust Board Secretary
	Ms K Calvin-Thomas	- MLCO
	Mrs S Ward	- Deputy Chief Nurse
Apologies:	Sir M Deegan	- Group Chief Executive
	Professor C Lenney	- Group Chief Nurse
	Miss T Onon	- Joint Group Medical Director

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS' MEETING (Public)

ACTION TRACKER

Board Meeting Date: 12th March 2018			
Action	Responsibility	Timescale	Comments
Update Report on Never Events action plans to mitigate risk of recurrence to be presented to the Board in six months.	Group Joint Medical Director	September 2018	

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Directors
Paper prepared by:	Gareth Summerfield, Head of Information, Information Management, CMFT
Date of paper:	31st August 2018
Subject:	**Board Assurance Report – July 2018**
Purpose of Report:	Indicate which by ✓ • Information to Consider ✓ • Support • Resolution • Receive
Consideration of Risk against Key Priorities:	The Board Assurance Report is produced on a monthly basis to inform the Board of compliance against key local and national indicators as well as commentating on key issues within the Trust.
Recommendations:	The Board of Directors is asked to Consider the content of the report
Contact:	Name: **Gareth Summerfield** Designation: **Head of Information** Tel No: **0161.276.4768** E-mail: Gareth.Summerfield@cmft.nhs.uk

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS

BOARD ASSURANCE REPORT

(JULY 2018)

1. Introduction

The Board Assurance Report is produced on a monthly basis to inform the Board of compliance against key local and national indicators as well as commentating on key issues within the Trust.

2. Overview

The Board Assurance Report provides further evidence of compliance, non-compliance and/or risks to the achievement of the required thresholds within individual indicators. The report also highlights key actions and progress in addressing any shortfalls.

3. Key Priority Areas

The report is divided into the following six key priority areas:

- **Safety**
- **Patient Experience**
- **Operational Excellence**
- **Workforce & Leadership**
- **Finance**
- **Strategy**

Headline narratives provide context to the above key priority areas, stating current issues, identifying where progress is 'good', identifying future challenges and risks, and commenting on the latest developments around performance of the various indicators.

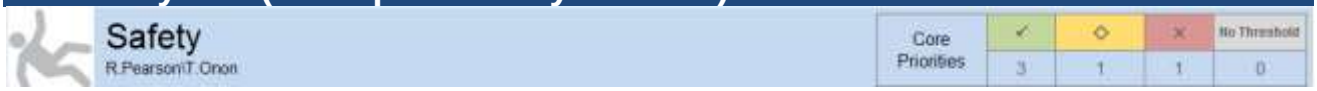
The narrative is provided by the person(s) accountable for the individual priority areas.

'Guidance Notes' are also included to support the interpretation of the data presented each month.

> Board Assurance Narrative Report – Guidance Notes

The purpose of this document is to assist with the navigation and interpretation of the Board Assurance Report, taking into account Trust performance, indicator statuses, desired performance thresholds as well as who is accountable for the indicator. The report is made up six distinct domains as follows: Safety, Patient, Operational Excellence, Workforce & Leadership, Finance, and Strategy. Each domain is structured as follows:

Summary Bar (Example –Safety Domain)



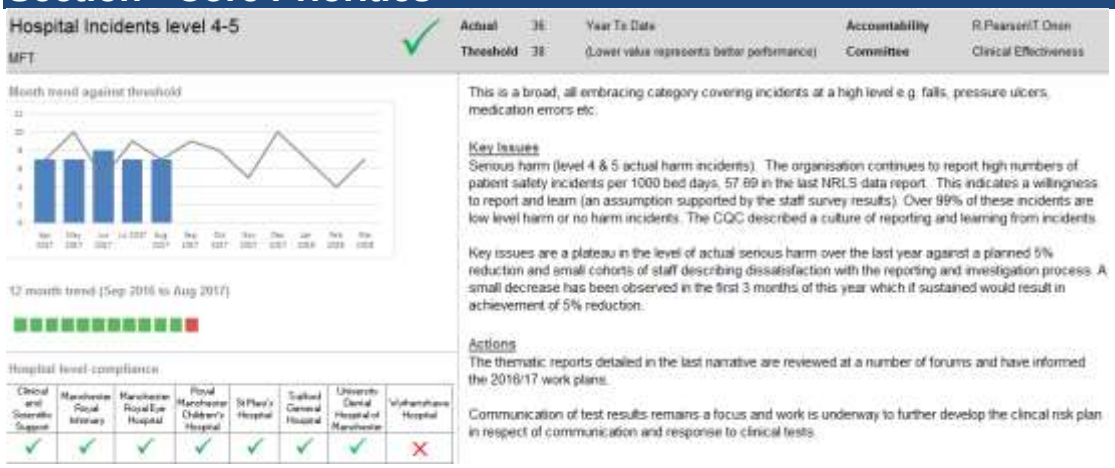
The bar at the very top of each page identifies the domain and accountability. To the right of the top bar is a summary of the core priority indicators associated with the domain. For the example of Patient Safety:

- 3 indicators are flagged as achieving the Core Priorities desired threshold
- 1 indicator is flagged as a warning. A warning may relate to the indicator approaching a threshold or exceeding the threshold by a set margin.
- 1 indicator is flagged as failing the desired threshold
- 0 indicators have no threshold attributed. In some cases, indicators will not have a national of local target/threshold in which to measure against.

Headline Narrative

Headline narratives give context to the domain, stating current issues, good news stories, future challenges and risks, and commenting on the latest developments around performance of the indicators. Narrative is provided by the person(s) accountable for the individual domain

Section - Core Priorities



Each of the individual core priorities are set out as above. Firstly with an individual summary bar detailing:

- **Actual** – The actual performance of the reporting period
- **Threshold** – The desired performance threshold to achieve for the reporting period. This may be based on a national, local, or internal target, or corresponding period year prior.
- **Accountability** - Executive lead
- **Committee** – Responsible committee for this indicator
- **Threshold score measurement** – This illustrates whether or not the indicator has achieved the threshold, categorised into three classifications: Meeting threshold (green tick), approaching threshold (amber diamond) and exceeding threshold (red cross). Amber thresholds are indicator specific.

Below the summary box detail on the left hand side of the page are 3 graphics, as follows:

- **Bar Chart** – detailing the monthly trend (bar) against the threshold for this particular indicator (line)
- **12 month trend chart** – Performance of this indicator over the previous 12 months.
- **Hospital Level Compliance –** This table details compliance of the indicator threshold by hospital

On the right hand side of these graphics is the executive narrative which details the key issues behind indicator compliance and the actions in place to mitigate this.

NHS
Manchester University
NHS Foundation Trust

> Board Assurance

July 2018

Safety

R.Pearson\T.Onon

Core Priorities	✓	◇	✕	No Threshold
	3	0	2	0

Headline Narrative

Core priorities for patient safety are currently being met with one exception. The Group has had a number of Never Events reported over the last 12 months. There have, to date, been eight reported events.

In response to this the following actions are underway and will be included in a review of the group risk (Never Events - 3228).

- The Local Safety Standards for Invasive Procedures (LocSSIPs) are being reviewed as a matter of urgency and the two hospitals with the highest reported incidence (RMCH and Wythenshawe) are a priority in this review.
- Trust wide alerts and safety information have been disseminated across February and March 18
- Group wide work is being undertaken on Safe Surgery Checklists
- Work is being undertaken with the National Health Safety Investigation Branch (HSIB) on learning
- Work is being undertaken with the Shelford Safety leads to ascertain if there is further learning and action that can be shared
- A review is being undertaken of policies for safe procedures and the aim is to bring these together as one document
- A further Safety Alert has been circulated to all Hospital sites with required actions

The Quality and Safety Committee will be overseeing this work and the aim continues to be to eradicate these events.

Serious harm incidents so far this year are just above the threshold compared with same period last year.

Safety - Core Priorities

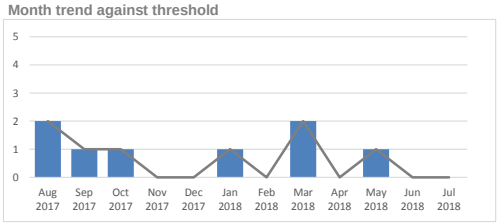
Never Events

MFT

✕

Actual	1	Year To Date	**Accountability**	R.Pearson\T.Onon
Threshold	0	(Lower value represents better performance)	**Committee**	Clinical Effectiveness

Month trend against threshold



12 month trend (0 to 0)

Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Trafford General Hospital	Wythenshawe Hospital
✕	✓	✓	✓	✓		✓	✓
1	0	0	0	0		0	0

Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

Key Issues

Never events are those clinical incidents that should not happen if appropriate policies and procedures are in place and are followed. The list is determined nationally.

Since April there has been 1 Never Event a misplaced NG Tube in Wythenshawe ICU.

Actions

Working groups are reviewing local risks and implementing solutions to reduce harm with the ongoing implementation of Local Safety Standards for Invasive Procedures (LocSSIPs).
The never events risk is under review.

Progress

Following these events a number of immediate actions were implemented including issuing of Trust wide alerts. Investigations have been undertaken to identify learning with associated action plans in place. In addition we are working with the Healthcare Safety Investigation Branch on the wrong route medication Never Event to contribute to national learning and solution development.

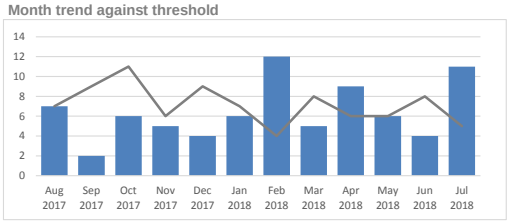
Further work is now being undertaken Group wide on safer surgery checklists and item counts, this work will be reported to the Quality and Safety Committee.

Hospital Incidents level 4-5

MFT

Actual	30	Year To Date	**Accountability**	R.Pearson\T.Onon
Threshold	25	(Lower value represents better performance)	**Committee**	Clinical Effectiveness

Month trend against threshold



12 month trend (to)

Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Trafford General Hospital	Wythenshawe Hospital
✗	✗	✗	✗	✓		✗	✓
3	10	2	5	0		3	5

This is a broad, all embracing category covering incidents at a high level e.g. falls, pressure ulcers, medication errors etc. (These figures include incidents that are unconfirmed so may decrease)

Key Issues

Serious harm (level 4 & 5 actual harm incidents). The organisation continues to report high numbers of patient safety incidents per 1000 bed days, (Central and Trafford site hospitals 57.69 and Wythenshawe Hospital 55.54) in the last NRLS data report. This indicates a willingness to report and learn (an assumption supported by the staff survey results). Over 99% of these incidents are low level harm or no harm incidents. The CQC described a culture of reporting and learning from incidents within Central and Trafford site hospitals and described Wythenshawe Hospital as having a strong focus on patient safety and an open culture for reporting incidents.

The overall number of serious harm incidents ytd compared to the same period last year is just below the threshold. In terms of hospital sites the threshold is based on the same period last year and it can be seen that some have seen an increase, however these are small numbers and natural variation will occur. In addition as services change / reconfigure this may impact on this method. Therefore alternative approaches to this are being considered.

Actions

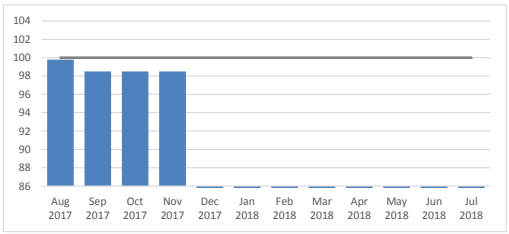
Communication of test results remains a focus across the Group and work is underway to further develop the clinical risk plan in respect of communication and response to clinical tests.

Thematic reports are reviewed at a number of forums and will inform the 18/19 work plans.

SHMI (Rolling 12m)

MFT

Actual	98.5	Latest Period	**Accountability**	R.Pearson\T.Onon
Threshold	100	(Lower value represents better performance)	**Committee**	Clinical Effectiveness



12 month trend (100 to 105)

Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Trafford General Hospital	Wythenshawe Hospital
NA	✗	NA	✗	NA		✓	✓
NA	105.7	NA	136.6	NA		86.3	92.9

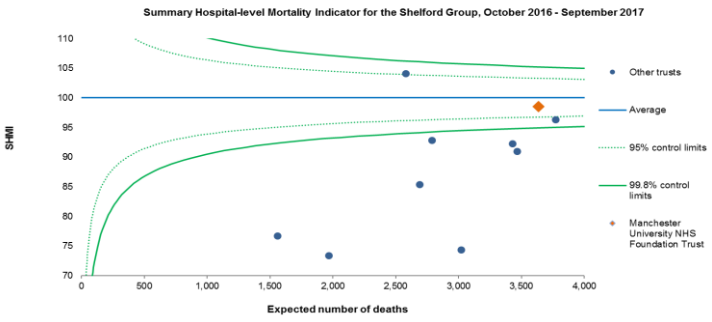
The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. The SHMI indicator gives an indication of whether the mortality ratio of a provider is as expected, higher than expected or lower than expected when compared to the national baseline.

Progress

The Learning from Deaths process is currently under review and a Group wide Strategy and Policy is in development. This aims to address inconsistencies in both review and coding to improve learning and assurance processes.

SHMI is a weighted metric for all adult acute settings (RMCH, REH and UDHM are excluded). Risk adjusted mortality indices are not applicable to specialist children's hospitals. All child deaths undergo a detailed mortality review.

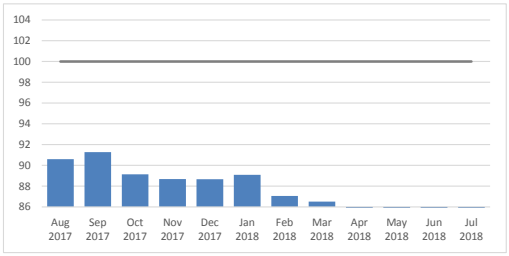
Performance is within the expected range.



HSMR (Rolling 12m)

MFT

Actual	86.5	Latest Period	**Accountability**	R.Pearson\T.Onon
Threshold	100	(Lower value represents better performance)	**Committee**	Clinical Effectiveness



12 month trend (100 to 105)

Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Trafford General Hospital	Wythenshawe Hospital
NA	✓	NA	✓	NA		✓	✓
NA	83.4	NA	95.4	NA		82.5	88.3

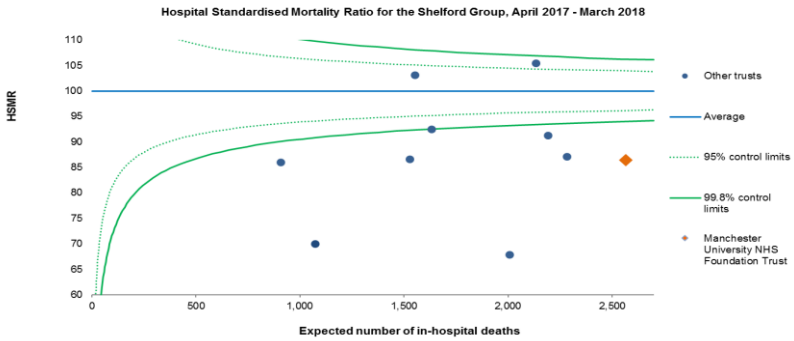
HSMR monitors a Trust's actual mortality rate when compared to the expected mortality rate. It specifically focuses on 56 diagnosis codes that represent 85% of national admissions.

HSMR is a metric designed for adult practice.
Risk adjusted mortality indices are not applicable to specialist children's hospitals. All child deaths undergo a detailed mortality review
HSMR is a weighted metric for all adult acute settings (RMCH, REH and UDHM are excluded)

The Learning from Deaths process is currently under review and a Group wide Strategy and Policy is in development. This aims to address inconsistencies in both review and coding to improve learning and assurance processes.

Progress

The Group HSMR is within expected levels.

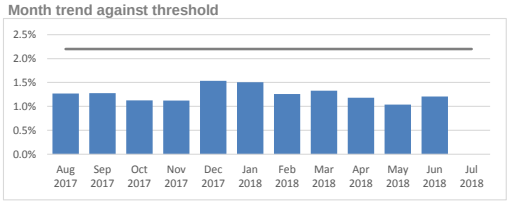


Crude Mortality

MFT

Actual	1.14%	Year To Date	**Accountability**	R.Pearson\T.Onon
Threshold	2.20%	(Lower value represents better performance)	**Committee**	Audit Committee

Month trend against threshold



12 month trend (0.0209 to 0.0264)

Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Trafford General Hospital	Wythenshawe Hospital
NA	✓	✓	✓	✓		✓	✓
NA	1.8%	0.3%	0.3%	0.0%		0.4%	1.1%

A hospital's crude mortality rate looks at the number of deaths that occur in a hospital in any given year and then compares that against the amount of people admitted for care in that hospital for the same time period.

Key Issues

Crude mortality reflects the number of in-hospital patient deaths divided by the total number of patients discharged as a percentage and with no risk adjustment.

The Group site hospitals have the lowest crude mortality rates in the North West (Central and Trafford – 1.3, Wythenshawe - 1.2), and amongst the lowest in England, with trend over the last three years showing a steady rate with no variation which would cause concern.

Progress

The Trust is currently reviewing Elective crude mortality which whilst still low has increased in the quarter.

There is currently consideration being given to mortality metrics in RMCH, deaths per 1000 bed days will now be reported to allow for additional benchmarking with other specialist children's hospitals.

Patient Experience

C.Lenney

Core Priorities	✓	◇	✕	No Threshold
	4	0	4	2

Headline Narrative

The number of new complaints received across the Trust during July 2018 was 167; this compares to 148 in June 2018 and 182 in May 2018. Performance is monitored and managed through the Accountability Oversight Framework (AOF). At the end July 2018, there was a total of 102 cases over 41 days old compared to 102 cases at the end June 2018 and 185 cases over 41 days old at the end May 2018. The reduction of the number of complaints from May 2018 to June 2018 is predominantly as a result of the closure of cases at Wythenshawe that were registered prior to 1st April 2018.

Extensive work has been undertaken during 2017/18 to develop the complaints systems and processes for the newly formed Manchester University NHS Foundation Trust and work continues to align the Complaints/PALS management system, processes, recording and reporting across the Group. Devolution of responsibility of specific aspects of the complaints management process to the Hospital Chief Executives and Directors of Nursing continues to progress.

MFT continues to promote the Friends and Family Test (FFT) with 75.9% 'Extremely Likely' to recommend the service they received to their Friends & Family during July 2018 this compares to 76.6% in June 2018 and 74.8% in May 2018.

Patient Experience - Core Priorities

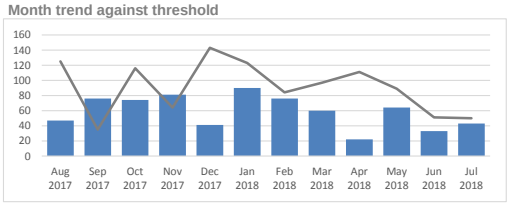
Compliments

MFT

✕

Actual	162	Year To Date	**Accountability**	C.Lenney
Threshold	301	(Higher value represents better performance)	**Committee**	Quality Committee

Month trend against threshold



12 month trend (to)

Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Trafford General Hospital	Wythenshawe Hospital
✕	✓	✓	✓	✓		✕	✕
2	51	6	9	31		28	23

The number of compliments received by the Trust through the office of the CEO are recorded on the Safeguard system.

Progress

Work continues to increase the number of compliments recorded across all Hospitals/MCS, with 43 compliments received in July 2018, compared to 33 in June 2018 and 64 in May 2018. During July 2018, Trafford Hospital recorded the highest number of Compliments with 16 (37.2%).

The Hospital/ MCS level performance against this indicator for year to date is detailed in the Hospital Level Compliance Chart.

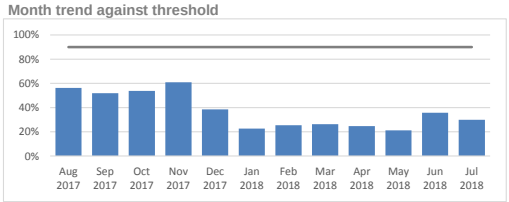
Percentage of complaints resolved within the agreed timeframe

MFT

✕

Actual	27.6%	Year To Date	**Accountability**	C.Lenney
Threshold	90.0%	(Higher value represents better performance)	**Committee**	Quality Committee

Month trend against threshold



12 month trend (0.69993 to 0.9)

Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Trafford General Hospital	Wythenshawe Hospital
✕	✕	✕	✕	✕		✕	✕
50.0%	10.6%	20.9%	22.0%	51.2%		29.4%	30.9%

The Trust has a responsibility to resolve complaints within a timeframe agreed with the complainant. The timeframe assigned to a complaint is dependent upon the complexity of the complaint and is agreed with the complainant.

Progress

The percentage of complaints resolved within the agreed timeframe with the Complainant is closely monitored and work is on-going to ensure timeframes are appropriate, agreed with complainants and achieved in all cases.

The overall MFT performance for July 2018 was 29.9%, which compares to 35.8% in June 2018, 21.2% in May 2018 and 24.6% in April 2018. In July 2018 the closure of complaints within the agreed timesclaes in MRI has been identified as a concern with only 10.6% of expected cases closed within the agreed timeframe. The issue has been identified and an improvement programme developed with a trajectory for improvement to be agreed.

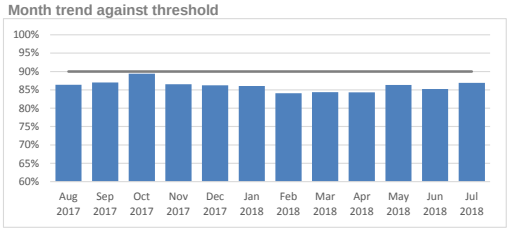
The Hospital/ MCS level performance against this indicator for year to date is detailed in the Hospital Level Compliance Chart. It should be noted that were Hospitals/MCS receive lower numbers of complaints, small numbers can result in high percentages.

Nursing Workforce – Plan v Actual Compliance for RN

MFT

Actual	86.9%	Latest Period	**Accountability**	C.Lenney
Threshold	90.0%	(Higher value represents better performance)	**Committee**	Quality Committee

Month trend against threshold



12 month trend (0.9 to 0.9)

Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Trafford General Hospital	Wythenshawe Hospital
✗ (Site level currently unavailable)							✗
86.1%							88.4%

As part of Safer Staffing Guidance the Trust monitors wards compliance with meeting their planned staffing levels during the day and night. This KPI provides the overall % compliance across all wards within the Trust with meeting the planned staffing levels. The actual staffing includes both substantive and temporary staff usage. There has been a decrease in the number of wards meeting their planned staffing levels during February due to the high number of hospital admissions and the requirement to open additional unfunded capacity.

Progress

Established escalation and monitoring processes are in place to ensure delivery of safe and effective staffing levels to meet the acuity and dependency of the patient group.

Areas with high number of vacancies are supported through the use of temporary nursing staff of which the acuity of individual areas, the usage and cost is monitored through weekly bank and agency meetings chaired by the Directors of Nursing.

Actions

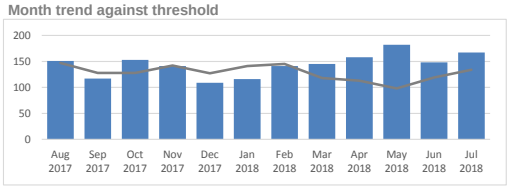
Acuity and dependency data is captured through Health roster SafeCare system with monthly reports provided to the Heads of Nursing and Directors of Nursing to inform monitoring of safe staffing levels across the Group.

Complaint Volumes

MFT

Actual	655	Year To Date	**Accountability**	C.Lenney
Threshold	464	(Lower value represents better performance)	**Committee**	Quality Committee

Month trend against threshold



12 month trend (to)

Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Trafford General Hospital	Wythenshawe Hospital
✗	✗	✗	✗	✗		✗	✓
37	187	61	72	43		55	145

The KPI shows total number of complaints received. Complaint volumes will allow the trust to monitor the number of complaints and consider any trends.

Key Issues

The number of new complaints received across the Trust in July 2018 was 167. This compares to 148 in June 2018 and 182 in May 2018.

Manchester Royal Infirmary and WTWA received the highest number of formal complaints in July 2018 with 47 complaints received for both MRI and WTWA. For comparison, Manchester Royal Infirmary received 54 complaints in June 2018 and 51 May 2018 and WTWA recieved 45 complaints in June 2018 and 55 in May 2018.

At the end July 2018, there was a total of 102 cases over 41 days old compared to 102 cases at the end June 2018 and 185 casesover 41 days old at the end May 2018. The reduction of the number of complaints from May 2018 to June 2018 is predominantly as a result of the closure of cases at Wythenshawe Hospital that were registered prior to 1st April 2018.

The Hospital/ MCS level performance against this indicator for year to date is detailed in the Hospital Level Compliance Chart.

Actions

All Hospitals/ MCS continue to prioritise closure of complaints older than 41 days. Chief Executives are held to account for the management of complaints cases that exceed 41 days through the Accountability Oversight Framework.

Progress

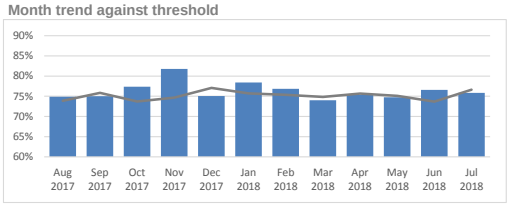
All Hospitals/ MCS are progressing establishment of their governance frameworks to focus on the management of complaints, specifically those that exceed 41 days with a view to expediting closure and identifying learning to inform future complaints management.

FFT % Extremely Likely

MFT

Actual	75.7%	Year To Date	**Accountability**	C.Lenney
Threshold	75.2%	(Higher value represents better performance)	**Committee**	Quality Committee

Month trend against threshold



12 month trend (to)

Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Trafford General Hospital	Wythenshawe Hospital
✗	✓	✗	✓	✓		◇	✓
73.0%	67.3%	67.0%	79.8%	87.0%		83.9%	80.7%

The Friends and Family Test (FFT) is a survey assessing patient experience of NHS services. It uses a question which asks how likely, on a scale ranging from extremely unlikely to extremely likely, a person is to recommend the service to a friend or family member if they needed similar treatment. This indicator measures the % of inpatients 'extremely likely' to reccommend the service.

Actions

Each Hospital and Managed Clinical Service continues to review and monitor their FFT response rates and identify areas for improvements.

Progress

The overall Trust Response Rate for Inpatients is 20.6% in July 2018; this compares to 23.8% in June and 26.1% in May 2018.

For Emergency Departments (ED) the response rate in July 2018 is 15.0%; this is compares to 15.5% in June and 15.4% in May 2018 2018.

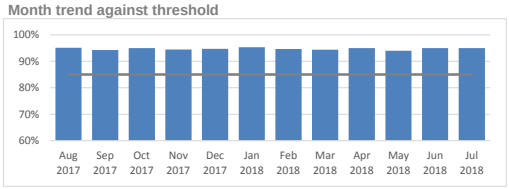
Both the Quality Improvement and Patient Experience Teams continue to work together with Hospitals / MCS/MLCO, Wards, Departments and frontline teams to provide advice and support FFT collection processes.

Food and Nutrition

Central and Trafford Sites Only

Actual	94.8%	Year To Date	**Accountability**	C.Lenney
Threshold	85.0%	(Higher value represents better performance)	**Committee**	Quality Committee

Month trend against threshold



12 month trend (0.85 to 0.85)

Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Trafford General Hospital	Wythenshawe Hospital
✓	✓	✓	✓	✗		✓	✓
97.6%	93.5%	92.6%	95.8%	77.0%		93.9%	96.4%

The KPI shows the % of the total responses to food & nutrition questions within the Quality Care Round that indicate a positive experience.

Progress

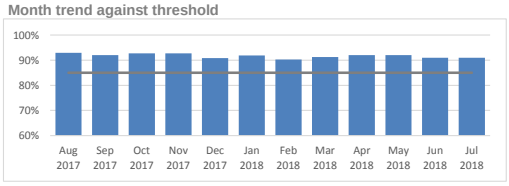
Improvement work continues at Ward and Trust-wide level across all aspects of food and nutrition. Both ORC and WTWA have Patient Dining Groups to support the Improvement Programme Good to Great co-ordinated by the Facilities Matrons for Dining.

Pain Management

Central and Trafford Sites Only

Actual	91.5%	Year To Date	**Accountability**	C.Lenney
Threshold	85.0%	(Higher value represents better performance)	**Committee**	Quality Committee

Month trend against threshold



12 month trend (0.85 to 0.85)

Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Trafford General Hospital	Wythenshawe Hospital
✓	✓	✓	✓	✓		✓	✓
96.1%	85.8%	87.3%	93.9%	97.7%		94.4%	95.6%

The KPI shows the % of the total responses to pain management questions within the Quality Care Round that indicate a positive experience.

Progress

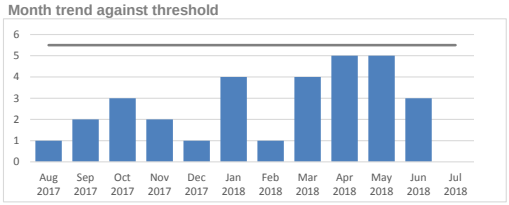
Work continues across the Trust to drive improvements in pain assessment and management.
The oversight for this work is provided by the Director of Nursing, MREH who is currently leading an exercise to map existing work and establish a future plan. Performance against this KPI is monitored through the Trust Harm Free Care structure.

Clostridium Difficile – Lapse of Care

MFT

Actual	13	Year To Date	**Accountability**	C.Lenney
Threshold	35	(Lower value represents better performance)	**Committee**	Quality Committee

Month trend against threshold



12 month trend (5.5 to 5.5)

Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Trafford General Hospital	Wythenshawe Hospital
✓	✗	✓	✓	✓		✓	✓
0	6	0	0	0		0	7

Each Clostridium difficile infection (CDI) incident is investigated to determine whether the case was linked with a lapse in the quality of care provided to patient. The maximum threshold for the Group is 105 lapses in care. The contractual sanction applied to each CDI case in excess of the target is £10,000. The KPI shows the number of CDI incidents that were linked to a lapse in the quality of care provided to a patient.

Progress

Wythenshawe site has a maximum annual threshold of 39 lapses in care: there have been 9 cases determined as lapses in care for the financial year 2018/2019, (3 in April, 2 in May, 2 in June, 2 in July). There is one case pending review.

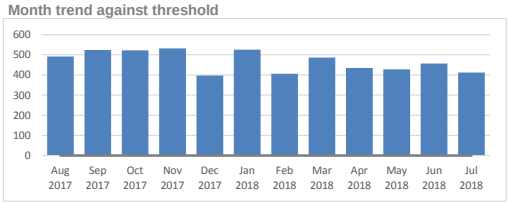
Central and Trafford site has a maximum annual threshold of 66 lapses in care: there have been 6 cases have been attributed as lapse of care for the financial year 2018/2019, (2 in April, 3 in May, 1 in June). There are a number of cases pending review due to the reconfiguration of accountability meetings.

PALS – Concerns

MFT

Actual	1732	Year To Date	**Accountability**	C.Lenney
Threshold	None	(Lower value represents better performance)	**Committee**	Quality Committee

Month trend against threshold



#VALUE!

Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Trafford General Hospital	Wythenshawe Hospital
-	-	-	-	-	-	-	-
57	511	160	100	158		166	472

The number of PALS enquires received by the Trust where a concern was raised.

Key Issues

A total of 412 PALS concerns were received by MFT during July 2018. This compares to 457 PALS concerns received during June 2018 and 428 PALS concerns received during May 2018. This is within the limits of normal variation and is monitored closely.

The Hospital / MCS level performance against this indicator for year to date is detailed in the Hospital Level Compliance Chart. This is the first time Hospital / MCS level performance has been available.

Actions

For the Hospitals / MCS based on the Oxford Road Campus, concerns are formally monitored alongside complaints at weekly meetings within the Hospital / MCS.

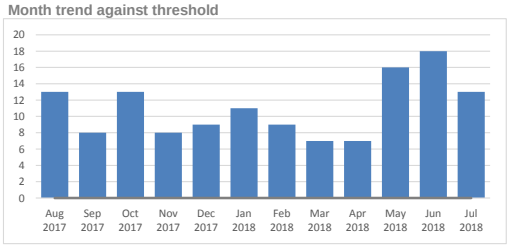
Work continues to reduce the time taken to resolve PALS enquiries with formal performance management of cases over 5 days in place.

All Attributable Bacteraemia

MFT

Actual	54	Year To Date	**Accountability**	C.Lenney
Threshold	None	(Lower value represents better performance)	**Committee**	Quality Committee

Month trend against threshold



#VALUE!

Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Trafford General Hospital	Wythenshawe Hospital
-	-	-	-	-	-	-	-
1	35	4	1	0		1	12

MRSA and E.coli. There is a zero tolerance approach to MRSA bacteraemia.
For healthcare associated Gram-negative blood stream infections (GNBSIS), trusts are required to achieve a 50% reduction in healthcare associated GNBSIs by March 2021, with a focus on a 10% or greater reduction of E.coli in 2017/18 (based on number of incidents for 2016/2017). There are currently no sanctions applied to this objective.

Progress

The Wythenshawe site have had 4 attributable MRSA bacteraemias since April '18, and 12 attributable E. coli bacteraemias.

Central and Trafford site have had 1 attributable MRSA bacteraemias since April '18, and 46 attributable E. coli bacteraemias.

Operational Excellence

J.Bridgewater

Core Priorities	✓	◇	✕	No Threshold
	6	2	3	0

Headline Narrative

• The Diagnostic wait list has increased by 3% in the last 10 months. June performance was 1.59%, which is better than the national picture, and an improved position compared to June. The Trust is predicting delivery of the 1% standard by October 2018, a key success factor is the recruitment of anaesthetists for paediatric MRI.

• A&E 4 hours - In July MFT delivered 86.54%. The Trust has opportunities in relation to reducing stranded patients, and are working with GM partnership in relation to this. There has been improvement in the performance compared to winter despite significantly higher demand in Q1. MFT has seen higher demand increases that the national position, particularly for admissions, coupled with ED majors/minors split of 45 and 55% respectively, suggest high acuity of patients. The Trust transformation team have conducted a review of urgent care at Wythenshawe Hospital and MRI, developing a 30, 60 and 90 day action plan for each site to continue a momentum of improvement against the challenge of higher demand.

• RTT marginal reduction in July, with MFT reporting 89.22% for the month. Nationally, RTT performance has seen a deterioration with a +7.5% increase in waiting lists, however MFT has maintained the national requirement to sustain the waiting list as at the level at the end of March 18.

• The national requirement is to reduce RTT +52 week breaches by half by March 2019. The initial risk had been identified at Wythenshawe with the challenge of highly complex DIEP surgery, and a trajectory to reduce these numbers to 15 by year end. However, as previously reported by the COO, following a review of the longest waiting patients, and subsequent investigation of the Oxford Road PAS system, an additional 293 patients over 52 week waits were reported in June. In response, a task force jointly chaired by the Deputy COO and Chief Information Officer, with support from external partners, has been established with an action plan in place, with clinical review of all patients and a focus on treating patients prior to September. In July there was an improvement in teh performance with 228 +52 week breaches, a reduction of 65 patients having received surgery.

• Cancer 62 Day - Performance against the cancer standard is challenged on the Oxford Road campus, with strong performance at the Wythenshawe site. The Trust reported 83.2% against the 85% standard for Q4. GM declared 85.8% for Q4, although faced a more challenging period in Q1. The key driver challenging performance at MFT is significant growth in demand for cancer services, which increased by 12% in Q1 compared to winter and a 21% increase compared to last year, which is far in excess of the national demand profile, in addition capacity pressures related to diagnostic tests.

•The Board Assurance includes data aligned to Managed Clinical Sites, and whilst some sites will note a shift in performance, there has been no change to final submissions for the Trust.

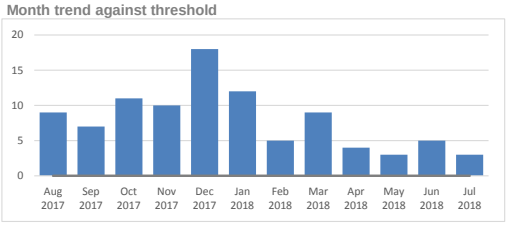
Operational Excellence - Core Priorities

Cancelled operations - rescheduled <= 28 days

MFT

Actual	15	Year To Date	**Accountability**	J.Bridgewater
Threshold	0	(Lower value represents better performance)	**Committee**	Trust Board

Month trend against threshold



12 month trend (0 to 0)

Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Trafford General Hospital	Wythenshawe Hospital
✓	✕	✓	✓	✓		✓	✕
0	9	0	0	0		0	6

Patients who have operations cancelled on or after the day of admission (for non clinical reasons) must be offered a binding date for their surgery to take place within 28 days.

Key Issues

Risk of non elective patient outliers in elective bed capacity.
System response to stranded patients > 7 and >21 days.

Actions

28 Day cancelled operations will be monitored and managed through the Trust Performance and Delivery Assurance Group.

Progress

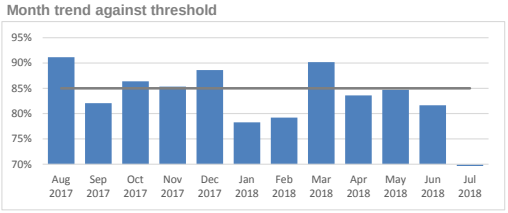
Hospital Directors of Operations are involved in the day to day oversight and management of all cancelled elective surgery, including the risks against the 28 day breach standard. There are no reported 28 day breaches for July across the Trust.

Cancer 62 Days RTT

MFT

Actual	83.2%	Quarterly	**Accountability**	J.Bridgewater
Threshold	85.0%	(Higher value represents better performance)	**Committee**	Trust Board

Month trend against threshold



12 month trend (0.85 to 0.85)

Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Trafford General Hospital	Wythenshawe Hospital
NA	✓	NA	✗	NA		✓	✓
NA	72.5%	NA	73.0%	NA		89.4%	88.7%

The percentage of patients receiving first treatment for cancer following an urgent GP referral for suspected cancer that began treatment within 62 days of referral.

Key Issues

• The Trust continues to experience a significant increase in the demand for cancer services in excess of the national profile, 12% increase in Q1 verses winter and 21% increase compared to the same period last year.
• Capacity is affected in services where there are known national workforce shortages particularly radiology.

Actions

• Oversight and Monitoring by Hospital Cancer Boards.
• Assurance and challenge through AOF
• Senior Corporate monitoring and escalation of delays in patient pathway on cancer PTL
• Speciality level recruitment of workforce to match demand.
• Lung pathway reviewed and improvements implemented, Lung team are linking with sector based diagnostics to implement the lung optimum pathway and support access to diagnostic tests.
• Perfect month for LGI planned for September at MRI.
•Revision of Cancer dashboard to provide all Hospital sites with depth of information required to focus on increasing the number of patients seen within 7 days for a first appointment.
• Cancer Peer Review undertaken in June 2018 with outcomes discussed through the Trust Cancer Board
• Additional radiology reporting outsource secured for tumour pathways with longest waits.

Progress

•The Trust is underperforming against the 62 day standard although this has remained stable despite significant increase in excess of the national profile, +12% increase in Q1. Planning for the Perfect Month in September for LGI. MRI is in progress and additional radiology reporting outsourcing secured by Managed Clinical Services for those patients with longest waits to results.

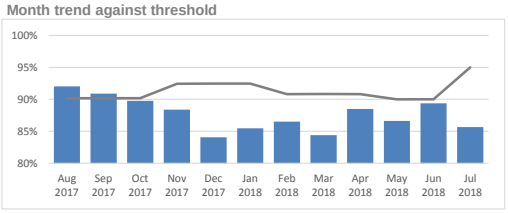
GM has a strong track record of performance against the 62 day standard, but is forecasting Q1 underperformance of the standard. MFT provisional Q1 peformance of 83.21% (as of 23.08.18) still subject to change.

A&E - 4 Hours Arrival to Departure

MFT

Actual	85.65%	Quarterly	**Accountability**	J.Bridgewater
Threshold	89.00%	(Higher value represents better performance)	**Committee**	Trust Board

Month trend against threshold



12 month trend (0.8948016 to 0.924)

Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Trafford General Hospital	Wythenshawe Hospital
NA	✓	✓	◇	✓		✓	✗
NA	78.6%	96.3%	98.1%	100.0%		99.6%	76.9%

The total time spent in A&E - measured from the time the patient arrives in A&E to the time the patient leaves the A&E Department (by admission to hospital, transfer to another organisation or discharge). With a target that 95% of all patients wait no more than four hours in accident and emergency from arrival to admission, transfer or discharge.

Key Issues

• Higher demand levels than the winter period, +4% in Q1 compared to Q4 17/18.
• Q1 NEL admissions remained consistent with the winter period although were +10% compared to the same period last year.
• A high proportion of patients (45%) are classified as Majors, coupled with NEL admissions would suggest high acuity of patients is a factor.
• The Trust continues to focus on reducing long LoS patients across all sites, however stranded patient data suggests there is a further opportunity.

Actions

▪ Weekly Task Group in place, chaired by Deputy COO/Director Performance.
▪ MRI/WTWA have improvement programmes in place, focused on actions identified from the urgent care reviews undertaken in June/July.
▪ Weekly Hospital trajectories in place aligned to the urgent care review actions.
▪ Wythenshawe and MRI have created a Patient Flow Improvement Board which will take key areas within the patient journey, and provide a targeted response to manage a reduction in waiting times.
▪ MADE events with commissioning and provider partners.
▪ Increased Primary Care streaming, GM review of models at Wythenshawe and MRI Hospitals.
▪ Capital upgrade to Wythenshawe complete, MRI schemes progressing through project RED, PED capital schemes at design phase.
▪ Implementation of GM standards for patient choice, Trusted Assessor and Discharge to Assess.
▪ MFT representation at GM Action on A&E events.
▪ MHCC Trafford/ Manchester tactical urgent care workshop 1.8.18.
▪GM Health Care Professional workshop 8.8.18.
▪ Joint Mental Health Operational Group, commencing 16.08.18

Progress

• The Trust reported 85.65% Q1 against STF 90%.
• MFT reported 86.54% for July, ranking the Trust 5th with GM.
• Central/ Oxford Road campus 89.99%, Wythenshawe 76.94%.
• Following a review of urgent care by the transformation team a 30, 60 and 90 day action plan in progress.
• Greatest challenges by Hospital include: Wythenshawe workforce deficits, MRI capacity and flow.

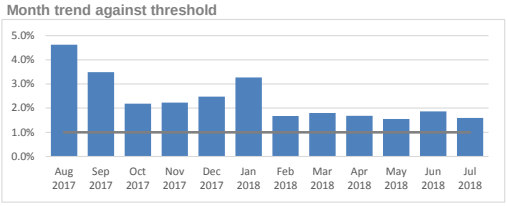
Diagnostic Performance

MFT

Actual 1.6% Latest Period **Accountability** J.Bridgewater

Threshold 1.0% (Lower value represents better performance) **Committee** Trust Board

Month trend against threshold



12 month trend (0.01 to 0.05)

Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Trafford General Hospital	Wythenshawe Hospital
◇	◇	✗	✗	NA		NA	✓
1.5%	2.2%	7.3%	11.8%	NA		NA	0.2%

The number of patients waiting over 6 weeks for a range of 15 key diagnostic tests.

Key Issues

- Ability to secure consultant anaesthetist paediatric MR.
- Capacity to deliver a reduction in breaches in adult Endoscopy and Cardiac Echo, MRI.
- Ability to secure ad hoc sessions and workforce to increase capacity and reduce backlog.

Actions

- Recovery trajectory revised for the key under performing tests with monitoring through the Trust AOF process.
- Paediatric MRI - Additional anaesthetic capacity is required for sustainable reductions in breach volumes, created by increased demand outstripping capacity, Managed Clinical Services and RMCH are jointly working on further solutions, and actively seeking to secure additional capacity.
- Implementation of the business case for the 3rd MRI scanner.
- Monthly forecasting in place, and weekly oversight meetings to identify issues early and escalate as appropriate.

Progress

- MFT continues to predict recovery to the 1% standard by October 2018.
- MFT diagnostic performance is better than the national position, with demand increases inline with the national profile. Significant improvement sustained over last five months, Wythenshawe site continues to provide strong performance below 0.25%.
- Paediatric Endoscopy recovery inline with trajectory.
- Performance trajectories are in place for the Central/ Oxford Road Campus with actions taken to address immediate longer term sustainability of diagnostic performance.

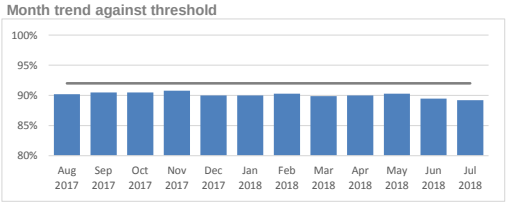
RTT - 18 Weeks (Incomplete Pathways)

MFT

Actual 89.2% Latest Period **Accountability** J.Bridgewater

Threshold 92.0% (Higher value represents better performance) **Committee** Trust Board

Month trend against threshold



12 month trend (0.874 to 0.92)

Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Trafford General Hospital	Wythenshawe Hospital
◇	✓	◇	✗	✓		◇	◇
90.9%	92.1%	87.7%	82.1%	93.1%		90.1%	88.4%

The percentage of patients whose consultant-led treatment has begun within 18 weeks from the point of a GP referral. Incomplete pathways are waiting times for patients waiting to start treatment at the end of the month.

Key Issues

- Demand and associated capacity pressures remains a challenge at SMH, RMCH, WTWA.
- WTWA DIEP service - A trajectory to reduce breaches by 50% by March 19 is in place.
- Oxford Road Campus - A review of long waits, has identified additional 52+ week breaches.

Actions

- RTT Task force focusing on long wait patients, chaired by Deputy COO/ Chief Informatics Officer, in place.
- Action plans in place which includes clinical review and focus on patient safety. Patients offered TCI dates.
- Continued timely validation by Hospital sites.
- Monthly data quality audits on going.
- RTT PMO office to be established from September.
- Delivery of Divisional transformation and capacity plans.
- Standard Operating Policies are being developed to support the Single Hospital Access Policy.
- Participation in the NHSI Masterclass for RTT
- Participation in NHSI Capacity and Demand modelling training.

Progress

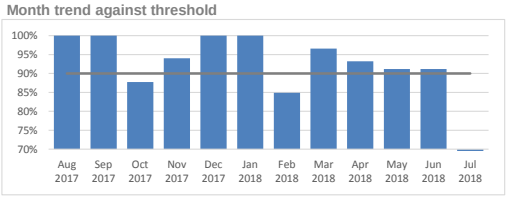
- Trust RTT performance whilst below the standard is better than national position, and contrary to the national and GM profiles the waiting list has remained stable
- MFT reported RTT performance of 89.22% for July. Achieving 89.57% on the Oxford Road campus and 88.39% at Wythenshawe Hospital.
- Following a review of longest waiting patients, and some subsequent investigation of the PAS system, along with capacity pressures within the Wythenshawe Plastics Service 293 +52 week waits have been reported to the Board of Directors in June, with a reduction seen in July with 228 breaches.

Cancer 62 Days Screening

MFT

Actual	91.8%	Quarterly	**Accountability**	J.Bridgewater
Threshold	90.0%	(Higher value represents better performance)	**Committee**	Trust Board

Month trend against threshold



12 month trend (0.855 to 0.9)

Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Trafford General Hospital	Wythenshawe Hospital
NA	✗	NA	NA	NA		NA	✓
NA	28.6%	NA	0.0%	NA		NA	98.9%

The percentage of patients receiving first definitive treatment for cancer following referral from an NHS cancer screening service that began treatment within 62 days of that referral.

Key Issues

The Trust has delivered performance against this standard.

Actions

Actions to improve and refine current cancer pathways included in Divisional cancer plans submitted to Cancer Board.

Progress

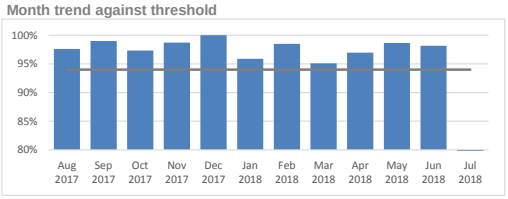
The Trust achieved this target.

Cancer 31 Days Sub Surgical Treatment

MFT

Actual	97.9%	Quarterly	**Accountability**	J.Bridgewater
Threshold	94.0%	(Higher value represents better performance)	**Committee**	Trust Board

Month trend against threshold



12 month trend (0.94 to 0.94)

Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Trafford General Hospital	Wythenshawe Hospital
NA	✓	NA	✗	NA		NA	✓
NA	96.6%	NA	93.8%	NA		NA	98.7%

The percentage of patients that waited 31 days or less for second or subsequent treatment, where the treatment modality was surgery.

Key Issues

The Trust met the target for Q4.

Actions

Actions taken as per the 62 day standard.

Progress

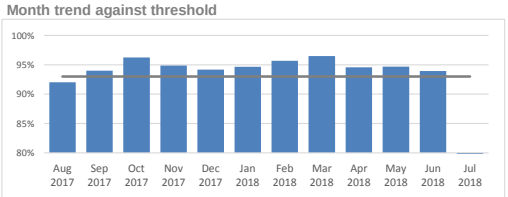
Forecast continued performance against this standard.

Cancer Urgent 2 Week Wait Referrals

MFT

Actual	94.4%	Quarterly	**Accountability**	J.Bridgewater
Threshold	93.0%	(Higher value represents better performance)	**Committee**	Trust Board

Month trend against threshold



12 month trend (0.93 to 0.93)

Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Trafford General Hospital	Wythenshawe Hospital
NA	✗	✓	✓	✓		✓	✓
NA	91.8%	100.0%	93.4%	100.0%		93.1%	95.8%

The percentage of patients urgently referred for suspected cancer by their GP that were seen by a specialist within 14 days of referral.

Key Issues

Increased demand in 2 week wait referrals continues to place pressure on MFT cancer services.

Actions

Collaborative actions taken with speciality teams to strengthen performance and increase the volume of patients seen within 7 days, within the workforce available.
Commissioners and local health economy providers have in place a cancer work programme which incorporates a number of standards that underpin delivery of the main national cancer standards, the Trust is working towards delivery of these with oversight from the Trust Cancer Board.
Overarching Trust Cancer Action plan is in place.
Gynaecology - Hospital teams at St Marys have secured a workforce plan to address capacity challenges.

Progress

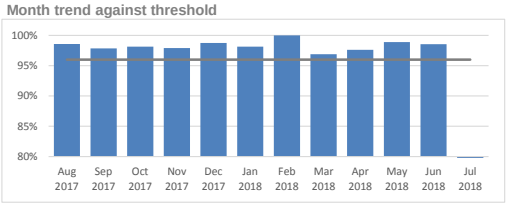
Weekly PTL's attended by the Trust Cancer Manager to provide expertise and monitoring against the target.

Cancer 31 Days First Treatment

MFT

Actual	98.4%	Quarterly	**Accountability**	J.Bridgewater
Threshold	96.0%	(Higher value represents better performance)	**Committee**	Trust Board

Month trend against threshold



12 month trend (0.96 to 0.96)

Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Trafford General Hospital	Wythenshawe Hospital
NA	✗	✓	✗	NA		✓	✓
NA	95.5%	100.0%	95.7%	100.0%		98.4%	99.3%

The percentage of patients receiving their first definitive treatment for cancer that began that treatment within 31 days.

Key Issues

The Trust has achieved this standard.

Actions

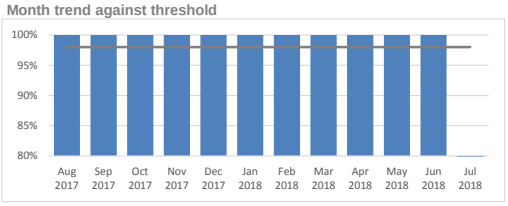
Actions taken as per the 62 day standard.

Cancer 31 Days Sub Chemo Treatment

MFT

Actual	100.0%	Quarterly	**Accountability**	J.Bridgewater
Threshold	98.0%	(Higher value represents better performance)	**Committee**	Trust Board

Month trend against threshold



12 month trend (0.931 to 0.98)

Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Trafford General Hospital	Wythenshawe Hospital
NA	✓	NA	NA	NA		NA	✓
NA	100.0%	NA	NA	NA		100.0%	100.0%

The percentage of patients that waited 31 days or less for second or subsequent treatment, where the treatment modality was an anti-cancer drug regimen.

Progress

The Trust continued to achieve the standard.

Actions

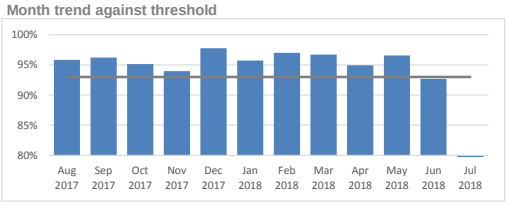
Actions taken as per the 62 day standard.

Cancer 2 Week Wait - Breast

MFT

Actual	94.7%	Quarterly	**Accountability**	J.Bridgewater
Threshold	93.0%	(Higher value represents better performance)	**Committee**	Trust Board

Month trend against threshold



12 month trend (0.93 to 0.93)

Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Trafford General Hospital	Wythenshawe Hospital
NA	NA	NA	NA	NA		NA	✓
NA	NA	NA	NA	NA		NA	94.7%

Any patient referred with breast symptoms would be seen within 2 weeks, whether cancer was suspected or not.

Key Issues

Specialist cancer services are provided by Wythenshawe Hospital. The Hospital continues to deliver strong performance against this standard.

Progress

The Trust over achieved by (+2.8%) against the national standard of 93%.

Workforce and Leadership

M.Johnson

Core Priorities	✓	◇	×	No Threshold
	4	1	6	3

Headline Narrative

The Trust has launched its recruitment of freedom to speak up champions this month. The recruitment process has attracted 28 high quality candidates and the selection process will take place during August.

The Human Resources Directorate ran the first workshop to develop the workforce section of the Equality & diversity strategy. Engagement will be taking place across the Trust during September to seek colleagues views.

Nominations are currently being sought for the Clinical Leadership programme that commences in October 2018.

Filming is currently taking place for the new Values & Behaviours video.

Workforce and Leadership - Core Priorities

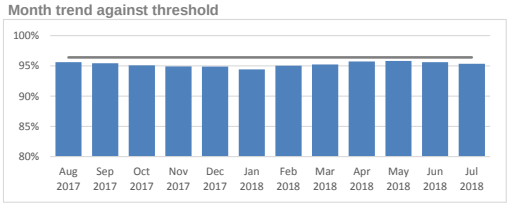
Attendance

MFT

Actual 95.3% Latest Period **Accountability** M.Johnson

Threshold 96.4% (Higher value represents better performance) **Committee** HR Committee

Month trend against threshold



12 month trend (0.9610116 to 0.964)

Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Trafford General Hospital	Wythenshawe Hospital
×	×	×	×	×		×	×
96.1%	95.1%	47.6%	96.0%	94.6%		93.1%	94.9%

This monitors staff attendance as a rate by comparing the total number of attendance days compared to the total number of available days in a single month.

Key Issues

The Groups attendance rate for July has fallen slightly to 95.3% compared to the previous months figure (95.6%)
This time last year the attendance percentage was 95.5% (July 2017).
Attendance has peaked at 95.8% (May 2018).
Over the past 12 months performance has not yet achieved the desired threshold of 96.4%.

Actions

Across the Group work is being completed in each Hospital/MCS to agree trajectories and attendance improvement plans to meet the threshold by March 2019. In the Manchester Royal Infirmary weekly scrutiny meetings continue to track absences where a central spreadsheet has been created to record all sickness cases that are not on the Absence Manager system yet.

In Wythenshawe, Trafford, Withington and Altrincham (WTWA) sites their has been an emphasis on greater benefits realisation through Absence Manager and the associated benefits of increased data capture and accuracy. Monitoring of managers compliance in relation to call back and return to work discussions is measured through the Absence Manager dashboards at Divisional Performance Review meetings.

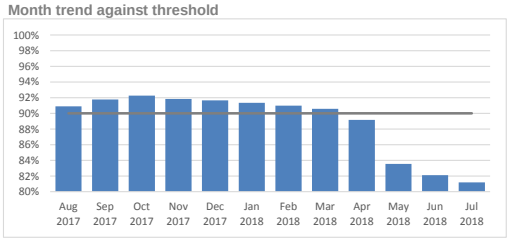
Trust Mandatory Training - Clinical

Central and Trafford Sites Only

Actual 81.2% Latest Period **Accountability** M.Johnson

Threshold 90.0% (Higher value represents better performance) **Committee** HR Committee

Month trend against threshold



12 month trend (0.9 to 0.9)

Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Trafford General Hospital	Wythenshawe Hospital
×	×	×	✓	×		×	NA
87.8%	72.3%	79.3%	91.1%	84.3%		83.0%	NA

This indicator measures the % of staff who are compliant at the point the report is run. Staff are compliant if they have undertaken clinical mandatory training within the previous 12 months.

Key Issues

Currently mandatory training is reported in different ways for the Central and Wythenshawe sites. A paper was presented at GMB on 30th April by the Executive Group Director of Workforce and OD recommending the future approach to compliance reporting.

Compliance fell by 0.9% in July to 81.2%.

The July compliance rate for Level 2 Mandatory training for the Wythenshawe site is 78.7% which is a decrease of 1% on the June figure.
This measure is an aggregate of the 5 topics that are part of the Core Skills Training Framework (these topics are also part of the Clinical Mandatory Training programme at the Oxford Road Campus).

Actions

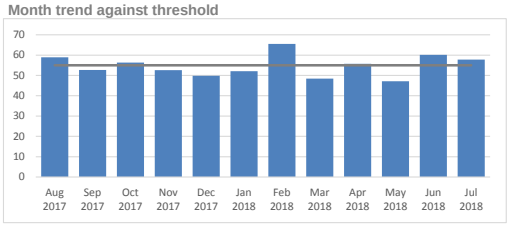
The Group Executive Director of Workforce and OD is writing to the CEOs of those hospitals that are not achieving target compliance to request assurance that they have plans in place in order to address this compliance issue.

Time to fill vacancy

MFT

Actual	57.8	Latest Period	**Accountability**	M.Johnson
Threshold	55.0	(Lower value represents better performance)	**Committee**	HR Committee

Month trend against threshold



12 month trend (52.25 to 55)

Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Trafford General Hospital	Wythenshawe Hospital
✗	✗	✗	✗	✗		✗	✓
66.2	62.5	69.7	61.5	62.1		66.8	51.3

This indicator measures the average time it takes, in days, to fill a vacancy. It measures the time taken from the advertising date (on the TRAC Recruitment system), up to the day of unconditional offer. The graph shows an in month rate.

Key Issues

Group wide, the Time to Fill figure (which doesn't include Staff Nurses) has fallen from 60.1 days and now stands at 57.8 days for July. This is an improvement on last year where the number of days taken to fill a vacancy was 61.4.

Actions

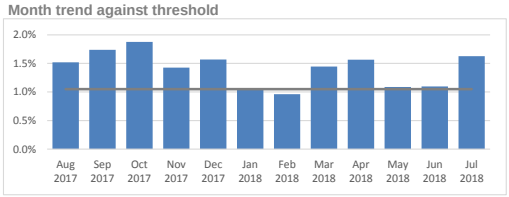
The Trust 'Time to Hire' for July 2018 is 57.8 working days on average, this is without Band 5 nursing confirmed starts in the figure and is a reduction of 2.3 days, in comparison to the previous month. Activity levels in recruitment have been higher than average, with 775 adverts published during the month of July, attracting 7199 candidates to submit an application. This is a 10% increase in the average number of applications MFT attracts on a monthly basis and gives appointing managers a broader range of applications to review at shortlisting. 255 candidates booked start dates with the Trust in July, as well as 174 internal staff agreeing start dates to move into new posts within MFT.

B5 Nursing and Midwifery Turnover (in month)

MFT

Actual	1.63%	Latest Period	**Accountability**	M.Johnson
Threshold	1.05%	(Lower value represents better performance)	**Committee**	HR Committee

Month trend against threshold



12 month trend (0.009975 to 0.0105)

Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Trafford General Hospital	Wythenshawe Hospital
✗	✗	✗	✗	✓		✓	✗
1.29%	1.59%	1.43%	2.43%	0.00%		0.00%	2.47%

This indicator measures and monitors the turnover of Band 5 Qualified Nursing & Midwifery staff within the organisation by comparing the total number of leavers and the total number of Full Time Employment (FTE) staff as a rate (excludes Fixed Term Contract staff). The graph show the rate in a single month.

Key Issues

The turnover for the month is 1.63% against a monthly target of 1.05% This B5 Nursing and Midwifery turnover figure is higher than the same reporting period last year which was 1.51% (July 2017).

Actions

Nursing and Midwifery Retention Strategies are in place across the Trust Group. Work is now underway to align the strategies and will continue to focus on the following work streams:-

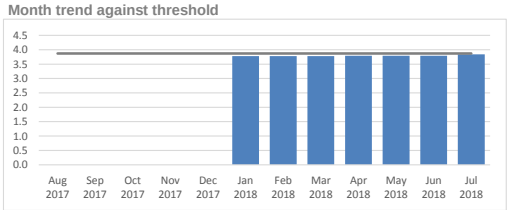
- Recent Chief Nurse engagement sessions held with newly qualified staff nurses and Oxford Road campus and Wythenshawe
- Divisional work streams focusing on wellbeing/staff focus groups/take a break
- Nursing and Midwifery extended induction for new starters
- Introduction of 12 hour shifts for staff who wish to condense their hours over a shorter working week
- Identifying new roles within the unregistered workforce to support careers/skills escalator
- Specialty rotation programmes
- Introduction of band 5 rotation programmes for newly qualified staff within a number specialties

Engagement Score (quarterly)

MFT

Actual	3.84	Latest Period	**Accountability**	M.Johnson
Threshold	3.87	(Higher value represents better performance)	**Committee**	HR Committee

Month trend against threshold



12 month trend (3.87 to 3.87)

Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Trafford General Hospital	Wythenshawe Hospital
✗	✗	✓	✓	✓		✗	✗
3.79	3.80	3.87	3.90	3.92		3.80	3.85

This indicator measures the Staff Engagement score taken from the annual Staff Survey or quarterly Pulse Check. This score is made up of indicators for improvements in levels of motivation, involvement and the willingness to recommend the NHS as a place to work and be treated.

Key Issues

The overall Group staff engagement score for 2018-19 Q1 Pulse Check was 3.84. This represents an increase of 0.05 from the previous quarter. There were improved scores in all three of the engagement domains – advocacy, involvement in improvements and change, and motivation – most noticeably the 'improvement score' which increased from 3.63 to 3.73.

Actions

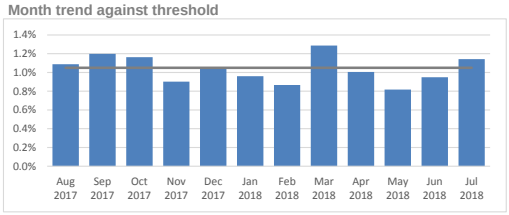
The Q1 2018-19 pulse check results have been shared with hospitals, managed clinical services and corporate directorates across the Group for action. The quarter two 2018-19 Pulse Check will run during late August/early September, and the full results will be available in mid-October. In addition to the core questions asked in each Pulse Check, the quarter two survey will include questions covering staff satisfaction with the quality of care they are able to deliver, and MFT's vision and values.

Turnover (in month)

MFT

Actual	1.14%	Latest Period	**Accountability**	M.Johnson
Threshold	1.05%	(Lower value represents better performance)	**Committee**	HR Committee

Month trend against threshold



Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Trafford General Hospital	Wythenshawe Hospital
◇	✗	✓	✗	◇		✓	✗
1.00%	1.28%	0.74%	1.32%	1.01%		0.59%	1.43%

This indicator measures and monitors the turnover of staff within the organisation by comparing the total number of leavers and the total number of Full Time Employment (FTE) staff as a rate (excludes the naturally rotating Foundation Year 1 and Year 2 junior medical staff and the Fixed Term Contract staff). The graphs shows a single month rate.

Key Issues

Turnover has broadly reduced over the past 12 months, although in month it is above the threshold.
The position is similar to this time last year 1.05% (July 2017) to 1.14% (July 2018) The single month turnover position for the group has increased slightly and now stands at 1.14% compared to 0.95% for the previous month.

Actions

Retention plans underpinned by staff engagement plans are in place across hospital and MCS sites
At Wythenshawe Hospital, turnover continues to be monitored via the monthly Divisional Performance reviews with hotspot areas providing assurances that plans are in place.

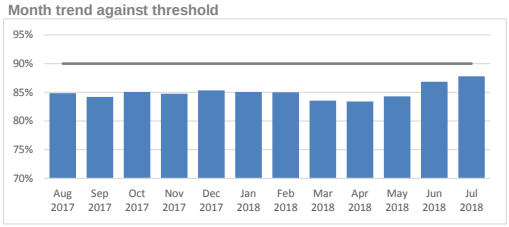
Staff engagement sessions for all staff are also planned for the MRI, Clinical Scientific Services and the Children's Hospital.

Appraisal- non-medical

MFT

Actual	87.8%	Latest Period	**Accountability**	M.Johnson
Threshold	90.0%	(Higher value represents better performance)	**Committee**	HR Committee

Month trend against threshold



12 month trend (0.855 to 0.9)

Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Trafford General Hospital	Wythenshawe Hospital
◇	✓	✗	✓	✓		◇	✓
88.8%	95.5%	83.1%	92.9%	91.6%		88.3%	92.3%

These figures are based upon compliance for the previous 12 months, new starters are now included in these figures and will be given an appraisal date with a 3 month compliance end date, in line with the appraisal policy statement: 'new starters should have an initial appraisal meeting within three months of commencement in post'. These figures do not include Medical Staff.

Key Issues

Appraisal compliance for the Group in July increased by 1.0% to 87.8% This position is slightly improved on July 2017 (87%) .

Actions

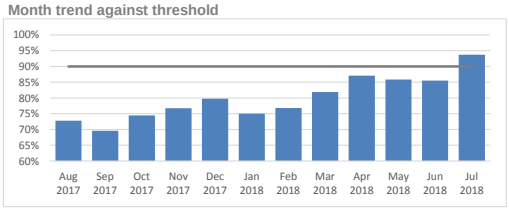
All Hospitals are currently working to plans that were presented to the HR Scrutiny committee. These plans aim to achieve insistent and sustainable compliance by March 2019. Quarterly pulse checks now ask staff about the quality of appraisals and this feedback will further inform delivery of effective annual appraisals.

Appraisal- medical

MFT

Actual	93.7%	Latest Period	**Accountability**	M.Johnson
Threshold	90.0%	(Higher value represents better performance)	**Committee**	HR Committee

Month trend against threshold



12 month trend (0.855 to 0.9)

Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Trafford General Hospital	Wythenshawe Hospital
✓	✓	✓	✓	✗		✓	✓
97.1%	95.3%	96.1%	96.1%	81.5%		96.9%	90.9%

These figures are based upon compliance for the previous 12 months for Medical & Dental staff.

Key Issues

Appraisal compliance for the Group increased by 8.2% in July to 93.7%.

Actions

All Hospitals are currently working to plans that were presented to the HR Scrutiny committee. These plans aim to achieve consistent and sustainable compliance by March 2019.

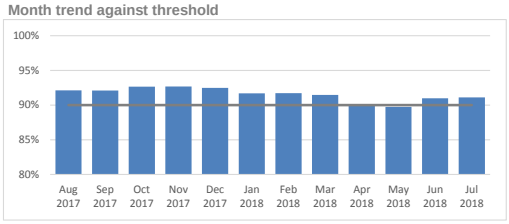
Appraisal Medical reporting is currently under review at the Dental Hospital as the hospital moves away from manual reporting and starts to use the Equiniti system.

Level 1 CSTF Mandatory Training

MFT

Actual	91.1%	Latest Period	**Accountability**	M.Johnson
Threshold	90.0%	(Higher value represents better performance)	**Committee**	HR Committee

Month trend against threshold



12 month trend (0.9 to 0.9)

Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Trafford General Hospital	Wythenshawe Hospital
✓	✗	✗	✓	✓		✓	✗
92.2%	88.8%	89.9%	95.0%	93.4%		93.7%	89.5%

This indicator measures the % of staff who are compliant at the point the report is run. Staff are compliant if they have undertaken corporate mandatory training within the previous 12 months.

Key Issues

Performance in July for the Group has seen compliance increase by 0.1% to 91.1%

Actions

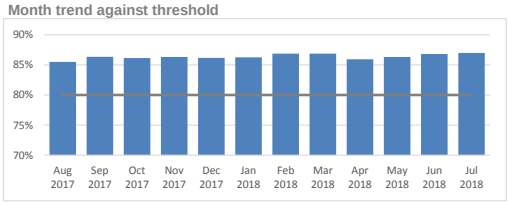
Detailed monthly reports continue to be shared with HRDs to ensure target compliance is sustained.

Nurse Retention

MFT

Actual	87.0%	Latest Period	**Accountability**	M.Johnson
Threshold	80.0%	(Higher value represents better performance)	**Committee**	HR Committee

Month trend against threshold



12 month trend (0.8 to 0.8)

Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Trafford General Hospital	Wythenshawe Hospital
✓	✓	✓	✓	✓		✓	✗
92.3%	84.7%	85.2%	87.3%	89.0%		89.1%	0.0%

This indicator measures the Nursing & Midwifery staff retention rate. It measures, by %, the Nursing & Midwifery registered staff in post for the Trust 12 months ago who are still employed in the organisation to date.

Key Issues

Nursing retention now stands at 87.0% which is a slight increase from the previous month's figure (86.8%)

Actions

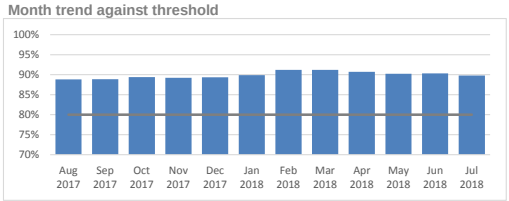
The retention threshold target for nursing and midwifery staff provides a strong indication of whether we are able to retain staff across the Trust and whether our polices, procedures and practices are supportive of the Trust being seen as a good place to work. The overall retention rate is good at 87.0%.

BME Staff Retention

MFT

Actual	89.8%	Latest Period	**Accountability**	M.Johnson
Threshold	80.0%	(Higher value represents better performance)	**Committee**	HR Committee

Month trend against threshold



12 month trend (0.8 to 0.8)

Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Trafford General Hospital	Wythenshawe Hospital
✓	✓	✓	✓	✓		✓	✓
90.2%	87.4%	92.5%	90.2%	91.0%		87.6%	89.8%

This indicator measures the Black minority & Ethnic (BME) staff retention rate. It measures, by %, the BME staff in post for the Trust 12 months ago who are still employed in the organisation to date. The retention rate information excludes the naturally rotating Foundation Year 1 and Foundation Year 2 junior medical staff. The rate is shown as a rolling 12 month position.

Key Issues

We continue to track BME staff which for July was 89.8% for BME staff and 89.1% for White Staff.

Action

Overall BME staff retention continues to track at a higher rate than White staff retention. There are two Hospitals/Managed Clinical Services where BME staff retention is below White retention for July, this will be tracked over the next few months to see if this is an ongoing trend.

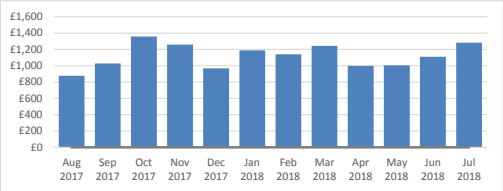
Medical Agency Spend

MFT

Actual £1,282.0 Latest Period **Accountability** M.Johnson

Threshold None (Lower value represents better performance) **Committee** HR Committee

Month trend against threshold



#VALUE!

Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Trafford General Hospital	Wythenshawe Hospital
-	-	-	-	-	-	-	-
£2.1	£563.3	£110.6	£2.6	£105.9		-£92.9	£287.9

The Medical and Dental Agency Spend figure represents the cost of supply/temporary M&D staff throughout the Trust. This may represent cover for long term absences either through vacancies, long term illnesses or for other specific staffing requirements. The value is in £000s and is the reported month cost.

Key Issues

For July 2018 the total value of Medical and Dental agency staffing was £1,282k.

Actions

All hospital sites have developed agency reduction plans and trajectories and performance against these is monitored as part of the AOF. The Liaison TempRE Bank & Agency booking system continues to be embedded at the Trust, with booking processes being re-evaluated and streamlined where possible. The Medical Bank continues to grow on both the Oxford Road Campus and the Wythenshawe Campus, with new applicants being added on a daily basis. The growth in the medical bank will help to reduce the short term agency expenditure, however there are a number of long term vacancies that continue to be covered by agency staff.

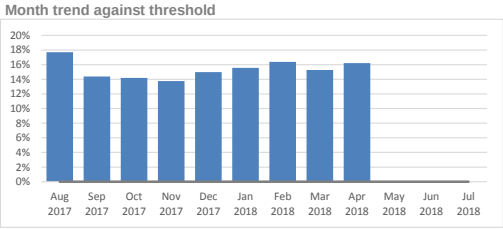
Qualified Nursing and Midwifery Vacancies B5 Against Establishment

MFT

Actual Latest Period **Accountability** M.Johnson

Threshold None (Lower value represents better performance) **Committee** HR Committee

Month trend against threshold



#VALUE!

Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Trafford General Hospital	Wythenshawe Hospital
-	-	-	-	-	-	-	-

The Qualified Nursing and Midwifery vacancy rate represents the total number of posts vacant within the Band 5 Nursing and Midwifery staff group, including Operating Department Practitioners.

From March 2018 Band 5 and 6 Midwifery vacancies are reported together as these posts are transitional posts for entry level (newly qualified) midwives who progress to band 6 on completion of preceptorship.

Key Issues

Actions

- Greater Manchester Nurse Recruitment campaign continues

- Recruitment of Student Nurses continues with newly qualified nurses coming into post in September and October

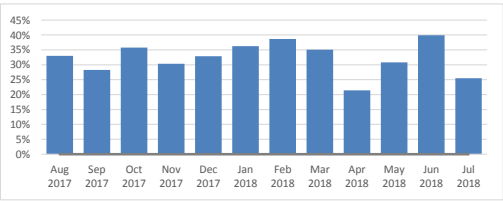
% BME Appointments of Total Appointments

MFT

Actual 25.5% Latest Period **Accountability** M.Johnson

Threshold None (? value represents better performance) **Committee** HR Committee

Month trend against threshold



12 month trend (3.87 to 3.87)

Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Trafford General Hospital	Wythenshawe Hospital
-	-	-	-	-	-	-	-
15.4%	38.0%	11.8%	13.3%	33.3%		0.0%	35.6%

This indicator measures the number of BME appointments as a percentage of all appointments. This is measured through the Trust's Recruitment system (TRAC). The graph shows an in month rate.

Key Issues

Black and Minority Ethnic (BME) appointments now stands at 25.5% which is an decrease compared to the previous month's figure (39.9%)

Actions

This figure is still showing significant variance month by month. The team are now reviewing the reporting cycle for this data to understand what the data is telling us over a longer period of time.

Finance

A.Roberts

Core Priorities	✓	◇	×	No Threshold
	0	1	0	0

Headline Narrative

- Please see agenda item 5.2

Finance - Core Priorities

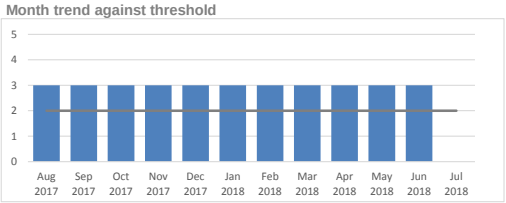
Regulatory Finance Rating

MFT

Actual Latest Period **Accountability** A.Roberts

Threshold (Lower value represents better performance) **Committee** TMB and Board Finance Scrutiny Committee

Month trend against threshold



12 month trend (2 to 3.5)

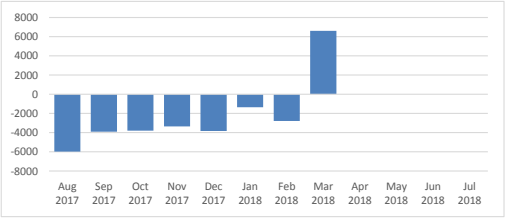
The regulatory finance rating identifies the level of risk to the ongoing availability of key services. A rating of 4 indicates the most serious risk and 1 the least risk. This rating forms part of Monitors risk assessment framework, incorporating two common measures of financial robustness : Liquidity and Capital Service Capacity.

Operational Financial Performance

Actual Year To Date **Accountability** A.Roberts

Threshold **Committee** TMB and Board Finance Scrutiny Committee

Month trend against threshold



Comparing the financial actual expenditure against the agreed budget (£'000). A negative value represents an overspend. A positive value represents an underspend.

Please see agenda item 5.2

Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Trafford General Hospital	Wythenshawe Hospital
⊘	⊘	⊘	⊘	⊘		⊘	⊘

Strategy

Core Priorities	✓	◇	×	No Threshold
	1	1	0	0

Headline Narrative

The Trust is in the process of developing its Service Strategy. This will describe an overarching group level strategy and a series of more detailed service level strategies. Through this process a range of metrics will be identified for each service and Hospital/MCS which will be incorporated in their Annual Plan. Through the Annual Planning process a number of key milestones will be agreed that will be used to monitor progress through the year. The percentage of the agreed milestones achieved will be used to determine the RAG rating.
As these are strategic aims, assessment will be carried out on a quarterly / 6-monthly basis.
In the interim three generic indicators have been selected to assess performance in relation to strategy: (1) existence of a 5 year strategy, (2) existence of an annual plan and (3) delivery against the anual plan. The third indicator cannot be assessed until Divisions/Hospitals/MCSs have undertaken their self-assessment and presented progress at the Autumn round of Divisonal Reviews.

Strategy - Core Priorities

Agreed 5-year strategy in place

MFT

Actual Amber **Accountability** D.Banks
Threshold **Committee** Service Strategy Committee

Each service should have a 5 year strategy setting out their vision and strategic aims and the key milestones towards achieving their vision. This should be approved by the Trust Service Strategy Committee. The service level strategies will form the basis of a Hospital / MCS level strategy.
Green indicates that a strategy has been completed and approved by the Trust Service Strategy Committee
Amber indicates that a strategy has been developed but not approved.
Red indicates that there has been no progress towards the development of a strategy

Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Trafford General Hospital	Wythenshawe Hospital
◇	◇	◇	◇	◇		◇	◇

Agreed annual plan for 2017-18

MFT

Actual Green **Accountability** D.Banks
Threshold **Committee** Service Strategy Committee

Each service should have an annual plan setting out the actions that they are going to take in the coming year to deliver all local and national targets and actions towards achieving their vision and strategic aims. It will include a financial plan showing how this will be achieved within budget.
Green indicates that an annual plan has been completed and approved by the Trust Service Strategy Committee
Amber indicates that an annual plan has been developed but not approved.
Red indicates that there has been no progress towards the development of an annual plan

Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Trafford General Hospital	Wythenshawe Hospital
✓	✓	✓	✓	✓		✓	✓

Progress against delivery of service strategy milestones in annual plan

MFT

Actual **Accountability** D.Banks
Threshold **Committee** Service Strategy Committee

Progress against the strategic development plans set out in the annual plan will be monitored on a quarterly basis. The proportion of the agreed key milestones achieved will be used to RAG rate each Hospital / MCS.

Hospital level compliance

Clinical and Scientific Support	Manchester Royal Infirmary	Royal Manchester Children's Hospital	St Mary's Hospital	Manchester Royal Eye Hospital	University Dental Hospital of Manchester	Trafford General Hospital	Wythenshawe Hospital
⊘	⊘	⊘	⊘	⊘		⊘	⊘

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Peter Blythin, Director Single Hospital Service
Paper prepared by:	Peter Blythin, Director, Single Hospital Service
Date of paper:	10th September 2018
Subject:	Progress report on the Manchester Single Hospital Service
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Resolution • Approval
Consideration of Risk against Key Priorities:	Failure to deliver the Manchester Single Hospital Service Programme effectively will present risks to all of the Trust's Key Priorities, but particularly Priority 1: - to deliver the merger of the two organisations with minimal disruption whilst ensuring that the planned benefits are realised in a timely manner.
Recommendations:	The Board of Directors is asked to receive the report and note the progress made and on-going actions.
Contact:	Name: Peter Blythin Director Single Hospital Service Tel: 0161 701 8573

1. Introduction

This report provides an update on the progress being made to implement the Manchester Single Hospital Service (SHS) as part of the overarching Manchester Locality Plan. It addresses post-merger integration and project two, the proposed transfer of North Manchester General Hospital (NMGH) to Manchester University NHS Foundation Trust (MFT).

2. Integration

Integration activity across MFT continues to make significant progress. The main focus is on the implementation and planning for the more complex strategic programmes of work due to deliver in years 1 and 2, post-merger. This work is overseen by the Integration Steering Group (ISG) and cross referenced with the design of an MFT Clinical Service Strategy and operational initiatives, all with the collective aim of delivering a major transformation programme.

The progress of integration activity, including oversight and management of the anticipated merger benefits, continues to be closely monitored and reported on by the SHS Integration Management Office (IMO). The primary purpose of the work is to ensure that key deliverables are being realised in a timely manner. In addition, progress against the Manchester Investment Agreement improvement targets is also being tracked. This involves regular reports to the ISG, direct contact with operational teams, as well as liaison with Hospital / Managed Clinical Service Chief Executives.

The first formal reporting against these objectives was presented on 1st August 2018 and involved two early integration targets: the Urgent Gynaecology Surgery List and the reduced waiting time for access to kidney stone removal procedures. Both trajectories met their agreed targets. Further details on both of these programmes of work are outlined below.

Furthermore, KPMG recently concluded an audit of the Post-Transaction Integration Plan and related matters. The audit concluded that the SHS Programme had established effective governance and oversight with regards to tracking and monitoring of integration deliverables and benefits. The SHS Team is committed to maintaining robust oversight and assurance practices throughout the integration programme as noted by KPMG.

Updates on the key progress for some of the main programmes of work underway are outlined below:

- Urology teams from Wythenshawe and Manchester Royal Infirmary (MRI) Hospitals have continued to work on improving services for patients with kidney stones through increased utilisation of the Lithotripter at Wythenshawe Hospital. The objective is to ensure that this service is available to MRI and Wythenshawe patients throughout the week, and that no patient waits more than a maximum of four weeks. In March 2018, on average, 60 patients were waiting longer than four weeks for their procedure. However, in July 2018, this was significantly reduced and no patients waited longer than four weeks for their treatment. The urology teams have also been identifying how capacity for routine patients can be optimised across all MFT sites through the joint day case project between the Wythenshawe and MRI teams which involves improved access for patients by developing a pooled day case list across the new organisation.

- Orthopaedic services are now running joint Multidisciplinary Teams (MDTs) across all MFT sites for key clinical groups including hip/knee, and shoulder/elbow. This group is currently exploring 'virtual MDTs' for shoulder/elbow and foot/ankle patients, where pooled waiting lists are operating across MFT. The MDTs help to ensure that best clinical practice is applied consistently across MFT and that the pooled waiting lists increasingly reduce a patient's Referral to Treatment (RTT) waiting time.

- In respect of Acute Coronary Syndrome (ACS), a new shared pathway has been piloted and is now being implemented across MFT. This pathway provides high-risk ACS patients access to the catheter laboratory within 24hrs (compared to a usual wait of 3 days). This is a unified pathway across both MFT sites with a view to extend to all ACS patients across the Greater Manchester conurbation. This pathway standardises patient care and, in a pilot study, has already been shown to reduce the length stay thus freeing bed days and streamlining care.

- Additional urgent gynaecology surgery lists across Wythenshawe and St Mary's Hospital are in place which offers patients additional choice for their procedures in terms of both time and location. The baseline figure for this metric was 3.3 days, however, on average, patients waited 2.5 days for their procedure in July 2018 and 1.63 days in August 2018. Staff continue to review the service across the sites to continue to drive operational efficiencies to help improve patient experience.

- The organisation is also continuing to discover 'emergent benefits' whereby additional benefits are realised as projects continue to progress and services begin to integrate, for example:

    - Due to the increased size of MFT, the Trust has been chosen as a centre for the Mary Seacole NHS Leadership Academy programme. This six month course provides colleagues with training and development opportunities to become leaders in the NHS. So far, the Trust has attracted over 70 participants to the programme.

    - MFT staff have benefited from the merger with an integrated staff assistance programme offering support with any issues that staff may be facing. The Employee Assistance Programme offers services including 24/7 confidential advice and access to a wellbeing portal. There has been positive feedback for this service from staff throughout the Trust.

    - Through the merger, benefits for the Research and Innovation Team have begun to emerge. For example, through collaboration between Saint Mary's Hospital and Wythenshawe Hospital, a new post for a Research Midwife was created in the Wythenshawe Team. This post means that more patients in Manchester now have the opportunity to take part in maternal and fetal health research studies, which will help drive innovation to ultimately improve patient care. In addition the Research and Innovation Team has been able to standardise project management practices and systems across all sites which means all research study information is securely stored on a central server which can be accessed across all sites. The centralisation of studies means that staff can work more efficiently from any site and encourages cross site collaboration.

Integration planning for year 2 and beyond is underway which includes a re-fresh of the Post Transaction Integration Plan (PTIP). This will be the fifth iteration of the PTIP and it is anticipated that this will be the final PTIP for Project One. The Director for the Single Hospital Service will, however, continue to work closely with Group Executive Directors and Hospital /Managed Clinical Service Chief Executives to drive integration plans and embed change as part of the MFT approach to business as usual. In tandem with this, the SHS Team will maintain oversight of integration and ISG will continue its reporting relationship with the Group Executive Team, Group Management Board and ultimately through to the Board of Directors.

As part of the integration work, a year one post-merger report is currently being produced to evaluate the first year of operation of the new organisation. The report will be shared widely.

3. North Manchester General Hospital (Project 2)

Work is progressing on the second phase of the SHS Programme: the proposed acquisition of North Manchester General Hospital (NMGH) by MFT.

NHS Improvement (NHS I) has set out a proposal for MFT to acquire NMGH as part of an overall plan to dissolve Pennine Acute Hospitals Trust (PAHT), and to transfer the remaining hospital sites to Salford Royal NHS Foundation Trust (SRFT). The intention for MFT to acquire NMGH is consistent with the Manchester Locality Plan objective to establish a Single Hospital Service within the City of Manchester.

The transaction process continues to be managed in line with the NHS I national transaction guidance. A Transaction Board, to oversee the dissolution of PAHT, chaired by Jon Rouse, Chief Officer for the Greater Manchester Health and Social Care Partnership (GMH&SCP) is now well embedded and associated sub-groups have been established.

As predicted, the process for MFT to acquire NMGH is proving complex and requires a significant degree of effort across a range of interactions with stakeholders. Notwithstanding the challenges, MFT remains committed to acquiring NMGH and is working collaboratively with local and national stakeholders to ensure the safe and secure transfer of NMGH can be delivered at the earliest practicable opportunity.

Specific point of progress;

- Manchester Health and Care Commissioning and the North East Sector Commissioners are leading processes to develop a service model for acute services at NMGH and the other PAHT sites, respectively. GMH&SCP is also working to support this process. As a result commissioning plans across Oldham, Heywood, Middleton & Rochdale, Bury and Manchester will be consistent.

- MFT has started the process of familiarisation with the clinical services at NMGH. This commenced with the sharing of written clinical service profiles by PAHT and has now progressed to face to face discussions with clinical leads. At present, the SHS team has met over 60 individuals and meetings with the remaining services will take place over the coming month. This work will support the ongoing development of the Strategic Case and will feed into the due diligence processes.

- Work to undertake vendor due diligence is progressing and a shared approach to acquirer due diligence is being agreed. The shared approach on acquirer due diligence will help to ensure the process is effective and efficient, whilst providing the required information.

- The Single Hospital Team met MFT Council of Governors on 28th August 2018 to provide key updates on the progress of the proposed acquisition. The session served as an opportunity for the Council of Governors to learn more about the services and footprint of NMGH. It also afforded the opportunity to consider the important role Governors have with regard to considerations to be made by the Board of Directors about the proposed transfer of NMGH to MFT.

- A staff engagement plan for NMGH has been developed and sessions open to all staff at NMGH continue to be scheduled. The first session took place on 11th July 2018, feedback from which was positive. A subsequent session is planned for 12th September 2018.

4. Recommendations

The Board of Directors is asked to:

- Receive the report and note the work underway to progress the post-merger integration plans.

- To note the position of the proposed transfer of North Manchester General Hospital as part of NHS Improvement's plan for the dissolution of Pennine Acute NHS Trust

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Adrian Roberts – Chief Finance Officer
Paper prepared by:	Ursula Denton – Director of Finance
Date of paper:	16th August 2018
Subject:	Financial Performance for 2018/19
Purpose of Report:	Indicate which by ✓ • Information to note • Support • Resolution • Receive ✓
Consideration of Risk against Key Priorities:	Maintaining financial stability for both the short and medium term
Recommendations:	The Board of Directors is asked to Receive the Chief Finance Officer's Report and recommendation(s) that Intense leadership focus is needed to: • Drive agency costs reductions • Continue savings delivery • Sustain income delivery • Maintain and further strengthen grip and control over expenditure
Contact:	Name: Adrian Roberts, Group Chief Finance Officer Tel: 0161 276 6692

Executive Summary

1.1	**Delivery of financial Control Total**	The financial performance for the first four months of the year was **a bottom line deficit** (on a control total basis excluding Provider Sustainability Fund) **of £7.7m** (**1.4%** of operating income). Trusts' financial performance is assessed with PSF excluded. The Trust is very narrowly within the delivery plan profile submitted to NHS Improvement – *and would be missing this profile by £1m with the carve-out of the community services underspends within the Manchester LCO*.
1.2	**Run Rate**	This underlying deficit of £7.7m over 4 months represents **a run rate deficit of £1.9m per month,** which is not compatible with delivery of a £12m deficit excluding PSF over the year as a whole. Hospitals/MCS' have aggregate Trading Gap targets of £66.5m. The reported position across the Turnaround programmes highlights that insufficient delivery plans have been developed, with **a gap of £22m**. To date, delivery plans totalling £44.4m have been identified up to delivery standard, with a further pipeline of around £6m currently in development across Hospitals/MCS'. **Agency spending now exceeds the ceiling set by NHSI for MFT by over 25%** This represents the worst performance by the Trust since the inception of the agency ceiling. ***Actual agency spending has increased by 8% over these 4 months compared to 2017/18.*** Table 2 on page 5 provides the Hospital/MCS performance against ceilings. Given the continuing significance of agency spend in the overall deficit position, the ceiling/breach positions for each Hospital/MCS will be included in this report.
1.3	**Risk**	Insufficient control over medical agency and locum costs, together with slippage in delivery of savings plans, continue to represent material risks to sustained delivery in 2018/19 financial year. Intense leadership focus is needed to: • Drive agency costs reductions • Continue savings delivery • Sustain income delivery • Maintain and further strengthen grip and control over expenditure
1.4	**Cash & Liquidity**	As at 31st July 2018 the Trust had a cash balance of £132.9m.
1.5	**Capital Expenditure**	The Capital Plan for 2018/19 is £74.0m. Capital expenditure in the year to date was £14.5m against a plan of £20.4m. In light of the factors causing slippage over the early months, the forecast spending to March 2019 now requires review.

Financial Performance

Income & Expenditure Account for the period ended 31st July 2018

		Year to date - Month 4				
	Annual Plan	Year to date budget	Variance from budget	Variance as % of budget	Variance to Month 3	Year to date Actual
INCOME	**£'000**	**£'000**	**£'000**	**%**	**£'000**	**£'000**
Income from Patient Care Activities						
A and E	45,379	15,261	59		14	15,320
Non-Elective (includes XBD's)	263,388	87,486	796		620	88,282
Elective (includes Day Case & XBD's)	213,805	70,174	-588		-54	69,586
Out-Patients (includes First & Follow up)	173,805	57,386	609		566	57,995
Other NHS Clinical Income	474,905	159,317	-798		-1,105	158,519
Community Services (includes LCO)	103,421	34,475	-15		-13	34,460
Drugs (excludes Blood Products - HAEM)	105,319	35,108	-648		-700	34,460
Sub -total Income from Patient Care Activities	**1,380,022**	**459,207**	**-586**	**-0.1%**	**-672**	**458,621**
Private Patients/RTA/Overseas(NCP)	8,001	2,632	129		22	2,761
Total Income from Patient Care Activities	**1,388,023**	**461,839**	**-456**	**-0.1%**	**-650**	**461,383**
Training & Education	61,163	20,390	-11		-88	20,379
Research & Development	55,629	18,544	-933		291	17,611
Misc. Other Operating Income	109,714	36,470	-5,118		-4,963	31,352
Other Income	**226,506**	**75,404**	**-6,062**	**-8.0%**	**-4,760**	**69,342**
Total Income	**1,614,529**	**537,243**	**-6,519**	**-1.2%**	**-5,410**	**530,724**
EXPENDITURE						
Pay	-917,483	-305,634	-2,367	-0.8%	-167	-308,001
Non pay	-634,454	-214,659	7,829	3.6%	5,176	-206,830
Total Expenditure	**-1,551,937**	**-520,293**	**5,462**	**1.0%**	**5,009**	**-514,831**
EBITDA Margin (excluding PSF)	**62,592**	**16,950**	**-1,057**	**-6.2%**	**-401**	**15,893**
Interest, Dividends and Depreciation						
Depreciation	-30,226	-10,076	1,043		728	-9,033
Interest Receivable	443	147	43		29	190
Interest Payable	-41,138	-13,755	34		20	-13,721
Dividend	-3,755	-1,000	0		0	-1,000
Surplus/(Deficit) on a control total basis	**-12,084**	**-7,734**	**63**	**0.8%**	**376**	**-7,671**
Surplus/(Deficit) as % of turnover	**0**					**-1.4%**
PSF Income	**44,931**					**6,815**
Non operating Income						**54**
Depreciation - donated / granted assets						**-188**
Impairment						**-432**
	32,847					**-1,422**

Operating Unit Performance against breakeven measure

Income	Pay	Non Pay	Trading Gap	Hospital	Variance to breakeven budgets - (adverse) / positive			Variance to Control Total		I&E Annual Turnover
Year to date variance					Year to date (to month 4)		Comparative position as at month 3	Indicative control total (YTD)	Variance to control total	
£000s					£000s	%	£000s	£000s	£000s	£000s
293	-214	-494	-178	Clinical & Scientific Support	-593	-0.8%	10	-132	-461	219,450
350	2,029	-1,393	-1,015	Facilities, Research & Corporate	-29	0.0%	-185	0	-29	211,819
25	1,586	-188	-336	Manchester LCO	1,087	5.8%	284	0	1087	55,946
1,036	-2,861	841	-8,634	MRI	-9,618	-7.5%	-6,896	-7,812	-1,806	385,522
579	277	446	-1,838	REH / UDH	-536	-2.1%	-535	-1,000	464	77,789
31	-96	165	0	RMCH	100	0.1%	368	500	-400	223,147
-129	93	17	-1,172	Saint Mary's Hospital	-1,191	-2.2%	-1,001	-600	-591	161,607
36	-599	-169	-7,431	WTWA	-8,163	-6.1%	-7,346	-7,045	-1,118	399,251
2,221	**214**	**-775**	**-20,604**	**Trust position**	**-18,944**	**-3.3%**	**-15,301**	**-16,089**	**-2,855**	**1,734,531**

Key Run Rate Areas

1. 2018/19 Trading Gap challenge

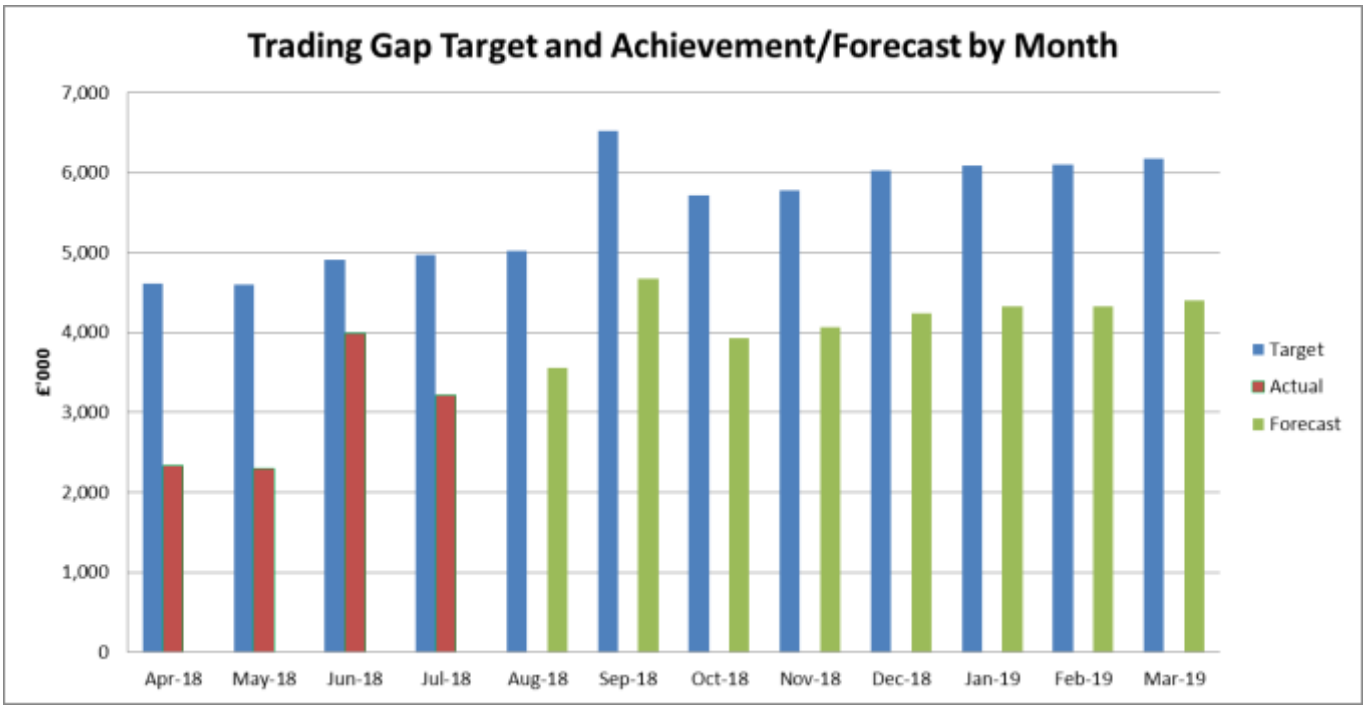
Theme Breakdown	Savings to date				Forecast to year-end			
	Target £'000	Achieved £'000	Variance £'000	Financial RAG	Target £'000	Forecast £'000	Variance £'000	Financial Forecast RAG
Admin and clerical	702	283	(419)	40%	2,189	1,767	(422)	81%
Blood Management	4	1	(3)	25%	14	7	(7)	50%
Contracting & income	2,393	2,581	188	108%	7,917	8,159	242	103%
Hospital Initiatives	1,136	1,351	215	119%	6,724	7,036	312	105%
Length of stay	0	0	0	0%	50	50	0	100%
Outpatients	395	547	152	138%	1,225	1,369	144	112%
Pharmacy and medicines management	467	412	(55)	88%	1,871	1,769	(102)	95%
Procurement	982	723	(259)	74%	4,615	5,310	695	115%
Theatres	504	671	167	133%	2,742	2,809	67	102%
Workforce - medical	1,229	981	(248)	80%	5,342	4,985	(357)	93%
Workforce - nursing	428	438	10	102%	1,643	1,622	(21)	99%
Workforce - other	343	690	347	201%	672	1,018	346	98%
Full year effect of prior year schemes	3,159	3,154	(5)	100%	9,476	9,476	0	100%
Unidentified	7,349	0	(7,349)	0%	22,045	0	(22,045)	0%
Grand Total	**19,091**	**11,832**	**(7,259)**	**62%**	**66,525**	**45,377**	**(21,148)**	**68%**

Financial RAG

The RAG Rating in the table above is the overall financial risk rating based on the criteria defined below. There are many individual schemes within each main savings theme, and at a detailed level there will be a range of ratings within each theme.

Financial Delivery less than 90%
Financial Delivery greater than 90%, but less than 97%
Financial Delivery greater than 97%

Graph 1

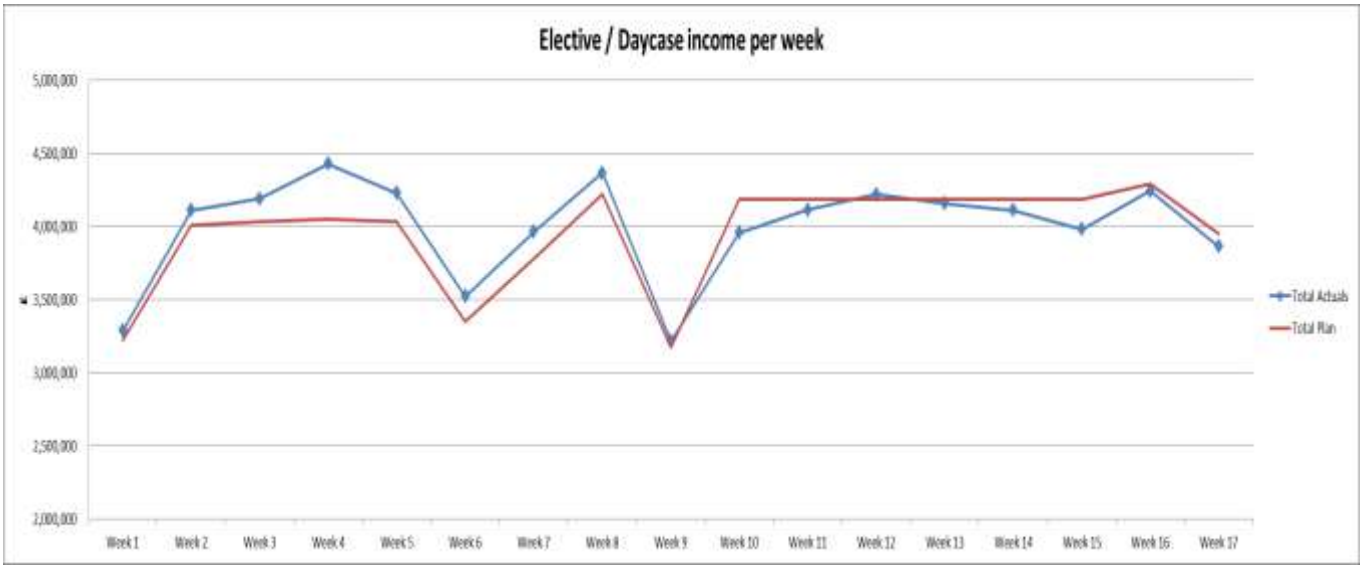


2. Agency spend by Hospital / MCS

	Agency spend M1-4 (£000)	Agency ceiling M1-4 (£000)	Difference (£000)
Clinical & Scientific Support	1,826	1,523	303
Manchester LCO	197	18	179
MRI	3,749	3,014	735
REH / UDH	458	356	102
RMCH	552	468	84
Saint Mary's Hospital	156	117	39
WTWA	3,589	2,494	1,095
Total	**10,527**	**7,990**	**2,537**

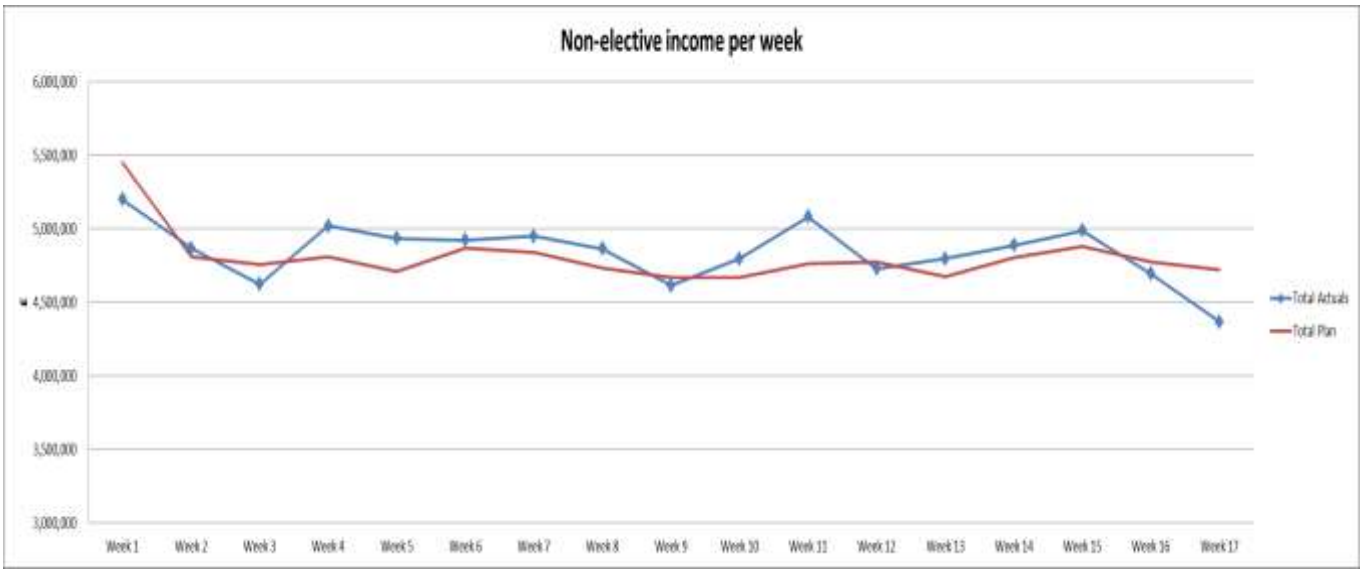
3. Elective / Daycase income: July 2018

Graph 2

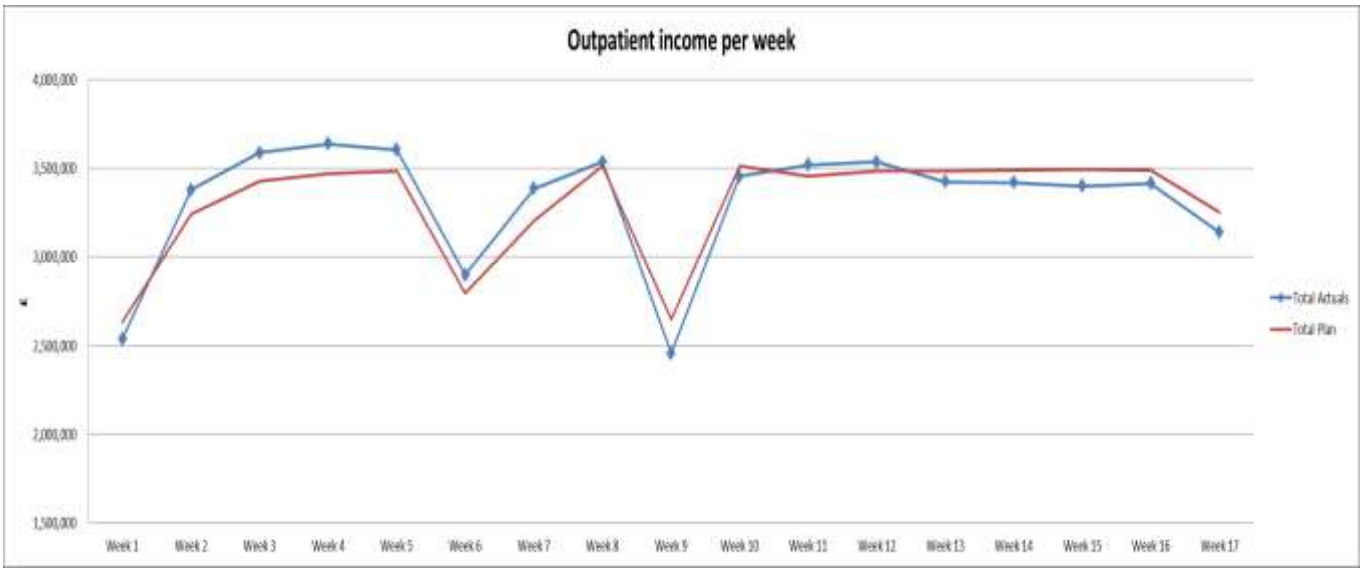


4. Non-Elective income: July 2018

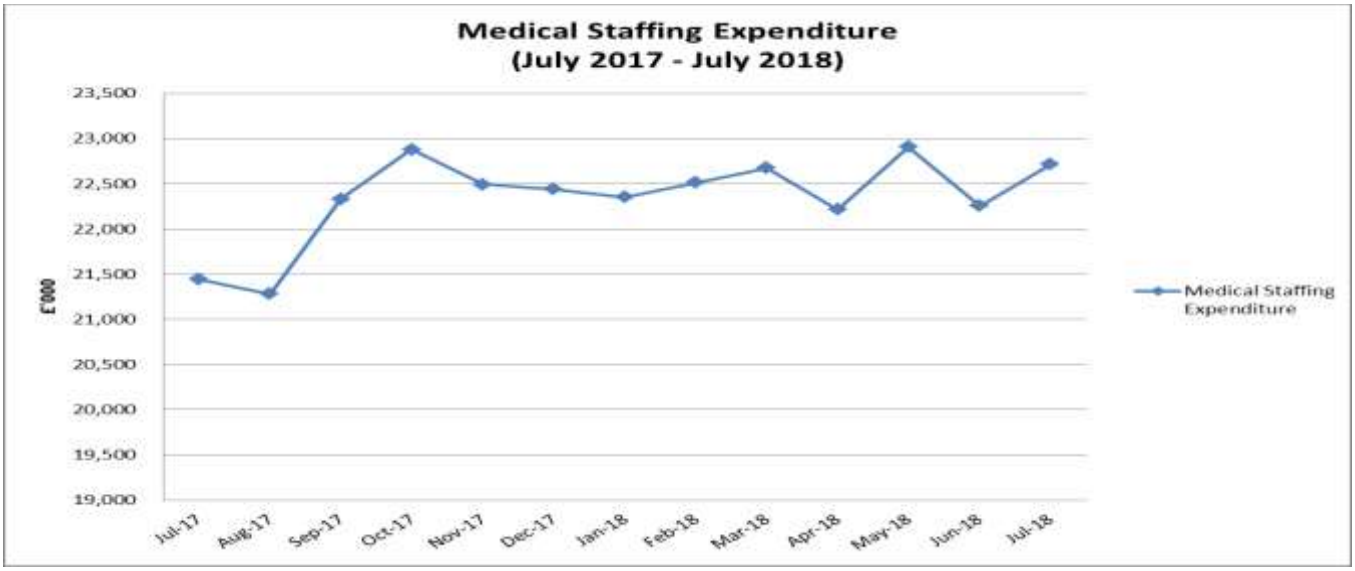
Graph 3



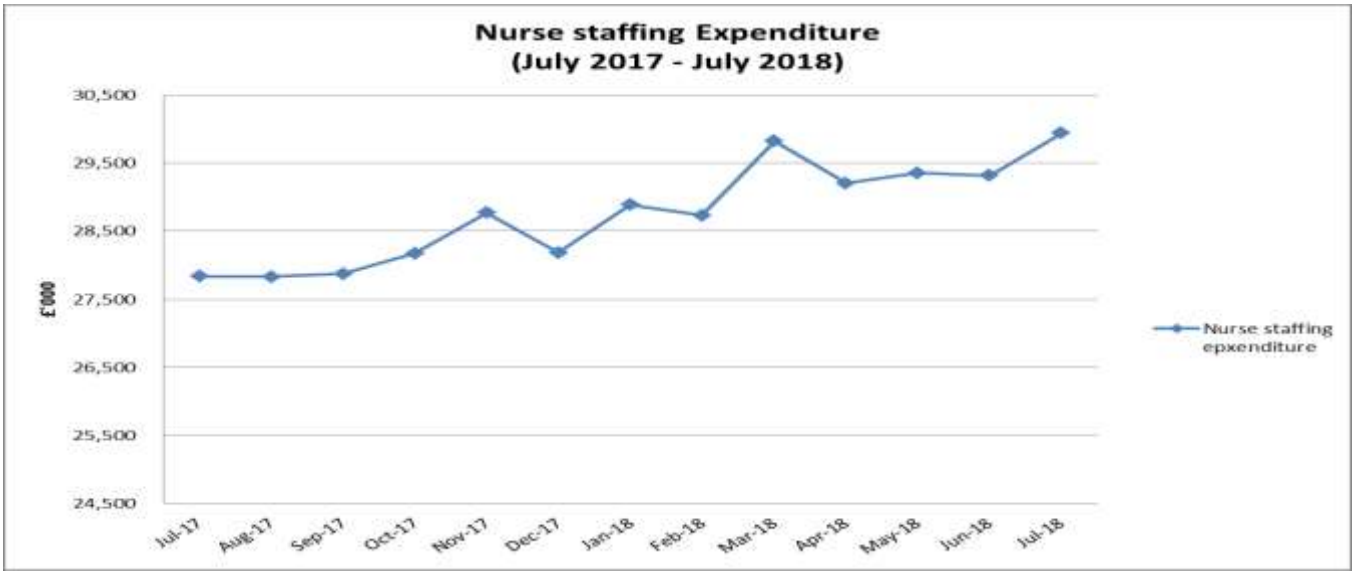
5. Outpatient income: July 2018 Graph 4



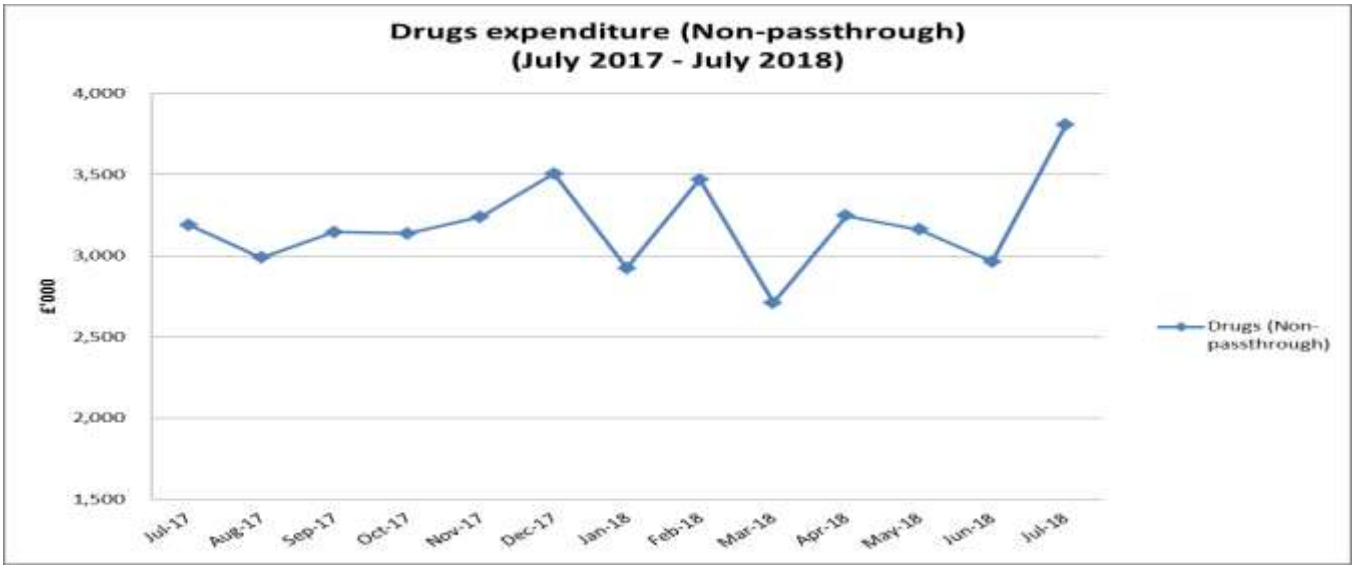
6. Medical Staffing: July 2018 Graph 5



7. Nurse staffing: July 2018 Graph 6



8. Prescribing Drugs: July 2018 Graph 7



NHS Improvement's KPIs

	Plan YTD		*Actual YTD*	
	Metric	***Level***	***Metric***	***Level***
Liquidity ratio	2.5	1	1.2	1
Capital servicing capacity	1.2	4	1.0	4
I&E Margin	0.4%	2	(0.2%)	3
I&E margin: Distance to financial plan	0.0%	1	(0.6%)	2
Agency spend Metric - above / (below) the agency ceiling	10.3%	2	25.3%	3
Use of Resource (UOR) metrics - Level 1 being highest		**2**		**3**
	Annual Plan (full year)		***Forecast 18/19***	
	Metric	***Level***	***Metric***	***Level***
Liquidity ratio	0.2	1	(3.0)	2
Capital Servicing Capacity	1.6	3	1.3	3
I&E Margin	2.0%	1	0.9%	2
Variance in I&E Margin as a % of income	0.0%	1	(1.1%)	3
Agency spend Metric - above / (below) the agency ceiling	8.1%	2	14.0%	2
Use of Resource (UOR) metrics - Level 1 being highest		**2**		**2**

Narrative:

Under the Use of Resource (UOR) metrics, the Trust achieves an overall level 3.

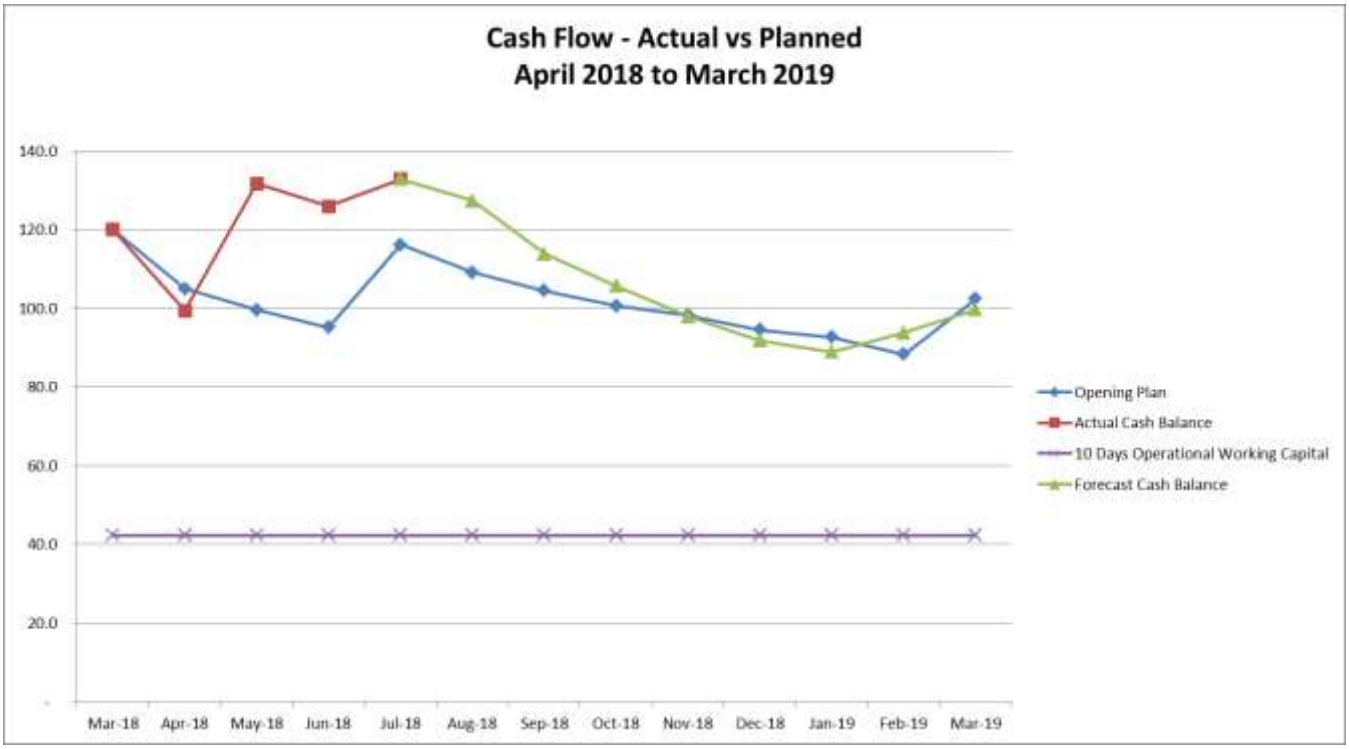
Performance is consistent with the plan submitted to NHSI with the exception of two elements:

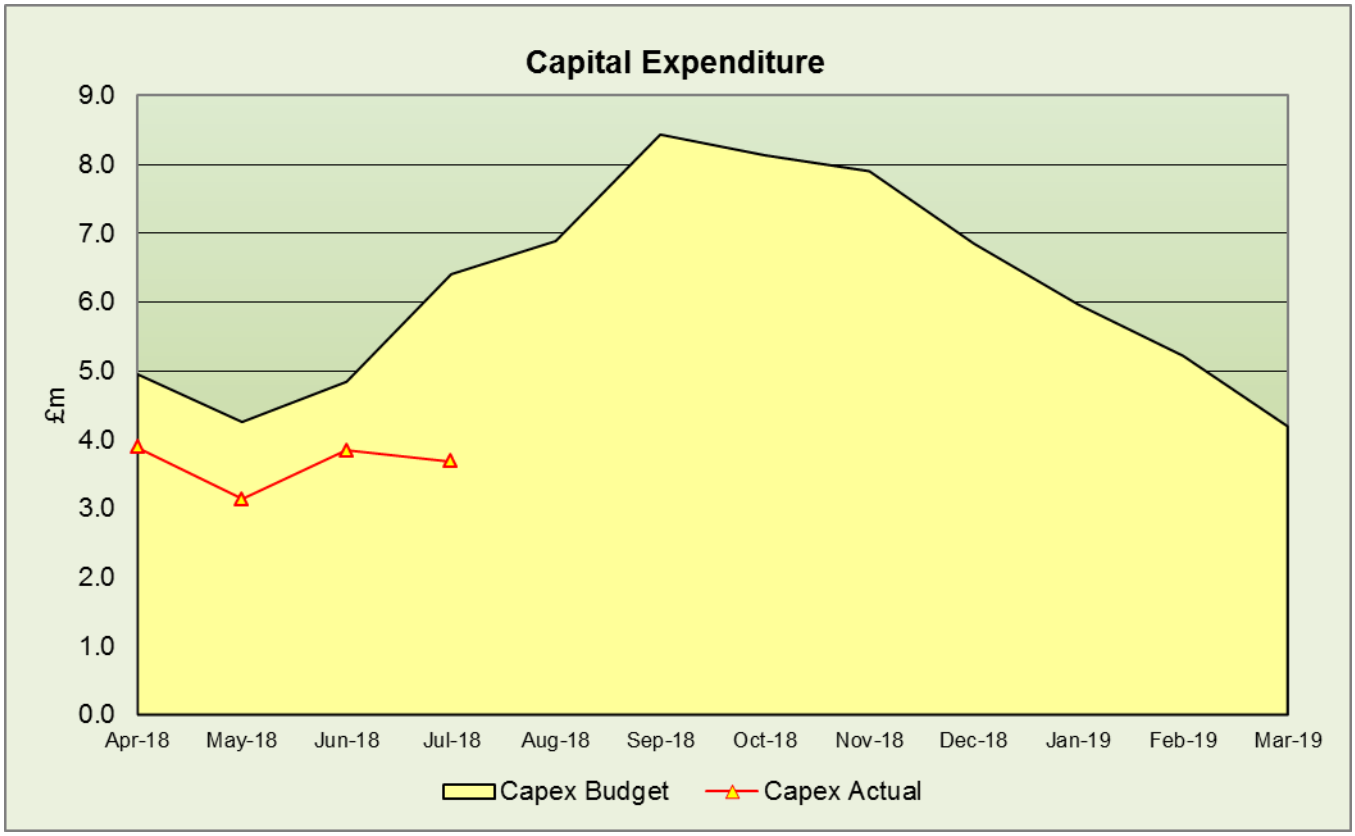
- An adverse variance on the agency spend, which now exceeds the agency ceiling by 25% in-year.
- The loss of the Provider Sustainability Fund associated with A&E performance.

Balance Sheet

	Actual Opening Bals 01/04/2018 £000	Actual Year to Date 31/07/2018 £000	Movement in Year to Date £000
Non-Current Assets			
Intangible Assets	4,397	3,639	(758)
Property, Plant and Equipment	617,672	623,702	6,030
Investments	866	866	0
Trade and Other Receivables	5,591	6,736	1,145
Total Non-Current Assets	**628,526**	**634,943**	**6,417**
Current Assets			
Inventories	17,026	17,000	(26)
NHS Trade and Other Receivables	90,505	87,604	(2,901)
Non-NHS Trade and Other Receivables	41,863	49,047	7,184
Other Current Assets	0	0	0
Non-Current Assets Held for Sale	210	210	0
Cash and Cash Equivalents	119,896	132,857	12,961
Total Current Assets	**269,500**	**286,718**	**17,218**
Current Liabilities			
Trade and Other Payables: Capital	(9,497)	(10,147)	(650)
Trade and Other Payables: Non-capital	(154,265)	(185,277)	(31,012)
Borrowings	(22,286)	(22,933)	(647)
Provisions	(23,052)	(18,543)	4,509
Other liabilities: Deferred Income	(22,635)	(27,623)	(4,988)
Other Liabilities: Other	0	0	0
Total Current Liabilities	**(231,735)**	**(264,523)**	**(32,788)**
Net Current Assets	**37,765**	**22,195**	**(15,570)**
Total Assets Less Current Liabilities	**666,291**	**657,138**	**(9,153)**
Non-Current Liabilities			
Trade and Other Payables	(2,601)	(2,600)	1
Borrowings	(423,858)	(418,103)	5,755
Provisions	(7,251)	(8,461)	(1,210)
Other Liabilities: Deferred Income	(5,252)	(2,068)	3,184
Total Non-Current Liabilities	**(438,963)**	**(431,232)**	**7,731**
Total Assets Employed	**227,328**	**225,906**	**(1,422)**
Taxpayers' Equity			
Public Dividend Capital	203,291	203,291	0
Revaluation Reserve	45,408	45,408	0
Income and Expenditure Reserve	(21,371)	(22,793)	(1,422)
Total Taxpayers' Equity	**227,328**	**225,906**	**(1,422)**
Total Funds Employed	**227,328**	**225,906**	**(1,422)**

Cash flow and Capital Expenditure





Scheme	Plan £'000	Plan YTD at 31st July 2018 £'000	Spend YTD at 31st July 2018 £'000	Spend in future months £'000	Forecast Year End £'000
Property and Estates schemes					
Helipad	5,246	1,325	45	3,921	3,966
Diabetes Centre	1,849	369	90	1,759	1,849
Emergency Department - Wythenshawe	5,548	1,848	2,026	3,522	5,548
MRI ED redevelopment	3,992	804	44	3,948	3,992
RMCH ED redevelopment	1,000	332	0	1,000	1,000
Property & Estates Schemes - Compliance Work	18,534	5,785	4,815	13,719	18,534
Property & Estates Schemes - Development	11,862	3,834	610	6,632	7,242
Property & Estates - sub-total	**48,031**	**14,297**	**7,630**	**34,501**	**42,131**
IM&T schemes					
Electronic Patient Records (EPR)	2,100	363	637	1,463	2,100
IM&T Rollng Programme	1,555	520	153	1,402	1555
IM&T Strategy	7,949	1,304	1,712	6,237	7,949
IM&T - sub-total	**11,604**	**2,187**	**2,502**	**9,102**	**11,604**
Equipment rolling replacement programme	**6,904**	**1,471**	**1,862**	**5,042**	**6,904**
PFI Lifecycle	**7,500**	**2,500**	**2,552**	**4,948**	**7,500**
Total expenditure	**74,039**	**20,455**	**14,546**	**53,593**	**68,139**

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Director of Strategy
Paper prepared by:	Group Executive Director of Strategy
Date of paper:	22nd August 2018
Subject:	Strategic Development Update
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Resolution • Approval
Consideration of Risk against Key Priorities:	All individual strategic developments are risk assessed and monitored through the Board Assurance and Risk Management processes.
Recommendations:	The Board of Directors is asked to note the report and in particular: - Updates on the GM Theme 3 transformation programme and constituent projects. - Progress on the development of an overarching group service strategy and the clinical service strategies.
Contact:	Name: Darren Banks, Group Executive Director of Strategy Tel: 0161 276 5676

Introduction

The purpose of this paper is to update the Board of Directors in relation to the strategic issues that we are progressing.

1. National

NHS 10 Year Plan

Work has begun on developing the NHS 10 Year Plan, with the announcement of a number of work streams along with leads from arms-length bodies and provider CEOs. Mike Deegan will be leading the Efficiency and Productivity work stream along with Jeremy Marlow, NHSI's Executive Director of Operational Productivity. Once all work streams have been set up, engagement is expected to begin in September, with working groups defining their outputs in October for the Plan to be published in November. The previously announced NHS Assembly will then oversee the implementation of the Plan.

2. Greater Manchester

Theme 3 transformation

The status of the remaining Theme 3 projects in the transformation and design stage are set out in table 1 below.

Table 1: Theme 3 projects in transformation stage

Theme 3 transformation projects									
Provider lead	MFT				MFT & Wigan	MFT and ODN	SRFT	SFT	WWL
	Vascular	Breast cancer	Paediatrics	Respiratory	Cardio	Critical care & anaesthetics	Neuro Rehab	Benign urology	Ortho MSK
Case for change	√	√	√	√	√		√	√	√
Co-dependencies and clinical standards	√	√	√				√	√	√
Model of care	√	√	√	√	√		√	√	√
ECAP approval		√					√		
Options appraisal									

Updates on MFT-led transformation projects:

- *Vascular*
  - The model of care is now completed and is progressing through the approval process.

- *Breast cancer*
  - The model of care has been approved by the External Clinical Advisory Panel (ECAP)). The document describing the model of care is being strengthened based on the feedback from the various theme 3 governance groups.

- *Paediatrics*
  - The surgical model of care is now complete and endorsed by the Clinical Reference Group (CRG) and Workforce Reference Group (WRG).

  - The medical model of care will now be developed; this work will commence towards the end of September.

- *Respiratory*
  - Draft case for change and model of care reviewed by the CRG and Finance & Estates Reference Group (FERG) with feedback to be incorporated into the draft
  - Further work on the model of care will be resumed in late August
  - Design oversight forum scheduled for late September
  - Document will be presented to the CRG in final week of September

- *Cardiac*
  - Draft case for change and model of care reviewed by the CRG and FERG with feedback to be incorporated into the draft
  - Further work on the model of care will be resumed in late August when Programme Manager returns from annual leave
  - Design oversight forum scheduled for late September
  - Document will be presented to CRG in final week of September

- *Critical care and anaesthetics*
  - The project is being supported by the Operational Delivery Network and drafting of the case for change is in progress

3. MFT

Service strategy development

Overarching group service strategy

Views have been sought from a wide range of parties and individuals in order to inform the content of the service strategy. This has included:

- A workshop with the Council of Governors to discuss key questions related to the strategy.
- Smaller workshops with individuals identified as innovators across the trust to inform key themes in the strategy.
- Engagement with external stakeholders including MHCC, Trafford CCG, specialist commissioning, the LCO, Health Innovation Manchester, the Biomedical Research Centre, and Health Education England.

A survey has been distributed to all staff to gather views and the results now being analysed.

The Group Service Strategy Committee (GSSC) has held three workshops in which the themes that have come through from the engagement have been discussed in detail and a draft strategic framework has been developed which we will continue to iterate. The draft over-arching Group Service Strategy document is currently being written and will be shared at the Board Seminar on October 8th for discussion.

A communications strategy for the programme has been developed and has been shared with GSSC which addresses how we will engage internally and externally.

Clinical service strategies

Two of the three workshops for each of the wave one clinical services have now taken place. These have had strong attendance from individuals both internal and external to MFT, and high levels of engagement. Workshop 3 for each wave one service will be taking place over the next few weeks.

A number of focused group and 1-2-1 sessions with key stakeholders have taken place for each wave one service to discuss particular topics and challenges. A session on the wave 1 clinical services with the Council of Governors took place on 28th August.

Engagement sessions with colleagues from North Manchester General Hospital representing each wave one service are currently being arranged and will take place over the next few weeks. These will involve MHCC and the Single Hospital Service team to ensure that we are all aligned in relation to planning for NMGH.

Development of the draft clinical strategy documents has begun with the clinical leads.

Planning for waves 2 and 3 and folding in the Managed Clinical Services are currently underway. The recruitment process for clinical leads for waves 2 and 3 will begin from Tuesday 28th August.

4. Actions / Recommendations

The Board of Directors is asked to note the report and in particular:

- Updates on the GM Theme 3 transformation programme and constituent projects.
- Progress on the development of an overarching group service strategy and the clinical service strategies.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Michael McCourt Chief Executive, Manchester Local Care Organisation
Paper prepared by:	Tim Griffiths Assistant Director – Corporate Affairs, Manchester Local Care Organisation
Date of paper:	August 2018
Subject:	**Manchester Local Care Organisation - Update**
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Resolution • Approval
Consideration of Risk against Key Priorities:	N/A
Recommendations:	The Board of Directors is asked to note the contents of the Update Report.
Contact:	Name: Elliot Shuttleworth Tel: 07779981115 Name: Tim Griffiths Tel: 07985448165

1. Introduction

1.1 Further to the establishment of MLCO in April 2018, this report provides a further update from the MLCO to the Board. It covers the following:

- Internal Governance;
- Regulatory Assessment;
- Partnering Agreement Update;
- Memorandum of Understanding Development;
- North Manchester Community Services Transfer;
- Joint working with Partners;
- New Care Models

2. Internal Governance

2.1 The MLCO has now fully established its internal governance arrangements which includes the establishment of an MLCO Quality and Safety Committee and a Clinical Advisory Group. The CAG has not been created as an internal management control but as system wide piece of architecture to drive the clinical priorities of the city, as such its membership is drawn from across the Manchester health and care system and as such will report into the Health and Wellbeing Board. Due to the developing nature of the MLCO as an organisation the internal governance will continue to iterate as the organisation develops.

2.2 In July further revisions were made including the reconstitution the Finance and Performance Group, to ensure it has ability oversee a range of functions including Internal Audit. In addition, Design and Transformation Group which had a responsibility for overseeing the transformation programmes of MLCO has formally been stood and replaced with governance to support the development of work at both Neighbourhood and Locality level, that now feeds into an MLCO Programme Board.

2.3 Work to ensure that there is alignment between MLCO governance structures and MFT's is now complete, with MLCO senior officers now forming part of a number of MFT committees including Quality and Safety Committee and Clinical Advisory Committee.

3. CQC

3.1 The MLCO, as with the rest of the Group, will be subject to regulatory assessment in Autumn 2018. In preparing for this it is timely to acknowledge that the MLCO was established through the signing of a Partnering Agreement which defines MLCO's responsibility for delivering a range of community health and adult social care services.

Despite the signing of the agreement, the statutory responsibility remains unchanged with Manchester City Council retaining responsibility for Adult Social Care and MFT retaining responsibility for the provision of community health services. In support of the regulatory assessment MLCO has mobilised supporting governance arrangements, including monthly SHINE meetings chaired by the Chief Executive, these will feed directly into arrangements put in place by MFT.

3.2 In addition MLCO has mobilised dedicated programme management support has been secured and a clear programme has been developed which includes the development of a risk register, and communications strategy.

3.3 MLCO continue to work closely with colleagues at MFT to ensure that the organisation is able to appropriate support the regulatory inspection.

4. Partnering Agreement

4.1 As per the original terms of establishment it was agreed by the Partnering Agreement would be subject to review. A working group, comprised of senior representation from the respective signatories to the Partnering Agreement, continue to have oversight of this work stream and progress continues to be made with a number of schedules having either been redrafted or a process put in place to ensure that schedules are accurate including Schedule 1 (MLCO Partnership Board/Executive Team), Schedule 9 (MCC ASC Service Level Agreement), and Schedule 12 (Property Arrangements).

4.2 Other schedules, notably Schedule 11 (Provisional Resource Assumptions) are subject to and reliant on the completion of ongoing pieces of work.

4.3 The Board are advised that as discussions in regards to Phase II develop, it is possible that the Partnering Agreement and associated schedules will require further review and update.

5. Memorandum of Understanding Development

5.1 MLCO is currently working with a range of partners across the Manchester system, and is in the process of developing a number of MOU's to formalise various working relations that will be required to enable MLCO to operate effectively, including:

- **VCSE** – the MOU with the VCSE will set out how MLCO will work with the VCSE to commission, deliver and shape services that fall with the MLCO ambit. A process to develop the strategy has been agreed and mobilised with the initial phase of work expected to conclude in September 2018.

- **North West Ambulance Service -** The roll-out of the Crisis response service in Central and South Manchester will see NWAS Amber pathway calls being diverted to the Crisis teams. As part of NWAS Governance a Memorandum of Understanding will be signed between the MLCO and NWAS setting out how the interface between the Paramedics and Crisis Team Advanced Practitioners will operate. The MoU is currently being drafted and will be taken through the MLCO's Quality & Safety Committee prior to it being formally signed.

- **Manchester Primary Care Partnership (MPCP) –** the MoU with MPCP will describe the working relationship between the MLCO team and MPCP. The work to date has focused on 4 key areas: services, strategic alignment, conflict of interests and organisational development. It will be finalised at the next MHCC and MPCP Exec to Exec in September.

6. North Manchester Community Services Transfer

6.1 Following the transfer of North Manchester Community Services contract to MLCO via Manchester University Foundation Trust on April 1st 2018, the TUPE transfer of staff associated with the contracts happened on July 1st 2018. This transfer will be supported by a service level agreement between relevant parties, which is in the process of development.

6.2 Any emerging issues will be managed through agreed governance which includes the NMCS Transfer Committee, and the NMCS Implementation Group. In addition, Executive Teams from both organisations (MLCO and NMCO) met to explore how the two organisations can continue to work together effectively. The transfer governance arrangements are being reviewed to ensure they are fit for purpose for remained of 2018/19, as well as looking forward to any contractual discussions that may be required for 2019/20.

7. Joint working with Partners

7.1 MLCO continue to foster and develop collaborative relationships with a range of partner across the Manchester system, a number of these relationships are subject to the development of MOU's as per section five of this update.

7.2 Joint work with MHCC continues to make positive progress and as per discussions with MHCC there remains a positive will to support MLCO to develop.

7.3 The MLCO has commenced a joint project of work with the MFT to identify the system challenges, and the short and longer term opportunities to help address the operational challenges being faced on the MRI site in relation to numbers of patients attending the site and the current number of inpatients. This work is jointly led by Sarah Tedford (MRI CEO), Dr Jon Simpson (MRI MD), Mark Edwards (MLCO COO) and Bernie Enright (MLCO Director Adult Services). To date the work, the success of which has been contingent on MLCO co-ordinating a system response, has seen a significant number of complex patients supported to a more suitable place of care. It is also establishing a joint prioritised programme of work to change systems and processes to sustainably manage patient flow into and out of hospital.

8. NCM update

8.1 The New Care Models (NCM) which the MLCO is responsible for mobilising, continue to progress through the key phases of business case, design, mobilisation, implementation and evaluation. The priority for 2018/19 will be threefold:

- High Impact Primary Care
- Manchester Community Response
- Integrated Neighbourhood Teams

- **High Impact Primary Care** that wraps health and care support around residents at greatest risk is showing good evidence of early success and demand reduction on services. It is being piloted in three locations in the city (North, Central, and South). The programme is having a significant impact on those people that are referred into the surface and work is ongoing to increase the level of referrals into the services.

- **Manchester Community Response** is developing a new system way of responding to get people out of hospital quickly and preventing admission. As part of this programme 48 additional reablement staff have been recruited in the city, and the recruitment process used has seen the additional benefit of having secured employment for Manchester residents who had previously been long term unemployed.

- **Integrated Neighbourhood Teams** are the building blocks of the MLCO target operating model. Each of the 12 neighbourhoods will have a senior manager overseeing a range of integrated services and recruitment to the 12 key roles (INT Lead) across the city is now underway which is expected to be completed by early Autumn.

  The hubs for the Integrated Neighbourhood Teams (INTs) across Manchester continue to be mobilised, which will ensure that staff from across health and social care are physically co-located. The locations of the hubs are as follows:

Central	–	Chorlton
Central	–	Gorton District Office
Central	–	Vallance Centre
Central	–	Moss Side Health Centre
North	–	Victoria Mill
North	–	Cheetham Hill PCC
North	–	Cornerstones
North	–	Harpurhey District Office
South	–	Etrop Court
South	–	Burnage
South	–	Parkway Green House
South	–	Withington Community Hospital

  To date Estates and IM&T work in six of the 12 hubs has been completed with Health staff operating out of all six. There remains a number of challenges that colleagues across the system are working to resolve to ensure that all 12 can become operational as quickly as is possible.

9. Recommendations

9.1 The Board is asked to note the contents of the report.

MANCHESTER HOSPITALS NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Chief Nurse Professor Cheryl Lenney
Paper prepared by:	Director of Clinical Governance, Sarah Corcoran
Date of paper:	August 2018
Subject:	Regulatory Inspection Update
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Resolution • Approval
Consideration of Risk against Key Priorities	Quality, safety, experience, research, innovation and teaching
Recommendations	The Board of Directors are asked to note the content of this report
Contact:	Name: Sarah Corcoran Tel: 0161 276 8764

1. Introduction

1.1. A briefing paper was submitted to the Board of Directors in June 2018 detailing the regulatory obligation of the CQC to undertake an inspection within a year of establishment of the Manchester University NHS Foundation Trust.

1.2. This paper sets out the formal notification and associated processes to that inspection.

2. Regulatory Inspection

Care Quality Commission

2.1. The Trust has now received formal notification of the announced CQC inspection of Hospital and MLCO Services.

2.2. It has been confirmed that the dates of inspection will be as follows:

- Week 1 w/c 1st October — Royal Manchester Children's Hospital, Manchester Royal Eye Hospital, University Dental Hospital
- Week 2 w/c 8th October — Wythenshawe Hospital
  - Trafford Hospital
  - Withington Community Hospital
  - Altrincham Hospital
- Week 3 w/c 15th October — Manchester Local Care Organisation
- Week 4 w/c 22nd October — Manchester Royal Infirmary
- Week 5 w/c 29th November — Corroboration
- Week 6 w/c 5th November — Group Level Well-led Review

2.3. The ratings will be applied as per CQC guidance, across the core services for Safe, Caring, Effective, Responsive and Well-led. They will all be aggregated up to give an overall rating. The Well-led assessment rating will be presented separately. Each Hospital will receive a rating in the same way.

2.4. All logistical arrangements are now in progress.

2.5. A programme of communication for patients, the public, staff and stakeholders is in place.

Use of Resources

2.6. Prior to the CQC inspection NHS Improvement (NHSI) will visit the Trust to undertake the Use of Resources[1] review which will inform the assessment of the Well-led domain. The date of assessment is yet to be confirmed.

2.7. Use of Resource assessments are designed to improve NHSI's understanding of how effectively and efficiently trusts are using their resources. Assessments form part of NHSI's approach to oversight and improvement through the Single Oversight Framework (SOF), identifying support needs and good practice to help drive improvement.

2.8. The assessment will consider MFT's performance in a number of Key Lines of Enquiry (KLOES) and the impact that this performance has on the delivery of a high quality of care, maximisation of patient benefits and continuation of sustainable services:

[1] https://improvement.nhs.uk/documents/1537/Use_of_Resources_assessment_framework_final.pdf

2.8.1. Clinical services
2.8.2. People
2.8.3. Clinical Support Services
2.8.4. Corporate services, procurement, estates and facilities
2.8.5. Finance

2.9. Executive leads for the 5 KLOEs were determined in June.

2.10. Weekly meeting in June and July ensured that correct preparation took place (through internal review and assessment of performance for each KLOE); and that intelligence gathered from external stakeholders on the likely timing and format of the assessment could be shared on a timely basis.

2.11. Following the final KLOE assessment and review session, a consolidated summary briefing report has been drafted containing narrative responses, areas of best practice and potential areas of potential risks.

2.12. A key area of focus for the KLOE Leads period leading up to the assessment will be the identification and collation of appropriate evidence and examples of best practice performance to submit to NHSI. The Trust's Turnaround team are supporting this process.

Well-led Self-Assessment and Review

2.8 A component part of the CQC comprehensive inspection is the key line of enquiry 'Well-led' KLOE. In addition, based on the CQC's key lines of enquiry for its well-led domain, is the NHS Improvement requirement to undertake a self-assessment exercise (NHSI Developmental Review of Leadership and Governance).

2.9 This process includes a self-review by an Foundation Trust's Board of Directors, following which an appraisal of this self-assessment is undertaken by an external, independent party with recommendations for consideration by the Board of Directors (BoD) and subsequent translation into a BoD development plan and other action plans as appropriate.

2.10 In keeping with the process & timelines outlined to the BoD in early July 2018, the following stages of the Well Led review exercise have now been completed:

i) a Group level desk-top review against the eight Well-Led KLOEs and NHS I supporting guidance (signed-off by the Board of Directors in July 2018);

ii) a Hospital/MCS Well-Led Self-Assessment (also signed-off by the Board of Directors in July 2018);

iii) an external, independent objective assessment of Group level Leadership and Governance arrangements (KPMG commissioned to undertake the work entitled 'Post Transaction Integration Plan Follow-up') and progress made since the Reporting Accountant work undertaken in preparation for the merger back in September 2017;

iv) a second external, independent objective assessment of the Hospital/MCS level Leadership and Governance arrangements (Ernst Young commissioned to undertake the work) has now also been completed. The aim of this exercise was to review how the local Hospital/MCS leadership and governance arrangements work within the Group to ensure appropriate oversight and accountability.

2.11 The results of the internal self-assessments and external, independent reviews and the subsequent improvement plan (approved by the BoD in mid-August 2018) will be submitted to NHS I as evidence to support the NHSI requirement to complete a Developmental Review of Leadership and Governance using the Well Led framework.

2.12 A summary overview of the MFT Well Led Assessment, key recommendations and Action Plan will be received by the Board of Directors at its meeting on 12th November 2018.

3. Recommendations

3.1. The Board of Directors are asked to note the contents of the paper and the preparations in progress for receiving the CQC inspectors, for the announced inspection of all core services from October 2nd to November 8th 2018.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Professor Cheryl Lenney – Chief Nurse
Paper prepared by:	Karen Meadowcroft, Corporate Director of Nursing Debra Armstrong, Assistant Chief Nurse
Date of paper:	August 2018
Subject:	Quarter 1 Complaints Report, Financial Year 2018/19
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Resolution • Approval
Consideration of Risk against Key Priorities:	Patient & Staff Experience
Recommendations:	To note the content of the report and the progress of the Complaints Transformation Programme.
Contact:	**Name**: Debra Armstrong – Assistant Chief Nurse **Tel:** 0161 276 5061

Manchester University NHS Foundation Trust (MFT)
Complaints Report 1st April – 30th June 2018

1. Executive Summary

1.1 Members of the Group Board of Directors are asked to note the Quarter 1, 2018/19 complaints report for Manchester University NHS Foundation Trust, covering the period 1st April – 30th June 2018.

1.2 This report provides an overview of the Complaints and PALS performance for Quarter 1, 2018/19. Where legacy data is not available, this has been indicated within the report.

1.3 During Quarter 1, 2018/19, work continued to integrate the Trust's complaints functions and develop a single set of performance metrics. This will enable comparisons to be made between the Hospitals/Managed Clinical Services (MCS)/ Manchester Local Care Organisation (MLCO) across the Group. An integral part of the integration has involved the reporting alignment of Formal Complaints to Hospitals/ MCS/MLCO for services they manage across all Hospitals. The subsequent changes in reporting have had either a positive or negative impact on the number of formal Complaint received for some areas, as formal Complaints are now aligned to the relevant MCS MLCO. Data for these specific areas like with like comparison will be available from Quarter 2 2018/19.

1.4 During Quarter 1, 2018/19, there were a total of 461 new formal complaints received. This compares to 420 received in Quarter 4, 2017/18, 408 received in Quarter 3, 2017/18 and 400 formal complaints received in Quarter 2, 2017/18. There was a 9.76% increase in formal complaints (increase of 41 in number) received in Quarter 1, 2018/19 compared to Quarter 4, 2017/18. Whilst the natural variation is considered when reporting the number of complaints received is being monitored by the Assistant Chief Nurse. If the increasing trend continues into Quarter 2 a detailed analysis will be undertaken, by each of the Hospital/ MCS/ MLCO teams.

1.5 The largest numerical increases in the number of complaints received over this period were within Clinical and Scientific Services with an increase of 12 (85.7%) cases and Manchester Royal Infirmary (MRI) with an increase of 12 (9.9%) cases. The largest decrease in the number of complaints from Quarter 4 to Quarter 1, 2018/19 was at Wythenshawe Hospital which had a reduction of 75 cases (-46.9%). The variation for both Clinical and Scientific Services and Wythenshawe Hospital is due to the transfer of services and changes in reporting of complaints for Managed Clinical Services (MCS) from 1st April 2018, which is discussed in detail in Section 2 of this report. The increase in the number of complaints received by MRI is currently being investigated.

1.6 A significant improvement in reduction of complaints responses over 41 days relates predominantly to the reduction in the number of unresolved cases at Wythenshawe Hospital following the implementation of an improvement programme as previously reported to the Board of Directors.

1.7 There was an increase (positive) in the proportion of complaints closed within 25 days with 36.7% of the total complaints closed in Quarter 1, 2018/19 compared to 26.4% of the total closed in Quarter 4, 2017/18. There was an increase (negative) of 2.6% of cases closed at 41 days or more days between Quarter 4 and Quarter 1.

1.8 The NHS Complaint Regulations (2009) stipulate that complaints must be acknowledged in writing no later than 3 working days after the complaint is received. The Trust achieved 100.0% compliance with this Key Performance Indicator during Quarter 1, 2018/19.

19. The Complaints Scrutiny Group met once during Quarter 1, 2018/19. The Medicine and Surgery Divisions from Wythenshawe, Trafford, Withington and Altrincham Hospitals (WTWA), each presented a case at the July 2018 meeting and the learning identified is outlined in the report.

1.10 The Parliamentary and Health Service Ombudsman (PHSO) introduced a new clinical standard in August 2018, the 'Ombudsman's Clinical Standard', in an attempt to provide greater clarity and predictability as to how the PHSO consider the appropriateness of care and treatment. The 'Ombudsman's Clinical Standard', has been circulated to the Hospital/ MCS/ MLCO senior teams to circulate to clinicians so that they are fully informed of the approach the Ombudsman takes when investigating complaints about clinical care and treatment

2. The Group Board of Directors is asked to note the information within the report and the ongoing integration and development of the complaints system during Quarter1, 2018/19.

3. Overview of Quarter 1 Performance

PALS

3.1. During Quarter 1 (01/04/18 – 30/06/18) there was a total of 1,324 PALS concerns received. This compares to 1,460 concerns received in Quarter 4; which equates to a 9.3% decrease in concerns compared to Quarter 4, 2017/18. Numerically this equates to a decrease of 136 PALS concerns.

3.2. As appropriate and in agreement with the complainant, PALS concerns can be escalated to formal complaints or formal complaints de-escalated to PALS concerns. Historically, escalated and de-escalated cases data has not been collected for Wythenshawe and Withington Hospitals. The number of cases escalated and de-escalated has been collated across all Hospitals/ MCSs since 01st April 2018 as an integral part of the implementation of the new Trust Ulysses Safeguard Complaints Module.

3.3. There were 20 PALS cases escalated for formal investigation during Quarter 1, this compares to 32 PALS cases escalated during Quarter 4. Cases are in the main escalated due to the complexity of the complaint received and following discussion with the complainant advising that formal investigation needs to be undertaken.

3.4. Conversely 4 formal complaint cases were de-escalated during both Quarter 1, 2018/19 and Quarter 4, 2017/18.

3.5. The Hospital with the highest number of PALS concerns raised during Quarter 1, 2018/19 was Manchester Royal Infirmary with 405 cases (30.6%), followed by Wythenshawe with 319 cases (24.1%) of the PALS cases received.

3.6. The majority of PALS concerns during Quarter 1, 2018/19 related to the Outpatient areas, which accounted for 893 (67.4%) of the 1,324 contacts received. This compares to 776 (53.2%) of concerns raised during Quarter 4 in relation to the Outpatient areas.

3.7. **Table 1** shows the timeframes in which PALS concerns have been resolved during the previous four Quarters.

Table 1: Closure of PALS concerns within timeframes.

	Quarter 2, 2017/18		**Quarter 3, 2017/18**		**Quarter 4, 2017/18**		**Quarter 1, 2018/19**	
Days to close	Number of cases resolved within timeframe	Percentage of cased closed within timeframe	Number of cases resolved within timeframe	Percentage of cased closed within timeframe	Number of cases resolved within timeframe	Percentage of cased closed within timeframe	Number of cases resolved within timeframe	Percentage of cased closed within timeframe
0-5	909	58.2%	949	53.2%	900	62.5%	789	65.3%
0-7	1063	68%	1107	62.1%	1075	74.6%	922	76.3.%
8-14	320	20.5%	281	15.8%	292	20.3%	247	20.4%
15+	180	11.5%	394	22.1%	74	5.1%	40	3.3%

2.9 In Quarter 1, 2018/19 the number of cases taking longer than 14 days to close decreased from 74 cases to cases 40. This represents a 45.9% decrease (positive) in the number of long-standing cases. There has been a significant improvement in PALS performance at Wythenshawe Hospital and this is reflected in the improved Quarter 1 performance.

New Formal Complaints

2.10 An integral part of the implementation of the new Trust Ulysses Safeguard Complaints Module was the reporting alignment of Formal Complaints to Hospitals/ MCS/MLCO for services they manage across all Hospitals. The changes in reporting have resulted in an increase in the number of complaints recorded by Clinical Scientific Services, Royal Manchester Children's Hospital, St Mary's Hospital and Corporate Services as formal complaints from all hospital sites are now aligned to these MCS/ MLCO. This has conversely resulted in a reduction of Formal Complaints assigned to Wythenshawe Hospital, as whilst services continue to be delivered at Wythenshawe Hospital, formal Complaints received are now aligned to the relevant MCS. As such data for these specific areas like with like comparison will be available from Quarter 2 2018/19.

2.11 During Quarter 1, 2018/19, there were a total of 461 new formal complaints received. There was a 9.76% increase in formal complaints (increase of 41 in number) received in Quarter 1, compared to Quarter 4, 2017/18. As this level is higher than recent variation levels the number of complaints received is being monitored closely by the Assistant Chief Nurse, if the trend continues into Quarter 2 a detailed analysis will be undertaken, by each of the Hospital/ MCS/ MLCO teams.

2.12 The largest numerical increases in complaints over this period were Clinical Scientific 12 (85.7%) and Manchester Royal Infirmary 12 (9.9%). The largest decrease in complaints from Quarter 4 to Quarter 1, 2018/19 was at Wythenshawe Hospital which had a reduction of 75 cases (-46.9%). It is important to note that where a relatively small number of complaints are received, large percentage variations can be caused by relatively small numerical fluctuations hence the numerical figures are also reported.

2.13 During Quarter 1 of 2018/19, there were 152 new complaints made relating to Inpatient services and 208 in relating to Outpatient services. For Inpatient services, this represents an decrease of 7.3% compared to Quarter 4 (164) and for Outpatient Services, this represents an increase of 33.3% compared to Quarter 4 (156). The area with the highest number of outpatient complaints for Quarter 1 was MRI with a total of 54 of the 208 total (26%).

2.14 The National Statutory Requirement for the acknowledgement stage of formal complaints handling, according to the NHS Complaints Regulations (2009), is to acknowledge 100% of all complaints no later than 3 working days after the complaints are received. The Trust achieved 100.0% compliance with this Key Performance Indicator (KPI) during Quarter 1, 2018/19, compared to 98.5% compliance in Quarter 4, 2017/18. The improvement was realised following a system review and improvements made to ensure complaints are acknowledged within the expected timeframe.

Current Complaints

2.15 The accountability for complaints management and monitoring has been fully devolved to the Hospital/MCS Chief Executives during Quarter 1 2018/19 and performance is now being monitored at a group level via the Accountability Oversight Framework (AOF).

2.16 At the end of Quarter 1, there were 329 unresolved formal complaints compared to 351 unresolved at the end of Quarter 4. This is a 6.3% decrease (positive) at the end of Quarter 1, compared to the end of Quarter 4 equating to 22 fewer complaints within the unresolved category. The unresolved complaints comprised 164 (49.9%) which had been registered between 0-25 days, 82 (24.9%) between 26-40 days and 83 (25.2%) had been registered for 41 or more days.

2.17 There were 63 cases unresolved at 41 or more days at the end of Quarter 1 (2018/19) compared to 109 complaints unresolved at 41 or more days at the end of Quarter 4 (2017/18). The significant improvement relates predominantly to the reduction in the number of unresolved cases at Wythenshawe Hospital following a detailed analysis of all unresolved cases received at Wythenshawe Hospital prior to 01st April 2018 and the implementation of an improvement programme. At the end of Quarter 4 (2017/18) there were 144 unresolved cases received prior to 01st April 2018 at Wythenshawe Hospital at the end of Quarter 1 (2018/19) the number of cases received prior to 01st April 2018 that remained unresolved was 5 of a total of 72 cases unresolved at the end of the Quarter.

2.18 The oldest complaint case closed during Quarter 1 was registered at Saint Mary's Hospital on the 14th August 2017 and was 216 days old when closed on 22nd June 2018. The complaint involved a Level 3 Severity Concise Investigation within Saint Mary's Hospital, which involved a meeting between the complainant and members from of the Hospital Team following completion of the investigation.

2.19 Manchester Royal Infirmary had the highest number of unresolved cases at the end of Quarter 1 with 113 open cases, of these 61 (53.9%) were within 0-25 days, 32 (28.3%) were between 26-40 days old and 20 (17.6%) were over 41 days old.

Resolved Complaints

2.20 **Table 2** provides a comparison of formal complaints resolved within each timeframe from Quarter 2, 2017/18 to Quarter 1, 2018/19.

Table 2: Comparison of formal complaints resolved by timeframe

	Quarter 2 2017/18	Quarter 3 2017/18	Quarter 4 2017/18	Quarter 1 2018/19
Formal complaints resolved	366	404	295	177
Resolved in 0-25 days	138 (37.7%)	153 (37.9%)	78 (26.4%)	65 (36.7%)
Resolved in 26-40 days	113 (30.9%)	128 (31.7%)	88 (29.8%)	30 (17.0%)
Resolved in 41+ days	115 (31.4%)	123 (30.4%)	129 (43.7%)	2 (46.3%)

2.21 The proportion of cases resolved within 0-25 working days increased from Quarter 4 (2017/18) to Quarter 1, (2018/19) by 10.3% (positive). There was a reduction of 12.8% (positive) in the number of cases resolved between 26-40 days, between Quarter 4 (2017/18) and Quarter 1, (2018/19) conversely, there was an increase (negative) in the number of cases resolved at 41+ days of 2.6%.

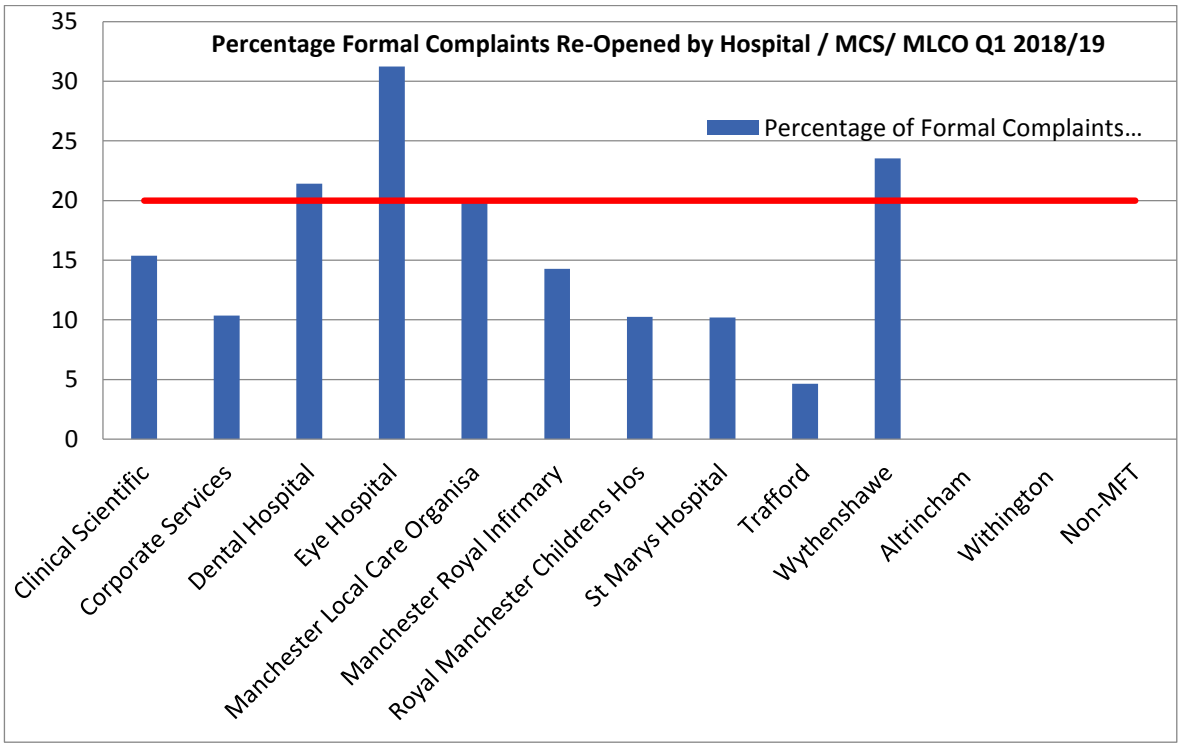
2.22 The Board was advised in the Quarter 3 and 4 Complaint Reports of the anticipated increase in the number of cases that would be resolved in 41+ days during Quarter 4, 2017/18 and Quarter 1, 2018/19. This is primarily due to the identification of system issues and an unplanned and significant reduction in the number of PALS staff available to support the management of complaints relating to Wythenshawe Hospital. The issue was identified, immediate action taken and an improvement Programme developed and implemented. During Quarter 1, significant progress has been made with the closure of cases received prior to 01st April 2018 at Wythenshawe Hospital, with only 5 cases remaining open at the end Quarter 1, 2018/19.

Reopened Complaints

2.23 Re-opened formal complaints are used as a proxy indicator to measure the quality of the initial response. A tolerance threshold of 20% has been agreed by the Group Chief Nurse. There was a reduction in the number of formal complaints re-opened (dissatisfied) during Quarter 1 of 2018/19 (66). This compares to 70 in Quarter 4, 2017/18, which is a decrease (positive) of 5.7%. Overall dissatisfied cases accounted for 14.3% of all complaints received.

2.24 **Graph 1** illustrates Hospital/MCS/MLCO performance against this threshold in Quarter 1, 2018/19. The University Dental Hospital 21% (3 re-opened cases), Manchester Royal Eye Hospital 31% (5 re-opened cases) and Wythenshawe Hospital 24% (20 re-opened cases) exceeded the 20% threshold during Quarter 1, 2018/19. All the other Hospitals/MCS/MLCO were at or below the threshold. It should be noted, however, that small fluctuations in the **total number** of complaints received in a Hospital/MCS/MLCO can result in large percentage changes for those sites with overall low number of complaints.

Graph 1: Percentage of re-opened Formal Complaints (Quarter 1, 2018/19).



Trust-Wide Compliments

2.25 The registration of compliments received by the Group Chief Executive is managed by the PALS Team and the Hospital/MCS management teams manage registration of locally received compliments on the Safeguard Complaint Management System. All responses are managed locally by the Hospitals.

2.26 The Trust receives many formal compliments from patients, their families and friends and action continues to be undertaken to increase recording of such invaluable feedback. **Table 3**, below, shows the numbers of compliments registered for each Hospital/ MCS/MLCO and relevant Division where applicable. The number of compliments registered during Quarter 1 of 2018/19 was 144. This compares to 224 in Quarter 4, 2017/18. This represents a decrease of 80 (35.7%) between Quarter 4, 2017/18 and Quarter 1, 2018/19.

Table 3: Distribution of Formal Compliments received from Quarter 2, 2017/18 to Quarter 1, 2018/19.

	Number of Compliments received by Division				
Hospital/MCS	**Division**	**Q2**	**Q3**	**Q4**	**Q1**
Unknown	Division not recorded	26	20	9	10
MLCO	Manchester Local Care Organisation	-	-	-	16
CSS	Clinical Scientific Services	11	4	4	2
Corporate	Corporate Services	1	0	2	0
MREH/UDHM	University Dental Hospital of Manchester	5	0	0	3
	Manchester Royal Eye Hospital	14	7	12	21
RMCH	Royal Manchester Children's Hospital	11	3	5	5
St. Mary's	St Marys Hospital	18	6	8	6
MRI	Specialist Medical Services	11	6	11	8
	Medicine And Community Service	15	40	43	11
	Surgery	12	25	36	21
	Unknown	0	0	0	6
Wythenshawe, Trafford, Altrincham and Withington	Trafford and Altrincham Hospitals	28	19	15	10
	Wythenshawe and Withington Hospitals	26	69	79	25
	Total	**178**	**199**	**224**	**144**

3.0 Care Opinion and NHS Choices feedback

3.1 Care Opinion (previously Patient Opinion) and NHS Choices are independent healthcare feedback websites whose objective is to promote honest and meaningful conversations about patient experience between patients and health services.

3.2 The number of Care Opinion and NHS Choices responses by category; positive, negative and mixed positive and negative comments, are detailed in **Table 4**.

3.3 The Care Opinion and NHS Choices feedback demonstrates that over half of the overall comments (55.2%) received in Quarter 1 (2018/19) were positive. This represents a slight reduction compared to Quarter 4 (2017/18) when the overall positive comments represented 65.9% of the total. Negative comments equate to 32.4% of the overall total received during Quarter 1 (2018/19), which compares to 25.0% during Quarter 4 (2018/19). Mixed responses relate to 12.4% of comments.

Table 4: Number of Care Opinion/NHS Choices postings by Hospital/ MCS/ Division in Quarter 1, 2018/19.

Number of Postings received by Division (Q1, 2018/19)			
Hospital/ Managed Clinical Service (MCS)/ Division	**Positive**	**Negative**	**Mixed**
MRI - Medicine And Community Service (MRI)	4	2	6
MRI - Specialist Medical Services (MRI)	3	5	1
MRI Surgery (MRI)	3	1	1
MRI Total	10	8	8
Clinical Scientific Services	1	0	0
Corporate Services (Estates and Facilities)	0	0	0
Dental Hospital of Manchester	3	2	1
Manchester Royal Eye Hospital	7	0	0
Royal Manchester Children's Hospital	3	1	0
St Marys Hospital	8	1	3
Trafford General	7	5	0
Altrincham General	5	8	0
Clinical Support Services, Wythenshawe and Withington	2	0	0
Scheduled Care (Maternity), Wythenshawe and Withington	3	0	0
Scheduled Care (Surgery), Wythenshawe and Withington	2	5	1
Unscheduled Care, Wythenshawe and Withington	7	4	0
WTWA Total	26	22	1
Overall Total	**58**	**34**	**13**

3.4 **Table 5** provides four examples of the feedback received and the subsequent responses posted on Care Opinion and NHS Choices websites during Quarter 1.

Table 5: Example NHS Choices/Care Opinion Postings and Reponses

Quarter 1, 2018/19: Royal Manchester Children's Hospital
World Class - Probably the best hospital ward in the cosmos. The care my daughter received in ICU and HDU in this hospital was absolutely first class. The staff are kind, caring, compassionate, considerate and totally 100 percent professional. I was genuinely moved to tears on more than one occasion at the way they cared for my daughter who has complex needs. I love our NHS and I love this hospital. You people are amazing.

Response

Thank you so much for taking the time to post your comments following your daughter's recent stay in ICU and HDU at Royal Manchester Children's Hospital to the NHS Choices website, we really appreciate it.

We were delighted to receive your positive feedback, which reflects the commitment, hard work and dedication of our staff. Your comments have been shared with key medical and nursing staff in Critical Care who will make sure that they are shared with the wider team.

Quarter 1, 2018/19: Emergency Department, MRI

Attended MRI Accident & Emergency in June 2018 with a friend on a weekday evening. Given this an A&E in a major city, I was quite surprised at how small the facility was, with a small waiting room and only one/two staff members running the triage. It took 30 minutes for my friend to be triaged and then a further 3 hours 15 minutes to be seen by a doctor. The doctor was extremely good, and took time to carefully examine my friend and explain treatment options to her. Whilst all the staff we encountered were pleasant and professional, I am left concerned by our experience, both by the lack of a quicker triage and the overall time taken.

Response

Thank you for your comment posted on the NHS Choices website regarding the care and treatment you received from the Accident and Emergency Department of Manchester Royal Infirmary. It was very kind of you to take the time to write and compliment the staff as it is good to receive feedback which reflects their hard work and dedication.

Mrs Sarah Sankey, Matron for the Emergency Department (ED) would like to thank you for the kind comments you have made about the team in the Accident and Emergency Department and this has been shared with them.

However, Matron Sankey would like to apologise for the time you had to wait for your friend to be seen by the triage team and that you also had a long wait to see the doctor. The MRI management team recognises that the department is small and would like to reassure you that plans are in place to improve the physical environment.

Quarter 1, 2018/19: Unscheduled Care, Wythenshawe Hospital

Intensive Care at Wythenshawe Hospital a rating of 5 stars My experiences in Primary Care Unit and Doyle Ward. I was transferred to Wythenshawe from Tameside whilst in an artificially-induced coma after suffering a heart attack and kidney failure resulting from pneumonia. I woke up in the Primary Care Unit to be looked after by a bunch of the most provident people imaginable, everyone in there knew what they needed to do and did it superbly well. Form the consultants, doctors, nurses and support staff they were all brilliant and so were the physiotherapists who got enough of my mobility back to enable me to be discharged without undue delay. After the extraordinary treatment in the Primary Care Unit I was able to be discharged from there and the first available bed was in Doyle Ward. In there I was looked after tremendously well under the watchful eye of one staff member assisted by a bunch of good people. The care in this ward was excellent and it was also done in what I found to be a pretty easy-going, relaxed atmosphere whilst fully addressing the care requirements. Nobody wants to be in there and the staff made the stay as pleasant as possible whilst giving good care. I had, and still have to an extent, a problem with drop-foot resulting from being in the coma but the people at Wythenshawe helped with that as much as possible both during my stay and after being discharged, the condition is improving and is something I can manage and cope with.

There is no doubt in my mind that without the level of care I received firstly at Tameside hospital then at Wythenshawe I would not be as good as I am today, in fact without it I might well not be here at all. Please pass my thanks to the people in both departments at Wythenshawe.

Response

Thank you for taking the time to share your kind feedback about your positive experience of the care and treatment that you received from Wythenshawe Hospital, particularly from the Primary Care Unit and Doyle Ward. It is important to us that comments are reviewed and we see it as an opportunity for the service to make improvements and implement change wherever possible.

We were pleased to read that the medical, nursing, staff in both units and the physiotherapists on the Doyle Ward looked after you very well and that you felt that the care and treatment you received was excellent.

We were also pleased to note that the staff made you feel comfortable and that their care has helped in your condition improving. We can assure you that your feedback has been passed on to the Head of Nursing for Scheduled Care so that this can be shared with the wider team. We wish you all the best in your recovery.

Quarter 1, 2018/19: ENT, Trafford

Results?? I attended on 25th April @ ENT was told I could go for blood tests (i did on that day) but as yet I haven't got any results neither has my GP.I have tried to phone for these but got no answer, I am disappointed in the delay of this. Visited in April 2018.

Response

We are sorry to receive your comments and concerns via the NHS choices website about your experiences of the ENT clinic on the 25th April 2018, and to learn that your experience was not as positive as we would hope. It is important to us that comments are heard and seen as an opportunity provided to the service to make changes and improvements wherever possible.

In response to your comments, your blood results should normally be available after 10 working days. After the blood samples have been taken in Phlebotomy, and if you live within the Trafford area, when the results become available, it should be possible for your G.P to view them. You should have received an appointment to return to the ENT Outpatient Department in 2 weeks after your original appointment, to discuss the results of your blood tests with a member of the medical staff. We are sorry that this has not been possible on this occasion. If you still have not received your appointment, then we would suggest that you contact your ENT Consultant's secretary.

We take all issues surrounding patient care very seriously and would very much like to hear from you directly about this. If you contact our Patient Advice and Liaison Service on 0161 276 8686 or by e-mailing pals@cmft.nhs.uk quoting reference number: PO18/0055, they will be happy to discuss this with you.

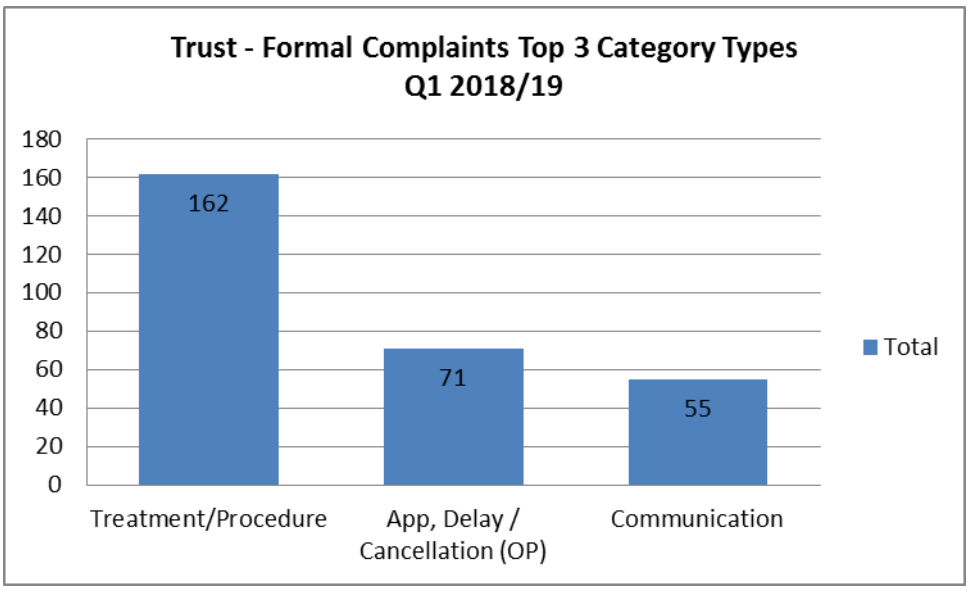
4. Themes from Complaints and PALS contacts

4.1 In Quarter 1, the medical staffing group were cited in 42.0% of all PALS contacts, compared to 31.8% in Quarter 4, 2017/18. This group was also cited in 52.0% of Formal Complaints in Quarter 1, compared to 36.5% in Quarter 4, 2017/18. Recording limitations prevent further analysis of this data to determine whether these references relate to specific grades of medical staff. Actions in relation to this trend are undertaken on a case by case basis by the relevant Hospital/MCS/MLCO. In addition, the Customer Services Manager provides educational input with regard to customer service and complaints management on the New Consultants Programme.

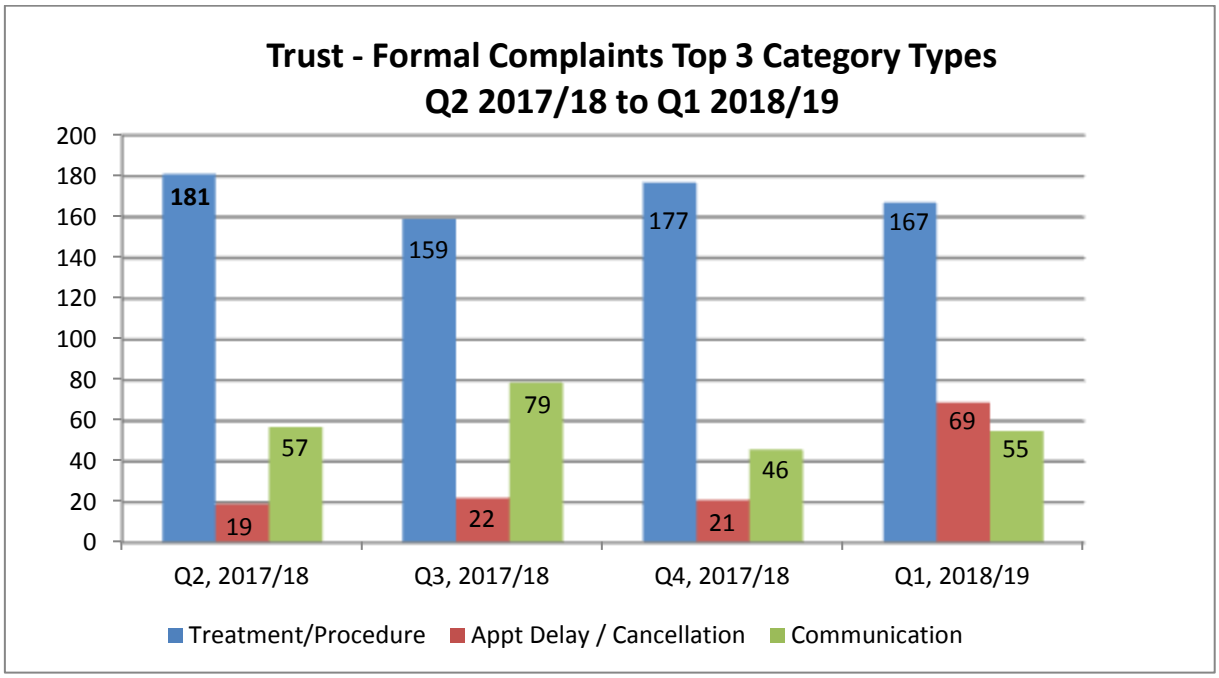
4.2 The Trust-wide top three category types for Formal Complaints for Quarter 1, 2018/19 are shown **Graph 2a** top three category types for Formal Complaints from Quarter 2, 2017/18 to Quarter 1, 2018/19 are shown in **Graph 2b**.

4.3 'Treatment/Procedure' and 'Communication' remain in the top three categories; however, in Quarter 1 (2018/19) 'Appointment Delay/ Cancellation' is within the top three categories replacing 'Access, Admission, and Discharge'.

Graph 2a: Formal Complaints – Top 3 Categories for Quarter 1, 2018/19



Graph 2b: Formal Complaints – Top 3 Categories Q1, 2018/19 Quarter 2, 2017/18, Quarter 3, 2017/18 and Quarter 4, 2017/18



4.4 Theming Complaints

Following implementation of the new Safeguard Complaints Management module for MFT in Quarter 1(2018/19), work has been undertaken to theme complaints to the new MFT Trust Values; ***Everyone Matters, Working Together, Dignity & Care & Open and Honest.*** As the dataset develops it will be included in future reports.

5. Complaints Scrutiny Group

5.1 In accordance with the agreed schedule, the Complaints Scrutiny Group, which is chaired by a Non-Executive Director, met once during Quarter 1, 2018/19. The Medicine and Surgery Divisions from Wythenshawe, Trafford, Withington and Altrincham Hospitals (WTWA), each presented a case at the July 2018 meeting.

5.2 The learning identified from the cases presented and the actions discussed and agreed at the meeting are outlined in **Table 6**. Transferable learning from complaints is identified and shared through this committee.

Table 6: Actions identified at the Trust Complaints Scrutiny Committee during Quarter 1 of 2018/19.

Division/ Hospital	Learning	Actions
WTWA (Medicine)	Call Bell out of Reach.	▪ Regular audits to be undertaken. ▪ Matron rounds to be undertaken.
	Lack of support & detection of mental health problem (Delirium)	▪ Look into what other areas across MFT offer to support patients with Delirium. ▪ Consider and adopt good practice.
WTWA (Surgery)	Issues identified with End of Life Care	▪ To continue with ongoing improvements to End of Life Care
	Copy of the Lead Trust's complaint response not shared with MFT.	▪ Copy of final response to be requested from Lead Trust. Following the meeting the complaint response was requested, received and shared with the WTWA team.

6. Parliamentary and Health Service Ombudsman (PHSO)

6.1 The Trust had 25 cases under the review of the Parliamentary and Health Service Ombudsman at the end Quarter 1, compared to 26 under review at the end of Quarter 4. Table 7 provides details of the progress of each PHSO case and shows the distribution of PHSO cases across the Hospitals/MCSs.

Table 7: Overview of PHSO Cases open as at 30th June 2018

Hospital/MCS Division	Case/s	Progress
CSS	1	Investigation on-going: Awaiting draft report
RMCH	1	Investigation on-going: Awaiting final report
MRI (SMS)	3	Investigations on-going: Awaiting proposed scope (1 case) Awaiting draft report (1 case) Awaiting final report (1 case)
MRI (DMACS)	4	Investigations on-going: Awaiting proposed scope (1 case) Awaiting draft report (2 cases) Awaiting final report (1 case)
MRI (Surgery)	5	Investigations on-going: Awaiting draft report (4 cases) Awaiting final report (1 case)

SMH	3	Investigations on-going: Awaiting draft report (2 cases) Awaiting final report (1 case)
UHDM	2	Investigations on-going: Awaiting draft reports
WTWA	6	Investigations on-going: Awaiting draft report (5 cases) Awaiting proposed scope (1 case)
Total	**25**	

6.2 The PHSO closed 6 cases in Quarter 1; of these cases 3 cases were partially upheld and 3 cases were not upheld, indicating that these complaints were managed effectively by the Trust. The PHSO advised the Trust to award compensation to one of the complainants to the value of £100.

Table 8: PHSO closed cases in Quarter 1, 2018/19 presented by outcome.

Division/ Hospital	Outcome	Date original complaint received	PHSO Rationale/ Decision	Recommendations
RMCH	Party Up-held	06/05/18	Failings in care and communication	Provide an acknowledgement and apology for the distress and failings identified in the report. Explain what actions have been taken to address the failings in the report.
WTWA	Partly Up-held	03/04/18	Failings in care	Provide a full acknowledgement and apology for the distress and failings identified in the report. Award compensation of £100. Explain what actions have been taken to address the failings identified in the report
WTWA	Partly Up-held	20/06/17	Complaint handling not in line with Regulations or PHSO principles.	Provide a full acknowledgement and apology for the distress and failings identified in the report.

				Explain what actions have been taken to address the failings identified in the report
MRI (SMS)	Not Up-held	28/07/17	No failings found	None
MREH	Not Up-held	07/09/17	No failings found	None
CSS	Not Up-held	23/08/17	No failings found	None

7. Learning from Feedback

Implementing Learning to Improve Services

7.1 All Hospital/ MCSs regularly receive their complaint data and review the outcomes of complaint investigations at the Hospital/ MCS Meetings. **Table 9** demonstrates how learning from a selection of complaints has been applied in practice to contribute to continuous service improvement within the Hospitals/ MCSs.

Table 9: Examples of the application of learning from complaints to improve services

Division	Learning & Improvements
CSS	**Imaging : Communication** A female patient with Asperger's syndrome came to the Imaging Outpatient Department for a Computerised Tomography (CT) scan. One of her triggers related to her Asperger's syndrome for anxiety and panic, was sudden loud noises. Unfortunately, there were no flags in the electronic booking system that highlighted this and the lady did not disclose this when she on her arrival in the department. Once in the CT scanner she became very upset and her complaint centred on the lack of information provided about the loud noises, and she was concerned that staff were not trained in how to communicate with autistic people. As a direct result of the complaint the following actions were taken: ▪ Staff involved in this patients care undertook online autism training and a review is underway to identify other key staff within the department to undertake this training ▪ The complaint was shared anonymously with the team to promote awareness of the importance of explaining procedures to all patients

	▪ A poster called 'behind the door' was put on the doors to the scan rooms which has images of the CT scanner, including the warning that for some patients, their care will involve machines that cause noises that may affect them Clinical and Scientific Services, is involved in improving compliance across all departments with the Accessible Information Standard to ensure that any information regarding special requirements for communication is flagged and shared with relevant health professionals and on relevant systems in the future.
MREH	**Improving staff awareness, communication, access and services for Children and People with Learning Difficulties** A difficult and distressing situation occurred for a mother and her daughter when they attended the MREH outpatient service. The mother and daughter had been waiting for a significant period of time and during the wait the daughter had become restless and started to run around, including behind the reception desk. This raised a comment by a staff member which was upsetting for the mother to hear. Subsequently the mother wrote a formal complaint letter which highlighted the poor awareness, communication and support for children and young people with Learning Difficulties (LD). As a result of the investigation into the formal complaint the team at MREH are working with the mother to improve several areas of our services. Firstly to raise awareness and improve communication the team are developing with the mother an audio story for use by staff as an LD teaching resource and to cascade the learning via its presentation at the Hospital Clinical Effectiveness Board and other MREH training events as well as LD awareness session presented by the Optometry Lead for Children's Services in MREH. The team at MREH have also approached the Children's hospital in relation to part funding of a play therapist who would be able to provide play therapy sessions at the MREH outpatients, at present MREH is working with the Trust Charity team to source funding for this role.
MRI (Surgery)	**Communication issues leading to late cancellation of surgery** Following pre-operative preparation for a live donation, kidney surgery was planned to go ahead on the 6th April 2018. However, late identification of a kidney stone in the donors remaining kidney meant that surgery was cancelled shortly before the patient was due to go to theatre for the procedure. It transpired that there was a failure in communication on two separate occasions that could have prevented the very short notice of the cancellation. The investigation into the concerns raised by the patient identified the following actions: ▪ All communications will be copied to the patient ▪ System of recording outstanding actions to be reviewed as a team and followed up on a regular weekly basis ▪ Review of communications from MDT Meetings ▪ Review of Transplant Co-ordinator role in the pathway with regard to follow-up of patient's treatment

MRI **(SMS)**	**Patient's Painful Experience during Femoral Line Insertion** A patient reported they had experienced a considerable amount of pain during a femoral line insertion after it had failed to be inserted twice. The patient had been given local anaesthetic but was unaware during the procedure the clinical team had taken the decision to turn off the Entonox due the patient becoming agitated and making lots of sudden movements. **Lessons Learnt:** The investigation into the concerns raised by the patient identified: ▪ Although the patient was asked to stop using the Entonox the reason for this was not clearly communicated. Turning off the Entonox without the patient knowing was not acceptable. ▪ Pain assessment scores were not used during the procedure which left the clinical team unaware of the level of pain the patient was in. **Actions:** ▪ Ward Manager to audit pain management on the Haematology Day Unit, as part of the Improving Quality Programme. These results will be shared on the Improving Quality Programme board on the Haematology Day Unit. ▪ Ward Manager to consider service improvement in the apheresis service; this includes the femoral line insertion service.
RMCH	**Delayed Diagnosis** A complaint was received from a patient's mother regarding a delayed diagnosis. A urine sample was taken from the patient at a clinic appointment and the child's family were contacted by their GP two weeks later advising that the patient had an infection and required antibiotics. The family complained that it took too long for RMCH to notify the General Practitioner (GP) of the child's infection which delayed treatment. On investigating the matter, the child had attended clinic for a diabetes appointment and the Consultant had obtained a routine urine sample. The child was not showing any signs of a urine infection at that time of the appointment. Routinely, results from urine samples taken from clinic are then sent to the requesting Consultant for review. Any significant abnormal results are discussed directly with the requesting Consultant by telephone or email. On this occasion the results were sent to the Consultant during a Bank Holiday weekend when he was on annual leave. On return from leave the Consultant reviewed the results and immediately notified the child's GP. As a result of the complaint and to avoid a similar incidents happening in the future, the Diabetes team and the Diabetes Nurse Specialists now chase up urine samples taken from patients in clinic and arrange for them to be reviewed promptly to avoid any delays.

St Mary's Q1	**Positive Communication** The admission of an infant to the Neonatal Intensive care unit is a highly stressful and emotional time for any family and establishing a positive relationship between the family and the large medical and nursing teams is essential to ensure that they feel informed and can make decisions regarding the ongoing care of their baby. A recent complaint from parents whose baby spent some time on Neonatal Intensive Care Unit (NICU) and the Paediatric Intensive Care Unit (PICU) highlighted how essential positive communication is in managing parental expectations and their understanding of their baby's condition and supporting them when difficult news has to be shared. Clinicians have a duty of candour and must give factual information when managing a complex situation. It is essential that the nursing and medical teams take time to ascertain what message the parents have 'heard' and their understanding of the implications of this. The use of the intranet and other sources of information by parents related to infant care can lead to some challenging conversations and where there are more than one Consultants involved in one infants care, the parents can feel they are excluded from the care and decision making process. The Nursing and medical teams involved in the care of this family have reflected on how this relationship faltered at times and how they can manage difficult conversations in a caring, but open and honest manner. The Patient Experience Lead will be working with the team to help them improve the support mechanisms for parents and staff and enhance the positive experience that most families receive.
UDHM	**Post-Graduate Student's Behaviour** A patient raised a formal complaint regarding treatment undertaken by an undergraduate student when he attended the oral surgery department to have several teeth extracted. At the end of the surgery an incident occurred involving the student sustaining a needle stick injury to his hand. The patient felt the way in which the student behaved during his treatment and afterwards was unprofessional and inappropriate. He found the student to be very insulting, humiliating and homophobic. The patient stated that the nature of his complaint put into question a number of professional standards that he felt had not been met. **Action:** A full investigation was undertaken into the matter with regard to the complaint. In addition, the matter was brought to the attention of the University of Manchester where a full investigation was undertaken in relation to the student's behaviour. The student acknowledged that he reacted inappropriately following the injury that occurred during the treatment. Recommendations following the investigation from the University were that further education and training is provided to the student as a priority in relation to blood borne infectious diseases and transmission as well as professionalism, care and communication.

WTWA **Surgery: Specialist Surgery**	**Communication** A complainant was transferred to the ENT Ward, F9, at Wythenshawe Hospital from Macclesfield General Hospital. The patient felt that there was a lack of communication between the two hospitals and between the departments at Wythenshawe Hospital. The complaint was received via Healthwatch Cheshire East, and requested: ▪ A review of the systems of communication between the hospitals ▪ A review of the system of communication between the departments, which left the complainant waiting for 2 hours and left him without food ▪ An update and explanation on the patient's hearing loss **Findings** ▪ The investigation identified that a doctor-to-doctor referral from Macclesfield General Hospital to Wythenshawe Hospital took place. The agreed pathway for the patient should have been transferred to the Emergency Department (ED) at Wythenshawe, for an ENT assessment. However, the ambulance team brought the patient directly to ENT ward. ▪ The Rapid Access ENT outpatient clinic was fully booked and this caused the patient a long delay before he was seen. As the patient was delayed returning to the ward he missed the ward lunch service. Unfortunately, a snack box had not been ordered and the complainant missed his meal The Consultant at Wythenshawe Hospital has liaised with his colleagues at Macclesfield General Hospital to highlight the patient's ongoing concerns regarding his hearing loss. As a result, the Consultant at Macclesfield General Hospital arranged to review the patient to discuss his concerns at his next outpatient appointment **The following actions were taken immediately following receipt of the complaint:** ▪ Manchester University NHS Foundation Trust complaints team have requested information from the complaints team at Macclesfield General Hospital and the ambulance service to identify the reason for the concerns with the patient's transfer. ▪ The complaint has been discussed with ward and clinic staff to ensure that inpatients are seen in a timely manner when attending the ENT Rapid Access clinic. ▪ Ward F9 staff have been reminded of the process for obtaining snack boxes and fluids for patients who have missed a meal due to being away from the ward at meal times. ▪ The complaint was used as means of educating ward staff.
WTWA **Cardiology**	**Communication and Attitude of Staff** A complaint was received from a patient about appointment cancellations without communication and explanation. The patient perceived that the secretarial staff were unfriendly and unhelpful, and one individual staff member was specifically highlighted in the complaint. The patient did not feel they were treated as an individual.

	The investigation into the concerns raised concluded that there was an assumption made by the administration team to cancel an appointment following an answerphone message left by the patient asking for all appointments to be together. A phone call was not returned to the patient. **Actions:** The Divisional Management Team have reiterated to all administrative staff that any appointment that is changed should be addressed through consultation with the patient, and not through making changes automatically based on an answer machine message. This has been reiterated to the administration team in a recent meeting. It is now departmental policy that all messages are reviewed from the answer machine and responded to within 24 hours Monday – Friday. Staff have also reminded that all patients should be treated in a respectful manner and that if a member of the administrative team cannot deal with an issue they should refer the matter to the Administration Manager to speak to the patient and resolve the issue. Members of the administrative team will attend customer care training. The Head of Nursing for Heart and Lung will also meet with the Administration Manager to promote 'What Matters To Me' amongst the administration team. The Division is currently working to embed the Outpatient Standards which will include a focus on promoting customer care, and improving the overall patient experience.
WTWA **Division of Medicine: Sexual Health Clinic**	**Appointments** A patient complained about access to Sexual Health clinic appointments at Withington Community Hospital. The complainant also expressed concern about having to queue up outside the clinic, which he felt was undignified and a breach of his confidentiality and that when he rang for an appointment the clinic was full and there was no alternative service available. **Lessons Learned:** The investigation into the concerns raised identified that there was a problem with clinic capacity particularly at certain times of the day (early am and late afternoon). The team identified that the communication with patients from the administration team needed to be improved in relation to the alternative clinic availability and information provided including signposting to alternative services. The team now understand the impact on the privacy and dignity of patients if they are required to queue outside the clinic. **Actions:** The Sexual Health services have reviewed the clinic templates and have identified ways to flex the capacity to meet demand, with changes already implemented.

	The Administration Team have been educated to provide appropriate advice to patients who cannot be accommodated in a clinic, including signposting to other services which offer testing. The clinic is reviewing a number of options to avoid patients needing to wait outside, including advertising the opening times.
WTWA **Trafford**	**ReSPECT** ReSPECT is a process that creates personalised recommendations for a person's clinical care in a future emergency in which they are unable to make or express choices. It provides health and care professionals responding to that emergency with a summary of recommendations to help them to make immediate decisions about that person's care and treatment. ReSPECT can be complementary to a wider process of advance/anticipatory care planning. A complaint was received raising concerns that attempts were made to resuscitate a patient when a ReSPECT form was in place. The form documented the patient's wishes in regards that they were not to be resuscitated. It was found that the patient had two large volumes of notes; with the older second volume being stored on a lower shelf of a ward trolley. The ReSPECT form was in the second volume of notes, and only the first set of notes were check by the attending CPR team. **Action/Learning identified:** The Ward Clerk now checks Patients' notes each morning to ensure that ReSPECT forms are in place and visible. Any discrepancies found by the Ward Clerk are escalated to the Ward Manager or Matron immediately. The Head of Nursing Trafford Hospital is overseeing the implementation of a daily review process across all medical wards to ensure that ReSPECT forms are in place and visible.

8. Developments and Service Improvements

8.1 Benefits of the new MFT Ulysses System.

During Quarter 1, a new single Ulysses Safeguard System has been implemented across the Trust. The Customer Service Module of the MFT Ulysses System captures and tracks the receipt and progress of Complaints, PALS Concerns and Compliments.

The MFT Ulysses system has been tailored and configured to meet the specific needs of the single hospital service, which provides a single streamlined clinical governance process across all sites using the same data sets. The single database is now accessible for all staff across all sites within MFT and will enable more robust data sharing throughout the Trust.

The new system will assist in the ability to provide more effective and efficient Group-wide, Hospital, Managed Clinical Service and MLCO data analysis. This in turn will support monitoring and management of clinical governance services throughout the Trust. It will also be of great value with the development and design of specific service reports at all levels within the organisation.

8.2 **Single Hospital Service**

Work continued during Quarter 1 of 2018/19 to align the complaints processes of the legacy Trusts to ensure Manchester University NHS Foundation Trust maintains compliance with the NHS Complaints regulations (2009).

The Formal Complaints service based at Wythenshawe Hospital continued to face staffing challenges during Quarter 1, 2018/19 and the integrated management arrangements continued to provide resilience to the service. As described in Section 2, improvements led by the Director of Nursing for WTWA, resulted in the backlog of cases at Wythenshawe Hospital being significantly reduced during Quarter 1, with only 5 cases remaining open at the end Quarter 1, 2018/19. This work has resulted in a higher number than average of Formal Complaints being resolved at more than 41 days in Quarter 1.

During Quarter 1, 2018/19 the accountability for complaints management, which includes Quality Control processes and monitoring has been fully devolved to the Hospital/MCS/MLCO Chief Executives who sign off of complaint responses relating to their area of responsibility. Performance is continues to be monitored at a Group level via the Accountability Oversight Framework (AOF).

As the Trust now provides services across six sites and community locations it is important that patients, relatives and carers wishing to raise a concern/complaint know how to do so and who to contact, and that in line with the 'My Expectations' principles complainants find it easy to make their complaint. To provide ease of access to the PALS service the team have developed a single point of access to the service via one telephone point, one email point and one postal point. In addition during Quarter 1 (2018/19) a MFT PALS leaflet has been designed and is now available for teams to order and on the MFT website, which informs patients, carers and relatives how to register compliments and raise concerns and complaints.

PALS Leaflet

8.3 **Educational Sessions**

Following the previous successful educational sessions for staff involved in responding to Complaints, a further Complaints Educational Session was arranged by the Corporate PALS team and facilitated at Wythenshawe Hospital during Quarter 1, 2018/19.

During Quarter 1 (2018/19), the Corporate PALS team also held a further Safeguard Masterclass for staff at Wythenshawe Hospital to support the effective use of the electronic system used to record and track Formal Complaints, PALS Concerns and Compliments.

Further Complaints Educational Sessions and Safeguard Masterclasses are being planned throughout 2018/19.

8.4 **Complainant's Satisfaction Survey**

The Complaints Satisfaction Survey is based upon ***'My Expectations'***[1] paper and has been developed by the Picker Institute. It is sent to complainants covering all MFT Hospitals/MCS/MLCO and during Quarter 1 (2018/19) 55 responses to the survey were received.

8.5 **Survey results for Quarter 1 of 2018/19 indicate:**

- 56.86% of complainants found it completely easy and 37.25% found it easy to some extent to make a complaint to the Trust.
- 75.93% of complainants felt they received an acknowledgement within an acceptable timeframe.
- 69% of complainants felt they were informed of a timescale for responding to their complaint and were satisfied with this.
- 74% of complainants stated that they had a single point of contact at the organisation(s) complained to and they knew who to approach if they had any questions.
- 61.54% of complainants said they received the outcome of their complaint within the given timescales.

8.6 **Comments received during Quarter 1, 2018/19 include the following:**

- The process went according as it said in the PALS leaflet.
- Personal contact from my Case Manager was very professional, helpful and efficient. I was made to feel at ease when discussing my concerns.
- It was difficult when complaining as I really didn't want my care to be affected. I'm unsure if I could have been reassured further.

[1] http://www.ombudsman.org.uk/__data/assets/pdf_file/0007/28816/Vision_report.pdf

9. Equality and Diversity Monitoring Information

9.1 **Table 10** provides Equality and Diversity information gathered from complainants for Quarter 1 of 2018/19. The collection of Equality and Diversity data has improved since the introduction of the new Complaints Satisfaction Survey, however it is clear that this is not consistent across all Hospitals/MCS/MLCO. Work continues to improve the quality of data across the Trust.

9.2 As this dataset becomes more representative of the complainant population, it is anticipated that it will enable Patient Services to monitor whether any specific patient group is making a disproportionate number of complaints, or if any group is under-represented, thereby enabling the Trust to ensure services are fair and equitable.

Table 10: Quarter 1, 2018/19 Equality and Diversity monitoring information

Disability	
Yes	42
No	63
Not Disclosed	356
Total	**461**
Disability Type	
Learning Difficulty/Disability	1
Long-Standing Illness Or Health Condition	16
Mental Health Condition	3
No Disability	0
Other Disability	6
Physical Impairment	14
Sensory Impairment	2
Not Disclosed	419
Total	**461**
Gender	
Male	183
Female	261
Transgender	0
Not disclosed	17
Total	**461**
Sexual Orientation	
Heterosexual	98
Homosexual / Gay Man	2
Lesbian / Gay Woman	1
Do not wish to answer	3
Not disclosed	357
Total	**461**
Religion/Belief	
Buddhist	0
Christianity (All Denominations)	75
Do Not Wish To Answer	338
Muslim	6
No Religion	35
Other	5
Sikh	0
Jewish	0
Hindu	0

Not disclosed	0
Total	**461**
Ethnic Group	
White – British	118
White – Irish	5
White – Other	1
Asian or Asian British – Bangladeshi	0
Asian or Asian British – Indian	1
Asian or Asian British – Pakistani	9
Asian or Asian British – Other Asian	2
Black or Black British – Caribbean	2
Black or Black British – African	2
Mixed – White and Asian	1
Mixed - White and Black Caribbean	4
Mixed – Other Mixed	1
Any other ethnic group	2
Do not wish to answer	63
Not stated	250
Total	**461**

10. PHSO Update (August 2018)

10.1 For information the Group Board of Directors is asked to note that the Parliamentary and Health Service Ombudsman (PHSO) introduced a new clinical standard in August 2018, the 'Ombudsman's Clinical Standard', in an attempt to provide greater clarity and predictability as to how the PHSO consider the appropriateness of care and treatment.

10.2 The PHSO has advised that when they are considering complaints about NHS clinical care and treatment, they aim to establish what would have been good clinical care and treatment in the situation complained about and whether what actually happened fell short of that. The Ombudsman's 'Clinical Standard' describes how they approach determining this.

10.3 The 'Ombudsman's Clinical Standard', has been circulated to the Hospital/ MCS/ MLCO senior teams to circulate to clinicians so that they are fully informed of the approach the Ombudsman takes when investigating complaints about clinical care and treatment.

11. Recommendation

11.1 The Group Board of Directors is asked to note the content of the Quarter 1, 2018/19 Complaints Report and the on-going work of both the Corporate teams and the Hospital/MCS/MLCO teams to ensure that the Trust is responsive to concerns raised and learns from patient feedback in order to continuously improve the patient's experience when accessing services or when raising complaints, concerns or providing complimentary feedback about the Trust's services.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Miss Toli S Onon, Group Joint Medical Director
Paper prepared by:	Ann Parker-Clements, Associate Director of Clinical Governance
Date of paper:	10th September 2018
Subject:	'Never Events'
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Resolution • Approval
Consideration of Risk against Key Priorities:	To improve Patient Safety, Clinical Quality and Outcomes
Recommendations:	The Board of Directors is requested to note the information and the actions planned to mitigate risk of recurrence.
Contact:	Ann Parker-Clements 0161 276 6179

1.0 Background

1.1 Never Events are defined nationally as incidents which are wholly preventable - as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. Serious harm does not need to have occurred for an event to be defined as a Never Event.

1.2 The Never Event Framework was updated in January 2018, there have been a number of changes to existing definitions and guidance. Key changes have been communicated throughout the organisation and risk assessments have also been completed.

1.3 Never Events are included on the MFT Accountability Oversight Framework under the Patient Safety section.

1.4 In 2017-18 there were 7 Never Events reported (2 from legacy CMFT, 1 from legacy UHSM and 4 from MFT).

1.5 Since April 2018 there have been a further 4 Never Events reported.

2.0 Summary of Events

2.1 The 2017/18 Never Events included:-

• 3 wrong site surgery (Insertion of grommets in error, undertaking a cysto-vaginoscopy rather than a vaginoscopy and wrong side bronchoscopy and lung biopsy)

• 2 Retained Foreign Objects (a retained valve opener and a guide wire which had been left in a urinary catheter*)

**Currently in discussion with commissioners to determine if meets criteria of a Never event.*

• 1 wrong route medication (Oral sedation given via the intravenous route for renal biopsy)

• 1 Connection to air instead of oxygen. (New Never Event type since February 2018)

2.2 The Hospitals where the above never events occurred were: 3 within the Royal Manchester Children's Hospital, 3 within Wythenshawe, Trafford, Withington and Altrincham (WTWA) and one in St Marys Hospital.

2.3 The Never Events since April 2018 are 2 misplaced naso-gastric (NG) tubes within Intensive Care setting, 1 wrong device implanted (right instead of left wrist plate) and 1 wrong side block.

2.4 Duty of candour has been completed for each incident.

2.5 Full root cause analysis investigations have been undertaken or are underway for each incident.

2.6 In addition the Trust has been working with the Healthcare Safety Investigation Branch (HSIB) to support National learning relating to wrong route medication. A national investigation into medication errors is on-going.

2.7 Medical staff in training were involved in 2 of the incidents and appropriate referrals to the Dean were made.

3.0 Key Findings / Themes

3.1 Local Safety Standards for Invasive procedures had not been developed for some procedures across the organisation including the renal biopsy procedure.

3.2 Whilst the safe surgery checklist processes were completed for the 3 wrong site surgery incidents there were deficiencies in how they were undertaken and a lack of clarity identified within the policy as to the exact requirements for each stage for example attendance at Team Brief and the need for view of consent by surgeon as part of Time Out.

3.3 There were issues relating to the Consent Policy and the level of understanding of this including taking consent on the day of elective procedures and not detailing laterality on consent form.

3.4 The Medicines Policy was not followed in relation to the preparation and administration of medicine.

3.5 Wall mounted air flow meter connections were still present in some areas of the Wythenshawe site.

3.6 The correct procedures were followed in one of the incidents of misplaced naso-gastric tubes however despite this human errors were still made.

3.7 A summary table of key findings and actions for each event is included in Appendix A.

Summary of Investigation Recommendations and Actions

4.1 A number of recommendations have been identified as part of each investigation with a range of actions to achieve these already undertaken or planned.

4.2 The key recommendations are focussed on reviewing Safe Surgery, Sedation and Consent policies, review of risk assessments, development of Local Safety Standards for Invasive procedures and education and awareness raising across the Trust.

4.3 A multi-disciplinary workshop was held in April 2018 and a programme of work is being undertaken following this.

4.4 The protocol for checking NG tube placement in critical care meets national guidance which allows any medical staff who have been trained and competency assessed to check NG tube position on x-ray images. This protocol and the audit arrangements for it are currently under review.

4.5 Following the recent Never Events the risk score is being reviewed.

4.6 Learning from Never Events incidents has been shared across the organisation and includes a range of articles in Safety Matters @MFT and Safety One Liners.

Recommendation

5.1 The Board of Directors is requested to note the information and the actions planned to mitigate risk of recurrence.

5.2 An update report will be provided on progress with actions in 3 months.

Appendix A Analysis of key findings from each incident

2017 / 18			
Incident Details	Summary	Key Findings	Key Recommendations / Actions
1123185 01/08/17 RMCH	*Wrong Site Surgery* *Grommets were inserted in error.* The wrong procedure had been transcribed from the operating list on to the theatre whiteboard, the surgeon did not view the consent form but read out from the whiteboard whilst another team member checked against consent.	The procedure was transcribed incorrectly as insertion of grommets and tonsillectomy. This was the procedure planned for the child immediately after. The Team Brief was undertaken purely against the whiteboard and this was not checked against the theatre list. The Time Out was undertaken without all staff members having sight of the consent form to check against.	The processes around Safe Surgery should be reviewed and improved. Actions completed include awareness raising of need for operating surgeon to view consent at timeout which has been added to the monthly audit and the process and responsibility for completing the whiteboard have been changed within paediatric theatres
1123295 02/08/17 RMCH	*Wrong Route Medication* *Oral midazolam was administered intravenously.* The oral solution was correctly placed in a purple oral syringe the nurse who drew up the medication was not present at administration. When the purple syringe could not be connected the doctors transferred the solution to an intravenous syringe and then started to administer.	There were no Local Safety Standards for renal biopsies undertaken on wards The medicines policy was not followed as the nurse who prepared the medication was not present at administration There was a lack of awareness of the purple oral syringes amongst the medical staff and a lack of ANTT training relating to the appropriateness of transferring medication between syringes	A Local Safety Standard for Renal Biopsy and other invasive procedures (as required) should be developed and implemented A policy and procedure for administration of safe intravenous sedation in children should be developed and implemented. The Trust is working with eth Healthcare Safety Investigation Branch to develop a simulation video to be used nationally for staff training. Development of skills for nursing staff supporting renal biopsies on the ward.
104904 26/09/17 WTWA	*Wrong Site Procedure* *Wrong side bronchoscopy and biopsy.* Patient underwent a routine follow up bronchoscopy and lung biopsy as part of the normal post-transplant monitoring however the wrong side was selected.	The procedure consent form did not indicate the laterality of the biopsy procedure as it was not current practice The department did not undertake a safety briefing at the start of their procedure lists. The department used a SSCL but this did not include a ‘Time Out’ process.	There is a need for peer audit of the SSCL process in non-traditional theatre settings. The importance of the Team Brief being completed with all team members being present should be reinforced. The checklist utilised in the bronchoscopy unit has been adopted to improve the WHO process.

2017 / 18			
Incident Details	Summary	Key Findings	Key Recommendations / Actions
			Further actions planned include consideration of a visual 'site marking' aid and implementation of a safety briefing at the start of the list.
1129905 23/10/17 RMCH	*Wrong Site Procedure* *Cystoscopy performed in error* Child was admitted for vaginoscopy however a cystovaginoscopy was performed in error.	The operating surgeon for this case was not present for Team Brief Consent for patients was being taken on the day of procedure which added to the time pressure The operating surgeon did not view the consent form as part of timeout, this was read aloud by the scrub nurse	The Safe Surgery processes and supporting policy and documentation should be reviewed and updated in line with key learning from all incidents The Consent Policy and supporting training package should be reviewed to include clarification with regards to taking consent
1142076* 11/03/18 SMH	*Retained Foreign Object* *Guidewire left in Catheter* Conducting top to toe check on new-born infant at start of shift; noticed guide wire had been left in catheter **Currently in discussion with NHS England to determine if meets criteria of a Never Event*	Neonate had urinary catheter inserted at approximately 19:20 the usual stock of neonatal catheters was not available as it had inadvertently been removed from the stock list and therefore a specialist catheter was accessed. Local procedures had been followed on insertion of catheter and a guidewire was not part of a formal count or check as the urinary catheters in use on NICU did not previously include guidewires.	Urinary catheter stock and supply chain on NICU requires review to ensure sufficient supplies are delivered. The process for stock amendment within the procurement team needs to be determined and strengthened so that any changes they make to stock requirements are automatically highlighted to the NICU team. There is a need to review, with input from the urology team, the urinary catheter requirements for neonatal use.
112574 19/01/18 WTWA	*Retained Foreign Object* *Valve Holder left in situ* The Retention clip that holds and supports the value was not removed when the valve was initial inserted in to the hemashield graft.	The heart valve was implanted in the patient. The valve holder was not included on the formal 'Swab. Suture and Instrument' count or recorded on the 'Swabs and Sutures board' and was left in situ when it should have been removed.	The Valve Handle and Holder need to be included as part of the Scrub Practitioner's formal 'Swab, Sutures & Instrument Count'. This learning has also been shared with MRI cardiac theatres.

2017 / 18			
Incident Details	Summary	Key Findings	Key Recommendations / Actions
		Communication issue following a handover and change in the scrub practitioner during the procedure at the aortic valve implantation stage	The Safer Surgery Checklist to be updated to include the requirements at each stage of the process.
116688 21/03/18 WTWA	*Connected to Air Instead of O2* Patient Transferred to cublicle in Majors area and connected to wall mount air flow meter rather than oxygen flow meter	Air flow meters were still available within the Wythenshawe A&E setting and the physical barrier of black flip did not prevent connection. As no Oxygen flow meter within room this may have led to the connection to Air being used	Air Flow terminals have been capped off and no longer available for use. Piped air flow meters stored in agreed locations within neonatal resuscitation area and Cystic Fibrosis Unit. Risk assessments of areas with remaining piped air and flowmeters to be undertaken.

2018 / 19			
Incident Details	Summary	Key Findings	Key Recommendations / Actions
2006878 15/05/18 CSS	*Misplaced Naso-Gastric Tube* Patient developed low saturations. It was found that feed was coming up from the suction catheter. The NG feed was immediately stopped. The CXR showed the patient had 2 NG tubes in place. A ryles tube could be seen below the diaphragm but the feeding tube was seen in the left main bronchus on the CXR	Investigation on-going	
2021225 11/08/18 WTWA	*Wrong Implant* Patient with left wrist fracture underwent internal fixation, surgeon requested and inserted a right wrist plate. The fixation achieved is optimal no revision surgery required.	Investigation on-going	

2018 / 19			
Incident Details	Summary	Key Findings	Key Recommendations / Actions
2022057 16/08/18 CSS	*Misplaced Naso-Gastric Tube* Ventilated patient requiring NG tube for medication. Nasogastric tube inserted by Anaesthetic Registrar. Followed the protocol as nil aspirate. X-RAY ordered and reviewed by Dr and needed to reposition the NG tube a further 5-10cm. This was then re-checked and confirmed by the Dr who advised to give oral medication. Total volume of 40 mls administered by nurse. Patient desaturated Dr informed care provided. Second chest x-ray ordered which confirmed that the NG was in Right bronchus.	Investigation on-going	Immediate action implemented in all critical care areas NG tube placement sign off now only to be undertaken by Consultant or Radiologist.
2023187 23/08/18 CSS	*Wrong site surgery (block)* Patient listed for right shoulder subacromial decompression on elective ortho list ABT6 under regional anaesthesia block. All safety checks were undertaken but in the anaesthetic room the left shoulder was blocked. Staff realised what had happened. Patient was then given general anaesthetic and surgery undertaken as planned. Patient had successful surgery and in recovery it was explained to her that she had received a block to the left shoulder. It was also explained that she would have an overnight stay to allow the effects of the block to wear off.	Investigation on-going	Group wide alert sent to all Hospitals / MCS instructing a review of the Never Events list and all associated procedures

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Director of Workforce and Organisational Development
Paper prepared by:	Mags Bradbury, Associate Director of Employee Wellbeing, Inclusion & Community
Date of paper:	September 2018
Subject:	**Update Report on the Freedom to Speak Up Programme**
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Resolution • Scrutiny & Assurance ✓
Consideration of Risk against Key Priorities:	• To improve patient safety, clinical quality and outcomes • To improve the experience of patients, carers and their families • To develop our workforce enabling each member of staff to reach their full potential
Recommendations:	MFT's Board is asked to note the report on: • The number of cases raised with the Freedom to Speak Up Guardian since October 2017 • The work undertaken by the Freedom to Speak Up Guardian • Progress on implementing the Freedom to Speak Up Champions
Contact:	Name: Mags Bradbury, Associate Director of Employee Wellbeing, Inclusion & Community Tel: 0161 701 3516

1.0 Introduction

1.1 This report outlines the work undertaken to deliver the Freedom to Speak Up Programme (F2SU) in MFT including the changes made to implement the new guidance issued by NHS Improvement in May 2018[1]. Also included is the number of cases raised with the Freedom to Speak up Guardian for the period October 2017 to March 2018.

2.0 Concerns Raised through the Freedom to Speak up Guardian

2.1 The national office requires that all Trust's report information on concerns raised at least twice a year. Six concerns have been raised with the Freedom to Speak up Guardian since October 2017.Five out of the six were raised anonymously, two had elements of patient safety/quality and four had elements of bullying/harassment. One indicated they had suffered detriment due to the concern they were raising.

2.2 The greatest of number of concerns raised were by nurses. The majority of the cases were raised by staff based at Wythenshawe; however this may be attributed to a greater awareness on the Wythenshawe site of how to raise a concern due to the visibility of on-site posters advertising F2SU. Posters advertising the F2SU Champions (outlined below) will be displayed across the whole Trust from October following the recruitment drive that is currently taking place. Out of the six cases of concerns raised three are now closed.

3.0 Roles & Responsibilities within the Freedom to Speak up Programme

3.1 Board Roles & Responsibilities

3.1.1 It is also critical for transparency and for the system to work effectively that all staff understand what they can expect from all those with specific F2SU responsibilities. NHSI guidance on the roles and responsibilities of Boards and senior leaders proposes defined non-executive and executive roles to support the work of the Guardian. MFT has therefore reviewed the current agreements and implemented the following changes:

- Appointed Ivan Benett as the Board Non-Executive Champion
- Appointed Gill Heaton as the Board Executive Champion
- Appointed David Cain as the Trust's Freedom to Speak up Guardian

3.1.2 The full set of roles and responsibilities for MFT is set out in the table in appendix A.

3.2 Hospital Roles & Responsibilities

3.2.1 To reflect MFT Group structure the roles and responsibilities of the hospitals and managed clinical services have now been defined and are also included in appendix A. Freedom to Speak up Champions are currently being recruited to support the Hospitals/Manged Clinical services deliver the Trust's commitment to the Freedom to Speak Up Programme.

[1] https://improvement.nhs.uk/documents/2468/Freedom_to_speak_up_guidance_May2018.pdf

The recruitment campaign was launched on the 18th July with training and the programme launch planned for September. Due to the overwhelmingly positive response to the recruitment campaign 30 applicants will be interviewed over three days in August and September with the aim of recruiting up to 20 Champions across the Group. A communication plan is in place to publicise the names of the successful champions and a training programme is developed to support the Champions in delivering their responsibilities. A second wave of targeted recruitment will take place in September/October to fill any identified gaps from the first round of recruitment.

4.0 Recording and Reporting

4.1 A reporting cycle for Freedom to Speak Up has now been agreed with the proposal that the Board of Directors will receive two reports a year in September and March. Champions will be asked to keep confidential and anonymous records, which will form part of the report to the Board. The reporting process is outlined below:

Report 1 – September F2SU Annual Report	Report 2 – March FTSU Half Year Report
• Report half yearly data and activity	• Brings together wider data to provide an opportunity for learning and organisational development • Summary of report will be used in the annual report

5.0 Policy Alignment

5.1 As part of the PTIP key policies will be reviewed to ensure they support and cohere with the Trust's Freedom to Speak Up programme. A supporting policy is the MFT policy on Whistleblowing. One single Trust policy will be in place by November 2018.

6.0 Trust Performance

6.1 MFT is currently undertaking a review of the work to date on F2SU using the NHSi review toolkit. This will be completed in August 2018 and any gaps identified built into the development programme. Performance measures will be developed linked to the staff survey:

Staff Survey Question	Rationale
If you were concerned about unsafe clinical practice, would you know how to report it?	Champions & Guardians should be sign posting people to the right place and supporting F2SU communications material should also reinforce key messages about how to raise concerns
Senior managers in this organisation promote a culture of patient / service user safety.	Trust wide discussion and promotion of the F2SU roles will further demonstrate the Trusts leadership commitment to the culture of patient safety

6.2 Initially the Group may experience an increase in the number of concerns raised, demonstrating staff know how to contact and feel able to speak to the F2SU Guardian/Champion. This should be seen as a positive performance measure for the F2SU programme.

7.0 Recommendations

7.1 It is recommended that the Board of Directors:

a) Support and promote the role of Champions across MFT

b) Note the report on concerns raised through the Freedom to Speak up Champion from the 1st October 2017

Appendix 1

	Roles within the F2SU Programme
Freedom to Speak up Guardian	The role as defined nationally is to: • Protect patient safety and the quality of care • Improve the experience of workers • Promote learning and improvement By ensuring that: • Workers are supported in speaking up • Barriers to speaking up are addressed A positive culture of speaking up is fostered. Issues raised are used as opportunities for learning and improvement
	Expectations set are that Freedom to Speak Up Guardians: • Operate independently, impartially and objectively, whilst working in partnership with individuals and groups throughout their organisation, including their senior leadership team • Seek guidance and support from and, where appropriate, escalate matters to, bodies outside their organisation • Support, and contribute to, the national Freedom to Speak Up Guardian network, comply with National Guardian Office guidance, and support each other by providing peer-to-peer support and sharing learning • Should be supported with the resources they need, including ring-fenced time, to ensure that they meet the needs of workers in their organisation. • Their views on the impact of activities and decisions on Freedom to Speak Up should be actively sought

Freedom to Speak up Champion Role	The role as defined by MFT is: • To act as a local resource to support staff who raise concerns • The post holder will have direct access to the Freedom to Speak Up Guardian • The post holder will have the ability to access key individuals within the Trust • The post holder will work with other Freedom to Speak Up Champions in local areas • The post holder will have dedicated time to perform the role The expectations of this role are: • To become an expert in all aspects of raising and handling concerns and to offer support and advice including signposting to other staff or Trust services that can help resolve issues to those staff who wish to raise concerns, or to those staff who handle concerns. • To ensure that any safety issue are raised appropriately and seek assurance that relevant/appropriate action has been taken and feedback is given to the member of staff who raised it. • To safeguard the interests of the individual raising a concern, ensuring that there are no repercussions for them either immediately or in the longer term, as appropriate. • To contribute to the development of an organisational culture where every single member of staff feels able to raise a concern. • To feedback on themes and trends to ensure that concerns raised aid learning and improvement
Role of the Board	• Receive and scrutinise the F2SU Board Report • Ensure that the culture of MFT is open and honest. Supporting and listening to staff who speak up and share concerns
Role of the Chairman of the Board of Directors	The role of the Chairman, as defined by national guidance is to: • Be responsible, along with the Chief Executive for ensuring the annual report contains information about F2SU and that the Trust is engaged with both the regional Guardian network and National Guardians Office • Be the final point of escalation on un-resolved concerns • Receive and scrutinise the F2SU Board Report • Ensure that the culture of MFT is open and honest. Supporting and listening to staff who speak up and share concerns

Role of the Group CEO	The role of the CEO, as defined by the national guidance is: • The CEO is responsible for appointing the F2SU Guardian and is ultimately accountable for ensuring the F2SU arrangements meets the needs of the workers in their Trust • To champion the F2SU across the Trust • To meet to be the final operational point of escalation for concerns raised with the F2SU Guardian • Ensure that the culture of MFT is open and honest. Supporting and listening to staff who speak up and share concern • Appoint a member of the Executive Team to support the F2SU Guardian
Role of the Hospital/MCS CEO	The role of the Hospital/MCS CEO, as defined by MFT is: • In line with the 2017 F2SU review the Hospital/MCS CEO meets with the F2SU Champion and ensures the Hospital/MCS executive is accessible to the Guardian. • To champion F2SU across the Hospital/MCS • To be the final operational point of escalation for concerns raised in each Hospital/MCS with the F2SU Champions & Guardian • Ensure that the culture of MFT is open and honest. Supporting and listening to staff who speak up and share concern
Executive Lead for F2SU	The executive lead as defined by the national guidance is responsible for: • Ensuring they are aware of latest guidance from National Guardian's Office • Overseeing the creation of the FTSU vision and strategy • Ensuring the FTSU Guardian role has been implemented, using a fair recruitment process in accordance with the example job description and other guidance published by the National Guardian • Ensuring that the FTSU Guardian has a suitable amount of ring-fenced time and other resources and there is cover for planned and unplanned absence. • Ensuring that a sample of speaking up cases have been quality assured • Conducting an annual review of the strategy, policy and process • Operationalising the learning derived from speaking up issues • Ensuring allegations of detriment are promptly and fairly investigated and acted on • Providing the board with a variety of assurance about the effectiveness of the trusts strategy, policy and process.

Non-executive lead for FTSU	The non-executive lead as defined by the national guidance is responsible for: • Ensuring they are aware of latest guidance from National Guardian's Office • Holding the CEO, Executive FTSU lead and the board to account for implementing the speaking up strategy. Where necessary, they should robustly challenge the Board of Directors to reflect on whether it could do more to create a culture responsive to feedback and focused on learning and continual improvement • Role-modelling high standards of conduct around FTSU • Acting as an alternative source of advice and support for the FTSU Guardian • Overseeing speaking up concerns regarding board members

Who	
Freedom to Speak up Guardian	Any member of MFT staff or Board of Directors, appointed by the Trust's CEO as recommended the May 2018 Guidance from NHSI. The Guardian will be interviewed prior to appointment and be assessed against the required skills, values and behaviours.
Freedom to Speak up Champion Role	MFT colleague - at least 3 per hospital/Managed Clinical Service dependent on size or structure of the hospital/service recruited through a robust process aligned to a role description and competency framework. A full role description is under-development to be a guide for recruitment and selection.

Terms of Office	
Freedom to Speak up Guardian	• It is proposed that the Guardian is appointed on a three year term of office that can be renewed for up to two terms. The process for the renewal of the terms of office will be based on performance measures and the activity reports. These would be agreed with the Guardian at the start of every term. • The renewal of the terms of office will be undertaken by the Group CEO. If the terms of office are related to the performance of the Guardian the CEO may seek external advice and guidance.
Freedom to Speak up Champion Role	• It is proposed that the Champions are appointed on a two year term of office that is formally reviewed annually A Champion may serve a maximum two terms. • The process for the renewal of the terms of office will be based on performance measures and the activity reports. • These would be agreed with the Champion at the start of every term. • The renewal of the terms of office will be undertaken by the Guardian, the lead and the line manager.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse – Professor Cheryl Lenney
Paper prepared by:	Sue Ward, Group Deputy Chief Nurse Karen Meadowcroft, Corporate Director of Nursing Debra Armstrong, Assistant Chief Nurse: Quality, Practice and Cancer Janice Streets, Head of Quality Improvement Yvey Blore, *"What Matters to Me"* Programme Manager
Date of paper:	August 2018
Subject:	**Patient Experience Annual Review**: Presentation of all mandatory national patient surveys and Friends and Family Test and an update on the on-going implementation of the Trust Patient Experience Programme *'What Matters to Me'*
Purpose of Report:	Indicate which by ✓ Information to note ✓ Support ✓ Resolution Approval
Consideration of Risk Against Key Priorities:	Delivering an excellent experience for patients, their families and their significant others.
Recommendations:	Members of the Board of Directors is asked to note the content of the report and support the actions required to ensure continuous improvement.
Contact:	Name: Debra Armstrong, Assistant Chief Nurse (Quality and Professional Practice) Tel: 0161 276 5061

1. Executive Summary

1.1 Patient Experience feedback provides a rich source of data to support continuous improvement of the services provided by Manchester University Hospitals NHS Foundation Trust (MFT). Patient feedback is sought continuously through a range of formats. These findings inform improvement activity at both strategic and at local levels.

1.2 This report provides a summary of the results of the mandatory national surveys that have been published this year, including the Emergency Department Survey (2016), the Children and Young Peoples Survey (2016) the Maternity Survey (2017) and the Adult National Inpatient Survey (2017). As the surveys were completed prior to the establishment of MFT in October 2017, separate reports were published by the Care Quality Commission (CQC) for the former Central Manchester University Hospitals NHS Trust (CMFT) and former University Hospital of South Manchester NHS Foundation Trust (UHSM). Alignments are made in the analysis where this is possible within this report and comparisons are made with other Shelford Group Trusts, specialist Trusts (where appropriate) and with the Trust's own *'**What Matters to Me'*** patient experience survey data. The interval between completion of the surveys and publication of the reports for all participating trusts means that there is a time lag before the comparative data included in this report becomes available to inform local analysis.

1.3 Many positive elements of patient experience are identified by the both the national and local survey results. The findings of the national surveys also show that the Trust generally falls within the average range for almost all factors that influence patient experience when compared to other Trusts. Areas that persistently receive low scores in previous national surveys, such as food and clean, have shown slight improvement but scores remain comparatively low and an extensive work programme continues to drive improvement.

1.4 This report also includes an update regarding activity undertaken to align reporting and improve the response rate to the Friends and Family Test, which provides an additional mechanism by which patients can feed back about their experience.

1.5 In October 2017, the Group Board of Directors agreed that ***'What Matters to Me'*** (WMTM) would continue to be developed as the approach to patient experience across the newly formed MFT. This report provides an update on the positive progress of the WMTM work programme which supports continuous improvement of the quality of individualised patient experience. The next stage of this programme is described and the continued support of the Group Board of Directors is sought to continue to embed this approach, with the aim of realising the benefits of delivering a high quality, efficient and effective, personal experience for each patient or service user.

Image 1: Proud to Care on Camera, Patient Choice Winner

2. Introduction

2.1 On the 1st October 2017 Manchester University NHS Foundation Trust (MFT) was established following the merger of Central Manchester University Hospitals NHS Foundation Trust (CMFT) and the University Hospital of South Manchester NHS Foundation Trust (UHSM).

2.2 Understanding people's experiences of care and treatment provides key information about the quality of services, which can be used to drive improvement both nationally and locally[1].

2.3 The NHS Patient Survey Programme is overseen by the Care Quality Commission (CQC) and covers a range of NHS settings on a rolling programme of surveys. The CQC publishes the results of the surveys on its own website. In 2017/18, the CQC published the following 4 surveys:

- Emergency Department Survey 2016 published in October 2017[2]
- Children and Young People's Survey 2016 published in November 2017[3]
- Maternity Services 2017 published in January 2018[4]
- Adult Inpatient Survey 2017 published in June 2018[5]

2.4 The sample of patients included in the surveys was prior to the merger and establishment of MFT therefore separate reports have been published for the former Central Manchester University Hospitals NHS Foundation Trust (CMFT) and University Hospitals of South Manchester (UHSM).

2.5 This report provides a summary and analysis of the published results for the ***Emergency Department, Children's and Young People's, Maternity Services and Adult Inpatient Surveys*** along with a comparison of the former Trusts' survey results, with other Shelford Group trusts or where applicable specialist hospitals.

2.6 Triangulation of the results for key questions contained within the National Adult

[1] NHSE: National Patient and Staff Surveys. Available from: https://www.england.nhs.uk/statistics/statistical-work-areas/patient-surveys/

[2] CMFT: http://www.nhssurveys.org/Filestore/ED16_BMK_Reports/ED16_RW3.pdf UHSM: http://www.nhssurveys.org/Filestore/ED16_BMK_Reports/ED16_RM2.pdf

[3] CMFT: http://www.nhssurveys.org/Filestore/CYP16_BMK_Reports/CYP16_RW3.pdf UHSM: http://www.nhssurveys.org/Filestore/CYP16_BMK_Reports/CYP16_RM2.pdf

[4] http://www.nhssurveys.org/surveys/1132

[5] CMFT: http://www.nhssurveys.org/Filestore/IP17_BMK_Reports/IP17_RW3.pdf UHSM: http://www.nhssurveys.org/Filestore/IP17_BMK_Reports/IP17_RM2.pdf

Inpatient Survey with the Trust's local ***'What Matters to Me'*** Patient Experience survey findings is also presented. The Friends and Family Test (FFT) is a further mechanism by which the Trust receives feedback on Patient Experience; therefore detail is provided of FFT performance and comparisons are provided against other Shelford Group Trusts.

2.7 Finally this report provides an update on the Trust's Patient Experience Programme, ***What Matters to Me***, which focuses on the delivery of **personalised** care for every patient or service user with a view to improving care outcomes across all quality domains.

3 Emergency Department Survey 2016

3.1 The Trust is required by the CQC to obtain feedback to improve local services for the benefit of patients and the public who access the Emergency Department based on patient experience. The results also contribute to the Trust's Quality & Risk Profile outcomes and form the basis of quality improvements which are monitored through the Trust's contracts with its commissioners. The CQC published the Emergency Department Survey on 17th October 2017.

3.2 Previous Emergency Department Surveys have focused on the experiences of patients who attended a ***Type 1 Emergency Departments*** (major 24 hour department's that are consultant led). However, for the first time in 2016, patients who attended **Type 3 Emergency Departments** (minor injury units or urgent care centres) managed by an acute NHS Trust were included in the survey.

3.3 The Emergency Department survey does not include ***Type 2 Emergency Departments*** (consultant-led speciality emergency service e.g. ophthalmology, dentistry) or ***Type 4 Emergency Departments*** (NHS Walk in Centres).

3.4 The 2016 Emergency Department Survey is the sixth survey with similar surveys being carried out in 2003, 2004, 2008, 2012 and 2014.

3.5 Whilst many of the Survey questions have remained unchanged in the 2016 Survey the CQC have advised that the 2016 Survey is not comparable to previous surveys due to significant changes in sampling and analysis strategies[2]. The changes to the Survey included:

- Month of sample period
- Scope of the survey with the addition of Type 3 Emergency Departments
- Increase in sample size
- Amendments to the weighting methodology

3.6 The survey of patients attending Emergency Departments is part of the National Patient Survey Programme and is undertaken on behalf of both former Trusts by an independent provider, who administers a postal survey, observing approved methodology. A postal questionnaire was sent to a random selection of 1,250 patients for each former trust; comprising a sample of 950 patients from ***Type 1 Emergency Departments*** and 300 patients from ***Type 3 Emergency Departments.***

3.7 Patients were eligible to participate in the Survey if they were aged 16 years or older, had attended an Emergency Department during September 2016 and were not an inpatient during the sampling period. The response rate to the Emergency Department Survey (2016) for former CMFT was 16% (number 140) with former UHSM achieving a response rate of 26% (number 309) compared to the national average of 28%. The former CMFT response rate in 2014 was 27% with former UHSM achieving a response rate of 33% compared to the national average of 34%. Establishment of MFT as a Single Hospital Service clearly provides an opportunity to share learning to support an increased response rate on the Oxford Road Campus.

3.8 The Emergency Department Survey (2016) included 53 questions of which 8 establish demographic details with the other questions relating to, the reason for attending and getting to the hospital. There are a total of 35 questions that require respondents to indicate the standard of care they received, which receive a score out of 10 based on the responses of the sample population. A higher score is better and indicates a more positive patient experience. The survey is organised under the following nine key themes:

1. **Arrival at the Emergency Department**
2. **Waiting Times**
3. **Doctors and Nurses**
4. **Care and Treatment**
5. **Tests (answered by patients who had a test)**
6. **Hospital Environment and Facilities**
7. **Leaving the Emergency Department**
8. **Respect and Dignity**
9. **Experience Overall**

3.9 If there are fewer than 30 responses to a question, no score is displayed for this question or the corresponding overall theme section.

Survey Analysis

3.10 The published CQC reports only include details of results for Type 1 Emergency Departments, as the data set for Type 3 Emergency Departments was found to be too small for analysis.

3.11 **Charts 1 and 2** compare the former CMFT and UHSM overall Quality Score for the past three surveys, 2012, 2014 and 2016, demonstrating on-going improvement in scores for both former Trusts.

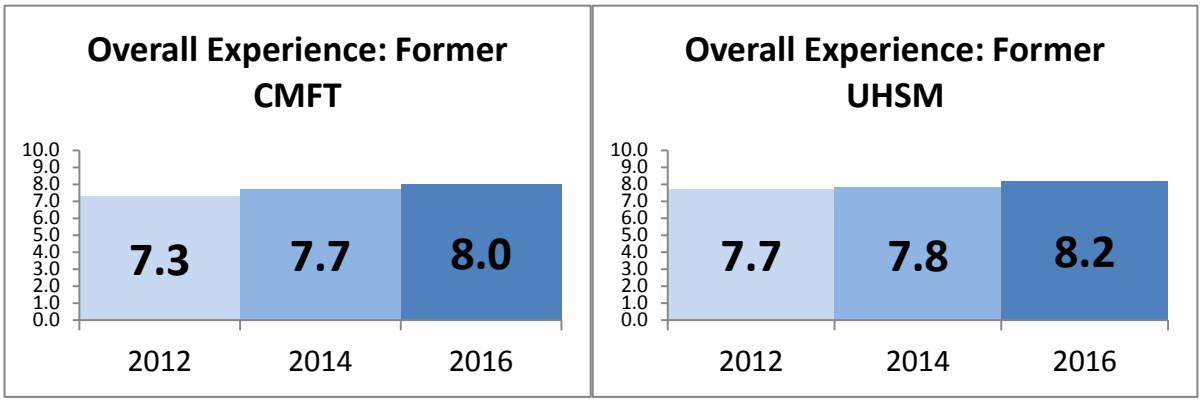


Chart 1: Former CMFT Overall Experience Score 2012-2016

Chart 2: Former UHSM Overall Experience Score 2012-2016

National Benchmarking

3.12 **Chart 3** compares the Trust's results for each of the nine key themes alongside the highest and lowest scores achieved nationally. There are two themes with no overall result for former CMFT as these sections received less than 30 responses.

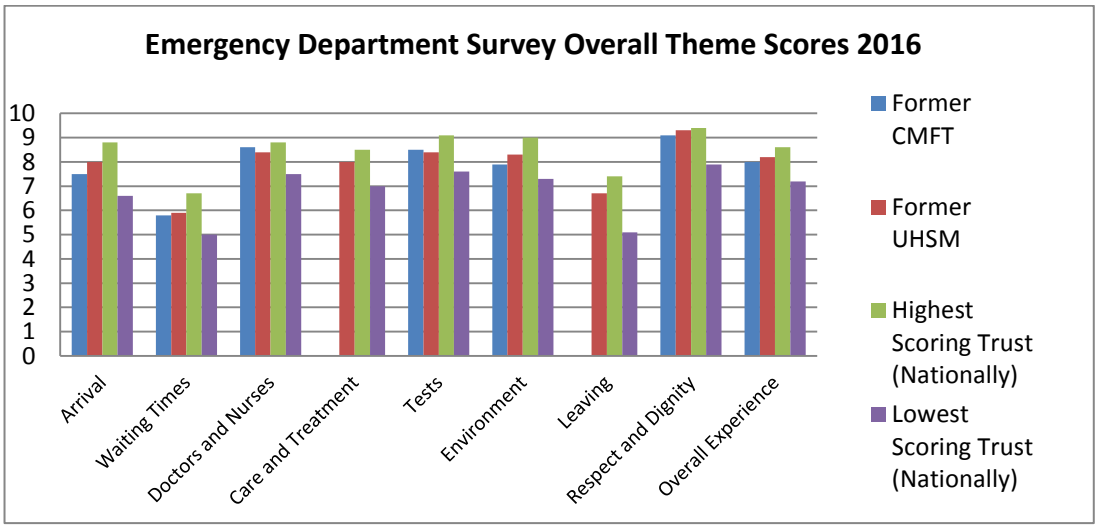


Chart 3: Former CMFT and UHSM section score compared to highest and lowest scoring trusts

3.13 The chart highlights that the scores for both former CMFT and UHSM fall between the highest and lowest scoring Trusts nationally for all key themes. The overall Trust position for all the key themes is categorised as 'about the same' as other Trusts.

Comparison with Shelford Group Trusts

3.14 The response rates for the Shelford Group trusts ranged from 31% (Cambridge) to 16% (Former CMFT). Although the former CMFT had the lowest response, the former UHSM response rate of 26% improves the combined MFT position to 3rd position when compared to the Shelford Group Trusts.

3.15 The overall quality experience scores for Shelford Group trusts ranged from 7.4 to 8.4, as demonstrated in **Chart 4.** The former CMFT's score of 8.0 placed the Trust in seventh position, noting there is only a 0.4 point difference in scores between first and seventh place and the former UHSM's score 8.2 compared favourably with the Shelford Group trusts.

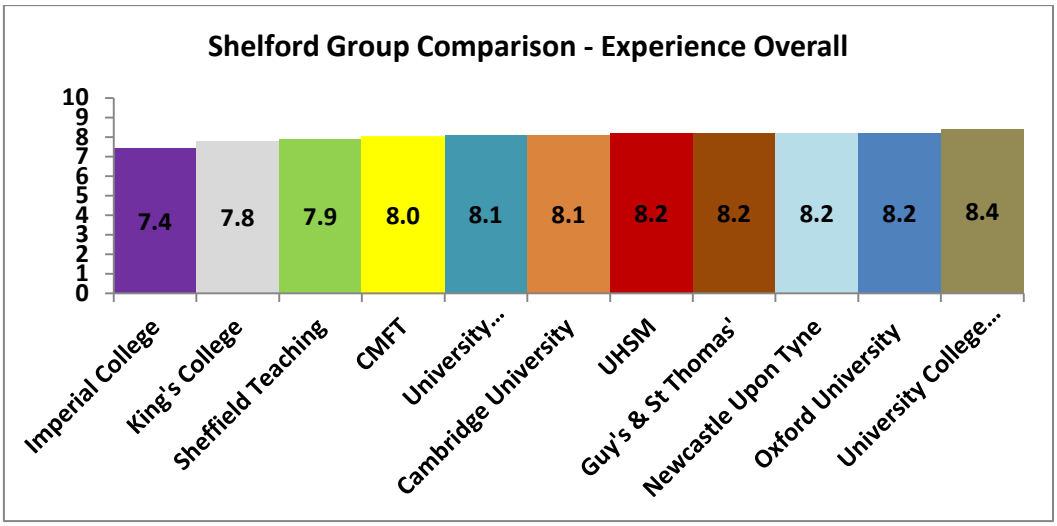


Chart 4: Shelford Group Comparison – overall experience

Summary

3.16 Overall both former trusts were categorised as ***'about the same'*** as other organisations for all key themes.

3.17 The 2016, Emergency Survey has undergone extensive development and cannot be compared to previous surveys. As such the results for the 2016 Survey provide baseline data for future MFT surveys.

4 Children and Young People's Inpatient and Day Case Survey (2016)

4.1 The CQC requires the Trust to conduct the National Children's and Young People's Inpatient and Day Case Survey in order to obtain feedback to improve local services for the benefit of children and young people based on patient and parent experience. The results also contribute to the Trust Quality & Risk Profile outcomes and form the basis of quality improvements which are monitored through the Trust's contracts with its commissioners. The CQC published the Children and Young People's Survey (2016) on 21st November 2017[3].

4.2 The 2016 survey was the second National Children's and Young People's Inpatient and Day Case Survey to be undertaken and involved extensive redevelopment. It is noted whilst many of the questions have remained unchanged the CQC have advised that the survey is not comparable to the initial survey in 2014. The changes include moving questions into different sections, the removal and adding of questions and a change to the month of the sample period. A total of 15 were new questions were included.

4.3 The survey sought feedback directly from children and young people, alongside their parent or carer and includes eight key categories. Unlike other national surveys there is no overall score for each of the categories.

4.4 The 2016 survey involved a postal questionnaire being sent to 1,250 children and their parents/carers in February 2017, who had been an inpatient or undergone a planned day case procedure between 1st November 2016 and 31st December 2016, who were between 15 days and 15 years (inclusive) at the time of their discharge.

4.5 The 2016 survey of children and young people used three different questionnaires, each one appropriate for a different age group:

- The 0-7 questionnaire; sent to patients aged between 15 days and 7 years old at the time of discharge
- The 8-11 questionnaire; sent to patients aged between 8 and 11 years old at the time of discharge
- The 12-15 questionnaire; sent to patients aged between 12 and 15 years old at the time of discharge.

4.6 Questionnaires sent to those aged 8-11 and 12-15 had a short section for the child or young person to complete, followed by a separate section for their parent or carer to complete. Where a child was aged 0-7, the questionnaire was completed entirely by their parent or carer.

Response Rate

4.7 The Trust's response rate to the Children's Inpatient and Day Case Survey (2016) for former CMFT was 22% (277 responses), with former UHSM achieving a response rate 24% (298 responses) compared to a national average of 26%. The response rates in 2014 were 25% and 24% respectively for former CMFT and former UHSM compared to a national average of 27%.

Children and Young People's Inpatient and Day Case Survey (2016) Results

4.8 The number of questions in the Children and Young People's Inpatient and Day Case Survey (2016) was dependent upon the questionnaire within each age group. The questionnaires were structured as follows:

- The questionnaire for parents/carers of 0-7 year olds consists of 52 questions
- The questionnaire for 8-11 year olds consists of 59 questions; with the first section for the child and consisting 22 questions
- The questionnaire for 12-15 year olds consists of 60 questions; with the first section for the child and consisting 23 questions

4.9 Respondents are required to indicate the standard of care they received by providing a score out of 10. A higher score is better and indicates a more positive patient experience. The survey is structured into the following categories relating to the patient and parent's experience.

- Going to Hospital
- The Hospital Ward
- Hospital Staff
- Facilities for Parents and Carers
- Pain Management
- Operations and Procedures
- Leaving Hospital
- Overall Experience

4.10 If there are fewer than 30 respondents to a question no score is displayed; this is because the uncertainty around the result is too great.

4.11 The overall quality scores are detailed in **Chart 5** suggesting overall children and young people's experiences of inpatient and day case care were mostly positive.

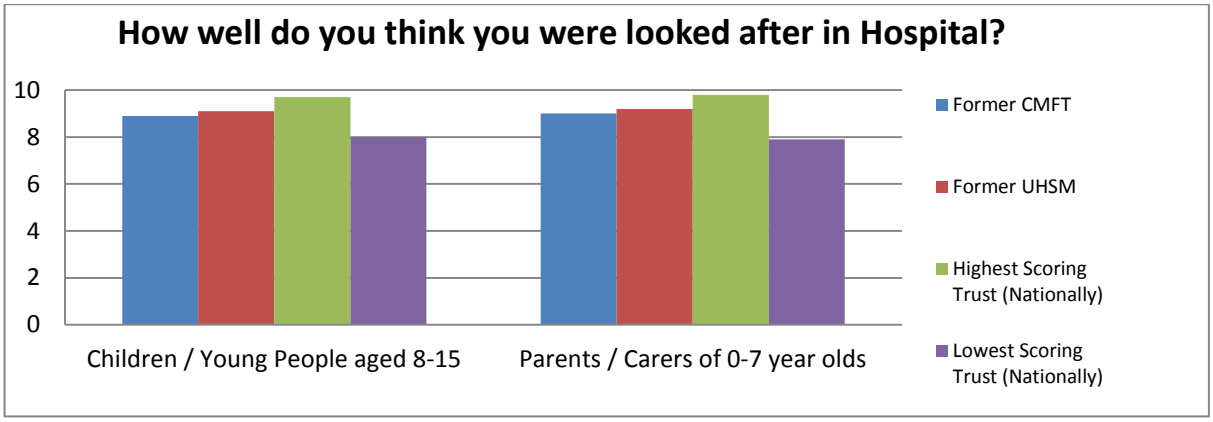


Chart 5: Overall Experience

4.12 Each survey question is categorised as ***'better'***, ***'about the same'*** or ***'worse'*** based on comparison to other organisation's scores. The results for former CMFT demonstrated that with the exception of one question, where the score was categorised as ***'worse'*** all other questions scored ***'about the same'*** when compared to other organisations. The question which scored worse was ***'Did the hospital change your admission date at all?'***. This question was answered by parents/carers of 0-7 year olds.

4.13 The results for former UHSM demonstrated that with the exception of four questions where the scores were categorised as ***'better'*** all other questions scored ***'about the same'*** when compared to other organisations. The questions which scored '**better'** were:

- Question answered by parent/ carers 0-7 year olds:
  - Did the hospital give you a choice of admission dates?
- Questions answered by parents/carers of 0 to 15 year olds
  - For most of their stay in hospital what type of ward did your child stay on?
  - Did the ward where your child stayed have appropriate equipment or adaptations for your child's physical or medical needs?
  - Were the different members of staff caring for and treating your child aware of their medical history?

Comparison with Other Children's Hospitals

4.14 As part of the analysis of the Children and Young People's Inpatient and Day Case results have been compared to the following other Children's Hospitals: Alder Hey, Birmingham, Bristol, Great Ormond Street, Leeds and Sheffield.

4.15 The former CMFT response rate of 22% and UHSM 24% response rate is less than the response rate of other Children's Hospitals who achieved response rates between 25% (Alder Hey) and 30% (Bristol).

4.16 **Charts 6** compares former CMFT and UHSM overall experience scores for 8-15 year olds with other Children's Hospitals. Former CMFT and UHSM scored less than 4 other Children's Hospitals. **Chart 7** shows that **f**ormer CMFT also scored worse overall based on responses from parents and carers of 0-7 year old children.

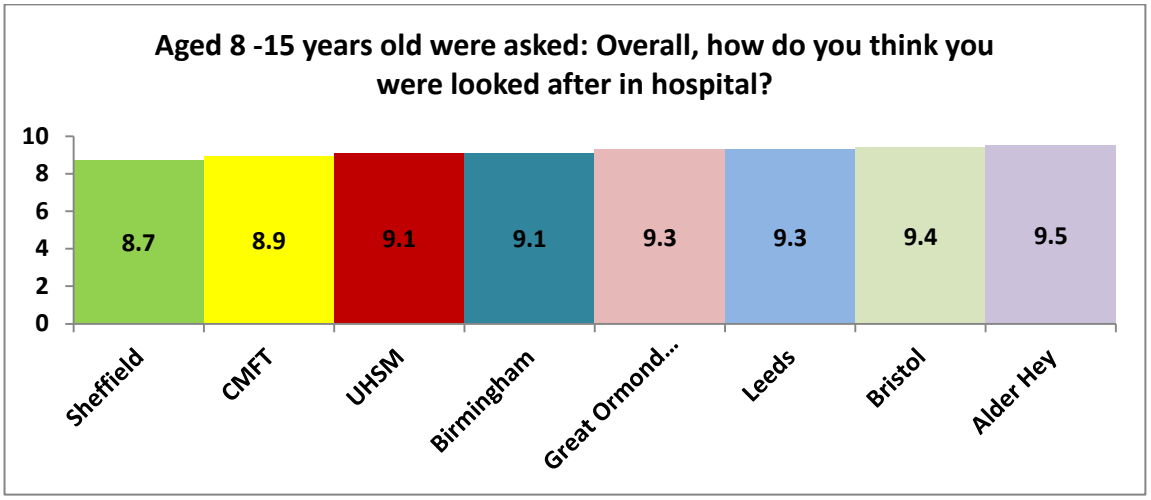


Chart 6: Overall Scores for Children/Young people age 8 to 15 responses to *'Overall, how well do you think you were looked after in hospital?'*

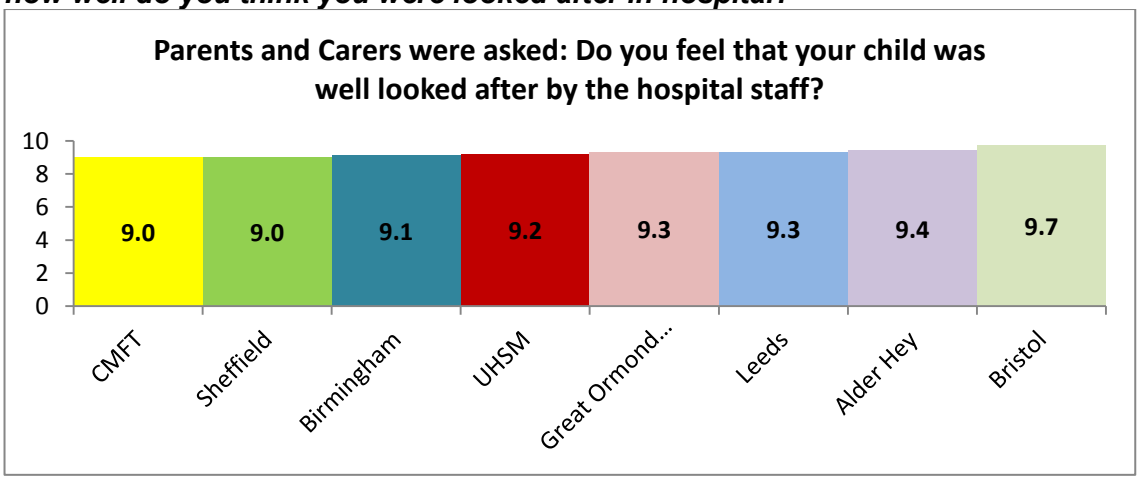


Chart 7: Parents/carers of 0-7 year olds responses to *'Do you feel that your child was well looked after by the hospital staff?'*

Summary

4.17 Overall both former trusts were categorised as **'about the same'** as other organisations for all key themes nationally but scored lower than most other Children's Hospitals. The Royal Manchester Children's Hospital (RMCH) Managed Clinical Service, which now manages the children's services based at Wythenshawe Hospital has developed and implemented an action plan in response to the survey outcomes and continues to network with other children's hospitals to share learning and best practice.

Image 2: Proud to Care on Camera, winner 2018

5 Maternity Services Survey 2017

5.1 The National Maternity Survey is a CQC requirement to obtain feedback to improve local maternity services for the benefit of women based on women's experiences. The results also contribute to the Trust Quality & Risk Profile outcomes and form the basis of quality improvements which are monitored through the Trust's contracts with its commissioners.

5.2 The survey involved a postal questionnaire being sent to eligible women, aged 16 and over, who had a live birth during February 2017 and the CQC published the National Maternity Survey, 'Women's Experience of Maternity Care' (2017) in January 2018. The Survey was published in 3 separate reports aligning to different aspects of the maternal pathway, namely: antenatal care, labour and birth and postnatal care. Previous surveys were undertaken in 2007, 2010, 2013 and 2015

5.3 Respondents are required to indicate the standard of care they received by providing a score out of 10. A higher score is better and indicates a more positive patient experience. The survey is structured into the following categories relating to the maternal pathway:

- Antenatal Care
  - The start of your pregnancy
  - Antenatal check ups
  - During your pregnancy

- Labour and birth
  - Labour and birth
  - Staff
  - Care in hospital after birth
- Postnatal Care
  - Feeding
  - Care at home after the birth

5.4 Since the previous survey, the questionnaire has been redesigned with changes to the structure of some of the questions.

Response Rate

5.5 The response rate to the Maternity Services Survey (2017) for former CMFT was 31% (number 201 patients) with former UHSM achieving a response rate 42% (number 125 patients) compared to a national average of 38%. The former UHSM response rate therefore exceeded the national average.

Survey Analysis

5.6 Whilst there is an overall score for each of the categories there is no question relating to overall experience. Each survey question is categorised as ***'better'***, ***'about the same'*** or ***'worse'*** based on comparison to other organisations' scores.

5.7 The results for former CMFT demonstrated that seven questions were categorised as ***'better'***, with all other questions scoring ***'about the same'*** when compared to other organisations. One of the questions categorised as ***'better'*** achieved the highest score nationally: ***Did you feel that the midwife or midwives that you saw always listened to you?*** This may be reflective of the embedding of the What Matters to Me patient experience philosophy in St Mary's Hospital.

5.8 The results for former UHSM demonstrated that 4 questions were categorised as ***'better'***, 1 categorised as ***'worse'***, with the remaining questions scoring ***'about the same'*** when compared to other organisations. One of the questions categorised as ***'better'*** achieved the highest score nationally: ***When you were at home after the birth, did you have a telephone number for a midwife or midwifery team that you could contact?*** The question that was categorised as ***'worse'*** *related to 'During your antenatal check-ups, did a midwife ask you how you were feeling emotionally'?*

National Benchmarking

5.9 **Chart 8** compares the Trust's results for each of the eight key themes alongside the highest and lowest scores achieved nationally.

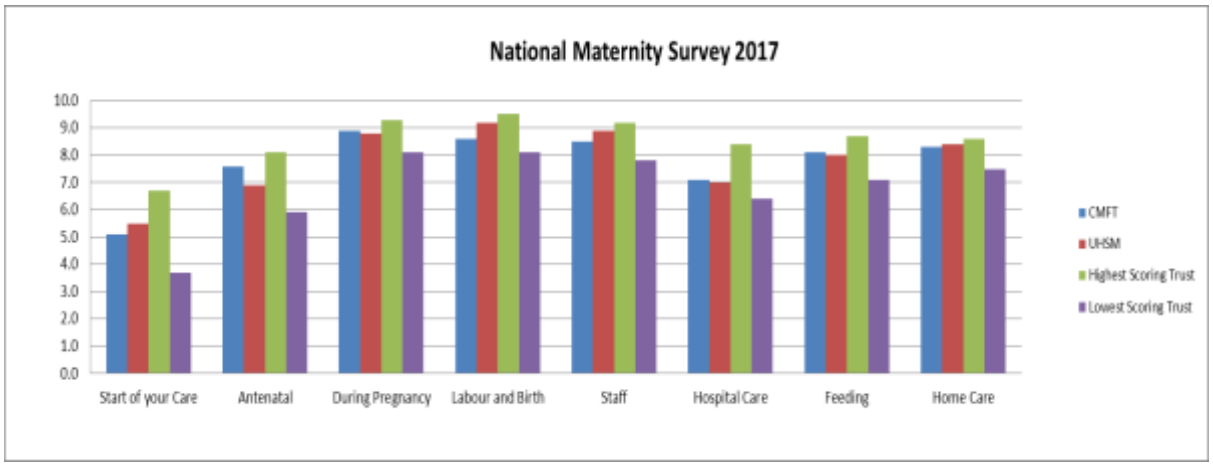


Chart 8: Former CMFT and UHSM scores compared to highest and lowest scoring trusts nationally

Comparison with Shelford Group Trusts

5.10 The response rates for the Shelford Group Trusts ranged from 29% (Birmingham) to 52% (Oxford and Cambridge). The former CMFT response rate of 31% places the former CMFT in 9th position in the Shelford Group. The former UHSM response rate of 42% would place the Trust in fourth position when compared to the Shelford Group Trusts.

5.11 The Maternity Services Survey does not include an overall experience score which precludes comparison with other Shelford Group Trusts. Comparison for each section is provided at Appendix 1 of this report for information.

Summary

5.12 Overall, women cared for by former CMFT and UHSM reported positive experiences of maternity care in 2017, and there were small incremental improvements in results across most questions.

Image 3: Proud to Care of Camera, 3rd Place

6 Adult National Inpatient Survey 2017

Background and Methodology

6.1 The annual Adult National Inpatient Survey is a CQC requirement to obtain feedback to improve local services for the benefit of patients and the public based on adult inpatient patient experience. Survey results are reported to the CQC, contribute to the Trust Quality & Risk Profile outcomes and form the basis of quality improvements which are monitored through the Trust's contracts with its commissioners. The CQC published the results of the National Inpatient Survey (2016) on 13th June 2018[1].

6.2 The survey of inpatient services is part of the National Patient Survey Programme and the 2017 survey was undertaken on behalf of the legacy trusts by independent providers who administered a postal survey, observing nationally approved methodology. The 2017 survey involved the postal questionnaire being sent to 1,250 people from both legacy Trusts in September 2017, who had been an inpatient and who had at least one overnight stay in the Trust during July 2017.

6.3 Unfortunately, there were errors in the questionnaire used by the former CMFT contractor for the Survey. These errors affected all organisations who used this provider and resulted from transcription errors. In addition, all questionnaires and organisations were affected by a question routing error which was a result of an error made by the Survey Coordination Centre.

As a result the CQC excluded the results of two survey questions from national and trust level analysis. Data analysis carried out by the Survey Coordination Centre indicated that most of the errors did not affect the results of the survey. However the routing error impacted significantly on the numbers of patients skipping: questions 55 ("When you left hospital, did you know what would happen next with your care?") and 61 ("Did a member of staff tell you about any danger signals you should watch for after you went home?"). Patients who did respond to these questions were therefore not representative and the Survey Coordination Centre considered that including the results for these two questions would not be appropriate. Unfortunately, one of the question (Q61) is an Overall Patient Experience Score (OPES) question. After consultation with NHS England was decided that Q61 was omitted from the OPES scoring for all trusts this year.

Response Rate

6.4 The response rate for former CMFT was 33% (n388) compared to 37% (n441) in 2016 and 39% (n474) in 2015. The response rate for former UHSM was 33% (n406) compared to 42% in 2016 and 46% in 2015. The national response rate was 41% compared to 44% (2016) and 47% (2015). The reduction in response rates over the last 3 years for both former Trusts is reflected in the national response rate, which also experienced a reduction.

Adult National Inpatient Survey (2017) Results

6.5 The survey involved 80 questions, of which 62 require respondents to indicate the standard of care they received, with 18 questions being demographic information and or routing questions. Due to the exclusion of 2 questions, as explained above there are 60 questions with responses within the report. There were 7 new questions and hence there are no equivalent questions with which to compare.

6.6 Survey results are organised under the following eleven key themes:

1. The Emergency/A&E Department (answered by emergency patients only)
2. Waiting list and planned admissions (answered by those referred to hospital)
3. Waiting to get a bed on the ward
4. The hospital and ward
5. Doctors
6. Nurses
7. Care and treatment
8. Operations and procedures (answered by patients who had an operation or procedure)
9. Leaving hospital
10. Overall views of care and services
11. Overall experience

6.7 **Chart 9**, below, shows the results for the former trusts for each of the eleven themes; the highest and lowest scores achieved nationally are also presented. This chart highlights that the Trust's scores are generally midway between the highest and lowest scoring trusts for most key themes.

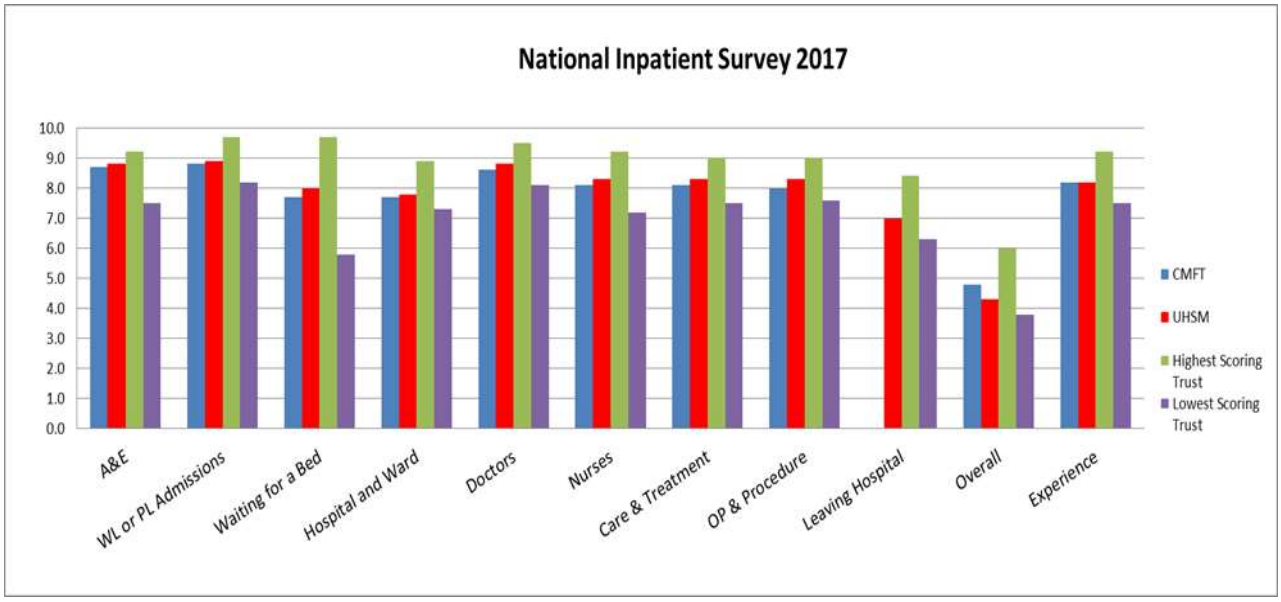


Chart 9: Former CMFT and UHSM scores compared to highest and lowest scoring trusts nationally

6.8 The overall experience score for both former CMFT and UHSM was 8.2, which is an improvement for both former organisations when compared to 2016. **Charts 10 and 11** show the former trusts' overall Quality Score for the past three years.

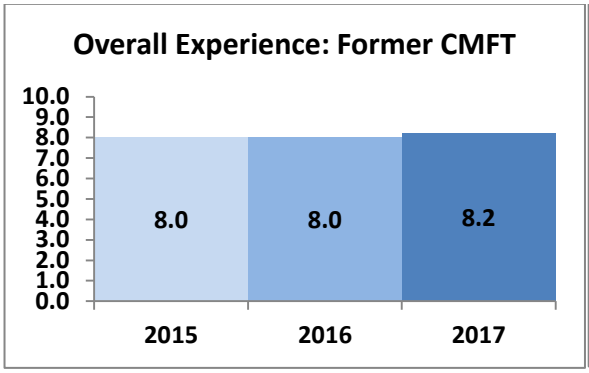


Chart 10: Former CMFT Overall Experience score

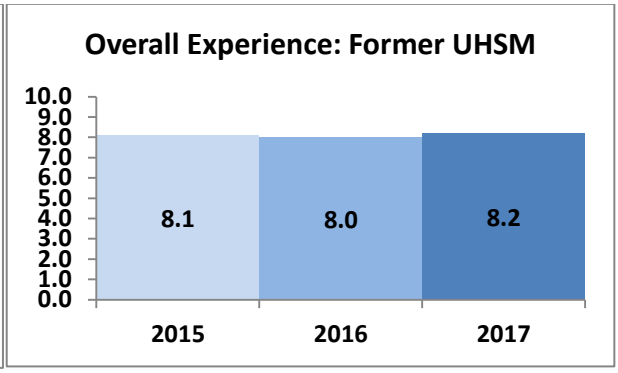


Chart 11: Former UHSM Overall Experience Score

Survey Analysis

National Benchmarking

6.9 Each survey question is categorised as ***'better'***, ***'about the same'*** or ***'worse'*** based on comparison to other organisations' scores. When compared with other trusts there were no questions categorised as ***'better'***, 56 questions categorised ***'about the same'*** and 4 questions categorised as ***'worse'*** for former CMFT and 1 question categorised as ***'better'***, 58 questions categorised ***'about the same'*** and 2 questions categorised as ***'worse'*** for former UHSM.

6.10 The questions categorised as 'worse' was as follows,

Former CMFT:

- How would you rate the hospital food? The recorded score was 4.9 (2017), which compares to 4.8 (2016).
- During your time in hospital, did you get enough to drink? The recorded score was 8.9. There is no previous comparative data as this was a new question for 2017; it is however the lowest score nationally.
- Discharge delayed due to wait for medicines/to see doctor/for ambulance. The score recorded was 5.5, which compares to 5.6 (2016).
- How long was the delay? The score recorded was 6.7, which compared 6.9 (2016).

Former UHSM:

- How would you rate the hospital food? The recorded score was 4.9 (2017), which compares to 4.8 (2016).
- Did you see, or were you given, any information explaining how to complain to the hospital about the care you received? The recorded score was 1.8 (2017), which compares to 1.9 (2016).

6.11 The question categorised as ***'better'*** was as follows:

Former UHSM:

- Did you have confidence and trust in any other clinical staff treating you? The recorded score was 9.1 (2017). There is no previous comparative data as this was a new question for 2017.

6.12 The overall position is consistent with the previous year's position when the Trustss scores for all the 11 key theme categories were ***'about the same'*** as other Trusts.

Improvements and Deteriorations Compared to 2016 Results

6.13 Six questions received ***significantly higher*** scores in 2017 compared to responses from the 2016 survey for former CMFT and 1 question for former UHSM, as detailed below:

Former CMFT:

- From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward, score improved by 0.7.
- Were you ever bothered by noise at night from hospital staff (high score indicates patient were not bothered by noise), score improved by 0.6.
- Did nurses talk in front of you as if you weren't there (high score indicates nurses did not talk in front of patients), score improved by 0.4.
- Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand, score improved by 0.7.
- Were you told how to take your medication in a way you could understand, score improved by 0.8.
- During your hospital stay, were you ever asked to give your views on the quality of your care, score improved by 0.8.

Former UHSM:

- Were you given enough notice about when you were going to be discharged, score improved by 0.5

6.14 No questions received responses that were ***significantly lower*** in 2017 compared to 2016 for either CMFT or UHSM, indicating improvement.

Notably High Scores

6.15 Former CMFT scored above 9 out of 10 in five questions and former UHSM scored above 9 out of 10 in 8 questions, which are presented in **Table 1** below. These high scores provide a level of confirmation regarding the impact of activity undertaken by the Trust in relation to priority issues such as privacy and pain management. The scores for these questions compared to 2016, again suggest that improvement is being sustained.

Survey Question	**Former CMFT Score**	**Comments**
Were you given enough privacy when being examined or treated?	9.4	Deteriorated by 0.1 when compared to 2016
Did nurses talk in front of you as if you weren't there?	9.2	Improved by 0.4 when compared to 2016
Overall, did you feel you were treated with respect and dignity while you were in the hospital?	9.2	Improved by 0.2 when compared to 2016
Did you ever share a sleeping area with patients of the opposite sex?	9.1	No comparative results as question changed for 2017
Did you feel well looked after by the non-clinical hospital staff?	9.1	No comparative results as new question for 2017
Survey Question	**Former UHSM Score**	**Comments**
Were you given enough privacy when being examined or treated?	9.6	Improved by 0.1 when compared to 2016.
During your time in hospital, did you get enough to drink?	9.5	No comparative results as new question for 2017
Had the hospital specialist been given all necessary information about your condition/illness from the person who referred you?	9.3	No change from 2016

Did nurses talk in front of you as if you weren't there?	9.2	No change from 2016
Did you ever share a sleeping area with patients of the opposite sex?	9.2	No comparative results as question changed for 2017
Did you have confidence and trust in any other clinical staff treating you?	9.1	No comparative results as new question for 2017
Was your admission date changed by the hospital?	9.1	+0.1
Overall, did you feel you were treated with respect and dignity while you were in the hospital?	9.1	Deteriorated by 0.1 when compared to 2016

Table 1: 2017 Survey Questions with Scores above 9 out of 10

Notably Low Scores

6.16 Former CMFT and UHSM scored below 5 for 4 questions, which are detailed in **Table 2** below. The questions that scored less than 5 for were the same four questions for both former trusts. It is noteworthy that although these scores were low, there had been improvement for all 4 questions for former CMFT and for 3 of the 4 questions for former UHSM, indicating that focused improvement work in these areas had begun to impact the quality of patient experience. It is clearly vital, however, that this work continues in order to further improve and sustain the improvement.

Survey Question	**Former CMFT Score**	**National Score Range**	**Comments**
How would you rate the hospital food?	4.9	4.7-8.0	Improved by 0.1 when compared to 2016.
Did a member of staff tell you about medication side effects to watch for when you went home?	4.7	3.7-7.6	Improved by 0.1 when compared to 2016.
Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?	2.8	1.4-5.1	Improved by 0.5 when compared to 2016.
During your hospital stay, were you ever asked to give your views on the quality of your care?	2.5	0.7-3.6	Improved by 0.8 when compared to 2016.
Survey Question	**Former UHSM Score**	**National Score Range**	**Comments**
How would you rate the hospital food?	4.9	4.7-8.0	Improved by 0.1 when compared to 2016.

Did a member of staff tell you about medication side effects to watch for when you went home?	4.4	3.7-7.6	Improved by 0.2 when compared to 2016.
During your hospital stay, were you ever asked to give your views on the quality of your care?	2.2	0.7-3.6	Improved by 0.1 when compared to 2016.
Did you see, or were you given, any information explaining how to complain to the hospital about the care you received	1.8	1.4-5.1	Deteriorated by 0.1 when compared to 2016

Table 2: 2017 survey questions with scores fewer than 5 out of 10

6.17 The findings from the Adult Inpatient Survey' from both former organisations provides MFT with key areas of focus for improvement across the organisation in a number of key areas. The plans for improvement related to the questions that score notably low are discussed further in Section 7 of this report.

Comparison with Shelford Group Trusts

6.18 The response rates for the Shelford Group Trusts ranged from 32% (Imperial College London) to 57% (Cambridge). The former CMFT and UHSM response rate of 33% places the former organisations in ninth position in this group. The Trust will continue to explore, with Shelford partners, approaches to improve the local response rate.

6.19 The overall quality scores for Shelford Group Trusts ranged from 8.0 to 8.7, as demonstrated in **Chart 12.** CMFT and UHSM's scores of 8.2 placed the former organisations in joint sixth position with 3 other Trusts in this group.

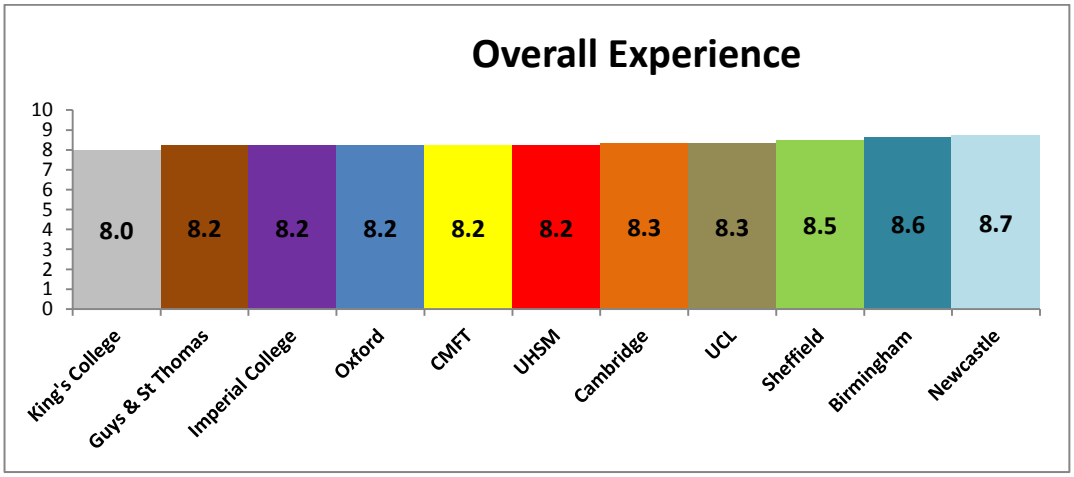


Chart 12: Overall Patient Expereince Score, Shelford Group Trust Comparison

6.20 Compared to the results from 2016 survey, only 3 Shelford Group Trusts improved the overall experience score (former CMFT, Sheffield Teaching Hospitals NHS Foundation Trust and The Newcastle Upon Tyne Hospitals NHS Foundation Trust), with 4 Trusts experiencing a deterioration in the score and 3 organisations remaining the same.

7 Real Time Patient Feedback

Image 4: Proud to Care on Camera, runner-up

7.1 It is valuable to cross reference the snap shot provided by the National Survey results with real time feedback from the Trust's electronic ***'What Matters to Me'*** patient experience surveys. These MFT surveys are locally developed based on the questions in the national patient experience surveys. The surveys ask patients about their experiences in the following themed categories:

- **Communication**
- **Involving patients/ carers**
- **Privacy and Dignity**
- **Clean**
- **Equality and Diversity**
- **Hygiene and Personal Care**
- **Infection Prevention Control**
- **Nutrition and Hydration**
- **Pain**
- **Patient Safety**

7.2 Specific surveys have been developed for patients being cared for in Adult/Children and Young People's inpatient areas, day-case/ treatment areas, Emergency Departments and Outpatient Departments. Additionally specific surveys have been developed for Maternity Services and CAHMS.

7.3 Since the introduction on 1st April 2018 of a newly procured electronic system to capture and report the MFT ***'What Matter to Me'*** patient experience data, frontline teams have had real-time access to patient experience feedback, inclusive of qualitative comments provided by patients for each of the themed categories, with 5928 questionnaires completed April – July 2018.

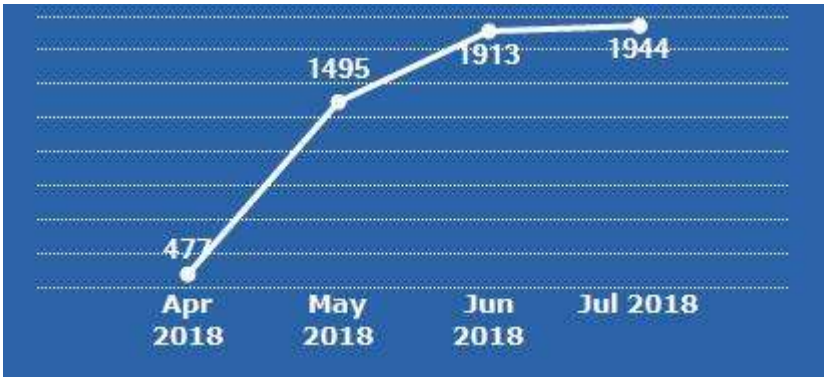


Chart 13: Patient Experience Survey Responses

7.4 The electronic system allows analysis to be undertaken at ward, hospital/ MCS and Trust Level for overall patient experience satisfaction and each of the themed categories. Analysis of the ***'What Matters to Me'*** survey data shows an overall patient experience score in July 2018 of 89.13%, which is a 1.83% increase since April 2018. Comparison with previous years is not possible due to the changes to the system and questions contained within the surveys. Data collected in 2018/19 will therefore provide a baseline position for MFT.

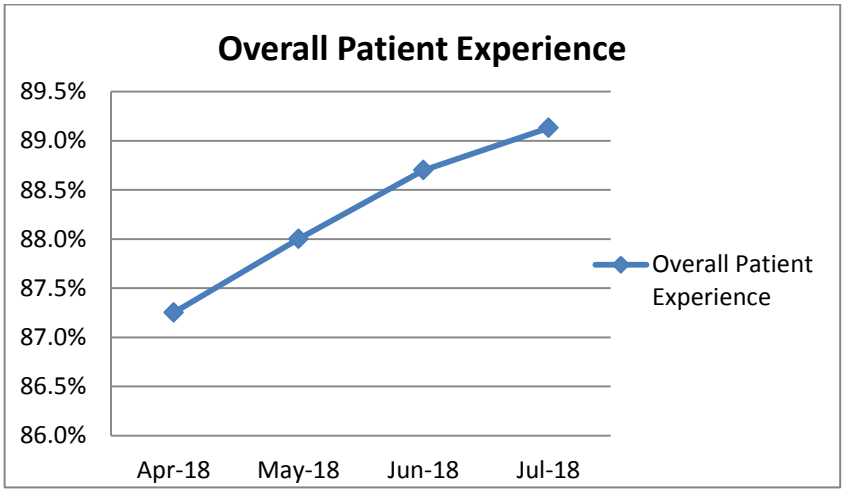


Chart 14: MFT Overall Patient Experience Score April – July 2018

7.5 As noted in section 6 of this report, the Adult National Inpatient Survey indicates specifically low scores for both former CMFT and UHSM in the following areas:

- Quality of Food
- Whether patients were given, any information about how to complain to the hospital about the care they received?
- Whether patients were asked to give views on the quality of care they received?

- Whether patients were told about the medication side effects to watch out for when they went home?

These areas are therefore considered in further detail below.

Quality of Food

7.6 This question received 4.9/10 in the National Inpatient Survey (2017) for both former CMFT and UHSM. Based upon the analysis of ***'What Matters to Me'*** survey data for 976 (July 2018) respondents; patients' satisfaction across the Trust demonstrates 69.4% satisfaction rate with the quality of food, compared to a minimum target of 85%.

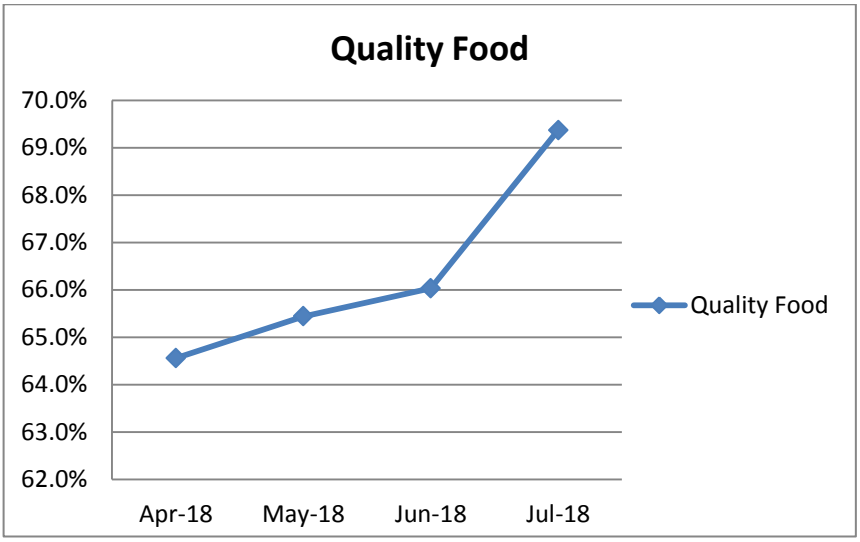


Chart 15: Quality of Food Score April – July 2018

7.7 In recognition of the need to further improve the quality of food a designated work programme with collaboration between Nursing, Estates and Facilities and the Trust's PFI Partners, Sodexo was established in 2017, on the Oxford Road Campus. Funding was identified for a Matron for Dining to support this work and the post-holder commenced in post in October 2017. Through a process of wide engagement during Quarters 1 and 2 2017/18 a detailed action plan for improvement was developed. The engagement and development of an action plan and work programme to replicate the improvement programme on the Oxford Road Campus is due to commence at Wythenshawe and Trafford Hospitals, which will include oversight from Patient Dining Groups at Oxford Road Campus, Wythenshawe and Trafford Hospitals respectively.

Quality of Care

7.8 As part of the roll out of the newly procured electronic system to capture and report the patient experience surveys extensive work has been undertaken to increase the number of patients who are asked about the quality of care they have received, including:

- Roll out of ***'What Matters to Me'*** Patient Experience Survey already in place on the Oxford Road Campus and Trafford Hospital to Wythenshawe and Withington Hospitals.
- Regular ***'What Matters to Me'*** articles in MFTiNews to support spread and embedding of this approach to personalised patient experience.
- Purchase of an additional 285 tablet devices to capture patient experience surveys electronically.
- Education and training of staff on how to use the devices and the electronic capture and reporting system and the development of user a guide for the devices to ensure staff are equipped with the skills to utilise them effectively.
- In addition a Business Case is under development to roll-out the ***'What Matters to Me'*** Patient Experience Survey to Manchester Local Care Organisation (MCLO)

Information about Complaints

7.9 The National Inpatient Survey (2017) score for this question was 2.8/10 for former CMFT and 1.8/10 for former UHSM. Analysis of the ***'What Matters to Me'*** survey data for 1,939 respondents in July 2018, shows a 69.7% satisfaction rate across the Trust in relation to being given any information explaining how to complain to the hospital about the care received. This data indicates a need for improvement.

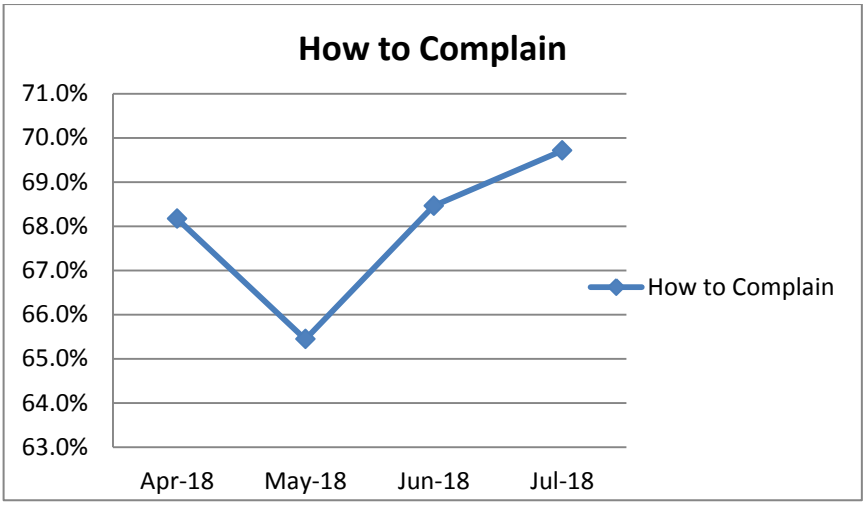


Chart 16: How to Complain Score April – July 2018

7.10 To provide ease of access to the PALS service the team has now developed a single point of access to the service via one telephone point, one email point and one postal point. Posters identifying how patients can provide feedback compliments, concerns and complaints are being revised to include this single point of contact. In addition a new MFT PALS leaflet has been implemented, which informs patients, carers and relatives how to register compliments and raise concerns and complaints.

7.11 Following the relocation of front of house PALS service on the Oxford Road Campus in 2017, initial discussions have been undertaken about relocating the PALS Service at Wythenshawe Hospital to a larger, more visible location.

7.12 There has been, and continues to be, considerable focus on all the above areas through the Complaints Improving Quality Programme. In addition a complaints reduction and transformation programme will be developed in Quarter 3, led by Head of Nursing for Quality and Patient Experience.

Information about Medication

7.13 The ***'What Matters to Me'*** survey does not specifically ask whether staff advise patients about medication side effects to watch for when they go home; the survey asks 'Did a member of staff detail the medications you were taking home in a way you could understand?'

7.14 Analysis of the ***'What Matters to Me'*** survey data for 771 inpatient respondents in July 2018, shows that 87.6% of respondents across the Trust reported that they had received information explaining their medication in a way that they could understand. This result exceeds the Trust's minimum target of 85% but highlights the need for continued focus on this aspect of patient experience.

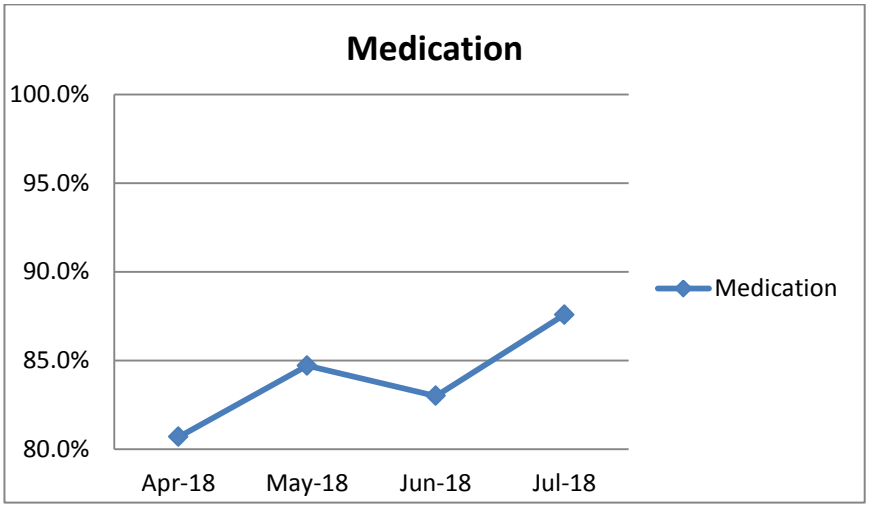


Chart 17: Medication Score April – July 2018

8 Response to the National Survey Results

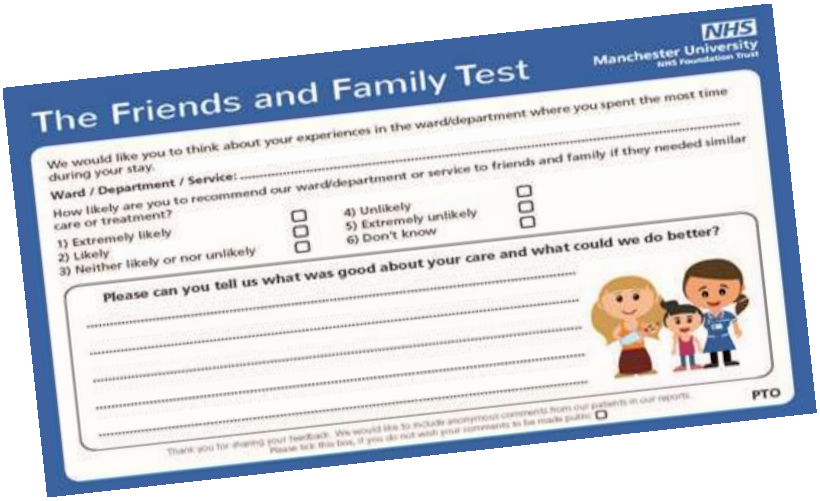
8.1 Overall the former CMFT and UHSM was categorised as ***'about the same'*** as other organisations for responses to the Patient Surveys outlined within this report. Recognising that when comparing results over time, this can be affected when trusts have merged[6], the 2017 survey results for former CMFT and UHSM, alongside real time MFT feedback, provide a baseline and real-time information for the new organisation, enabling priorities to be identified and improvements realised.

[6] NHS England (2018) Statistical Bulleting: Overall Patient Experience Scores: 2017 Adult Inpatient Survey Update. Available from: https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2018/08/Bulletin_2017IP_Final-v1.1.pdf

8.2 The survey results have been shared through Hospital/MCS structures and actions identified as required, to build on existing improvement work. Additionally, Trust-wide work continues through the Patient Environment of Care Group in order to address the persistently low scoring areas of food and clean. Further analysis will be undertaken to drill down to service level, specifically for the Adult Inpatient Survey when site level information is made available from the CQC and where sufficient responses have been received to ensure a representative result.

8.3 The Trust's ***'What Matters to Me'*** Patient Experience Programme, will be fundamental to achieving continued improvement in the Trust's annual National Survey scores. This programme of work aims to engage staff at all levels, creating individual ownership for the delivery of **personalised** care. Further detail of this programme is provided in Section 10 of this report.

9. Friends and Family Test (FFT)


The Friends and Family Test

NHS Manchester University NHS Foundation Trust

We would like you to think about your experiences in the ward/department where you spent the most time during your stay.

Ward / Department / Service:

How likely are you to recommend our ward/department or service to friends and family if they needed similar care or treatment?

1) Extremely likely
2) Likely
3) Neither likely or nor unlikely
4) Unlikely
5) Extremely unlikely
6) Don't know

Please can you tell us what was good about your care and what could we do better?

PTO

Thank you for sharing your feedback. We would like to include anonymous comments from our patients in our reports. Please tick this box, if you do not wish your comments to be made public

Background

9.1 The FFT is a single question survey, which asks patients whether they would recommend the NHS service they experienced to friends and family who need similar treatment or care.[7] FFT results are published monthly on the NHS England website and the NHS Choices website and are monitored by the CQC as part of their inspection process. The Trust's FFT results are also included in the Board Assurance Report and Performance is manged via the Accountability Oversight Framework (AOF). FFT performance including qualitative comments provided by patients is accessible via the Meridian Patient Experience Portal – the Trust's electronic patient experience system, which is used locally to inform and support service improvements.

9.2 The FFT is an important source of information that provides information about ***What Matters to Patients*** about the care and treatment they receive. It is important that patients are given the opportunity to complete the FFT question and that they are able to add comments about their experience. The feedback informs continuous improvements and transformation of services to provide a high quality patient experience.

[7] NHS, England (2014, updated March 2015) **The Friends and Family Test.** Available from: http://www.england.nhs.uk/ourwork/pe/fft/

9.3 To maximise feedback from the FFT responses are captured through a variety of different methods including; FFT postcards, electronic devices, kiosks, the bedside entertainment system, online surveys and SMS text messaging.

FFT Performance

9.4 Following the launch of FFT in April 2013, and up until March 2015 there was a CQUIN target of a 40% response rate for inpatient areas and 20% response rate for Emergency Departments. Reporting response rates is only a requirement for Inpatients and Emergency Departments and not the other categories. Post April 2015 there have been no CQUIN targets, however the Trust has continued to seek to achieve the previous targets. In recognition and agreement with local commissioners the Quality Schedule includes targets that the Trust will be expected to improve the FFT response rates year on year.

9.5 Since the formation of MFT work has been undertaken to align FFT reporting. The Performance for FFT response rate and responses are detailed in **Table 3** October 2017 – March 2018.

Friends and Family Test Response and Results		
Area	**Response Rate 2017/18 (October 2017 to March 2018)**	**Percentage of patients who were 'extremely likely' and 'likely' to recommend our services**
Inpatients	27.5%	96.6%
Emergency Departments	17.8%	88.7%
Outpatients	N/A	94.5%
Community	N/A	98.5%
Maternity	N/A	98.1%

Table 3: FFT Response and Results

Shelford Group Comparison

9.6 The overall inpatient FFT response rates for the Shelford Group for the period October 2017 to March 2018 ranges from 8.9% to 33.6% as demonstrated in **Table 4.** MFT response rate is 27.5% which places MFT in third position in the Shelford group. The percentage of patients who were extremely likely/likely to recommend the MFT to friends and family who need similar treatment or care was 96.6%, for this period, which compares favourably to a range from 94.2 to 98.1% across Shelford Group trusts.

Friends and Family Test Response and Results: Inpatients		
Area	**Response Rate 2017/18 (October 2017 to March 2018)**	**Percentage of patients who were 'extremely likely' and 'likely' to recommend our services**
Imperial College Healthcare NHS Trust	33.6%	97.4%
Sheffield Teaching Hospitals NHS Foundation Trust	29.8%	95.9%
Manchester University Hospitals NHS Foundation Trust	27.5%	96.6%
Guy's and St Thomas' NHS foundation Trust	20.2%	95.2%
Oxford University Hospitals NHS Foundation Trust	21.4%	96.1%
Kings College Hospital NHS Foundation Trust	20.2%	94.5%
University College London Hospitals NHS Foundation Trust	18.4%	94.2%
University Hospitals Birmingham NHS Foundation Trust	17.5%	96.3%
Newcastle upon Tyne Hospitals NHS foundation Trust	13.3%	98.1%
Cambridge University Hospitals NHS Foundation Trust	8.9%	95.5%

Table 4: Comparison of MFT Inpatient FFT response rate and responses compared to Shelford Group Trusts

9.7 The overall Emergency Department FFT response rates for Shelford Group trusts for the period October 2017 to March 2018 ranges from 3.2% to 21.3% as demonstrated in **Table 5**. MFT response rate is 17.8% which places MFT in fifth position in the Shelford Group. The percentage of patients who were extremely likely/likely to recommend the MFT Emergency Department services is 88.7%, which places MFT in third position compared to other Shelford trusts.

Friends and Family Test Response and Results		
Area	**Response Rate 2017/18 (October 2017 to March 2018)**	**Percentage of patients who were 'extremely likely' and 'likely' to recommend our services**
Guy's and St Thomas' NHS foundation Trust	21.3%	84.5%
Oxford University Hospitals NHS Foundation Trust	20.6%	85.9%
Cambridge University Hospitals NHS Foundation Trust	20.4%	92.5%
Sheffield Teaching Hospitals NHS Foundation Trust	18.9%	86.0%

Manchester University Hospitals NHS Foundation Trust	17.8%	88.7%
Imperial College Healthcare NHS Trust	14.9%	93.1%
University College London Hospitals NHS Foundation Trust	14.7%	82.7%
Kings College Hospital NHS Foundation Trust	12.7%	81.6%
University Hospitals Birmingham NHS Foundation Trust	12.3%	82.4%
Newcastle upon Tyne Hospitals NHS foundation Trust	3.2%	93.2%

Table 5: Comparison of MFT Emergency Department FFT response rate and responses compared to Shelford Group Trusts.

FFT Improvement Plan

9.8 Initiatives implemented and undertaken during 2017/18 to support the delivery of the FFT improvement plan are detailed in **Table 6** below:

FFT Improvements
The processes for the mandatory reporting of FFT have been aligned between both legacy organisations
The Quality Improvement and Patient Experience teams have worked collaboratively with Hospitals/Managed Clinical Services/MCLO to promote the FFT survey and support processes for collecting FFT
The Quality Improvement and Patient Experience teams have continued to provide advice to all staff and supported education programmes to raise awareness of FFT
In April 2018, following the commissioning of a new provider for the Trust patient experience feedback system, work commenced to implement the new systems and processes; this work has concluded and includes new FFT cards and uploading the new surveys onto the hand held devices
Following continued positive feedback from service users, staff and patients, the use of postcards for FFT collection has been extended to include all services
FFT section on the Trust website has been updated to promote the FFT with service users
From April 2018, the option to collect FFT in languages other than English has been developed and is available on the hand held devices and Trust website.

Table 6: Action taken to improve FFT Response Rates

Future Development of FFT

9.9 In order to continue to improve the response rate, the following further actions are planned for 2018/19:

- Continue to publicise the importance of FFT to staff and patients;
- Develop 'Focus on FFT' events for 2018/19
- Continued work in collaboration with Hospital/MCS/MCLO teams to increase FFT response rates and promote the FFT survey
- Work collaboratively with RMCH and Informatics' contracting team to introduce a SMS text service for Paediatric Emergency Department and OPD areas across the RMCH foot print
- Increase capacity within the Trust, through service redesign to collect patient feedback, including FFT

10 What Matters to Me: Trust Patient Experience Programme

Background:

10.1 Patient experience is one of the three dimensions of quality[8] alongside patient safety and clinical outcomes. There is a body of research[9][10][11][12][13] to indicate that delivering excellent Patient Experience can support a number of benefits for patients and healthcare organisations, including lower staff turnover and absenteeism, enhanced recovery, improved productivity and efficiency and informed choice by patients. Improving the experience for patients, carers and their families is a strategic aim of the Trust and this is influenced by every member of staff, in every staff group in the organisation.

10.2 The Trust's Quality and Safety Strategy (2018-2021) sets out a commitment to provide the quality of care that matters to patients and their families and caring for the wellbeing of staff. The strategy is underpinned by the Trust Vision, Values Statement that ***'Together Care Matters'*** and a values and behaviours framework.

10.3 As previously reported to the Board of Directors; in 2016 following an extensive period of engagement with patients, staff and other stakeholders the former CMFT, Board of Directors approved a fresh approach to patient experience across the Trust, entitled ***'What Matters to Me'.*** The overarching principle of the ***'What Matters to Me'*** programme is to treat every patient as an individual, to encourage staff to ask patients 'what matters' to them as they travel through services, to listen, and to respond to those needs.

[8] NHS England. https://www.england.nhs.uk/about/our-vision-and-purpose/imp-our-mission/high-quality-care/

[9] NHS Confederation, http://www.nhsconfed.org/Publications/Documents/Feeling better Improving patient experience in hospital. Report.pdf

[10] The King's Fund, Seeing the Person in the Patient, The Point of Care Review, 2008

[11] The Beryl Institute (2011), Return on Service, The Financial Impact of Patient Experience and HFM, Building the Business Case for Patient-Centred Care

[12] Studer Group (2007) http://www.studergroup.com/newsletter/Vol1_Issue8/spring2007_sec8.htm

[13] Charmel PA, Frampton SB (2008) Building the business case for patient-centered care. Healthcare Financial Management. March, vol 62(3), pp.80-5

10.4 Momentum continued in 2017 to embed the ***'What Matters to Me'*** approach across all services and in October 2017, the Board of Directors agreed that the programme should be rolled out the across the entire newly formed Trust. Subsequently, in February 2018, the first of a series of ***'What Matters to Me'*** staff and patient engagement sessions took place at the Wythenshawe Hospital Site, to introduce the ***'What Matters to Me'*** Programme. Further sessions have been since been undertaken at Wythenshawe, Altrincham and Withington Hospitals. **Figure 1** provides a visual portrayal of the group discussion at a staff engagement session held at Wythenshawe Hospital in March 2018.

Figure 1: Graphic from Wythenshawe Engagement Session, March 2018

What Matters to Me

10.5 The overarching principle of the ***'What Matters to Me'*** programme is to treat every patient as an individual, to encourage staff to ask patients 'what matters' to them as they travel through services, to listen, and to respond to those **personal** needs. The six key elements of the programme are identified in **Figure 2** below, along with the months upon which the programme has a specific focus on each element. These relate to the essential elements of an excellent patient experience as identified by staff and patients during the development of the programme. These are all underpinned by other organisational strategies and are connected to the Trust's values and behaviours.

Figure 2: Overarching elements of excellent personalised patient experience

Programme Update

10.6 Supported by the investment of Charitable Funds, a dedicated Programme Manager was recruited in February 2018 to lead the ***'What Matters to Me'*** initiative. As well as promoting '***What Matters to Me'*** and supporting trust-wide engagement work, the Programme Manager is establishing networks throughout the organisation and is working in partnership with a variety of multi-disciplinary teams to integrate ***'What Matters to Me'*** into new organisational strategies, policies and educational programmes.

10.7 Each of the ***'What Matters to Me'*** six key elements have been grouped into bi-monthly themes **(Figure 2**), to provide a framework on which to focus events and planned improvement initiatives. An example of some of the events and improvement initiatives are detailed below:

- **Employee Well Being:** recognising an empowered and motivated workforce typically delivers the highest quality of care for patients[14], the former 'Brilliant Basics' quarterly quality initiative, saw the introduction of the 'Take-a-Break' campaign in January 2018. This campaign encouraged wards and departments to promote and encourage staff breaks. Many areas created staff wellbeing boxes which contained items for staff to promote health and wellbeing, for example herbal teas and positive, motivational comments.

[14] The Kings Fund (2018), 'The Risks to Care Quality and Staff Wellbeing of an NHS System Under Pressure'. www.picker.org/risks-to-care-quality-and-staff-wellbeing

Image 5: 'Wellbeing Box' created by staff in the Gynaecology Outpatient Department at St Mary's Hospital.

The staff member leading Employee Wellbeing within this department commented:

'We spend so much time thinking about the wellbeing of our patients that we often forget about our own wellbeing. It is lovely to think of our colleagues and do something thoughtful to brighten their day'.

- **Employee Well Being**: ***'What Matters to Me'*** was introduced at recruitment events within the Trust in March 2018, with the underpinning concept to collect information about 'What Matters' to new employees before they commence employment within the organisation, to inform induction and education events for new staff.

- **Positive Communication:** The Bee Brilliant Quarter 1 Quality event encouraged staff across the organisation to focus on Positive Communication and 'What Matters' by setting the following call to action for improvement work:

    - ***How do you demonstrate that your patients feel you care about them?***

- **Positive Communication:** Recruitment of two '***What Matters to Me'*** Educators, supported by Charitable Funding, who have, in collaboration with the Organisational Development and Training Team and members of the Trust Administrative and Clerical Teams co-designed a 'First Impressions Training Programme' for Administrative and Clerical Staff. This programme recognises the key interface that Administrative and Clerical staff have with patients at their first point of contact with the organisation. The 'face-2-face' aspect of the Programme was piloted in June 2018, with development of a supporting e-learning module the Programme is scheduled for roll-out in September/ October 2018.

- **Professional Excellence:** Historically, patients who were admitted for elective endoscopic investigations and treatments, once ready to go home, were seen and discharged by a member of the medical team, but other responsibilities often led to delays in discharging these patients and a subsequent delay for patients awaiting admission. A comprehensive training and competency package for senior nurses was developed to support a Nurse Criteria Led Discharge Service. ***'What Matters to Me'*** feedback was used to identity what mattered to patients about their discharge and supported the development of the service and on-going feedback will be utilised to continue to improve the service.

10.8 In line with the NHS Identity Guidelines the What Matters to Me visual identity and all associated resources have been updated in Quarter 2 of 2018/19 (**Figure 3**).

Figure 3: 'What Matters to Me' visual identity

Sustaining Momentum

10.9 Momentum for the programme has been maintained through an extensive engagement and communication approach, which involves staff and encourages a personal commitment to introduce ***'What Matters to Me'*** conversations into interactions with patients at all levels. Regular communication and engagement across a range of channels includes:

- A weekly update in MFTiNEWS
- ***'What Matters to Me'*** patient video stories at the commencement of Board of Directors Meeting and other Group-wide meetings such as Cancer Board
- Regular "Tweetathons" are held encouraging people to share information and celebrate individual progress with the campaign through the use of the hashtag #**WMTM**. To date, there has been widespread engagement and in May and June 2018 alone, there were a total of 252,179 unique impressions of the #**WMTM** tweets
- Regular screensavers, E-shots and communication bulletins
- Development of an enhanced electronic resource pack available on the Trust Learning and Resource hub, examples of the resources, including resources specific for Children and Young People and in 6 different languages, based on the most commonly spoken languages (English, Urdu, Punjabi, Cantonese, Arabic and Polish); examples are available at Appendix 2.
- ***'Matters to Me'*** has been embedded into the Accreditation process and Senior Leadership Walk Rounds, with senior leaders asking staff and patients 'What Matters to Them' as part of the Walk Rounds
- Embedding ***'What Matters to Me'*** as part of Corporate Induction and the new Consultant Leadership Programme, with the new consultants being encouraged to utilise ***'What Matters to Me'*** for the improvement element of the programme

- A programme of ***'What Matters to Me'*** events held across the Trust in Mental Health Awareness week in May 2018, on International ***'What Matters to Me'*** day in June 2018
- Engagement events with staff, for example, a theatre staff engagement event was held in June 2018 across the Oxford Road Campus, Wythenshawe and Trafford involving over 180 theatre staff
- To promote the 'Positive Communication' theme a series of events were organised by the Palliative Care Team and Interpretation and Translation Team to promote the 'Big Word' telephone interpretation system and Sage and Thyme person-centred communication skills training for staff.

Feedback

10.10 The feedback from patients, gathered since the launch of the programme is used to provide local insights regarding how care can be more patient centred. This has allowed real time changes and adjustments to be made based upon the feedback received, to essentially respond to ***'What Matters'*** to patients. In addition, the Patient Experience Team has developed a database, which allows feedback to be themed against the 6 key elements of the programme. **Chart 18** demonstrates the percentage of feedback currently mapped against each theme. This highlights the importance of positive communication, professional excellence, and organisational culture to staff and patients.

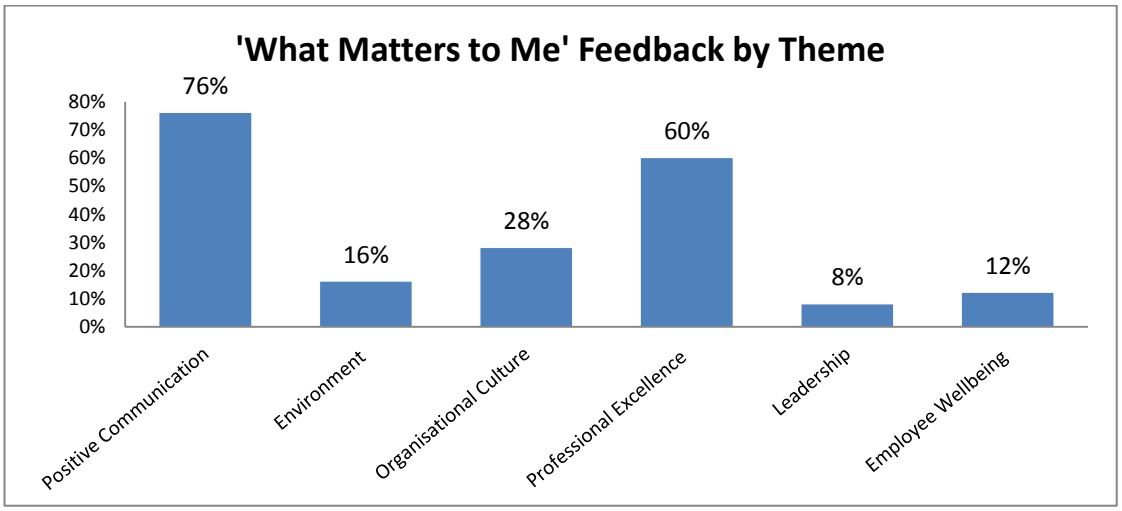


Chart 18: Percentage of patient feedback mapped to each key theme.

Adult Critical Care Case Study:

10.11 In the Adult Critical Care Unit at Manchester Royal Infirmary, work has been undertaken to embed ***'What Matters to Me'*** into every day practice. The team introduced the following question: *'What would you like to ask the doctor today?'* **(Figure 3)** which patients and their families are utilising in order to prompt this discussion with the medical teams.

Figure 3: Critical Care's Speech Bubble – As the Doctor?

10.12 ***'What Matters to Me'*** has also supported the Critical Care team's focus on making personalised patient care a priority. The team now use a ***'What Matters to Me'*** document, with their patients, which prompts staff to think about and act on the things that really matter to the individual and ensure this is shared between staff caring for the patient. In order to improve patient experience each patient also has a bed side poster **(Figure 4)** highlighting what matters to them in key areas that can affect their experience whilst in Critical Care.

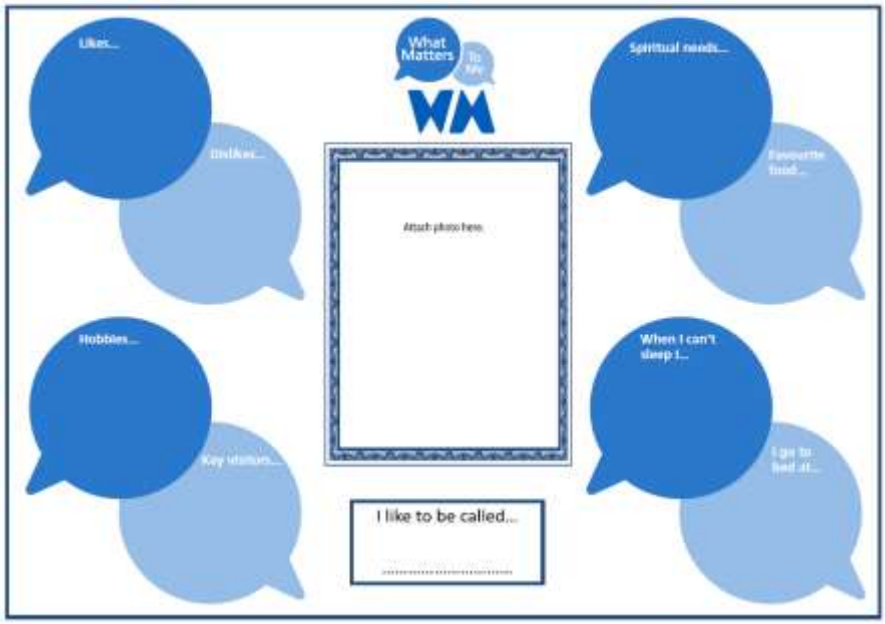


Figure 4: *'What Matters to Me'* Bedside Poster

10.13 What Matters to Me patient experience survey data for MRI Critical Care shows that patient satisfaction with feeling involved in decisions improved from 75% in April 2018 to 100% in August 2018, and 100% of patients who undertook the survey in August 2018 reported being asked what mattered to them compared to 50% in April 2018.

10.14 The What Matters to Me approach has also been applied to support staff experience in MRI Critical Care; in recognition of the inextricable link between patient and staff experience. Notably, the Quarter 1 2018/19 Staff Friends and Family Test survey shows a high level of motivation and engagement with improvement in questions relating to staff experience compared to the previous Quarter, such as:

I would recommend my organisation to friends and family as a place to work: increased from 74% to 80%
I look forward to going to work: increased from 56 to 67%
I am enthusiastic about my job: increased from 74 to 80%

10.15 The approach taken in Critical Care has been shared across the organisation and many areas are now utilising the bedside posters to support delivery of individualised care. The example bellow demonstrates the impact for one patient :

- A gentleman with learning disabilities was admitted to critical care and on admission staff used the ***'What Matters to Me'*** document, in conjunction with the Trust 'traffic light passport' and 'carers pack', to ensure all his needs and those of his mother; who was also his carer were met. It highlighted to the team that the gentleman did not like any care, specifically involving physical contact to commence before this was explained to him and he was verbally warned about any necessary contact before it happened. The team identified that the patient quickly became distressed if any care was not explained fully and he had not been given the time to comprehend the information. His reactions were to thrash out and grab. How staff talked to him was extremely important to make him feel calm. In previous hospitals the reaction of staff had been to use sedatives to calm him down leading to the gentleman feeling drowsy. When asked about her son's care, the gentleman's mother said:

'Understanding my son and knowing what makes him calm really helps. I feel here I have been listened to and they have took the time to make sure the things that my son likes and doesn't like are recognised. They have been considerate of all his needs'.

Future Development of What Matters to Me

10.16 The graphics developed from all patient and staff engagement sessions will be combined to develop a MFT graphic that can be used to support ***'What Matters to Me'*** communication, events and conversations.

10.17 Wall banners will be developed to display across the Trust outlining the ***'What Matters to Me'*** programme and identifying how patients can provide feedback about ***'What Matters to Them'*** to inform service improvements.

10.18 ***'What Matters to Me'*** will continue to be embedded in strategies, policies, job descriptions and education programmes

10.19 Common themes identified from the information collected through the use of ***'What Matters to Me'*** at recruitment events in March 2018 will be utilised to inform pre-employment and induction programmes.

10.20 Collaborative working between the University of Manchester, MFT Pain Team and the ***'What Matters to Me'*** Programme Manager will continue to consider the effectiveness of pain management evaluation as part of a PhD study; part of which involves asking patients about ***'What Matters to Them'*** about pain management.

10.21 Further staff and patient engagement sessions will be undertaken, with plans already in place for staff engagement sessions with the Finance and Procurement teams.

11 Conclusion and Recommendation

11.1 The patient feedback received through the National Surveys identifies that overall the former CMFT and UHSM, and therefore MFT, were categorised as ***'about the same'*** as other organisations, with some evidence of improvement compared to the Trust's previous scores.

11.2 Overall real time patient experience feedback from the ***'What Matters to Me'*** Patient Experience Survey shows more positive results, demonstrating that progress has been made since the surveys were undertaken to deliver improvements in some key areas, whilst highlighting the continued activity that must be undertaken to drive a shift from 'average' to 'excellent'.

11.3 The Trust's approach to Patient Experience, ***'What Matters to Me',*** places the focus on delivering a **personalised** approach to care. This Programme has gained good momentum and has maintained the commitment and enthusiasm of a wide range of staff across many disciplines with significant progress to roll out the approach across the organisation and embed the approach into all activities across the Trust. There is emerging evidence that ***'What Matters to Me'*** can be used to effectively support clinical and non-clinical improvement in order to improve the quality of staff experience and the experience provided to patients and their families and carers and ultimately to impact on care outcomes.

11.4 The Board of Directors is asked to note the results of the patient surveys presented in this report along with the local patient experience survey findings and to support the development of ***'What Matters to Me'*** Patient Experience Programme.

Appendix 1: Maternity Services Survey (2017) comparison of former CMFT and UHSM scores by category to Shelford Group Trusts.

Antenatal Care

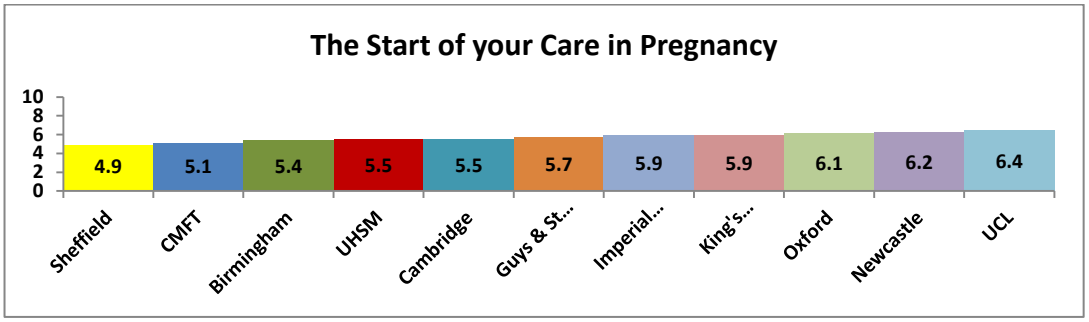


Chart I: Overall Scores for 'The start of your pregnancy'

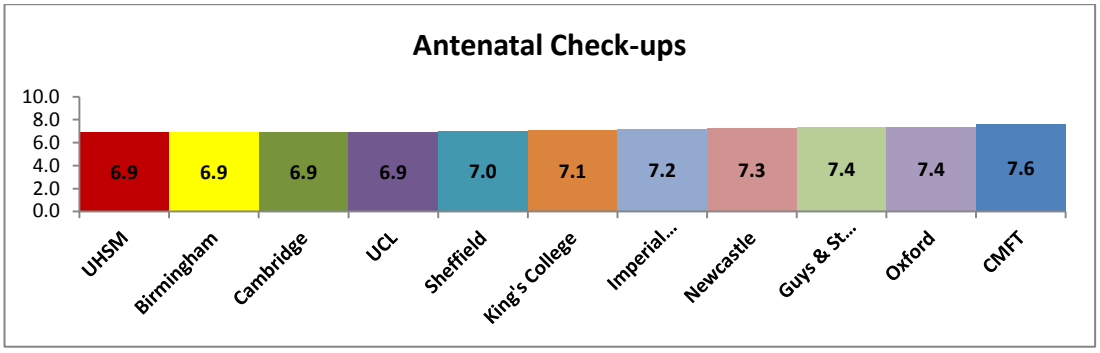


Chart II: Overall Scores for 'Antenatal check ups'

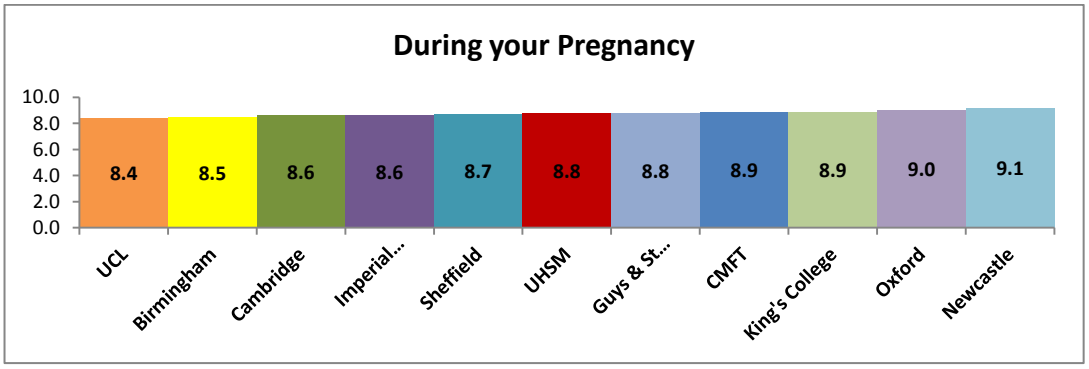


Chart III: Overall Scores for 'During your pregnancy'

Labour and Birth

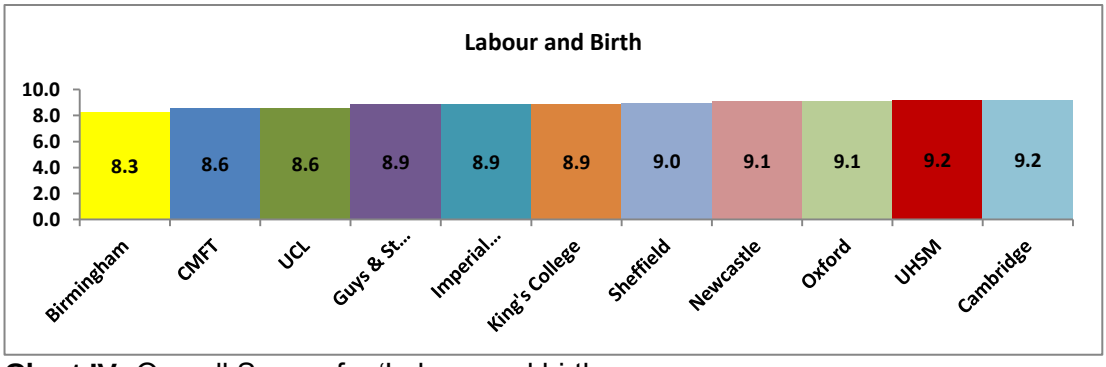


Chart IV: Overall Scores for 'Labour and birth

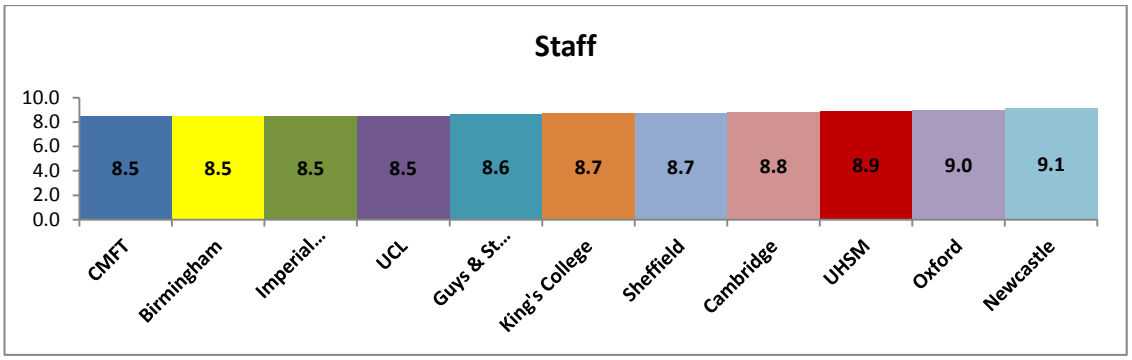


Chart V: Overall Scores for 'Staff'

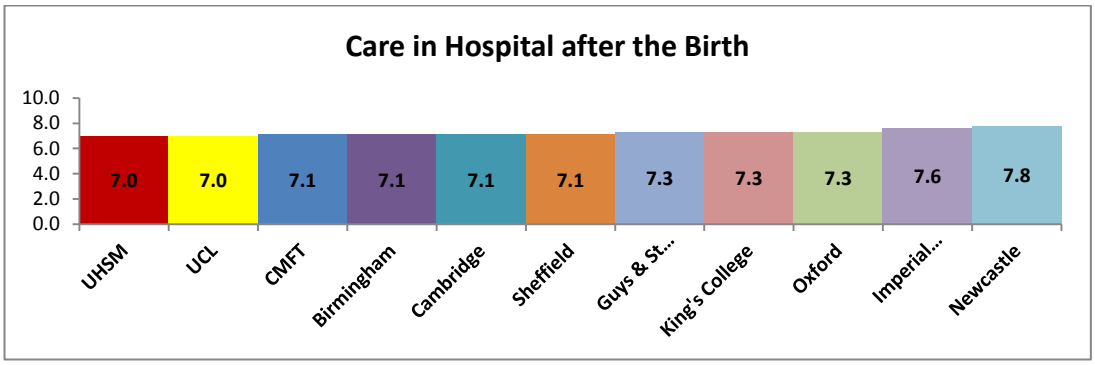


Chart VI Overall Scores for 'Care in hospital after birth

Postnatal Care

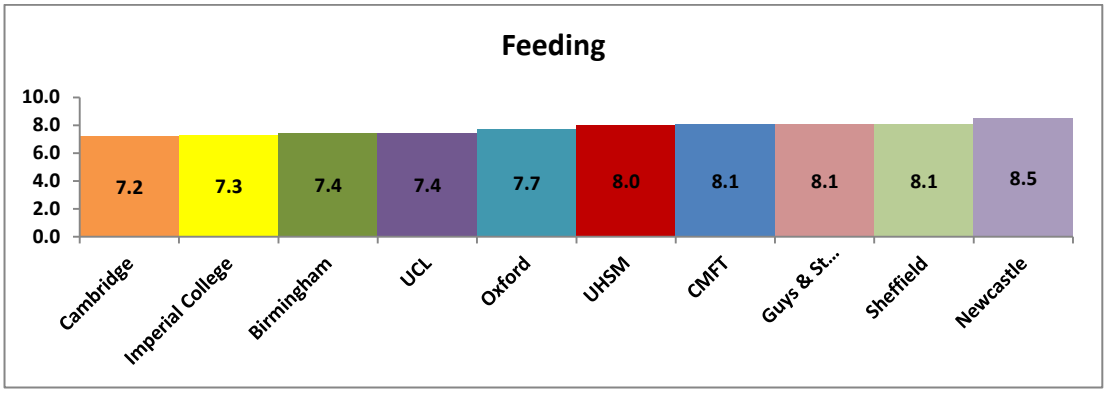


Chart VII: Overall Scores for 'Feeding'

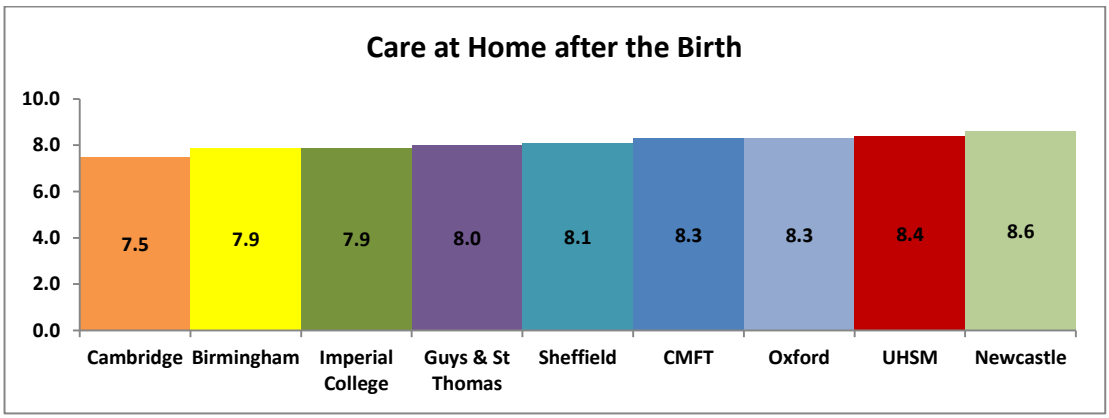


Chart VIII: Overall Scores for 'Care at home after the birth'

Appendix 2: Examples of What Matters to Me Resources

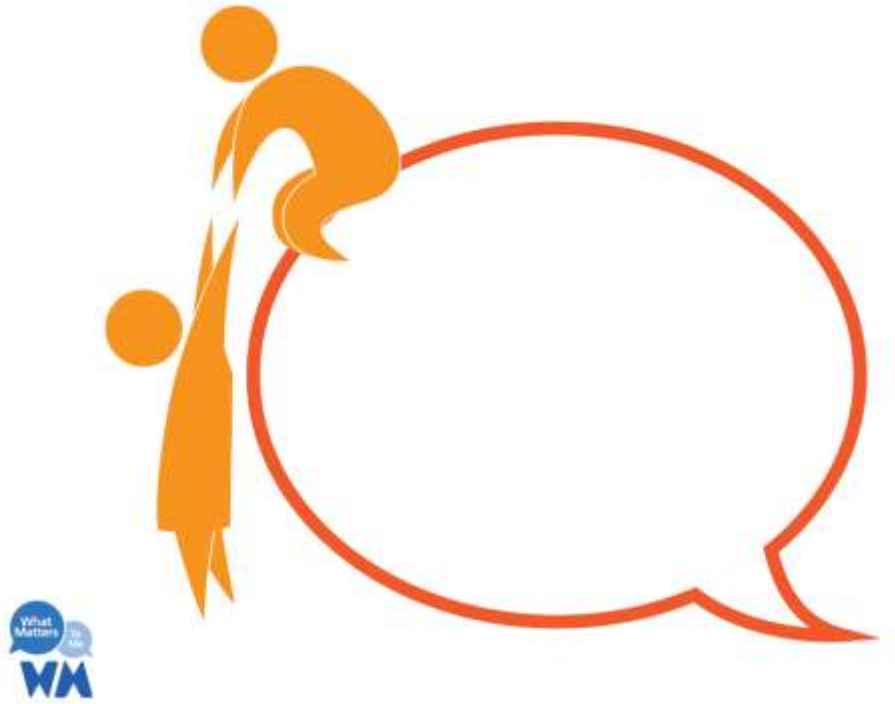


Figure I: Standard WMTM Feedback Speech Bubble

Figure II: Children and Young Person's WMTM Speech Bubbles

Figure III: Cantonese WMTM Speech Bubble

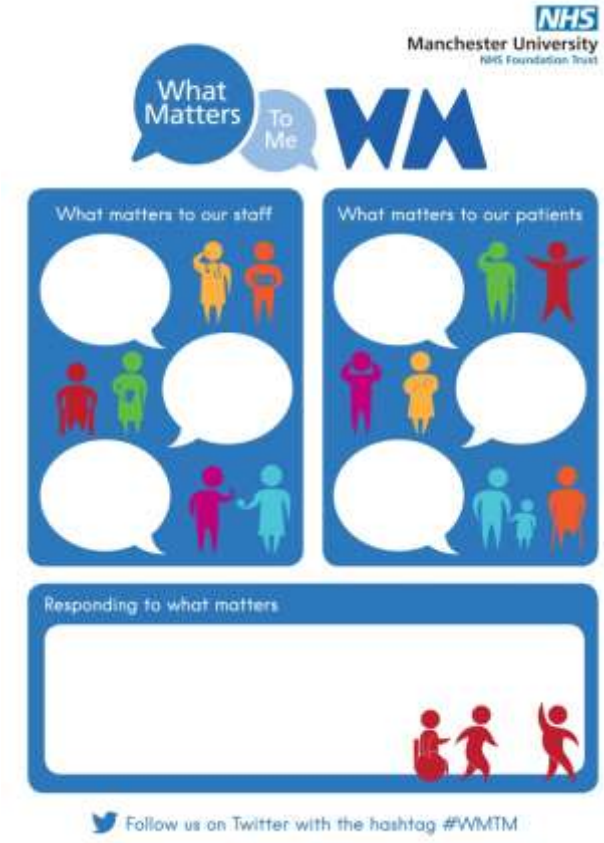


Figure IV: 'You said… we did' WMTM poster

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Professor Cheryl Lenney - Chief Nurse Miss Toli Onon, Joint Medical Director
Paper prepared by:	Sarah Corcoran, Director of Clinical Governance Sue Ward – Deputy Chief Nurse
Date of paper:	September 2018
Subject:	**Response to the Gosport Inquiry Report**
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Resolution • Approval
Consideration of Risk against Key Priorities:	To improve patient safety, clinical quality and outcomes
Recommendations:	The Board of Directors is asked to note the content of this report.
Contact:	Name: Sarah Corcoran, Director of Clinical Governance Tel: 0161 276 8764

1. Executive Summary

1.1. *Gosport War Memorial Hospital - The Report of the Gosport Independent Panel* was published in June 2018. The report details the findings of an independent panel set up to investigate concerns raised by families and nursing staff at the Gosport War Memorial Hospital from 1991 onwards.

1.2. This paper sets out the main findings and an analysis of the position at Manchester University NHS Foundation Trust (MFT) in respect of the potential for this practice to have arisen in the past or in the future.

1.3. The Gosport Report was presented to the Group Quality and Safety Committee in August 2018 and a number of questions raised in response. It was agreed that the questions would be reviewed both by the hospitals and MCSs and by the corporate Medical and Nursing Teams.

1.4. In summary, a review of the current reporting and oversight on mortality, clinical outcomes and patient experience indicators indicates that the situation that arose at the Gosport War Memorial Hospital could not happen at MFT.

1.5. The Trust and its legacy organisations have had in place, for approximately 10 – 15 years, a process of triangulation of information which would identify the patterns.

These include, but are not limited to:

- Mortality data review (SHMI and HSMR)
- Mortality case review
- Clinical Audit
- The Freedom to Speak Up programme
- The Trust incident and investigation policies – including the option to report anonymously
- PALS and complaints processes – including thematic analysis and reporting
- Clinical effectiveness metrics
- Staff surveys (including Pulse Check)
- External review of cases and clinical incident reports

Further detail is contained in the body of the report.

1.6. Whilst it is not possible to say with absolute certainty that events such as these could not have taken place historically at any of our hospital sites or legacy organisations there is no evidence apparent of high levels of concern being raised. Many of the hospitals within the Group are large training centres, not stand alone services such as Gosport which also mitigates the risk of such an event.

1.7. External bodies have reviewed NHS Trusts regularly since 1993 (when the NHS Litigation Authority commenced their assessment of clinical risk standards) and all of the component parts of the Trust have had systems such as incident reporting and analysis in place since that time.

2. The Gosport Report

2.1. In his forward to the Gosport Report the Right Reverend James Jones KBE states:

> *"The documents that the Panel has found reveal that, as demonstrated in Table 1 at the end of the Report, during a certain period at Gosport War Memorial Hospital, there was a **disregard for human life** and a **culture of shortening the lives** of a large number of patients by prescribing and administering **"dangerous doses"** of a hazardous combination of medication not clinically indicated or justified. They show too that, whereas a large number of patients and their relatives understood that their admission to the hospital was for either rehabilitation or respite care, they were, in effect, put on a terminal care pathway. They show that, when relatives complained about the safety of patients and the appropriateness of their care, they were **consistently let down** by **those in authority** – both individuals and institutions. These included the senior management of the hospital, healthcare organisations, Hampshire Constabulary, local politicians, the coronial system, the Crown Prosecution Service, the General Medical Council and the Nursing and Midwifery Council. **All failed to act** in ways that would have better protected patients and relatives, whose interests some subordinated to the reputation of the hospital and the professions involved.*
>
> *In the relationship with these powerful public bodies, the **families have felt powerless**. The Panel's Report gives voice to their historical concerns and substantiates them."*[1]

2.2. It is evident in the report that nurses raised concerns in 1991 about the prescribing and administration of medication using syringe driver pumps and that the hospital management team was aware of the concerns. However, there were a number of changes to management and oversight of the issue and the panel was established 22 years later to investigate the concerns.

2.3. The Panel's analysis demonstrated that the lives of over **450 people** were shortened as a direct result of the pattern of prescribing and administering opioids that had become the norm at the hospital, and that probably **at least another 200 patients** were similarly affected.

3. Investigation findings

3.1. The investigation at Gosport found that the pattern of opioid prescribing of concern occurred during the period between 1989 and 2000 at the Gosport War Memorial Hospital and that over the period the panel concluded that:

- There was a disregard for human life and a culture of shortening the lives of a large number of patients.
- There was an institutionalised regime of prescribing and administering "dangerous doses" of a hazardous combination of medication not clinically indicated or justified, with patients and relatives powerless in their relationship with professional staff.

- When the relatives complained about the safety of patients and the appropriateness of their care, they were consistently let down by those in authority – both individuals and institutions.

[1] Gosport War Memorial Hospital: The Report of the Gosport Independent Panel. June 2018 p.vii

- The senior management of the hospital, healthcare organisations, Hampshire Constabulary, local politicians, the coronial system, the Crown Prosecution Service, the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC) all failed to act in ways that would have better protected patients and relatives, whose interests some subordinated to the reputation of the hospital and the professions involved."

3.2. The report further details issues in relation to focussing on one rogue individual, listening and responding to staff, interaction between different organisations (particularly the police and regulatory bodies) and suspending investigations or actions on the basis that a police or other independent investigation is being undertaken.

4. MFT Response

4.1. In August 2018 the MFT Quality and Safety Committee reviewed the findings of the report and agreed that the conclusions of the investigation presented a number of questions about which the Trust should seek assurance. Hospital/MCS Directors of Nursing/Midwifery/Healthcare Professionals, Medical Directors and relevant Corporate Directors subsequently conducted a local analysis of the questions and sought where possible, assurance on the answers provided. These questions and the responses are set out below.

4.1.1. Could these events have happened historically at any of the legacy hospitals or community services within the MFT Group?

It is not possible to say with absolute certainty that events such as these could not have taken place historically at any of our hospitals sites or legacy organisations. It is however correct that there are a number of examples over the years across the hospitals where data or information has indicated there may be an issue with patient outcomes and as a result internal or external reviews have been commissioned. These reviews have been considered through the governance arrangements of the previous legacy organisations. From the reviews available no related concerns have been raised. These include, but are not limited to:

- Learning from national reports and recommendations including:
  - The Mid Staffordshire NHS FT Public Inquiry (Francis), February 2013
  - The Morecambe Bay Inquiry (Kirkup), March 2015
  - The Savile Investigation (DoH), June 2014 and November 2015
- Single investigations into unexpected deaths and clinical incidents
- An external review of maternal deaths in Saint Mary's Hospital **2014/15** following a higher than usual number of maternal deaths in one year
- A review of all deaths at Trafford General Hospital for the period **2011/12** following raised HSMR immediately prior to acquisition
- An external review of TAVI (transcatheter aortic valve implantation) deaths and the TAVI service overall in Wythenshawe Hospital in **2017**, following a cluster of deaths in one year
- A service review on the paediatric ward, Nesta Wells Unit, at Saint Mary's Hospital following an unexpected death in **2002**
- All paediatric deaths reviewed in RMCH since **2001**
- All sites have regularly reviewed both HSMR and SHMI data since it was available

4.1.2. Could these events happen in the future?

It is highly unlikely that the events as described in the Gosport Report could happen in the Trust in the future, the rationale for this conclusion is:

- In respect of the use of Graseby Syringe Pumps (used to deliver opiates) it is confirmed that the Trust responded to a National alert on their use and a response submitted for all sites through the survey monkey link provided. There are no Graseby MS16 or MS26 pumps left on any of the Trust sites and they were replaced some years ago.

- The organisation has improved access to data on outcomes and increased monitoring of mortality rates has been in place for just over 10 years. All staff, including Board members, can track mortality data down to the level of most specialties on the Hive (online system) and this is reported monthly. This is currently under review so that the approach is consistent across all sites. Current Trust performance is below the national baseline and where specialty performance is above, or on an increasing trajectory, this is reviewed. The data is scrutinised at the Group Mortality Review Group and at Hospital / MCS level.

- Mortality rates are tracked nationally for most specialties and the Trust receives alerts if it appears it is a National outlier on any outcomes. The Trust also contributes to all applicable National Audits including Cancer Peer Review, MBRACE, PICANet and ICNARC.

- The Trust has a process of structured Mortality review which includes a review of prescribing and administration of medication.

- The Trust is well supported by Palliative End of Life Care Teams who support patients and their families at the end of their lives. They also provide support and training to staff on prescribing and administration of palliative care medicines. Care and treatment is based on National prescribing and administration guidelines. End of Life Care is subject to regular audit and review.

- The Trust has been an early adopter of the ReSPECT documentation

- The Trust, and its legacy organisations, have a proven track record on reporting of incidents consistently performing above the National baseline. A culture of openness and speaking up is encouraged across all sites and this is now being strengthened by the further development of the Freedom to Speak Up Guardian role and supporting Champions.

- Controlled drug policies are in place and audited across all sites.

4.1.3. Are working practices across all clinical specialties within agreed clinical norms?

The Trust has a number of governance processes in place to support all Teams to provide care within agreed clinical norms. Evidence based practice is encouraged and research undertaken to further support that evidence and contribute to developments in practice.

New procedures and treatments are scrutinised at the recently-established Clinical Advisory Committee and the emerging Clinical Standards Groups will further support this scrutiny.

There is a comprehensive programme of both clinical and internal audit to measure compliance with accepted standards and this programme is overseen by sub-Board committees.

Ward accreditation, internal and external quality review and a number of external inspection and validation processes support the assessment of practice.

4.1.4. How are concerns raised by patients and their families responded to?

The Trust has a PALS and a complaints team in place and all staff are trained to listen and respond to the concerns of patients and their families. There are systems in place through the Bereavement Centre for patient's families to request a mortality review if they wish, and these are always undertaken if requested. The Trust is committed to explaining and apologising when things go wrong and undertaking investigation of all concerns raised by patients and/or their families.

All clinical incidents where significant harm has occurred are investigated and duty of candour is monitored to ensure that patients and their families receive an explanation when things go wrong. Current performance for stage one (an initial explanation and apology) is 100%.

The Trust has a comprehensive programme of patient and staff engagement including the 'What matters to me' and 'Tell Us Today' programmes of work.

4.1.5. How are concerns raised by staff responded to?

There are a number of processes that staff can use for raising concerns and all staff are required to speak up if they are concerned about safety or quality of care. Firstly if a staff member was concerned about impending risk they can speak to their team and line managers, use of the Risk Register is encouraged.

Staff can raise concerns about specific issues or events using the incident reporting system (online and easily accessible). The Trust has excellent reporting rates (in the top quartile nationally) and low rates of serious harm.

The Trust has in place a Freedom to Speak Up Guardian and is currently in the process of appointing local Champions so that staff have someone in their own area they can approach if needed.

The Trust has a Raising Concerns at Work Policy, use of which is monitored.

There is a significant amount of evidence available on the response to concerns being raised which include patient safety programmes across all of our sites, notes of meetings, programmes of work such as the Emergency Surgery Trauma Unit (ESTU) improvement programme. This work is detailed regularly in the Trust publication 'MFT Safety Matters'.

The Staff Survey asks questions about response to concerns and feedback. The Trust is seeking to improve performance on the feedback following incidents which staff have raised as an issue.

4.1.6. How are concerns about medical staff practice or a particular doctor, nurse or other practitioner responded to?

There are a number of key policies in place to respond to concerns about staff of all disciplines, these include:

- Disciplinary Procedures
- Raising Concerns at Work Policy
- Incident Reporting and Investigation Policies
- Complaints Policy

The Trust has appointed two Associate Medical Directors (AMDs) who oversee the process and all concerns raised in respect of Medical Staff. The AMDs ensure that medical staff are properly supported, that they concerns about doctors' practice and conduct are appropriately investigated and the that correct action is taken in response. This may include onward referral or notification to the professional or regulatory body.

There are close links with the University and HEE; and there is an Associate Medical Director/AMD for Medical Education who oversees the management of concerns in respect of undergraduates and postgraduate Trainees.

Nurses, allied health professionals (AHPs) and other staff are overseen by their professional leads supported by the policies detailed above.

Disciplinary matters, including suspensions, are monitored and reported on at Group level.

There is a substantial amount of evidence in place on the use and management of the processes above.

4.1.7. How are deaths reviewed? How does the organisation respond to fluctuations (up or down) in crude or expected death rates?

The Wythenshawe sites site- historically chose to use the Structured Judgement Review tool (SJR, developed by the Royal College of Physicians). This methodology for adult mortality reviews uses a scoring system for quality of phases of care, and an internationally recognised 1-6 scoring methodology for likelihood of a death being avoidable. The organisation is currently moving towards use of the Structured Judgement Review across all sites and managed clinical services (MCS).

The Oxford Rd campus used an in house developed review form, and a slightly different methodology for scoring the possibility of avoidability. These minor differences in methodology did not have a significant impact on overall outcome, but harmonising the systems employed across MFT is preferable for consistency and internal benchmarking.

Any deaths identified as potentially avoidable are subject to a Serious Incident Investigation), if this has not already occurred.

Any serious incident identified following an Emergency Bleep Meeting (EBM) or Mortality Review is recorded as such and investigated (see section 4.1.8). Full duty of candour procedure is applied.

Mortality Review processes are overseen by a Non-Executive Director and the Associate Medical Director for Clinical Effectiveness who meet regularly with clinical teams to discuss findings and response.

Mortality indicators are monitored constantly with fluctuations and alerts received being responded to immediately. There are many examples of investigation of these alerts and changes made on the back of findings. These Mortality indices indicators form part of the Accountability Oversight Framework (AOF) under which the Sites/MCS operate.

Full detail on the process, themes identified and action taken can be found in the Mortality Annual Report presented at the Quality and Safety Committee in April 2018.

4.1.8. How are deaths investigated? For all serious incidents what processes are in place to ensure investigation and action when third party investigators (such as the Police or a Serious Case Review) are involved?

Deaths are investigated through both the processes outlined above (mortality review and serious incident investigation). There is also an established process on the Oxford Road Campus, now being rolled out across all sites, of Emergency Bleep Review meetings. This process examines all emergency bleep calls to review when and how the patient deteriorated and what the response was, in order to raise awareness of the signs of impending collapse or cardiac arrest, and to learn from the events leading up to the major deterioration.

In support of this a number of Trust sites have Patientrack (planned for complete roll out across MFT). This is an electronic alerting system that responds to patient – observations taken and alerts medical staff automatically when a patient requires attention. It has a built in escalation system and response times are monitored. The Trust Incident Reporting and Investigation Policy clearly outline what to do in the event of an unusual or suspicious death. Appendix 7 of the policy details the memorandum of understanding and arrangements for working with the Police and other agencies.

4.1.9. How is the use of controlled drugs monitored? In particular when used at end of life. Are high usage areas scrutinised?

Following changes to Controlled Drugs (CD) regulation resulting from the Shipman Inquiry, MFT has a Controlled Drugs Accountable Officer registered with CQC who links into with national Local Information Networks (LIN). This individual has oversight of CD arrangements and usage across MFT.

Furthermore MFT has well developed arrangements to oversee CD usage, namely:

- The Palliative Care Team work with patients and staff on prescribing and administration of drugs at end of life
- A detailed Controlled Drugs Policy describing the framework for controlled drugs use across MFT.
- Post of CD Lead Pharmacist who works closely with the Medicines Safety Lead Pharmacist.
- Good incident reporting culture and all reported CD incidents are monitored and investigated if appropriate. All CD incidents are notified to the GM LIN via a mandatory quarterly Occurrence Report.
- A CD Annual Report is submitted to the Group Q&S Committee with a series of recommendations for further improvement of our CD systems.
- Formal Quarterly CD audits are undertaken in all areas which use CDs, the results of which are reported to Hospital Q&S Committees with recommendations.
- The majority of acute site wards and clinical areas have regular clinical pharmacist cover
- The Pharmacy department has software which monitors trends in usage of any drugs identified as liable for diversion including CDs.

4.1.10. What clinical audits are undertaken that would contribute to our understanding of the issues raised in this report and are there any gaps?

The organisation contributes to all relevant National Audits that review mortality in particular specialties. As detailed above the use of controlled drugs is audited regularly and there is a programme of clinical audit which reviews compliance with recognised pathways and procedures of care. The National Audit programme and percentage of data submitted is detailed in the annual Quality Report. Clinical Audit plan completion is monitored at the Group Clinical Governance Committee.

4.1.11. How are staff, patients and their families encouraged to speak up and what assurance does the organisation have on response?

The Trust has well established programmes of work in this area and a large amount of evidence to demonstrate listening and response.

The Values and Behaviours Framework launched in May 2018 and details very clearly the requirement for staff to be honest, speak up and directly refers to speaking up when standards are not being maintained. There are a number of examples where staff have reported using the incident system that colleagues are not upholding these values and behaviours and response to those reports.

The development of the Freedom to Speak Up process and subsequent outcomes form a key component of the assurance process to meet the Trust's strategic aim to deliver safe and high quality care. The establishment of a repository of the issues raised and responses made to concerns will enable themes to be identified to enable learning and continuous development as well as informing the Trust's quality and safety Key Performance Indicators.

Our widely embedded Improving Quality Programme (IQP) is underpinned by safety and quality audit data and Patient Experience feedback and can be applied to any circumstance where change is needed.

Patients are encouraged to raise concerns directly to staff and staff are trained to listen and respond. There are established PALS services and Patient Experience Teams serving all sites and a Complaints Team. PALS concerns and complaints performance is monitored and regularly reported on at every level I the organisation. A complaints scrutiny group chaired by a non-executive director considers individual complaints selected at random for each hospital/MCS this includes discussions on trends, learning from complaints and prevention of future concerns.

The 'What Matters to Me' programme seeks information from Staff and Patients on the areas of improvement that matter most to them using patient feedback mechanisms that are transparent and actions are visible as improvement programmes in the clinical areas.

5. Areas for action/further assurance

5.1. The local assessment and a review of ongoing work have identified some gaps in assurance.

As stated at earlier it is not possible, with absolute confidence, to state that these events could not have happened historically in the legacy organisations. However, there is no evidence to suggest at this point that concerns were raised that were not responded to, nor have there been, since the data was reported on, mortality data that would suggest an issue.

5.2. In respect of whether the events could take place in the future the assessment indicates that the systems in place now would prevent such events occurring, especially over such a long period of time. There are some improvements the Trust can make in response to this report but none of these are thought to pose a significant risk and all have remedial action in place as part of existing work programmes. The gap analysis and progress will be reviewed again and reported to the Quality and Safety Committee.

5.3. Identified Areas for improvement:

Improvement Required	Reported to	Lead
Further alignment of the monitoring of NICE guidance and associated clinical audit programme	Quality and Safety Committee	Director of Clinical Governance
Improvements to the controlled drugs audit tool	Medicines Management Committee	Directors of Pharmacy
Improvements to the complaints management process and timeliness of response and alignment of systems across all sites	Quality and Safety Committee	Deputy Chief Nurse
Feedback to staff following reporting of serious incidents and themes identified	Quality and Safety Committee	Director of Clinical Governance
Pharmacy support – consistency across all sites	Medicines Management Committee	Directors of Pharmacy
Consistency and completeness of mortality reviews	Group Mortality Review Committee	Associate Medical Director - CE
Availability of site level data for some outcomes and specialty SHMI	Group Mortality Review Committee	Director of Digital Delivery
Storage and security of medicines	Medicines Management Committee	Directors of Pharmacy
Completion of Freedom to Speak Up Champion appointments	HR Scrutiny Committee	Associate Director Inclusion & Community

6. Conclusion

6.1. The review of the current reporting and oversight on mortality, clinical outcomes and patient experience indicators indicates that the situation that arose at the Gosport War Memorial Hospital could not happen at MFT.

6.2. Whilst it is not possible to say with absolute certainty that events such as these could not have taken place historically at any of our hospital sites or legacy organisations there is no evidence apparent of high levels of concern being raised.

7. Recommendations

7.1. Assessment of the issues raised in the report has been undertaken and the Board of Directors are asked to note the assurance detail above.

7.2. Hospitals and MCS will monitor the improvements required at Hospital/MCS Quality and Safety committees and report on progress as part of their on-going patient safety reporting

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Professor Cheryl Lenney Chief Nurse
Paper prepared by:	Karen Connolly Chief Executive Saint Mary's Hospital
Date of paper:	10th August 2018
Subject:	**Compliance with Kirkup Recommendations following the transfer of SafePlace (SARC) services from Liverpool Community Health May 2017**
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Resolution • Approval
Consideration of Risk against Key Priorities	To improve the quality and safety for clients and staff who attend or work in the sexual assault and referral service in Liverpool
Recommendations:	The Board of Directors is asked to note this report.
Contact:	Name: Karen.Connolly@mft.nhs.uk Tel: 0161 276 6200

Implementation of the Kirkup Recommendations 6.6 and 6.7 following the transfer of SafePlace Merseyside (SARC) from Liverpool Community Health

Background

As part of the dissolution process for Liverpool Community Health NHS Trust (LCH), Manchester University Hospitals NHS Foundation Trust (MFT) was asked to takeover provision of the Sexual Assault Referral Service which LCH were commissioned to provide for Merseyside.

Following a period of due diligence and contract negotiation with commissioners from NHS England and authorisation from NHS Improvement the service transferred to MFT on the 1st of May 2017 where it has been managed and run by Saint Mary's SARC.

Correspondence received from the Delivery and Improvement Director of NHS I (Cheshire and Merseyside) in March and April 2018 requested assurance as to how the transfer of services addressed the recommendations highlighted in the Kirkup Review; namely recommendations 6.6 and 6.7. NHSI suggested a number of questions for MFT to respond to. This report is provided to inform the Board of Directors of the position.

Kirkup Recommendations

Recommendation 6.6: Organisations taking on former Liverpool Community Health NHS Trust (LCH) services should review the handling of previous serious incidents to ensure they have been properly investigated and lessons learned.

Prior to the novation of the Sexual Assault Referral Centre (SARC) contract from LCH to MFT a due diligence questionnaire was issued. LCH reported that there were no ongoing Serious Untoward Incidents. LCH subsequently made MFT aware of two incidents relating to missing client records. A Root Cause Analysis investigation report dated the 30th of April 2017 was shared by LCH with MFT during October 2017, 6 months after the transfer of the Merseyside Sexual Assault Referral Centre (SARC) service.

LCH were to notify the Information Governance Commissioner regarding these incidents. Confirmation was given via email to the Saint Mary's Divisional Director on the 28th of August 2017 that following the SI investigation that the storage of SARC records was now secure and a tracking and tracing procedure was in place with evidence of it being used. Since the transfer of the service in May 2017 there is no requirement for any records to leave the SARC premises, other than when required for court and the storage and tracking of records is being aligned to the established process at the MFT SARC site.

Review of the incident report showed that improvements could have been made with the quality of the report and the level of training of the investigator.

Recommendation 6.7: Organisations taking on former LCH staff as part of service transfers should review the handling of disciplinary and whistleblowing cases urgently to ensure that they have been properly and appropriately resolved. These organisations should ensure that staff are not placed back into working relationships previously the subject of bullying and harassment.

MFT can confirm that at the time of the transfer of service to MFT all disciplinary processes were complete with no outstanding actions. This was appropriately communicated to the SARC Directorate Manager and Saint Mary's Divisional Human Resources Business Partner. Since the transfer there have been no complaints about any previous disciplinary cases or actions taken.

No cases of whistleblowing were provided as part of the transfer of this service.

There were no cases of bullying and harassment which were upheld at the time of transfer and no staff transferring where reasonable adjustments had to be made.

Conclusion

The Board of Directors is asked to note the contents of this paper and to gain assurance that the actions taken by MFT on the transfer of SafePlace services were undertaken appropriately and safely, in line with the Kirkup recommendations.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Margot Johnson , Executive Director of Workforce & OD
Paper prepared by:	Alwyn Hughes, Director of Corporate Services / Trust Secretary
Date of paper:	3rd September 2018
Subject:	Board Assurance Framework (September 2018)
Purpose of Report:	Indicate which by ✓ • Information to note • Support • Accept ✓ • Approval
Consideration of Risk against Key Priorities:	**(Impact of report on key priorities and risks to give assurance to the Board that its decisions are effectively delivering the Trust's strategy in a risk aware manner)** In the absence of robust and comprehensive BAF, the opportunities for supporting and enhancing organisational governance by using a body of good practice outcomes and evidence will be diluted.
Recommendations:	The Board of Directors to accept the BAF aligned to the MFT Strategic Aims and Key Objectives for 2018/19
Contact:	Name: Alwyn Hughes, Director of Corporate Services / Trust Secretary Tel: 0161 276 4841

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

THE BOARD ASSURANCE FRAMEWORK (September 2018)

1. Background

Performance against the Board Assurance Framework (BAF) is reviewed at every formal Board of Directors via the Intelligent Board metrics.

Significant risks to achieving the Trust's key priorities are reviewed and reported on at the Group Risk Management Committee (GRMC) and across other boards and, where necessary, appropriate committees dependent on the risk rating.

The Trust Scrutiny Committees, on behalf of the Board of Directors, utilise the BAF to inform and guide their key areas of scrutiny and especially targeted 'deep dives' into areas requiring further assurance.

The full BAF is received and noted at least twice a year by the Board of Directors.

2. Review of the Strategic Aims

Key Priorities & Risks associated with the following Strategic Aims are reviewed at MFT Scrutiny Committees and the Audit Committee during 2018/19:

- *To complete the creation of a Single Hospital Service for Manchester/ MFT with minimal disruption whilst ensuring that the planned benefits are realised in a timely manner*
- *To improve patient safety, clinical quality and outcomes*
- *To improve the experience of patients, carers and their families*
- *To achieve financial sustainability*
- *To develop single services that build on the best from across all our hospitals*
- *To develop our research portfolio and deliver cutting edge care to patients*
- *To develop our workforce enabling each member of staff to reach their full potential.*

3. Development of the Board Assurance Framework

Following a developmental review of Leadership & Governance arrangements using the Well Led framework during the Summer, a Task & Finish Group will be convened in September 2018 to refine the format, content and operational effectiveness of the current BAF. Once completed, an updated BAF will be re-presented to the Board of Directors in November 2018. An Internal Audit review will also consider the changes made to the format and content of the BAF against good practice and the wider governance environment of the organisation.

The Audit Committee will continue to focus on seeking assurance that the process outlined has been adhered to along with any gaps in control/assurances; the committee will also consider whether any actions are clearly identified to mitigate and/or reduce the risk(s).

4. Recommendation

The MFT Board of Directors is requested to accept the latest Board Assurance Framework (BAF) for September 2018.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

THE BOARD ASSURANCE FRAMEWORK

(September 2018)

Introduction

The Board Assurance Framework is one of the tools that the Trust uses to track progress against the organisation's Strategic Aims. As part of the development of the Board Assurance Framework each financial year, the Key Priorities for the year are identified and the potential risks to achieving these assessed for inclusion on the framework. As such, all risks on the Board Assurance Framework are set out under the Strategic Aims.

The Board Assurance Framework is based on seven key elements:

- Clearly defined Key Priorities for 2018/19 (aligned to the Trust's Strategic Aims)
- Clearly defined principal risks to the key priorities together with an assessment of their potential impact and likelihood.
- Key controls by which these risks can be managed
- Potential and positive assurances that risks are being reasonably managed
- Board reports detailing how risks are being managed and objectives met, together with the identification of gaps in assurances and gaps in controls.
- Risk reduction plans, for each risk, which ensures the delivery of the objectives, control of risk and improvements in assurances.
- A target risk rating

Risk Matrix

The table below demonstrates the Trust's risk matrix that is used within the framework:

Severity ↓	Likelihood →				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
1: Low	1 Very Low	2 Very Low	3 Very Low	4 Very Low	5 Very Low
2: Slight	2 Very Low	4 Very Low	6 low	8 low	10 Medium
3: Moderate	3 Very Low	6 Low	9 Medium	12 Medium	15 High
4: Major	4 Very Low	8 Low	12 Medium	16 High	20 High
5: Catastrophic	5 Very Low	10 Medium	15 High	20 High	25 High

1	Strategic Aim: To complete the creation of a Single Hospital Service for Manchester/ MFT with minimal disruption whilst ensuring that the planned benefits are realised in a timely manner

Principal Risk: 1. There is a risk that it will not be possible to access the resource needed to manage the acquisition and transformation of NMGH.	Enabling Strategy	Associated Committee
	Single Hospital Service	Board of Directors
	Lead Director	Operational Lead
	Director Single Hospital Service	Director Single Hospital Service

Inherent Risk Rating Impact / Likelihood	Consequences	Controls	Current Risk Rating Impact / Likelihood	Gaps in Control	Gaps in Assurance	Potential Assurance	Positive Assurance	Target Rating Impact / Likelihood
16 4x4	The process of acquisition may not be well managed, and/or the financial risks will be too great and the transaction will not be supported by the MFT Board.	Application of GM Transformation Funds to support effective programme management arrangements. Detailed Counterfactual Case being developed (supported by Vendor Due Diligence in key areas) and processes being established to facilitate appropriately senior conversations about financing.	16 4x4	Resourcing of programme management functions outside MFT less well established. The outcome of the negotiations around financial support are not entirely within the control of the Trust.	Now there is an agreed Programme Plan GMHSCP/NHS I need to increase the pace of delivery in order to realise the projected timeline for the dissolution of PAHT. The Counterfactual Case requires sign off locally in preparation for national discussions - a firm schedule and sequence of meetings is yet to be settled on.	Continue to refine and apply the acquisition programme plan with milestones and reporting structures. Ensure the additional resources allocated to the GMHSCP/NHS I team are used to best effect. Continue regular "stock take" meetings between Chief Execs. Finance Working Group (sub-group of PAHT Transaction Board) to provide effective management of Counterfactual development.	Track record and experience gained from the CMFT / UHSM merger and full compliance with GMH&SCP governace arrangement and NHS I Regulatory processes.	9 3x3

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Scrutinise and test the Counterfactual case and the disaggregation model (as part of the work of the Finance Sub Group). Respond effectively to the Counterfactual case on the Strategic Case/Business Case development process.	Group Chief Finance Officer	31/08/2018 30/11/2018	Board of Directors	Counterfactual established as basis for acquirers' "ask", and funding negotiation process agreed.	Work underway led by GMHSCP/NHSI to agree the Counterfactual by August 2018 subject to management of risk associated with the Vendor Due Diligence on Estates. Size of acquirers' "ask" likely to make funding discussions challenging - meetings currently being arranged.

Principal Risk: 2. There is a risk that the timescale for completing the acquisition and transformation of NMGH will become excessively delayed.			Enabling Strategy			Associated Committee		
			Single Hospital Service			Board of Directors		
			Lead Director			Operational Lead		
			Director Single Hospital Service			Director Single Hospital Service		
Inherent Risk Rating Impact / Likelihood	**Consequences**	**Controls**	**Current Risk Rating Impact / Likelihood**	**Gaps in Control**	**Gaps in Assurance**	**Potential Assurance**	**Positive Assurance**	**Target Rating Impact / Likelihood**
9 **3x3**	The governance and management arrangements for the acquisition fail to deliver a timely outcome, and the problems currently being experienced by the PAHT services remain unaddressed and/or deteriorate further.	Agreed GM Programme Plan with multi-agency support, and greater clarity about roles of NHS I and GM H&SCP. Adequate resource identified to support the programme management of the NMGH acquisition process within MFT, and SHS Team working closely with existing management teams.	**6** **3x2**	Resourcing of programme management functions outside MFT less well established. The process and arrangements for the negotiations around financial support are not entirely within the control of the Trust.	GMHSCP/NHS I need to increase the pace of delivery in order to realise the projected timeline for the dissolution of PAHT. The Counterfactual Case requires sign off locally. Challenges with the completion of the Vendor Due Diligence for Estates need to be managed. Adequate preparation needs to be made for the national discussions - including a firm schedule and sequence of meetings .	Continue to refine and apply the acquisition programme plan with milestones and reporting structures. Ensure the additional resources allocated to the GMHSCP/NHS I team are used to best effect. Continue regular "stock take" meetings between Chief Execs. Finance Working Group (sub-group of PAHT Transaction Board) to provide effective management of Counterfactual development.	Track record and experience gained from the CMFT / UHSM merger and full compliance with GMH&SCP governace arrangement and NHS I Regulatory processes.	**6** **3x2**

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Maintain a detailed NMGH acquisition project plan and milestones sensitive to MFT responsibilities, yet aligned to the PAHT Transaction Board Programme Plan for the dissolution of PAHT.	Director Single Hospital Service	On-going	Board of Directors	Clear milestones agreed and tasks/actions in place to deliver.	Programme management arrangements generally functioning well, but Financel work stream (Counterfactual development, funding discussions, etc) still likely to be the most significant rate-determining process.

Principal Risk: 3. There is a risk that decisions about NMGH service provision taken by Commissioners and/or SRFT in the period prior to acquisition could change the nature of these services and the role of NMGH within the Manchester healthcare system and the MFT service strategy.	Enabling Strategy	Associated Committee
	Single Hospital Service	Board of Directors
	Lead Director	Operational Lead
	Director Single Hospital Service	Director Single Hospital Service

Inherent Risk Rating Impact / Likelihood	Consequences	Controls	Current Risk Rating Impact / Likelihood	Gaps in Control	Gaps in Assurance	Potential Assurance	Positive Assurance	Target Rating Impact / Likelihood
9 3x3	The effect would be potentially to fragment or destabilise services and reduce the potential Single Hospital Service benefits of acquiring NMGH .	MFT's membership of the GMHSCP Transaction Board and sub-groups. MFT's involvement in the NM Strategy Board, NM Master Planning group and other subcommittees. Also, MFT involvement in other GMHSCP forums (e.g. Theme 3, SPB, PFB). Stocktake of existing NMGH services that has been carried out. MFT service strategy development programme takes account of NMGH services. MFT / MHCC working relationship.	6 3x2	SRFT is currently managing services at NMGH and working with some Commissioners to make decisions about service provision on the NMGH site. Decisions about NMGH are not totally within the control of MFT.	Lack of visibility of changes being made at service level if these are not communicated at NM Strategy Board or through the PAHT Transaction Board Commissioning sub-group.	Feedback from clinical teams at MFT and PAHT, providing routes to communicate any service changes to MFT corporate level if needed. Increased understanding of current NMGH service provision through service familiarisation and categorisation process.. MFT sighted on SRFT proposals for PAHT Financial Recovery Plan (through dialogue between DoFs). PAHT Transaction Board Commissioning Strategy sub-group assessment and control of any changes proposed at NMGH.	Agreements that April 2017 should be the baseline for the NMGH services for the purposes of the transaction, subject to PAHT Financial Recovery Planning process.	3 3x1

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Strengthen intelligence by building links with NMGH clinical community and wider stakeholders. Continue to build working relationships with MHCC with regard to NMGH.	Director Single Hospital Service	On-going	Board of Directors	Better information on which to build challenges to any proposed services changes at NMGH.	The eventual recognition of MFT's legitimate interest in the current PAHT Financial Recovery Plan process is helpful. Otherwise, too early to determine.

Principal Risk: 4. There is a risk that the proposed transaction could create uncertainty amongst staff at NMGH and this could exacerbate recruitment and retention difficulties, particularly if the transaction process is protracted.			Enabling Strategy			Associated Committee		
			Single Hospital Service			Board of Directors		
			Lead Director			Operational Lead		
			Director Single Hospital Service			Director Single Hospital Service		
Inherent Risk Rating Impact / Likelihood	**Consequences**	**Controls**	**Current Risk Rating Impact / Likelihood**	**Gaps in Control**	**Gaps in Assurance**	**Potential Assurance**	**Positive Assurance**	**Target Rating Impact / Likelihood**
16 4x4	If recruitment and retention difficulties are exacerbated this could mean that MFT would acquire an organisation with significantly worse staff shortages.	MFT and SRFT both recognise the issue and will work together to mitigate the risk. As a first step joint recruitment activity across MFT and NMGH for consultant medical staff in hard-to-fill services has already commenced and will continue. Communications and engagement work with NMGH staff has been ongoing since Project 1 and will continue for the duration of Project 2. Partnership arrangements (e.g. staff side) are currently being reviewed to take account of NMGH requirements.	16 4x4	Greater Manchester Health and Social Care Partnership (GMHSCP) has over-arching responsibility for communications about the dissolution of PAHT, therefore MFT does not have complete control over the content or timing of communications messages. In addition, communications need to be agreed across multiple partners which can cause delays.	Generation of key messages for staff (and other audiences) following Transaction Board meetings is not working effectively. Development of communications materials (eg Frequently Asked Questions) is slow. Arrangements for engaging with key stakeholders are not effective.	Production of more extensive communications materials. Creation of a tri-partite workforce partnership forum with trade unions, MFT and SRFT. Promotion of NMGH/MFT as an attractive place to work and learn.	Completion of the transaction Project Plan to inform communication and engagement activity with NMGH staff. Completion of a transaction communications plan signed-off by all parties.	**12** **4X3**

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Continue to engage effectively with GMHSCP and other partners in the transaction to influence key decisions. Establish and strengthen relationships with trade unions and SRFT..	Director Single Hospital Service	Ongoing.	Board of Directors	Solid information about the transaction to convey to NMGH staff and agreed mechanisms for communication and engagement.	Progress with staff communications activities continues to be too slow and too limited.

2	**Strategic Aim:** To improve patient safety, clinical quality and outcomes

Principal Risk: Underachievment of the A&E / Urgent Care Waiting Time standard could impact on clinical outcomes and patient experience and affect the Trusts reputation (001707)			**Enabling Strategy**			**Associated Committee**		
			Hospital Transformation Programme			Hospital Boards		
			Lead Director			**Operational Lead**		
			Chief Operating Officer			Director of Performance & Resilience		
Inherent Risk Rating Impact / Likelihood	**Consequences**	**Controls**	**Current Risk Rating Impact /Likelihood**	**Gaps in Control**	**Gaps in Assurance**	**Potential Assurance**	**Positive Assurance**	**Target Rating Impact / Likelihood**
20 4x5	Clinical Outcomes	The Accountability Oversight Framework (AOF) Board Assurance Report Reporting to the Quality and Scrutinity Committee. Board of Director receive routine information on operational performance, transformation improvements and system wide resilience to gain assurance of patient timely care and safety. GM Urgent Care Board and NHSI oversight. Manchester Urgent Care Transformation Board and supporting Operational De;ivery Groups. LHE Oerational Pressures Escalation Level reporting and teleconferences GM Emergency Hub daily reporting Daily SITREP reporting. Patient Flow Boards at MRI and Wythenshawe Hospitals. Transformation review of urgent of urgent care at Wythenshawe and MRI Hospitals with 30,60 and 90 day action plans. Urgent Care internal governance arrangements reviewed in August 18 and assurance arrangements in place to support weekly escalaton, weekend planning, group oversight.	20 4x5	Workforce pressures Demand levels in excess of planned levels Mobilisation of GM policies: Home of choice, D2 Assess, Stranded patient (reducing los) and ambulance handover. Mobilisation of OPEL across the economy Reliance on partners and external capacity to enable timely discharge and reduction of DToCs and stranded patients.	Factors which can cause significant and sustained surges in demand	Performance reporting to Board of Directors.	Risk Management Committee. Quality and Performance Scrutiny Committee. Board of Directors	**12** **3x4**

Risk Reduction Plan

Key Actions		**When**	**Monitoring Committee**	**Planned Outcome**	**Progress Evaluation**
MRI/WTWA have improvement programmes in place, focused on actions identified from the urgent care reviews undertaken in June/July. Weekly Hospital trajectories in place aligned to the urgent care review actions. Weekly assurance meetings in place All Hospitals have in place Capacity plans 18/19 MADE events with commissioning and provider partners. Increased Primary Care Streaming, GM review of models at Wythenshawe and MRI Hospitals. Capital upgrade to Wythenshawe complete, MRI schemes progressing through project RED, PED capital scheme at the design phase. Implementation of GM standards for patient choice, trusted assessor and Discharge to Assess. Participation in GM Action on A&E events. MHCC Trafford/Manchester Tactical urgent Care workshop 1.8.18. MFT representation. GM Health Care Professional workshop 8.8.18, MFT Representation . Mental Health Operational Group, commencing 16.08.18.	Clinical Divisions / Health System	on-going	Quality & Performance Scrutiny Board of Directors	Improved Patient Flow / Greater Seasonal resilience	MFT performance in line with the national profile. There has been improvement in the performance compared to winter despite significantly higher demand in Q1. Higher admissions coupled with ED majors/minors split of 45 and 55% respectively, suggest high acuity of patients. The Trust has opportunities in relation to reducing stranded patients, and are working with GM partnership in realtion to this. MFT July performance 86.54%. August performance (28.08.18) 89%, + 2.5% improvement from July.

Principal Risk: If mortality rates are not below 100 before rebasing then this may indicate poor quality outcomes and will impact negatively on organisational reputation (2848C)			Enabling Strategy				Associated Committee	
			Mortality Review Strategy				Mortality Review Group	
			Lead Director				Operational Lead	
			Medical Directors				Associate Medical Director / Director of Clinical Governance	
Inherent Risk Rating Impact / Likelihood	**Consequences**	**Controls**	**Current Risk Rating Impact / Likelihood**	**Gaps in Control**	**Gaps in Assurance**	**Potential Assurance**	**Positive Assurance**	**Target Rating Impact / Likelihood**
20 4x5	Poor patient outcomes Reputational impact Associated business continuity	Hospital/MCS Structure CD Programme and leadership development Standards of clinical care Pathways in place NICE/NCEPOD monitoring High Level Investigation thematic reviews Mortality Review Groups in place - Group arrangements being clarified Coding differences betweeen the larger sites under review and being standardised Revalidation and appraisal process Patient safety projects Clinical audit processes Structured Judgement Review training undertaken	**12** **4x3**	Coding inaccuracies Adherence to record keeping standards Gaps in compliance with new National guidance	Lack of confidence in accuracy of coding information	Intelligent Board Framework Mortality dashboard Benchmarking using NHSIC data Further clinical audits on pathways Health Education North West visit data Internal Audit Central Portal GMC survey data Monthly CQC feedback Full evaluation of Leadership schemes	Aqua Regional Report on Mortality Current Group SHMI and HSMR ≤100	4 2x2

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Development of a joint work programme by the Clinical Governance Team the Informatics Team and the OD&T Team on the quality of the patient record. See risk 2848 MFT 000748 for detailed action. Work underway to meet the requirements of the new National guidance. Standardisation of approach across the Group - use of the structured judgement review Establishment of a separate review panel for deaths of patinets with a recognised Learning Disability	Bronwyn Kerr - Associate Medical Director Sarah Corcoran - Director of Clinical Governance Alison Daily - Director of Informatics	2018	Quality and Safety Committee	SHMI <100 HSMR <100	SHMI ≤100 HSMR ≤100

Principal Risk: Underachievement of the Diagnostic 6 Week standard could impact on clinical outcomes and patient experience, and affect the Trusts reputation (001701)			Enabling Strategy			Associated Committee		
			Transformation Programme			Transformation Programme Board		
			Lead Director			Operational Lead		
			Chief Operating Officer			Director of Performance & Resilience		
Inherent Risk Rating Impact / Likelihood	**Consequences**	**Controls**	**Current Risk Rating Impact /Likelihood**	**Gaps in Control**	**Gaps in Assurance**	**Potential Assurance**	**Positive Assurance**	**Target Rating Impact / Likelihood**
16 4x4	Clinical Outcomes	Accountability Oversight Framework Board Assurance Framework and Board Assurance report provides group monitoring and governance. Patient Access Policy Hospital/MCS operational KPI meetings Recovery trajectories in place for risk tests. Monthly forecasting in place for all sites	16 4x4	Demand in excess of planned levels National cancer campaigns Patient Choice Failures in equipment Workforce pressures	Reliance on private sector GM capacity constraints across a number of providers	Performance reporting to Quality and Performance Scrutiny Committee and Board of Directors.	Risk Management Committee. Quality and performance Scrutiny committee. Board of Directors	**12** **4x3**

Risk Reduction Plan

Key Actions		When	Monitoring Committee	Planned Outcome	Progress Evaluation
Recovery trajectories refreshed in July 2018. completion of capital works and opened new Adult Endoscopy department on the MRI site, securing JAG accreditation and providing additional capacity. RMCH endoscopy - securing of additional ad-hoc sessions and workforce to increase capacity and reduce the backlog. Paediatric MRI - additional anaesthetic sessions secured from the end of August onwards, however demand has increased in excess of these levels and therefore further recruitment for additional paediatric anaesthetists is ongoing. Interim additional waiting list sessions being undertaken. Implementation of the business case for the 3rd MRI scanner	Clinical Services	Trajectory to meet 1% standard in Q3 2018/19	Quality and Performance Scrutiny Committee	Waiting times delivered	MFT Diagnostic performance is better than the national position, with demand increases in line with the national profile. Significant improvement has been sustained over the last four months. Wythenshawe site continue to provide strong performance of below 0.5% and this is forecast to continue. Performance trajectories are in place for the Oxford Road Campus with actions taken to address immediate and longer term sustainability of diagnostic performance. MFT has reported 1.59% for July. Areas of risk and dependant upon appointment of substantive consultant anaesthetists is Paediatric MRI.

Principal Risk: Underachievement of the Cancer Waiting Time standards could impact on clinical outcomes and patient experience, and affect the Trusts reputation (001708)			Enabling Strategy: Hospital Transformation Programme			Associated Committee: Hospital Boards		
			Lead Director: Chief Operating Officer			Operational Lead: Director of Performance & Resilience		
Inherent Risk Rating Impact / Likelihood	**Consequences**	**Controls**	**Current Risk Rating Impact / Likelihood**	**Gaps in Control**	**Gaps in Assurance**	**Potential Assurance**	**Positive Assurance**	**Target Rating Impact / Likelihood**
16 4x4	Clinical Outcomes	Accountability Oversight Framework Board Assurance Report Group Cancer Committee, underpinned by Hospital/MCS Cancer Boards Patient Access Policy Cancer dashboards in place. Group and local PTL meetings and management of patients through the pathway. RCAs undertaken for all breach patients Harm reviews undertaken for any patient +104 days on a pathway Escalation process in place to ensure timely action of patients along the pathway. GM Cancer Access Policy updated and signed off by NHSI in February 18. Trust Capacity Group receives risk assessment/capacity plans for national cancer campaigns to mitigate demand increases. Cancer peer review undertaken on an annual basis and completed in June 18. Trust compliant with the 10 High Impact Actions for Cancer, and has reviewed national best practice ensuring this is taken into consideration within the Trust action plan Trust Action plan in place, which has been externally assured by NHSI/GM Partnership	16 4x4	1. Pathway management across multiple Trusts. 2. Patient choice 3. Demand in excess of planned levels 4, Critical care constraints affecting elective activity 5. Diagnostic capacity pressures impacts on pathways.	Adherence to GM developed cancer pathways Surges in demand. Changes to national cancer standard, breach allocation.	Performance reporting to Board of Directors. Oversight of performance delivery at the Trust Cancer Committee chaired by the COO Performance oversight through local Hospital Executives.	Risk Management Committee. Quality and performance committee. Cancer Board	**12** **3x4**

Risk Reduction Plan

Key Actions		When	Monitoring Committee	Planned Outcome	Progress Evaluation
Cancer site level action plans - focused on increasing capacity for first appointment, diagnostic scanning and reporting and surgical capacity in Urology. Hospital Cancer Boards and operational KPI meetings undertake local actions in response to capacity pressures. Weekly monitoring/management of individual patients that are +30 days on the PTLs Perfect month planned for LGI in September. MRI. Task force being established with Radiology and MRI to support delivery of the standard in Q3 Cancer site pathways - lung working to implement optimum pathway.	Hospital Executives, Corporate Performance Team	Q3 18/19.	Cancer Committee	Delivery of Cancer Standards	The Trust is underperforming against the 62 day standard although this has remained stable despite significant increase in excess of the national profile, +12% increase in Q1. Wythenshawe site continues to have strong performance against the 62 day standard. GM has a strong track record of performance against the 62 day standard, but is forecasting Q1 underperformance of the standard. MFT provisional Q1 performance of 83.21% (as of 15.08.18) still subject to change.

Principal Risk to Key Priority:	Failure to deliver the Medical Workforce Projects		Enabling Strategy				Associated Committee	
							HR Scrutiny Committee	
			Lead Director				Operational Lead	
			Medical Directors				Dave Pearson/Claire Macconnell	

Inherent Risk Rating Impact / Likelihood	Consequences	Controls	Current Risk Rating Impact / Likelihood	Gaps in Control	Gaps in Assurance	Potential Assurance	Positive Assurance	Target Rating Impact / Likelihood
12 4x3	Failure to deliver the Medical Workforce projects could lead to patient safety risks associated with inability to fill medical shifts, loss of control of agency and internal locum spend, and impact on Turnaround	1.Group Executive Sponsors of Medical Workforce Workstream 2. Hospital management teams 3. Accountability Oversight Framework (AOF) 4. Job Planning Tool implementation and outputs 5. 7DS Group and 7DS RAG-rated Action Plan 6. 7DS Joint Assurance Group (Central and Wythenshawe) 7. HR Scrutiny Committee oversight 8. Finance Scrutiny Committee oversight 9. LNC liaison 10. Turnaround Committee 11. Medical Staffing Costs monthly dashboard 12. Internal Locum Dashboard (eWIP) 13. Top Earners (Additional Shifts) Report 14. WAVE monitoring 15. NHS I Weekly Agency Report 16. Trackers to underpin locum and agency use within the Divisions 17. MIAA Audit Recommendations	12 4x3	Consistency in approach of Hospitals/ Divisions Consistency in approach at regional and national level (Different levels of engagement displayed by Hospitals/ Divisions) Consistency around key Medical Workforce processes (e.g. Annual Leave, Agency approval process) Differing approaches to management and reduction of locum and agency spend across Hospitals/ Divisions Gaps in the workforce information recorded and monitored by Hospitals/ Divisions;and lack of tools to effectively manage available workforce information No prompts in the paper patient record - EPR would resolve this (7DS) Transition to new Hospital Management Structures and dissolution of MWP Team	Assurance that key information is cascaded appropriately within Hospitals/ Divisions (e.g. from Senior Management Teams down) Robustness of Job Planning Tool and ensuing reports Difficult to qualify/ quantify impact of Medical Workforce projects on Turnaround MWP Team will cease to exist in its current format	CEO Forum reports Regular updates to Joint Group Medical Director and Group Director of Workforce and OD HR Scrutiny Committee progress reports NHSE Monitoring Reports Turnaround Control Group	Steady progress to 100% Consultant Job Plans available via Job Planning tool and evidence of annual review Reducing Locum/ Agency Spend Visible improvement in each 7DS Self Assessment Survey cycle (currently Spring) Tangible progress/ completion against recommendations set out in the MIAA Audit of Locum and Agency Staff	6 3x2

Risk Reduction Plan

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Update
On-going Actions from August and October BAF Documents					
Provide training (Job Planning Tool; Team Job Planning)	Alison Wake, Ash Sukthankar	Q1	- CEO Forum - HR Scrutiny Committee - Turnaround Control Group - Quality and Performance Scrutiny Committee - Board of Directors - GMB - Operational Workforce Committee	All Consultant Job Plans are input to the Job Plan tool; and approved Divisions are engaged in Team Job Planning; and can use reports produced by the Job Plan tool to inform changes and improvements for the next job planning cycle	Job planning cycle for Job Plans effective 18/19 has begun, with Divisions undertaking Team Job Plan meetings prior to agreeing changes to individual job plans. 96% of consultants at Oxford Road a job plan created on the system, with the majority of those outstanding being new starters to MFT. A number of Team Job Plan training sessions have been successfully run on the Oxford Road campus; similar sessions have now been offered to South sites, to be arranged.
Provide regular job plan status reports to Divisions	Cameron Chandler	On-going		Divisions are well-informed regarding the progress of input and approval of Job Plans	Weekly reports are sent to Hospital /MCS Medical Directors and HR Directors with the overall status of job plan progress and the status of each individual clinician in their Hospital / MCS.
Coordinate MIAA audit of processes for booking locum medical staff; and work with Divisions to standardise processes and implement recommendations from this audit	MVP Team	Q2/3		Reduction in locum and agency spend following the introduction of improved processes and/or replication of areas of good practice Trust-wide	MIAA Report and recommendations have been sent to each Hospital and the actions are being managed accordingly in new hospital structures. New electronic system is being introduced across Trust so that all medical agency bookings are electronic. Suite of reports being generated to help manage agency action plans
7DS Autumn Survey (September)	Divisions, supported by Cameron Chandler	Q2		Improvement in Trust-wide and individual Division results from the Spring Survey	The Spring 7DS Survey ran from 10th - 17th April. There was an overall improvement from the last survey for Oxford Road Campus for Standard 2, from 74% to 84%. All divisions saw an improvement. Results for this survey were for the whole of MFT for the first time and with the inclusion of Wythenshawe data, the Trust achieved the required 90% target for Standard 2.
Review Allocate products for Job Planning; Appraisal; and Medics' rostering: - Demonstrations of products - Commercial considerations (e.g. procurement, costs, SHS) - Development of Business Case	MWP Team	Q2		A robust Business Case is developed to support the introduction of a suite of tools that will provide a more detailed understanding of the medical workforce, enabling better management of this resource	Business Case Approved 26.02.18. Work has commenced on rolling out Allocate to the Oxford Road Campus for the job planning and medic rostering modules. These are currently in place in Wythenshawe . Work is being undertaken to align the job planning language across all Hospitals / MCSs.
Work with Divisions to begin the next cycle of Job Planning; and monitor progress	MWP Team	Q2/3		Divisions use Team Job Planning to update existing Job Plans and approve all Job Plans by close of 2018/19	Hospitals/ Divisions have been sent generic WAVE milestones in line with national job planning guidance as part of their Turnaround Opportunity Pack for Medical Workforce. These milestones have been discussed with Hospitals/ Divisions at their January meetings with the MWP Teams and have now been transferred to the individual hospital medical workforce boards for delivery
Support Divisions to identify persistent gaps in Junior Doctor Posts	MWP Team	Q3		Divisions are able to understand any recurrent or persistent gaps in staffing, and identify the best means of addressing these gaps (e.g. re-modelling, making posts more attractive through rotations etc)	Hospitals are now managing this workstream via their individual medical workforce boards. The Group Medical Education team have been successful in application for Tier 5 employment status for international doctors which will allow the development of Group wide medical rotations
Work with Divisions to establish Local Consistency Panels for Job Plans	MWP Team	Q3		Each Division has a Local Consistency Panel that is able to resolve discrepancies and locally mediate any disputed job plans	All hospitals are in the process of setting up consistency panels as part of their medical workforce boards
Create Transition/ Handover Pack for Hospitals/ Divisions	MWP Team	Q4		Hospitals/ Divisions are well positioned to pick up the Medical Workforce agenda, and have clarity regarding the escalation and Group assurance routes	Completed 27.02.18
Handover meeting with the Medical Workforce Workstream Executive Sponsors	All Hospitals/ Divisions; MWP Team	Q4		Hospitals/ Divisions outline how they will pick up the Medical Workforce workstream agenda, and provide assurances to the Group Executive Sponsors of their commitment to deliver this workstream	Completed 27.02.18

Principal Risk: Underachievement of the Referral To Treatment 18 week standard could impact on clinical outcomes and patient experience, and affect the Trusts reputation (Risk 001493)			Enabling Strategy				Associated Committee	
			Performance Management				Quality & Performance Scrutiny	
			Lead Director				Operational Lead	
			Chief Operating Officer				Director of Performance & Resilience	
Inherent Risk Rating Impact / Likelihood	**Consequences**	**Controls**	**Current Risk Rating Impact / Likelihood**	**Gaps in Control**	**Gaps in Assurance**	**Potential Assurance**	**Positive Assurance**	**Target Rating Impact / Likelihood**
16 4x4	Clinical Outcomes	Governance and Oversight provided by Accountability Oversight Framework, Board Assurance Framework and exception reporting. Patient Access Policy Weekly RTT Task Force in place chaired by Deputy COO and Director of Informatics, with supporting action plan and commissioner support in place, PMO approach established from September. Hospital Boards and local KPI meetings to manage performance and capacity risks. Capacity and Demand planning completed for 18/19. Hospital Data Quality Audits continue, with planned audits of all waiting lists. RTT Trajectories in place for all Hospitals/MCS External audit on data quality undertaken By Deliotte in 2017/18, outcomes reported in the Trust Quality Report.	16 4x4	Commissioner decisions around alternate providers Non compliant RTT PAS system. Outsourcing capacity and capability of additional capacity.	Robustness and quality of commissioned alternatives	Performance reporting to Board of Directors. Trust Performance and Delivery Assurance Group.	Risk Management Committee. Quality and performance Scrutiny Committee.	**12** **3x4**

Risk Reduction Plan

Key Actions		When	Monitoring Committee	Planned Outcome	Progress Evaluation
RTT Task force focusing on long wait patients, chaired by Deputy COO and Chief Informatics Officer, in place. supporting action plan in place and patients are being contacted to schedule surgery dates. Focus on clinical review and patient safety. RTT PMO approach to be established from September Continued timely validation by Hospital Sites Monthly data quality audits are on-going. Delivery of Divisional transformation and capacity plans. Hospital Site PTL meetings continue to ensure the effective management of waiting times. Standard Operating Policies are being developed to support Single Hospital Access Policy. Participation in GM master classes for RTT Participation in NHSI Demand and Capacity modelling training.	Hospital Sites	On-going	Quality & Performance Scrutiny	Activity Levels Delivered and Waiting times improve	Trust RTT performance whilst below the standard is better than national position, and contrary to the national and GM profiles the waiting list has remained stable MFT reported RTT performance of 89.29% for July. Achieving 89.47% on the Oxford Road campus and 88.96% at Wythenshawe Hospital. Following a review of longest waiting patients, and some subsequent investigation of the PAS system, along with capacity pressures within the Wythenshawe Plastics Service 293 +52 week waits have been reported to the Board of Directors in June, with a reduction seen in July with 228 breaches.

Principal Risk: If appropriate safeguarding systems and processes are not in place then Children and Adults at risk of abuse or neglect may not be safeguarded from harm			Enabling Strategy: Safeguarding annual plan			Associated Committee: Safeguarding Committee	
			Lead Director: Chief Nurse			Operational Lead: Group Deputy Chief Nurse	

Inherent Risk Rating Impact / Likelihood	Consequences	Controls	Current Risk Rating Impact / Likelihood	Gaps in Control	Gaps in Assurance	Potential Assurance	Positive Assurance	Target Rating Impact / Likelihood
15 5x3	Adults and children adults at risk of abuse or neglect may come to harm	1. Safeguarding Governance Structures in place. 2. Safeguarding policies and procedures. 3. Safeguarding Teams actively support staff. 4. Safeguarding lead Director oversees delivery and monitoring of annual safeguarding work programme and Assistant Chief Nurse for Safeguarding in post. 5. Directors of Nursing/Midwifery/Healthcare Professionals accountable for safeguarding within each hospital/MCS/MLCO. Medical Safeguarding Leads identifed for all hospitals/MCS/MLCO. 6. Named Doctors and Named Nurses in place to provide professional support and advice. 7. Senior representation at MSCB and MSAB and underpinning Leadership/Executive Groups to support statutory duty to cooperate. 8. Safeguarding adults and children's training programme in place and updated yearly as per Intercollegiate guidance to ensure up to date and relevant information is contained and staff have contemporary safeguarding information to support practice, and learning from SCRs/SARs/DHRs disseminated through safeguarding leads. 9. Safeguarding Supervision in place and monitored. 10. Learning Disability flag in place to alert LD Specialist Nurse to review patient. 11. Hospital/MCS safeguarding assurance processes to assess compliance with CQC requirements. 12. Incident reporting of non attendance by Trust staff at statutory child protection meetings in place. 13. Policies contain the most up to date information and guidance for the Trust to follow to ensure patients and clients at risk of abuse and neglect are protected. 14. Reports provided to statutory meetings if staff are unable to attend. 15. Child Protection Information Sharing System (CP-IS) in place in PED and Wythenshawe ED to alert Local Authorities to a child's ED attendance. Implementation of CP-IS progressing for MREH Emergency Eye Dept., Dental Hospital, Trafford UCC and Emergency Gynaecology Unit.	**10** **5x2**	1. Delays in Best Interest assessment and DoLS authorisation by Local Authority due to insufficient capacity to respond to high number of DoLS applications. 2. Inconsistent quality of MCA assessment and DoLS applications. 3. Not all hospitals achieve full compliance with required training attendance. 4. Limited LD specialist nurse capacity and no provision to cover leave.	1. OLM report does not provide detail of training attendance at a level to assure that an individual has undertaken training relevant to their role . 2. Invitations to case conferences and strategy meetings are not received at a single point therefore there is no single monitoring system for the Trust. 3. Prevent training compliance below target.	1. Incident Data. 2.Training attendance data. 3. Divisional Assurance assessments. 4. DoLS/MCA Assessment Records. 5. Annual Audit Programme Outcomes. 6. External Review (Ofsted/CQC inspection, Section 11 Audit, CCG review of safeguarding and LAC provision) 7. Case conference/strategy meeting attendance records 8. Post Transaction Integration Plan to integrate safeguarding function.	1. Annual Safeguarding Report to Board of Directors. 2. Hospital/Managed Clincal Service annual Safeguarding Work Programme, monitored by Safeguarding Committee chaired by Chief Nurse. 3. Hospital Managemet Team Safeguarding Assurance meetings (re: compliance with CQC regulations) with Group Deputy Chief Nurse, Assistant Chief Nurse (Safeguarding) and NED with safeguarding lead - reported to the Safeguarding Committee. 4. Completion of SCR actions - reported to the Safeguarding Committee. 5. Local Safeguarding Children's Board Section 11 audit - reported to the Safeguarding Committee. 6.Submission of MSAB Annual Assurance statement and supporting evidence.	**8** **4x2**

Risk Reduction Plan

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Deliver annual safeguarding work programme	Head of Safeguarding	31/03/2018	Safeguarding Committee	Safeguard people at risk of abuse or neglect	MFT Safeguarding Committee, chaired by Chief Nurse, established and meeting quarterly. Sub-Group structure ratified by Safeguarding Committee and sub-groups established. Safeguarding PTIP on track and nearing completion. Annual safeguarding work programme developed for 2018/19. Level 1 MFT safeguarding training developed and implemented, MFT Level 2 training is being finalised and will be implemented from September 2018. Level 3 safeguarding training package is being integrated and updated as per the safeguarding PTIP. Existing level 2 and 3 training maintained until the new integrated training programmes commence. Single Prevent training programme implemented across MFT. Integration of core safeguarding policies completed and programme of integration of underpinning safeguarding policies progressing as per schedule agreed by MFT Safeguarding Committee. MFT Hospital/MCS Safeguarding Assurance process ratified by Safeguarding Committee and will commence in Q2 2018/19. Assistant Chief Nurse (Safeguarding) and Head of Safeguarding leading work to integrate safeguarding teams. MSAB aware of delays in Best Interest assessment and DoLS authorisation. Following on from the Law Commission's recommendations to make changes to the DoLS process, the Mental Capacity (Amendment) Bill was introduced to the House of Lords on 3 July 2018 with a second reading on 16 July. The Bill is scheduled to progress to the House of Lords Committee stage on 5th September 2018. Positive section 11 Peer review meeting held with MSCB. Adult annual assurance statement completed and submitted to MSAB with positive feedback. CQC review of safeguarding children and looked after children services in Manchester conducted and report received in January 2018, highlighting many areas of good practice. Action plan progressing to address recommendations and monitored by Safeguarding Committee. Ofsed inspection of MCC children's services conducted in October 2017 and report published in December 2017 -identified good practice across the partnership, including MFT, and rating improved from Inadequate to Requires Improvement. Governance structure established for Mental Health Act (MHA) through the Safeguarding governance structure and expansion of MHA administration capacity progressing.

Principal Risk: If the Group fails to demonstrate and evidence high quality standards consistently in the delivery of care, leadership and use of resources then the organsation may fail to achieve appropriate ratings from regulatory bodies (5447C)	Enabling Strategy	Associated Committee
	Quality and Safety Strategy / OD&T Strategy / Transformation Strategy	Quality and Safety Committee
	Lead Director	Operational Lead
	Medical Director / Chief Nurse	Director of Clinical Governance

Inherent Risk Rating Impact / Likelihood	Consequences	Controls	Current Risk Rating Impact / Likelihood	Gaps in Control	Gaps in Assurance	Potential Assurance	Positive Assurance	Target Rating Impact / Likelihood
16 4x4	Reputational impact Associated business continuity	SHINE Oversight Group Executive Leadership Regulatory Engagement Meetings Organisational Governance Structure Self Assessment Programme Organisational self assessment Policies & Procedures Pathways Values & behaviours Ward accreditation programme	16 4x4	Self assessment has proven to be unreliable.	CQC Comprehensive Inspection Report now >12 months old Well-led assessment not yet undertaken Use of resources assessment not yet undertaken	Group and Hospital Governance arrangements Board Assurance Framework CQC Insight Report - currently no overall rating available Board of Directors Reports Internal / External Audit Patient and Staff surveys External Visit Data CQC internal monitoring CQC relationship meetings IQP data Clinical quality metrics Accountability Oversight Framework data	CQC Comprehensive Inspection Report Nov 15 and January 16 Quality Review reports 2016 Deanery and GMC training survey	9 3x3

Risk Reduction Plan

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
As a new organisation, MFT has agreed clinical and other governance structures to ensure that evidence of the high quality, evidence based safe care and the 'well-led' requirements can be met. The clinical governance arrangements are now largely in place and a self assessment of the well-led KLOE has been undertaken. The CQC comprehensive inspection KLOE have been shared across the Hospitals and MCS and a self asessment process has been completed. A 'Continuing to Shine' Group has been established and a number of workstreams are now in place. The Clinical Governance Team are reviewing the previous legacy reports and action plans.	Sarah Corcoran	Oct-18	Quality and Safety Committee	Movement to a CQC rating of 'outstanding' or 'good' across all services Compliance / appropriate ratings across all other external regulation	Timeline complete for CQC/NHS I assessments Executive leadership arranagements in place Structure agreed Self-assessment process underway

Principal Risk: If patient care is not delivered to a high level of safety and quality patients could be harmed, staff could be harmed, the organsation could fail to meet regualtory standards and reputation would suffer.			Enabling Strategy			Associated Committee		
			Quality and Safety Strategy / OD&T Strategy / Transformation Strategy			Quality and Safety Committee		
			Lead Director			Operational Lead		
			Medical Director / Chief Nurse			Director of Clinical Governance		
Inherent Risk Rating Impact / Likelihood	**Consequences**	**Controls**	**Current Risk Rating Impact / Likelihood**	**Gaps in Control**	**Gaps in Assurance**	**Potential Assurance**	**Positive Assurance**	**Target Rating Impact / Likelihood**
15 3x5	Poor patient outcomes Poor staff experience Failure to meet regulatory standards on quality and safety Reputational impact Associated business continuity	Organisational Clinical Governance Structure - including specialist functions such as Infection Control, VTE and EPR Board Organisational self assessment Education and Training Integrated Governance System Policies & Procedures Pathways Values & behaviours Ward accreditation programme	**9** **3x3**	Self assessment has proven to be unreliable.	CQC Comprehensive Inspection Report now >12 months old	Board Assurance Report Accountability Oversight Framework Board of Directors Reports Internal Audit Patient and Staff surveys External Visit Data Internal Quality Review Reports CQC internal monitoring / Insight Reports IQP data Consultant metrics Clinical Audit Data - local and National Peer Review Processes	CQC Comprehensive Inspection Reports Nov 15 and Jan 16 in legacy organisations Quality Review reports 2016 in CMFT Legacy organisaiton Deanery and GMC training survey CQC Insight Reports	**9** **3x3**

Risk Reduction Plan

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Comprehensive programme of work on communication of diagnostic and screening test results (Risk 3305 MFT/001701)	Sarah Corcoran/Gill Bell	January 2019	Informatics Strategy Board	10% reduction in harm	See risk register
Comprehenisive programme of work on meeting all infection control standards (Risk 1970 MFT/001123)	Andy Dodgeson / Moira Taylor	October 2018	Infection Control Committee		
Comprehensive programme of work on the management and quality of the health record (Risk 5045C/5048C/5300U MFT/000359)	Sarah Corcoran / Alison Dailly	January 2019	Informatics Strategy Board		
Comprehensive programme of work on the care of patients detained under the Mental Health Act in acute care (MFT/000867)	Sarah Corcoran	Complete	Quality and Safety Committee		

Principal Risk: Availability and Management of Patient Records Risks 5045C/MFT/000359/5300U			Enabling Strategy			Associated Committee	
						Group Informatics Strategy Board	
			Lead Director			Operational Lead	
			Group Chief Finance Officer			Group Chief Informatics Officer	
Inherent Risk Rating Impact / Likelihood	**Consequences**	**Controls**	**Current Risk Rating Impact / Likelihood**	**Gaps in Control**	**Gaps in Assurance**	**Potential Assurance**	**Positive Assurance**	**Target Rating Impact / Likelihood**
16 4x4	Patient Harm as a result of inaccessibility of case notes Reputational Damage arising from poor quality data. Inadequate assurance on quality of care. Financial and reputational damage arising out of failure to meet regulatory quality standards such as CQC. Financial damage resulting from inaccurate coding	Oxford Road Campus (ORC): Best Practice Standards for Records Management in place & achievement of the standard monitored through a suite of KPIs which improve availability at point of need. Improve visibility of electronically captured patient information by providing access through one system. Creation of Case Notes reduced to 5 areas and the PAS district number has replaced the maually allocated case note number for ORC, to become the unique identifier in the system. Clinic preparation for ORC has moved to ORC Health Records Hub 3rd Floor RMCH. New sets of case notes now labelled with barcodes to faciliate tracking. Obstetric notes will be retained in the Health Records Hub (3rd Floor RMCH) from Sep 2018.	16 4x4	Best Practice Records Management Standards not followed Full KPI suite not yet embedded into operational practice Full EPR not in place	Monitoring of available case notes not in place.	Accurate monitoring and identifying issues in place and reporting to the Group Information Governance Board.	Health Records Improvement Programme in place and funded reporting to formal Group Informatics Governance Board.	**6** **3x2**

Risk Reduction Plan

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Significant progress made on a range of Actions completed 2017/18. Continued tactical development of EPR in place to for 2018 -2020 and procurement and full implementation of new EPR solution. Ongoing implementation of best practice standards for records management implemented through Health Records Improvement Programme. Further Business Case approved to facilitate the turning of the whole library to Terminal Digit Filing. Patient Records campaign on what is a patient record and promoting the use of the electronic systems has commenced.	Director of Digital Delivery	On-going	Group Informatics Strategy Board (Performance Indicators on availability are monitored at the Group Information Governance Board which is chaired by the Group CIO)	Best Practice Health Records Standards in place.	

Principal Risk: Cyber Security Risk - Trust IT Risk: MFT/000363			Enabling Strategy			Associated Committee	
						Group Informatics Strategy Board	
			Lead Director			Operational Lead	
			Group Chief Informatics Officer			Group Chief Informatics Officer	
Inherent Risk Rating Impact / Likelihood	**Consequences**	**Controls**	**Current Risk Rating Impact / Likelihood**	**Gaps in Control**	**Gaps in Assurance**	**Potential Assurance**	**Positive Assurance**	**Target Rating Impact / Likelihood**
15 5x3	If there are malicious attacks to IT system, vulnerabilities could compromise or disable access to systems and or data. Delivery of patient care could be affected by loss of access to systems and/or data leading to patient harm and patient experience adversely impacted (e.g. wait times increased) as well as Financial & reputational damage.	Appropriate Controls are in place to manage the threat of cyber attack and other IT vulnerabilities and security threats.	15 5x3	Reguar reviews are undertaken to manage any gaps in control & mitigate any emergent risk.	Emerging Cyber Risk may mean gap in assurance through non-availbility of specialist knowledge at point of risk.	Independent assurance scheduled at regular intervals to ensure best practice in addressing cyber threat and other IT security vulnerabilities	All agreed actions carried out in line with approved plan timescales.	**12** **4x3**

Risk Reduction Plan

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Continual service improvement in key IT infrastructure and raising organisation understanding through appropriate guidance, to reduce the incidence and impact of cyber risk. Additional improvements have been carried out and Cyber Essentials pluss action plan updates submitted to NHS Digital for ratification.	Group Chief Informatics Officer	on -going	Group Informatics Strategy Board	Minimise risk to the Trust.	

Principal Risk: If the Trust fails to recruit and retain a nursing and midwifery workforce to support evidence based nursing and midwifery establishments due to national Nursing and Midwifery workforce supply deficit, the quality and safety of care may be compromised			Enabling Strategy				Associated Committee	
			Nursing and Midwifery Retention Strategy and Recruitment Work Programme				Nursing, Midwifery& AHP Professional Board and Human Resources Scrutiny Committee	
			Lead Director				Operational Lead	
			Chief Nurse				Corporate Director of Nursing	
Inherent Risk Rating Impact / Likelihood	**Consequences**	**Controls**	**Current Risk Rating Impact / Likelihood**	**Gaps in Control**	**Gaps in Assurance**	**Potential Assurance**	**Positive Assurance**	**Target Rating Impact / Likelihood**
16 4x4	Compromised care and patient experience. Poor retention of nursing and midwifery staff.	1. Nursing, Midwifery and AHP Professional Board, Clinical Risk Management Committee and HR Scrutiny committee monitor controls in place 2. Domestic recruitment 'proud to care' campaign continues to attract applicants. 3. Candidate engagement processes established to maintain candidate interest in role from application to commencing in post. 4. Regular reports from recruitment management system to identify delays in process and enable actions to be taken 5. Programme of international recruitment from EU and India is in place 6. Nursing and Midwifery retention strategy 7. Monthly ESR reports established to monitor turnover and new starter activity 8. Acuity and dependency monitoring undertaken in all areas where validated tool is available 9. Developed reporting mechanism from e rostering and safe care system to enable effective management of resource in line with patient acuity 10. Implemented revised nursing and midwifery workforce reporting processes aligned with finance and workforce planning data 11. Board support to recruit to turnover for band 5 and band 2 roles within the Trust 12. Analysis of integrated governance information such as complaints and incidents against staffing levels	**9** **3x3**	Current recruitment process provides limited assessment for values and behaviours Embedding use of E roster and safe care in real time within all clinical areas. Brexit and regulatory changes to English language requirements have led to a marked decline in the number of EU nurses applying to work in the UK which has an impact on supply.	Ability to reduce number of vacancies against the national workforce supply issues in terms of qualified nurses and midwives.	1. Recruitment campaigns resulting in substantive appointments of both nurses and midwives 2. Unify data reported from Health Roster to ensure accuracy of planned and actual staffing data 3. On target for progress against recruitment plans monitored through nursing and midwifery recruitment meetings. 4. Regular reports from recruitment management system to identify delays in process and enable actions to be taken 5. Reduced turnover and improved retention rate in band 5 roles. 6. Time to fill reporting by recruitment phase to support continuous improvement cycle 7. Reduced overall qualified vacancy levels and vacancy levels of staff nurse (band 5 roles) since July 2017 8. E Rostering and Safe care module used effectively by all wards and departments 9. Control and challenge meetings implemented in all areas to ensure effective rostering of staff 10. Programme of work in partnership with HR to reduce nursing and midwifery absence rates	1. Bi annual Safer Staffing reports to Board of Directors. 2. Nursing and Midwfery vacancies and turnover reported againsnt Hospital/MCS AOF KPI's 3. Reports to Group Management Board, HR Scrutiny Committee, Risk Management Committee. 4. Establishments reviewed as part of annual budget setting process or when there are any significant changes in service or patient cohort. 5. Acuity and dependency monitoring undertaken in all areas where a validated tool is available. 6. Recruitment & Retention Strategy to be developed in partnership with HR and through trust wide engagement to reflect needs of new organisation 7. The Trust is part of GM pilot for trainee nursing associate roles. A second cohort of trainees commenced in the Trust in May 2018 resulting in a total of 171. A third group of 40 trainees are due to commence in September	**6** **2x3**

Monthly

Key Actions	Responsibility	When	Monitoring Committee	Progress Evaluation
Please see actions detailed in Trust Risk Management Report (risk 4117C) Revision of nursing and midwifery recruitment plans and retention strategy.	Nursing and Midwifery Workforce Development Group	Sep-18	Nursing, Midwifery and AHP Professional Board	Programme of recruitment events ongoing to support attraction of staff. Recruitment and retention schemes have resulted in reduction in vacancy rate for band 5 roles from 18% (July 2017) to 15.4% (April 2018). It is predicted that the vacancy rate will increase slightly in Q1-2 whilst awaiting staff to complete programmes of training. There are 326 student nurse and midwives progressing through recruitment checks who will commence in post following graduation in September 2018. There are 63 wte nurses and midwives currently with conditional jobs offer due to commence in Trust before October 2018. Trustwide nursing open days are planned for October 2018 to attract Registered, student and return to practice nurses into the Trust. Improved retention rate of band 5 staff nurses and midwives over last 12 months to 86.9% . The annual Trust turnover rate for nursing and midwifery is 14.8% (Shelford average 13.8%). In January 2019 the first cohort of 81 TNAs will qualify - a recruitment event is planned for September 2018. A second cohort of 90 TNAs commenced in May 2018 bringing the total number of trainees to 171wte The Trust continues to source nurses from overseas (India) through targeted overseas recruitment campaigns. The total number of International nurses recruited through the Trusts overseas recruitment campaign is 215 since December 2015 with a further 106 nurses who have achieved the English language requirements and are currently in the NMC application process. Monthly SKYPE recruitment also takes place to recruit nurses from India and UAE. This programme of work will continue in 2018/19. Divisional sickness/absence reduction trajectories established with associated WAVE schemes.

3	Strategic Aim: To improve the experience of patients, carers and their families

Principal Risk: If we do not comply with appropriate building regulations or maintenance requirements there is a risk to the critical infrastructure of the hospitals that could result in harm to staff, patients or the public			Enabling Strategy: Safe operation of the site infrastructure			Associated Committee: CEO Forum		
			Lead Director: Chief Operating Officer			Operational Lead: Group Director of Estates & Facilities		
Inherent Risk Rating Impact / Likelihood	**Consequences**	**Controls**	**Current Risk Rating Impact / Likelihood**	**Gaps in Control**	**Gaps in Assurance**	**Potential Assurance**	**Positive Assurance**	**Target Rating Impact / Likelihood**
15 3x5	Loss of operational area(s) and potential impact for harm to staff, patient of public	Detailed business continuity plans to mitigate the impact of any failure Multiple redundancy and layered systems to prevent the escalation of an issue (eg fire alarms; fire doors and sprinkler system). Agreed maintenance regimes to ensure the infrastructure is maintained to the required level External reviews of systems and processes to highlight gaps and required actions	15 3x5	Not all maintenance regimes have been adhered to and not all infrastructure schematics accurately represent the 'as built' estate Some controls are reactionary, based on minimising impact should an issue occur	Time taken to complete external reviews and surveys & undertake any required remedial works	Ongoing survey and audit reports to reduce level of unquantified risk and support that adequate controls are in place. Expert analysis of risk as developed through Trust and independent experts to confirm the adequacy of the controls	Ongoing certification of actions completed by the team undertaking the remedial actions reducing the number of outstanding defects Focus remains on key clinical areas for remedial actions	**6** **3x2**

Risk Reduction Plan

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Complete the ongoing survey works across all sites Complete all remedial works across the sites	Director of Estates & Facilities	Jun-19	CEO Forum	Survey work completed & remediation carried out	Survey and remediation work on track with the exception of electrical infrastructure on the Oxford Road site. Further work ongoing with ProjectCo and Sodexo to address this

Principal Risk: If there are insufficient trained mental health support this could impact negatively on patient outcomes and experience (Risk 4140C)			Enabling Strategy: Quality and Safety Strategy			Associated Committee: Quality and Safety Committee		
			Lead Director: Medical Director			Operational Lead: Director of Clinical Governance		
Inherent Risk Rating Impact / Likelihood	**Consequences**	**Controls**	**Current Risk Rating Impact / Likelihood**	**Gaps in Control**	**Gaps in Assurance**	**Potential Assurance**	**Positive Assurance**	**Target Rating Impact / Likelihood**
16 4x4	Poor patient outcomes Poor patient experience	Safeguarding Team Policy guidance on the Mental Health Act specifically Guidance on the Mental Capacity Act Training to ensure clincal understanding on quality of care Mental Health Nurses Mental Health Act Manager Staff expertise Specialist recruited to review	**9** **3x3**	Formalised arrangements for Psychiatric Liason support	Lack of qualititative data on services	Clinical audit Patient feedback External review	None	**6** **3x2**

Risk Reduction Plan

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Working with Greater Manchester Mental Health Foundation Trust and Manchester CCG have formalised arrangements. Support funded and recruited to maintain progress in year Group governance structure now established	Sarah Corcoran/Sue Ward	Mar-18	Quality and Safety Committee	Support available to patients and staff when needed	Sitle level meetings now in place for the larger sites Policies drafted and in some cases approved

Principal Risk: If appropriate systems and processes are not in place to support End of Life Care this could result in poor experience for patients and their families approaching end of life and variation in service delivery (Risk 4548)			Enabling Strategy: Palliative and End of Life Strategy 2016-2018 Lead Director: Chief Nurse			Associated Committee: Adult Palliative and End of Life Group Operational Lead: Director of Nursing, MREH/UDHM (EoL Care Lead)		
Inherent Risk Rating Impact / Likelihood	**Consequences**	**Controls**	**Current Risk Rating Impact / Likelihood**	**Gaps in Control**	**Gaps in Assurance**	**Potential Assurance**	**Positive Assurance**	**Target Rating Impact / Likelihood**
16 4x4	Variation in the levels of assurance which can evidence the delivery of End of Life Care across the different models across the Trust Risk of poor experience for patient's and their family approaching the end of life	1.Executive lead for End of Life care - Chief Nurse, who chairs Executive Oversight Group. 2. Reporting and goverance structure implemented and in place, governance harmonisation plans in place from June 2018 from to drive improvements across MFT. 3. Adult Palliative and End of Life Group and Babies, Children and Young People End of Life Group chaired by clinical leads. 4. Palliative and End of Life care strategic plans and work programmes delivered through respective groups, overseen by Executive Oversight Group. 5. Implemented Adults Priorities of Care for the Dying Person care plan to support evidence based care delivery for patients and families, audit programme in place. 6. Single MFT standard developed for End of Life Care. 7. Revision and updating of number of policies and guidelines available through the Specialist Palliative Care website to support evidence based quality end of life care. 8. Appointment of x 1.8 Consultants to proved 7 day pallaitive service for ORC Adult patients. 7 day palliative care nursing service in place on ORC. Plans to develop RMCH Palliative Care Team in progress - August 2018. 9. Participating in the NHS England programme, Transforming EoLC in Acute Hospitals Programme.	4 2x2	None	Variation in evidence to demonstrate that palliative and end of life care to patients and their families is evidence based and meets their individual needs across the different models within the Trust.	1. Palliative and End of Life Care Strategy including Children, being reviised as part of harmonisation process, draft document circulated for comments Auguist 2018. 2. Reports to the Quality and Safety Committee from Palliative and End of Life Work Groups delivering related work programmes. 3. Updates to Risk Managment Committee, with risk reduced in May 2016 to 3x3 = 9 4. End of Life Oversight Group. 5. Working Groups work programmes monitored through the End of Life Oversight Group to ensure delivery of actions. 6. National Care of Dying Audit outcome for Trust demonstrate above average compliance with the 5 clinical quality indicators reviewed. 7. 7 day per week palliative care nursing and Consultant service implemented in June 2017 ORC Adult service. 8. Implementation of 'Comfort' observations for patients recieving EoLC across ORC plans to extend to WTWA. 9. Participation in National Transformation programme ACP and Rapid Discharge, Participation National Dying Matters Week. 10. Feedback cards for patient relatives in place on ORC, complaints review by EoLC Matron. 11. NHSI/NHE Supportive Review Visit in July 2018, positive feedback with areas of harmonisation work identified.	Audits completed as follows: Care of Deceased Adult Care of Deceased Child/Young Person Audit of Adult priorities of care individualised care plan standards Audit of Child/Young Person invidualised care plan standards Results from National End of Life Care Audit in Adult patients demonstrates good compliance with standards. End of Life Care Dashboard (adults) Internal Review - postive results Completion of Adult Morturay corridor and 'offices' works Divisional work plans in progress to address variation in EoLC	4 2x2

Risk Reduction Plan

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Implemenation of End of Life Strategy and work programmes Development of mechamisms to gain feedback from families in relation to end of life care	Sue Langley, Director of Nursing	Q3 2018	Quality and Safety Committee	Assurance that EoLC is consistently high quality and evidenced based across all care settings	Work programmes progressing in line with expected delivery dates. Workshop held in June 2018 to plan harmonisation across Adult and Babies, Children and Young Peoples Groups covering adult inpatient and community and RMCH MCS. 2 Palliative Care Consultants appointed in line with CQC recommendations. Positive MIAA audit report highlighting good practice. Work to develop patient experience feedback mechanisms progressing - patient stories collected and feedback cards introduced. Work planned to align EoL strategies across MFT. NHSI invited review of EoL and palliative care in July 2018 - report received in August citing "many areas of excellent practice and professional and passionate staff committed to delivering excellent EOLC to patients and their families". Recommendations relate to the continued integration of audits and standards. A focus group has been set up with relevant teams to seek their views on the EoL symbol and setting of standards. August 2018 - in view of progress and assurance, risk reduced to from 3x2 = 6 to 2x2 =4.

Principal Risk: If the care provided to patients is not responsive to their individual needs and the environment is unsuitable, this could impact negatively on patient experience, outcomes and reputation			Enabling Strategy			Associated Committee		
			Quality and Safety Strategy			Quality and Safety Committee		
			Lead Director			Operational Lead		
			Chief Nurse			Corporate Director of Nursing		
Inherent Risk Rating Impact / Likelihood	**Consequences**	**Controls**	**Current Risk Rating Impact / Likelihood**	**Gaps in Control**	**Gaps in Assurance**	**Potential Assurance**	**Positive Assurance**	**Target Rating Impact / Likelihood**
12 **4x3**	Adverse patient experience Damage to the Trust reputation Failure to comply with regulatory standards	1. Corporate and hospital/MCS/MLCO Quality governance and delivery structures. 2. Patient Environment of Care Group supported by relevant expert groups oversees delivery of work programme and monitors impact through patient feedback mechanisms. 3. Contract monitoring focused on patient experience outcomes. 4. Monitoring and reporting systems in place for complaints, concerns and compliments. 5. MFT Compliments, Complaints and Concerns Policy ratified by Quality and Safety Committee on 2nd August 2018. 6. Complaints management guidance provided to Hospitals/Managed Clinical Services. 7. Performance regarding over 41 day complaints cases monitored through AOF. 8. Improving Quality Programme in place across the Trust. 9. What Matters to Me Patient Experience programme established.	**6** **3x2**	1. Patient experience programme - What Matters to Me - still embedding across Wythenshawe and Withington Hospitals.	1. Scores are below average for food and aspects of discharge in national inpatient survey (2017).	1. Reports to Quality & Safety Committee. 2. Performance reporting to BoD and Quality and Performance Scrutiny Committee. 3. Internal and external Patient survey results. 4. MFT Quality Care Rounds and WMTM (Patient Expereince) survey data. 5. Joint audits of compliance with standards with Sodexo. 6. Accreditation outcomes. 7. Outcomes of the Quality Reviews reported to Board of Directors. 8. Harm free care data monitored and reported through Hospital/Managed Clincal Service governance systems and to Professional Board. 9.Reports to the Board of Directors and its sub-committees on progress and results of the Accreditation Programme. 10. External reports such as CQC assessment. 11. Friends and Family Test data. 12. Reports to Professional Board.	1. Improvements in care evident from Quality Care Rounds and Patient Experience survey data. 2. Accreditation outcomes 3.SHINE walkarounds Senior Leadership Walkrounds	**6** **3x2**

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Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Embed Patient Experience Framework - WMTM across MFT Refresh Brilliant Basics and Keep Me Safe Programmes to align with patient experience programme Deliver Dining Action Plan Deliver Enviroment of Care Group work programme	Hospital Directors Deputy Chief Nurse and Assistant Chief Nurse (Quality, Professional Practice and Cancer)	Mar-18	Quality and Safety Committee	Improve areas of patient experience that consistently score below average in national patient surveys	Good engagement with, and spread of What Matters to Me (WMTM) approach to patient experience - from staff and patients. Series of engagment sessions undertaken with Wythenshawe, Trafford, Altrincham and Whithington Hospital teams to further develop WMTM for MFT. Ongoing improvement plan for food and nutrition. Draft Nutrition and Hydration Strategy completed for review by Quality and Safety Committee. Two FM Matrons in post on Oxford Road campus and FM Matron in post for WTWA (FM Matron Team totals 3wte) enabling dedicated leads for food/nutrition and environment. The per centage of patients who indicate a positive experience in response to Quality Care Round survey questions about food and nutrition continues to exceed 90% across MFT against a target of 85%. Patient Environment of Care Group terms of reference revised to ensure Trust-wide representation and work programme developed to include all hospitals/Managed Clinical Servcies. New Quality Care Round and What Matters to Me (Patient Experience) survey system implemented with effect from April 2018. Survey questions reviewed and aligned to National Patient Surveys. MFT accreditation programme commenced in May 2018. Wythenshawe Hospital complaints backlog now addressed with five remaining cases being actively managed. MFT Quality and Safety Strategy ratified by BoD in July 2018 follwoing recommendation by Quality and Safety Committee.

Principal Risk: If we do not have an embedded transformation programme we will not be able to deliver the clinical integration benefits and improve the experience and services for patients at the scale and pace required			Enabling Strategy			Associated Committee		
			Transformation strategy /Quality Strategy/OD&T Strategy			Transformation Operational Board		
			Lead Director			Operational Lead		
			Chief Operating Officer			Group Chief Tranformation Officer & Deputy Group COO		

Inherent Risk Rating Impact / Likelihood	Consequences	Controls	Current Risk Rating Impact / Likelihood	Gaps in Control	Gaps in Assurance	Potential Assurance	Positive Assurance	Target Rating Impact / Likelihood
6 3x2	We do not deliver improved quality, experience or the financial savings. We will not deliver sustainable change at the pace and scale required.	Transformation annual plan approved by BODs with quarterly progress report to TMB and BODs Monthly Divisional Reports Monthly Transformation Operational Board Updates to Quality Committee & Finance Scrutiny Committee Quality Gate Reviews PMO Governance Process PIDs with KPIs and measurements	6 3x2	Lack of upto date benchmarking information to assess against peers and identify/assess areas for opportunities. Ability to routinely measure progress against SAFER, elective and outpatient standards as data is not automated.	Membership of Dr Foster tools reduced. Work ongoing with informatics to ensure meansurement.	Shelford Transformation Network used to benchmark specific measurements Contribute to NHS Benchmarking Projects Annual Trust Capacity Tool designed to benchmark through HES data Get It Right First Time programme	n/a	4 2x2

Risk Reduction Plan

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Group: Implement complex integration projects to deliver clinical and financial benefits Hospital / MCS: Embed SAFER, elective and outpatient standards	Chief Transformation officer CEOs	31/12/2018	Operations and Transformation Oversight Board	Standards to become business as usual	Updates on progress presented to Quliaty Committee.

4	**Strategic Aim:** To achieve financial sustainability

Principal Risk: If the Trust fails to consolidate financial recovery achieved by CMFT/UHSM and /or to meet further annual efficiency challenges as these arrive then the Trust may not be financially sustainable.	**Enabling Strategy**	**Associated Committee**
	-	Finance Scrutiny Committee & Risk Management Committee
	Lead Director	**Operational Lead(s)**
	Chief Finance Officer	Hospital Finance Directors

Inherent Risk Rating Impact / Likelihood	Consequences	Controls	Current Risk Rating Impact / Likelihood	Gaps in Control	Gaps in Assurance	Potential Assurance	Positive Assurance	Target Rating Impact / Likelihood
20 5x4	Breach of Control Total leading to loss of Sustainability Funding would significantly jeopardise the ability to invest in and sustain improvments for patients	1. 2019/19 Control totals at hospital/MCS level have been agreed at Finance Scrutiny Committee (FSC) on 5/9/18 2. Hospital/MCS forecast for months 6-9 have been reviewed and challenged by CFO/GDoF 3. FSC has reviewed progress against control totals both YTD and Months 6-9 forecasts at a hospital/MCS level on 5/9/18 4. CEO and DoF of MRI have presented plans and progress update against their delivery plan at FSC in March & September 2018 5. Hospital/MCS' with deficit Control Totals have provided first outlines of plans to complete recovery to breakeven within one or two year period as appropriate 6. All delivery plans continue to benefit from structured Quality Impact Assessments at Hospital/MCS, which are further QA'd at Group level	20 5x4	None	None	Each month the Hospitals/MCS are assigned an AOF rating against the finance domain based on their performance, which determines the level of proress recognised, intervention and support required	An extensive framework of review, challenge and escalation is fully embedded within the organisation	**12** **3x4**

Risk Reduction Plan

Key Actions	Responsibility	When	Monitoring	Planned Outcome	Progress Evaluation
Sustained delivery against forecast trajectories remains critical to risk reduction. Progress against delivery will be examined at Finance Scrutiny Committee.	Hospital Leadership Teams	Monthly	Finance Scrutiny Committee	-	-

Principal Risk: The Trust remains at a lower level of digital maturity than its ambition in order to support Trust strategy. Risk: MFT/000920			Enabling Strategy New Strategy to be confirmed. Lead Director Group Chief Informatics Officer			Associated Committee Group Informatics Strategy Board Operational Lead Group Chief Informatics Officer , Corporate Directors and Hospital CEO's		
Inherent Risk Rating Impact / Likelihood	**Consequences**	**Controls**	**Current Risk Rating Impact / Likelihood**	**Gaps in Control**	**Gaps in Assurance**	**Potential Assurance**	**Positive Assurance**	**Target Rating Impact / Likelihood**
12 **4x3**	Trust remains at a lower level of digital maturity than its ambition, impacting on delivery of benefits, patient care and reputation	Monitoring of * Delivery of Informatics Plan. * Benefits Realisation - Qualitative and Quantitative. * Digital Maturity index for Trust. * Integration Steering Group monitoring of Informatics PTIP Plan. * Strategic Business case approved. * Procurement has commenced for strategic EPR solution. * Trust Board EPR Task & Finish Committee has been established for Gateway Approval	**6** **3x2**	Change in external landscape	The significant workload to understand the landscape of the 2 organisations and the planned programmes of work.	Introduction of SHS Informatics Governance in 2018/19 Group Management Board approval made in January 2018 to go to Open Procurement for an EPR. Strategy work commissioned for expected completion by end of October 2018.	Monitoring against HIMSS digital maturity Index. Regular updates to Hospitals and Group. Informatics Membership on Boards. Informatics PTIP Reporting	4 2x2

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Robust Monthly Monitoring against plans Good development work with both EPR Tactical Business cases going through the approval process. EPR Innovation Council is being set up.	Group Chief Informatics Officer	Monthly	Group Informatics Strategy Board	Achieving priority	as per controls

5	**Strategic Aim:** To develop single services that build on the best from across all our hospitals

Principal Risk: There is a risk that commissioners will further consolidate specialised services at a national level (e.g. ACHD), where MFT is not made the designated provider.			**Enabling Strategy**			**Associated Committee**		
			Group Service Strategy / Clinical Service Strategies (in development)			Board of Directors		
			Lead Director			**Operational Lead**		
			Executive Director of Strategy			Informatics , Corporate and Hospital/MCS CEO's		
Inherent Risk Rating Impact / Likelihood	**Consequences**	**Controls**	**Current Risk Rating Impact / Likelihood**	**Gaps in Control**	**Gaps in Assurance**	**Potential Assurance**	**Positive Assurance**	**Target Rating Impact / Likelihood**
9 **3 x 3**	Loss of service leading to reduction in range of services offered within GM and, as an impact, loss of income, damage to reputation, loss of staff and reduction in research opportunities.	Involvement in the GM Partnership forums to provide a united voice on maintaining GM-based services. Involvement in strategic clinical networks Regular discussions with NHS England Medical Director Representation through the Shelford group Active involvement in Operational Delivery Networks Regular meetings with NHSE North established	**6** **3 x 2**	Management capacity within corporate team to identify ongoing risks and issues against each of the our specialised services (as flagged through quality surveillance reviews)	Feedback from MFT clinicians with local, regional or national clinical leadership roles.	Outcome of quality surveillance reviews	Status as largest provider Trust and with highest proportion of specialised services nationally Ability to offer co-located services Award of national tender for Auditory Brainstem Implantation - one of only two providers in the country	3 3x1

Key Actions	**Responsibility**	**When**	**Monitoring Committee**	**Planned Outcome**	**Progress Evaluation**
Completed the annual surveillience reviews across central and Wythenshawe sites and have made overall assessment of areas of compliance across the Group.	Strategy Team	Jul-18	Group Management Board	Have a trust wide view of compliance across all specialist services.	Completed
Work through areas of non-compliance with hospitals and MCSs as part of annual planning.	Strategy Team	Sep-18	Group Service Strategy Committee	All hospital and MCS annual plans for 19/20 will include plans for addressing compliance issues in specialised services.	Scheduled
National specialised services under review by NHSE to be analysed and individually risk rated by the strategy team as part of the corporate team's regular risk management process. This will identify specialised services viewed as being most vulnerable to consolidation away from MFT.	Strategy Team	May - December 2018	Group Service Strategy Committee	Risk rated list of specialised services under NHSE review for prioritisation and further action.	In progress
Maintain regular dialogue with NHSE contacts regarding portfolio of national clinical service reviews	Strategy Team	Ongoing	Group Service Strategy Committee	Strategy team to remain informed regarding NHSE clinical service review priorities and timescales	Ongoing

Principal Risk: The decisions made through the Greater Manchester governance structure do not align with MFT's plans for service development.			Enabling Strategy			Associated Committee		
			Taking Charge - Manchester Stategic plan			Board of Directors		
			Lead Director			Operational Lead		
			Executive Director of Strategy			Group Directors, Corporate Directors, Hospital/MCS CEOs		
Inherent Risk Rating Impact / Likelihood	**Consequences**	**Controls**	**Current Risk Rating Impact / Likelihood**	**Gaps in Control**	**Gaps in Assurance**	**Potential Assurance**	**Positive Assurance**	**Target Rating Impact / Likelihood**
8 **4x2**	Services do not develop in line with wider GM plans.	MFT representatives on SPB, PFB, Chairs' group, HR, DoFs, Director's of Strategy, Directors of Ops, JCB Executive Group etc. MFT representatives on Theme 3 Board and Theme 3 Executive PFB enables providers to engage as a group with GM Devolution Process in place for GM decision making which involves and recognises the Trust's decision making requirements Development of MFT clinical service strategy, taking GM decisions into account and forming coherent strategies for the Trust.	**6** **3x2**	Voting structures are based on majority voting (75% majority) with a single vote for each stakeholder group (NHS England, local authorities, CCGs, providers).		Reconfiguration of Theme 3 services aligned with MFT aims	MFT designated lead provider for specialist emergency care and emergency general surgery (Healthier Together) MFT (Wythenshawe) designated lead provider for urology cancer surgery (Theme 3) MFT designated lead provider for Haematological Malignancy Diagnostics Services across GM GM PACS procurement in alignment with MFT aims	3 3x1

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Continual attendance by Chair, Chief Exec, Director of Stategy at GM meetings, fully briefed by strategy team	Strategy team	Ongoing	Board of Directors	Ongoing ability to influence GM decisions that impact on MFT	Ongoing
Develop the MFT clinical service strategy and underpinning service level strategies.	Strategy team	Dec-18	Group Management Board	A MFT clinical strategy that reflects GM decisions and develops an appropriate strategic vision and plans for the Trust, underpinned by detailed strategies for groups of services.	In progress

Principal Risk to Key Priority: If there is a lack of clinical buy-in this could impact negatively on the achievement of single services			Enabling Strategy			Associated Committee		
			Transformation Strategy and Leadership and Culture strategy			SHS Programme Board		
			Lead Director			Operational Lead		
			Joint-Medical Director			Group Deputy Director of Workforce & OD		
Inherent Risk Rating Impact / Likelihood	**Consequences**	**Controls**	**Current Risk Rating Impact / Likelihood**	**Gaps in Control**	**Gaps in Assurance**	**Potential Assurance**	**Positive Assurance**	**Target Rating Impact / Likelihood**
6 **3X2**	Failure to achieve clinical buy-in could mean that although the Trusts technically become a single organisation, the clinical staff do not work together and become single teams functioning as single services.	Clinical engagement sessions held in early phases of review that led to the recommendation of SHS in order to increase collaboration across Trusts Appointment of clinical leads in SHS team Clinical engagement in development of clinical services framework Clinical engagement in development of single service models for individual specialties Creation of clinical structure for SHS that facilitates collaboration across sites and agreement on single service models Clinical Advisory Group established. OD programme in place Operations and transformation working group established that incorporates OD elements Appointment of Joint Medical Directors to Board Clinical representation on the Values and behaviours steering group	3 3x1	Feedback that key information and messages relating to the new organisation are not being cascaded fully to clinical teams	History of failed attempts at collaboration. No routine mechanism to assess attitude to merger	Lessons learned from previous service mergers Results of next quarterly staff online pulse check surveys.	Positive feedback on values and behaviours work through ACE day cascade. Feedback from engagement events (SHS updates to BoD) Level of clinical involvement in SHS events (SHS updates to BoD) Areas where clinicians are already working together - cardio-respiratory, urology (theme 3), vascular (theme 3), Progress with Healthier Together (SD update to BoD) Medical engagement scores in Staff survey and where possible pulse checks. Clinical staff have been involved in shaping the new organisational values and behaviours Senior clinicians are included in the new organisational values video In Q1, 68% (+4% on Q4) of medical staff agreed that they had frequent opportunities to show initiative. 73% of medical staff agreed that they were able to suggest improvements in their area of work (+8%). 52% of medical staff reported that they were able to implement improvements (+1%).	3 3x1

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Values and behaviours work shared and discussed via quarterly ACE days and poll	OD team and divisional management teams	End Sept - start nov	SHS Programme Board	Development of the right culture and behaviours to deliver the Trust's strategy in the new organisation.	Completed
Information and messages relating to the merger shared with newly qualified consultants as part of the NACs programme.	OD team and Medical Directors	12th October	SHS Programme Board	Continued staff awareness of and engagement in activites relating delivering the benefits of the merger. Opportunity to identify and address staff concerns.	Completed
Staff engagement events with briefings from the Chief Executive	Communication team	September to October	SHS Programme Board	Continued staff awareness of and engagement in activites relating delivering the benefits of the merger. Opportunity to identify and address staff concerns.	Completed
Staff engagement sesssions led by Executive Directors	OD team	Tranche 1: August - September Tranche 2: October - November	SHS Programme Board	Continued staff awareness of and engagement in activites relating to delivering the benefits of the merger. Opportunity to identify and address staff concerns.	Completed
Delivering tailored support to 27 teams that make up the 'Operational and Transformation project list'	OD, transformation and SHS teams	Ongoing	Transformation & Operations Oversight Committee	Rapid delivery of benefits relating to the merger.	Ongoing and aligned to clinical strategy development
Opportunity provided to share and discuss values and behaviours work with all staff during NHS Change week	OD team	Week commencing 13 November	SHS Programme Board	Development of the right culture and behaviours to deliver the Trust's strategy in the new organisation.	Completed
Circulate enabling strategies (Transformation and Leadership and Culture) during NHS Change week	OD and transformation teams	Week commencing 13 November	SHS Programme Board	Awareness of and engagement in implementing strategies for delivering benefits of the merger.	Completed
Values and behaviours framework developed by hospital leadership teams to be approved at GMB (May 2018)	OD team	21st May 2018	Workforce & Education Committee	MFT values & behaviors framework to support the development of the organisation's culture	Completed
New timetable of CEO Staff Engagement Events	Communication team	6 Monthly	Workforce & Education Committee	Supporting staff - listening and continuing engagement, encouraging creativity	Ongoing

6	Strategic Aim: To develop our research portfolio and deliver cutting edge care to patients

Principal Risk: If there is a failure to secure Genomic Laboratory Hub designation then there could be loss of staff, reduced income and an negative impact on reputation			Enabling Strategy -			Associated Committee: Group Service Strategy Committee & Research Effectiveness		
			Lead Director: Joint Medical Director			Operational Lead: CEO - Saint Mary's Hospital		
Inherent Risk Rating Impact / Likelihood	**Consequences**	**Controls**	**Current Risk Rating Impact / Likelihood**	**Gaps in Control**	**Gaps in Assurance**	**Potential Assurance**	**Positive Assurance**	**Target Rating Impact / Likelihood**
5 5x1	Risk to clinical income. Loss of key clinical academic staff. Impact on research standing. Weakens Precision Medicine proposition. Loss of commercial opportunities.	Genomics Division Leadership Team Saint Mary's Management Team North West Genomics Strategic Partnership Board	**10** **5x2**	Reliant on external partners to support bidding process and subsequent service delivery if successful in securing GLH status.	*Redacted - Commercially sensitive)*	*Redacted - Commercially sensitive)*	Bid to secure GLH status submitted with the written support of relevant external partners. *(Redacted - Commercially sensitive)*	5 5x1

Risk Reduction Plan

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
1. Establish mobilisation and contract negotiation operational group to handle anticipated contract negotiation and mobilisation of GLH in anticipation of contract award.	1. Ian Daniels	1. 2018 Q3	1. Saint Mary's Hospital Management Board	1. Secure designation by NHS England as one of 7 national genomics laboratory hubs.	Governance paper to support the formation of an Operational Delivery Group to manage contract negotiations and mobilisation has been written and shared with stakeholders.
2. Appoint key GLH roles on an interim basis to oversee contract negotiation and mobilisation.	2. Ian Daniels	2. 2018 Q3	2. Saint Mary's Hospital Management Board	2. Provide NHS England with confidence that the Trust is preparing to mobilise the GLH.	

7	**Strategic Aim:** To develop our workforce enabling each member of staff to reach their full potential.

Principal Risk: If the OD Strategy and therefore a high performing, inclusive and values based culture that increases organisational resilience and agility and City of Manchester system leadership and integration (LCO) is not implemented then quality, safety and patient experience may be compromised.			**Enabling Strategy**			**Associated Committee**		
			OD Strategy			HR Scrutiny Committee		
			Lead Director			**Operational Lead**		
			Executive Director of Workforce & OD			Group Deputy Director of Workforce & OD		
Inherent Risk Rating Impact / Likelihood	**Consequences**	**Controls**	**Current Risk Rating Impact / Likelihood**	**Gaps in Control**	**Gaps in Assurance**	**Potential Assurance**	**Positive Assurance**	**Target Rating Impact / Likelihood**
12 **3x4**	1. Insuffient number of high calibre leaders for business critical roles 2. Poor culture (including leadership) undermines Trust performance 3. Unable to maximise the organisational opportunities offered by the Manchester Transformation agenda 4. Low functioning teams impacting on the quality of care 5 Poor staff engagment and therefore low advocacy and impact on patient care	Deputy Group Director of Workforce and OD lead and set clear objectives for OD&T team Leadership and Culture Strategy and implementation plan approved Appraisal policy in place and quality standards monitored Service level Workforce Plans in place Accountability Oversight Frameowrk with KPIs to measure performance Hospital/MCS Directors of HR & OD and team in place to support local Managers and Leaders. People Management Skills programme in place Programme to build effective teamworking in place	**9** **3x3**	1. No Systematic Values Based Recruitment process 2. No Talent Management and succession plans	1. No Systematic application and monitoring of a talent management process. 2. Not testing systematically values at recruitment 3. Poor HR I.T. systems to support monitoring and lack of informatics expertise.	1. Accountability oversight framework 2. Staff engagement in hospital/turnaround and transformation programmes reported to HR Scrutiny Committee and Transformation and Operations Oversight Committee 3. Leadership development outputs reported to HR Scrutiny Committee and Transformation and Operations Oversight Committee 4. Speak Out campaign reported to Clinical Effectiveness Committee 5. Appraisal training - HR Scrutiny Committee 6. Pulse Checks results reported into HR Scrutiny Committee	1. Above national average for Staff Engagement 2. Above the national average for staff advocacy rates 3. Staff attendance on leadership and management programmes 4. 90 % compliance with appraisals 5. Transformation Case studies and assurance reported to the Operations and Transformation Group 6. 90% compliance with Clinical Mandatory training 7. 90% compliance with Corporate Mandatory training 8. Assurances for all of the above are reported to HR Scrutiny Committee and Trust Risk Committee	**6** **2x3**

Risk Reduction Plan

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
1 Complete Phase 3 of NHS Improvement Culture Programme to develop Leadership and Culture Strategy 2. Secure investment from Transformation fund for implementation of intergration OD plans 3. Implement actions arising from 2017 staff survey & pulse checks 4. Finalise development and embedding of values and behaviours in line with integration plans and leadership and culture strategy 5. Continue quarterly pulse checks to monitor staff experience 6. Expand delivery of VBR incrementally within current capacity and capability 7. Support Hospitals with the implementation of staff engagement and medical engagement programmes 8. OD& T Business Plan 2018-19 9.. Implement Leadership & Culture Strategy	HR/OD&T	Mar-19	HR Scrutiny Committee	Maintain the 2017 response rate to Staff Survey Improve Staff engagement score to above average Number of key findings in the staff satisfaction survey scoring above average increased	•Leadership and Culture strategy ratified by the Board in Nov 2017 - Locality OD team in place -Values and behaviours Framework will be finalised and launched- Single MFT pulse check administered for Q1 - staff engagement sessions in place - plan to improve Appraisal complaince in place In the 2017 Staff Survey the former CMFT and UHSM were both benchmarked as 'average' for Staff Engagements. For staff advocacy rates the former CMFT was benchmarked as 'average' and the former UHSM was benchmarked as 'Above Average' - 90% Target compliance achieved for both types of Mandatory training at the former CMFT site - a common reporting process across MFT being established for 2018/19.The 2018-19 Q1 •Pulse Check saw an increase in the oversall Staff Engagement score for the Group to 3.84 (3.79 in Q4 2017-18). This is in line with the final pre merger Pulse Check score (Q2 2017-18). The score for all three componets of engagement - advocacy, involvement in change and motivation all saw an improvement to their score. • Policy Development group established. Joint working with Trade Unions to produce single set of policies for MFT. • Engaged TMP to support with consultant hard to fill posts, campaign to focus on attraction and media platforms

Principal Risk: If the organisation is unable to deliver the best quality assured education and training then workforce capability and capacity, quality, safety and patient experience may be compromised.			Enabling Strategy			Associated Committee		
						Strategic Education and Workforce Committee		
			Lead Director			Operational Lead		
			Executive Director of Workforce & OD			Group Deputy Director of Workforce & OD		
Inherent Risk Rating Impact / Likelihood	**Consequences**	**Controls**	**Current Risk Rating Impact / Likelihood**	**Gaps in Control**	**Gaps in Assurance**	**Potential Assurance**	**Positive Assurance**	**Target Rating Impact / Likelihood**
12 **4x3**	1. capability and capacity compromised- leading to poor performance and poor quality of care 2. Lack of flexibility to change and implement quality improvements 3. staff vacancies and diffuclt to fill critical posts 4. high turnover 5. lack of innovation 6. Limited succession planning 7. Negative impact on Trust reputation	1. Learning and Education Policy 2.Induction and Mandatory Training Policy 3. Learning and Development Agreement 4. Education Quality Review process (Medical) 5. University, Deanery and GMC surveys 6. Leadership and Mangement Development Programmes 7. Apprenticeship Strategy in place 8. Workforce and Education Committee Established 9. Nursing and AHP Workforce Group	**12** **4x3**	1. Consistent and collective education and training evaluation process 2. Integrated Learning and Education Strategy 3. Lack of consistent and collective training needs analysis process 4. Workforce planning process not fully embedded 5. Unclear of impact of post bursery and education funding gaps	1. Assessment of quality of education and training provided by OD&T 2. Organisational Training needs analysis beyond mandatory training. 3. Development of national standards for Apprenticeships and impact levy spend	1. Cross professional learning and education monitored and reported to HR Scrutiny Committee via the Workforce and Education Committee 2. Apprenticeship programme monitoterd and reported to the Apprenticeship Steering Group and into the Workforce and Education Committee and HR Scrutiny Committee 3. Medical Education Board 4. GM Nurse Associate Partnership and PMO 5. individual professional risk registers 6. Healthcare Science Workforce Group	1. Meeting our staff retention targets 2. Above the national average for staff engagement and learning development as part of staff survey results 3. 90% compliance with Mandatory training 4. Meeting our apprentice starter target 5. Student/trainee feedback 6. GMC Surveys and benchmarks 7. Accreditation and accredited services 8. 100% of Appreciceship and Levy committed.	**8** **4x2**

Risk Reduction Plan

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
• Deliver an active and engaging Widening Participation Programme • Expand and develop apprentice programme in line with national targets and MFT strategy • Deliver actions set out in the Talent for Care strategy • Develop an MFT integrated Learning and Education Strategy • Coordinate learning and education evaluation • Ensure that the positive aspects of and improvements made to the service are communicated to staff across the Group • The GM PMO programme of work around Nurse Associate and Graduate Nurses • Deliver the N & M Workforce Group programme of work	Helen Farrington Karen Meadowcroft Margaret Kingston	Mar-18	Newly establsihed Workforce and Education Committee	• Mandatory Training compliance at 90% • Achieve national target for new apprenticeship targets • To be above average (as compared to benchmark group) for all indicators relating to pledge 2 of the staff survey 'to provide staff with personal development, access to appropriate training and education to do their jobs and line management support to enable them to fulfil their potential • To be above the national average for staff enagement • Improvements in the Junior Doctors experience where this has been identified as a requirement by the GMC/Deanery survey	Continued to deliver supported internships and pre-employment opportunities through active involvement with schools. - Nurse Associate apprenticeship programme began in April with 94 people on programme, with a further intake of 50 planned for September 2018 • Apprenticeship programme now expanded to include A&C Apprenticeships and 25 staff have successfully secured places on the new Chartered Management Degree Apprenticeship. 17 started in Jan 2018 and 8 starting in Sept 2018. Next round of recruitment has begun • All potential apprentiship opportunities being scoped out via the Apprenticeship Steering Group • Talent for Care strategy actions implemented including improving learner facilities • Workforce and Education Committee operational and being developed to lead learning and education strategy for MFT On plan to achieve the national target of 2.5% of the workforce on apprenticeships well in advance of the 2020 timeline - currently on 414 apprenticeship starts against a target of 460 • A new integrated Level 1 Mandatory Training programme developed and implemented since May . Compliance exceeding target at 91% • Process to produce MFT Education Stategy in development

Principal Risk: If there is a loss of funding for teaching for Undergraduate Education,(SIFT - Service Increment For Teaching) and/or changes made to the training programme by the University this could result in a reduced ability to fund the infrastructure required to deliver high quality education.			Enabling Strategy			Associated Committee		
			-			-		
			Lead Director			Operational Lead		
			Joint Medical Directors			Associate Director (Operational) Medical Education		
Inherent Risk Rating Impact / Likelihood	**Consequences**	**Controls**	**Current Risk Rating Impact / Likelihood**	**Gaps in Control**	**Gaps in Assurance**	**Potential Assurance**	**Positive Assurance**	**Target Rating Impact / Likelihood**
12 **4x3**	Impacts on the ability to fund the infrastructure required to deliver high quality medical education.	1. Close monitoring of income/spend 2. Reduced the overall cost of the service. 3. Prevent loss of further income	**12** **4x3**	Inability to influence the decisions made by the University re student placements	None	Monthly review of budgets with Divisional Accountant which forms the basis of a Divisional report shared with Senior finance officers . Comparison of reference cost, the results of	Feedback from yearly Student survey undertaken by the University, the results of which are sent to the Medical Director. Success rates for Medical exams - (97.35% in 16/17)	**8** **4x2**

Risk Reduction Plan

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Explore further options to reduce the cost of the service	G Terriere	Jun-17	Turnaround	Deliver 17/18 Trading gap	Achieved 01/04/17
Explore possibilities of increasing income	G Terriere	Jul-17	Turnaround	Possibility of Financial model to be introduced in 17/18	Initial discussion with Head of Medical school re amended funding model which would potentially increase the income to MFT. This has not yet been agreed by Health Education England. And therefore unlikely to have an impact om 17/18.
Explore possibility of increasing the number of students who undertake their projects at MFT	G Terriere	Jun-17	Turnaround	Increased student weeks and income	Increase in student numbers achieved which should be reflected in income for 18/19

Principal Risk: If the Trust fails to meet statutory Equality and Diversity obligations then the perceived reputation of the Trust as an employer of choice may be negatively impacted upon. Trust risk numbers - 2503C/5378U			Enabling Strategy			Associated Committee		
			ED&I Strategy			HR Scruntiny Committee/Quality Committee		
			Lead Director			Operational Lead		
			Executive Director of Workforce & OD			Associate Director of Employee Wellbeing, Inclusion & Community		
Inherent Risk Rating Impact / Likelihood	**Consequences**	**Controls**	**Current Risk Rating Impact / Likelihood**	**Gaps in Control**	**Gaps in Assurance**	**Potential Assurance**	**Positive Assurance**	**Target Rating Impact / Likelihood**
15 3x5	Negative financial impact and negative impact on MFT's Brand. Impacts ability to recruit the best staff	1. Governance reviewed to ensure clear accountability for ED&I 2.Year 1 action plan in place part of SHS programme management 3. KPI tracked at the board level on the retention of BME staff 4. Systems in place e.g. WRES, EDS 2 and Equality Impact Assessments includes 2 metrics charting BME recruitment and retention 5.AOF	**12 3x4**	1. MFT E&D Strategy not yet in place, part of year 1 plan	1. Staff behaviour, whilst supported by clear HR policies and the Values programme will continue to be a risk for any employer aspiring to be a leader in the ED&I field. 2. Resource pressures on the Trust to deliver new mandated programmes by NHS England and HT/GM 3. Not all the ED&I data is robust with gaps in monitoring and quality for specfic protected characteristics 4. We are seeing a rise in patients being abusive to our staff with a focus on racist abuse 5. Accessibility Information Standard is not consistently embedded across MFT 6. Not all relevant Staff Survey indicators average or above.	1. Action plan in place for WRES, AIS and Year 1 deliverables 2. Issues regarding accessibility are reported and monitored as the Trust Accessibility Board 3. MFT E&D Governance agreed and being established 4. Managing poor behavriour programme 5. F2SU process developed. 6. Significant increase in EQIA's across the group.	1. No further high profile Employment Tribunals have taken place - monitored by the HR teams 2. CQC report outlined progress in ED&I 3. Removed off the EHRC watch list 4. BME staff retention meeting standard retention rate 5. Relevant Staff Survey indicators average or above	**9 3x3**

Risk Reduction Plan

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
1. Deliver the actions as outlined in the E&D Action Plan. 2. Improve patient data through the Patient Profiling Working Group with Divisional Leads. 3. Improve workforce profile data through a campaign with colleagues. 4. Embed Equality Impact Assessments into all aspects of decision making. 5. Enhance the mechanism for staff to report incidents relating to ED&I through the Trusts systems, monitor and develop programmes to address key areas of concern. 6. Implement new KPI to monitor recruitment/promotion of BME staff	Associate Dir EW,I&C	Apr-19	HR Scruntiny Committee	Reduction in patient complaints & Improvement is staff survey results	- Key metrics on staff and patient engagement - New KPI built into Intelligent Board report - Pilot of trained BME managers on panel interviews for posts baded 8a and above - ED&I team redesigned to support delivery of group priorities - Workforce elements of E, D & I strategy in development following luanch workshop - Significant increase in workforce profile in relation to race equality

Principal Risk: If there is inadequate focus on: workforce information and policies, workforce design and succession planning, attraction and resourcing; staff engagement; talent and performance management this may result in a negative working environment, loss of discretionay effort, productivity and high staff turnover / vacancies			Enabling Strategy: People Strategy			Associated Committee: HR Scrutiny Committee		
			Lead Director: Executive Director of HR and OD			Operational Lead: Group Associate Director of Workforce, Quality & Governance		
Inherent Risk Rating Impact / Likelihood	**Consequences**	**Controls**	**Current Risk Rating Impact / Likelihood**	**Gaps in Control**	**Gaps in Assurance**	**Potential Assurance**	**Positive Assurance**	**Target Rating Impact / Likelihood**
12 **3x4**	Inability to attract, source and recruit the right numbers of skilled people aligned to our workforce plans and culture. High Temporary Staffing costs. Potential negative effect on staff morale, engagement and wellbeing. Inability to support the implementation of new service delivery models and maximise opportunities presented by the Manchester Transformation agenda. Increased potential for employee litigation as a consequence of TUPE/service change.	•Trust wide People Strategy against 5 deliverables delivered through detailed HR work plan that is reviewed on a quarterly basis. Underpinned by KPI's that are reported monthly to GMB and BoD • Hospital/MCS workforce plans aligned to Business plans and the People Strategy. • Hospital vacancy control panel, agency and bank expenditure financial anlaysis and reporting and compliance with NHSI agency reporting requirements. Consistency panels for consultant recruitment. • Trust wide attraction strategy for all roles. International and domestic (Proud to Care) recruitment campaigns for nursing and other hard to fill roles. Consultant recruitment campaigns for hard to fill posts and joint attraction strateg for single hospital service including North Manchester General. • Operational HR service delivered through Hospital/MCS operational teams & specialist/transactional services at group level. Comprehenisve HR policy framework in operation under review. • Working in partnership with staff side to ensure positive employment relations culture. • Electronic job planning model introduced for medical staff with comprehensive training to support implementation and identified approach to team job planning. • Introduction of new Health & Wellbeing serivce model with development of Health and Wellbeing Strategy. • Development of a Workforce Technology strategy and delivery plan which encompasses all workforce systems including the development of an Electronic Workforce Intelligence Portal (EWIP) reporting model and HR portal supporting performance data analysis. • Apprenticeship Strategy supporting the delivery of new roles and career pathways, talent management and local community attraction across the whole workforce.	**9** **3x3**	Commitment to values based recruitment practice to strengthen selection processes across all staff groups. Capacity with both HR and line managers to deliver buisness as usual and transformational change. Impact of external market forces on hard to fill posts and agency supply and cost. Low control over actions of others within wider GM. Ongoing development and refinement of HR IT systems to support monitoring & people management	Fully embedding lessons learnt in future ER practice underpinned by inadequate case management reporting system. Maintaining attendance at 96.4% -	**Reported to HR Scrutiny Committee** Reduction in bank and agency. spend to cover sickness absence. Reduction in sickness absence rates. Staff Survey & Pulse Checks. Delivery of People Strategy deliverables. **Trust wide** Hospital reviews against Accountability Oversight Framework. Quality Reviews Speak Out campaign People and Development Performance Dashboard with Workforce KPIs NHSI Agency Caps reported on a weekly basis and data monitored for compliance **Reported to Strategic Workforce and Education Committee** Workforce plans	Key metrics delivered as reported in the new People & Development Performance Dashboard and Accountability Oversight Framework. Vacancies reduce by 5% (all staff groups) by March 2019. Time taken to fill vacancies achieved revised target of 55 days in Janaury 2019. Retention of staff with over 12 months service at more than 80%. Revised target set to 89% Maintaining attendance at 96.4% or better.	**6** **2x3**

Risk Reduction Plan

Key Actions	Responsibility	When	Monitoring Committee	Planned Outcome	Progress Evaluation
Comparative assessment of HR IT solutions and systems between sites for HR areas of practice and development of visiosn for HR systems for the single hospital service. Continue to develop managers' competence and capability on people management issues. Further development of the HRBP model to support managers through the provision of advice, guidance and information. Ongoing development of workforce planning and data collection and analysis via ESR, including automation of operational processes to improve efficiency of service delivery. Further development of e-Wip and ESR to support the production of meaningful workforce intelligence including the launch of the HR Console for key performance metrics. Develop resources to equip the Trust to plan and implement organisational and system wide change, including development of a suite of HR tools to support collaborative management arrangements and integration. Delivery of Proud to Care nurse recruitment campaigns using social media and engaging candidates strongly in the organisation at an early stage. Refresh of the Trust's Workforce Strategy (Q2/3) following integration of hospitals and evaluation of new HR model for delivery with resource, capacity and capability to deliver the Workforce strategy. Support to targeted work programmes for maintaining attendance with identified staff groups. Delivery of competence and values based selection processes on an incremental scale within current capacity and capability. Introduce modern approaches to attraction and selection that will enhance our position as an employer of choice in the market, both local, national and international. Review of consultant recruitment processes to enhance the candidate experience, revisit the investment proposal for nehanced consutlant recruitment processes and, if investment secured, consider the application of values based recruitment. Develop and implement the new employee health and wellbeing delivery model and strategy. Develop framework to integrate learning from employee relations cases.	HR/OD&T	Planned phased delivery throughout 2018/19	HR Scrutiny Committee. Operational Workforce Committee. Strategic Workforce and Education Committee HR Performance & Governance Group Governor Staff Experience Group	Compliance to Divisional and Trust sickness absence trajectories/targets Maintain the staff response rate (Staff Survey) to ensure it is either equal to or above the national average. To be above average (as compared to benchmark group) for all indicators relating to pledge 3 of the staff survey 'To provide support and opportunities for staff to maintain their health, wellbeing and safety'. Ongoing delivery of efficient and effective NHS compliant recruitment practice. Vacancy rates reduced to 5% through planned and coordinated recruitment campaigns and processes and the delivery of strong retention interventions. Agreed approach to managing workforce issues across integrated services supported by HR protocols and operational guidance. Clear understanding of health and social care workforce resource and development requirements. To achieve improvements in performance against key metrics as defined in the Workforce Strategy. Positive employment relations culture.	HR Work Plan18/19 The 2018-19 Q1 Pulse Check saw an increase in the oversall Staff Engagement score for the Group to 3.84 (3.79 in Q4 2017-18). This is in line with the final pre merger Pulse Check score (Q2 2017-18). The score for all three componets of engagement - advocacy, involvement in change and motivation all saw an improvement to their score. • Policy Development group established. Joint working with Trade Unions to produce single set of policies for MFT. • Workforce Technology strategy and delivry plan developed. Programme Board established to track and monitor progress • Engaged TMP to support with consultant hard to fill posts, campaign to focus on attraction and media platforms • Employee relations oversight group established to provide oversight, triangulation and analysis of cases and to learn lessons as appropriate • Developing revised AAC process for consultant recruitment • Temporary staffing programme board in development to oversee policy and process development Revised EHWB model being implemented

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS' MEETING
(MEETING IN PUBLIC)

TO BE HELD ON MONDAY, 10th SEPTEMBER 2018
AT 2.00PM IN THE MAIN BOARDROOM

A G E N D A

1.	Apologies for Absence	
2.	Declarations of Interest	
3.	Patient Stories	*(DVD)*
4.	To Approve the Minutes of the Board of Directors' meeting held on 9th July 2018	*(Enclosed)*
5.	**Matters Arising**	
6.	**Chairman's Report**	*(Verbal Report of the Group Chairman)*
7.	**Chief Executive's Report**	*(Verbal Report of the Group Chief Executive)*
8.	**Operational Performance**	
	8.1 To Consider the Board Assurance Report	*(Summary Enclosed)*
	8.2 To Receive a Progress Report on the Single Hospital Service	*(Report of the Director of SHS Enclosed)*
	8.3 To Receive the Group Chief Finance Officer's Report	*(Report of the Group Chief Finance Officer Enclosed)*
9.	**Strategic Review**	
	9.1 To Receive an Update on Strategic Developments	*(Report of the Group Executive Director of Strategy Enclosed)*
	9.2 To Receive an Update Report on the Manchester Local Care Organisation	*(Report of the Chief Executive MLCO Enclosed)*
10.	**Governance**	
	10.1 To Receive an Update Report on the Regulatory Assessment Process 2018/19	*(Report of the Group Chief Nurse Enclosed)*
	10.2 To Receive the Q1 Complaints Report (2018/19)	*(Report of the Group Chief Nurse Enclosed)*
	10.3 To Receive an Update Report on 'Never Events' Action Plans to Mitigate Risk of Recurrence	*(Report of the Joint Group Medical Director Enclosed)*

10.4 To Receive an Update Report on the 'Freedom to Speak Up' Programme (2018) *(Report of the Group Executive Director of Workforce & OD Enclosed)*

10.5 To Receive a Report on the Patient Experience Annual Review (inc. Patient Surveys; Friends & Family Test, and, 'What Matters to Me') *(Report of the Group Chief Nurse Enclosed)*

10.6 To Receive a Report on the Gosport Inquiry Report *(Report of the Joint Group Medical Director Enclosed)*

10.7 To Receive a Report on Compliance with the Implementation of the Kirkup Recommendations *(Report of the Group Chief Nurse Enclosed)*

10.8 To Accept the Board Assurance Framework (September 2018) *(Report of the Group Executive Director of Workforce & OD Enclosed)*

10.9 To note the following Committees held meetings:

10.9.1 Group Risk Management Committee held on 2nd July, 2018

10.9.2 Audit Committee held on 23rd May, 2018 and Part 2 meeting held on 4th April 2018

10.9.3 Quality & Performance Scrutiny Committee held on 9th July and 6th August, 2018

10.9.4 HR Scrutiny Committee held on 7th August, 2018

10.9.5 EPR Task & Finish Group held on 6th August, 2018

10.9.6 Charitable Funds Committee held 9th July 2018

11. Date and Time of Next Meeting

The next meeting will be held on **Monday 12th November 2018** at **2pm** in the **Main Boardroom**

12. Any Other Business